Report to the Council from the Policy and Research Board meeting on 18 April 2018

Purpose of paper	To report on the key items considered by the Policy and Research Board at its meeting on 18 April 2018.
Action	For noting.
Corporate Strategy 2016-19	Performance objective 1: To improve our performance across all our functions so that we are highly effective as a regulator.
Business Plan 2017	Priority one: Continue to build a cost effective and efficient organisation.
Decision Trail	In accordance with the General Dental Council Standing Orders for the Non-statutory Committees of Council 2018 the Policy and Research Board will report to the next Council meeting following its meeting.
Recommendations	The Council is asked to note the report.
Authorship of paper and further information	Kairen Zonena, Senior Governance Manager kzonena@gdc-uk.org 0207 167 6311
Appendices	1. Briefing on Human Factors

1. Executive summary

1.1. This paper reports on key issues considered by the Policy and Research Board (the Board) at its meeting on 18 April 2018. The Council is asked to note the update from the Board.

2. Introduction and background

2.1. The key purpose of the Board as defined in its terms of reference is to provide oversight of the development and implementation of strategy, policy and research initiatives and report on them to the Council. In so doing, the Policy and Research Board will work with the Executive to ensure that strategy and policy making is coordinated across the GDC, liaising with other committees as appropriate.

2.2. In accordance with the General Dental Council Standing Orders for the Non-Statutory Committees of Council 2018, the Board is required to report to the Council meeting following each meeting.

3. Workshop – Human Factors in Dentistry

3.1. Simon Wright, Clinical Lead Postgraduate Dental Programmes and Research, Edge Hill University, presented results of comprehensive research he had conducted over several years into the application of Human Factors (HF) to dentistry. The Board also received a briefing (attached at Appendix 1).

3.2. The consideration of "human factors" acknowledges that everyone, no matter how well trained and motivated they are, can make errors, and that in some workplaces, the consequences of such errors can be severe. Human failure, in some form, is often a contributory factor to accidents, both within and outside healthcare. But as in the case of technical failure, robust management of, and focused efforts to prevent, human failure can prove effective.

3.3. Simon Wright proposed a National Human Factors Advisory Workgroup, which he hoped would include the GDC on its Board, which would help take matters forward. Other useful approaches which could be explored by such a group were also suggested.

3.4. The Board welcomed the presentation and the approach, which was relevant to so many aspects of the GDC's work. Moreover, it was also entirely consistent with the thrust of Shifting the Balance, and the GDC's move towards more supportive regulation.

4. *Shifting the balance* programme update

4.1. The Board reviewed the recent programme update. In providing a more narrative, qualitative sense of progress with various projects, the Board had been provided with a more summarised programme overview than usual. It appreciated the intention but formed a view that the balance between headlines and detail needed to be reviewed, which the Executive undertook to do.

4.2. With the appointment of the Programme and Portfolio Manager (Corporate Projects), considerable work had been done on the programme to accelerate progress, by bringing greater clarity to scope and deliverables in some areas.

5. Promoting Professionalism

5.1. This workstream, an important component of our upstream work, is intended to broker a conversation between the public and the profession about the nature of professionalism in dentistry and how the GDC can use its regulatory influence to effect positive change. Considerable progress had been made in recent weeks, and an active programme of evidence gathering was now in hand. A more detailed update would be submitted to the next meeting of the Board in June.

6. Student engagement

6.1. The Executive was pursuing an ambition to engage with all students at a very early stage of their training. It was developing a series of prototype engagement events with a number of institutions across the country. Seven out of eight Dental Schools had been contacted and had responded positively to the approach – a series of engagement events were planned for November 2018 with Year 1 BDS. The Executive was looking for a cross sections of opportunities, including across the four nations and seeking to involve DCPs.

It was intended that any programme would be developed with input from tutors. The Board noted that this project intersected with several existing workstreams (education policy and outcomes, embedding standards, future of CPD, and complaints handling).

7. Risk-based Quality Assurance

7.1. The consultation on the proposed approach to quality assurance was due to finish on 23 May. Following analysis, consultation responses would be submitted to the Board's September meeting.

