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Clinical Governance: A Friend or Foe to Dental Care Practice in the UK?

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Abstract

This paper presents a literature review of clinical governance and its impact upon dental health care in the UK. Whilst the value of clinical governance is recognised, the findings illustrate that the concept of clinical governance remains challenging to dental care practitioners, illustrated by lack of knowledge and confidence in its application and evaluation. The study also identifies a distinct paucity of research concerning impact and makes recommendations to enhance clinical governance in practice.

Key words: *Clinical Governance, Dental Care; Mentoring; Quality, Excellence*

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Defining Clinical Governance

Clinical governance is not a new concept in healthcare (McSherry and Pearce, 2011). The phrase was originally coined by Sir Liam Donaldson and introduced into the National Health Service (NHS) England as part of the healthcare reforms of 1997. Clinical governance was defined as:

"a framework through which NHS organizations 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." (Department of Health, 1997)

Since the inception of this definition we have witnessed a proliferation by professional bodies in redefining and applying this important phrase in an attempt to protect and safeguard the quality and standards of care for staff and patients across a number of health disciplines. Some examples have included: Occupational Therapy, 'a framework for combining a full range of quality activities, building first upon what is already being carried out' (Sealey, 1999: 265);physicians, 'the main vehicle for continuously improving the quality of patient care and developing the capacity of the NHS in England to maintaining high standards (Scally and Donaldson, 1998), and nurses, 'a framework which helps all clinicians – including nurses – to continuously improve quality and safeguard standards of care' (Royal College of Nursing, 2016).

What is significant about all of these definitions is the universal appeal of clinical governance in providing a quality framework for continually improving standards and protecting staff, patients and the public.

The British Dental Association (BDA) recognised the importance of clinical governance in 2006, suggesting that it is part of the NHS drive to improve the quality of healthcare and to make providers accountable for delivering a consistent standard on which patients can rely. The importance of making individuals, and by extension teams, organisations, regulators and/or commissioners accountable is paramount within the definition. This is because we are all responsible and accountable for delivering and maintaining our professional standards and practices as part of our professional codes of conduct and contracts of employment, which is a lifelong and continuous process, aligned with professional development. The BDA recognise these important characteristics and attributes of clinical governance in their 'Advice Sheet Continuing Professional Development, Clinical Governance, Clinical Audit, and Peer Review. Due emphasis is placed upon this in the framework published by the NHS (2006) in presenting their Primary Care Dental Services Clinical Governance Framework that attempts to translate Clinical governance, establishing greater relevance to the dental primary care setting.

A commonality and consensus emerging throughout the various definitions and applications of the phrase clinical governance is the premise that systems and processes are in place guaranteeing clinical quality improvements at all levels of healthcare provision. Furthermore, clinical governance is everyone's responsibility and business.

What is the Purpose of Clinical Governance for Dentistry?

Indubitably, the purpose of clinical governance is to safeguard and protect patients, staff and the public. This is achieved by having a robust quality framework that draws together and/or integrates the various departments and associated systems and processes within an organization. These may include: risk management, where sharing and learning occurs from incident and complaints reporting and monitoring, and quality improvement, which is associated with having the systems and processes in place to encourage innovation and change by individuals who are encouraged and supported to design, implement and evaluate their service and practice. NHS (2006, pp. 7-12) highlight 12 key themes that need to be considered when addressing clinical governance, these include: 'infection control, child protection, radiography, staff, patient, public and environmental safety; evidence based practice and research; prevention and public health; clinical records, confidentiality and privacy; staff involvement and development; clinical staff requirements and development; patient information and involvement; fair and accessible care, and clinical audit and review.' Arguably, the

ultimate purpose of clinical governance is the drawing together of a number of important themes including accountability, team working, quality, safety, continuous learning and sharing to demonstrate excellence in practice (McSherry and Pearce, 2011).

What are the Actual Benefits of Clinical Governance to Dentistry Practice?

It could be argued that the real testimony and/or benefit of the impact and outcome of clinical governance is in the way in which the term and associated quality framework has become globally recognised. This is further evidenced by the emergence of a body of knowledge derived from the findings of several international, empirical-based studies (Hastings, et al., 2014; Benson, et al., 2006; Health Service Executive, 2014; McSherry and Pearce, 2011), which reveals that clinical governance is making a difference in some fundamentally important aspects of healthcare. In brief, these are largely associated with organizational cultures and working environments, continuous quality improvement and accountability, and leadership and management. The lesson to be learned from the growing numbers of studies focusing on the impact and outcome of clinical governance is as noted by Halligan (2006, p. 6) 'What we have learnt, more than anything else, is that if clinical governance gains purchase in the hearts and minds of frontline staff and is built up from the bottom, then the strength of that frontline mandate is unstoppable.' Halligan offers a truly remarkable statement, and one for us all to review and contemplate upon for the future with regard to our own contribution to the clinical governance agenda. However, whilst exploring literature that can be utilised to evaluate the efficacy and impact of clinical governance in dental care, it is clear that, despite the purported benefits of clinical governance, it is characterised by a paucity of research-based literature. Consequently, recognising the lack of research exploring clinical governance in dental health care, the broad aim of this literature review is to explore the effectiveness and impact of clinical governance in dental care practice. Whilst clinical practice is clearly evidence based, and the profession clearly values clinical research, there does seem to be a mismatch between good, clinical, evidence-based practice and the availability of research that has

