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Clinical governance in Iran: theory to practice

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Abstract

Clinical governance is being implemented in a number of countries as a key strategy in quality improvement. The aim of this study is to evaluate medical universities and their affiliated hospitals in the way of implementing clinical governance. Clinical governance implementation was assessed by means of indicators designed by CG officers in MOHME. These indicators were classified in to 7 categories with totally 1900 score. Assessment was conducted in 3 phases based on documentation review, interview and direct observation of the related fields. Total score of each university and affiliated hospital were analyzed by SPSS. Multiple comparison show significant statistical difference in use of information in type 1 universities compared with type 2 (P=. 0001) and type 2 with type 3 (P=. 031). Clinical effectiveness had significant statistical difference between type 1 and 2 universities (P=. 034). Clinical audit had significant statistical difference between type 1 and 2 (sig=. 071) and type 2 and 3 universities (P=. 014). Results show strengths and weaknesses of medical universities in implementing CG also transfer best practices of them throughout the country.

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1. Introduction

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 (Scaly G, 1998).

A wide range of tools and techniques is used for identifying, measuring, prioritizing and improving processes, which are critical to quality (Lazare, 2000). In recent years, health system pioneers in different countries used various methods to improve quality and safety of health services which can be categorized in two main groups: 1) models based on external evaluation that increase the commitment toward quality 2) models that help quality

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management in organizations. Hospital accreditation can be mentioned as a first category and clinical governance as a second group in a way of implementing high quality standards (Oyebode F, 2000). Clinical governance is being implemented in a number of countries as a key strategy to improve quality of services. It has been the central point of health reform efforts in the United Kingdom since the late 1990s. The reason for investing in clinical governance is to improve quality of care and response to public and governmental intolerance of poor performance in health care. There are social and economic motives for clinical governance, which ensure that potential benefits to patients can be maximized, and unnecessary risks can be avoided (Wright L, 2001). Clinical governance is a "framework through which NHS organizations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (Malcom L, 2000 & Yaghoubi N, 2011). The challenge is to create an environment that fosters health care that is evidence based, with sophisticated information technology, rewarding quality and owning the workforce ready for rapid change in the interest of better service to patients. Clinical governance is central to this notion of a quality service, where quality is defined as doing the right things for the right people at the right time and doing them right first time (Evaluation and accreditation center for curative affaires, 2011). In the beginning of 2010, clinical governance office was established in Iran Ministry of Health in order to plan, organize, implement and monitor clinical governance programs also to coordinate clinical governance offices of medical universities all over the country. This office had some priorities to be accomplished such as creating a supportive culture for quality improvement, training clinical governance concepts, planning, organizing, establishing appropriate structures for clinical governance development, implementing clinical governance programs according to determined policies and objectives, monitoring the implementation process and coordinating different organizations, institutions or departments having the role in the success of clinical governance program (Clinical Governance office report, 2012). In the way of assuring implementation of clinical governance in all hospitals and medical universities also developing a supportive culture for quality, the clinical governance office in ministry of health triggered to set up a festival by emphasizing on appreciating good performing universities in implementing clinical governance criteria and sharing successful experiences of universities all over the country. The criteria focused in the clinical governance festival are: public private involvement, patient safety and risk management, education and personnel management, use of information, clinical audit and clinical effectiveness. According to the festival criteria, the universities and their hospitals were ranked regarding to their performance in quality improvement and the level of clinical governance implementation (Clinical Governance office report, 2012). The purpose of this study was to evaluate universities and hospitals' assessment grades to compare their function in quality improvement.

2. Method

At the time of study, there were 46 medical universities and 876 active hospitals in Islamic Republic of Iran. Clinical Governance office of MOHME designed indicators to assess the level of implementing program in hospitals. . These indicators classified into 8 categories (management, patient safety and risk management, education and staff management, patient and public involvement, use of information, clinical effectiveness, clinical audit and advanced indicators). Total score of these indicators is 1900, which is shown in bellow table.

Table 1. Scores of each indicator

Indicators	Scores
Management	100
Risk management and patient safety	700
Patient and public involvement	260
Use of information	260
Staff management and education	170
Clinical effectiveness	40
Clinical audit	220
Advanced performance indicator	150

Assessment process was based on documentation review, interview with hospital staff and direct observation of related fields. Total score of each indicator is calculated by summing up the scores gained by these 3 methods. In our assessment model pre assessment preparation was conducted in early phase of assessment (designation of indicators and validation of them by clinical governance officers in universities and affiliated hospitals) then hospital self-assessment and university assessment of their hospitals was performed. Assessment process consisted of: one hour for opening meeting and hospital briefing, 4-8 hour for documentation review and interview with staff, and finally site visit from at least 4 wards (emergency, ICU, medical and surgical ward). Each hospital assessment lasted for 1-2 days. Data related to universities and hospitals' scores gathered and entered in SPSS for analysis. Different statistical methods including t-test, one-way Anova and multiple regressions were used.

3. Results

518 hospitals in 3 university types were assessed to identify how well they implemented clinical governance. Types of these hospitals were: public hospitals 79%, social security hospital 6.9%, private hospital 6.75% and others 6.37%. In type 1 universities, 147 hospitals (87.5%) had self-assessment results, 103 hospitals (61%) had university assessment done by clinical governance officials in the university and 84 hospitals (50%) had university and self-assessment together. In type 2 universities, 188 hospitals (75.2%) had self-assessment, 228 (91.2%) had reports of university assessment and 167(67%) had both university and self-assessment. In type 3 universities, 76 hospitals (76%) had self-assessment, 65 hospitals (65%) university assessment and 47(47%) university and self-assessment together.

