INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

People Centred | Improvement Focused

The Scottish Public Services
Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

INWO
Bridgeside House
99 McDonald Road
Edinburgh
EH7 4NS

Tel **0800 008 6112**
Web **www.inwo.org.uk**

Report of the Independent National Whistleblowing Officer

Overview

Scottish Parliament Region: Edinburgh and Lothians East

Case ref: 202505555

NHS Organisation: Lothian NHS Board

Subject: Patient safety

This is the report of the Independent National Whistleblowing Officer (INWO) on a 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 four confidential appendices, it is a full and fair summary of the investigation.

Executive summary

1. C raised several concerns about the care of patients with Hepatocellular carcinoma (HCC), which is the most common type of liver cancer. C described a number of issues that they believed contributed to delays or variability in the care of patients.
2. The Board handled C's concerns at stage 2 of the procedure in the National Whistleblowing Standards. The investigators met with C and spoke with several other staff involved in the care of patients with HCC.
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 advised that

some of C's concerns had been upheld. The response also included details of recommendations made because of the findings.

4. Following the stage 2 response, the Investigation Commissioner met with C several times to keep them informed and involved in the development of an action plan.

5. C was dissatisfied with time taken to develop the action plan and was unhappy with how their concerns had been handled. C asked the INWO to independently review the Board's handling and investigation of their concerns.

6. Following discussion with C, my office notified the Board of C's complaints and requested evidence from the Board. The complaints I have investigated are:

   a) **The Board's investigation did not fully address C's concerns (*upheld*)**
   b) **The Board have not taken timely action to address the risks (*upheld*)**
   c) **The Board did not handle the concern in line with the National Whistleblowing Standards (*upheld*)**
   d) **The Board did not take reasonable steps to provide C with support and protection (*upheld*)**

7. To support my investigation, a complaints reviewer carried out several interviews, including with one of the investigators and staff involved in the care of patients with HCC. I also obtained independent advice from a suitably qualified professional to inform my assessment of the Board's investigation and recommendations.

8. As a result of my findings, I am asking NHS Lothian to implement a number of recommendations that aim to support learning in concern handling and build on the improvements that the Board have already made in relation to the care pathway for HCC.

9. My investigation also identified a number of areas of good practice by the Board. I have included this feedback at the end of this document.

Publication

10. 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.

11. 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.

12. 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.

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

Findings and decisions

Complaint (a) – The Board's investigation did not fully address C's concerns

14. In their complaint to the INWO, C said that the Board's investigation did not fully address their concerns about the radiology involvement. C felt there should have been consideration of the delays in the pathway contributed by radiology processes.

NHS Lothian's response

15. In the stage 2 response, the Board said 'The NHS Lothian approach to managing the demand for radiological tests and investigations is not to allocate protected slots but enable the radiology department to manage their own planning to optimise the use of all resources. This concern is not upheld.'

16. The Board's investigation included a recommendation that 'time to staging scans' should be monitored.

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

    17.1. At the outset of the whistleblowing process, Heads of Concern were agreed with C. The agreed Heads of Concern included the following statement:

    > Areas outside of the remit of this investigation are: (however, we will note them in the report): Radiology input and capacity – however, how the waiting list / time for radiology is monitored will be explored.

18. It is the Board's view that in relation to radiology involvement, the investigation covered what was agreed as part of the Heads of Concern.

19. There were scheduled care plans in place to provide additional radiology capacity in 25/26. Planning has taken place with the aim of sustaining the improvements in 26/27. There are active plans to increase MRI, Ultrasound, and CT provision through a combination of overtime, short-term additional activity, and collaboration with other NHS organisations. These measures run alongside our longer-term developments, which include expanding permanent capacity by recruiting additional radiographers,

sonographers, and radiologists. This expansion will enable us to increase service coverage to a full 7-day model.

The National Whistleblowing Standards

20. Paragraph 43 of Part 3 of the Standards sets out the expectations in relation to the investigation of a concern:

> 'The investigation must focus on the practices or procedures that are unsafe or inappropriate. It must focus on patient safety, safe working practices and good governance; it must be fair, robust and proportionate to the risks identified. It must aim to handle and provide a full response to all the issues involved in the whistleblowing concern that has been raised.'

Advice received

21. To support my investigation of C's complaint, my office received independent advice from a suitably qualified professional (the Adviser).

