Whistleblowing disclosures report 2019-20

Publication date: 30 September 2020

Publication code OPS-0920-441

Every person in Scotland has the right to high-quality, safe and compassionate social care and social work services that make a real and positive difference to their lives. The Care Inspectorate is the national agency responsible for regulating care services including services for adults, early learning and childcare, children's services, and community justice. This includes registration, inspection, complaints, enforcement and improvement support. We make sure services meet the right standards and help them to improve if needed.

We work in partnership with other scrutiny and improvement bodies, looking at how care is provided by community planning partnerships and health and social care partnerships across local authority areas. This helps all stakeholders understand how well services are working together to support positive experiences and outcomes for people

Our job is not just to inspect care but help improve the quality of care where that is needed. This means we work with services, offering advice and guidance and sharing good practice, to support them to develop and deliver improved care.

If we find that care isn't good enough, we take action. We identify areas for improvement and can issue requirements for change and check these are met. If we believe there is a serious and immediate risk to life, health or wellbeing, we can apply to the Sheriff court for emergency cancellation of a service's registration or apply for changes to how they operate.

We support people to raise concerns and we deal with complaints made to us about registered care services. We robustly challenge poor-quality care and we are independent, impartial and fair. We have a duty to protect people and will refer adult and child protection concerns to the relevant social work agencies or Police Scotland.

We influence social care policy and development both nationally and internationally, sharing our learning with others and enabling the transformation of social care in Scotland.

We led the development of the Health and Social Care Standards, jointly with Healthcare Improvement Scotland, on behalf of the Scottish Government. The Standards are clearly focused on human rights and wellbeing and we use them when we inspect services.

The Care Inspectorate was established on 1 April 2011, by s44 of the Public Services Reform (Scotland) Act 2010. In terms of s102 of that Act, it is the statutory successor to the Scottish Commission for the Regulation of Care, established on 1 April 2002, by s1 of the Regulation of Care (Scotland) Act 2001.

We have the general duty of furthering improvement in the quality of social services, set out at s45(2) – 45(5) of the 2010 Act, and must act in accordance with the following principles:

- the safety and wellbeing of all persons who use or are eligible to use any social service are to be protected and enhanced
- the independence of these persons is to be promoted
- diversity in the provision of social services is to be promoted with a view to those persons being afforded choice

- good practice in the provision of social services is to be identified, promulgated and promoted

The Prescribed Persons (Reports on Disclosures of Information) Regulations 2017, requires us to report annually on:

a) the number of workers' disclosures received during the reporting period that it reasonably believes are qualifying disclosures within the meaning of section 43B of the Employment Rights Act 1996 and which fall within the matters in respect of which the Care Inspectorate is prescribed. 'Matters relating to the provision of care services, as defined in the Public Services Reform (Scotland) Act 2010'.

b) the number of those disclosures in relation to which the Care Inspectorate decided during the reporting period to take further action.

c) a summary of:

   i. the action that the Care Inspectorate has taken during the reporting period in respect of the workers' disclosures.

   ii. how workers' disclosures have impacted on the Care Inspectorate's ability to perform its functions and meet its objectives during the reporting period.

d) an explanation of the Care Inspectorate's functions and objectives.

Complaints received

In 2019/20 we received 1,377 whistleblowing complaints. These were complaints from workers in registered social care services relating to alleged failures to comply with legal obligations, or allegations that the health and safety of an individual or individuals had been or was likely to be, endangered. We received no internal whistleblowing complaints from staff.

The complaint pathways, introduced in November 2017 were designed so, following a risk assessment process, we could determine the most appropriate action to resolve a complaint about a registered care service. They allow us to take a proportionate and intelligence-based approach in how we respond, and seek to resolve simple matters more quickly, so that we focus more attention on more serious issues. This enables us to decide how we will proceed and what action we need to take to achieve the best outcome for people experiencing care. There are four routes we can take:

- **Intelligence:** where we receive information about a care service, we may use the information given by a person as intelligence about the service, to help inform future scrutiny activity

- **Direct service action (previously known as frontline resolution)**: where we contact services and ask them to engage directly with complainants to resolve the complaint. Assessing whether direct service action is appropriate takes into account the nature of the allegations and complaint and the profile, knowledge and risk in relation to the provider and regulatory history.

- **Provider resolution**: where we contact the provider and ask them to investigate the concerns and send us written confirmation of the action taken to resolve the complaint.

- **Investigation by the Care Inspectorate:** depending on our assessment of risk, we may decide that we need to formally register and investigate the complaint.

Of the 1,377 whistleblowing complaints received in 2019/20

- 90 complaints (7%) were resolved by direct service action without the need for a formal investigation

- we logged 465 concerns as intelligence (34%)

- 250 cases (18%) were passed directly to providers to investigate.

Revoked complaints

Many complaints do not proceed to a full complaint investigation for a number of reasons, for example concerns not being within our remit, the issues raised in complaints being addressed through the inspection process and complainants not wishing to proceed with the complaint. In these cases, the complaint is revoked.

Of the 1,377 whistleblowing complaints received in 2019/20, 330 (24%) were revoked. This includes 30 cases (2%) which identified child or adult protection concerns and were passed to the appropriate authorities (police or local authority) to investigate.

Complaint investigations completed

Once our investigation is complete the inspector decides if the complaint should be ‘upheld’ or ‘not upheld’. If we have investigated and found there is a lack of evidence to substantiate a complaint, the complaint outcome will be ‘not upheld’. If we have investigated and found evidence that the cause of the complaint is substantiated, the complaint will be ‘upheld’ and we will take action, letting both the complainant and the care service know about any requirements or recommendations we have made.

In 2019/20 we completed 277 investigations of whistleblowing complaints, of which 145 (52%) were upheld.

Impact of whistleblowing complaints

Complaints are an important source of information, and whistleblowing complaints form a significant part of the overall number of complaints we receive. In 2019/20, 24% of the complaints we received were whistleblowing complaints. These complaints serve an important purpose in informing the nature and extent of the regulatory activity that we undertake in the services to which they relate, and can bring to our attention, situations where people experiencing care are at risk and where we need to act urgently to ensure their safety and wellbeing.

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