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CHALLENGES IN IMPLEMENTING CLINICAL GOVERNANCE: A QUALITATIVE STUDY IN YAZD, IRAN
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CHALLENGES IN IMPLEMENTING CLINICAL GOVERNANCE: A QUALITATIVE STUDY IN YAZD, IRAN

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ABSTRACT

***Background*: Clinical Governance is considered as a system or strategy to improving performance standards and quality of healthcare services.**
***Objective*: To explore barriers in implementing clinical governance and propose related solutions in Teaching Hospitals of Shahid Sadoughi University of Medical Sciences.**
***Design*: A qualitative study.**
***Setting*: Hospitals affiliated to Shahid Sadoughi University of Medical Sciences in Yazd, Iran.**
***Subjects*: Thirteen participants selected among clinical governance executives of under study hospitals and members of clinical governance office in curative deputy of the University.**
***Results*: Eight major challenges in implementing clinical governance were identified including inadequate staff, unsupportive culture, inappropriate training, lack of financial and physical resources, weaknesses in management performance, inadequate monitoring and lack of regulation. To facilitate successful implementation of the programme, appropriate infrastructure, managers' commitment, supporting culture and adequate knowledge were proposed.**
***Conclusion*: Managers and policy makers can accelerate clinical governance implementation by identification and elimination of barriers to remedy existing challenges and improve quality of healthcare services.**

INTRODUCTION

Today, health systems face with an increasing pressure for improved performance, higher quality and efficiency (1). In 1997, the UK Department of Health introduced clinical governance (CG) as a strategy to improve healthcare quality and a responsive method for provision of trustworthy medical services. Scaly and Donaldson stated another definition for CG as "a system through which health organizations are accountable for continuously improving quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (2, 3). CG encompasses a set of activities to minimize potential risks for both patients and hospital staff through timely identification of major complications, investigation of patients' complaints, use of the best available evidence in clinical decision making, self assessment of performance, application of effective methods to change service providers' behaviour and continuous assessment of programmes related to personnel job promotion (4). In fact CG integrates a wide range of strategies to improve quality of healthcare services including research and development, continuous learning, evidence based performance, clinical audit, clinical change mitigation, teamwork, performance measurement, risk management, participation of patients and healthcare professionals (5, 6).

Several studies have assessed the barriers in implementation of CG in different healthcare settings and proposed corrective solutions for improvement. In a study conducted by Ravaghi et al (2014), some of the main challenges in the process of CG implementation have been addressed such as unsupportive management and lack of their

commitment in quality improvement programmes, staff shortage and their resistance toward change, insufficient resources, educational barriers and lack of knowledge about CG concept and disciplines (7). Lathman similarly explored the barriers in successful implementation of CG and focused on the necessity to provide adequate information technology system and facilitate cultural change to resolve existing shortcomings (8). Campbell *et al* (2002) also found lack of managers' commitment as well as insufficient financial, cultural and professional support as important barriers (9). Other obstacles toward CG implementation were mentioned as incomplete records and documentation, lack of defined policies or adequate regulation, inappropriate monitoring and lack of inter-sectoral coordination (10). Literature suggested early training as an effective strategy to bulid trust and improves understanding of quality care systems (11, 12). Konteh found that managers were willing to reconstruct organizational culture in a way to reform health systems (13). A study conducted by Ravaghi *et al* (2013) also mentioned adequate knowledge and positive attitude toward CG, supporting culture, managers' commitment, effective communication and well designed incentives as facilitating factors (14).

Since 2009, Iranian Ministry of Health and Medical Education (MOHME) has applied CG as a framework in all hospitals to implement the policy of quality improvement and patient safety. Such a framework consists of seven pillars including patient and public involvement, education and training, clinical effectiveness, clinical audit, human resources management, risk management and use of information (14-16). Implementation of CG with an emphasis on increasing responsiveness and satisfaction, standardisation, quality assurance, accreditation of healthcare and continuing medical education was focused by MOHME to be followed in healthcare organizations (14, 17). Identification of barriers in the way of implementing clinical governance program from the executives' viewpoint can have a positive impact on solving existing problems. Therefore in current study we attempted to explore barriers and propose related solutions from CG executives' perspective in Shahid Sadoughi University of Medical Sciences in 2014.

