Ghana Health Service
Guidelines for the Implementation
of the National Healthcare Quality Strategy

Ghana Health Service, Accra.
September 2019
**TABLE OF CONTENTS**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOREWORD</td>
<td>4</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>5</td>
</tr>
<tr>
<td>ACRONYMS</td>
<td>6</td>
</tr>
<tr>
<td><strong>1.0 BACKGROUND</strong></td>
<td>7</td>
</tr>
<tr>
<td><strong>2.0 GHS APPROACH TO QUALITY MANAGEMENT</strong></td>
<td>7</td>
</tr>
<tr>
<td><strong>3.0 GOVERNANCE STRUCTURE FOR QUALITY MANAGEMENT</strong></td>
<td>8</td>
</tr>
<tr>
<td>3.1 National-Level Structure for Quality Management</td>
<td>8</td>
</tr>
<tr>
<td>3.2 Regional-Level Structure for Quality Management</td>
<td>9</td>
</tr>
<tr>
<td>3.3 District-Level Structure for Quality Management</td>
<td>9</td>
</tr>
<tr>
<td>3.4 Sub-District-Level Structure for Quality Management</td>
<td>10</td>
</tr>
<tr>
<td>3.5 Community-Level Structure for Quality Management</td>
<td>10</td>
</tr>
<tr>
<td>3.6 Facility-Level Structure for Quality Management</td>
<td>10</td>
</tr>
<tr>
<td>3.6.1 Hospitals</td>
<td>10</td>
</tr>
<tr>
<td>3.6.2 Smaller Facilities</td>
<td>11</td>
</tr>
<tr>
<td>3.7 Organograms</td>
<td>11</td>
</tr>
<tr>
<td><strong>4.0 QUALITY MANAGEMENT ROLES AND RESPONSIBILITIES BY LEVEL</strong></td>
<td>11</td>
</tr>
<tr>
<td>4.1 National Level</td>
<td>11</td>
</tr>
<tr>
<td>4.1.1 Role</td>
<td>11</td>
</tr>
<tr>
<td>4.1.2 Responsibilities</td>
<td>11</td>
</tr>
<tr>
<td>4.2 Regional Level</td>
<td>12</td>
</tr>
<tr>
<td>4.2.1 Role</td>
<td>12</td>
</tr>
<tr>
<td>4.2.2 Responsibilities</td>
<td>12</td>
</tr>
<tr>
<td>4.3 District Level</td>
<td>13</td>
</tr>
<tr>
<td>4.3.1 Role</td>
<td>13</td>
</tr>
<tr>
<td>4.3.2 Responsibilities</td>
<td>13</td>
</tr>
<tr>
<td>4.4 Sub-District Level</td>
<td>14</td>
</tr>
<tr>
<td>4.4.1 Role and Responsibilities</td>
<td>14</td>
</tr>
<tr>
<td>4.5 Community Level</td>
<td>14</td>
</tr>
<tr>
<td>4.5.1 Role and Responsibilities</td>
<td>14</td>
</tr>
<tr>
<td>4.6 Facility Level</td>
<td>14</td>
</tr>
<tr>
<td><strong>5.0 NHQS IMPLEMENTATION FRAMEWORK</strong></td>
<td>14</td>
</tr>
<tr>
<td>Strategy 1: Establish quality structures at all levels</td>
<td>16</td>
</tr>
<tr>
<td>Strategy 2: Develop and implement a uniform national policy on data reporting and data use</td>
<td>17</td>
</tr>
<tr>
<td>Strategy 3: Improve patient safety, client satisfaction and the participation of patients and the community</td>
<td>18</td>
</tr>
</tbody>
</table>
Strategy 4: Improve the quality culture among health workers ............................................................. 19
Strategy 5: Create the “joy at work” environment ................................................................................. 21
Strategy 6: Rank facilities and agencies in league tables for awards .................................................. 22
Strategy 7: Improve supportive supervision and monitoring ................................................................. 23

6.0 ACCOUNTABILITY ......................................................................................................................... 25
  6.1 Performance Management System ............................................................................................... 25
  6.2 Routine Reports ............................................................................................................................ 25
  6.3 Periodic Performance Reviews .................................................................................................... 25
  6.4 Peer Review ............................................................................................................................... 25
  6.5 Community Engagement / Community Scorecard ..................................................................... 25
  6.6 Annual Quality Conference ........................................................................................................ 26
  6.7 Monitoring and Evaluation ......................................................................................................... 26

7.0 SUSTAINABILITY ......................................................................................................................... 26
  7.1 Governance and Leadership ....................................................................................................... 26
  7.2 Continuous Improvement ............................................................................................................ 27
  7.3 Stakeholder Engagement ........................................................................................................... 27

APPENDICES .................................................................................................................................. 28
  Appendix 1: Sample Appointment Letter for Quality and Safety Managers ........................................ 28
  Appendix 2: National-Level Quality and Safety Coordinating Organogram ...................................... 30
  Appendix 3: Regional-Level Quality and Safety Coordinating Organogram ...................................... 31
  Appendix 4: District-Level Quality and Safety Coordinating Organogram ........................................ 32
  Appendix 5: Regional Hospital Quality and Safety Coordinating Organogram .................................. 33
  Appendix 6: District Hospital Quality and Safety Coordinating Organogram ...................................... 34
  Appendix 7: Polyclinic, Health Centre / Maternity Home Quality and Safety Organogram ............... 35
  Appendix 8: Summary of the Ghana Health Service Quality and Safety Management Organogram ....... 36
FOREWORD

The Ghana Health Service (GHS) is not a novice in the management of healthcare quality. The Service had experimented with quality assurance and quality improvement initiatives until it launched two formal pilots in the mid-1990s — one in the Upper West Region supported by DANIDA, and the other in the Eastern Region supported by the Liverpool School of Tropical Medicine. Quality was mainstreamed in the mid-2000s with the setting up of a Quality Assurance (QA) Department in the Institutional Care Division of the Ghana Health Service (GHS). Since then GHS has pioneered a number of innovative initiatives in quality management. At the same time several organisations, notably development partners have experimented with quality initiatives, sometimes in an uncoordinated manner with the result that the average health worker was bombarded with varied terminologies and dissimilar reporting requirements, thereby adding to their workload.

The GHS therefore collaborated with the Ministry of Health and other agencies to develop the National Healthcare Quality Strategy for 2017-2021 (NHQS), which is an attempt to harvest lessons learned from past quality initiatives. The strategy seeks to harmonise quality planning, assurance and improvement approaches to achieve better health outcomes with the patient and the community at the centre of quality service provision. The NHQS is certainly not the first national strategy known by the GHS; the first national strategy was developed as far back as 2002. The difference however, is that the NHQS is the strategy for all agencies in the health sector.

In response to NHQS requirements, these guidelines outline the roles of the various levels and seeks to build quality structures upon existing GHS structures. The idea is that quality should permeate all activities at all levels. The guidelines also defines a framework for delivering the strategic objectives of the NHQS and identifies accountability and sustainability mechanisms. The document is designed to be still relevant even after the year 2021 in the implementation of quality systems within the Ghana Health Service. Ghana Health Service shall strive to achieve better health outcomes, more coordinated quality systems and improved client and staff satisfaction by implementing these Guidelines.

With the National Health Quality Strategy and Ghana Health Service Guidelines for the implementation of the NHQS, the expectation is that no conflicting quality management approaches shall be implemented anywhere within the Ghana Health Service by any organisation or development partner without the express approval of the Director General of Ghana–Health Service.

