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The Draft National Whistleblowing Standards

Summary of consultation processes and recommendations for changes to the Standards

October 2019

Introduction

1. This report summarises key findings from the consultation on the draft National Whistleblowing Standards, which ran from 1 May to 28 June 2019. There were a total of 86 responses to the survey. In addition to the surveys, we consulted directly with a range of stakeholders during the consultation period, including stakeholders from:
    1.1. health and social care;
    1.2. voluntary sector; and
    1.3. primary care[1].

2. We analysed all closed response questions and compared the proportion of responses for each option from organisations and individuals. There were responses from 53 individuals and 33 organisations, though not all of them responded to every question. Where there was a substantial difference between the responses from organisations and individuals we have noted this below, and highlighted the figures in red. If there is no breakdown of responses, this is because the differences between the two groups were minimal.

3. This report represents the findings and feedback from both these processes, and presents recommendations for changes to the Standards, aimed at making them easier to implement, more robust and clearer for all those needing to use them. It takes into account the SPSO Leadership Team's decisions in relation to publication of the Standards in a web-based format and printable versions.

4. Each recommendation is followed by a short statement (in italics) indicating what action will be taken forward. This follows on from, and reflects, discussions with the Whistleblowing Standards Working Group and with the SPSO Leadership Team (LT) following an early review of these findings.

Structure of the Standards

5. Respondents were asked if the current structure of the Standards was appropriate, or whether they would like to see changes. There were 78 responses to this question. These responses indicate that, while the current structure is generally sound, some consideration should be given to where it might be appropriate to amalgamate sections of the Standards.

[1] Consultations included the Royal College of GPs, British Dental Association, Scottish Royal Pharmaceutical Society, Care Inspectorate, Scottish Social Services Council, Scottish Government's Chief Social Work Officer and representative from their integration team, Health and Care Professions Council, Allied Health Professions Federation, Scottish Council for Voluntary Organisations, Coalition of Community Care Providers, Voluntary Health Scotland and NHS Education Scotland.

	Additional documents are needed for specific purposes	Fewer documents would be better	The current structure is good
% of respondents to this question	12%	41%	47%

6. Respondents were asked whether it was clear which organisations and individuals the Standards apply to, its purpose and audience. There were 71 responses to this question. The figures below suggest that the vast majority of respondents considered the Standards to be largely clear, though there are elements that can be further clarified.

	Completely	Mostly	Partly	Not at all
% of responses to this question	42%	44%	14%	0%

7. There were a range of comments on the structure, reflecting the responses above; some people identified new documents needed:
   7.1. documents aimed at staff who intend to raise concerns and separate documents for organisations implementing the Standards.

8. Others were keen to have fewer documents:
   8.1. merge the principles and overview;
   8.2. merge the procedure sections (Parts 2,3 and 4);
   8.3. merge the governance sections (Parts 5,6 and 7); and
   8.4. amalgamate Parts 7, 8 and 9 as they all refer to the Board and other providers.

9. Others wanted to be able to print the whole document at once. This can be accommodated for the final version.

10. There were several comments about reducing the length, and eliminating any repetition, keeping content simple, and including clear instructions.

11. Others asked for emphasis and repetition to ensure the information was clear and easy to access from different parts of the Standards. It is hoped that having a web-based version will facilitate access across different parts of the Standards.

12. There were requests for summaries with key messages/info for target groups, and for more flowcharts for different scenarios, e.g. primary care.

Recommendations for LT consideration

R1 Merge and streamline Parts 2 and 3, and highlight the definition

Agreed; Standards will be amended.

R2 Merge the governance sections (see R27f or details).

Discussions concluded that the current structure was more helpful for steering staff towards what they need, and that, given the balance of opinion both for and against reducing the number of documents, it would be reasonable to keep the current structure of the Governance sections.

R3 Develop lists of content for specific groups – staff, managers/investigators, managers involved in governance arrangements, Board members – for use in signposting web-based content.

Agreed; this will be reflected in the website, but not in the full text documents.

R4 Develop the Standards in a more interactive, web-based format, with alternative routes to navigate through the content – e.g. routes for different users and/or process oriented routes.

Agreed; this will be reflected in the website, but not in the full text documents.

R5 Identify content which could be displayed in alternative formats, particularly flowcharts, and develop these.

Agreed; this will be reflected in the website, but not in the full text documents.

Whistleblowing Principles

13. Respondents were asked to what extent they agreed with the *Principles*. There were 70 responses to this question. The figures show that there is a very high level of satisfaction with the Principles in their current form.

	Completely	Mostly	Partly	Not at all
% of responses to this question	63%	26%	11%	0%

14. However, we also received comments and suggestions for a range of changes to the Principles. The most significant suggestions were to:
    - 14.1. emphasise the importance of protection for all involved;
    - 14.2. emphasise the importance of confidentiality;
    - 14.3. emphasise the importance of 'business as usual' – concerns being raised and acted on locally;
    - 14.4. emphasise the importance of independence of the 'speak up recipient';
    - 14.5. include a focus on learning as well as improvement;
    - 14.6. include reference to legal protection available to staff; and

14.7. include a focus on improving the process over time as well as improvements to other services.

15. Several comments referred to the need to add the principle of ‘transparency’, with a focus on the governance of findings and lessons learned, as well as public information on satisfaction with the outcomes, while maintaining confidentiality. Aligned to this were calls for the need for accountability for the implementation of improvements as well as any detriment suffered. There was also a suggestion that this could be improved by inclusion of oversight in the Principles, for example through the involvement of a third party such as a union.

