Whistleblowing disclosures report 2020-21

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Introduction

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 section43B 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.

During the reporting period 2020/2021, the delivery of health and social care was seriously affected by the unprecedented impact of the COVID-19 epidemic. This not only impacted on the way in which the Care Inspectorate undertook its business but the focus of much of the scrutiny shifted to how services were managing in the pandemic and protecting people.

Complaints received

In 2020/21 we received 1340 whistleblowing complaints, of which 974 were anonymous. These complainants stated that they were workers and ex-workers in registered social care services and the complaints related 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. As well as anonymous complaints, workers can make confidential complaints and we will keep their identity confidential from the care service.

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 five routes we can take:

- **Intelligence -** where we receive information about a care service, we may use the information as intelligence about the service to help inform our scrutiny and improvement support activity. For example, bringing forward a full, unannounced inspection of a service.

- **Direct service action –** when issues are straightforward and suitable for quick or immediate action, we contact the service and ask that they engage directly with the person making the complaint to resolve the issues directly with the person. Typically, this is used to intervene quickly and achieve a positive result.

- **Investigation by the care provider –** when issues are suitable for the complaint to be investigated via the service's complaint procedure, we obtain consent to share the person's contact details with the service and we require the service provider and ask them to investigate the concerns and respond to the complaint.

- **Complaint investigation by the Care Inspectorate –** following assessment, we investigate serious complaints about failings in care that have led to or are likely to lead to poor outcomes from an individual or individuals.

- **Adult and children support and protection –** any concerns which require to be assessed as adult or child protection concerns are referred to the lead agency, the Social Work Department. We keep in touch with the Social Work Department until a decision is made about if an investigation will take place. If a decision is made that no investigation is required by them, the issues will be re-assessed and investigated by the Care Inspectorate if this is appropriate.

Of the 1340 whistleblowing complaints received in 2020/2021, 174 complaints (13%) were resolved by direct service action without the need for a formal investigation. We logged 818 concerns as intelligence (61%), while 101 cases (7%) were passed directly to providers to investigate. 56 (4%) complaints were investigated by the Care Inspectorate. The pandemic significantly affected the whistleblowing complaints the Care Inspectorate received and our response. For example, a higher proportion of complaints related to infection prevention and control and the supply of PPE. Public health guidance meant that onsite complaint investigation was not always possible due to the risk of transmitting and spreading infection. We carried out additional risk assessments on all complaints to determine the most appropriate response. This helped us quickly identify the most urgent and serious concerns and take robust action. With regard to complaints about infection control and PPE for instance, we put in place clear escalation processes to ensure the correct practice was being followed by checking the position with the service and we worked with Scottish Government to ensure immediate access and supply of PPE to services..

We shared all concerns relating to Infection Prevention and Control (IPC) and PPE with local health protection teams to ensure support to services and oversight.

We continued to assess all complaints for protection issues, acting swiftly and robustly and making referrals to partner agencies including Police Scotland and local authority social work services as required, to ensure people were protected.

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 1340 whistleblowing complaints received in 2020/2021, 191 (14%) were revoked. This includes 39 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 2020/2021 we completed 56 investigations of whistleblowing complaints, of which 44 (79%) 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 2020/2021, 29% 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.

The complaints function of the Care Inspectorate is an important element in the continuum of our regulatory methodology and contributes to direct action and the accumulation of important intelligence. Each whistleblowing complaint irrespective of its disposal and outcome contributes to the overall scrutiny of care services and their journey of improvement. All complaints influence the shape, focus and timing of inspection activity. Of the 44 complaints which were upheld, 23 of these resulted in requirements for improvement. These requirements then have imposed a need for care services to make improvements in the following areas:

- Healthcare (including inadequate healthcare or healthcare treatment, nutrition, infection control issues, medication issues oral health and palliative care)
- Food quality (2)
- Staff (including staffing levels, training and qualifications along with other fitness issues, recruitment procedures and disclosure checks) (19)

- Protection of people in relation to both adults and children (4)
- Wellbeing concerns generally (3)
- Choice in relation to recreational activities (1)
- Financial issues (1)
- Environment (including fitness of premises or other environment concerns) (1)
- Conditions of registration (1)

There were also 28 services which received formal enforcement notices.

Impact of the pandemic

In this reporting period which has been affected so significantly by the pandemic it is worth reflecting on the impact. While it is not possible to establish specifically how it affected each case, there are some significant points which can be proposed.

Interestingly there were 37 fewer whistleblowing complaints, which is itself a fluctuation which would not necessarily be of great significance. However, it does perhaps indicate that despite the impact of the pandemic, the issues which drove whistleblowing were not significantly different from before.

61% percent of complaints were logged as intelligence compared to 34% in the previous period. This is because of the need to reduce the number of onsite visits to minimise the spread of the virus and a need to approach many cases differently. During this period the reduction in onsite visits was mitigated by significantly increased virtual contact with care services. It was a necessary and proactive decision to approach complaint handling differently resulting in fewer investigations, but all of them still addressed in a variety of ways laid out in the pathways described above. 79% of those investigated were upheld compared to 52% from the previous period. This is arguably evidence of strong assessment in making decisions about what constituted a need for a full investigation based on presenting evidence and perceived risk.

There was minimal difference in those referred to adult and child protection authorities. Only 7% of whistleblowing were passed directly to providers to investigate compared to 18% in the previous period. This is indicative of our risk assessment of the complaints and that a high number were anonymous and we could not establish that they were from staff or from different people and were then dealt with as intelligence to inform the scrutiny assessment of the service. It is important to note that during the period of time covered by this report, many services such as day care for children and adults were not operating during the height of the pandemic, which would otherwise have led to the Care Inspectorate receiving more complaints overall.

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