NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**28th July 2026**
Title:	**Annual Whistleblowing Report 2025-26**
Responsible Executive:	**Gareth Adkins, Director of People and Culture**
Report Author:	**Dominic Watson, Head of Corporate Governance**

Report Recommendation: The Board is asked to note substantial assurance, based on the content and format of the annual whistleblowing report demonstrating compliance with our reporting requirements under the standards.

1 Purpose

This is presented to Committee for:

- Assurance

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centered

2 Report summary

2.1 Situation

Appendix 1 includes our Annual Whistleblowing Report covering 2025-26 for consideration. The report has been considered at APF and the Staff Governance Committee before being provided to the Board for approval.

2.2 Background

The whistleblowing standards were introduced in April 2021 and include a requirement for every NHS board to produce quarterly reports and an annual report. The annual report summarises activity including nationally agreed Key Performance Indicators and also provides an overview of the learning outcomes from cases concluded during the year.

The annual report must be submitted to the Independent National Whistleblowing Officer (INWO) within three months of the end of the financial year. Where it is not possible to meet this timescale, the report should be submitted as close to the deadline as possible and INWO informed of the reason for any delay.

2.3 Assessment

Appendix 1 includes our Annual Whistleblowing Report which will be submitted to INWO following board approval at the end of July 2026.

The key points from the report are summarised below.

- There has again been a small number of cases raised during 2025-26
- The confidential contacts service was taken in-house on 1 December 2025 and is now provided by the internal team within OpenLine. The contract with the Guardian Service concluded on 30 November 2025.
    - The Guardian Service reported 84 cases between 1 April and 30 November
    - OpenLine reported 41 cases between 1 December 2025 and 31 March 2026
- There is learning from the small number of upheld whistleblowing cases outlined in this report, but caution is required in interpreting the wider implications of the outcomes of these cases. (Further details are provided within the report.

2.3.1 Quality/ Patient Care

The whistleblowing process primarily focuses on resolving individual issues, including concerns related to the quality of care.

The annual report provides some insight into areas for improvement but given the limited number of cases, caution is required when interpreting the findings of these cases. However, the findings do align with issues the board is aware of and the organisational priorities for the board for quality of care.

2.3.2 Workforce

The annual report demonstrates transparency in reporting our implementation of the whistleblowing standards and supports our commitment to encouraging staff to speak up and raise concerns.

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

The main risk identified from the annual report is the timeliness of our investigations and challenges associated with meeting the 20 working days standard. However, we are committed to ensuring that thorough investigations are completed and actions progress to
address any risks identified. This includes addressing any immediate risks to the organisation at the start of an investigation where this is required.

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

The annual report will be considered and approved by the following groups prior to board approval:

- Area Partnership Forum
- Staff Governance Committee
- Clinical Governance Committee

2.4 Recommendation

This report proposes the following level of assurance:

Substantial	X	Moderate	
Limited		None	

The Committee is asked to note substantial assurance based on the content and format of the annual whistleblowing report demonstrating compliance with our reporting requirements under the standards.

3 List of appendices

The following appendices are included with this report:

Appendix 1 – Annual Whistleblowing Report 2025-26

Annual Whistleblowing Report 2025-2026

1 Introduction

This is our fifth annual report which builds on last year's report in relation to learning from feedback about the whistleblowing procedures and acting on specific concerns raised, as well as wider themes that are emerging, taking into account the feedback from previous years.

This report provides an overview of NHS Highland's whistleblowing cases received and progressed during 2025-26, including the key performance indicators used to benchmark the whistleblowing standards across NHS Scotland.

NHS Highland is committed to effective implementation of the standards, supporting staff to speak up and act where required to improve how we work with our staff to deliver health and care services. This report includes a summary of the findings from the concerns investigated, as well as Independent National Whistleblowing Officer (INWO) reviews of some of our cases. We have also included details of changes and improvements resulting from these findings as well as some reflection from last year's report.

2 KPI 1: Learnings, Changes and Improvements as a result of considering Whistleblowing concerns

Our learning from whistleblowing concerns in 2025-26 can be drawn from concerns upheld by NHS Highland. In this section we outline the findings and the changes and improvements we have planned and implemented or are in delivery.

