Report of the Steering Committee on Review of Hospital Authority

Food and Health Bureau
The Government of the
Hong Kong Special Administrative Region

Report of the Steering Committee on Review of Hospital Authority

July 2015

CONTENTS

GLOSSARY

Central Committee (CC)

- CC is a committee of respective service that serves as a platform for clinical leaders to deliberate issues including manpower, training, services, quality, technology and therapeutics and thus plays an important lead and advisory role in the Hospital Authority (HA) for that service.

Cluster

- A cluster is a network of medical facilities and services grouped together to help HA ensure that patients would receive a continuum of high-quality care within the same geographical setting and throughout their episode of illness. There are seven clusters in HA, namely Hong Kong East, Hong Kong West, Kowloon East, Kowloon Central, Kowloon West, New Territories East and New Territories West.

Cluster Chief Executive (CCE)

- CCE is the head of the cluster responsible for the overall budget and operation of the hospitals and services for the cluster. The CCE is also part of the Chief Executive/HA's senior management team in the HA Head Office.

Coordinating Committee (COC)

- COC is a committee of respective specialty or clinical grade that serves as a platform for clinical leaders to deliberate issues including manpower, training, services, quality, technology and therapeutics and thus plays an important lead and advisory role in HA for that respective specialty or clinical grade.

Controlling Officer's Report (COR)

- COR of the annual Estimates of Expenditure for the Health Branch of the Food and Health Bureau (FHB), which forms part of the Government's annual Estimates of Expenditure, sets out HA's key activity targets and indicators in support of policy objectives related to public healthcare services.

Chief of Services (COS)

- COS is the overall manager of a clinical specialty department responsible for service delivery and development, planning and budgeting, quality assurance and staff development.

HA Head Office (HAHO)

- HAHO, led by the Chief Executive/HA, plays a strategic role in leading corporate development, aligning corporate values and directions, and supporting the clusters and frontline delivery of healthcare services.

Hospital Chief Executive (HCE)

- HCE is the overall manager of a hospital and he/she reports to CCE of the cluster to which the hospital belongs.

Key Performance Indicator (KPI)

- KPIs are quantitative indicators derived to reflect the outcome of major initiatives taken and drive service improvement through performance benchmarking.

EXECUTIVE SUMMARY

BACKGROUND

Since its establishment over 20 years ago, the Hospital Authority (HA) has been providing a wide range of quality healthcare services with the highest professional standard. The Hong Kong healthcare system, in which HA plays a linchpin role, has long been held in high regard around the world. Hong Kong has been consistently rated as having one of the most efficient healthcare systems in the world[1].

2. The reliable and high quality services provided by HA and the professionalism displayed by its staff are very well received by Hong Kong people. According to a patient satisfaction survey commissioned by HA and conducted by the Chinese University of Hong Kong in 2013, over 80% of the respondents rated the care provided by HA doctors and nurses as good or very good[2]. On the operational front, our public hospitals have demonstrated remarkable professionalism and resilience in tackling unprecedented threats of infectious diseases pandemics in recent years. At the corporate level, HA received the Directors of the Year Award 2014 and the special recognition of Excellence in Board Diversity from the Hong Kong Institute of Directors.

3. Some 18 public hospitals, in a few years' time, have achieved full accreditation status by the Australian Council on Healthcare Standards since 2009. Various public hospitals have received different Asian Hospital Management Awards, which recognise hospitals in Asia for outstanding programmes and best practices. Professionally, renowned medical teams in HA excel in advanced treatment options as reflected, for example, in breakthroughs in organ transplant and bone marrow transplant operations and robot assisted technology in surgeries, winning international acclaims and more importantly benefiting local patients.

4. HA also supports the Government through a well-established emergency preparedness and contingency response mechanism to assist in natural and civil disasters, pandemics and major international events. Examples include providing emergency response support in the ferry collision off Lamma Island in

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[1] Hong Kong was rated the first and second by Bloomberg in its ranking of the "Most Efficient Health Care Systems in the World" in 2013 and 2014 respectively.

[2] Hospital-based Patient Experience and Satisfaction Survey 2013 Report, the Jockey Club School of Public Health and Primary Care of the Faculty of Medicine of the Chinese University of Hong Kong, http://www.ha.org.hk/visitor/ha_view_content.asp?Parent_ID=220239&Content_ID=222116&Ver=HTML

2012, and sending rescue medical teams in emergency operations outside Hong Kong.

