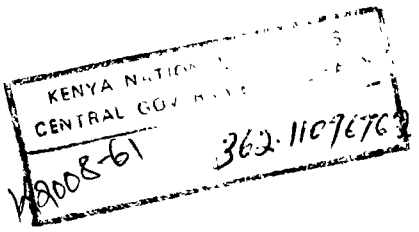
Report of the Commission into the Management of Kenyatta National Hospital

June 1991



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His Excellency The President of Kenya
The Hon Daniel T. Arup Moi C.G.H.M.P.,
State House,
NAIROBI,
Kenya.

EGL/SA45

4th June 1991.

Your Excellency,

MANAGEMENT OF THE KENYATTA NATIONAL HOSPITAL

We have great pleasure in presenting our report, in accordance with your commission of the 9th April. During our one month review we spoke to over 50 staff and other people concerned with the management of the Kenyatta National Hospital. We are very grateful for their help. We are also thankful for the many long and detailed reports written about the Kenyatta National Hospital (KNH). It is not our intention to add to their number. Instead we have attempted to provide a brief diagnosis of the main problems faced by the hospital, a description of some of the symptoms we found and recommendations for action. We have ensured that the steps we recommend will complement the long term programme of reforms on which the KNH is embarked, and are capable of being implemented in the short term, to provide visible signs of improvement.

In brief our recommendations are as follows:

1. The KNH is not only a major referral, teaching and research centre it also serves as the main general hospital for Nairobi. The referral and teaching roles of the KNH are in danger of being overwhelmed by local demand for general hospital services. To prevent this separate areas of the hospital should operate with defined budgets for referral purposes and for the provision of local general hospital services.

2. The operation of the hospital is currently severely constrained by its financial position. Debts to suppliers and staff mean that the KNH is often unable to obtain the resources it needs, and when it does, it pays a high price for them. Paying off these debts would enable the KNH to obtain resources at lower cost and would provide an immediate improvement in services. In the longer term an allocation agreed with the Ministry of Health for referral services and for local general services should be paid by the Treasury direct to the KNH as a parastatal. We recognise that the allocation may be limited to its current proportion of the national health budget. In times of epidemic this sum might be supplemented by a national disaster fund.

3. The areas of the hospital providing referral services and examples of modern medical practice on which teaching will be based, should be operated to a very much greater level of effectiveness and efficiency than at present. This requires a budget based on the number of patients treated, with careful thought as to the types of condition for which treatment is most effective. Greater use of day surgery and hostel accommodation would also improve cost effectiveness and improve access to services for patients from distant parts of the country. Efficiency can be improved by re-balancing the service, using less medical staff and more supplies and greatly reducing lengths of stay and cancelled operating sessions.

4. Amenity beds should also be used for teaching purposes and should maintain high standards of modern medicine. The number of amenity beds should be increased quickly. Charges for these beds should at least cover the costs of supplies and can contribute to staff and overhead costs. Doctors can be encouraged to use amenity beds by enabling them to charge separately for their services provided in their own time.

5. Improvements in local general hospital services should also be sought, but it must be recognised that in this area of the hospital longer lengths of stay will be likely and services will be limited by the funding available. At the same time, efforts to improve local clinics and dispensary services in Nairobi should continue. Appropriate levels of cost sharing must be seen to be fair and good value for money by patients and should be at different levels for dispensaries, local general hospital services and referral services. Such arrangements should ensure that patients use services appropriate to their needs. It is also important to eliminate practices such as illicit demands for payment and queue jumping which were widely reported.

6. While the KNH has a long term plan for improvement and many staff are clearly able and working well at a detailed level, it is evident that KNH lacks management. There is an urgent need to strengthen management, not only in fields such as administration, finance and support services but also with regard to the management of clinical services. To provide an injection of management in these fields in the short term and to provide the basis for long term development of modern hospital management in Kenya, we recommend that a contract should be established with a prestigious teaching hospital. This should provide for a twinning relationship which should exchange management staff, including clinicians with management responsibilities, on contract terms with clear performance improvement and operational targets to be achieved. Further details of the steps required to implement these measures are set out in the accompanying report. These steps should be coordinated with the measures already proposed with World Bank and USAID support.

