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MALAYSIA

KEMENTERIAN KESIHATAN MALAYSIA

# NATIONAL POLICY FOR QUALITY IN HEALTHCARE

*Bridging Silos, Accelerating Improvements*


2022 - 2026

# NATIONAL POLICY FOR QUALITY IN HEALTHCARE

Bridging Silos, Accelerating Improvements

**National Policy for Quality in Healthcare (NPQH)**
**2022-2026**

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# *Foreword*

# *Foreword*

As a nation, Malaysia is fully committed to the achievement of the Sustainable Development Goals (SDG), which emphasise the attainment of Universal Health Coverage (UHC). Through UHC we aim to "ensure that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship".

The development and execution of the National Policy for Quality in Healthcare **(NPQH)** is ideally suited to guide improvement of performance of our healthcare system. Our noble objective is to enhance our healthcare system, foster collaboration across ministries, cultivate inter-organisational collaboration as well as partnerships with the community to understand what truly matters most to those who use the health system. Towards achieving UHC in Malaysia, the focus on primary healthcare approach will continue to be the basis upon which the **NPQH** will be implemented.

Implementation of **NPQH** calls for strong leadership to coordinate the system of healthcare quality at all levels and areas of the health system, across both the public and private sectors, to address identified gaps as well as oversee the successful and robust execution of the policy. Leadership at every level should be clearly visible and engaged in their support towards quality improvement, as they lead by example in demonstrating quality culture through their actions.

The **NPQH** hopes to nurture leaders that will support and ensure that the effort that is put into quality improvement is valued, receives recognition and visibility, with steering of adequate resources to drive quality improvement initiatives.

**YBhg Dato' Mohd Shafiq bin Abdullah**
*Chief Secretary, MOH*

# *Foreword*

Developing integrated people-centred healthcare systems will produce necessary benefits to the health and healthcare of all people, including improved access to care, improved health and clinical outcomes, better health literacy and self-care, increased satisfaction with care, improved job satisfaction, improved efficiency of services, and reduced overall costs. Malaysia is committed to the WHO Framework on Integrated People-centred Health Services that has a vision for the future for all people to have access to health services provided in a way that responds to their preferences, coordinated around their needs, and is safe, effective, timely, efficient, and of acceptable quality.

To further cement this effort, the Ministry of Health is embarking on its journey in the development, refinement, and execution of the National Policy for Quality in Healthcare **(NPQH)**. The **NPQH** serves as a constant reminder that quality is at the heart of our healthcare system, irrespective of challenge, such as the current COVID-19 pandemic. Quality improvement initiatives as the core component of **NPQH** can provide an innovative response to the population health needs emerging from the pandemic and particularly in maintaining the quality of essential health services.

This policy emphasises on the definition of quality in Malaysia's context to provide high-quality healthcare that is safe, timely, effective, equitable, efficient, people-centred, and accessible (STEEEPA). The high-quality healthcare must be responsive to the needs tailored precisely to local communities and delivered in a team of caring professionals to improve overall health outcomes. This **NPQH** document seeks to internalise quality culture throughout the health system through fostering partnerships, healthy team-working environments and sharing of experiences, which are integrated throughout every organisation. Through achieving a sustainable quality culture, transparent and open communication across all levels, we intend to support healthcare providers and make them feel valued and appreciated.

Building onto this, Malaysia will embark on its unique pathway to attain Universal Health Coverage, with a meticulously designed and integrated national approach to quality which will bridge silos that are inherent in many healthcare systems in the world today. This will represent a pragmatic and visionary milestone for Malaysia, in its endeavour to be a nation of people working together for better health.

**YBhg Tan Sri Dato' Sri Dr Noor Hisham bin Abdullah**
*Director General of Health, Malaysia*

# *Foreword*

In the past decade, there has been a growing consensus and concerted global effort around the key domains of quality in healthcare. The development, refinement and implementation of the National Policy for Quality in Healthcare **(NPQH)** is a coordinated and systematic effort to nurture, envision and institutionalise an improved quality of healthcare. The **NPQH** is aligned with the MOH Strategic Plan as well as other quality-related policies and strategies which exist in various different domains, to ensure its implementation is relevant and coherent.

A diligent attempt to lead national efforts, the **NPQH** envisages patient care that is enriched with quality through a reorganised integrated healthcare system under proactive leadership, to harmonise and build on existing quality efforts. This document envisions the growth of quality improvement initiatives to greater heights by highlighting the alignment of policies, organisations, methods, capacities and resources under one umbrella to institutionalise quality improvement in our health systems.

Implementation of this policy aims to enhance solidarity, complement existing quality improvement initiatives, modifying the roles of patients and professionals, as well as strengthen the use of data and incentives. To ensure optimal implementation, we will combine sound organisational processes with complementary technology to achieve our desired outcomes.

While no single actor will be able to effect all these changes, an integrated approach whereby different constituents and units work together to accomplish their mutual responsibilities, will have a demonstrable effect on the quality of healthcare services in Malaysia.

**YBhg Datuk Dr Hishamshah bin Mohd Ibrahim**
*Deputy Director General of Health*
*(Research & Technical Support)*

# *Foreword*


Policy in healthcare is a cardinal element of health systems to guide action, steer desired outcomes and guide decision making. In response to the worldwide strategy to achieve UHC, as well as the increasing recognition of the role of quality initiatives in building reliable, sustainable, resilient health systems, Malaysia has embarked on its journey in the development, refinement and execution of the National Policy for Quality in Healthcare **(NPQH)**.

This document highlights the main challenges as well as cogent practices in the current health system, and to identify the major areas for improvements in healthcare quality. The seven priority domains identified in the **NPQH**, include collective innovative strategies and action plans to facilitate its operationalisation.

Although this policy delineates practical strategies, its successful implementation requires all responsible parties to unite in executing and monitoring the outlined plan through empirical performance assessments. Our goal is to drive quality improvement efforts from the ground up.  Such an assimilated strategy would bring both cohesion and emphasis to improving the quality of care for our progressively diverse patients.

We aspire that the **NPQH** will not merely be an addition to the reservoir of national policies, but to be a dynamic document, serving as a compass that navigates the future direction of quality improvement initiatives.

**Dr Nor Izzah Hj Ahmad Shauki**
*Director of the Institute for Health Systems Research (IHSR)*

# *Preface*

Evolution in the field of healthcare quality since the publication of the MOH's Strategic Plan for Quality in Health in 1998, has necessitated its revision into a much-awaited new national policy - the National Policy for Quality in Healthcare **(NPQH)**, guided by principles outlined in the WHO's approach to National Quality Policy and Strategy (NQPS).

Responding to this need, the Institute for Health Systems Research (IHSR) as the Secretariat for Quality Assurance/Quality Improvement Programme in the MOH and the WHO Collaborating Centre for Quality Improvement, engaged an international consultant through WHO Office, Dr Bruce Agins, to assist in the development of the **NPQH**. His expertise and insights indeed proved to be invaluable in the formulation of the Malaysian **NPQH**. Concurrently, the requisite formation of a Technical Working Group (TWG) using an existing QA Technical Committee platform was entrusted with the myriad challenging tasks involved in formulating the **NPQH** document.

January 2019 marked the beginning of a meticulously planned endeavour. The WHO Office Malaysia provided critical support for a 2-week workshop in July 2019, for the second engagement with the Consultant, which was officiated by the DDG (Research & Technical Support) with the WHO Representatives in attendance, at the opening ceremony.

The Technical Working Group conducted a situational analysis, which involved a review of historical and current information as well as the collation of new data utilising a"mixed methods" approach with the requisite material being obtained from a diverse range of sources encompassing existing quality related documents, opinions of healthcare providers and the people of Malaysia. A subsequent series of engagement sessions with the relevant key stakeholders from multiple health sectors, including the public, was organised to attain consensus on priorities areas and further build on the draft for the new policy.

After the third briefing session with the Consultant in mid-February 2020 on the latest update progress, the Secretariat led the way in the challenging task of preparing the policy draft, together with the TWG. Findings, contents, as well as progress updates for the **NPQH** development were presented to the National QA Committee and the National Steering Committee on Innovation, for further refinements of the policy. The contents of this new policy were also presented at the DG Special Meeting (*Mesyuarat KPK Khas*) to obtain input from the top policy-making leadership at both Ministry and State levels.

The **NPQH** would not have materialised without the concerted efforts and support of the numerous quality champions and stakeholders. It is hoped that this effort will be translated into a systematic and coherent action plan to ensure that the vision for quality of the Ministry of Health is achieved, so that all Malaysians will have access to high quality of health care services.

# *Acknowledgement*

The Ministry of Health is truly indebted to many partners, individuals and organisations that have helped to shape this National Policy for Quality in Healthcare. We thank the stakeholders at all levels within the Ministry of Health, public universities, private sectors, professional associations and organisations as well as the public. Their thoughts and insights on the current state of quality in Malaysia and the way forward, were shared through multiple engagement sessions conducted consisting of large and small group discussions, a survey as well as other forums.

The Ministry of Health highly acknowledges the Technical Working Group steered by the Institute for Health Systems Research for working tirelessly in putting this document together, right from the conceptual planning, conducting the situational analysis, the initial drafting and the subsequent reviews leading to the finalisation of this document. In addition, special gratitude towards the Innovation Steering Committee, members of the *KPK Khas Meeting*, the Quality Assurance/Improvement Committee and the Quality Assurance/Improvement Technical Committee for their supervisory efforts, guidance and support.

We would like to express our appreciation and acknowledge the technical expert contribution of Prof Dr Bruce Agins from the Institute for Global Health Sciences, University of California San Francisco who had been assigned as the project consultant. He had assisted us since we embarked on this journey, which commenced with the inception meeting, followed by conceptually designing the situational analysis component, facilitating the first stakeholder's engagement session and finally, the several rounds of reviewing and refining the policy draft.

We also wish to recognise the valuable contribution of Dr Shams Syed, Head of Unit, Quality of Care, WHO Headquarters Geneva, who played a significant role at two points; the first was at the planning stage, when we had a one-day session to learn and plan the process in taking forward the task of developing this policy, and the second was his critical review on the policy draft.

We would also like to express gratitude to the WHO Office Malaysia, under the leadership of Dr Lo Ying-Ru Jacqueline, Head of Mission and WHO Representative to Malaysia, Brunei Darussalam and Singapore, for their financial support in engaging a technical expert for this project.

We also acknowledge Datin Dr Siti Haniza Mahmud's contribution for reviewing the initial draft of this document twice and IHSR's internal reviewers team; Dr Zalilah Abdullah, Dr Shakirah Md Sharif and Dr Nurul Iman Jamalul-lail in providing constructive feedback for improvement. We are hopeful that this document will be used by all actors in the health sector to ensure harmonisation of existing quality improvement initiatives, in working towards the shared national aim of institutionalising quality across all levels of Malaysia's health system.

# List of Abbreviations

| | |
|---|---|
| **ADAF** | *Audit Dalam Amalan Farmasi* |
| **BCG** | *Bacillus Calmette–Guérin* |
| **BPL** | *Bahagian Pengurusan Latihan* |
| **BPKK** | *Bahagian Pembangunan Kesihatan Keluarga* |
| **BPTM** | *Bahagian Pengurusan Teknologi Maklumat* |
| **COMBI** | Communication for Behaviourial Impact |
| **CPG** | Clinical Practice Guideline |
| **CPSU** | Clinical Surveillance Performance Unit |
| **DDG** | Deputy Director General of Health |
| **DG** | Director General of Health |
| **DPT-HiB** | Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, and Haemophilus influenzae type b |
| **HCP** | Healthcare provider |
| **HPU** | Health Performance Unit |
| **HO** | House Officer |
| **IHSR** | Institute for Health Systems Research |
| **ISO** | International Organization for Standardization |
| **IT** | Information Technology |
| **KIK** | *Kumpulan Inovatif & Kreatif* |
| **KOSPEN** | *Program Komuniti Sihat Pembina Negara* |
| **KOTAK** | *Kesihatan Oral Tanpa Amalan Merokok* |
| **KPI** | Key Performance Indicator(s) |
| **KPK** | *Ketua Pengarah Kesihatan* |
| **LMICs** | Low- and middle-income countries |
| **M&E** | Monitoring & Evaluation |
| **MaHTAS** | Malaysian Health Technology Assessment Section |
| **MMR** | Measles, mumps, and rubella |
| **MOD** | Ministry of Defence |
| **MOE** | Ministry of Education |
| **MOH** | Ministry of Health |

# List of Abbreviations

| | |
|---|---|
| **MyHDW** | Malaysian Health Data Warehouse |
| **NCD** | Non-Communicable Disease |
| **NHMS** | National Health Morbidity Survey |
| **NIA** | National Indicator Approach |
| **NQPS** | National Quality Policy Strategy |
| **NPQH** | National Policy for Quality in Healthcare |
| **OSH** | Occupational Safety and Health |
| **PCC** | People-centred Care |
| **PIK** | *Pusat Informatik Kesihatan* |
| **PKD** | *Pejabat Kesihatan Daerah* |
| **QA** | Quality Assurance |
| **QAP** | Quality Assurance Programme |
| **QI** | Quality Improvement |
| **QII** | Quality Improvement Initiative(s) |
| **SDG** | Sustainable Development Goals |
| **SP** | Strategic Priorities |
| **SWOT** | Strength Weakness Opportunity Threat |
| **TOR** | Term of Reference |
| **TWG** | Technical Working Group |
| **UHC** | Universal Health Coverage |
| **VAS** | Value Added Services |
| **WHO** | World Health Organization |

# *Executive Summary*

The **National Policy for Quality in Healthcare (NPQH)** for Malaysia – is formulated to guide both the public and private health sectors to improve the quality of healthcare. **NPQH** aims to systematically plan for enhanced quality of healthcare by providing an official, explicit policy statement regarding the approach and actions required at all levels of health service delivery across Malaysia's health system.

Together with its partners within and outside the MOH, the Institute for Health Systems Research (IHSR) as the MOH Secretariat for QA/QI Programme and the WHO Collaborating Centre for Health Systems and Quality Improvement, took the lead to realise this mission with the guidance of the WHO Consultant. The WHO NQPS framework highlighting eight main elements in developing national quality policy and strategy was used as the main reference for the policy development.

**NPQH** is built upon a comprehensive situational analysis of the state-of-quality of healthcare in Malaysia which applied a mixed-methods approach, involving review of data and qualitative assessment of stakeholders. Various quality related documents were retrieved and reviewed, diverse groups of stakeholders including public population were identified and engaged to voide their opinions about quality of the health system, and existing Quality Improvement Initiatives were listed and mapped.

A SWOT analysis revealed 10 key issues in the current state-of-quality of healthcare in Malaysia which shaped the development of domains in the policy statement and strategy for improvement. The local definition of quality was revised through extensive review of both local and international quality related documents and gathering input from key stakeholders to bring clarity to the concept of quality that will unite both patients and healthcare providers with common domains for measuring and monitoring quality of healthcare.

The **NPQH** focuses on the policy statement based on the findings from the situational analysis. The agreed **QUALITY DEFINITION** focuses and consolidates all the other elements or components. This clear definition better aligns quality oversight with patient expectations and the health care delivery system's evolution, expansion, and complexity.

Providing **high quality** healthcare that is **SAFE, TIMELY, EFFECTIVE, EQUITABLE, EFFICIENT, PEOPLE-CENTRED, and ACCESSIBLE [STEEEPA]** which is innovative and responsive to the needs of the people and is delivered as a **TEAM**, in a **CARING** and **PROFESSIONAL** manner in order to improve health outcomes and client experience.

This is followed by policy statements for each of the seven Strategic Priorities (SP) areas that were identified for improvement. The seven strategic priorities areas are;


Appropriate and measurable objectives were formulated to address each strategic priority area for improvement in the form of five-year (2022-2026) action plan. Mechanisms to implement the strategies were delineated in the fourth section.

**NPQH** calls for multi-level actions from each of the key players that need to cohesively work together with a sense of urgency to enable the achievement of national strategic objectives for quality in health care.

With this strong team work and collaboration, we aim to **bridge silos** within the health sector to **accelerate improvements**. This can be achieved through seamless alignment between the **NPQH** and overall national health policy as well as quality related policies and strategies that exist in different areas.

# NPQH at a Glance

**What is NPQH?**

NPQH is a country level document which will provide an official, explicit policy statement and strategies require to enhance quality of Malaysia's healthcare system. This policy seeks to address and provide guidance on 7 Strategic Priorities (SP) Areas derived from the situational analysis through adoption of systematic and collective plan of actions.

**What are the key areas of concern identified by the Situational Analysis?**

1. People-centred holistic approach
2. Governance & organisational structure for quality
3. Stakeholder Engagement
4. Health management information & quality monitoring and feedback system
5. Workforce competency & capability towards quality management
6. Quality culture
7. Resources
8. Knowledge exchange, communication & coordination among programs
9. Quality indicators & core measures
10. Quality improvement initiatives M&E

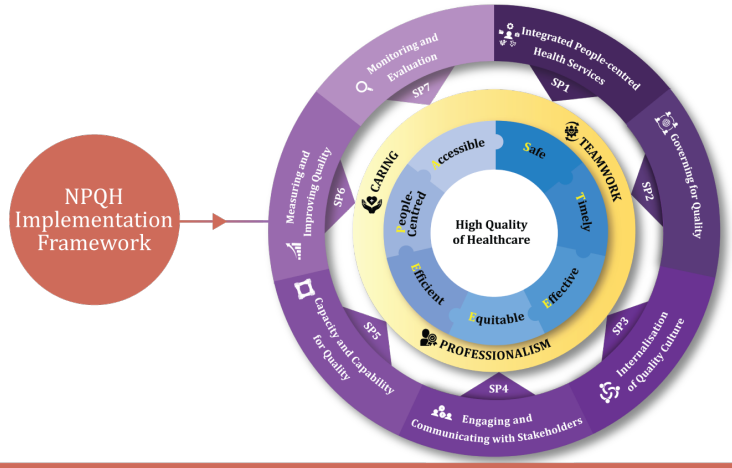
**How do we define QUALITY in our local context?**

Providing high quality healthcare that is

**SAFE, TIMELY, EFFECTIVE, EQUITABLE, EFFICIENT, PEOPLE-CENTRED, and ACCESSIBLE [STEEEPA]** which is innovative and responsive to the needs of the people and is delivered as a **TEAM**, in a **CARING** and **PROFESSIONAL** manner in order to improve health outcomes and client experience.

**How will we implement NPQH?**

NPQH Implementation Framework




## 7 Strategic Priorities (SP)—Policy Statement & Strategic Plan

| | Objectives | Actions | Indicators |
|---|---|---|---|
| **SP 1**: Improving integrated people-centred services | 2 | 3 | 6 |
| **SP 2**: Strengthening governance for quality | 4 | 8 | 7 |
| **SP 3**: Strengthening internalisation of quality culture among all healthcare staff | 5 | 6 | 8 |
| **SP 4**: Enhancing communication and engagement of stakeholders for quality | 3 | 5 | 7 |
| **SP 5**: Building effective capacity and capability for quality | 2 | 7 | 8 |
| **SP 6**: Enhancing measurement and quality improvement initiatives | 4 | 9 | 6 |
| **SP 7**: Strengthening monitoring and evaluation of quality programmes or initiatives | 2 | 5 | 5 |

# *Part 1*

# *Introduction*

# 1.0 Introduction

## 1.1 National Quality Policy and Strategy (NQPS) Within the Global Context

Quality is central to healthcare service delivery. In Target 3.8, the Sustainable Development Goals (SDG) state clearly that to achieve universal health coverage, including financial risk protection, people must have access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. The WHO states that Universal Health Coverage (UHC) means "Ensuring that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship".

In 2018, three Global Quality Reports (1–3) were published that highlighted three key themes affirming quality as central to UHC;

- Theme 1: Poor quality of care imperils global efforts to achieve SDG.
- Theme 2: Health systems need to measure outcomes and what matters most to people.
- Theme 3: Assuring-and improving-the quality of care requires system-wide action: a shared vision of quality, a coordinated quality strategy, continuous learning, and a clear structure of accountability.

Through these reports, a call was made for high-level action by key constituencies for quality in health care, which emphasised the role of all governments, health systems, citizen and patients, the top priority being the possession of a national quality policy and strategy.

In recognition of this need, the World Health Organization published a practical handbook for developing National Quality Policy and Strategy (4) in healthcare to help provide guidance for countries wishing to develop their very own national quality policy and strategy. The NQPS is defined in the WHO Handbook as an organised effort by a country to promote and plan for improved quality of care, outlined in a document and providing an official, explicit statement of the approach and actions required to enhance the quality of healthcare across a country's health system.

Reasons cited as motivating factors for addressing healthcare quality include suboptimal of care in the face of increasing burden of illness and the rising healthcare costs globally.

Some widespread evidence of poor quality from the aspect of accessibility, costs of implication and power of prevention (5) include the following:


In high income countries, 1 in 10 patients is adversely affected during treatment


In high income countries, 7 in 100 hospitalised patients can expect to acquire a healthcare-associated infection


Sixty per cent of deaths in LMICs from conditions requiring healthcare occur due to poor quality care, whereas the remaining deaths result from non-utilisation of the health system.


Inadequate quality of care imposes costs of US$ 1.4–1.6 trillion each year in lost productivity in LMICs.


It has been estimated that high quality health systems could prevent 2.5 million deaths from cardiovascular disease, 900,000 deaths from tuberculosis, 1 million newborn deaths and half of all maternal deaths each year.

Reasons for focusing on the NQPS (4) include:

i. The need to create a culture shift that supports providers to deliver and users to demand quality care
ii. Traversing traditional silos by bringing together multiple quality initiatives under a systematic and organised effort to improve quality of care across the health system
iii. Securing high-level commitment to quality through stakeholder engagement and consensus-building, in order to deliver on national health objectives
iv. Clarifying structures for governance, accountability and monitoring national quality efforts

## 1.2 Overview of the Malaysian Healthcare System

At present, Malaysia has a dichotomous public-private system of health care services delivery **(Figure 1)**. In the public sector, the Ministry of Health is the main provider of healthcare services in the country, services are also provided by other ministries such as the Ministry of Higher Education, Ministry of Defence, Ministry of Women, Family and Community Development, Ministry of Home Affairs as well as the Ministry of Housing and Local Government.

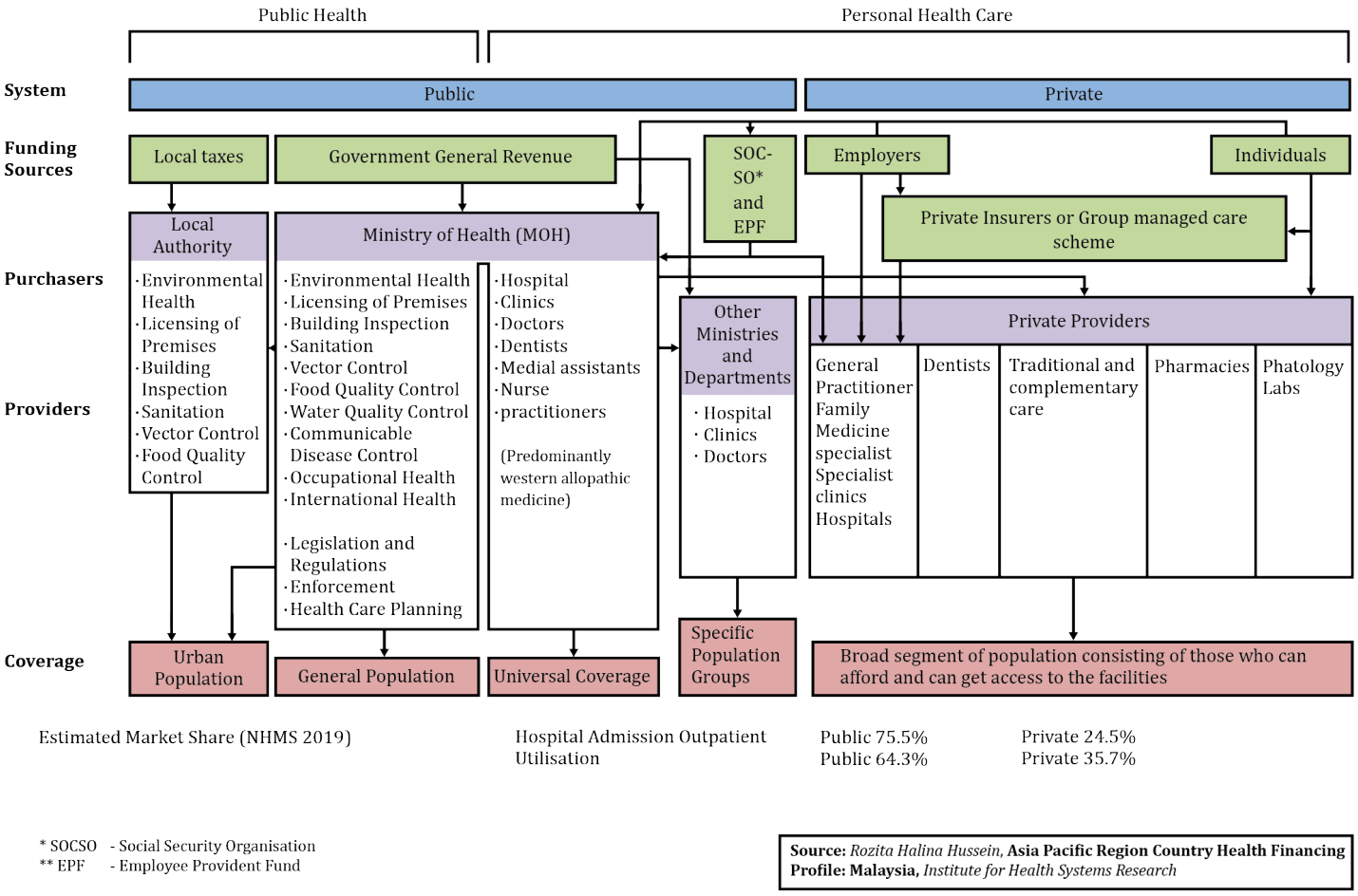



**Figure 1**: Schematic Overview of Malaysian Healthcare System

The private sector, which includes for-profit companies, non-profit organisations, educational institutions, and individual practitioners, contributes significantly to the provision of health care services and is governed by the Private Healthcare Facilities and Services Act.

