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CLINICAL GOVERNANCE AND HEALTH WORKERS PERCEPTIONS OF HOSPITAL PERFORMANCE IN PSYCHIATRIC HOSPITALS IN GHANA

BY

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DECLARATION

I hereby declare that this thesis has been submitted to the University of Ghana. This is a record of an original work done by me, under the supervision of Patience Aseweh Abor (PhD). All references used in the work has duly been acknowledged.

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CERTIFICATION

We hereby certify that this thesis was supervised in accordance with the procedures laid down by the University.

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PATIENCE ASEWEH ABOR (PhD) DATE

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AARON ASIBI ABUOSI (PhD) DATE

(Co-Supervisor)

DEDICATION

I dedicate this thesis to God Almighty for making this journey successful. Secondly, to my caring family for their immense support and encouragement throughout my studies. Thirdly, I dedicate this work to the memory of my caring Dad whose advice and counsel still inspires me to till now and finally to my caring Mum; Comfort Yaa Ahorlu.

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TABLE OF CONTENT

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

NGO	Non-Governmental Organizations
IGF	Internally Generated Fund
CHRAJ	Commission on Human Rights and Administrative Justice
NRCD	National Redemption Council Decree
WHO-AIMS	World Health Organization Assessment Instrument for Mental Health Systems
CAM	Complementary and Alternative Medicine
FDA	Food and Drug Authority
CSRPM	Centre for Scientific Research into Plant Medicine
UNICEF	United Nations International Children's Emergency Fund
PHCS	Primary Health Care Services
PPE	Personal Protective Equipment
CHPS	Community-Based Health Planning and Services
OPD	Out Patient Department
POW	Program of Work
SPSS	Statistical Package for Social Sciences
MD	Mean Difference
QIC	Quality Improvement Coordinator

ABSTRACT

Promoting Clinical Governance among health facilities is critical for healthcare quality improvement. It also ensures transparency, effective risk management and provides educational opportunities for health workers. The main aim of this study was to assess clinical governance and its effect(s) on perceived hospital performance among health workers in Psychiatric hospitals in Ghana. Both qualitative and quantitative research approaches and cross-sectional survey were adopted for the study. A total of two hundred and thirty respondents (n=230) were selected for the study, using purposive and simple random sampling techniques. Data were analyzed using Statistical Package for Social Scientist (SPSS) version 20.0 and thematic analysis. The study found clinical effectiveness, clinical audit, risk management, quality assurance, research and development, and educational and training as the main clinical governance structures at the two hospitals. The study also found a statistically significant difference between the means of the two hospitals in terms of clinical effectiveness, risk management and quality assurance. A statistically significant association was found between clinical effectiveness, clinical audit, risk management, quality assurance and type of facility. The main strategies mostly used in the implementation of clinical governance activities in the two hospitals were teamwork, communication, and auditing of all activities at the hospital. Clinical Governance implementation was more effective in Pantang Psychiatric Hospital than at Accra Psychiatric Hospital. Again, the relationship between clinical governance dimensions and health workers perception of hospital performance was found to be positively related. The challenges that were identified to be hampering the effective implementation of clinical governance activities at the two hospitals and addressing these challenges will promote effective implementation of clinical governance activities which will also lead to an increase in the performance of hospitals.

CHAPTER ONE

1.0 Introduction

This section of the study comprises the background to the study, the problem statement, the study objectives and research questions. This chapter also looked at the significance of the study, the scope of the study and the chapter outline.

1.1 Background to the study

Clinical Governance is gaining global recognition among healthcare practitioners, especially in developing countries (Frenk & Moon, 2013). In the desire to improve the quality of healthcare services within health systems, governments, healthcare providers and other allied agencies are investing more resources in Clinical Governance (Nmai, Mensah, & Delle, 2015). Clinical Governance has received varied definitions. For instance, according to Braithwaite and Travaglia (2008), clinical governance refers to the measures adopted by health institutions to promote clinical quality and high standards through the creation of an enabling environment to enhance quality health care services. According to them (Braithwaite and Travaglia, 2008), Clinical Governance is categorized into two main perspectives; that is; "external quality assurance and internal continuous quality improvement". Evidence from the literature suggests that Clinical Governance can be grouped into structures of controls assurance and systems approach to ensure continuous improvement in health care quality (Mickan and Boyce, 2018).

Clinical Governance uses some key pillars with the aim to deliver quality healthcare (Gray, 2005). Several studies such as Nmai *et al*. (2015), Braithwaite and Travaglia (2008), and Fardazar, Safari, Habibi, Haghighi, and Rezapour (2015) have come out with different number of pillars for clinical governance but it is widely agreed that, for an effective 'clinical quality' to be achieved, it is recommended that healthcare facilities adopt seven clinical governance pillars. Such pillars as put forward by Khayatzadeh-Mahani, Nekoei-Moghadam, Esfandiari, Ramezani, and Parva (2013) include "clinical effectiveness, risk management, patient experience and involvement, communication, resources effectiveness, strategic effectiveness, and learning effectiveness".

Literature has established that for quality healthcare delivery to be enhanced, these key pillars of clinical governance must be implemented to ensure responsible and continuous improvement of health service delivery under the highest standard in order to achieve the quality patients or clients require especially in mental health facilities (Crook, 2002; Halligan & Donaldson, 2001). Fardazar et al. (2015) posited that the implementation of clinical governance should ensure performing the right work, for the right person, at the right time. Explanation of the concept and how it helps in quality healthcare delivery is as follows.

Clinical effectiveness ensures that clinical interventions bring about a positive effect on the health of patients within available means. Risk management effectiveness ensures that clinical governance goal is achieved through effective, efficient health care and patient safety by minimizing human errors (Fardazar *et al*., 2015). Patient experience is the means through which quality healthcare is determined by the patients' experience which is the source of information to improve the services being rendered (Fardazar *et al*., 2015). Communication effectiveness also

looks at sharing an understanding between people. The role of communication in health services cannot be underestimated since it is the means by which health professionals and patients can measure the quality of care. Resources effectiveness ensures that staff are empowered, which enables them to have a sense of organization ownership (Smith, Latter & Blenkinsopp, 2014).

Strategic effectiveness ensures that there is a strategic plan guided by the mission and vision of the organization which focuses on the patient-professional partnership with respect to improving quality care (A. Smith et al., 2014). Learning effectiveness ensures professionals are up to date on technological advancement to equip them with current changes affecting their field of work (Crook, 2002). The learning effectiveness improves communication skills, management skills and medical skill of the practitioners in order to improve upon the quality of care. The essence of learning in health service delivery is that it provides an opportunity to obtain and implement new skills and knowledge to work (Crook, 2002; Halligan & Donaldson, 2001).

Ahmed, Sabitu, Idris, and Ahmed (2013) outlined a number of the benefits that a health facility could enjoy as a result of proper clinical governance structures, including the creation of a united management, structural and clinical approaches to improving the quality of the care provided by healthcare institutions and ensuring the development of employees, especially nurses and doctors. Promoting a high standard of clinical quality through Effective clinical governance leads to the reduction avoidable cost and enhances positive financial benefits to hospitals (Rodella *et al*., 2018). A study conducted by Gauld (2017) in the United State reveals that all hospitals that adhered to clinical governance principles showed better performance standards towards clinical quality and were all ranked among the best hundred in the United State of America. A similar study in the

United Kingdom points to the fact that there is a positive link between improvements in the health system and vigorous commitment to clinical governance standards (Stephen Gillam & Siriwardena, 2018).

Undeniably, Health institutions are mandated to implement a coherent scheme approach to improving the quality health care of patients (Fardazar *et al*., 2015). To date, there is restricted proof from literature, if any, of any easy approaches that can provide a guarantee of clinical governance in teams and providers seeking quality healthcare services (Fardazar *et al*., 2015). Certainly some significant ideas about what works were explored, such as how to give team visibility and ownership of comparative information works to drive efficiency and how to transfer clinical governance dashboard instruments across fields (Fardazar *et al*., 2015). Olsen, Saunders, and McGinnis (2011) argued that the main reasons for clinical governance are to help healthcare institutions to be abreast with current patterns or trends with respect to new clinical services. It ensures transparency as there is constant auditing, it ensures effective risk management and also provides educational opportunities. Clinical governance therefore emphasizes hospitals having an effective system that creates an enabling environment for quality clinical care to thrive.

1.2 Problem Statement

Mental health care services in Ghana remain highly fragmented, poorly coordinated and uneven in quality (WHO, 2014). The major available sources of funding for mental healthcare in Ghana remains largely by government and supported by internally generated funds and donor supports. Data from World Health Organization report (WHO, 2011) shows that out of about the thirty (30) million population of Ghana, it is observed about 2.4 million persons are suffering from mental illness (WHO, 2011). Negative cultural beliefs about mental illness coupled with inadequate mental health facilities in the country compel many to seek help from unprofessional mental health care provider such as traditional and faith-based practitioners who offer the varying quality of service and level of efficacy (Ofori-Atta, Read, & Lund, 2010).

In addition, low government spending on mental healthcare has been identified as the main issue hindering the performance of the mental healthcare facilities in Ghana. Majority of mental health care facilities are located at the heavily populated capital city of Accra leaving much of the rest of the country with very sparse provision. Development of the mental health system had been neglected despite pressure and advocacy from able mental health leaders in the country (Fardazar et al., 2015; Nmai et al., 2015; Powell, Davies, & Thomson, 2003). Despite some efforts being put in place, mental healthcare facilities in the country are still faced with a lot of challenges such as shortage of drugs, lack of funds to pay suppliers leading to a shortage of food for the inmates, inadequate safety measures at the hospital among others (Nmai *et al*., 2015). It is possible that the performance issue in the psychiatric hospitals could partly be a clinical governance challenge and therefore the need for this study.

However, there is limited literature on clinical governance in Ghana, especially from the perspective of mental health care workers. The few existing studies focused on general hospitals (Nmai et al., 2015) with most of these studies being conducted from the perspectives of developed countries, with little done in developing countries (McSherry & Pearce, 2011). To the best of the candidate's knowledge, no study has looked at clinical governance in the context of psychiatric hospitals in Ghana. Therefore, this study sought to this gap. Studies of this nature are crucial for health policy and quality improvement interventions, especially among mental healthcare providers.

1.3 Objectives of the study

1.3.1 Main Objective

The main objective of this study is to assess clinical governance and health workers perception of performance in Psychiatric hospitals in Ghana.

1.3.2 Specific Objectives

1. To explore clinical governance structures of psychiatric hospitals in Ghana?
2. To examine the implementation approaches for clinical governance in Psychiatric hospitals in Ghana.
3. To examine the association between clinical governance and health workers perception of performance in Psychiatric hospitals in Ghana.
4. To examine the challenges faced in implementing clinical governance activities in Psychiatric hospitals in Ghana.

1.4 Research Questions

1. What clinical governance structures are available at Psychiatric Hospitals in Ghana.
2. What are the implementation approaches for clinical governance in Psychiatric Hospitals in Ghana?
3. What is the relationship between clinical governance and health workers perception of performance at psychiatric hospitals?
4. What are the major challenges faced by psychiatric hospitals in implementing clinical governance activities in Ghana?

1.6 Significance of the Study

Clinical governance emphasizes on hospitals having effective systems that create enabling environment for quality clinical care to thrive. Therefore, the findings of this study will afford psychiatric facilities in particular to put in place measures that promote patient-professional partnership with respect to improving quality care. this could undeniably lead to an enhanced treatment and nursing of patients at our health facilities especially psychiatric hospitals in Ghana.

This also study adds to the limited existing literature with regard to clinical governance in mental health care institutions. The findings provide valuable information for health policy and decision-makers. It will enable them to develop policies and strategies on how to ensure effective clinical governance in Ghanaian psychiatric hospitals. It will also be very useful to healthcare institutions as it will enable them to address issues hindering effective clinical governance in respective healthcare institutions. This can help bridge the gap between policy and practice. This study also

provides important information on clinical governance and health workers perception of hospital performance.

The study provides vital information to the management of the psychiatric hospitals to put measures in place effective systems to promote clinical governance activities at these facilities and this will go a long way to help providers to fully appreciate the essence of having effective clinical governance activities at the facilities. The study will also help providers at the psychiatric facilities to improve on the quality of services they render to their client. The study further reveals some major challenges confronting psychiatric hospitals and how they are affecting the effective implementation of clinical governance activities. This will help policymakers and other major stakeholders to put in measures to address these challenges which will go a long way to improve the performance of psychiatric hospitals in the country. In terms of literature, the study adds to the existing literature on clinical governance and serves as a reference material for future works on clinical governance and health workers perception of hospital performance.

1.7 Scope of the Study

The scope of the study was narrowed to two public Psychiatric healthcare Hospitals in Greater Accra Region of Ghana. These include Pantang Psychiatry Hospital and Accra Mental Hospital. The choice of this scope was due to the fact that these are the only three public Psychiatric hospitals in Ghana that the researcher could use for the study. Though all the three Psychiatric hospitals were invited to take part in the study, only two honoured the invitation. Additionally, the scope was also due to the fact that clinical governance is a subject of interest in these institutions and therefore warranted the conduct of this study.

1.8 Chapter Outline

This study is organized into six chapters. **Chapter One** discusses the background to the study, the research problem, objectives and research questions of the study and the significance and scope of the study. **Chapter Two** discusses the review of all relevant literature regarding clinical governance and hospital performance. The chapter also looks at the theories underpinning the study, evolution of clinical governance, structures(pillars) of clinical governance, author's conceptual framework, the healthcare system of Ghana, Psychiatric hospitals in Ghana, Financing Mental Health in Ghana, challenges of Mental Health system, review of empirical literature on clinical governance and hospital performance and chapter summary.

Chapter Three presents the research methodology. Specifically, it looks at the research approach and research design, population and study area, sample and sampling techniques, sources of data, data collection instrument, data collection procedure, data analysis, ethical considerations and chapter summary. **Chapter Four** covers the presentation of data analysis and results. **Chapter Five** consists of the discussion of findings. **Chapter Six** constitutes a summary of key findings, conclusion and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter focused on the review of related literature. The study ensured that only relevant literature on clinical governance and hospital performance were reviewed. The chapter also discussed some governance theories that are relevant to the study, the evolution of clinical governance and the author's conceptual framework.

2.1 Theoretical Framework

There are several governance theories such as the agency theory, stewardship theory, stakeholder theory, institutional theory, managerialism theory, resource dependency theory and many others that could be used to underpin the theoretical relationship between clinical governance and hospital performance. However, for the purpose of this study, the agency, stakeholder and the stewardship theories were used to discuss the link between clinical governance and health workers perception of hospital performance.

2.2 Agency theory

Agency theory refers to a situation where one or more persons (the principals) engage another person or persons (the agents) to perform some service on their behalf, which includes delegating some decision making authority to the agent (Abera, Tesfaye, Belachew, & Hanlon, 2014; Jensen & Meckling, 1976; Sarkar, Wingreen, & Cragg, 2017). "If both parties to the relationship are utility maximisers, then there is good reason to believe the agent will not always act in the best interests of the Principal" (Boivie, Bednar, Aguilera, & Andrus, 2016).

A study by Nmai et al. (2015) has shown that the principal-agent theory is always the preferred theory when dealing with issues of corporate governance originating from the classical thesis on the Modern Corporation and Private Property. According to classical thesis, the major agency problem in modern firms is primarily due to the separation between finance and management (Chen, 2010; Laiho, 2011). Modern companies are seen to suffer from ownership and control separation and are therefore run by professional managers (agents) who cannot be held responsible by distributed shareholders. The aim of this separation was to prevent potential abuse of corporate authority and called for increased responsibility, compliance and autonomy at the board level, separation of the board's role from that of the Chief Executive, as well as more efficient involvement by non-executive directors on boards.

Health facilities (Hospital) are far different from all other corporate entities and as such, the application of the concept of the agency theory may differ (Tricker & Tricker, 2015). This may be due to the fact that various stakeholders involved, including patients, hospital, medical staff, and community care groups, amongst others. Nonetheless, there is sufficient evidence in the literature that demonstrates that problems can and inevitably occur which may result in a situation whereby the agent may not always acting in the best interests of the principal (Murphy & O'Donohoe, 2006). In an attempt to minimize the potential for opportunistic decision-making by the hospital medical staff, it is suggested that outside physicians help to monitor the information given by their colleagues so as to decrease the medical staff's potential to influence the board into making decisions intended to serve their own personal interests at the expense of other stakeholders and the hospital as well as give a more objective perspectives on prevailing issues within the medical field (Tilba, 2017). The participation of external doctors serves as a point of reference for

monitoring the suggestions of the board of medical employees, thereby reducing opportunism for members of the medical personnel (Abor, 2019). Agency theorists advocated enhanced involvement by outside boards to safeguard equity and financial interests of shareholders. Hence, hospitals with medical employees outside the board of doctors will, therefore, have better economic performance than boards with the involvement of medical insiders and no outside doctors (Molinari, Alexander, Morlock, & Lyles, 1995).

Therefore, the focus is on preventing prospective abuse of corporate authority and calling for higher accountability, compliance and independence at board level, separating the position of board chairman from that of chief executive, as well as more efficient involvement of non-executive directors in boards (Tilba, 2017).

