Report on Outcomes from Independent National Whistleblowing Officer Engagement Events

Tracy Boylin, MCIPD

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EXECUTIVE SUMMARY

Background

E1 The Cabinet Secretary for Health and Sport announced in 2015 that the role and functions of an Independent National Whistleblowing Officer (INWO) for NHS Scotland would be established. This was in direct response to the recommendations which came out of the Freedom to Speak Up Review, chaired by Sir Robert Francis QC. Although the Review was related entirely to NHS England, it provided independent advice and recommendations aimed at creating an open and honest reporting culture.

E1.1 Following this announcement the proposed role and remit for the INWO were the subject of a full public Scottish Government consultation from November 2015 to February 2016. 58 responses were received, the majority of which were from health-related organisations and individuals. The proposals outlined in the consultation were welcomed with strong support.

E1.2 The consultation identified The Scottish Public Services Ombudsman (SPSO) to be the preferred host to undertake the new role and functions of the INWO. The Scottish Government engaged closely with the SPSO following this outcome to start to develop and consider the policy, powers and model required for the role to be effective.

Scope and content of the workshops

E1.3 The Scottish Government commissioned Tracy Boylin to run four workshops, which were held with a total of 39 delegates attending. Delegates included 14 whistleblowers; academics; staffside representatives; HR Directors and Deputy Directors; and, Non-Executive Whistleblowing Champions. In addition Rosemary Agnew, the Ombudsman attended one of the workshops and also a deputy from the National Guardians Office in England. All four workshops were facilitated by Tracy Boylin, the author of this Report, and officers from the Scottish Public Services Ombudsman assisted facilitating the separate table discussions and ensuring all delegate views were captured. Officers from Scottish Government attended each day to provide context in terms of the background and rationale for these workshops and to oversee the smooth running of the arrangements for the workshops. Appendix A shows the session plans and areas the workshop covered. When setting out and planning the workshops it was also considered relevant not to lose the information already received from the Consultation responses and to reflect and consider this alongside the outcomes from the Workshops.

E1.4 Twenty six evaluation forms were completed and handed in by delegates. 13 delegates thought the workshops were good and 13 rated them as excellent. A mini evaluation report compiled by the Scottish Government is attached at Appendix B.

E1.5 The workshops, as can be seen from the session outline in Appendix A, focussed on the key areas of the proposed role and remit of the INWO. Delegates welcomed the opportunity to engage and assist in informing the process. This led to constructive feedback and good ideas from all delegates. This report is informed by the responses of the delegates who attended the workshops along with the additional information from the earlier consultation and therefore may not and cannot necessarily represent the views of a wider population. The workshops were also held under Chatham House Rules and delegates could add their views to the anonymised feedback the facilitator was taking at each table. There was also the opportunity to complete post-it notes with views and to leave them for collection in the workshop venue. Therefore, in terms of allocating actual percentages from delegates to the views collected from each workshop, it is not possible for the purposes of this report. All that can be provided is a summary of delegate feedback at the end of each discussion. This represents what many of the delegates were feeding back or just a small number.

1 INTRODUCTION

Scope and Challenge of the Independent National Whistleblowing Officer role

1.1 Under the current system there are practical challenges that both Whistleblowers and Health Boards are experiencing in drawing some cases to a conclusion where the whistleblower is not satisfied with the decision-making outcome or handling of the investigation where a concern has been raised. This was also highlighted to some extent in the consultation. It was considered therefore, that in such cases, the INWO role will address this so that potentially vulnerable NHSScotland staff, and ultimately patients, are protected, by providing an effective mechanism for external review where individual NHSScotland staff have a legitimate concern about a Health Board's handling of their case. This would include the application of the local process, decision making, and the outcome. In addition where a whistleblower claims to have suffered detriment as the result of raising a concern, the INWO will also have a role in reviewing the treatment of the individual, and in the longer term, the organisational culture. The intention is to provide closure for the individual and provide learning to improve organisational culture which would bring greater patient and staff safety and increase overall wellbeing.

1.2 To enable more culture change across NHS Scotland it was considered that the INWO will also have a national leadership role, providing support and guidance to Health Boards and promoting high standards in learning, improvement and reporting. The INWO could and would also encourage and promote good practice and highlight any concerns about internal mechanisms.