2.1 Upheld Concerns

Of the 4 cases closed in 2025-26 the following outcomes were recorded:

- 2 concerns upheld; 1 concern out of scope
- 2 concerns upheld; 1 concern partially upheld
- 1 upheld, 1 not upheld
- 1 partially upheld; 3 not upheld

The decision was taken to close one case before full investigation took place.

Two cases which were received in 2025-26 remain open whilst investigations take place.

The key findings from the investigations of upheld concerns and resultant agreed actions are outlined below:

Case 1

The first concern related to the use of funding within the department. The concerns had already been investigated under the NHS Scotland conduct policy, but a member of staff remained concerned that this had not been fully investigated.

The investigation concluded that available records did not reliably demonstrate that all expenditure directly benefited those involved. The lack of a robust audit trail was identified as a weakness in financial assurance and non-compliance with NHS standards. The concern was therefore upheld.

The second concern was that there was insufficient governance, documentation, and audit trail to demonstrate that expenditure decisions were compliant with the purpose of the funding and relevant guidance. The concern was upheld and was primarily related to the purchase and use of vouchers as part of the distribution of benefits using the funding available.

The third concern sought assurance that the issues had been appropriately investigated under the relevant workforce policies, insofar as they related to the conduct of one or more NHSH staff connected with the use of the funding. This concern was not eligible for consideration under this investigation, as it related to issues already considered through separate workforce processes conducted in line with NHS Scotland policy. Therefore, it was considered as out of scope.

Key finding: The investigation identified the same issues that had been identified during the conduct investigation including weaknesses in financial governance, with insufficient documentation and audit trail to demonstrate compliant use of funding, while workforce conduct matters were deemed out of scope. The key weakness related to the purchase and use of vouchers. This has been eliminated as vouchers can no longer be purchased through NHS Highland financial processes due to the challenges associated with ensuring robust, auditable tracking of the use of vouchers.

Case 2

Three concerns were raised within this case relating to a community-based service. It is important to note that there were ongoing investigations through professional oversight arrangements for this service which had already identified issues that needed to be addressed. However, the staff raising concerns felt their concerns had not been fully explored and wished to have a separate whistleblowing investigation.

The first was whether care had been delivered in a safe, patient-centred manner. The investigation upheld this concern noting issues with medication administration that had been reported through the adverse event reporting system. This related to different groups of staff involvement in medication administration: care at home staff and a personal assistant employed by the client. In addition there was variation in practice relating to the recommended 2:1 ratio for client care related to a difference in practice between groups of staff. There were some instances where 2:1 care was not adhered to when staff were available to provide this ratio of staffing but also instances where 1:1

care was provided due to not following an agreed process to request assistance from the family or escalating the issue with management to request additional assistance.

Further training has been provided on medication administration to the individuals in this case. In addition, a review of the NHS Highland guidance on medication administration processes for families, personal assistants and care at home staff has been recommended. Guidance has been provided on managing 2:1 care and escalating staffing issues for this particular case.

The second concern was whether staff were supported within the workplace. The investigation partially upheld this concern as there was not sufficient evidence to indicate that concerns raised by staff had been acted upon and staff did not feel supported to raise concerns with line management (see linked concern below). However, there was evidence that staff receive regular supervision including observation of practice through line management arrangements although supervision records did not include sufficient detail and could be improved.

The third concern was whether there was a clear process for raising and investigating concerns. The investigation upheld this concern in relation to understanding of raising concerns with managers and with recording adverse events through the Datix system. Although managers felt it was clear there was a process for raising concerns, staff themselves were unclear on how to raise concerns. In addition, not all staff were not clear the process for raising clinical and care issues through the datix reporting system resulting in incomplete reporting.

Key finding: The investigation found failures in safe, patient-centred care delivery, insufficient staff support, and inadequate processes for raising and investigating concerns. The recommendations of the report included wider implications for NHS Highland care at home in relation medication administration guidance for staff, families and personal assistants. Training and guidance on raising interpersonal issues through workforce policies as well as re-enforcing the importance of raising concerns with managers has been recommended as well as training the use of datix. Supervision processes are also to be improved.