22. I asked the Adviser whether the recommendation for 'time to staging scans' to be monitored and reported to the HPB MDT (Hepatobiliary and Pancreatic Multidisciplinary Team Meeting[1]) was a reasonable way of maintaining ongoing oversight over the delays and the risks these present.

23. The Adviser said that this was not reasonable. They considered the Board should have supported the clinical team to develop an adequately designed and resourced Quality Improvement project including documentation of control measures. A more comprehensive piece of Quality Improvement work would involve a clear strategy and plan, with a cycle of testing and change. This would involve looking at the different stages from referral to treatment, with consideration of each factor that influences performance and how it could be improved. This would support the Board to more effectively monitor whether a change is producing the intended effect and whether the process remains stable over time.

[1] A regular meeting involving surgeons, hepatologists, oncologists and radiologists

Findings

24. It is firstly notable that the reasons shared with C in the stage 2 response were limited. It is regrettable that the stage 2 response did not include further information about the extent of the findings regarding radiology. If it had done so, this may have offered C some reassurance that the evidence supported their concerns about delays.

25. It appears that the Board decided to not uphold the concern because C's suggested outcome of creating protected slots was not feasible. Hower, the investigation accepted that some patients had waited a long time for scans. As it can reasonably be inferred that delays in the treatment pathway would be associated with a risk of harm, I would expect this aspect of C's concern to have been upheld.

26. I am mindful that the Board's investigation did not involve detailed consideration of specific patient journeys and whether the delays could have resulted in harm or impacted on clinical outcomes. Although the Board made a recommendation to monitor time to staging scans, the advice that I have received indicates that this is not enough to address the risks.

27. The Adviser considered that a more comprehensive piece of quality improvement work would have been appropriate. I accept this advice. The evidence I have gathered from interviews supports that there are a number of areas where further improvements can be made that could reduce timescales and reduce risk of delays in the early stages of the patient pathway.

28. In summary, I have concluded that:

    28.1. The level of detail shared in the Board's stage 2 response and the decision to not uphold this part of C's concern was unreasonable.

    28.2. The recommendation to monitor time to staging scans was not sufficient to address the risks that delays in radiology contribute to the patient pathway. A more comprehensive piece of quality improvement work would support more effective improvement.

29. I uphold this complaint. I have made a number of recommendations in view of my findings.

Complaint (b) – The Board have not taken timely action to address the risks

30. In their complaint to the INWO, C said that they believed that the Board had not taken action to address the risks identified following the conclusion of the investigation. C believed that patients remained at risk due to lack of appropriate cancer pathways and treatment management. C also highlighted delays in the Board developing the action plan.

NHS Lothian's response

31. In response to our enquiries, the Board provided a copy of the action plan, with details of progress against the recommendations. The Board also provided details of an audit carried out to measure the effectiveness of a previous improvement initiative.

32. The Board acknowledged that there had been a delay in developing the action plan but explained that this did not impact on the actions to address the risks identified.

The National Whistleblowing Standards

33. A key principle within the Standards is that the procedure is 'focused on improvement'. As part of this, organisations are expected to:

> 'Use the outcomes of concerns to identify and demonstrate learning and improvement and share best practice, both in providing services and in the procedure itself.'

Findings

Recommendations to monitor the performance of the HCC pathway

34. The Board's investigation found that, historically, the HPB MDT meeting was oversubscribed. The investigators found that the service had introduced new referral forms and set up a specific HPB MDT meeting for HCC patients. They expected that these changes should improve performance against the relevant Cancer Quality

Performance Indicators[2]. Some of the recommendations from the Board's investigation intended to monitor the impact of these changes.

35. The evidence I have gathered from witnesses supports the conclusion that the change to the MDT format (so that all HCC patients are discussed at a single meeting) had been helpful, and the time between referral and discussion at the MDT had reduced.

36. Witnesses were also supportive of the change to the MDT referral form and observed that there had been improvements in the information available to the MDT (which helps to ensure that a timely decision about treatment can be made). The Board provided results from a recent audit of 50 patients that had been referred to the MDT with the new referral form. While this measured performance against elements of the Cancer Quality Performance Indicators, the advice I received was that it offered limited assurance about the performance of the pathway.

37. The Board's action plan also referred to a long term action to monitor attainment of Quality Performance Indicator (QPI) 2 via HepatoPancreatoBiliary Cancer Clinical Audit Reports. The Adviser noted that whilst this would support monitoring of QPIs, it did not provide assurance about the timing of the different stages in the pathway from suspicion of HCC to diagnosis or treatment.