1.3 As the role is embedded it is possible that themes and recurring issues may emerge across the system. There was general consensus from delegates that the role should have a learner focus approach to cases and be able to act as a catalyst for wider cultural and system change.

Consideration of Statutory Powers

1.4 Delegates were in general consensus that for the INWO to be effective and credible it would be necessary for the INWO to have the statutory powers outlined in the consultation. However, as in the consultation there was a minority view from delegates that sufficient powers already existed in relation to the PIN policy. Therefore how the INWO acted within these powers and the process for doing so needed further consideration and input especially in relation to the PIN policy for NHSScotland. The proposed areas in terms of the considered statutory powers are as follows:

- Take evidence under oath

- Compel a public body to provide evidence
- Report publically on its findings (where appropriate and considerate of confidentiality)
- Make recommendations Report to Parliament when these recommendations are not met
- Where appropriate, refer cases to Health Boards and/or scrutiny bodies/regulators for investigation/re-investigation

1.5 Again, in principle, delegates were in agreement about the potential options identified as potential redress for the individual complainant but felt expectations had to be managed throughout the process for any of the recommendations to bring some closure. The options consisted of:

- An explanation and/or a written apology
- Reviewing a decision
- Reviewing or recommending changes to an internal process
- Improvement to general working practices within the organisation
- Suggesting mediation is considered – where this had not already done so
- Recommending that an investigation should be re-run or that an independent investigation be undertaken

Consideration of what was outside the Independent National Whistleblowing Officer role

1.6 Under the current arrangements, the SPSO cannot investigate matters at their own initiative without first receiving a complaint from the individual. Generally, it was considered that this should also be applied to the INWO role and that the complaint should be raised by the individual member of staff who had raised the concern. Delegates were in agreement that the INWO should not investigate matters on their own initiative. However, a small number of delegates in terms of building trust and confidence within their own Health Boards, raised the question that if the process was breaking down, despite the best intentions of the Health Board, could they have the option of referring the case to the INWO to review matters; or, jointly suggest to the whistleblower that they do so together in order for early intervention. This was especially if independence was proving to be the sticking point as this would allow for that independent scrutiny. This could potentially assist in resolving matters earlier before they become too protracted and relationships break down to the extent that they are not recoverable. This could form part of the exceptional circumstances where relationships and communication as a result is proving fraught and would allow for what could be deemed an appropriate early intervention process.

1.7 Delegates were in general agreement that all local procedures should have been exhausted first and that the complaint should be made within 12 months of the outcome (apart from in exceptional circumstances at the INWO's discretion). However a small number felt that the early interventions identified in 1.6 were worth further consideration.

1.8 There were mixed views from delegates about whether historic cases should be included and reviewed by the INWO. The practicalities of this were further explored with delegates around the potential lapse of time that had occurred. This included staffing changes that could prove difficult in obtaining information as well as the volume of cases potentially making this an unmanageable reality. Delegates who felt they should be included where concerned about the potential loss of learning that could be built into future processes and systems if these cases were not considered. Whether, therefore, there is a separate piece of work that could look at historic cases outside of the INWO role from a learning perspective, and appropriate outcomes shared across the wider system is perhaps worthy of some further consideration.

1.9 In addition there was general consensus the INWO should not duplicate the functions or work of the existing regulatory and scrutiny bodies (including inspections), but that it should have the ability to refer cases or matters from cases to regulators/scrutiny bodies for investigation/re-investigation. In principal despite the agreement and consensus with delegates regarding this they felt it was essential communication was key with all parties involved in the case.

2 HOSTING AND SCOPE OF THE INDEPENDENT NATIONAL WHISTLEBLOWING OFFICER ROLE

2.1 The decision to host the INWO role under the jurisdiction of the SPSO was generally welcomed by most delegates in the workshops as the right outcome. Discussions covered the views that they felt the independence of the INWO was seen as critical. The fact that this would sit outside the governance of NHSScotland most delegates felt was a key factor in ensuring that independence and enabling trust to be built with the INWO. Delegates stated they would have confidence once the role was established if they could see the process was transparent, timely and trusted.

