Bonfire of the verities

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In brief

Suggests that the current focus in governance arrangements centres on apportioning blame on individuals when things go 'wrong'; an approach that has singularly failed to address matters.

Highlights that in other sectors an approach that recognises the wider determinants of poor performance has shown a positive response in raising standards.

Proposes that those responsible for improving the governance arrangements need to recognise the part that the system plays in determining performance and develop accountability arrangements to help achieve this goal.

The emphasis on ensuring improved governance within the UK dental care system continues to rely on the identification of poorly performing individuals. Such an approach, while addressing certain political expediencies, fails to take into account both the wider system issues and the extensive literature on how to influence performance in a positive way. If sustainable improvements in the qualities of care are to occur, an acknowledgement of the system's shortcomings by the main parties must be made and where individual performance has fallen below that regarded as acceptable, the contribution of the delivery system in general needs to be noted. In addition, changes to the clinical negligence arrangements away from an adversarial approach to one that uses an open non-punitive process is necessary. As in health, the environment that individuals find themselves in is a major determinant of good outcomes.

There is something fundamental, perhaps universal, about the assignment of accident causality (and sometimes blame) to the actions and dispositions of human beings. When a problem arises, there is a rush to identify the individual responsible and hold them accountable. Holden[1] highlighted the discrepancy that while accidents are often caused by multiple factors and occur due to the complex interactions of numerous work system elements, human and non-human, person-centred approaches to safety management still prevail. Holden concluded that such a focus on human failure is counterproductive. However, nearly ten years later, the on-going emphasis in governance arrangements in the dental care delivery system remains on identifying individuals who, using the current reported metrics, appear to be performing 'poorly'.

The regulatory agency for the dental professions, the General Dental Council (GDC), is at the time of writing conducting a review on the future of dental regulation.[2] In the Chair's foreword, a number of factors are identified that it is suggested create challenges to the goal of delivering safe and effective care. However, the emphasis throughout the document remains on the failings of individual professionals as to why problems exist. If the actions of the identified individuals are addressed, the system will improve. The problem is that to date such an approach has singularly failed: there are growing numbers of registrants being asked to attend hearings with little evidence that standards have improved. Most importantly, no attention appears to have been given to the work by Holden (and more recently many others) on the importance of the system at large in determining 'good' practice and ensuring adherence to professional standards. This failing is reinforced by the work of Bevan and Wilson[3] who highlighted that performance measures improved standards not through consumer choice or strengthened regulation, but by the fact that no one wanted to be at the tail end of the distribution. Why then is there this continuing emphasis on identifying what appears to be the problematic individual?

Established by the Government in January 2013, Healthcare UK is a venture between the Department of Health and UK Trade and Investment with an aim to helping UK healthcare providers do more business overseas. All very laudable, not least now perhaps with one eye on the need to develop trade agreements following the decision to leave the European Union. The vision presented in Healthcare UK's annual reports and what is happening in reality appears to be at odds. For example, reference is made to the NHS being 'world-class' (compared to what?) and the text includes statements such as 'expertise in areas such as funding, strategy, and regulation [...] making the NHS one of the world's very best healthcare systems' permeate the documents. No mention of the issues arising from Mid Staffordshire,[4] Morecambe Bay[5] or other ongoing issues that have led to suboptimal care provision; all failings of the system at large. This would suggest that it is not just the wish to find scapegoats when problems arise but, in addition, a narrative that pleases the system's political masters; the same that the GDC is ultimately accountable to.

A second and equally pervasive reason for the continued emphasis on seeking solace in the identification of individuals lies with issues surrounding the legal framework

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underpinning activities in the care delivery system; the clinical negligence arrangements. As has been highlighted by Robertson and Thomson,[6] despite strong arguments following the Bristol Child Heart Surgery Inquiry report[7] there has been a continued failure to move away from a model in which the legal profession seeks to prove blame on the part of an individual to obtain financial recompense, an adversarial system of litigation, to an arrangement in which there is an 'open non-punitive environment'. While there are cases that do run based on 'system failure' they are nebulous and difficult to prove: it is so much easier to pin the blame on individual failings.

Stevens[8] argued that there is a need to recognise that the choice of evidence used in policy-making is likely to reflect the power to make decisions. If the power in decision-making is not democratic or equally distributed we could not expect the use of evidence to be even-handed. Both the above examples concerning individual regulation and that of the narrative used to 'sell' the expertise in a system are examples of selective use of evidence. Indeed, with the ongoing work to develop a new contractual arrangement to deliver care through the NHS in England, it is imperative that all the evidence is made available from the prototype arrangements and that shortcomings are identified and considered not simply a report on where the system is 'working' well.

If progress is to be made, four key changes are required. First, an acceptance by all parties that the system is a contributor to the wider failings in the qualities of care provision not simply shortcomings in a number of individuals. Second, there is a need to develop a reporting arrangement in which all bodies involved in regulation provide an indication of the contribution that the system as a factor has made to the pool of individuals deemed to have performed poorly. Third, an acceptance that Parliament, and ministers in particular, have responsibilities for the creation of the system in which care provision occurs and a willingness to recognise their role in underperformance. Finally, there is a need to change the approach concerning clinical negligence from one that uses an adversarial approach to one based on an open non-punitive environment, a key feature that has contributed to the improvements seen in safety arrangements in the airline industry. Over 20 years ago, Oxman and his co-workers[9] stated:

'There is a need in the area of health professional performance to include appropriate diagnostic strategies (to determine the reasons for suboptimal performance and to identify barriers to change) and to select carefully the interventions most likely to be effective in light of the diagnosed problem.'

Improvements in the governance and subsequent performance of the care delivery system must acknowledge the wider determinants of poor performance, not simply continue to try and identify individuals at one end of a performance distribution at one moment in time. As with improvements in health, the environment in which individuals are asked to carry out their activities is critical. Under performance of certain individuals will always come to light when examining a distribution of performance: someone has to be at the tail end. However such an approach fails to recognise the wider determinants of performance; the environmental context of the system. Recognising and accepting the limitations of a delivery system, being able and willing to 'speak truth unto power'[10] and acceptance by policy makers would be a start.

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