Case 3

The first concern was that there was a lack of general basic care within a specified ward. The investigation concluded that there was insufficient evidence in current practice to uphold this concern.

The second concern was that a patient had been identified as requiring 1:1 nursing care but not consistently receiving that level of care. The investigation concluded that there was sufficient evidence to uphold this concern.

Key finding: While there was no evidence of widespread basic care failures, the investigation upheld that required 1:1 nursing care was not consistently provided. The investigation highlighted that a

number of improvements had already been identified and progressed in relation to the quality of care on the ward. Some additional actions were identified and added to the recommendations of the report and communicated to the whistleblower. The recommendations were welcomed by the whistleblower and demonstrated the value of raising concerns in order to improve quality of care.

Case 4

The first concern raised was in relation to staffing and potential service delivery failures within the specified service and actual harm arising due to a shortage of staff. The investigation partially upheld this concern in relation to acknowledging that the service has had persistence challenges with staffing levels due to challenges with workforce availability and ability to recruit into vacancies. However, there was no evidence that harm had occurred to individuals that the service was responsible. It was acknowledged that the staffing levels and resulting mitigations utilized for periods of short staffing did have an impact on the frequency of contact between staff and service users, which staff would like to see addressed.

The second concern was that there had been a potential delay in identifying a medical issue and whether understaffing had contributed to 'a service delivery failure' with a potential link to delayed recognition of a serious injury. The investigation did not uphold this concern.

The third concern related to workload and whether warnings about unsustainable caseloads had been ignored and were creating unacceptable safeguarding risks. The investigation did not uphold this concern.

The fourth concern related to the impact on safeguarding decisions and whether management pressures, combined with inadequate staffing, had directly impacted on the team's ability to deliver safe, timely care. The investigation did not uphold this concern.

Key findings: Although staffing levels were found to be impacting on service delivery and no evidence was identified linking this to specific harm, delayed injury recognition, or compromised safeguarding decisions.

Case 5

The decision was taken to close this case prior to full investigation as the whistleblowing asked for their concerns to be withdrawn. This was a complex case that involves multiple processes under workforce policies that are still ongoing. The option remains open to the whistleblower to request concerns to be progressed

The learning themes from these cases have some similarities to last year's report:

- Availability of permanently appointed workforce is an ongoing area of concern for staff in relation to the impact it has on staff morale and the potential for workforce shortages to impact on quality of care.
- Staff are concerned about the persistence of challenges and issues relating to service pressure including the impact on quality of care and believe that either actions have not been identified or are not progressing quickly enough
- Staff may not feel supported or be aware of how to raise clinical and safety concerns on a day-to-day basis through operational and professional management
- Staff may not feel supported or be aware of how to raise clinical and safety concerns through clinical governance processes including datix reporting

There are some new themes this year:

- All 4 cases had some overlap with ongoing investigations and/or quality improvement work, some of which related to investigations related to workforce policies
- Due to the confidential nature of workforce policy investigations staff are not necessarily aware of actions that may address some of their concerns and this can result in a staff feeling that some of their concerns have not been addressed
- The whistleblowing investigations provided some additional information that supplemented ongoing investigations and resulting recommendations.
- The whistleblowing investigations provided assurance to staff that action was being taken in relation to upheld concerns where they may not have been aware of actions already initiated through other routes of identifying issues with quality of service or quality of care.

As with previous year's, the small number of cases does make it difficult to generalize the findings to the wider organization, however two specific recommendations were generated that have wider organizational applicability:

- The use of vouchers was identified as a weakness that could be eliminated by changing wider organizational policy, albeit that this has not been an issue that is widespread.
- A review of guidance on medication administration in situations where NHS employed staff work alongside carers and personal assistance employed by service users will help clarify roles and responsibilities across NHS Highland.

2.2 Concerns not progressed as whistleblowing

One concern did not progress to investigation under the standards as it was agreed with the whistleblowers that further discussion with management would be appropriate. The concerns related to the impact of delays in agreeing to a future funding model for service delivery that had initially been funded on a fixed term basis. Service delivery had been impacted by the lack of confirmation of ongoing funding which has now been resolved but the staff were unhappy with the delays in the progress of the development of the service and the impact was having on service users.

