Whistleblowing disclosures report 2022-23

Publication date: October 2023

Publication code COMMS-1023-463

Introduction

Everyone in Scotland has the right to access 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 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 supporting quality improvement. Our role is to ensure that services meet the right standards, provide the quality of care that meets the needs of people experiencing care and support and to support 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 to support improvement in the quality of care where it 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 impose an improvement notice or apply to the Sheriff court for emergency cancellation of a service's registration.

We support people to raise concerns and we handle 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, contributing to 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 the Public Services Reform (Scotland) Act 2010. It is the statutory successor to the Scottish Commission for the Regulation of Care, established on 1 April 2002, by the Regulation of Care (Scotland) Act 2001.

We have the general duty of furthering improvement in the quality of social services, set out in 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

Complaints about the Care Inspectorate

In 2022/23, we received no internal whistleblowing complaints from staff.

Complaints about registered care services

In 2022/23, we received 5910 complaints about care services. This continues a ten-year trend for increasing numbers of complaints being submitted to the Care Inspectorate. From the complaints received, 26% (1536) were identified as whistleblowing concerns raised by employees of care services. Of this group, 22% (1300) were identified as current employees and 4% (236) were identified as former employees. This is a reduction of 1% on the rate of whistleblowing concerns raised by employees from last year's figures.

Our complaints process allows people to remain anonymous when submitting a complaint. This means their identity is unknown to the Care Inspectorate. Over the past year (2022/23) 67% of people chose to remain anonymous, which is the same rate as the previous year. Where someone chooses to remain anonymous, they also self-identify their relationship to the service, which cannot be verified by us. Over the past year, we have seen an increase in the number of people who wished to be anonymous and self-identified as an employee or ex-employee. In 2022/23, 78% of

people who identified as an employee or ex-employee chose to remain anonymous compared to 73% in the previous year (2021/22). In contrast, 61% of relatives/carers and 43% of people who experienced care chose to remain anonymous.

Complaints about care services 2022/23

Number

- All complaints: 5910
- From people experiencing care: 414
- From relatives/carers: 2778
- From whistleblowers: 1536

% of all complaints

- All complaints: 100
- From people experiencing care: 7
- From relatives/carers: 47
- From whistleblowers: 26

% change from 2021/22

- All complaints: 6
- From people experiencing care: 0
- From relatives/carers: +3
- From whistleblowers: -1

% anonymous

- All complaints: 67
- From people experiencing care: 43
- From relatives/carers: 61
- From whistleblowers: 78

Our latest published full complaints report, Complaints about care services 2019-20 to 2022-23, can be accessed here.

How we deal with complaints

Our complaints procedures are designed to be open, transparent, risk-based and focused on people's experiences. We have two complaints procedures, one for complaints about care services and the other for complaints about the Care Inspectorate. We aim to resolve simple matters quickly and focus our attention on more serious issues. This approach is based on complaint handling guidance from

the Scottish Public Services Ombudsman, in its Model Complaints Handling Procedure. The aim of this model is to standardise and streamline complaints handling procedures across all public bodies. The guidance shows that complaints about a service are best resolved as close to the point of service delivery as possible. Therefore, our approach includes direct service action or investigation by the provider, where we encourage the service to resolve the complaints directly, where appropriate.

We use a risk assessment process that takes into account what else we know about the service, including findings from our regulatory activity, including inspections and intelligence logged from previous complaints, to help us decide how to proceed and what action we need to take to achieve the best outcome for people experiencing care.

Before we act, we assess complaints to ensure that they fall within our remit to investigate; that we have enough information to understand the substance of the concerns; and that we have agreement from the complainant to proceed. If the complaint is not within our remit or the complainant does not wish to proceed, the complaint is revoked, which means no further action is taken. All revoked complaints are still shared with the inspector of the service as intelligence. All potential complaints (including those that were revoked) are logged and included in the count of complaints received. We assess all concerns for any child or adult protection issues. We log and report any protection concerns to the relevant statutory body, for example social work or Police Scotland.

Once we decide to proceed, there are four pathways we can take to reach a complaint resolution.

