

# **Report on the Baseline Survey of Management Systems at Queen Elizabeth Central Hospital, Malawi**

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MSH Malawi

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## **1. BACKGROUND**

USAID is providing support to the MOHP Hospital Autonomy Program, for strengthening central hospital management systems and institutional development. USAID support is funded through the project "Reducing Child Morbidity and Strengthening Health Care Systems in Malawi" and Management Sciences for Health is the prime contracting agent. Health Partners Southern Africa (Pty) Ltd is contracted to MSH to provide technical support to the Hospital Autonomy component of the project.

The JIP Sub-committee on Hospital Autonomy is overseeing and monitoring the implementation of the MOHP Hospital Autonomy Program. On the 7th November 2003 the JIP Sub-committee approved the two year Roadmap Work Plan for Hospital Autonomy, based on the understanding that quarterly and annual activity plans would be flexible enough to accommodate changing needs and priorities as the rolling work plan evolved.

A critical component of the Roadmap Work Plan was the undertaking of baseline surveys at QECH and LCH. The first survey was scheduled for November/December 2003 and focused on addressing those management systems that could be strengthened prior to passing legislation on hospital autonomy. The second survey, which will be conducted in the latter part of 2004, will focus on the specific management systems that would need to be changed to enable the central hospitals to be managed as autonomous institutions, subsequent to the legislation having been passed. This would include hospital governance, financial and human resources management.

## **2. OBJECTIVES**

The broad objectives of the baseline survey are to:

- Develop a thorough understanding of central hospital management systems that are critical to improving the overall performance of the hospitals
- Provide baseline information for assessing the impact of the Hospital Autonomy Program and to identify key performance indicators that can be used to monitor progress
- Formulate proposals and an implementation plan for strengthening central hospital management systems in each hospital over the next twelve months

## **3. METHODOLOGY**

A team of three external consultants jointly conducted the Baseline Survey with key members of the management teams of Queen Elizabeth Central Hospital, with each consultant assessing different functions over the same time period. The external consultants have extensive experience in hospital services appraisal and management, and relevant experience in conducting similar hospital baseline surveys.

The hospital management team was fully involved in all stages of the situational analysis, and through this, have developed the necessary skills to conduct surveys and to monitor the progress in the future. Selected candidates will undergo facilitator training in the Peer and Participatory Rapid Hospital Appraisals (PPRHA), which is an international development programme. The selection criteria for candidates will be based on the level of knowledge and practical application of the learned skills.

The first baseline survey addressed the following eight main areas:

- a) Decentralisation of management (both from MOHP to central hospital and from hospital management to cost centres)
- b) Strategic and operational planning and performance management
- c) Financial management
- d) Human resource management
- e) Documentation of hospital management systems
- f) Management of equipment, drugs and medical supplies, and dental, radiographic and medical laboratory supplies
- g) Care delivery improvement
- h) Hospital management information system

There is considerable overlap between some of these areas and it was addressed in a consistent and integrated manner.

In order to effectively monitor the improvement in management systems, the baseline survey identified and assessed several measurable indicators, with proposed target dates, all of which are included in the implementation plan for Lilongwe Central Hospital and Queen Elizabeth Hospital.

Finally, this survey was not intended to be an exhaustive study of all management systems that have been identified. Indeed, the timeframe did not permit this. Rather the over-riding consideration was to identify those systems/processes/procedures that, if addressed, will have a significant impact on the overall performance of the hospitals.

## **4. DECENTRALISATION OF MANAGEMENT**

### **4.1. Activities**

The survey focussed on the following issues:

- Establish the level of delegation of responsibility to hospital management from MOHP;
- Establish the level of delegation of responsibility to cost centres from hospital management;

- Identification of the constraints and hindrances to delegations of responsibility from MoH to hospital management and from hospital management to cost centres;
- Propose key interventions that will strengthen cost centre management.
- Identify key performance indicators for development of cost centre management in central hospitals, establish baseline and formulate realistic targets for strengthening cost centre management.

The level of delegations were analysed within the context of the following areas:

- Financial management;
- Personnel management;
- Procurement of equipment and supplies; and
- Entering into service contracts

## **4.2. Key Findings**

### **4.2.1. Decentralised Management from MOHP to Hospital**

The decentralisation from MoHP to hospital management is very limited and hospital management are mere operational coordinators. This has an adverse impact on the day-to-day operations as well as strategic management of the hospital. Although the hospital does the “footwork” for various requirements, they cannot make decisions on these strategic and operational requirements because the decision-making is centralised. The issues listed cannot be addressed without the passing of legislation. The survey highlighted that decision-making in the following areas is centralised:

#### *4.2.1.1. Organisational development & review*

The organisational structure is developed at central level with inputs from the hospital. The hospital can therefore not align their structure with its strategic objective in terms of service delivery and managerial lines of responsibility and communication. Organisational development largely depends on the way the hospital is structured and it must therefore be aligned with the hospitals role as part of the health system. The hospital organogram doesn't identify the managerial and professional relationships of all members of staff within the hospital. A senior manager within the organisation (probably the Human Resources Manager) should have responsibility for reviewing the organogram annually and ensuring that it is updated to reflect changes in responsibility. Currently this is done centrally.

#### *4.2.1.2. Personnel administration*

The lack of authority of hospital managers and human resource managers within the hospital provides no incentives for efficient personnel management. The centralised personnel management systems are so slow and unresponsive that managers frequently give up attempting to manage their most important resource. This leads to man-hours lost and low productivity levels. Which makes QEH more complex are the

integrated personnel from the college of medicine that are utilised within the hospital. These staff members are not managed by the hospital.

#### *4.2.1.3. Medical stores*

The hospital manager cannot achieve acceptable levels of service delivery without essential drugs. The continuous “out of stock” items are increasingly adversely impacting on patient care and also affects protocols. Hospital managers cannot obtain critical drugs and the current centralised medical store system is seen to be very slow, inefficient and unresponsive. It is clear that the central medical stores (CMS) and the hospital do not interact effectively. CMS does not provide stock on the basis of utilisation but on the basis of the percentage budget allocated to the hospital. CMS purchases bulk stock of selected items and allocate a percentage of the stock to each hospital. Recently CMS embarked on a process of establishing consumption driven procurement. This however is fed by the hospital drug management system. The hospital’s drug management system is not effective in providing accurate data for the ordering of drugs and medical supplies from the units but also from the hospital. On the other hand, the central medical stores are bound to the percentage budget allocated to each of the hospitals from the MoHP. This illustrates that the consumption of drugs and medical supplies are not the main driver in budget allocations or drug distribution to hospitals.

Drug and medical supply donations are also creating more chaos in terms of over supplying stock, which hospitals do not or cannot use.

#### *4.2.1.4. Financial management*

No sophisticated financial infrastructure exists due to the current level of management responsibility delegated to the hospital. At a minimum there are procedures for setting a budget annually, which needs to be approved by MoHP. Information on expenditure against budget for some areas is also provided on a monthly basis. It is not clear if all financial transactions comply with the Malawi Treasury Financial Instructions. The financial manager who has the responsibility of the financial functions can not sign a document which states that he read and understood the Malawi Treasury Financial Instructions for the hospital and that he will comply with these at all times because he doesn’t have any authority. The hospital does not have the authority to take responsibility for the management of pay, internal audit, cash management etc.

#### *4.2.1.5. Procurement*

The hospital has authority to purchase with quotations for up to the amount of MK 300 000 for goods and MK450 000 for services. The process of obtaining approval for the invitation of tenders on services and goods takes too long thus adversely affecting service delivery in terms of patient care. Patient care requires rapid response when it comes to stock e.g. food supplies, equipment and cleaning. All requirements above MK 300 000 must go out on tender approved by GCOU (Government Contracting Out Unit).

#### *4.2.1.6. Clinical service contracting*

The contracting of services is managed centrally resulting in the hospital being without specialised services from time to time. The hospital must be proactive in obtaining

approval for essential service contracts and even then they are sometimes out of services. This again will impact negatively on patient care.

#### 4.2.2. Decentralised Management from Hospital to Cost Centres

The hospital organizational structure does not allow for cost centre management. The following aspects, which are critical for effective unit operations, are centralized:

##### *4.2.2.1. Hospital centralised budgeting and insufficient expenditure reviews*

The hospital compiles five different annual budgets. The hospital budget committee compiles these budgets. At a minimum there should be procedures for setting budgets annually and providing information on expenditure against budget to units on a monthly basis. This area is not adequately addressed through the current procedures. Unit supervisors are requested to submit requirements. These requirements are then costed by the budget committee and prioritised by the internal procurement committee. Units are therefore not entirely aware of budget allocations and expenditures against their respective budgets. Unit expenditures are not reviewed in relation to their budgets and outputs. Expenditures are also not analysed in relation with hospital objectives and outputs. The overall hospital performance can therefore not be measured.