38. The evidence from interviews indicates that the pathway for HCC patients is highly complex and a number of factors impact on its performance and reliability. Even though significant improvements have been made in recent years, overall, I am not convinced that the Board's investigation and recommendations are sufficient to address the remaining risks and variability in the performance of the pathway.

39. The comments from witnesses in Appendix 2 provide insight into the ongoing challenges and the risks these create. There was a strong sense from witnesses that the hepatology service was under resourced and that additional investment in an

[2] *HepatoPancreatoBiliary Cancer Clinical Quality Performance Indicators (2023)*

HCC coordinator and HCC cancer specialist nurses would go a long way towards addressing some of the challenges in the HCC pathway.

40. In conclusion, I consider that a more detailed review of the different stages of HCC pathway (from surveillance to treatment) is needed to understand the performance of the pathway and inform further improvement.

Introducing a dedicated HCC pathway

41. One of the recommendations in the Board's action plan was to create a dedicated HCC care pathway. The evidence I received indicated that this had not been completed as intended.

42. The advice I have received is that a documented HCC pathway would clarify roles which different team members play, times of each step and how to escalate if timelines risk not being met.

43. A number of the witnesses that my office spoke with were supportive of establishing a dedicated HCC pathway. It is my understanding that this would likely support more effective management and oversight over the investigations in the early stages and prior to the referral to the MDT.

44. I was also told about areas of the pathway where the responsibility or accountability for actions was not clear and would benefit from clarification. Based on the advice I have received, I expect that a more detailed pathway would help to address this.

45. Overall, I have concluded that the Board has taken insufficient action to implement this recommendation.

The time taken to develop the action plan

46. More than seven months passed between the investigation report being completed and the action plan being finalised. While I accept that the process of sharing the plan with relevant stakeholders and refining it following feedback takes time, a period of seven months is unreasonably long.

Conclusion

47. In conclusion, the evidence supports that the change to the MDT format and referral form have had a positive impact and reduced delays in the pathway.

48. Evidence from witnesses involved in the MDT also indicated that there are a number of other areas that involve risks of delay. Although the Board have carried out an audit and have arrangements to monitor QPI performance, I consider that a more detailed review of the different stages of the HCC pathway (from surveillance to treatment) is needed.

49. I have also concluded that the Board have not taken reasonable action to introduce a dedicated HCC pathway and that there was an unreasonable delay in the Board finalising the action plan following the investigation.

50. I uphold C's complaint and make recommendations.

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

51. In their complaint to the INWO, C said that meetings with the investigators were not arranged in a sufficiently private location. C also had concerns that their identity may have been shared during the development of the action plan.

52. C said that there had been a number of delays in NHS Lothian's investigation. There was also a lack of administrative support with meetings, which created delays with the need to correct statements.

53. Finally, C was dissatisfied with a number of aspects of the communication during the process.

NHS Lothian's response

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

    54.1. They fully respect whistleblower confidentiality. Meeting locations were shared in advance with C; however, we acknowledge that the room used did not meet the C's expectations for privacy. Investigations since, have had agreement from the whistleblower on a suitable meeting place prior to any meeting.

    54.2. They understand that C was concerned about their identity being compromised during the development of the action plan. Although C was offered a meeting with others (who were not aware of their identity), C's identity was not shared at any point, as permission had not been granted by C.

The National Whistleblowing Standards

Confidentiality

55. A key 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.'

Timescales

56. 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.'

Sharing learning

57. Another principle within the Standards is that the procedure is 'focused on improvement'. As part of this, organisations are expected to:

> 'Use the outcomes of concerns to identify and demonstrate learning and improvement and share best practice, both in providing services and in the procedure itself.'

Findings

58. I found that the investigator took C's preferences around confidentiality seriously. Unfortunately, the room they booked for the second meeting with C was not available on the day. An alternative meeting room was identified, but this was in an area that increased the risk of C being identified. On balance, I was satisfied that the Board took reasonable care to maintain C's privacy during the meetings. Whilst I recognise that changing the room location for the second meeting increased the risk to C, this had to be balanced against the need to progress the investigation in a timely way and avoid further delays. This was reasonable.

59. During the process of developing the action plan, the Investigation Commissioner suggested that C could meet with those involved in implementing the plan. C responded to share their reservations about this and asked for their identity to be protected. The Investigation Commissioner confirmed that they would continue to maintain confidentiality and protect C's identity. I have seen no evidence that C's identity was shared with others without their permission. More generally, the evidence shows that there was consideration about maintaining confidentiality throughout the process. This suggests to me that it is highly unlikely that C's identity was shared with the clinicians without their permission. Overall, I found the Board's approach reasonable.