MATERIALS AND METHODS

This was a qualitative study conducted among CG officers in Shahid Sadoughi University of Medical Sciences and its affiliated hospitals in 2014. Face to face interviews were applied with a purposeful sample of university and hospital staff including executive managers and CG officers working in hospitals and curative deputy of medical university. Sampling continued to reach data saturation and finally 13 CG officers were interviewed. On the basis of literature review and expert viewpoints, an interview guide was developed which covered key elements of CG and barriers to implement it. Each interview took about 40 minutes and conducted by a researcher who has been trained on how to properly interview with study participants. All interviews were tape recorded and notes were taken to facilitate data analysis. Using a qualitative thematic framework, data analysis included five stages of familiarisation, developing a thematic framework, indexing, charting, mapping and interpretation (7). In a familiarisation step, a table of themes and sub-themes conceptualising barriers to CG implementation from the participants' viewpoint was developed. Each interview was coded by one of the researchers and ultimately was analysed in a panel of study group to apply any necessary modifications in defined codes. In the charting stage, interviewees' points of view were compared. Member check strategy was done to increase the validity of final analysis and ensure the correspondence of findings with interviewees' perceptions. In all steps of data analysis, Atlas Ti software was used. The approval of ethical committee in Shahid Sadoughi University of Medical Sciences was taken before conducting the interviews. Also all participants were informed of study objectives and stated their verbal consent to participate in the research.

RESULTS

Six themes and 27 sub-themes were explored as major challenges in CG implementation (table 1).

Theme 1 Human Resources Challenges: Interviewees believed that lack of staff and sense of engagement among them was main barriers in CG implementation.

"According to the standard, one CG officer is required for every 100 hospital beds, while in existing situation with almost 500 beds, we have just one personnel working in CG department".

"Feel of resistance toward CG is also noticeable among medical staff particularly nurses. Actually they see themselves overwhelmed with high burden of responsibilities regarding to documentation and other tasks related to CG implementation. Additionally lack of supporting mechanisms to provide adequate salaries for staff being involved in such programmes is another challenging issue".

Theme II. Weaknesses in Managerial Performance: Lack of appropriate planning dealing with main probable obstacles was considered as an important barrier in CG implementation from the interviewees' viewpoint. Participants emphasized that clear goals, objectives and activities could effectively achieve success in quality programmes.

"Unwillingness to follow CG principles and

implement related activities is mainly due to lack of positive attitude toward CG program among hospital staff. They mention such a program as a time consuming activity which imposes additional workload on them. Instability in managerial positions reinforces such a negative viewpoint and disappoints employees about the continuation of the program".

Lack of managers' commitment and support, inappropriate coordination among deputies of health ministry and unfamiliarity with quality issues among managers were also regarded as weaknesses in managerial performance both at medical university and ministry level.

"Our hospital manager has no commitment toward CG. He expects us to run the program while he does not participate in any related meetings. This causes frustration and reluctance among head nurses to pursue CG program".

"To implement CG project, officials in curative deputy of the medical university did not attempt to engage those who are responsible in health and education deputies. They neither clarified the duties of different departments in this regard. Lack of transparency in such areas brought many problems in CG implementation".

Theme III Educational Issues: Most of the interviewees regarded lack of education as one of the main challenges to implement CG program. Some of the most cited barriers from participants' points of view were inappropriate educational planning to make staff aware of vision, goals and principles of CG, inadequate training sessions, shortage of trainers with sufficient knowledge and expertise, non-functional and low effectiveness of training courses and finally lack of physicians' participation in such meetings.

"Proper notification about the importance of implementing CG program should be done hierarchically from managerial levels of the health ministry to university executives' levels. Furthermore, to encourage the cooperation of all hospital employees (including cleaning staff, nurses and physician) in quality improvement programmes is not an easy task for hospital authorities. Lack of adequate personnel with real commitment to the program and necessary knowledge about CG implementation principles are the main inhibitors for the issue".

"In a hospital with over 300 personnel, only a sample of ten individuals was selected to pass training courses at ministerial level that often were not able to transfer learned concepts to other staff".

Them IV Cultural Issues: Developing a proper culture which focuses on continuous quality improvement, teamwork and necessity to be patience until achieving desirable outcomes has been focused by almost all participants.

"Unfortunately we are hasty in implementing CG program, so that in the absence of immediate achievement of desired results, we put the program aside and become disappointed of its continuity".

Interviewees added that successful implementation of CG requires a proper adoption of the model in the national level. Considering local conditions and cultural issues has a great priority in implementation of the program".

"I think it is easier to focus on five or even three pillars of CG to run the model more effectively".