In addition, staff were unhappy that additional fixed term funding remained unutilized at the end of the financial year due to the delays in agreeing permanent funding and delays in utilizing the fixed term funding.

Further discussions were planned and agreed between management and the whistleblowers to address their concerns.

2.3 Organizational Changes and Improvements

As outlined above each case was responded to individually and appropriate recommendations agreed with whistleblowers. The small number of cases do make it difficult to generalize but broadly speaking they align with areas of ongoing improvement work as outlined below.

Health and Care Staffing Act Programme

We are continuing to strengthen our ability to use the tools and methods associated with the Health and Care Staffing Act to identify areas of ongoing challenge in relation to workforce availability and work with staff to mitigate the impact on staff and service delivery. This includes:

- Continuing roll-out of safe care to support real time staffing assessments and risk escalation and management
- Testing of a service planning framework in maternity services to identify options for a sustainable workforce and service delivery model

Workforce availability

The use of agency has continued to reduce with recruitment to our workforce aided by a range of initiatives including our employability strategy and associated action plan.

Our Quality Framework

Progress has been made with establishment of a new head of clinical governance and quality who is leading the implementation of our quality framework across NHS Highland. This will continue our work to:

- Foster a culture in which staff feel confident to raise concerns about the safety and quality of clinical and care services

- Strengthen clinical and care governance arrangements to ensure concerns are identified, addressed and reflected in improvement planning
- Promote a shared understanding of quality to support the delivery of high-quality services within available resources

3 KPI 2 - Experiences of all those involved in the whistleblowing procedure

The number of whistleblowing cases raised and concluded each year remains small and the key information we have available to us to assess experience is feedback from:

- Individuals involved in the process
- INWO case reviews

Individual Feedback

Feedback from the four cases concluded this year is limited but, in all cases, there was a mix of concerns which were upheld; partially upheld; and not upheld by NHS Highland.

In two cases the whistleblowers were satisfied with the outcomes of the reports which included a mixture of upheld, not upheld and partially upheld concerns. A key part of this successful outcome was the investigator meeting with the whistleblowers to discuss and explain the outcomes.

In one case the whistleblower remained unsatisfied with the outcomes of the final report where the concerns were not upheld. This case is now under review by INWO. It is understandable that some individuals will be dissatisfied with the outcomes of an investigation and where INWO upholds these concerns we will act.

In relation to the remaining case, we have received no further feedback from the individual.

Once case involved multiple witnesses being interviewed in relation to the concerns related to the quality of care provided and potential harm to service users. It was reported by some of these witnesses that this was a difficult experience for them as they felt this may be perceived as a reflection of their own personal and professional practice as these witnesses were involved in service delivery. This is a difficult dynamic to manage, however the lead investigator took all steps possible to handle interviews as sensitively as possible.

INWO case reviews

Two INWO case reviews remain open, and we will await the outcome of the investigations. No INWO case reviews were concluded during 2025-2026 from which to draw experiential learning.

4 KPI 3: Levels of staff perceptions, awareness and training

We continue to promote routes for staff to speak up through a range of mechanisms, including the formal whistleblowing policy and standards. Our confidential contacts service is now delivered in-house and is promoted widely across the organization. Since its launch on 1 December 2025, 41 staff have used the service for advice and support, including helping to access the whistleblowing procedure.

While staff do use both the confidential contacts service and the whistleblowing procedure to raise concerns, awareness of the standards and, to a lesser extent, the confidential contacts service remains variable. We will therefore continue to prioritize awareness-raising across the organization.

Speak Up Week

NHS Highland participated in National Speak Up Week, led by the INWO, from 29 September to 3 October 2025.

During the week, the Guardian Service, acting as our Whistleblowing Confidential Contacts, visited sites across the Board area to promote speaking up and the Whistleblowing Standards. This was supported by local and national resources, press activity and social media. Members of the executive team also took part in sessions across the organization to raise awareness and support speaking up, alongside pledges to reinforce this message.