2.3 Stakeholder Theory

It is said that the broader determining factors influencing the governance of private and public sector organizations are indirectly attributable to the evolving setting in which organisations function (Chourabi et al., 2012; Cummings & Worley, 2014). It is suggested that a significant portion of this evolving setting includes a higher level of social obligations and third-party interest in organizations, extending responsibilities from a single shareholder to numerous stakeholders (Christopher, 2010). Patients or clients, governments, creditors, bankers, media, suppliers and many others are widely considered to be the major stakeholders to Healthcare institutions (Abor, 2019). Therefore, the performance of these healthcare institutions (Hospitals) would be to some large extent measured by the quality and safe services they render to their stakeholders and particular patients whose satisfaction is usually used as a measure of the effectiveness or

performance of these institutions (Atinga, Abekah-Nkrumah, & Domfeh, 2011; Grol, Wensing, Eccles, & Davis, 2013; Langabeer & Helton, 2015).

It was stated that the theory of stakeholders is essential to the theory of corporate governance because it offers the foundation for executives to comprehend and reconcile the different requirements of the expanded stakeholder base with the different purposes of the organization (Harrison, Freeman, & Abreu, 2015). This allows them to maximize value for stakeholders. The stakeholder theory was stated as needed in the context of the expanded governance paradigm to complement the theory of agencies by providing a more inclusive attitude to corporate governance (Christopher, 2010; Fontaine, Haarman, & Schmid, 2006). This strategy has been defined as a comparatively latest phase in corporate governance growth (Brennan & Solomon, 2008) and has resulted in increased studies in the field of social accountability as a means of enhancing corporate accountability for a wide spectrum of stakeholders (Unerman & O'Dwyer, 2007).

Other studies that have recognized this extended stakeholder concept of governance include Boiral (2013), Collier (2008), Sikka (2008), Sikka (2008), Solomon (2007), Christopher (2010) and many others. In short, a significant dimension of the wider influencing forces is addressed by the stakeholder theory. The theory acknowledges that organisations have a multitude of stakeholders and then attempts to incorporate their requirements by creating various goals. "It is argued that this theory is particularly important for developing and implementing adequate governance mechanisms and processes relative to the broader environmental influences and interdependencies of organizations with various internal and external stakeholders" (Armstrong & Taylor, 2014). The list and intensity of influences by stakeholders are growing given the increasing interest by social

and environmental constituents on corporations. There is also a growing concern of society given the increased number of corporate scandals, the current global financial crises, its links with poor governance of organizations and its consequent impact on economies of nations and society.

Freeman (1983) proposed the theory of stakeholders for organizational strategic management in the late 20th century. This theory became so important later in this era, with important works by Clarkson (1995), Donaldson and Preston (1995), Mitchell, Agle, and Wood (1997), Rowley (1997) and Frooman (1999) enhancing theoretical depth and growth. The theory has developed over the years and was embraced as a leadership instrument by many organisations (Wagner Mainardes, Alves, & Raposo, 2011; Wagner Mainardes, Alves, & Raposo, 2012). Other studies reiterate the need for organisations to go beyond traditional shareholder pools and consider fresh external stakeholders to legitimize new types of management knowledge and intervention (Rwamigisa, Birner, Mangheni, & Semana, 2018). Until recently, hospital governance was primarily about handling the structure and facilities, departments and divisions, but looking to the future, patient care needs and other stakeholders ' needs will be the primary focus (Eeckloo, Van Herck, Van Hulle, & Vleugels, 2004).

It is important that, for organizations to address the needs of all stakeholders, they must identify the interest of each of these stakeholders and tackle them through appropriate strategies (Christopher, 2010). Therefore, the stakeholder theory of clinical governance seeks to highlight the various constituents of an institution, whether formal or informal (Nmai et al., 2015). A study by John and Senbet (1998) posited that there are many parties with competing interests in the operations of healthcare institutions who naturally would want their needs met (Abor & Adjasi,

2007) by such institutions. They also highlighted the role of non-market mechanisms such as board size, committee structure as important for company performance or efficiency (Abor & Biekpe, 2007). Against this background, the inclusion of clinical governance with the objective of ensuring the delivery of secure and quality healthcare services would guarantee the effectiveness of hospitals.

2.4. Stewardship Theory

According to the stewardship theory, the primary goal of a manager is to maximize a company's efficiency because when a company performs well then the accomplishment and success of a manager are met (Davis, Schoorman, & Donaldson, 1997; Donaldson & Davis, 1991; Muth & Donaldson, 1998).

The stewardship theory, which has its origins in psychology and sociology, fundamentally argues that the interests of managers and management are in reality compatible with those of shareholders. The theory indicates that managers are driven by the need to attain, offer high-level dedication and gain inherent satisfaction through difficult job and exercise accountability and power to obtain recognition from colleagues and bosses (Christopher, 2010; Davis et al., 1997; Donaldson & Davis, 1991). The Stewardship theory offers an alternative underlying theory for an organisation to react properly to a dimension of the inner and external influencing forces affecting its paradigm of governance (Christopher, 2010; Davis et al., 1997; Donaldson & Davis, 1991). In short, Stewardship Theory acknowledges the effect on the governance paradigm of a dimension of the broader influencing forces and offers organisations with the flexibility to determine the correct combination or degree of intensity of governance mechanisms and procedures to be established

and enforced to accomplish efficient governance. According to Christopher (2010); (Davis et al., 1997; Donaldson & Davis, 1991), stewardship theory is a complement to the theory of agencies, stakeholder theory and the theory of resource dependence and needs to be integrated into any governance model in order to provide a more holistic perspective of governance. It, therefore, suggests that clinical governance would provide the correct structure for the efficient discharge of healthcare services in order to meet the main goals and ambitions of healthcare organizations (Christopher, 2010; O'Connell, 2007).

The Stewardship theory places great importance on the role of management in protecting the interest of the shareholders (Courtemanche, Côté & Schiehll, 2013; Farnham & Horton, 1993; K. G. Smith & Hitt, 2005). The firm's efficient leadership involves the establishment of qualified executives and the adoption of suitable procedures of governance. Such qualified executives are anticipated to keep a certain level of professionalism and may belong to professional bodies with their own professional and ethical rules and codes of behaviour appropriate to attaining the organization's efficient governance (Nordberg, 2010). When regarded in conjunction with the existence of suitable compulsory governance frameworks at the domestic level, this climate of professionalism offers a control component in the organizational setting that affects company behaviour in line with the expectations of owners (Christopher, 2010).

The sociological, ethical and cultural values of the nation in which these organizations are located are also helpful in determining the composition of confidence that can be put in organizational management. These environmental variables differ with nations and organizations and would, in turn, determine the sort of surveillance and control mechanisms for governance to be adopted (Khan, Muttakin, & Siddiqui, 2013). It is asserted that in nations where there are advanced levels of government laws and powerful professional and ethical rules, the cost of control systems tends to give less space for flexibility in introducing procedures that are more inherent and empowering than extrinsic rewards and control procedures (Christopher, 2010). Clinical governance would provide the correct structure for the efficient release of health care services in order to meet the main goals and ambitions of health care organizations.

2.5 The Evolution of Clinical Governance

In latest years, the word "governance" has become an increasingly important area of concern mainly owing to the number of corporate scandals that led to a decrease in shareholder value, a decrease in investor confidence and, in some instances, major bankruptcies (Abor, 2015). Good governance within health facilities is important for promoting and maintaining equity, accountability and transparency (Abor, 2015; Murphy & O'Donohoe, 2006). The concept of “clinical governance” originated from ‘corporate governance’, a widely used concept in the corporate world (business environment) with a fundamental goal to safeguard corporate accountability (McSherry & Pearce, 2011; Nmai *et al*., 2015). Applying this notion to health care facilities, it was stated that 'corporate governance' focuses primarily on addressing the purely administrative problems of hospitals and thus ensuring a holistic management of health facilities, there is a need for a correct scheme that addresses and promotes the quality of the hospital's

healthcare services, hence the word ' clinical ' governance rather than corporate governance in this context was suitable (Abor, Abekah-Nkrumah, & Abor, 2008; McSherry & Pearce, 2011). Increasingly, questions have been raised based on the fact that "the professional competence of the medical profession was the best guarantee of an acceptable level of medical care," hence the emergence of clinical governance (Nmai *et al*., 2015). Several events and happenings have justified the need for effective clinical governance to be introduced in healthcare institutions. For example, issues such as "decline in clinical standards, service provision and delivery, reinforced by the media coverage at the time of clinical failures necessitated the incorporation of clinical governance" in health care systems (Culley, 2003; Nmai *et al*., 2015).

2.6 Conceptualizing Clinical Governance

The main foundation of clinical governance has to do with the provision of healthcare services that promote safety and quality health care at all times. To enhance the quality of health care, the key pillars of clinical governance must be implemented to be responsible for continuous improvement of health service delivery under the highest standard in order to achieve the quality patients required especially in mental health hospitals (Crook, 2002; Halligan & Donaldson, 2001). With this conviction, clinical governance has provided hospitals with a legal responsibility to seek quality improvements in health care within their facilities (Brandao, Rego, Duarte, & Nunes, 2013; Goeschel, Wachter, & Pronovost, 2010). Many authors have tried to explain the concept of clinical governance but this study considers the definition by Tabish (2012) as more suitable, as such has adopted it. Tabish (2012) defined clinical governance as "the process of steering the overall functioning and effective performance of a hospital by defining its mission, setting objectives and, having them realized at the operational level".

Globally, quality health service delivery is a fundamental facet of every health sector which is central to clinical governance (Azami-Aghdash, Tabrizi, Sadeghi-Bazargani, Hajebrahimi, & Naghavi-Behzad, 2015). It has been recognized that clinical governance is the model that guides health facilities to be accountable for continuous improvement of quality of services and safeguarding high standards of care by creating an enabling atmosphere for clinical care excellence and better quality healthcare to thrive (Halligan & Donaldson, 2001; Ham, Berwick, & Dixon, 2016). The clinical governance theory uses some key pillars with the aim of improving the quality of health care delivery (Gray, 2005). Khayatzadeh-Mahani *et al.* (2013), identified; "clinical effectiveness, risk management, patient experience and involvement, communication, resources effectiveness, strategic effectiveness, and learning effectiveness" as the seven pillars of clinical governance and went further to look at how each of the pillars contributes to quality of health service delivery.

Literature has established that for quality healthcare delivery to be enhanced, key pillars of clinical governance must be implemented to ensure responsible and continuous improvement of health service delivery under the highest standard in order to achieve the quality patients or clients required especially in mental health facilities (Crook, 2002; Halligan & Donaldson, 2001). Fardazar et al. (2015) posited that the implementation of clinical governance should ensure "doing the right work, for the right person, at the right time". Explanation of the concept and how it helps in quality healthcare delivery is as follows:

Clinical effectiveness ensures that clinical interventions bring about a positive effect on the health of patients within available means (Abor, 2019). Patient experience is the means through which quality healthcare is determined and is the source of information to improve the services being rendered (Weisleder, 2015). Risk management effectiveness ensures that the goal of clinical governance is achieved through effective, efficient health care and patient safety by minimizing human errors (Fardazar et al., 2015). Communication effectiveness also looks at sharing an understanding between people. The role of communication in health services cannot be underestimated since it is the means by which health professionals and patients can measure the quality of care. Resources effectiveness ensures that staff are empowered through resources, which enables them to have a sense of organization ownership. Strategic effectiveness ensures that there is a strategic plan guided by the mission and vision of the organization which focuses on patient-professional partnership with respect to improving quality care (Fardazar et al., 2015).

Learning effectiveness ensures professionals are up to date on technological advancement to equip them with current changes affecting their field of work. Learning effectiveness improves communication skills, management skills and medical skill of the practitioners in order to improve upon the quality of care. The essence of learning in health service delivery is that it provides an opportunity to obtain and implement new skills and knowledge to work (Crook, 2002; Halligan & Donaldson, 2001).

2.6.1 Clinical Effectiveness

The priority of 'Clinical governance' is to uphold standards of safety of clinical activities that are performed within health facilities (Kaufman & McCaughan, 2013). Clinical effectiveness shows the level to which clinical standards and safety have been achieved. Clinical effectiveness evaluates the level to which a particular clinical intervention strives in health facilities. (Laubscher, 2008). Clinical effectiveness measures if the interventions put in place by the various health facilities have achieved the desired outcomes (Chourabi *et al*., 2012). Pearson, Field, and Jordan (2009) and Mann and Executive (1996), define clinical effectiveness as the use of knowledge-based evidence through research and valid data that, understanding of patient needs and clinical experience to achieve desired quality health care for patient/clients. This calls for putting in place a robust system of informing, changing and monitoring clinical practices. Pearson *et al*. (2009) further established that in order to enhance clinical effectiveness as a catalyst to achieving clinical governance, two crucial elements should be present; one, the activities performed must be appropriate and two, they must reflect value for money. Pearson *et al*. (2009) explained appropriateness to mean the services provided must be necessary. The services must be provided timely, with the appropriate methods, at the precise place and must have the purpose of producing accurate outcomes (Weisleder, 2015). Measuring clinical effectiveness requires the existence of standards and policies which must comply especially with National Standards. This could be measured through surveys.

2.6.2 Quality Assurance/ Openness

Quality assurance is a systematic approach of continuously monitoring, evaluating and improving quality health service delivery (Gomes, Yasin, & Yasin, 2010). Quality Assurance is the state and the process by which managers and staff ensure that services provided meet the set requirements, have little or no variations and provide continuous ways of improving health (Bowling, 2014). Quality assurance also allows health providers to identify poor performance and find solutions to discourage it. Laubscher (2008) argued that quality assurance is a tenet of clinical governance because it encompasses reviewing, checking and evaluating activities of health providers to assess if they meet health standards. The key feature of quality assurance is openness, where the activities of the health organizations are open to scrutiny while patients' confidentiality is in check (Al-Mandhari et al., 2014; Mohammad and Mosadeghrad, 2013). One tool used in assessing quality (Guirguis & Lee, 2012)Assurance in health organizations is the quality assurance check which is used to evaluate the activities organized under the auspices of health facilities to enhance effective outcomes.

To achieve clinical governance, quality assurance is a foundation that must not be taken for granted (Offei, Bannerman, & Kyeremeh, 2004; Offei, 2012). Quality Assurance can also be measured by taking into consideration poor performance and poor practices within the institution as far as health care service is concerned (McSherry & Pearce, 2011). Quality assurance could be achieved if health care institutions put in place all the necessary precautionary measure in meeting the needs of the healthcare seekers where then means that there is the need for health care providers to assess and understand all the problems that they may encounter during the performance of tasks as professionals (Adindu, 2010). Additionally, in measuring quality assurance, institutions must

ensure processes are scrutinized and modified to ensure quality healthcare is provided and in situations where processes involve patients or healthcare provider's confidentiality, then this must be respected (Offei et al., 2004; Offei, 2012). Different tools exist that could be used to evaluate and measure Quality Assurance including surveys.

2.6.3 Research and Development

Clinical effectiveness, quality assurance and clinical governance as a whole cannot maintain or upgrade standards. Activities must continually improve based on research, training and development which bring forth new evidence (Kapur, 2009; White, Lemak, & Griffith, 2011). Health organizations must have different knowledge pools abreast with all current medical practice for effective service delivery (Wennberg, 2006; White *et al*., 2011). Programs, activities, skills, facilities and processes become outdated as new health problems arise and therefore health organizations must be current to be able to face these problems head-on (Chourabi et al., 2012; Kapur, 2009). Chourabi *et al*. (2012) and Laubscher (2008) further established that, in order to maintain current standards in quality healthcare, health practitioners and management must focus their attention on specific areas such as sound project management, development of guidelines and protocols as well as implementation strategies that can serve as catalysts to effective clinical governance system leading to more transparent and accountable health care systems. Without research and development, programs and processes of health organizations would remain stagnant, which would impede the progress of ensuring quality in practice (Duffy, 2018).

Additionally, the level of research and development level of an institution could also be measured based on the existence of a knowledge pool which keeps healthcare providers abreast with current medical practices (Barends, Ten Have, & Huisman, 2012; Kapur, 2009). Therefore, research and development are best assessed by the number of successful research and developmental programs realised by the healthcare institution and this can be measured through the use of a survey (Kapur, 2009).

2.6.4 Clinical Audit

Clinical audits are assessment tools designed to enhance the quality of clinical care (Abor, 2015). Clinical audit is mostly considered as a way that clinicians evaluate the quality of the care they offer. It provides them with the opportunity to compare their performance against a standard to see how they are doing and identify opportunities for improvement (Abor, 2015). Changes can then be made, followed by further audits to see if these changes have been successful. The aim of the audit process is to ensure continuous monitoring of clinical practice and to correct deficiencies in relation to established standards of care (Abor, 2015). It involves a process of reviewing clinical performance and refining clinical practices as a result of the measurement of performance against agreed standards (Gillam & Siriwardena, 2013).