7.2. In relation to BDS inspections in 2018/19, annual monitoring information had been collated, all programmes were to be inspected, and a combination of any known issues, self-assessment and risk would determine the scope of inspections of Dental Schools. The Board remarked on the importance of education in embedding work on Human Factors.

8. CPD

8.1. The Board noted progress on the next phase of this project, which included a business case being prepared for the work, the framework for an Advisory Group and a first meeting date. The evidence base (an in-depth analysis of the StB consultation responses, and a literature review to gather evidence and best practice for StB proposals) was being gathered.

9. Self-triage webform analytics – improving complaints handling

9.1. The on-line self-triage process launched in September 2017, for users wishing to make a fitness to practise complaint, was designed to help the public direct issues to the right body, and, in terms of fitness to practise complaints, improve the quality of information provided at the earliest stage.

9.2. Data collected so far suggested that the process was working well, however more targeted and specific data would be sought to better measure the impact of the new process. Other research was planned to look at the accessibility of complaints processes, both the GDC's and others'.

9.3. At an appropriate point, the results of the work would be shared with the PSA.

10. Profession-wide complaints handling working group

10.1. This project, together with partners in dentistry in a working group, was developing a profession-wide complaints handling initiative to improve first-tier complaints resolution, including the production of a set of public-facing principles, and a joint statement on the principles to dental professionals. A public-facing visual would be developed using a PHSO-based approach to a user-led vision of the complaints system. Additional signposting tailored to the specific needs of Scotland, Northern Ireland and Wales would be added.

10.2. The GDC's Word of Mouth Panel would be consulted over the terminology used. The Board expressed interest in the debate over the extent to which the material captured the "consumer" element of dental services as well as the pure healthcare provision, and the executive undertook to involve the board going forward.

10.3. A dissemination strategy for rolling out the material, and reaching and engaging all professionals, would be considered at the working group's next meeting, after which the approach would be piloted and evaluated.

11. Material for new Registrants

11.1. The Board received a summary of suggested material for newly qualified DCPs and dentists to welcome them to the profession. It would set out the GDC's role, information about professional standards, and signpost registrants to sources of useful information and help. This was proactive support designed to improve customer service and complaints handling, and embed professionalism and learning, focusing on the upstream element of regulation in accordance with the thrust of Shifting the Balance. It was agreed to add the sign-posting of mental health services to the material.

11.2. The proposed channels for communicating this included interactive web content, an app, a dedicated new registrant web-page, social media and case studies. Timescales for publishing would be included in the Programme update to the next Board.

12. Research Plan

12.1. The Board were informed of the Executive's research plans for 2018, noting that scope was being retained to develop it as new ideas and opportunities for collaboration were encountered.

13. Registrants' Survey 2017

13.1. Matt Thurman, from the research company Enventure which had managed the survey and analysed the results, gave a presentation on the findings, which would come to a future meeting of Council (either May or June).

13.2. It was also agreed that a short governance protocol would be produced to establish a pre-publication approval process for research.

14. Values-based Practise: promoting professionalism and embedding standards for patients and health professionals

14.1. The Board received an update on the project being undertaken in partnership with the General Osteopathic Council and Oxford University Collaborating Centre for Values-Based Practice in Health and Social Care, to understand how to better support the application of standards in context and in practice. A joint workshop last November with all three partner organisations was to be followed by a dental-only workshop in June, to further explore initial findings and develop some prototype tools. This would also provide information to help assess whether or not to undertake a separate piece of work to address the needs of vulnerable people.

15. FtP: Impairment and Serious Misconduct Literature Review

15.1. The Literature Review was the first part of work to ensure the GDC took a proportionate response to enforcement action, to develop and deploy an explanation of impaired fitness to practice that makes a clear link between public protection and confidence (but was not simply about meeting public opinion), and to develop a hierarchy of risk.

15.2. Both the NMC and the GMC had committed to jointly funding a piece of work on this. The research brief was being finalised and would come to the next meeting of the Board for information.

15.3. The PSA was also supportive and interested. A Steering Group on cross-regulatory research would be established, which Matthew Hill would chair, and to which the PSA would be invited.

