OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 28 May 2019

Session 5

The Scottish Parliament
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Tuesday 28 May 2019

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HEALTH AND SPORT COMMITTEE
15th Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Rosemary Agnew (Scottish Public Services Ombudsman)
Rhona Atkinson (NHS Grampian)
Jeane Freeman (Cabinet Secretary for Health and Sport)
Dr Stephen Lea-Ross (Scottish Government)
Bob Matheson (Protect)
Alison Mitchell (NHS Lothian)
Anas Sarwar (Glasgow) (Lab)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 28 May 2019

[The Convener opened the meeting at 10:00]

Proposed Draft Order

Scottish Public Services Ombudsman (Healthcare Whistleblowing) Order 2019 (SG/2019/66) and Proposed Explanatory Document (SG/2019/67)

The Convener (Lewis Macdonald): Good morning and welcome to the 15th meeting in 2019 of the Health and Sport Committee. We have received apologies from David Stewart MSP—Anas Sarwar MSP is attending the meeting as his substitute—and Miles Briggs MSP. I ask everyone in the room to please ensure that mobile phones are switched off or to silent mode and are not used for photography or recording.

Agenda item 1 is consideration of the proposed draft Scottish Public Services Ombudsman (Healthcare Whistleblowing) Order 2019, which is subject to the super-affirmative procedure. That means that an additional stage of scrutiny—today—is required in which Parliament considers a proposal for a statutory instrument before the instrument is formally laid. The procedure is used for instruments that require a particularly high level of scrutiny.

We invited John Sturrock QC, Sir Robert Francis and a representative from Unison to give evidence today, but they were all unable to attend, for various reasons. However, I am delighted that we are joined by Rosemary Agnew, the Scottish Public Services Ombudsman; Rhona Atkinson, non-executive director, vice chair and whistleblowing champion at NHS Grampian; Alison Mitchell, non-executive board member and whistleblowing champion at NHS Lothian; and Bob Matheson, the head of advice and advocacy at Protect, the whistleblowing charity.

We will move directly to questions. I encourage colleagues to indicate to me when they wish to ask about any aspects that are raised in the evidence. I look forward to hearing what the witnesses have to say.

Clearly, it is important that we get the draft order right. Although it has been understood for some time that the independent national whistleblowing officer would be located within the purview of the Scottish Public Services Ombudsman, it was not as widely anticipated that the two roles would be held by the same person. What are the witnesses' views of the draft order and of the benefits or disbenefits of the two roles being carried out by the same person?

Rosemary Agnew (Scottish Public Services Ombudsman): It seems logical for me to start.

The Convener: It does, indeed.

Rosemary Agnew: It is worth remembering and reflecting on why the two roles will be carried out by the same person. The decision was made in response to the Government's consultation, which suggested that the role should be carried out by the ombudsman because of our independence—I say "our" because I think of myself as representing the whole office: we all deliver the service. We have a track record on, and a lot of knowledge about, complaint handling. We all fully accept that whistleblowing is not exactly the same as complaint handling and that there are some significant differences. However, we already have some of the underlying skills that we will need when investigating and setting the standards, so we are able to hit the ground running.

The challenge with which I will be presented is to ensure that, although I, as an individual, will have both of the duties and areas of responsibility, our processes and internal approaches recognise the different roles, particularly in relation to confidentiality, because we might be investigating complaints about an organisation at the same time as we are looking at whistleblowing issues. On the whole, the benefits will outweigh any of those procedural issues; the important thing is that we recognise them.

For me, the benefits are the independence; the ability to scrutinise and, bearing in mind that the order builds on powers that I already have, the ability to shine a light on things and to encourage learning and engagement; and the opportunity to develop and contribute to a national culture in which openness and trust are the norm, as opposed to having to rely on a process that is bolted on at the end.

I will stop there and let some of my esteemed colleagues have their say.

Rhona Atkinson (NHS Grampian): I concur with what the committee has just heard. I think that having the two roles in one person holds no disadvantages for the national health service and that it holds significant benefits. There are distinct differences between complaints and whistleblowing. Something that escalates to become whistleblowing might cover some aspects that would not be part of a complaint. My experience of the ombudsman handling complaints in the NHS is that, when we have to go to that level, we get not only conclusions but positive feedback about what we can learn for the

future. If we can tap into the experience of the existing ombudsman staff and relate that to the specifics around whistleblowing and complaints around situations that may lead to whistleblowing in the NHS, there is great benefit to be had by all. We should not underestimate the experience that those people have and the learning that we can take from them.

Alison Mitchell (NHS Lothian): I agree with my colleagues. It is imperative that there is independence, and the ombudsman brings that in great quantity. The distinction between whistleblowing and complaints is really important. Therefore, the definition of what is deemed to be whistleblowing is also important if the ombudsman's role is to be effective. There can often be a conflation of whistleblowing on matters of public interest or patient safety with personal grievance, and it is important to understand what area the ombudsman's jurisdiction would cover.

I am content with the skills that the ombudsman staff bring and the advice and support that they give on complaint handling, which has, in my view, been nothing but beneficial to the NHS. I believe that they will bring that core skill set. However, I have concerns when I read about model procedures and efficiency. Those things are important, but whistleblowing issues tend to be somewhat different, culturally, from standard complaints or factual operational complaints. By their nature, they are pretty comprehensive.

I am concerned when reference is made to "efficiency", because the most important thing about investigating whistleblowing complaints is that it is done thoroughly and appropriately, sensitively, in many cases, and by the right people. That kind of investigation can take time, and it can take time to identify appropriate individuals to undertake such investigations. They sometimes have to be drawn in from outside the organisation because of the nature of the issue under scrutiny. Taking account of that, I see no reason why the role should not sit very comfortably with the ombudsman.

Bob Matheson (Protect): I will provide a small bit of background for committee members who are not aware of Protect and our work. We are a whistleblowing charity: that is what we specialise in and are expert in. We are based in London but operate UK-wide. Because we speak to a lot of whistleblowers—I speak to a lot of them in my day-to-day job—I am fortunate, perhaps, to understand the nuances in dealing with those sorts of problems.

If there is an obvious issue or challenge with placing the INWO inside the SPSO, it concerns the distinction between complaints and whistleblowing, which has been seen clearly for a long time. Adding to what has already been said around that, the big difference is the position of the person who is reaching out to the oversight body. In a complaint, that is ordinarily very much the person who is affected—something has happened with their care or the health treatment that they have received—whereas the ordinary place of the whistleblower is as the witness. That is a really important distinction. Although the INWO will obviously play a role in looking at how the whistleblower has been treated, in the sense that the whistleblower is complaining about what has happened to them, it is really important not to lose sight of the whistleblower as the witness. The concern is the focus of what we are trying to resolve in such cases. Ultimately, we want to ensure not only that whistleblowers are safe in the health service, but that the concerns that they raise are listened to.

The main difference is in what can be expected from the investigation process, as a complainant in a complaints process and a whistleblower have different rights and different sorts of redress. That is the obvious challenge, but it is not at all insurmountable and the SPSO has already done lots of work on how it can adapt its processes to meet the needs of whistleblowing, which is quite different from complaints. As long as that is an on-going process and there is training to enable its staff to make the adjustment, and as long as there is on-going stakeholder engagement, I do not see that as too big a problem. Certainly, when one looks at the advantages—both personal and from our organisation's perspective—of placing the procedure within the SPSO, the pros definitely outweigh the cons. The fact that the SPSO is an established organisation with processes and staff already in place means that it will be much quicker to get the service off the ground. The SPSO is also trusted and seen to be independent.

The Convener: The Royal College of Physicians of Edinburgh was one of the respondents to our consultation on the order, and it said that there is a concern that

"the intended potency of the INWO will be lost and merely absorbed into a multitude of other functions."

For the SPSO, there is clearly a question of whether it is able to accommodate a very significant new set of responsibilities within existing significant ones. Can you respond to the RCPE's concern and explain how you intend to address it?

Rosemary Agnew: We are grateful to everybody who responded to that consultation and to our own consultation on the draft standards that we put out. I completely understand and appreciate why there may be concern that whistleblowing is not complaint handling, and we have not lost or ignored that point at any stage in the development of the standards. We are

collaborating with and talking to a multitude of stakeholders.

The best assurance that I can give, in terms of our own function and structure, is that we are not looking at absorbing whistleblowing complaints—as they are referred to—within our general workload. We are looking at establishing a specific team to handle whistleblowing concerns because there are a number of significant differences between them and complaints, as has been pointed out. One of the most significant differences between a complaint about service and something that is escalated from the raising of a whistleblowing concern is that there are likely to be one or two core issues that mean they come to us: one is patient safety in the public interest and the other is the treatment of the individual. Those issues cannot wait but have to be addressed relatively quickly.