explored clinical governance and its impact upon quality in dental care. This paper explores in a detailed review literature examining the impact of clinical governance and its challenges to practice.

Method

A literature review is a precise, detailed and extensive examination and interpretation of literature that relates to an exact subject (Ali et al. 2015). A method for seeking knowledge and answers to a specific question or questions, by searching and analysing literature (Aveyard, 2014) and is especially useful in these areas of health care practice that are characterised by limited research. The review provides insight, knowledge and understanding of the topic under review in order that practitioners are able to utilise findings to enhance practice. Literature reviews are important, as they seek to summarise the literature that is available on any one topic, expediting access to knowledge and making best use of time and resources (Ali et al. 2015). It brings together a body of research and presents an analysis of the available literature so that the reader does not have to access each individual research article or report covered by the review, (Aveyard 2014). It is especially useful in those aspects of practice that are not characterised by extensive research.

A literature review using a systematic approach as suggested by Aveyard (2014) was performed covering the period January 1993 - July 2016 with the aim of identifying the impact of clinical governance on dental care. The goal of the review was to recognize and appraise all relevant literature that met the inclusion and exclusion criteria of the study. The search strategy, drawing upon the framework proposed by Aveyard (2014) and illustrated successfully by Ali, et al (2015) included setting specific inclusion and exclusion criteria, relevant to the field of clinical governance and dental care, formulating key terms, language(s), time scale of the search, and the type of sources to assure the quality and rigour of findings (Aveyard, 2014).

The inclusion criteria used were all English language publications in indexed and peer-reviewed journals for the period January 1993 until July 2016, which addressed the goal of the study; exploring how clinical governance and its efficacy

in dental care practice was used. Peer reviewed articles, including empirical studies of both a quantitative and qualitative approach, literature reviews, and organisational reports were included. All "grey" materials including letters to the editor, online leaflets and pamphlets, editorial commentaries and unpublished work were excluded using data base search filters (Aveyard, 2014). Electronic searches were conducted using EBSCO host, Medline; CINHAL; AMED; Science direct; NICE; SUMMON and PubMed databases. The following key words were used: Clinical Governance OR/AND dentistry, Clinical Governance AND dental care, Clinical Governance AND dental care practitioners, clinical governance OR/ AND nursing. The key term 'clinical governance' was used initially; however, this generated an inordinate amount of material necessitating further refinement by combining terms such as 'clinical governance' and 'dentistry', 'dental care' and 'dental practitioner'. Initially this produced an excessive amount of literature; however, once the terms were refined to include specific reference to the context of dental care, significantly fewer results were generated. What was clear, as suspected by the authors of this paper, was that dental care and its relationship to clinical governance is characterised by a paucity of research. This is despite the growth in empirical research conducted in other health care professions, suggesting that the research community has not responded to this challenge.

In order to ensure a systematic process to the review was followed, the recommendations of Aveyard (2012) and Bettany-Saltikov (2016) were followed; each article's title, abstract and, if judged to be relevant at this initial assessment, the complete article was screened to assess whether it met the inclusion criteria. Those articles that met the inclusion criteria were diligently reviewed and analysed and any relevant sources cited in the article were also reviewed and reliance to the inclusion criteria considered. Only those studies that were judged to be methodologically robust were included in the review. Consequently, data extraction (Booth, Papaioannou and Sutton, 2012; Aveyard, 2014) was based on the quality of each article and draws upon review criteria illustrated by CASP (2013) as recommended by Aveyard (2014). (CASP, 2013) ensuring a consistent and methodologically systematic review of each article. This included, exploring the strengths and weaknesses of each articles elected, commenting upon each component of the article under review, including the research design and methodology, sample size, assessment and congruence of validity and reliability measures, and appraisal of potential bias in conclusion and recommendations made.

A review grid based on the meta summary approach suggested by Aveyard (2014) was developed to organise the selected articles. The aim of the meta summary approach was to organise the in a logical manner to enable comprehension and to assess any themes presented within the literature. Using the Critical Appraisal Skills Programme, (CASP, 2013) frameworks, a hierarchy of evidence was established ensuring rigorous and systematic critical appraisal of each article under review (Booth, et al., 2012; Aveyard, 2014; Bettany-Saltikov 2016). This process also resulted in four further papers being excluded from the review. In order to ensure personal bias in the review was reduced, each article was reviewed blind by two academic reviewers. Summary notes in the form of a diary werealso maintained both through hand-notes and online endnote memos, to keep track of and record any excluded documents, highlighting the reasons for exclusion for future reference (Snowden, 2015) and the outcome of discussions between reviewers.