60. In total, almost 11 months passed between the date C's concern was recorded and the date C received the stage 2 response. I found that several factors contributed to the time taken to complete the investigation, including:

60.1. Prolonged engagement and discussion about the heads of concern and scope

60.2. The decision to change one of the investigators following feedback from C

60.3. The challenges associated with arranging interviews with 7 witnesses

60.4. Working around the clinical commitments and annual leave of the investigators

60.5. The complexity of the investigation

61. Taking into account the above factors, the time taken to carry out most of the stages of the process does not appear to be disproportionate. However, one area where it appears there is potential for improvement is the report writing stage. In total, it took over three months following the final interview to finalise the investigation report. Whilst it is important to take time to get this right, this was a significant contributor to the overall time taken.

62. I found that there was some slippage in the timescales for concluding the investigation. The Board provided successive updates where the timescales for concluding the investigation were missed. These updates would not have been

effective at managing C's expectations about how long it would take to conclude the investigation. In this context, and noting the length of the investigation, it is understandable that C was concerned about delays.

63. I found that it was a deliberate decision not to have a note taker at the meeting with C. I am satisfied that this decision was made with C's wellbeing in mind and I have concluded that the approach was reasonable.

64. Following the investigation, the Board provided an update about the timescales for concluding the action plan and the plan to update relevant staff groups about the outcome of the investigation. I found that the Board did not share the action plan or update the relevant staff groups about the outcome of the investigation within the timescales that they said they would.

65. Given that the Board set out clear timescales for informing relevant staff groups of the outcome and sharing the action plan, I can understand C's frustration when these timescales were not met. C was entitled to expect that the timescales the Board outlined would be met and I have concluded that the delays were unreasonable.

66. In conclusion, I have identified a number of areas where the Board's handling of C's concern was reasonable. However, in view of the issues with communication, on balance, I uphold C's complaint.

Complaint (d) – The Board did not take reasonable steps to provide C with support and protection

67. In their complaint to the INWO, C said they did not feel supported during the process. They said that there was no protected time to contribute to the investigation and their work was not generally covered when they attended meetings. C also said that they did not expect to be so closely involved in the process once the report was issued.

68. We informed C that the INWO's investigation would focus on what measures NHS Lothian took to ensure that they were supported and protected through the process. We explained that our findings would seek to support organisational learning regarding support for whistleblowers, rather than focus on the conduct of individuals.

The Board's response

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

69.1. Throughout the whistleblowing investigation, C was supported by one of NHS Lothian's Speak up Ambassadors and a Partnership Lead, who attended meetings with C.

69.2. For any member of staff taking part in an employment process, there is an expectation that reasonable time off will be given to attend meetings, but this always needs to be subject to the demands of the service. Whilst time off can usually be given, it is difficult to also cover the work of the individual.

69.3. The Whistleblowing Programme and Liaison Manager is also available for support and guidance throughout the process. Had the concerns about lack of support been raised with them, further support would have been considered.

69.4. There was ongoing engagement with the complainant, particularly following the conclusion of the investigation and during the development of the action/implementation plan – to seek their input into the action plan in an attempt to address their concerns and to continue to listen to the complainant.

The National Whistleblowing Standards

70. One of the principles of the procedure in the National Whistleblowing Standards is that it is Supportive to people who raise a concern and all staff involved in the procedure. As part of this, NHS organisations are expected to:

    70.1. Offer support and protection to all staff, students and volunteers who raise a concern or who are directly involved in a concern, at all stages of the process.

    70.2. When someone raises a concern, listen to them, support them, treat them with dignity and respect, and be sensitive and professional.

    70.3. As far as the law allows, respect the confidentiality of any person who raises a concern, unless they agree that you do not have to.

    70.4. People who raise a concern must not be victimised or suffer detrimental treatment as a result of raising a concern. This includes bullying and harassment, inappropriate use of policies, breaking the terms of their contract, financial loss and reputational or professional damage.

Findings

71. Following investigation, I have identified a number of areas of good practice:

    71.1. C was able to access a Confidential Contact who provided advice and support throughout the process

    71.2. Early in the process, the investigator took time to listen to C's concerns about confidentiality and explain what the process would involve

    71.3. The Board's update letters consistently referred to the support available and invited C to contact the Whistleblowing Programme and Liaison Manager if they wanted to discuss anything.