Dr. Anthony Nsiah-Asare
Director General, Ghana Health Service

31st August, 2019
ACKNOWLEDGEMENTS

The Ghana Health Service thanks the Quality Assurance Department for leading the process to develop the Guidelines for the implementation of the National Healthcare Quality Strategy (NHQS). The Service also wishes to thank the following individuals for their contributions to these guidelines and to improving quality in the healthcare delivered to the people of Ghana.

<p>| 1. Dr Nicholas A. Tweneboa | Consultant |
| 2. Dr Samuel Kaba Akoriyea | Director – Institutional Care Division | HQ |
| 3. Dr (Mrs) Mary Eyram Ashinyo | Deputy Director – Quality Assurance | HQ |
| 4. Marni Laverentz | USAID Systems for Health |
| 5. Kathryn Fleming | USAID Systems for Health |
| 6. Isaac Amenga-Etego | USAID Systems for Health |
| 7. Dr Ernest Asiedu | Quality Management Unit – Ministry of Health |
| 8. Dr Cynthia Sottie | Deputy Director – Mental Health | HQ |
| 9. Dr Kwabenya Boateng Boakye | Deputy Director – Clinical Information Monitoring | HQ |
| 10. Dr Lawrence Ofori Boadu | Deputy Director – Clinical Services Development | HQ |
| 11. Theresa Sekoh | Administrator – Institutional Care Division | HQ |
| 12. Gifty Nagai | Administrator – Institutional Care Division | HQ |
| 13. Dr Fred Adomako-Boateng | DDCC – Ashanti Region |
| 14. Dr Kofi Amo-Kodieh | DDCC – Bono, Bono East and Ahafo Regions |
| 15. Dr Abdul Razak | DDCC – Upper East Region |
| 16. Dr Atsu Dodor | DDCC – Western Region |
| 17. Dr Emmanuel Amoah | DDCC – Eastern Region |
| 18. Robert Adatai | DDCC – Volta Region |
| 19. Gladys Brew | Family Health Division | HQ |
| 20. Divine Darlington Logo | Research Division | HQ |
| 21. Seth Adjei | Health Promotion Division | HQ |
| 22. Linda Asamoah | Human Resource Division | HQ |
| 23. Robert Adatai | DDCC – Volta |
| 24. Dr Braimah Baba Abubakari | DDCC – Northern Region |
| 25. Pharm Sarah Amissah Bamfo | DDCC – Greater Accra |
| 26. Dr Stephen Anyomi | DDCC – Central Region |
| 27. Portia Agbo | Western Regional Health Directorate |
| 28. Laila Adutwum | Ashanti Regional Health Directorate |
| 29. Kingsley Addai-Frimpong | WHO, Ghana |
| 30. Philomina Amofah | Ubora Quality Institute |
| 31. Dr Jacob Abeberese | Former Deputy Director – Clinical Services Development Institutional Care Division |</p>
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHMC</td>
<td>Community Health Management Committee</td>
</tr>
<tr>
<td>CHO</td>
<td>Community Health Officer</td>
</tr>
<tr>
<td>CHPS</td>
<td>Community Based Health and Planning Services</td>
</tr>
<tr>
<td>CNO</td>
<td>Chief Nursing Officer</td>
</tr>
<tr>
<td>CP</td>
<td>Chief Pharmacist</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>DDCC</td>
<td>Deputy Director – Clinical Care</td>
</tr>
<tr>
<td>DDHS</td>
<td>District Director of Health Services</td>
</tr>
<tr>
<td>DDQA</td>
<td>Deputy Director – Quality Assurance</td>
</tr>
<tr>
<td>DDQSMMD</td>
<td>Deputy Director – Quality and Safety Management Department</td>
</tr>
<tr>
<td>DHD</td>
<td>District Health Directorate</td>
</tr>
<tr>
<td>DHIMS</td>
<td>District Health Information Management System</td>
</tr>
<tr>
<td>DQSMU</td>
<td>District Quality and Safety Management Unit</td>
</tr>
<tr>
<td>DQSTC</td>
<td>District Quality and Safety Technical Committee</td>
</tr>
<tr>
<td>FQIT</td>
<td>Facility Quality Improvement Team</td>
</tr>
<tr>
<td>FQSMU</td>
<td>Facility Quality and Safety Management Unit</td>
</tr>
<tr>
<td>GHS</td>
<td>Ghana Health Service</td>
</tr>
<tr>
<td>HASS</td>
<td>Health Administration and Support Services</td>
</tr>
<tr>
<td>HEFRA</td>
<td>Health Facilities Regulatory Agency</td>
</tr>
<tr>
<td>HQIT</td>
<td>Hospital Quality Improvement Team</td>
</tr>
<tr>
<td>HQSMU</td>
<td>Hospital Quality and Safety Management Unit</td>
</tr>
<tr>
<td>ICD</td>
<td>Institutional Care Division</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NHIA</td>
<td>National Health Insurance Authority</td>
</tr>
<tr>
<td>NHQS</td>
<td>National Healthcare Quality Strategy</td>
</tr>
<tr>
<td>NQSCC</td>
<td>National Quality and Safety Coordination Committee</td>
</tr>
<tr>
<td>PHU</td>
<td>Public Health Unit</td>
</tr>
<tr>
<td>PMS</td>
<td>Performance Management System</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>QAD</td>
<td>Quality Assurance Department</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>QIT</td>
<td>Quality Improvement Team</td>
</tr>
<tr>
<td>QMS</td>
<td>Quality Management System</td>
</tr>
<tr>
<td>QMT</td>
<td>Quality Management Team</td>
</tr>
<tr>
<td>QMU</td>
<td>Quality Management Unit</td>
</tr>
<tr>
<td>QSMD</td>
<td>Quality and Safety Management Department</td>
</tr>
<tr>
<td>RDHS</td>
<td>Regional Director of Health Services</td>
</tr>
<tr>
<td>RQSMU</td>
<td>Regional Quality and Safety Management Unit</td>
</tr>
<tr>
<td>RQSTC</td>
<td>Regional Quality and Safety Technical Committee</td>
</tr>
<tr>
<td>SDQSMT</td>
<td>Sub-District Quality and Safety Management Team</td>
</tr>
<tr>
<td>SDQSMU</td>
<td>Sub-District Quality and Safety Management Unit</td>
</tr>
<tr>
<td>TOT</td>
<td>Training of Trainers</td>
</tr>
<tr>
<td>USAID</td>
<td>US Agency for International Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WIT</td>
<td>Work Improvement Team</td>
</tr>
</tbody>
</table>
1.0 BACKGROUND

Quality is embedded within a larger global movement towards universal health coverage. This objective is addressed in Sustainable Development Goal 3, as defined by the World Health Organization (WHO). Goal 3 aims to ensure healthy lives and promote well-being for all at all ages. This global agenda explicitly sets forth the idea that quality is essential to achieving safe, effective care and improved health outcomes, especially as access to care expands (WHO, 2016).