Findings

Thirty-one papers were determined, and after excluding twenty-four that did not meet the inclusion criteria, twelve were considered for in-depth review, following which, a further five were rejected for methodological failings. Whilst Aveyard (2014) suggests that reviewing references in papers selected for review can be fruitful, on this occasion no further papers were selected.

Nicklin and Batchelor (1999) drawing upon a small scale (n=71 response= 88%) convenience sample study explored what dental care providers understood by the term clinical governance and how it impacted upon their activities. Data was collected by use of a self-completed questionnaire administered to participants on a two-day postgraduate course. Significantly, this was an atypical group as the participants included consultants in dental community and public

health and members of a health authority, and many held postgraduate qualifications such as the postgraduate Diploma in General Dental Practice. This research was conducted in the early stages of the implementation of Clinical Governance and, as a consequence, some of the findings and conclusions drawn from this research may be mitigated. The research demonstrated a lack of understanding of clinical governance and little knowledge and awareness of how it may impact upon the profession. However, it could be argued that this was an elite group of dental care practitioners, leaders in the field who are highly educated and skilled, and therefore greater insight may be envisaged. The findings of the studyalso indicated one key area of one key area of concern regarding professional development. This is a bit clumsy. Try 'one key area of concern regarding professional development.' Then begin a new sentence with 'The study illustrated a high number of respondents that reported not being up to date in the development of clinical knowledge and skill. The respondents remained positive however in the belief that Clinical Governance did raise standards of care.

McCormick and Langford (2006, p. 215), explored principal dentist's attitudes and opinions to aspects of clinical governance within a strategic health authority in four key areas: 'views on clinical governance; quality improvement; risk management and clinical governance, and dental policy.' Data was collected via a Likert scale questionnaire consisting of 26 statements in four pre-determined subject areas. The questionnaire was subject to a rigorous process of internal and external review to ensure validity and congruence with study aims, and distributed to 208 dental practices within four geographic areas. In total, 150 questionnaires were returned indicating a good response rate of 72%.

The data from this large-scale quantitative study provided details, as follows:

1. Views on Clinical Governance

The respondents in the survey largely considered themselves and their practices prepared and ready for the demands required to meet the challenge of clinical governance; nonetheless, a distinct number of the respondents did consider themselves to be confused or unsure concerning the application of clinical governance to practice. Suggesting a lack of confidence in their ability to maintain and adapt to processes associated with successful clinical governance. Furthermore, 50% of the respondents considered that the implementation of clinical governance was too expensive. Although the notion of clinical governance was generally accepted with the sample, the majority of the respondents in this study believed more resources in the form of time, money and guidance were required for implementation to be successful (McCormick and Langford, 2006, p. 216).

2. Quality Improvement

While 54% of respondents believed that clinical governance and the processes that underpinned successful clinical governance was about quality improvement, only 46% believed that clinical governance would tangibly raise standards in the provision of dental care. Respondents typically expressed the view that it would primarily be a vehicle to improve the practice of some dental care practitioners and practices, but not necessarily their own (McCormick and Langford, 2006, p. 216).

3. Risk Management

Over 70% of respondents held the view that risk management was an important facet fo clinical governance, and that the notion of clinical governance was developing their awareness of risk to the development of practice and dental care (McCormick and Langford, 2006, p. 216).

4. Clinical Governance and Dental Policy

A large majority of' majority of respondents believed that more resources and especially more funds should be made available for the implementation of clinical governance. Less than one third of the respondents within this study believed that patient confidence in the delivery of dental care would improve with the introduction of clinical governance (McCormick and Langford, 2006, p. 216).

Holden and Moore (2004) highlight the deficiency in guidance provided for practice in developing priorities within dental care. In response, Holden and Moore (2004, p. 21) provide an illustration and

evaluation of an assessment tool and model 'developed to support clinical governance within the dental primary care sector.' The model 'brings together key quality assurance and governance components to create an integrated standard working model for service and practice development. The model comprises of 14 key components that define structure, control process and assure the outcome. Each component consists of a number of indicators, which are scored on an ascending scale in turn. The results are then weighted to emphasise those that are more critical, producing a hierarchy of action that is objective and quantitatively assured' (Holden and Moore, 2004, p. 21) However, the authors emphasise the importance of ensuring that the process does not simply become a "box ticking" exercise and encourage a reflective stance when assessing the outcome. The 'model has been tested in a variety of contexts and found to be useful in identifying areas that would benefit from development and to support action planning' that will sustain quality and service development (Holden and Moore, 2004, p. 21).