16. There were several comments on accessibility, with reference to the need to ensure that any need for reasonable adjustments is appropriately taken into account. These comments included the need to make information about the Standards available in different formats, to facilitate access by all staff.

17. Comments also highlighted the need for access to the Standards to be easy, including the availability of several channels/routes into the Standards (phone, email and face-to-face). It was highlighted that this should always include access to someone with independence from the situation of concern (linked to *Principle 4 – Supportive of people raising concerns*).

18. There were requests for more detail/definitions of particular terms, for example, ‘senior staff’. Each of these suggestions will be considered to see if rewording can make the sentence clearer, or whether a definition needs to be added.

Recommendations

R6 Add a principle of Transparency, with reference to governance of the procedure, sharing lessons learned and accountability for improvements both to services and to the procedure.

Agreed in principle; however, there was discussion around the difference between transparency and openness, and which would be more appropriate given the need to maintain confidentiality. An additional Principle will be added, to reflect the need to share the learning and have a transparent process for handing concerns.

R7 Increase emphasis on key points using bold text rather than more words.

Agreed; Standards will be amended.

R8 In relation to access to the Standards, add reference to the need for a variety of options for staff, including access to a confidential and impartial contact.

Agreed; Standards will be amended.

R9 Review terminology to ensure the use of plain English, with definitions/explanation where necessary.

Agreed to look into the option for external Plain English review of the Standards.

Overview of the process, when to use the procedure, and the flowcharts (Parts 2 and 3)

19. Respondents were asked how clear they found *Part 2: Overview of the Procedure*. There were 64 responses to this question. The figures below indicate that, while the majority of respondents found the overview clear, there is still some room for improvement in this section, to ensure clarity for all readers.

	Completely	Mostly	Partly	Not at all
% of responses to this question	28%	55%	12%	5%

20. Respondents were asked whether *Part 3: When to use the Procedure* provides clear information for staff about what they need to know, particularly in relation to support and protection. Again, there were 64 responses to this question, and again, there is a need to review the content to ensure that staff have access to the information they need, and/or to provides greater signposting to other parts of the Standards.

	Completely	Mostly	Partly	Not at all
% of responses to this question	30%	48%	17%	5%

21. This section of the survey generated more open responses than most of the others. The comments indicated some concerns around clarity and consistency, particularly in relation to consistency between the flowcharts in Part 2 and the text in Part 3. There were also suggestions to amalgamate Parts 2 and 3, or to move a range of different sections of Part 3 into Part 2.

22. The more **straightforward comments**, which will be taken forward in the revised Standards, include:
    - 22.1. increased signposting within the Standards;
    - 22.2. increased emphasis on protection, including moving this section to Part 2;
    - 22.3. highlight all channels for raising concerns;
    - 22.4. more examples/links to case studies;
    - 22.5. include reference to reporting of concerns in Part 2, to show transparency;
    - 22.6. the appendix of other organisations at the end of Part 3 should include the professional bodies – along with various other clarifications in relation to this list; and
    - 22.7. add references to guidance and advice for specific professional groups within the appendix.

23. The reference in Part 2, paragraph 11.3 to people from BME communities was picked up by several respondents. We made reference to this group, as we had heard of the particular vulnerabilities of some people from this group due to their immigration status. However, the consultation responses noted that people from all equalities groups can be put at increased risk of detriment, and this statement should therefore be expanded to include reference to all groups. This should be taken forward in the final version of the Standards.

24. We received some specific comments in relation to the **definition of whistleblowing**, partly to ensure internal consistency with text in the rest of the Standards. There was also a concern that, while this was intended to cover Integration Joint Boards (IJB) and third sector organisations providing health services, this was not clear from the current definition. There were also requests for removal of any link to 'formal' concerns.

25. There were some specific concerns raised with the current text, which are worth exploring in more detail. The most significant of these relates to 'business as usual'.

Moving from 'business as usual' to the Standards

26. **General comments** were raised in relation to this process, and access to the Standards, in relation to both Parts 3 and 4. These comments are combined here. The most **straightforward comments** included:
    - 26.1. identification of a concern as potentially whistleblowing should come before discussion about whether to pursue through the Standards;
    - 26.2. ensure the flowchart mirrors the text, which is clear;
    - 26.3. include reference to interaction with grievance and other HR issues within the flowcharts;
    - 26.4. clarify how to handle a concern that raises an immediate risk to patient safety, in relation to access to the Standards;
    - 26.5. the 'initial discussion' (when the worker decides whether they want to access the Standards) should be fully documented, with the record agreed by both sides; and
    - 26.6. a simple guide on the 'pros and cons' of using the procedure would be helpful.

27. These can largely be taken forward in the revised text without any difficulty.

28. Specific concerns raised around business as usual came from Protect and some Boards. Protect noted that this is where most concerns are currently raised, and that there needs to be protection for people at this level. A few organisations recommended adapting the current procedure, to allow business as usual to be considered at Stage 1 of the Procedure (or an informal stage, similar to other new Once for Scotland procedures), with two subsequent stages, as currently set out. This would create a three stage process. They recommend adjusting

recording requirements to make them less onerous, but otherwise having the same requirements as at Stage 1, including similar expectations about timescales, standards of responses and lack of detriment. These could then be fully considered by the Independent National Whistleblowing Officer (INWO).