Initiatives to improve the quality of healthcare are not new to Ghana. At the start of formal healthcare quality processes, two concurrent pilot projects were implemented in the mid-1990s – one in the Upper West Region, with support from DANIDA, and the other in the Eastern Region, supported by the Liverpool School of Tropical Medicine (Offei, Bannerman, & Kyeremeh, 2004). These projects were focused on process quality without ignoring structure and outcome quality. A nationwide review of quality improvement (QI) initiatives conducted by the Ministry of Health (MOH) followed in 1998. Recommendations from the review included harmonisation, institutionalisation of efforts and pre- and in-service training in healthcare quality (Offei et al, 2004). In 2000, under the Liverpool School of Tropical Medicine, a team of nine national trainers was sent for a six-week course at the Royal Tropical Institute in Amsterdam (Offei et al, 2004). Widespread training was then instituted, and client satisfaction surveys became a useful tool for health facilities to identify quality gaps with a view to implementing improvement interventions.

QI efforts were mainstreamed in the mid-2000s when the Quality Assurance Department (QAD) was established in the Institutional Care Division (ICD) of the Ghana Health Service (GHS). Since then, GHS has developed a quality assurance (QA) strategy; produced a large number of standards, protocols and guidelines; issued a Patients Charter; and released three editions of QA manuals, culminating in publication of the 2013 book Quality and Patient Safety in Health Care. Besides the initiatives by GHS, several development partners have supported experimentation with various QA and QI initiatives. These initiatives by the GHS and others have provided the lessons on which the country’s National Healthcare Quality Strategy (NHQS) is built.

The NHQS was developed and launched by MOH in December 2016. The goal of the NHQS is to continuously improve the health and well-being of Ghanaians through the development of a better-coordinated health system that places patients and communities at the centre of quality care. The strategy specifically seeks to achieve improved health outcomes in priority health areas, a coordinated healthcare quality system and improved experiences for patients and the community. Seven strategies have been identified, each of which is described in detail in Section 5: appropriate structures at all levels, a uniform national data policy, client and community participation and satisfaction, improvement of the quality culture, creation of joy in the work environment, league tables for awards and improved supportive supervision and monitoring.

2.0 GHS APPROACH TO QUALITY MANAGEMENT

Following the development of the NHQS, all agencies under the MOH were required to put in place mechanisms for operationalizing the strategy. In response, the GHS ICD developed guidelines for use at all levels of the Service to ensure smooth implementation of the policy. The process involved
broad stakeholder engagement, technical working group meetings and review of relevant documents. Divisions of the Service and directorates at all levels (national, regional, district and sub-district levels) were involved in the development of these implementation guidelines.

The GHS seeks to use these guidelines to implement the NHQS by building upon useful lessons from previous healthcare quality initiatives. Ultimately, the goal of these implementation guidelines is to improve health outcomes and client satisfaction. The guidelines discuss the following topics, each covered in turn in subsequent sections of this document:

- Governance structures for the quality management system (QMS) at all levels of the Service
- Roles and responsibilities pertaining to the QMS for various levels within the Service
- The NHQS implementation framework
- The accountability framework
- Measures to enhance the sustainability of QMS implementation, including incorporating the QMS into routine service delivery systems

These implementation guidelines constitute the GHS approach to healthcare quality management in line with the NHQS. In this regard, to ensure a coordinated QMS and avoid the resurgence of fragmented QMSs within the GHS, all levels of the Service shall adhere strictly to the guidelines. The expectation is that no conflicting or divergent quality management approaches, in terms of structures or processes, shall be implemented anywhere within the GHS by any organisation or development partner without the express approval of the GHS Director General.

3.0 GOVERNANCE STRUCTURE FOR QUALITY MANAGEMENT

The governance structure for the implementation of quality and safety management plans and strategies in the GHS builds on the Service’s existing structures. Managers at all levels shall ensure representation of the community in quality governance structures. They shall also include health workers who are not health professionals.

3.1 National-Level Structure for Quality Management

At the national level, there shall be two bodies responsible for quality management:

1. The existing Quality Assurance Department
2. The National Quality and Safety Coordination Committee (NQSCC)

The members of the NQSCC shall be appointed by the Director General and comprise representatives drawn from all divisions at GHS Headquarters as well as Health Partners, the National Health Insurance Authority (NHIA), the Health Facilities Regulatory Agency (HEFRA) and other regulatory bodies in the health sector with strong community representation. The NQSCC shall have a chairperson and a coordinator. The chairperson shall be the ICD Director while the coordinator shall be the head of QAD. The overall objective of the NQSCC is to provide technical support to the QAD in its functions of planning, implementing and supervising; the NQSCC will monitor and evaluate the implementation of quality and patient safety plans and strategies at all levels of the GHS. Also, the NQSCC shall review and approve protocols for use at all levels of care
and source funds for the implementation of quality management at all levels of care. The committee shall hold meetings every quarter.

It is proposed that the name of the existing QAD in the GHS ICD be changed to the Quality and Safety Management Department to reflect the current emphasis on patient safety as a critical dimension of quality. The substantive head, the Deputy Director – Quality Assurance (DDQA), shall then be called Deputy Director – Quality and Safety Management (DDQSM). The head reports to the Director of ICD. The DDQA shall be supported by focal persons for various QI programmes. The QAD has national oversight responsibility for implementing quality plans and strategies. In this regard, QAD shall monitor the performance of regions and provide feedback. It shall also provide incentives or administer sanctions when absolutely necessary.

The ICD Director shall report to the Director General on all quality issues, and the GHS shall report to the MOH through the Director General.

3.2 Regional-Level Structure for Quality Management
There shall be two bodies at the regional level responsible for the implementation of quality and patient safety plans and strategies throughout the region:

1. The Regional Quality and Safety Management Unit (RQSMU)
2. The Regional Quality and Safety Technical Committee (RQSTC)

The RQSMU shall be located at the Regional Clinical Care Department, with a designated full-time Regional Quality and Safety Focal Person / Manager. The manager shall report to the Deputy Director – Clinical Care (DDCC) on all issues related to the quality of healthcare in the region. The DDCC shall, in turn, report to the Regional Director of Health Services (RDHS), who shall be the chair of the RQSMC. The RQSMU shall plan, supervise, monitor and evaluate the implementation of quality and patient safety programmes within the region. The RQSMU shall conduct reviews biannually and provide feedback to the districts and regional facilities.

Membership of the RQSTC shall be appointed by the RDHS and shall comprise persons drawn from the various departments of the Regional Health Directorate (HASS, PHU, CNO, CP, programme focal persons). In addition, members will be drawn from a pool of private practitioners and representatives of the quasi-government sub-sector, HEFRA, Regional Advisory Committee, Regional Coordinating Council, NHIA, Ghana Water Company and other relevant stakeholders. The committee shall be chaired by the RDHS. The RQSTC shall be responsible for monitoring adherence to quality and safety guidelines and protocols. The technical committee shall also monitor the implementation of quality and safety strategies and plans by agencies and stakeholders within the region. The RQSTC shall therefore monitor progress towards the realisation of NHQS strategic objectives in the region. The committee shall have strong community representation.

3.3 District-Level Structure for Quality Management
District quality and safety management structures shall comprise the following entities:

1. The District Quality and Safety Technical Committee (DQSTC)
2. The District Quality and Safety Management Unit (DQSMU)
The DQSTC shall be chaired by the District Director of Health Services (DDHS). Membership of the DQSTC shall be appointed by the DDHS and comprise the DDHS, District Quality and Safety Manager, Medical Superintendent of the District Hospital, District Health Information Officer, District Public Health Nurse and District Pharmacist, as well as officers drawn from the NHIA, private sector, quasi-government sub-sector, district assembly, Ghana Education Service, community and any other relevant stakeholder group. The committee shall have strong community representation.