15.4. The Literature Review would be shared with Council electronically prior to publication.

16. Audience Engagement Project

16.1. This project had now been re-scoped and re-focused. Phase 1 would involve a baselining exercise to find out from key stakeholders and registrants their views on how the GDC engages currently, both in terms of channel and tone. This would be accompanied by work on stakeholders' general media preferences to ensure communications were better targeted. Patients would probably form an element of this research. Results would be reported in November.

16.2. Phase 2 of the project would look at branding, tone of voice and how to maximise resources, by which time the stakeholder engagement unit should be well established.

16.3. In relation to patient involvement, it was noted that a Workshop involving the patient voice was planned for the June PRB meeting. Staff were asked to consider how best to communicate and involve the Council in the patient engagement aspect of PRB's work.

17. Date of the next meeting

17.1. 29 June 2018

18. Recommendations

18.1. The Council is asked to note the items discussed by the Board on 18 April 2018.

Appendix 1

Briefing for the meeting with Simon Wright Clinical Lead Postgraduate Dental Programmes and Research Faculty Health and Social Care Edge Hill University

1. Background

1.1 The consideration of "human factors" acknowledges that everyone, no matter how well trained and motivated they are, can make errors, and that in some workplaces, the consequences of such errors can be severe. Indeed, human failure, in some form, is often a contributory factor to accidents, both within and outside healthcare. However, as in the case of technical failure, robust management of, and focused efforts to prevent, human failure can prove effective. The aviation industry, for example, has made significant progress in reducing avoidable harm.

1.2 The role of human factors in healthcare is concerned with ensuring patient safety through promoting efficiency, safety and effectiveness by improving the design of technologies, processes and work systems[1]. The concept has over several years and following the tragedies in Mid Staffordshire among others become a more important feature in supporting safe and effective delivery of healthcare. The focus to date has been largely in the secondary care sector and in relation to medicine. Simon Wright, Clinical Lead Postgraduate Dental Programmes and Research, is critical of the absence of the approach in primary care and argues that the human factors concept should be applied not only to dental practices but critically to undergraduate teaching and core CPD.

How are human factors defined?

1.3 There are helpful definitions and examples of what the Human Factors theory in healthcare looks like:

It is about 'enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings'[2].

[1] Russ AL, Fairbanks RJ, Karsh B-T et al. The science of human factors: separating fact from fiction. BMJ Qual Saf 2013; **10**: 802−808.

[2] Clinical Human Factors Group (CHFG) https://chfg.org/learning-resources/human-factors-common-terms/

Human factors principles aim to understand the 'fit' between an employee, their equipment and the surrounding environment, which can include learning styles, behaviours and values, leadership, teamwork, the design of equipment and processes, communication and organisational culture. Through a better understanding of these principles, changes can be made that result in a reduction of human error and higher quality care and patient safety[3].

The principles and practices of Human Factors focus on optimising human performance through better understanding the behaviour of individuals, their interactions with each other and with their environment[4].

1.4 At the core of the human factors approach to healthcare is a shift from a blame culture when things go wrong in healthcare to one where learning is extracted from an error and a more positive constructive approach in the workplace is fostered which actively seeks to prevent recurrences. This means that the focus is on working towards safer environments for patients as opposed to blaming an individual for what went wrong.

1.5 The culture in medicine and dentistry has meant that professionals consider that they must be infallible and that this is an expectation that is rooted in education and training as well as organisational and to a degree societal pressures. This culture makes it difficult to admit that errors are possible and leads to refusals to acknowledge an error has occurred. It has been argued that this refusal to acknowledge that errors can and do occur compromises patient safety and limits professional performance. Simon Wright calls for a paradigm shift from a culture of blame to a just culture, where it is accepted that despite technical abilities, character and talents humans are going to commit errors.

2 Human factors in relation to dentistry

2.1 The Human Factors approach chimes with the direction of travel for the GDC. In *Shifting the Balance,* the GDC set out proposals to provide a more supportive model of regulation, based on providing dental professionals with the information and tools they need to meet and maintain high professional standards. This involves working with partners in building a career-long learning-based system and culture aimed at ensuring that patient protection is at the forefront of everything the profession and the GDC do. Further, the GDC's reform plans which also seek to address the

[3] Health Education England https://hee.nhs.uk/our-work/human-factors

[4] NHS England 2013 commitment https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf

climate of fear in the current system recognises that the regulatory system should support people in doing the right thing because it is the right thing to do; not solely because they fear the consequences of doing the wrong thing.