The MOH is consisted of two major components- the technical programmes and the administrative arm. There are six technical programmes— Public Health (which includes public health and primary health care), Medical (hospitals and specialist care), Oral Health, Pharmaceutical Services, Food Safety and Quality, and Research & Technical Support—each headed by either a Deputy Director General (DDG) or Senior Principal Director, who reports to the Director General of Health. In addition, various administrative arms of the ministry, including Management and Finance, are led by respective Deputy Secretary Generals and report directly to the Secretary General (6).

The public healthcare system is largely funded by the government and financed mainly from public tax revenue. On the other hand, healthcare services delivered by the private sector are funded primarily through private health insurance, out of pocket payment by consumers, and also by non-profit institutions. The public health sector provides approximately 75.5 % of inpatient care and 64.3% of ambulatory care while the private sector provides the remaining inpatient and ambulatory healthcare services (7).

The growth and sophistication of the Malaysian healthcare system has been impressive, expanding from a rudimentary system inherited by the British since the nation's Independence in 1957 to the modern, complex system that we have today and which has achieved wide coverage and equity as well notable improvements in the population's health status over the years **(Table 1)**. Currently, non-communicable diseases account for the majority of the nation's mortality and morbidity **(Table 2)** but communicable diseases, such as dengue, and pandemics such as Covid-19, avian flu, continue to be of concern.

**Table 1** : Key health indicators

| Indicator | 2016 (8) | 2017 (9) | 2018 (10) | 2019 (11) |
|---|---|---|---|---|
| Life expectancy at birth (in years)- total | 74.4 | 74.4 | 74.5 | 74.5 |
| Infant mortality rate (per 1,000 live births) | 6.7 | 6.9 | 7.2 | NA |
| Under five mortality rate (per 1,000 live births) | 8.1 | 8.4 | 8.8 | NA |
| Maternal Mortality ratio (per 100,000 live births) | 29.1 | 25.0 | 23.5 | NA |
| Childhood immunisation coverage | | | | |
| » BCG for infants | 98.26% | 98.50% | 98.43% | 98.48% |
| » DPT-HIB for infants (3rd dose) | 97.97% | 98.89% | 100.22% | 98.39% |
| » Polio for infants (3rd dose) | 97.97% | 98.89% | 100.22% | 98.39% |
| » MMR for children aged 1 to < 2 years | 94.37% | 88.80% | 87.75% | 97.67% |
| » Hepatitis B for infants (3rd dose) | 97.97% | 98.15% | 99.16% | 97.30% |
| » HPV for girls aged 13 years (2nd dose) | 83.02% | 99.40% | 82.23% | 99.45% |

**Table 2** : Prevalence of NCD

| Prevalence of NCD | NHMS 2011(12) | NHMS 2015(13) | NHMS 2019(7) |
|---|---|---|---|
| Diagnosed Diabetes (Adults) | 7.2% | 8.3% | 9.4% |
| Undiagnosed Diabetes (Adults) | 8.0% | 9.2% | 8.9% |
| Hypertension ≥ 18 years | 32.7% | 30.3% | 30.0% |
| Hypercholesterolemia | 35.1% | 47.7% | 38.1% |

## 1.3 Quality in the MOH

### 1.3.1 Quality Journey

More than three decades ago in 1985, the Ministry of Health Malaysia had the visionary foresight to formally demonstrate its commitment to Quality Improvement with the launching of the Quality Assurance Programme (QAP), which aims to improve quality, efficiency and effectiveness of health services rendered by the MOH and to provide an organised and systematic evaluation of quality activities (14). The creation of the QAP was consistent with the emphasis on quality and the coordination of quality-related activities that were called for in Fourth Malaysia Plan (1981-1985).

Even before that, the statutory registration of health professionals such as doctors, nurses and pharmacists, licencing of healthcare facilities including hospitals, clinics and pharmacies, regulations for medicines and codes of conduct and ethics have been in effect for decades. Regulation in healthcare has three key purposes: (i) to improve performance and quality; (ii) to provide assurance that minimally acceptable standards are achieved and (iii) to provide accountability both for levels of performance and value for money (15).

More initiatives have been introduced over the years as shown in **Figure 2** and among the key milestones were:

Publication of The Strategic Plan for Quality in Healthcare in 1998 which was the seminal document that was formulated to provide the impetus and the direction for MOH to achieve its goals to institutionalise and internalise quality in the health system to an optimal level within the next decade. This document outlined four policies and 14 strategies (16).

Establishment of the MOH Innovation Steering Committee in 2011 following government (Prime Minister's Office) instruction co-chaired by the DG and the Secretary General. This changed the existing structure of quality committees in the MOH whereby the National QAP Committee previously chaired by the DG is now one of the three subcommittees under the new structure and led by the DDG for Research & Technical Support.

# Quality Journey in MOH

## 1981-1985

4th Malaysia Plan and coordination of quality related activities

**1985 QAP was launched**

1985 NIA

## 1986-1995

1990 Clinical Audit
1990 QA (HSA/DSA)
1990 Innovation
1990 Corporate Culture
1991 Creative & Innovative Circle (CIC)
1991 Confidential Enquiry Maternal Death (CEMD)
1991 Perinatal Mortality Review
1992 Clinical Practice Guideline (CPG)
1992 Peri-operative Morality Review (POMR)
1993 Client Charter
1994 Occupational Health Services

## 1996-2005

**1998 Strategic Plan for Quality in Health document was published**
1998 Accreditation
1999 Incident Reporting & Learning System
2001 Infection Prevention & Control
2001 COMBI for Dengue Prevention & Control
2002 Credentialing & Privileging (Nursing)
2003 Patient Safety
2003 National Nursing Audit (NNA)
2005 KPI
2005 Value Added Service (VAS)
2005 Private Healthcare Facilities and Services Act

## 2006-2015

2007 Training & Supervision -CPD
2007 Pharmacy Internal Audit (*ADAF*)
2007 Know Your Medicine
2007 Medication Error Reporting System (MERS)
2009 Wound Care
2009 Safe Surgery Saves Lives (SSSL)
2010 Credentialing & Privileging (Primary Care)
2011 Pain Free
**2011 New Structure for Quality in MOH**
2012 National Operating Room Nursing Audit (NORNA)
2013 Customer Complaint Management
2013 *KOSPEN*
2013 Malaysian Patient Safety Goals (MPSG)
2013 Credentialing & Privileging (Allied Health)
2013 Cluster Hospital
2014 Antimicrobial Resistance Containment Programme
2014 Lean Healthcare
2014 Credentialing (Pharmacy)

## 2016-2020

2016 *KOTAK*
2016 Dental Icon
**2018 Malaysian's global leadership in hosting the ISQua Conference following which a design meeting with WHO Technical Expert was held to shape the trajectory of NPQH**

Proposal for development of the National Policy for Quality in Healthcare (NPQH)

2020 COVID-19 Mortality Surveillance & Mortality Review

**Figure 2:** MOH Quality Journey

## 1.3.2 Quality Improvement Initiative (QII) Definition and Categorisation

In the Malaysian context, a quality improvement initiative (QII) is a continuous change process that is data-driven and based on systematically planned action, to increase the likelihood of optimal quality of care measured by improved healthcare processes, outcomes and client experience.

Each QII in MOH has distinct roles in improving quality of the healthcare delivered. **Figure 3** illustrates the categorisation of the QII. Detailed mapping of these QIIs by leading programme and governance structure is shown in **Appendix 1**.

## 1.3.3 Quality Improvement Initiative (QII) Organisational Structure

In the Ministry of Health, implementation and monitoring of QIIs is strongly supported by a clear and strong organisational structure across different levels from national to facility level. Each programme has a particular division/department/section/unit for quality. The task to lead a particular QII at the national level is being shared by different programmes as assigned by the top management. Each quality initiative usually has its own committee/sub-committee to supervise the activities. Similarly, there are also Quality Committees at the states, hospitals and health district offices level. The current organisational structure for quality at the national level (MOH) is shown in **Figure 4**.

# Quality Improvement Initiatives (QII) Mapping

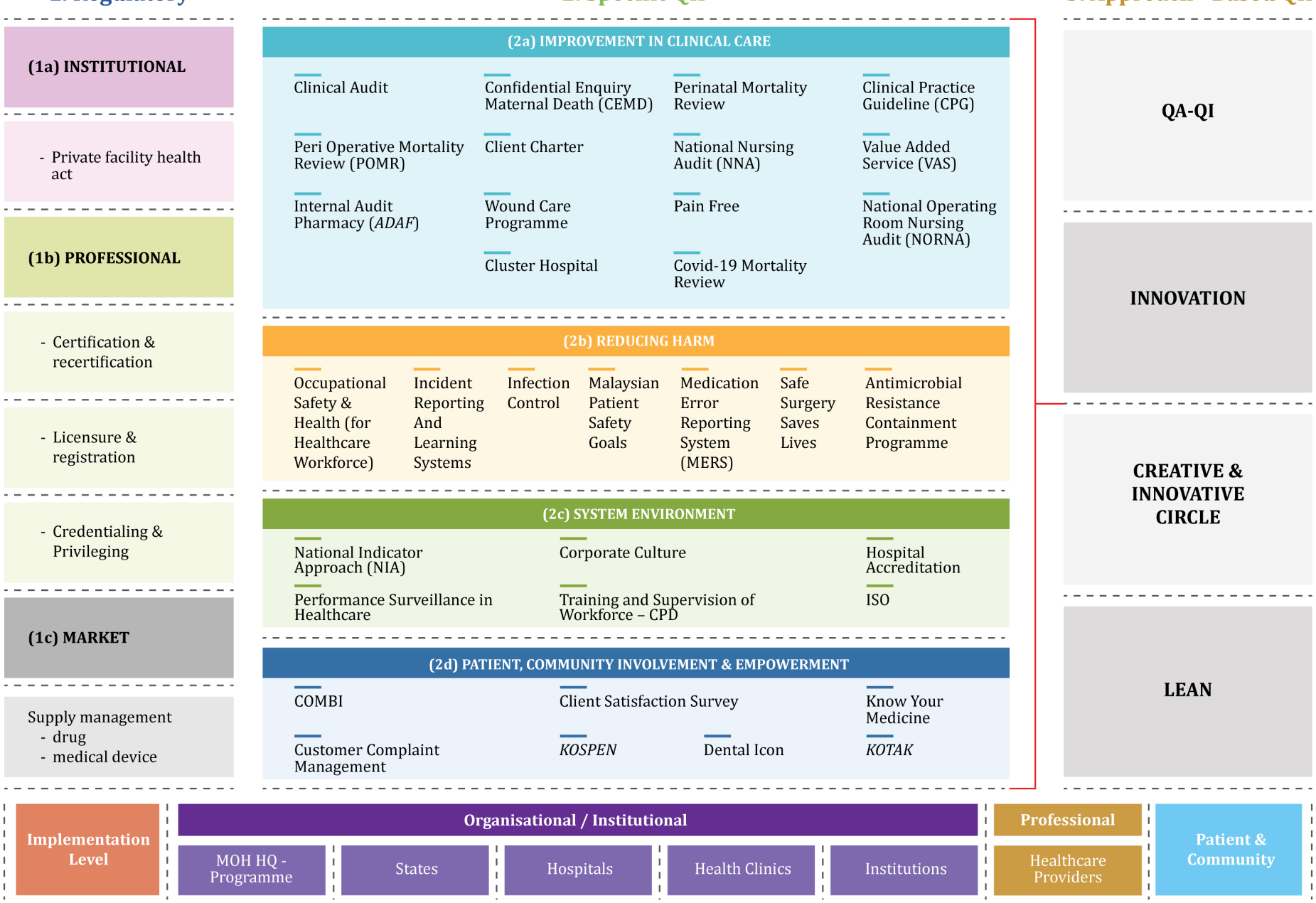



**Figure 3:** Categorisation of Quality Improvement Initiatives

# Governance & organisational structure

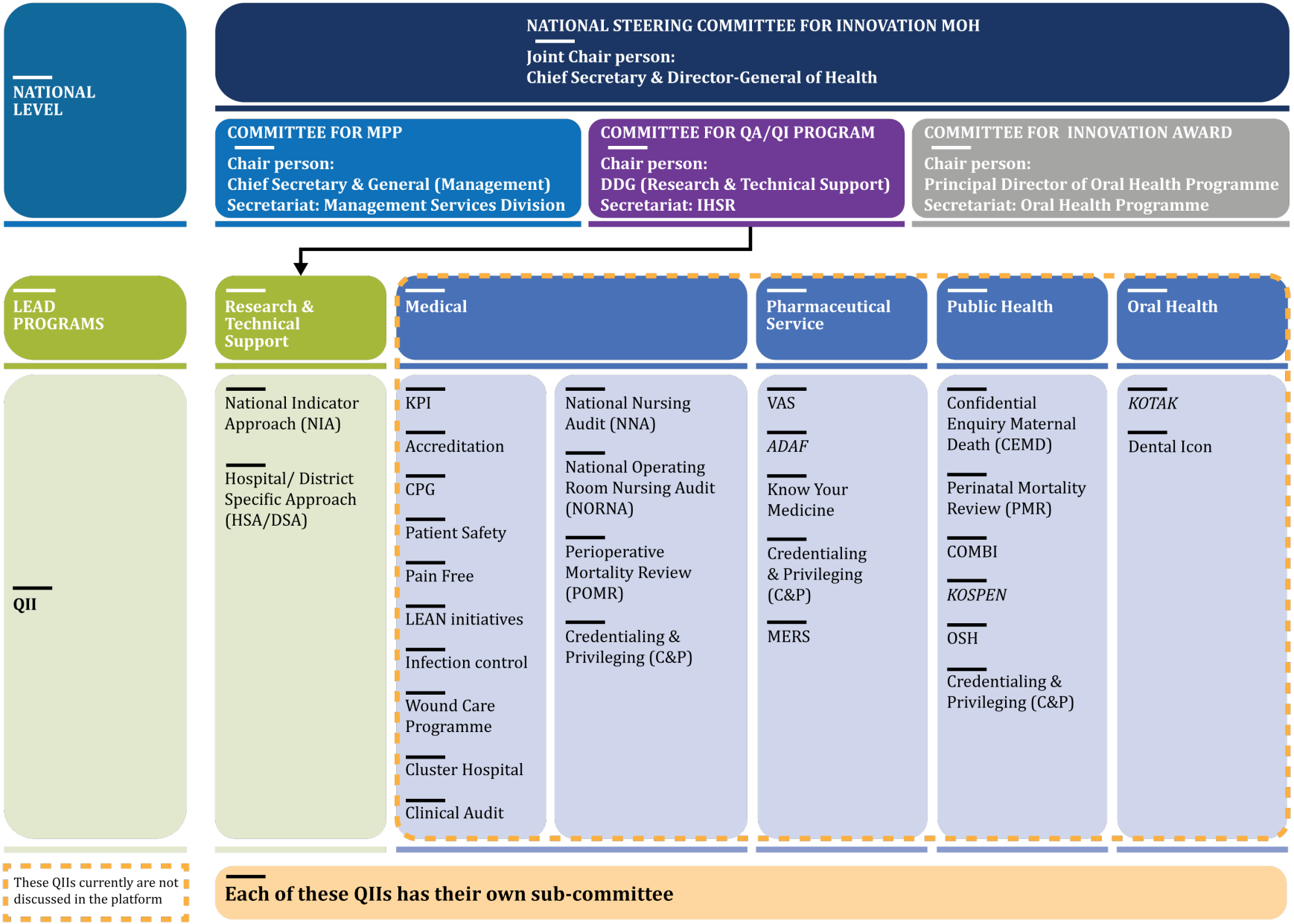



**Figure 4:** Governance & Organisational Structure for Quality in the MOH (National Level)

## 1.3.4 Achievement of QII

This section highlights a summary of the substantial progress and achievement of each QII that was introduced during the last five years. The arrangement is according to the categorisation in 1.3.2. The governance structure for each QII is tabled in **Appendix** 1.

### 1.3.4.1 Regulatory

*a) Institutional*

Regulations that specify standards for healthcare facilities and services such as the Private Healthcare Facilities and Services Act (PHFSA), which has been in force since 2005.

*b) Professional*

Regulations that provide oversight of health care providers, including doctors, nurses, medical assistants, dentists, pharmacists and allied health professionals to govern the practice of these professionals in the interest of the public and the nation.

**Licensure & Registration**

- Mandatory registrations of various healthcare professionals (HCP) in Malaysia currently include doctors, dentist, pharmacists, nurses and medical assistants. A probationary or temporary registration will be issued on first registration followed by a full registration after the HCP has completed the probationary period and fulfils criteria for full registration. The attainment of full registration needs to be done only once throughout a lifetime of the HCP.
- The implementation of mandatory HCP registrations was executed through the endorsement of acts and laws for specific profession by the Laws of Malaysia. Some of the existing acts include Nurses Act 1950, Registration of Pharmacists Act 1951, Medical Act 1971, Dental Act 1971 and Medical Assistants (Registration) Act 1977.
- The most recent act that has been passed in the Law of Malaysia is the Allied Health Profession Act 2016 which among others, mandates the registration of allied health professionals in Malaysia.
- A specific license or permit is also required in special circumstances, for example, Type A Licence is mandatory for a registered pharmacist to import, store and deal generally by retail and/or wholesale, in all poisons in accordance to the Poisons Act 1952.

### Certification and Recertification

- Certification by accredited body is mandatory for a healthcare professional to practise legally in Malaysia. A certificate known as Annual Practicing Certificate (APC) is required before a HCP starts practising and needs to be renewed annually.
- The issuance of ACP is governed by specific professional council or board such as Malaysian Medical Council, Malaysian Nursing Board, Malaysian Dental Council, Pharmacy Board Malaysia and Medical Assistant Board.
- Among the most recent development is the establishment of Malaysian Allied Health Professions Council in 2020 which works towards the implementation of mandatory registration and certification for allied health professions in Malaysia.

### Credentialing and Privileging (C&P)

**(Year Introduced: 2001- Depending on programme)**

- The circular on the "Guidelines on Procedures in the Credentialing and Privileging System in the MOH" was disseminated in 2001. The initial phase of implementation involved physicians before being expanded to include the other services under MOH.
- **The Credentialing and Privileging System for the Nursing Division**, which was initially under the Allied Health Sciences under the MOH, was handed over to the Nursing Program in 2016 to continue the system. The nursing division has 12 disciplines under their Credentialing and Privileging system. From 2015-2020, the overall passing rate for the recredentialing and credentialing of the 12 nursing disciplines were 97.7% and 95.4% respectively.
- **The Pharmacy Program was implementing the credentialing system** since 2014, starting with a focus on the pharmacy practice areas. Up until 2020, there are 16 credentialing fields for pharmacists, and one field for Assistant Pharmacists established. The cumulative number of pharmacists who had received their credentialing from 2016 until 2020 is 501 pharmacists.
- **Guideline for C&P at Primary Health Care facilities** was published in 2010 and the latest amendment was made in year 2020. Currently, five (5) categories of officers were included in the guideline: Family Medicine Specialists, Medical Officers, Assistant Medical Officers, Trained Nurses and Community Nurses.

    a. In 2020, total of three (3) procedures have been approved for C&P among Family Medicine Specialist (FMS), four (4) procedures for medical officer, nine (9) procedures for assistant medical officer, nine (9) procedures for trained nurse and four (4) procedures for community nurse.
    b. The number of health personnel given C&P for the last 5 years was 2,606 in 2016; 2,765 in 2017; 3,247 in 2018; 3,362 in 2019 and 1,349 in 2020. During the 5-year period, 48.8% of those given C&P were community nurses, 22.3% were trained nurses, 10.6% were medical officers, 9.3% were assistant medical officers and 0.2% were FMS.

- **The Credentialing System under Allied Health Professional** currently covers for nine (9) professions with five (5) professions started in 2013 i.e. Physiotherapy, Occupational Therapy, Diagnostic Radiographer, Radiation Therapist and Dental Technologist. The second group follows in 2015 involves four (4) more professions namely Optometrist, Dietician, Speech Language Therapist and Audiologist. Up to 2020, a total of 7756 personnel has been credentialed for these nine professions.

c) *Market (commodities and devices)*

Regulations that specify standards for healthcare facilities and services such as the Private Healthcare Facilities and Services Act (PHFSA), which has been in force since 2006.

- Under the Control of Drugs and Cosmetics Regulations 1984, the Drug Control Authority (DCA) is the executive body established to ensure the safety, quality, and efficacy of pharmaceuticals, health, and personal care products marketed in Malaysia.
- The Medicines (Advertisement and Sale) Act 1956 regulates product advertisement in the market which requires Medicine Advertisement Board (MAB)'s approval prior to publication except for total prohibition of 20 diseases and certain conditions of human beings as specified under the Act.
- Thus, current regulations administer the quality, safety, and efficacy of healthcare supply management such as drugs and the quality and safety of food and medical devices.