The DQSTC shall be responsible for supervising, monitoring and evaluating the implementation of quality and safety management plans and strategies within the district. The committee shall be responsible for the dissemination of quality guidelines and protocols, and it shall conduct quarterly monitoring and supportive supervision visits and provide feedback to district and sub-district facilities. The DQSTC shall hold quarterly meetings.

The DQSMU, which shall be responsible for the implementation of quality and safety plans and strategies within the district, shall have a full-time Quality and Safety Manager who will be on professional grade and earn its equivalent salary. The District Quality and Safety Manager shall coordinate activities of both the DQSTC and the DQSMU and report to the DDHS, who in turn shall report to the RDHS. The DDHS shall chair DQSMU meetings, which shall be held once a month.

3.4 Sub-District-Level Structure for Quality Management
There shall be a Sub-District Quality and Safety Management Team (SDQSMT) and a Sub-District Quality and Safety Management Unit with a Quality and Safety Focal Person. The SDQSMT shall have membership with strong community representation appointed and chaired by the Sub-District Leader. The SDQSMT shall be coordinated by the Sub-District Quality Focal Person, who shall report to the Sub-District Leader. The Sub-District Leader shall, in turn, report to the DDHS. The SDQSMT shall be responsible for monitoring quality implementation within the sub-district.

3.5 Community-Level Structure for Quality Management (CHPS)
The Community Health Officer (CHO) In-Charge shall be the Focal Person for Quality at the community level. The Community Health Management Committees (CHMCs) shall work closely with the CHO In-Charge to address all quality issues at the community level.

3.6 Facility-Level Structure for Quality Management
3.6.1 Hospitals
Every hospital shall constitute a Hospital Quality Improvement Team (HQIT) and a Hospital Quality and Safety Management Unit (HQSMU). Additionally, Work Improvement Teams (WITs) shall be established in each department. The HQIT shall directly supervise all departmental WITs.

The HQIT shall be appointed and chaired by the Medical Superintendent or Medical Director. The HQIT shall comprise the Hospital Quality and Safety Manager, a representative of the DHMT and representation from the following divisions: Clinical Care, Nurse Manager, Maternity Ward, Administration (including transport and estate), Finance, Pharmacy, Paediatric Ward, Surgical Ward, Internal Medicine, Public Health Unit and Health Advisory. HQIT membership shall extend beyond the hospital to include NHIA, HEFRA, community members (traditional rulers) and any other relevant stakeholders. The HQIT shall report to the DQSTC. The function of the HQIT is to provide
direction and technical support to the HQSMU. It shall also secure from management the resources needed to implement planned QI projects in the departments and units. The HQIT shall have strong community representation and hold meetings every month.

The HQSMU is responsible for planning, implementing, monitoring and evaluating safety and QI programmes within the hospital. The HQSMU shall be headed by a full-time Hospital Quality and Safety Manager who will be on professional grade and earn its equivalent salary. The sole responsibility of the Hospital Quality and Safety Manager shall be the management of quality and safety, supporting the departments and units (WITs) to plan and implement QI projects and monitoring and evaluating such QI projects. The Quality and Safety Manager shall report to the Clinical Care Coordinator, who shall, in turn, report to the facility head.

WITs shall be appointed by the respective departmental head with a focal person and team leader and shall be responsible for QI projects within their respective departments. WIT focal persons and team leaders shall not be full-time appointments. WITs shall report to the HQIT through the Hospital Quality and Safety Manager, and a representative of each departmental WIT shall be part of the HQIT. Membership of WITs shall be multidisciplinary, including but not limited to auxiliary staff (drivers, security staff, orderlies), nurses, pharmacists, laboratory staff, clinicians, public health practitioners and administrative/support staff.

3.6.2 Smaller Facilities
Facilities smaller than a hospital – such as polyclinics, health centres and maternity homes – shall have a Facility Quality Improvement Team (FQIT) that has community representation and is chaired by the head of the facility. The FQIT comprises heads of units at the facility. A Facility Quality and Safety Focal Person shall report to the facility head, who shall, in turn, report to the DDHS. In smaller facilities, the Facility Quality and Safety Focal Persons shall not be full-time appointments. Each FQIT shall be responsible for implementing QI activities within its facility. It shall also report quality data into the District Health Information Management System (DHIMS).

3.7 Organograms
Organograms to support quality management for the national, regional and district levels, as well as for regional and district hospitals and other facilities, are attached as Appendix 2 to Appendix 8.

4.0 QUALITY MANAGEMENT ROLES AND RESPONSIBILITIES BY LEVEL
Quality management roles and responsibilities shall be viewed as part of the core business of the various levels. The roles, strategies and activities required are outlined in this section.

4.1 National Level

4.1.1 Role
The role of the national level is to support the regions to implement quality plans and strategies.

4.1.2 Responsibilities
The ICD, through the QAD (proposed name change to Quality and Safety Management Department), will initiate and collaborate with all directorates, departments and programmes to
provide technical support, resources and oversight to the regions. The national level will engage with stakeholders in other service delivery agencies and organisations.

**Technical support**
The QAD of GHS Headquarters will develop guidelines for implementation of quality and patient safety plans and strategies at all levels of the Service. The QAD will also conduct training of trainers (TOT) for the regions to enable the regions to support lower levels and health facilities. The QAD will further support the regions in the development of regional work plans (action plans). It will also provide supportive supervision to the regions to address implementation and outcome gaps as well as to provide coaching, mentoring and resource support to improve performance. Finally, it will lead human resource capacity building (including training) for all QI projects of the GHS.

**Resources**
GHS Headquarters will ensure the provision of human resources to all levels in adequate numbers and with the right skills mix. The national level will also ensure the availability of adequate and functional infrastructure, equipment, supplies and financial resources.

**Oversight**
To support the implementation of quality and patient safety plans and strategies in the regions, the GHS shall perform national oversight activities, including the development of a standardised tool for regions to conduct baseline assessment, identification of a standardised set of indicators for all levels and monitoring and evaluation. GHS Headquarters shall also institute and maintain league tables to rank the regions and organise a national quality conference once a year to review the performance of the regions and reward deserving regions, districts, sub-districts and facilities.

**Stakeholder engagement**
The GHS will collaborate with other healthcare service provider organisations – such as teaching hospitals, quasi-government agencies, the Christian Health Association of Ghana and the private sector – to share and learn from each other in their quality management efforts. The collaboration will be accomplished both through the MOH and through direct collaboration with other agencies.

**4.2 Regional Level**

**4.2.1 Role**
The role of the regional level is to supervise the implementation of quality and patient safety plans and strategies within the entire region.

**4.2.2 Responsibilities**
The regions will provide oversight and technical support to the districts and hospitals. Each region will also coordinate stakeholder engagement to strengthen partnerships among stakeholders relevant to health within the region.

**Oversight**
- Establish the RQSMU and RQSTC
- Supervise the districts to set up DQSMUs and DQSMCs
- Conduct baseline assessments for districts using the standardised national tool
- Support the institutionalisation of the national priority indicators within the district
e. Develop an indicator tracker for districts and hospitals
f. Review districts’ and hospitals’ quarterly reports on quality management activities and outcomes. Provide feedback

g. Manage league tables for districts and for hospitals of the same level. Input the data into national league tables

**Technical support**

a. Train staff on quality management and the implementation of quality and patient safety plans and strategies
b. Provide technical support in quality and safety management to districts and hospitals

**Stakeholder engagement**

a. Engage stakeholders for the implementation of quality and patient safety plans and strategies. Stakeholders shall include teaching hospitals and the private, quasi-government and faith-based sub-sectors.
b. Liaise with stakeholders to solicit resources for the implementation of quality and patient safety plans and strategies.

