Written evidence submitted by The British Association of Dermatologists (PSN0003)

Health and Social Care Committee's Expert Panel

The British Association of Dermatologists (BAD), a charity whose objectives are the practice, teaching, training and research of Dermatology. The BAD works with the Department of Health and Social Care, NHS England, CQC, patient bodies and commissioners, advising on best practice and the provision of Dermatology services across all service settings.

	Independent inquiry or review recommendation under evaluation	**Has the recommendation been implemented? Or (in the case of a recommendation whose deadline has not yet been reached) Is the recommendation on track to be implemented?**	**Has there been specific and adequate funding to enable the recommendation to be implemented?**	**Has there been a positive impact on patients and people in receipt of social care as a result of the recommendation being implemented**	**Was the Government's interpretation and implementation of the recommendation appropriate?**
3	**Culture of safety/whistleblowin g** **Recommendation 1:** "Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns. Action 1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis. Action 1.2: System regulators should regard departure from good practice,	1. Are there any mitigating factors or conflicting policy decisions that may have led to the recommendation not being implemented or not being on track to be implemented? How significant are these? Was appropriate action taken to account for any mitigating factors? Yes, open to interpretation and lack scrutiny and escalation outside Trusts. Where they are escalated there is no structure within NHSE to effectively enforce change. 2. To what extent has the NHS's Covid-19 response affected progress on implementing the recommendation? N/A 3. How has this recommendation been interpreted in practice at trust/patient level? N/A 4. Does data show achievement against implementing the recommendation (if applicable)? Most Trusts' published cultural behaviour reviews lack significant action plans and a programme of improvement to take these forward. 5. Have there been any important developments since the recommendation was made or accepted that affect its implementation? For example, has the implementation of the recommendation been superseded, and if so, has the superseding recommendation been implemented? From our own investigations we have found evidence that cultural reviews are ineffective, and have identified issues with lack of infrastructure and accountability, with HR	1. Were specific funding arrangements made to support the implementation of the recommendation? If not, why? If so, what were these, when and where were they made? N/A 2. What factors were considered when funding arrangements were being determined? N/A 3. Do healthcare stakeholders view the funding as sufficient? N/A 4. Was any financial commitment a 'new' resource stream? If not, did	1. Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the implementation of the recommendation? N/A 2. Will (or have) service users benefit(ted) directly, indirectly or both? N/A 3. What category of service users have benefitted? And why? N/A 4. Have (some) service users been hindered by the recommendation being implemented? N/A 5. Was (or is) the recommendation likely to achieve meaningful improvement for service users, healthcare staff and/or the healthcare system as a whole?	1. Has the implementation of the recommendation had any unintended consequences? N/A 2. Was the level of ambition as expressed by the implementation of the recommendation reasonable, or has it been surpassed by developments since? N/A 3. How has working to implement the recommendation affected other aspects of care? N/A 4. Did the system

	as identified in this report, as relevant to whether an organisation is safe and well-led." (From the Freedom to Speak Up Review, 2015)	processes often ineffective and flawed. We have found the following: • Lack of infrastructure and reportable accountability • Freedom to Speak up not used by staff due to concerns regarding confidentiality and issues already being raised to the board • There should be standardised processes, benchmarked across Trusts • Staff sickness should be measured by specialty. Long term sickness and reasons for sickness should also be monitored	reallocation of funds result in any unforeseen consequences/ undesirable 'work arounds' at local level? N/A 5. What factors were considered when funding arrangements were being determined? N/A	No, there has been a direct result on staff leaving organisations, in some cases leaving organisations with no staff in practice for dermatology departments. With already overstretched departments, this in turn leads to impacts on patient care.	have the relevant tools to support the change? No, organisational service infrastructure is lacking, with inadequate measurement of those outcomes for Trusts, allowing variation within those frameworks.