### 1.3.4.2 Specific QII

*a) Improvement in Clinical Care*

| **Clinical Audit**<br>**Year Introduced: around 1990** | Improvement in Clinical Care |
|---|---|

- Clinical Audit activities at the hospital level have grown rapidly since 2017, with continuous training conducted for hospitals.
- Guidelines on Clinical Audit was produced. At the same time, National Audit on Dengue, Lymphoma and Chest Tube Injury have been carried out.
- As of 2019, the Oral Health Programme embarked on its clinical monitoring initiative, which includes the conduct of clinical audits at dental clinics/schools and audit of patients' treatment records/cards.

| **Confidential Enquiry into Maternal Deaths (CEMD)**<br>**Year Introduced: 1991** | Improvement in Clinical Care |
|---|---|

- Publication on CEMD related materials such as:
  - National Policy on Administration of Thromboprophylaxis during postnatal
  - CEMD Report in triennial since1991; e.g. CEMD Report for 2009-2011, 2012-2014, 2015–2017
  - Case Illustrations 1996 -2020
  - Annual CEMD Bulletin since 2012
  - Training Manual e.g. Training Manual on Management of Postpartum Haemorrhage 2016, Quick Reference Guide on Postpartum Haemorrhage 2016, Hypertensive Disorder in Pregnancy 3rd Edition 2018, Prevention and Treatment of Thromboembolism in Pregnancy and Puerperium 2nd Edition 2018
  - Consensus Statement e.g. Consensus Statement on Malaysia Guideline for the Management of the Placenta Accreta Spectrum 2020, Consensus on Management of Hyperemesis Gravidarum 2020

| **Peri-natal Mortality Review**<br>**Year Introduced: 1991** | Improvement in Clinical Care |
|---|---|

- The Stillbirth and Under 5 Mortality Reporting (SU5MR) System, was fully implemented in July 2013.
- Perinatal mortality rates for the past 5 years were 8.4 (2015), 8.1(2016), 8.4 (2017), 8.8 (2018) and 7.7 (2019).
- A National Framework to Reduce the Under-5 Mortality and Support Child Growth & Development, (National Plan of Action for Child Health 2021-2030) was approved in *Mesyuarat KPK Khas* on 8 December 2020 and also approved by *Mesyuarat Jawatankuasa Dasar dan Perancangan KKM* (JDPKK) on 23 February 2021.

| Clinical Practice Guideline<br>**Year Introduced: 1992** | Improvement in Clinical Care |
|---|---|

- In April 2001, CPG development came under purview of Malaysia Health Technology Assessment Section (MaHTAS), Medical Development Division, MoH.
- In the past five years (2016-2020) a total of 16 CPG (7 new CPG and 9 updated CPG) were approved to be published and implemented. These include various specialty/discipline; cancer, mental health, infectious disease, gastrohepatology, respiratory, orthopaedics, rheumatology, nephrology, dermatology, haematology, endocrinology, ophthalmology and otorhinolaryngology.
- Six CPG related manuscripts were published in local and international journal in 2017-2021.
- Various types of implementation strategies were developed (2016-2020) namely Quick Reference (n=14), training module and training of core trainers at national level (n=11) and launching of new references (n=14).

| Peri-Operative Mortality Review (POMR)<br>**Year Introduced: 1992** | Improvement in Clinical Care |
|---|---|

- After the POMR was introduced in 1992, the POMR reporting rate was being monitored since then, and in 2015 it has been one of the indicators for Global Surgery 2030.
- The reporting by hospital through vPOMR.
- Training Module has also been developed for the purpose of Hospital Training in POMR.

| Client Charter<br>**Year Introduced: 1993** | Improvement in Clinical Care |
|---|---|

- This initiative monitors 15 MOH's *Piagam Pelanggan Teras* (Core Client Charter) in 2 core categories.
- In ensuring client satisfaction with the service delivered (Jan-Dec 2020):
  - 100% of customer complaints are given early feedback within 1 working day from the date the complaint is received
  - 91.96% clients were seen by a medical officer within 90 minutes (TPC Data)
  - 96.95% prescriptions are dispensed within 30 minutes
  - 83.14% patients are called to be seen by a dental officer within 30 minutes
  - 91.96% medical reports prepared within the stipulated time
  - 98.30% patients satisfied with the dental service delivered
- In ensuring application and approval of various services are processed and completed within the stipulated time frame from the date the complete application form is received which meets the application and legal requirements (Jan-Dec 2020):
  - 100% achievement for multi-service application process and approval; Pharmacist Registration Certificate, Private Dental Clinic Registration, Fumigation License (*Lesen Pewasapan*), Midwife Board Examination Results, HACCP Audit Report Results and Health Promotion Services
  - 93.19% achievement for Nurse Registration Certificate issued within 14 working days
  - 93.75% for Packaged Drinking Water and Natural Mineral Water License issued within 5 working days
  - 89.01% License for Radiation Apparatus / Radioactive Materials (New and Renewed) issued within 7 working days

| National Nursing Audit (NNA)<br>**Year Introduced: 2003** | Improvement in Clinical Care |
|---|---|

- NNA (Medical) performance from 2017 until 2020:
  - Three of the five elements (aseptic wound dressing, administration of intravenous infusion and pain as 5th vital sign) met the target of 90%. However, another two elements assessed namely administration of oral medication and blood component transfusion were slightly below the standard of 100%.
- NNA (Public Health) performance from 2017 until 2020:
  - Most of the elements monitored (10/12) has consistently achieved the target with increasing trend over the years.
  - Two elements which are administration of injectable immunisation and cold chain system management were slightly below the standard.
  - For element on management of malnutrition in children aged 6 months to 6 years, despite low achievement in 2017, the indicator showed a considerable progress and exceeded the target in 2020.

| Pharmacy Value Added Service (VAS)<br>**Year Introduced: 2005** | Improvement in Clinical Care |
|---|---|

- The concept of VAS was initially started in 2005 with the implementation of Integrated Medicine Dispensing System (*Sistem Pendispensan Ubat Bersepadu* -SPUB) which allows patients to request a further supply of medicines at the nearest healthcare facilities.
- The emerging concept was then evolved with the introduction of Pharmacy Appointment System; Drive-Through Pharmacy; Medicines by Post (*Ubat Melalui Pos*, UMP) and Locker4U.
- Over the last 5 years (2016 to 2020), the percentage repeat prescriptions dispensed through VAS has increased from 18.3% (2016) to 34.4 % (2020).
- In response to combat COVID-19 outbreak, the MOH decided to bear the UMP delivery charges from 5th April 2020 to 30th June 2020. Following the delivery charge subsidy and various promotional activities, the use of UMP has increased rapidly, with 188,244 medicine's packages in three months (April to June 2020) as compared to 254,530 packages for the whole year of 2019.
- In 2020, a total of 68 Local Follow-up Medicines Supply Centres (*Pusat Pembekalan Ubat Susulan Setempat* - PPUSS) have been established to provide convenience and better option for patients' access to their medication through VAS.

| Pharmacy Practice Internal Audit (ADAF)<br>**Year Introduced: 2007** | Improvement in Clinical Care |
|---|---|

- In 2007, ADAF implementation was conducted based on qualitative assessment of facilities compliance level (good, moderate, poor).
- Starting in 2019, ADAF scoring system was introduced to improve and standardise the assessment of facilities compliance levels involving 11 key areas.
- The recent guideline (*Panduan ADAF 2020*) was issued in 2020 following improvements made to the scoring system.

| Wound Care Programme<br>**Year Introduced: 2009** | Improvement in Clinical Care |
|---|---|

- In 2011, Director General Circular on the Guidelines for the Establishment of Wound Care Team in MOH Hospitals was released.
- Wound Care Quick Reference, 1st Edition was developed in 2019.
- As of 2020, 113 MOH hospitals have established wound care team (MOH Action Plan 2016-2020) and RM 5 million has been dedicated for wound care programme annually.

| Pain Free Programme<br>**Year Introduced: 2011** | Improvement in Clinical Care |
|---|---|

- This Programme encompasses of Pain as the 5th Vital Sign (P5VS) and Pain Free Hospital (PFH).
- This initiative also involved the Dental Programme, Public Health Programme and Pharmacy.
- P5VS is being implemented at all government hospitals and selected Health Clinics throughout Malaysia. As of 1st January 2021, Pain as 5th Vital Sign (P5VS) and Pain Management, initiative entered its third phase of implementation at all government dental clinics at all districts/states nationwide.
- At the end of 2020, 32 hospitals were awarded Pain Free Hospital Certification.

| National Operating Room Nursing Audit (NORNA)<br>**Year Introduced: 2012** | Improvement in Clinical Care |
|---|---|

- Four elements are monitored under NORNA; (i) Receiving patient at the reception area (ii) Scrubbing, gloving and gowning (iii) sponges, sharps and instruments count and (iv) care of patient at the recovery bay. Based on data from 2016-2020, all elements showed achievement that were slightly lower against target with almost similar percentage every year from 2016-2020.

| Cluster Hospital<br>**Year Introduced: 2014** | Improvement in Clinical Care |
|---|---|

- The Cluster Hospital initiative began its pilot project implementation in 2014 with 3 Cluster Hospitals. Subsequently, in 2016, the Cluster Hospital Policy Framework and Guidelines were revised. From 2016-2020, MOH decided for a nationwide expansion of this initiative in phases to include all suitable MOH hospitals. In 2018 the Hospital Cluster Administrative Guideline was published to support the program.
- 2014-2015 : 3 pilot cluster hospitals involving 11 hospitals
- 2016 : 3 new cluster hospitals involving 11 hospitals
- 2017 : 4 new cluster hospitals involving 15 hospitals
- 2018 : 3 new cluster hospitals involving 11 hospitals
- 2019 : 12 new cluster hospitals involving 44 hospitals
- 2020 : 17 new cluster hospitals involving 47 hospitals
- From 2021-2025, the aim is to strengthen the initiative to ensure its sustainability by internalising the cluster hospital initiative among the State Health Departments and the Ministry of Health Headquarters.

| COVID-19 Mortality Surveillance and Mortality Review<br>**Year Introduced: 2020** | Improvement in Clinical Care |
|---|---|

- National COVID-19 Mortality Surveillance and Review have been conducted since the pandemic started in March 2020.
- COVID-19 mortality cases can be divided into two categories – "Inpatient death" and "Brought in dead". The main objectives are to monitor magnitude and trend of death as well as factors contributed to COVID-19 death in Malaysia. Hence improvement in terms of clinical management and preventive aspect can be instituted.
- Clinical Audit Unit, Medical Care Quality Section, Medical Development Division, MoH is the Technical Secretariat at Ministry level which work closely with clinicians, Public Health Programme, State Health Department and District Health Office to collect reliable data in timely manner.

*b) Reducing Harm*

| Occupational Health Services<br>**Year Introduced: 1994** | Reducing Harm |
|---|---|

- Occupational health activities were initiated under the Workers Environmental and Health Unit which was developed in MOH following the gazettement of the Occupational Safety and Health Act 1994, which eventually progressed to become the Occupational and Environmental Health Sector under the Disease Control Division, Ministry of Health. Later in 2007, Occupational Safety and Health Unit was also established in Medical Development Division, MOH to focus on occupational safety and health aspect in MoH hospitals.
- Occupational health activities carried out for MOH include notification of occupational injuries and diseases, Sharps Injuries Surveillance Program, Tuberculosis (TB) Screening Program, Hepatitis B Immunisation Program, Investigations as well as Safety and Health Audits
- In MOH hospitals, additional programmes are established such as – risk management, emergency and disaster preparedness, chemical management in hospital, prevention of violence at workplace, COVID-19 prevention among health care workers and strengthening of Safety and Health Committee.
- As per requirements of the law, a Safety and Health Committee has been established in facilities with forty or more employees which carry out the occupational activities in the various facilities together with the Occupational Health Units where they exist.
- Achievements over the past 5 years include a reduction in the incidence rate of sharps injuries among the healthcare workers from 8.1/1000 healthcare workers in 2016 to 6.2/1000 healthcare workers in 2020 as well as a reduction in the incidence rate of TB among healthcare workers from 87.7/100,000 healthcare workers in 2016 to 65.6/100,000 healthcare workers in 2020.
- The sector works closely with the Department of Occupational Safety and Health (DOSH) and the Social Security Organization (SOCSO)under the Ministry of Human Resources as well also provides occupational health technical support to all other stakeholders and agencies.
- The sector is also actively involved in the workplace management of outbreaks and was integral in the development of all workplace Safety Operating Procedures (SOP's) for the various industries in the recent COVID-19 pandemic.

**Incident Reporting & Learning System for MOH Hospitals**
**Year Introduced: 1999**

Reducing Harm

- Incident Reporting is the first Patient Safety activity implemented in MOH. Following an incident report, investigation need to be conducted to find contributing factors and root cause. Then, actions need to be taken to prevent similar incident from happening.
- In 2018, a new IR system (IR 2.0) using online reporting e-IR and simpler work process has been introduced. Reporting of incident does not need approval from superior, in fact it can be done by any staff and goes directly to Ministry. With this new system, more reporting of incidents is seen compared to the manual system.
- Emphasis was also given on the importance of Root Cause Analysis and Action as well as effective Risk Reduction Strategies.
- Actions are taken at both ministry and facility level. At ministry level, new policies, programmes, promotional and educational activities are among the action taken.
- Root Cause Analysis (RCA) training started in 2007 as an investigation tool following an Incident Reporting. It was further enhanced to RCA2 (Root Cause Analysis and Action) in 2018 to emphasize the importance of taking effective Risk Reduction Strategies.
- Main aim of RCA is to identify main contributing factors to incident, take effective action to prevent similar incident from happening.

**Infection Prevention and Control**
**Year Introduced: 2001**

Reducing Harm

- Infection Prevention and Control was introduced mainly to prevent and control spread of infection in healthcare facility. This is because healthcare associated remain one of the main patient safety issues across the globe.
- "Clean Care Safer Care" initiative is one of the Malaysian Patient Safety Goals with the target of at least 75% hand hygiene compliance during each audit.
- Based on 2015/2016 WHO Hand Hygiene Self-Assessment Framework Survey, Malaysia showed the highest participation among 91 participating countries, with 150 hospitals on board.
- Malaysia also achieved the highest score when audited by the Joint External Evaluation team of International Health Regulation.
- Nursing Post Basic Training on Infection Control was upgraded to Advance Diploma with the 5 moments of hand hygiene & hand hygiene compliance audit included.
- Policies and Procedures on Infection Prevention and Control, 3rd Edition was successfully updated and published in 2019.
- Hand Hygiene Train the Trainer Course was conducted in 2017 and 2019 which was facilitated by University of Geneva and attended by MOH, Private and University Hospitals. 140 auditors have been qualified as Hand Hygiene Auditor.
- Annual Infection Control seminar is held in conjuction with World Hand Hygiene Day.

**Patient Safety Malaysia**
**Year Introduced: 2003**

Reducing Harm

- Malaysian Patient Safety Goals-MPSG (Year Introduced 2013)
  - » Malaysian Patient Safety Goals has created a significant impact in highlighting importance of patient safety among healthcare staff & patients.
  - » It is a singular benchmarking on patient safety which is applicable to all healthcare facilities throughout the country.
  - » MPSG has ignited a massive interest on patient safety throughout the country.
  - » There are 13 goals for hospitals and 4 goals for clinics. In 2022, a revised edition of goals, known as MPSG 2.0 will be implemented. A more refined, simpler and macro goals will be implemented. There will be 7 goals for hospitals and 4 goals for clinics.
  - » Annual performance is presented to Patient Safety Council Malaysia and shared in Patient Safety Council Malaysia website. Improvements are taken at national and facility level
- Patient Safety Awareness Course for House Officers (Year introduced 2017)
  - » This course comprises of 7 modules, based on WHO Patient Safety Curriculum Guide for Medical Schools and amended to suit Malaysia scenario.
  - » It was piloted in 2016. In 2017, it has been implemented in all 46 hospitals conducting Houseman Training. Assessment is held after the training. Impact of this course has been positive.
  - » In 2019, MOU between MoH and International Medical University were signed to establish online course based on this module. It was launched during World Patient Safety Day National Webinar 17th September 2021 and will be used for medical students as well as junior doctors.
- World Patient Safety Day (Year Introduced: 2019)
  - » 17th September has been declared as “World Patient Safety Day” during the 72nd World Health Assembly in May 2019 as a symbol of global commitment and solidarity in improving patient safety.
  - » The first theme was "Patient Safety: A Global Health Priority".
  - » Apart from patient safety activities; historical buildings, landmarks and monument are lit up in orange as a highlight to this important day.
  - » In Malaysia - KL Tower (2019), Putrajaya City (2020) and Prime Minister’s Building (202) were lit up in orange

| **Medication Error Reporting System (MERS)**<br>**Year Introduced: 2007** | Reducing Harm |
|---|---|

- Medication Error Reporting Systems (MERS) was strengthened to include verification of medication error reports at the state level for close monitoring.
- Medication Without Harm initiative was launched in 2017 with the aim of reducing severe avoidable medication related harm by 50% in the next five years. The campaigns and programs were carried out at the states and facilities in 2018.
- In 2018, Medication Safety Self-Assessment Checklist with criteria for medication safety principles and practices evaluation had been established.
- The reviewed and published guidelines in 2019 and 2020 included Guideline on Medication Error Reporting System (2019), Dilution Guideline for Injectable Drug -Part 1 -Antibiotics (2020) and Guideline on Safe use of High Alert Medications-2nd edition (2020). In addition, Medication Safety Newsletter was rebranded to Medication Safety Alert Publication.

| **Safe Surgery Saves Lives Programme (SSSL)**<br>**Year Introduced: 2009** | Reducing Harm |
|---|---|

- Safe Surgery Save Lives Programme was introduced with the main aim of improving surgical safety such as prevention of wrong surgery and unintended retained surgical item.
- The main element of this programme is the use of Peri-Operative Check List which consist of 4-page documents which are – Pre-Operative Check List, Operating Team Check List, Swab & Instrument Count Form and Pre-Discharge Check List.
- It is implemented nation-wide and become one of the Malaysian Patient Safety Goals. It is also part of Patient Safety Training for House Officers and part of the Masters Training in Surgery. Safe Surgery Saves Lives 2.0 has been implemented since 2019.

| **Antimicrobial Resistance Containment Programme**<br>**Year Introduced: 2014** | Reducing Harm |
|---|---|

- Launch of Malaysia Action Plan on Antimicrobial Resistance (MyAP-AMR) 2017-2021.
- One Health Integrated Antimicrobial Resistance (AMR) Surveillance Manual involving human and animal health was developed in 2019
- MOH-WHO: Tricycle Project - Innovative Approach to Monitor Antimicrobial Resistance in Malaysia (Study budget: MYR350,000).
- Annual Antimicrobial Resistance Seminar is held in conjunction with World Antimicrobial Awareness Week (WAAW)

### *c) System Environment*

| **National Indicator Approach (NIA)**<br>**Year Introduced: 1985** | System Environment |
|---|---|

- Monitoring a set of quality indicators known as National Indicator Approach (NIA) to address quality issues prioritise by programme
- As of 2021, a total of 51 NIA is monitored by 10 programmes/divisions nationally.

| Corporate Culture<br>**Year Introduced: 1990** | System Environment |
|---|---|

- MOH invented corporate culture since 1990 with three core elements of caring, professionalism and teamwork.
- Corporate culture trainings in the MOH are conducted every year, however the number was reducing since 2018 – 2020 (2086, 2074 & 926).
- Besides trainings, every month, an infographic poster on different theme of the three elements will be circulated to all staff through email and physical posters as a strategy to continuously remind the staff about this culture.
- Corporate Culture Short Video Competition was held from 1 October 2019 to 29 October 2019 as another means for staff to appreciate the culture and present it in the form of video.

| Hospital Accreditation<br>**Year Introduced: 1998** | System Environment |
|---|---|

- By the end of 2020, there were 71 out of 145 MOH hospitals with valid accreditation status by Malaysian Society for Quality in Health.
- A total of 6 Training of Trainers (TOT) courses for the 5th Edition Accreditation MSQH Standard have been conducted nationwide to enhance the awareness and facilitate the implementation of accreditation standards at the healthcare facilities.
- MOH also involved in giving awareness and training of accreditation standards to Malaysian Armed Forces hospitals and university hospitals.
- 6th Edition Accreditation Standard will be implemented in 2022.

| Performance Surveillance in Healthcare<br>**Year Introduced: 2005** | System Environment |
|---|---|

- Performance surveillance is one of the quality tools designed to assess quality of healthcare. The Key Performance Indicators (KPI) are selected based on global/ national priority areas and the impact to the population.
- Different sets of indicators are formulated to measure performance of specific groups:
  - Technical Performance Monitoring KPIs for high level leaders (Director General of Health, Deputy Director General of Health, Director of Division and State Health Director) started in 2015
  - Clinical Service KPIs developed in 2014 and is used to monitor the performance of the clinical services.
  - Hospital Performance Indicator for Accountability began in 2014 and is used to monitor the hospitals management.
  - Clinical Performance Verification Form was implemented in 2016 with main objective is to identify the workload or output of clinicians.

| Training and Supervision of Workforce - CPD<br>**Year Introduced: CPD in 2007** | System Environment |
|---|---|

- Workplace training and supervision are ongoing processes.
- Annual trainings, including those related to Quality Improvement Initiatives, are part of the Continuous Professional Development (CPD), which is planned at the start of the year or at the end of the previous year and linked to the *Pelan Operasi Latihan* (POL) or Training Operational Plan for budgeting purposes.

- CPD is a systematic continuous learning programme that aims to contribute to the increase of knowledge, skills and experience that can help to enhance the professionalism of the officers in their respective fields. CPD was started in 2007 for 3 schemes i.e. medical officers, dental officers and pharmacists. Following this success, the programme was expanded to other scheme including research officer, allied health professionals, nurses, assistant medical officer, engineer and tutor in 2010. In 2014, the implementation of the CPD programmme for the implementers group of the allied health sciences profession was applied extensively.
- A structured mechanism was established to ensure all staff at every level had opportunity to participate in CPD programme which is coordinated, monitored and evaluated by committee at facility, state and national level. MyCPD, an online monitoring system was developed to monitor CPD.
- Cumulative CPD credit point is used for multiple purposes including
  - Renew of Annual Practicing Certificate (APC)
  - Requirement of 7 days annual training for public servant
  - Renew registration of National Specialist Register (NSR)
  - Key Performance Indicator (KPI)
  - Assessment for *Anugerah Perkhidmatan Cemerlang* (Excellence Service Award)

*d) Patient, Community Involvement and Empowerment*

| **Communication for Behavioural Impact (COMBI) for Dengue Prevention and Control**<br>**Year Introduced: 2001** | Patient, Community Involvement and Empowerment |
|---|---|
| - At the end of 2020, a total of 3065 locations for COMBI initiative had been identified nationwide with a total of 27,535 members.<br>- Cumulatively, from 2015 to 2020, a total of 12,825 COMBI leaders has been trained. | |
| **Know Your Medicine**<br>**Year Introduced: 2007** | Patient, Community Involvement and Empowerment |
| - In ensuring rapid dissemination of medicines information and patient education, Know Your Medicines Ambassadors (*Duta Kenali Ubat Anda*) programme started its implementation in 2012. This programme focuses on empowering community leaders thus encouraging their active involvement in promoting quality use of medicine. Until 2020, a number of 1540 *Duta Kenali Ubat Anda* has been trained nationwide.<br>- In 2019, the initiative has appeared as one of the finalists representing the Ministry of Health for the MOH *Konvensyen Penilaian* Outcome, while in 2020, it was selected as one of the Top 20 Groups (5 Stars) in the National Team Productivity and Innovation Excellence Conference and Innovation 2020 (APIC). | |
| **Customer Complaint Management**<br>**Year Introduced: 2013** | Patient, Community Involvement and Empowerment |
| - Complaint Management Committee (JKPA) in MOH was established in 2013 in accordance with the Guideline No 1 of 2013: Improving Complaint Management in Malaysian Public Sector Agencies published by Public Complaint Bureau (BPA) under the Prime Ministry Department. This guideline stipulated that all public sector agencies need to establish a Complaint Management Committee (JKPA) to strengthen the management of their respective complaints. Public can channel their complaint through online platform known as SISPAA (*Sistem Pengurusan Aduan Awam*) developed by BPA. | |

- The committee will have a meeting three times per year with Deputy Chief Secretary (Management) as the chairperson to report the achievement of complaint management. The Corporate Communications Unit (UKK) acts as the Secretariat. JKPA has also been implemented at the State Level to monitor the management of complaints at the state level. The key indicator monitored is percentage of normal case resolved within 15 working days.

**Healthy Community, Building the Nation (KOSPEN)**
**Year Introduced: 2013**

Patient, Community Involvement and Empowerment

- *Komuniti Sihat Pembina Negara* (KOSPEN), or literally translated to "Healthy Communities, Building the Nation", introduced in 2013, is a programme aimed at bringing NCD risk factor interventions to the community by creating trained community health volunteers. The basis of KOSPEN is community and individual empowerment towards implementing healthy policies and practising healthy lifestyles, facilitated by these health agents of change at localities taking part in KOSPEN.
- By end of 2020, there are 1,085 KOSPEN localities with 7,148 trained KOSPEN volunteers. A total of 1,039,603 adults aged 18 years and above have been screened under this programme.
- In promoting active lifestyle, 85% of the localities achieved the target for provision of the 10,000-walking track.
- With regards to implementing healthy eating policies during official functions, 73% of the localities reached the target of separating sugar from hot beverages, 71% achieved the target of serving fruits with heavy meals and 73% achieved the target of serving vegetables with heavy meals.
- In enforcing non-smoking practices; 62.4% of the localities met the target for smoke-free homes, and 83% achieved the standard for placing smoking prohibition signage in public areas.

**Dental Icons**
**Year Introduced: 2016**

Patient, Community Involvement and Empowerment

- The main objective of this initiative is to empower influential individuals known as "Dental Icons" in the community to disseminate oral health information to their families and communities. Eventually the community shall take charge to improve their oral health status.
- Till May 1, 2021, there are 660 active Dental Icons nationwide who have been trained on the oral health education modules.
- In 2020, a total of 3,263 activities were carried out by the dental icons in all states.

| **Smoke Free Oral Health (KOTAK)**<br>**Year Introduced: 2016** | Patient, Community Involvement and Empowerment |
|---|---|

- *KOTAK*, a screening and smoking cessation programme for schoolchildren was introduced in 2016, in tandem with Malaysia's vision of being tobacco free by the year 2045.
- This community initiative is a collaborative effort between Oral Health Programme (OHP), Ministry of Health (MOH), Disease Control Division, MOH and the School Education Division, Ministry of Education (MOE), Malaysia and has been incorporated in the School Dental Service (SDS) programme.
- All primary and secondary schoolchildren in national/ public funded schools have been screened for smoking till 2020. Identified smokers will have to undergo smoking intervention to help them quit smoking.
- As of 2019, 99.4% and 97.4% of primary and secondary schoolchildren respectively were examined and assessed under this programme. However, in 2020, due to the movement control order to curb Covid 19 infection, coverage dropped to 44.0% and 47.0 % of primary and secondary schoolchildren respectively. OHP, MOH aims to emerge above these uncertain circumstances and situation by implementing SDS -*KOTAK* namely, on a virtual platform.