According to the National Institute of Clinical Excellence in the United Kingdom, as cited by O'Mahony, Murthy, Akunne, and Young (2011), clinical audit refers to “a quality improvement process that seeks to improve patient care and outcome through a systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where

indicated, changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery" (Braithwaite & Travaglia, 2008). For clinical audits to be effective, they must be professionally led, that is, clinicians, hospital boards and other executives must play a leading role in conducting such reviews (Bullivant & Corbett-Nolan, 2010).

Intuitively, health care providers (Trained professional), at all the levels of health care provider that is; the facility level through to the national level must always be seen facilitating the process for transparency (Bullivant & Corbett-Nolan, 2010). Effective audits cannot take place in the absence of explicit criteria, and tracks of previous performance (Buetow & Roland, 1999). "Clinical audits assist organizations to know and appreciate their current state and to know the effectiveness of policies and changes that have been effected in the organization (Gillam & Siriwardena, 2013). It is therefore vital for the sustenance of clinical governance and need not be overlooked or done haphazardly. The clinical audit, therefore, can be measured through clinical surveys (Amegavi, 2018)

2.6.5 Risk Management

The goal of Clinical governance may not be achieved by only adherence to what seems appropriate. There should be a development plan showing explicitly how continuous quality care can be achieved. The development of a clinical risk plan must take into consideration as well as inputs from patients/clients and assessment of the exposure of clinical risks and unmet training needs (Halligan & Donaldson, 2001).

Risk can manifest through several forms such as strategic planning, power, assets, operational and financial forms, and may be specific to the patient, the practitioner or provider organization. Most of these risks are life-threatening and disastrous making risk minimization very important in the delivery of healthcare (Wennberg, 2006). Risk management could be enhanced when effective systems are instituted which could easily identify and reduce the occurrence of a potential risk, and the evaluation of adverse events (errors) to establish causative factors and assess how the risk is within and across the service or adhering to already existing standards and policies (Wennberg, 2006). For example, the Patients' Charter is also a document which states explicitly how patients could be protected and minimizes patient-related risks.

Furthermore, risks to practitioners can also be minimized by conducting compulsory periodic medical check-ups, provision of Personal Protective Equipment (PPE), immunization against infectious diseases and providing conducive and safe working environments amongst others. Cost of poor health care quality is a major problem for health institutions. It is therefore vital for healthcare institutions to as much as possible reduce their own risks alongside risks to patients and practitioners (Qaseem, Mir, Starkey, & Denberg, 2015). This can be achieved when providers are made to at all times ensure high-quality employment practice, adherence to standards or regulations of professional bodies, and designing high-quality policies (Guyatt, Rennie, Meade, & Cook, 2002). The main pursuit of clinical governance is to improve clinical practice. Excellent clinical practice is devoid of errors or risks, therefore managing risks in clinical governance is very vital.

Risk management can be measured using consumer feedback and complaints systems and clients and providers satisfaction surveys. Through the feedbacks and complaints, the healthcare institutions could ensure the minimization of risks to patients and to the healthcare providers (Abor, 2019).

2.6.6 Education and Training

It is no longer acceptable for healthcare practitioners to not further their education or enrol in training programs after their qualification because knowledge in science or medicine is changing rapidly. New knowledge and ways of doing things are emerging making the current methods or procedures crude. It is therefore important for management to put structures in place to encourage and support professional development for the diverse professionals in the workplace (Bhattarai, 2015).

For example, facilitating staff registration with regulatory bodies, postgraduate education allowances, sponsored Continuous Professional Development for staff, Study Leave with or without pay, and other related packages can all be promoted at the facility level to keep professionals abreast with scientific and medical developments (Bhattarai, 2015). In some jurisdictions, funds are allocated both at the national and facility level to finance educational and training programmes. Knowledge is very crucial to medical practice and the delivery of medical care. However, education and training could be measured using surveys.

Based on the Clinical Governance model adopted by Scally and Donaldson (1998), this framework was developed to guide the research on how the model ensures high performance that is based on professional competences in application of present knowledge, available technologies and resources, efficiency in the use of resources, minimal risk to the patient and staff, satisfaction of the patient and health outcomes (Shaw, 2003).

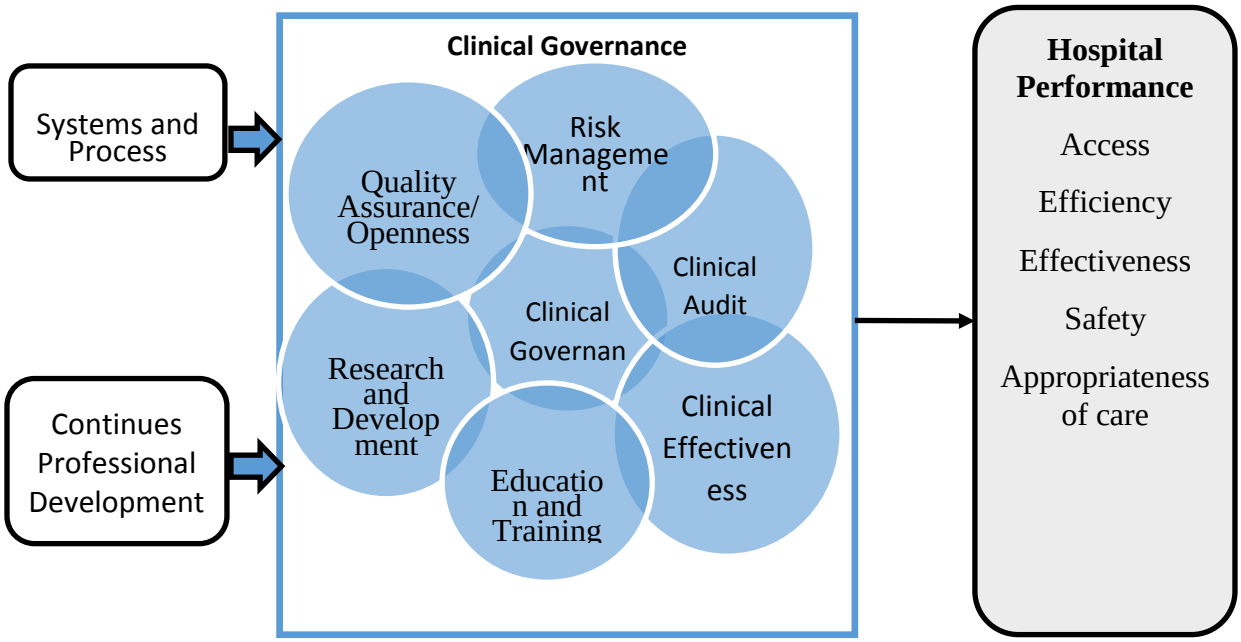

Figure 2.1 Conceptual Framework

Adopted from Scally and Donaldson (1998)

With inference to the conceptual framework, clinical governance can, therefore, be said to be "the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimizing risks, and fostering an environment of excellence in care for consumers and safeguarding high standards of care" (Bodolica & Spraggon, 2014; Prenestini, Calciolari, Lega, & Grilli, 2015). All these could be

realized by establishing an organizational atmosphere which promotes transparency and accountability for maintaining standards whiles encouraging excellence in clinical care.

2.7 Healthcare Quality and Clinical governance

The attention of health care delivery has shifted over the years with clinicians and hospitals, in particular paying attention to delivering desirable healing and treatment services to patients as the key stakeholders thus promoting sustainable health for the community at large (Trong Tuan, 2014). The incorporation of "Patient-centeredness" and "patient care quality improvement" as the main constituent of clinical governance system (Braithwaite & Travaglia, 2008) is said to yield enhanced treatment and nursing of patients (Trong Tuan, 2014). "Sustainable clinical leadership" component of clinical governance supports effective learning and research to enhance quality healthcare for patients which then translate invariably into better primary and preventive healthcare for the community as a whole (Trong Tuan, 2014).

The acquisition of skills and attitudes by providers through education, training and experiences ensures higher quality health care services to patients. It is therefore argued that Clinical governance structures have a direct influence on the "reliability" aspect of healthcare quality (Trong Tuan, 2014) and places much emphasis on the ability of clinicians to render quality healthcare to clients/patients. Notwithstanding the focus on "patient-centeredness" and "patient care quality improvement," by healthcare facility, which direct providers to learn from patients' diseases to improve their knowledge, "sustainable clinical leadership" and "supporting nurses" aspects of clinical governance focuses on providers knowledge and expertise (Braithwaite & Travaglia, 2008) and therefore help build confidence in patients, in so doing improving

"assurance" element of patient quality care which most often make reference to providers knowledge and ability of service to encourage trust (Parasuraman, Zeithaml, & Berry, 1988). The components of "patient-centeredness" and "patient care quality improvement" strategies of clinical governance focuses on positioning services that not only meet and exceed patients expect in terms of the kind of treatment and nursing they received but also the full compliments of care that consider the entity services which may include life-related care as a result of impact of life factors on the effectiveness of care. Supportive practices from the hospital contribute greatly to enhancing providers(clinicians) knowledge as well as showing empathetic attitudes toward patients.

Sustainable clinical leadership further supports learning among clinical members with the aim of providing tailored services to all manner of persons which requires that they possess "technical skill, scientific knowledge and human understanding" (Trong Tuan, 2014). It is therefore argued that components of clinical governance primarily seek to promote the "empathy" element of patient quality care service (Parasuraman et al., 1988). Given that, in a clinical governance system, clinical staff and the facility as a whole, centre on patients (Braithwaite & Travaglia, 2008; Trong Tuan, 2014) with strong motivation to enhance quality of patient care (Scally & Donaldson, 1998), clinical staff are in responsive and proactive provision of care toward patients. All components of clinical governance seek to promote three main objectives; responsiveness, patient-centeredness and patient care improvement (Braithwaite & Travaglia, 2008; Scally & Donaldson, 1998).

2.8 Barriers to Clinical Governance

Clinical governance has proven to improve the overall outcomes of health organizations - in terms of interventions, programs and processes among others. Like all other programs, clinical governance comes with its challenges that management and the health organization as a whole must try to combat to ensure effectiveness. These underlying challenges must not be left unattended, because they would hinder continuous health improvement which is an underlying objective of clinical governance.

A constraint identified by (Freeman & Walshe, 2004; Walshe, Cortvriend, & Mahon, 2003) was the lack of resources to sustain the activities of clinical governance. This barrier cuts across the six pillars of governance- clinical audit, effectiveness, risk management, quality assurance, research and development, as well as education and training and must not be underestimated. Resources that are needed to implement clinical governance include but are not limited to; time, staff, material, financial and others (Walshe et al., 2003).

Every framework needs people to operate with, materials and finances within a particular time frame to be successful and clinical governance is no different (Dehnavieh et al., 2013). It needs the corporation of health practitioners, management, patients; materials like hospital beds, drugs; finances like money, discount services, credit options to work (Dehnavieh et al., 2013). Without these resources, clinical governance becomes defunct. The lack of these resources makes it almost impossible for clinical governance to succeed (Dehnavieh et al., 2013).

Hooshmand, Tourani, Ravaghi, and Ebrahimipour (2014) stated that the lack of requisite skills and expertise makes operating clinical governance challenging. According to Laubscher (2008), knowledge and skills become outdated with time and need a constant upgrade. Emerging health problems call for improved skills and interventions. However, most health care providers(clinicians) are not up to speed with modern medical practice, thus they cannot tackle these problems. Health practitioners who have current medical knowledge also lack guidelines to enable them to practice (Culyer et al., 2007). The lack of requisite skills and competence on the part of health professionals is a major constraint in clinical governance as it causes more health problems instead of helping to solve them.

Dehnavieh et al. (2013), mentioned that communication is a barrier to effective clinical governance implementation. Dehnavieh et al. (2013) further stated that the absence of an effective communication system hinders the activities of parties concerned in clinical governance. The lack of communication among health practitioners in health organisations impedes the progress of clinical governance. Smith, Caffery, Saunders, Bradford, and Gray (2014) mentions that poor communication and poor working relationships hinder the facilitation of clinical governance. People play key roles in the operations of clinical governance, thus, there should be systems to transmit information from one person to another; or one level to the other. When these systems are ineffective information flow is inadequate. And without information, clinical governance implementation becomes impossible.

Another hindrance to achieving clinical governance is the inadequacy of regulation, monitoring, poor performance, review and evaluation of the activities performed under the auspices of health organizations (Darling Downs Hospital and Health Service, 2014). Regulations and supervision are low because the laws and rules are not incorporated into activities of the health organizations (Dehnavieh et al., 2013). Without regulations, monitoring and supervision, health professionals cannot identify problems or variations which is an impediment to the progress of clinical governance.

2.9 Reviews of Empirical Literature

The literature reviewed so far on clinical governance indicates that the concept of clinical governance has not received the needed attention and priority in Ghana and Africa as a whole. For example, a study conducted by Smith, Walshe, and Hunter (2001) as cited by Nmai *et al*. (2015), reported that "although there is support for the concept of clinical governance in literature, the implication of it was found to be hindered by available resources, time and skills". It, therefore, suggests that the setback of an effective clinical governance system is largely attributed lack of proper structures and strategies, leadership, reliable clinical information systems and examination of services. Intuitively, in Ghana and Africa as a continent, the major problem has to do with leadership and accountability than lack of resources.

Another qualitative study by Smith et al. (2001) the impact of external reviews of clinical governance, as cited by Nmai *et al*. (2015) which sought to investigate the use of external approaches to quality improvement in health care organizations in one region found that "preparing for interviews was a substantial and time-consuming task, but in all did not generate wholly new

knowledge and did not lead to major new policy change". The study further revealed that not enough studies exist to explore the value of external quality reviews within health facilities and recommended that emphasis be placed on studies that focused on uncovering the benefits of external reviews in terms of costs and effects minimization.

A study by Levy and Rockall (2009) investigated the function of clinical audit in clinical governance with an objective of discussing the role and process of clinical audit within the perspective of clinical governance. The study found that, although often poorly understood and understood, auditing is a mechanism aimed at improving patient care and its quality by regularly evaluating the treatment they receive, contrasting it with certain established standards that may lead to change. (Levy and Rockall, 2009). Levy and Rockall (2009) revealed that the clinical audit processes are an integrated part of a larger system referred to as 'Clinical Governance', which ensure that Health Institutions are accountable for endlessly providing better quality care services and upholding high clinical standards by establishing an excellent environment for clinical care to succeed.

The National Health Service Quality Improvement of Scotland (Scotland, 2010) also undertook a study on the topic "National standards: clinical governance and risk management: achieving safe, effective, patient-focused care and services". The rationale of the study was to use these standards to evaluate healthcare quality services within the National Health System of Scotland.

It was found out that, the NHS as a way of ensuring effective risk management has put in place several measures. Some of these measures include the NHS board in establishing an effective monitoring system to monitor the robust risk management systems across all Health Institutions. Furthermore, it was found that the NHS board had put in place an effective emergency and continuity planning arrangement across the health facilities and finally, the National Health Board has set up an effective monitoring system to monitor the adherence to the protocols for clinical effectiveness and quality improvement throughout the health system.

Another study conducted by Spigelman and Rendalls (2015) on "background and context to clinical governance in Australia, areas for further development and potential lessons for other jurisdictions". The study adopted a systematic and non-systematic approach to review relevant literature on the subject matter (background and context to clinical governance). The study revealed that Clinical governance in Australian Health System shows variation among provinces, an indication of a fragmented health system with responsibility for funding, policy and service provision being divided between levels of government and across service streams.

This, therefore, implied that the systems instituted to protect and engage with consumers are influenced by the community or state where client/patient lives. It has also been identified that information on quality and safety results often varies; it is hard to find and often does not drill up to a level of service that is useful for informing customer treatment decisions. (Allen et al., 2018). The study thus identified organizational stability as the key contributing component in realizing and sustaining the desire to improve quality health care services.

Another barrier to achieving clinical governance is the inadequacy of regulation, monitoring, poor performance, review and evaluation of the activities performed under the auspices of health organizations (Darling Downs Hospital and Health Service, 2014). Regulations and supervision are low because the laws and rules are not incorporated into activities of the health organizations. Without regulations, monitoring and supervision, health professionals cannot identify problems or variations which is an impediment to the progress of clinical governance.

Nmai *et al*. (2015) undertook a study on Clinical governance and organizational effectiveness. The study adopted a 'Cross-sectional survey design' to examine the link between clinical governance and organizational effectiveness in public and private hospitals in Ghana. The quantitative research approach was used and questionnaires were administered to 143 respondents who were drawn from the two hospitals. Their study established significant association between clinical governance and hospital effectiveness and further made a case that, effective clinical governance structures safeguards the provision of quality health care, adherence to standard clinical practices and improves the performance of the health care organization (Nmai et al., 2015).

2.10 Chapter Summary

The chapter reviewed related and relevant literature on clinical governance and its barriers linking them in the Ghanaian context specifically the psychiatric hospitals in Ghana. It also reviewed the literature on the pillars of clinical governance as well as empirical literature. A conceptual framework was also adopted to serve as a guide in assessing how clinical governance can influence hospital performance at the two psychiatric hospitals in Ghana.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter discusses research approach, design, population and study area, sample size and techniques, data sources for study, instruments for data collection, data collection procedure, analysis of data, ethical considerations and chapter summary.

