**Report of the commissioning officer for the investigation of concerns raised by [redacted]**

## 1.0 Introduction

This report concludes the deliberation of the commissioning officer regarding the above investigation undertaken by the Investigating Officer (IO) Mr Jonathan Walters QC on behalf of Betsi Cadwaladr University Health Board. Mr Walters is an independent senior barrister who has extensive experience of having been involved in advising upon, and conducting, internal disciplinary hearings on behalf of organisations in both the private and public sector, including whistleblowing cases. As the Investigating Officer notes "The purpose of the investigation is to gather evidence to inform the commissioning officer as to whether the whistle-blower held a reasonable belief that the wrongdoing [redacted] alleges had in fact occurred and, if the evidence gathered in support of [redacted] contention is capable of belief (and is not utterly fanciful), to decide what action if any should be taken in respect of it."

As commissioning officer, I have drawn entirely on the report of the investigating officer and the supporting evidence files and wish to acknowledge that some written aspects of this report are directly lifted and/or quoted, from parts of said report at all times respecting the anonymity of those who participated. It is normal procedure in these cases for the investigating officer to provide a report to the commissioning officer containing only the evidence obtained. However, due to the sheer magnitude of the evidence in this case (961 pages of transcripts), it was agreed that Mr Walters would provide observations on the evidence wherever he considered it necessary in order to be of assistance to me as the commissioning officer in making a decision on what, if anything, should be done as a result of the concerns being raised by [redacted] I wish to acknowledge how useful this has been but note it remains my role of commissioning officer to determine the outcomes based upon all the evidence available to me and not just what is evidenced in the body of the report.

As part of the internal assurance process and sign off of my report a second view of the recommendations relating to concerns raised about patient safety and clinical quality was commissioned from an independent professional,. This was undertaken

in order to have confidence that the recommendations were fair and reasonable based on the evidence from the IO report in relation to this important concern. This is included as appendix 1.

I also reviewed all concerns raised on the incident reporting system DATIX for SLT services in West Area from 2012-2019 to look for supporting evidence in relation to the recommendations.

## 2.0 Background

[redacted] (hereinafter referred to as [redacted] is a former employee of BCUHB. [redacted] was employed as a speech and language therapist. In [redacted].

On the 27th June 2016 [redacted] raised concerns formally about a number of aspects of [redacted] own treatment at BCUHB west and the treatment of others and the service being provided in the west generally. [redacted] did this via the Safe Haven mechanism.

[redacted] also wrote a detailed summary of [redacted] concerns on the 8th August 2016 and it is that document which formed the basis of the decision to investigate the concerns being raised by [redacted] under the auspices of the All Wales Raising Concerns Policy. There was then rather a lengthy period of delay in getting the investigation underway with an agreed investigating officer appointed on the fourth occasion following concerns and objections to the previous three.

I was approached on the 31st October 2016 to act as a commissioning officer following concerns raised that the process should be handled outside of the West Area team. Corporate Workforce and Organisational Development support was provided by East Area to continue to ensure impartiality. I am therefore not entirely sighted on the reasons for all the initial delays, however they are not part of the terms of reference for this investigation and it is therefore unnecessary for me to comment on the earlier difficulties.

Given a decision to investigate the concerns formally an investigation had to take place and to that end Mr Walters was appointed as investigating officer in January 2017. An electronic copy of the IO's report was received in the organisation on the 26th March 2019, however the appendices, which are held as hard copies in multiple lever arch files were not available to BCUHB until the 29th April 2019 and, to me as the reviewing manager, until the 16th May 2019 (after photocopying). In order to assist the IO with the investigation, BCUHB appointed an external and independent senior clinical manager with a background in Speech and Language Therapy. This was necessary because [redacted] wished to emphasise that [redacted] was raising clinical concerns and to ensure the perspective of clinical governance was understood.

I note that very few of the matters raised by [redacted] in [redacted] initial complaint or subsequently were within [redacted] direct knowledge and, in the view of the investigating officer, "very few of the allegations were matters about which [redacted] had received detailed evidence from the therapists with whom [redacted] had been in contact". The IO notes that "[redacted] did not commence [redacted] service in BCUHB SLT west until [redacted]. [redacted] time there was short. [redacted] could only have direct knowledge of events which occurred whist [redacted]was working in SLT west. In effect a period of about 6 weeks".