On the point about the whistleblower being a witness, what people have to physically say is as important as any written concerns. That is leading us to think—subject to all the responses that we get to the consultation—that the whistleblowing team will need to take a different approach to addressing such concerns, partly so that they are addressed thoroughly and partly to ensure that learning is picked up and fed back, as well as to ensure that something happens quickly. For example, a patient safety issue should not have to wait until the end of an investigative process if it obviously should be put right straight away.

Although I cannot say definitively that we are going to do X, Y and Z, I hope that sharing with you our current thinking about how we see the whistleblowing function working within the organisation gives some reassurance. However, it raises one of my major concerns: resourcing. When I talk about resourcing, I am talking not only about the SPSO but about the NHS itself. If the service is going to work as envisaged and contribute to more robust governance and to open and trusting cultures in which people are confident about raising concerns as part of their everyday work long before that becomes whistleblowing, it has to be adequately resourced to ensure that investigations can happen quickly. A mark of success will be that both the NHS and the SPSO are adequately resourced to deliver the service in the way that the policy and the order envisage.

10:15

Emma Harper (South Scotland) (SNP): Good morning, everybody. What is the estimated level of funding that the INWO role would require?

Rosemary Agnew: We have not come to a figure, as we are still at the planning stage. It is part of the on-going programme of discussions with the Government. Our relationship with the Government in developing the policy has been very positive up to now. I raise the point about resourcing not because there is an issue but because the adequate resourcing of not just the SPSO but the NHS will be a factor in the policy's success.

Emma Harper: Would the funding come from the Government or from an NHS pathway?

Rosemary Agnew: I would expect it to come from the Government. Where that money was diverted or brought from would be a matter for the Government.

The Convener: Would NHS boards have sight of that?

Alison Mitchell: That is something that we are very concerned about. In putting together NHS Lothian's new policies and procedures investigation process, it has become clear that the management time that will be required to implement it comprehensively and appropriately—particularly when such issues tend to be complex by their nature—is very significant. The managers who will be pulled in to carry out investigations have full-time day jobs in the NHS. They are under huge pressure and are delivering against a series of other targets.

As far as possible, engagement must come from within the organisation, because it is about encouraging a culture change and ensuring that the organisation listens to the individual instead of that listening being imposed on it by some outside organisation. If we are to be held to targets and to follow certain model procedures, we would be concerned how that could be delivered alongside the day job without additional resource.

NHS Lothian recently decided to go beyond policies and procedures because we feel that a culture change is needed. Hearing whistleblowing concerns is not a process change or a transaction. We have, therefore, appointed two "speak up" ambassadors and we are about to support them with a network of about 20 individual "speak up" advocates across the organisation to encourage and support whistleblowers and ensure that they get the proper support and treatment throughout any whistleblowing process.

However, as I said, those managers will be taken away from their day jobs—it is additional work. If we are to commit to the approach and do it properly, everyone must realise that it is not a box-ticking exercise. There must be a commitment and a passion to create an environment in which concerns can be raised freely and without fear, for the benefit of all.

Rhona Atkinson: Similarly, in taking forward the whistleblowing champions role in NHS

Grampian, we have looked at two things. First, if something has reached the point of having become a serious complaint or whistleblowing, we must ensure that whoever has taken that stance is fully protected and that there is a process that they can go through to reach a conclusion. Secondly, in parallel to that, we are trying very hard to ensure that we do not get to that point, and that is where the resource needs to go.

We are looking at different forms of mentoring and support, listening skills, how to handle complaints when they come to managers and how managers can put up their hands and ask for help with such things. Everyone on the front line is under a great deal of pressure, and there will be slip-ups and further slip-ups—they may be unintended, but they will escalate. It is about having almost a duty of candour in the staff cohort. We need to find space to allow people to say that they need time out to look at an issue, discuss it and get to a better place to prevent it escalating.

In NHS Grampian, we are trying hard to go down both routes and push through both processes, although we appreciate that some concerns—rightly—will not be resolved in that way but will escalate to become more serious complaints or whistleblowing if we are really unlucky. A huge cultural change is needed.

The Convener: I guess that change comes with resource implications.

Rhona Atkinson: It has resource implications.

Rosemary Agnew: I echo Rhona Atkinson in saying that one of the significant differences between the whistleblowing standards on which we are consulting and service complaint handling is that the standards explicitly and deliberately recognise that formal whistleblowing is not the beginning of the process. Probably more important is what we refer to as "business as usual", in which people raise any concerns that they have as part of their everyday job of work; that is where the culture change needs to be. That is where the concept of efficiency comes in—not as in pound notes, but as in picking up issues early; developing an environment of trust and confidence; and getting the right outcome for patient safety at the earliest possible time.

I will also pick up the point about timescales, because something has been lost in translation. The standard procedures on which we are consulting have timescales attached to them, but they are not absolute targets, as in, "You will be held to account if you do not meet them." They are the expected timescales, but if a situation means that they need to be extended, they can be, as long as there are good reasons. We have included timescales not to impose something that is unrealistic but to ensure that things keep moving in the process—we have learned that from complaint handling. I understand the concerns and, if other panellists think that we could articulate it better, we would be happy to discuss that.

The Convener: I always think that committees work well when we have negotiation in public.

Bob Matheson: The question of what is whistleblowing is central to the discussion. The standards that I have seen do not envisage whistleblowing as just a final escalation point to an outside body but as the raising of concerns within the organisation as well. The vast majority of the people whom I advise never go beyond raising their concerns with their line manager, or they might escalate them to a senior manager. That is the norm that happens in the main, and those people are still suffering. That point is important when we consider the wider perspective of what whistleblowing is about and when we consider funding.

Although I absolutely support calls for the SPSO to receive the funding that it needs—it will probably need quite a lot of funding to do what is a big role—and I support the NHS receiving more money to be able to do this, it is important to recognise that we are asking organisations to do what they should already be doing and what the public expects them to do. When people raise concerns about someone getting hurt or about risks, we are looking for them to be listened to properly, dealt with quickly and not targeted as a result. We are not asking the organisation to do much that is different, although there may be a bit more admin. What is being introduced is someone to oversee that process to make sure that it is done properly.

I support the call for more funding, but our perspective should be that it is not for a cherry on top for the health service in Scotland but for what we expect the health service to do anyway. It is important to have someone to help, support and oversee, to make sure that it is done.

Brian Whittle (South Scotland) (Con): The approach to defining what constitutes whistleblowing is that it will be in the complaint handling procedure rather than in the order. Has consideration been given to whether there should be legislative oversight of the definition? Should the definition sit in the order?

The Convener: The point is that the definition will be in the standards but not in the order.

Rosemary Agnew: Brian Whittle has hit on my second concern. I am comfortable that my organisation and I have understood and defined whistleblowing, which is the result of a lot of collaboration and co-production. However, I am not comfortable that the definition is entirely down

to the ombudsman; that is not because I feel that we cannot deal with that but because the level of scrutiny is not the same as would apply to a definition in an instrument that was subject to parliamentary oversight.

There are two approaches. The obvious way is to include in the order a non-exhaustive definition—a bit like the definition in our standards—that is not restricted to one thing but gives a good definition that people can work with and which will be relatively flexible in the light of experience.

If the definition were not to be in legislation, it could go in the principles that we are required to lay before Parliament. As part of my wider SPSO powers, I must lay complaint handling principles, which will include the whistleblowing complaint principles. The decision is down to the Government but, if the definition were not in legislation, it could go in the principles, because they go before Parliament and are subject to scrutiny in public. I am concerned that the definition is purely down to the SPSO to draft.

The Convener: Do other witnesses have a view? I assume that the mechanism is legally competent, but is it appropriate? No one else seems to have a view.

Brian Whittle: I echo Rosemary Agnew's point that defining what legislation pertains to is an issue.

The draft order depends on a third party that is not subject to parliamentary scrutiny. Do you have other examples of that or is it unique?

The Convener: That is a fair question. It might be for the cabinet secretary; I do not know whether Rosemary Agnew is aware of other definitions that are in effect matters of law being left outwith legislation.

Rosemary Agnew: I cannot think of any such examples, but I will take the question away and come back to you.

The Convener: We might come back to the issue later.

Sandra White (Glasgow Kelvin) (SNP): I declare an interest as a member of the Scottish Parliamentary Corporate Body.

I will raise two small issues. Rosemary Agnew mentioned that the timescales are extensive. I might be wrong, but did you say that there is no cut-off point for investigating a difficult case?

Rosemary Agnew: We were referring to timescales for the NHS. The standards provide that, if an individual feels that something is taking too long, they can tell us directly that they have raised something and nothing much is happening. To an extent, that is in the individual's gift if they feel that the process is taking too long.

My experience of complaints is that, as long as there is no huge impact that needs to be addressed straight away, a thorough investigation in which the organisation concerned learns for itself and maybe identifies deeper issues that sit around the concern is the best place for learning. I am not trying to do us out of work, but I would much rather provide support on how to do good investigations than put resource into picking up something at the final stage.

