INDEPENDENT
NATIONAL
WHISTLEBLOWING
OFFICER

People Centred | Improvement Focused

The Scottish Public Services
Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Report of the Independent National Whistleblowing Officer

Overview

Scottish Parliament Region: Lothian

Case ref: **202507513**

NHS Organisation: Lothian NHS Board

Subject: **Implementing improvement actions after a whistleblowing investigation**

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/

It is a full and fair summary of the investigation.

Executive summary

1. The complainant (C) complained to the INWO about Lothian NHS Board (the Board).
2. Between October 2024 and June 2025, the Board carried out a whistleblowing investigation under the National Whistleblowing Standards (the Standards) into C's concerns about the numbers of children and adolescents waiting for neurodiversity assessments.
3. C's concerns related not only to the length of the waiting list, but also to the impact on potentially vulnerable patients and their families who were unable to receive a diagnosis and access the appropriate treatment and support that would normally follow.

4. The Board's investigation upheld all of C's concerns. However, it has not yet developed or put an appropriate action plan in place to fully address the investigation findings.

5. The complaint I have investigated is:

   5.1. The Board has not effectively implemented the improvement actions identified following their investigation of C's concern (**upheld**)

6. As a result of my findings, the Board has been asked to implement several recommendations.

7. I have published a brief public report in this case as the findings have wider relevance across NHS organisations particularly in relation to how promptly and effectively improvement actions are implemented following whistleblowing investigations. The INWO regularly receives complaints from staff across NHS boards regarding delays in translating local whistleblowing investigation findings into tangible improvements.

8. To prevent unnecessary complaints to the INWO, boards should ensure that their whistleblowing arrangements are fully aligned with the National Whistleblowing Standards. This includes ensuring that concerns are handled in a way that is timely, transparent, and focused on delivering meaningful improvement, supported by robust governance arrangements.

Publication

In the interests of transparency and sharing learning to drive improvement, the INWO makes public the details of findings and conclusions as far as they are able. The INWO cannot make public every detail of his report. This is because some information must be kept confidential because the Act says that, generally, reports of investigations should not name or identify individuals. In this context in the report names have been pseudonymised, and gender-specific pronouns and titles removed.

Approach

The investigation

9. For something to be whistleblowing, it must be in the public interest, rather than primarily concerned with a personal employment situation. In this case, I was satisfied that there was a public interest in C's concerns given the impact on children and adolescents of delayed assessments.

10. In order to investigate C's complaint, the INWO

    10.1. took evidence from C in written format and by telephone

    10.2. obtained and reviewed the Board's Stage 2 response and a draft action plan, and

    10.3. obtained comments from the Board.

11. Evidence was assessed and analysed and from that, a finding and recommendations made, and a decision taken. This report provides a summary of the evidence upon which I relied, and my findings and recommendations.

12. C and the Board were given an opportunity to comment on a draft of this report.

Findings and decision

Point 2.1 - The Board has not effectively implemented the improvement actions identified following their investigation of C's concern

13. The key issue considered under this complaint was that the Board has not yet developed nor implemented an appropriate action plan for improvement in response to the findings of their investigation into C's concerns.

2.1 Findings

14. C told the INWO that they raised concerns with the Board in October 2024 about the number of children and adolescents waiting for neurodiversity assessments. C was concerned about the impact of the delays in diagnosis on potentially vulnerable children and adolescents. They said that at the time they first raised concerns the waiting list was around 7,500 patients.

15. In addition, C was concerned about how the Board

    15.1. managed the risks relating to delayed assessments

    15.2. reported on the waiting list, and

    15.3. managed inconsistencies across different localities within the Board.

16. The Board issued a stage 2 response to C on 10 June 2025 upholding all of C's concerns and making recommendations for improvement.

17. The stage 2 response noted that responsibility for the assessment waiting list was potentially being transferred between the Royal Edinburgh Hospital and Associated Services and the Royal Hospital for Children and Young People.

18. C was informed that an action plan to address the findings would be developed within six to eight weeks (ie by mid-August 2025). However, when this was not forthcoming, C complained to the INWO in October 2025.

