NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**29th September 2026**
Title:	**Quarter 1 Whistleblowing & Confidential Contact Report**
Responsible Executive:	**Gareth Adkins, Director of People & Culture**
Report Authors:	**Gareth Adkins, Director of People & Culture** **Carolynn Lawrie & Peri Stewart, Confidential Contact Advisors**

1 Purpose

This is presented to the Committee for:

- Assurance

This report relates to a:

- Legal requirement

This report will align to the following NHSScotland quality ambition(s):

Safe, Effective and Person Centred

This report relates to the following Strategic Outcome(s)

Start Well		Thrive Well		Stay Well		Anchor Well	
Grow Well		Listen Well	X	Nurture Well		Plan Well	
Care Well		Live Well		Respond Well		Treat Well	
Journey Well		Age Well		End Well		Value Well	
Perform well	X	Progress well					

2 Report summary

2.1 Situation

This report is for Quarter 1 covering the period April to June 2026.

This is provided to give assurance to the committee of our performance against the Whistleblowing Standards which have been in place since April 2021.

2.2 Background

All NHS Scotland organisations including Health and Social Care Partnerships are required to follow the National Whistleblowing Principles and Standards which came into effect from 1 April 2021. Any organisation providing an NHS service should have procedures in place that enable their staff, students, volunteers, and others delivering health services, to access the National Whistleblowing Standards.

As part of the requirements, reports are required to be presented to the Board and relevant committees and IJBs, on an annual basis, in addition to quarterly reports. The Area Partnership Forum plays a critical role in ensuring the Whistleblowing Standards are adhered to in respect of any service delivered on behalf of NHS Highland. Both quarterly and annual reports are presented at the meetings and robust challenge and interrogation of the content takes place. The Confidential Contact Service, known as OpenLine, provides our Whistleblowing Standards confidential contacts service. OpenLine will ensure:

- that the right person within the organisation is made aware of the concern
- that a decision is made by the dedicated officers of NHS Highland and recorded about the status and how it is handled
- that the concern is progressed, escalating if it is not being addressed appropriately
- that the person raising the concern is:
  - kept informed as to how the investigation is progressing
  - advised of any extension to timescales
  - advised of outcome/decision made
  - advised of any further route of appeal to the Independent National Whistleblowing Office (INWO)
- that the information recorded will form part of the quarterly and annual board reporting requirements for NHS Highland. Staff can also raise concerns directly with:
  - their line manager
  - The whistleblowing champion

- The executive whistleblowing lead

Trade union representatives also provide an important route for raising concerns. In the context of whistleblowing standards, the trade union representatives can assist staff in deciding if:

- an appropriate workforce policy process could be used including early resolution
- the whistleblowing policy and procedures could be used to explore and resolve concerns that involve wrongdoing or harm

Information is also included in the NHS Highland Induction, with training modules still available on Turas. The promotion and ongoing development of our whistleblowing, listening and speak up services is a core element of the Together We Care Strategy and Annual Delivery Plan.

2.3 Assessment

2.3.1 Quarterly Activity Update

Summary of Quarter 1 Whistleblowing covering the period April to June 2026:

- Two concerns were raised to be considered under the whistleblowing standards:
  - One case is being resolved through ongoing dialogue with complainants and service managers
  - One case was deemed ineligible due to length of time since the event (2021) and an ongoing grievance process which relates to the concern raised
- One case was closed with 2 concerns upheld and 1 concern out of scope with recommendations in Appendix 1

Two cases remain under investigation:

- A case involving clinical decision-making related to conveyance to hospital or treatment at home and the outcome for the patient

- An Investigation remains ongoing into the case reopened by INWO, as reported in the last quarter.

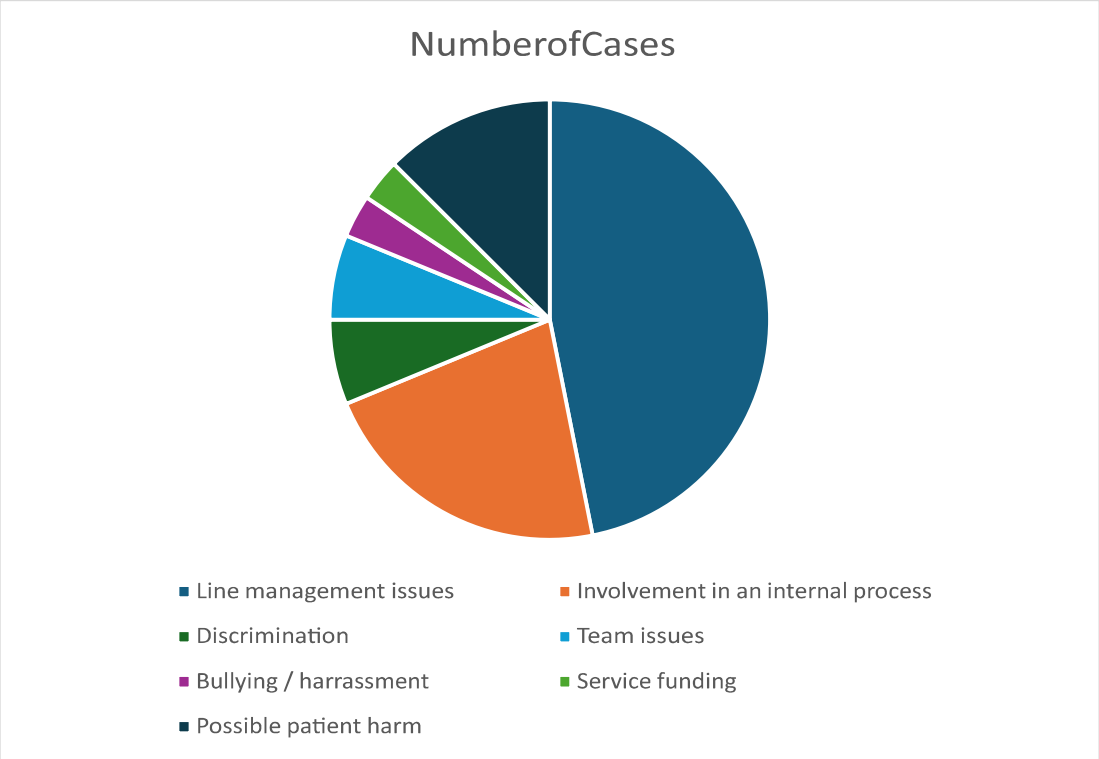
A previously closed case with 1 partially upheld concern and 3 concerns not upheld is being reviewed by INWO to determine whether they will formally investigate.

The table in Appendix 1 summarises the cases with recommendations that are still in progress and review dates. It is worth noting that recommendations are dependent on the specific context and circumstances and the associated governance arrangements will vary. However, a review date has been set for the whistleblowing function to check with those tasked with the recommendations on progress to date. This will include considering whether the work requires a further review date set.

Summary of Quarter 1 Confidential Contacts covering April to June 2026:

- 32 cases were received in the quarter, up to 30 June 2026 (one case related to both service funding and possible patient harm):
  - Fifteen cases relate to line manager issues
  - Seven cases relate to involvement in an internal process (primarily lack of information / update on a process)
  - Four cases relate to possible patient harm
  - Two cases relate to discrimination
  - Two cases relate to team issues
  - One case relates to bullying / harassment
  - One case relates to service funding

- The 32 cases were split fairly equally between phone calls and emails. Some follow-up meetings took place on Teams or in person.



- As of 30 June 2026, one case remains open.

2.3.1 INWO Investigation Outcome – Vascular Services

The Independent National Whistleblowing Officer (INWO) has issued its final report (Appendix 3) and accompanying decision letter (Appendix 2) regarding a whistleblowing complaint raised with INWO on 25th July 2025 which related to vascular services.