29. Moving to a three stage process is not considered an appropriate way forward, given the potential for this to increase timescales and create a longer end-to-end process. We also received a clear and strong view from many members of the Working and Steering groups that 'business as usual' concerns form a significant proportion of NHS time and any requirement to log, record or write them up would be overly bureaucratic and impact of effective working. However, there may be ways to incorporate changes to the existing structure that go some way to allay the concerns around the current proposals. The key concerns are:
    - 29.1. the level of protection given during the ‘business as usual’ stage; and
    - 29.2. the level of scrutiny INWO has over actions taken at this stage.

30. Another concern was that it should not be for the whistleblower to identify an appropriate procedure for their concern; rather, the organisation should determine which policy is appropriate, and their decision is then open to scrutiny by the INWO.

31. **Taking this forward**, while acknowledging the concerns around this issue, the most appropriate approach may be to clarify that staff need to be treated with dignity and respect at all times, and that staff should be encouraged to raise concerns as good practice, as early as possible. But to ensure oversight of this, actions taken during the 'business as usual' stage would be open to review by the INWO (in her remit relating to the organisation’s culture), and that those that struggle to access the Standards could seek advice from the INWO; we would then decide what level of intervention might be appropriate.

32. Linked to the issues around access to the Standards, comments were made about **anonymous** concerns. The following suggestions were put forward:
    - 32.1. wording should be more encouraging of anonymous concerns;
    - 32.2. include information about the limitations of investigating anonymous concerns;
    - 32.3. progressing with an anonymous concern may breach professional codes; and
    - 32.4. clarify how anonymous concerns raised through staff surveys, for example, should be handled.

33. However, of more significance were concerns that, when individuals decide not to use the whistleblowing procedure, their concern is recorded as an anonymous concern. It was suggested that instead, those raising concerns should be able to use 'business as usual', rather than default to an anonymous concern, as they have not consented to being involved in whistleblowing. This was supported further by a concern that it would be hard to check that the decision to be

anonymous was an informed choice. It would also significantly simplify processes for handling comments raised in staff surveys.

34. In relation to **HR involvement**, and the distinction between grievance and whistleblowing, there were several comments around the need to keep HR policies separate from the investigation of whistleblowing concerns. However, some organisations also noted that HR was where there was most experience of handling such concerns, and that they were best placed to offer support.

35. In relation to **support and protection**, respondents noted:
    - 35.1. it would be helpful to have clear examples of support available;
    - 35.2. current HR structures are often unable to provide effective protection from victimisation;
    - 35.3. friends and family should be able to represent the person or support them at meetings, not just professional representatives; and
    - 35.4. an individual's own access to health care should be explicitly protected.

36. There were also several comments noting that there needs to be reference to **malicious concerns**, and the need for protection and support for those accused, particularly when an investigation is ongoing and no fault has yet been found.

37. The role of professional membership and regulatory bodies were referenced by some respondents in relation to:
    - 37.1. need to highlight the support provided by unions and other membership organisations;
    - 37.2. re-registration processes potentially being used to intimidate staff, and this should be noted as a form of detriment; and
    - 37.3. concerns about the actions or behaviours of health professionals should ultimately be referred to their regulatory body.

38. We received varying comments on whether it was appropriate to promote the covert approach to investigating concerns, as indicated in Part 3, paragraph 26 (for example, conducting a random spot check, rather than announcing an investigation). Protect strongly advocated this approach, and said it would be helpful to provide more information and examples, which they could assist with. Others said that this would appear to be advocating covert operations which would not support the ethos of an open and transparent culture aimed at service improvements. While further text may not be required here, it would be worth developing a case study for the appendix, with a link from this paragraph.

39. Part 3 makes reference to **concerns raised in relation to another organisation**, and the consultation responses indicated that there is a need to ensure there is clarity in who is responsible for taking forward such a concern, including how this is fed back to the person raising the concern, and the provision of assurance that appropriate action has been taken. This should also be linked

to clarifications in the Governance section and those relating to primary care and IJB concerns.

Recommendations

R10 Expand flowcharts, to incorporate more information about initial discussions, anonymous concerns and decision-making around whether it meets the definition, ensure consistency with text and add in links to the text.

Agreed; Standards will be amended. This could include further details around access to the Standards and expectations at 'business as usual'.

R11 The definition agreed for the legislation will need to be inserted as appropriate.

Agreed; Standards will need to be amended once legislation has been agreed. Clarification around who this covers should also highlight the vulnerabilities of all equalities groups.

R12 Limited amendments to business as usual, to encourage concerns at this level, including 'good practice' in how such concerns should be handled, with appropriate signposting and access to the Standards.

Agreed; Standards will be amended.

R13 Clarify that when a concern comes to the INWO, the review may take account of how the individual was treated at the 'business as usual' level.

Agreed; Standards will be amended.

R14 Clarify that concerns can come directly to the INWO, if access to the Standards is denied or problematic; the INWO will then take appropriate steps to ensure the concern is progressed appropriately.

Agreed; Standards will be amended.

R15 Reconsider the current approach to anonymous concerns as falling within this procedure, and instead move to an approach that advocates recording and investigating such concerns through whatever procedures the organisation considers appropriate.

Agreed; Standards will be amended. Discussed the various scenarios, and agreed to clarify the difference between 'truly' anonymous concerns, 'unnamed concerns' and confidential concerns. Anonymous concerns and unnamed concerns cannot access the Standards/INWO, though the organisation can choose what action to take, bearing in mind that good practice would be to follow the Principles and investigate in line with the Standards, though this would not be required through the Standards.

R16 Take account of the need for wider clarification as noted in paragraph 31.

Agreed; Standards will be amended.

R17 Clarify that if someone raises an immediate safety issue, action will be taken, and there should **also** be a discussion around use of the Standards for a full investigation if appropriate, with protection of the individual.