7. Management in clinical fields requires control of the use of time by doctors. To this end we recommend that doctors should be contracted specifically for the amount of time they are required to work in the hospital, or to be on call. Currently KNH has many more doctors than can be usefully deployed on a full-time basis, therefore, the options of either offering part-time contracts (which we believe many would prefer) or redeploying doctors to other hospitals should be implemented. Heads of clinical departments should have authority over all staff regardless of whether they are appointed by the Medical School or Hospital, noting only that their contracts will define different responsibilities for such staff. Overall responsibility for the operation of the hospital should be vested in the Director of the KNH but we recommend a small executive team should be formed including the Dean of the Medical School in order to ensure that in managing the Medical School and Hospital staff the KNH speaks with one voice.

8. Pathology services require immediate improvement. We recommend that these services should be provided under a management contract specifying the services to be provided to the KNH and the charge for services. Under such arrangements an in-house service with better management could also carry out tests for other hospitals in Kenya. It will be necessary to develop a detailed contract for such services, which should also provide for teaching commitments.

9. Maintenance and the operation of the laundry also require urgent action. While steps are in hand which are designed to improve the planning of maintenance and to refurbish the laundries, we recommend that most of these services should be carried out under contract.

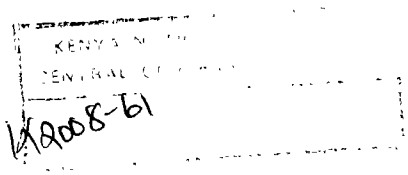
10. We believe these steps together with the proposed refurbishment of the KNH and measures already in hand to improve management in the long term will provide a new starting point for the hospital. A symbol of this new start would be to repaint the hospital as these measures are announced, this would have a significant impact on staff morale.

In the report which follows we identify the potential for very great improvements in performance of the hospital. In order to ensure that these are carried through we suggest that the twinning contract should establish more exact targets. Progress towards these targets should be reported to the Board of the KNH and to your office in order to ensure that the pressure to improve services to the people of Kenya is maintained.

Your Excellency, we have arrived at these conclusions after careful consideration of the facts set out in the report which follows. We hope that our contribution will help to establish a new era of effective management at this vitally important national institution.

Yours faithfully,

Dr. G. Lister
Partner Responsible for Health Care Management
Coopers & Lybrand Deloitte.



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London.

REPORT OF THE COMMISSION INTO THE MANAGEMENT OF THE KENYATTA NATIONAL HOSPITAL

Introduction

1. This report presents the findings of a Commission into the management of the Kenyatta National Hospital (KNH). The commission was appointed by His Excellency the President of Kenya to carry out a one month review and report on key management issues, constraints on current arrangements and to recommend options for improvement.

2. During the review the Commission visited virtually every part of the KNH and spoke with over fifty members of staff and others concerned with its management. In addition a series of reports on management were studied including the Abdullah Report on the delivery of Public Health Services of February 1985, the KNH Financial Resources and Proposed Sources of Funding of November 1987, the Reach Report, the Board KNH Plan of Action for Reform of May 1988, the Report on the Organisation Structure and Staffing of the KNH by the Directorate of Personnel Management of September 1990 and the report by MSH on Accounting and Financial Systems of April 1991. The review team also met with representatives of USAID and the World Bank to discuss ongoing proposals for assistance to KNH. The Commission agreed with the steps proposed and being put in hand, noting only that in some areas further action would be required to achieve the desired improvement in the short and medium term.

3. The Commission does not wish to represent its work as being a substitute for the detailed studies which have preceeded it. This report will, therefore, not repeat in detail comments and proposals contained elsewhere but will attempt to put forward a series of proposals to strengthen and add to the actions already in hand. These include a major refurbishment programme for the building and equipment, restructuring of management, measures to develop improved financial systems, and support in relation to management development, financial management, quality assurance and the planning of maintenance.

4. The findings and recommendations of the Commission are set out under the following headings :-

- Clarifying the Role of KNH
- Resolving Financial Uncertainty
- Improving Effectiveness and Efficiency
- Strengthening Management
- Improving the Management of Pathology Laboratories
- Improving Maintenance and Laundry Services
- Building Staff Morale and Discipline

In each field we present a diagnosis of the problem, some of the symptoms which are apparent and recommendations for action.

Clarifying the Role of the Kenyatta National Hospital

5. It is impossible to exercise management unless the role and objectives of the organisation are clear. In the case of the KNH, while there are statements of what it should be doing, in practice the hospital finds that it is trapped between excessive demand and limited resources.

6. The KNH intends to be a major centre for referral services to treat cases too complex for other hospitals and a teaching hospital offering experience of appropriate modern clinical practice. In fact it is overwhelmed by demand for local general hospital services and in the case of the Casualty Department demand for primary health services which Nairobi City Commission facilities are unable to meet. This coupled with the limited resources available is diluting the general quality of services which can be provided in all parts of the hospital.