**4.3 District Level**

**4.3.1 Role**
The role of the district is to supervise the implementation of quality and patient safety plans and strategies at the sub-district, community and facility levels.

**4.3.2 Responsibilities**
The districts will provide oversight and technical support to the sub-districts and health facilities in the implementation of quality and patient safety plans and strategies. Each district will also coordinate stakeholder engagement to build partnerships within and outside the district.

**Oversight**

a. Support health facilities to set up FQITs and departmental WITs as applicable.
b. Carry out monitoring visits to sub-districts, communities and health facilities.
c. Identify priority indicators for sub-districts within the framework of national priorities.
d. Track and monitor priority indicators.
e. Develop year-to-year comparisons for districts and sub-districts using standardised national indicators.

**Technical support**

a. Build capacity on the implementation of quality and patient safety plans and strategies for sub-districts, communities and facilities.
b. Orientate community health committees on the implementation of quality and patient safety plans and strategies.
c. Carry out supportive supervision visits with coaching and mentoring to sub-districts, communities and health facilities.
Stakeholder engagement

a. Engage stakeholders for the implementation of quality and patient safety plans and strategies.
b. Set up, support and maintain a DQSMUs and DQSMCs.
c. Liaise with stakeholders to solicit resources for the implementation of quality and patient safety plans and strategies.
d. Carry out QI activities.
e. Submit quarterly feedback to the sub-district.
f. Submit quarterly reports to the Regional Director of Health Services

4.4 Sub-District Level

4.4.1 Role and Responsibilities

The role of the sub-district is to support the implementation of quality and patient safety plans and strategies in the sub-district/community. The sub-district’s responsibilities include the following:

a. Set up QI teams supported by QI coaches at the sub-district level.
b. Carry out QI activities.
c. Submit quarterly reports to the district.

4.5 Community Level

4.5.1 Role and Responsibilities

The role of the community is to implement and report on QI activities and their outcomes. In this regard, community officials have the following responsibilities:

a. The CHO shall work closely with the CHMC to carry out QI activities.
b. The CHO, with the support of the CHMC, shall submit quarterly reports to the sub-district.

4.6 Facility Level

The facility’s role is to implement QI activities to achieve positive health outcomes and the satisfaction of the client. For example, healthcare facilities should strive to achieve improved outcomes in priority areas, which include the following: maternal health; child health, encompassing neonatal, infant and under-5 health; implementation of the provisions of the patients charter, referral and emergency services; customer care and patient experience; infection prevention and control; water, sanitation and hygiene; surgical safety; medication and transfusion safety; adverse event reporting systems; community scorecards; communicable diseases, focusing on malaria as well as the epidemic-prone diseases of cerebrospinal meningitis and cholera; non-communicable diseases, prioritising hypertension and diabetes mellitus; mental health; and geriatric care.

5.0 NHQS IMPLEMENTATION FRAMEWORK

This section outlines how the NHQS will be implemented within the GHS. The ensuing tables identify the key strategies; activities to implement the strategies; relevant levels and associated
responsibilities; time frames; and how to measure progress in the implementation of each strategy and in the realisation of the expected results.

The section is arranged under the seven key strategies to be implemented within the plan period:

1. Establish [or revamp] **structures** at all levels and train in quality and managerial skills.
2. Implement a uniform national policy on **data**.
3. Improve **client and community** participation, safety and satisfaction.
4. Improve the **quality culture**.
5. Create an environment that cultivates **joy at work**.
6. Rank like facilities and like levels in **league tables** for awards.
7. Improve **supportive supervision and monitoring**.
### Strategy 1: Establish quality structures at all levels

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>ACTIVITIES</th>
<th>LEVELS AND RESPONSIBILITIES</th>
<th>TIME FRAMES (Quarters of Years)</th>
<th>MEASURING PROGRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish structures at all levels of the health system to lead quality efforts across planning, control/assurance and improvement activities</td>
<td>1.1 Revamp and inaugurate quality management structures</td>
<td>(a) National-level structures established by Director General in consultation with the ICD Director (b) Higher levels facilitate the establishment of structures at lower levels</td>
<td>Structures revamped or set up at all levels by the end of Quarter 1 of Year 1 (Q1-Y1)</td>
<td>(a) National quality structures established (b) Proportions of respective levels and facilities with functioning quality management structures</td>
</tr>
<tr>
<td></td>
<td>1.2 Train Quality Management Units and Teams (QMUs and QMTs) in quality management and QI</td>
<td>(a) National-level training or orientation led by ICD (b) National level conducts TOT to build a pool of trainers from regional and district levels (c) Pool of trainers train lower levels and facilities</td>
<td>(a) National and regional levels by the end of Q1-Y1 (b) All other levels by end of Q2-Y1 (c) Continuing for new staff</td>
<td>(a) Requisite training provided for the national level (b) Proportions of QMTs trained in the respective levels and facilities</td>
</tr>
<tr>
<td></td>
<td>1.3 Train facility managers in basic managerial skills</td>
<td>National level decides what training and how (e.g. what skills, in-house or outsourced)</td>
<td>(a) By end of Y2 (b) Continuing for new managers</td>
<td>Proportion of eligible staff trained for various levels and various facilities</td>
</tr>
<tr>
<td></td>
<td>1.4 Monitor the performance of QMUs and QMTs at all levels</td>
<td>(a) Monitoring by higher levels (b) Monitoring through peer review</td>
<td>From Q4-Y1</td>
<td>(a) Proportions of respective levels and facilities monitored, as required by the GHS (b) Proportions of like facilities peer-reviewed in the year</td>
</tr>
<tr>
<td>STRATEGY</td>
<td>ACTIVITIES</td>
<td>LEVELS AND RESPONSIBILITIES</td>
<td>TIME FRAMES (Quarters of Years)</td>
<td>MEASURING PROGRESS</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 2. Develop and implement a uniform national policy on data reporting and data use by health workers and health-sector agencies | 2.1 Develop a national health data policy; train data officers in public, private, teaching hospitals, agencies, etc. | (a) National level of the GHS collaborates with the MOH to review or develop a national health data policy  
(b) GHS trains data officers through TOT                                                                                                           | (a) Policy ready by end of Q2-Y1  
(b) GHS data officers’ training completed by end of Q3-Y1 | (a) Policy document reviewed /developed and disseminated  
(b) Proportion of GHS data officers trained in the national health data policy                                                                  |
|                                                                         | 2.2 Monitor data policy implementation in sector agencies, districts and facilities (data collection, entry/reporting, local use) | Higher levels of the GHS monitor the implementation of the policy at lower levels                                                                                | From Q4-Y1                                              | (a) Proportions of respective levels and facilities reporting all relevant data into DHIMS  
(b) Proportion of respective levels and managers adhering to all data management protocols (data generation, processing and use) |
### Strategy 3: Improve patient safety, client satisfaction and the participation of patients and the community