Cameron, et al., (2007) provide evidence from a mixed methods study exploring the impact of offering support on quality from Clinical Governance advisers within dental care practices. A cross-sectional sample was employed representing the community from which it was drawn, and the study compared progress made by practices receiving personal support from advisors with those that did not utilising longitude assessment data.

The study identified that clinical governance processes and systems at the initial assessment were very weak in the sample under scrutiny, and that cost of managing systems and processes and the lack of resources and support were viewed as distinct challenges and presented as barriers to practice development. Those practices that received clinical governance adviser support did benefit from the experience and support provided and made distinct improvements in developing care compared with those that had not received support. Cameron, et al. (2011) recommend that dental practices should consider the experience and skills of coaches to develop and enhance this aspect of practice and that self-assessment checklists could be used to promote reflective learning; they should not be relied upon to indicate standards.

Snowden, et al. (2016) conducted a mixed methods case study exploring the knowledge and attitude of a multi-disciplinary group of dental care practitioners. Whilst this study acknowledges its limitation in view of small sample size and replicability, it does provide a valuable insight into knowledge and application of clinical governance in contemporary dental care. The study identified that dental care practitioners had sound knowledge of the notion of clinical governance; however, they did emphasise that they lacked confidence in its application. Snowden, et al. (2016) placed emphasis on the observation that significant support was needed to develop their understanding of this aspect of their role, yet very little time and training was allocated to this. The study acknowledged that participants felt strongly that, as part of the dental team, they should be active participants in clinical governance processes, placing due emphasis upon NHS (2006) clinical governance framework requirements for staff involvement.

Discussion and Conclusion

This literature review has demonstrated a distinct paucity of evidence-based research that practitioners implementing and participating in clinical governance can draw upon to provide guidance. Whilst there has been progress meeting the concerns of practitioners highlighted by Nicklin and Batchelor (1999), those concerns are still relevant today. McCormack and Longford in 2006, Holden and Moore (2007), Cameron, et al., and most recently, Snowden, et al. in 2016 all allude to the lack of knowledge and confidence when applying clinical governance to practice. Cameron, et al. and Snowden, et al. offer strategies to support the development of clinical governance. Whilst Cameron, et al. propose the benefit of professional coaching to support guidance, Snowden, et al. go further by emphasising the role of a mentor in the development of knowledge and practice. The benefits of mentoring in dental practice and professional and clinical development are well documented (Schrubbe 2004; Cho, et al., 2011). Whilst there is little doubt that mentorship will contribute positively to personal growth and development there has been scant attention to the impact it has upon successful learning and the

development of dental health care practice. Success, however, is largely assumed rather than demonstrated; nonetheless, Holt and Ladwa (2008), Snowden (2012), Snowden and Halsall (2014), Elwood (2016), Snowden, et al. (2016) and Edwards, et al. (2016) allude to the potential benefits of mentorship on performance and learning for mentees and mentors. One of the key strengths of mentoring is that the relationship developed enables the mentee to access the craft, or the inside knowledge of the mentor that has been developed during their professional life course.

The nature of clinical governance in health care is becoming increasingly complex and dental health care is no exception to this. Greater support is required by practitioners to translate it into practice. The mentor expedites this process and is seen as a crucial guide and enabler to support practice development and to provide the realist perspective that enhances practice. Mercer et al (2007, p. 753) conducted a survey of attitudes of general dental practitioners (GDP's) and dental nurses in continuing education identifying that practice based learning was the preferred mode of delivery. Holt and Ladwa (2009) allude to the benefits of developing mentoring strategies primarily as a quality assurance tool for dental practitioners, and as having great potential for enhancing clinical governance.

The best fit tool for supporting the quality of care, albeit indirectly, is mentoring suggest Holt and Ladwa (2008, p. 145); they explain how there has been a drive for quality across health care and that clinical audit 'and clinical governance are two of the quality assurance tools that have been developed.' Whilst they suggest that the most significant actor in the quality of care is the dentist, and that dentist is given support and encouragement by their peers, this clearly does not fit with the accepted notion of clinical governance (NHS, 2006); as McSherry and Pearce (2011) assert, team working, continuous learning and sharing are required to demonstrate excellence in practice and are not simply the prerogative of a single professional.

This paper recognises the value of clinical governance. The review, whilst recognising the paucity of literature in this area, presents a limited review of its impact. The conclusion is clear: further work needs to be conducted, exploring the impact of clinical governance upon practice and for health care educators to consider ways of providing support and guidance in the form mentoring strategies that will enhance knowledge and confidence in the application of clinical governance. Embracing clinical governance as an ally will contribute to the developing quality relationship, continually improving standards and protecting staff, patients and the public.

Conflict of Interest: None.

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