Intelligence: this is where we record the information given to us and highlight this to the inspector for that service. This approach is only used for lower-risk complaints and complaints where we do not have enough information to proceed. This helps our inspectors develop a broader overview of complaints about a service, which in turn informs the timing and focus of our inspections. For example, additional intelligence from one or several complaints may result in the inspector reviewing the regulatory activity plan for the service. In 2022/23, 790 or 50% of whistleblowing complaints were recorded as intelligence. Many anonymous complaints lack sufficient detail for investigation and are therefore noted as intelligence. We are encouraging more complainants to remain confidential rather than anonymous in the process. This allows us to talk to them when we do not have enough information.

Direct service action: this is where we contact the service and ask them to engage directly with the person making the complaint in order to resolve it. Typically, this is used for straightforward or simple matters where people are unsatisfied with their experiences, and we intervene quickly with a care service to achieve a positive outcome. In 2022/23, 182 or 11% of whistleblowing complaints were referred to the provider for direct service action.

Investigation by the care provider: this is where the risk assessment suggests the issue is suitable for the complaint to be investigated using the service's own complaints procedure. Where possible, we obtain consent to share the person's contact details with the service. We contact the service provider and require them to investigate and respond to the complaint, ensuring a copy of the complaint outcome is shared with the Care Inspectorate. In 2022/23, 130 or 8% of whistleblowing complaints were referred to the provider to investigate.

Investigation by the Care Inspectorate: this is where our risk assessment identifies more serious complaints and we directly conduct an investigation. In 2022/23, 151 or 10% of whistleblowing complaints were investigated by the Care Inspectorate.

Impact of whistleblowing complaints

While the primary responsibility for protecting whistleblowers lies with the provider of the registered care service as the employer, the Care Inspectorate informs whistleblowers of their rights and signposts them to sources of support.

For the regulation of services, all complaints are an important source of information, and whistleblowing complaints form part of the overall number of complaints we receive about care services. In 2022/23, 26% (1536) of the concerns we received were defined as whistleblowing complaints, which is a slight reduction from last year when 29% of all complaints were whistleblowing complaints. Intelligence from complaints serves an important purpose in informing the nature and extent of regulatory activity we undertake in services. Complaints about care services also bring to our attention situations where people experiencing care are at risk and where we need to act to ensure their safety and wellbeing.

The complaints function of the Care Inspectorate is an important element of our regulatory methodology, contributes to direct action and enables us to gather important intelligence. Each whistleblowing complaint contributes to the overall scrutiny of care services and their journey of improvement. All complaints are included in our scrutiny assessment tool (SAT) which directly influences the shape, focus and timing of our inspection activity.

Of the whistleblowing complaints about care services investigated by the Care Inspectorate, 102 or 68% were upheld. Of the 102 complaints that were upheld, 39% of these resulted in requirements for improvement. These requirements imposed an obligation for care services to make improvements in the following areas.

- Choice regarding care and treatment (2)
- Communication (2)
- Environment (4)
- Food (2)
- Healthcare (including inadequate healthcare or healthcare treatment, nutrition, infection control issues, medication issues oral health and palliative care) (24)
- Policies and procedures (3)
- Privacy and dignity (1)
- Property (1)
- Protection of people (6)
- Record keeping (3)

- Staff (19)
- Wellbeing (4)

The Care Inspectorate follows up on all requirements and publicly reports through an inspection report detailing progress on each requirement.

Supporting whistleblowers

When someone tells us they are a staff member or ex-staff member, we inform them of their protection under the whistleblowing legislation. We include information for whistleblowers on our website and when we write to people, we include the following statement in our letter to them:

“As you have identified yourself as an employee/ex-employee in the registered care service, we are informing you that you have rights to protection under the Public Interest Disclosure Act. It can be stressful to raise a concern at work and as a whistleblower you should be supported.”

The Care Inspectorate/SSSC leaflet, Raising concerns in the workplace, gives further information regarding whistleblowing and signposts whistleblowers to organisations that can provide support, including Protect, which is a charity that provides free, confidential legal advice to people who are concerned about wrongdoing at work and not sure whether or how to raise a concern.

Conclusion

The Care inspectorate takes all concerns raised with us seriously. We support whistleblowers, where known to us, to resolve their concerns. We confirm their rights with their employer and signpost them to other sources of support. As a result of receiving and addressing whistleblowing and other complaints, the Care Inspectorate works to make a positive difference to people experiencing care and support improvements in the provision of care services. For next year’s annual whistleblowing report, we will review our policy and analyse different types of whistleblowing complaints against the criteria set out in the statutory guidance for the Public Interest Disclosure Act.

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