Non-Executive Whistleblowing Champion visits

As noted in previous reports, our Non-Executive Whistleblowing Champion undertakes regular visits to sites across the Board area throughout the year. These visits provide opportunities to hear directly from colleagues and to reflect on their experiences and insights.
Whistleblowing Champion carries out regular visits throughout the year to key locations and sites across the Board area. He listens to colleagues and reports back on his experiences and insights.

Executive visits, engagement and visibility

The executive team also undertakes regular visits to locations across the Board area and listens directly to colleagues. While these visits cover a broad range of issues and are not solely focused on speaking up, they contribute to senior management and Board visibility across the organization.

Induction and training

All new staff attend the 'Welcome to NHS Highland' induction, a half-day online session covering NHS Highland, our services, strategy, values and leadership. This includes guidance on raising concerns, speaking up, the Confidential Contacts Service (OpenLine) and the Whistleblowing Standards, so colleagues understand from the outset how concerns can be raised and addressed.

We continue to signpost colleagues to TURAS online learning whenever we promote speaking up and whistleblowing. Investigating managers are also directed to this learning at the start of each new concern to ensure they remain up to date. We recognize that uptake of specific whistleblowing standards training remains relatively low but are also aware that staff may choose not to complete this training until they have a need to understand the whistleblowing standards in more depth when they have a concern to raise.

5 KPI 4: Total Number of Concerns Received

During the period 1 April 2025 to 31 March 2026, NHS Highland received six whistleblowing concerns, of which five were received in Quarter 2, one in Quarter 3 and one in Quarter 4. Five were closed in the period; one remains ongoing.

In the first case the concerns related to expenditure initially incurred during the 2022/23 financial year, where funding designated specifically for the benefit of a service was alleged to have been used in part for purposes not directly aligned with that intention. The concerns were initially raised internally in 2024, that some expenditure may have personally benefited NHSH staff or the general operation of the service, which included service users other than the intended recipients.

The individual subsequently contacted INWO in July 2025 to express their concerns about accessing the local whistleblowing procedure. INWO advised that the individual had raised a concern through supervision meetings and with managers between January and September 2024 whilst working for the Board. The individual had been given assurances that matters were being investigated. However, the individual advised INWO that they had not been interviewed regarding their concerns, evidence had not been taken up until they left the Board, and they were not aware of any investigation outcome.

The investigation started in October 2025 and completed in March 2026. Two of the concerns were upheld; one concern was deemed out of scope. Four recommendations were made and these are now being progressed.

The second case was received in August 2025 from the Guardian Service where staff had raised their concerns on three topics: whether care was delivered in a safe, patient-centered manner (this was upheld); whether staff were supported within the workplace (this was partially upheld); and whether there was a clear process for raising and investigating concerns (this was upheld). The investigation began in September 2025 and was completed in March 2026.

Four recommendations were made regarding: a review of administration of the medication process; clear processes should be put in place for all staff regarding raising concerns to their line managers; carry out a review of datix handling; and carry out a review of supervision and appraisal process. These recommendations are being implemented as required.

The third case was received via a union and related to concerns regarding patient safety in a hospital ward. The concerns were specifically that there was a lack of general basic care on the ward, and that a patient requiring 1-1 nursing care was not consistently receiving it.

The investigation took place in September 2025 and on completion concluded that there was insufficient evidence in current practice to uphold a number of the concerns relating to the first area raised. There was, however, evidence to uphold some of the concerns relating to the first concern, and also to the second concern about 1-1 care.

Eight recommendations were made, which included the need for additional staff; the reinforcement of training and supervision; adaptation of the ward safety brief; continued investment to allow staff to progress through competency frameworks; continued engagement with visiting services to provide a variety of specialist education; and continued support of the senior staff member by providing a visible and consistent presence on the ward.

The fourth case was received in August 2025 and related to whether staffing shortages in a specified service meant that service needs could not be met (this concern was partially upheld); whether delays led to a potential delay in identifying a medical condition (this concern was not upheld); whether warnings related to workload were ignored (this concern was not upheld); and whether there had been an impact on safeguarding decisions (this concern was not upheld).

