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Original Article

Facilitators and Barriers to Implementing Clinical Governance: A Qualitative Study among Senior Managers in Iran

Hamid RAVAGHI [1], *Sima RAFIEI [2], Peigham HEIDARPOUR [3], Maryam MOHSENI [4]

1. *School of Health Management and Information Sciences, Iran University of Medical Sciences, Tehran, Iran*
2. *Dept. of Management and Health Economics, School of Public Health, Tehran University of Medical Sciences, Tehran, Iran*
3. *Deputy of Curative Affaires, Clinical Governance Office, Ministry of Health and Medical Education, Tehran, Iran*
4. *Dept. of Community Medicine, Shahid Beheshty University of Medical Sciences, Tehran, Iran*

***Corresponding Author:** Email: sima.rafie@gmail.com

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Abstract

Background: Health care systems should assign quality improvement as their main mission. Clinical governance (CG) is a key strategy to improve quality of health care services. The Iranian Ministry of Health and Medical Education (MOHME) has promoted CG as a framework for safeguarding quality and safety in all hospitals since 2009. The purpose of this study was to explore perceived facilitators and barriers to implementing CG by deputies for curative affairs of Iranian medical universities.

Methods: A qualitative study was conducted using face to face interviews with a purposeful sample of 43 deputies for curative affairs of Iranian Medical Universities and documents review. Thematic analysis was used to analyze the data

Results: Five themes were explored including: knowledge and attitude toward CG, culture, organizational factors, managerial factors and barriers. The main perceived facilitating factors were adequate knowledge and positive attitude toward CG, supporting culture, managers' commitment, effective communication and well designed incentives. Perceived barriers were the reverse of facilitators noted above in addition to insufficient resources, legal challenges, workload and parallel quality programs.

Conclusions: Successful implementation of CG in Iran will require identifying barriers and challenges existing in the way of CG implementation and try to mitigate them by using appropriate facilitators.

Keywords: Attitude, Clinical governance, Senior managers, Facilitators, Barriers

Introduction

Clinical quality has become a crucial movement in health systems of all countries. The main concern is to ensure the highest possible standard for the services provided and to meet the needs of individual service users and communities (1).

In 1997, the UK Department of Health introduced Clinical Governance (CG) as a strategy for improving quality of health care services (2). The classic definition of CG is provided by Scally and Donaldson as "a system through which [health] 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" (2, 3).

The Iranian Ministry of Health and Medical Education (MOHME) has applied CG as a framework for improving quality and safety in all hospitals since 2009. MOHME used the definition cited above as a guide to implement the policy. The CG model developed in Iran consists of seven interlocking components including: clinical effective-

ness, clinical audit, risk management, patient and public involvement, education and training, staff and staff management, and use of information (4). Systems awareness, leadership, ownership, teamwork, and communication are considered as a foundation of this model. MOHME required curative deputy of medical universities and hospital managers to work together to implement such initiatives in Iranian hospitals. The deputies for curative affairs in each medical university have the role of leadership in planning, implementing, monitoring and following up ministry of health policies particularly in quality improvement programs including CG (5).

A number of studies have assessed the implementation of CG in different health systems and health care settings (6-11). Insufficient knowledge and attitude toward CG, Lack of resources, inadequate information technology systems, resistance to change, necessity of cultural change and professional boundaries were the main factors explored by Lathman et al. (6). Another study using qualitative research identified some barriers such as speed of CG implementation, workload and earmarked funding in CG implementation (7). Campbell et al. (2002) considered lack of adequate senior management support as well as resources, structural and cultural issues as obstacles (8). The scarcity of resources was one of the most important barriers in implementation of CG noted by Walsh et al. (9).

In a survey conducted by Ravaghi et al. a number of factors were identified which ultimately could affect the success of quality improvement activities. Raising awareness of CG among managers, supportive culture and sufficient resources were some of the main considering points. (10). Khayatzadeh et al. declared that state level accountability in clinical governance implementation could be addressed by allocating proper resources and empowering policy implementers with proper performance control system (11).