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>ACTIVITIES</th>
<th>LEVELS AND RESPONSIBILITIES</th>
<th>TIME FRAMES (Quarters of Years)</th>
<th>MEASURING PROGRESS</th>
</tr>
</thead>
</table>
| 3. Improve patient safety, client satisfaction and the participation of patients and the community in quality governance structures at all levels | 3.1 Involve patients and the community in QI through participation in QMTs at all levels | (a) National level of the GHS, led by ICD, develops and disseminates guidelines on how to involve patients and communities in quality management  
(b) All levels comply with guidelines | (a) Policy development and dissemination by end of Q2-Y2  
(b) Involvement at all levels from Q3-Y2 | Proportions of respective levels and facilities involving patients and communities in quality teams |
| | 3.2 Involve patients in defining quality through biannual client satisfaction surveys | (a) ICD reviews quality indicators for use in client satisfaction surveys  
(b) Relevant staff trained in the administration, analysis, interpretation and use of the results of patient surveys  
(c) Client satisfaction surveys conducted at all levels two times a year | (a) Review of indicators and training by Q4-Y2  
(b) Surveys conducted from Q1-Y3 | Proportions of respective levels that conduct client satisfaction surveys two times a year and use the results in decision-making |
| | 3.3 Scale up implementation of the national patient safety policy to all public and private service delivery sites and teaching hospitals; monitor implementation | (a) Train staff not already trained on the national patient safety policy (led by ICD using TOT)  
(b) National, regional, district and sub-district levels monitor implementation of the policy at all service delivery facilities / service delivery points under their respective supervision | Train all health workers in care delivery by end of Q2-Y1 (possibly along with Activity 4.1) | Proportion of care delivery staff at the respective service delivery facilities / service delivery points trained in patient safety (survey) |
<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>ACTIVITIES</th>
<th>LEVELS AND RESPONSIBILITIES</th>
<th>TIME FRAMES (Quarters of Years)</th>
<th>MEASURING PROGRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Improve the quality culture in health workers through training in the requisite clinical skills, in QI methods and in the incorporation of quality-related performance indicators in their job descriptions</td>
<td>4.1 Provide in-service training on QI for the workforce (in service provision sites and within sector agencies) and incorporate ethics and quality-related standards in the job descriptions of health workers; also, train selected staff in sign language</td>
<td>(a) Train staff not already trained in QI (coordinated by ICD using TOT) (b) GHS Human Resource Division, in collaboration with ICD, incorporates ethics and quality responsibilities into job descriptions of all staff at all levels (c) Managers at all levels build quality and ethical responsibilities of staff into the appraisal system (d) Managers at all levels support staff training in sign language and in technical skills through accredited continuing professional development (CPD) programmes</td>
<td>(a) Train all staff at all levels by end of Q2-Y1 (possibly along with Activity 3.3) (b) Job descriptions and performance management systems (PMSs) incorporate quality and ethical responsibilities from Q1-Y2</td>
<td>(a) Proportion of staff trained in QI at respective levels and facilities (survey) (b) Proportion of respective levels and facilities incorporating quality and ethical responsibilities into the PMS (survey) (c) Proportion of staff at respective service delivery facilities/points literate in sign language (survey) (d) Average number of CPDs attended by respective cadres of health workers in a year (survey)</td>
</tr>
<tr>
<td></td>
<td>4.2 Build quality into health workers’ training and deliver the training to health workers</td>
<td>(a) GHS Headquarters advocates for pre-service training institutions to incorporate healthcare quality management in the curriculum (b) In-service training, as well as training for students on attachment, incorporates quality at all levels</td>
<td>From Q2-Y1</td>
<td>(a) Proportion of respective training institutions that have incorporated healthcare quality in the curriculum (b) Proportion of in-service training that incorporates quality aspects (c) Proportion of respective health facilities that incorporate quality when training students on attachment</td>
</tr>
<tr>
<td></td>
<td>4.3 Apply sanctions for non-compliance with ethics, breeches of the Patients Charter or reporting false</td>
<td>As much as possible, managers must identify and address system factors that result in or facilitate a “misdemeanour”; sanctions shall be applied only where absolutely necessary</td>
<td>Rarely</td>
<td>Number of staff who had sanctions applied to them</td>
</tr>
<tr>
<td>STRATEGY</td>
<td>ACTIVITIES</td>
<td>LEVELS AND RESPONSIBILITIES</td>
<td>TIME FRAMES (Quarters of Years)</td>
<td>MEASURING PROGRESS</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>----------------------------</td>
<td>-------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td></td>
<td>data, in accordance with the Code of Ethics and Code of Discipline</td>
<td>(a) National level of the GHS should identify and adopt/adopt protocols or guidelines for health priority areas without adequate or up-to-date protocols or guidelines (b) Train all relevant staff at all levels on the protocol and guidelines, coordinated by ICD using TOT (c) Supervisory levels monitor compliance at levels within their purviews</td>
<td>(a) Protocol review/development and training completed by Q1-Y3 (b) Implementation and monitoring from Q2-Y3</td>
<td>(a) Proportion of identified health priorities with adequate and up-to-date protocols/ guidelines (b) Proportion of relevant staff trained in each set of protocols/guidelines (c) Proportion of staff sampled in a survey who comply with identified protocols/guidelines in the identified health priority area</td>
</tr>
<tr>
<td>4.4 Adopt/adapt protocols for the management of health priorities (including traditional medical practice), train relevant workers and monitor adherence to protocols</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20
### Strategy 5: Create the “joy at work” environment

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>ACTIVITIES</th>
<th>LEVELS AND RESPONSIBILITIES</th>
<th>TIME FRAMES (Quarters of Years)</th>
<th>MEASURING PROGRESS</th>
</tr>
</thead>
</table>
| 5. Create the “joy at work” environment to enable health workers to    | 5.1 Provide medicines and logistics for service provision at all levels,   | (a) Medicines and logistics provided by managers at national, regional, district, sub-district and facility levels  
(b) National (GHS Headquarters) level, coordinated by ICD, develops and disseminates incentives policy, including rural incentives  
(c) All levels and facilities fully implement the incentive policy | (a) Provision of medicines and logistics from Q1-Y1  
(b) Policy developed and disseminated by Q2-Y1  
(c) Policy implemented at all levels from Q3-Y1  | (a) Incentive policy developed and disseminated  
(b) Proportion of respective levels fully implementing the incentive policy (routine reports)                                                                                                   |
| consistently deliver safe and high-quality care through the provision of | as incentives, including rural incentives                                    |                                                                                                                                                                                                                          |                                                                                             |                                                                                                                                                                                                                      |
| essential inputs, incentives, recognition and reward                    |                                                                           |                                                                                                                                                                                                                          |                                                                                             |                                                                                                                                                                                                                      |
|                                                                         | 5.2 Implement occupational health and safety policy to protect all health  | (a) GHS Headquarters disseminates and trains all staff, both health and non-health professionals, in the policy  
(b) Training cascaded through TOT  
(c) Policy implemented at all levels; implementation monitored by implementing levels and by higher levels | (a) From Q1-Y1  
(b) Completed by Q3-Y1  
(c) From Q1-Y2 | (a) Proportion of staff at respective levels trained  
(b) Proportion of respective levels implementing the policy  
(c) Improved staff safety outcomes                                                                                             |                                                                                                                                                                                                                      |
|                                                                         | workers                                                                   |                                                                                                                                                                                                                          |                                                                                             |                                                                                                                                                                                                                      |
|                                                                         |                                                                           |                                                                                                                                                                                                                          |                                                                                             |                                                                                                                                                                                                                      |
|                                                                         | 5.3 Develop and apply indicators to reward/award deserving staff at facility,  | (a) National level, coordinated by ICD, develops and disseminates award criteria  
(b) Respective levels apply indicators and give awards to winning levels, facilities and individuals  
(c) National awards for the overall best three in each category at the annual quality conference | (a) Award criteria and policy developed and disseminated by Q1-Y2  
(b) Awards at all levels begin from Q2-Y2  
(c) National awards begin Q4-Y2 | (a) Criteria and policy developed and disseminated  
(b) Proportion of respective levels implementing award schemes  
(c) National awards given in the last quarter of the year                                                                 |                                                                                                                                                                                                                      |
### Strategy 6: Rank facilities and agencies in league tables for awards