5.   The scope and level of services provided by HA are enormous.   In 2014-15, HA provided 7.0 million specialist outpatient clinic (SOPC) attendances, 8.0 million patient days (including inpatient and day inpatient services) and 2.2 million accident and emergency (A&E) attendances.   The inpatient services of HA are particularly important as HA accounts for almost 90% of inpatient services in Hong Kong in 2013[3].

6.   With the rapid ageing of the local population and increased aspiration for healthcare services in Hong Kong, the demand for quality public services is high and will be even higher in coming years.   HA faces the double challenges of the increasing cost of providing hospital care due to advance in medical technology and rising demand of an ageing population with changes in diseases pattern such as increased prevalence of chronic diseases.   In this connection, the Chief Executive announced in his Policy Address in 2013 that the Government would set up a steering committee to conduct a comprehensive review of the operation of HA to explore viable measures for enhancing the cost-effectiveness and quality of its services with a view to providing HA with increased capability to cope with the future challenges.

THE REVIEW

7.   The Steering Committee (SC) on Review of HA, chaired by the Secretary for Food and Health, was set up in August 2013.   The Review covers the major areas that impact on HA's operation and service provision, including management and organisation structure, resource management, staff management, cost effectiveness and service management, and overall management and control.

8.   The SC convened nine meetings, conducted three public fora and three stakeholders' fora, met with 31 professional organisations and patient groups, and participated in eight HA staff fora to listen to and exchange views with stakeholders.   The SC has also received a total of 28 written submissions.

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[3]   Based on "Public/private share by inpatient bed days occupied in 2013" from HA and Department of Health

SUMMARY OF FINDINGS AND RECOMMENDATIONS

9.   This report sets out the findings and recommendations of the SC. Chapter 1 outlines the membership and terms of reference of the SC and Chapter 2 highlights the work of the SC, including the conduct of a comprehensive Public Engagement Programme as part of the Review to solicit views from HA's stakeholders.   Chapter 3 gives an overview on the present situation and major challenges facing HA.   Chapters 4 to 8 detail the SC's findings and recommendations on five areas concerning HA's operation, namely –

(a)   Management and organisation structure;
(b)   Resource management;
(c)   Staff management;
(d)   Cost effectiveness and service management; and
(e)   Overall management and control.

10.   On the management and organisation structure of HA, while the SC recognises the merits of having a cluster structure for HA and considers the present arrangement of having seven clusters appropriate, it recommends refining the delineation of cluster boundary so as to ensure a closer match between the supply of and demand for healthcare services in each cluster.   For example, while Wong Tai Sin district is part of Kowloon West Cluster (KWC), it tends to be closer to Kowloon Central Cluster (KCC) in physical location with the majority of the acute patients there seeking services at the Queen Elizabeth Hospital in KCC. The SC recommends HA to consider re-delineating Wong Tai Sin district from KWC to KCC by adjusting the cluster boundaries of KWC and KCC, which may bring about greater benefits and convenience to the patients.

11.   The SC understands that resource management, especially the internal allocation of resources between clusters, is an area of major concern to the staff of HA and other stakeholders.   After reviewing HA's present resource allocation mechanism, which is mainly based on the scale of baseline operations and approved new services of each cluster, the SC recommends HA to adopt a refined population-based approach to enhance transparency, consistency and fairness of allocating resources between clusters.   The SC considers that a population-based model better reflects the service demand of individual clusters. However, a simple "population-based" model is too crude to deal with the complexity of services provided across HA and reflect the division of role and responsibility between clusters or hospitals due to the unique nature of providing advanced medical care.   The SC recommends that HA should develop a "refined population-based" model with a built-in mechanism to take into account, for example, the provision and development of tertiary and quaternary services

provided by designated hospitals and other central clinical or support services not being provided across all clusters, as well as the natural movement of patients between clusters due to referrals, proximity of services or patients' choice.

12.   In a huge organisation like HA, effective human resources management is of paramount importance to the motivation of staff, development of their potential, ensuring the smooth operation of HA and effective delivery of services.   The SC recognises that the objective of the cluster-based decentralised organisational structure of HA is to enable hospital care to be provided in response to the demographic and epidemiological characteristics of the local population. While there is a need to draw a right balance between central coordination and decentralisation on matters relating to recruitment, promotion and deployment of staff to reflect the cluster concept of delivery of services, HA Head Office (HAHO) should enhance its coordinating role to ensure greater consistency, fairness and parity in human resources management and practices in and between clusters. Furthermore, HAHO should strengthen its staff development programme for senior managerial and clinical staff, including cross posting, to widen their exposure to and familiarisation with different areas of work in HA and to promote a corporate spirit among the senior staff.   HA should also strengthen the rotation arrangement for trainees as part of their training programme to inculcate in them a broader organisational view and a stronger foundation for their future professional and career development.