Sandra White: I apologise for having to say that I had not heard of Bob Matheson's organisation, but I welcome his comments. How many cases has it picked up from the Scottish Parliament or other organisations, such as the NHS?

Bob Matheson: Each year, about 3,000 individuals come to us for advice. We do not see them all as whistleblowers or as being directly within our remit, but the vast majority are. For some time now, we have run NHS Scotland's advice line and we get a lot of cases through that, so we are experienced in advising the sorts of individuals involved in those cases.

10:30

Sandra White: Thank you. I wanted to clarify that.

Emma Harper: I have a supplementary question about the definition of whistleblowing. I declare an interest as a former clinical educator and nurse in NHS Dumfries and Galloway; I used to look at issues such as central line associated infections and patterns in care or behaviour.

This whole process is about escalating or addressing concerns. Most concerns will be dealt with as business as usual. We are thinking about someone who does not necessarily feel under threat of losing their job but who might feel under threat from intimidating processes. The whole issue is about a step process whereby the whistleblower is the final part of something that could perhaps have been dealt with earlier if leadership processes had been better. The cabinet secretary has talked about changing the culture in order to address processes, so that we do not need the whistleblower in the first place.

The definition should allow us to be flexible in the approach, because the cases or presentations will be varied. Do you agree that it would not be appropriate to lock down a tight definition of whistleblowing?

Rosemary Agnew: That is what we mean by wanting a non-exhaustive definition. The definition that we have put in the draft standards covers a number of things, but we clearly say that

"this list is not exhaustive".

Something always comes from left field that is not covered by specific wording but comes under a general definition.

The other reason why a definition of whistleblowing and raising a concern is important is that "whistleblowing" and "whistleblower" often get conflated. Whistleblowing is a specific thing in which an individual has chosen, for whatever reason, to be part of a more formal process that gives them the protections that whistleblowing brings.

A lot of this comes from the non-exhaustive definition. However, I agree that the definition should not lock us down to the point that it prevents other things being brought into it.

Bob Matheson: This is probably repeating what I said before, but it is important that we do not cut that day-to-day activity out from what we see as whistleblowing. The people I speak to commonly do not realise that they are whistleblowing. They have concerns, they speak to their line manager and then all hell breaks loose. They are so scared that they might never say anything about it again. The INWO has to look at that sort of situation. It would undermine its purpose if we say that, because those people are not formally calling it whistleblowing, we cannot treat it under the process. We need to be careful not to cut out the business-as-usual stuff, which is just as much whistleblowing as escalating a concern externally.

Rhona Atkinson: On the question of definition, you almost have to turn it on its head. If you give a tight definition, it will become too easy to measure negativity against the definition, as opposed to looking at negativity in its own right. People would use the definition to ask whether a situation is covered by whistleblowing as opposed to looking at a situation, asking whether it is perhaps not good and doing something about it. If we put in too tight a definition, we almost stop things being taken the full course of resolution.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, panel, and thank you for coming to see us today. Policy change is only as good as the difference that it brings about. This committee and other stakeholders in the health community are still reeling from the revelations in the Sturrock review of the bullying and systemic problems in NHS Highland. I acknowledge what Rosemary Agnew said about whistleblowing not being a replacement for a normal grievance procedure. Many of the Sturrock review revelations were around the handling of grievances and relations between staff, but some were about systemic issues. Had the policy change on whistleblowing been in effect in NHS Highland previously, do you think that the situation might have been different or that issues would have been handled differently?

Rosemary Agnew: There is always the answer, "Yes, probably," but it is difficult to say, "Yes, definitely." There would have been the opportunity to handle issues differently because there would have been much more focus on integrating whistleblowing with governance, human resources procedures and how the organisation is run and how it encourages people at every level. I concur with the view that some of that is not about management but about how a team might operate and how staff relate to the organisation that they are part of. The whistleblowing policy change might have strengthened those areas and perhaps averted issues, as they would have come out into the open a lot sooner. The approach that we are taking recognises that concerns that arise in the usual run of business can require either a grievance procedure or whistleblowing.

A challenge that we all have is that whistleblowing is not particularly well recorded at the moment. However, if whistleblowing had been in place previously, it would have given individuals more empowerment to say either, "No, I want this to be recognised as whistleblowing," or, "I want this to be recognised as a grievance against individuals." Whistleblowing also gives an individual a safety net if an organisation decides to go down one route but they think that it should have gone down another, because they can say to the INWO that the issue is more suitable for a grievance or for whistleblowing.

The issue of bullying and harassment is interesting in the context of whistleblowing and allaying concerns about whether it will stray into HR policy territory. Whistleblowing about bullying is a good example of how whistleblowing can work in practice. An individual could say, "I am being bullied by X," which I suggest would be a grievance against an individual. However, if someone said "There is a pervasive culture of bullying in this organisation that means that I am afraid to speak up about things that I see are wrong," that would be whistleblowing.

It is important to explore what an individual raises at the outset and to fully understand it. However, there can also be an issue at the end of a grievance process around the treatment of an individual if they say, "I raised these issues and I now feel that I am subject to bullying and harassment." The output of the Sturrock report is about having more safeguards earlier on but, equally, a recognition that we have to dovetail those safeguards with good bullying and harassment policies and wider organisational approaches to how the organisation is developed.

I therefore cannot say that having a whistleblowing policy in place would have changed

anything in NHS Highland, but I can say with some confidence that concerns would probably have been treated differently or have been escalated more quickly.

Alex Cole-Hamilton: Can I unpack that further with you? You have given several examples of how an issue stops being a grievance and becomes recognition about something in the culture. Perhaps you can clarify whether the concern that I will raise will be dealt with in how we will do things differently. My concern is about staff who do not have any faith in the HR processes of their health board or their locale because of the culture. That might be linked to their being bullied because they started asking questions or raising concerns, or it might be linked to bullying by bullies who are themselves in the strata of the complaint processes. Do those people have an opportunity to circumvent local processes and go straight to you or the whistleblowing function? If so, how can we get that message out to staff to make them feel confident that, if things are bad in their locality, they can circumvent the processes there?

Rosemary Agnew: I will try to unpick that one. The short answer is yes, there is such a provision. Although the order makes it clear that an individual is expected to raise the matter with the organisation in question, which will either try to resolve it or investigate it in detail, it also recognises that that process might not be ideal for some people, who would have the opportunity to contact us directly. At that point—this is where things would become very case dependent and dependent on the individual or group of individuals—we could do a number of things. Theoretically, we could look it ourselves from the beginning, or we could raise it with the organisation and say, "You should be looking at this." The latter course would give a very different level of expectation, because it would be very clear to the organisation that it was under the spotlight. The important point, though, is that more than one route is available.

The other point—which to an extent also comes back to resources—is that it is really important for organisations, with support from us, to put some time into awareness raising and training on how concerns can be discussed in a business-as-usual way and under whistleblowing procedures. Organisations also need to ensure that line managers—indeed, everyone—are aware of how to signpost and how to advise people on what they can do. Without that awareness, you run the risk of isolation and people not knowing where to go.

There are, therefore, two issues: building trust in and reassuring people about the system, which I think can be done only through showing that it works, and ensuring that people are familiar with where they can go and what they can do. Organisations such as Protect, which also gives advice, and our own advice function would pick up those issues.

Alison Mitchell: NHS Lothian is one of the larger boards in Scotland, with up to 26,000 people. It is multisite, and although we have an underlying culture and values, every one of those sites has a different culture and feel. Wherever they are and whatever their discipline, people will have different management systems and different tiers of management. After a particular whistleblowing investigation had ceased, feedback that I received from whistleblowers was that they did not know where to go; they could not complain at the unit in question, because their complaints involved the people with whom they were working, and they needed someone to tell them what to do. They had no way of understanding otherwise.

That is the sort of thing that we are trying to address by appointing guardians and advocates. It is all about education. In fact, a massive communication exercise is about to commence at NHS Lothian to ensure that people who have no access to the online system—many of our people do not have computer terminals or access to computers—have somewhere to go to find out this information. As the ombudsman has said, it is all about raising awareness; the culture change will take time, because it takes time to build trust. We know that people will be sceptical, but we hope that eventually the approach will be completely superfluous and we will not need whistleblowing champions or the ombudsman to intervene, because such action will have become second nature.

NHS Lothian has recognised that having a policy with named contacts, as long as you can access it or know it exists, is a start, and we have put in place a huge educational initiative. We also have a mediation service to try to resolve grievances at the lowest level. We are trying to do things informally so that staff can speak up and get matters addressed at local level. Instead of such things being reported formally, we should just deal with them and be seen to be dealing with them, because that is what builds trust in the culture.

There is a huge learning curve for all those who are involved, and we need to give it time and investment. There also needs to be commitment from the top: it has to be a leadership-driven exercise, and it cannot be imposed on an organisation. The point about an organisation needing to learn for itself is valid. It is not about someone coming in and telling an organisation how to do things; it is about an organisation finding out where it has gone wrong and putting it right.

