Witness Name: [XXXX]
Statement No.: [XXXX]
Exhibits: [XXXX]
Dated: [XXXX]

THIRLWALL INQUIRY

WITNESS STATEMENT OF ROSEMARY AGNEW

I, Rosemary Agnew, will say as follows: -

1. I was appointed to the post of Scottish Public Services Ombudsman on 1 May 2017 for a term of eight years.

About the Scottish Public Services Ombudsman

2. As the Scottish Public Services Ombudsman (SPSO) I have a wide remit, covering a range of functions and services. The Ombudsman's powers and duties come (predominantly) from the Scottish Public Services Ombudsman Act 2002 (the 2002 Act), which gives me four distinct statutory functions

    a. the final stage for complaints about most devolved public services in Scotland including councils, the health service, prisons, water and sewerage providers, Scottish Government, universities, and colleges.

    b. specific powers and responsibilities to publish complaints handling procedures, and monitor and support best practice in complaints handling (for both public service complaints and whistleblowing concerns).

    c. independent review service for the Scottish Welfare Fund (SWF) with the power to overturn and substitute decisions made by councils on Community Care and Crisis Grant applications.

    d. Independent National Whistleblowing Officer for the NHS in Scotland (INWO), the final stage for complaints about how NHS Scotland considers whistleblowing disclosures and the treatment of individuals concerned.

About the Independent National Whistleblowing Officer for the NHS in Scotland (INWO)

3. The INWO post went live on 1 April 2021. The post was created by the Public Services Reform (The Scottish Public Services Ombudsman) (Healthcare Whistleblowing) Order 2020 (the Order). The Order built on the SPSO's existing powers, as set out in the 2002 Act. Prior to that, I and my organisation, contributed to the consultation on the creation of the legislation and the co-production of the Whistleblowing Standards.

4. The aim of the function is to ensure everyone delivering NHS services in Scotland can speak up with confidence, to raise concerns when they see harm or wrongdoing putting patient safety or service delivery at risk. People must be able to raise concerns or speak up about concerns that others raise, confident that they can do so in a protected way, which will not cause them personal detriment. They also need to be confident they have the right to an independent review if dissatisfied with how the concern was investigated at local level.

5. As INWO I have the power to set principles and must produce and publish a procedure for NHS Scotland providers to use in handling whistleblowing concerns. I provide the independent review stage of this procedure. The principles are approved by the Scottish Parliament and the legislation makes compliance with the principles and procedure mandatory.

6. The principles and supporting procedures for investigating concerns are set out in the National Whistleblowing Standards (the Standards, exhibit 1). The Standards were developed through co-production, with a wide range of stakeholders, overseen by a Steering Group.

7. The Standards apply to all NHS providers in Scotland, including primary care and contracted providers. They also apply to students, trainees, and volunteers; and both temporary and permanent staff.

8. The Order and the Standards include the definition of whistleblowing which is used by the INWO and all NHS services. To be considered whistleblowing, a concern must meet this definition, which is.

> "when a person who delivers services or used to deliver services on behalf of a health service body, family health service provider or independent provider (as defined in section 23 of the Scottish Public Services Ombudsman Act 2002 raises a concern that relates to speaking up, in the public interest, about an NHS service, where an act or omission has created, or may create, a risk of harm or wrong doing"

9. As the final stage of the whistleblowing process, I can consider all action taken in the NHS organisation's investigation and their response to the concern. This includes any decisions made about the substantive matter (not just the handling of the concern), and can consider any clinical judgement made or relied upon. The INWO is given explicit powers to comment on (speak up) culture and whether there has been any detriment to any individual.

10. Where needed, I recommend the NHS organisation take action. My recommendations are outcome focussed. They can cover redress for an individual, action to address the underlying issue, areas for learning and improvement, and how the concern was handled at local level and compliance with the Standards.

11. My INWO investigation reports are laid before the Scottish Parliament. I also have the power to lay other reports, including reporting if an organisation does not implement my recommendations.

12. The INWO has a national leadership role providing support and guidance to NHS organisations. This focuses on resolution, transparency, and good practice in whistleblowing handling; and governance such as recording, reporting, and acting on learning to drive improvement.

Experience to date

13. The Order was passed by the Scottish Parliament in November 2019 with implementation planned for mid-2020. Implementation was delayed until 1 April 2021 because of the impact of Covid-19; a challenging time for the NHS to introduce a new approach to handling protected disclosures (i.e. whistleblowing). Although I now have three complete years of experience, I would describe INWO and the NHS as still being in a learning phase. This is predominantly because, compared to other complaints work, the volume is lower; INWO and the NHS are still experiencing new issues; and there has been no real testing of the legislation.