2.2 Health Education England (HEE) considers that human factors practice and principles should be an be an integral part of all education and training and has described it as a 'priority workstream'.

2.3 We understand that there are discussions taking place regarding the establishment of a national steering group on this issue, and that there may be an opportunity for GDC involvement in that group.

Human factors practice and principles

The role of human factors in healthcare is concerned with ensuring patient safety through promoting efficiency, safety and effectiveness by improving the design of technologies, processes and work systems[5]. Wright defines this as encouraging standardisation and examining and designing out error.

Practical examples of factors that can reduce error:

- Effective teamworking
- Checklists (in dentistry this could be audit cycles, clinical effectiveness dashboards and prospective and retrospective risk analysis)
- Communication
- Leadership - encouraging open communication allowing all to speak out to prevent errors
- Addressing fatigue – fatigue and working long hours affect judgment and behaviour
- Identify and report threats
- Evaluate incidences and establish best practice
- Build a safety culture which does not promote blame
- Measuring compliance with the above factors

Implications for practice

2.4 As highlighted above, the theory posits that the majority of the causes of error in healthcare are related to human factors rather than technical ability or inadequate knowledge. Wright considers this has major implications for primary care practice, as the focus rests too heavily on the use of

[5] Russ AL, Fairbanks RJ, Karsh B-T et al. The science of human factors: separating fact from fiction. BMJ Qual Saf 2013; **10**: 802−808.

technology and intellectual capabilities, rather than learning from the hospital setting in secondary care, or other high-risk organisations, and implementing learning from these areas.

Discussion points/Questions

- We understand that the root of the human factors approach came from large scale disasters in aviation, off shore oil platforms, railway networks, nuclear power plants etc. Can you talk us through the origins of this concept in a bit more detail and explain how it could practically apply to a dental practice?
- You argue that there are many impediments to progress in this area. What do you consider are the key barriers to applying human factors to primary care?
- What practical steps could the GDC and its partners take to address these barriers?
- Do you have any examples of good practice in applying the human factors approach in the dental sector to date or primary care more broadly? If not in this country are there examples from other jurisdictions that he could share?
- HEE has said that they are continually exploring how human factors can be integrated at work and embedded across all education and training. Do you have any more information about HEE's plans?
- You raise an interesting point about error and that there can be a refusal to acknowledge error, can you provide some more information about that? Does this possibly refer to an earlier age when healthcare professionals were seen as infallible and the relationship was more paternalistic? Are younger healthcare professionals more likely to be more open to admitting errors or is this all to do with organisational culture?
- Is there a concern that focusing on system failures removes to some degree a professional's accountability for their own actions?
- You call for a paradigm shift from a blame culture to a just culture. What are your thoughts on the Bawa-Garba ruling[6]. Do you agree with the medical profession that the case has significant implications for the 'no blame' culture in the NHS and for open learning from errors?
- You describe the way in which an error can escalate to an adverse event and describes that this happens because of multiple system failure. Can you provide more details about the models you mention that explain this progression, for example the PRISMA model (Prevention and Recovery Information System for Monitoring and Analysis)?

[6] A paediatric registrar, Dr Hadiza Bawa-Garba, was convicted of manslaughter. She was given a 24 month suspended sentence at Nottingham Crown Court. As part of the proceedings, a reflective note Dr Bawa-Garba had created after the event was allegedly used in evidence against her. Dr Bawa-Garba was held responsible for a sequence of failings. She did not recognise the early features of sepsis in the child and as such appropriate antibiotic treatment was delayed. She appeared not to recognise the implications of seriously deranged blood gas results and failed to fully communicate the implications to her consultant. When the child suffered a cardiac arrest there was a further problem as the patient was wrongly identified as another child for whom a DNACPR order applied. A local investigation failed to find a single cause of the poor outcome but rather a complex systemic set of errors and failings.