The complaints investigated were:

- The Board have not taken reasonable action to manage the risks in the Vascular Service (upheld)
- The Board's investigation did not make reasonable recommendations (not upheld)
- The Board did not handle C's concern in line with the National Whistleblowing Standards (upheld)

The Ombudsman considered comments submitted by NHS Highland on the draft report and made a number of factual amendments and clarifications to the final report, including changes to protect confidentiality and corrections to factual inaccuracies.

The public summary report will be published on 23 September 2026, with private appendices remaining confidential and subject to restricted circulation. NHS Highland is required to provide evidence of implementation of the recommendations within the timescales specified in the final report, including provision of an apology within four weeks of publication.

An apology has been drafted and is ready to issue and an executive group has been established and met to consider the report recommendations. The group includes the Medical Director, Chief Officer of Acute Services and the Director of People and Culture and has agreed operational leads who will develop and progress an action plan to respond to the recommendations.

The Ombudsman acknowledged improvements already implemented by NHS Highland and noted that a planned internal audit of whistleblowing arrangements will support implementation of recommendations.

The recommendations and outcomes of the action plan will be reported to INWO and through quarterly whistleblowing reports to the staff governance committee

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	x
Limited		None	

Comment on the level of assurance

The committee is asked to take moderate assurance on basis of improvements required to the process that will be progressed through an action plan including an internal audit of the process.

3 Impact Analysis

3.1 Quality/ Patient Care

The Whistleblowing Standards are designed to support timely and appropriate reporting of concerns in relation to Quality and Patient Care and ensure we take action to address and resolve these.

3.2 Workforce

Our workforce has additional protection in place under these standards.

3.3 Financial

The Whistleblowing Standards also offer another route for addressing allegations of a financial nature.

3.4 Risk Assessment/Management

The risks of the implementation have been assessed and included.

3.5 Data Protection

The standards require additional vigilance on protecting confidentiality.

3.6 Equality and Diversity, including health inequalities

No issues identified currently.

3.7 Other impacts

None.

3.8 Communication, involvement, engagement and consultation

N/A

3.9 Route to the Meeting

N/A

4 Recommendation

Moderate Assurance – To give confidence of compliance with legislation, policy and Board objectives noting challenges with timescales due to the complexity of cases and investigations.

4.1 List of appendices

The following appendices are included with this report:

Appendix 1 – Case recommendations and Governance Summary report

Appendix 2 – Letter to Board – INWO Final Report

Appendix 3 - INWO Final Report

Appendix 1 – Case Recommendations and Governance Summary

Case ID	Summary	Recommendations	Actions	Review date	Update
WB20 2025-26	Misuse of funds	• Remove voucher-based expenditure and reinforce policy compliance • Reinforce compliance with applicable Standing Financial Procedures and other relevant workforce policies • Introduce and/or improve standardised documentation and audit trail requirements	As per recommendations	N/A	Actions complete as this was a review following a previous HR based investigation
WB17 2025-26	Concerns raised in relation to whether care was being provided in a safe, patient centred manner	• Review of Administration of Medication process to prevent situation arising whereby both NHS Highland staff and families can order and dispense medication independently of each other • Clear processes should be put in place for all staff regarding raising concerns to their line managers. Staff should feel safe at work and confident that any concerns are heard and responded to in a professional, open and honest manner. • Any interpersonal professional issues should be dealt with using the Once for Scotland policies and recorded accordingly. • Training should be provided to team leads and all relevant staff. • Review of datix handling. • Staff should all be able to complete a datix electronically and receive notification of investigation and learning outcome. • Staff training should be provided for datix completion and equipment available to complete in a timely manner. • • Review of supervision and appraisal process. • Supervision should be provided on a more regular basis with clear guidance on the aims of supervision with record being kept and shared with staff member.	• Undertake audit regarding administration and training • Provide refresher training • Ensure all staff have access to DATIX and receive appropriate feedback • Ensure supervision takes place regularly and appraisals to be undertaken annually	October 2026	

		• Appraisals should take place annually in line with NHS Highland expectations and electronic system used to conduct these meetings, sign off but both parties.			
WB18 2025-26	Lack of general basic care on concerns with consistent provision of 1:1 nursing care	• Review senior nursing staff levels and support roles on ward • Improve staff training and supervision, particularly for enhanced care and 1:1 patients. • Streamline the ward safety brief to improve communication and efficiency. [WB report • Continue investment in clinical education and specialist support services. • Maintain visible senior nursing leadership and management support on the ward.	As per recommendations	September 2026	
WB19 2025-26	Under Staffing and Service Delivery Failures Potential Delay in identifying patient harm Impact on Safeguarding Decisions	• Ensure the findings of this investigation are formally incorporated into the Argyll & Bute Health Visiting Service Review and used to inform a sustainable future service model. • Commission an immediate review of the reduced staffing guidance, including the traffic light approach, to ensure it is risk assessed, version controlled, consistently applied and does not result in prolonged gaps in planned contact with children and families. • Seek assurance that the requirements of the Health and Care Staffing Act are fully embedded, including real-time staffing assessment, risk escalation, staff training and routine governance reporting. • Develop and implement a workforce action plan covering staffing capacity, skill mix, workload allocation, administrative support and protected leadership time for the Health Visiting Team Lead. • Strengthen staff communication and engagement by ensuring regular feedback on huddles, team meetings, Datix incidents, supervision, service developments and multi-agency issues.	As per recommendations	October 2026	

		• Establish robust assurance arrangements for professional practice, including record keeping, caseload supervision, visibility of children and families, and consistent use of escalation and support processes. • Use the service review to identify and implement practical improvements to service access and efficiency, including clinic arrangements, electronic records, reduced travel time and stronger professional links across Argyll & Bute and NHS Highland.			

INDEPENDENT NATIONAL WHISTLEBLOWING OFFICER
People Centred | Improvement Focused

Bridgeside House
99 McDonald Road
Edinburgh
EH7 4NS

Tel 0800 008 6112
Fax 0800 377 7331
Web inwo.spso.org.uk

CONFIDENTIAL

Ms Fiona Davies

15 September 2026

Our ref: 202408925

(by email)

(please quote our reference on all correspondence)

Dear Ms Davies

Complaint about Highland NHS Board

Please note that the Public Summary Report is embargoed until 12:00 (noon) on 23 September 2026

1. I refer to the draft report my office sent to you on 21 August 2026. Thank you for Mr Adkins' email with initial comments dated 25 August and Dr Peters' email confirming accuracy dated 4 September.

2. I considered Mr Adkins' comments when finalising my report and I have summarised my response to them in Annex 2 at the end of this letter.

3. I also received comments from the complainant and I have made a small number of minor changes as a result. I have summarised these changes in Annex 3.

4. Following comments received from Scottish Government and NHS Scotland, I have added two paragraphs to the Executive Summary of the Public Summary Report to provide a summary of the comments received.

5. Finally, I have added a paragraph to more clearly explain the scope of my investigation at paragraph 13, under the heading 'Publication'. I have also made it

clear in paragraph 75 that my investigation has not involved a review of specific patient cases.

Final report

6. I now attach the final report of my investigation which is made under Section 15(1)(a) of the Scottish Public Services Ombudsman Act 2002. The investigation has been conducted with the support of my complaints reviewer and I am satisfied that all relevant issues have been addressed in the investigation. The enclosed report represents my final decision and the conclusion of my investigation. A copy of the public summary report, with public appendices will also be sent to Scottish Ministers and laid before the Scottish Parliament (see also paragraph 10 below). When this happens, the report becomes a public document which means that the media has access to it and may publicise it.

7. Section 15(3) of the Scottish Public Services Ombudsman Act says that, generally, reports of investigations should not name or identify individuals. For this reason, the complainant is referred to as 'C'.

8. The final report includes the dates by which I expect your organisation to provide evidence that the recommendations have been implemented. I regret that the draft report erroneously specified a twelve-week timescale for the apology recommendation. I have updated the date so that the evidence of an apology is due within four weeks from the date of publication. Please accept my apologies for this error. If there are any questions about the recommendations, please do not hesitate to contact my complaints reviewer.