##### *4.2.2.2. Poor personnel management*

Some units are not in control of their personnel. Personnel rotate without a coordinated scheduling control mechanism. Individual employees therefore can stay away from work without being identified. With the existing staff shortages this has a severe impact on patient care and service delivery. The large number of staff employed by colleges and other donor projects that are utilised in the hospital creates a situation where accountability and responsibility are avoided because of the hospital not being able to discipline staff not employed by them. The lack of appropriate leave management and absenteeism systems also contributes significantly to the staff shortages which ultimately impacts on service delivery. Personnel administration is done centrally which creates opportunity for staying away from work for various staffing categories.

##### *4.2.2.3. Inappropriate revenue management*

The hospital does not set any revenue targets for its paying wards. Without determining potential revenue estimates, the hospital cannot review its performance of revenue generation and collection. This also limits the hospital's ability to evaluate billing and debt collection. The number of patients in the paying wards are not reconciled with the amount of payments receive. This is due to the possible inaccuracy of the patient statistics and details on each patient on the number of days admitted. The current revenue management is done centrally and units are not informed on the criteria and procedures for revenue distribution.

##### *4.2.2.4. Insufficient performance review*

Virtually no hospital performance reviews are done at QE Central Hospital. Analysis of resource allocation and management per unit according to performance can therefore not be done. It is also difficult for QEH to do performance reviews due to the large

number integrated resources not paid from the hospital budget. Over resourced units will remain over resourced and those units that are struggling will keep on struggling.

### **4.3. Critical Area for Intervention: Development of Cost Centre Management**

#### **4.3.1. Intervention: Development of Cost Centre Management**

The selection of an appropriate intervention for decentralisation of management was made on the basis of identifying the critical area that can be changed prior to legislation being passed. The intervention is also proposed because it can be implemented by/with in the hospital and will have a significant impact on service delivery and improve patient care. By establishing cost centres the various units can be managed as cost centres with a clearly defined service delivery framework, specific workload related staff allocation, appropriate budget allocation, and expenditure and performance reviews. The hospital management can do accurate planning and identify critical problem areas through cost centre analysis. Cost centres will also form the base for implementation of some of the other interventions proposed.

The creation of cost centre management will have a positive impact on all clinical units because of resources being allocated appropriately. Administrative units and logistical support units will benefit because they will be able to do accurate costing of resource used and allocated to each cost centre. The hospital management will benefit because cost centres will enable them to do adequate planning for service delivery and will be able to do accurate budgeting and performance reviews. The patients will ultimately benefit the most from cost centre creation because of streamlined and appropriate workload related resource allocation.

#### **4.3.2. Performance indicators: Development of Cost Centre Management**

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Cost Centre Organisational Structure Developed	Completed organogram based on the cost centre principles.	February 2004
Cost Centre Resources Allocated	Staffing and budget allocations done according to cost centre structure	March 2004

## **5. STRATEGIC AND OPERATIONAL PLANNING AND PERFORMANCE MANAGEMENT**

### **5.1. Activities**

The survey focussed on the following issues:

- Status of business planning and management cycle.
- Action plan for strengthening business planning and management cycle that will be facilitated by mentors.
- Identify key performance indicators for business planning and management cycle in central hospitals, establish baseline and formulate realistic targets for strengthening business planning and management cycle.
- Compile composite list of all key performance indicators for monitoring quality and efficiency of hospital services proposed by different sections of baseline survey. Select core list of indicators that will be monitored routinely by hospital management.
- Phased action plan for development of an Integrated Performance Management System (IPMS). This will include prioritising integration of various datasets, phased development of reporting function and development of an appropriate software tool.

### **5.2. Key Findings**

#### **5.2.1. Hospital Business Planning**

The hospital does strategic planning from a budgetary point of view. All strategic objectives and goals are aligned with the budget compilation process. Although the MoHP has a strategic framework, the hospital does not have a consolidated annual hospital business plan. They do however have a strategic financial plan with incorporated sections of personnel budget, capital development budget, maintenance budget and recurrent expenditure budget. There is no annual hospital performance review report with the hospital business plan as baseline.

#### **5.2.2. Integrated Service Delivery Framework**

The number of beds within the various clinical units do not relate in any way with the number of patients and the number of admissions in specific units. There is no integrated service delivery framework that defines the type, level and quantity of services to be delivered in a unit in relation to logistical and clinical support units to optimize service delivery. This has a significant effect on the expenditure of the units in relation to their workloads. The lack of operational planning may result in inappropriate expenditures in clinical areas and also contributes to the ineffective performance management in terms of service delivery protocols. The hospital renders all levels of care within the health system at inappropriate costs. It is subsidizing district hospital services and health centre services. Without a clear integrated service delivery

framework the hospital will continually demonstrate high expenditure and provision of inappropriate levels of care.

#### 5.2.3. Availability of Accurate Information

For any hospital to do adequate strategic, service and operational planning, it needs accurate and readily available information. Currently a wide range of data sets is available but the accuracy and relevance thereof is questionable. This creates a scenario whereby the hospital can do planning at all levels with specific outputs based on inaccurate data.

#### 5.2.4. Performance Management

Virtually no hospital performance management is done. Neither the hospital nor the units are evaluated against set objectives and/or expenditure. Expenditure is also not analysed against workloads within the various clinical and other units. Selected analysis is done within some of the units but not to the extent of measuring performance. No integrated system or approach exists for performance management. Management of the units and of the hospital does not have a set of key hospital performance indicators that can be used for performance reviews.

### **5.3. Critical Area for Intervention: Hospital Business Planning**

#### 5.3.1. Intervention: Hospital Business Planning

The term “business planning” is used to refer to the overall annual strategic and operational planning exercise for the hospital. The hospital must be managed as a non-profit business. This means that all aspects of business planning should be addressed when strategic and operation planning is done. It is however critical that the planning cycle and plan format be established and developed because the hospital business plan needs to be aligned with all strategic planning frameworks within a national context. The following areas will be incorporated in the hospital business plan:

- Hospital mission & vision
- Short & medium term objectives
- Service delivery and quality of care framework
- Human resource management & planning
- Capital planning framework
- Hospital information system framework
- Organisational development framework
- Budget forecasts and planning
- Risk management

The establishment of a business planning cycle and appropriate business plan format will have an impact on the organisational development and long term planning of the hospital. Resource management will be done according to the business plan, which will

also be the baseline for performance reviews in terms of expenditure and patient care. A comprehensive business plan will enable hospital management to manage the hospital as a business, optimising resource utilisation in relation to outputs or service delivery. The MoHP will benefit from the hospital business plan because it illustrates the hospital's strategic intent and profile. It will provide them with a baseline for reviewing the hospitals performance and achievements of set targets.

#### 5.3.2. Performance Indicators: Business Planning

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Business planning cycle established	Business planning process & time frame established and approved.	March 2004
Business plan format developed	Business plan format approved and available for distribution.	April 2004

### **5.4. Critical Area for Intervention: Hospital Performance Management**

#### 5.4.1. Intervention: Hospital Performance Management

In order for any hospital to perform effective performance management, it needs accurate and accessible processed information that is a true reflection of the operational activities in the hospital. Currently there are various information systems operational within the hospital each with its purpose and specific outputs addressing specific requirements. These outputs are not all accurate and not processed into a format that management can use for effective decision-making. Management's requirement is to be able to access all information sets that are already processed and analysed on a single integrated dataset. The development of an integrated performance management system (IPMS) through the incorporation of all existing information system outputs and establishing a user-friendly reporting interface would address these management requirements.

Through the IPMS, both the day-to-day and strategic management of the hospital will improve significantly. With set performance indicators processed and measured through IPMS, hospital management will have a hands-on, real-time decision-making tool providing them with all relevant information they need to manage the hospital.

