Written evidence submitted by the British Dental Association (PSN0016)

Section 3

Culture of safety/whistleblowing 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.

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?

There have been some activities about development of a learning culture in primary care dentistry.

Primary care dentistry has suffered for many years from defensive dentistry due to concerns of punitive fitness to practise processes from the regulator and, sometimes, the CQC or NHSE; in fact, 'triple jeopardy', namely having cases on the same issue by all three regulatory authorities, is a real concern of the profession. More recently, the GDC has contributed to work around improving perception and processes, as well as engaging with projects to support the development of a learning culture, including the NHS reporting structures. It was a positive development that wrong-site extraction was taken out of the NHS Never-Events list in 2021 and wider work has been done on human factors and support mechanisms through a number of cross-professional projects, for example around primary care dentistry and Learning from Patient Safety Events (LFPSE). These are positive developments but to gain the profession's trust more needs to be done.

The healthcare regulators publish an annual report on Whistleblowing Disclosures. On a regular basis, the disclosures to the GDC are higher than those to other regulators. This is often explained by the GDC by referencing the fact that many other professions are more likely to work in managed, or employed, settings, so that concerns are raised at that level rather that reported immediately to the regulator, potentially triggering FTP processes. However, we are also concerned about a high number of professionals reporting colleagues to the GDC in a way of 'weaponising' the regulatory procedures for internal disagreements and are considering how this approach could be addressed ("blue-on-blue").

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?

As a result of the Freedom to Speak Up Report (2015), there have been attempts to set up a system in the primary care/general dental practice sphere. These attempts have so far not borne fruit, as the structures in general dental practice are not conducive to such processes in the same way as they might be in bigger entities such as hospital trusts.

The most recent FTSU Annual Report says that work is progressing in primary care; however, there are significant issues and we do not currently see that these are being addressed. One of the main issues in primary care is that of protection of the person raising an issue. The FTSU Scheme is founded on the Public Interest Disclosure Act which is not applicable to the largely self-employed workforce in dentistry. Legislative change is necessary to provide such protection; without it the FTSU approach exposes the individual to significant risk and detriment.

Staff directly employed by ICBS are required to have access to routes for speaking up including FtSU guardians and associated arrangements. ICBs have been asked to think about primary care workers across the ICS also having access to routes for speaking up including access to a guardian and there is a plan to share further information by 31 March 2024 about the precise expectations of ICBs in regard to Freedom to Speak Up for primary care workers.

The definition of 'primary care workers' is not given, and it is not clear if this means dentists. The vast majority of dental practices will not be NHS organisations and their dental staff (outside SC and Paediatrics) will be directly employed by the practice and therefore will have no/little protection under the Public Interest Disclosure Act 1998. For this reason, we assume that dental staff are not 'primary care workers' as they are not contracted to the NHS, nor do they enjoy the benefits of being part of an NHS organisation.

2. To what extent has the NHS's Covid-19 response affected progress on implementing the recommendation?

A report on whistleblowing disclosures, conducted by several healthcare professional regulators, including the General Dental Council (GDC) was published in 2021. The GDC reported that the number of disclosures received decreased from 116 in 2019-2020 to 100 in 2021. It was highlighted that the likely cause of this reduction was due in part as a result of the COVID-19 pandemic, as the provision of, and access to, dental services was significantly impacted at this time. The GDC also reported an increase in whistleblowing complaints raising concerns related to the pandemic, such as allegations of not using PPE or inappropriate use of PPE, poor cross infection procedures and not adhering to social distancing rules.

3. How has this recommendation been interpreted in practice at trust/patient level?

Every dental practice to have a whistleblowing policy

4. Does data show achievement against implementing the recommendation (if applicable)?

The CQC "failures" may list which subjects were failed, but they do not seem to collect it on a subject basis.

Dentists can record patient safety events directly to LFPSE (*by setting up an online). The OCDO states that corporates with a dedicated risk management system for the recording of patient safety events can upgrade so that their local system is LFPSE compliant, and everything is automatically uploaded to the LFPSE system.).*

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?

There is ongoing work in primary care to work towards a learning culture. The BDA has been one of the stakeholders involved in Project Sphere – a group committed to working together to embed a culture of fairness, openness and learning in regard to patient safety in dental settings. This has sought to raise awareness of the national learn from patient safety events (LFPSE) recording

mechanism. It has also looked to introduce well-being support for staff reporting incidents and learning and development for the practice team as well as producing templates to aid discussions about learning from safety events.

Another important recent development is the work on the development of a draft Primary care patient safety strategy identifying national and local commitments for implementation.

It is vital that general dental practitioners are actively involved in all this work and that the documents that are produced are informed by feedback from the profession (BDA and LDCs) before they are signed off.

5. What factors were considered when funding arrangements were being determined?

Q1-5 – no funding given or maybe it wasn't required – we produce a policy – the practice distributes it to staff.

Not specifically aware of funding being given to primary care for any of the above.

Has there been a positive impact on patients and people in receipt of social care as a result of the recommendation being implemented?

1. Has (or will) there been (or be) a meaningful improvement in measurable outcomes, reasonably attributable to the implementation of the recommendation?

We are not aware that it has.

2. Will (or have) service users benefit(ted) directly, indirectly or both?

Presumably – if a member of staff was acting incorrectly and that behaviour has now stopped, then that must be a benefit to patients.

3. What category of service users have benefitted? And why?

Dental patients. In terms of the learning culture – if there eventually is more trust in the system then that would be beneficial both to professionals and to patients; but unclear that there has been a significant improvement.

4. Have (some) service users been hindered by the recommendation being implemented?

In terms of the learning culture – if things are not improved, then professional trust in the system will not increase and the attempts to create a no blame learning culture will not succeed.

The 'registrant v registrant' whistleblowing disclosures at GDC are unhelpful if they are made for the wrong reasons, i.e. to 'get back' at a colleague to make their life difficult. This will not be all of them, of course – but a certain proportion.

We have outlined issues with the protection of those raising concerns under freedom to speak up arrangements.

5. Was (or is) the recommendation likely to achieve meaningful improvement for service users, healthcare staff and/or the healthcare system as a whole?

As above; in terms of the learning culture – if there eventually is more trust in the system then that would be beneficial both to professionals and to patients; but unclear that there has been a significant improvement.

Was the Government's interpretation and implementation of the recommendation appropriate?

1. Has the implementation of the recommendation had any unintended consequences?

However, the 'registrant v registrant' whistleblowing disclosures at GDC are unhelpful if they are made for the wrong reasons, i.e. to 'get back' at a colleague to make their life difficult. This will not be all of them, of course – but a certain proportion.

There are also concerns about FTSU in primary care, as outlined earlier, in terms of the protection for those raising concerns.

2. Was the level of ambition as expressed by the implementation of the recommendation reasonable or has it Health and Social Care Committee's Expert Panel 4 and inclusive future report, 2022) Specific evidence needed: - Examples of local initiatives of induction training for entry-staff joining health, and social care organisations. - Analysis or evaluations of impact of induction training for entry-level staff. - Examples of targeted interventions on collaborative leadership and any evaluations of such initiatives. - Examples of national level issued guidance for running collaborative leadership, or entry-level induction, training. on implementing the recommendation?

The ambition for FTSU arrangements in primary care has so far failed, at least as far as dentistry is concerned.

3. How has this recommendation been interpreted in practice at trust/patient level?

Every practice to have a whistleblowing policy.

4. Does data show achievement against implementing the recommendation (if applicable)?

No data is collected on this.

Jan 2024