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>ACTIVITIES</th>
<th>LEVELS AND RESPONSIBILITIES</th>
<th>TIME FRAMES (Quarters of Years)</th>
<th>MEASURING PROGRESS</th>
</tr>
</thead>
</table>
| 6. Enhance transparency through the ranking of like facilities and like agencies in **league tables**, with awards at the annual quality conferences that involve patients, communities and providers | 6.1 Agree on quality metrics; build the indicators into the performance contracts of sector agencies and health facilities of all ownerships | (a) National level of the GHS coordinates the building of quality metrics into the performance contracts of regions, levels and facilities  
(b) Relevant levels are oriented in the use of the indicators  
(c) Respective levels and facilities monitor indicators for the levels/staff under their supervision | (a) Metrics developed and disseminated by Q1-Y2 (along with Activity 5.2)  
(b) Indicators built into performance contracts for relevant levels from Q2-Y2 (along with Activity 5.2)  
(c) Monitoring of quality indicators begins Q4-Y2 (along with Activity 5.2) | Quality indicators incorporated into the performance assessments of relevant facilities and levels |
| 6.2 Maintain league tables for like health facilities and for other health-sector agencies | (a) National level develops and disseminates guidelines in the maintenance of league tables for relevant levels and facilities  
(b) Regions, districts and sub-districts maintain league tables for respective levels and facilities | From Q2-Y2 (awards along with Activity 5.2(b)) | (a) Guidelines developed and disseminated  
(b) Proportion of respective levels and facilities maintaining league tables |
| 6.3 Hold annual national quality conference to evaluate NHQS implementation and award deserving agencies, health facilities and health workers | (a) GHS national level, coordinated by ICD, collaborates with the MOH national QMU to organise an annual conference  
(b) Winners from lower levels are collated to higher levels, up to the national level, for a determination of overall winners. Categories: respective levels and facilities, e.g. Best in quality Community-Based Health Planning and Services facility for the year 2021 | Every Q4 of the year, from Q4-Y2 (along with Activity 5.2(c)) | Annual national quality conference held in Q4 of each year (conference reports) |
<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>ACTIVITIES</th>
<th>LEVELS AND RESPONSIBILITIES</th>
<th>TIME FRAMES (Quarters of Years)</th>
<th>MEASURING PROGRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Improve supportive supervision and monitoring across all MOH directorates, sector agencies and service delivery sites in the public and private subsectors and teaching hospitals</td>
<td>7.1 Adopt/adapt existing supportive supervision guidelines and tools, train supervisors and monitor the implementation of supportive supervision in all MOH directorates, agencies and service delivery facilities and sites</td>
<td>GHS national level scales up the implementation of supportive supervision to all levels</td>
<td>Continue from Q1-Y1</td>
<td>Proportions of respective levels implementing supportive supervision (by survey)</td>
</tr>
<tr>
<td></td>
<td>7.2 Adopt/adapt existing peer-review guidelines and tools, train relevant managers and monitor the implementation among like agencies and like providers</td>
<td>(a) GHS national level harmonises peer review tools for the various levels (b) GHS national level initiates and supports the training of all levels and facilities on the harmonised peer review tools, using TOT (c) Respective facilities and levels implement peer review</td>
<td>(a) Harmonisation of peer review tools by end of Q2-Y1 (b) Training completed by Q4-Y1 (c) Implementation and monitoring from Q1-Y2</td>
<td>(a) Peer review tools harmonised for respective levels and facilities (b) Proportions of staff trained at various facilities and levels (survey) (c) Proportions of respective levels implementing harmonised peer review tools (survey)</td>
</tr>
<tr>
<td></td>
<td>7.3 Develop reporting format for MOH directorates, sector agencies, facilities (public, private, teaching); monitor reporting quarterly and provide feedback</td>
<td>(a) GHS national level, coordinated by ICD, consults with the MOH national QMU in the development and dissemination of reporting formats for all respective levels and facilities (b) Higher GHS levels review quarterly reports from levels and facilities under their supervision</td>
<td>(a) Reporting formats developed and disseminated by Q3-Y1 (possibly Q2-Y1 along with the training of quality teams, per Activity 1.2(b)) (b) Reporting format in use by Q4-Y1</td>
<td>Proportions of levels and facilities adhering to reporting formats (survey)</td>
</tr>
<tr>
<td>STRATEGY</td>
<td>ACTIVITIES</td>
<td>LEVELS AND RESPONSIBILITIES</td>
<td>TIME FRAMES (Quarters of Years)</td>
<td>MEASURING PROGRESS</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>-----------------------------</td>
<td>---------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>7.4 Undertake sector-wide reviews once a year</td>
<td>GHS collaborates with the MOH and sister agencies to hold an annual health forum which incorporates quality</td>
<td>Continuing from Y1</td>
<td>Health forums incorporating quality implementation processes and outcomes</td>
<td></td>
</tr>
</tbody>
</table>
6.0 ACCOUNTABILITY

The following are included among the mechanisms to safeguard accountability for the implementation of quality and patient safety plans and strategies as well as the realisation of agreed-upon outcomes:

- Staff performance management system (job description and performance appraisal)
- Routine reports
- Periodic performance reviews (lessons learned forum / shared learning)
- Peer reviews
- Community engagement / community scorecard
- Annual quality conferences
- Publication of a national quality magazine
- Monitoring and evaluation

6.1 Performance Management System

The NHQS requires that health workers’ quality management functions shall be incorporated into their job descriptions. Quality management objectives and targets will then be built into the workers’ PMS based on their respective quality management responsibilities. Rewards shall be applied for performance and support provided to bridge performance gaps. Sanctions shall be applied only when absolutely necessary and without external interference from politicians, chiefs and other highly placed stakeholders.

6.2 Routine Reports

Routine reports for use at the level of generation and for onward transmission to higher levels shall incorporate performance on the standardised quality indicators. The reports shall include quality indicators on health outcomes, client satisfaction and performance on stakeholder management. Stakeholder management reports shall include client relations as well as performance on the implementation of the Patients Charter and community engagement. The GHS at the national level will report to the MOH as required.

6.3 Periodic Performance Reviews

Existing periodic performance reviews shall incorporate a review of the progress on implementing quality and patient safety plans and strategies.

6.4 Peer Review

The planned harmonisation of the peer-review system across the country shall incorporate indicators to assess the progress on the implementation of quality and patient safety plans and strategies, on agreed health outcomes, on client satisfaction and on client and community engagement.