2.2 To enable those views some delegates felt it was critical to ensure that it was totally independent of all other parts of the healthcare system in reviewing and making its findings and that by sitting within the SPSO ensured that. In particular that it was entirely separate from any operational, regulatory, financial, commissioning and procurement functions but established on a similar permanent institutional footing with powers being equal to other regulators with some delegates feeling that those powers should be more than what has been set out and identified in the consultation. Other delegates had the view that these additional powers were not required as existing mechanisms in place such as the PIN policy and existing legislation should suffice.

2.3 There was general consensus that although it should be independent of all other parts of the healthcare system that it must not duplicate the role of any existing body. However, it was felt that greater consideration and clarity was required in relation to Healthcare Professionals' professional duty to report concerns, which needs to be taken into account and reflected by the INWO when receiving concerns from whistleblowers.

2.4 In principle there was general agreement from delegates that the internal process should be exhausted first before a complaint could be escalated to the INWO. However, some delegates felt that if the process was becoming unnecessary protracted then there should be the option of raising this with the INWO at an earlier stage and flexibility was required of the INWO for this. The views from delegates around this tended to be in line with a number of the responses from the consultation.

2.5 Delegates questioned how this role and its process would apply to primary care. There was consensus that it should do but it was recognised that there were no delegates present from primary care. It was agreed that liaising with stakeholders from primary care to enable further work in this area was required and this would be taken forward by SG and SPSO.

2.6 Including the title ‘whistleblowing’ was discussed and there were mixed views from delegates on this. Although many agreed it could have some negative connotations they felt it was understood and set out clearly what the purpose of the role was. In changing culture they also felt that if success was achieved it could start to change those negative connotations.

2.7 Delegates were asked to consider the scope of the role in investigating concerns and SPSO colleagues shared that it was proposed that it followed a similar pattern to the current complaints process. This in essence meant that the role would investigate if NHS organisations had fairly applied the local whistleblowing policy, including examination on the decision making and outcomes of the concern(s) raised, and, if in raising the concern, the individual had suffered any detriment or unfair treatment. In general most delegates agreed with this, with just a small number feeling that the impact on their employment and concerns being turned into employment matters needed to also be considered. Other delegates felt that by reviewing detriment and unfair treatment that may have been suffered would in effect highlight any such issues.

3 DEFINITION OF WHISTLEBLOWING AND WHISTLEBLOWER FOR PURPOSES OF THE INDEPENDENT NATIONAL WHISTLEBLOWING OFFICER INVESTIGATION

3.1 Delegates discussed whether the legal definition of whistleblowing should be used as access criteria for staff who want to raise a concern to the INWO . Most delegates felt that this is a legal test and too difficult to prove outside a non- legalistic process and that the current definition of whistleblowing was open to interpretation. In addition, many delegates felt the Public Interest Disclosure Act 1998 (PIDA) definition wasn't wide enough to cover the health sector and risked excluding issues which were in the public interest but not reflected in the PIDA criteria. For many delegates they felt NHS staff viewed whistleblowing as the end of the process when staff had to escalate it beyond the organisation and it going public or external to the organisation in some way.

3.2 Delegates felt language was very important. The Royal College of Nursing had drafted a 'Raising Concerns' document and this was cited as good practice by some delegates and concerns being viewed as the right language to use to align with this document in the Principles and Standards. Some delegates raised the concern that PIDA also placed the burden of evidence on the employee and required them to find the evidence/information before whistleblowing. The delegates who raised this felt this was a complicated test and did not align with their duty under their codes of conduct as healthcare professionals, which is to raise any concerns they had even if they did not have evidence to be absolutely sure. There was a view from these delegates that having to meet this complex legal test under current arrangements before raising any concerns, was the factor that led to the concerns being turned into employment matters.

3.3 There was general consensus therefore by many delegates that 'whistleblowing' or 'complaints' were not good terms and 'concerns' was more understood by staff and meant more to staff. A small number of delegates however felt the term whistleblower should not be avoided and should in some way be reflected that anyone who does whistleblow, should be commended as this being a positive thing to do.

3.4 Overall delegates felt there should be no distinction between raising concerns and whistleblowing. Most delegates felt that to demonstrate they were right before raising an issue placed the onus and burden of investigation on them. They considered that it should be the responsibility of the organisation to investigate the concerns raised regardless.