The effect of this invited a "'fishing expedition' approach to the investigation in order to identify evidence in respect of matters which [redacted] felt were worthy of investigation. The problem with conducting an investigation on that basis is that it potentially leads to "an inordinately unwieldy and disproportionate trawl through the minutiae of everyday working life". This approach, in my view, has also contributed along with other events to the very lengthy timeline behind this investigation.

However, notwithstanding the ambiguity and lack of detail from the evidence provided by [redacted] a considerable amount of information was provided to the investigation by therapists in respect to the issues [redacted] had raised. I note that "every witness to the investigation was given an opportunity to provide evidence about their working experiences within BCUHB SLT west". In total 29 individuals, including [redacted] chose to provide evidence which largely focussed on the period 2014-2016 although witnesses were of course able to provide evidence up to, and beyond, the date they were interviewed until the cessation of the investigation by the IO.

There are, of course, a wide range of potential outcomes which an employer can initiate as a result of a whistleblowing investigation ranging from concluding that the evidence put before the commissioning officer even at its highest could not amount to any wrongdoing within the terms of the policy or that it could not ever justify any further action or it could, at its most serious, lead to a referral of the allegations against one or more individuals for disciplinary investigation under the terms of the disciplinary policy. This paper sets out my conclusions and a set of recommendations based upon the facts as presented by the investigating officer.

Finally, as commissioning officer, I find it worthy to note that, barring what might be said to be a demonstrably malicious and knowingly false allegations, then those who raise concerns should have no detriment imposed upon them.

**3.0 Concerns raised and conclusions**

I have set out my conclusions against the broad themes of the concerns that the investigating officer grouped his evidence within his report in line with the terms of reference for the investigation listed below. However, due consideration to commonality across concerns has also been given as the IO notes “I have heard evidence from therapists which would fit into a number of categories of concern”.

**3.1 Workload pressures and risk management**

- Couldn’t cope with caseloads
- Concerns not being dealt with (see 3.6)
- Lack of strategic planning
- Failure to use the risk management process
- Stress (see 3.3)

In conclusion I have found:

- No evidence of disciplinary proceedings being undertaken against any staff in response to the pressures they were under.
- Evidence that the speech and language therapy department had done lots of strategic and operational planning.
- Evidence that speech and language therapy department did not utilise the risk management framework as effectively as they should do.

- Evidence that the decision to move to provide more clinic-based assessment rather than school based is not best practice. There is evidence that this was a management decision derived from the intention to maximise the impact of the SLT service delivery on as many children as possible against a backdrop of significant operational service pressures. I am satisfied that, although the practice of clinic-based assessments was not optimal, it was better than not seeing the children at all and a pragmatic attempt to ensure the best care within the resources available (see section 3.7).
- Evidence that some caseloads were higher than they should have ideally been but the reasons for the cause of the situation are multi-factorial with both clinical staff, teams and management contributing to the situation and include (taken directly from the IO report):
    - Inadequate staff numbers caused by budgetary constraints and the difficulty of recruiting staff to work in the west.
    - Inappropriate referrals and a failure to adequately triage. Too many patients being accepted who could not benefit from SLT intervention
    - Therapists wasting capacity
    - Inefficient case load practice: seeing the wrong people and for too long. Patients being retained who cannot get benefit from SLT intervention
    - Failing of staff to adhere to the guidance and training provided on case load management
    - Reluctance of some therapists to engage in case load validation and to implement/adhere to SMART working
    - SLI therapists refusing to assist in reducing the burden on others
    - A failure of certain managers to engage in the process of case load reduction
    - A failure of some managers to challenge poor practice and a reluctance to engage capability processes and/or disciplinary processes and then to manage those appropriately
    - The refusal of some team leaders to follow and/or maintain best practice
    - The undermining of managers by some therapists

- The failure of some therapists to recognise that they are working in the NHS which necessarily imposes both financial and time constraints on the service they are able to provide
- A lack of a 'can do' culture. The negativity towards change, new methods of working and different ways of working
- The changes in management personnel
- Whether the current structure of locality managers not being responsible for line managing individuals working in their locality is sensible
- The failure of senior managers to address the problems in the department in a timely manner or at all
- The undermining and/or overloading of lower level managers by their own managers.

