IN BRIEF

- GDPs perceive clinical governance to be good for dentistry but its introduction is likely to encounter some resistance.
- Lack of guidance, time and cost of implementation are seen as the main barriers to the introduction of clinical governance within dentistry.
- Most dentists consider risk management important and clinical governance is making them more aware of risk.
- Dentists' issues of concern are very similar to those of medical practitioners when clinical governance was introduced into medical practice.

VERIFIABLE CPD PAPER

Attitudes and opinions of NHS general dental practitioners towards clinical governance

R. J. McCormick[1] and J. W. Langford[2]

Aim To assess the attitudes and opinions of NHS general dental practitioners towards clinical governance.

Design This was a questionnaire based study, sent to NHS principal dentists within the West Midlands area.

Method A Likert scale questionnaire was developed, consisting of 26 statements in four subject areas. It was internally and externally validated, and sent to 208 practices within four geographic areas.

Results A total of 150 questionnaires were returned; a response rate of 72%. For each question, no significant difference was found between areas. The cost and time involved with clinical governance emerged as the most important issues, with many respondents considering that costs of implementation might make more dentists leave the NHS. Dentists were largely positive about the principles of clinical governance and evidence based practice, but were concerned about the possibility of increasing complaints and some doubted that it would result in improved patient care. Many respondents claimed to be still confused about clinical governance and the majority considered that more guidance should be available to assist with development within dental practice.

Conclusions This survey showed that some problems exist around the introduction of clinical governance within NHS general dental practice.

INTRODUCTION

Within the National Health Service (NHS), the concept of clinical governance was first introduced in a White Paper in 1997 called 'The New NHS: Modern, Dependable'.[1] This was further developed with the publication of 'A First Class Service: Quality in the new NHS'[2] by the Department of Health in 1998, which initiated the development of the principles of clinical governance within the health professions. From this paper came the often quoted definition of clinical governance – '*a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish*'.

Scally and Donaldson,[3] in 1998, outlined their view on clinical governance in a paper on the 50th anniversary of the NHS. They define a number of areas upon which clinical governance will impact. It is stated that '*clinical governance is to be the main vehicle for continuously improving the quality of patient care and developing the capacity of the NHS in England to maintain high standards (including dealing with poor professional performance)*'. Clinical leadership and organisational culture was required to change, leading to the development of new ways to recognise and promote good practice, and identify and remedy poor practice and under-performance. It was now to be '*a statutory duty to seek quality improvement through clinical governance*'.

Clinical governance within dentistry

The provision of dental care could not continue outside of this new vision for the NHS and perceived quality problems within NHS dentistry have taken on a much higher profile over the past few years. Nicklin and Batchelor[4] undertook the first study into what members of the profession understood by clinical governance in 1999. This was based on a questionnaire given to participants at two postgraduate courses on clinical governance, organised by the University of York. Of significance, this was not a typical group of individuals, and included 12% of attendees who were either consultants in dental public health or members of a health authority, and many held postgraduate qualifications eg 21% with the Diploma in General Dental Practice. It was surprising then that this motivated and highly educated group would consider themselves lacking in a clear understanding of the principles of clinical governance. In a commentary on this paper,[5] John Renshaw, then Chairman of the British Dental Association NHS Policy Group, stated that *'if practitioners do not know or understand what is being asked of them there is precious little chance of them being able to comply'*. He did acknowledge the significance of the finding that the group studied were positive about the principles of clinical governance.

As part of the Department of Health's initiative to promote the principles of clinical governance within general dental practice, in May 2001, Amendment No. 87 to the Statement of Dental Remuneration set three new Terms and Conditions of Service requirements with regard to clinical governance, and set dates by which compliance was to be achieved. All practices were to submit a

[1*]SpR in Dental Public Health, [2]Consultant in Dental Public Health, Department of Dental Public Health, Rowley Regis and Tipton Primary Care Trust, Kingston House, 438 High Street, West Bromwich, West Midlands, B70 9LD
*Correspondence to: Colonel Robert McCormick
Email: robmccormick100@hotmail.com

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Table 1 Views on clinical governance

Statement	Agree or Strongly Agree	Undecided	Disagree or Strongly Disagree
1. I consider myself well prepared to address the issues of Clinical Governance.	57.14%	27.89%	14.97%
2. I am still confused about Clinical Governance.	35.14%	25.00%	39.86%
3. This Practice already meets the requirements of Clinical Governance.	56.08%	30.41%	13.51%
4. There is not enough guidance on implementing Clinical Governance.	72.79%	14.97%	12.24%
5. Cost is a major negative factor in implementing Clinical Governance.	52.03%	18.24%	29.73%
6. Implementing Clinical Governance takes too much time.	71.62%	16.89%	11.49%
7. The initiative of Clinical Governance is unnecessary.	27.89%	25.85%	46.26%
8. I understand the difference between audit and peer review.	90.54%	6.08%	3.38%