Personnel resistance toward change, poor teamwork in some departments, employee distrust about the usefulness of CG program, weakness in localizing and application of a CG model, lack of commitment and adequate cooperation among medical staff particularly physicians were considered as barriers to successfully implement CG.

"I believe that hospital staff specially those with higher levels of work experience show more resistance toward change and do not easily replace traditional procedures with the new ones. Additionally some people tend to work individually and are reluctant to promote teamwork as a necessity for successful implementation of quality improvement programmes such as CG".

Theme V Regulation and Monitoring Problems: In an organization, there might be a proper planning, a suitable organizational structure and motivated personnel but still there is no certainty for achieving determined objectives. In this regard, monitoring as the last ring in the chain of management tasks has a great importance. Lack of proper policy making in the monitoring process, weaknesses of feed back systems also inadequate regulation were mentioned by interviewees as barriers in CG implementation.

"Personally I believe that there is no adequate supervision for CG program. When the time comes to evaluate, all personnel actively work to implement CG standards; however after the inspection time, every thing returns to a normal situation and staff quit working on quality improvement. In fact some rules are necessary to give official approval for continuation of the program".

Them VI Financial Resources and Equipment: Provision of financial resources is an essential requisite for CG implementation. Study participants mentioned adequate equipment and financial problems as other obstacles of the program.

"Provision of quality services can not be only achieved through written plans or objectives but also financial and physical resources are required".

Table 1
Main Themes of Participants' Viewpoint toward CG Barriers

Main Themes	Sub-themes
Human Resources Issues	• Lack of skillful staff
	• Lack of adequate motivation among personnel
	• Inadequate number of personnel
Weaknesses in Managerial Performance	• Inappropriate planning for CG implementation
	• Lack of commitment among senior managers
	• Lack of senior managers' support and cooperation
	• Lack of coordination among deputies of the health ministry
	• Unfamiliarity of senior managers with quality issues
Educational Problems	• Inappropriate educational planning
	• Personnel empowerment issues
	• Lack of knowledgeable and skillful trainers
	• Inadequate training courses
	• Low effectiveness of training sessions
	• High educational costs
	• Physicians' absence in training programmes
Cultural Issues	• Being hurry to achieve results
	• Use of different quality improvement models without appropriate planning
	• Personnel resistance toward change
	• Lack of teamwork
	• Weaknesses in localizing and application of CG program
	• Distrust of some personnel toward the usefulness of the program
	• Lack of commitment and cooperation among physicians
Regulation and Monitoring Problems	• Inappropriate policy making for monitoring process
	• Weaknesses in monitoring and feedback system
	• Inadequate regulation
Financial Resources and Equipments	• Inadequate physical resources
	• Inadequate financial resources

Solutions

Four main themes were explored from the interviewees' statements (table 2).

Theme I Provision of Necessary Infrastructure: According to interviewees' viewpoint, adequate financial and physical resources, performance based payments and financial incentives for personnel were the most important infrastructures to implement CG program.

"To successfully implement the program, sufficient financial resources, manpower, space and equipment should be allocated. In current situation and regarding the deficiencies existing in hospitals, we can not achieve considerable progress in the direction. Lack of appropriate incentive system is another problem which disappoints committed personnel toward the program".

Theme II Senior Managers' Commitment and Support: Most of the study participants believed that successful implementation of CG program depends on managers' commitment and cooperation in quality procedures.

"Developing a CG office in the hospital is not a proper sign for managers' commitment toward quality improvement programmes. Instead they should actively motivate head of departments and individuals to implement CG principles and remove any challenges in the way. They can also be helpful in eliminating medical staff particularly physicians' resistance toward CG through mentioning positive effects of such programmes on promotion of medical services' quality".

Theme III. Promotion of a Supportive Culture: Study participants believed that a supportive culture which focuses on continuous improvement, readiness to change, teamwork and development of new ideas could be a proper solution to resolve most of the challenges existing in CG implementation process.

"To develop CG culture in our hospital, we took advantage of employee participation in quality improvement programmes. In addition to enhance the acceptability of the program, we localized CG principles and procedures based on existing situation and facilities".

Theme IV. Educational Solutions: Personnel can not effectively implement CG programme unless they spend adequate time and energy to learn about CG concept, principles and standards. Planning for nursing education during their working hours and revision of curriculum content for medical sciences students to include quality improvement issues were proposed by interviewees as educational solutions to resolve obstacles existing in the implementation process.