3.1 Research Approach

Different types of research approaches exist that researchers can use to investigate any phenomenon. For example, Creswell and Creswell (2017) and Lewis (2015), identified three types; namely qualitative research approach, quantitative research approach and mixed-method (qualitative and quantitative). Johnson and Onwuegbuzie (2004) on the other hand, identified two broad types of research approaches which they said are widely used. Per their study, the two main research approaches were qualitative and quantitative approaches.

Johnson and Onwuegbuzie (2004), however, admitted in their study that there are instances where the two research approaches may complement each other hence must be employed together, which invariably means that the researcher adopts the "mixed method" that combines quantitative and qualitative research methods. Using this approach is said to provide a deeper appreciation of a research problem compared to either quantitative or qualitative approaches (Creswell, 2012b). Thus, Creswell (2012b), defines mixed methods as procedures for the selection, analysis and mixing of both quantitative and qualitative data in a single study or multi-phase research sequence.

Johnson and Onwuegbuzie (2004), also argued that quantitative research is one that is more geared towards the measurement of quantity or amount. Quantitative research is more related to phenomena that can be expressed in terms of quantity. Intuitively, their study sought to suggest that, qualitative research, is more applicable to a qualitative phenomenon, which places more emphases on issues that have to do with the quality of its kind. This qualitative approach is normally used to investigate and understand the behaviour of people and their reasons for such behaviour. It has been argued that the advantage of employing a qualitative research is the fact that it enhances better appreciation of a phenomenon from the perspective of respondents and therefore avoids situations where its specific social and institutional context may largely be lost when textual data are quantified (Bryman, 2016; Kaplan & Maxwell, 1994; Silverman, 2015).

Boateng (2016), argued that a qualitative approach tends to explore the meanings, attitudes, values, and beliefs people associate with a phenomenon in order to establish a better understanding, rather than to test to either support or disprove a relationship. It focuses on the interpretation of a phenomenon in their natural settings make sense in terms of the meaning people bring to these settings. Creswell (2014a), argued that the major reason for conducting a qualitative study is that the study is exploratory. This usually means that not much has been written about the topic or the population being studied, and the researcher seeks to listen to participants and build an understanding based on what is heard. According to the study, qualitative research ensures that the researcher to "get closer to what is being investigated" while gaining a deeper and complete understanding of the consequences in order to explain complex social and cultural issues (Baker, Edwards, & Doidge, 2012). This gives the implications that conducting qualitative research allows

the researcher to gain not just an in-depth understanding, but also get to know current trends with regards to the subject matter being investigated (Qu & Dumay, 2011).

Considering the nature and objectives of the study, the mixed method approach was adopted for this study. Mixed methods according to Creswell (2014b) refers to an approach to an inquiry involving collecting both quantitative and qualitative data, integrating the two forms of data, and using distinct designs that may involve philosophical assumptions and theoretical frameworks. According to him (Creswell, 2014b page 263-275), one major advantage of using mixed approach is the fact that it leads to a more holistic understanding of a research phenomenon or problem which otherwise could not have been possible when the study adopted only one approach.

To Boateng (2016), both qualitative and quantitative research approaches have their strengths and weaknesses. Adopting both qualitative and quantitative research approaches, therefore, tends to combine the strengths of the two approaches to conduct research. The choice of this research approach is due to the fact that it makes it possible for the researcher to gain a deeper and holistic understanding of how Clinical Governance can affect the performance of hospitals from the perspective health workers in Psychiatric hospitals in Ghana.

3.2 Research Design

Comparative Case study design was adopted in this study. This design was chosen for this study because it allows the researcher to investigate a particular subject while comparing two or more entities such as people, cultures, organizations or even countries (Clark & Creswell, 2010; Creswell & Creswell, 2017).

Abadie, Diamond, and Hainmueller (2010) in their study indicated the importance of adopting a comparative case study. According to Abadie, Diamond, and Hainmueller (2010), this type of study permits the researcher to compare two groups of entities with the aim of establishing similarities and differences on a common subject. The study further added that adopting a comparative case study enables the researcher to acquire a deeper understanding between societies and cultures thus help in the construction of a foundation for collaboration and compromise. Abadie et al., (2010) also posited that comparative case studies may contain both qualitative and quantitative research approaches and methods (Abadie et al., 2010). Due to the fact that the study hopes to investigate clinical governance and health workers perception of hospital performance in the psychiatric hospitals, a comparative case study research design was suitable and appropriate (Abadie et al., 2010; Abadie, Diamond, & Hainmueller, 2011).

3.3 Study Population

According to Fowler, (2013), study population refers to a group of people or subjects within a particular environment or area with identifiable characteristics from which samples are selected for a particular study which the researcher may be interested in generalizing their findings on a specific topic.

The population for the study included all health professionals employed by "Ministry of Health" at Pantang and Accra Psychiatric Hospitals at the time of data collection. The target population included management members, as well as all clinical staff of the two psychiatric hospitals in Ghana which included nurses, physician assistants, doctors, administrators, laboratory technicians and ward assistants. The total staff strength of the two psychiatric hospitals as at 2014 according to Roberts, Mogan, and Asare (2014), stands at nine hundred and twenty-one (921), with 464 and 451 in Pantang psychiatric hospital and Accra psychiatric hospital respectively. However, for the purposes of this study, the inclusion criteria were based on all those in the managerial positions who are responsible for implementing clinical governance decisions for the entire hospital and clinical staff. Therefore, all clinical staff and management members of the two (2) hospitals were considered in the study. Exclusion criteria constitute all non-clinical staff and staff that are not involved in strategic decision making for the hospitals.

3.4 Sample Size

Sample size according to (Fowler, 2013) refers to a subset of the total population under consideration by the researcher from which data will be collected and analyzed. Fowler, (2013) further posited that responses and findings from the subgroup are mostly projected to reflect the entire population as such the sample must always be reflective of the total population (Fowler, 2013). This is to ensure the accuracy of the findings, especially within a qualitative research perspective. However, Fowler, (2013) further argued that, for more qualitative studies, attention should not be concentrated on the extent of the sample as a large sample size will lead to data saturation and redundancy (Marshall, Cardon, Poddar, & Fontenot, 2013). As such, qualitative studies deal with only a few or little sample sizes with an emphasis on ensuring only key respondents from whom critical information or data on the subject matter will be obtained.

Normally, the sample size in qualitative studies may not necessarily be supportable (Marshall et al., 2013), nevertheless, scholars have always been particular about using an appreciable or appropriate number (Dworkin, 2012). This proposition was in line with the propositions of (Boddy, 2016) who indicated that in a qualitative study, the researcher only needs to ensure there is enough data and that it should not be greater than thirty (30) respondents. One review by Mason (2010) identified that "samples of 20 and 30 (and multiples of 10) were most common with 25-30 being a typical recommendation" (Mason, 2010). Therefore, a sample size of seven (7) participants in total was sampled for the qualitative data with three from Pantang Psychiatric Hospital and four (4) from Accra Psychiatric Hospital respectively. This included; the Medical Director or Clinical Coordinator, Administrator and the Human Resource Managers of each of the two facilities. But

in the case of Accra Psychiatric Hospital, the Head of Quality Improvement Coordinator (QIC) was included.

With regard to the quantitative data, the Stovin's sample size determination formula was used to calculate for the samples of the various populations. The choice of this formula is due to the fact that "it allows to calculate an ideal sample size given a desired level of precision, desired confidence level and the estimated proportion of the attribute present in the population" (Suprayitno, Saraswati, & Fajrinia, 2017; Tejada & Punzalan, 2012). This formula is given below;

$$n = \frac{N}{1 + Ne^2}$$

That is;

e = the desired level of precision (margin of error)

n = the estimated proportion of the population which has the attribute in question

N= population size

Therefore with the 5% margin of error and 95% confidence level, the total number of two hundred and forty (240) clinical staff were sampled from each of the two Psychiatric Hospitals for the survey which include, Doctors, Pharmacists, Laboratory Technicians and Nurses/Midwives, Physician Assistants and Management members making the total healthcare providers to be studied 240.

3.5 Sampling Technique

Presently, Ghana has Pantang, Ankaful and Accra Psychiatric Hospitals as the only specialist existing functional psychiatric hospitals. These facilities are the only major psychiatric hospitals that serve the whole nation and also serve as the only public tertiary hospitals for psychiatric cases across the country (de-Graft Aikins, 2018; Roberts et al., 2014). This study, therefore, employed convenient and purposive sampling techniques to gather data from participants. Ritchie, Lewis, and Elam (2013) posited that "purposive sampling involves selecting participants who portray key characteristics or elements with the potential of yielding the right information available for the study". This sampling approach was employed in selecting four (4) management members (i.e. the Medical Director/ Clinical Coordinator, Administrator, Quality Improvement Coordinator and Human Resource Manager) each from the two (2) psychiatric hospitals (Pantang and Accra Psychiatric) who were directly involved in the implementation of clinical governance activities.

The simple random sampling procedure was adopted in selecting a total of two hundred and forty (240) clinical staff from the two Psychiatry Hospitals. This approach was used to ensure that the data collection process was not delayed due to the busy nature of their work hence clinical staff who were ready and willing to take part in the study were recruited. Again, purposive sampling procedure was adopted in selecting two out of the three Psychiatric Hospitals for the study. The choice of this approach was due to the fact that both Pantang and Accra Psychiatric Hospitals are located in Accra and therefore may share a similar characteristic. Another reason for the choice of purposive sampling procedure was due to the fact that management of Ankaful was reluctant in granting approval for the study to be conducted hence the researcher was left with no option than to adopt this method since the two facilities have granted approval for the study to be conducted.

3.6 Source of Data

Field data, interviews, documents, observations among others have been identified as some of the major sources data that a researcher could rely on during a study (Boateng, 2016). According to Boateng (2016), qualitative research "holds observations that yield detailed, thick description; inquiry in depth; interviews that capture direct quotations about people's personal perspectives and experiences; and careful document review". The findings of Boateng (2016) was supported by Creswell (2014b) who was in agreement with the three major sources of data for qualitative research but also went ahead to add a fourth source; interviews, observations, documents, and audiovisual. Hence, the source of data for this study was from a primary source, which involves the use of an interview guide and questionnaires to soliciting information from respondents. respondents.

3.7 Instrument for Data Collection

Due to the fact that this study has employed the mixed-method approach and wishes to find out facts or opinions or both for that matter, interview guides and questionnaires were most suitable tools for gathering data for this study. Interview guide took into account the research objectives which seek to establish clinical governance structures and implementation strategies, literature review and other relevant materials. The rationale for the use of interview guide was to allow the researcher to probe further with questions during the interview session, thereby collecting more data as well as gaining more insight on the subject matter (Creswell, 2014b). Another reason for the use of an interview guide is that "it will allow the respondents to express themselves as far as the subject matter is concerned and with this, respondents are able to tell exactly what is on the ground as far as the subject matter is concerned" (Creswell, 2012a, 2014b; Creswell & Creswell,

2017). The questionnaires were developed based on the "Performance Indicators for measuring the quality of Mental Health Care" adopted from the works of (Spaeth-Rublee, Pincus, Huynh, & IIMHL Clinical Leaders Group, 2010) which aimed at answering the third research objective. Clinical Governance was measured using six dimensions namely; clinical audit, clinical effectiveness, clinical risk management, education and training, and research and development.

Based on the clinical governance dimensions, questionnaires were designed on a 5-liker scale where 1,2,3,4 and 5 which represents **agree strongly, agree, either, disagree** and **disagree strongly** and respondents were asked to select the option that best represents their opinion. The questionnaire was used to collect data to establish the link between clinical governance and health workers perception of hospital performance at these hospitals. The questionnaires were distributed to the clinical staff to fill on their perceived effectiveness of the Clinical Governance to their work delivery.

3.8 Data Collection Procedure

Data for the study was collected for a period of thirty (30) days, with 15 days for each of the two healthcare institutions. With the help of the administrators of the hospitals, management members of the hospitals who deal directly with the governance of the hospital were selected and an appointment scheduled with each of them. Each appointment lasted for about 30 minutes. On the average, the appointments lasted about 25 minutes with all the administrators, clinical coordinators, quality improvement coordinators and human resource managers of the two hospitals. All interviews were recorded with the consent of each of the participant. Questionnaires were distributed to clinical staff who were willing and ready to take part in the study and given

some time to complete the questionnaires. The contact of the researcher was provided to all the respondents in case they may want any clarification. The clinical staff that were considered in the study included doctors, nurses, physician assistants, pharmacists and lab technicians. All staff on clinical rotation, students on clinical attachments and all other categories of staff not classified as clinical staff were excluded from the study.

3.9 Data Analysis

For the qualitative data, analysis progresses alongside other aspects of the study, which may include, but not limited to, data collection and transcription. At the time the interview is ongoing, for instance, data collected earlier could be analyzed whiles at the same time the researcher may by writing transcripts which could eventually be considered as a narrative and organization of the final work (Creswell, 2014b; Creswell & Creswell, 2017). According to Guest, MacQueen, and Namey (2012), as quoted by (Creswell, 2014b) for a qualitative study, it is always not possible to encode every information due to the fact that words and information may be very complex and indigestible. Therefore, to overcome this hurdle in qualitative data analysis, it is important to "winnow" the data (Guest *et al*., 2012); which has to do with focusing on the most relevant aspect of the data and disregarding other parts that may not be very important to the study (Creswell, 2012b). This approach, unlike quantitative research where the investigator places much emphasis on data preservation and reconstructing or replacing missing data. This is one major characteristic that distinguishes qualitative from quantitative research. For qualitative studies, a major influence of the "winnow" has to do with the aggregation of all the data into a smaller number of themes, mostly between five (5) to seven(7) themes (Wisdom & Creswell, 2013).

Due to the fact that the study adopted the mixed-method approach, the study employed both quantitative and qualitative techniques to analyze the data. The qualitative data were analyzed using the Thematic Analysis based on themes and subsequently presented a quotation from the interview with the participants. Statistical Package for Social Science (SPSS) version 20.0 was used in analyzing the quantitative data. The results from the quantitative data analysis were presented using descriptive statistics, charts, correlation, independent T-Test and regression. Correlation analysis was done using Pearson's Correlation Coefficient to ascertain the association between Clinical Governance and Hospital Performance. Correlation is a statistical tool used to measure the degree of association between two or more variables. The primary purpose of correlation is to establish an association between any two random variables. The degree of correlation between variables is explained by the correlation coefficient. The correlation coefficient is a statistic that quantifies the strength of the nexus between two variables. Therefore, the study computed the correlation statistic to find out if there was any association between clinical governance and hospital performance at the two psychiatric hospitals. The study computed totals of the clinical pillars which included; Clinical Effectiveness, Clinical Audit, Risk Management, Quality Assurance, Research and Development, and Education and Training

To check for the association between categorical variables, the Chi-Square test which is a "non-parametric" test, is always recommended. Also, to find out if two categorical variables are related, the Chi-Square test is most suitable (Pallant, 2005). To be able to use the Chi-Square test, some basic assumptions underlying the use of Chi-Square must be satisfied. The study must adopt a random sampling method, at least one hundred (100) sample size is recommended and the study must also ensure that both the dependent and independent variables are categorical (Pallant, 2005).

Therefore, to ensure that these assumptions are met, all the clinical governance dimensions were "re-coded" into "High and Low". A total score between 5- 12 points were re-coded as Low while a total score between 13–20 points were re-coded as High. For clinical governance dimensions with only three variables, a total score between 3- 9 points were classified as Low and a total score between 10-15 points was classified as High.

3.10 Data Reliability

An important concept to consider in the selection of an instrument for collection of data is what is known as "Reliability of Data" which ensures that the same instrument is reliable enough to produce similar results when applied to different locations or times. The reliability of the instrument or scale is the extent to which the scale or instrument must at all times be without random error. A broadly accepted measure of the reliability of a scale or instrument is the use of the Cronbach Alpha. A Cronbach coefficient of 0.70 and above is recommended. Therefore, the Cronbach Alpha coefficient for the instruments or scales used for this research was 0.915 for the scale used for Clinical Governance and 0.715 for the scale for Hospital performance. An overall Cronbach Alpha coefficient for the scale used was 0.735. This, therefore, confirmed that all the instruments used for the data collection for this study can be said to be statistically reliable. Refer to Tables; 3.1, 3.2 and 3.3

Table 3. 1 Reliability Statistics for Clinical Governance instruments

Cronbach's Alpha	N of Items
.915	23

Source: Field survey, (2019)

Table 3. 2 Reliability Statistics for Hospital Performance instruments

Cronbach's Alpha	N of Items
.731	19

Source: Field survey, (2019)

Table 3. 3 Overall Reliability Statistics all the instruments

Cronbach's Alpha	N of Items
.735	51

Source: Field survey, (2019)

3.11 Ethical Consideration

Ethical issues were appropriately addressed considering the various precautionary approaches. Oliver (2010), suggests that in all investigations involving the gathering of data from human beings, there is a basic ethical responsibility to deal with those people. Thus, they must be treated according to ethical standards and values. Ethical clearance was obtained from the Ghana Health Service Ethics Committee, Mental Health Authority and the Hospital Authorities of all the two (2) facilities before the data collection for the study began and ethical practices were strictly adhered to during the study. The purpose and objectives of the study were also carefully explained to all

the respondents. Their confidentiality was assured and their informed consent was sought and alerted that participation was voluntary. Additionally, I was very flexible, treated the respondents with respect, before, during and after the interview process. Denscombe (2014), suggests that potential participants should never be forced or pressured to participate in the study the potential participants' participation must always be voluntary and they must have enough information about the study in order to decide whether to participate or not.

