PE1979/AA: Establish an independent inquiry and an independent national whistleblowing officer to investigate concerns about the alleged mishandling of child safeguarding enquiries by public bodies

Scottish Public Services Ombudsman written submission, 3 April 2024

SPSO experience as Independent National Whistleblowing Officer (INWO) for the NHS in Scotland

1. The INWO was established in response to concerns about how the NHS was responding to concerns raised by those delivering services. It has a broad definition of service delivery covering clinical staff, all NHS employees, contractors directly providing services, volunteers, students, and trainees. While this is significantly broader than protected disclosure legislation, it is not a whistleblowing or complaints procedure for the public.

2. My office is also the independent stage for complaints from members of the public. However, this covers only complaints about the service received by someone and is not a route to raise wider issues.

3. The INWO approach is underpinned by Principles, approved by the Scottish Parliament; it includes whistleblowing standards, and procedures for applying them. These were issued by INWO, following co-production with a range of stakeholders including whistleblowers, NHS employers and employees, and Unions. The approach provides mandatory guidance and procedures for investigating whistleblowing concerns and how to escalate them to the INWO as complaints.

4. I have a duty to monitor the Standards, and also provide support and promote best practice**.** The Standards require mandatory annual reporting by boards. INWO analyses annual reports and publishes our summary report. We also use this to target engagement and support.

5. I am pleased to report that much is working well, though there are gaps in my legislation and scope for development through learning. One area working well is the required support for <u>all</u> those involved, including whistleblowers, those who may be the subject of whistleblowing or may be witnesses, and those who are investigating concerns or supporting whistleblowers. Though this support under my legislation applies only if someone formally whistleblows invoking the Standards.

6. I have reported publicly (as far as I am able because of confidentiality) on a number of investigations. Whistleblowing investigations are more complex and

resource-intensive than complaints from the public. They require significantly more engagement with the whistleblower and others in the organisation.

7. I have also found that resolution-based approaches which facilitate open discussions between the whistleblower and their organisation, can lead to quicker and often better outcomes than committing to a longer and more formal investigation.

8. I have identified areas for improvement. In particular, it has proven more difficult to embed the approach in primary care; there remain difficulties when whistleblowing is around the actions of senior staff; and governance structures need to take a more holistic approach to their organisations' data and concerns raised by whistleblowers to identify and drive improvement and learning. A significant gap in my legislation is the lack of powers to undertake investigations under my own initiative. The practical impact of this is an example where an employee whistleblows via the press or social media but does not invoke the Standards. Even if in the public interest, I cannot investigate these instances; I must have a complaint to become involved.

9. Ultimately, the INWO legislation was, in my view, the right one for the NHS.

Should the INWO role be extended

10. I agree that good-quality, timely investigations might reduce the need for later public inquiries. They are more cost effective and, in my experience, more likely to lead to improvement as they make findings and recommendations closer to the events concerned.

11. It is difficult to hear the concerns of the petitioners and the evidence being shared with the Scottish Child Abuse Inquiry, without having considerable understanding and recognition of the call to make improvements. I note the Children and Young Person's Commissioner for Scotland also has concerns about the current system and said that an INWO role for Education and Children's services merits exploration. I would suggest that this should dovetail with the recently passed UNCRC Act which takes effect in July 2024, in particular with child friendly complaints.

12. I would raise a word of caution however, about rushing into a specific delivery model or role. I recently responded to the Finance and Public Administration Committee's inquiry on the commissioner landscape. In it, I set out my concerns that in a complex scrutiny and regulatory landscape, there are risks when creating new institutions or functions about adding to that complexity. Creation of new roles should, ideally, be after careful analysis of the issues and a full understanding of the existing landscape and where the gaps are. Complexity can deter and prevent concerns being raised, and dilute accountability and responsibility, making failure more and not less likely, however well-meaning the intent behind them.

13. Setting up the INWO was not straightforward.

    13.1. The legislation was complex as anything that touches on the employer/employee relationship is closed to reserved areas. It took considerable time to unpick all of the issues. In the context of legislation relating to children, I can see this being even more complex.

    13.2. The NHS is relatively easy to demarcate but there are challenges where there are shared services about how far I can consider the work of contractors. In the context of this petition, it will be more difficult to set out where education and children's services start and end, and thought would need to be given to that. For example, if a council employee who is not directly providing education or children's services has concerns, could they use the system? Would children's services include all services provided for the benefit of children, or only services which are only provided directly to children?

    13.3. Scrutiny and accountability are easier when whole organisations are covered by single systems. Fragmentation of investigation systems can lead to the real risk of significant issues being lost in the gaps.

    13.4. Co-production is essential but takes time and resources.

14. While I am pleased that the benefits of the INWO model are being recognised, applying this approach to such a different context is not a simple undertaking. It would require careful design to ensure that it was the correct approach to achieve the outcomes desired, based on an understanding of why the current perception, or in some cases reality, is that existing systems are not fully effective.

15. If it is decided that further exploration to establish a new INWO role should be progressed, I would be very happy to contribute to that essential research.