7. The effect of this is to compromise the quality of teaching available to doctors in training and other grades of staff by providing insufficient experience of modern medical practice. It also results in a very uneven quality of service and difficulty in planning and providing efficient treatment. For example in orthopaedic surgery

modern medical practice is to internally fix fractures with plates, pins or screws. This can result in a length of stay of about six days. Lacking such supplies the patient may be treated by being left in traction for up to twelve weeks.

8. Over the past 15 years since the KNH was expanded, modern medical practice has led to a far more intensive use of hospital beds. Thus over this period a teaching hospital in London has reduced its beds from 2,400 to 1,200 while still increasing the number of patients served. This hospital plans a further reduction of 200 beds while still maintaining or increasing services by the provision of day surgery. Thus, using modern medical practice the KNH could treat many more patients than originally planned. However, such medicine is also very expensive and it is apparent that within the allocation available to the KNH it cannot afford to run all its beds at this level.

Recommendations

9. The options facing the KNH are, therefore, to greatly increase its income to reduce overall number of beds in use or to differentiate between referral beds and those offering examples of modern medicine for teaching purposes and beds offering local general hospital services. On balance, while opportunities can be sought to increase income, the feasible option is to differentiate services. This is done by teaching hospitals in the UK which distinguish between beds allocated for specialist services and those for local general acute services. In teaching all grades of staff it would then be possible to provide clear examples of appropriate modern medicine as well as experience of local general hospital services.

10. There are a number of ways in which this distinction could be made, for example; by defining referral only specialties such as renal, cardiac, neuroscience, oncology and medical sub-specialties such as dermatology, gastroenterology, chest medicine and endocrinology. In addition separate floors could be identified with local or specialist services. Amenity beds could be expanded and used more extensively for teaching modern medical practice. It may also be possible to transfer patients from the IDH to the main building and use the beds for local general services.

11. Such measures would greatly strengthen steps which are in hand to introduce referral protocols, by defining the types of service available as referral or local services. The capacity which could be made available at the KNH by more intensive use of beds needs to be taken into account in planning other health care facilities in Nairobi. However, this should certainly not halt efforts to upgrade primary health care services, provided by the Nairobi City Commission which are also essential to reduce pressure on the KNH.

12. The role of the Medical School in teaching and research also requires some clarification, particularly in respect of the development of other medical training facilities in Kenya. This could best be achieved by giving greater emphasis to research into appropriate modern hospital treatment protocols for Kenya. At the same time the relationship between the Medical School and the hospital shows many signs of strain. This occurs in virtually all teaching hospitals throughout the world because of the different priorities and requirements of medical schools and hospitals. Greater cohesion will be achieved if there is a common agreement as to the standards of clinical practice, services and supplies to be followed. Differentiating areas of the hospitals would permit higher standards appropriate to teaching to be followed in defined areas of the hospitals. It is also vitally important that there should be a clear lines of authority throughout the KNH. It is suggested that all medical staff whether employed by the university or the hospital should be accountable to the heads of clinical division and that they in turn should be accountable to the Assistant Director (Clinical) of KNH for their clinical work and to the Dean of the Medical School for teaching and research. In order to ensure that KNH speaks with one voice on key management issues, a small executive committee should be formed including the Director of the KNH, the Dean of the Medical School, the Director of Clinical Services KNH, the Chief Nurse, the Deputy Director (Administration) and the Finance Manager. These measures are intended to complement and strengthen steps currently being taken to establish a formal agreement between the Medical School and Hospital and to introduce a new management structure.

Resolving Funding Uncertainty

13. The Commission accepts that the financial allocation to the KNH must be limited to a level affordable within the national health budget. There is no 'right' level for this allocation, the KNH must plan its services within the finances available. As indicated the current level does not permit all the beds in the KNH to be operated intensively in accordance with modern medical practice.

14. It is, however, an essential prerequisite for management that finance should be clear and certain. This has not been the case for the KNH since its creation as a parastatal. The greatest source of uncertainty has arisen from the payment of its allocation through the Ministry of Health. KNH figures show that the hospital has not received its full grant allocation over the past three years and that the amount not received corresponds to the increase in debt which it has incurred over this period. Ministry of Health officials provided a different explanation, that money has been paid in the form of salaries and that the debt, therefore, represents an overspend. The Commission can only observe that there is uncertainty between the KNH and MOH over the amount of income received and this needs to be resolved. There has also been some uncertainty over the amount of income which can be obtained from cost sharing, though the amounts involved are far less in this case.