### 1.3.4.3 Approach Based QII

**QA-QI**
**Year Introduced: 1990**

- Nearly 1000 MOH healthcare workers have been trained at the national level since 2004 in quality improvement methods, to guide them in carrying out quality improvement studies at their own facilities.
- The biennial National QA Convention organised since 2001 serves as a sharing platform for local quality improvement studies featuring more than 500 multidisciplinary projects involving multiple professions.
- The new Q Bulletin, which was launched in October 2019, has been upgraded to an online peer-reviewed journal, to provide the opportunity for publication of local QA/QI projects

**Innovation**
**Year Introduced: around 1990**

- From 2016 until 2020, increasing numbers of innovations were produced by the programmes/division. The total highest innovations were produced by the medical program (195) followed by public health (139) and pharmacy services (125).
- Project named; Single Channel Cystometry (SCC) from the Department of Rehabilitation Medicine, Sungai Buloh Hospital has won several awards including the "Silver Award-Malaysian Invention, Innovation and Design Exhibition (IIDEX) 2015 and the MOH Premier Innovation Award on 9 December 2019. This innovation has been applied in six (6) hospitals in Malaysia that provide rehabilitation medicine services.
- Internationally, Malaysia has maintained its 26th position as the most innovative country in the Bloomberg 2019 Innovation Index out of 200 countries.
- Since 2006, the Oral Health Programme has been the main secretariat to oversee and coordinate the running of the Innovation Award, MOH (*Anugerah Inovasi Kementerian Kesihatan Malaysia* (AIKKM)) together with the Information Management Division (*Bahagian Pengurusan Maklumat*), Family Health Development Division (*Bahagian Pembangunan Kesihatan Keluarga*) and Policy and International Relations Division (*Bahagian Dasar dan Hubungan Antarabangsa*).

**Creative and Innovative Circle (CIC)**
**Year Introduced: 1991**

- This initiative was initially introduced in 1991 to be implemented across all public services mainly aiming to improve all aspects of service delivery in the public sector.
- The initiative was first known as *Kumpulan Meningkat Mutu Kerja* (KMK), which later evolved into the Creative and Innovative Circle or *Kumpulan Inovatif dan Kreatif* (KIK) in 2009 and more recently in 2016, the initiative was upgraded into KIK: New Horizon. The New Horizon approach highlights the concept of "Fast, Accurate, Integrity – Productivity, Creativity and Innovation", supports the National Blue Ocean Strategy (NBOS), Value Innovation principle and Public Services for the People (*Merakyatkan Perkhidmatan Awam*) concept.
- The areas of innovation in KIK can be Social Innovation or Service Delivery Innovation and each area is further categorised into new creation or improvement of existing products or processes. Each project can be done primarily by a group that comes from one particular agency, or hybrid where the initiative involves multiple agencies or inter-agencies collaboration.
- At the MOH level, an Innovation and KIK Award was conducted annually since 2011 where winners will compete at the National-Level Public Sector KIK Convention. Various KIK projects from the MOH had been featured and received recognition at the inter-ministerial national level.

**Lean Healthcare**
**Year Introduced: 2014**

- The pioneer LEAN Emergency Department (ED) / Medical Ward (MW) initiative has been expanded to a total of 52 major hospitals through the LEAN Agile approach, following the success in the 2014 pilot project. Among the main outcomes measured in this initiative are arrival-to-consultation and length-of-stay throughput in the emergency department, and discharge time, bed waiting time and bed occupancy rate in the medical ward.
- Around 1197 healthcare workers have been trained at various levels since 2014. Four training modules were published between 2018 until 2020 to fulfil the need to build capacity for lean healthcare.
- 47 MOH healthcare workers have been recognised as Lean Champions
- Numerous articles related to implementation of Lean Healthcare in MOH facilities has been published in international and local journals since 2015
- The initiative has received the Gold Medal for Public Service Innovation Award during the Malaysian Technology Expo 2019 in the 18th International Expo on Inventions and Innovations.
- The initiative has also received Silver Award at the International Conference and Exposition on Inventions by Institutions of Higher Learning (PECIPTA'19) for the project titled “e-IMCIFOD for Healthcare Service Delivery Transformation”.

## 1.3.5 Key Challenges and Way Forward for QIIs

Despite the long history of quality and the significant achievements of QIIs which are already currently in place, the coordination and interaction of these multiple QIIs remain a significant challenge. There is a strong need to bridge the silos among these initiatives within and across health sectors and bring them together, to accelerate the improvement of healthcare quality.

In the occurrence of a pandemic, such as COVID-19, these QIIs should be more proactive, responsive and innovative in modifying existing organisational processes, to maintain the quality of essential health services.

A few examples of such adaptations during the pandemic are:

- Value-Added Services (VAS) in ensuring patients get their routine medications on time.
- The development of MyUbat which consists of a smartphone application for patients and their caregivers to keep track of their medication usage and supplies as well as web consoles for Pharmacy staff for a more efficient registration process and follow-up medications at pharmacy counters.
- Developing new guidelines for the COVID-19 infection control and clinical guidelines on COVID-19 vaccination
- Blood taking drive-through service for neonatal jaundice
- Development of online appointment systems in keeping with the new norms of social distancing
- Use of telehealth systems in managing chronic disease, health maintenance and wellness.

These adaptations are not just effective for making rapid adaptations in a crisis but, if properly supported, these beneficial new processes can be sustained, which may contribute to future resiliency in the event of another pandemic.

## 1.4 The Need for National Policy for Quality in Healthcare for Malaysia

The need to have a new national policy and strategy for quality in healthcare in Malaysia stems from the strong belief that quality is the foundation of healthcare, that healthcare is a public good, and that every citizen should have universal access to healthcare of good quality to lead productive lives. These principles underpin the solid commitment of the Malaysian Government towards attaining the noble goal of UHC for its *rakyat* or citizens, whereby no one is left behind.

The scope and elements inside this new policy are upgraded to align with the current global frameworks for quality in healthcare including a strong focus on the primary health care approach in achieving UHC.

Thus, this policy has been named as the **NATIONAL POLICY FOR QUALITY IN HEALTHCARE** which will subsequently be referred to as the **NPQH**.

The following are eight rationales for the establishment of the **NPQH**:

1. **To strengthen governance and structure:**
   The structures for governance, accountability and monitoring & evaluation of national quality initiatives in healthcare will be strengthened and enhanced
2. **To align with national health priorities:**
   The quality policy will reflect the current shift in disease burden.
3. **To share a common goal:**
   Act as a main guide and reference for all healthcare sectors by having a shared vision and mission for quality.
4. **To move together in tandem:**
   Multiple quality improvement initiatives will be brought under a systematic and organised effort to enhance the quality of care across the whole health system.
5. **To conduct meaningful measurement:**
   The current healthcare measurement system will be better aligned with global indicators in both public and private sectors
6. **To undertake smart partnerships:**
   Collaboration and partnerships between multiple healthcare sectors and the community will be better facilitated and enhanced through stakeholder engagement and consensus-building.
7. **To internalise a quality culture:**
   A culture of quality will be nurtured and promoted as well as practised so that it is seen as a way of life across the whole health system
8. **To support the achievement of SDG 3.8:**
   Achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

*Part 2*

# *Development Process*

# 2.0 Policy and Strategy Development Process

## 2.1 Policy Development Approach

The development of **NPQH** involved an implementation-informed policy and strategy development model, as illustrated in **Figure 5** (4). This approach facilitated building a sense of ownership among those entrusted with implementation of the policy and also to ensure that products are grounded in the realities of service delivery and patient and community experience. This method requires sustained and meaningful engagement with stakeholders across the health system and throughout the process, embracing both a "top-down" and "bottom-up" approach to improving quality.

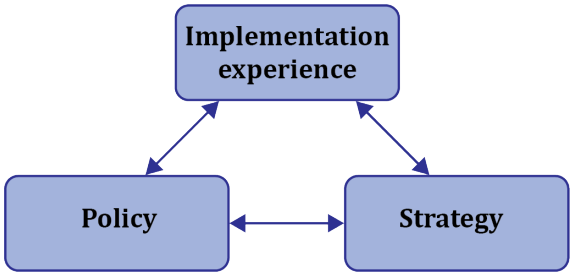



**Figure 5:** Implementation-informed Policy and Strategy Development Model

## 2.2 The Eight Elements

These elements were adopted from the WHO Eights Elements of NQPS (4).

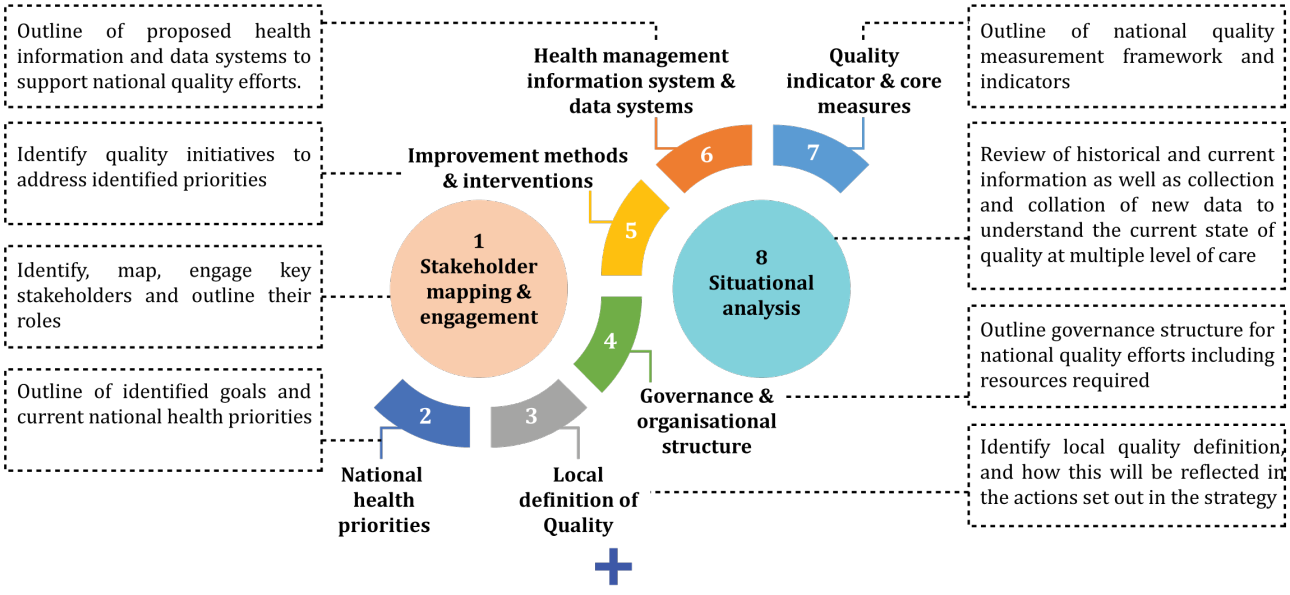



**Figure 6:** The Eight Elements Applied in Developing the NPQH

## 2.3 Policy and Strategy Development Process

Together with its partners, within and outside the MOH, the Institute for Health Systems Research (IHSR) as the MOH Secretariat for the QA/QI Programme and the WHO Collaborating Centre for Health Systems and Quality Improvement, took the lead to develop this policy through a consultative process, engaging multiple stakeholders **(Appendix 2-6)**. The **NPQH** development process was initiated in 2018 before it was officially launched on 5 October 2021. **Figure 7** outlines the timeline and key activities in the development process. Details of the situational analysis methodology are illustrated in **Figure 8**.

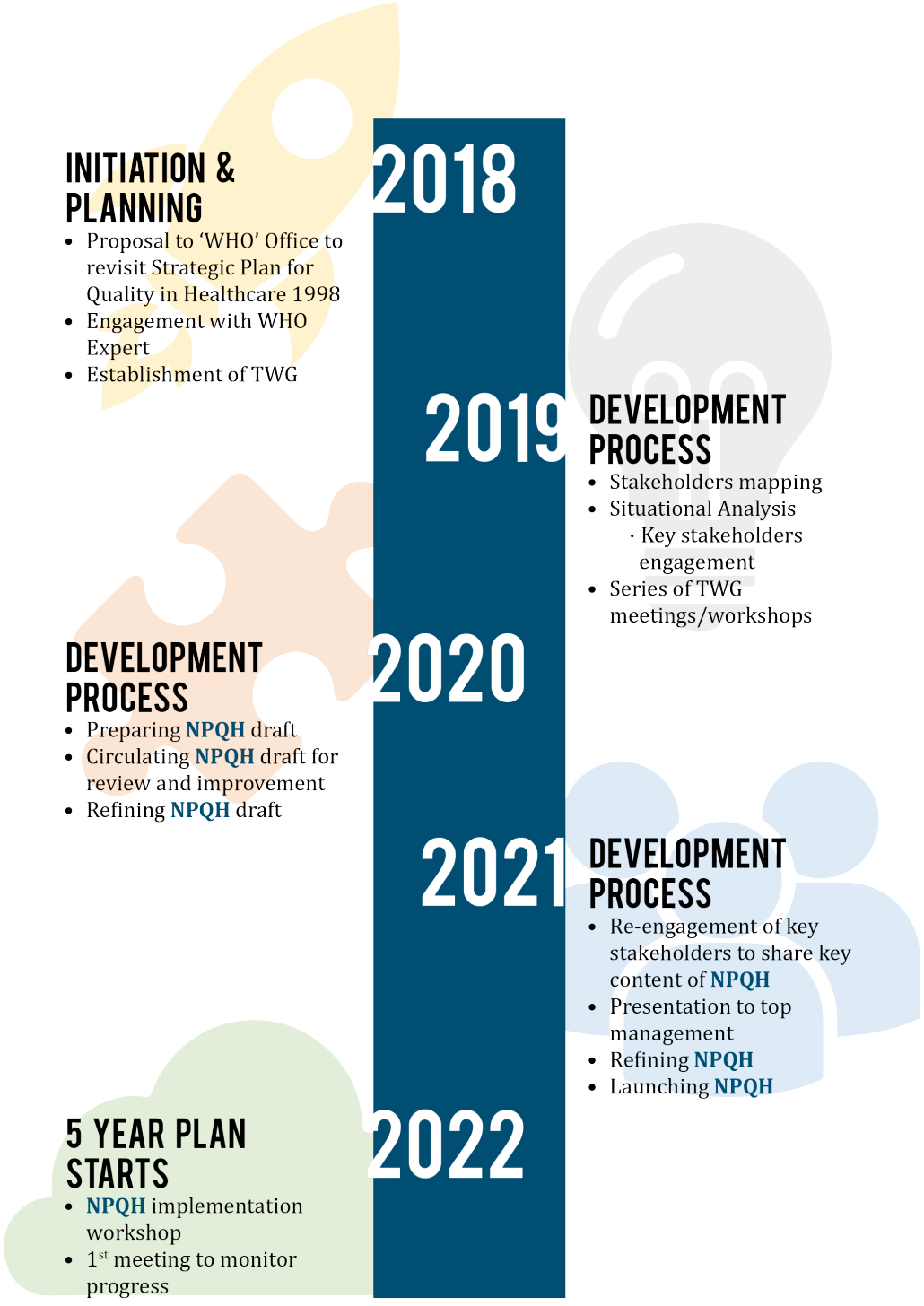



**Figure 7:** NPQH Development Process Timeline

## 1 Document Review

- Development of a spreadsheet comprising all the categories of quality-related documents.
- Distribution of the spreadsheet to all the Head of Programmes in the Ministry of Health (MOH).
- Internet search by the research team exploring related documents including MOH websites and specific programme / department websites.
- Collection of a complete spreadsheet from each programme as well as their softcopy/hardcopy.

## 2 Quality Improvement Initiatives (QII) Mapping

- Development of a spreadsheet to gather relevant information on current active QII in the Ministry of Health (MOH).
- Distribution of the spreadsheet to the Quality Leads in the MOH.
- Discussion session with the Quality Leads to complete the excel document.
- Collection of QII-related information in other healthcare facilities (private/university/ military) through online platform
- Internet search by the research team exploring for QII-related information and documents in other healthcare facilities websites.

## 3 Stakeholder Engagement

A diverse group of stakeholders were identified and engaged to explore their views and opinions in order to understand the current state of quality, contextual factors, and historical quality journey in Malaysia. They were engaged through the methods stated below:

### a In-person Engagement Session

**Small Group Work Approach**
Used for healthcare workers with similar role in relation to implementing quality initiatives but from different agencies/ programme/ levels of care.

**Semi Structured Interview**
Used for healthcare workers identified as key informants for a specific programme/quality initiative who were not available for small group work session.

**Pre-determined Questions**

1. What are the quality-related issues that you encountered in your programme/at your state/workplace?
2. How do we define quality of healthcare in Malaysia context?
3. How can we move forward in terms of improving the implementation of national quality improvement interventions?
4. How to implement quality in primary care?
5. How can we work together (between public and private sectors) more effectively in Malaysia to improve quality of health of the nation?
6. How do you receive feedback from patients?
7. What did you (private sector) do in terms of quality improvement interventions that we (public sector) can replicate?
8. How can we foster integration among the vertical programs and between vertical and Quality Initiative/programs?
9. Please identify specific suggestions on strategies to accomplish this goal.

### b Online survey

**Tool Development**
The draft questionaire (in Bahasa Malaysia and English) was shared with a few quality experts for content validity and revised based on the expert's feedback.

**Data Collection**
Convenient sampling . Distribution of survey link and QR code through various channels including (but not limited to); emails, MOH postmasters, Facebook, websites, WhatsApp groups etc.

**Respondents**

1. Public/community who utilise any healthcare facilities (public and private).
2. Healthcare workers in the government and private sectors

**Questions- Healthcare Worker**

1. Based on your experiences, what is the strength of our healthcare system with respect to providing quality services?
2. Thinking about your personal experiences, identify area(s) that you find need the most improvement in our healthcare system in relation to quality of healthcare.
3. What is your opinion on quality activities/initiatives at your workplace?
4. What do you think can be improved about quality activities/initiatives at your workplace?

**Questions- Public**

1. What matters to you most when you visited any hospital or clinic?
2. Which area did you find worked well?
3. What can be done to improve the quality of services in hospital or clinic?

**Figure 8** : Situational Analysis Approaches

# 2.4 Analysis and Key findings - The Current State of Quality

Multiple approaches taken in the situational analysis as described in **Figure 8** provided rich data which aided the understanding of current key quality issues

Key findings were synthesised to provide a clear and holistic view of the quality issues

Similar key findings were grouped together and thematised

The relationship between the key findings under each theme were mapped using the SWOT technique (Strength, Weakness, Opportunity, Threat)

Final output – 10 thematic areas of concern were identified with each highlighting their own set of:

- Strengths to be focused and optimised
- Weaknesses to be prioritised, addressed and improved
- Opportunities that need to be taken advantage of
- Threats that are essential to be taken into consideration

1. People-centered holistic approach
2. Governance & organisational structure for quality
3. Stakeholder engagement
4. Health management information & quality monitoring and feedback system
5. Workforce competency & capability towards quality management
6. Quality culture
7. Resources
8. Knowledge exchange, communication & coordination among programs
9. Quality indicators & core measures
10. Quality improvement initiatives M&E

The SWOT Analysis for each area of concern has been tabled under **Appendix 7**

**Figure 9:** Analysis and Key Findings

Following brainstorming sessions on ideas to address each of the 10 areas of concern, it was decided that some of these concerns could be addressed using similar strategies. This gave rise to the formation of seven strategic priorities, which are outlined below and will be the focus of **NPQH** in the next five years.

| Strategic Priority (SP) | Areas of Concern Addressed |
|---|---|
| **SP 1: Improving integrated people-centred services** | • People-centered holistic approach |
| **SP 2: Strengthening governance for quality** | • Governance & organisational structure for quality<br>• Resources |
| **SP 3: Strengthening internalisation of quality culture among all healthcare staff** | • Quality culture |
| **SP 4: Enhancing engagement and communication with stakeholders for quality** | • Stakeholder engagement<br>• Knowledge exchange, communication & coordination among programs |
| **SP 5: Building effective capacity and capability for quality** | • Workforce competency & capability towards quality management |
| **SP 6: Enhancing measurement and quality improvement initiatives** | • Health management information & quality monitoring and feedback system<br>• Quality indicators & core measures |
| **SP 7: Strengthening monitoring and evaluation of quality programmes or initiatives** | • Quality improvement initiatives M&E |

*Part 3*

# *The Policy & Strategy*

# 3.0 The Policy and Strategy

## 3.1 Goal

**NPQH** is aimed to systematically plan for enhanced quality of healthcare by providing an official, explicit policy statement and direction regarding the approach and actions required at all levels of health service delivery across Malaysia's health system.

## 3.2 Objectives

**NPQH** provides a pertinent guide for both the public and private sectors to improve the quality of care that is delivered. The strategy lays out the government's main priorities of maintaining healthcare accountability and continuously improving the care provided. To achieve a quality health care system for all Malaysians, a national commitment must be made to measure, improve and maintain the highest standards of quality healthcare. To accomplish this goal, the gaps between standards and actual practice must be measured. Targeted, practical and innovative solutions must be identified to close identified gaps. Aligned with **NPQH**, healthcare providers should set specific measurable goals for each strategic objective to track success in achieving these goals.

This policy seeks to address and provide guidance on the **7 Strategic Priorities (SP)** Areas identified in the situational analysis through the adoption of systematic and collective plan of actions.

To operationalise each Strategic Priority, a set of objectives and actions have been formulated. Level of implementation, responsible organisations and yearly targets for each action was identified and agreed upon. Output indicator to track on the progress was also developed. These are outlined in detail in the action plan.

## 3.3 Linkages Between NPQH and Other National/ Programmes' Policy, Strategy and Priorities

The development of **NPQH** is aligned with broader international and national health planning including:

- Sustainable Development Goals (SDG)(17) and Universal Health Coverage (UHC) (18)
- Shared Prosperity Vision 2030 (19)
- 12th Malaysia Plan
- Vision and Mission of the Ministry of Health(20)
- MOH Strategic Plan (2021-2025)

**NPQH** is very relevant in supporting the MOH Strategic Plan (2021-2025) under the objective of strengthening healthcare service delivery which is of high quality, sustainable, equitable and affordable.

Implementation of the strategic priority in the **NPQH** should be linked or aligned with other national and programme-based goals, priorities, actions or strategic framework (if any) that are related to quality in healthcare.

## 3.4 Target Audience

The **NPQH** targets actions across 4 levels of audience:

### National level

- Head of Programmes
- Head of Divisions/ Department/ Centre/Section/ Institution
- Programme Managers
- Chief Executive Officers/ Presidents
- Quality Department/ Section/ Committee/ Council
- Quality Lead Coordinators
- Healthcare Providers

### State level

- Directors and Deputy Directors
- Hospital Directors
- District Health Officers
- Dental Health Officers
- Managers at Private Hospitals
- Quality Divisions/ Units
- Quality Lead Coordinators
- Healthcare Providers

### Facility level

- Directors
- Deputy Directors
- Hospital Directors
- District Health Officers
- Head of Departments
- Quality Divisions/ Units
- Healthcare Providers

### Community level

- Civil Society Organisations
- Community Leaders
- Citizen and clients

## 3.5 Bringing Clarity to "Quality" in the Malaysian Context

Quality is interpreted differently by service providers, patients and other main stakeholders involved in the healthcare system, leading to the use of different quality assessment approaches. Therefore, having a succinct and well-accepted local definition of high-quality healthcare is crucial to uniting the viewpoints of both patients and health care providers, providing a common frame of reference for stakeholders to measure, compare against set standards and subsequently, to improve the quality of our healthcare services. This overarching framework informs all activities undertaken in pursuit of quality. In particular, measurement, monitoring and evaluation of the health system performance should be congruent with this quality definition.

An extensive review of the relevant documents revealed that within our local context, no explicit written definition of quality of healthcare exists. Concepts articulated in earlier documents address quality in healthcare within the MOH's mission statement below:

The mission of the Ministry of Health is to lead and work in partnership:

i. to facilitate and support the people to:
   - attain fully their potential in health
   - appreciate health as a valuable asset
   - take individual responsibility and positive action for their health

**ii. to ensure a high-quality health system that is:**
   - **customer centred**
   - **equitable**
   - **affordable**
   - **efficient**
   - **technologically appropriate**
   - **environmentally adaptable**
   - **innovative**

iii. with emphasis on:
   - professionalism, caring and teamwork value
   - respect for human dignity
   - community participation

This statement has been used as the basis for establishing the local definition/concept of quality through a series of engagements with the key stakeholders. The results of the interactive sessions were then mapped with relevant local and international domains of quality. Some of the elements from the existing mission statement were reaffirmed while new important elements were added. This new proposed local quality definition was re-presented to the key stakeholders during follow-up meetings, for further feedback and input.

