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Health Policy and ManagementJournal homepage: <http://ijhpm.com>**Original Article****Senior Managers' Viewpoints Toward Challenges of Implementing Clinical Governance: A National Study in Iran**Hamid Ravaghi¹, Peigham Heidarpour², Maryam Mohseni³, Sima Rafiei^{4*}¹Health Management and Economics Research Center, School of Health Management and Information Sciences, Iran University of Medical Sciences, Tehran, Iran²Department of Hospital Management, Clinical Governance Office, Ministry of Health and Medical Education, Tehran, Iran³Department of Community Medicine, Shahid Beheshti Medical University, Tehran, Iran⁴Department of Management and Health Economics, School of Public Health, Tehran University of Medical Sciences, Tehran, Iran**ARTICLE INFO****Article History:**

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ABSTRACT**Background:** Quality improvement should be assigned as the main mission for healthcare providers. Clinical Governance (CG) is used not only as a strategy focusing on responding to public and government's intolerance of poor healthcare standards, but also it is implemented for quality improvement in a number of countries. This study aims to identify the key contributing factors in the implementation process of CG from the viewpoints of senior managers in curative deputies of Medical Universities in Iran.**Methods:** A quantitative method was applied via a questionnaire distributed to 43 senior managers in curative deputies of Iran Universities of Medical Sciences. Data were analyzed using SPSS.**Results:** Analysis revealed that a number of items were important in the successful implementation of CG from the senior managers' viewpoints. These items included: knowledge and attitude toward CG, supportive culture, effective communication, teamwork, organizational commitment, and the support given by top managers. Medical staff engagement in CG implementation process, presence of an official position for CG officers, adequate resources, and legal challenges were also regarded as important factors in the implementation process.**Conclusion:** Knowledge about CG, organizational culture, managerial support, ability to communicate goals and strategies, and the presence of effective structures to support CG, were all related to senior managers' attitude toward CG and ultimately affected the success of quality improvement activities.**Background**

The way to address clinical quality has become an important movement all over the world. The core responsibilities of health-service providers for quality improvement are different. In each case, they will ideally be committed to the broad aims of quality policy for the whole system, but their main concern will be to ensure that the services they provide are of the highest possible standard and meet the needs of individual service users, their families, and communities (1).

In order to respond to the increasing demand for clinical effectiveness, efficiency and value for money, clinical governance (CG) foundation was laid in the late 1980s (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" (3).

The reason for focusing on CG is to improve the quality of care and respond to government's intolerance of poor standards. The new point about CG is the focus on leadership, organizational

culture, organizational quality strategies and corporate accountability for clinical quality (3,4).

Regarding the international experiences on CG implementation all over the world, the Ministry of Health and Medical Education (MoHME) of Iran has also realized the importance of CG as an opportunity to develop the fundamental components required to facilitate the delivery of quality care. At the beginning of 2010, CG office in MoHME was established in order to support and monitor the implementation of CG in Medical Universities of all over the country. This model is emphasized by the health minister owing to its centralization on patients and public needs and the attempt to meet them. MoHME used the seven pillars model as a guide to implement the policy (5). The model consists of seven inter-locking components including clinical effectiveness, clinical audit, risk management, patient and public involvement, education and training, staff management, and use of information (5). These pillars are founded on important factors highlighting systems awareness, leadership, ownership, teamwork, and communication. The MoHME mandated curative deputies of Medical Universities and hospital managers to work

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voluntarily together in order to implement such initiatives in all Iranian hospitals consisting public, private, affiliated by social security organization, military, petroleum and others (6).

Delivery of healthcare services should assign quality improvement as their main mission (7). Senior managers of curative deputies in each Medical University have the role of leadership in planning, implementing, monitoring and following up the ministry of health polices particularly in quality improvement. Therefore, understanding their viewpoints toward the implementation process of CG is crucial in the successful achievement of the program (6,7). The aim of this study is to identify the key contributing factors in the implementation process of CG from the viewpoints of senior managers in curative deputies of Iranian Universities of Medical Sciences.

Methods

In total, 43 senior managers of curative deputies belonging to three types of Medical Universities (type I, type II and type III) participated in the study. Medical Universities are classified on the basis of different criteria such as: financial, executive and scientific capacities in areas of education, research and delivery of healthcare services. To collect the data, ethics approval was obtained from the Local Research Ethics Committee.

In order to determine the viewpoints of senior managers in curative deputies of Medical Universities toward CG implementation, quantitative data were collected using a questionnaire to classify and describe the viewpoints of managers. The questionnaire consisted of 20 questions on five main parts (knowledge and attitudes, culture, organizational factors, managerial factors and barriers). Each part of the questionnaire had different questions which are shown in Table 1.