9. Section 15(4) of the Scottish Public Services Ombudsman Act 2002 requires you to make arrangements for members of the public to inspect or obtain copies of the report and to publicise such arrangements. It is not for my office to direct how this is to be achieved. However, I generally suggest to public bodies that the simplest and most effective method would be for them to carry an announcement (on their websites) that the Ombudsman had issued a Whistleblowing Complaint Report relating to their organisation and providing a hyperlink to the published text of the

report on our website. I have been advised that this would comply with Section 15(4) referred to above.

10. Please note that only the summary report will be published. This is to protect the identity of the complainant and those involved in the investigation.

11. **Please take steps to ensure the private appendices are not shared with individuals beyond those outlined in Annex 1, below.**

Yours sincerely

Paul McFadden
Scottish Public Services Ombudsman

Enc: Final Report
Final Appendices

Investigations by the Scottish Public Services Ombudsman (the INWO is part of the Scottish Public Services Ombudsman) are to be carried out in private, in terms of the Scottish Public Services Ombudsman Act 2002. This helps prevent any prejudice to the confidentiality of our investigations. Accordingly, we ask recipients to respect this privacy. This does not affect the rights of recipients to seek legal advice in relation to this complaint. We also ask that recipients respect the privacy of our staff. Where appropriate, recipients are reminded of their obligations under Data Protection Legislation in relation to the processing of personal and sensitive personal data. If you want to know more about how we handle your own personal information, you can read our Privacy Notice on our website at https://www.spso.org.uk/privacy-notice-and-disclaimer or ask us for a copy.

Annex 1: Summary of documents that make up the full INWO report and restrictions on publication

Document Name	Description	Restrictions at final stage
Summary Report on complaint about the Board Reference: 202408925	Pseudonymised summary of complaint investigation and findings	None Published in full
INWO - Appendix 1 - Detailed Consideration (a) and (b)	Confidential discussion of complaints (a) and (b)	• Complainant • Chief Executive • Internal investigator • Whistleblowing Lead (Director of Workforce) • Board Medical Director • Operational Medical Director • Chief Officer (Acute) • Head of Operations • Former Clinical Director for Surgery • Current Clinical Director for Surgery • The External Reviewer • Whistleblowing Champion (Appendix must not be shared wider.)

Document Name	Description	Restrictions at final stage
INWO - Appendix 2 - Interview evidence (a) and (b)	Confidential overview of evidence from interviews regarding points (a) and (b).	• Complainant • Chief Executive • Internal investigator • Whistleblowing Lead (Director of Workforce) • Board Medical Director • Operational Medical Director • Chief Officer (Acute) • Head of Operations • Former Clinical Director for Surgery • Current Clinical Director for Surgery • Whistleblowing Champion (Appendix must not be shared wider.)
INWO - Appendix 3 - Detailed Consideration of Complaint (c)	Confidential discussion of the points considered within complaint (c)	• Complainant • Chief Executive • Internal investigator • Whistleblowing Lead (Director of Workforce) • Head of Corporate Governance • Board Medical Director • Whistleblowing Champion (Appendix must not be shared wider.)

Annex 2: My response to your comments on the provisional decision

In the following, I have summarised your comments in bold text. My responses can be found below each of your comments in plain text.

Comments within Mr Adkins' email dated 25 August

1. **We did engage with INWO standards team to discuss managing business as usual versus whistleblowing standards and the option to manage as business as usual was acknowledged as one option – We have already learnt from this case from 2 years ago and are more thoughtful of initiating the WB process sooner rather than later. A wider observation is that some WB cases we are handling are now running alongside multiple business as usual processes and for the avoidance of doubt it may better to accept potential duplication and initiate WB processes even if there are other processes underway investigating similar concerns. Our annual report for this year notes the overlap that exists for several of our recent cases.**

   My response: Thank you for your reflections on my findings. It is encouraging to hear that the learning from this case has been embedded within current practice.

2. **We have an internal audit scheduled for WB processes which will be helpful in meeting the recommendation to review governance and our WB processes.**

   My response: I acknowledge the planned audit and I agree this should support NHS Highland to meet the recommendation.

3. **Appendix 2 refers to Occupational therapy support for staff – section 26 – I think this should be occupational health**

   My response: Thank you for highlighting this error. I have amended the relevant text in paragraphs 26 and 29.

4. **I am concerned that the identity of the confidential contact could be compromised as it will be well known across a wide number of staff that there are only 2 individuals in this role**

My response: I accept this point. At paragraph 98[1], I have updated 'Confidential Contact' to 'witness with experience of the organisation's speak up process' and removed further text that would imply their role. At paragraph 106, I have changed 'Confidential Contact' to 'witness'.

5. **We will review information governance but I would like to highlight that both myself and the head of corporate governance would have access to the WB data given our roles in the process so I am unclear why the confidential contact has raised concerns about our access to this data.**

   My response: I acknowledge that you are unclear why a Confidential Contact would have concern about you having access to personal data of people accessing Open Line and details of concerns discussed. Having reviewed paragraph 10.13 of Appendix 3, I believe I have included sufficient information to explain their concern and so I have not made changes.

   The first aspect of the concern is that the Confidential Contacts had provided staff with assurance that their name and what they want to discuss is confidential and is not further shared. However, if other senior managers have access to the names and details of the concerns, then this undermines the assurance provided by the Confidential Contact.

   The second aspect of the concern is that staff who approach Open Line may wish to confidentially discuss concerns about senior managers. If staff with these concerns knew that their name and details of their concerns could be accessed by a senior manager and director, they may not feel comfortable discussing their concerns with Open Line, which would undermine the effectiveness of the service.

6. **I am unclear why the confidential contact has raised concerns regarding the wider confidential contacts service and in particular:**

   6.1. The responsibility for whistleblowing sitting with HR was a barrier to some staff speaking up

[1] Paragraph numbers have changed in the final report due to the addition of two paragraphs to the Executive Summary

6.2. A number of staff would prefer the speak up service (Confidential Contacts) to still be with the Guardian Service.

My response: To be clear, the comments from the Confidential Contact were based on their experience of speaking to staff working in NHS Highland and their confidence in using the local whistleblowing system.

7. **These concerns have not been raised with me and whilst I respect an individual's perspective I am concerned that this is then reflected in the report as :**

7.1. The evidence gathered from a Confidential Contact indicates that the non compliance with the procedure may not be an isolated example and there may be wider issues with the culture of handling concerns and implementation of the National Whistleblowing Standards within NHS Highland.

8. My response: I regret that this comment does not meet the grounds. Nevertheless, I am satisfied that, when read with paragraph 108, the findings are evidence based and proportionate.

Annex 3: Overview of changes based on comments from the complainant

Section	Change
Summary Report – paragraph 20	I have added a footnote to clarify that the North of Scotland Vascular Surgery Operational Delivery group included NHS Highland, NHS Grampian and NHS Tayside.
Summary Report – paragraph 22	C highlighted that, by end of 2024, all mainland health boards, including NHS Glasgow and NHS Lothian, were involved. I have removed 'the North of' to avoid potential confusion about the extent of involvement of other boards as 2024 progressed.

Report of the Independent National Whistleblowing Officer

Overview

Scottish Parliament Region: Highlands and Islands

Case ref: 202408925

NHS Organisation: Highland NHS Board

Subject: Patient Safety

This is the report of the Independent National Whistleblowing Officer (INWO) on a whistleblowing complaint about the handling of a whistleblowing concern. It is published in terms of section 15(1) of the Scottish Public Services Ombudsman Act 2002 which sets out the INWO's role and powers. There is more information about this here: https://inwo.spso.org.uk/

Supported by the private appendices, it is a full and fair summary of the investigation.

Executive summary

1. The complainant (C) had concerns about issues with the provision of the Vascular Service within NHS Highland and the impact of these issues on patients and staff. Initially, C experienced difficulty accessing NHS Highland's whistleblowing procedure. After approaching the INWO, my office set out the expectations of the National Whistleblowing Standards and sought assurance that C's concerns would be handled under the procedure.