- Evidence that some staff did not assist others in reducing the caseload of the mainstream service when the situation was particularly difficult.

- Evidence that managers recognised the service and staff pressures and did make attempts to deal with the often conflicting priorities of care, performance targets and staff stress.

### 3.2 Bullying behaviours by managers

- Bullying by managers in particular [redacted] and [redacted]

In conclusion I have found:

- That I agree with what the IO notes as "a key feature of the evidence provided to the investigation is the disquiet caused by the perceived ill-treatment of a former employee…with the suggestion that [redacted] was improperly the subject of a disciplinary process by management in [redacted]". The individual resigned before any formal process was concluded. From this disquiet I summarise that a good deal of the emotion, in the main fear and anxiety, of a number of therapists has emanated. I also can conclude from the evidence that there was a basis for legitimate concerns that the staff member was not performing

to the expected standards and thus it was reasonable for an organisational process to have been started to address this situation. It is of course not possible to determine what the outcome would have been.

- There is evidence of factionalism between staff and staff groups within the SLT department with the inference that this was, in part, to mask their own poor performance but also to look after their own interests rather than acting for the collective good of the department. The IO notes that “to a neutral observer it might also appear that amongst SLTs there was a degree of frustration with each other and mild animosity”

- That the most strident complaints of bullying arise from those themselves alleged to have been failing to meet their own professional obligations and “resented the interventions and decisions of line managers”.

- It is therefore reasonable to conclude that complaints of bullying may have been a reaction to managers attempting to deal with poor performance, however there is also some evidence that some management behaviour should have been better.

- There is some evidence of poor behaviour by [redacted] described as uncaring and overly officious.

- There is limited evidence of poor behaviour by [redacted]

### 3.3 Workplace stress

- Target driven culture
- Bullying (see 3.2)
- High caseloads (see 3.1)
- Lack of management support (see 3.1, 3.2, 3.4, 3.6)

In conclusion I have found:

- Stress has existed in the whole department for a long period.

- There is evidence that several therapists and managers have experienced stress and stress related work absence.

- The cause of stress in the department is multi-factorial, linked often to pressure in their working environment and the behaviours of both clinical and management staff, but it is not all work related.

- That given the range of concerns raised and investigated in this report and, sections 3.1, 3.2 and 3.6, it is not unexpected that stress within department is present.
- There is evidence of a significant gap between the understanding between some therapists and the managers of the importance to the organisation, and therefore the service, to deliver an access target of 14 weeks. For example, the evidence available to support section 3.1 highlights the belief of some therapists "that their caseloads are high because of a slavish adherence to this target". In contrast the evidence also highlights the inefficiency of the service and poor adherence from some staff to engage in service improvements designed to help address such pressures and deliver said target.

### 3.4 Workplace culture

#### 3.4.1 Alleged sexist comments by [redacted]

In conclusion I have found:

- That in respect to the alleged sexist comment made towards a [redacted] there is a glaring conflict of fact between [redacted] and [redacted] about the incident. The therapist in question has not been able to be identified by the IO and therefore no evidence from that individual is available to this investigation.

- There is a considerable amount of evidence to suggest that [redacted]. The IO notes that "Not all those

comments are unwanted e.g. compliments on appearance and clothing and therefore, such comments could never be viewed as acts of sexual harassment."

- There is some evidence to support a conclusion that "some of the comments (if made by [redacted] would have been unwanted and may, on occasions, meet the definition of sexual harassment under s.26 of the Equality Act 2010".

- That the IO has noted that "[redacted] and that such behaviours are simply part and parcel of the working relationships that have existed amongst colleagues who, in some cases, have known each other for many years."

3.4.2 Alleged sexist comment by [redacted]

In conclusion I have found:

- That [redacted] did make the alleged comment.