Previous literatures mainly provide inadequate understanding about senior managers' viewpoint toward facilitators and barriers in implementation of CG. In the current study an effort was done to capture both facilitators and barriers in CG implementation from the viewpoint of curative deputies in Iranian Medical Universities.

Materials and Methods

To obtain a comprehensive understanding about senior managers' viewpoint toward CG barriers and facilitators, a qualitative research was employed. To do so, two main information sources were used: face to face interviews and relevant document reviews. Deputies for curative affairs of all types of Iranian medical universities were purposefully selected to maximize the sample diversity and provide a comprehensive view toward CG implementation. The sampling continued until reaching data saturation. Finally, forty three deputies were interviewed. In the first step, an interview topic guide was developed on the basis of findings of literature review and expert opinions (Table 1). It covered the concept of clinical governance, key factors relating to clinical governance implementation process, facilitators and barriers that hospitals were experiencing. Ethics approval was obtained from the Local Research Ethics Committee.

Most interviews took about-30 minutes and notes were taken from all interviews. Permission to record the interviews was obtained in all cases. Some relevant documents were also analyzed such as CG annual reports, audit reports and minutes of meetings. The qualitative thematic framework analysis was used to analyze the data with the assistance of the Atlas-Ti, qualitative data analysis software. Data analysis process includes five stages: familiarization, developing a thematic framework, indexing, charting, and mapping and interpretation (12). To increase the validity, the member check strategy was used and comments were incorporated in the final analysis. It helped to ensure that the findings were congruent with participants' perceptions, beliefs and opinions (13).

Table 1: Summary of interview questions in topic guide

Sample of Questions Asked through the Interview
What do you understand by the term "clinical governance"?
What are the principles of clinical governance?
What are the factors affecting implementation of clinical governance?
In your view, what are the potential facilitators which foster the implementation of clinical governance?
What are the main barriers in implementing clinical governance?

Results

The five main themes were explored and presented according with their sub-themes in (table 2).

Knowledge and attitude toward clinical governance

Most senior managers accepted that improving quality of health care should be integral to their role and essential to safeguard patient care. They believed that quality improvement is a strategic goal, to achieve central government targets. They also felt that this perception would encourage staff to contribute in service improvement. The findings demonstrated the willingness to support and positive attitude towards clinical governance. . Senior managers also declared that having adequate knowledge about clinical governance also positive attitude toward the necessity of the program are the main factors affecting clinical governance implementation. The level of enthusiasm expressed by senior managers seemed to be related in particular to their knowledge and attitude about CG concept and components. Those managers who had gained such knowledge were more optimistic toward success of the program.

"Continuous training about clinical governance concept and principles can make a positive attitude toward the program".

Table 2: Main themes of senior managers' viewpoint toward CG barriers and facilitators

Main themes	Sub themes
Knowledge and Attitude	-Regarding CG as an important key in organization performance -Regarding CG as a main role -Adequate knowledge about clinical governance -Positive attitudes toward clinical governance (CG) -Awareness toward the vision, mission and goals of CG
Culture	- Team work - Reaction to change - Effective organizational culture supporting CG program
Organizational factors	- Senior managers' commitment to CG program - Effective internal and external communication - Establishment of a position for CG officers in organizational chart - Development of medical standards and guidelines
Managerial factors	-Stability in managerial and executive levels - incentive tools - managerial support from CG - executive ability of managers
Barriers	- Availability of resources - Legal challenges - Parallel quality programs (such as accreditation, EFQM, etc) - Work load - Parallel functions in different departments of curative deputy - Stability of CG program - Physician and clinical staff support from CG - Supporting system for the staff responsible for CG implementation

Culture

It was stated that such quality improvement program may facilitates the development of a culture focusing on continuous improvement. Most interviewees declared that appropriate culture for improving quality in the organization; team work and readiness toward change are the main factors which influence CG implementation. Culture of openness in which staffs are willing to bring ideas related to service quality development was the other important factor mentioned by participants. It was believed that culture which promotes alignment of clinical governance goals at both managerial and staff level should be developed. They also stated that clinical governance components needed to be embedded in day to day work.

"At first, we should culturalise CG in our work place".

Organizational Factors

Interviewees believed that adequate organizational commitment toward clinical governance should be created in order to increase the likelihood of program progress.