2. The Board then handled C's concerns at stage 2 of the procedure in the National Whistleblowing Standards. The investigator met with C and spoke with several other staff involved in the Vascular Service.

3. At the conclusion of the investigation, the Board shared a stage 2 response to inform C about the outcome of the investigation. The stage 2 response upheld C's concern and made recommendations.

4. C was not satisfied with the recommendations from the Board's investigation and remained concerned about how the Board had managed the risks in the Vascular Service. C asked the INWO to independently review the Board's actions in response to the concerns they raised about the service.

5. The complaints I have investigated are:

    5.1. The Board have not taken reasonable action to manage the risks in the Vascular Service (*upheld*)

    5.2. The Board's investigation did not make reasonable recommendations (*not upheld*)

    5.3. The Board did not handle C's concern in line with the National Whistleblowing Standards (*upheld*)

6. My investigation has focussed on the period spanning November 2023 to July 2025, the date that C approached my office following NHS Highland's investigation.

7. To support my investigation, a complaints reviewer carried out several interviews with NHS Highland staff involved in the delivery and management of the service. I also obtained independent advice from a suitably qualified professional to inform my assessment of the Board's actions to manage the risk.

8. As a result of my findings, I am asking NHS Highland to implement a number of recommendations that aim to support learning and improvement in concern handling and ensure robust governance regarding potential patient harm and Duty of Candour

9. While I recognise the significant support that other boards have provided to NHS Highland from 2024 onwards, I am concerned about the effectiveness of the system that supported, but also limited, NHS Highland's access to mutual aid.

10. In view of the significant systemic barriers to NHS Highland managing the risks identified, I shared a draft of this report with the Scottish Government and NHS Scotland and sought their comments on a recommendation that aims to ensure that consideration is given to establishing an effective and reliable framework in place for mutual aid that prioritises timely, fair and equitable access to care for patients in NHS Scotland.

11. In response, I was informed that, last year, DL 2025(25)[1] was issued to establish Sub-National Planning arrangements across NHS Scotland. These arrangements support broader priorities for health service reform and renewal, providing strategic leadership and oversight to progress work on sustainable service models, including those relating to vascular care.

12. Scottish Government and NHS Scotland both described their intention to work with the Sub National Planning and Delivery Committees to jointly agree an approach for mutual aid arrangements whilst long term sustainable solutions for services are developed and implemented.

[1] *Implementation of sub-national planning: co-operation and planning directions 2025 (NHS Scotland)*

Publication

13. In publishing this report, I recognise that my findings may be a source of concern for patients and their families that have used the Vascular Service in recent years. It is important to note that my investigation has not involved a review of the care and treatment provided to individual patients, but instead how NHS Highland managed the risks within the service and the systemic factors that impacted on this. NHS Highland retains responsibility for meeting the Organisational Duty of Candour and the recommendations from my investigation will seek assurance that this has happened.

14. To be transparent and help improve services, the INWO publishes its findings and conclusions whenever possible. However, it cannot publish all the details of its reports because some information must remain confidential. Under the SPSO Act 2002, investigation reports should generally not identify individuals. To protect privacy, names in the report have been changed and gender-specific titles and pronouns have been removed.

15. This summary report is supported by several private appendices that contain more detailed analysis of the evidence. To protect the confidentiality and identity of C and others involved in the investigation, these appendices have not been published. Access to them is limited to only those within the Board who need to see them.

16. This document includes a **Summary of documents that make up the full INWO report**, including a list of the appendices and the restrictions relating to their publication and sharing.

17. Both C and NHS Highland were given an opportunity to comment on a draft of this report.

Background

18. NHS Highland's Vascular Service has experienced workforce challenges for several years. In September 2023, NHS Highland commissioned an external review of Vascular Surgery, including 'an assessment of the current configuration and sustainability of the independent Vascular Services within Highland Health Board.'

19. In November 2023, the external review concluded. The report included recommendations for short, medium and long term changes. The report noted:

    19.1. 'A combination of factors causes the Vascular Services in Highland Health Board to be an extremely 'fragile' service. The only conclusion is an inevitable collapse of the currently configured service in the short to medium term (0-2 years) but potentially occurring more suddenly with little to no notice.'

20. Following the report, the North of Scotland Vascular Surgery Operational Delivery group formed to facilitate discussions between the three mainland Health Boards in the North of Scotland.[2]

21. The long-term aim was for vascular services in the North of Scotland to be reconfigured in a 'hub and spoke' model. This means that there would be an agreement with one or two other health boards (hubs) to provide Vascular Surgery services to NHS Highland (as a spoke).

22. In 2024, NHS Highland's Vascular Service became increasingly dependent on support from other boards. Throughout 2024, short periods of mutual aid support were agreed with other health boards to cover periods of staff leave. However, no other health board in Scotland had capacity to provide long term support for NHS Highland Vascular patients.

23. In June 2024, the Vascular Task and Finish Group was formed. The group was chaired by an independent vascular consultant with experience in service redesign and involved representation from across NHS Scotland. The terms of reference stated that 'The purpose of the Task and Finish Group is to focus on supporting

[2] The group included NHS Highland, NHS Grampian and NHS Tayside.

sustainability by planning on a population basis across Scotland to improve access to safe, quality services for our population.'

24. In September 2024, the actions from the meeting of the Vascular Task and Finish Group included plans to establish an emergency pathway and support for elective surgery for NHS Highland patients for the next 2-3 months.

25. In the final quarter of 2024, NHS Highland continued to escalate the risks and clinical pressures and request mutual aid support.

26. Following a further reduction in staffing, in early 2025, NHS Highland decided to stop arterial surgery. An agreement was reached between the medical directors of NHS Tayside, NHS Grampian, NHS Lothian and NHS GGC to provide 'mutual aid' vascular support to NHS Highland on a rotating basis, each doing one week in turn.

27. Under this interim model, NHS Highland's Vascular Service was responsible for triaging referrals from primary care and facilitating transfers to other health boards. These arrangements provided access to care for patients that needed emergency care, but there was a group of patients with serious vascular conditions that did not have a pathway to receive treatment for their condition.

28. The Vascular Task and Finish Group continued to meet in 2025. In March 2025, it was noted that 'the mutual aid model had highlighted the need for vascular services to be redesigned and that the problem exists for the whole of Scotland to contribute and manage. [NHS Tayside] highlighted that [they] cannot take Highland patients without support from elsewhere.'

29. In May 2025, NHS Highland highlighted that, with no clear pathways, there was further significant risk as waiting patient cases deteriorate and become emergencies.

30. Despite extensive discussions about a sustainable operating model for the North of Scotland, it was not possible to implement the recommended option of the Task and Finish Group in a timely way.

31. Over the course of 2025, the mutual aid arrangement continued and NHS Highland worked to improve access to care for the non-emergency patients. In August 2025, a

group of higher priority patients were divided between five health boards with plans for treatment.

Findings and decisions

Complaint (a) – The Board have not taken reasonable action to manage the risks in the Vascular Service

32. In their submission to the INWO, C raised a number of different complaints about how the Board managed the risks in the Vascular Service. In view of the issues raised, my investigation has considered:

    32.1. The Board's actions following the independent review in November 2023

    32.2. The decision to stop arterial surgery in January 2025

    32.3. The Board's communication with stakeholders

    32.4. The Board's approach to reviewing incidents and concerns reported by staff

    32.5. The handover of patients as part of a staffing change

NHS Highland's response

33. NHS Highland's whistleblowing investigation upheld C's concerns about the delivery of NHS Highland Vascular Services and the impact this has on patient care. The investigation report noted:

    33.1. 'It has been established that the current service provision does not meet the standard set for the Provision of Vascular Service. It is noted that the current established service neither functions as a main Vascular Centre (Hub) or a Centre within a clearly defined Vascular Network (Spoke).