15. The consequence of this uncertainty has been an increase in KNH debts to some Ksh 140 million. This is owed principally to suppliers and to its own female staff who opt for contract terms, no bonuses having been paid on these contracts for nearly four years. This has resulted in suppliers charging very high prices. Since the value of money to such suppliers is likely to be at least 20% per annum it is likely that an equivalent premium is being added to KNH supplies. Others have simply ceased trading with KNH until outstanding invoices are cleared. As a result staff often have to use more expensive supply items because cheaper items are not available. For example, because disposable gloves are not available staff have to use and re-use surgical gloves which are more expensive and less hygienic. The non-payment of bonuses has not only had a very bad impact on staff morale but has also made it more difficult for KNH to recruit staff.

Recommendations

16. The most urgent requirement is to prepare a schedule of outstanding creditors and pay off the KNH debts of Ksh 140 million. This will immediately resolve some of the supplies difficulties which are a major cause of inefficiency in the hospital. However, in the short term it may also be necessary to offer short payment terms to suppliers in order to negotiate the level of discounts which KNH should expect to receive. At the same time it is essential to streamline supplier ordering procedures because current procedures take so long that in many cases the tender is no longer valid by the time the contract is placed. This weakens KNH's negotiating position.

17. In the future the financial allocation to the KNH should be agreed by the MOH with defined allocations for referral services for patients from Nairobi and from other hospitals in Kenya related to the numbers of patients to be treated. In addition there should be an allocation for local general hospital services. The allocations should be paid direct to KNH as a parastatal by Treasury.

18. Uncertainty has also arisen in past years as a result of epidemics. For example, an epidemic of meningitis caused a major increase in costs. One way of reducing this uncertainty would be to establish a national disaster fund which could be released in special circumstances.

19. The main way in which the KNH can expand the resources available for the practice of modern medicine and teaching is by extending the number of amenity beds. The current amenity ward operates well, has attractive rooms and highly qualified medical and nursing staff are available. At present only thirty four of the ninety six beds designated for amenity use are operated though there is a waiting list. Opening these beds must be accompanied by measures to extend the quality services available on the amenity floor. For this reason it will be important to ensure that the charges for amenity beds cover any additional costs incurred, this will still leave amenity beds much cheaper than any comparable private sector beds. One measure which would generate additional use of amenity beds would be to allow doctors to charge for their services and retain income provided they spend their own time on such services. This

would attract doctors to use amenity beds and also to make use of the consulting rooms at the hospital which are currently planned.

20. Cost sharing for other services could also generate additional income, though it is recognised that such charges must be seen to be fair and value for money. The Commission took the view that the primary purpose of cost sharing was to ensure that services are used wisely and effectively. Proposals for introducing cost sharing together with recommended rates and cost control procedures have already been devloped but are not applied. At the time of the review it appeared that maternity service charges were actually higher at the Pumwani Hospital than at KNH. This created an incentive for mothers to use the KNH for simple births, and created overcrowded conditions, whereas the KNH's proper role is to provide for complex cases. Cost sharing at different levels for Nairobi City Commission services, casualty, local general hospital services and referral services should encourage a more appropriate use of services with referral to general hospital or specialist services only when necessary.

Improving Effectiveness and Efficiency

21. The Commission noted that there was considerable scope to improve the effectiveness and efficiency of services and to reduce costs. An examination of operating lists suggest that considerable resources are currently being spent on cases for which treatment offers relatively low returns in terms of chances of recovery and quality of life. This sometimes seems to result from the fact that supplies are not available for the more benefical types of treatment. The proposed measure to introduce Quality Assurance will be helpful in establishing appropriate treatment protocols.

22. Efficiency can be greatly improved. It was noted that excluding obstetrics and gynaecology services, certain paediatric services and observation wards the average length of stay is over twenty days. Properly managed with modern medical practice the average length of stay could be reduced to less than ten days.

23. It was also noted that a high number of planned operations are cancelled. This results in part from the lack of preparation of patients, often caused by the inability to perform tests due to breakdown of equipment and lack of supplies. It was also noted that operating theatre sessions are cancelled due to lack of supplies or equipment failure in the theatres, for examples lack of surgical gloves and blood were major problems. On occasions sessions are cancelled due to the non-availability of medical staff. The main suite with twelve operating theatres achieves a workload that could be dealt with in about four fully equipped and well supplied operating theatres.