"When continuous meetings are hold in high managerial levels of medical university about reporting our progress in implementing CG, it makes me sure that there is an organizational commitment."

Effective organizational interactions both within and between departments was the other organizational key factor highlighted by senior managers. They emphasized that clinical governance activities would be more effective if all departments in organization accept the importance of CG and participate in the implementation process.

"Everywhere in our organization you can see something about CG definition, process, implementation and so on."

They stated that most of staff working in this program does not have official position in the organizational chart which negatively affects their work. They suggested that creation of such position can guarantee stability and legitimacy of staff in their workplace and have positive effect. Senior managers accepted that allocating adequate staff to undertake the responsibilities required by program had a critical role in pushing forward the program. The other important factor recognized as an organizational factor was the necessity for development and dissemination of national standards. They should be met using guidelines. Interviewees believe that establishment of such standards and presence of guidelines is prerequisites of such huge quality improvement program. In addition, it can help to conduct evaluation against determined standards which shows gaps in delivery of services.

Managerial factors

One of the factors was managerial commitment toward clinical governance and their executive ability in implementing the program. Most of senior managers mentioned themselves ultimately accountable for clinical activities and quality of care in their organization. They also believed that successful outcome of quality activities depends on managers' participation in quality procedures and the level of their commitment. Interviewees added that senior managers themselves should demonstrate executive capabilities in order to motivate departments to implement clinical governance principles, provide adequate resources, facilitate staff training and remove any obstacle in the way.

"I feel positive about the future of clinical governance because of my involvement with the program".

Furthermore, managers should use appropriate incentive mechanisms to sustain staff motivation and participation.

"The matter is that how top managers will motivate us in implementing quality programs besides doing our regular organizational task."

Interviewees highlighted that stability in managerial and executive positions is crucial to maintain the consistency and continuity of the program. Such unnecessary managerial position changes not only waste money and reduce the program progress, but also, ruin the managers' motivation.

"Major changes in top managerial positions threaten the stability of CG and other quality improvement programs."

Barriers

Most of the senior managers agreed that shortage of staff and limited dedicated resources to implement clinical governance were main barriers in implementing clinical governance. They believed that such barriers leave many managers feel belea-

guered and faced with problems to effectively perform the program.

"I think a major challenge in implementation of CG is lack of resources especially staff and money."

Senior managers mostly emphasized that fostering a sense of engagement among medical staff especially physicians is important. Interviewees addressed staff resistance against the program as an important barrier. One of the reasons for resistance was that the staff is overwhelmed by high workload and different responsibilities. They are seeing the program as being imposed and as policing their performance, rather than supporting quality improvement.

"There is somehow resistance to clinical governance among some physicians and medical staff which I think it is because they are overwhelmed with the responsibilities they have regarding to care giving".

Some managers had a concern that this program might be temporary and act as a wave. In addition some issues such as lack of support from physicians and medical staff, legal challenges, parallel quality improvement models running in the hospitals, increased workload, parallel functions in different domains of curative deputy and inadequate supporting systems developed for the staff in the way of clinical governance implementation were mentioned as barriers. The participants believed that such factors can negatively affect the clinical governance implementation.

"Much of work I perform on clinical governance is done on my own limited time competing with other activities on my time. I have lots of responsibilities to undertake and this encounters me with lack of time".

Some activities were also addressed by senior managers in order to mitigate problems in five afore-mentioned domains. They can potentially promote CG program. These activities are shown in table number 2.

Discussion

In the present study, we tried to explore senior managers' viewpoint about the facilitators and barriers in CG implementation. We found that sufficient knowledge and clear understanding about the principles and practice of CG have major roles in achieving desired improvement in service quality and patient safety in health care settings. This study has also highlighted the importance of supporting culture, appropriate organizational structure and managerial commitment as perceived facilitators in CG implementation. There was also a strongly accepted view that staff at all levels should be consulted, involved in planning and implementation of CG programs. The main identified obstacles were lack of adequate managerial support as well as resource, structural and cultural issues and professional boundaries.