Distinction between whistleblowing and employment human resource issues

3.5 There were many delegates who felt it was important for the definition of whistleblowing to distinguish clearly between raising concerns and employment issues such as grievance, bullying and harassment. Several delegates felt that if the concerns related to a clinical issue, then the remit and oversight of the investigation should not sit with the Human Resources function. Their concerns were that if Human Resources had oversight of this, then it was more likely to be linked with other policies such as grievance, capability, bullying and harassment leaving the initial clinical concern to get lost amongst those processes. Some delegates also raised that when the concern got split into areas of human resource policy along with whistleblowing policy, it meant individuals were required to go through many investigations and the differing outcomes of those investigations made the situation and overall outcome much more complex. These delegates also stated that where bullying and harassment matters were raised, it was important to assess what the underlying issues for the bullying and harassment were. If this pointed to the raising of the concern, then the scope of that should be able to be dealt with under the auspices of the whistleblowing process and investigation and not as a separate bullying and harassment process.

4 HOW THE INDEPENDENT NATIONAL WHISTLEBLOWING OFFICER SHOULD CONSIDER CASES

Whistleblowing Champions

4.1 When considering cases a small number of delegates held the view that there should be strong links between the Non- Executive Whistleblowing Champion and the INWO. These delegates also felt that when cases were still at the internal stage, that the Non-Executive Whistleblowing Champion should be the direct contact for staff who wish to raise concerns and that they should have that contact with them throughout their case. In its current assurance role they felt that staff could not put their trust in this and did not see it as independent.

4.2 Many delegates had concerns that if the role did have that contact with the whistleblower then that would potentially provide a conflict. The role is predominantly an assurance role focussing on ensuring Health Boards comply with that responsibility and systems are in place and working effectively. It is clear that as it is currently set up, the role should have no involvement in the application of the policy and that by having direct contact with individuals, this does start to raise conflict with what the role was set up to do.

4.3 The counter argument to this, by those delegates who held the view that champions should have that direct contact, raised concerns about the accuracy of information being provided to Whistleblowing Champions. They held the view that without this direct contact they will only have one side of a picture about how cases are being handled.

4.4 For the delegates who held the view that there should be strong links between the Whistleblowing Champions and the INWO, they also felt the links should be extended to any intelligence that could be gathered from the Whistleblowing Alert Line. These delegates also stated they were not clear about how Whistleblowing Champions were appointed and that this should be very clear and transparent along with robust processes for the appointments with the INWO being responsible for these appointments. In considering cases some delegates felt that there should be some form of arrangements for consulting and involving current or former whistleblowers in the case process to provide that additional perspective.

Management of distinction between whistleblowing (public interest) matters and grievance/bullying and harassment (private employment) matters

4.5 A number of delegates shared the view that there should be some form of independent scrutiny early in the process to ensure concerns were not being turned into private employment matters. These delegates stated if this was not the role of the Whistleblowing Champion then there should be some way of raising an alert about this and escalating the concern to the INWO under exceptional circumstances. In addition, these delegates also felt where there was some organisational history and evidence of poor practice and concerns being turned into employment matters, this should also fall under exceptional circumstances allowing concerns to be raised direct with the INWO. This correlated with some of the views from the consultation that stated in principle, internal processes should be exhausted first. However, where there was knowledge of poor history or culture in this area, then there was no merit letting a case run through the internal processes and it should be allowed that in these circumstances cases can be passed to the INWO to allow for early intervention under exceptional circumstances.

4.6 In order for there to be safe disclosure of the concern all delegates gave the view that more support and protection for whistleblowers was required. Delegates felt it was important for the INWO to consider this issue. An example that was given was that if internal processes were exhausted and the raising of concerns had been turned into employment matters, the lack of early intervention had often led to reputational and psychological damage. The impact of this was often long lasting and therefore early interventions or mechanisms to support this was required as part of the case consideration.

4.7 Some delegates, particularly amongst whistleblowers participating within the workshops had concerns around the interaction with Human Resources and the fact that some concerns were being wrongly classified as employment matters. Therefore, in setting the standards and any associated guidance, it felt the INWO would not only have to be clear about the difference, but also about the interaction where one leads into the other. These delegates felt that once this guidance was established, it was critical for anyone who would lead such investigations to be trained and have the appropriate expertise, knowledge and understanding of the relevance of the interaction. This was critical to Health Boards but also critical for the INWO where there could be a number of investigations running parallel under different processes and ensuring terms of reference of each did not undermine or counteract against each other.