We agreed that our definition of quality should also encompass elements of two important components of measuring quality in health care which are, **technical quality** and **experiential quality.**

(i) **Technical Quality** is generally defined as "the degree to which the industry is able to do things 'right,' as measured against a technical industry standard." In other words, quality of healthcare services is usually perceived by the healthcare providers as effective and safe.

(ii) **Experiential Quality** is that which is predominantly perceived by patients. It is the manner in which services are delivered to customers and represents how the customer experiences the human interactions that occur during the process of care. This usually translated into patient-centred and equitable service.

Patient experience is "the sum of all interactions, shaped by an organisation's culture, that influence patient perceptions across the continuum of care". It is about overall service and includes the summation of both technical and functional components.

Considering elements in both quality components that emerged during the development process, the following is Malaysia's generally accepted local definition of quality;

> Providing **high quality** healthcare that is **SAFE, TIMELY, EFFECTIVE, EQUITABLE, EFFICIENT, PEOPLE-CENTRED, and ACCESSIBLE [STEEEPA]** which is innovative and responsive to the needs of the people and is delivered as a **TEAM**, in a **CARING** and **PROFESSIONAL** manner in order to improve health outcomes and client experience.

The definition is expected to help create a common understanding on what quality health care means in the context of Malaysia. Achieving quality of care as stated in the definition is the ultimate ambition and a long-term goal, which will need continuous effort.

## Definition of Domains

| | | | |
|---|---|---|---|
| **Quality Domain** | **Safe** | **Timely** | **Effective** |
| **Definition** | Avoiding or minimising risk and harm during the process/delivery of healthcare for both patients and providers. | Reducing delays in providing and receiving healthcare. | Providing the best healthcare services through competent healthcare personnel utilising the best available evidence |
| **Quality Domain** | **Equitable** | **Efficient** | **People-centred** |
| **Definition** | Delivering healthcare that does not differ in quality according to personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status. | Delivering healthcare in a manner that makes the best use of the resources while also avoiding waste (such as underuse or overuse). | Providing care that is respectful of and responsive to individual patient preferences, needs and values, in partnership with patients and ensuring that patient values guide all clinical decisions. |

**Quality Domain** | **Accessible**

**Definition** | **Physical accessibility**

Availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects of service organisation and delivery that allow people to obtain the services when they need them.

**Economic accessibility or affordability**

Ability to pay for services without financial hardship. It takes into account not only the price of the health services but also the indirect and opportunity costs (e.g. the costs of transportation to and from facilities and of taking time away from work).

**Information accessibility**

The right to seek, receive and impart information and ideas concerning health issues.

Alongside measuring the technical aspects of quality that will lead to good health outcomes, attention should be given to ensure a positive healthcare service experience. Therefore, the three existing core values of **CARING, TEAMWORK** and **PROFESSIONALISM**, under MOH's Corporate Culture that has been long nurtured since 1990s should be upheld as a fundamental aspect of care by healthcare providers. These core values demonstrate the spirit of compassion, the human aspect that drives service delivery which is associated with positive patient perception of care and health worker productivity. Compassion in our context is linked with a desire to assist and to treat others with empathy, respect and dignity. The mind and the hands of healthcare workers should strive to deliver high-quality and safe treatment to patients while also expressing compassion to patients and their families.

Some elements in the core values of Corporate Culture are as follows (21):

| | | | |
|---|---|---|---|
| **Caring** | Courtesy | Considerate | Ready to serve |
| | Proactive | Responsiveness | Punctuality |
| | Tolerance | Emotional Control | Exemplary character |
| **Professionalism** | Commitment | Discipline | Best way |
| | Work ethic | Standard of work | |
| **Team Work** | United towards a common goal | The spirit of togetherness | Leadership |
| | Mutual trust and respect | Accountability | Knowledge and skill |
| | Creativity and innovation | Unity and cooperation within the team/ unanimity | Exemplary character |

The **QUALITY DEFINITION** is the focal point to galvanise and consolidate all the other elements or components. This definition will help to better align quality oversight with patient expectations and the health care delivery system's evolution, expansion, and complexity.

1. This quality definition should be compellingly communicated to all healthcare providers/stakeholders at all levels of care by top management and senior leaders.
2. Knowledge and skills around this definition and quality domains need to be developed amongst all healthcare providers/stakeholders.
3. All healthcare providers must understand, appreciate, practice and deliver healthcare to attain the levels as promised in this definition.
4. There should be a clear framework for monitoring healthcare quality performance aligned with this definition.
5. There should be quality committee(s) at all levels of the health care system with clear roles and responsibilities to monitor performance based on this definition.
6. There should be a set of indicators to measure quality performance, based on the domains outlined in the quality definition.
7. There should be continuous feedback and periodic assessment of the quality performance.

## 3.6 NPQH Implementation Framework

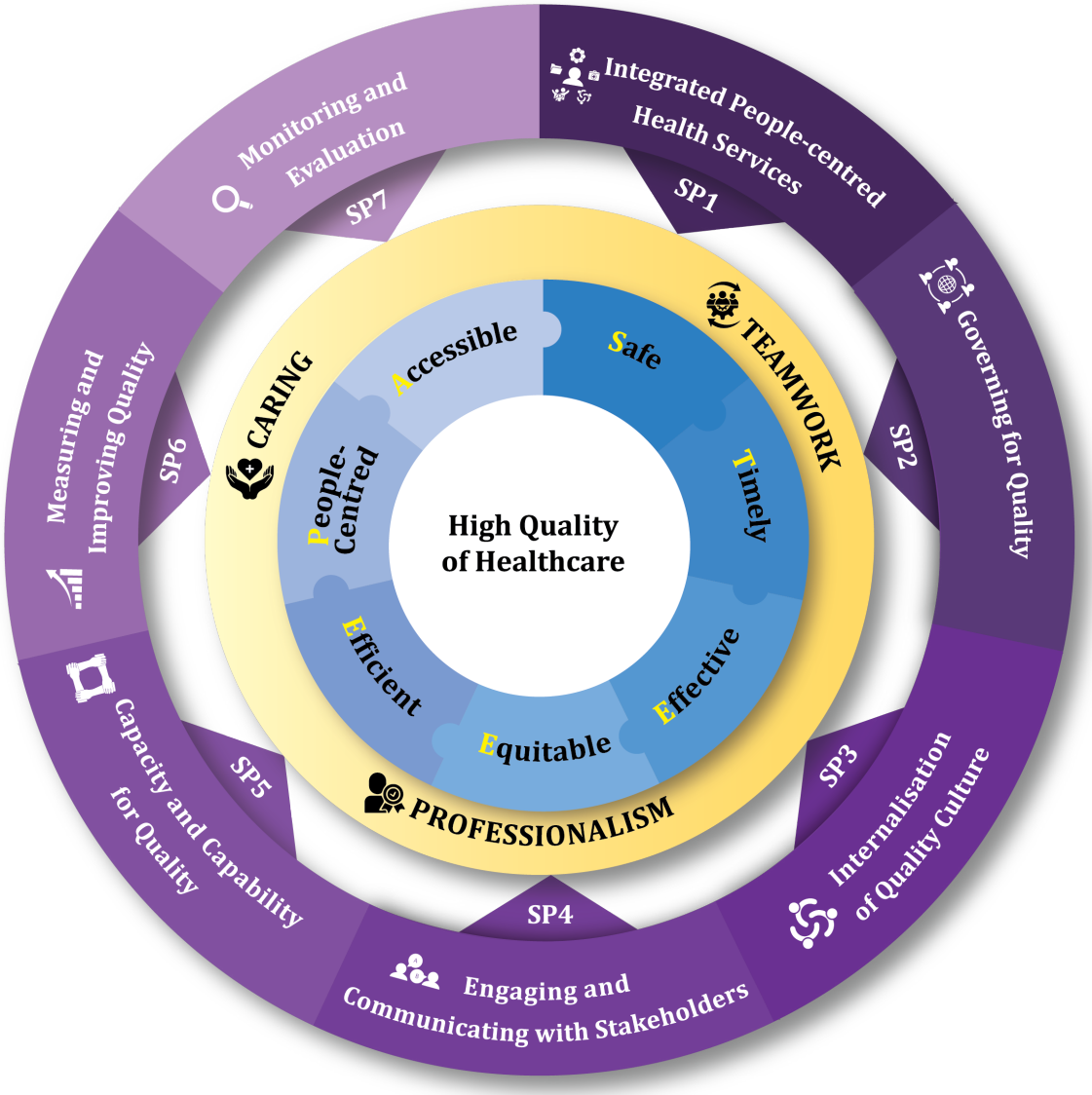



**Figure 10**: **NPQH** Implementation Framework

Central to the **NPQH** Implementation Framework (**Figure 10**) is our aim to deliver high quality of care for the people that is **SAFE, TIMELY, EFFECTIVE, EQUITABLE, EFFICIENT, PEOPLE-CENTRED** and **ACCESSIBLE (STEEEPA)**. These technical quality domains are strongly supported by the three core values as our culture of work; **CARING, TEAMWORK** and **PROFESIONALISM**. Seven priorities areas were the focus of **NPQH** that need to be strengthened and enhanced; **(i) Integrated people-centred health services (ii) Governing for quality (iii) Internalising quality culture (iv) Engaging and communicating with stakeholders (v) Capacity and capability for quality (vi) Measuring and improving quality (vii) Monitoring and evaluation.**

# 3.7 Policy

## 3.7.1 Integrated People-Centred Health Services

UHC will be achieved with improvements in service delivery so that all people are able to access high quality health services that meet their needs and preferences. By adopting people-centred and integrated health services across the life cycle, health systems will be able to provide services that are of better quality, are financially sustainable and more responsive to individuals and communities.

To achieve this integrated people-centred health services concept, we will adapt the WHO's five interdependent strategic goals (22,23):

i) **Empowering and engaging people**
Empowering and engaging people is about providing the opportunity, skills and resources to enable individuals make effective decisions about their own health and enable communities to become actively engaged in co-producing healthy environments, providing care services in partnership with the health sector and other sectors, and contributing to healthy public policy.

ii) **Strengthening governance and accountability**
Strengthening governance and accountability involves improving policy dialogue as well as policy formulation and evaluation together with citizens, communities and other stakeholders. It is about promoting transparency in decision-making and generating robust systems for the collective accountability of policy-makers, managers, providers and users through aligning governance, accountability and incentives.

iii) **Reorienting the model of care**
Reorienting the model of care means ensuring that efficient and effective health care services are provided through models of care that prioritise primary and community care services and the co-production of health with a shift from inpatient to outpatient and ambulatory care. This requires investment in holistic and comprehensive care, including health promotions and ill-health prevention strategies that support people's health and well-being.

iv) **Coordination of services**
Coordinating services involves coordinating care around the needs and preferences of people at every level of care, as well as promoting activities to integrate different health care providers and create effective networks between health and other sectors. It focuses on improving the delivery of care through the alignment and harmonizing processes of the different services.

v) **Creating an enabling environment**
In order for the four previous strategies to become an operational reality, it is necessary to create an enabling environment that brings together the different stakeholders to undertake transformational change. This is a complex task involving a diverse set of processes to bring about the necessary changes in legislative frameworks, financial arrangements and incentives, and the reorientation of the workforce and public policymaking.

## 3.7.2 Governing for Quality

### 3.7.2.1 Leadership's Commitment to Quality

Managers and leaders across different levels have an over-arching responsibility to make better quality of care their organisation's first and primary concern. To demonstrate strong commitment to improving the quality of healthcare services that are being delivered, they must engage in setting priorities for learning and culture change. EFFECTIVE LEADERSHIP is critical to the provision of better quality and safer health care. Managers and leaders across different levels should:

i) Lead and set clear goals in making Quality a top priority agenda for all with STEEEPA dimensions and experiential aspects of quality as the key guide

ii) Ensure roles and clear accountability

iii) Shape organisational high-quality culture characterised by three core values: Caring, Teamwork and Professionalism

iv) Establish system-wide measures of quality and dash board

v) Use data including patient feedback effectively

vi) Ensure the right mix of people and equip them with the requisite skills

vii) Commit to and enable continuous learning

viii) Allocate dedicated sources for quality initiatives

ix) Show tangible involvement in improving quality of care

### 3.7.2.2 Governance Structure for Quality

A specific quality department/unit to look into quality of healthcare should be established and strengthened at various levels. This department/unit should be part of the overall governance at the facility and state levels. Across all levels, this department/unit should oversee various quality related committee(s) that need to be strengthened to ensure the QII are implemented in a more holistic manner in order to integrate and synergise the capability and strength of each QII in accelerating improvement. Roles and responsibilities of each committee and committee members should be clear to assist in the monitoring and evaluation of each QII and avoid redundancy. It is highly recommended that each committee looks at the achievement of all quality domains to find gaps and strategies to further improve.

This change in governance structure for quality is fundamental in bridging the silos between different quality initiatives and enhance communication between all quality players. The effective governance and monitoring system should avoid unnecessary bureaucracy in order to facilitate information and knowledge sharing. In addition, existing laws or prevalent work cultures that may hinder knowledge sharing or coordination may need to be reviewed. A platform should also be provided by the governing body to consider the views of all stakeholders, inclusive of patients and user representatives and form a basis for policy reviews based on the stakeholders' inputs. These platforms should be autonomous in their functions thereby guaranteeing impartiality. [Refer 3.7.4: Engaging and Communicating with Stakeholders]

### 3.7.2.3 Investing in Quality

A combination of inaccurate diagnosis, prescription errors, inappropriate and unnecessary treatment, insufficient or unsafe clinical facilities or practices are all prevalent across the globe, resulting in poor quality health services (1). For an instances, despite the fact that acquired infections can be easily avoided through better hygiene, improved infection control practices, and appropriate use of antimicrobials, 10% of patients hospitalised in low- and middle-income countries can expect to acquire an infection during their stay, compared to 7% in high-income countries. The economic and social costs of poor-quality care, including long-term disability, impairment and lost productivity, imposes additional spending for families and health systems.

Therefore, optimal and prudent financial resource management are vital to the successful implementation of all components of quality improvement programmes. Attention must be focused on ensuring that QI-specific financial allocation has been made and the best value for money is attained. It is axiomatic that resources are scarce and that innovative strategies and methods should be explored to address funding limitations.

This includes (but not limited to) allocation for:

- Training / Continuous Professional Development
- Reward and recognition
- Implementing intervention
- Conducting research
- Monitoring and evaluation
- Supporting local innovation

### 3.7.3 Internalising Quality Culture

Quality culture should be at the heart of high performing organisations. At all levels of the health system, quality culture can be understood as, an inherent and explicit recognition of the value of efforts to improve the quality of care provided, and such efforts are systematically promoted within an enabling environment that encourages engagement, dialogue, openness and accountability (4). Quality culture affects the way people and groups interact with each other, with clients, and with stakeholders. These relational aspects of human interactions within the system are critical to consider when nurturing a culture of quality. Indeed, a strong quality culture, with compassion as a core attribute, is integral to long-term organisational sustainability and success, where the people in the organisation must hold to common values that can drive quality-related efforts at all levels of the system. In our context, the MOH Corporate Culture consisting the elements of "Caring, Professionalism and Teamwork" is an essential feature of quality culture, which needs to be embraced and translated into daily practice.

The mindset and awareness to embrace quality culture should ideally be incorporated as part of a mandatory set of components of the Training Curriculum for MOH staff at all levels, from the entry-level (new entrants to the MOH system - University, colleges, pre-employment, orientation for new staff) to all other levels such as in-service training (Refer 3.7.5: Capacity and Capability for Quality). The use of various modes of media to publicise or increase awareness of the elements of this corporate culture should be made.

It is also important to ensure due recognition and incentives are in place for everyone who is involved in QI to keep the motivation high. Appropriate reward and recognition will help to foster and ensure sustainability of the quality culture on top of continuous organisation-wide learning.

## 3.7.4 Engaging and Communicating with Stakeholders

### 3.7.4.1 Engaging Stakeholders

Meaningful stakeholder collaboration and engagement are facilitated by effective communication between ministries, programmes, healthcare workers, patient and family and should be achieved from top-down and bottom up, as well as horizontally across the continuum of care delivery. In this way, effective communication can improve patient outcome, patient safety and perception of quality (24).

In order to ensure that all the significant factors and issues that influence quality of health services can best be addressed, the stakeholder engagement process should adopt the following principles:

i) **Purposeful**: Every engagement should begin with a clear understanding of what we want to achieve.

ii) **Inclusive**: A broad set of stakeholders across the healthcare system at all levels should be identified and engaged.

iii) **Clarity of function**: Each stakeholder(s) should be clear about their potential commitment, roles and responsibilities.

iv) **Timely**: Stakeholders should be involved from the very beginning and agreement should be arrived as when and how the engagement should be conducted.

v) **Transparent**: The engagement should be conducted with openness and honesty.

vi) **Respectful**: The expertise, perspective, and needs of stakeholders should be acknowledged and respected.

### 3.7.4.2 Communicating with Stakeholders

The following principles can be utilised in the dissemination and exchange of knowledge amongst stakeholders:

i) **Ensuring validity of information**: All data and information including their sources should be verified before dissemination.

ii) **Optimising use of technology communication channels**: All available and relevant intra and inter-organisational communication platforms should be used for effective knowledge dissemination.

iii) **Effective communication**: The strengthening of communication skills, which are essential for healthcare competence, should be undertaken.

iv) **Timeliness and appropriateness**: Knowledge sharing should be conducted in a timely and appropriate manner including deciding on the amount of information and their security level, adapted to the knowledge and literacy levels of the different audiences.

v) **Learning from best practices within the country**: The need to strengthen and enhance organisation-wide learning mechanisms by which healthcare workers can learn from their peers.

vi) **Feedback & evaluation**: Continuous feedback and evaluation of the communication processes, systems and strategies is important to identify what could be improved, what worked well, what was critical for success, what was not successful and what can make it better.

## 3.7.5 Capacity and Capability for Quality

### 3.7.5.1 Capacity for Quality

Optimal allocation of human resource is the key pre-requisite for the success of quality programmes. The availability of a stable, capable health care workforce is critical to the efficient and effective delivery of health services. Organisations should value the human factor and obtain their involvement by making them participants and creators of the culture of their organisation.

i) **Investing in human resource for quality**: Appropriate investment in and optimal allocation of the necessary human resources for quality improvement programmes is essential to support the smooth implementation of systems and processes that improve care quality in a strategic manner.

ii) **Providing people with skills**: Numbers alone are not enough. The ensuing task is then to ensure the establishment of a training programme to build up the numbers of suitably skilled personnel.

iii) **Dedicated people for quality**: The placement of an appropriate mix of dedicated staff (with designated post) that have been assigned clear roles and responsibilities is essential for quality at every level of care. It must give emphasis to:

   a) Competency-based recruitment
   b) Training and development
   c) Performance tracking
   d) Appraisal and appreciation
   e) Incentive
   f) Retention strategies (including career development in quality)

### 3.7.5.2 Capability for Quality

Building competency in quality improvement amongst the providers is vital in ensuring the sustainability of quality improvement programmes and should include the following:

i) **Investment in training**: While optimal resources for training may not be readily available, innovative methods to implement training programmes must be explored.

ii) **Incorporating training for quality**: Quality improvement training for varying levels of audience expertise must be an integral part of training for all levels of healthcare and should be accessible across all sectors of healthcare including undergraduate and postgraduate training. A pool of quality champions to act as trainers should be identified and secured to propagate a legacy of quality in the health system.

iii) **Innovative learning & training methods**: Training materials and methods need to be continuously updated and improved in line with global trends and advancement.

iv) **Identifying centres of excellence**: Centres of excellence for the various quality improvement initiatives should be identified and mapped to enable coordination of quality improvement activities, foster shared learning and collaborative practice, stimulate innovation, highlight expertise and enhance opportunities for quality improvement learning. Ideally, a central repository/body should be entrusted with this function.

v) **Evaluating training for quality**: Evaluation of the capacity and capability to conduct training in quality improvement should be performed regularly as to maintain and improve the quality of the training provided. Identification and development of a database of individuals trained must be established with the aim of sharing resources across institutions.

## 3.7.6 Measuring and Improving Quality

Objective measures of quality across the level of care and dimensions will foster evidence-based policy making. This will entail the use of meaningful indicators to assess whether or not a standard in patient care is being met. They may not provide definitive answers but rather, are designed to indicate potential problems that might need addressing, identifying variations within data and rectification where needed. This will enable benchmarking against comparable organisations as a way to monitor progress, and the identification of areas for improvement.

### 3.7.6.1 Measuring Quality

i) **Overarching Measurement Framework**: There should be a healthcare quality framework in keeping with evolving global effort to guide what should be measured to inform and drive efforts to improve healthcare quality.

ii) **Quality Measures** should:

a. be aligned with current health care needs and priorities

b. encompass targeted quality domains (STEEEPA) across the various stages of care especially on patient outcomes (Refer to (iii) for work-in progress for a set of STEEEPA indicators

c. be determined via the input and coordination between key stakeholders

d. be evidence-based, internationally comparable and have feasible data collection

e. be periodically reviewed

f. embrace Donabedian's structure-process-outcome model of quality

g. comprise technical quality and experiential quality

h. be made transparent to the entire organisation and stakeholders

iii) **Measuring quality** according to STEEEPA domains

a. Existing monitored indicators were collected, extracted and mapped according to STEEEPA domains from various key sources (NIA, KPI, QII, SDG, UHC) to develop a practical set of indicators that can be feasibly measured without undue measurement burden and provide a platform for future development.

b. We aim for no more than 10-15 indicators to reflect each domain with a balance across structure (input), process and outcome measures that can best be shared and used for benchmarking, guiding and informing improvement.

c. The initial list for STEEEPA indicators is in **Appendix 8**

iv) **Managing Quality Data**: Evidence-based decision making requires the availability of data that are accurate, complete and timely. A robust data and information system should have the following characteristics:

a. Centralised, streamlined and integrated data system utilising the appropriate technology that is supported by all key stakeholders. As much as possible, a set of prioritised indicators should be incorporated within the health information management system.

b. Good data governance including:
   - clear data sharing policies
   - standardised reporting format
   - analysis and feedback mechanisms

c. Structured training for data collection, analysis and remedial action

d. Routine audit of data quality

e. Quality performance should be effectively communicated to key audiences and stakeholders

v) **From Data to Action**: To promote the culture of data use, measurement and comparison should be translated into positive action to identify the root causes of shortfall in quality, potential solutions to close the loop and evaluation of the effectiveness of those solutions. Measurement should also be used to identify high performers to deliver due recognition, and sub-optimal performers to offer necessary support and assistance.

### 3.7.6.2 Quality Improvement Initiatives

The existing quality improvement initiatives have potential impact to improve the healthcare system environment, reduce harm to patients, improve clinical effectiveness and engage the family and community. These quality improvement initiatives should:

i) be fully utilised, optimised and strengthened before considering a new approach

ii) be supported with knowledge exchange, sharing of expertise and peer learning between different initiatives with dissemination of best practices across healthcare sectors/type of health provider and levels of the health system

iii) engage patient, family and community to enhance the impact of the intervention

iv) foster collaboration among the quality improvement initiatives to enhance the potential impact on quality healthcare

v) be streamlined to reduce redundancy and promote efficiency

### 3.7.7 Monitoring and Evaluation (M&E)

In ensuring effectiveness and efficient use of resources for any quality improvement initiative, including the execution and implementation of this new policy, M&E should be integrated as part of the implementation plan.

The following are the fundamental steps in carrying out M&E:

i) Construct a results framework for the quality initiatives
ii) Develop an M&E plan
iii) Select indicators
iv) Collect information on the selected indicators
v) Analyse the information gathered
vi) Compare results with the programme's initial goals & objectives
vii) Share/Use the data

Depending on the resources available, evaluation will be carried out by an in-house team or commissioned from an external team or both.

Outcome of the evaluation should be able to identify the gaps in implementation, capture the impact of improvement, and provide further recommendations, such as cost effectiveness and sustainability of the QII activities.