6.5 Community Engagement / Community Scorecard

All levels shall take advantage of community engagement forums to report on the status of healthcare quality. The forums will empower the community to play their role to increase client satisfaction and adherence to the Patients Charter in order to improve health outcomes. The
Patients Charter shall be disseminated to clients daily and to staff once a quarter. Quarterly assessments of performance shall be completed using the community scorecard.

6.6 Annual Quality Conference
Annual conferences will be the platform for shared learning and rewards. League tables shall be instituted to feed into the agenda of each annual quality conference. District league tables shall be consolidated at the regional level and regional league tables consolidated at the national level. The league tables shall be based on agreed standardised indicators for health outcomes, client satisfaction and performance on stakeholder management. The league tables shall form the main basis for awards to deserving regions, districts, sub-districts and facilities.

6.7 Monitoring and Evaluation
The standardised quality indicators that will be agreed upon shall be part of the DHIMS data. Routine monitoring and periodic evaluation shall involve review of the standardised indicators through operational research, peer reviews, client satisfaction surveys and other identified methods. The outcome of monitoring and evaluation shall inform areas for supportive supervision.

7.0 SUSTAINABILITY
The underpinning philosophy for ensuring the sustainability of quality and safety management for improved healthcare is that quality management shall be mainstreamed into activities at all levels of the GHS.

To achieve this conviction, quality and safety management implementation is designed around the following three strategic domains:

- Governance and leadership
- Continuous improvement
- Stakeholder engagement

7.1 Governance and Leadership
These implementation guidelines include governance and leadership plans to achieve sustainability. The following key design elements are intended for this strategic domain:

1. Establish clear structures that build on existing GHS structures to better embrace change.
2. Define high-level leadership at all levels to stimulate commitments from top-level managers and leaders.
3. Involve all levels and all divisions, departments and units, making quality management a visible agenda.
4. Designate systems for accountability to elicit a sense of responsibility and commitment.
5. Involve patients, the community and other stakeholders – whose activities affect the quality and safety of healthcare – to build ownership and empowerment, which the stakeholders can safeguard.
6. Define an NHQS implementation framework for the GHS, which clarifies the needed activities, responsibilities by level and time frames.
7. Build in advocacy and resource mobilisation.

7.2 Continuous Improvement
To sustain continuous improvement, the GHS shall pursue the following objectives:

1. Undertake continuous/regular capacity development — that is, institutional in-service training with an emphasis on coaching and mentorship.
2. Implement supportive supervision for all levels.
3. Establish or strengthen existing quality management structures and systems.
4. Harmonise, strengthen and scale up facility peer review.
5. Incorporate healthcare quality into existing review meetings.
6. Incorporate health quality indicators into existing data management system at all levels.
7. Promote biannual regional and district health quality bulletins.
8. Promote the annual publication of *Healthcare Quality Magazine*, led by ICD with support from the Research Division at the national level, to facilitate knowledge sharing and learning.

7.3 Stakeholder Engagement
Stakeholder engagement shall focus on advocacy with the following:

1. Political systems
2. Training institutions
3. Regulatory bodies
4. Metropolitan, municipal and district assemblies
5. Traditional authorities and communities

7.4 Celebration of World Patient Safety Day
The World Patient Safety Day shall be celebrated **annually on September 17th** at all levels of the Ghana Health Service to create awareness on Quality and Safety in Healthcare and demonstrate commitment by all stakeholders for Quality and Safety.
APPENDICES

Appendix 1: Sample Appointment Letter for Quality and Safety Managers

A. ELEMENTS OF THE DRAFT APPOINTMENT LETTER TO A QUALITY AND SAFETY MANAGER

The appointment letter to a prospective Quality and Safety Manager shall include the following:

1. Where the job is situated
2. Date of the assumption of duty
3. Who to report to
4. Job description
5. Instructions for responding
B. SAMPLE LETTER OF APPOINTMENT FOR QUALITY AND SAFETY MANAGER AT HOSPITAL LEVEL

Dear Dr ABC,

I am glad to inform you that you have been offered an appointment as the Quality and Safety Manager for Seaside District Hospital, XYZ Town, effective 1 October 2019.

Your position is tasked with managing quality and safety full time, and your job description will include the following responsibilities:

1. Manage the Hospital Quality and Safety Management Unit (HQSMU).
2. Plan and implement safety and quality improvement activities in line with national guidelines and strategies as well as hospital goals and objectives.
3. Coordinate quality and safety activities within the hospital.
4. Support and supervise quality improvement projects in the various departments of the hospital.
5. Monitor and evaluate safety and quality improvement programmes and activities within the hospital.
6. Organise monthly meetings of the Hospital Quality Improvement Team (HQIT).
7. Perform any other duties that will be assigned to you by the Clinical Coordinator or the Medical Superintendent.

You will report to the Clinical Care Coordinator of the hospital.

You shall progress on your professional grade with its corresponding salary.

You are required to respond to this letter within two weeks from the date of receipt, indicating your willingness and availability to take up the appointment or otherwise.

Yours sincerely,

Dr ............

Medical Superintendent

Cc:

RDHS

DDHS
Appendix 2: National-Level Quality and Safety Coordinating Organogram

Director General

Director, Institutional Care Division

Quality Assurance Department

Other Divisions

National Quality and Safety Coordination Committee (NQSCC)
Appendix 3: Regional-Level Quality and Safety Coordinating Organogram

Regional Director of Health Services

Deputy Director Clinical Care

Regional Quality and Safety Management Unit (RQSMU), headed by the Quality and Safety Manager

Other Departments

Regional Quality and Safety Technical Committee (RQSTC)
Appendix 4: District-Level Quality and Safety Coordinating Organogram

District Director of Health Services

Quality and Safety Manager
  District Quality and Safety Management Unit (DQSMU)

Other Department Heads
  District Quality and Safety Technical Committee (DQSTC)
Appendix 5: Regional Hospital Quality and Safety Coordinating Organogram

Medical Director

Clinical Coordinator

Hospital Quality and Safety Management Unit (HQSMU)

Departmental Work Improvement Teams (WITs)

Heads of Public Health and Other Departments

Hospital Quality Improvement Team (HQIT)
Appendix 8: Summary of the Ghana Health Service Quality and Safety Management Organogram

**GHS Headquarters QM Structure**
1. National Quality and Safety Coordinating Committee (NQSCC)
2. Quality Assurance Department (QAD in ICD)

**Regional-Level QM Structure**
1. Regional Quality and Safety Technical Committee (RQSTC)
2. Regional Quality and Safety Management Unit (RQSMU)

**District-Level QM Structure**
1. District Quality and Safety Technical Committee (DQSTC)
2. District Quality and Safety Management Unit (DQSMU)

**Sub-District-Level QM Structure**
1. Sub-District Quality and Safety Management Team (SDQSMT)
2. Sub-District Quality and Safety Management Unit (SDQSMU)

**Community-Level QM Structure**
1. Community Health Officer (CHO), Community Health Management Committee (CHMC) and community members

**Regional Hospital**
1. Hospital Quality Improvement Team (HQIT)
2. Hospital Quality and Safety Management Unit (HQSMU)
3. Work Improvement Teams (WITs)

**District/Primary Hospital**
1. Hospital Quality Improvement Team (HQIT)
2. Departmental Work Improvement Teams (WITs)
3. Hospital Quality and Safety Management Unit (HQSMU)

**Polyclinic, Health Centre or Maternity Home**
1. Facility Quality Improvement Team (FQIT)
2. Facility Quality and Safety Management Unit (FQSMU)