Table 2 Quality improvement

Statement	Agree or Strongly Agree	Undecided	Disagree or Strongly Disagree
9. Clinical Governance has little to do with quality improvement.	29.93%	15.65%	54.42%
10. It is straightforward to measure quality of clinical care.	16.89%	20.27%	62.84%
11. Clinical Governance is good for my Practice.	58.50%	29.93%	11.56%
12. Evidence based Practice is good for dentistry.	82.99%	11.56%	5.44%
13. Current clinical standards in dentistry are poor.	19.73%	19.73%	60.54%
14. Quality in this Practice will not be improved by Clinical Governance.	30.61%	29.93%	39.46%
15. It is possible to have a no-blame learning culture in dentistry.	36.55%	41.38%	22.07%
16. Clinical Governance will raise standards in dentistry.	46.26%	36.05%	17.69%

return to their Primary Care Trust (PCT) on their practice based quality assurance system by 30 June 2002, for the previous year. But by the autumn of 2002, it was becoming clear from the low numbers of returns from practices within the West Midlands, that some barriers or problems might exist with compliance with the implementation of clinical governance. This questionnaire-based study would set out to investigate this.

METHOD

Questionnaire design

A Likert scale based questionnaire exploring the attitudes and opinions of general dental practitioners to aspects of clinical governance was constructed, and sent to all principal dentists within the strategic health authority area.

An initial question bank was produced by 'brainstorming' possible questions and themes. A total of 58 questions, all considered to elicit possible attitudes to aspects of clinical governance from the target population, were initially produced. Four themes were identified.

The questions were also initially graded to be either a positive or a negative theme, by majority agreement between the authors and two colleagues, one a consultant in dental public health and the other a general dental practitioner, not included in the intended study. The questions were assembled in random order within the respective theme groups. A process of internal validation by correlation and an external pilot study reduced the questionnaire to 26 questions in four theme categories as follows:

- views on clinical governance
- quality improvement
- risk management
- clinical governance and dental policy.

Fourteen questions were considered positive to concepts in clinical governance and 12 considered negative.

The study population and sample size

The target population for this study was principal dentists of all practices within the eight West Midlands South Primary Care Trusts holding an NHS contract, ie those practices that were required to comply with the Terms and Conditions of Service for the NHS, and the requirements for clinical governance. The area spans three counties and eight Primary Care Trusts (PCTs). The total number of practices within the HA area was 208. One questionnaire was sent to the sole, or most senior, principal dentist in each practice.

A prepaid reply envelope and a covering letter were enclosed with each questionnaire and a reminder was sent out two weeks after the first posting.

RESULTS

The results were initially examined for any differences between the four areas by equity of populations test (Kruskal-Wallace one-way analysis of variance by ranks). No significant difference was found between the study areas for any of the questions. The results were then combined and considered as a whole.

1. Views on clinical governance

This section informed on general attitudes and opinion towards clinical governance (Table 1). While most of the respondents considered themselves and their practice prepared and ready for the requirements of clinical governance, a substantial majority still considered themselves to be confused, or unsure. This may have reflected a simple anxiety about scope of clinical governance and the standards required of them.
A substantial fraction considered that clinical governance required too much time and over 50% considered that the implementation of clinical governance was too costly.

In the past there had been confusion between audit and peer review. However, over 90% of respondents claimed that they understood the distinction today. Also found was that while almost 28% considered clinical governance an unnecessary initiative, 46% of principals disagreed with this statement. A large majority considered that more guidance was required on implementation.

Just over half of respondents considered themselves well prepared, and while clinical governance was generally accepted, the

majority indicated that they considered more time, money and guidance were required.

2. Quality improvement

While 54% of respondents considered that clinical governance was about quality improvement, 30% thought that it had little to do with improving quality (Table 2). And while the majority considered that clinical governance was good for their own practice, and over 80% considered evidence based practice good for dentistry, they were however more evenly divided on whether clinical governance would improve their own quality of care. How quality is evaluated was seen as a problem, as was the concept of a no-blame learning culture. Only 46% considered that clinical governance would raise standards in dentistry.

The overall opinion from this section was quite positive about clinical governance and the principles of evidence-based practice. And while many considered that clinical governance would raise standards in dentistry and that clinical governance was good for their practice, many saw it improving the practice of others, but not necessarily that of themselves.

3. Risk management

Over 70% of respondents acknowledged risk management to be an important part of clinical governance (Table 3). A substantial proportion considered liability attribution as the prime reason for clinical governance and a substantial number indicated they were becoming more defensive in the way they treated patients and reported an increase in risk awareness. While so many indicated that they were becoming more defensive, only 29% considered that clinical governance would result in fewer complaints.

4. Clinical governance and dental policy

The great majority of respondents considered that more funding was needed for the implementation of clinical governance (Table 4). Less than one third believed that patient confidence in the NHS would improve with the introduction of clinical governance and almost 60% of respondents believe that clinical governance was more about politics than patient care. A similar number considered that the cost of clinical governance might make more dentists leave NHS practice. Almost 60% of NHS principal practitioners considered that clinical governance should be compulsory within private practice.

5. Practitioner comments

A comments section to the questionnaire provided further insight into the feelings and attitudes of a substantial proportion of the respondents to this study.