Agreed; Standards will be amended.

R18 Concerns that appear to be malicious: Include the requirement to focus on the concern to establish if there is any substance to it, rather than the motivations for raising it. Include the need to ensure that protections are offered to both/all parties.

Agreed; Standards will be amended.

R19 Work with Protect to develop a case study that explores the use of investigation techniques which use 'business as usual' processes to investigate sensitive, confidential concerns.

Agreed, though this will sit with the other case studies, outside the Standards (see Recommendation 43).

R20 Clarify respective roles and responsibilities when concerns are raised within one organisation about the actions of another organisation.

Agreed; Standards will be amended.

R21 Make minor amendments based on all points noted at paragraph 22.

Agreed; Standards will be amended.

Process for handling whistleblowing concerns

40. The survey asked how clear *Part 4: The Whistleblowing Concerns Handing Procedure* is in how it should be applied. There were 65 responses to this question. The figures below indicate that, while the majority of respondents found the overview clear, there is still some room for improvement in this section, to ensure clarity for all readers. In particular, individual respondents found the Procedure less clear than organisations in how it should be applied.

% of responses to this question	**Completely**	**Mostly**	**Partly**	**Not at all**
Individual	36%	42%	14%	8%
Organisation	55%	35%	3%	7%
All responses	45%	38%	9%	8%

(Numbers highlighted in red indicate where there is a difference of 10% or more between the individual and organisational responses.)

41. To gain a greater understanding of how respondents perceived the Procedure, the survey asked them how reasonable they considered the Procedure to be. Again, there were 65 responses to this question. As indicated by the figures below, there was some uncertainty about its reasonableness. Interestingly, there was little difference in response rates from individuals and organisations.

	Completely	Mostly	Partly	Not at all
% of responses to this question	27%	48%	19%	6%

42. Responses to open questions on this section indicate some options for improving the Procedure. Again, there were requests for more flow diagrams to explain the text and guidance/a toolkit for those receiving concerns.

43. Comments on Stage 1 of the process included:
    - 43.1. need to offer a number of channels or routes to raise concerns;
    - 43.2. need to encourage support from a third party at both stages;
    - 43.3. two comments that timescales were not long enough;
    - 43.4. need to ensure that those steered towards a grievance rather than whistleblowing are also signposted to the INWO, so if they do not agree with this decision, they can bring it to the INWO; and
    - 43.5. need for all Stage 1 concerns to get a written response; others said that a record should also be kept of the initial discussion (where access to the Standards is discussed), and for this record to be agreed by both sides.

44. With the exception of the timescales (given the very limited level of criticism expressed about this), there would be merit in making these additions. In relation to written records, a written response at Stage 1 should be sufficient, in that if there is disagreement about what action should be or is taken, the person can take their concern to Stage 2, particularly if appropriate action is not taken to put things right.

45. Comments on Stage 2 of the process included:
    - 45.1. the recipient at Stage 2 should be independent of the situation;
    - 45.2. need to clarify the reporting requirements so all staff are aware;
    - 45.3. investigators need to be independent, properly trained, and given dedicated time to investigate;
    - 45.4. where a third party has been involved, any response should be copied to them, so the worker can be offered appropriate support;
    - 45.5. clarify that concerns can be handled directly at Stage 2, in text and on flow diagram;
    - 45.6. consider how an anonymous concern at Stage 1 could be progressed to Stage 2;
    - 45.7. clarify the scope of the investigatory process, including anticipated outcome; and
    - 45.8. clear criteria for identifying an appropriate investigator.

46. These issues can largely be taken account of in the text, with minor additions, though there will need to be some flexibility around the requirements for investigators, to take account of varying organisational size.

47. The survey specifically asked what respondents thought of the timescales for Stage 2. Again, there were 65 responses to this question. It is significant that the majority of respondents considered the 20 day timescales to be reasonable – around two thirds. However, nearly a third of organisations considered it to be too short, while only a fifth of individuals said this.

% of responses to this question	No, 20 days is too little	No, 20 days is too much	Yes, 20 days is reasonable	Not sure
Individual	19%	6%	67%	8%
Organisation	31%	3%	66%	0%
All responses	24%	5%	66%	5%

(Numbers highlighted in red indicate where there is a difference of 10% or more between the individual and organisational responses.)

48. Of those who wanted longer timescales, there were varying requests for timescales from 30 days to three months. Others wanted shorter timescales, with several respondents suggesting ten days. However, of those that provided comment, around half said that the current timescales were reasonable, though they gave caveats to this, such as:
    - 48.1. need for an emphasis on flexibility;
    - 48.2. it is likely to be frequently extended, though the aim is necessary; and
    - 48.3. only realistic if there is a pool of investigators ready to respond, and they are not required to carry on with normal duties during the investigation.

49. Other comments on timescales included:
    - 49.1. emphasise the importance of updates;
    - 49.2. need to review timescales after two years, to ensure the Standards are realistic; and
    - 49.3. consider introducing mid-point reporting for extended investigations, to address urgent issues of 'quick win' elements.

50. However, on balance, the 20 day timescale is considered to be reasonable. There appears to be a need to emphasise further the availability of flexibility in the timescales. The current text can be reviewed with this in mind, highlighting the importance of making continuous progress and the need for thorough investigations.