    33.2. 'The investigator is aware of the current ongoing discussions being had with respect to the NHS Highland being potentially affiliated with NHS Tayside as part of a Network.

    33.3. These discussions are ongoing with other Health boards with a potential to realign networks to ensure populations sizes are within the limits.'

34. NHS Highland provided detailed comments on each of the issues raised by C in their complaint. I have summarised the key points as part of my findings below.

Advice

35. I obtained independent advice from a suitably qualified professional to inform my assessment of the Board's actions to manage the risk. I have summarised the key points as part of my findings below.

Findings

The Board's actions following the independent review in November 2023

36. C said that they were supportive of the External Reviewer's Report, but it appeared that senior managers were not happy with report or could not follow it.

37. In response to my enquiries, the Board said:

37.1. The external review was accepted in full from the point that it was received. This was a review that was commissioned by the Board in response to concerns raised by the clinical teams and the aim was to get an objective view of how services could be provided in Highland against the recommendations of The Vascular Society of Great Britain and Ireland (VSGBI).

37.2. It became clear that a single board was not able to take on NHS Highland as a 'Spoke' service in the medium to long term and work began across the North of Scotland with planning support to move to a Network approach.

37.3. Over the last 10 years, vascular surgery has moved to greater Interventional Radiology (IR) and hybrid IR and minimally invasive surgical methods. The number of IR consultants has not matched this demand and this puts further pressure on Boards to deliver the required number of procedures.

37.4. This meant that the number of Boards required to support NHS Highland increased from one to four. This required escalation to the Scotland wide Chief Executives group, National Services Scotland Planning group and to the Cabinet Secretary for Health and Social Care as well as the executive of NHS Scotland.

37.5. It is extremely hard to see any single intervention or group of interventions that would have made a demonstrable change [to the situation]. However, being able to provide capital investment in physical capacity for Interventional radiology in a centre with sustainable staffing would have reduced the time to preparing a target national operating model. Retrospective learning is that an earlier forum to discuss clinical Mutual aid would have been helpful. This has been introduced at a national level for Oncology and this has been a useful forum.

38. The Adviser said this case illustrates some of the issues affecting many parts of the NHS. While responsibility for operational service delivery sits with health boards, there must also be a framework in place to ensure all parties engage effectively when service delivery spans several boards and other agencies. After a promising start with a clear definition of what the vascular service serving the patients in the North of Scotland should look like, the transition has not been achieved over two years later.

39. The Adviser considered that the Board had taken reasonable steps to implement the recommendations from the External Reviewer's Report. However, it had not been possible to implement the transition due to factors outwith NHS Highland's control. Capacity issues at the other Health Boards involved mean that the creation of a North of Scotland Vascular Service has stalled.

40. The Adviser was also satisfied that NHS Highland made a reasonable attempt to escalate the risks, and continued to seek support on a continuing basis from other health boards.

41. I gathered detailed evidence from witnesses about how NHS Highland managed the risks and the impact of the issues on patients and staff. It was clear that several factors impacted on the Board's ability to provide timely and effective care and treatment to patients including:

41.1. Challenging working relationships within the service made it harder for the Board to recruit and retain locum consultant surgeons.

41.2. Limited radiology capacity and lack of arterial duplex scanning[3] contributed to delays in patients receiving treatment.

41.3. When arterial surgery stopped in in January 2025, the mutual aid arrangements were generally effective at ensuring that patients could access emergency care. However, there was a large group of patients with serious vascular conditions that did not have access to a pathway until later in the year.

41.4. Discussions with other boards about mutual aid could be challenging. Meetings were also occurring at different levels of management, which meant that agreements reached at one level were not always upheld at other levels.

41.5. A lack of alignment amongst the Clinical Leadership about how the Vascular Service should be delivered put strain on working relationships with other boards and added complexity to discussions about mutual aid.

42. The evidence provided by NHS Highland and the information I have gathered from witnesses demonstrates multiple factors impacted on NHS Highland's ability to transition to a spoke centre as part of a sustainable operating model. I accept the advice received that the Board had taken reasonable steps to implement the recommendations from the External Reviewer's Report.

43. It is striking that the External Review report from November 2023 accurately predicted the collapse of the Vascular Service, but despite the efforts to anticipate the collapse and establish a sustainable model, it was not possible for the service to transition in the same way that other Boards in the same position had done previously.

44. The lack of capacity in Vascular Services across NHS Scotland was the primary barrier to transitioning to a sustainable model. I recognise that there are likely to be multiple contributory factors to this. I also acknowledge NHS Highland's view that is

[3] Duplex scanning is a non-invasive ultrasound technique that evaluates both the structure of blood vessels and the flow of blood within them.

extremely hard to see any single intervention or group of interventions that would have made a demonstrable change.

45. While I recognise the significant support that other boards have provided to NHS Highland from 2024 onwards, I am concerned about the effectiveness of the system that supported, but also limited, NHS Highland's access to mutual aid. Both the Adviser and the External Reviewer involved in the review of DATIX made similar observations about the need for a framework for mutual aid that ensures a fair distribution of capacity and equitable delivery of services to all patients in Scotland. In the absence of this, there was a significant delay in NHS Highland agreeing a pathway that ensured access to care for patients that needed urgent, but not emergency, treatment for their condition. Multiple witnesses said that patients had been disadvantaged and experienced delays due to issues with pathways.

46. I recognise that NHS Highland staff worked hard to provide the best care possible in extremely challenging circumstances. However, due to the lack of pathways for some groups of patients, I have concluded that it is likely that patients came to harm as a result.

47. In view of my findings, I am asking NHS Highland to engage with key stakeholders across the NHS in Scotland to develop a framework for mutual aid to avoid a repeat of the same situation impacting on patients that rely on other fragile services in Scotland.

The decision to stop arterial surgery in January 2025

48. C said that in January 2025 NHS Highland decided to stop arterial surgery at Raigmore Hospital in the full knowledge that no alternative arrangements were in place.

49. The Board said that all guidance and directives provided by the National Vascular society are clear that a population of 800,000 is required to sustain a modern vascular service. This takes account of the move from open surgery to procedures carried out using Interventional radiology. This requires 24 hour a day cover, six surgeons and five to six interventional radiologists to maintain skills for all required

procedures and MDT support for decision making, best practise being that two to three of each profession are present at each weekly or bi-weekly meeting.

50. The Board said there were concerns from the Clinical Team that NHS Highland could no longer function as an arterial centre and that alternative arrangements had to be made at pace. The escalation from the Clinical Team that NHS Highland should no longer offer arterial surgery was accepted and escalated to the North of Scotland Boards and onwards to national planning and to Chief Executives and Scottish Government.

51. Witnesses told my office that:

51.1. By late 2024, it became increasingly clear that the service NHS Highland was providing was not the same standard of care as in other health boards. It was not possible for NHS Highland to try to continue vascular surgery when the service did not have 24/7 safe inpatient coverage and so the decision was made to cease arterial surgery.

51.2. Because of the geography for NHS Highland, it was not possible to cease the service entirely as this would have left patients with no service whatsoever with no guarantee of access to care via mutual aid. This approach would have resulted in patients presenting to the Emergency Department with the Raigmore Team needing to phone around other boards for support, which was an unacceptable model of care. NHS Highland escalated everywhere it could, asking for support to be able to say it was not an arterial centre and the organisation finally got to that point in January 2025.

52. The Adviser noted that there were substantial attempts to try and keep a viable service, but this was not possible due to both external and internal factors. They noted that NHS Highland reached a point where they could not safely provide that service and felt it was safer to no longer offer patients that service. In their opinion, this was reasonable.

53. The comments from NHS Highland and the witnesses involved in my investigation provide a clear rationale for stopping arterial surgery in early 2025. The advice I have received is that this was a reasonable decision. I accept this advice and I have concluded that the decision to stop arterial surgery in January 2025 was reasonable.