INWO Statistics

14. I should first caveat that these statistics should be read in the context of my jurisdiction and the size of the NHS in Scotland.

Cases received by year (April—March)			
21—22	**22—23**	**23—24**	**24—25 (Apr-Dec, Q1,2 & 3)**
113	125	122	90

15. Thirty cases have been closed at stage 3 (detailed investigation stage).

Investigation outcomes	
Upheld (fully or in part)	20
Not upheld	3
Resolved	5
Discontinued	1
Withdrawn	1

16. Cases that are recorded as resolved when the Whistleblower and the NHS organisation agree on what action will be taken to address their concern(s) as a result of INWO involvement. Most commonly to date, this has been when the authority has upheld a case, but did not the actions they said they would, or keep the whistleblower updated, until INWO intervened.

Monitored referrals

17. The INWO advice line provides information and advice to anyone delivering NHS services in Scotland about the Standards, how to raise a concern, and what alternative action may be appropriate. This includes information about whom a whistleblower can contact in their own organisation in confidence (these staff are generally referred to as Confidential Contacts).

18. Learning from potential whistleblowers' reactions when signposted to local processes, I implemented a specific approach for when I receive an enquiry from someone who meets the definition for whistleblowing but is reluctant to raise the concern for fear of the consequences. I have put in place a monitored referral process.

19. A monitored referral is where the INWO, with the whistleblower's consent, refers the concern to the NHS organisation on their behalf. I do not give direction about how it should be investigated beyond reminding the organisation of their responsibilities under the Standards (and by definition the legislation), including the need for confidentiality and protection from detriment. There are two approaches I take, depending on the circumstances, summarised as.

    a. I simply refer the matter on with a reminder about responsibilities, or

    b. I refer the matter on, and ask the NHS organisation to provide me with information about their plans to protect the whistleblower from detriment, and to update me on progress.

20. It is for the NHS organisation to apply the Standards, including early decisions about whether there is a more appropriate alternative route, such as through

Human Resources policies. This is important as it may still be referred to the INWO if the whistleblower is dissatisfied with the handling or claims detriment as a result of raising the concern.

21. The benefits of this approach are that it gives whistleblowers the reassurance that the INWO is aware of the issue; and it puts the NHS organisation on notice that the INWO is aware of the issue. It also highlights for both parties that advice and support is available.

22. I have made about 19 monitored referrals in total. With such small numbers, it is difficult to draw definitive conclusions, but one indicator of effectiveness is that, so for, only a small proportion of these have come back to the INWO for further investigation.

Outcomes

23. I have published nine public reports into my investigations and eighteen summary reports. These aim to set out findings in sufficient detail for outcomes to be understood, to share learning, and as far as possible to highlight what evidence I took into account. Care is taken to ensure that no individual can be identified from information that is published in my reports.

24. Public reports are often supported by private appendices which are shared with the whistleblower and specified individuals within the NHS organisation. These appendices set out findings and reasoning in greater detail, ensuring both transparency of decision-making and to share specific learning and feedback. To date, I have made 68 recommendations

    a. 24 for personal redress (which may include an apology or specific action)

    b. 17 for learning and improvement

    c. 27 about how the concern was handled at local level

Promotion and support

25. Promotion of the Standards and how to access them is the responsibility of both the INWO, and NHS organisations, particularly Boards[1].

26. At national level, as INWO

a. I offer dedicated advice lines about how to apply the standards to whistleblowers and NHS providers (to ensure independence, advice to NHS organisations is generic not case specific)

b. I supported the creation of a practitioner forum for staff involved in coordinating and responding to concerns. INWO input to this group.

c. I supported the creation of a Confidential Contacts network for those who receive enquiries and support whistleblowers at local level. INWO also input to this group.

d. I, and colleagues, have delivered subject specific webinars (e.g. the role of Trade Union Reps), which are available on my website.

e. I monitor whistleblowing complaints and offer support if I identify recurring issues under my Support and Intervention Policy (exhibit 2).

f. I (and/ or colleagues) attend the Whistleblowing Champions network by invitation (whistleblowing champions are Non-Executive Directors appointed to NHS Boards by the Scottish Government through the (Scottish) Public appointments process).

g. I attend (by invitation and at my request) meetings such as NHS CEO meetings, NHS Board or other senior meetings, NHS Board Chairs' meetings

h. I issue a monthly e-newsletter highlighting learning, events and spotlighting specific sections of the Standards

i. I and colleagues, respond directly to requests to engage in other ways and with other groups (e.g. conferences, awareness sessions, HR and workforce forums.

27. I and colleagues will also respond to requests for specific training or to develop training materials, but this is dependent on available resources.