13.   While the quality of HA services is well recognised and well received by the community, the long waiting time for SOPC services in many specialities and the disparity of waiting time among clusters remain an ongoing and major concern of the public.   The SC recommends that HA should implement a comprehensive plan to shorten waiting time for SOPC and A&E services with a view to enabling timely access to medical services and minimising cross-cluster variance in waiting time between clusters and hospitals.   HA should also coordinate with relevant specialties to address the serious access block problem in the A&E Departments in concerned hospitals.

14.   The full set of the ten recommendations made by the SC is as follows –

Management and Organisation Structure
- *Strengthening governance and rationalising the organisation structure*

Recommendation 1

(a) The HA Board, being the managing board, should play a more active role in leading and managing HA;

(b) The existing arrangement of having seven clusters should be maintained;

(c) The delineation of cluster boundary, particularly those of the Kowloon clusters, should be refined having regard to the supply and demand for healthcare services as well as the hospital development/redevelopment plans in the respective cluster; and

(d) In reviewing the cluster boundary, opportunities should be taken to maximise coherence on vertical integration of services to ensure continuity of care for patients within the same cluster.

Recommendation 2

(a) HAHO should strengthen overall coordination on service provision to minimise inconsistencies among clusters while exercising control over the development and introduction of highly specialised services and advanced technology to ensure well-coordinated development of services among clusters;

(b) To ensure better division of labour, more effective support in cluster management, as well as better alignment of service provision at cluster level consistent with organisation goals, HA should –

 (i) re-examine the overall cluster management structure, focusing on and streamlining the roles of the Cluster Chief Executive (CCE), Hospital Chief Executive (HCE), Coordinating Committee (COC) / Central Committee (CC), etc.; and

 (ii) strengthen CCEs' participation in the overall management of HA, particularly on staffing, resources and services planning; and

(c) To enhance cooperation, coordination and role differentiation of hospitals within the cluster, HA should consider –

(i) where appropriate, grouping two or more hospitals under the management of one HCE to bring the scope of duties of all HCEs to a comparable level and to facilitate job rotation among HCEs; and

(ii) delineating the role of individual hospitals within a cluster so as to ensure the coordinated and planned development of all hospitals within the cluster and between clusters.

Resource Management
- *Enhancing equity and transparency in resource management*

Recommendation 3

(a) HA should adopt a refined population-based resource allocation model by reviewing the present approach and taking into consideration the demographics of the local and territory-wide population. The refined population-based model should take into account the organisation of the provision and development of tertiary and quaternary services, and hence the additional resources required by selected hospitals or clusters, as well as the demand generated from cross-cluster movement of patients; and

(b) HA should develop the refined population-based resource allocation model and implement through its service planning and budget allocation process within a reasonable timeframe. To avoid unintentional and undesirable impact on the existing baseline services of individual clusters, HA should consider appropriate ways to address the funding need of clusters identified with additional resources requirement under the new model, while maintaining the baseline funding to other clusters.

Recommendation 4

(a) HA should work to improve and simplify the procedures of bidding new resources by clusters for new or improved services at the next resource allocation exercise (in 2016-17), with a view to streamlining and expediting the process and minimising the administrative

workload of frontline clinical staff, balancing the need for efficiency and accountability; and

(b)   HA should enhance transparency of the resource bidding and allocation processes through better internal communication with clusters and within clusters on the methodologies, priorities and selection criteria. For the same reason, HA should explain the rationale and considerations behind the final decisions and allocation result starting with the next resource allocation exercise (in 2016-17) so that clusters can have a better understanding of how priorities are being determined and how resources are being allocated within the whole organisation.

Staff Management
- *Enhancing consistency in staff management and strengthening staff development*

Recommendation 5

(a)   While there is a need to draw a right balance between central coordination and decentralisation on matters relating to recruitment, promotion and deployment of staff to take into account the cluster-based organisational structure of HA, HAHO should enhance its coordinating role to ensure greater consistency, fairness and parity in human resources management and practices in and between the clusters. In particular, HA should exercise greater central coordination in the annual recruitment of Resident Trainees and their placement to different specialties to promote a corporate identity and spirit;

(b)   Transparency in staff promotion and transfer processes should be enhanced through involvement of HAHO.   HA should also enhance transparency in promotion with clear criteria and guidelines and well defined foci of representatives from HAHO and/or Hong Kong Academy of Medicine as appropriate;