How the INWO could investigate the treatment of the whistleblower

4.8 Timescales are often an issue for whistleblowing cases and the length and how protracted this can become was also a factor raised by many who had whistleblown. It was proposed therefore that within the standards, the timescales the SPSO currently used for complaints (5 and 20 days) would be used as a guideline. There were mixed responses from delegates regarding this. From a staff perspective delegates agreed the proposals would be welcome. From a management and staffside perspective, although delegates again felt in principal the quicker the situation could be dealt with the better, there was some real challenges to achieving these timescales. The challenges they cited included investigations were often undertaken by individuals who still had a main role to deliver within the Board and availability of representatives to accompany witnesses.

4.9 The SPSO explained that these timescales were a guide and an aim to work towards. However, as with complaints there were often occasions these timescales needed to be extended. It was explained that within this process as long as there was a good explanation of why, and that clear communication had been passed back to the whistleblower in explaining the reasons for any delays, that would be taken into consideration. In principle delegates accepted this would be a good aim to work towards as part of the standards. A small number of delegates felt that if delays for good reason were to be accepted there should be some form of advocacy support for whistleblowers which included checking they were okay from a well-being perspective and discussing any support needs which were required in the meantime. In addition to the fact that Sir Robert Francis had identified that some groups could be more disadvantaged when raising concerns the advocacy role could ensure that fairness and equity was being applied and no discrimination on any grounds was taking place.

4.10 In terms of the duty of care organisations have for staff, a number of delegates felt it was important the INWO assessed as part of the case the support put in place by organisations to ensure there was no impact on health, which included from a psychological aspect.

Role of INWO in organisational culture

4.11 In this discussion the issue of historic cases again came into the equation Some delegates felt it was critical these were reviewed and investigated by the INWO. However, a number of other delegates raised the fact that in reality this would be so difficult to do and not feasible for such cases to be included due to the lapse of time, potential volume of cases and significant changes in staffing where many key individuals may have moved on to different

organisations. Delegates remained divided on this. The ones who felt they should be included felt key learning from these cases would be missed as a result and an opportunity to inform future management of cases and changes to culture that would be required lost.

4.12 With regards to the proposal that cases should be brought to the INWO within 12 months of the conclusion of a case investigated by a Health Board the majority of delegates felt that was a reasonable and achievable proposal

4.13 Questions had been asked if it was possible to raise concerns anonymously with the INWO. Some exploration with delegates was therefore undertaken to explore how this would work in practice. On further exploration delegates mainly had the view that it should be possible to do so but that this would severely limit the effectiveness of the INWO to be able to investigate. It was felt the only potential benefit of this was potential intelligence regarding data and that potential patterns that may exist may come to light. Therefore anonymous concerns should not be disregarded.

4.14 A small number of delegates felt it was important that a national database of whistleblowing incidents was kept to again inform key culture changes that was required.

4.15 A majority of delegates felt for there to be a major change in perception and culture there should be some form of public recognition for whistleblowers who had been courageous enough to raise concerns and brought system or patient safety changes as a result. It was felt that the INWO could have a key role in this. This could assist in changing the perception of whistleblowing or raising concerns being a negative thing to do.

4.16 In addition the majority of delegates would like to see the INWO working with organisations in a positive problem solving way to identify improvements for raising concerns as themes develop from the cases they review. This concurs with comments from the consultation that intelligence gathering and the sharing of intelligence should be part of the principles to identify themes and trends that need addressing with other NHS bodies.

4.17 A small number of delegates raised that they felt that some data and information reported was not always accurate and therefore there had be some sort of process where the individual who had raised the concern got the opportunity to check the information reported for accuracy before any decisions were made by the INWO on the case. Ideally they felt this should be undertaken before any information was submitted to the INWO but if factual accuracy was disputed ideally there should be some form of independent arbitration. If this could not be achieved then there had to be some form of

record that a dispute over the accuracy of the information existed when it went to the INWO to ensure some trust in the process.

4.18 Many delegates felt it was important to obtain some further clarity on cases where recommendations were made by the INWO and how these recommendations would be monitored and recorded to ensure they were implemented. In addition, if common themes were constantly raised how these could be shared to build into lessons learned and change systems or culture going forward as appropriate.