24. One reason for long lengths of stay and under use of theatre time was a failure to manage resources flexibly or to communicate. Thus, for example, some patients not ready for discharge following one ward round often had to wait until the doctor made a further round in the following week before they were discharged. Equally, while all hospitals find some operations have to be cancelled, it is often possible to re-arrange sessions so that the patient can be operated on the following day. At the KNH the management of patients seemed very inflexible and staff were not informed before the session of possible cancellations. This made it difficult to be flexible in the use of theatre time and meant that patients often had to wait a week if a session was cancelled.

25. Savings could be made in the use of medical staff time. It appears that the KNH employs some 370 full-time medical staff in addition to the 200 academic staff at consultant level and some 50 staff in training with only 20 of these being interns. A comparable teaching hospital in the UK would expect to achieve a higher throughput of patients with about 100 whole time equivalent medical staff and academic consultants and 200 staff in training grades. This suggests that there is not enough work for the medical staff to do, which is one reason why many staff were obviously absent from the hospital. It also suggests an imbalance in the levels of medical staff time available.

Recommendations

26. It is recommended that the KNH should review staff requirements in each field and only contract for the amount and type of medical staff time required. This could be achieved by offering medical staff part time contracts for specified sessions. It is believed that this would be welcomed by some doctors as it would enable them to use their own time for private practice including use of the amenity beds at KNH. Alternatively the number of staff could be reduced by posting medical staff to other hospitals. Money saved by reducing staff time could be allocated to supplies.

27. Effectiveness can be improved by involving clinicians in planning services to ensure that treatments are provided which will provide most long term benefit to patients. The effectiveness of services could also be improved by greater use of day surgery and hostel accommodation. This would also improve the accessibility of services to patients from up-country. The introduction of clinical directorates will assist in strengthening clinical management, the Commission suggests that further steps should be taken to provide training and support in this field.

28. These measures could greatly increase the capacity of the KNH to treat patients within the resources available. However, improving throughput will add to to the cost of operating the KNH. Thus, it is not considered feasible to attempt to run all the beds at maximum throughput rates. Local general hospital services could be operated to good standards but using methods and lengths of stay typical of other general hospitals in Kenya.

Strengthening Management

29. It was noted that there are high level plans for improving the performance of the hospital and in some areas the dedication of staff and their hard work were remarkable. However, between the high level direction and detailed operation there is a void. It appeared that in a great many areas no one was prepared to take charge

and make things happen. This applies not only to administrative fields but also to the management of medical and technical staff.

30. The symptoms of lack of management were numerous. In virtually every department visited problems were pointed out that required urgent decisions yet no one at this level appeared to be responsible for taking action. Problems ranged from relatively simple issues such as the need to fix castors onto trolleys to major shortages of equipment and supplies. All such issues seemed to be referred up to the highest level before any action was taken. Few staff seemed to be prepared to take the initiative, foresee problems and try to solve difficulties before they became problems. For each problem there was an easy answer - nothing can be done because of lack of finance - but there was also a more difficult answer, with better management and clinical cooperation many of the problems could have been resolved.

31. Operational management of a modern hospital is a very complex field which has advanced rapidly in recent years as medicine has demanded more intensive use of resources. The KNH plans to introduce operational managers - the Deputy Director (Administration) and the Director (Clinical Services), plus head of clinical division who will also have responsibility for clinical operations and to introduce a finance officer and financial systems. While these developments are welcomed the KNH has a great deal to learn in this field. Training in hospital administration in Kenya has not been provided for some seven years and much has changed in this time. It will, therefore, be important to support this organisational change by the injection of management expertise and by continued training and support to accelerate development in this field.

Recommendations

32. The Commission considered a number of options for providing this acceleration. A contract could be drawn up specifying the input of experienced management staff, these might be obtained from public or private sector hospitals with English speaking managers. Various forms of twinning relationship are currently operated by many hospitals in the Middle East and Africa. It is considered most

desirable for the input to be in the form of a twinning relationship with a prestigious teaching hospital. This should provide not only for the input of management expertise but also for the exchange and training of Kenyan staff in the host country. This should feed into and support a long term management development programme at the KNH and should provide a model for the management of other hospitals in Kenya.

33. The terms of the contract should provide for the following:-

- to provide on a full time basis an experienced Operational Manager to act as a counterpart to the Deputy Director (Administration) and the Deputy Director (Clinical Services). This manager would identify performance improvement targets and implement them;

- to provide on a full time basis a qualified and experienced hospital accountant to support the Finance Manager (unless a qualified and experienced manager can be obtained through the existing programme of support funded by the World Bank).