10:45

Anas Sarwar (Glasgow) (Lab): I will follow up on Alison Mitchell's points about trust and culture, which are really important. I take what Rosemary Agnew said about having the right framework and structures and having the guardians and champions, but we also need to live in the real world. In the real world, NHS staff are being bullied every single day in every health board, probably in every hospital and in almost every setting across the country. We can have the best processes in the world, but unless we change the culture in which lots of busy people do lots of work with more and more pressure and demands and less and less resource, people will still be bullied every day, without having somewhere to turn. How do we change that culture?

Alison Mitchell: It is about empowerment and ensuring that people have the confidence to speak up because they know that steps will be taken. We have to build that culture. We cannot just say that we now have a culture in which we will listen to people; we have to be seen to not only to listen but to act. We need to reflect back and ensure that people at every level have someone else to speak to; the term "safe space" is often used.

Someone who is working in a large organisation could feel very isolated and not know where to turn, whereas smaller organisations tend to be somewhat more collegiate. However, we have tight-knit units that are out in the middle of nowhere, so we in the centre might not see it when individuals are being bullied under that leadership. As a non-executive whistleblowing champion, my worry is what I do not know and do not see. We need to get as many people as possible to be the eyes and ears.

The ambassadors' role is not to go into problem areas but to have conversations with staff and to hear how they feel about the current culture. We are constantly embedding values, and we have rolled out huge amounts of training on the whistleblowing process and policy. However, I feel passionately about moving beyond process and policy, because it is all about changing the culture. Box ticking and having in place a process and policy does not achieve the goal; it is about how we enact the approach on the ground.

Anas Sarwar: Let me give you a few practical examples of the cases that I am dealing with. In one case, a consultant who raised concerns about how some patients were treated and what resources and materials were used for individual operations has been viewed as a troublemaker. Three other consultants in the ward gang up on him and try to reduce his hours, because they say that it is his clinical practice that is in doubt, not theirs. He will not become a whistleblowing champion because he will not get career progression. Instead, he has had his hours reduced and is now actively trying to find a job somewhere outside Scotland's NHS. He will not become a whistleblowing champion because his seniors will not support him.

In another case, a general practitioner has raised concerns about resources in an area in which there is higher deprivation and higher demand. They have been agitated by other GPs who have looked at that GP's registration and background to find examples of cases in which they have got things wrong, and the other GPs have opened up investigations into how that person operates their practice. That GP will not become a whistleblowing champion. Who would they turn to? Where would they go?

In another case, a nurse has raised concerns about there being too much pressure on her. Her seniors have said, "We're all under increasing pressure. What are we going to do?" There is nowhere for that nurse to go.

Such situations will not be resolved by having a whistleblowing champion. How do we change that culture?

Alison Mitchell: It is about listening properly and being seen to hear concerns. It might be about having the issue raised at the right level, because some people might block a concern if it is raised locally. We are undertaking a significant exercise to identify the barriers to speaking up. What is it that makes people feel uncomfortable? The most common reasons are fears about career progression or direct bullying. People need to see that there is proper investigation into valid concerns that are raised.

I have been involved in a whistleblowing case in which an individual raised valid concerns about a situation. The investigation found that there were many technical dimensions, but it was not considered that there were flaws or that the issue was serious. The secret there was to give the whistleblower feedback and the full explanation as to why something was as it was and was not being changed. I spoke to the individual after the investigation was closed—because I do not get involved at all during any investigation process—and they said that they accepted the situation now that they understood it, but to them it had looked like X, Y or Z. That person felt that they had been taken seriously. The outcome was not any different, but they understood what had happened and why.

That is the kind of feedback and acceptance that is needed, but it takes time. Every whistleblower will need that kind of feedback and explanation. The processes that we have in place are not doing that, which is why we have appointed the ambassadors and advocates. Their

role is not about representing the individuals, but about advocacy and support. It is about signposting to someone else who will listen to them—an external organisation such as the royal college, perhaps. It is about signposting appropriately and giving the support that people need.

This is the start of a process. It will be organic and it is not going to happen overnight, but if it is driven from the top and from all quarters, it will seed and grow.

The Convener: I recognise the critical importance of culture, but the question whether the powers in the order are adequate to allow the ombudsman and others to address that culture is also central to our consideration.

Rosemary Agnew: I will echo what we have said: the process is only part of the solution. The whistleblowing, the creation of the INWO and the order are only part of something wider. Of itself, the process will not address bullying and harassment, but it will address the consequences for individuals in a different way. The question that came to my mind when you were speaking was this: why is there so little faith in the system that people cannot speak out? If we can address why there is so little faith, we will probably find that we do not need such stringent whistleblowing.

We keep referring to process, which is easy to do, but what we are putting in place is whistleblowing standards, of which a process is just part. One of the things in the standards is about recording and learning lessons. As the INWO, my organisation will have a duty to ensure that, as far as we can, we are monitoring and ensuring not only that whistleblowing is looked at, but that there is evidence of learning in the way that a whistleblowing complaint has been looked at. What is the organisation doing to address systemic issues? That is where there is a similarity with complaint handling

There is also a requirement in the standards for boards, staff and leadership to meet them. Although the standards are only one bit of the answer, there is, if you like, the circular idea that if we can start to establish accountability at a different level, that is another factor that will contribute towards changing the culture. I agree that it will not be an overnight change. It will be a bit like a snowball: once we start the journey we will get to a much better place more quickly than we would do if we did not have whistleblowing standards.

Bob Matheson: How we change the culture and make people feel safe and supported in speaking up is an excellent question. It will not surprise you to learn that the issue is not confined to the health service. All the work that Alison Mitchell talked about is incredibly important in doing that—putting things in place in the organisation to ensure that it has the structures to encourage listening and to train managers so that they can see things in the necessary way. A lot of what Protect does involves training organisations.

That is all very important, but what is missing, which is an uncomfortable thing to come up against, is accountability. It is about changing the incentives and disincentives for individuals who would seek to ignore whistleblowing concerns—people do ignore such concerns. Time and again I have seen people ignore such emails because they are difficult to deal with when someone is coming to them with a hard problem. The powerful stories that we have talked about have been about trying to treat those individuals differently. Having spoken to many people in that position, I would say that it comes down to what the incentives for them are at those points.

We need accountability and we need to ensure that individuals who have done wrong are held to account. That feeds into the question of what powers are available to the INWO. If we do not expect the INWO to create that accountability, are there other structures in society that we expect to do that? For example, we have not touched on the way in which Healthcare Improvement Scotland would interact with the INWO. Somehow, we need to ensure that when something goes wrong, it is not just the case that we all write that down and reflect on it, but that the situation of people who have been the wrongdoers is changed.

Rosemary Agnew: I go back to something that I said earlier: the powers would be additional to the powers that I have as the ombudsman. I understand why there may be concerns, because I do not have binding powers; I make recommendations, but they are not binding. In all the time of the ombudsman, including during the time of my two predecessors, we have never had to exercise our powers to the utmost—if recommendations are not complied with, we can bring the matter to Parliament. That is a powerful indicator of itself. When we make recommendations and follow them up—that is the important thing—we make them in relation to personal redress, learning and improvement of the service. The way in which complaints are handled is important.

In that context, I am comfortable that replicating the way in which we operate in relation to complaints will be effective. That approach is effective because it is not binding. That may sound contradictory, but it allows us to develop a different relationship with organisations. That is not about cosying up or being on the same side, but about recognising that there are occasions when sitting around a table to talk about something—it might

be our recommendations—is more effective than an adversarial situation.

In relation to other organisations, it is important to recognise the differences between whistleblowing concerns and pure grievances. There are already provisions in law in relation to things such as bullying and grievances, and other organisations would be a more appropriate place for those.

One of the things that the set of standards brings is the recognition that there is an ability to share information to get the redress to the right place. That does not automatically mean that something is whistleblowing or that it goes down the HR grievance route, but it is important that we have enough ability between us to share the information to get the right outcome, rather than the outcome that results from slavishly following the process.

Brian Whittle: I want to follow on from what Anas Sarwar was saying. For a whistleblowing and complaints procedure to be effective, it needs to be seen to be valid. As Anas Sarwar suggested, many people in management see whistleblowing as a threat. To be accountable, there has to be training and support for management, all the way through to board member level. Are training and support in place to support the work that you are currently doing?

Rhona Atkinson: That is a valid point about accountability and whether we support it. I suspect that, in general, we do not.

We live in a very performance-driven environment that is also numerically driven, which tends to lead people to think that not achieving something or something being wrong is bad. Something not being right—or being wrong—can be learned from. We have to drive that message through the culture. A person's not agreeing with or not understanding something does not reflect on them, but on the organisation of which they are part, which is not supporting them to learn, grow and develop. Managers should be able to help people to do that.