- That [redacted] admits the comment was made and acknowledges it was a mistake, ill-judged and meant as joke.

3.4.3 Alleged Ageist comments and behaviour

In conclusion I have found:

- That based on the evidence presented that there was no age-related discrimination or harassment in the department.

3.4.4 Alleged behaviours towards [redacted] April 2016-June2016

- Victimisation by [redacted] – breach of confidentiality
- Victimisation by [redacted] - for raising concerns

In conclusion I have found:

- Concerns about sexist and age-related harassment are dealt with in sections 3.4.1, 3.4.2 and 3.4.3

- There is no evidence that [redacted] knew what [redacted] was concerned about and therefore no breach of confidentiality by [redacted].

- It was unwise of [redacted] to push [redacted] to speak to [redacted] if [redacted] did not wish to do so and [redacted] should have recognised that [redacted] did not to have to speak to [redacted] line manager to raise [redacted] concerns.

- There is no evidence of [redacted] victimising [redacted] for raising concerns. There is evidence that [redacted] had intended to speak to [redacted] about [redacted] behaviour before being made aware of [redacted] concerns.

### 3.5 Use of Therapy Manager software system

- Misuse of the system to scrutinise and intrusively manage staff

In conclusion I have found:

- That Therapy Manager is a useful operational management tool which allows managers to know where their staff are and what they are doing with their paid time. In general, its use should be encouraged.

- There is no evidence of misuse by managers.

- There is some evidence that therapists use the system to compare their workload with other therapists

- There is, however, a mistrust of the system from some therapists and evidence that a formal training programme does not exist.

### 3.6 Raising concerns

- No action when therapists raise concerns
- After raising concerns, they were targeted (bullying)

In conclusion I have found:

- Some evidence that when concerns are raised there appears to have been little in the way of adherence to organisational process in the way they were then dealt with. In the main these relate to two incidents of concerns being raised, firstly by [redacted] in July 2015 and, secondly, by [redacted] in January 2016.

- That the lack of process, the more informal manner in which they were dealt with, has led to a perception from some staff that complaints aren't taken seriously.

- That, in line with the findings of section 3.2, "a small number of the complainants may have their own agendas to pursue".

- That there have been a number of "wasted opportunities" to deal with the issues facing this department which is regrettable.

- There is no clear evidence of people being victimised for raising concerns but people's perceptions of the lack of response to their concerns has led to a belief that raising a concern was an unwelcome activity.

### 3.7 Patient safety and clinical quality.

In conclusion I have found:

- As stated earlier there is evidence of therapists holding caseloads which are disproportionate to the clinical time available. The IO notes that "There is considerable evidence of patients whether children or, to a lesser extent, adults not receiving the level of care that therapists would consider necessary." The provision of care by the mainstream school service is perhaps the only significant example from the evidence and relates to a past

decision taken to assess children in a clinic-based setting rather than in schools. The rationale for the decision has been discussed earlier and I remind the reader that you cannot assume that if a school based service had remained in place at that time that children would have received therapy from the SLT. At the time of the decision the school based provision was extremely limited, especially on Anglesey. The move to clinical based provision necessitated a review of the caseload to identify the highest priority children.

- As per section 3.1 I am satisfied that although the practice of clinic-based assessments was less that satisfactory, in the context of why the decision was taken to address the excessive workloads of mainstream therapists it was better than not seeing the children at all. The IO notes that “within the context of a significantly depleted staff it was a moment in time, and it was a risk-based decision” which is sadly a fact of life for most, if not all, NHS services on a day to day, week by week basis. Further context of organisational change, changes in leadership and the special measure status created a particularly difficult period for the SLT department during 2014 to 2016.

- There is evidence that the senior SLT leadership team endeavoured, despite the contextual challenges, to pursue its vision of a safe, equitable, effective quality service. The school based model of provision, at that time, was far from optimal either due to the same operational pressures that precipitated the decision for clinic based care.