51. In relation to a referral to INWO, comments included:
    - 51.1. requests for extension to the timebar;
    - 51.2. need to clarify how the timebar would be applied for ongoing issues;
    - 51.3. need to clarify whether the new procedure is only available for issues which occurred after the introduction of the INWO, or

whether concerns can be raised within the Standards about issues which emerged in the six months prior to the Order coming into force; and

51.4. requests for details of whether and how concerns could be taken directly to the INWO; one Board noted that they would expect a requirement for someone to have tried to access the local procedure.

52. These points raise issues about our own handling of concerns, and while we may want to clarify what options people have, it would not be helpful to provide details on this which may change. It is therefore suggested that we clarify that we can provide information and advice, that we always advocate investigations at the local level, and in limited circumstances we may be able to assist in ensuring a case is appropriately progressed.

53. Comments in the subsequent Governance sections indicated that it would be helpful to understand what actions/sanctions the INWO would take if they found failings. This could best be clarified in the text on INWO intervention.

Recommendations

R22 Include a paragraph on third party support for those raising concerns, including when they could be involved and what information should be shared with them.

Agreed. In addition, it was considered appropriate to include additional information about their role (support rather than advocacy – the person raising concerns is still speaking for themselves as a witness) and any risks for them.

R23 Consider developing guidance or criteria for identifying appropriate investigators.

Agreed; this supporting guidance would sit outside the Standards.

R24 Take forward suggested amendments to Stages 1 and 2 (see paragraphs 43, 45 and 48), while taking account of the need for organisational variations and the benefits of timely responses to concerns.

Agreed; Standards will be amended.

R25 Require a written responses at Stage 1 for all concerns.

Consideration was given to this, but there was concern that this would limit the option of a quick and straightforward oral response in some cases. To accommodate this, it was agreed that the default should be for a written response to be provided. Where the individual agreed this was ***not*** *necessary, no written response would be required, though this decision must be recorded.*

R26 Some additional detail on the INWO role, including advice on access to the Standards, the legislative scope of our investigations and likely outcomes.

Agreed; it was also agreed that there should be further clarification that individuals can come directly to the INWO, though this would not automatically meant the INWO would investigate in the first instance, but that INWO would forward onto the organisation, for them to investigate with INWO monitoring progress.

Governance of the procedure

54. In relation to the overall structure of the Governance sections of the Standards – Parts 5-7 – there were suggestions from several respondents that these sections could be combined and streamlined, and that this might reduce length of text.

55. The survey asked how clear *Part 5: Governance – Board and staff responsibilities* is in relation to Board's responsibilities. There were 61 responses to this question. The figures below indicate that the majority of respondents considered Board responsibilities to be clear, and this was particularly true of organisations. Individuals, however, found this part of the Standards less clear, and we will consider below how they can be clarified.

% of responses to this question	**Completely**	**Mostly**	**Partly**	**Not at all**
Individual	34%	44%	19%	3%
Organisation	48%	48%	0%	4%
All responses	41%	46%	10%	3%

(Numbers highlighted in red indicate where there is a difference of 10% or more between the individual and organisational responses.)

56. Comments in relation to Part 5 indicated the need to promote the Board's responsibilities for building trust, promoting the raising of concerns, and the importance of ensuring staff are all appropriately informed and trained. There was a suggestion that two departments/functions should be involved in monitoring concerns and promoting and implementing the procedure, to ensure consistency and oversight.

57. Comments highlighted the expectations for particular staff groups included:
    - 57.1. **Board members:**
        - 57.1.1. must be responsible for ensuring that speak up arrangements promote trust;
        - 57.1.2. need to promote the use of third parties (such as unions) at each stage of the process; and
        - 57.1.3. must investigate any reasons behind low numbers of concerns being raised.

57.2. **HR:**

57.2.1. should have a greater role in this procedure, given their role in providing support and their experience;

57.2.2. limiting their role restricts the Chief Executive's authority to delegate responsibilities; and

57.2.3. all suspensions and redeployments should be reviewed by HR to consider if they are linked to whistleblowing.

57.3. **Recipients of concerns:**

57.3.1. must have the skills, resources and time to listen and respond in full, including documenting the process; and

57.3.2. must have training, including the role of the INWO.

57.4. **Confidential contact:**

57.4.1. there should be a range of routes available to staff, not just one individual, and this should include by phone, email or in person;

57.4.2. this role should include promotion of trust in raising concerns, through direct contact with frontline staff;

57.4.3. should work closely with Chief Executive (though not necessarily with HR); and

57.4.4. must understand how to handle concerns raised about another service provider/by an employee from a different organisation.

57.5. **Managers:**

57.5.1. must consider the barriers they and other managers have to responding to concerns, and work to remove these barriers.

57.6. **All staff:**

57.6.1. should have responsibility for raising concerns; and

57.6.2. need training in how to raise concerns and the channels to use.

57.7. **Union reps:**

57.7.1. need to ensure third parties are involved in implementation and monitoring of the procedure, as a way of balancing organisational power structures.

58. There were several comments about the need for staff training. This included requests for training for various groups:

58.1. all staff – to promote and raise awareness of access to the Standards;

58.2. those receiving concerns; and

58.3. investigators.

59. There were requests for more information on:

59.1. the role of the Whistleblowing Champions;

59.2. the INWO liaison officer role;

59.3. requirements (or not) to have confidential contact/whistleblowing ambassadors, and if required, is a separate new unit required;

59.4. concerns about senior staff – to ensure consistency in how these are handled; and
59.5. what is meant by 'conflict of interest'.

60. In relation to working with other organisations, there was concern that Boards did not have the jurisdiction to compel contractors or primary care providers to record and report concerns. It may therefore be helpful to clarify the legislative route for this requirement. There was also a suggestion that Boards should have a role in assisting GP practices with investigations, to ensure the investigator is independent and has sufficient seniority to influence GPs.