19. In November 2025 the INWO proposed a resolution based on the Board providing an appropriate action plan.

20. The Board shared a draft action plan in December 2025. The draft action plan did not directly address the issue of the waiting list, which C told the INWO was now circa 11,000 children and adolescents.

21. C met with the Board in January 2026 and expressed their disappointment with the draft action plan. The Board asked C for more time to improve upon it. C agreed to this, however, after several deadlines passed without delivery C referred the matter back to the INWO in March 2026.

2.1 Decision

22. The complaint I have investigated is that the Board has not effectively implemented appropriate improvement actions to fully address the findings of their investigation of C's concerns.

23. While I recognise that there have been internal discussions regarding management responsibility for the action plan, the Board's slow progress is concerning given the nature of the issues identified and their impact on potentially vulnerable children and adolescents.

24. This does not align with key principles of the National Whistleblowing Standards, in particular:

    24.1. Principle 6 ("simple and timely"), which requires that concerns are progressed without unnecessary delay, and

    24.2. Principle 2 ("focused on improvement"), which requires that organisations take prompt and effective action to address issues identified.

25. Where boards fail to implement improvements in a timely manner, whistleblowers may perceive that their concerns have not been valued. This perception can adversely affect their willingness to engage with the whistleblowing process in the future, thereby depriving boards of important feedback and insight.

26. In cases involving potentially vulnerable groups, delays in implementing improvement actions may cause harm, prolong risks or reduce opportunities to improve outcomes. This makes timely implementation particularly important.

27. To mitigate this risk, in line with the Standards, boards should have effective governance arrangements in place with clearly defined ownership, timescales and escalation pathways to oversee the implementation of recommendations and actions arising from upheld investigations.

28. Overall, the Board has not demonstrated that it has met the expectations set out in the National Whistleblowing Standards in delivering timely, effective, and improvement focused action.

29. I uphold this complaint as the Board has not yet developed nor implemented an action plan of improvements to fully address the findings from their investigation. In addition, I consider that the Board's whistleblowing governance has not been sufficiently robust to ensure the effective and timely delivery of an appropriate action plan.

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 INWO are asking the Board to do for C

Rec. No	What INWO found	Outcome needed	What INWO need to see
1.	I found: • The Board has not developed or implemented an appropriate action plan to address the findings of its own investigation. • The Board's whistleblowing governance has not been sufficiently robust to ensure the efficient and timely delivery of an appropriate action plan.	Apologise to C for the failings identified. 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: 19 August 2026

What INWO are asking the Board to improve:

Rec. No	What I found	Outcome needed	What INWO need to see
2.	I found: • The Board has not developed an appropriate action plan to address the findings of its own investigation.	The Board should develop and begin implementing a comprehensive action plan, in line with their investigation findings and the National Whistleblowing Standards.	Evidence that the Board has developed an appropriate action plan to address the findings from C's concern. This should include • actions linked to findings • named leads/owners • measurable outcomes • timescales The Board should also put arrangements in place with timescales for communicating progress to stakeholders, including the whistleblower. In addition, the Board should provide updates to children, young people, families and carers where elements of the updated action plan are likely to have an impact upon access to neurodiversity assessments and treatment. By: 19 August 2026

3.	I found: • The Board's whistleblowing governance has not been sufficiently robust to ensure the efficient and timely delivery of an appropriate action plan.	The Board should ensure governance arrangements are fully aligned with the National Whistleblowing Standards, including: • executive oversight • escalation routes • monitoring of delivery and impact	Evidence that the Board has appropriate governance and oversight arrangements in place to deliver the action plan. Evidence should include details of: • the Board's whistleblowing governance arrangements, including policies/procedures, organisational charts and escalation routes • how the executive are kept informed of the findings, actions and ongoing risks relating to this and other whistleblowing investigations. The Board should provide evidence of critical reflection, including: • why delays occurred • how governance failed • how recurrence will be prevented The critical reflection should result in clearly documented improvements and, where necessary, updated procedures. By: 16 September 2026