11:00

Management in the NHS is also under incredible pressure, and there is a tendency—which came through in the Sturrock report—to focus on the numbers but not on the story behind the numbers. I am not arguing that we should not have performance indicators and targets, but there needs to be a balancing out of what can actually be achieved, taking into consideration how we can make for people a good, safe and honourable place in which to work. That means supporting staff and managers to allow them to say "I don't understand this" or "I don't like this", and providing space in which to discuss how to move forward. Support is needed.

Emma Harper: I have a wee supplementary question. It would be interesting to hear how Alison Mitchell's 20 people who will support folk to speak up will be monitored and measured, and to hear how we might create a safe culture. The Sturrock review report talked about

"a need to rebuild confidence in and of managers."

and said that

"A programme of action learning, training, review, coaching and support is essential"

That is maybe not happening across NHS boards, at the moment. Would you support action learning and engagement in education, so that people's ability to report and flatten the hierarchy can be part of the learning?

Alison Mitchell: I absolutely would support that. We have created two new ambassador roles that will be supported by the network of advocates. We have taken time; we appointed the ambassadors last month and we are waiting until we are sure that the processes are in place and are robust so that the advocates can be effective in their roles, when the scheme is rolled out. It is a new initiative for which we have taken inspiration from the guardianship model down south. We have engaged with colleagues there and found out where the real wins are to be had in that kind of structure.

We will build in feedback and review as intrinsic parts of that process, in order to develop the service so that it will be organic. Sturrock vociferously makes the point that feedback and constantly reviewing what we are doing and what we are putting in place are very important. There is no one-stop shop: we cannot say, "I've ticked the box—I've done a training initiative and everyone is trained now, so that's fine." We need ask whether training is effective, so we will put in place a continuous improvement feedback process through the whole exercise.

We have already done that in NHS Lothian, which was recently the subject of external review on waiting times and unscheduled care. At the end of the day, an organisational development exercise took place, working with managers to find out what they needed. What they needed was not assumed. We did not decide what managers required, as John Sturrock describes in his report: we went in and collaboratively identified needs and worked out what we could do together. That is our approach: it is not about imposition but about constant monitoring and review, and collaboration to make what is done successful.

The Convener: We have a brief question from Sandra White.

Sandra White: I am sorry convener, but I want to fit in a more substantial question about integration authorities.

The Convener: We will come to that shortly. Rosemary Agnew mentioned sharing information with organisations. Again, in response to the committee's consultation, the General Pharmaceutical Council suggested that you should be enabled by the order not merely to share information with bodies with which you already share information, such as Audit Scotland, but to extend that to regulatory bodies of professions, such as in pharmacy, thereby assisting in improving their understanding and action. Do you have a view on that, and have you garnered other views?

Rosemary Agnew: Unsurprisingly, I have several views on that. Any sharing of information that enables a more collaborative way of addressing a problem is good. However, we have to balance information sharing with the rights of individuals. The more fundamental issue for me is about the primary legislation for my role. We would welcome a different way of information sharing, because always naming individual bodies is not necessarily the most effective way of getting the right information sharing. Whistleblowing is likely to highlight that the issues can be so varied that we might need to do different things at different times.

Sharing information with professional bodies is a good thing; we can already do that, to an extent, under existing legislation if, for example, we think that there is a public safety issue. However, information sharing would be of more benefit in respect of lessons learned because what works well for one set of professionals might work well with another set. Being able to share information about wider learning, as we currently do with HIS intelligence, would enable us to pick up on the organisational learning issues that we have talked about. That would be about sharing what we have learned from an individual complaint more widely, which we currently cannot do because of restrictions. Sharing information with professional bodies is a good thing, but there is a more fundamental issue about my existing powers.

The Convener: Is it your understanding that the draft order would have to be amended to enable you to share information with professional regulatory bodies?

Rosemary Agnew: I think that the draft order is about naming organisations, and not about more general information sharing. However, I am not sure that the order would be the most sensible place in which to address the wider issues, because they have not been scrutinised and I would not want unexpected consequences. For not just the NHS but the public sector generally, that is an area that we could perhaps take a step back from and examine, because the Scottish Public Services Ombudsman (Scotland) Act 2002 has been in place for a long time now.

The Convener: Addressing those wider issues would require primary legislation, through the SPSO act, whereas the order might enable you to share information more widely with organisations.

Rosemary Agnew: The order would need to have the right spread of organisations. Ultimately, that would be a matter for the Government, but we would happily contribute to that consideration. However, wider information sharing is a longer-term issue.

David Torrance (Kirkcaldy) (SNP): Good morning. How long does it typically take for whistleblowing concerns to be investigated internally?

Bob Matheson: I have spoken to an awful lot of people about that issue. How long is a piece of string? I am not being facetious, because the answer is completely context dependent.

In terms of what we are talking about, there is a challenge in having standards that reflect that there should be pressure on organisations not to kick whistleblowing concerns into the long grass. That happens: it is a way of not dealing with issues. Standards should also be flexible enough to ensure that the facts of a situation do not place completely unreasonable expectations on the organisation. As Alison Mitchell said earlier, organisations already have day jobs and some might also have clinical duties.

Rhona Atkinson: It all comes down to the content of the complaint. I will reflect on something that we have done in NHS Grampian.

We were concerned that we were not recording any whistleblowing, which did not seem to be right. We therefore went back over some complaints that had not been handled as whistleblowing complaints to see whether they were whistleblowing. In essence, they were not whistleblowing, but they had not been properly handled. We then took a step back and went back to all the people involved and asked whether we could start again at the beginning to see whether we could get them a better outcome. We learned quite a lot from that, including that a complaint's being anonymous does not mean that we cannot identify where in the organisation the matter has occurred or find ways to be helpful. We also found that moving away from managementspeak to everyday language makes a big difference.

In NHS Grampian, we have a thing called values-based reflection, which is mediated time-out for a team that has been under pressure. The team sits and discusses how the day has gone, in

terms of our values and principles, and what they can do for each other to make it better. That is spreading significantly throughout the organisation because it allows people to bring out, in a safe environment, things that they are not happy about, and to reach collective agreement about how to move forward.

We have learned that we cannot really put a time on how long such processes take because it depends on what we are dealing with: sometimes we have to break away from the process and the accounting of that process to focus on the individuals and the situations that they are dealing with.

David Torrance: Rosemary Agnew mentioned that time limits are flexible and that individuals can take the case to the next step if they feel that the internal investigation is taking too long. To save confusion, would it be more appropriate for the 12-month time limit to start once the internal case has been finished?

Rosemary Agnew: Do you mean a 12-month time limit to bring the case to us?

David Torrance: Yes—I mean the limit for referral.

Rosemary Agnew: There is something to be said about existing powers and time limits for bringing something to INWO—or the SPSO, which will have the role. Even within the legislation, I have the flexibility to take things outside the time limit. Two of the very strong reasons that we accept for taking processes beyond time limits are individuals' situations and overwhelming public interest. If a complaint is taking an organisation time to look into and address, and the individual is content and so does not come to us, its taking longer than 12 months would not automatically mean that a case is looked at. We already have flexibility to accept such cases. It is likely that the new responsibility will test that.

Sandra White: We have heard a lot about culture and change, which is why I wanted to ask about integration. We know that there have been lots of changes in health and social work services, but the SPSO powers in respect of whistleblowing in the order extend only to the NHS. The SPSO draft standards on whistleblowing include a section with advice to integration joint boards on signposting to appropriate bodies, such as the Care Inspectorate, Audit Scotland or even the INWO, which will be under the SPSO. I hate using all those bits and pieces and acronyms: it gets very confusing.

What are your thoughts on Anas Sarwar's suggestion that it is difficult to integrate the two cultures? Does the Care Inspectorate have the powers to investigate handling of whistleblowing cases? I might be putting you on the spot, but would there be merit in simply extending your whistleblowing powers to social care?

Rosemary Agnew: That is a tricky question. Whether to extend the powers beyond the health service is a matter for policy makers. We will do our best to deliver a good service whatever the scope of the powers. The issue of integration is not dissimilar to some of the issues in relation to complaint handling: it is not a question of who does it, but of whether it gets done.

Signposting is important: we want to avoid people being kicked from pillar to post because no one is quite sure where they should go. In respect of the draft order and complaint handling, we are very clear that if people come to us, we will give them advice about where to go, and they can come back to us if that does not work. Ultimately, if people express concern about how a whistleblowing concern has been handled, that can be a good way to see that an element of the process is not working.

At this point, integration is not about whether other organisations have the powers, because we are focused on the order and what it means for us, but about helping individuals to get to the right place, quickly. There is sometimes general confusion about that, which is not related only to whistleblowing.

11:15

Sandra White: The Health and Sport Committee has done a lot of work on integration of social care and healthcare, which has been a difficult job. I raised the issue because despite their having been integrated, social care is seen differently from how healthcare is seen. When the SPSO gets the powers through the order, people in local government or who work in social care might think that people who work in the health service have a better whistleblowing service. I do not like to think that that will be the case. Are you saying that, with the new powers, people will be able to come straight to you and bypass parts of their organisation, such as in the local authority or social care?