Many (27%) took the opportunity to comment further on clinical governance. In addition to the extra costs involved and the lack of time for implementation, the desire for more guidance and training emerged again as principal issues.

DISCUSSION

Following the passage of the Health and Social Care Act, PCTs will become responsible for the local commissioning of dental care. Assuring the quality of clinical care will be important in the commissioning process. Integrating sound principles of clinical governance into general dental practice is therefore a priority and the attitudes of practitioners will be an important factor for success. This study investigated the attitudes and opinions of practitioners within the West Midlands area, using a Likert scale questionnaire. A total of 208 practice principles were asked to participate and a return rate of 72% was achieved.

Concerns about the time involved complying with the requirements, and the associated costs, were prominent findings, with a large majority of GDPs believing that more money needed to be made available. This, along with unease about more management rather than more patient care, is comparable with the concerns expressed by the medical profession some five years earlier, when clinical governance was being introduced into medical practice. Of potential significance, many consider that costs could make more dentists leave the NHS. A comment from one practitioner indicated that he had employed a part-time manageress to help with clinical governance, subsidising the cost by private income. Numerous additional comments about time and cost added support to the quantitative evidence of the questionnaire data.

Feelings of frustration, along with some cynicism, about clinical governance and the belief of some responders that clinical governance was a political exercise rather than a desire to improve quality of care, does need some consideration. The difficulty of encouraging a no-blame learning culture, while promoting accountability, is a difficult problem to reconcile. A similar problem also surrounds risk management and the possibility of defensive behaviour caused by increased risk awareness. To some extent these conflicting drivers may find their own balance as clinical governance is implemented over a period of time.

It was observed that the issues and concerns identified by this project are very similar to those encountered by the medical profession some years earlier.

Wallace and Stoten, 1999,[6] undertook a survey of 30 West Midlands trusts to evaluate their progress with evidence-based medicine and their readiness to embrace clinical governance. They found that at this time few trusts had begun to tackle the responsibilities that

Table 3 Risk management

Statement	Agree or Strongly Agree	Undecided	Disagree or Strongly Disagree
17. Risk management is an important part of Clinical Governance.	70.27%	23.65%	6.08%
18. Clinical Governance is all about holding people responsible for adverse incidents.	16.11%	22.15%	61.74%
19. Clinical Governance is making me more defensive in my treatment.	26.17%	27.52%	46.31%
20. Clinical Governance will make me less likely to have complaints.	28.86%	28.86%	42.28%
21. Clinical Governance issues are making me more aware of risk.	60.40%	18.79%	20.81%

Table 4 Clinical governance and dental policy

Statement	Agree or Strongly Agree	Undecided	Disagree or Strongly Disagree
22. Clinical Governance should be compulsory in Private as well as NHS practice.	67.11%	14.77%	18.12%
23. More money needs to be made available for Clinical Governance.	88.59%	8.05%	3.36%
24. Clinical Governance will improve patient confidence in the NHS.	27.52%	36.91%	35.57%
25. The costs of Clinical Governance will make more dentists leave NHS practice.	59.73%	29.53%	10.74%
26. Clinical Governance is more about politics than patient care.	56.67%	23.33%	20.00%

they were about to have. On perceived barriers to clinical governance, over 80% considered demand on clinical time and poor IT systems to be important issues. Over 60% considered professional resistance and conflicting priorities as important, along with '*external stakeholder'* disinterest and lack of clinical staff skills.

A postal questionnaire survey, conducted in 1999 by Hayward, Rosen and Dewar,[7] looked into the experience of clinical governance within primary care groups (PCGs). An 86% response rate from clinical governance leads produced some interesting results. Seventy-two percent stated '*improvement in quality, equity and standards of care*' to be the most positive aspects of clinical governance. All had some serious concerns, especially around '*lack of resources – especially money and time'*. Fear of failure, lack of knowledge and concerns about '*apathy, hostility, suspicion and non co-operation from colleagues'* also featured. The majority cited poor external support for clinical governance, including support provided by the health authority. They concluded with the statement that the '*biggest risk to clinical governance in PCGs is probably lack of resources*'.

Further investigation is therefore recommended into how clinical governance has been developed within medicine, how problems were overcome and clinical governance funded, and whether 'lessons learned' may be of value in avoiding further and future problems within dentistry.

CONCLUSIONS

The biggest change in the provision of NHS dentistry since the beginning of the Health Service is about to be implemented. The biggest risk to access to NHS dental care in recent times may also occur with a potential public health impact both for access and for efforts to reduce inequalities. This project has identified the implementation of clinical governance as an area of concern. The potential for more dentists to leave the NHS is a real one, and perhaps the most important challenge for PCTs is to become aware of the problems and begin to address them as a priority now, before local commissioning begins.

In addressing the agenda for quality in care, it may be important to consider the prevailing negative attitudes within the profession. Already many practices may be technically in contrvention of the NHS requirements for clinical governance; however health authorities and PCTs should be aware of the potential for further harm that may be done by any action that may be perceived as unconstructive. It is suggested that PCTs, where possible, may wish to support and assist practices towards achieving compliance with clinical governance requirements and standards in order to help improve quality in clinical care.

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