4.19 Many delegates felt that any case management system used by NHS bodies should record when the concern was raised and then solved from their perspective. Even if there is a dispute between the whistleblower and organisation regarding this as it would demonstrate that the internal process had been exhausted. However, because of the many different routes for raising concerns currently within some NHS bodies, this further highlighted the need for a 'Once for Scotland' system for doing so. Many delegates felt that key fields within such a system would include the root cause of the concern and when it was raised so there could be some analysis and scrutiny about if it had been appropriate for these to become employment matters if they had done so.

4.20 Despite the concerns raised by delegates over Datix, with regards to culture change, some delegates still felt there was a role for both Boards and the INWO to review data and intelligence from such a system. However, it needed to be looked at alongside other intelligence from the same areas on staffing levels, absence, disciplinary, grievance and turnover.

5 FRAMEWORK FOR A WHISTLEBLOWING PROCESS

Timescales and standards

5.1 Following on from the earlier discussions this part of the workshop focussed specifically on the framework and process for raising concerns that the INWO should operate under. Having had the opportunity for some consideration of this earlier in the day, the majority of delegates welcomed the two stage process of 5 and 20 days with cases being assessed against clear standards. However, it was critical to ensure that these were the starting points and to be worked towards wherever possible. Where a case was complex or other factors could be demonstrated that showed this was not achievable, the set of circumstances relating to that case that NHS organisations were not then penalised as a result. SPSO staff advised that with complaints in those circumstances as long as individuals had been communicated with appropriately there were no criticism of organisations. This meant that a general consensus was achieved by all delegates that this should be an aim in order to stop concerns slipping into a protracted process.

Recording and reporting of all concerns raised

5.2 Delegates felt data and intelligence could play an important role in shaping, influencing and changing poor practice therefore the INWO should have systems in place for doing so. In addition, most of this intelligence would be gathered from NHS organisations.

5.3 Delegates shared the many different methods currently available within Health Boards for the raising and recording of concerns. The most common method used appeared to be by the completion of a Datix. However, this often took 30 minutes to complete and the form was too complex. Also, Datix is not universally used across Scotland and even where it is used it is not always set up and configured in the same way within each Health Board, meaning different permissions and escalation processes were in place. Furthermore, not all staff had access to the Datix system and completing these forms in confidence. Where staff did have access, confidence was not possible as often this had to be done on a computer at a busy ward station where other staff could see what you were doing.

5.4 In addition, if the two-stage process of 5 and 20 days was adopted then the recording of concerns, the investigation and responses also needed recording against these timelines along with reasons for any potential slippage and eventual timescales met. It was felt by some delegates therefore that a further piece of work was required for this with a view to agreeing a ‘Once for

Scotland system across Scotland that could be adopted by all NHS organisations.

Confidentiality and anonymity

5.5 Confidentiality and anonymity was one area that resulted in a lot of discussion. A number of delegates felt that currently there is a long way to go before staff felt able to raise concerns openly and therefore the options to do so anonymously and confidentially needed to remain but this was also currently limited. These delegates therefore felt that other options for raising concerns confidentially should be considered and cited examples such as apps and alert lines for doing so. In addition to raising concerns in this way with their Health Boards, they also felt the option to use these options with the INWO should be available. They accepted the restrictions as previously mentioned around investigation, but it still allowed them to flag up matters and as long as they were investigated as far as possible, this would be viewed as acceptable because of the restrictions.

5.6 Questions were asked if ex-employees could raise concerns with the INWO as they might feel it is safer to do so after they had left the employment. Some delegates agreed in principle this should be an option, but a time limit should be factored in. There was mixed responses from delegates about what the time limit should be which ranged from 3 months to 12 months.

6 CONCLUSIONS AND CONSIDERATIONS

Set out below is where there was mainly clear agreement during discussions. In addition areas have been highlighted that perhaps need some further consideration and there may be some additional work streams that could be considered once the INWO role is established as a result of these outcomes from the workshops.

6.1 Both from the workshops and the consultation it is fair to say all participants felt that the INWO role should include a learner focus approach to cases that could act as a catalyst for wider cultural and system change. That it should be independent of all other parts of the healthcare system in reviewing and making its findings and a similar model of principles and standards as there is for complaints would be welcomed for the reviews.

6.2 There was general consensus that statutory powers were required as proposed in the consultation with only a few feeling what was in place already was sufficient.