Our results are parallel with the findings of many other studies. A model developed by O' Brien et al. can be helpful in demonstrating main lessons of this study. The model outlines four dimensions in successfully implementation of clinical governance: cultural, technical, structural and strategic. The cultural dimension related to beliefs, values, norms and behaviors in the organization which either suppress or support quality improvement activities. An organization with strong and clear vision and goals, stable managerial leadership, supportive structures for team work, effective interactions and inter professional relationships and continuous learning culture is more likely to successfully implement clinical governance (14). In our study it is clear that senior managers' perception about the important factors in implementing clinical governance were classified in five main domains. The domains were knowledge and attitude, culture, organizational factors, managerial factors and barriers. Most of the senior managers believed in knowledge and attitude toward clinical governance and culture as the most important factors in CG implementation. This was thought to be a major factor in achieving improvement in service quality and patient safety mentioning in another study.

Similar to O' Brien study, our findings showed that culture is also an important factor and many organizations expend much effort to shape their culture in a way to improve quality. A sense of ownership toward quality improvement and a positive attitude to contribute new ideas also provide an organizational climate necessary to allow

alignment of attitudes and values with a continuous quality improvement.

In Hogan study about "Consultants' attitudes to clinical governance", quality improvement was considered as an integral part of consultants' role and they accepted that maintaining service standards, monitoring and improving outcomes for patients were activities they should undertake. There was also recognition about the importance of team based approaches to quality improvement (15). This supports the findings of our study which focuses on the importance of being involved in quality improvement activities by all staff especially physicians and medical staff. Our findings further introduced a variety of approaches to successfully implement clinical governance. These include structures and processes with clear vision and goals toward quality improvement, involving staff in the process of change, rewarding positive behaviors, improving the effectiveness of communication across the organization and providing opportunity for team work.

Campbell study on "the role of CG as a strategy for quality improvement in primary care" found significant barriers in the way of CG implementation. These included in appropriate culture, too few staff, limited resources, disengagement by some practices and staff, lack of time to perform quality activities (8). Our study supported the above findings and declared that some senior managers felt powerless with the volume of work and shortage of resources. Meaningful engagement and commitment at all levels of managers and staff has been highlighted as a major factor in implementing CG. The managerial level needed to match its commitment to a program of change with realistic timetables to secure the cultural and organizational changes needed to improve quality of care. The need for top management support is the most frequently cited imperative for success of any program. Wilkinson and Witcher in an examination of factors important in successfully implementation of clinical governance stressed on the importance of quality committed senior managers and staff effectively involved in all levels of organization (16). Fenton O' Creevy suggests that the most consistently barrier to the success of every quality improvement program is resistance from managers (17). Dawson found that one of the major problems encountered in implementing quality program is lack of commitment at the middle and supervisory management. They suggest that many of the problems of survivor syndrome arise from the breakdown of traditional psychological contract where managers promised job security (18). In our study, the necessity of physicians and medical staff participation in clinical governance program has been emphasized. Some of the literatures on employee involvement are particularly relevant to this research. Lawler, Mohrman and Ledford have demonstrated the close relationship between success of quality programs and employee involvement initiatives (19).

Another issue is the importance of having an employee recognition and rewards system with supporting mechanisms providing adequate salaries for the staff being involved in the implementation of clinical governance program. Encouraging workers to become involved in continuous improvement activities is relatively an important factor (20). Wilkins and Witcher suggest that employees who are highly skilled, with adequate salaries and incentives are typically more likely to accept the program (16).

Master produced a list of eight barriers in the way of implementing a quality improvement program includinglack of management commitment, lack of training, inability to adopt organizational culture suitable for quality improvement, lack of employee involvement, lack of resources, improper planning, in compatible organizational structure and inadequate use of team work (21). The results of his article are similar with our result. Feigenbaum clearly recognized the importance of effective communication in the implementation of quality program. He declares that quality improvement activities, team work, effective communication and supporting the quality program in all organizational levels are of great importance (22).