Speak Up Week

28. I addition to the above examples I have established an annual "Speak Up Week" which takes place in October each year. Although INWO promotes, coordinates and drives the week, it is a national campaign. INWO encourages Boards and others to contribute by running events highlighting the benefits of a strong speak up culture, to raise awareness of the Standards, demonstrate leadership, and to share learning and experience. Over the three years, activities during the week have included INWO live streamed events, local promotion and events run by Boards, senior management and government

statements of support and commitment, videos from whistleblowers and organisations who have engaged with the Standards, and curation of social media activity.

29. Interest in the event has increased significantly over the three years and is a primary channel for promotion and sharing learning.

NHS bodies

30. NHS bodies are required by law to comply with the Standards. No Board has ever refused to comply with the Standards to provide INWO with information during an investigation, nor to refuse to implement INWO recommendations.

31. In addition to responding to concerns in line with the Standards and to cooperate with INWO investigations, NHS Boards are required under the Governance section of the Standards, to report and reflect on whistleblowing concerns; quarterly internally, and annually to publish annual whistleblowing reports.

32. The quality of these annual reports varies, and in 2024 I issued a good practice guide to drive improvement in reporting from the 2024—2025 reporting year.

33. Each annual report should

    a. summarise and build on the quarterly reports produced by the Board.

    b. include performance against Key Performance Indicators as set out in the Standards.

    c. include and comment on the issues that have been raised. They should reflect on learning from concerns and set out the actions that have been or will be taken to improve services as a result (ideally with a supporting action plan against which to track and report progress).

34. Boards are also required to collate statistics relating to the number of concerns raised with family health providers and with contractors, though to date the numbers of such cases has been minimal (it is not clear if this is because of low numbers or lack of reporting).

35. In 2022—23 Boards reported that 91 concerns had been received at local level, a decrease of 14% on the previous year. 31 had been responded to at stage 1, and 60 at stage 2. The average timescales for dealing with a concern were 12 working days for stage 1, and 75 for stage 2.

36. Analysis of the 2023—24 reports is in progress. Indications are there has been a decrease in numbers of concerns, but an increase in the uphold rate. I will publish our analysis once it is complete.

37. There remains significant variability with some Boards reporting no or limited numbers in some years, and this is an area we continue to offer guidance on and monitor closely (see also my comment below about impact, at paragraph 38 et sec about data from before the Standards came into effect).

Impact

38. Evaluating and judging the impact of the INWO function and Standards is challenging as there is relatively little comparative data. Early indicators include

    a. comparison with the number of concerns raised at local level before the INWO was created. Experience during the development of legislation and the Standards highlighted a significant lack of data, with many Boards saying they had not received any concerns raised as protected disclosures under PIDA.

    b. the volume being received and considered by this office.

    c. the last two rounds of NHS staff survey (the IMatter survey) have included questions about speaking up which means this can now be tracked both nationally and at individual Board level. The most recent headline figures are:

        i. in relation to being confident to speak up, in 2023, 79% of NHS staff said they were, and in 2024 this remained the same.

        ii. in relation to confidence that concerns would be followed up and responded to in 2023, 74% felt confident, and in 2024 this fell marginally, to 73%.

39. From INWO's direct experience of casework and engagement with Boards, indications are that those Boards that have had several cases referred to me for review have, in many cases, shown improvements in their concern handling because of their involvement with the INWO. Some of this is evidenced from the implementation of recommendations relating to concerns handling. More broadly, the support provided through engagement with the INWO and the spotlight that this brings to the whistleblowing function internally has often led to improvements, which have been evident when I receive subsequent cases.

40. And, finally, we are able to share data and learning from whistleblowing concerns with other oversight bodies to support collective identification of trends.

41. While the early indications are broadly positive, there is still progress to be made to achieve the underlying aim of people delivering NHS services being confident to speak up confidently about patient safety and culture. For example, INWO have learned from casework and stakeholder engagement

    a. that there are still staff who either do not feel confident to speak up (even through the Standards) or confident that they will be listened to.

    b. while not quantifiable by INWO, engagement with other organisations suggests there are significant numbers of concerns being raised anonymously, suggesting more needs to be done to build confidence.

    c. leadership culture varies across NHS Boards. There are still Boards which engage poorly with the INWO. This is evident, for example, in a lack of engagement with governance and reporting requirements, limited engagement with the INWO during Speak Up Week or through practitioner forums.

    d. there is an appetite for more training and guidance.

Reflections

42. I provided evidence to the UK Parliament in March 2024. I have provided that as a document alongside this statement. I can confirm that evidence is still accurate (exhibit 3).