Rosemary Agnew: I am not saying that they can come to us to bypass their organisation: I am saying that if people raise concerns that come within the remit of whistleblowing, but are from social care rather than health, what is important is that there are organisations that will ensure that something is done. That is why signposting is important.

On the wider question whether there are different levels of service, that could apply to the whole of public service. For the sake of my sanity and that of my office, we have focused on healthcare services.

Sandra White: Thank you.

The Convener: I thank the witnesses. The evidence has been extremely helpful. We will, no doubt, come back to those issues when we consider the instrument formally. In a few moments we will hear from the cabinet secretary, when we will, I am sure, raise with her some of the points that we have just heard.

11:17

Meeting suspended.

11:22

On resuming—

The Convener: I welcome Jeane Freeman, Cabinet Secretary for Health and Sport, and Dr Stephen Lea-Ross, head of workforce practice with the Scottish Government, to consider further the instrument that is subject to the super-affirmative procedure.

I want to ask the cabinet secretary about the decision that the role of the independent national whistleblowing officer should be carried out by the Scottish Public Services Ombudsman and that, rather than it simply coming within the ombudsman's remit, the two posts should be combined in a single individual. We have heard support for that position this morning, but we have also received submissions that raised some questions about it; in particular, they asked whether it runs the risk of whistleblowing being absorbed among many other responsibilities. I am interested to hear from the Scottish Government on that matter.

The Cabinet Secretary for Health and Sport (Jeane Freeman): It was clear to us that the independent nature of the SPSO role and office is well established and respected; it is an office that carries considerable influence in our public sector. Rather than creating something entirely separate with a separate bureaucracy and so on, it seemed sensible to have discussions to see how the SPSO office and the SPSO felt about the INWO role and whether the SPSO believed that it could be accommodated and would be a fit without detracting from or being subsumed within other areas of work. Happily, the ombudsman believes that the SPSO is the right place for it, so the sensible decision seemed to me to be that the INWO should be in that office because of its clearly established independence from any part of the public sector and from Government.

Emma Harper: In the previous evidence session, I asked a question about the costs and the resources that will be assigned. We do not know how busy the INWO will be, because we have no projections at the moment. What work has been done to estimate the likely workload of the INWO or the resources that will be required?

Jeane Freeman: I will ask Dr Lea-Ross to respond with some of the detail on that question. Estimating the likely workload is not straightforward. That was part of the discussions with the ombudsman's office, because it wants to be clear that it will have the resources to meet the additional workload. In relation to the convener's question, that work has been done to ensure that one part of the ombudsman's business does not lose out when additional responsibilities come along.

Dr Stephen Lea-Ross (Scottish Government): As part of our exercise on staff who are going into monitoring, we ask all Scottish health boards to provide the number of stage 2 whistleblowing complaints that they have under their existing policy and process. That work reveals that there is a fairly small number of such cases overall. For example, NHS Lothian reported that it had only five live cases in the monitoring return, and similar numbers abound across the piece.

We recognise that the introduction of the INWO might rightly increase the number of individuals who seek redress through that function. That is a fundamentally sound proposition from that perspective. We are in active discussion with the corporate body about monitoring the likely number of cases that will be heard, particularly during the transition period, and we have undertaken to meet the costs that are associated with such cases. We anticipate that the numbers will rise above the level of the current small crop.

The Convener: I think that you said that the Government has given an undertaking to the Scottish Parliamentary Corporate Body that it, rather than NHS Scotland, will cover whatever resources are required.

Jeane Freeman: Yes.

Brian Whittle: The definition of the term "whistleblower" will be handled under the complaints handling procedure. What consideration has been given to the fact that the Government is presenting legislation that does not define what it is meant to deliver? We are leaving the legal definition of "whistleblower" to the SPSO to come up with. Is there a danger in doing so?

Jeane Freeman: There might be a small risk, but there would be a greater risk if we proceeded without having the clarity that will be provided by the standards that the SPSO sets. To the best of our knowledge, we have not found a United Kingdom or internationally agreed definition of "whistleblower". If we had found such a definition, we might well have used it. However, it makes sense to us for the SPSO to work on the basis of

the standards that she sets, because that will allow for a more effective allocation of the work that she is there to do. The matter was the subject of considerable debate and discussion.

Dr Lea-Ross: After our discussions, we deliberately left it for the ombudsman to define "whistleblower" in the context of its model complaints handling procedure. That was because, logically, the definition of a "whistleblowing matter" or a "whistleblower" could evolve over time, and we do not want to exclude people arbitrarily or unnecessarily from bringing legitimate cases simply on the basis of a definition that is set out in legislation. The ombudsman is consulting on the standards and her proposed definition, so we feel that there will be a measure of transparency around what the function will look like, who can be a whistleblower and what a whistleblowing complaint is.

11:30

Brian Whittle: In the evidence that we heard earlier, I think that there was a bit of nervousness from the SPSO around the fact that it will be defining a legal term. It was suggested that a non-exhaustive definition of "whistleblower" should be set within the legislation. Have you considered that?

Dr Lea-Ross: We have considered that and taken advice on it. There is a legislative issue in the sense that we do not put non-exhaustive definitions in legislation because, when it comes to interpreting them, they will be interpreted exhaustively. We also considered putting the definition in terms of the principles, but the existing legislation requires only a single set of principles for all model complaints handling procedures that cut across the ombudsman's jurisdiction. As such, we felt that the safest approach was to place it in the model complaints handling process.

Brian Whittle: That means that the legislation will be dependent on third parties who are not subject to parliamentary scrutiny. Do you have any other examples of that that you can share with the committee?

Jeane Freeman: I am sorry—can you explain what you mean by that?

Brian Whittle: In that situation, the definition of the legislation will be left to a third party that is not subject to parliamentary scrutiny. Are there any other examples in which that is working? Are there examples of a third party having that level of input into legislation?

The Convener: In other words, leaving the definition out of the order means that it is not part of the legislation, as such. I think that Brian Whittle is asking whether you can offer other examples in which such an important definition has been left for another party to include in subsequent provision.

Dr Lea-Ross: I cannot think of anything offhand. The process that we have chosen to pursue in allowing the ombudsman to bring forward definitions in the model complaints handling process is commensurate with the process that is taken by the ombudsman to exercise any of its other complaints handling functions. As I said, we took advice on the potential risk of arbitrarily or accidentally excluding folk from being able to bring a complaint. If we give the ombudsman the capacity to set what the model complaints handling procedure is, it is logical for it to determine whether a complaint is sound on the basis that it has discretionary authority to take that complaint forward.

The Convener: I am still, like Mr Whittle, a bit concerned about the nature of the answers that we have received about where the definition should lie. Stephen Lea-Ross said that a non-exhaustive definition should not be included in legislation because it might be interpreted as exhaustive, but I can think of many examples in which legislation says "such and such shall include but not be confined to." That is a fairly standard provision in law, is it not, for matters of this kind?

Jeane Freeman: You are right, convener, in as much as I have seen that elsewhere. However, the logic of the position that we have taken is exactly as Dr Lea-Ross outlined. That seemed to us to be the correct approach, given what the ombudsman is there to do and that it proceeds in that fashion in dealing with other matters.

Brian Whittle: We are suggesting that we will not put a non-exhaustive definition into legislation, but my understanding is that the SPSO definition will be non-exhaustive. I do not understand why it is all right for the SPSO to sit with a non-exhaustive definition while we cannot have it within legislation.

Dr Lea-Ross: The discretionary authority that we have given to the ombudsman is precisely to allow the definition to evolve over time. The point is that it does that more readily in the context of the complaints handling process than on the face of the order.

Alex Cole-Hamilton: Good morning, cabinet secretary and Dr Lea-Ross. We had the ombudsman before us earlier and I will start with the same question for you that I started with for her. Policy change is only as good as the difference that it makes. Given that we are all still absorbing the findings and recommendations of the Sturrock review of NHS Highland, are you confident that things would have been different

had the whistleblowing policy change been in effect before things got bad in NHS Highland?

Jeane Freeman: I will make a couple of points in response to that. The Sturrock report is about a great deal more than whistleblowing. It is about a workplace culture that was operating poorly to the extent that, in particular, four individuals felt compelled to raise their concerns publicly. Had the whistleblowing policy been in place, they might have raised their concerns through the INWO. However, that does not detract from what compelled the concerns to be raised in the first place.

The INWO might be advantageous for individuals, because it is hard to raise concerns publicly and cope with the personal exposure that that brings. Doing so requires a degree of personal confidence and resilience, but I do not want it to be the case that individuals have to have sufficient personal confidence and resilience in order to raise concerns. The INWO provides a safer route for raising concerns, but it is of course just one part of the overall jigsaw in terms of whistleblowing; the other element will be the directly appointed whistleblowing champions attached to each board, who will have a much more focused local role—almost as advocates at that level—and will be directly accountable to the minister.