Oliver (2010), indicates in his study that as stated in the principles of freedom and autonomy, during the research process the participants must feel free to withdraw at any time. According to Denscombe (2014), signing a consent form does not force participants to remain in the study if the participants do not wish to continue. It was explained to all respondents that, they have the right to withdraw from the research at any point in time during the data collection, but once data analysis begins it would be difficult to remove the data.

Anonymity ensures that participants' identity is concealed in a research report (Punch, 2013). To ensure this, during the qualitative data gathering, each respondent was assigned a pseudonym to protect their identities. King and Horrocks (2010) and King, Horrocks, and Brooks (2018), stated that confidentiality indicates that participants should be able to count on their information being kept protected with data that would enable participants to be identified as being kept securely by the investigator. With this in mind, their confidentiality was assured and that all data that were collected was purely for academic purposes and that, their participation does not have any relationship with their job evaluation.

3.12 Chapter Summary

The chapter discussed all the steps the researcher used in conducting this study. The chapter discussed in details the research approach and design, sample size and sampling procedures, sources of data for the study and all the instruments used to gather data for the study. The chapter also focused on how the data was analyzed and the reliability of the instruments used to collect the data was discussed. Ethical issues were also discussed appropriately. A Thematic Analysis and quantitative data analysis techniques were used to analyze the qualitative and quantitative data respectively

CHAPTER FOUR

ANALYSIS, PRESENTATION AND DISCUSSION OF RESULTS

4.0 Introduction

This chapter presents the results of the study using descriptive statistics, univariate, bivariate and thematic analysis.

4.1 Demographic Characteristics of Respondents

It was found that out of the 270 health care providers invited to participate in the study, 230 health care providers honoured the invitation. This represents a response rate of ninety-six per cent (96%). It was found that of the two hundred and thirty (230) respondents one hundred and thirty-seven (137) were females. Fifty-nine percent (59%) of the females were recruited from Pantang Psychiatric Hospital and forty-one percent (41%) were recruited from Accra Psychiatric Hospital. Ninety-three (93) of the respondents were males, with forty-nine (49) recruited from Pantang Psychiatric Hospital and forty-four (44) recruited from Accra Psychiatric Hospital.

With regard to the age of the respondents, about 12.6% (n=29) were within 21-25years, 33.5% (n=77) were within 26-30 years, 30.4% (n=70) were within 31-35 years, 15.2% (n=35) were within 36-40 years and 8.3% (n=19) of the respondents were above 41 years of age. In addition, it was found that the majority of the respondents had between 1- 5 years'-working experience while the minority, 38% had more than 6 years'-working experience. Of the 230 respondents, 16 were doctors, with 56.3% and 43.7% from Pantang Psychiatric Hospital and Accra Psychiatric Hospital

respectively. Thirty-three (33) of the respondents were Physician Assistants; with 73% from Pantang Psychiatric Hospital and 27% from Accra Psychiatry Hospital.

Furthermore, 179 of the respondents were nurses of which 53% of them were from Pantang Psychiatric Hospital and the remaining 47% (n=179) of the nurses were from Accra Psychiatric Hospital. It was found that two of the respondents were medical laboratory officers with all from Pantang Psychiatric Hospital. See Table 4.1

Table 4. 1 Demographic Characteristic of Respondents

		Name of Facility	
		Pantang Hospital	Accra Mental Hospital
Variables	**N**	**%**	**%**
Sex			
Female	137	59	41
Male	99	53	47
Age (Years)			
21-25years	29	55	45
26-30 years	77	49	51
31-35 years	70	56	44
36-40 years	35	63	37
41 years and above	19	79	21
Job position			
Doctor	16	56	44
Physician Assistant	33	73	27
Nurse	179	53	47
Lab	2	100	0
Experience			
1-2 years	50	66	34
3-4 years	45	29	71
4-5 years	47	60	40
5-6 years	35	63	37
7-8 years	25	68	32
9 years and above	28	64	36

Source: Field data (2019).

4.2 Frequency Distribution for Dimensions of Clinical Governance

4.2.1 Clinical Effectiveness

It was found that more than half (78.7%) of the respondents indicated that there is an evidence-based approach to patient management in the hospitals. With regard to the respondent's perception of standards put in place by management to ensure clinical services produces the desired results. About 67.9% were of the opinion that the facility has some measures in place to ensure clinical services produces a satisfactory result. Assessing the respondent's perception of the length of services rendered to clients, about 60.4% of the respondents thought that there were systems in place to ensure that clinical services are provided to clients timely. Concerning the appropriateness of the methods, the majority, 67.4% of the respondents were of the view that there are standards in place to ensure that services are provided according to accepted protocols or procedures. See Table 4.2

Table 4. 2 Frequency for clinical effectiveness

Variables	n	Strongly Disagree %	Disagree%	Neither%	Agree%	Strongly Agree%
There is evidence-based approach to patient management	230	1.3	7.0	13.0	50.0	28.7
Standard in place to ensure clinical services produces desired results	230	3.0	13.9	15.2	48.3	19.6
Standards in place to ensure services are delivered timely	230	3.5	17.0	19.1	44.3	16.1
Standards in place to ensure services are provided using an appropriate method	230	4.3	13.9	14.3	52.6	14.8

Source: Field data (2019)

4.2.1 Clinical Audit

The results revealed that majority (67.4%) of the respondents thought that there are regular peer-review activities within the hospitals. With regard to staff involved in clinical evaluation activities, 55.2% of the respondents indicated that staff were mostly involved in the evaluation of clinical activities. The majority (54.4%) of the respondents were of the opinion that there are regular performance review meetings in the hospitals. However, with regard to financial audits, less than half (30.9%, n=230) of the respondents thought that the current system is to prevent misuse and leakages within the hospitals.

Table 4. 3 Frequency distribution for Clinical Audit

Items	N	Strongly Disagree%	Disagree%	Neither%	Agree%	Strongly Agree%
Constant peer review activities	230	3.5	7.8	21.3	39.1	28.3
Staff are involved clinical evaluation activities	230	3.5	18.7	22.6	36.1	19.1
There are regular performance review meetings	230	5.1	17.0	23.5	39.6	14.8
Adequate system in place to control financial leakages	230	10.0	29.1	27.0	20.0	13.9

Source: Field data (2019)

4.2.3 Risk Management

The results revealed that most of the respondents (51.3%) were of the view that the hospitals had effective systems to address clinical risk when identified. But close to 30% of the respondents indicated that the current systems of the hospitals are not effective to solve clinical risks when identified. The majority, (61.3%) of the respondents indicated that an incident register is always provided. About 45.4% of the respondents indicated that the hospitals have systems in place to reduce the high incidence of risk to both providers and patients. The majority (50.1%, n=230) of the respondents indicated that the hospitals have systems that promote organizational learning, thus learning from the mistake. See Table 4.4

Table 4. 4 Frequency for Risk Management

Items	N	Strongly Disagree%	Disagree%	Neither%	Agree%	Strongly Agree%
Always action to address clinical risk when identified	230	7.4	22.2	19.1	37.0	14.3
Incidence register is always provided	230	4.8	11.7	22.2	43.0	18.3
Systems in place to reduce risk to staff and patients	230	10.9	21.7	23.0	35.7	8.7
The system promotes learning lessons from adverse events	230	6.1	18.7	29.6	36.5	9.1

Source: Field data (2019)

4.2.4 Quality Assurance

It was found that 43.9% of the respondents were of the opinion that the hospitals have instituted enough quality improvements activities but about 34% of the respondents had a contrary opinion. Also, 43% of the respondents thought the hospitals did not have strategies to enhance and protect the safety of staff. For medication safety, 42.2% of the respondents indicated that staff are regularly trained and updated on issues regarding medication safety. Majority of the respondents were of the view that the hospitals had adequate systems to ensure the safety of clients. See Table 4.5

Table 4. 5 Frequency for Quality Assurance

Items	n	Strongly Disagree%	Disagree%	Neither%	Agree%	Strongly Agree%
There are lots of quality improvement initiatives	230	8.3	25.7	22.2	31.3	12.6
Measures in place to protect the safety of staff	230	12.6	30.4	19.6	29.1	8.3
There is always staff training on medication safety	230	9.1	22.6	26.1	34.8	7.4
Adequate measures in place to protect patients/client's safety	230	9.1	22.6	19.1	38.3	10.9

Source: Field data (2019)

4.2.5 Research and Development

The majority (49%) of the respondents stated that there was no database of information available for staff to access and enhance their work. Close to half (49.6%) of the respondents stated that staff were regularly trained on best practices in healthcare delivery but 51.7% did indicate that management did not provide enough opportunities for staff to make good use of the skills acquired through training. About four in tens of the respondents indicated that the hospitals did not support staff continuous professional development programs. See Table 4.6

Table 4. 6 Frequency for Research and Development

Items	N	Strongly Disagree%	Disagree%	Neither%	Agree%	Strongly Agree%
There is a knowledge pool or database of information that staff can easily accessed	230	10.9	33.0	23.5	24.3	8.3
Staff regularly train on best practices	230	3.9	17.8	28.3	38.3	11.3
Few opportunities to uses new skills learned	230	5.2	16.1	27.0	35.2	16.5
The hospital supports staff Continuous Professional Development	230	13.5	22.6	23.0	27.0	13.9

Source: Field data (2019)

4.2.6 Education and Training

It was revealed that most (53.9%) of the respondents stated the hospitals had opportunities for all staff to address their educational and training needs and 47.8% of the respondents alluding to the fact that mechanism for selecting candidates for training was made known to all staff. Moreover, it was found that 71.3% of the respondent was of the view that appraisals were done regularly to assess staff performance. See Table 4.7

Table 4. 7 Frequency for Education and Training

Items	n	Strongly Disagree%	Disagree%	Neither%	Agree%	Strongly Agree%
Available training and educational programs for staff	230	11.3	15.7	19.1	41.3	12.6
Mechanism for selecting candidates for training are known to all staff	230	15.2	20.0	17.0	39.1	8.7
Appraisals are done regularly to enhance staff performance	230	4.3	9.1	15.2	49.1	22.2

Source: Field data (2019)

4.3 Frequency Distribution for Dimensions of Hospital Performance

4.3.1 Access

A larger proportion (51.8%) stated that the hospitals had implemented measures to reduce clients/patients waiting time. A majority (62.2%) of the respondents indicated that some of the staff did not report for duty on time. With the affordability of the hospital services, 48.7% of the respondents stated that the hospitals provide services that all clients/patients can afford. See Table 4.8.

Table 4. 8 Frequency for Access

Items	N	Strongly Disagree%	Disagree%	Neither%	Agree%	Strongly Agree%
Patient waiting time reduced to the barest minimum	230	7.0	17.0	24.3	39.6	12.2
Staff report for duty on time	230	15.2	47.0	16.5	17.4	3.9
We provide services that patients can afford	230	8.7	20.9	21.7	37.4	11.3

Source: Field data (2019)

4.3.1 Efficiency

With regard to efficiency as an indicator of hospital performance, 69.6% of the respondents stated that the facilities often run out of very essential materials needed for effective healthcare services delivery at the hospitals. The results further show that the majority (48.7%, n=230) of the respondents were of the view that the hospitals do generate enough revenue but the problem has to do with accountability. The results again show that most (48.7%) of the respondents stated that there are a lot of financial leakages at the Hospital. Concerning the staff strength against the

demand of patients/clients, the majority (53.5%) of the respondents stated that their current number (staff strength) is not enough to meet all the demands of their patients/clients. See Table 4.9

Table 4. 9 Frequency for Efficiency

Items	n	Strongly Disagree%	Disagree%	Neither%	Agree%	Strongly Agree%
The facility often runs out of essential materials	230	2.6	15.7	12.2	40.0	29.6
The facility generates much revenue but can't account for it	230	3.5	20.9	27.0	27.4	21.3
Lots of financial leakages at this Hospital	230	4.3	14.3	32.6	20.9	27.8
Inadequate staff strength to meet increasing demand of patients	230	5.2	22.6	18.7	27.0	26.5

Source: Field data (2019)

4.3.3 Effectiveness

Out of the 230 (100%) respondents, 44.8% of the respondents posited the hospitals have experienced some decline in acute inpatient readmission cases over the years. Half (50%) of the respondents stated that the facilities have enough bed capacity to meet the demands of inpatients. However, the majority (62.2%) of the respondents did indicate accommodation for staff was not enough. Also, the majority of the staff were not motivated to make changes to clinical practices. See Table 4.10

Table 4. 10 Frequency for Effectiveness

Items	n	Strongly Disagree%	Disagree%	Neither%	Agree%	Strongly Agree%
Decline in acute inpatient readmission rate	230	3.9	22.2	29.1	35.7	9.1
Adequate bed capacity to meet inpatient demand	230	10.9	21.3	17.8	35.2	14.8
Adequate accommodation for staff	230	37.8	24.8	14.3	14.8	8.3
Staff are highly motivated to make changes to clinical practices	230	23.9	30.4	25.2	13.0	7.4

Source: Field data (2019)

4.3.4 Safety

Close to 40%, of the respondents, indicated that little is done to address clinical risk when identified at the Hospitals. To find out how errors are addressed when it occurs, 43.9% of the respondents indicated that when an error occurs, the focus is always on the individual rather than looking for failures in systems. For medication safety, 37.9% of the respondents indicated that staff of the hospitals are regularly trained and updated on issues regarding the safety of their medications prescribed to clients/patients, while 37% of the respondents stated that, they do not receive any training with regards to the medications they prescribe to patients/clients. About four out of ten respondents indicated that staff mostly embark on follow-up on patients to ensure adherence to treatment instructions. See Table 4.11

Table 4. 11 Frequency for Safety

Items	n	Strongly Disagree%	Disagree%	Neither%	Agree%	Strongly Agree%
Actions are always taken to address clinical risk when identified	230	10.6	29.1	27.0	24.3	8.3
We look for system failures in systems rather than blame individuals when errors occur	230	15.2	38.7	21.7	15.7	8.7
There is always staff training on medication safety	230	11.3	25.7	25.2	29.6	8.3
Frequent follow-up on patients to ensure adherence to treatment instructions	230	12.6	22.2	26.1	28.3	10.9

Source: Field data (2019)

4.3.5 Appropriateness of Care

It was found that out of the 230 respondents, the majority (53.9%) were of the view that, the hospitals always have adequate treatment protocols for all staff. With regard to best practices in mental healthcare, more than half (50.5%) of the respondents did indicate that there is regular training on best practices within the hospital. Furthermore, the results showed that 47.4% of the respondents indicated that there were fewer opportunities for staff to contribute their skills to the development of the hospitals. Again, it was found that the majority (54.8%) of the respondents stated that, there were a lot of quality improvement activities within the facilities but there is very little change. See Table 4.12

Table 4. 12 Frequency for Appropriateness of Care

Items	n	Strongly Disagree%	Disagree%	Neither%	Agree%	Strongly Agree%
There are always treatment protocols for staff	230	9.1	18.3	18.7	40.9	13.0
Regular training on best practice in mental healthcare	230	7.8	22.2	19.6	40.9	9.6
Few opportunities to use skills learned as part of development	230	4.8	24.3	23.5	34.8	12.6
There are lots of quality improvement activities be little real change	230	3.0	17.4	24.8	38.7	16.1

Source: Field data (2019)

4.3.6 Overall Performance of the Hospital

From Figure 4.1, it can be observed that Pantang Psychiatric Hospital (PPH) performed relatively better than Accra Psychiatric Hospital. For instance, only eight respondents from PPH rated performance as ‘poor’ while 23 respondents from APH also rated performance as ‘poor’. Additionally, 60 respondents from PPH rated performance as ‘good’, while only 24 respondents from APH rated performance as ‘good’. Details are provided in Figure 4.1