72. I have also identified a number of areas where the Board's approach does not appear to have been effective at supporting C:

72.1. When C raised the concern, it does not appear that the initial discussions covered what support C might need during the process. This may have impacted on C's understanding of what support could be provided and their ability to access this later in the process.

72.2. It is clear from the evidence C shared that they found the demands of the meetings and correspondence following the investigation challenging. C said they expected the action plan to be ready at the time of the first meeting with the Investigation Commissioner in March 2025. While it was good practice for the Board to keep C informed and involved in the action plan, it was unreasonable that it took until September 2025 to finalise the action plan.

73. In conclusion, I recognise that there were a number of elements of good practice in the Board's approach to ensuring C was supported. I have also identified areas where their approach was less effective. On balance, I uphold C's complaint.

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 we are asking Lothian NHS Board to do for C:

Rec.	What we found	What the organisation should do	What we need to see
1.	The level of detail shared in the Board's stage 2 response and the decision to not uphold C's concern about radiology involvement was unreasonable. The Board did not provide accurate information about the timescales for concluding the investigation. The Board did not share the action plan or update the relevant staff groups about the outcome of the investigation within the timescales that they said they would. There was no initial discussion with C about what support they might need. The time taken to finalise the action plan was unreasonable.	Apologise to C for: • The lack of detail in the stage 2 response and the decision not to uphold C's concern about radiology involvement. • The issues with communication during and following the investigation. • The lack of initial discussion regarding support needs and the delay in finalising the action plan. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy or record of the apology. By: **17 September 2026**

We are asking Lothian NHS Board to **improve the way they do things**:

Rec. number	What we found	Outcome needed	What we need to see
2.	The recommendation to monitor time to staging scans was not sufficient to address the risks that delays in radiology contribute to the patient pathway. Evidence from witnesses indicated that there are a number of other areas that involve risks of delay. The Board have not taken reasonable action to introduce a dedicated HCC pathway.	The Board have a comprehensive understanding of the factors that contribute to risk of delay and variation in the standard of treatment in the HCC pathway. The Board have developed an adequately designed and resourced quality improvement programme to support improvement in the performance of the pathway. A dedicated HCC pathway document is developed and approved.	Evidence that the Board have undertaken a comprehensive review of the HCC pathway, from surveillance through to treatment, to identify delays, constraints, variation in practice, and risks to timely diagnosis and treatment. Evidence that, using the findings of the review, the Board have developed a quality improvement programme with clear objectives, measures, responsibilities and timescales to support timely diagnosis and treatment. By: **11 December 2026**

We are asking Lothian NHS Board to **improve their compliance with the Standards**

Rec. number	What we found	Outcome needed	What we need to see
3.	The level of detail shared in the Board's stage 2 response and the decision to not uphold C's concern about radiology involvement was unreasonable. The Board did not provide accurate information about the timescales for concluding the investigation. The Board did not share the action plan or update the relevant staff groups about the outcome of the investigation within the timescales that they said they would. There was no initial discussion with C about what support they might need. The time taken to finalise the action plan was unreasonable.	The investigation must focus on the practices or procedures that are unsafe or inappropriate. It must focus on patient safety, safe working practices and good governance; it must be fair, robust and proportionate to the risks identified. It must aim to handle and provide a full response to all the issues involved in the whistleblowing concern that has been raised. NHS organisations should ensure the outcomes of concerns identify and demonstrate learning and improvement and share best practice, both in providing services and in the procedure itself. The procedure must be supportive to people who raise a concern.	Evidence that those involved in the handling of C's concerns have reflected on the INWO's findings and considered what further action would support improvement in the investigation and handling of concerns. By: **1 October 2026**

Feedback for the Board

Whistleblowing concerns handling

1. Early in the process, the investigator took time to listen to C's concerns about confidentiality and explain what the process would involve. This was good practice. More generally, I consider that the approach taken to maintaining C' confidentiality was reasonable.

Response to INWO investigation

2. There were repeated delays in the Board's responses to my office's enquiries. This unreasonably prolonged the timescales of my investigation to the detriment of the complainant.

Points to note

3. While my office heard different and sometimes conflicting views about the matters I have investigated, it was apparent that there was considerable professional respect and appreciation for the work that different roles bring to the MDT.

Summary of documents that make up the full INWO report

Document Name	Description	Published/private
Summary Report Reference: 202505555	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
Private Appendix 4: Detailed Consideration (d)	Confidential discussion of complaint point (d)	Private