The investigation was completed in December 2025, and 19 recommendations were made as a result. These are now progressing.

The fifth case was received in November 2025 from the Guardian Service and related to the ability to provide a safe, effective service which had been negatively impacted by the use of contractors; the rework of the service following its return from contractors; delays due to the contractors; machine breakdowns due to lack of investment; plus use of non-framework contractors.

After consideration it was agreed to cease this investigation under the whistleblowing standards.

The second open case was received in January 2026 and relates to the circumstances surrounding a patient's treatment. An investigating officer was identified in March and is now progressing the investigation.

There are no other cases open from previous reporting years.

6 KPI 5: Concerns closed at stage 1 and stage 2 of the whistleblowing procedure as a percentage of all concerns closed

All cases that were investigated and closed were stage 2 concerns (100% stage 2).

7 KPI 6: Concerns upheld, partially upheld, and not upheld at each stage of the whistleblowing procedure as a percentage of all concerns closed in full at each stage

Of the 4 concerns closed in 2025-26 the outcomes all 4 were partially upheld (100%)

8 KPI 7: The average time in working days for a full response to concerns at each stage of the whistleblowing procedure

The average time in working days for all cases closed in 2025-26 was 94.8 working days. The minimum was 29 and the maximum was 184. The longest period related to a case which was being investigated over the Christmas and New Year holiday, and this hampered arrangements for meetings with witnesses. As this was a case referred by INWO, they were kept updated on progress throughout the investigation.

9 KPI 8: The number and percentage of concerns at each stage which were closed in full within the set timescales of 5 and 20 working days

There were no Stage 1 concerns raised in this period.

None of the Stage 2 concerns raised within this period were within the 20 working days standard.

We recognize that the average and maximum times of these cases significantly exceed the 20 working days for Stage 2 concerns within the standards. As noted in our previous annual reports, we have worked on reducing avoidable delays in our whistleblowing processes. One particular aspect we have improved is the identification and assignment of investigating officers and ensure they have adequate time to undertake the task. This does not appear to be the main factor impacting on duration of investigations.

The complexity of the cases is the main factor in the timescales including:

- the amount of data and evidence to gather and review
- Liasing with witnesses and whistleblowers to gather witness statements
- Analyzing data and evidence to produce a final report and recommendations

While we continue to focus on a timely investigation, it is equally important to focus on achieving the outcomes sought by the whistleblower and maintaining the quality of both the investigation and the final report.

10 KPI 9: The number of concerns at stage 1 where an extension was authorized as a percentage of all concerns at stage 1

There were no Stage 1 concerns raised in this period.

11 KPI 10: The number of concerns at stage 2 where an extension was authorized as a percentage of all concerns at stage 2

There were five concerns resolved at Stage 2; 100% of these had extensions granted.

12 Reporting processes

Quarterly Reporting
NHS Highland Executive Whistleblowing Lead presents the quarterly Whistleblowing reports to the following formal governance committees:

- NHS Highland Board
- NHS Highland Staff Governance Committee
- NHS Highland Area Partnership Forum

All efforts are made to ensure that reporting is timely and prompt, however, it has to be noted that meetings of governance committees are bi-monthly and so often there will be some lag. However, all committees are given time and space to scrutinize the reports and discuss.

In addition, there is dynamic discussion and reporting via the Executive Lead into the Executive Directors Group as well as to specific leaders, to ensure that any urgent matters are rapidly addressed.

2025 / 2026 reporting

Quarter	Period covered	Area Partnership Forum	Staff Governance Committee	NHS Highland Board
Q4 2024-25	1 January - 31 March 2025	13 June 2025	1 July 2025	29 July 2026
Q1 2025-26	1 April – 30 June 2025	15 August 2025	02 September 2025	30 September 2025

Q2 2025-26	1 July – 30 September 2025	10 October 2025	3 November 2025	25 November 2025
Q3 2025-26	1 October – 31 December 2025	13 February 2026	03 March 2026	31 March 2026
Annual Report 2025-26	1 April 2025 - 31 March 2026			