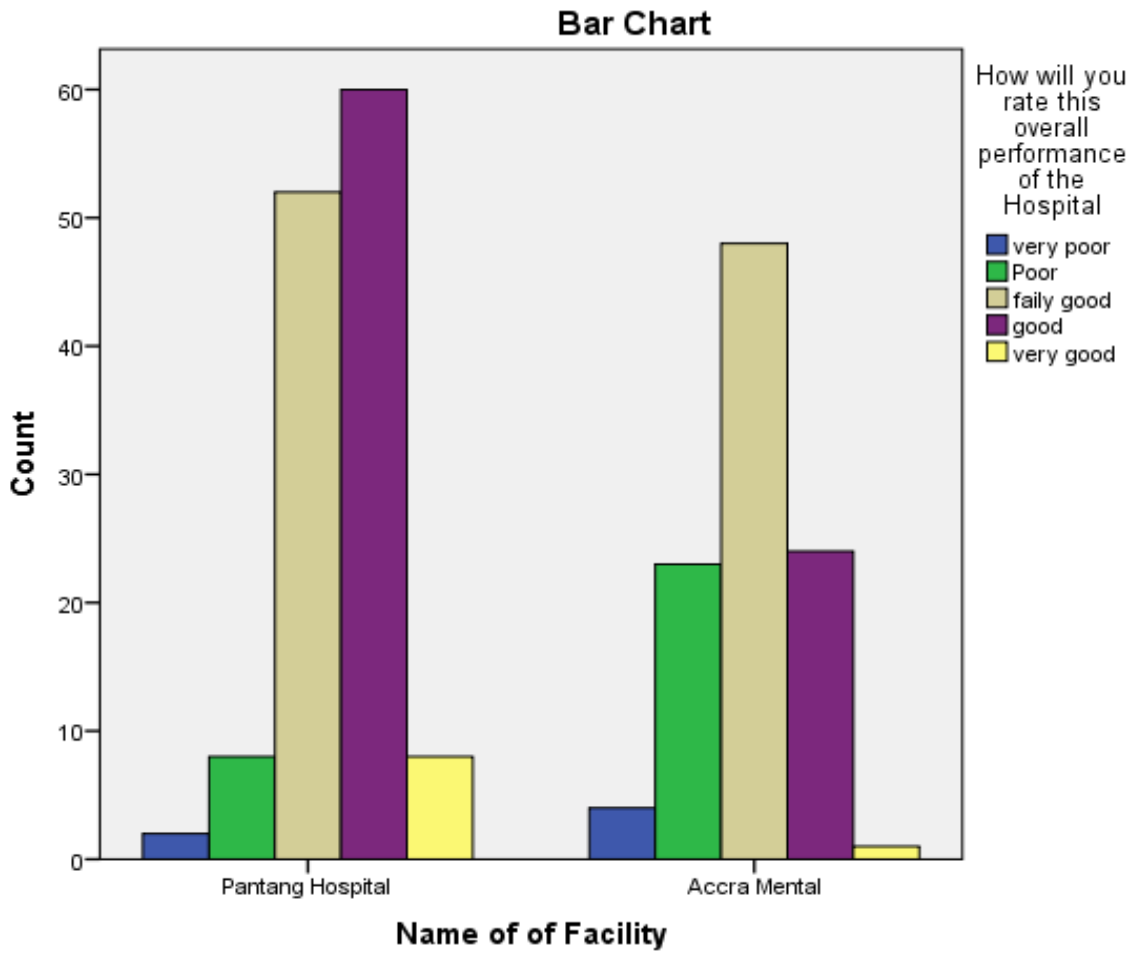

Figure 4. 1 Frequency for staff perception of the overall performance of the hospital

Source: Field data (2019)

4.4 The Independent t-test

To compare the means of the two hospitals, an Independent t-test analysis was computed. For clinical effectiveness, a statistically significant difference was found between the means of the two hospitals (MD =.754. p =.002). Similarly, a statistically significant difference (MD =1.600, p =.000) was found between the means of the two hospitals in terms of risk management. Regarding quality assurance, a mean difference of (MD =1.985. p =.000) was found between the two hospitals. However, concerning clinical audit; research and development; and education and training, no statistically significant difference was found between the means of the two hospitals. See Table 4.13

Table 4. 13 Independent t-test

Dimensions	Facility Type	N	Mean	Standard Deviation	Mean difference	t	df	p-value
Clinical Effectiveness	PPH	130	13.75	1.575	.754	3.185	228	.002*
	APH	100	13.00	2.015				
Clinical Audit	PPH	130	13.91	3.168	.338	.773	228	.441
	APH	100	13.57	3.433				
Risk Management	PPH	130	13.90	3.060	1.600	3.719	228	.000*
	APH	100	12.30	3.448				
Quality Assurance	PPH	130	13.18	3.403	1.985	4.021	228	.000*
	APH	100	11.20	4.078				
Research and Development	PPH	130	11.93	2.491	.171	.492	228	.623
	APH	100	11.76	2.760				
Education and Training	PPH	130	10.22	2.411	.265	.740	228	.460
	APH	100	9.95	3.026				

Source: Field survey, (2019). **Note**: PPH (Pantang Psychiatric Hospital), APH (Accra Psychiatric Hospital)

4.5 Chi-Square

Chi-square test for independence was computed to find out the association between clinical governance dimensions and facility type (i.e. Pantang and Accra Psychiatric Hospitals). At the 0.05 significance level, the chi-square test indicated a statistically significant association between clinical effectiveness and facility type, (X^2 *(1, n =230) =9.288, p =.00)*. A statistically significant association was found between clinical audit and facility type, (X^2 *(1, n =230) =4.969, p =.026)*. Similarly, risk management was found significantly associated with the facility type, (X^2 *(1, n =230) =22.572, p =.000)*. In addition, a statistically significant association was found between quality assurance and facility type, (X^2 *(1, n =230) =20.297, p =.000)*. However, no statistically significant association was found between research and development and facility type, (X^2 *(1, n =230) = .519, p = .475)*. Finally, education and training were independent of facility type, (X^2 *(1, n =230) =2.606, p =.106)*. See Table 4.14

Table 4. 14 Chi-Square

Dimensions	Facility Type	Low	High	Chi-Square	Sig.
Clinical Effectiveness	Pantang Psychiatric Hospital	28	102	9.288	.002*
		21.5%	78.5%		
	Accra Psychiatric Hospital	41	59		
		41%	59%		
Clinical Audit	Pantang Psychiatric Hospital	40	90	4.969	.026*
		30.80%	69.20%		
	Accra Psychiatric Hospital	46	54		
		46.00%	54.00%		
Risk Management	Pantang Psychiatric Hospital	34	96	22.576	.000*
		26.20%	73.80%		
	Accra Psychiatric Hospital	58	42		
		58.00%	42.00%		
Quality Assurance	Pantang Psychiatric Hospital	47	83	20.297	.000*
		36.20%	63.80%		
	Accra Psychiatric Hospital	67	33		
		67.00%	33.00%		
Research and Development	Pantang Psychiatric Hospital	72	58	.519	.471
		55.40%	44.60%		
	Accra Psychiatric Hospital	61	39		
		61.00%	39.00%		
Education and Training	Pantang Psychiatric Hospital	45	85	2.606	.106
		34.60%	65.40%		
	Accra Psychiatric Hospital	46	54		
		46.00%	54.00%		

Source: Field data, (2019).

4.6 Correlation Analysis

Pearson Correlation Coefficient was computed to find out the relationship between clinical governance dimensions and health workers perception of hospital performance. A positive significant association was found between clinical effectiveness and health workers perception of hospital performance *(r =.290, p =.000).* There was also a positive significant association between clinical audit and health workers perception hospital performance *(r = .352, p = .000).* The following clinical governance dimensions also associated significantly with perceived hospital performance: risk management *(r = .374, p = .000)*; quality assurance (*r = .416, p = .000);* research and development *(r = .312, p = .000)* and education and training *(r = .330, p = .000).* The relationships, however, were not very strong. See Table 4.15.

Table 4. 15 Correlation matrix

	Overall performance	Clinical Effectiveness	Clinical Audit	Risk Mgt	Quality Assurance	Research and Dev.	Edu. and Training
Overall performance	1.00						
Clinical Effectiveness	.290**	1.00					
Clinical Audit	.352**	.400**	1.00				
Risk Mgt	.374**	.317**	.571**	1.00			
Quality Assurance	.416**	.431**	.507**	.617**	1.00		
Research and Dev.	.312**	.223**	.412**	.493**	.509**	1.00	
Education and Training	.330**	.372**	.509**	.533**	.549**	.375**	1.00

Source: Source: Field survey (2019). Note: ** significant at .01

4.7 Regression Analysis

Regression model: OHP= β0+β1TCE+β2TCA+β3TRM+β4TQA+β5TRD+β6TET+ε

(Where: OHP- the overall perception of hospital performance; β- beta; TET-Total Education and Training; TCE-Total Clinical Effectiveness; TRM-Total Risk Management; TRD-Total Research and Development; TCA-Total Clinical Audit; TQA- Total Quality Assurance; ε- error term).

In the model, clinical governance dimensions were used as predictors of the overall perception of hospital performance. See table 4.16. The regression coefficients (R) for the model is (r=0.471). this shows that there is a relationship between the overall perception of hospital performance and clinical governance dimensions. The R Square (0.222 ×100) indicates that about 22.2% of the variation in the dependent variable is accounted for by the independent variables.

Table 4.16 Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.471	.222	.201	.747

Predictors: (Constant), Total Education and Training, Total Clinical Effectiveness, Total Risk Management, Total Research and Development, Total Clinical Audit, Total Quality Assurance

Dependent Variable: How will you rate this overall performance of the Hospital

Source: Field survey, 2019.

4.7.1 ANOVA table for the model

To find out the significance of the regression relationships, ANOVA table was computed. In table 4.17, the regression relationship is significant (F= 10.582, p= .000). This shows that there is a significant relationship between Clinical Governance dimensions and health workers perception of hospital performance. This implies that holding all other factors constant, the perceived overall performance of the hospitals was influenced by clinical governance dimensions.

Table 4.17 ANOVA table

	ANOVA					
		Sum of Squares	**Df**	**Mean Square**	**F**	**p-value**
Model 1	Regression	35.430	6	5.905	10.582	.000
	Residual	124.436	223	.558		
	Total	159.865	229			
	Dependent Variable: How will you rate this overall performance of the Hospital **Predictors**: (Constant), Total Education and Training, Total Clinical Effectiveness, Total Risk Management, Total Research and Development, Total Clinical Audit, Total Quality Assurance					

Source: Field survey, 2019.

4.7.2 Evaluation of each (Predictors) independent variable in Model 1

To find out the significance of each predictor's contribution to the dependent variables, further analysis was done. It was revealed that not all clinical governance dimensions made a significant positive contribution to the overall perception of hospital performance. For example, a unit increase in Quality Assurance (p=0.017) will lead to 0.207 units increase in the overall perception of hospital performance. See table 4.18.

Table 4.18 Regression of clinical governance dimensions on the overall perception of the performance of the Hospitals

Independent variables	B	Std. Error	Beta	T	p-value
(Constant)	.982	.411		2.386	.018
TCE	.049	.031	.105	1.563	.120
TCA	.028	.020	.110	1.402	.162
TRM	.028	.021	.113	1.352	.178
TQA	**.045**	**.019**	**.207**	**2.410**	**.017**
TRD	.029	.025	.089	1.143	.254
TET	-.004	.025	-.012	-.143	.886
Dependent Variable: How will you rate this overall performance of the Hospital					

Source: Field survey, 2019.

4.7.3 Evaluation of each (Predictors) and controlled variables independent variable in Model 1

To examine the significance of each predictor's contribution to the dependent variables, further analysis was done. It was revealed that not all clinical governance dimensions made a significant positive contribution to the overall perception of hospital performance, controlling for socio-demographic characteristics. For example, a unit increase in Quality Assurance (p=0.024) will lead to 0.189 units increase in the overall perception of hospital performance. However, the name of the facility (p=0.000), a controlled variable, had a significant negative influence on the overall perception of hospital performance. Nonetheless, the influences of the other controlled variables such as gender, age, job title, number of years served and qualification were all not statistically significant. See Table 4.19.

Table 4.19 Regression of clinical governance dimensions on the overall perception of the performance of the Hospitals

Independent variables	B	Std. Error	Beta	T	p-value
(Constant)	1.836	.694		2.645	.009
NCE	.029	.024	.083	1.195	.233
NCA	.029	.023	.092	1.303	.194
NRM	.024	.021	.092	1.146	.253
NQA	**.035**	**.015**	**.189**	**2.267**	**.024**
NT	.031	.024	.099	1.316	.189
Name of Facility	**-.413**	**.109**	**-.246**	**-3.797**	**.000**
Sex of Respondents	.140	.101	.082	1.380	.169
Age of Respondents	-.003	.014	-.023	-.221	.825
Position/job tittle of Respondents	-.008	.093	-.005	-.082	.935
Number of years served in the facility	.000	.019	.002	.016	.987
Qualification of Respondents	-.070	.092	-.049	-.767	.444
Dependent Variable: How will you rate this overall performance of the Hospital					

Source: Field survey, 2019.

4.8 Qualitative results

4.8.1 Clinical Governance Structures

Generally, all the hospitals had some clinical governance structures in place that shape all their procedures but with some variations.

4.8.2 Clinical Effectiveness

The focus on this theme was to find out the state of clinical effectiveness within the two hospitals. The results revealed that Pantang Psychiatric Hospital had some effective standards in place that enables interventions to thrive in the hospital. According to a management member:

> *"We have protocols that we work with. Periodically, we audit the effectiveness of these protocols to see whether it's giving us the needed results. An example is, about two years ago, we audited all the recorded incidents on the ward, to look at how they are recorded, who is recording them, content of it, interventions taken and also what kind of incidence are being recorded to see if we needed to put in an intervention to make sure that it does not recur. And even if it does, we record it in a manner that is accepted standardized and then the interventions are properly laid out for everybody to understand"* (**Management Member, PPH)**.

However, on the part of Accra Psychiatric Hospital, though it has clinical effectiveness as one of the pillars of clinical governance in place, the hospital was yet to developed its own standards to ensure clinical intervention thrives in within the facility but relies on other existing ones such as Standard Treatment Guidelines. For instance, one of the interviewees stated that;

> "*We don't have written down protocols yet. Those ones are being worked on but everybody here knows what we do in an emergency situation, yes so, we have such guidelines but not written down specifically for the hospital. We use the protocols made available to us by the government so we have the Standard Treatment Guidelines which we use*" (**Management Member**, **APH).**

In addition, it was found that, both hospitals had systems in place to ensure that clinical services produce the desired results, are delivered on time, and through the accepted method.

> "*When it comes to people coming for reviews, they just have to come to the consulting room where they were seen and then it's the consulting room that gets them their folder, their BP, everything is checked in the consulting room and then they see a prescriber. So that was meant to cut down wait time instead of all of them going to congregate at the records to pick folders and you just go straight to your consulting room and there's a recorder attached to most of these consulting rooms*" (**Management Member**, **APH).**
>
> *"We conduct a customer satisfaction survey that looks at customers or service users give us their impression of our service delivery and whether they are satisfied with the waiting time and all that are used as measures of assessing our service, whether it's progressing positively or we are – and so we compare year on year to see where we are, whether we are falling behind or we are same or we are doing well"* (**Management Member**, **PPH).**

4.8.3 Quality Assurance

The results from the study revealed that both hospitals had systems in place to ensure that the concept of quality assurance is achieved. For instance, it was found from the interview that both hospitals had quality improvement units headed by a quality improvement manager with the responsibility of dealing with all issues concerning quality improvement activities within the hospitals. The quality improvement unit is mandated to coordinate all matters concerning planning, monitoring, evaluation and developing quality indicators for the various units within the hospitals.

> "*So, we have a Quality Improvement unit with a head and an office. We have a checklist that we go by. And indeed year in, year out, we conduct a customer satisfaction survey that looks at customers or service users give us their impression of our service delivery and whether they are satisfied with the waiting time and all that are used as measures of assessing our service, whether it's progressing positively or we are – and so we compare year on year to see where we are, whether we are falling behind or we are same or we are doing well",* **(Management Member**, **PPH).**

> "*There are indicators that are monitored. So, first of all, we have a unit that monitors those indicators. We have established those indicators for the various units which this unit as I mentioned monitors. We do that review I think every 6 months, to see how progress is being made"*- (**Management Member, APH).**

It was further revealed that; each unit has a supervisor who ensures that all clinical activities are performed in accordance with laid down procedures. It was also found that there were regular meetings of all clinical staff to discuss issues concerning clinical services. In the case of Pantang Psychiatric Hospital, there are clinical meetings every morning from Monday to Friday. However, Accra Psychiatric Hospital only meets on Tuesday and Wednesday mornings.

> "*We have morning meetings or clinical meetings in this hospital twice a week, Tuesday mornings and Wednesday mornings* and also we have instituted health screening for our staff (**Management Member**, **APH).**

The study further established that the participants were of the opinion that, these procedures will enhance their quest to achieving the objectives of their facilities hence leading to the attainment of effective clinical governance at their facility level.

> "*I remember when it was started about three years ago there were certain things, we were doing routinely but waiting period we were not documenting. So now we are conscious of making sure that we document everything that we do. And there are some processes that were not standardized. So, every unit has its own – so maybe it will vary from clinician to clinician. But now we are trying to standardize all these and document them and make it a part of what we do day by day. And if I look at the scores or the ratings, three before last year and what was done, at least we are doing better than before*". **Management Member**, **PPH.**

"*Based on the response from the staff and then the patients through surveys maybe this year, next year we repeat some of the questions, the key areas, those that the patients raised concerns. So, we then compare the data and then you see whether there is an improvement or not, then we try to improve on areas where we seem not to be doing better*", **Management Member**, **APH**.