#### 5.4.2. Performance Indicators: Hospital Performance Management

<b>Milestone</b>	<b>Description</b>	<b>Target Month</b>
Information systems Interface Established	All existing information systems (MASH, PMIS, HMIS) interface with IPMS	April 2004
Hospital performance management system developed	Integrated performance management system (IPMS) development completed and piloted.	September 2004
Hospital performance management system implemented	IPMS implemented and rolled out.	December 2004

## **6. FINANCIAL MANAGEMENT**

### **6.1. Activities**

The survey focussed on the following issues:

- Financial management of cost centres
- Feasibility of revenue management system and the management thereof
- Assessment of the management accounting system for hospitals (MASH) and formulation of a plan to incorporate MASH into a comprehensive integrated performance management system (IPMS)
- Identify key financial performance indicators that will be utilised in expenditure and performance reviews of central hospitals to be initiated in the second year

### **6.2. Key Findings**

#### **6.2.1. Budgeting Process, Cycle and Format**

The hospital's centralised budgeting process creates a gap between the budget allocation and expenditure of units. Units are not aware of the funding brackets available and the allocation thereof. The hospital has a committee responsible for compilation and an internal procurement committee that prioritises needs submitted by various units. From the submitted needs, a budget is compiled. The hospital has 5 different budgets:

- Recurrent expenditure budget
- Personnel budget
- Capital planning/maintenance budget
- Supplementary recurrent expenditure budget

- Drug & medical supplies budget (Not hospital based)

Although units are represented on the budgeting committee they do not set budgets for their own respective units. Units do not have comprehensive budgets against which they can monitor expenditure. They cannot do analysis of expenditure against workloads and set objectives.

#### 6.2.2. Revenue Management

The hospital has no formal revenue management system in place. Analysis is done on the fluctuation of revenue which is collected on a quarterly basis. Analyses of potential revenue that can be collected, revenue identified (billed), and actual revenue collected against paying patient workload is not done. Annual revenue targets are not set. This is critical, especially with the MOHP policy that the retention of 80% of revenue collected has been approved and implemented. There are various developments underway on the patient classification structure and patient fee structure system. However, once these structures are approved they need to be implemented within the context of optimizing the system through identification, billing and collection of revenue as well as the setting of revenue targets. The implementation of these structures without having an appropriate revenue system to implement it with, will not achieve the anticipated increased effectiveness in the revenue management process.

#### 6.2.3. Expenditure Reviews

The existing expenditure reviews are not adequate in addressing the various areas of expenditure containment. Expenditures from the various units are not analysed in relation to their outputs/workloads. There are no means for identifying inappropriate expenditure other than the internal procurement committee prioritising the needs submitted by the units. These priorities are not always aligned with the service delivery outputs of the units. There is a general feeling that not all of the unit supervisors are appropriately trained for effective financial management. This is the main reason why the finance function is greatly centralised.

#### 6.2.4. Management Accounting System for Hospitals (MASH)

The management accounting system for hospitals (MASH), recently developed, was introduced at LCH but has not been rolled out to QECH. QECH uses a manual accounting system and monthly reports on information provided by the various statements are submitted to the hospital management. This system is fairly accurate but is limited in its scope and does not provide financial analysis per unit and expenditure analysis in relation to workloads and outputs (performance assessment).

### **6.3. Critical Area for Intervention: Strengthening Revenue Management**

#### 6.3.1. Intervention: Strengthening Revenue Management

The main focus for this intervention will be to strengthen the management of revenue through the development and implementation of a revenue management model. The revenue model will incorporate the patient classification structure, patient fee structure

and the procedure description. With the above items incorporated, the model will generate the following outputs by analysing of these items in terms of actual patient workloads:

- Accounts/Cash raised (Revenue identified)
- Revenue collected
- Cash fees collected
- Potential revenue (Target)
- Percentage of potential revenue claimed
- Percentage of potential revenue collected
- Percentage of identified revenue collected
- Approximate % of cash fees collected
- Total revenue lost

From the above outputs the hospital can monitor and manage revenue effectively. By analysing the various revenue indicators with assistance of the model, it will be possible to highlight where problems are occurring in revenue management.

Improvement of revenue management is crucial especially now that the hospital can retain 80% of all revenue collected. Patient care can be improved significantly if the hospital can invest 80% of revenue collected in the upgrading of facilities and the ward environment. This will attract more paying patients, which again will increase the revenue.

#### 6.3.2. Performance Indicators: Strengthening Revenue Management

<b>Milestone/Performance Indicators</b>	<b>Description</b>	<b>Target Month</b>
Revenue management model developed	Incorporation of patient classification and patient fee structure into the revenue model.	January 2004
Revenue model implemented	Revenue model implemented, users trained and outputs monitored.	March 2004

### **6.4. Critical Area for Intervention: Expenditure Review Improvement**

#### 6.4.1. Intervention: Expenditure Review Improvement

The hospital submits budgets to MoHP annually, which then allocates a specific amount for the financial year for the hospital. This budget allocation from MoHP is not necessarily the amount requested by the hospital and in most cases is less than the approved monthly budget. The hospital must prioritise all needs according to specific criteria. Without expenditure control in the form of reviews, hospital management will

not be able to manage expenditure effectively. Through establishing a financial review format, hospital management and cost centre supervisors will be able to have hands-on control over expenditure per unit. This will have a significant impact on cost control if implemented as part of cost centre management.

#### 6.4.2. Performance Indicators: Expenditure Control Improvement

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Format for financial review established	Financial review formats and establishing financial review sessions with managers.	May 2004
Cost centre managers trained	Financial review principles and formats workshops for all cost centre managers conducted.	June 2004

## 7. DOCUMENTATION OF HOSPITAL MANAGEMENT SYSTEMS

### 7.1. Activities

The survey focussed on the following issues:

- Establish current status of the documentation of hospital management systems in each hospital in terms of written policies/ procedures/ and processes. This includes procurement and financial management systems (including revenue management), personnel administration, patient administration including PMIS, monitoring and evaluation systems including HMIS, governance, quality assurance, clinical support systems (including X-ray, laboratory, dental, pharmacy, rehabilitation) and non-clinical support systems (including PAM, transport, catering, laundry, waste disposal).
- Assess availability of documents to hospital managers.
- Identify priorities for documentation (and improvement in accessibility) to facilitate hospital autonomy.
- Propose an action plan for documentation of management systems in each hospital.
- Identify key performance indicators for documentation of management systems in central hospitals, establish baseline and formulate realistic targets for strengthening documentation of management systems.
- Contribute to the selection of a core list of key performance indicators that will be monitored routinely by hospital management and proposal on phased action plan for development of the IPMS.

## **7.2. Key findings:**

Policy documents are issued by the MOHP and other Ministries on an ad hoc basis that are relevant to most management systems. However, these documents are not readily available to all employees that are required to implement them.

There is a general lack of documentation of management processes and procedures and virtually no formal management manuals exist. The lack of procedural guidelines means that there is in general no framework within which to operate and that performance cannot be measured as norms and standards have not been set. The policies, as determined by the MOHP, should be used as the basis from which to work, and the procedures that outline the step-by-step process to follow should emanate from these policies.

The lack of procedural documentation for both clinical and non-clinical services could hamper effective day-to-day hospital management and service delivery. The majority of the current systems are run manually, often without the correct mechanisms in place for optimal expenditure and cost management. Sections appear to be run on a “silo” approach and information is not consolidated.

## **7.3. Critical Intervention: Documentation for management systems**

### **7.3.1. Intervention: Documentation for management systems**

In order to improve day-to-day hospital management, policy and procedure manuals will need to be developed for all management systems in both Clinical and Non-Clinical Support Services. The necessary forms and documentation should be developed and/or upgraded and based on a systemic approach to hospital information management. Manuals need to be developed for the following systems:

- Procurement and financial management systems (including revenue management)
- Human resource management (Refer to next section)
- Patient administration including PMIS and monitoring and evaluation systems such as HMIS
- Governance (Deferred till strategic framework approved)
- Quality assurance (Incorporated in each system)
- Clinical support systems (including X-ray, laboratory, dental, pharmacy, rehabilitation)
- Non-clinical support systems (including PAM, transport, catering, laundry, waste disposal).