A five-point likert scale was used ranging from strongly disagree (1) to strongly agree (5). Mean scores were calculated for responses to allow a degree of comparison between responses. In line with the Ministry of Health research governance process, ethical approval was sought and received. Inclusion criteria were all senior managers of curative deputies in Iranian Medical

Universities. Questionnaires were distributed in February 2012 to each manager (n=43) with a covering letter describing the purpose of the study. All the questionnaires were distributed among senior managers who had participated in a formal meeting set up by hospital management office of the MoHME. At the end of the meeting, participants were asked to answer the questions and all of them answered the questions validating their desire toward overcoming challenges and barriers existing in CG implementation. The internal reliability of the questionnaire was tested using Cronbach's coefficient alpha (85%). Face validity and content validity of the questionnaire were checked in an expert panel set up by a number of professional experts in the field of quality improvement and CG, to see if the questions were relevant, clear and unambiguous. Descriptive and analytical analysis of the data were carried out using SPSS 16.5 (SPSS Inc., Chicago, IL, USA).

Results

Totally, 43 questionnaires were returned with a response rate of 100%. The total returned questionnaires comprised 18.6% senior managers of curative deputies in Medical Universities type I, 46.5% type II and 34.9% type III. Analysis revealed that a number of items were important in the successful implementation of CG from the senior managers' viewpoints. These items included: knowledge and attitude toward CG, teamwork, organizational commitment and the support given by top managers, official position for CG officers, physicians and medical staff engagement in CG implementation process, adequate resources and legal challenges. Table 2 shows the frequency of responses identified as important factors in CG implementation from the viewpoints of senior managers.

Responses to knowledge and attitudinal statements

Majority of senior managers (76.1%) agreed that receiving adequate knowledge about CG concepts and principles through training/education could play an important role to be actively involved in CG implementation. They also focused on the important role of knowledge and attitude as the key factors in

Table 1. Different parts of the questionnaire

	Number of questions	Questions in Detail
Part 1	3	<ul style="list-style-type: none"> • Importance of adequate knowledge and training about CG • Attitude toward CG • Awareness toward the vision, mission and goals of CG
Part 2	3	<ul style="list-style-type: none"> • Importance of an appropriate culture for implementing CG • Teamwork • Reaction to change
Part 3	4	<ul style="list-style-type: none"> • Organizational commitment to CG • Effective communication • Existence of an organizational position for CG officer • Existence of medical standards and guidelines
Part 4	4	<ul style="list-style-type: none"> • Stability in managerial levels • Managerial support from CG • Existence of incentive tools • Executive ability of managers in implementing CG.
Part 5	6	<ul style="list-style-type: none"> • Importance of resources • Stability of CG program • Physician and medical staff support from the program • Existence of supporting system for the staff responsible for CG implementation • Working load, legal challenges • Existence of parallel quality programs also parallel functions in different departments of curative deputy.

the successful implementation of CG. Although 21% had no idea in this field and 2.9% were disagreeable about the importance of knowledge and attitude in CG implementation process.

Responses to organizational culture

The second most responses were given to organizational culture as a key factor in implementing CG. 68% of respondents declared that the priority must be given to changes in the culture of implementing CG program. Using developmental, facilitative and supportive climate was also emphasized by them. 4.5% of respondents were disagreeable with the important role of culture in supporting CG activities and believed in other factors as key elements.

Responses to organizational factors

62.6% of respondents felt that the successful implementation of CG depends on organizational factors such as: organizational commitment to CG, effective organizational interactions, existence of organizational position for CG officers, national standards, and an action plan for quality improvement. These factors have the third priority in the successful implementation of CG from senior managers' viewpoints.

Responses to managerial factors

Minority of respondents (55%) mentioned managerial factors as key elements in CG implementation process. They regarded other factors an necessary in order to implement CG successfully.

Responses to barriers

57.3% of respondents believed that CG will fail unless it is funded adequately and essential structures are provided to support CG activities. They also agreed that clinical staff's support from CG, stability of the program, resolving legal challenges and integrating different quality programs in a unique comprehensive program would definitely help the program successfully be achieved.

Mean scores for attitudinal statement, organizational culture, organizational and managerial factors and barriers are shown in Table 2. For grouped statements, the most perceived important factor in CG implementation was knowledge and attitude with a mean score of 2.8 (SD=0.8). Culture, organizational and managerial factors were next with mean scores of 3.1 (SD=0.9), 3.4 (SD=0.6) and 3.6 (SD=0.7) Respectively. The least perceived key factor was barrier with a mean score of 3.8 (SD=0.6). The findings were then classified on the basis of university types as shown in Table 3.

In Medical Universities type I and II, the senior managers believed that knowledge and attitude toward CG and organizational culture were the most important factors in the successful implementation of CG. After these two main factors; organizational, managerial and barriers were the other elements which managers emphasized on them.

Medical Universities type III were somehow different from the other two types of Universities. The senior managers in this type believed that incentive tools designed by managers, managerial support from the program and their ability to perform the program were the second priority factors in implementing CG. Besides, the existence of a supporting system for the staff responsible for CG implementation, availability of resources, legal challenges, physicians and clinical staff support from the CG program were the third priority factors in CG implementation. It is worthy to mention that managers in all three types of Medical Universities believed that receiving training courses and getting adequate knowledge and awareness toward the vision of CG were in appropriate condition and most of the universities were ready to change and use teamworking for the purpose of CG implementation.