In the next step, the differences in mean score of university assessments in three types of universities were tested using one-way analysis of variance. There was significant variation between mean assessment score of universities ($P=0.006$). Multiple comparisons were performed using Turkey test. This difference is observed between type1 and 2 ($P=.004$) indicated in table 2.

Table 2. Mean and standard deviation of scores related to clinical governance indicators

Indicator	University type	Score mean	Score std. deviation	P value
Management	1	70.91	22.71	0.2
	2	67.34	22.11	
	3	66.62	22.55	
Risk management and PS	1	443.10	154.34	0.41
	2	434.82	134.82	
	3	460.17	137.98	
PPI	1	169.43	56.32	0.13
	2	157.05	58.58	
	3	162.97	58.07	
Use of information	1	134.04	70.12	<.001
	2	96.83	62.84	
	3	118.65	72.45	
Staff management and education	1	102.17	39.99	0.22
	2	100.45	38.93	
	3	108.97	38.14	
Clinical effectiveness	1	19.49	14.23	0.02
	2	16.11	10.34	
	3	18.95	12.15	
Clinical audit	1	78.92	59.68	0.008
	2	94.28	67.26	
	3	101.01	61.13	

Multiple comparison using Turkey test shows significant statistical difference in use of information in type 1 universities compared with type 2 ($P= .0001$) and type 2 with type 3 ($P= .031$). Clinical effectiveness had significant statistical difference between type 1 and 2 universities ($P= .034$). Clinical audit had significant statistical difference between type 1 and 2 ($\text{sig}= .071$) and type 2 and 3 universities ($P= .014$). The relationship between each indicators and total score of university assessment were estimated using multiple linear regression (table 3).

Table 3. Multiple linear regressions of total score in each clinical governance pillars

Indicator	University type	Coefficient	P value
Management	1	0.12	0.001
	2	0.16	0.005
	3	-0.04	0.78
Risk management and patient safety	1	0.31	0.001
	2	0.34	0.001
	3	0.12	0.51
Patient and public involvement	1	0.17	0.001
	2	0.17	0.009
	3	0.19	0.19
Use of information	1	0.17	0.001
	2	0.13	0.18
	3	0.12	0.42
Staff management and education	1	0.15	0.001
	2	0.1	0.07
	3	0.14	0.39
Clinical effectiveness	1	0.05	0.79
	2	-0.06	0.18
	3	-0.29	0.04
Clinical audit	1	0.19	0.001
	2	0.15	2.79
	3	0.49	2.53

4. Discussion

Reviewing the level of implementation of clinical governance can demonstrate the extent of quality improvement across hospitals. The assessment tool prepared for this purpose was designed by clinical governance office of Iran MOHME. This provides a framework consisting 7 pillars, which enabled assessors to assess consistently over the hospitals.

By reviewing clinical governance implementation in medical universities and affiliated hospitals we found that most of them had reached the implementation level of attainment for each of 7 categories of indicators, although the indicators were designed not very strict for the first year of implementation. A few number of hospitals achieved excellent results in all seven components, which demonstrate the potential of Iranian hospitals to implement such a quality improvement program. These hospitals can play as a role model for other Iranian hospitals.

Fortunately management indicator had fairly acceptable score in all type of universities. The “clinical governance festival” had a motivational role for such a relative commitment. Mean scores of hospitals affiliated by type 1 university, was higher than type 2 and 3 which met our expectation as they have excellent human, physical and facility resources. Specifically, these hospitals show better scores in use of information and clinical effectiveness which Risk management obtained the least proportion of scores in type 1 hospitals which seem type II and III universities types which shows that these hospitals might treat risk management indicators harsher than others. In addition, such hospitals might be more conservative to present their result of error reporting system in order to be less blamed. This had reduced their score.

Clinical governance assessment in this model had similarities with different models used in other studies (Buetow SA, 1999, Specchia ML, 2010, Campbell SM, 2002, Marshal M, 2002, Heard SR, 2001, Jones G, 2005, Bailie R, 2011 & Freeman T, 2003). Most of them emphasized key areas including standardization, strategic capacity, resources and processes and use of information. These areas cover all important issues which clinical

governance focuses on them particularly accountability and structures, strategies and plans, application of policies, , learning and training for staff, adjusting with our model.

In our assessment model greater portion of score specified to management, patient and public involvement, staff management, education and clinical audit criteria, respectively. Clinical effectiveness had least proportion that is similar to clinical governance base-line assessment in another study. This difference has multiple causes such as inter and intra assessor differences, over simplification of some indicators by hospitals, fair knowledge about clinical governance concept, inadequate national guideline, lack of difference between assessment and clinical audit, insufficient culture for patient and public involvement.

5. Conclusion

This study provides the opportunity to know the strengths and weaknesses of hospitals and demonstrates the executive potential for implementation of clinical governance in some Iranian hospitals. It can help the process of implementation of clinical governance for next years and depict the points that MOHME and medical universities should focus for successful implementation. It is also suggested to:

- ✓ Make Clear the role and responsibilities of clinical governance officers in hospitals and universities
- ✓ Teach and train clinical audit
- ✓ Focus on practical conceptualization of clinical governance
- ✓ Focus on risk management and patient safety
- ✓ Define the role of EBM in order to make clinical effect popular
- ✓ Train assessors in order to have more consistent assessing process

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