### 7.3.2. Performance Indicators: Documentation of Management Systems

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Framework for Financial and Procurement policy and procedure manual designed	Collect documentation, design framework, identify development requirements	April 2004
Financial and Procurement policy and procedure manual developed	Develop manual with documentation of policy, processes and procedures	August 2004
Pilot run of Financial and Procurement policy and procedure manuals	Key Financial and Procurement staff, management and other users trained	Oct 2004
Select key clinical support and clinical services for manual development	Identify and prioritise key clinical policy, procedures and guidelines required	July 2004
Develop policy and procedure guidelines manuals for selected clinical support and clinical services	Clinical policy, procedures and guidelines developed	Nov 2004
Implement selected clinical support services and clinical procedural guidelines in hospitals	Clinical staff trained and system implemented	Feb 2005
Select key non clinical support services for manual development	Identify and prioritise key policy, processes, procedures and guidelines required	May 2004
Develop policy and procedure guidelines manuals for non-clinical support services	Non-clinical policy, procedures and guidelines developed	September 2004
Implement non-clinical procedural guidelines for non-clinical support services in hospital	Non-clinical support services staff trained and system implemented	Jan 2005
Design a new Transport System	Collect documentation, design framework, identify development requirements	April 2004
Transport policy and procedure manual developed	Develop transport manual with documentation of policy, processes and procedures	June 2004

## **8. HUMAN RESOURCE MANAGEMENT**

### **8.1. Activities**

The survey focussed on the following issues:

- Review Human Resources management policies, procedures and processes currently available at central hospitals;
- Identification of crucial deficiencies in Human Resources management that hinder efficient utilisation of human resources at central hospital level;
- Proposal of an action plan for strengthening Human Resource management in each of the central hospitals;
- Identification of key performance indicators for Human Resource management in central hospitals, as well as the establishment of a baseline and the formulation of realistic targets for strengthening care delivery;
- Assessment of in-service training programmes of health workers with regard to management systems, and recommendations on the impact of effective documentation of management systems that can be incorporated into training materials and training programmes;
- Make recommendations on the compilation of a senior hospital manager's "toolkit" that will assist managers in optimal hospital management.

### **8.2. Key Findings**

#### **8.2.1. Lack of Human Resources policy and procedure manuals**

There is a general lack of human resource policy and procedure manuals, and what is available, is not always up to date. Certain Human Resources documents are available but the forms only record data, without the necessary means of recording, verification, analysis and consolidation of the information contained thereon.

There is a lack of coordination in the recruitment of new employees as medical doctors often have to wait for up to four months for their salaries. This system in particular needs to be documented and a checklist document designed to ensure that this function is streamlined, as the hospital cannot afford to lose medical doctors because this will have a direct impact on service delivery and patient care.

#### **8.2.2. Human Resource Management**

Human Resources management is loosely run and the function is not integrated with the strategic and operational hospital management. Human Resources statistical data is not always available or consolidated and reports provide fragmented information.

### 8.2.3. Performance Management

No Performance Management System is in place and the annual salary increases are not subject to any formal performance rating or evaluation. No performance agreements or other performance-related documents are available. There is no mechanism in place to identify training needs, or to track individual development plans.

### 8.2.4. Human Resources Plan

There is no Human Resources Plan in place.

### 8.2.5. Post and Job analysis

Job descriptions are not in place, and what are available, needs to be upgraded.

### 8.2.6. Registry System

The Registry Office lacks procedural guidelines and does not have an effective mail or staff filing management system. Incoming and outgoing mail is not recorded; mail is not collected or delivered to the various sections in the hospital, but is slotted into pigeonholes in the library.

Salary slips are not recorded and signed for by the section heads or the individual employees. Employee numbers are not recorded on the personnel files and each file has been assigned another number, located in a different register. Finding files is therefore time-consuming and the files contain large volumes of information.

### 8.2.7. Human Resources Development and Training

There is no Human Resources Development and Training policy and procedure manual, and no training-related information or documentation is available. Training Needs Analyses are not conducted and individual development plans are not in place. There is no Skills and Competency database available, which means that when an employee in a particular section is away, there is no one to stand in while they are away, and the function then grinds to a halt.

### 8.2.8. Staff Attraction and Retention strategy

No Staff Attraction and Retention Plan is available, nor is there a specific strategy in place for the employment of foreign-qualified doctors. There appears to be no Memorandum of Agreement with local or international academic institutions at the hospital level. There appear to be no educational exchange agreements for medical students with universities in other countries.

### 8.2.9. Leave Management System

The Leave Management system is not functional and there is no procedure or documentation in place. The current leave records are not up to date and the leave application form reflects what each individual *states* the leave balance to be. No leave reconciliation is done and no monthly leave reports are generated for verification by each individual.

#### 8.2.10. Development of the Manager's Toolkit

There are no guidelines for managers and there is no Management Development Programme in place for management, other than the centrally arranged block of training that clinicians attend prior to commencing duties at the hospital, and documentation on this was not available.

### **8.3. Critical Intervention: Human Resources Policy and Procedure Manuals**

#### 8.3.1. Intervention: Human Resources Policy and Procedure Manuals

Of critical importance are the development of the Human Resources policy and procedure manuals as well as the development and/or upgrading of all the relevant forms and documentation. This will provide management and staff with an established framework and guidelines within which to optimally manage human resources. The current system consists of a series of circulars sent to the hospitals for distribution.

Training, coaching and guidance should be on an individual basis, or for no more than three people at any given time. Empowerment through this process should result in increased levels of knowledge and motivation.

#### 8.3.2. Performance Indicators: Human Resources Policy and Procedure Manuals

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Human Resources policy and procedure manual developed	Develop Human Resources policy and procedure manual with documents	March 2004
Pilot of Human Resources policy and procedure manual completed	Key Human Resources staff, management and other users trained	May 2004
Roll out plan developed	Training and implementation plan formulated	June 2004

### **8.4. Critical Intervention: Human Resource Plan**

#### 8.4.1. Intervention: Human Resource Plan

An Integrated Human Resources Plan that is aligned to the Hospital Strategic Plan will be written and implemented. This will incorporate all critical factors and will have measurable outputs for each year, and the contents thereof will be presented in section-based information workshops, including management.

However, many other systems need to be in place prior to the development of such a plan, such as strategic plans, organisational structure and budget information. The development of an Integrated Human Resources Plan is therefore an iterative process

that will take place over several months by incorporating all subsequent HR needs and developments.

#### 8.4.2. Performance Indicators: Integrated Human Resources Plan

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
First draft Integrated Human Resources Plan framework developed	First draft framework discussed with key role players for input	January 2004
Second draft Integrated Human Resources Plan framework completed	Input from key role players incorporated and presented to management for acceptance	June 2004

### **8.5. Critical Intervention: Registry System**

#### 8.5.1. Intervention: Registry System

A new Registry System will be developed and implemented, with procedure manuals on the different sub-sections in Registry. This will incorporate revised management systems for mail, staff files, payslip registers, attendance registers and management of all hospital documentation and archive systems.

#### 8.5.2. Performance Indicators: Registry System

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Design new Registry System	Mail management, new staff files (with sub-files) and payslip management systems.	Feb 2004
Policy and procedure manual for Registry System developed	Formulation of procedural guidelines completed	April 2004
Pilot run of new Registry System completed	Systems in place and registry staff trained in registry management	June 2004

### **8.6. Critical Intervention: Human Resources Development and Training**

#### 8.6.1. Intervention: Human Resources Development and Training

The Human Resources Development and Training policy and procedure manual will be developed. This will include new and/or revised documentation for training. A comprehensive Training Needs Analysis will be conducted and management and staff

training needs, current competencies and skills will be incorporated into a consolidated Skills Database.

Individual Development Plans will be drawn up and incorporated into the Performance Management System. A Management Development Programme will be developed that incorporates both in-house and external education, training and development as part of individual Career Path development and Succession Planning.

#### 8.6.2. Performance Indicators: HR Development and Training

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Human Resources Training and Development policy and procedure manual developed	HR Training and Development policy and procedure and relevant documents, forms and records in place	August 2004
Human Resources Training and Development policy and procedure manual implemented	Human Resources Training and Development procedures implemented and users trained	October 2004

### 8.7. **Critical Intervention: Staff Attraction and Retention strategy**

#### 8.7.1. Intervention: Staff Attraction and Retention strategy

This will be developed and presented to management as part of the Human Resources Plan and will incorporate inputs and collaborative agreements with the relevant academic institutions.

#### 8.7.2. Performance Indicators: Staff Attraction and Retention Strategy

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Develop strategy to retain current staff and to attract new staff	Presentation of first draft of strategy to management, get inputs and do final draft.	January 2004
Implementation of Staff Attraction and Retention strategy	Strategy implemented and management and users trained	March 2004

## 8.8. Critical Intervention: Leave Management System

### 8.8.1. Intervention: Leave Management System

The Leave Management system will be developed and implemented, together with new forms and documentation. The generation of accurate leave printouts, annual leave planner template and updated records on each employee's file must be implemented.