61. The question was also asked as to whether confidential contacts would be able to accept concerns from other organisations, as they would relate to another employer. The issue of the status of the whistleblowing procedure as an employee/employer function came up in various ways, and it is important that the Standards are clear that concerns can be raised about all NHS services, through a range of routes, depending on local structures and Board arrangements. Including this in a Q & A web page may be helpful.

62. The survey also asked how clear *Part 6: Governance: from recording to learning lessons* is on the requirement to record, report, monitor and learn from concerns. There were 61 responses to this question. Again, organisations showed greater confidence in their understanding of what was required than individuals, though overall, the information provided in Part 6 seems to be clear.

% of responses to this question	**Completely**	**Mostly**	**Partly**	**Not at all**
Individual	31%	47%	19%	3%
Organisation	55%	38%	3%	3%
All responses	43%	43%	11%	3%

(Numbers highlighted in red indicate where there is a difference of 10% or more between the individual and organisational responses.)

63. There were, however, a few comments and suggestions on how to improve clarity. Comments in relation to **recording** included:
63.1. need to be careful of overcounting if confidential contacts are recording concerns that may be 'Stage 1', or may just relate to advice provided;
63.2. request for Boards to work together to share implementation planning and knowledge;
63.3. concern around the resource requirements for recording, and the significant level of information that is being requested for each case; and
63.4. request for further information about confidentiality and the availability of information about concerns through FOI requests.

64. Comments in relation to **monitoring** included:
    64.1. need to emphasise the importance of thematic analysis; and
    64.2. organisations should monitor the volume of concerns, and take action if this is *low*.

65. Some said the indicators should focus on outcomes, not process measures, while others requested additional indicators, including complaints of victimisation for raising a concern and claims against the organisation for whistleblowing detriment.

66. The survey also asked how clear *Part 7: Governance – Board requirements for external services* is on how Boards ensure access to the Standards within organisations that provide services on their behalf. There were 62 responses to this question, with little difference between individuals and organisations in their responses. This part of the Standards appears to need more improvement than the other sections, to ensure it is clearly understood, particularly by the organisations that will be implementing it.

% of responses to this question	Completely	Mostly	Partly	Not at all
All responses	34%	55%	8%	3%

67. Comments on the interaction between the Board and their contractors and primary care providers included several expressions of concern about how this could be implemented (in terms of resources), monitored and enforced. There were requests for greater clarity on the Board's powers to enforce. There was a suggestion that it would be easier to specify the requirements to meet the Standards as a whole in contracts, so that failure to meet them would be a breach of contract. Others suggested that the Standards were too burdensome for small organisations/contractors, and that there is a need for flexibility in how they apply the Standards.

68. In relation to reporting by external organisations, there was a suggestion that Boards should be provided with annual reports, which include how the local systems for raising concerns have been improved following feedback.

69. There was also a request to clarify how accountability would be applied if a Board investigation identified failings in primary care.

70. Concerns were also raised about the resources required to provide confidential contacts for primary care and to assist in primary care investigations. However, the General Medical Council (GMC) pointed out that their clinical governance handbook sets out governance expectations for a learning culture and how it is established and maintained, which are in line with the Standards. This is for

those employing, contracting and overseeing the practice of all doctors – so Boards and GP practices should already have in place systems to support this approach. The GMC have a self-assessment tool to help organisations with this.

Recommendations

R27 There is currently some overlap between Parts 5 - 7, and these sections of the Standards should be amalgamated in the interests of reducing duplication and improving clarity.

Decision taken not to take this recommendation forward – see R2.

R28 Amend the Standards to take account of comments in relation to Board members, Confidential Contacts, managers, all staff and union representatives.

Agreed; Standards will be amended.

R29 In relation to HR involvement in the Standards, this should include reference to signposting and support with other relevant policies and procedures, and staff protections for all parties, but to make reference to investigations being separate from HR.

Agreed; the amendments should clarify that the management and oversight of whistleblowing concerns is not an HR function, however, there may be occasions where expert HR involvement is required to facilitate/support the whistleblowing process.

R30 Include a requirement for training for particular groups as noted in paragraph 58.

Agreed; Standards will be amended. This will include the need for training in supportive conversations/interview skills, given the emphasis placed on the 'initial discussion'.

R31 Provide further information as outlined in paragraph 59, with a particular focus on concerns about senior staff, and how these should be handled.

Agreed; Standards will be amended.

P32 Ensure that Part 1 of the Standards clarifies that the role of the Standards is to provide various routes for raising concerns about *any* service that is delivered by or on behalf of NHS Scotland, and these routes cover a range of 'worker'/employer variations, to ensure safe access for all. Further clarification can be provided in supporting web-based information such as a Q & A page.

Agreed; Standards and web-based information will be amended.

R33 Review text on monitoring of concerns, to emphasise the need to monitor and take action based on themes and trends.

Agreed; Standards will be amended.

R34 Clarify the requirements for all NHS providers to implement the Standards, and the Board's role in ensuring all services provided on their behalf have access to them.

Agreed; Standards will be amended.

Information for other providers and non-employees

71. The survey also asked how clear *Parts 8 and 9* are on the application of the Standards within Primary Care and for IJBs. There were 56 responses to this question. Response rates were similar for individuals and organisations, and indicate that the majority of respondents considered these parts of the Standards to be completely or mostly clear.