4.8.4 Research and Development

It was found that both hospitals had some form of research and developmental programs in place. For instance, a management member stated;

"*Indeed, as part of our mandate as an institution, research is part of what we do. We have a research committee that takes on itself, developing the research agenda of the institution. We've sponsored some person from the committee to go for external training and then they come back to re-train other members of the committee"*- **(Management Member**, **PPH).**

"The hospital also ensures that before you practice, at the beginning of the year, everybody has been registered and we know that, at least for MDC, you need to have attended a certain number of hours of CPDs before you can register. In addition to that, we have morning meetings or clinical meetings in this hospital twice a week, Tuesday mornings and Wednesday mornings clinicians update their knowledge on new emerging cases and so these are all forms of teachings even accredited by MDC for registering" **(Management Member**, **APH).**

However, both hospitals did not have any knowledge pool or database that easily serves as reference material to clinicians. They mostly depend on the use of internet, treatment guidelines and the facility library. Both hospitals had desktop computers in most of the units which are most at times connected to the internet for the clinicians to use.

4.8.5 Clinical Audit

The study found that clinical audit was a normal practice within the two hospitals.

> *"So, the audits are in various parts, there is an internal audit, one we just finished about a week ago. Then there is the inter-institutional audit. So, our mother agency, the Mental Health Authority every year, comes around with a team to do these same activities as we have done internally with persons from sometimes outside the facility. Yes, we are all outside the facility to give an objective account of how we are doing. And then also, as part of the work of drug and therapeutic committee, they also do a form of auditing where they audit our prescription patterns, certain key indicators that are necessary for improved care of our clients. So those are various things that we do"*- **(Management Member, PPH).**

However, it was further found that, in Accra Psychiatric Hospital, some level of clinical audit activities was in place but most of them were not routinely done. The level of staff participation in evaluation processes was also found below.

> *"The clinical audits, we don't really but we have peer review. We have internal peer review which we do twice a year. The first one will be done in July, then the second one will be done in December. And then apart from that, we have external peer review. But*

then you know the peer review is not just for the clinical aspect, it's for the whole hospital, in addition to the other departments"- **(Management Member, APH).**

4.8.6 Risk Management

The results showed that to some extent the two-hospitals had instituted measures within the facilities to identify and prevents risks to staff and patients. It was further revealed that systems were in place at these facilities to ensure the safety of both clients and staff. However, there were variations in the effectiveness of the two hospitals.

"*We believe in a preventive approach and not putting in measures when events occur. So, we have protocols on aggression management and we emphasize being able to detect even before it happens. So recently we had a refresher training for our prescribers, we've had one for the nurses at the OPD and we do that periodically to ensure that everybody is abreast with the protocols that we work with. Apart from that, we ensure that we create a conducive environment with the needed tools and resources to work. There are incident books in each unit, the OPDs, the wards, and they all collated at the nursing directorate and they are reported periodically"*. **(Management Member, PPH).**

However, clinical risk management activities at Accra Psychiatric Hospital seemed not to be very effective. There was a lack of proper protocols and standards available. It was revealed that the hospital was developing most of their protocols which would serve as a guide to staff and patients' safety.

"*All our protocols are now being developed, unfortunately. But yes. I mean, for instance, there is some sort of besides we don't consult alone, there is always a nurse with a doctor in the consulting room, should something happen to you while attending to a patient, we know – the steps to take to get redress are clearly spelt out. So, if you are looking for a document, no. we don't have a document*" – (**Management Member**, **APH)**.

4.8.7 Education and Training

With regards to education and training, it was found that the two hospitals had some programs in place to help staff update their knowledge and skills in their area of specialization. It was also revealed that both hospitals had an in-service training unit that sought to constantly train and orient clinical staff on new trends in treatment procedures. The in-service training unit also conducts regular training needs assessment to identify areas where staff need support and then organizes training for them.

"*So, as part of our HR policy, we offer support for education or self-development. So, when you have gone through the process, you are due, and you are given study leave for further training and all that"*- **Management Member, PPH.**

"*We go by the policy that has been drawn by the Mental Health Authority to guide us. we have priority areas the staff are advised to select. and if you do qualify then we can recommend for you to go on the study leave with pay. Of course, you know there are various categories: the full leave with pay, the sandwich, the weekend and then the evening"- Human* **(Management Member, PPH).**

It was further revealed that the two hospitals had educational opportunities for all their staff and the procedures for selecting staff for further studies and other programs were all made known to every clinical staff.

> "*Well, we depend on MHA for directions when it comes to those things and according to MHA, there are criteria for who can qualify for further studies and who can't. Once you qualify, you apply and go and do further training*"- (**Management Member, AHP).**
>
> *"Aright so Mental Health Authority has an HR capacity building policy that they have outlined all the criteria for qualifying for study leave with pay or without pay, reasons why you should-maybe you may be denied and avenues for you seek redress if you think that you have a challenge with the process"* (**Management Member, PPH).**

4.9 Clinical Governance Implementation Strategies

It was found that the main strategies mostly used in the implementation of clinical governance activities in the two hospitals were teamwork, protocols, committees, communication, ownership or participation of all staff, good leadership and auditing of all activities at the hospital. But there were some variations based on the facility type. In terms of teamwork, it was found that both hospitals had measures to promote teamwork which then serves as a strategy for the implementation of clinical governance activities.

> "*One means of ensuring that we offer the best care, that we have developed is what we call the Multi-Disciplinary Team approach to care. So, during our rounds, it's not just the clinical team, we have other players in mental health joining to bring their expertise on board"* **(Management Member**, **PPH).**

"*As part of the governance structure, I can mention we have quality control team or quality assurance team which periodically, they also have their plans and periodically, they go to the field to assess the service delivery, assess the waiting time of clients, make sure that resources are always available, identify the weaknesses in the service delivery or the gaps in the service delivery and make a report to management for the necessary actions",* **(Management Member**, **APH)**.

It was also found that protocols played a major role in clinical governance implementation especially in Pantang Psychiatric Hospital. Most of their activities were governed by laid down protocols and procedures.

"*We have protocols that we work with. Periodically, we audit the effectiveness of these protocols to see whether it's giving us the needed results. An example is, about two years ago, we audited all the recorded incidents on the ward, to look at how they are recorded, who is recording them, content of it, interventions taken and also what kind of incidence are being recorded to see if we needed to put in an intervention to make sure that it does not recur. And even if it does, we record it in a manner that is accepted, standardized and then the interventions are properly laid out for everybody to understand"*- **(Management Member, PPH).**

However, although Accra Psychiatric Hospital had some protocols for implementing clinical governance structures, most of the protocols were yet to be developed.

> *"We don't have written down protocols yet. Those ones are being worked on. We use the protocols made available to us by the government so we have the Standard Treatment Guidelines"*- **(Management Member, APH)**.

With regards to standing committees, it was revealed that both facilities had committees responsible for the implementation of clinical governance activities.

> *"We have a protocol committee who also periodically they draw their own programs and I think every quarter or so, they are supposed to submit a report to management. So, they also go to the field. They ensure that the protocols that have been drawn, are being adhered to by service providers, that is those on grounds. So, we have measures that we've put in place to ensure that protocols have been adhered to. We also hospital management committee, there is accommodation committee, there is a food committee but we are yet to actually put together the disciplinary committee*"- (**Management Member**, **APH)**.

> *"We work with either committees or teams and also part of the peer review checklist, the HR office is audited and they look at the processes you go through to – you give award to study for certain staff and then also promotions will also come under that as well"*- **(Management Member, PPH).**

4.10 Clinical Governance Implementation Challenges

From the interview with the participants, it was found that the two hospitals faced major challenges that hindered the effective implementation of clinical governance activities.

> *"Our major challenges I'm sure everybody has heard about it. One of them is financing and human resource, getting the right human resource mix. Another is resources and indeed it all boils down to finance. The other challenge has to do with stigma. There are instances where somebody is posted to this institution, because of it being a psychiatric institution predominantly, some people may refuse posting. We wait for them, they never show up, we contact them, they find places elsewhere"*- **(Management Member**, **PPH).**

> *"The level of funding for the institution. the funding is inadequate and the responsibilities enormous. We have about 300 patients on admission which have to be fed, clothed, accommodated and in some cases, we do everything including brushing of the teeth and for the shortage of drugs it's even nationwide it's not only here, it's nationwide. Psychiatry drugs are not available. In fact, what we get is very, very inadequate. So, it's a major problem, it's a big, big problem. the shortage of medicines, the psychotropic medicines. And then the working environment is not very conducive. I mean, this is a 113-year-old hospital. Maintenance has not been that sustained. So largely because it is the first region, funding is not enough and major renovation of the facility has not taken place for a very long time"*- **(Management Member, APH).**

4.11 Discussion of findings

4.11.1 Demographic Characteristics of Respondents

The study found that females constituted the majority of respondents. This finding does not come as a surprise because anecdotal evidence indicates that female nurses are always more than male nurses. It was therefore expected that female nurses would be more than male nurses. It was also found that the ages of the respondents range from 21 through to above 40 years. The study further found that the years of experience of the workers varied from one year to above nine years. The least year experience was one year and the maximum years of experience were above 9 years. In all, sixteen (16) medical doctors, one hundred and seventy-nine (179) nurses, thirty-three (33) physician assistants and two medical laboratory assistants participated in the study.

4.11.2 Clinical Governance Structures

Evidence indicates that the success or otherwise of the clinical governance system depends to a large extent of having effective structures in place that serve as catalysts to quality healthcare outcomes (Nmai et al., 2015). According to the results of the study, reflects that for effective clinical governance to exist and influence performance of hospitals, Clinical Effectiveness, Clinical Audit, Risk Management, Quality Assurance, Research and Development, and Education and Training are very important.

Clinical effectiveness as one of the pillars of clinical governance is about striving to ensure that the practice is based on the best available data and evidence to which clinical standards and safety have been achieved. The two hospitals had an appreciable level of clinical effectiveness activities in place. For instance, it was realised that Pantang Hospital had protocols that they work with and periodically, they audit the effectiveness of these protocols to see whether it is giving them the needed results or not. This finding is consistent with the position of Weisleder, (2015), which suggests that measuring clinical effectiveness requires the existence of standards and policies which must comply with existing national standards.

However, on the part of Accra Psychiatric Hospital, though it has clinical effectiveness as one of the pillars of clinical governance in place, the hospital was yet to develop most of its own standards to ensure clinical intervention thrives within the facility. Nonetheless, the hospital relies on other existing ones such as Standard Treatment Guidelines. For clinical services to be effective, the services must be provided timely, with the appropriate methods, at the precise place and must have the purpose of producing accurate outcomes. Again, it was found that both facilities have systems in place to ensure that clinical services produce the desired results, are delivered on time and through the accepted method.

Clinical audit as a dimension of clinical governance has to do with the process of improving quality the quality of services provided by hospitals. It comprises evaluating a clinical result or process against well-defined norms, based on evidence-based medicine principles. The comparison of clinical practice and norms contributes to strategies for improving the quality of daily care. In this study, it was found that the two hospitals had some clinical audit activities that were used to

evaluate all clinical activities. For example, the two hospitals had both internal and external peer-reviews activities. This finding is consistent with the position held by Abor, (2015), who argued that the aim of the audit process is to ensure that clinical practice is continuously monitored and that deficiencies in relation to set standards of care are remedied.

In the study, less than half of the respondents stated that the current system was to prevent misuse and leakages within the hospitals. The majority of the respondents stated that staff were mostly involved in the evaluation of clinical activities. These findings are consistent with the literature. Studies have found that a unique feature of clinical audit is the initiative's "professionalism," demonstrated by some typical components such as participants' clinical competence, the confidentiality of the outcomes and the object highly linked to the "quality" of practitioners (Abor, 2015; Esposito & Dal Canton, 2014; Merali et al., 2014).

Quality assurance is a key dimension of clinical governance. The study found that the two hospitals had systems in place to ensure that the concept of quality assurance is achieved. For instance, the study showed that the two hospitals had quality improvement units headed by a quality improvement coordinator (QIC) with the responsibility of handling issues that had to do with quality improvement within the hospitals. The quality improvement (assurance) unit is mandated to coordinate all programs concerning planning, monitoring, evaluation and development of quality indicators for all the various units within the hospitals. The study further revealed that both hospitals had instituted client satisfaction surveys for both clients and staff. However, the study found that staff and clients did not have access to most of these reports. These findings are

consistent with studies by Al-Mandhari et al. (2014), Mohammad Mosadeghrad (2013), (Guirguis & Lee, 2012) and Laubscher (2008).

Additionally, it was found that quality assurance activities at Accra Psychiatric hospital were not as effective as the majority of respondents at the hospital rated quality assurance activities at the hospital as 'Low'. Also, the majority of the respondents from the two hospitals stated that hospitals did not have adequate strategies to enhance and protect the safety of staff. With regards to medication safety, the results of the study show that staff were regularly trained and updated on issues regarding medication safety even though the two hospitals had what was termed morning meetings where issues concerning clinical cases and medication were discussed. For instance, at Pantang Psychiatric Hospital, there were clinical meetings every morning, from had Monday to Friday and Accra Psychiatric Hospital meets on Tuesday and Wednesday mornings. These findings are consistent to findings of (Gomes et al., 2010) which found that hospitals are becoming increasingly aware of the need to tailor services and service performance to meet the emerging needs of increasingly sophisticated patients and competitive pressures. Hence In healthcare operational settings, monitoring, tracking and enhancing service quality, availability and efficiency are becoming more critical than ever.

Risk management is a major dimension of clinical governance. Clinical risk and may be specific to the patient, the practitioner or provider organization. Most of these risks are life-threatening and disastrous making risk minimization very important in the delivery of healthcare (Wennberg, 2006). Risk management can be achieved by having an effective system in place that can easily identify and reduce the occurrence of potential risk and the evaluation of adverse events (errors)

to establish causative factors and assess how the risk is within and across the service or adhering to already existing standards and policies. Per the study, the majority of respondents stated that the two hospitals had effective systems to address clinical risk when identified them. For example, more than half of the respondents stated that incident registers were always provided at all the units within the two hospitals. Also, majority of the respondents were of the thought that the hospitals had systems that promote organizational learning, thus learning from the mistake. Furthermore, the study revealed that clinical risk management activities at Accra Psychiatric

The hospital seemed not to be very effective. There was a lack of proper protocols and standards available. It was revealed that the hospital was now developing most of its protocols which would serve as a guide to staff and patients' safety. This finding was contradictory to previous studies by (DiCenso, Guyatt, & Ciliska, 2014) which found that clinical risk management could be achieved when providers are made to at all times ensure high-quality employment practice, adherence to standards or regulations of professional bodies, and designing high-quality policies

Research and development as one of the dimensions of clinical governance is very crucial due to the fact that programs, activities, skills, facilities and processes become outdated as new health problems arise and therefore health organizations must be current to be able to face these problems head-on (Chourabi et al., 2012; Kapur, 2009). The findings revealed that in order to keep abreast with time, the two hospitals had a research and development program in place for staff. Also, some of the respondents stated instances where some of them had been allowed to go and further their education to develop themselves in their respective fields and later came back to apply their new knowledge.

However, the study further saw that more than half of the respondents stating that management did not provide enough opportunities for staff to make good use of the skills acquired through training. Also, the majority of respondents stated there was no database of information for staff to access and enhance their work and this may to some extent affect the output of staff. Pantang Psychiatric Hospital was in the process of securing a deal with University of Ghana Balm Library to allow clinical staff of the hospital to access the off-campus library for clinical staff to easily access some clinical online materials. Pantang Psychiatric hospital had also initiated the process to have all desktop computers in consulting rooms and OPDs connected to the internet for ease of work and for research purposes.

However, it was not the same in the case of Accra Psychiatric Hospital. Even though most consulting rooms had desktop computers, they were yet to be connected to the internet for use by staff. These findings are in contradictory to previous studies by (Duffy, 2018; Wennberg, 2006; White et al., 2011), which established that, in order to maintain current standards in quality healthcare, health practitioners and management must focus their attention on specific areas such as sound project management, development of guidelines and protocols as well as implementation strategies that can serve as catalysts to effective clinical governance system leading to more transparent and accountable health care systems. Without research and development, programs and processes of health organizations would remain stagnant, which would impede the progress of ensuring quality in practice.

Education and training are another dimension of clinical governance which has to do with the acquisition of knowledge and skills. This is crucial to medical practice and the delivery of medical care. The study found that the two facilities had programs in place to help staff update the knowledge and skills in their field of specialization. For instance, the study found that the two hospitals had an in-service training unit that sought to constantly train and orient clinical staff on new trends in treatment procedures. The in-service unit also conducts regular training needs assessment to identify areas where staff need support and then organizes training for staff. that the research revealed that performance appraisal was mostly used to identify the training needs of staff.

For instance, in the study when the appraisal is conducted, management look at the dominant areas where staff were mostly performing poorly, then internal workshops and training were organized for staff on those specific areas. The two hospitals had educational opportunities for all staff and the procedures for selecting staff for further studies and other programs were made known to every clinical staff. These findings are consistent with the findings of Bhattarai (2015). The study argued that it was important for management to put structures in place to encourage and support professional development for the diverse professionals in the workplace. For example, facilitating staff registration with regulatory bodies, postgraduate education allowances, sponsored Continuous Professional Development for staff, Study Leave with or without pay, and other related packages can all be promoted at the facility level to keep professionals abreast with scientific and medical developments.