### 8.8.2. Performance Indicators: Leave Management System

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Leave Management policy and procedure manual designed	Collect documentation, design framework, identify development requirements	February 2004
Leave Management policy and procedure manual and documentation developed	Leave Management procedures, documents, template, records and reports developed	April 2004
Pilot run of new Leave Management System completed	Leave procedures and documentation implemented and users trained	May 2004
Roll out and training plan for leave developed	Training needs identified and implementation plan formulated	June 2004

## 8.9. Critical Intervention: Development of the Manager's Toolkit

### 8.9.1. Intervention: Development of the Manager's Toolkit

Development of the Manager's Toolkit is quintessential to successful management in both non-clinical and clinical support services. The toolkit will contain management and leadership guidelines on human and other resources management:

- Synopsis of the most important human resources policy procedures
- Guidelines on the Staff Performance Management System
- Framework for dealing with disciplinary and grievance matters
- Guidelines for effective conflict resolution
- Mentoring, management and leadership framework
- Guidelines on effective interpersonal skills
- Framework for effective communication and meetings
- Effective people management guidelines
- Guidelines on motivating staff

The contents of the Toolkit will be explained to managers through small individual coaching and/or small workshops of no more than three people at any given time.

The Toolkit will be an essential aid for the Management Development Programme, which will provide the framework for individual development, career path and succession planning is an essential part of management development.

#### 8.9.2. Performance Indicators: Manager's Toolkit

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Managers' Toolkit designed	Collect documentation, design framework, identify development requirements	April 2004
First Version of Managers' Toolkit developed	Key guidelines developed and first version produced	June 2004

## **9. HEALTH MANAGEMENT INFORMATION SYSTEM**

### **9.1. Activities**

The survey focussed on the following issues:

- Establish current status of the HMIS in each hospital. This will include the capacity to provide timely and reliable information that can be used for management purposes.
- Propose an action plan for strengthening the HMIS in each hospital.
- Identify key performance indicators for HMIS in central hospitals, establish baseline and formulate realistic targets for strengthening HMIS.
- Make recommendations on how key information from HMIS can be integrated into the IPMS

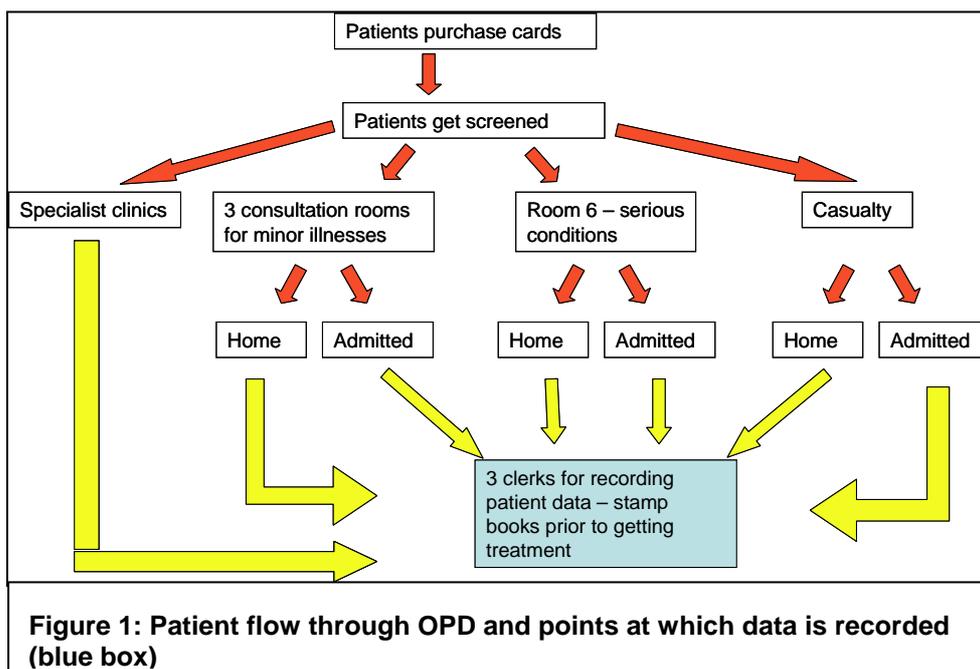
### **9.2. Key Findings**

The HMIS unit has been active in terms of entering data into the DHIS and providing feedback to management and clinical heads of department through Quarterly Information Reviews. Many of the observations made in the Lilongwe report are valid for Queen Elizabeth Hospital as well, namely:

- The HMIS dataset is almost complete;
- Some financial data has been entered into the system;
- There is some awareness of the value of information, and a growing appreciation that this aspect needs to be improved.

- There is also a recognition that data is not of a high quality, does not reflect the picture accurately, and that the disease profiles are not accurate.
- Some departments collect information through their own parallel systems;

There are some very simple interventions that could improve the quality of data. This was identified in fact during an interview in the OPD/casualty department where the flow of patients through the department was tracked and the point at which data was recorded documented (figure 1).



We see here that the recording of data becomes a bottleneck once patients have been seen. Patients are required to get a stamp on their cards indicating that they have passed through this point before they get their medication, but this means that those that do not need medication can bypass this point, and it is not certain whether this rule is strictly adhered to at the pharmacy. What is also apparent is that the clerks recording the data do not necessarily have an interest in ensuring that the data is accurate. Clinicians seeing the patients would have much more of an incentive to ensure that the data is accurate, but may not be prepared to allocate the time required to enter the data. However, with a very small time investment, some significant steps can be taken to strengthen the system and improve the quality of the data.

Data from the outpatient encounter is recorded in the OPD/Casualty Register, and this is consolidated on a quarterly basis in a report that is submitted to the HMIS office for data capture into the District Health Information System (DHIS).

For in-patient encounters, two sources of data are used (the admissions register, and the ward record book) to complete the quarterly ward report. In the HMIS office this data is entered into the DHIS.

Problems occur in the flow of data from the various sites where patients are seen, to the time when the data is entered into the DHIS.

### **9.3. Critical Area for Intervention: Strengthening Hospital Management Information System**

#### **9.3.1. Intervention: Strengthening Hospital Management Information System**

It is envisaged that the quality of data can be improved, firstly, by:

- Clarifying flows in OPD/casualty, and making sure that all points are well covered in terms of recording patient data (stopping the gaps in the system)
- Clarifying data elements needed (wards and OPD) – there are some data elements that are seldom used, or which record highly inaccurate information. In addition, some departments have their own information systems. Bringing the HMIS and department specific systems together would make sense, and provide incentives on both sides to ensure accurate data. This step involves prioritizing those that are considered important for each department, clarifying their definitions, and mechanisms of recording the information.
- Refining data collection tools – for example, a simple midnight census form would improve data on the numbers of in-patient days

The above steps will ensure that the primary sources of data collection are improved.

In addition, the use of the PMIS that has been developed at Lilongwe should be considered for roll-out in QECH. It is proposed that this is explored further and that an action plan for this is developed, should the various parties be interested.

Following this, the collation through the reports from the wards and OPD needs to be strengthened. This will ensure that accurate data flows into the HMIS, following which we will pay attention to the generation of reports and feedback to the wards. This latter step will entail using the DHIS report generator functions to make reports available on a regular basis and participating in review meetings on HMIS to ensure that heads of departments are satisfied with the reporting format and data accuracy.

The proposed process for this will be based on the following:

- Developing close linkages with the HMIS team (Mr Seakale and his team) at the hospital so that their ability to manage the system is developed;
- Working closely with heads of departments to clarify their needs;
- Working closely with the ward and OPD staff responsible for the primary data collection to make sure that they understand the principles and importance of accurate information.

9.3.2. Performance indicators: Strengthening Hospital Management Information System

Milestone/ Performance Indicator	Description	Target Month
Quarterly reports produced and circulated	Through discussions with management and clinical heads of department a format for production of quarterly reports based on the HMIS is determined and implemented	April 2004
Integration with PMIS discussed and action plan submitted	An action plan available for integration of HMIS and PMIS.	April 2004
Improved accuracy of HMIS data	Through the process of clarifying data flows, and data elements and indicators required, the data set will reflect more accurately the service delivery profile of the hospital	May 2004

**10. MANAGEMENT OF EQUIPMENT, DRUGS AND MEDICAL SUPPLIES, AND DENTAL, RADIOGRAPHIC AND MEDICAL LABORATORY SUPPLIES**

**10.1. Activities**

The survey focussed on the following issues:

- Establish current status of standardization and specification of essential equipment for each clinical and support service.
- Propose key activities for strengthening management of equipment in collaboration with PAM project.
- Make recommendations on how key information from PAM software can be integrated into the IPMS.
- Establish current status of drugs and clinical/medical supplies management.
- Propose key activities for strengthening drugs and clinical/medical supplies management in each central hospital.
- Identify for these areas key performance indicators, establish baseline and formulate realistic targets.