43. When I look back on the situation prior to 2021, my view is significant and genuine progress has been made across Scotland. NHS Boards now have systems in place to consider concerns under the Standards and are complying with them (to a greater or lesser extent), including with annual reporting requirements. Those Boards who have had more cases have, in general, gained in experience and confidence in addressing concerns in line with the Standards.

44. Challenges remain; progress is not consistent across Boards, and indications are that primary care and contracted services have made less progress in implementing the Standards. Some of this can be attributable to the challenges facing small teams trying to maintain confidentiality; some to not all services delivered by those organisations are NHS services so not covered by the Standards; and some down to lack of resources and expertise (which may only need to be drawn on rarely).

45. There is also a universal challenge to the NHS is being able to source sufficiently skilled and independent investigators, which is amplified in small organisations.

46. As a direct result of our early experience, I have initiated plans to consult on and review the Standards. This will ultimately be a matter for my successor but to be effective this should focus both on the process as experienced (e.g. timescales for investigation of concerns), and on whether the underlying structural arrangements in relation to governance and provisions for primary care and contractors can be strengthened. It also needs to consider how effective support and development can be provided to continue to improve consistency and impact

47. While there is still progress to be made, I consider, that as the Inquiry has already heard, that there are likely lessons to be learned from INWO's experience by other UK nations. That said, I am mindful that the populations, and NHS structures, systems and scale vary considerably across the four nations. This suggests to me that it is unlikely to be appropriate to simply replicate the INWO model in each nation.

48. In the event of a plan to take forward a proposal to develop a model appropriate to meet the needs of the NHS in England, I would be very happy to engage directly. At this stage, I offer a few initial thoughts

    a. the main benefit of the INWO function, is the mandatory status of standards which allow for all organisations to be held account. This gives the INWO a clear mechanism for requiring action and giving direction over how concerns are handled.

    b. I strongly support local consideration of concerns as that is where the greatest learning occurs, and is where there is the greatest opportunity for rapid action and resolution. With hindsight, I would have supported more discussion about a model that enabled concerns to be raised with the INWO (or an independent body) in the first instance, to be referred on to NHS organisations. This comes from reflection on the emergent need to develop a monitored referral approach, the number of anonymous concerns, and the inconsistency in Board reporting.

    c. the challenges for primary care are different and may require a different approach or focus.

49. The differences in scale and accountability mechanisms (within a legislative framework) between Scotland and other UK Nations (particularly England) are also significant when considering how such systems are structured and where they sit within wider accountability and governance systems, and whistleblowing (and speaking up) arrangements.

50. From my own experience, placing whistleblowing in the same organisation as public service complaints has had some distinct benefits for Scotland.

    a. I could draw on existing experience with setting standards for handling of public service complaints, and SPSO own investigation experience when setting up the INWO function.

    b. I had existing contacts and stakeholder engagement with Scottish NHS organisations (and oversight bodies).

    c. I could use existing corporate services and develop communications capacity to support the new function.

    d. the SPSO legislation relating to investigation already had significant powers such as the ability to require production of information, which now applies to both INWO and public service complaints.

    e. having an overview of both how public service complaints and whistleblowing concerns are handled within the same organisation facilitates identification wider issues that the relatively small number of whistleblowing complaints may not identify.

51. The underlying learning from this, is that there may be benefit to leveraging impact by strengthening what exists and building on experience already gained.

52. I also recognise that the Inquiry may be interested in INWO experience of complaints where clinicians have raised specific concerns that a colleague's practice and actions may be harming patients. By law I must investigate in private. This means I can only give a general indication of how we may approach such a situation. Each whistleblowing complaint I receive (irrespective of who the whistleblower is or their status) is considered on its merits and the facts and circumstances of the complaint.

53. Should I have urgent concerns about fitness to practice that may be putting patients at risk of harm, or consider that criminal activity may be taking place, I have a number of options to act quickly, such as

    a. if I consider a person is a threat to the health or safety of person or persons I have the power under section 19(3) of my legislation to disclose information to any person I think it is appropriate to do so. This would include the police and/ or regulators.

    b. I have information sharing powers which means that if I have evidence that does not identify a threat, but raises concerns, I can share these with scrutiny bodies such as Healthcare Improvement Scotland. This

means that it can be considered in a wider context alongside other evidence, to decide whether and what action can be taken.

c. if it is appropriate, I can highlight to an individual Board that I have concerns and ask they undertake their own investigatory work as a matter of urgency.

54. The benefit of these approaches is action can be taken quickly, with oversight, and appropriate accountability.

55. In closing, thank you to the Inquiry for inviting me to submit a statement on the work of the INWO and hope that this is of use in your deliberations.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: PD

Dated: 9 January 2025