"I think planning for personnel training in working hours saves both money and energy of the hospital and helps manpower to utilize their learned concepts in practice".

Table 2
Main Themes of Participants' Viewpoint toward Solutions for CG Implementation

Main Themes	Sub-themes
Provision of Necessary Infrastructure	• Adequate financial and human resources • Financial incentives for personnel • Performance based payment
Senior Managers' Commitment and Support	• Senior managers' support • Physicians encouragement
Promotion of a Supportive Culture	• Employee participation in quality improvement programmes • Localizing CG program
Educational Solutions	• Planning for personnel training during their working hours • Revision of curriculum content for medical sciences students

DISCUSSION

In the present study we explored barriers in CG implementation from the viewpoints of programme executives. We found eight major obstacles including lack of human, financial and physical resources, insufficient knowledge and attitude toward CG, unsupportive culture, weaknesses in managerial performance, lack of monitoring and inappropriate regulation. Similarly Karimi *et al* (2012) mentioned insufficient number of staff and high workload (19.4%), lack of managers' commitment and support (19.2%) and defects in training courses (16.1%) as the main important barriers in implementing CG (18). In another study findings revealed that shortage of personnel and necessary equipment for excellent performance of healthcare systems would decrease the quality of provided services (19). Non-supportive culture was one of the main problems that most of the study participants had emphasized. In fact, changes in employees' behavior would not be possible without amending the corporate culture. Kokabi *et al* (2010) also found that in many healthcare organizations there is a main reason for failure in implementing CG which is mainly related to lack of appropriate culture and poor management (20). In a study conducted by Coll *et al* (2000), a sense of ownership toward CG programme has been emphasized through acquisition of appropriate knowledge and a positive attitude toward the usefulness of CG programme (21). Ravaghi et al (2014) regarded culture as an important factor in implementing quality improvement programmes and emphasised on its role in achieving patient safety and quality promotion (7). Financial difficulties were other challenges which have been also emphasised in Shake shaft study. He mentioned lack of time and financial resources, ignorance the importance of CG in the provision of clinical care and insufficient critical evaluation skills as the main barriers of CG implementation (22).

In our study, there was also a strongly accepted view that proper infrastructure, managers' commitment and support, educational solutions and promotion of a supportive culture could facilitate CG implementation. Our results are parallel with the findings of Ravaghi *et al* (2014) study who noted that to institutionalise patient safety in hospitals, it is required to radically reform the executive structure, environment, equipment, processes, human resources, management and leadership (7). A supportive culture as the main important factor in the establishment of clinical governance was emphasised in Hogan *et al* (2007) research (23). In a study conducted by Shadpour (2006), it was recognised that the main reason for the failure of many development plans was lack of attention to human and organizational capabilities. Therefore addressing the issue of human resources has got the most important priority in the

health sector reform programme (24). Educational solutions as another findings of the study have been emphasized in Dehnavi *et al* (2014) research who concluded that training programmes need to focus on practical aspects of CG to clarify how to implement the acquired knowledge (25). Ravaghi *et al* (2013) got similar findings and mentioned adequate knowledge and positive attitude as the main perceived facilitating factors from senior managers' viewpoint (14). Wallace *et al* (2001) stated that most of the managers used training programmes and educational strategies to eliminate negative attitudes and resistance toward quality improvement (26).

In conclusion, our study explored main barriers perceived by CG executives working in Shahid Sadoughi University of Medical Sciences. Some major problems including inadequate staff and financial resources, weaknesses in managerial performance, inappropriate training courses, unsupportive culture and inadequate regulation call for immediate attention. Eliminating such barriers through the use of corrective strategies can be helpful in successful implementation of all quality improvement programmes including CG. Authors concluded that possible solutions were provision of proper infrastructure, promotion of a supportive culture and planning for personnel continuous training. Using incentive tools, having staff involvement and commitment also adequate monitoring through proper regulation were other solutions mentioned in this regard. It can be concluded that establishing such a comprehensive quality improvement program requires proper infrastructure and basic foundations such as regulations for adequate monitoring, provision of sufficient financial, physical and human resources, cooperative culture and teamwork also incentive tools to encourage active personnel in implementing CG.

One of the study limitations is that due to the qualitative nature of the research, results can not be generalised in a great extent. Furthermore, given that a considerable time has passed from the implementation of CG, it could be beneficial if more studies will be done with the purpose of investigating the reasons for programme failure in Iran.

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