Discussion

This quantitative study has highlighted several factors that influence senior managers' viewpoints toward CG in curative deputies of Medical Universities. The findings support many of the issues that the literature review suggests as important factors in implementing CG. Generally, we found positive attitude among managers toward CG which was consistent with the findings from similar studies elsewhere (8–14). They highlighted the important role of staff willingness to share good practice, communication across the organization, innovation and readiness to change.

In Hogan's study about "Consultants' attitudes to CG", 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 that they should undertake. There was also recognition about the importance of team-based approaches to quality improvement (8). 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.

The need for top management support was the most frequently cited item which is imperative for the success of any program. Wilkinson and Witcher in an examination of factors important

Table 2. The distribution of responses to different domains in Medical Universities as a whole

Domain	Distribution					Mean (SD)
	Strongly agree	Agree	No idea	Disagree	Strongly disagree	
Knowledge and Attitude	43.5	32.6	21.0	2.1	0.8	2.8 (0.8)
Culture	27.9	40.2	27.5	4.4	0.0	3.1 (0.9)
Organizational factors	25.6	37.0	31.3	5.2	0.9	3.4 (0.6)
Managerial factors	35.5	19.5	40.5	4.5	0.0	3.6 (0.7)
Barriers	19.3	38.0	25.2	15.6	2.4	3.8 (0.6)

Table 3. The distribution of responses to different domains in each type of Medical Universities

University type	Domain	% Frequency
I	Knowledge and Attitude	37
	Culture	25
	Organizational factors	15
	Managerial factors	15
	Barriers	8
II	Knowledge and Attitude	40
	Culture	22
	Organizational factors	15
	Managerial factors	12
	Barriers	11
III	Knowledge and Attitude	10
	Culture	8
	Organizational factors	47
	Managerial factors	25
	Barriers	10

in successful implementation of CG stressed that, effective involvement of quality committed senior managers and staff in all levels of organizations is important (9). Dawson and Palmer found that one of the major problems in implementing the quality program is the lack of commitment at the middle and supervisory management. They suggested that many of the problems of survivor syndrome arise from the breakdown of traditional psychological contract where managers promise job security (10). In our study, the necessity of physicians and medical staff to participate in CG program has been emphasized.

Another issue is the importance of having an employee recognition and rewards system with supporting mechanisms to provide adequate salaries for the staff to be involved in the implementation of CG program. Encouraging workers to be involved in continuous improvement activities is relatively an important factor. Wilkins and Witcher suggested that employees who were highly skilled, with adequate salaries and incentives were typically more likely to accept the program (11).

Sohal, Samson and Ramsay investigated the barriers of successful implementation of quality plan from the viewpoints of organizational management. They categorized the barriers in a number 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 structure) and resource management issues (lack of resources, inadequate number of personnel and additions to normal working load) (12). In our study, senior managers of curative deputies in Medical Universities declared that barriers exist in the way of CG implementation that are mainly categorized in five main domains: knowledge and attitude, culture, managerial factors, organizational factors and barriers.

Campbell's 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 inappropriate culture, too few staff, limited resources, disengagement by some practices and staff, lack of time to perform quality activities, etc (13). 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. Managerial level had to set a realistic and timetable program in order to apply cultural and organizational changes for improving quality of care.

Fenton O'Creevy suggested that the most consistent barrier to the success of every quality improvement program is the resistance from managers (14). Master produced a list of eight barriers in the way of implementing a quality improvement program. Based on the literature review, these are: lack of management commitment, lack of training, inability to adopt organizational culture suitable for quality improvement, lack of employee involvement, lack of resources, improper planning, incompatible organizational structure and inadequate use of teamwork (15). The results of his article are the same as our research. In our study, senior managers of curative deputies in Medical Universities declared that some barriers exist in the way of CG implementation that are mainly categorized in five main domains: knowledge and attitude, culture, managerial factors, organizational factors and barriers.

Conclusion

As a result it is obvious that adequate knowledge and positive attitude toward CG, supportive culture for quality improvement, managerial commitment, ability to communicate clear goals and strategies, a rewarding system to encourage positive behaviors and stability in managerial level are all necessary to shape senior managers' attitudes toward CG. In addition, engagement of different levels and the success of quality improvement activities are the key factors in the successful implementation of CG.

By successfully implementing the program, patients will benefit from quality services and practitioners will improve the care they provide. Also, they 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 the quality of care.

Ethical Issues

This study was approved by the Ethics Committee of Iran University of Medical Sciences.

Competing interests

The authors declare that they have no competing interests.

Authors' Contributions

SR, MM, PH and HR collected the data, performed data analysis and drafted the manuscript. All authors read and approved the final version of manuscript.

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