The Board's communication with stakeholders

54. C considered that the Board should have been more transparent about the issues with patients, primary care and other boards. C felt that this may have given a greater incentive to other boards to take over the service.

55. The Board said that, since December 2023, discussions have been ongoing around sourcing mutual aid. A public facing website was created, MSPs have been regularly briefed, senior clinical representation from NHS Highland and the three mutual aid health boards would meet regularly to discuss and coordinate remedies to the ongoing vascular and other issues.

56. The Board added that communication with referrers, including primary and secondary care referrers and colleagues is held in an electronic system called Treatment and Management (TAM). This was updated and was the primary source of information for referrals and information.

57. The Board noted that there was concern that the message used at some times by C that "there is no service" was not accurate, as during this time patients were receiving treatment and assessment, including across the Highlands. There were always arrangements for emergency and acute care for patients and escalation to the highest levels when this was under strain.

58. I found that whilst there was good evidence of early planning and execution of communication with some key stakeholders, it is not clear that the same level of planning and coordination of communication continued after January 2025. The evidence does support that there was close involvement from the Primary Care Clinical Leaders in developing communications with primary care in March/April 2025. Despite this, the feedback from witnesses suggests that the communication did not reach primary care early enough or was not effective.

59. I acknowledge that the rapidly evolving picture made it challenging to provide effective updates to primary care in early 2025. It also appears that the number of different staff involved in the discussions to agree communications was likely a barrier to issuing communications in a timely way.

60. More than one witness perceived that there had been reluctance to put out external communications as it was unclear what the final service model would be and there was concern that uncertainty would cause alarm. Another witness said if the community knew what was happening, they would be more willing to accept the situation and the need to travel. They noted that some of the media articles about the service misrepresented what was happening, but if NHS Highland had communicated sooner, it may have helped to counteract that.

61. Regrettably, the lack of alignment between a member of the Clinical Team and management meant that some patients received letters advising that there was no service. Along with the information published in the media, this correspondence likely caused patients alarm and additional stress.

62. While I recognise the significant work carried out to share information with stakeholders, on balance I have concluded that NHS Highland did not take reasonable action to maintain effective communication with stakeholders. Based on my review of the evidence, I consider that a more comprehensive plan that clearly considered the needs of the relevant stakeholder groups, and involved more proactive communication and engagement with patients, would likely have supported a more effective approach to communication. In particular, earlier communication with patients about the changes to the service and what they should expect would likely have improved the patient experience and also reduced the impact on staff.

The handover of patients as part of a staffing change

63. C was concerned that the handover did not include discussion of individual patients or plans for how to deal with them.

64. The Board said that there were a series of meetings with the wider clinical team. The waiting lists were consolidated and stratified by urgency. This exercise was then used to prioritise patients for onward referral.

65. The documentary evidence indicates that work was already underway to review patients on the waiting list and develop a plan for escalation in March 2025. There were further specific discussions about handover in late May before two further meetings in early July.

66. Although a clinician wished to provide a detailed handover with discussion of plans for individual patients, evidence from witnesses indicates that the handover provided was reasonable. There were consistent accounts about a spreadsheet of patients shared with the team and thorough review of this by the remaining team with oversight from clinical leaders.

67. I have concluded that the handover was reasonable in the circumstances, considering the context of the service provision at the time.

The Board's approach to reviewing incidents and concerns reported by staff

68. C submitted a high number of DATIX incident reports in relation to issues they observed in the Vascular Service. They also escalated mortality themes and trends to clinical leaders and were concerned that this did not receive a response.

69. The Board commissioned a review of the DATIX reports from an External Reviewer. The review concluded in July 2026, roughly 1 year following the commission. The review covered 140 Datix submissions about 126 individual patients spanning the period from April 2024 to June 2025. It concluded that:

    69.1. 'there was no immediate evidence of significant adverse events or significant patient detriment, though there are a small number of cases which do require further investigation.'

70. The External Reviewer also reflected that:

70.1. ‘Patients requiring care are the responsibility of NHS Scotland and all who work within it. Health Board boundaries should never be barriers to patient care. What is clear is that the delivery of Mutual Aid between Health Boards needs a clear structure with shared processes, protocols, documentation, communication and clinical governance structures. What is lacking is a National Mutual Aid Framework covering responsibilities, communication and Clinical Governance rather than depending on huge efforts by a small number of individuals on an ever-increasing number occasions.’

71. NHS Highland advised that, following receipt of the report, the 11 cases identified by the External Reviewer as requiring further review are being prioritised.

72. Having reviewed the terms of reference, the Adviser said that they considered the external review of all the DATIX reviews by an external subject expert was reasonable to provide assurance.

73. The Adviser noted the conflict between the outcome of the DATIX review and the recollection of witnesses who considered that patients had come to harm. They were mindful that there was a prolonged period where elective patients did not have access to a pathway and it was reasonable to infer that this group would likely have experienced some deterioration or detriment in care. Without knowing the median treatment times for equivalent patients in other centres, it would be difficult to determine harm. They suggested that any further review might include benchmarking against treatment provided in other centres.

74. While I am satisfied that the scope of the review was reasonable, I am mindful that there has been a significant delay in the Board fulfilling its governance requirements in relation to the incidents reported. I accept that the high volume of DATIX reports and the lack of capacity within the organisation to manage these are factors that contributed to the delay. However, the evidence indicates that it would likely have been clear by February 2025 that the volume was not manageable and external support might have been sought at this point.

75. Notwithstanding the fact that 11 cases require further review, it is notable that the conclusion of the review conflicts with the recollection of witnesses that patients came to harm as a result of the issues with the service. My investigation has not involved a review of specific patient cases and it is not within the scope of my investigation to reconcile this potential conflict. I have, therefore, made a recommendation for further review that will provide assurance about NHS Highland's duty of candour obligations.

76. In relation to C's escalation of mortality themes and trends, I was unable to identify specific correspondence relating to this. Witnesses were also unable to recall receiving this correspondence. In view of this, I have not made specific findings on how the escalation was managed.

77. However, I am mindful that C's expectation was for the Board to stop the interim model of service delivery and hand responsibility for the service to another centre. I have considered the Board's actions in response to the External Reviewer's Report and I am satisfied that this also addresses this aspect.

Conclusion

78. The complaint I have investigated is that the Board have not taken reasonable action to manage the risks in the Vascular Service.

79. In summary, the key findings from my review are that:

79.1. The Board took reasonable steps to implement the recommendations from the External Reviewer's Report.

79.2. The lack of capacity in Vascular Services across NHS Scotland was the primary barrier to transitioning to sustainable model.

79.3. There was a significant delay in NHS Highland agreeing a pathway that ensured access to care for patients that needed urgent, but not emergency, treatment for their condition. It is likely that patients came to harm as a result.

79.4. The decision to stop arterial surgery in January 2025 was reasonable.

79.5. NHS Highland did not take reasonable action to maintain effective communication with stakeholders.

79.6. The handover of patients following a staffing change was reasonable in the circumstances, considering the context of the service provision at the time.

79.7. While the scope of the DATIX review was reasonable, there was a significant delay in the Board fulfilling its governance requirements in relation to the incidents reported.

79.8. The conclusion of the DATIX review conflicts with the recollection of witnesses that patients came to harm as a result of the issues with the service. A further review is needed to provide assurance about NHS Highland's duty of candour obligations.

80. On balance, in view of my findings about the communication with stakeholders and the uncertainty about whether NHS Highland has met its duty of candour obligations, I uphold this complaint.

81. In view of my findings, I am asking the Board to take further action to obtain assurance that they have accurately identified cases involving potential harm and complied with organisational Duty of Candour requirements.

82. Both the Adviser and the External Reviewer involved in the review of DATIX made similar observations about the need for a framework to ensure fair distribution of capacity and ensure equitable delivery of services to all patients in Scotland. I am therefore asking NHS Highland to share the learning from this case with relevant national stakeholders and seek national consideration about the need to develop a framework for mutual aid to avoid a repeat of the same situation impacting patients that rely on other fragile services in Scotland.