Alex Cole-Hamilton: The ombudsman made an interesting point about the distinction between the whistleblowing function and normal HR grievance procedures. In the example of NHS Highland, bullying would be swept up in HR processes and grievance procedures and would not be a systemic issue. However, there are occasions when bullying is a symptom of a wider systemic problem and staff need to have the confidence that they can circumvent local HR procedures and go straight to the top. Are you confident that all staff will know that they can do that and that they will be able to do it?

Jeane Freeman: A number of elements are in play at the minute: the legislation to establish the INWO, the continuation of the helpline and the appointment of whistleblowing champions who are directly accountable to ministers. There is also the important piece of work that is the refreshing of that as an HR policy among other HR policies on a once for Scotland basis—that is, as a policy that will apply across all health boards to all staff and will not be open to individual interpretation by different boards. That is quite a significant step forward and will be in a number of HR policies.

In all those circumstances, there needs to be a parallel piece of work that ensures that all staff are informed of their rights and responsibilities as employees and workers in our health service and that they know where to go and what to do if they have concerns as individuals about how their employment affects them or concerns about an area of practice—for example, if they believe that that practice is not being undertaken as well as it should be and they have concerns about the impact of that on patients or others.

Ensuring that we get all that right and that people know how to operate the system is almost as important as all those other elements that we are undertaking. However, there will always be the backstop of the helpline and the INWO to go to when people are unsure or do not feel comfortable about pursuing local policies.

Anas Sarwar: Cabinet secretary, I welcome everything that you have just said, and I agree whole-heartedly with it. However, the reality is that we can have the best processes and mechanisms in place, and we can have all the whistleblowing guardians and champions we like, but if the culture is wrong and the trust does not exist, given how small a place Scotland is and how small Scotland's NHS is, it will not work. What are we going to do to change that culture and build that trust?

Jeane Freeman: You are absolutely right about that. I am keen that we get all the policies and processes right, and that people understand the standard policies on whistleblowing and human resources policies on grievance and so on. If we get all that right and involve all the unions and the appropriate representative bodies, the degree to which the policies are used will be the degree to which we are either successful or not successful in changing that culture and ensuring that it is one in which people feel able to raise concerns and that they are heard and their concerns are acted on, even if the view is reached that the concerns are not legitimate.

We are looking at doing a number of things, one of which—as I said when we published the Sturrock report—is to bring together all the leadership bodies in our health service, including all our royal colleges, regulatory bodies, boards, and unions, to look at the role that each of us can play in creating and promoting that positive workplace culture.

As you probably know, some of the royal colleges are already taking steps. For example, the Royal College of Surgeons of Edinburgh is running its own work called #LetsRemoveIt, which is about how surgeons behave as clinicians and with more junior members of their team and the kind of working relationships that they promote.

Part of this work links directly to our patient safety programme. Some of the work inside that positively encourages the raising of concerns, for example by checking that everything is okay before a particular procedure is started. There is a

safety pause in emergency departments and so on. The other part of the work will be the wellbeing summit, which is concerned in part with whistleblowing but also looks at mental wellbeing and stress in the workplace and what we specifically need to do.

We will also look outside the health service. For example, NATS—National Air Traffic Services Ltd—has achieved a culture in which mistakes and near misses are reported regularly, discussed and acted on, to the extent that people will report themselves for a mistake or a near miss that they recognise they have made. I am keen to know what NATS did to get from where it was to that point, because there is a comparator there with what we are doing.

Anas Sarwar: The NATS example is interesting in this context. The Bawa-Garba case shows how people can identify a mistake that they have made and reflect on it, and so not pay a price for it. The national health service has a long way to go in admitting mistakes because mistakes have consequences and, sadly, we live in a blame culture; that makes it much harder on the NHS.

From what you said earlier, there is clearly an issue around independence, anonymity and closed working spaces and how that anonymity and independence can be overcome when the people you are working with every day are those to whom you have to report incidents. That affects people's everyday working life and career progression, and how we build in that anonymity and independence is therefore really important.

We all accept that the pressure on staff is rising; our staff are telling us that. When you are under more and more pressure and you have less free time, how can you build understanding and the ability to raise concerns if you simply do not have the time?

11:45

Jeane Freeman: The surgical pause and safety pause in emergency departments are about making time to ensure that everything is safe, including everyone in the team, before proceeding. An element of the work is about focusing on what is safe and effective for patients, which can be used to ensure that the team is safe. We need to ensure that there is a space in which people can raise concerns. At its core, that is all about leadership, partly at senior level but also at different tiers further down, including clinician level and across every other element of the workforce in our health service.

As I am sure the committee knows, we have a very successful project lift leadership programme. I am keen to ensure that such training is delivered at every level, from basic supervisory level right through our health service, because it is at those levels that people are responding to pressure in a way that does not present the opportunity for somebody to say, "I will do that but, before I do, I'll just point out that that's not right over there." It might be that the cleaning room has been closed, so domestic workers cannot change the water, or it might be that not all the instruments in a theatre are where they need to be.

Anas Sarwar: I accept all that. However, do you accept that in the real world we need to work harder to care for those who care for us? Do you also accept that, in every health board across our national health service, members of the workforce are being bullied and intimidated every single day? Therefore, in standing up for our NHS staff, we should make changing that culture and building trust a national priority.

Jeane Freeman: I have made it clear that the mental wellbeing, as well as the physical wellbeing, of our NHS staff is important to me, and we are actively looking at improving wellbeing. That is a priority for me.

However, I am also clear that, in promoting a positive workplace culture and achieving some of the key changes that are needed, we should acknowledge that the majority of our staff report to us that they have confidence in, and are not fearful about, raising concerns. We are making positive steps to promote that change in culture, but that will not be achieved quickly. The NHS is Scotland's largest employer, with a wide range of jobs being done the length and breadth of the country, so a positive shift in culture will not be achieved overnight. The work in all the areas that I have talked about will combine to take us forward in that regard, but that does not mean that we have thought of everything.

Brian Whittle: Following on from what Anas Sarwar said, I think that, for whistleblowing to be effective, it needs to be accepted as a valid process by management. We would all accept that, in many cases, whistleblowing is seen as a threat to management. In the previous evidence session, we heard a lot about accountability. People need to have support and training available to them to make them accountable. Alongside the whistleblowing legislation, what plans are there to provide that support? We talk about a learning environment and wanting to learn from our mistakes, but, as we know, the reality is that that is not happening in our health service at the moment. What do we need to do to support management, from board level down, to accept whistleblowing as a valid process?

Jeane Freeman: Dr Lea-Ross might want to add some detail to what I will say. Before I answer the question in full, however, I will say that I am not prepared to accept that all managers across

our health service do not accept whistleblowing as a positive process. Undoubtedly, there are places where people feel threatened by it, which is an issue that we need to tackle. I also do not accept that we talk a lot about learning lessons but do not learn very many of them, because I think that we do learn them.

As I said to Anas Sarwar, quality leadership training is about recognising what responsibility and accountability are and how to promote them in the team that you are leading, as well as in yourself. Leaders should see the concerns, complaints and worries that people raise about practice and behaviours as opportunities to continuously improve. That is sometimes hard for folks to come to terms with because it can feel personal and threatening. However, quality leaders recognise it for what it is—an opportunity to improve the working practice of a team, whatever that team is doing. When I talk about leadership training at every level in our health service, I am talking about promoting that accountability and responsibility and helping people to understand what they are.

At the board, chief executive and chair levels, there is a range of opportunities for people to be supported in that regard. The Scottish Government's health directorate actively provides additional resources. For example, we are doing that for NHS Highland at the moment, in order to help the board, its chair and the chief executive take forward the Sturrock report recommendations. For many people, reading the report and then leading the improvement that is needed will be a painful exercise. Dr Lea-Ross may be able to add more detail.

Dr Lea-Ross: In the context of our work on specific initiatives to deliver training in the field of whistleblowing, we took the conscious decision, in discussion with the ombudsman, to have a six-month implementation period after the legislation comes into force. During that period, the Scottish Government and the ombudsman will work with health boards to help them understand the whistleblowing standards and the fundamental context in which our revised whistleblowing policy sits, and engender recognition that whistleblowing is a good thing in some instances—that it can be supportive and allow us to recognise that something has gone wrong and correct it. In addition, we will undertake a specific training and implementation programme when we publish the revised once for Scotland workforce policies. That training programme will take in leaders at all levels. We recognise that leadership in the health service is very diffuse and that we need to capture people at all levels.

Brian Whittle: I accept what you say, cabinet secretary, and the direction of travel that you want to take. However, the fact is that we have the Sturrock review and the issue in NHS Ayrshire and Arran, with nearly 100 radiographers signing a letter to say that there is a problem. I suggest that, when issues come to MSPs, we are the last resort. I think that all of us are dealing with such issues at the moment. I do not want to underplay this. My point is that we have to support management and help managers to deal with whistleblowing.