- Nonetheless it is clear that this model of clinic only based service is not optimal with evidence that children who have SLT needs, and who are of school age, should be assessed and seen for therapy in both an educational and a clinical setting in order to achieve optimal benefit of the SLT input. It is therefore possible to conclude that the decision to see children in a clinic-based setting will not have served to improve the quality of care those children received, although it possibly may have directed the very limited resource at that time to the most in need.

- The evidence of [redacted] provides only a generalisation and illustration of the concern raised in relation to quality and safety, linked through [redacted] evidence to the delivery of clinical standards and models of care. [redacted] view is therefore a broad assertion that, due to the system of working and impact on therapists, it would be inevitable that children were receiving inadequate care and their life changes were being impaired. [redacted] concerns required, by [redacted] own admission, a reliance on therapists to voluntarily provide more specific evidence to demonstrate this assertion over a longer period of time than the approximate 6 weeks than [redacted] was in the service. [redacted] [redacted] saw one child in [redacted] 6 weeks and did not evidence how this child was harmed beyond relating it to the generalised evidence noted above.

- That the IO notes that "the evidence from the therapists appears to measure quality in relation to process, such as completing reports in a given timeframe, seeing the child in school rather than clinic, who provided a direct intervention?" The premise is that by not proving optimal care based on these activities then patient safety is compromised. What is more important in determining quality, and, in particular, a question of safety or harm, is what the outcomes to the service users are.

- I have already noted above the limitations of a clinic based model in regard to meeting an optimal level of care. In regards to safety there are no clear and specific examples from within the testimony of the 29 participants within this report that provide evidence of outcomes of harm to users of the service. Neither the investigating officer, nor the clinical advisor, attempted to undertake specific examination of any cases and this is appropriate. With no clear evidence of harm presented, and no specific patient cases identified, it would have also taken another 'fishing trip' type exercise to explore further.

## 4.0 Recommendations

This section sets out what I believe are fair and proportionate recommendations that address my findings as commissioning officer. They will require BCUHB to support

and, where necessary, provide resource to ensure their successful implementation to address identified issues with the sole reason of improving the current situation.

1. Establish a steering group to oversee the implementation and delivery of the recommendations.

2. Introduce a revised governance framework for SLT within the umbrella of therapy services and the West leadership team to ensure clarity of responsibility and escalation pathways.

3. The BCUHB risk management policy is provided to all SLT staff and team based training on managing risk and escalation delivered.

4. Review existing fora for gaining service user and partner feedback, in particular the Local Education Authorities and Universities, and where necessary revise and improve to ensure this feedback can shape future service planning.

5. A range of short term actions to assist with workload pressures are undertaken whilst work to ensure service sustainability over the longer term is conducted.

   *Short term*

   - Consideration should be given to an immediate increase in clinical capacity through the employment of additional staff to the school service. Consideration of these posts being permanent to aid recruitment with the view that if the need is not proven as part of the longer time actions then they can be absorbed through natural wastage.
   - Complete the OCP process and, in partnership with the staff, review the remaining structure to ensure it is still fit for purpose
   - Ensure effective triage processes are implemented
   - Re-energise the existing improvement action plan devised in conjunction with the staff, reviewing progress to date.

- Establish a clear health and wellbeing framework using existing organisational resources such as Occupational Health to provide all staff with access to support in the post investigation period.
- Review of individual and team caseloads and agree effective escalation process for the management of.

*Longer term*

- Establish clear job plans setting out clear expectations for all staff.
- Benchmark staffing levels against whole BCUHB SLT departments and external peer organisations to assist in determining appropriate staffing levels to meet population need.
- Adopt the best practice of the All Wales SLT pathways and ensure all staff are supported to utilise them consistently
- Ensure compliance from all staff to agreed evidence-based practice moving away from individual practice behaviour to a more team-based approach.
- Working with staff side identify a staff stress action plan to improve and monitor stress levels.

6. Address under the BCUHB capability policy the [redacted]

7. Investigate under the BCUHB disciplinary policy the [redacted].

8. Through an informal discussion under the BCUHB disciplinary policy address the [redacted].

9. Counsel senior manager [redacted] on [redacted] responsibility to support staff who raise concerns, specifically to not push a complainant into meeting with a line manager against their wishes.