**10.2. Key Findings: Medical Equipment Procurement and Maintenance:**

From discussions with Heads of Department, the PAM unit, and the College of Medicine, it is apparent that the hospital at QEC in fact has a reasonably good

equipment base on which to work, although there are some basic gaps (e.g. diagnostic sets in wards and OPD/casualty). The anaesthetic department in particular appears to have an impressive array of basic equipment, which allows them to provide fairly reliable services. However, it was apparent that there is a:

- Need to implement the policy on Physical Assets Management within the hospital
- Lack of standardization of equipment both within and between departments
- Absence of prioritization of equipment needs
- Lack of standardised specifications for equipment detailing compatibility requirements, etc
- Need for greater co-ordination between departments
- Concern, raised by staff, that Malawi does not necessarily have the expertise to deal with sophisticated equipment

The result of this is that in many instances, donated equipment may in fact, be not needed, contrary to specifications and therefore if parts break, they may not be able to find replacement parts. It was also apparent that in some instances, donations consisted of defunct and out-dated equipment. Because the policy on accepting equipment donations, and the conditions attached thereto, has not been applied, the Hospital and MoHP is forced into the category of being a passive recipient.

Based on discussions with the staff at the PAM unit, at this point there is no urgency to interface the PLANAH database with that of the HMIS. There are however benefits to be obtained from close collaboration with them on the development of databases, utilisation of common facility lists and equipment specifications, and the on-going maintenance of the system.

### **10.3. Critical Area for Intervention: Strengthening Medical Equipment Procurement and Maintenance**

#### **10.3.1. Intervention: Strengthening Medical Equipment Procurement and Maintenance**

Based on these aspects, it is recommended that:

- The linkages with PAM team and processes be strengthened
- The policy on dealing with donated items be translated into a guideline document for the hospital
- Specifications for equipment be developed – these should take into account the Malawian context
- Hospital equipment needs be prioritised

In order to address these areas, it is suggested that either the existing equivalent of a “*Hospital Equipment Committee*” or a committee be established in order to:

- Prioritise equipment needs in the hospital

- Link with the PAM unit
- Co-ordinate equipment purchases, maintenance and condemning
- Determine specifications for future equipment purchases
- Ensure the application of the policy on Physical Assets Management

#### 10.3.2. Performance Indicators: Strengthening Medical Equipment Procurement and Maintenance

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Hospital Equipment Committee is established and meets on a regular basis	Committee established to prioritise needs, determine specifications and implement PAM policy	March 2004
Prioritised equipment list developed	This will enable hospital management to direct donations according to needs	May 2004
Guideline document on acceptance of donated equipment developed for hospital	Policy on physical assets management translated into guideline document for hospital	July 2004
Action plan developed for determining specifications for equipment purchases	Hospital management and clinical heads of department will have an action plan that can be used to guide the development of specifications for equipment purchases/ donations	September 2004

#### 10.4. Key Findings: Pharmaceutical supplies

Most departments express frustration regarding the way in which the Regional Medical Stores and CMS operate. They felt that these units were not providing the kind of service or support that they should provide to the hospital – items were often out of stock, ordered in insufficient quantity, and often not in accordance with the specifications or needs of the clinicians.

QECH pharmacy also has periods where certain key items are out of stock. As a result of the inefficiencies in pharmaceutical supply, almost all departments have developed coping mechanisms that allow them to provide some essential drugs to patients in the event of the system not being able to meet their needs. This involved getting containers of drugs from other countries, having special funds, which could be used to purchase special items, etc.

## 10.5. Critical Area for Intervention: Pharmaceutical Supplies

### 10.5.1. Intervention: Pharmaceutical Supplies

Since there are a number of initiatives to improve controls and management of the CMS and Regional Medical Stores, it is proposed that as an initial step, the HMIS tracking system that tracks the out of stock items at pharmacy be strengthened. In addition, it is felt that a policy framework for using internally generated revenue (IGR) to purchase critical items from other sources, or to purchase items from cheaper sources be developed. In addition, after discussions with the CMS, it became apparent that a system to determine usage of items is needed in order to enable CMS to accurately predict needs over a year.

In order to effect these recommendations, the following is proposed:

- Strengthen system for tracking out of stock pharmacy and stores items
- Policy developed for purchasing supplies using IGR
- Investigate and develop system for determining usage by cost centres

### 10.5.2. Performance Indicators: Pharmaceutical Supplies

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Regular reports received from pharmacy on out of stock items	Management able to quantify the out of stock items	April 2004
Policy for purchasing supplies using IGR developed	Hospital management and clinical heads of department will have a policy to guide the purchasing of supplies using IGR	June 2004
Action plan for implementation of system to determine usage of drugs by cost centres developed	Plan available detailing requirements to develop cost centre budgeting for pharmaceutical items	August 2004

## 10.6. Key Findings: Dental and Radiography Services

The dental department at QECH was not visited during this week. However the radiography department was visited and discussions with the persons in charge held. Issues that became apparent are similar to those described in the section dealing with clinical services and quality of care issues.

In terms of information systems, the radiography department has the same problems that were identified in the above section, and will be addressed through the interventions on the information system.

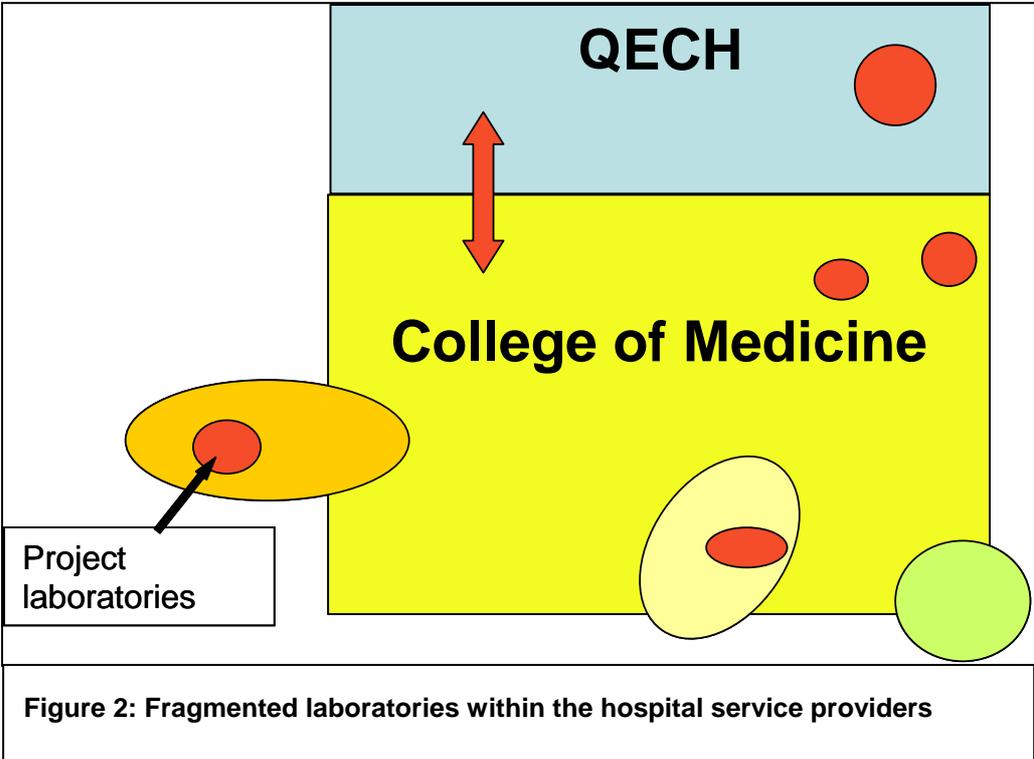
Issues relating to the purchase of supplies are similar to that for the other clinical departments, and will need to be addressed through the broader strategy to improve availability of drugs and supplies.