- to provide for the part time input of other management staff of twelve months per year as follows:
  - a maintenance engineer to draw up contracts for the provision of maintenance services and to monitor performance;
  - a pathology laboratory manager to draw up a contract for pathology services and monitor performance;
  - a laundry manager to prepare a contract for laundry operation and monitor performance;

- a supplies manager to advise on the streamlining of supplies procedures and negotiations with suppliers;
- a medical advisor panel to advise on medical policy and to establish a joint programme of research into appropriate acute medical practice (this should be in conjunction with the proposed assistance with regard to quality assurance). This panel would consist of senior Kenyan and overseas medical experts.

- to provide for secondment to the host country for relevant training and experience in substantive posts for
  - Deputy Director Administration - 6 months.
  - Finance Manager - 3 months.

- to build-up management, medical, research and teaching links.

34. The contract should be for three years with annual renewal. In the first year the contract should specify tasks as above in subsequent years performance improvement targets should be specified. It is estimated that such a programme would cost in the region of £200,000 - 300,000 sterling per year, for which aid funding should be sought. It is, however, possible that institutions would offer to meet these contract terms at a subsidised rate in view of the interest that many overseas institutions would have in establishing links with a leading teaching hospital in Africa.

35. It is recommended that the Chief Executive of the twinning institution, who would be responsible for the contract, should report progress to the Executive Team of KNH and to the Board. In addition reports on progress and problems should be submitted to the Office of the President in order to ensure that pressure is maintained to achieve improvements in this vitally important institution.

36. It is suggested that to implement these proposals assistance should be sought from World Bank and USAID offices to refine the terms of reference and agree on sources of funding. Proposals could be sought from interested institutions and a selection could be made on the quality and cost effectiveness of the support offered.

Improving Maintenance and Laundry Services

37. Maintenance and laundry services are operating at a very low level of efficiency. Both these services are frequently provided under contract in other countries.

Recommendations

38. Contracts for maintenance could be drawn up for most common areas. The provision of biomedical services is a possible exception. The laundry could easily be operated under contract terms. Once rehabilitated the laundry will have considerable spare capacity and the contractor could generate income from other sources. The contract should ensure that maintenance and replacement of laundry equipment is the responsibility of the contractor.

Improving the Management of Pathology Services

39. The pathology laboratories currently provide a very limited service. While there are extensive laboratories and large numbers of staff the number of machines which are functional is small and a shortage of reagents further limits the number of tests which can be carried out. There is an urgent need to improve the quality of pathology services since this is a major cause of inefficiency for the hospital as a whole.

Recommendations

40. The options for improving services include putting all tests out to private laboratories under contract. However, this option would limit teaching opportunities at KNH. It would, therefore, be preferable to establish a management contact for the operation of the pathology laboratories at KNH. The contract should define the

services to be provided and the teaching commitments required. Bids for operating the service should be evaluated on the basis of quality and cost effectiveness. The performance of the contractor should be monitored closely and if necessary the contract should be re-let.

Building Staff Morale and Discipline

41. It is important to record that the overall impression gained by the Commission was of a hospital with a remarkable number of skilled and dedicated staff. They carry out their work under extremely difficult circumstances and deserve the opportunity to practice high standards of medicine. To achieve this they require the support of highly skilled managers. At present there is a widespread feeling that they do not have this support. Staff morale and discipline is at a very low ebb in the KNH.

Recommendations

42. Morale will be improved by paying bonuses which are owed and by providing opportunities for private practice in amenity beds. Another step which would have a significant impact on morale would be to resolve the shortage of disposable and surgical gloves which, given the prevalence of dangerous infection, is a serious health hazard for staff. A re-painting programme would also be a very welcome symbol of a new start for the KNH.

43. Alongside these measures steps need to be taken to improve discipline. These should include measures to ensure that staff attend the KNH for their contracted hours and that tasks and duties are performed to the standard required. Nursing managers, clinical heads of division and other supervisors need to lead by example as well as maintaining time keeping and standards. Practices such as queue jumping, illicit demands for payment and theft of hospital supplies which were widely reported need to be eliminated by audit procedures, spot checks and disciplinary methods.

44. One step which would greatly improve discipline would be to control access to amenity beds so that only those staff maintaining high standards are permitted to practice in these areas. Heads of clinical division could exercise this control under the overall direction of the executive team. This would provide an effective basis for incentives and sanctions.