83. I recognise that ongoing work to plan and structure service delivery at a national level may mean that related work is already underway. If so, I trust that this will support the effective co-operation between organisations needed to implement this recommendation, or otherwise accelerate related work that will achieve the same outcome.

Complaint (b) – The Board's investigation did not make reasonable recommendations

84. In their complaint to the INWO, C expressed concern that the recommendations from the Board's whistleblowing investigation would further erode the capacity to provide patient care.

NHS Highland's response

85. The Board's investigation upheld C's concerns and the recommendations included:

85.1. The implementation of the Vascular Hub & Spoke model to be completed by the end of August 2025

85.2. Increase Locum cover on site by 1 whole-time equivalent

86. In response to our enquiries, the Board said

86.1. they were committed to working with staff providing the service to find a sustainable way forwards for service delivery. The investigation examined the concerns raised as well as the work that has been done to make recommendations for future service delivery prior to whistleblowing concerns being raised.

86.2. The report aimed to summarise a complex situation that continues to evolve as the board works to agree changes to service delivery with other boards that will satisfy the recommendations of two external reviews that are separate to the whistleblowing investigation. The report acknowledged the concerns and summarised the actions being progressed and the report content was agreed with the complainant with them indicating they were satisfied with the report.

86.3. Safe and equitable vascular care has been sought and now shared amongst national mutual aid health boards rather than reliance on one vascular surgeon. This approach has been escalated to Scottish Government, and the care of patients has been at the forefront of discussion.

Key evidence from interviews

87. Interviews with staff indicated that there were a range of views about the strategy the Board should have taken to ensure patients could access care. Some witnesses consider NHS Highland should have stopped the Vascular Service entirely, as this would have made it clear to other NHS boards that support was needed.

88. One witness explained that this was never an option and that NHS Highland had a duty to continue to provide a service. They explained that there was limited vascular capacity across Scotland and if Highland failed it would have severely impacted other boards.

Advice

89. The Adviser said that:

89.1. The establishment of the Hub and Spoke Model has proved impossible to implement. A key factor for this is that there appears to be no clear accountability for who is responsible. Various recommendations have been made, but implementation requires national intervention.

89.2. This is all against a very challenging financial environment, which contrasts with previous successful service redesigns that had access to additional resources to help implement the change.

89.3. In this context, it was reasonable that NHS Highland were doing what they could with the resources they can control. They did not believe that NHS Highland could have stopped the service entirely, as this would likely have caused more harm.

Decision

90. The complaint I have investigated is that the Board's investigation did not make reasonable recommendations. In particular, I have taken into account C's concern that the recommendations from the Board's whistleblowing investigation would further erode the capacity to provide patient care.

91. The Board's recommendation for implementing the Vascular Hub & Spoke model had a target date of the end of August 2025. On the one hand, this target date accurately reflected the urgency and importance of establishing a sustainable service delivery model. On the other hand, the recommendation did not reflect that NHS Highland had very limited power to implement the Hub & Spoke model.

92. Unfortunately, the course of events since the conclusion of the Board's investigation has demonstrated the challenges in reorganising services across the NHS in Scotland. In the circumstances, I am not critical of the recommendation or its timescales. There is clear evidence that NHS Highland was pursuing the implementation of the Vascular Hub & Spoke model prior to the whistleblowing investigation.

93. I have also considered whether the whistleblowing investigation should have recommended that the service cease entirely. The evidence I have gathered from witnesses provides a clear explanation as to why this was not a viable option. I also accept the advice I have received that this approach would likely have caused more harm.

94. In conclusion, I do not uphold this aspect of C's complaint.

Complaint (c) – The Board did not handle C's concern in line with the National Whistleblowing Standards

95. In December 2024, C approached my office in relation to the concerns they had raised with the Board. We confirmed that C's concerns had not been handled under the NHS whistleblowing procedure, even though C had attempted to access the procedure. In January 2025, we wrote to the Board to set out our expectation that C should have access to the NHS Whistleblowing Procedure. The Board provide C with a stage 2 response in June 2025.

NHS Highland's response

96. In response to our enquiries, the Board said that:

96.1. The approach to handling the concerns raised by the complainant was discussed several times with the individual and initially it was agreed that the concerns being raised would be managed through 'business as usual' processes which is an option within the standards.

96.2. The rationale for managing the concerns was they were known to the Board and the Board had proactively commissioned an independent report into the challenges faced by the board in delivering the service. [C] had been involved in discussions associated with developing and progressing actions to enact the recommendations from the external review and it was agreed that we would work closely with them to ensure they felt involved in the work going forwards. It has taken time to progress actions that included working with other boards to agree a future service delivery model in the context of a national review of this type of service.

96.3. In this case the board sought to work collaboratively with the complainant to understand the concerns and acknowledge them as well as keep them informed of actions we were taking to address the concerns. It was initially agreed that a full investigation would not add anything additional to the level of detail created through the external reviews and the focus should be on progressing recommendations and actions. An alternative action may have

been to undertake an investigation formally under the standards to acknowledge the concerns and set out the work already underway.

Evidence from witnesses

97. In relation to their experience during the process, C explained that:

97.1. The experience of raising concern was not what they expected, and it took a long time to get the process started. They were made to feel like their concern was not welcome and they were doing something wrong.

97.2. They had good conversations with the investigator, who listened to them and was empathetic. They had three meetings between February and June and they felt updated about what was happening.

97.3. The investigator asked them about their wellbeing and their line manager was also supportive. They had access to support, but this had not been arranged as part of the whistleblowing process.

98. We interviewed a witness with experience of the organisation's speak up process to understand whether there were barriers to accessing the process. The key points from the interview were that:

98.1. The responsibility for whistleblowing sitting with HR was a barrier to some staff speaking up.

98.2. A number of staff would prefer the speak up service (Confidential Contacts) to still be with the Guardian Service[4].

98.3. They had concerns about the robustness of NHS Highland's whistleblowing process, including the processes for tracking progress, updates, record keeping, oversight of recommendations and reporting.

[4] An external organisation previously contracted to deliver the Confidential Contact role within NHS Highland.

98.4. They had concerns about the handling of personal data relating to staff who approach Confidential Contacts.

Extracts from the National Whistleblowing Standards

Business as usual

99. The diagram 'Accessing the Standards' on page 18 of *the Standards* supports decision making regarding when business as usual processes may be appropriate and when to commence the whistleblowing process.

100. Paragraph 14 of Part 2 states that:

> People may report or mention issues through business as usual processes which could meet the whistleblowing definition. To avoid duplication and confusion, the procedure set out in these Standards should normally only be used if:
>
> - no other procedure or processes are being used;
> - an existing procedure or process has been used but has not resulted in the outcome the person raising the concern expected; or
> - the person asks for the whistleblowing procedure to be used.

Confidentiality

101. A fundamental principle within the Standards is that the procedure is 'supportive to people who raise a concern and all staff involved in the procedure.' To do this, confidentiality must be maintained. Paragraph 58 of Part 2 (of the Standards) states:

> 'Confidentiality refers to the requirement not to disclose information about the person raising a concern, unless the law says that it can or must be disclosed. This includes anyone else involved in the process, such as other witnesses.'

Support

102. In relation to support, paragraph 58 of Part 2 (of the Standards) states:

> 'Anyone receiving concerns must ask what support the person raising the matter may need and how this can be provided, when they first raise the concern. If support needs are identified, the appropriate resources must be provided wherever possible, and the person must be given contact details for support providers.'

Timescales

103. The timescales for stage 2 are set out at paragraph 30, Part 3:

> '[The organisation] should provide a full response to all concerns as soon as possible, and within 20 working days, unless it needs to extend this time limit.'
>
> ...
>
> 'The organisation should provide updates every 20 working days to everyone directly affected by the investigation. The updates should provide information about what progress has been made and what will happen before the organisation provides the next update or a full response.'