## 3.8 Strategic Plan

7 Strategic Priorities with objectives and actions plan were outlined to be monitored in the next 5 years as below.

**SP 1 Improving integrated people-centred services**

**SP 2 Strengthening governance for quality**

**SP 3 Strengthening internalisation of quality culture among all healthcare staff**

**SP 4 Enhancing engagement and communication with stakeholders for quality**

**SP 5 Building effective capacity and capability for quality**

**SP 6 Enhancing measurement and quality improvement initiatives**

**SP 7 Strengthening monitoring and evaluation of quality programmes or initiatives**

## 3.8.1 SP 1: Improving integrated people-centred services

| Objective | Action | Implementation Level | Responsibility | Target | | | | | Output indicator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 2022 | 2023 | 2024 | 2025 | 2026 | |
| 1. Strengthening commitment to improve people-centred care (PCC) | Support and facilitate researches, innovations and other quality projects on PCC | National | QA Technical Committee<br>Programme | ≥ 2 | ≥ 2 | ≥ 2 | ≥ 2 | ≥ 2 | Number of researches/ innovations/ quality projects/ other activities implemented related to PCC |
| | | National | Medical Care Quality Section (Medical Programme) | - | 1 | - | - | - | PCC policy or guidelines developed |
| | | National | MAHTAS | 4 | 4 | 4 | 4 | 4 | Number of CPG developed with element of PCC incorporated |
| 2. Empowering and engaging people | Ensure patient experience surveys are conducted on a regular basis | National | Medical Care Quality Section (Medical Programme) | 100% | 100% | 100% | 100% | 100% | % of MOH hospital which conduct Annual Patient Experience Survey |
| | | | Public Health Programme | 70% | 80% | 85% | 90% | 100% | % of MOH health clinic which conduct Annual Patient Experience Survey |
| | Create an enabling environment | National | Corporate Communication Unit | 100% | 100% | 100% | 100% | 100% | % of client feedback delivered within the stipulated time |

*Programmes- Refers to 6 Main Programmes in MOH*

## 3.8.2 SP 2: Strengthening governance for quality

| Objective | Action | Implementation Level | Responsibility | Target | | | | | Output indicator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 2022 | 2023 | 2024 | 2025 | 2026 | |
| 1. Strengthening leadership commitment in quality through the monitoring of current organisations' performances | Support and commitment towards quality initiatives' implementation through planned Quality Committee meetings to discuss on the organisations' performances and providing feedback to facilities on their performances | National | QA Technical Committee<br>Programmes<br>HPU | 2 | 2 | 2 | 2 | 2 | Number of quality-related meetings (discussing quality indicators' performances as one of the agendas) chaired by top leaders at respective programme levels or at the national level |
| 2. Underline the importance of quality in the MOH at top level management | Present quality-related initiative papers during the *KPK Khas* Meeting | National | QA Technical Committee<br>Programmes | 1 | 1 | 1 | 2 | 2 | Number of quality-related initiative papers presented during the *KPK Khas* Meeting |

| Objective | Action | Implementation Level | Responsibility | Target | | | | | Output indicator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 2022 | 2023 | 2024 | 2025 | 2026 | |
| 3. Strengthening governance of the Quality Committee/ Department/ Section | Establishment of a National Quality Directorate/Council directly under the purview of the DG (Inclusive of non-MOH and private) | National | QA Technical Committee<br>Programmes | - | - | - | - | / | Establishment of a National Quality Directorate / Council |
| | Integration of all existing quality committees under the QI umbrella | National | QA Technical Committee<br>Programmes | - | 1 | - | - | - | |
| | Periodic reviews of the TOR of existing Quality Committees at various levels within 3-5 years | National<br>Programme<br>State | QA Technical Committee<br>Programmes | 80% | 80% | 80% | 80% | 80% | % of the TORs of Quality Committees being reviewed |
| | Establish a Quality Department/unit or committee at district level | Public Health Programme<br>State<br>District | Public Health Programme<br>State<br>District | 20% | 50% | 75% | 85% | 100% | % of District Health Offices with a quality unit |
| 4. Improving resources for Quality | Propose dedicated posts/ human resources for the quality directorate in MOH/ programme/state level | National<br>Programme<br>State | QA Technical Committee<br>Programmes | 1 | - | - | - | - | Number of posts proposed for quality directorate in MOH/ programme/ state level. |
| | Top management to designate high priority towards the specific allocation of financial resources towards quality trainings | National<br>Programme<br>State | QA Secretariat<br>Programme | 5% | 5% | 5% | 10% | 10% | % of allocation for Quality related trainings |

*Programmes- Refers to 6 Main Programmes in MOH*

### 3.8.3 SP 3: Strengthening internalisation of quality culture among all healthcare staff

| Objective | Action | Implementation Level | Responsibility | Target | | | | | Output indicator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 2022 | 2023 | 2024 | 2025 | 2026 | |
| 1. Understanding current level of the organisation's quality culture, readiness for change and performances | Conduct periodical assessment of the organisation's quality culture | National<br>State<br>Facility | QA Technical Committee<br>Programmes | - | 1 | - | 1 | - | Number of organisations which have conducted assessment on quality culture |
| 2. Emphasis on employee wellness and welfare | Provide resources, tools and on-site healthcare opportunities/ services the staff requires to live their lives to the healthiest, through health and wellness promotion, including nutrition | National<br>State<br>Facility | KOSPEN Plus Unit – Occupational and Environmental Health Sector (Public Health Programme) | 50% | 50% | 50% | 50% | 50% | % of workers screened for risk factors of NCD in Ministry of Health settings that implemented the KOSPEN Plus programme in the current year |
| 3. Develop, implement and strengthen an engagement plan between top management and healthcare providers | Provide appropriate and up-to-date mechanism for staff to provide continuous feedback to the leaders | National<br>Programme | Programmes | 6 | 6 | 6 | 6 | 6 | Number of programmes / institutions that conducted Internal Client Satisfaction Survey |

| Objective | Action | Implementation Level | Responsibility | Target | | | | | Output indicator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 2022 | 2023 | 2024 | 2025 | 2026 | |
| 4. Strengthen the reward, incentive and recognition system and mechanism | Award regular recognition for active quality involvement | National<br>Programmes<br>State | QA Technical Committee<br>Programmes<br>States | 6 | 6 | 6 | 6 | 6 | Number of programmes/ organisations having an incentive and recognition system |
| | | | | Beating own standard | Beating own standard | Beating own standard | Beating own standard | Beating own standard | Number of quality trainers or officers given acknowledgement |
| | | | | Beating own standard | Beating own standard | Beating own standard | Beating own standard | Beating own standard | Number of institutions given acknowledgement |
| | Establish a mechanism of transparency through the ranking of like facilities and agencies in league tables, with awards at annual quality conferences. | National | QA Technical Committee<br>Programmes | - | 1 | - | - | - | Mechanism for healthcare facility ranking |
| 5. Review and optimise the system for healthcare facility accreditation to meet quality of care objectives | Identify potential healthcare facilities suitable to be accredited (subject to financial allocation and COVID-19 pandemic) | Medical Programme | Medical Care Quality Section (Medical Programme) | 50% | 60% | 70% | 85% | 100% | % of MOH lead hospitals accredited |

*Programmes- Refers to 6 Main Programmes in MOH*


## 3.8.4 SP 4: Enhancing communication and engagement of Stakeholders for Quality

| Objective | Action | Implementation Level | Responsibility | Target | | | | | Output indicator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 2022 | 2023 | 2024 | 2025 | 2026 | |
| 1. Strengthen the interaction among programmes **within the MOH** | Organise periodic high-level town hall sessions or dialogues within MOH | National | QA Technical Committee<br>Programmes | 1 | - | 1 | - | 1 | Number of dialogue sessions conducted |
| 2. Strengthen the interaction among MOH programmes **with other ministries, private sectors and the community** | Establish a formal interaction platform between MOH and other ministries/ private sectors/ the community | National | QA Technical Committee<br>Programmes | - | 1 | - | 1 | - | Number of dialogue sessions conducted |

| Objective | Action | Implementation Level | Responsibility | Target | | | | | Output indicator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 2022 | 2023 | 2024 | 2025 | 2026 | |
| 3. Foster knowledge sharing and knowledge translation platforms on quality improvement activities | Sharing best practices of quality through relevant platforms within and among organisations | National | QA Technical Committee<br>Programmes | 5 | 5 | 6 | 7 | 8 | Number of quality seminars/ conferences/ conventions conducted within MOH |
| | | | QA Technical Committee<br>Programmes | 2 | 2 | 2 | 2 | 2 | Number of quality collaborative seminars/ conferences/ conventions between MOH and other agencies |
| | | | QA Secretariat | ≥70 | - | ≥70 | - | ≥70 | Total number of quality projects presented at conventions/ conferences |
| | | | Oral Health Programme | ≥ 100 | ≥ 100 | ≥ 100 | ≥ 100 | ≥ 100 | |
| | | | Training Management Division | ≥ 80 | ≥ 80 | ≥ 80 | ≥ 80 | ≥ 80 | |
| | Publishing best practices | National<br>Programme | QA Secretariat<br>Programmes | 5 | 5 | 8 | 8 | 10 | Number of QA/QI projects manuscripts published |
| | Utilisation of online quality hub that fosters sharing of best practices/ quality projects, expertise and centre of excellence | National | QA Secretariat<br>Programmes | Base-line | +5% | +10% | +20% | +50% | Number of hits received for online quality page/ hub |

*Programmes- Refers to 6 Main Programmes in MOH*

## 3.8.5 SP 5: Building effective capacity and capability for Quality

| Objective | Action | Implementation Level | Responsibility | Target | | | | | Output indicator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 2022 | 2023 | 2024 | 2025 | 2026 | |
| 1. Strengthen in-service quality improvement training encompassing technical and soft skills | Conducting regular/ continuous training on quality improvement among all levels of HCWs, across the health sectors (in-person/ online) | National | QA Secretariat<br>Programme | 1 | 2 | 2 | 2 | 2 | Number of quality training within MOH conducted per program as per POL (*Pelan Operasi Latihan*) |
| | | | | Base-line | +5% | +10% | +15% | +20% | Number of HCWs trained in quality at national level per program per year |
| | Collaborate with other agencies beyond MOH for the training in quality healthcare | National | QA Secretariat<br>Programme | 1 | - | 1 | - | 1 | Number of collaborative QA/QI trainings conducted between MOH and other agencies |
| | Develop the capacity of a pool of trainers/ internal experts/ mentors/ champions, to conduct trainings at national/ international levels | National | QA Secretariat<br>Programme | Base-line | +5% | +10% | +15% | +20% | Number of core QA/QI trainers at the national/ international levels |
| | Develop, review or upgrade the quality training modules (conventional/e-module) | National | QA Secretariat | 1 | - | 1 | - | 1 | Number of training modules developed/ reviewed/updated |
| | Ensure staff working the quality department/initiative have competency and skill in quality | National<br>Programme | QA Technical Committee<br>Programme | - | 1 | - | - | - | Quality competency framework for quality developed |
| | Increasing the competency and capability of staff coordinating the quality initiatives | Programme | QA Technical Committee<br>Programme | - | - | - | 10% | 20% | % of competent staff working in quality department |

| Objective | Action | Implementation Level | Responsibility | Target | | | | | Output indicator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 2022 | 2023 | 2024 | 2025 | 2026 | |
| 2. Assessment of the training provided | Obtain regular feedback on the training provided | National<br>State<br>Facility | QA Secretariat<br>Programme | 1 | 2 | 2 | 2 | 2 | Number of training feedback obtained (national level, per program per year) |

*Programmes- Refers to 6 Main Programmes in MOH*

## 3.8.6 SP 6: Enhancing measurement and quality improvement initiatives

| Objective | Action | Implementation Level | Responsibility | Target | | | | | Output indicator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 2022 | 2023 | 2024 | 2025 | 2026 | |
| 1. Reviewing and strengthening the measurement and indicator framework | Assessing existing measurement systems and identifying gaps through engagement of key stakeholders | National<br>Programmes | QA Technical Committee<br>Programmes<br>HPU | 1 framework adopted | - | - | - | 1 framework reviewed | Framework adopted/ adapted/ reviewed |
| | Identify measurement gaps and streamlining existing or future indicators through engagement of key stakeholders | National<br>Programmes | QA Technical Committee<br>Programmes<br>HPU | - | / | / | - | - | A set of indicators finalised / adopted that measure technical and experiential component of quality and community engagement |
| | Measuring technical quality | National<br>Programmes | QA Technical Committee<br>Programmes<br>HPU | - | / | / | - | - | |
| | Measuring experiential quality | National<br>Programmes | QA Technical Committee<br>Programmes<br>HPU | - | / | / | - | - | |
| | Measuring community engagement | National<br>Programmes | QA Technical Committee<br>Programmes<br>HPU | - | / | / | - | - | |

| Objective | Action | Implementation Level | Responsibility | Target | | | | | Output indicator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 2022 | 2023 | 2024 | 2025 | 2026 | |
| 2. Improving data quality | Establish regional or state data audits to review data quality<br>• Data completeness<br>• Frequency of data submission<br>• Data verification to ensure data integrity and validity | National<br>State | QA Secretariat<br>Programmes | 1 | 1 | 1 | 1 | 1 | Number of audits conducted on the quality of QA/QI data per program |
| 3. Managing data and linking data sources – strengthening MyHDW | Integrating/ Linking data related to quality indicators in the existing data warehouse | National<br>Programmes | Planning Division<br>PIK<br>HPU<br>BPTM | - | 1 | - | - | - | Establishment of an integrated database |
| 4. Using data for decision making | Big Data visualising analytics (Dashboard):<br>a. National Level Performance | National | HPU<br>Programmes | 1 (MOH) | 1 (MOD) | 1 (MOE) | 1 (private) | 1 (private) | Number of new health sectors engaged/ participated |
| | b. Hospital Level Performance<br>• Readmission rate<br>• Length of stay<br>• Hospital mortality<br>• Patient satisfaction (SERVQUAL) | National | HPU<br>Medical Care Quality Section (CPSU)<br>Programmes | 1 (MOH) | 1 (MOD) | 1 (MOE) | 1 (private) | 1 (private) | Number of new health sectors engaged/ participated |

*Programmes- Refers to 6 Main Programmes in MOH*

## 3.8.7 SP 7: Strengthening monitoring and evaluation of quality programmes and initiatives

| Objective | Action | Implementation Level | Responsibility | Target | | | | | Output indicator |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 2022 | 2023 | 2024 | 2025 | 2026 | |
| 1. Organising/ conducting QII evaluations | Provide training for relevant staff on programme evaluations | National<br>State | QA Technical Committee<br>Programmes<br>State | 40 | - | 40 | - | 40 | Number of quality evaluators trained |
| | Conduct in-house evaluations | National<br>State<br>Facility | QA Technical Committee<br>Programmes<br>State | - | 1 | - | 1 | - | Number of in-house evaluations conducted by trained quality evaluators |
| | Conduct external or joint evaluations for each QII | National<br>State<br>Facility | QA Technical Committee<br>Programmes<br>State | - | - | 1 | - | 1 | Number of external or joint evaluations conducted by trained quality evaluators |
| 2. Dissemination and communication of evaluation results to close the loop | Strengthening the feedback loop of the analysis from the national level to the states and facilities to enable them to utilise the results for improvement | National<br>State<br>Facility | QA Technical Committee<br>Programmes<br>State | - | 1 | 1 | 1 | 1 | Number of evaluation summaries which include recommendations on possible remedial measures. |
| | Ensure states/ facilities/ institutions/ agencies identify root causes and implement remedial measures | National<br>State<br>Facility | QA Technical Committee<br>Programmes<br>State | - | 1 | 1 | 1 | 1 | Number of summaries which include Root Cause Analyses and remedial actions |

*Programmes- Refers to 6 Main Programmes in MOH*

*Part 4*

# *Mechanism for Implementation of NPQH*

# 4.0 Mechanism for Implementation of NPQH

The COVID-19 pandemic's changing epidemiology in Malaysia and around the world is expected to have an impact on NPQH's strategy implementation. Targets might not be at best/optimum level (as compared to previous data/achievement) and both targets and strategies need to be adjusted and re-visited due to a shortage of people, time, and other resources, in light of the current situation.

## 4.1 Roles and Responsibilities

Execution of **NPQH** requires commitment from all levels to achieve its objectives and goals.

**Top management and leaders should:**

a) Guide quality-related issues and be the change agents to catalyse and foster continuous improvement and learning culture

b) Demonstrate accountability for delivering high-quality services

c) Allocate resources to support quality improvement efforts and research

d) Reduce gaps between the actual and achievable performance in quality

e) Strengthen the partnerships between various healthcare facilities/providers from different sectors/agencies

f) Strengthen the partnerships between health providers and health users that drive quality

g) Strengthen and sustain health workforce with the capacity and capability to meet the demands and needs of the population for high-quality care

h) Ensure that health systems have an infrastructure of information (IT support) capable of measuring and reporting the quality of care

i) Strengthen the reward and incentives mechanism

**All leaders of the Quality Improvement Initiatives (QII team) should:**

a) Plan, promote, encourage or recommend activities for QIIs

b) Strengthen coordination of activities at national, state and facility level

c) Strengthen collaboration between the various QIIs—bridging the silos

d) Strengthen collaboration between various health sectors through QII

e) Strengthen the training component on quality improvement

f) Facilitate sharing and learning of best practices at the national level

g) Facilitate replication/upscale of best practices

**All managers/leaders at healthcare facilities, including the QI team should:**

a) Provide and secure continuous support for quality improvement efforts
b) Foster culture of quality
c) Ensuring delivery of high quality of care
d) Actively engage key stakeholders for quality improvement
e) Commit and facilitate documentation and sharing of learning activities within the facilities
f) Recognise and reward quality improvement
g) Establish and support a multidisciplinary QI team
h) Identify QI activities and training, develop and implement roadmap and operational plan
i) Conduct continuous measurement of quality and outcomes

**All the healthcare providers should:**

a) Embrace the culture of caring, teamwork and professionalism
b) Participate in quality measurement and improvement
c) Engage patients as partners in the delivery of care
d) Commit themselves to providing and using data to demonstrate the quality of care delivered

**All citizens or clients should:**

a) Be informed that it is their right to have access to care that meets achievable modern standards of quality
b) Be empowered to actively engage in care to optimise their health status
c) Receive support, information and skills to manage their own long-term health conditions
d) Be engaged in quality improvement initiatives
e) Play a role in the design of new models of care to meet the needs of the local community

## 4.2 Dissemination of NPQH

Appropriate actions will be taken to ensure **NPQH** reach its target audience through various channels including but not limited to as follows:

a) Launching of **NPQH** to create awareness at national level

b) Ensuring access of **NPQH** documents through dissemination of hard copies or soft copy made available on MOH and other agency websites

c) Publicise **NPQH** through promotional material, various social media platform, word-of-mouth advertising or key opinion leader

d) Sharing the process of developing the **NPQH** with other countries for country-to-country learning purposes

## 4.3 Monitoring and Evaluation of NPQH

Implementation of **NPQH** will be closely monitored for the next 5 years to ensure this policy and strategy will be a living document. Existing QA Committees roles and responsibilities at various levels will be strengthened to include this national agenda. Current TOR of these committees will be reviewed (if necessary) to include monitoring and evaluation of **NPQH**. Composition of the committees will be expanded to identify and appoint additional members as necessary to ensure wide and adequate representation of the stakeholders. Each committee will be meeting regularly (minimum annually) to monitor progress and achievement.

i) Quality Committee at programme, state and facility level

a. Monitor progress, issues, challenges and achievement of the strategies outlined at programme, state or facility level

b. Report progress, issues, challenges and achievement of the strategies outlined to QA Technical Committee, programme or state

c. Take appropriate action and re-strategise upon technical input, advise and recommendations from higher level or committee(s)

ii) QA Technical Committee at national level (chaired by IHSR Director)

a. Monitor progress, issues, challenges and achievement of the strategies outlined at national level

b. Provide technical input, advise and recommendations on **NPQH** related matter for respective programme and states

c. Report progress, issues, challenges and achievement of the strategies outlined to higher committee

d. Provide technical input, advice and make recommendations to higher committee on **NPQH** related matters

e. Establish and maintain contact and networking with local, regional and global organisations

f. Periodically review and revise **NPQH** to ensure it remains relevant to the current context

g. Take appropriate actions and re-strategise upon technical input, advice and recommendations from higher level or committee(s)

iii) QA Committee (chaired by DG)

a. Advocating, leading, oversee and provide guidance on the institutionalisation of quality initiatives through **NPQH** to support high quality of health care service delivery

b. Decide and make recommendations on the appropriate measures to be taken based on technical input of the QA Technical Committee on progress, issues, challenges and achievement of the **NPQH** strategies

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# *Appendices*

## **Appendix 1 :** Governance for each QII

| No | QII | Year Introduced | Leading Programme | Name of the Committee(s) at national level | Chairperson | Committee Member |
|---|---|---|---|---|---|---|
| 1 | REGULATORY | | | | | |
| 1a) | Institutional<br><br>Private Healthcare Facility Act | 1998 (gazetted) 2005 (enforced) | Medical Practice Division (CKAPS) | Guardian- CKAPS | Director-General of Health | - DDG (Medical)<br>- Director of Medical Practice Division<br>- Deputy Director CKAPS<br>- State Health Directors<br>- Deputy State Health Directors (Medical)<br>- Head of CKAPS at state level<br>- CKAPS Officers at MOH Headquarters and State Level |
| 1b) | Professional<br><br>Licensure and Registration | 1951 | Pharmacy | Pharmacy Board Malaysia | Director General of Health | - Director of Pharmaceutical Services<br>- Registered pharmacists in the public service (8)<br>- Registered pharmacists from any higher educational institution (3)<br>- Registered pharmacists not in the public service (2)<br>- Registered pharmacists not in the public service, nominated by the association representing pharmacists in private practice (3) |
| | Certification and Recertification | 1951 | Pharmacy | Pharmacy Board Malaysia | Director General of Health | - Director of Pharmaceutical Services<br>- Registered pharmacists in the public service (8)<br>- Registered pharmacists from any higher educational institution (3)<br>- Registered pharmacists not in the public service (2)<br>- Registered pharmacists not in the public service, nominated by the association representing pharmacists in private practice (3) |
| | Credentialing & Privileging | 2010 | Medical | National Credentialing Committee | Deputy Director General of Health (Medical) | - Director of Medical Development Division<br>- Director of Allied Health Sciences Division<br>- Under-Secretary of Training Management Division<br>- Director of Nursing Division<br>- Head of Assistant Medical Officer<br>- Specialty Sub-Committees Chairman |
| | | 2010 | Primary Health Care | Credentialing Committee for Primary Health Care | Director, Family Health Development Division | - Representatives from Disease Control Division<br>- Deputy Director (Family Health Section, FHDD)<br>- Deputy Director (Primary Care Section, FHDD)<br>- Head of Family Medical Specialist Profession<br>- Representatives from Nursing Board<br>- Representatives from Assistant Medical Officer Board<br>- State Pincipal Assistant Director (Primer) |
| | | 2013 | Allied Health | National Credentialing Committee (NCC) for Nurses, Assistant Medical Officers and Allied Health Professionals | Deputy Director General of Health (Medical) | - Director of Medical Development Division<br>- Director of Allied Health Sciences Division<br>- Under-Secretary of Training Management Division<br>- Director of Nursing Division<br>- Head of Assistant Medical Officer<br>- Specialty Sub-Committees Chairman |
| | | | | Subspecialty Committees (SSC) for Allied Health Professionals | MOH Head of Profession -Allied Health Professional | - 5 - 10 representatives (Allied Health Professional)<br>- 1 representative from MOH Training Division |

| No | QII | Year Introduced | Leading Programme | Name of the Committee(s) at national level | Chairperson | Committee Member |
|---|---|---|---|---|---|---|
| | Credentialing | 2014 | Pharmaceutical Services | Pharmaceutical Services Programme Credentialing Committee | Director of Pharmacy Practice & Development Division<br>Alternate chairperson: Director of Pharmacy Policy & Strategic Planning | - Director of NPRA<br>- Director of Pharmacy Enforcement<br>- Director of Pharmacy Board Malaysia<br>- Head Sector of Pharmaceutical Service, Public Health Development Division<br>- Head of Profession for Assistant Pharmacist, Pharmacy Policy & Strategic Planning Division |
| | Market - Medicine | 1985 | Pharmaceutical Services | Drug Control Authority (DCA) | Director General of Health | - Senior Director of Pharmaceutical Services<br>- Director of NPRA<br>- Consultant physician in public service (1)<br>- Pharmacist in public service (1)<br>- Local universities with expertise in pharmaceutical sciences (3)<br>- Fully registered medical practitioners (2)<br>- Veterinary practitioner in the public service (1)<br>- Secretary: Pharmacist from the public service. |
| | | 1976 | Pharmaceutical Services | Medicine Advertisement Board (MAB) | Director General of Health | - Senior Director of Pharmaceutical Services<br>- Director of Medical Service<br>- Director of Pharmacy Enforcement<br>- The Secretary, Malaysian Medical Association (1)<br>- The Secretary, Federation of Private Medical<br>- Practitioners Association (1)<br>- The Secretary, Association of Private Hospitals of Malaysia<br>- The Secretary, Association of Private Hospitals of Malaysia<br>- Physician in public service (1)<br>- Pharmacologist (1)<br>- Pharmacist in public service (1)<br>- Officer from the Ministry of Information (1) |
| 2 | SPECIFIC QII | | | | | |
| 2a) | Improvement in Clinical Care | | | | | |
| | Clinical/Medical Audit | 1990 | Medical | | Director (Medical Development Division) | |
| | CEMD | 1991 | Public Health/ FHDD | National Committee on the Confidential Enquiries into Maternal Deaths | Director (Family Health Development Division) | Co-chairman: Head of National Obstetrics & Gynaecology Service<br>- Health Development Division, MOH<br>- Matron of Family Health Development Division, MOH<br>- Matron of Division of Nursing, MOH |
| | Perinatal Mortality Review (Stillbirth and Under 5 Mortality Review) | 1991 | Public Health/ FHDD | National Perinatal Mortality Review Committee | Deputy Director General (Public Health)/Director Family Health Development Division) | - All states Director/Representatives<br>- States Paediatrician/Rep<br>- O & G State Representatives<br>- State MCH officers<br>- Representative from Nursing Division/ Medical Development Division/Public Health Development Division/Nutrition Division/ TCM |