10. To ensure full compliance with equality and diversity mandatory training across the whole SLT department.

11. BCUHB wide review of the recording of activity on Therapy Manager with a view of reducing the need to record activity to essential activity only.

12. Training need analysis for all staff in respect of Therapy Manager

13. Clearer process for access to formal training on Therapy Manager for all therapy staff.

14. Training for all managers in respect to managing concerns using recommendation 2. above to ensure this is embedded in practice.

15. Introduce an organisational development plan for the service, based around team work with an emphasis on openness and candour for all and the responsibilities of being a HCPC registrant. A clear approach to staff engagement should form part of this plan.

16. Leadership and management training and development within the SLT service should be reviewed with a focus on building and supporting engaged teams.

17. All managers, at all levels from Assistant Area Director down, to be reminded on their responsibilities towards managing concerns.

18. Undertake a rapid review of the current service model for mainstream school provision to provide assurance that the clinic only model is no longer the approach taken by the service and to benchmark with other SLT services to ensure the current model is in line with best practice such as the Bercow (2008) and Bercow 10 years on (ICAN 2018) reports.

19. Although outside of the terms of reference of this investigation it is recommended, as an opportunity for improvement within BCUHB that a desktop review of the way the original concerns were dealt with, and how delays throughout the whole investigative process occurred, is undertaken that could provide valuable learning for any future events.

## 5.0 Appendix 1

**Review of the report of the Commissioning Officer (CO) for the investigation of concerns raised by [redacted] with regard to patient safety and clinical quality in BCUHB**

I have been asked to provide a brief independent professional view as to whether the CO conclusions for the SLT investigation are fair and reasonable in relation to the concerns raised about patient safety and clinical quality. My opinion is based on sight of the following documents:

1. CO report
2. IO report Section 13 Evidence relating to patient safety and clinical quality
3. Transcript of [redacted] evidence pp17-32 (of 150)
4. 5 public policy documents setting out the evidence and standards for an integrated, multi-agency approach to supporting children with speech, language and communication needs

I am a [redacted]

### Patient safety and clinical quality

I concur with the CO report that the clinic-based service model followed at the time of the concern being raised fell short of providing the expected standard of care, set

out by the RCSLT and other policy documents available at the time. There also appears to be limited evidence of staff ownership of the service design or recognition by them that it was a temporary risk- mitigating approach to reduce the negative impact of a staffing shortage. There is limited evidence from the interviews that staff felt engaged and empowered to improve the service. This apparent lack of personal investment seems to have been compounded by limitations in leadership and management support.

I agree with the CO that 'although the practice of clinic-based assessments was not optimal, it was better than not seeing the children at all and a pragmatic attempt to ensure the best care within the resources available'. I agree also that there is no direct evidence of harm (as defined by the NHS National Patient Safety Agency (2004) as 'actual impact on a patient from a particular individual incident'). However, this is not to understate the potential additional benefit that could have been available to the children referred to the service, had a fully operational, integrated and multi-agency service been in place.

**Recommendations**

As stated in the CO report, the improvement plan should include a review of the current mainstream school-age service provision, making use of the evidence as highlighted in reports such as Bercow (2008) and also more recently, Bercow 10 Years On (ICAN, 2018) and the response by the RCSLT. The engagement of the full SLT team, as indicated by the CO, should strengthen the impact of the service improvement plan. A review conducted internally and validated externally would also serve to raise awareness of minimum standards as well as best practice within the team, and potentially be of value across the whole of the school-age SLT service in BCUHB.

A robust risk assessment, supported by training in risk management and escalation as set out in the CO report, should ensure an acceptable minimum standard of care can be put in place, as part of a business continuity plan, should a crisis in staffing arise again.

In addition, priority should be given to leadership and management training and development within the SLT service, with a focus on leading and building effective and engaged teams (e.g. Aston Team Based Working,; Patrick Lencioni, 5 Dysfunctions of a Team).

## Conclusion

I am of the opinion that the CO conclusions for the SLT investigation are fair and reasonable in relation to the concerns raised about patient safety and clinical quality.

[redacted]

2 October 2019