4.11.3 Clinical Governance Implementation Strategies

According to the study, the main strategies mostly used in the implementation of clinical governance activities in the two hospitals were teamwork, protocols, committees, communication, ownership or participation of all staff, good leadership and auditing of all activities at the hospital. However, there were some variations based on the facility type. In terms of teamwork. Per the study, the two hospitals had measures to promote teamwork which then serves as a strategy for the implementation of clinical governance activities.

Furthermore, protocols played a major role in clinical governance implementation, especially at the Pantang Psychiatric Hospital. Most of their activities were governed by laid down protocols and procedures. However, although the Accra Psychiatric Hospital had some protocols for implementing clinical governance structures, most of the protocols were yet to be developed. With regards to standing committees, it was revealed that both facilities had committees responsible for the implementation of clinical governance activities. These findings are consistent with Olsen et al. (2011).

4.11.4 Clinical Governance Implementation Challenges

From the interviews, the two hospitals faced major challenges that hindered the effective implementation of clinical governance activities. These challenges included infrastructural deficit, inadequate accommodation for staff, obsolete equipment and shortage of psychiatry drugs which were all in connection to implementing clinical governance activities. For example, respondents stated that when it came to human resource, their nursing department is in dire need of male nurses in order to augment staff strength. Furthermore, the level of funding for the two hospitals was

inadequate. The other challenge the study found had to do with stigma. According to the respondents, there were instances where personnel posted to these hospitals would not because they were predominantly psychiatric institutions. These findings are consistent with (Dehnavieh et al., 2013; Walshe et al., 2003).

4.11.5 Association between clinical governance and health workers perception of hospital performance

The efficient and effective discharge of health service is influenced by institutional structures and designs. The study showed that clinical governance was considerably associated with hospital performance. Also, there was a statistically significant difference between the means of the two hospitals in terms of clinical effectiveness, risk management and quality assurance. However, concerning a clinical audit, research and development, and education and training, no statistically significant difference was found between the means of the two hospitals.

According to the study, there was a statistically significant association between clinical governance dimensions and hospital status. For example, a statistically significant association was found between four clinical governance dimensions (clinical effectiveness, clinical audit, risk management and quality assurance) and hospital status. However, no statistically significant association was found between research and development, and training was independent of hospital status.

The study further found a positive association between clinical governance dimensions and overall performance of the hospitals. This, therefore, was an indication that clinical governance was positively associated with performance at the two hospitals. These findings are consistent with previous studies. For instance, there is evidence to show that clinical governance is associated with hospital performance (Nmai et al., 2015). The presence of clinical governance ensures the discharge of quality health care, standard clinical practice and improved performance of the healthcare institution (Maben, Morrow, Ball, Robert, & Griffiths, 2012; Nmai et al., 2015).

4.12 Chapter summary

This chapter presents the results and discussion of findings. In summary, there was a significant association between clinical governance and health workers' perception of hospital performance. There were effective implementation strategies in place at the two facilities to ensure that clinical governance activities thrive in the two hospitals. However, there are some variations in the clinical governance structures between the two hospitals.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

The chapter comprises the summary, conclusion and recommendations of the study. Exploring clinical governance structures, examining the implementation approaches and finding the association between clinical governance and health workers perception of hospital performance at the two Psychiatric hospitals were the objectives of the study.

5.1 Summary of findings

The main purpose of the study was to assess clinical governance and health workers perception of hospital performance in psychiatric hospitals in Ghana. The qualitative and quantitative research approaches and comparative research design were adopted for the study. Pantang Psychiatric hospital and Accra Psychiatric hospital were the study areas from which a total of two hundred and thirty respondents were selected for the study. Purposive and convenience sampling techniques were employed in selecting the respondents and the facilities for the study.

An interview guide and questionnaire were used to collect data for the study. Data collected was analyzed using Statistical Package for Social Scientist (SPSS) version 20.0 and Thematic analysis. The study found clinical effectiveness, clinical audit, risk management, quality assurance, research and development, and education and training as the main clinical governance structures at the two hospitals. The study also found these dimensions as factors the influence the performance of the two hospitals. The study found clinical effectiveness, clinical audit, risk management, quality

assurance, research and development, and education and training as the main clinical governance structures at the two hospitals.

The study also found a statistically significant difference between the means of the two hospitals in terms of clinical effectiveness, risk management and quality assurance. The study further found a statistically significant association between clinical governance dimensions and type of facility. A statistically significant association was found between clinical effectiveness, clinical audit, risk management, quality assurance and type of facility. However, the results of the study show that in terms of research and development the Pantang Psychiatric hospital was performing poorly. Accra Psychiatric hospital, on the other hand, had effective measures in place for risk management, quality assurance, and research development. Again, there was a positive significant association between clinical governance dimensions and health workers perception of hospital performance.

Additionally, that the study showed that the main strategies mostly used in the implementation of clinical governance activities in the two hospitals were teamwork, protocols, committees, communication, ownership or participation of all staff, good leadership and auditing of all activities at the hospital. However, Accra Psychiatric hospital was yet to develop most of its protocols and this delay was perceived to be hampering the effective implementation of most of the clinical governance dimensions at the hospital. Also, the study revealed that infrastructural deficit, inadequate funding, inadequate accommodation for staff, obsolete equipment, stigma, inadequate human resource base and shortage of psychiatric drugs were some of the major challenges facing the two hospitals in implementing clinical governance activities.

5.2 Conclusion

The result of this study shows that respondents perceived the performance of the two hospitals to be fairly good because the clinical governance structures though were available yet were not effectively implemented. A positive association between clinical governance and health workers perception of the performance of the two hospitals was also established in this study. However, infrastructural deficit, inadequate funding, inadequate accommodation for staff, obsolete equipment, stigma, inadequate human resource base and shortage of psychiatry drugs were discovered as some of the major challenges facing the two hospitals in implementing clinical governance activities.

5.3 Recommendation

Based on the findings of this study,

These are the recommendations based on the study:

- Management of Pantang Hospital should put measures in place to enhance research and development activities at the facility as this will be the surest way to improve on the quality of services provider render to client. Thus, leading to effective clinical governance activities at the hospital which then affects the performance of the facility.
- Management of Accra Psychiatric Hospital should put in place an effective management system to enhance risk management, quality assurance and, research and development activities at the facility. This will help establish an effective clinical governance system thus enhancing the performance of the hospital

- The Mental Health Authority and the Ministry of Health should put in place proper management systems to effectively monitor and evaluate clinical governance activities at the Psychiatric hospitals.
- Stakeholders such as Government of Ghana (Ministry of Health), NGOs, Donor partners and many others should increase their support towards psychiatric hospitals in Ghana to help mitigate the numerous challenges faced by these facilities.

5.4 Contributions of the study

Knowledge: the study has contributed knowledge to clinical governance and performance of psychiatric hospitals in Ghana. Currently, there exists little literature on clinical governance and health workers perception of hospital performance in Ghana. Therefore, the findings of this study add to the little existing ones and also serves as reference material for further studies on clinical governance and hospital performance at the psychiatry hospitals in Ghana.

Policy: The study also calls for an insight into the analysis of a policy for clinical governance especially for psychiatric hospitals. For example, the findings of the study could help agencies such as Mental Health Authority, Ghana Health Service and Ministry of Health to develop appropriate indicators for monitoring clinical governance activities and performance of Psychiatry hospitals in Ghana.

Practice: The study serves as a guide for health service providers to put in place measures that will promote the quality of services they render to clients at the psychiatric hospital. For example, the findings of the study can help healthcare providers at the Psychiatry Hospitals in Ghana to develop tailor service that sought to improve on the quality of services they provide to their clients.

5.5 Limitation of the study

The study was limited to only two Psychiatric hospitals namely, the Accra Psychiatric Hospital and the Pantang Psychiatric Hospital all in the Greater Accra Region and excluded the Ankaful Psychiatric Hospital in Central Region because of their unwillingness to take part in the study. In this regard, the generalization of the study findings must be done with care. Participants continued to cancel appointments due to their busy schedules and this however prolonged the data collection process.

Finally, evaluating the client's viewpoint, understanding their side of the tale concerning the dimensions of clinical governance and how they affect the performance of the hospital would have given the research problem wider knowledge. This research was, however, restricted in this regard, and future studies should, therefore, consider looking at this aspect.

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Appendix

University of Ghana Business School

DEPARTMENT OF PUBLIC ADMINISTRATION AND HEALTH SERVICES

Interview Guide (Management Members)

This interview guide seeks to collect information on ***clinical governance and health workers perception of hospital performance. A case study of psychiatric hospitals in Ghana***. Clinical governance is defined as "the process of steering the overall functioning and effective performance of a hospital by defining its mission, setting objectives and, having them realized at the operational level". Kindly answer the following questions as accurately as possible. The information will not be used for any other purpose than the research for which it is intended**.**

Biographic Information

Sex:

Age:

Position/job title:

Number of years served in this facility:

Level of education:

Clinical governance structures and approaches

Clinical Effectiveness

- Share with me if any, the clinical standards in place to ensure that new interventions and existing ones thrive in your institution?

- What measures do you have in place to ensure a particular clinical service is?
    - Appropriate to give the desired results?
    - Delivered timely or at the right time?
    - Administered using the appropriate method?

Quality Assurance/ Openness

- What quality improvement activities are employed in your facility?
- How effective are these procedures in meeting the objectives of attaining effective clinical governance at your institution?

Research and Development

- ✓ What programs has your institution put in place to ensure continuous professional development (CPD) of staff of your facility?
- ✓ Is there a knowledge pool or database that clinical staff could tap into and how often is this database updated?

Clinical Audit

- ✓ What are some of the clinical standards in place at your facility for structures, processes, procedures and outcome of clinical activities in your institution?
- ✓ Who does the evaluation of these standards and are staff involved in the process?

Risk Management

- ➢ Could you share with me some of the safety policies or measures in place at your facility to enhance patients, staff and equipment safeties?
- ➢ How often does your institution perform any safety audit with regards to the following and how?
    - Financial issues

- Clinical issues
- Operational issues

Education and Training

- Share with me if any, the educational and training packages or programmed in place for service providers by your institution?
- What are the mechanisms for selecting candidates for training?

Implementation Strategies

- Could you share with me measures you have in place to ensure all your strategies are successful?

Challenges

- What are the major challenges faced by your facility in implementing these clinical governance strategies and how were they resolved?

University of Ghana Business School

DEPARTMENT OF PUBLIC ADMINISTRATION AND HEALTH SERVICES

Questionnaire (Clinical staff)

This questionnaire seeks to collect information on ***clinical governance and health workers perception of hospital performance. A case study of psychiatric hospitals in Ghana***. Clinical governance is defined as "the process of steering the overall functioning and effective performance of a hospital by defining its mission, setting objectives and, having them realized at the operational level". Kindly answer the following questions as accurately as possible. The information will not be used for any other purpose than the research for which it is intended**.**

Biographic Information

Sex:

Age:

Position/job title:

Number of years served in this facility:

Qualification: Diploma {} Degree { } Masters { }

SECTION A: CLINICAL GOVERNANCE STRUCTURES AND APPROACHES

Thinking of the part of the hospital where you work, indicate whether you agree or disagree with each of the following statements with regards to these key performance indicators. Please rate all the statements on the 5-point scale by ticking the number that best represents your opinion.

1= Disagree strongly, 2= Disagree, 3= Neither, 4= Agree, 5= Agree strongly

S/N	Clinical Effectiveness	1	2	3	4	5
1	There is an evidence-based approach in the management of patients					
2	The hospital has standards in place to ensure that clinical services are appropriate to give the desired results					
3	Standards in place to ensure clinical services are delivered timely or at the right time.					
4	Standards in place to ensure clinical services are administered using the appropriate method					
	Clinical Audit					
5	There are constant peer review activities at this hospital					
6	Staff are involved in all evaluation processes.					
7	There are regular performance review meetings at this hospital					
8	Adequate system in place to control financial leakages					
	Risk Management					
9	When a clinical risk is identified, there is always action to address it					
10	Incident register is always provided					
11	Systems in place to reduce risks to staff and patients					
12	The system promotes learning lessons from any adverse events					
	Quality Assurance/ Openness					
13	There are lots of quality improvement initiatives					
14	There are measures in place to protect the safety of staff					
15	There is always staff training on medication safety					
16	Adequate measures in place to protect patients/client's safety					
	Research and Development					
17	There is a knowledge pool or database that clinical staff could tap into.					
18	Staff are regularly train on best practices					
19	There are few opportunities to use new skills learned as part of development					
20	The hospital supports staff Continuous Development (CPD) Programs					

	Education and Training					
	Educational and training packages or programs in place for staff					
	Mechanisms for selecting candidates for training are known to all staff					
	Appraisals are done regularly to enhance staff performance					

SECTION B: HOSPITAL PERFORMANCE

Please rate all the statements on the 5-point scale by ticking the number that best represents your opinion.

1= Disagree strongly, 2= Disagree, 3= Neither, 4= Agree, 5= Agree strongly

S/N	**Access**	**1**	**2**	**3**	**4**	**5**
1	Patient waiting time has been reduced to the barest minimum					
2	Staff report for duty on time					
3	We provide services that patients can afford					
	Efficiency					
4	The facility often runs out of essential material needed by staff to work					
5	The hospital generates much revenue but cannot account for it.					
6	There are a lot of financial leakage at this hospital					
7	Inadequate staff strength to meet the increasing demand of patients					
	Effectiveness					
8	Decline in acute inpatient readmission rate					
9	Adequate bed capacity to meet inpatient demand					
10	Adequate accommodation for staff					
11	People are highly motivated to make changes to clinical practice					
	Safety					

12	When a clinical risk is identified, there is always action to address it					
13	When there is an error, we look for failures in systems rather than blame individuals					
14	There is always staff training on medication safety					
15	There always follow up through phone call or face-to-face to ensure adherence to treatment instructions					
	Appropriateness of care					
16	There are always treatment protocols for staff					
17	Staff are regularly train on best practice in mental health care					
18	There are few opportunities to use new skills learned as part of development					
19	There are lots of quality improvement initiatives, but little real change					
	Overall performance					
	How will you rate the overall performance of this hospital					

1= Very poor, 2= Poor, 3= fairly good, 4= Good, 5= Very good

THANK YOU!!

Ethical Clearance

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

Research & Development Division
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MyRef. GHS/RDD/ERC/Admin/App 19/170
Your Ref. No.

6th May, 2019

Joshua Cobby Azilaku
C/O College of Health
P.O. Box 9
Kintampo

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC 086/04/19**
Project Title	Clinical Governance and Hospital Performance. A Comparative Case Study of Psychiatric Hospitals in Ghana
Approval Date	6th May, 2019
Expiry Date	5th May, 2020
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

OUR CORE VALUES:
- Dedication and Excellence
- Partnership
- Professionalism
- Teamwork

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My Ref. No. MHA/APH/C-109

Your Ref. No:

27th May, 2019

DR. PATIENCE ASEWEH ABOR
SENIOR LECTURER/SUPERVISOR
UNIVERSITY OF GHANA BUSINESS SCHOOL
DEPARTMENT OF PUBLIC ADMINISTRATION AND HEALTH SERVICES MANAGEMENT
LEGON

Dear Madam,

RE: LETTER OF INTRODUCTION

Reference is made to your letter dated 9th April, 2018 with reference number PAHS/26 on the subject above.

Management has approved your request for a student under your observation, Mr. Joshua Cobby Azilaku, to undertake his research project with title ***"Exploring the impact of clinical governance on hospital performance"*** in the Hospital.

The Deputy Director (Administration) will supervise this research project and offer him any assistance where necessary. However, he is expected to submit his proposal and questionnaire for our perusal and therefore we look forward to receiving them as he gathers his data. We would also wish to have a copy of the final research.

Thank you.

Dr. Pinaman Appau
Hospital Director

Cc: Mr. Joshua Cobby Azilaku

PANTANG HOSPITAL

OUR CORE VALUES:-
* Recognition of diversity
* Equal treatment
* Confidentiality
* Professionalism
* Compassion
* Teamwork

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15th May, 2019.

My Ref. No: MHA/PH/GF- 10/1915
Your Ref. No: .....

THE DEPT. OF PUBLIC ADMIN AND H/SERV. MGT.
BUSINESS SCHOOL
UNIVERSITY OF GHANA

Dear Patience Aseweh Abor (PhD),

RE: LETTER OF INTRODUCTION: MR. JOSHUA COBBY AZILAKU

Your letter dated 9th April, 2019 with ref. no. PAHS/26 on the above topic refers.

We are glad to inform you that, Mr. Joshua Cobby Azilaku has the permission of our facility to carry out data collection for his research titled: **"Exploring the impact of clinical governance on hospital performance".**

We hope he would implement the ethical considerations outlined in the proposal during collection.

Also, it is expected that he gives the facility a copy of the final work as part of his information dissemination process.

Thank you.

Yours faithfully,

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DR. LEVEANA GYIMAH
CLINICAL COORDINATOR (AG.)

FOR: HOSPITAL DIRECTOR (AG.)
PANTANG HOSPITAL

DR. LEVEANA GYIMAH
AG. CLINICAL COORDINATOR
PANTANG HOSPITAL