| No | QII | Year Introduced | Leading Programme | Name of the Committee(s) at national level | Chairperson | Committee Member |
|---|---|---|---|---|---|---|
| | CPG | 1992 | MaHTAS, Medical Development Division, Medical Programme | HTA-CPG Council | Director General of Health | Head of Divisions and National Head of Clinical Services, representatives from the main public universities, Academy of Medicine Malaysia, Malaysia Medical Association, Association of Private Hospital and other relevant stakeholders |
| | | | | CPG Technical Advisory Committee (TAC) | Appointed among the CPG TAC members based on consensus | Multidisciplinary Committee members (eleven disciplines), nominated by National Head of Clinical Services or Head of Programme |
| | | | | Review Committee | National Head of Service of specialty related to the CPG (commonly), or consultant from university or private sector (uncommonly in some circumstances) | Multidisciplinary senior consultants from public, private and universities, programme managers and patients/carers/non-governmental organisation relevant to the CPG topic |
| | POMR | 1992 | Medical | National Perioperative Mortality Review Committee | Chairperson appointed by the Committee | Committee member is appointed by the DDG (Medical) for a 3-year tenure |
| | NNA | 2003 | Nursing | National Nursing Audit (Medical &Public Health) Committee | Director Nursing | The members are nominated by the Head of Nursing Policies and Practices both representing Medical & Public Health nursing and Malaysian Nursing Board |
| | Pharmacy Value Added Service (VAS) | 2005 | Pharmacy | Ambulatory Committee | Chairperson appointed from the state | Appointed member in MOH |
| | *ADAF* | 2007 | Pharmacy | *ADAF* Technical Committee | Director A&P Pharmacy | Appointed member in MOH |
| | | | | *ADAF* Core Committee | Deputy Director Pharmaceutical Care | Appointed member in MOH |
| | Wound Care | 2009 | Medical | National Wound Care Committee | Director (Medical Development Division) | Appointed members from MOH (Related Divisions, hospitals and health clinics) involving all states |
| | Pain Free Programme | 2011 | Medical | Pain Free Committee | Chairperson appointed by the Committee | Committee member is appointed by the TKPK (Medical) for a 3-year tenure |
| | NORNA | 2012 | Nursing | NORNA Committee | Director Nursing | The members are nominated by the head of Nursing Policies and Practices |
| | Cluster Hospital | 2014 | Medical (Medical Services Development Section) | Steering Committee Cluster Hospital | Secretary General of Health & Director General of Health | Appointed members from MOH Top Management which include Medical Program, Public Health Program, all Deputy Secretary General and all divisions representative |
| | | | | Technical Committee Cluster Hospital | Deputy Director General of Health (Medical) | Appointed members from MOH which includes State Health Director, State Health Deputy Director, Hospital and Hospital Deputy Director |
| | National COVID-19 Mortality Review Committee | 2020 | Medical | Review Committee | Chairperson appointed by DG | Committee member is appointed by the DDG (Medical) for a 3-year tenure |

| No | QII | Year Introduced | Leading Programme | Name of the Committee(s) at national level | Chairperson | Committee Member |
|---|---|---|---|---|---|---|
| 2b) | Reducing Harm | | | | | |
| | OSH | 1994 | Public Health/ BKP | No national Committee | Organisation Meeting by KSU/ TKSU(P) at IPKKM | Secretary: Head of Sector KPAS, Disease Control Division |
| | Infection Control | 2001 | Medical | National Infection Control and Antibiotics Committee | Director General of Health | MOH representatives from related Divisions and State representatives, representatives from University Hospitals and appointed members, |
| | | | | National Antimicrobial Resistance Committee (NARC) | Director General of Health & Director General (Veterinary Services Department) | Representatives from MOH, University Hospitals, Department of Veterinary, Department of Fisheries, Ministry of Defense, Department of Environment, Professional Societies, Private sectors, NGOs and Consumer Organisations |
| | Patient Safety | 2003 | Medical | Malaysian Patient Safety Council | Director General of Health | Appointed members, Representatives from MOH, University Hospitals, Ministry of Defense, Private sectors, NGOs, National Head of Services, Patients |
| | Medication Error Reporting System (MERS) | 2007 | Pharmacy | MPSG: TWG To Ensure Medication Safety Committee | Director A&P Pharmacy | Appointed member in MOH |
| 2c) | System Environment | | | | | |
| | NIA | 1985 | Research & Technical Support (IHSR) | QAP Committee | Deputy Director General of Health (Research & Technical Support) | Head of Programmes: Medical, Public Health, Nutrition, Oral Health, Pathology, Pharmacy, Allied Health, Nursing, Food Safety & Quality, Planning and Training Division |
| | | | | QAP Technical Committee | IHSR Director | Representative from programme: Medical, Public Health, Nutrition, Oral Health, Pathology, Pharmacy, Allied Health, Nursing, Food Safety & Quality, Planning and Training Division |
| | Corporate Culture | 1987 | Management | Empowering the Public Service Committee | Deputy Chief Secretary (Management) | - All SUB<br>- Head of Programmes<br>- All Directors at IPKKM<br>- All Directors of Institutions |
| | Accreditation | 1998 | Medical | Accreditation Assessment & Program Achievement Committee | Director (Medical Development Division) MOH | - Director of Medical Development Division<br>- Deputy Director of Medical Care Quality Section<br>- Accreditation Unit Officers<br>- Directors of State Health Departments & Institutes |
| | KPI | 2006 | Medical | KPI Secretariat | Head secretariat KPI KPK (Technical) | Representatives from Programmes: Medical, Public Health, Pharmacy, Dental, Food Safety & Quality and Research & Clinical Support |

| No | QII | Year Introduced | Leading Programme | Name of the Committee(s) at national level | Chairperson | Committee Member |
|---|---|---|---|---|---|---|
| 2d) | Patient, Community Involvement & Empowerment | | | | | |
| | COMBI | 2001 | Public Health / HECC | National COMBI Committee | Rotation of the Chairman of the State COMBI Committee<br><br>For 2020/2021 term- - Chairperson for COMBI Committee JKN Johor | COMBI leaders<br>Head of Health Education Division,<br>Head of Programme<br>COMBI Coordinator |
| | Know Your Medicine | 2007 | Pharmacy | Use of Quality Medicine – Consumers Committee | Deputy Director (Use of Quality Medicine) | Appointed member in MOH |
| | *KOSPEN* | 2013 | Public Health (Disease Control Division) | KOSPEN-Agencies Technical Work Group | Deputy Director Disease Control (NCD)<br><br>Division Secretory of Ministry of Rural Development (Rural Community Division)<br><br>Division Secretory of Community Relations Division | Rural Community Division, Community Development Division, Disease Control Division, Nutrition Division, HECC, BPKK, Community Relations Division, Community and Neighbourhood Relations Division, |
| | Customer Complaint/ Feedback | 2013 | Management (Corporate Communication Unit) | Customer Complaint/ Feedback Committee | Deputy Chief Secretary (Management) | - All SUB dan Directors at MOH Headquarters<br>- Together with Customer Complaint Coordinator<br>- State Deputy Director (Management) together with Customer Complaint Coordinator<br>- All Customer Complaint Coordinator at institution level<br>- Public Relation Officer Hospital Kuala Lumpur |
| | Dental Icon (iGG) | 2016 | Oral Health Programme (OHP) | iGG Committee | Deputy Director (Oral Health Promotion Section) | - Advisor: Director of Oral Healthcare Division<br>- Secretariat: Deputy Director, Principal Assistant Directors and personnel of Oral Health Promotion Section<br>- Members: iGG coordinators from 15 State Oral Health Divisions |
| | *KOTAK* | 2016 | Oral Health Programme | *KOTAK* Committee | Deputy Director (Oral Healthcare Division) | - Advisor: Director of Oral Healthcare Division<br>- Secretariat: Deputy Director, Principal Assistant Directors and personnel of Oral Health Promotion Section,<br>- Members: *KOTAK* coordinators from 15 State Oral Health Divisions |

| No | QII | Year Introduced | Leading Programme | Name of the Committee(s) at national level | Chairperson | Committee Member |
|---|---|---|---|---|---|---|
| 3 | APPROACH-BASED QII | | | | | |
| | QA-QI | 1990 | Research & Technical Support (Institute for Health Systems Research) | QAP Committee | Deputy Director General of Health (Research & Technical Support) | Medical, Oral Health, Public Health, Pathology, Pharmacy, Engineering, Nursing, Allied Health, Food Safety & Quality, Planning and Training programme |
| | Innovation | 1990 | Management | National Steering Committee for Innovation MOH | Secretary General & Director General of Health | Head of Programmes; Medical, Public Health, Nutrition, Oral Health, Pathology, Pharmacy, Allied Health, Nursing, Food Safety & Quality, Planning and Training Division Representative from QA, KIK & Innovation secretariat |
| | KIK or ICC (Innovative and Creative Circle) | 1991 | Training Management Division | National Steering Committee for Innovation MOH | Secretary General & Director General of Health | DSG (Management), DSG(Finance), Head of Medical, Public Health, Research & Technical Support, Oral Health, Pharmacy and Food Safety and Quality Programme, all Undersecretary from Management Divisions, all Director from Technical Divisions and Representative from QA, KIK & Innovation Secretariat |
| | | | | KIK Sub Committee | Undersecretary, Training Management Division | Representative from State Health Department KIK Secretariat and Unit Inovasi, Bahagian Khidmat Pengurusan |
| | Lean | 2014 | Medical (Medical Services Development Section) | Steering Committee | Secretary General & Director General of Health | DDG Medical, DDG Public Health, DDG (Research & Technical Support), DSG (Management), DSG(Finance), Undersecretary Development Division, Director Medical Development Division, Director Public Service Delivery Transformation (PDST) PEMANDU |
| | | | | Technical Committee | DDG (Medical) | Under Secretary of Human Resource, Under Secretary of Finance, Director of Medical Development Division, Director of Family Health Services Division, Institute for Health Management Director, State Health Directors, Deputy Director Medical Services Development Section, Deputy Director Medical Care Quality Section, Hospital Directors |

**Appendix 2 :** List of Stakeholders Engaged (July 2019 session- MOH)

| BIL | NAME | DESIGNATION |
|---|---|---|
| **PHARMACEUTICAL SERVICES PROGRAMME, MOH** | | |
| 1 | Mrs. Masliana Awang | Senior Principal Assistant Director |
| 2 | Mrs. Norhayati Musa | Senior Principal Assistant Director |
| **MEDICAL DEVELOPMENT DIVISION, MOH** | | |
| 3 | Dr Zarina Sahrom | Senior Principal Assistant Director |
| 4 | Dr Faizah Muhamad Zin | Senior Principal Assistant Director |
| 5 | Dr Erlendawati Mohd Anuar | Senior Principal Assistant Director |
| 6 | Dr Puteri Fajariah Megat Mohd Ghazali | Senior Principal Assistant Director |
| 7 | Dr Norhafizah Mohd Noor | Senior Assistant Director |
| **FAMILY HEALTH DEVELOPMENT DIVISION, MOH** | | |
| 8 | Dr Idawaty Ibrahim | Senior Principal Assistant Director |
| 9 | Dr Noraini Mohd Yusof | Senior Principal Assistant Director |
| 10 | Dr Hazaimah Safii | Senior Principal Assistant Director |
| 11 | Mrs Azieta Yusof | Nursing Matron |
| **MALAYSIAN HEALTH TECHNOLOGY ASSESSMENT SECTION (MaHTAS), MOH** | | |
| 12 | Mrs Siti Aishah Fadzilah | Senior Assistant Director |
| 13 | Mrs Siti Mariam Mohtar | Assistant Director |
| **QUALITY CHAMPIONS** | | |
| 14 | Mr (Dr) Azmi Alias | Consultant Neurosurgeon |
| 15 | Dr Raja Zarina Raja Shahardin | Paediatric Dental Consultant |
| **STATE LIASON QUALITY OFFICER** | | |
| 16 | Dr Mohamad Ezzat Mohamad Ismail | Senior Assistant Director, State Health Department Perlis |
| 17 | Dr Zulaiha Marsan | Senior Assistant Director, State Health Department Penang |
| 18 | Dr Muhammad Amer Shafie | Senior Assistant Director, State Health Department Kedah |
| 19 | Dr Nor Hasnira Ningal | Assistant Director, State Health Department Perak |

| BIL | NAME | DESIGNATION |
|---|---|---|
| 20 | Dr Khairunnisa' Mohd Nahwari | Senior Assistant Director, State Health Department Selangor |
| 21 | Dr Nabilah Ayob | Senior Assistant Director, State Health Department Kuala Lumpur & Putrajaya |
| 22 | Dr Siti Hanisah Zainal | Assistant Director, State Health Department Negeri Sembilan |
| 23 | Dr Noordiana Ab Hamid | Quality Coordinator, State Health Department Melaka |
| 24 | Dr Dewi Juliana Mohd Namsah | State Health Department Johor |
| 25 | Dr Kang Kiat Hong | Senior Assistant Director, State Health Department Pahang |
| 26 | Dr Hasmani Hamat | Senior Assistant Director, State Health Department Terengganu |
| 27 | Dr Norhana Mohamed Fadzil | Quality Coordinator, State Health Department Kelantan |
| 28 | Dr Prabakaran Dhanaraj | Senior Assistant Director, State Health Department Sabah |
| 29 | Dr Faizudin Hafifi Maskam | Quality Coordinator, State Health Department Labuan |
| 30 | Dr Isabella Chia Yih Cyhuan | Senior Assistant Director, State Health Department Sarawak |
| 31 | Dr Hayaniza Awang Mosa | Quality Coordinator, Kuala Lumpur Hospital |

**Appendix 3 :** List of Stakeholders Engaged (July 2019 session -Private Sector /Public Universities/Association etc)

| | | |
|---|---|---|
| **UNIVERSITI KEBANGSAAN MALAYSIA MEDICAL CENTRE** | | |
| 1 | Mr. Khairul Anuar Baki | Executive |
| **ISLAMIC SCIENCE UNIVERSITY OF MALAYSIA** | | |
| 2 | Prof. Dr Mohd Fadzillah Abdul Razak | Coordinator/Medical Professor |
| 3 | Dr Normaliza Ab Malik | Coordinator/ Lecturer |
| **UNIVERSITY TECHNOLOGY MARA** | | |
| 4 | Prof. Dr Hajah Roziah Mohd Janor | Asst. Vice Chancellor |
| **MALAYSIAN SOCIETY FOR QUALITY IN HEALTH (MSQH)** | | |
| 5 | Prof. Madya M.A Kadar Marikar | CEO |
| 6 | Dr Shuba Srinivasan | Committee Members |
| **KPJ HEALTHCARE BERHAD** | | |
| 7 | Dr Anitha KV | Senior Corporate Manager |
| 8 | Mrs. Norazah Abu Samah | Deputy Corporate Manager, Quality Services |
| **PARKWAY PANTAI SDN BHD** | | |
| 9 | Dr Shazril Ezzany Mokhtar | Government Liaison Office<br>Malaysia Operations Division<br>Parkway Pantai |
| 10 | Dr Lisa Maria Schwanke | Medical Affairs Manager |
| **SUNWAY MEDICAL CENTER** | | |
| 11 | Dr Ang Kong Hui | COO Clinical Services |
| 12 | Pn Rugayah Md Yasin | Director-Quality |
| **MALAYSIAN MEDICAL ASSOCIATION** | | |
| 13 | Dr Ganabaskaran Nadasan | President |
| 14 | Dr Thirunavakarasu Rajoo | President PPSMMA |
| **FAMILY MEDICINE SPECIALIST ASSOCIATION OF MALAYSIA** | | |
| 15 | Dr Sri Wahyu Taher | President |
| 16 | Dr Vengketeswara Rao A/L Seetharaman | FMS |
| **MINISTRY OF DEFENCE MALAYSIA** | | |
| 17 | Kol Dr Mohd Rosli | IJ BPK |
| 18 | Dr Rosman Ab. Rahman | IJ BPK |

**Appendix 4 :** List of Stakeholders Engaged (Feb 2021 session-MOH)

| BIL | NAME | DESIGNATION |
|---|---|---|
| **PHARMACEUTICAL SERVICES PROGRAMME, MOH** | | |
| 1 | Mrs Rozita Mohamad | Deputy Director |
| 2 | Mrs Norhayati Musa | Senior Principal Assistant Director |
| 3 | Mr Manzatul Azrul Azrie Sulaiman | Senior Principal Assistant Director |
| 4 | Mrs Siti Nurul Fathihah Kanan | Senior Principal Assistant Director |
| 5 | Mrs Rachel Yew Poo Jing | Senior Principal Assistant Director |
| 6 | Mrs Komala Devi a/p Mariappan | Senior Principal Assistant Director |
| 7 | Mr Khairul Iman Muzakir | Senior Principal Assistant Director |
| **ORAL HEALTH PROGRAMME, MOH** | | |
| 8 | Dr Cheng Lai Choo | Deputy Director |
| 9 | Dr Salleh Bin Zakaria | Deputy Director |
| 10 | Dr Siti Sarah Soraya Binti Mohamad | Senior Assistant Director |
| 11 | Dr Yap Chia Wei | Senior Assistant Director |
| 12 | Dr. Enny Esdayantey Abdul Manab | Public Health Dental Specialist |
| **MEDICAL DEVELOPMENT DIVISION, MOH** | | |
| 13 | Dr Suraya Amir Husin | Senior Principal Assistant Director |
| 14 | Dr Faizah Muhamad Zin | Senior Principal Assistant Director |
| 15 | Dr Erlendawati Mohd Anuar | Senior Principal Assistant Director |
| 16 | Dr Zaleha Md Nor | Senior Principal Assistant Director |
| 17 | Dr Azlihanis Abdul Hadi | Senior Principal Assistant Director |
| 18 | Dr Mohd Suffian Mohd Dzakwan | Senior Principal Assistant Director |
| 19 | Dr Maizatul Izyami Kayat | Senior Principal Assistant Director |
| **FAMILY HEALTH DEVELOPMENT DIVISION, MOH** | | |
| 20 | Dr Majdah Mohamed | Senior Principal Assistant Director |
| 21 | Dr Nik Rubiah Nik Abdul Rashid | Senior Principal Assistant Director |
| 22 | Dr Hazaimah Safii | Senior Principal Assistant Director |
| 23 | Dr Zamzaireen Binti Zainal Abidin | Senior Principal Assistant Director |
| 24 | Dr Aminah Bee Mohd Kassim | Senior Principal Assistant Director |

| BIL | NAME | DESIGNATION |
|---|---|---|
| **MALAYSIAN HEALTH TECHNOLOGY ASSESSMENT SECTION (MaHTAS), MOH** | | |
| 25 | Dr Roza Sarimin | Public Health Specialist |
| **DISEASE CONTROL DIVISION, MOH** | | |
| 26 | Dr Norli Abdul Jabbar | Senior Principal Assistant Director |
| 27 | Dr Rosnah Ramly | Head of CVD/Diabetics/Cancer Sector |
| 28 | Dr Nor Saleha Ibrahim Tamim | Senior Principal Assistant Director |
| 29 | Dr Priya a/p Ragunath | Head of Occupational and Environmental Health Sector |
| **NURSING DIVISION, MOH** | | |
| 30 | Mrs Rosdalina Basri | Assistant Director of Nursing |
| 31 | Mrs Anisah Nanyan | Assistant Director of Nursing |
| 32 | Mrs Noor Azlina Masdin | Assistant Director of Nursing |
| 33 | Mrs Nor Laili Shahadan | Assistant Director of Nursing |
| **INSTITUTE FOR HEALTH MANAGEMENT, MOH** | | |
| 34 | Dr Nor Hayati binti Ibrahim | Director, Institute for Health Management |
| **QUALITY CHAMPIONS** | | |
| 35 | Mr (Dr) Azmi Alias | Consultant Neurosurgeon |
| 36 | Dr Raja Zarina Raja Shahardin | Paediatric Dental Consultant |
| 37 | Dr Cheah Wee Koi | Geriatric Physician |
| 38 | Dr Noorul Emilin Abdul Khalid | Medical Officer |
| 39 | Dr Zahar Azuar Zakaria | Consultant Obstetric & Ginekology |
| 40 | Dr Zuhaida Binti Che Embi | Assistant Director |
| 41 | Pn Fajaratunur A Sani | Pharmacist |
| 42 | Dr Azza Omar | General Physician |
| 43 | Dr Ngian Hie Ung | Hospital Director |
| **STATE LIASON QUALITY OFFICER** | | |
| 44 | Dr Mohamad Ezzat Mohamad Ismail | Senior Assistant Director, State Health Department Perlis |
| 45 | Dr Zulaiha Mrsan | Senior Assistant Director, State Health Department Penang |

| BIL | NAME | DESIGNATION |
|---|---|---|
| 46 | Dr Siti Norhasmawati Mat Lazim | Senior Assistant Director, State Health Department Kedah |
| 47 | Dr Nor Hasnira Ningal | Assistant Director, State Health Department Perak |
| 48 | Dr Quah Yen Yee | Senior Assistant Director, State Health Department Selangor |
| 49 | Dr Yuhin Norkamilah Yusoff | Senior Assistant Director, State Health Department Kuala Lumpur & Putrajaya |
| 50 | Dr Siti Hanisah Zainal | Assistant Director, State Health Department Negeri Sembilan |
| 51 | Dr Noordiana Ab Hamid | Quality Coordinator, State Health Department Melaka |
| 52 | Dr Dewi Juliana Mohd Namsah | State Health Department Johor |
| 53 | Dr Suhaila Abdul Shukor | State Health Department Johor |
| 54 | Dr Kang Kiat Hong | Senior Assistant Director, State Health Department Pahang |
| 55 | Dr Hasmani Hamat | Senior Assistant Director, State Health Department Terengganu |
| 56 | Dr Saiful Nazri Bin Satiman | Quality Coordinator, State Health Department Kelantan |
| 57 | Dr Valentine @ Japulee Gantul | Senior Assistant Director, State Health Department Sabah |
| 58 | Dr Faizudin Hafifi Maskam | Quality Coordinator, State Health Department Labuan |
| 59 | Dr Isabella Chia Yih Cyhuan | Senior Assistant Director, State Health Department Sarawak |
| 60 | Dr S Kasthoori Supramaniam | Quality Coordinator, Kuala Lumpur Hospital |
| 61 | Dr Nurul Shuhada Ramli | Quality Coordinator, Kuala Lumpur Hospital |
| 62 | Dr Janani Subash | Quality Coordinator, Hospital Tuanku Azizah |