### 10.7. Key Findings: Laboratory Services

The findings in this section can be summarized as follows:

- Insufficient financial allocations, especially in terms of funding maintenance contracts for machines/equipment
- Quality control standards were not being applied
- Poor quality services, with many basic tests not available because of malfunctioning equipment, or absence of reagents
- Huge inefficiencies in delivery of laboratory services

The huge inefficiencies are demonstrated by fragmented lab services provided by various laboratories in the hospital (including the College of Medicine laboratories), with little collaboration, or support between one another. In reality, it appeared as if they in fact competed with each other, and regarding staff in particular, the “non-ministry” labs were able to attract Ministry staff because of higher remuneration rates. This inevitably resulted in loss of staff to these laboratories, which compounded the problems in the hospital laboratory. The picture which emerged is that of many small fragmented laboratories functioning in an uncoordinated manner (see figure 2).



## **10.8. Critical Area for Intervention: Laboratory Services**

### **10.8.1. Intervention: Laboratory Services**

It would appear that the most important issue to address regarding laboratory services is around the fragmentation of services. It is suggested that the Hospital Autonomy Program should initiate a high level (involving hospital management and MoHP) discussion around the provision of laboratory services in the hospitals. A guideline document needs to be developed which will spell out the position of the MoHP in terms of:

- supporting integrated laboratory services in the hospital;
- suggest mechanisms for providing an integrated service which ensures availability of a minimum set of lab tests/investigations;
- ensures adherence to quality control standards in laboratories;
- prevents recruitment of staff from already depleted MoHP services;
- the conditions under which additional laboratory services will be accepted as part of projects, spelling out in detail the types of agreements that might be negotiated, the relative contributions to be made by each party, and the mechanisms that will be put in place to ensure maximum benefit to the health services and achievement of economies of scale in the provision of laboratory services;
- how revenue can be generated from the provision of laboratory services and how, even if this is 'contracted out', the ministry can still benefit from this source of funding and continue to ensure access to quality laboratory services by the indigent population.

Other areas of intervention relate to:

- Improvement of the information system (which will be addressed through the intervention on Hospital Management Information System)
- Determination of laboratory expenditure by cost centre (which will be addressed through the intervention on Hospital Management Information System and that related to Financial expenditure reports for cost centres)

### 10.8.2. Performance Indicators: Laboratory Services

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Improved information system for laboratory	Information system for laboratory available and reporting regularly	June 2004
Guideline document on provision of laboratory services in Central Hospitals produced	Guideline will help to co-ordinate lab services and achieve economies of scale	Dec 2004
Provision of regular reports on lab expenditure by cost centre	Management will have access to reports on lab tests/expenditure by cost centre	Dec 2004

## **11. CLINICAL SERVICES AND QUALITY OF CARE**

### **11.1. Activities**

The survey focussed on the following issues:

- Review quality assurance in clinical departments.
- Review progress in implementing infection control quality assurance programme at central hospitals.
- Propose an action plan for strengthening quality assurance in clinical departments
- Identify key performance indicators for care delivery in central hospitals

### **11.2. Key Findings: Clinical Services**

At QECH the picture that emerged was slightly different to that at Lilongwe. This was because of the role that is played by the College of Medicine, which employs all but 4 specialists. These specialists are at higher pay scales than their counterparts at Lilongwe, and in many instances the staffing ratios at QECH were more favourable than those at LCH. However, despite this the main areas of this evaluation were very similar, namely

- The lack of quality of care in many departments was a shared concern
- A vicious cycle existed between staff shortages, lack of equipment, and patient overload, and that these contributed to an inability to try to improve the quality of care
- Departments need to clarify their core functions and levels of care (this despite the fact that quite an extensive exercise had been undertaken some time back to clarify the levels of care that each department would provide). It was pointed out that in many instances, while the hospital claimed to be

providing tertiary care, it was in fact hardly able to deal with the load placed on it by patients requiring primary care services. Once these issues were clarified, staffing needs could be determined, equipment needs relevant to the level of service could be developed, and clarification of other needs would follow.

- The priority areas for developing quality of care programmes were the infection control program (which had already been initiated) and certain departments had identified a need for developing standard treatment guidelines.

Discussions during the feedback session highlighted the interdependency between hospital services, and primary health care services in the district. To this end it was recognised that:

- Hospital functioning was influenced by the quality of referrals from PHC services;
- Poor quality services in PHC would place a load on the hospitals;

### **11.3. Critical Area for Intervention: Clinical Services**

#### **11.3.1. Intervention: Clinical Services**

- Define levels of care. This should be done along with an evaluation of services provided in the PHC sector;
- Implement mechanisms to monitor level of care provided to patients. This included steps such as establishing a common entry point to the hospital for all patients, the acceptance of definitions of levels of care, and attempts by departments to provide services appropriate to their status as a tertiary care centre;
- Strengthen the infection control programme
- Support the development of clinical guidelines where requested

11.3.2. Performance indicators: Clinical Services

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Levels of care defined and accepted by hospital management and clinical heads	A basic requirement in order to determine type of care, equipment and staffing needs at the hospital	Feb 2004
Indicators determined to monitor provision of appropriate level of care.	Indicators to monitor types of admissions taking place and whether they are appropriate for the level of care	April 2004
Action plan clarified for strengthening the infection control programme.	A plan is available for strengthening the infection control programme	April 2004
Strategy for supporting development of clinical guidelines developed	Strategy for clinical guideline developed available	June 2004

**APPENDIX 1: COMPOSITE LIST OF INDICATORS/MILESTONES FOR QUEEN  
ELIZABETH CENTRAL HOSPITAL:**

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
<b>DECENTRALISATION OF MANAGEMENT</b>		
Cost Centre Organisational Structure Developed	Completed organogram based on the cost centre principles.	February 2004
Cost Centre Resources Allocated	Staffing and budget allocations done according to cost centre structure	March 2004
<b>STRATEGIC AND OPERATIONAL PLANNING AND PERFORMANCE MANAGEMENT</b>		
Business planning cycle established	Business planning process & time frame established and approved.	March 2004
Business plan format developed	Business plan format approved and available for distribution.	April 2004
Information systems Interface Established	All existing information systems (MASH, PMIS, HMIS) interface with IPMS	April 2004
Hospital performance management system developed	Integrated performance management system (IPMS) development completed and piloted.	September 2004
Hospital performance management system implemented	IPMS implemented and rolled out.	December 2004
<b>FINANCIAL MANAGEMENT</b>		
Revenue management model developed	Incorporation of patient classification and patient fee structure into the revenue model.	January 2004
Revenue model implemented	Revenue model implemented, users trained and outputs monitored.	March 2004
Format for financial review established	Financial review formats and establishing financial review sessions with managers.	May 2004
Cost centre managers trained	Financial review principles and formats workshops for all cost centre managers conducted.	June 2004

Milestone/ Performance Indicator	Description	Target Month
<b>DOCUMENTATION OF HOSPITAL MANAGEMENT SYSTEMS</b>		
Framework for Financial and Procurement policy and procedure manual designed	Collect documentation, design framework, identify development requirements	April 2004
Financial and Procurement policy and procedure manual developed	Develop manual with documentation of policy, processes and procedures	August 2004
Pilot run of Financial and Procurement policy and procedure manuals	Key Financial and Procurement staff, management and other users trained	Oct 2004
Select key clinical support and clinical services for manual development	Identify and prioritise key clinical policy, procedures and guidelines required	July 2004
Develop policy and procedure guidelines manuals for selected clinical support and clinical services	Clinical policy, procedures and guidelines developed	Nov 2004
Implement selected clinical support services and clinical procedural guidelines in hospitals	Clinical staff trained and system implemented	Feb 2005
Select key non clinical support services for manual development	Identify and prioritise key policy, processes, procedures and guidelines required	May 2004
Develop policy and procedure guidelines manuals for non-clinical support services	Non-clinical policy, pro- cedars and guidelines developed	September 2004
Implement non-clinical procedural guidelines for non-clinical support services in hospital	Non-clinical support services staff trained and system implemented	Jan 2005
Design a new Transport System	Collect documentation, design framework, identify development requirements	April 2004