% of responses to this question	**Completely**	**Mostly**	**Partly**	**Not at all**
All responses	40%	46%	7%	7%

72. Specific comments in relation to **primary care** included:
    - 72.1. NHS Boards should be responsible for providing confidential contacts for concerns raised about primary care where the employee does not feel safe in raising them internally, and feels the need to have external involvement in the process, and to try to protect their identity;
    - 72.2. staff (or students/trainees/volunteers) working within primary care settings, but employed externally should be able to raise their concerns either locally, or with the Board's confidential contact. This concurs with the need to provide a range of routes for raising concerns, as well as a focus on resolving concerns as close to the point of service delivery as possible, if circumstances allow;
    - 72.3. NHS Boards should be required to provide investigators where concerns from within primary care raise significant concerns which warrant external involvement. This follows discussions from the Royal College of General Practitioners (RCGP), which clarified that the option of using groups of GP practices, based on cluster arrangements, would not work, as there would not be sufficient independence or authority held by the investigator. (It is also noted that this aligns with the GMC's expectations of Boards in relation to their role with primary care doctors.) This will also become increasingly important as more Board and third sector employees are anticipated to work in GP practices over the coming years;
    - 72.4. concerns were raised in relation to the resource implications for both Boards and primary care providers in implementing the Standards;
    - 72.5. request for clarity/information as to how GPs could be protected through the Standards; and

72.6. Boards/INWO will need to provide guidance to practices on what's required for implementation and reporting.

73. It was noted that the contract for GP practices has been renewed, with significant implications for the future shape of general practice. The *2018 General Medical Services Contract in Scotland* does not mention learning from complaints or concerns, but it does reference continual improvement, and the need to share workforce data. Given the Board's role in delivering increased services through GP practices, and the risks involved in *not* having systems in place to ensure staff can raise concerns, there is a strong argument for requiring at least annual reporting to Boards.

74. Comments in relation to **integrated health and social care** included:

74.1. a need to clarify who is responsible for the initial stages of the process;

74.2. where possible, there should be support for health and social care integration within the Standards, and an acknowledgement that the level of integration is likely to increase over the coming years. Taking the focus away from raising concerns being a directly employee/employer issue should assist in this;

74.3. alternative options were put forward in relation to implementation and reporting, with one suggestion being that this should be taken through Chief Officers, and the other that this should fall to the Chief Social Work Officer. However, given the Chief Officer's superiority and their remit over health and social care services, it would be appropriate for this to sit with the Chief Officer;

74.4. suggestion that reporting of concerns should go to the Board's whistleblowing champion and to the INWO;

74.5. there is a need to clarify appropriate signposting at the end of Stage 2 for concerns raised within Health and Social Care Partnerships (HSCP). In particular, it should be clear what the Care Inspectorate (CI) and Audit Scotland (AS) would look at – neither of them will consider how the whistleblower has been treated through the process. AS confirmed that, at best, they can only consider issues within their jurisdiction: value for money, fraud and corruption. CI also confirmed they cannot consider whistleblowing concerns focused on social work services; and

74.6. helpful to have examples of good practice within an HSCP setting.

75. More generally, it was noted that it would be helpful to have more guidance for third sector providers, similar to that for primary care. It was also noted that it would be helpful to have greater clarification as to which organisations are covered by the Standards at the start of the Standards. There was also a request for clarity around how independent contractors could be protected.

76. In relation to the sections for **students and volunteers**, the survey asked how clear *Parts 10 and 11* are on how to apply the Standards for these groups. There

were 54 responses to this question. Again, the organisations seemed to find these sections of the Standards slightly clearer than individuals in how they should be applied. However, overall, the majority of respondents said they were completely or mostly clear.

% of responses to this question	Completely	Mostly	Partly	Not at all
Individual	44%	41%	11%	4%
Organisation	63%	26%	7%	4%
All responses	54%	33%	9%	4%

(Numbers highlighted in red indicate where there is a difference of 10% or more between the individual and organisational responses.)

77. Comments in relation to **students** included:
    - 77.1. clarity on whether medical students on placement should use Board or University procedures;
    - 77.2. clarity on whether consultants with teaching contacts should use NHS or University procedures;
    - 77.3. the need for clear information for medical schools so they can inform their staff and students and prepare for implementation;
    - 77.4. clarity around the role of NHS Education Scotland (NES) for trainees; whether this role is the same as an employer or a university, and whether it would vary for medical trainees (who have a contract with NES) and other trainees (whose training is overseen by NES, but who have contracts with Boards);
    - 77.5. NES have agreements in place with Boards (Allied Health Professionals' NES Practice Placement Agreements), and these should refer to the Standards, so Boards, universities and students are aware of the process;
    - 77.6. clarify any differences between students on placement and trainees; and
    - 77.7. include reference to apprenticeships and internships as being other forms of trainees.

78. Comments in relation to **volunteers** included:
    - 78.1. volunteers should have access to the same information and advice as staff, and there needs to be guidance to ensure this is delivered;
    - 78.2. emphasise early on in the Standards that volunteers should be encouraged to raise concerns;
    - 78.3. move the focus away from volunteers organised through charities, to include greater reference to those volunteering directly for the NHS, (of which there are over 6,000, coordinated by NHS staff) and those volunteering for third sector organisations where volunteers are placed in healthcare settings; and

78.4. the term ‘charity’ is too restrictive, as many other forms of organisation coordinate volunteers working in NHS settings. This includes small self-help or peer support groups. Healthcare Improvement Scotland recommended using ‘volunteer-engaging organisation’ instead.