Jeane Freeman: You are absolutely right; I do not disagree with you at all about that. Some issues end up as whistleblowing issues because they have not been responded to appropriately at an earlier stage by supervisors, managers, colleagues or whoever. People get to a point at which they blow the whistle because they feel that they are not getting anywhere.

Emma Harper: I go back to what Anas Sarwar said. I do not accept that there is a national blame culture in the NHS because, as a former nurse educator, I have participated in team work and multidisciplinary team approaches with consultants, surgeons, anaesthetists and everybody on things such as listening and communication exercises. However, I do accept that some people have had issues. Constituents have come to me—potentially as a last resort, as Brian Whittle described it. I welcome the education that will be provided to leaders. As a former nurse educator who was involved in those exercises, I think that it is great to see an emphasis on supporting leadership by providing education.

How will the office of the national whistleblower work with national whistleblowing champions or other leaders? Will the education for leadership be provided by NHS Education for Scotland or Healthcare Improvement Scotland, or is it just part of supporting a collaborative approach across a whole board?

Jeane Freeman: I will let Dr Lea-Ross answer the element of your question on education in various parts of the NHS.

Although I completely accept what you say, as a general point, we must recognise that the NHS as a service does not operate in isolation from the wider polity and people of Scotland. There can be—we have all seen it—a tendency to want to blame someone in the NHS when something goes wrong. Blame is very different from accountability. Collectively, we have a responsibility to be clear and consistent about accountability as opposed to blame. That is why, when I gave my answer to Mr Whittle, I talked about accountability and responsibility. In our health service, managers have accountability, to varying degrees, depending on their place on the ladder. Employees have responsibility for what they do; everyone has collective responsibility.

The job of whistleblowing champions sits at board level. They ensure that several things are happening inside their health board. They must ensure that the standard HR policies and processes are working. If people feel that that is not happening, they can go to the champions to say, "I raised an issue and I've got nowhere", "I raised an issue and it's been weeks and nobody's said anything", or "I raised an issue and suddenly they're not talking to me". Alternatively, people might come to them to say, "I raised an issue and here's how it worked out, which was good. If we can do it in that department, can we not do it over here in this department?"

The focus of the whistleblowing champions is at board level, but the independent national whistleblowing officer is of a different stripe. The INWO is for people who feel that they have exhausted the process and have got nowhere and want to take it further. They can go to the independent office, with its powers of investigation and so on, to take the matter forward.

Until now, the whistleblowing champion role at board level has been an additional responsibility for a non-executive board member. We intend to make it a specific role. The person will be a board member, so they will still have other responsibilities and be accountable to the board, but their focus will be to ensure that, in their board, the policies and procedures are working and relationships are working, so that people see the value of that approach and are able to hear properly the concerns and issues that are being raised. In that respect, once those people are in place and the system is up and running, they will have a role in that positive workplace culture.

Dr Lea-Ross: On the education and training point, we made a conscious decision that the new whistleblowing champions would come on stream at the point when we enter the six-month implementation period for the independent national whistleblowing officer. That is to allow the whistleblowing champions to become au fait with the standards and principles and to act, from before day 1, as an advocate within their health board. The Scottish Government will work with the SPSO on the delivery of that training and implementation. It has given an undertaking on the resources that that will require.

When it comes to implementing our revised suite of workforce policies, we will be working directly with NHS Education for Scotland, which has specialist expertise in many aspects of our current core suite of workforce policies, on the implementation phase of the programme.

12:00

The Convener: There is a provision in the draft order that would allow the SPSO as the INWO to share information with a number of bodies, such as Health Improvement Scotland, in addition to the bodies with which the SPSO can already share information. In its submission to the committee, the General Pharmaceutical Council suggested that the list of bodies might be extended to include health professional regulators because there would be mutual benefit in relation to addressing and improving standards. What is the Government's view of that suggestion?

Dr Lea-Ross: That is absolutely something that we would consider as part of the consultation process.

The Convener: So you do not have a firm view one way or the other but, at this stage, you are prepared to consider the advantages of the suggestion.

Jeane Freeman: To be more positive, we would not be averse to the suggestion and would welcome looking at the rationale for it. I can see why the regulatory bodies would find value in having information shared with them by the independent whistleblower.

David Torrance: We have heard evidence this morning that there is flexibility in the 12-month referral time limit, but would it not be more appropriate if the time only limit kicked in once an internal investigation had finished?

Jeane Freeman: Do you mean: when would we start the clock?

David Torrance: Yes. Should the 12-month referral period start once an internal investigation into the complaint was finished?

Dr Lea-Ross: The 12-month time limit is an existing provision in the 2002 act, which governs all complaints-handling processes, not just those for whistleblowing complaints. The ombudsman has discretionary authority to consider a case outwith that time limit, so we think that it is valuable to allow the existing provision to stand, on the basis that we should not encourage boards to unnecessarily take their time to conclude internal processes. We want boards to conclude their processes in line with the recommended time limits, which are set out in the whistleblowing standards. We need to be realistic about the ability of the ombudsman to investigate a complaint effectively when a significant period of time has elapsed and the evidence around the complaint has potentially degraded. Given the ombudsman's discretion to take a complaint outwith the time limit, we do not think that, fundamentally, the time limit needs to be revisited at this stage.

The Convener: Clearly there is discretion, but there is a choice about when to start the clock. Is there a reason for picking the earlier starting point, rather than a later one?

Jeane Freeman: As Dr Lea-Ross said, there is the matter of consistency. However, it is just as important—if not more important—that we do not run the risk that a significant amount of time is taken at board level, so that by the time the clock starts at the end of the local process, which could itself have taken a year, there is another year to deal with the complaint. That seems too long for individuals to wait. The standards and the model policy will require boards to deal with such matters fairly but quickly, because one of the reasons why people can be frustrated with local processes is that they feel that the processes take an unnecessarily long time and they do not get an early resolution to their concerns.

The Convener: Therefore, the time limit will be maintained, albeit it in a context of discretion.

Jeane Freeman: Yes, by allowing the INWO to have the discretion to take a different view.

Sandra White: I am interested in the issues around integration. We have talked about culture, training and so on, and we know that the integration of health and social care is a huge issue. The powers that it is proposed that the ombudsman will have basically concern only the health service. In the consultation that has been carried out, there was a suggestion that the IJBs would be involved in the process, and that people could be signposted to the Care Inspectorate or even Audit Scotland.

Do you think that the Care Inspectorate has sufficient powers, in the way that the ombudsman might have? Would it be a good idea if social work issues could be included with the whistleblowing issues?

Jeane Freeman: There is a logic to saying that the responsibilities should be extended to health and social care. Of course, health and social care provision at the local level, under the IJBs, involves our local authorities. The proposal is not something that we could impose on them. That does not mean that we could not discuss with them how the responsibilities could be extended, in due course. However, the change would need to fit with the HR policies and processes of individual local authorities. An accommodation would be needed to ensure that that happened.

We have deliberately ensured that the proposal extends to primary care in terms of the delivery of health and social care integration. You are right to suggest that health is covered in its entirety.

We have not closed our minds to the proposal, but this is not the time to include it without a lengthy discussion with local authorities. It seems sensible to introduce the proposal for the health service now and to continue to have discussions with the Convention of Scottish Local Authorities and its members. It is also a good idea to allow the change to play out so that we can see how the Care Inspectorate and the Scottish Social Services Council feel about their interrelationship with the independent national whistleblowing officer and whether they want us to extend their role or bring about an extension of the officer's role into health and social care, bearing in mind how that would sit with their respective roles.

The Convener: On that last point, is there a timeframe for making that judgment, or do you simply intend to see how things are going?

Jeane Freeman: Given the timeframe for introducing the INWO, appointing the local whistleblowing champions and allowing the SPSO's consultation to run its course, we expect to see things start to play out properly by the end of this year or the early part of next year. I think that those discussions with local authorities would start at some point in the middle of next year onwards, so that we can see what they feel about how things are playing out and what they want to do.

The Convener: Finally, what is the prize for getting this right? What will be the impact on patients, staff and services?

Jeane Freeman: Fundamentally, having a positive workplace in our health service where people are able to raise concerns, and feel safe and respected when they do so, will contribute directly to our continuing efforts to improve patient safety. The two issues are intrinsically linked. Introducing the independent national whistleblowing office is not a magic bullet, but it is one of a number of steps that we are taking to give people an assurance of a safe place where they can raise matters if they have not secured a resolution locally. The core of that has to be exactly what Anas Sarwar and others were talking about with regard to relationships, leadership and the quality of workplace culture.

The Convener: Thank you for your contribution to our consideration today. I look forward to seeing the order in its final form later this year.

12:09

Meeting continued in private until 12:17.

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