**Appendix 5 :** List of Stakeholders Engaged (Feb 2021 session-Non-MOH)

| | | |
|---|---|---|
| **UNIVERSITI KEBANGSAAN MALAYSIA MEDICAL CENTRE** | | |
| 1 | Prof Madya Dr Aniza Ismail | Medical Professor |
| 2 | Mrs Foziah Hanon Ahmad | Head of Quality Department |
| 3 | Mrs Analiza Abu Bakar | Administrative Officer |
| 4 | Mrs Nor Filzati Nabilah Mazlan | Administrative Officer |
| 5 | Mrs Siti Fairuz Mohd Saad | Assistant Administrative Officer |
| **UNIVERSITI MALAYA MEDICAL CENTRE** | | |
| 6 | Prof Madya Dr Mohd Idzwan Zakaria | Head of Quality & Medical Development Department |
| **ISLAMIC SCIENCE UNIVERSITY OF MALAYSIA** | | |
| 7 | Prof. Dr Mohd Fadzillah Abdul Razak | Coordinator/Medical Professor |
| 8 | Dr Normaliza Ab Malik | Coordinator/ Lecturer |
| **MALAYSIAN SOCIETY FOR QUALITY IN HEALTH (MSQH)** | | |
| 9 | Prof Dato' Dr Hj Abdul Rahim Abdullah | CEO |
| **PARKWAY PANTAI SDN BHD** | | |
| 10 | Dr Shuba Srivinasan | Vice President, Medical Affairs & Quality Department |
| 11 | Dr Lisa Maria Schwanke | Senior Manager Medical Affairs & Quality Department |
| **SUNWAY MEDICAL CENTER** | | |
| 12 | Mrs Rugayah Md Yasin | Director-Quality Resources |
| 13 | Mr Fong Wei Kie | Senior Manager Quality Resources |
| **FAMILY MEDICINE SPECIALIST ASSOCIATION OF MALAYSIA** | | |
| 14 | Dr Sri Wahyu Taher | President |
| **MINISTRY OF DEFENCE MALAYSIA** | | |
| 15 | Kol Dr Mohd Rosli | *Bhg Perkhidmatan Kesihatan* |
| 16 | Datuk Dr Rosman Ab. Rahman | *Bhg Perkhidmatan Kesihatan* |
| 17 | Kol (Dr) Hazudin Hassan | *Bhg Perkhidmatan Kesihatan* |

**Appendix 6:** Complete List of Potential Stakeholders

## 1. Government Health Organisations

- Ministry of Health
- Ministry of Education
- Ministry of Defence
- Ministry of Home Affairs
- Ministry of Women, Family and Community Development (KPWKM)
- Health Professional Council (MMC, MDC, LFM, Nursing Board, *Persatuan Pembantu Perubatan Malaysia* (PPP), Allied Health Professions (AHP)
- State Health Department, State Hospitals, Local Authorities (e.g *Jabatan Kesihatan* DBKL)
- Ministry of Housing and Local Government
- District Health Offices and District Health Offices
- National Data/ Informatics Specialists DOSM, MAMPU, PIK, NIH

## 2. Other/ Private Health Services Organisations

- Faith-based Health Services
- TCM Health Services (acupuncture, all registered TCM practioners)
- Private Hospitals (including private wings of public hospitals)
- GP Clinics
- Community Pharmacies
- Private dental Clinics
- Private Rehab Centres

## 3. Professional Bodies

- Academy of Medicines Malaysia
- Specialty Societies (FMS, Surgeons etc)
- Malaysian Pharmaceutical Society
- Malaysian Society for Quality in Health (MSQH)
- National Privileging and Credentialing Committee
- Malaysian Medical Association (MMA)

## 4. Other Line Ministries

- Ministry of Finance
- Ministry of Women, Family and Community Development (KPWKM)
- Ministry of Education
- Ministry of Rural Development
- Ministry of Economic Affairs
- Ministry of Domestic Trade and Consumer Affairs
- Ministry of Transport
- Ministry of International Trade & Industry

5. **Cooperating Partners**
   - Insurance Companies (AIA, GE etc)
   - MCMC

6. **Civil Society**
   - Kospen
   - *Ahli Lembaga Pelawat Hospital* (ALP)
   - Health Related NGOs (e.g Kasih Hospice Care, Klinik Wakaf Annur Johor)
   - Max Foundation

7. **Communities**
   - Patient Societies (e.g Rare Disease Society)
   - MAKNA
   - JKKK (*Jawatankuasa Kemajuan dan Keselamatan Kampung*)

## Appendix 7 : The Strengths, Weaknesses, Opportunities and Threats

### 1. Governance and Organisational Structure for Quality

**Strengths**

1. The existence of one standardised vision for quality, which are supported by capable leaders at multiple levels of the organisation
2. Established structures for individual QIIs

**Weaknesses**

1. Lack of coordination, integration and collaboration among QIIs within and beyond MOH leading to a siloed health system
2. Facility management capability needs to be enhanced in order to help improve work flow

**Opportunities**

1. The availability of an existing platform to develop a national policy for quality, based on the WHO's UHC initiative
2. Potential for restructuring of organizational structure to consolidate quality programs
3. Alignment with the 12th Malaysia Plan (2021) provide opportunities for innovation related to information technology

**Threats**

1. Inertia-continued segmentation of quality programs and initiatives

### 2. Knowledge Exchange, Communication & Coordination Amongst Stakeholders

**Strengths**

1. Good networking amongst the relevant ministries enables sharing of crucial information (National Security Council, *JK Bencana* etc.)
2. Availability of easily accessible and updated information through trusted online sources/ physical platforms
3. Multiple platforms for sharing knowledge especially in government sector, facilitates public awareness on health issues

**Weaknesses**

1. Ineffective communication stemming from inadequate understanding of relevant knowledge and ineffective communication skills
2. Perceived lack of confidence in the data quality (questionable data quality & unverified data) may decrease effectiveness at communicating evidence
3. Undue bureaucracy impedes the sharing the information leading to a lack of participation from beyond MOH

**Opportunities**

1. Optimising existing website/ social media etc
2. Exploration of best practices with the private/ other sectors (especially with regards to cost management)
3. Partnership with NGO, private etc.
4. Review of current policies related to information sharing
5. Availability of information technology advancements provide opportunities for innovations and integration of QII

**Threats**

1. Misinterpretation by the public as well as misuse of the information by outsiders
2. High expectation from the public
3. Gaps between knowledge & practice in the both government & non-government sectors
4. Inadequate participation from agencies beyond MOH

### 3. People-Centred Holistic Approach

S

#### Strengths

1. A few programmes utilising the people-centred holistic approach have been adopted by the community and healthcare facilities e.g. KOSPEN, *Hospital Mesra Ibadah*, Mother Friendly Hospital, Father Friendly Hospital
2. Improving people-centred care through value-adding service projects such as medication collection by "drive through", post, or self-collection through lockers, have been implemented

W

#### Weaknesses

1. The perceived lack of leadership in driving and emphasising people-centred care resulting in fragmented people-centred holistic "culture"
2. Lack of cooperation among staff of various categories as people-centred care is considered as optional by majority of people
3. The subjective measurement of people-centred care making its assessment and evaluation difficult
4. Lack of specific resource allocation to develop or enhance the methods in gathering data to measure performance of people-centred care

O

#### Opportunities

1. Quality domain has already been included as an element of Universal health coverage (UHC)
2. There are NGOs who are interested in improving patient-centred care services
3. Patient and family engagement already highlighted as an essential part of people-centred care

T

#### Threats

1. Lack of awareness on the importance of people-centred care among policy makers and healthcare staff

### 4. Health Management Information & Quality Monitoring and Feedback System

S

#### Strengths

1. Health Management Information Systems (HMIS) is already operational
2. MyHDW is MOH's main data warehouse with multiple data collection systems feeding in data to cater to different needs and purposes

W

#### Weaknesses

1. Lack of an integrated data system resulting in an uncoordinated data collecting system and issues related to data quality
2. Lack of routine data on community input to drive health system planning
3. Ongoing manual data collection with poor feedback mechanisms
4. Absence of disaggregated data to determine whether disparities in healthcare equity exists
5. Data quality problem

O

#### Opportunities

1. Data centralisation utilising the MyHDW platform as well as making individual patient-level data available for analysis
2. The government policy on Digital Government for data driven decision making

T

#### Threats

1. Data security regarding public data sharing of the organisation's quality performance may lead to threats on the provider's reputation

### 5. Resources

S

#### Strengths

1. Generally, facilities are conveniently located, clean, well-arranged with dedicated and passionate staff
2. NGO providing medical assistance (especially dialysis fee & services)

W

#### Weaknesses

1. Certain facilities face the challenges of inadequate infrastructure such as equipment and parking lots
2. Insufficient human resource dedicated to quality and high turnover rate due to the absence of a clear future pathway for quality professionals
3. Challenge in developing a succession plan for future champions/leadership in quality

O

#### Opportunities

1. Resource sharing with private sectors as an alternative to distributing the burden
2. NGOs providing medical assistance (especially dialysis fee & services) to assist public hospitals accommodating to large patient volumes

T

#### Threats

1. Insufficient funding for QI initiatives and activities including training

## 6. Workforce Capacity & Capability for Quality Improvement

### Strengths

1. Several quality-related training modules are available, which are acknowledged and awarded points through the Continuing Professional Development Programme (CPD)
2. Some elements under QI are incorporated in the induction course for new entrants (e.g. patient safety)
3. Availability of some champions from various methodologies

### Weaknesses

1. Sub-optimal workforce technical competency, soft skills and communication
2. Lack of adequate utilisation of quality trained staff in positions to achieve impact
3. Inadequate utilisation of local quality training modules as they are not regularly improvised to be comparable internationally
4. Awareness & knowledge about quality during undergraduate training is limited
5. Insufficient coordination to make quality improvement training and capacity building more accessible leading to suboptimal number of quality champions
6. Lack of provision of periodical incentives
7. Workforce already overburdened and the perception that quality improvement is a separate entity from core duties

### Opportunities

1. Ongoing training have produced a pool of passionate and dedicated QI practitioners and pensioners whose skill can be tapped
2. Presence of self-learning platforms as well as opportunities to learn from other sectors

### Threats

1. Budget constraints
2. Negative perception towards staff who are placed in quality as less capable, resulting in a lack of recognition of these staff

## 7. Quality Indicators & Core Measures

### Strengths

1. Indicators are monitored using readily available data
2. Good commitment from the ground in terms of data provision
3. Some mechanisms to verify data are already in place (i.e. audit KPI)

### Weaknesses

1. Oversupply and duplication of indicators due to parallel reporting systems lead to redundancy and overburdening of facilities
2. Indicators are less guided by current national health priorities and lacks comparability with international standards.
3. Inadequate action in identifying factors contributing to SIQ as well as post evaluation monitoring
4. Data from the private sector/ universities/ MOD is not routinely captured resulting in a less holistic representation of quality
5. No centralisation in governing various indicators from multiple initiatives that lead to lack of coordination

### Opportunities

1. To revisit, realign and harmonise existing indicators towards Malaysia plan goals and the Ministry of Health's Strategic plan
2. To create collaboration with the private sector/ universities/ MOD (i.e use statistician to analyse our data)

### Threats

1. Poor quality/inaccurate data may hamper decision-making at the national level
2. Political influence may result in focus directed towards certain achievable issues only

## 8. Stakeholder Engagement for Quality

### Strengths

1. Stakeholders, including the private sector, have shown support to improve integration and coordination of quality programs in healthcare
2. Open and transparent communication between stakeholders improves access to decision making processes, resulting in more efficient and responsive services
3. Contribution of opinions and insights by key stakeholders have been incredibly valuable in the early stages of the planning and development processes

### Weaknesses

1. Lack of stakeholder engagement activities resulting in limited opportunities for their input and concern about policies
2. Passive or inadequate involvement of stakeholders including within and beyond MOH
3. Inappropriate stakeholders are identified

### Opportunities

1. Private healthcare facilities possess strong quality systems which can be tapped through collaborative partnerships
2. It brings people together to pool knowledge, experience, and expertise to co-create solutions and share best practices

### Threats

1. Less responsive outcomes from the private sector
2. Stakeholders may develop a lack of confidence in the project team, either as a result of feeling their concerns and opinions have not been addressed or that risks are not being adequately managed

## 9. Quality Improvement Initiatives M&E

### Strengths

1. Existing successful quality activities include a wide range of improvement innovations.
2. Availability of quality experts from various disciplines
3. Existence of quality-sharing platforms to share successful best practices

### Weaknesses

1. Inadequate internal and external evaluations of the impact of quality improvement initiatives
2. Sub-optimal engagement at various implementation levels, including the community
3. The culture of siloed working has resulted in a lack of communication among programmes/ organisations

### Opportunities

1. Optimise the use of digital information technology to improve M&E
2. Platforms of communication are already available in abundance to publicise to relevant quality stakeholders

### Threats

1. Time-consuming
2. Over-stretched and overstressed human resources for quality due to insufficient staff

## 10. Quality Culture

### Strengths

1. MOH Corporate Culture incorporates quality culture
2. Existence of an established platform for QA/QI training and sharing
3. The implementation of some quality initiatives at facility/ district/ state levels are included as part of the performance measurement

### Weaknesses

1. Corporate culture is not well internalised or embraced
2. Persistence of a punitive or blaming culture would dampen the practice of learning from errors
3. Overstretched insufficient staff with a lack of recognition for quality eventually hinders the practice of quality culture

### Opportunities

1. Try different methods in assessing and managing local healthcare cultures
2. Nurture and reinforce positive deeper values through early professional education curriculum
3. Macro-policy environment can be utilized to encourage a shared way of thinking

### Threats

1. Resistance from staff due to possible unresolved issues of insufficient human resource

**Appendix 8 :** Initial List of Indicators According to STEEEPA Domains

## Safety Indicators

1. Patient Safety Indicators

| No | Programme | Indicator |
|---|---|---|
| 1. | Hospital | Hand Hygiene Compliance Rate |
| 2. | Hospital | Rate of Catheter Associated Blood Stream Infection (CABSI) --no of CABSI per 100 admissions |
| 3. | Hospital with OT | Numbers of wrong surgeries performed |
| 4. | Hospital with OT | Number of unintended retained surgical item (RSI) |
| 5. | Hospital | Number of incorrect Blood Component Transfused (IBCT) |
| 6. | Hospital + Clinic | Rate of patient fall (for inpatient and outpatient clinic) |
| 7. | Hospital + Clinic | Number of incidences caused by wrong patient identification (detected through incident reporting & investigation) |
| 8. | Hospital +Clinic | Number of medication error related to severe harm or death |
| 9. | Hospital +Clinic | Implementation of Incident Reporting & Learning System |
| 10. | Pharmacy | % of recall product directives issued within the stipulated timeline |
| 11. | Pharmacy | % of health facilities achieving full compliance ≥80% for medication safety self-assessment |
| 12. | Oral Health | % of MOH dental facilities which achieved at least 80% compliance during Safety and Health Audits to ensure audited facilities are at optimum levels |
| 13. | Nursing (All hospitals) | Compliance rate of administration of Oral Medication |
| 14. | Nursing (All hospitals) | Compliance rate of administration of Intravenous (IV) infusion |
| 15. | Nursing (All hospitals) | Compliance rate to Blood / Blood Component Transfusion |
| 16. | Nursing (All hospitals) | Compliance rate of Receiving patients at the reception area |
| 17. | Nursing (All hospitals) | Compliance rate of Sponges, sharp & instruments count |
| 18. | Nursing (All Public Health facilities) | Compliance rate of Cold Chain Management |

2. Staff Safety Indicators

| No | Programme | Indicator |
|---|---|---|
| 1. | Public Health | % of employee in the MOH settings which conducted KOSPEN Plus Programme screened for NCD risk factors in the current year |
| 2. | Public Health | Incidence rate of needle stick injuries (NSI) per 1000 health care workers within the Ministry of Health |

## Timeliness Indicators

| No | Programme | Indicator |
|---|---|---|
| 1. | Medical | % of patients with waiting time of ≤ 60 minutes to see the doctor by clinical service (Two or more registration areas involved) |
| 2. | Medical | % of patients with waiting time of ≤ 90 minutes to see the doctor by clinical service (Only one registration area involved) |
| 3. | Medical | % of Ischaemic Stroke (IS) patients receiving IV recombinant tissue plasminogen activator (IV rt-PA) therapy within (≤) 35 minutes of CT brain initiation. (From CT brain initiation to needle time) |
| 4. | Medical | % of complicated Tuberculosis (TB) cases seen within (≤) 2 weeks in Pulmonology/ TB clinic |
| 5. | Public Health | % of patient will be seen by Medical Officer within 90 minutes upon registration (In TPC Clinics) |
| 6. | Pharmacy | Proportion of prescriptions dispensed within 30 minutes |
| 7. | Oral Health | % of outpatients called for treatment by dental officer within 30 minutes duration. |
| 8. | Pathology | Laboratory timeliness for reporting of urgent small biopsies |
| 9. | Pathology | Urgent request for biochemistry test from emergency department / Unit meet the lab-TAT of ≤ 90 minutes and total-TAT of ≤ 120 minute |
| 10. | Allied Health Sciences | % of inpatient seen by dietitian ≤ 24 hours [one (1) working day] for Medical Nutrition Therapy (MNT) |

## Effectiveness Indicators

### 1. Non-Communicable Disease- Diabetes

| No | Programme | Indicator |
|---|---|---|
| 1 | National | Prevalence of Diabetes among adults |
| 2 | Public health | Proportion of T2DM patients who achieved HbA1C less than and equals to 6.5% (≤ 6.5%) |
| 3 | Public health | Number of localities under KOSPEN |
| 4 | Public health | Number of trained volunteers under KOSPEN |
| 5 | Public health | Number of adults aged 18 years and above have been screened for NCD under KOSPEN |
| 7 | Public health | % of localities reached the target of separating sugar from beverages |
| 8 | Public health | % of localities reached target of preparing fruits and and vegetables with heavy meals |
| 9 | Public health | % of localities met target for smoke-free homes |

### 2. Non-Communicable Disease- CVD

| No | Programme | Indicator |
|---|---|---|
| 1 | Medical | Heart Failure Case Fatality Rate (Within hospital) |
| 2 | Medical | Readmission within (≤) 1 month for Heart Failure |

### 3. Non-Communicable Disease-Cancer

| No | Programme | Indicator |
|---|---|---|
| 1 | Medical (Lab) | Accuracy of the External Quality Assurance (EQA) programme report for Anatomic Pathology (General Module) |
| 2 | Public health | Cervical screening coverage |

### 4. Non-Communicable Disease- Mental Health

| No | Programme | Indicator |
|---|---|---|
| 1 | National | National prevalence of depression among adults |
| 2 | Medical | % of MENTARI psychiatric patients in the community who undergo employment support programs are able to work in the open market |
| 3 | Public health | % of mental health treatment dropout rate in health clinics |
| 4 | Medical | Defaulter rate among Psychiatric outpatients |
| 5 | Medical | % of new patients reviewed by psychiatrist within (≤) 30 days at Psychiatry Outpatient Clinic |

### 5. Communicable Disease—TB

| No | Programme | Indicator |
|---|---|---|
| 1 | Public health | Treatment success rate for TB |
| 2 | Public health | % of Pulmonary TB (PTB) Smear Positive contacts examined at the first screening examination compared to a 1:10 contact target for TB index cases |
| 3 | Pathology | Accuracy of AFB smears examination in external quality assurance (EQA) performance |

### 6. Communicable Disease-Dengue

| No | Programme | Indicator |
|---|---|---|
| 1 | Public health | Implementation of Dengue Fever Education and Prevention activities by the COMBI Team |
| 2 | Public health | Dengue mortality rate |

### 7. Communicable Disease - Malaria

| No | Programme | Indicator |
|---|---|---|
| 1 | Public health | Communicable disease elimination: Zero indigenous human malaria |
| 2 | Public health | % of Indigenous & Introduced human malaria cases made by PCR test |
| 3 | Pathology | Accuracy of the External Quality Assurance (EQA) programme report for blood parasites (Malaria) |

### 8. Communicable Disease – HIV

| No | Programme | Indicator |
|---|---|---|
| 1 | Public health | Antiretroviral therapy coverage for newly diagnosed people living with HIV (PLHIV) |
| 2 | Medical | % of HIV patients achieving undetectable HIV viral load within (≤) 6 months of commencement of anti-retroviral therapy |

### 9. Communicable Disease – Vaccine Preventable Disease

| No | Programme | Indicator |
|---|---|---|
| 1 | Public health | % of immunisation coverage for Mumps, Measles, Rubella (MMR) for children at 9 months old of age (first dose) |
| 2 | Public health | Reduction in measles incidence |

## Efficiency Indicators

| No | Programme | Indicator |
|---|---|---|
| 1 | Medical | % of paediatric patients with unplanned readmission to Paediatric Ward within (≤) 48 hours of discharge |
| 2 | Medical | % of paediatric cardiology patients with unplanned readmission to Paediatric Ward within (≤) 48 hours of discharge |
| 3 | Medical | % of reject-retake images |
| 4 | Oral Health | % of failed restorations done under GA within 6 months |
| 5 | Pathology | Expiry rate of RBC |
| 6 | Pharmacy | % of value of stock disposed to value of stock handled |
| 7 | Pharmacy | % of facilities of the Ministry of Health Malaysia (MOH) achieving the optimal level of drug storage (1 - 3 months) |
| 8 | Planning (PIK) | Hospital readmission rate (Overall/by disease/by duration) |

## Equity Indicators

| No | Programme | Indicator |
|---|---|---|
| 1 | Research & Technical Support | % of PeKa B40 beneficiaries screened through Benefit 1 PeKa B40 (Health Screening) |
| 2 | Research & Technical Support | The ratio of the number of consultation and examination rooms of patients in health clinics under the Ministry of Health Malaysia to 10,000 residents |
| 3 | Research & Technical Support | Ratio of population to official MOH hospital beds |

## People-centred Indicators

| No | Programme | Indicator |
|---|---|---|
| 1. | Medical (Allied Health) | Patient with musculoskeletal condition reported a reduction in pain scale (VAS) for 3 consequences physiotherapy sessions within 2 months |
| 2. | Medical (Allied Health) | % of inpatients who are satisfied with the quality of food service in the hospital under the Ministry of Health Malaysia |
| 3. | Medical | % of new Psoriasis patients assessed for quality of life within (≤) 6 months of follow up under Dermatology Outpatient Clinic |
| 4. | Medical | Achievement of the number of new and updated Clinical Practice Guide (CPG) reports in a year |
| 5. | Medical | % of MOH hospital conduct Annual Patient Experience Survey |
| 6. | Public Health | % of MOH health clinic conduct Annual Patient Experience Survey |
| 7. | Public Health | % of assigned population screened for NCD risk at KK under EnPHC initiative |
| 8. | Nutrition | % of PIBG with Main Coach (*Jurulatih Utama*) (JU) C-HAT (*Cara Hidup Anda Terbaik*) performing nutrition and health activities |
| 9. | Oral Health | % of clients satisfied with dental services /treatment given |
| 10. | Oral Health | % of complaints resolved, whereby the complainants were satisfied with the remedial action |
| 11. | Nursing | Incidence of thrombophlebitis among inpatients with intravenous (IV) cannulation |
| 12. | Corporate Communication Unit | % of client feedback delivered within stipulated time (15 days) |
| 13. | Pharmacy | % of Counselling to Patients During Medication Therapy Adherence Clinic (MTAC)/ Medication Therapy Management (MTM) visit |

## Accessibility Indicators

| No | Programme | Indicator |
|---|---|---|
| 1. | National | Barriers to access healthcare |
| 2. | Medical | Defaulter rate among Psychiatric outpatients |
| 3. | Medical | % of hospital with Bed Waiting Time ≤ 240 minutes (4 hours) |
| 4. | Medical | % of non-life-threatening referral that are given appointment for first consultation within (≤) 1 month |
| 5. | Oral Health | % of dental clinics which provide services to improve population's access to oral healthcare services on a daily basis |
| 6. | Pharmacy | % of follow -up medication prescriptions dispensed through Value Added Service (VAS) |
| 7. | Public health | % of immunisation coverage for Mumps, Measles, Rubella (MMR) for children at 9 months (first dose) |
| 8. | Planning (PIK) | Outpatient service utilisation rate |
| 9. | Planning (PIK) | Immunisation coverage rate for DPT3 (diphtheria tetanus-pertussis) |

# *Annex*

# Policy Development Team

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## Technical Working Group

The Technical Working Group contributed to the development of this policy in one or more tasks as the following:

- Planned and provided strategic input to the development process
- Developed proposal to conduct situational analysis
- Involved in the data collection of the situational analysis
- Providing strategic information related to QII led or contributed by their respective programme/unit
- Involved in data analysis of the situational analysis
- Involved in the stakeholder's engagement sessions
- Reviewed and provided critical feedback to the policy draft

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| | | Mrs Noorhasidah Abd Rahman<br>Nursing Sister (till 21 January 2020) |
| | | Mrs Sarimah Ibrahim<br>Nursing Matron (till 20 Apr 2020) |
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| 7 | Hospital Management Service Unit<br>Medical Service Development Section | Dr Zuriyati Zakaria<br>Senior Principal Assistant Director | 1.3.4 Achievement of QII subsection on:<br>• Lean (Hospital) |
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| 13 | Practice Section Allied Health Sciences Division | Muthuraman A/l Sellathurai Pathar<br>Principal Assistant Director | 1.3.4 Achievement of QII subsection on:<br>• Credentialing & Privileging for Allied Health |
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| 15 | Pharmaceutical Services Programme | Khairul Iman Bin Muzakir<br>Senior Principal Assistant Director<br>Pharmacy Policy & Strategic Planning Division | 1.3.4 Achievement of QII subsection on:<br>• Client charter |
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