Decision

104. The complaint I have investigated is that the Board did not handle C's concern in line with the National Whistleblowing Standards.

105. I have identified a number of areas where the handling of C's concerns did not comply with the Standards:

105.1. Some of NHS Highland's initial responses to C's concerns could be interpreted as discouraging C from using the whistleblowing process. It is clear that C wished to use the NHS whistleblowing process and made sustained attempts to access it with support from the Whistleblowing Champion and a Confidential Contact. It was unreasonable that C's preference to use the

process was not respected. As a result, NHS Highland's process was not accessible, and this impacted on the timeliness of starting the investigation.

105.2. By identifying the witnesses involved in the investigation, the investigation report did not respect their right to confidentiality.

105.3. It does not appear that C was asked about their support needs when they first raised the concern.

105.4. It does not appear that C (and others involved) received consistent updates about the progress of the investigation in line with the requirements of the Standards.

106. The evidence gathered from a witness indicates that the non-compliance with the procedure may not be an isolated example and there may be wider issues with the culture of handling concerns and implementation of the National Whistleblowing Standards within NHS Highland.

107. In view of this evidence, it is essential that NHS Highland obtains assurance in relation to:

107.1. Information governance – ensuring privacy of data relating to staff that use the Open Line service.

107.2. Support - ensuring that people who raise a concern are supported, treated with dignity and respect, and those who handle concerns are sensitive and professional.

107.3. Procedures – ensuring there are processes in place to track progress of investigations and provide updates to those involved.

107.4. Learning and Improvement – ensuring robust governance arrangements are in place to monitor implementation of recommendations by an action owner against defined timescales.

107.5. Roles and responsibilities - ensuring the roles of those involved in the process are clearly defined and compliant with Part 4 of the Standards.

107.6. Decisions and signposting – ensuring reliable signposting where a decision is made that a concern is not suitable for the whistleblowing procedure.

108. While I recognise that some of the examples provided may not be representative of the experiences of everyone who has used NHS Highland's whistleblowing process, I consider there are opportunities for NHS Highland to improve the robustness of its whistleblowing procedures and governance. In turn, these improvements can support better experiences for those using the process and contribute to increased confidence in speaking up.

109. In view of my findings, I am recommending that the Board review their whistleblowing process and governance arrangements to ensure that they are compliant with the National Whistleblowing Standards. The SPSO's Improvement, Standards and Engagement Team is available to support with this work, and I would strongly encourage the Board to engage with them.

Recommendations

Learning from complaints

The Independent National Whistleblowing Officer expects all organisations to learn from complaints. The learning should be shared with those responsible for whistleblowing as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation.

What the INWO is asking the Board to do for C

Rec. No	What INWO found	Outcome needed	What INWO need to see
1.	Under complaint (c), I found that: • The Board's whistleblowing process was not reasonably accessible. • C was not asked about their support needs when they first raised the concern. • C did not receive consistent updates	Apologise to C that: • The Board's whistleblowing process was not reasonably accessible. • C was not asked about their support needs when they first raised the concern. • C did not receive consistent updates. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy of a letter or other record confirming an apology was given to C. **By: 22 October 2026**

What the INWO is asking the Board to do to for patients:

Rec. No	What I found	Outcome needed	What INWO need to see
2.	Under complaint (a), I heard evidence from multiple witnesses that patients had come to harm as a result of the issues facing the Vascular Service. An independent review of incident reports concluded that there was no immediate evidence of significant adverse events or significant patient detriment, though there are a small number of cases which do require further investigation.	The Board should be assured that they have accurately identified cases involving potential harm and complied with organisational Duty of Candour requirements.	Evidence that the Board has: 1. Engaged with staff that worked in the service since November 2023 to identify any further cases involving potential harm. 2. Benchmarked the treatment times for the group of patients that did not have a pathway in early 2025 against comparable patient groups in other boards. 3. Completed the review of reported incidents and the patient groups described in points 1 and 2 to identify whether the Duty of Candour procedure should be activated. **By: 17 December 2026**

What the INWO is asking the Board to do to ensure learning within NHS Highland from this case:

Rec. No	What I found	Outcome needed	What INWO need to see
3.	Under complaint (a) I found: • NHS Highland did not take reasonable action to maintain effective communication with stakeholders. • There was a significant delay in the Board fulfilling its governance requirements in relation to the incidents reported.	Communication about service changes should be robustly planned consider the needs of the relevant stakeholder groups. There are robust contingency arrangements in place to ensure continuity in fulfilling Clinical Governance requirements where there are changes in staff capacity or high numbers of incident reports to manage.	**1. Supportive Sharing of Investigation Findings** Evidence that the findings of this investigation have been shared with relevant staff in a supportive and reflective manner. **2. Action Planning** A clear outline of the actions the Board plan to take to embed learning and improvement regarding: • Communication and patient engagement about service change. • Organisational clinical governance capacity and contingency planning **By: 19 November 2026**

What the INWO is asking the Board to do to ensure wider learning and improvement across NHS Scotland from this case:

Rec. No	What I found	Outcome needed	What INWO need to see
4.	Under complaint (a) I found: • There were significant systemic barriers to NHS Highland managing the risks in the Vascular Service. • In particular, there was a lack of capacity across other vascular centres in Scotland to implement the Spoke and Hub model within a reasonable timeframe. • The national arrangements for supporting service redesign and managing capacity did not secure a sustainable solution within a reasonable timeframe.	The systemic barriers identified in this case are formally brought to the attention of the organisations with the authority to address them. NHS Highland has contributed to national consideration of how mutual aid arrangements can better support timely, fair and equitable access to specialist care, while maintaining appropriate interim arrangements to manage similar risks in fragile services.	Evidence that NHS Highland has: • Shared the findings and learning from this case with relevant national stakeholders; • Formally raised the need to review or improve the national framework for mutual aid; • Sought a coordinated response on how the issue will be addressed, including clarity on leadership of any further work; • Offered to contribute to any resulting improvement work • Documented interim arrangements to manage similar risks in fragile services in NHS Highland. **By: 20 January 2027**

What the INWO is asking the Board to do to improve their compliance with the Whistleblowing Standards

Rec. No	What INWO found	Outcome needed	What INWO need to see
5.	Under complaint (c), I found that: • The Board's whistleblowing process was not reasonably accessible. • The investigation report did not respect the witnesses' right to confidentiality. • C was not asked about their support needs when they first raised the concern. • C and others involved in the investigation did not receive consistent updates • There is evidence that may suggest wider issues with the culture of handling concerns and implementation of the National Whistleblowing Standards within NHS Highland	NHS Highland has obtained assurance that there are systems and governance arrangements in place that reflect the requirements of the National Whistleblowing Standards and data protection legislation.	Evidence that the Board have reviewed the whistleblowing process and governance arrangements to ensure that they are compliant with the National Whistleblowing Standards and data protection legislation. Evidence that NHS Highland has identified learning or improvement actions and developed a plan for how those actions will be taken forward and monitored. **By: 17 December 2026**

Feedback for the Board

Whistleblowing concerns handling

1. C provided positive feedback about the investigator. They said the investigator listened to them, was empathetic and kept them updated. I commend the investigator for their sensitive handling of the concern.

Response to INWO investigation

2. I am very grateful for the support provided by the Board's staff during my investigation. They spent a considerable amount of time and effort gathering and organising documents, and I also appreciate the time the witnesses gave to meet with my Complaints Reviewer.

Summary of documents that make up the full INWO report

Document Name	Description	Published/private
Summary Report Reference: 202408925	Pseudonymised summary of complaint investigation and findings	Published
Private Appendix 1: Detailed Consideration (a) and (b)	Confidential discussion of complaint points (a) and (b)	Private
Private Appendix 2: Confidential overview of evidence from interviews	Confidential overview of evidence from interviews	Private
Private Appendix 3: Detailed Consideration (c)	Confidential discussion of complaint point (c)	Private