<b>Milestone/ Performance Indicator</b>	<b>Description</b>	<b>Target Month</b>
Transport policy and procedure manual developed	Develop transport manual with documentation of policy, processes and procedures	June 2004
<b>HUMAN RESOURCES MANAGEMENT</b>		
Human Resources policy and procedure manual developed	Develop Human Resources policy and procedure manual with documents	March 2004
Pilot of Human Resources policy and procedure manual completed	Key Human Resources staff, management and other users trained	May 2004
Roll out plan developed	Training and implementation plan formulated	June 2004
First draft Integrated Human Resources Plan framework developed	First draft framework discussed with key role players for input	January 2004
Second draft Integrated Human Resources Plan framework completed	Input from key role players incorporated and presented to management for acceptance	June 2004
Design new Registry System	Mail management, new staff files (with sub-files) and payslip management systems.	Feb 2004
Policy and procedure manual for Registry System developed	Formulation of procedural guidelines completed	April 2004
Pilot run of new Registry System completed	Systems in place and registry staff trained in registry management	June 2004
Human Resources Training and Development policy and procedure manual developed	HR Training and Development policy and procedure and relevant documents, forms and records in place	August 2004
Human Resources Training and Development policy and procedure manual implemented	Human Resources Training and Development procedures implemented and users trained	October 2004
Develop strategy to retain current staff and to attract new staff	Presentation of first draft of strategy to management, get inputs and do final draft.	January 2004
<b>Milestone/ Performance</b>	<b>Description</b>	<b>Target Month</b>

<b>Indicator</b>		
Implementation of Staff Attraction and Retention strategy	Strategy implemented and management and users trained	March 2004
Leave Management policy and procedure manual designed	Collect documentation, design framework, identify development requirements	February 2004
Leave Management policy and procedure manual and documentation developed	Leave Management procedures, documents, template, records and reports developed	April 2004
Pilot run of new Leave Management System completed	Leave procedures and documentation implemented and users trained	May 2004
Roll out and training plan for leave developed	Training needs identified and implementation plan formulated	June 2004
Management Toolkit designed	Collect documentation, design framework, identify development requirements	April 2004
First Version of Management Toolkit developed	Key guidelines developed and first version produced	June 2004
<b>HEALTH MANAGEMENT INFORMATION SYSTEM</b>		
Quarterly reports produced and circulated	Through discussions with management and clinical heads of department a format for production of quarterly reports based on the HMIS is determined and implemented	April 2004
Integration with PMIS discussed and action plan submitted	An action plan available for integration of HMIS and PMIS.	April 2004
Improved accuracy of HMIS data	Through the process of clarifying data flows, and data elements and indicators required, the data set will reflect more accurately the service delivery profile of the hospital	May 2004
<b>MANAGEMENT OF EQUIPMENT, DRUGS AND MEDICAL SUPPLIES, AND DENTAL, RADIOGRAPHIC AND MEDICAL LABORATORY SUPPLIES</b>		
Hospital Equipment Committee is established and meets on a regular basis	Committee established to prioritise needs, determine specifications and implement PAM policy	March 2004
<b>Milestone/ Performance</b>	<b>Description</b>	<b>Target Month</b>

<b>Indicator</b>		
Prioritised equipment list developed	This will enable hospital management to direct donations according to needs	May 2004
Guideline document on acceptance of donated equipment developed for hospital	Policy on physical assets management translated into guideline document for hospital	July 2004
Action plan developed for determining specifications for equipment purchases	Hospital management and clinical heads of department will have an action plan that can be used to guide the development of specifications for equipment purchases/ donations	September 2004
Regular reports received from pharmacy on out of stock items	Management able to quantify the out of stock items	April 2004
Policy for purchasing supplies using IGR developed	Hospital management and clinical heads of department will have a policy to guide the purchasing of supplies using IGR	June 2004
Action plan for implementation of system to determine usage of drugs by cost centres developed	Plan available detailing requirements to develop cost centre budgeting for pharmaceutical items	August 2004
Improved information system for laboratory	Information system for laboratory available and reporting regularly	June 2004
Guideline document on provision of laboratory services in Central Hospitals produced	Guideline will help to co-ordinate lab services and achieve economies of scale	Dec 2004
Provision of regular reports on lab expenditure by cost centre	Management will have access to reports on lab tests/expenditure by cost centre	Dec 2004
<b>CLINICAL SERVICES AND QUALITY OF CARE ISSUES</b>		
Levels of care defined and accepted by hospital management and clinical heads	A basic requirement in order to determine type of care, equipment and staffing needs at the hospital	Feb 2004
Indicators determined to monitor provision of appropriate level of care.	Indicators to monitor types of admissions taking place and whether they are appropriate for the level of care	April 2004
<b>Milestone/ Performance</b>	<b>Description</b>	<b>Target Month</b>

Indicator		
Action plan clarified for strengthening the infection control programme.	A plan is available for strengthening the infection control programme	April 2004
Strategy for supporting development of clinical guidelines developed	Strategy for clinical guideline developed available	June 2004

## **APPENDIX 2: BRIEF REPORT ON PRESENTATION AND DISCUSSIONS AT QUEEN ELIZABETH HOSPITAL ON FRIDAY 12 DECEMBER 2003**

1. The meeting was called to order with a prayer at 09.30 and the Principal hospital Administrator, Mr. Mataka chaired the meeting. The Chief Nursing Officer for QECH made an opening speech on behalf of the Hospital Director Dr. Idana who was not present as he had other pressing issues to attend to. The meeting was mainly attended by representatives of almost all the departments of the hospital although it was noted that only few departmental heads were present. (See attached attendance register)
2. Mr. Michael Siebert of Health Partners Southern Africa (HPSA), a company contracted by Management Sciences for Health (MSH) to manage the Hospital Autonomy Programme informed the participants the purpose of the workshop which basically was to highlight baseline survey findings, prioritize hospital autonomy activities at QECH, identify key performance indicators for each intervention area and set targets for the same. He also introduced to the participants the External Technical Experts working on the projected which included Dr. Rodion Kraus, team leader of the programme, Dr. Vincent Shaw and Mrs. Karen Campbell. Mr. Trevor Kandoje, a local Technical Expert to be based at QECH was also introduced.
3. The methodology of the baseline survey at QECH included the following:
  - Familiarization with documents
  - Interviewing key individuals
  - Identification of problem areas
  - Identification of critical areas for intervention
4. Presentations were made based on a synopsis of the eight main focus areas of the Baseline Survey and were presented in the form of a flowchart depicting the key issue, intervention, proposed process and the measurable performance indicator of the intervention. The areas presented were:
  - Decentralization of management
  - Strategic and operational planning and performance management

- Financial management
- Hospital information systems
- Management of equipment, drugs and medical supplies, and dental, radiographic and laboratory supplies
- Care delivery improvement
- Human resource management
- Documentation of hospital management systems

5. Issues raised by the participants at the workshop were noted and are listed below:

#### **5.1 Clinical and Non-Clinical Services Management**

- Improvement of data collection tools
- Interaction between the buying section and end-user of equipment
- Levels of occupancy – reflection of accurate information
- Reducing competition for staff between the hospital and projects within the hospital
- Clarification on the relationship between the hospital and the College
- The hospital not being included when calling for stakeholders to deal with projects involving the hospital.
- Utilization of private patients wards
- The issue of bypass fee when PHC patients use the referral system
- Outsourcing and the introduction of cost centres can be considered to better manage costs and resources

## 5.2 Human Resources Management

- Responsibility of the whole HR process at hospital level and prioritization of issues
- Team-based approach to be used
- Availability of relevant documents such as HR policies and procedures to all staff
- Need for an induction manual
- Concentration on basic HR systems
- Non availability of Managers' tool kit

## 5.3 Finance issues

- ***Strategic Planning and Performance Management***
  - ✓ How to get started in developing justifiable indicators
  - ✓ Provision of incentives to performers and disciplinary action for non-performers
- ***Financial Management***
  - ✓ Capacity and skills of Accounts personnel to carry out certain accounting functions
  - ✓ Hospital Managers to be involved in the various processes of the interventions
  - ✓ On-the-job training approach to be applied
  - ✓ Define the level of the hospital system to be strengthened on budgeting
  - ✓ Hospital concerned with high Staff turnover and the cost involved in getting replacements

- ✓ Key personnel with long service either resign or are transferred to another institution leaving new staff with no Institution memory
  - ✓ No Staff retention strategies in place
  - ✓ The feasibility of the issue of Revenue collectors to be provided with incentives
  - ✓ No Information processing system on revenue
  - ✓ Problem of costing on paying patients due to lack of coordination amongst players
  - ***Decentralization of Management***
    - ✓ Power loss for some job holders due to establishment of cost centres
    - ✓ How to determine the appropriate number of cost centres to be established in each hospital
6. A comprehensive Baseline Survey Report has been compiled, and contains all the relevant details in the abovementioned eight areas, and will be made available to the QECH Management Team.