(c)   HAHO should strengthen its staff development programme for senior managerial and clinical staff whereby senior staff will be given wider exposure through different postings.   HA should also strengthen the rotation arrangement for trainees as part of their training programme;

(d)   HAHO should be able to assume the central coordinating role of staff

deployment within the organisation when situation so warrants, such as in response to a large emergency situation, staff shortage or surge in service demand;

(e) To address the needs of specific disciplines and maintain consistency in practices between hospitals, HA should enhance the coordinating role of COC in different specialties; and

(f) Regular communication and reporting between clusters and HAHO should be established to ensure common understanding on corporate personnel policies.

Recommendation 6

(a) HA plays a key role in training and developing future generations of healthcare professionals in Hong Kong. To ensure it performs this function effectively, HA should enhance its role in central planning and provision of training. More specifically, HA should set up a high-level central training committee under the HA Board to set overall training policy, allocate designated resources for training, and oversee implementation of the policy within HA; and

(b) Mechanism on selection of candidates for training should be put in place to enhance transparency and facilitate career development.

Cost Effectiveness and Service Management
- *Providing better services*

Recommendation 7

(a) The HA Board, being a managing board, should play a more active role in setting key standards and targets to –

    (i) monitor the overall performance and service provision for public accountability; and

    (ii) facilitate management decision to improve performance and drive best practices; and

(b) HA should enhance and refine the Key Performance Indicators in 2015 to better address service demand and management, facilitate service planning and resource allocation, and drive best practices

among various specialties, hospitals and clusters.

Recommendation 8

(a)   HA should implement a comprehensive plan to shorten waiting time for specialist outpatient clinics and accident and emergency services with a view to enabling timely access to medical services and minimising cross-cluster variance in waiting time; and

(b)   HA should coordinate with relevant specialties to address the serious access block problem in the Accident and Emergency Departments in concerned hospitals.

Recommendation 9

(a)   HA should enhance its service capacity and review its service delivery model to better prepare itself to meet the challenges of the ageing population;

(b)   Specifically, HA should enhance step-down care, strengthen ambulatory services, and enhance partnership with non-governmental organisations and the private sector with a view to providing comprehensive healthcare and support for patients, in particular elderly patients;

(c)   HA should actively work with the Department of Health and the welfare sector on healthcare services to promote and enhance primary care and rehabilitation services in non-hospital setting. The objective of this new model of care is not only to make better use of the resources but also to address the needs and provide better care for patients, in particular elderly patients, in an ageing society; and

(d)   HA should ensure an effective mechanism is in place to take into account patients' feedback for service planning and improvement.

Overall Management and Control
- *Enhancing the safety and quality of services*

Recommendation 10

(a)   HA should strengthen the roles of COCs on clinical governance, including the development of clinical practice guidelines, services

standards, introduction of new technology and service development plan for its respective specialty to achieve more standardised service quality and treatment and to ensure safety;

(b)   HA should review the role of Chief of Service (COS) with greater emphasis on clinical governance;

(c)   HA should review the inter-relationship of COC/CC and various services committees with a view to streamlining internal consultation on annual resource planning and clinical service development.   HA should address the concerns of frontline clinical staff and review their administrative workload to ensure they can concentrate and focus on their core duty of providing care for the patients;

(d)   HA should, through COCs, develop a system of credentialing and defining scope of practices to ascertain professional competence and to ensure patient safety;

(e)   HA should step up the implementation of clinical outcome audits as a tool to assess and monitor clinical competence and service outcome for seeking service quality improvement; and

(f)   In examining the root cause for the occurrence of a medical incident, HA should strengthen the sharing of lessons learnt among clusters to minimise the possibility of its recurrence, and consider measures to enhance communication with and support for patients.

Ultimate Goal : Benefits to the Public Healthcare System

15.   The purpose of the Review is to find ways to improve the service and operation of HA for the ultimate goal of bringing better healthcare services to Hong Kong.   The most important stakeholders for public healthcare services are undoubtedly HA staff and patients, who are the respective providers and ultimate users of the services.   The SC is keen to see that the Review and the implementation of the recommendations would bring about the following benefits –

For Patients
- Better services with shorter waiting time

- Increased service capacity to meet the growing public demand of services

- More efficient use of resources, greater choices and more diverse modes of service delivery to cater for different needs

- More consistent service provision among clusters

- Enhanced safety and quality of services

- Increased sustainability of the development of our healthcare system amid the challenges of increasing cost and ageing population