Sohal, Samson and Ramsay also investigated the barriers of successful implementation of quality plan from the viewpoint of organizational management. They categorized the barriers in a num-

ber of groups: organizational culture (top management support and effective involvement, changing values and culture to align with quality improvement requirements), strategic planning issues (lack of planning for quality, inappropriate organizational structural), resource management issues (lack of resources, inadequate number of personnel and additions to normal working load) (23). Another study conducted by Terziovski, Sohal and Moss showed that a successful quality organization would include the following characteristics: managers and staff with positive attitude toward quality, employment of quality management practices, dissemination of responsibility of quality to all staff at all levels, , leadership commitment, having strategic planning, providing adequate resources, focusing on training and adoption of appropriate culture (24). In our study, senior managers stated some recommendations for implementing clinical governance more effectively such as: creating a suitable culture for implementing quality programs, evaluating the quality of organization, determining the existing deficiencies, setting up appropriate strategic and functional plan to achieve determined objectives, following the programs, evaluating the results and encouraging quality improvement activities continuously (Table 3).

Table 3: Recommended activities by managers

Domain	Recommended Activities
Knowledge and Attitude	-Compilation a strategic plan focusing on clinical governance -changing the negative attitude toward quality programs by appropriate training in managerial levels -creating a positive attitude toward the necessity of clinical governance implementation in all curative deputies -Accepting and emphasizing on clinical governance as a generator culture by the university boards of chairmen -training all hospital staff about clinical governance principles -using experienced consultants in quality matters for managers
Culture	- Transforming concept of clinical governance to the belief - Creating a competitive morality among universities to implement clinical governance - Encouraging team work - Welcoming new approaches - Creating an effective organizational culture supporting CG program - Responsiveness of university president toward clinical governance
Organizational factors	- Codification of medical standards and guidelines - Approving CG organizational chart in both universities and hospitals - Recruiting required staff in administrative reform committee - Organizing effective communication with educational and research deputy - Organizing effective communication with food and drug deputy - Organizing effective communication with health deputy - Stability of CG director in universities and hospitals
Managerial factors	- encouraging staff in implementing clinical governance by using managerial techniques such as: reward and punishment system -determining payments according to the staff performance - job division and clarification of responsibilities for achieving the determines quality objectives -continuous monitoring from clinical governance foundation
Barriers	- Allocating adequate resources - Resolving the legal challenges - Decreasing parallel quality programs such as: EFQM, ISO… - Developing a supporting system which advocate staff in doing additional work load resulting from quality program implementation - Decreasing the parallel functions or responsibilities in different departments of curative deputy - Ensuring the stability of CG program - Encouraging Physician and clinical staff to support CG program by using merit rewards or necessitating their promotion to the degree of effective involvement in quality program

Limitation of the Study

Our study has some limitations. The interviews reflect only top managerial perspectives at medical university level and not managers working in hospitals who should play important role in CG implementation. In addition, due to the nature of qualitative studies the results cannot be generalized although we are looking for theoretical generalization. Although this study has provided the first evaluation of senior managers' viewpoint about facilitators and barriers in CG implementation in Iran, further research is required to track the progress of the CG policy as it unfolds over time.

Conclusion

This qualitative paper explores main facilitators and barriers perceived by deputies in curative affairs of Iranian medical universities. Identifying facilitators and barriers from the viewpoint of senior managers can have an effective role in successful progress of CG program. The reason is that these managers are directly responsible for piloting such quality programs and are the most familiar with challenges existing in the way of implementing CG. Mitigating these barriers by using appropriate facilitators can be helpful in implementation of CG. The authors conclude that one of the possible solutions is developing educational courses and workshops with the purpose of raising staff awareness toward CG concept and practice. Developing a supportive culture, having all levels of staff commitment and involvement, effective communication, developing clinical guidelines, using incentive tools and overcoming legal challenges are other resolutions mentioned in this regard. By successfully implementing the program, patients will benefit from quality services. Also health professionals take an advantage of working in a safer and more supportive system. Evidence suggests that governance needs to match its commitment to a program of change with realistic timetables to secure the cultural and organizational changes needed to improve quality of care.

Ethical considerations

Ethical issues (Including plagiarism, Informed Consent, misconduct, data fabrication and/or falsification, double publication and/or submission, redundancy, etc.) have been completely observed by the authors.

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