6.3 In principle delegates did feel that internal procedures should be exhausted first. For exceptional circumstances consideration should be given to referring matters to the INWO earlier, where it was clear from both parties this would not be able to be resolved internally and where relationships and communication was proving fraught despite best intentions. There were also views that there was some merit in Health Boards being able to refer cases to the INWO or for individuals and Health Boards to do so jointly.

6.4 It is fair to say that from opposing positions from delegates there were different views on the role of the Non-Executive Whistleblowing Champions. Once in post, it may be worth the INWO and Scottish Government undertaking a further piece of work around this role or if any additional roles are required that would have more of an advocacy type basis.

6.5 There is a clear gap identified from delegates regarding support to the whistleblower throughout the whole process to minimise any psychological impact and ensure equity and fairness for vulnerable groups. This could be considered if a further piece of work is undertaken as identified in line with 6.4. As well as whistleblowers, Health Boards do have concerns about this change and how the INWO role will work with them. This could be one piece of work establishing a very positive collaborative approach which would bring benefits for all and align with the INWO role having a leadership role and acting as a catalyst that could bring wider cultural change.

6.6 The ability for organisations and government to understand emerging themes where harm could be done is paramount. This is to ensure that we do not

continue to have those sudden exposure moments as we have seen with Mid Staffs and with other organisations where we have seen media coverage of systemic failure and harm including Oxfam, Hollywood (Weinstein) and even Houses of Parliament. Where the INWO can bring effective change to systems by enabling individuals to easily and effectively raise a concern with protection is critical, systems to enable effective reporting will offer the benefit of capturing and analysing data to highlight emerging themes. Data analysis provides the ability for intervention planning, with subsequent impact analysis of interventions. Being able to understand themes, positive impacts and lessons learned will further yield longer term benefits for the culture within healthcare. Real-time data would provide accurate and timely information, benefiting stakeholders with assurances for greater knowledge and confidence of transparency. It is essential therefore for there to be strong links with Scottish Government and Health Boards in working towards this culture change and developing these systems as an additional work stream.

6.7 Most delegates felt that historic cases were not possible to include. In practical terms few delegates disagreed, however, it was identified that this could result in loss of key learning from some. To counter this, once the INWO is in post, some workshops could be held with whistleblowers who had or have historic cases to tease out any relevant learning that could start to inform system and cultural change.

6.8 The principles and standards were welcomed as definitely a step in the right direction and delegates were pleased with the arrangements that a working group had commenced to work on these and refine these to the specific challenges of whistleblowing. A gap identified in them by delegates was the fact that the standards and principles needed to take into account Healthcare Professionals duty to also report concerns under their codes of conduct.

6.9 Most delegates stated whistleblowing and raising concerns should be deemed to mean the same thing for understanding by all staff and that the legalistic definition should not be used as this was not appropriate for the purposes of the INWO investigations.

6.10 To avoid concerns being turned into employment matters delegates felt the principles should set out very clearly and define what is employment matters and what is raising concerns.

6.11 There was consensus from delegates that it was important for the INWO role to also establish if the whistleblower had been treated reasonably as a result of raising a concern .

6.12 The timescales and two stage process of 5 and 20 days was generally agreed to be the appropriate starting point for the process for the INWO. Appropriate communication also would be taken into account that had taken place between parties.

6.13 As the INWO was established and an appropriate number of cases had been reviewed intelligence and any common themes would be gathered and shared back into the system with NHS organisations to allow for learning and change to occur.

6.14 Reporting on assurances that recommendations made by the INWO were implemented was also viewed as important for most delegates and a process for building this in needs to be considered.

6.15 Some delegates felt it would be helpful if Scottish Government could work with Health Boards to consider a 'Once for Scotland' approach in reporting and recording concerns. Again it was felt that this may need a separate piece of work with stakeholders on the current systems such as datix and others, available systems not being used that might provide an appropriate mechanism and how it could be used for benchmarking. This would provide helpful intelligence when having to pass information to the INWO for the purposes of their investigation.

6.16 Most delegates felt confidential and anonymous concerns should be allowed to be raised with the INWO for intelligence purposes only whilst trust was being built in the system. However, if it could be investigated from the information available then it should do so. It therefore may be worthwhile considering this.

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