79. When asked whether it would be helpful to have further targeted information for specific organisations or groups, 15 respondents said it would be. Suggestions included:
    79.1. contracted services/contractors/employees of contractors;
    79.2. agency staff;
    79.3. advocacy groups – including how to ensure raising concerns does not impact on future funding bids; and
    79.4. catch-all document for any other groups.

80. There was a suggestion that this could be in supplementary signposting, rather than as part of the Standards. It could include awareness of the Standards; who to contact; what point to raise concerns as whistleblowing concerns; other processes available to them.

Recommendations

R35 Set out requirements for Boards to provide Confidential Contacts for primary care providers and investigators for Stage 2 primary care investigations where necessary; the Board may also need to be involved in this decision.

Agreed; Standards will be amended.

R36 Ensure it is clear that *anyone* working/volunteering in healthcare settings should be able to raise concerns either locally or with their employer (if different), and have access to the Standards through either route.

Agreed; Standards will be amended.

R37 In relation to concerns within HSCP settings, clarify options/routes for raising concerns.

Agreed; Standards will be amended.

R38 Clarify that the Chief Officer should be responsible for ensuring implementation and subsequent reporting to the relevant NHS Board.

Agreed; Standards will be amended.

R39 Review signposting text for HSCP concerns, to clarify limitations for CI and AS.

Agreed; Standards will be amended.

R40 Clarify when a student should use a university procedure and when it should use the Standards, and how they can access the Standards.

Agreed; Standards will be amended.

R41 Expand application of volunteers section to include those coordinated through NHS and other third sector organisations, and amend language as appropriate.

Agreed; Standards will be amended.

R42 Include reference to protections for agency staff/contractors/advocacy services when raising concerns and include an example in case studies and signposting, rather than add a new section in the Standards.

Agreed; Standards will be amended, with case study to follow for the website.

Case studies

81. The survey asked whether *Part 12: Examples and case studies* provides appropriate information. There were 57 responses to this question. While organisations were again slightly more satisfied than individuals that this section provided them with the information they needed, in general there was a lower level of satisfaction with this section than with others. There is therefore scope to improve this section, based on comments made by respondents.

% of responses to this question	Completely	Mostly	Partly	Not at all
Individual	10%	56%	24%	10%
Organisation	46%	29%	18%	7%
All responses	28%	42%	21%	9%

(Numbers highlighted in red indicate where there is a difference of 10% or more between the individual and organisational responses.)

82. One critical issue is whether the case studies and examples should form part of the Standards, or sit alongside them. Given the requests we have had for expanding the range of examples, it is clear that they are useful. However, they do not directly add to the Standards, in terms of requirements or expectations. It would also be easier to add to them as experience grows, if they sat outside the Standards, but with links to them from relevant sections of text.

83. Some respondents identified improvements to the existing case studies:
    - 83.1. Datix case study – should reflect the fact that the manager should have an action plan in place, which should be triggered by concerns raised via Datix;
    - 83.2. GP case study – there is greater complexity to this example than is evident in the text. RCGP offered to assist with re-drafting; and
    - 83.3. student case study – representation of the charge nurse changing behaviour is unrealistic and should be revised.

84. There were many more requests for more case studies, with a range of suggestions for additional topics, including:

    84.1. clearer information/more examples about 'business as usual' and Stage 1, especially where initial raising of a concern doesn't get support;
    84.2. a concern that involves Counter Fraud services;
    84.3. more examples within small organisations;
    84.4. a malicious whistleblower;
    84.5. referral to the INWO;
    84.6. catering/support services;
    84.7. contractors;
    84.8. volunteers;
    84.9. where working practices are inefficient;
    84.10. where there is good support for implementing the Standards;
    84.11. health and social care services – both NHS and Local Authority staff, and relating to both health and social care issues;
    84.12. using real life examples;
    84.13. where managers are hostile/defensive;
    84.14. difficulties with evidencing a concern;
    84.15. community based examples, including allied health professionals/primary care/health visitor;
    84.16. where there has been detriment at 'business as usual' stage; and
    84.17. role of HR in the process.

85. There were also suggestions around the way the case studies should be formatted or presented, including:

    85.1. structure them so the reader can interact/choose action/outcomes;
    85.2. use flowcharts/info-graphics/images in examples to show the process at work; and
    85.3. make action focused examples.

Recommendations

R43 Remove the case studies from the Standards, and have them as supporting guidance, and include links from relevant parts of the text, particularly for web-based text.

Agreed; Standards will be amended.

R44 Increase the number and range of examples, based around the suggestions in paragraph 84, and with input from other stakeholders where possible.

Agreed; work with the Working Group to identify further case studies, to follow on after the final Standards are laid before Parliament.

R45 Explore options for developing greater variety in the way the case studies are presented, as we prepare for publication.

Agreed; options will be explored with Communications team once draft text has been developed.

Next Steps

86. This paper follows on from, and reflects the discussions had, at the Working Group meeting and the SPSO LT meeting on 10 September 2019.

87. Members of the Working Group have agreed to contribute to more significant changes to the Standards. Their contributions and other amendments to the Standards will be reviewed and collated by the INWO Standards Project Officer, ready for further scrutiny. The Standards will be shared with the Steering Group ahead of their meeting on 9 October 2019. Following comments from this group, the finalised Standards will be passed onto the Ombudsman for sign off by 25 October 2019, ready for laying before Parliament on 28 October 2019.

88. More rapid progress is required in relation to the National Whistleblowing Principles, as these need to be ready for publication on 7 October 2019; this is when they are due to be laid before Parliament, along with the revised draft Order.