INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF ROSEMARY AGNEW

I provide this statement in response to a request under Rule 9(1) and (2) of the Inquiry Rules 2006 dated 24 October 2022.

I, Rosemary Agnew, will say as follows: -

Section 1: Introduction

1. My name is Rosemary Agnew, my professional address is The Scottish Public Services Ombudsman, Bridgeside House, 99 MacDonald Road, Edinburgh, EH7 4NS.

2. My Date of Birth is GRO-C 1964.

3. There are no specific professional qualifications required for the role.

4. I took up the post of Scottish Public Services Ombudsman on 1 May 2017.

5. Prior to this I held senior roles (back to 2001) in:

   - the Commission for Local Administration in England (known as the Local Government Ombudsman and, now known as the Local Government and Social Care Ombudsman
   - from 2008, the Scottish Legal Complaints Commission
   - from 2012 to 2017, I held the office of the Scottish Information Commissioner

6. I have not had membership, past or present, of any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference.

7. I have not provided evidence to or been involved in any other Inquiries or criminal or civil litigation.

8. As already discussed with the Inquiry, at times, an SPSO investigation may touch on some of those issues. I should explain, I take complaints (several thousand a year) where an individual complainant is saying they received poor service resulting in a personal injustice. This means that on an individual basis, SPSO may have knowledge of issues specific to an individual, but unless there are sufficient complaints about the same issue my office may not have the information to make the same links and wider findings such as the inquiry might do.

9. In this context, I was happy to provide what information my office held, which may add value and enrich the Inquiry's wider understanding. While I am not personally involved in every complaint as I delegate my decision-making authority to my officers, I am confident that a thorough review of relevant casework was undertaken and information shared with the Inquiry.

Section 2: National Health Service

10. The NHS in Scotland is within my jurisdiction. This means I can consider complaints about the services provided by NHS Scotland or on their behalf. I can comment and make decision about both the service and the merits of clinical decisions. I issue recommendations for individual redress, learning to drive service improvement, and the way complaints are handled. I am unable to investigate matters beyond the complaints brought to me, i.e., if I do not receive a complaint about a matter, I cannot investigate it.

11. I have the powers to issue principles and model complaints handling procedures for all areas within my jurisdiction. The principles are laid before and approved by the Scottish Parliament, and apply to all sectors (except the Police and Judiciary). There is a specific model complaints handling procedure for the NHS. This has a local two-stage process, at which point a complaint can be made to me. Normally people need to complete the local process before I will take a complaint.

12. Since 1 April 2021, I have also been the Independent National Whistleblowing Officer for the NHS in Scotland. The powers are similar to those I have in relation to complaints from service users. The key difference is they apply to those delivering NHS services in Scotland. That is given a broad meaning in legislation and includes students, trainees and volunteers. I can also take complaints from anyone who has been impacted by a whistleblowing investigation and can consider whether there has been detriment to an individual (this is not only the whistleblower, but also includes others such as witnesses). I cannot become involved in matters of employment law.

13. I have laid principles before the Scottish Parliament and published Whistleblowing Standards, which is a model whistleblowing procedure for handling whistleblowing concerns in the NHS.

14. More detailed information is available on the SPSO's website.

Section 3: Patient Safety Commissioner

15. The Patient Safety Commissioner: Specialist Reference Group was established by the Scottish Government in October 2020.

16. In general terms, the aim of the group was to provide information about the existing landscape as the Scottish Government was developing a proposal for

consultation. I chaired the meetings and discussed the breadth of membership with the Scottish Government.

17. The Scottish Government also established a Patient Safety Group. The Scottish Government decided to merge the groups and after the consultation, an advisory group was established. I was invited to attend those meetings.

18. In response to the recommendations **[RLIT0001833],** the Scottish Government committed to introducing a Scottish Patient Safety Commissioner and conducted a public consultation.

19. My response to the Scottish consultation is available publicly on their consultation website. I have extracted the content of that and it is provided as Exhibit [**WITN7524002**]. In summary, I support the concept of a Patient Safety Commissioner for Scotland. While all organisations concerned with oversight have patient safety as a core outcome and embed patients' voices in their work, I see benefit in a statutory function which would have this as their sole focus.

20. My reservations that have emerged since I responded, are about how this is enacted. There is already a complex regulatory, scrutiny and oversight landscape for the NHS in Scotland; my concern is that creation of another oversight/ scrutiny body where their function and remit is not clearly articulated within the context of the wider landscape, will add confusion for patients (and those delivering services), unnecessary administrative burden for an already overstretched NHS, and crucially will not enable access to justice.

21. I am mindful that the proposal I considered was that made by the Scottish Government. The landscape in Scotland is different to other parts of the UK and the conclusions I have come to about the benefits for Scotland may not apply elsewhere.

22. When deciding whether or not to create or change existing oversight mechanisms, it is important to differentiate between different types of service delivery failure:

    - mismanagement, under-resourcing or restrictions in existing legislation for existing organisations
    - inadequate sharing of information and/ or working together because of exiting legislative constraints, particularly in the regulatory, scrutiny and oversight context
    - that resulting from gaps in the landscape or legislative lacunas which either require new functions to be created or changes to be made to the functions of existing organisations.

23. Each of these require different solutions and, significantly, if the problem is not correctly identified, the solution may exacerbate matters.

For example:

- if a particular outcome for patients is attributed to a gap in the landscape when the root cause was health care resourcing, the creation of a new organisation would not provide the solution, but would make matters worse by diverting funding from front-line services to oversight and scrutiny
- if an outcome for a patent or group of patients was attributed to a gap in the landscape, but was in practice, the result of the inability of existing oversight and scrutiny bodies to share information to give more complete intelligence, creation of such a body may contribute further to the underlying issue of complexity and lack of information sharing ability.

24. In short, complex landscapes can generate their own problems and any changes to them need to ensure a good understanding of the existing landscape *and* what needs to be put right, before implementing solutions to address them.

25. My final comments are that I have not yet been able to fully review the details of the Bill lodged and will be happy to share with the Inquiry my response to the detailed proposal when I have been able to do so.

26. For my response to the Scottish Government's consultation on the creation of a Patient Safety Commissioner, please see Exhibit [**WITN7524002**].

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed

GRO-C

Dated 24 November 2022

Table of exhibits

Exhibit number	Date	Description
WITN7524002	Undated	SPSO's Response to the Scottish Government's consultation on the creation of a Patient Safety Commissioner