For HA Staff

- More equitable and transparent resource allocation

- Provision of additional manpower support and resource to pressure areas

- Streamlined administrative and resource allocation procedures

- Greater transparency, consistency and fairness in staff management practices

- Better training and staff development

- Improved clinical governance and more advance service development

IMPLEMENTATION OF RECOMMENDATIONS OF THE REPORT

16.   In making the above recommendations, the SC is mindful that the recommendations should provide HA with the directions towards which it should implement enhancement measures to improve its operation. HA should be allowed the flexibility to formulate specific action plans for implementing the recommendations, with suitable engagement with its staff at appropriate stages. As proposed by the SC, the Government has set aside additional time-limited resources totalling $1,170 million for 2015-16 to 2017-18, on a one-off basis, on areas where further financial support would be necessary to facilitate HA in implementing the recommendations, as described in paragraphs 17 to 24 below.

Enhanced allocation of resources

17.   The SC recommends HA to adopt a refined population-based resource allocation model by reviewing the present approach and refining it to

take into account the different age groups within the population, as well as the patient population served by HA. The SC appreciates that it would take time and detailed deliberations to develop and agree on an appropriate methodology for incorporating relevant factors into the refined population-based model.

18.　　　To assess the impact of the proposed change, HA should conduct an initial review of the population distribution, demographics of different clusters and healthcare utilisation pattern of different clusters to identify those clusters which would receive a higher allocation of resources under the proposed new refined population-based model. This is to enable the early planning and formulation of catch-up plans to lessen the impact on individual clusters when the change in resource allocation model is implemented in future years. As the first step, it is found that there is a priority need for topping up funding for three clusters, namely New Territories West Cluster (NTWC), New Territories East Cluster (NTEC) and Kowloon East Cluster (KEC), so that they can build up the capacity progressively now to serve the growing population demand in their catchment districts before the switch over to the proposed refined population-based funding model. This echoes the concerns expressed at some staff consultation fora on under-provision of resources for some hospitals in these three clusters.

19.　　　The Government plans to allocate a time-limited funding of $300 million for the next three years from 2015-16 to 2017-18 to enhance the existing services of these three clusters pending the implementation of the refined population-based funding model.

Enhanced manpower

20.　　　The Government fully shares the concern of the SC and the general public on the insufficient level of services with manpower shortage being a major cause. Indeed, the successful implementation of a number of recommendations made by the SC (e.g. Recommendation 5 concerning staff deployment, Recommendation 6 concerning training, Recommendation 8 concerning the reduction of waiting time, and Recommendation 9 concerning the enhanced service capacity) hinges on, among other things, a sufficient supply of manpower.

21.　　　HA's manpower projection shows that 1,244 of its staff are due for retirement in 2015-16. In order to address the manpower shortage problem and encourage transfer of knowledge and experience, the Government would allocate to HA a time-limited funding of $570 million for 2015-16 to 2017-18 to re-employ suitable retirees of those grades and disciplines which are facing a severe staff shortage problem, for a specific tenure period to be considered by HA. For retiring medical staff, it is proposed that they would only be re-employed for

clinical duties and not management role, so as to help relieve staff shortage at service front without blocking normal career progression.   The re-employment of retirees would also help retain experienced staff for coaching new recruits, providing staff relief for training and enhancing staff training.

22.　　　For the longer term, in line with the Government's strategy, HA has adopted a higher retirement age of 65 for new recruits commencing employment on or after 1 June 2015.   For HA staff whose employment commenced before 1 June 2015, their retirement age will remain unchanged at 60.   They can apply for HA jobs in compliance with prevailing recruitment policies, practices and selection process should they wish to continue working for HA after retirement at 60.

Enhanced staff training

23.　　　Recommendation 6 sets out that HA should enhance its role in central planning and provision of training.

24.　　　The Government agrees that training of healthcare professionals is of paramount importance to sustaining Hong Kong's healthcare system and continued improvement of healthcare services, and that implementation of this recommendation should be given priority.   For this purpose, the Government would allocate a time-limited funding of $300 million for the next three years to HA for enhancing staff training, including strengthening of training support for staff, especially clinical staff, through scholarship, commissioned training programmes, staff rotation development programmes, simulation training courses and provision of additional manpower support for training relief.

Public-Private Partnership (PPP)

25.　　　The Government encourages HA to actively explore measures to reduce the long waiting time in certain specialties.   HA should also review its service delivery model in order to meet the challenges of the ageing population. To this end, the Government would facilitate HA to expand and roll out more PPP programmes to make better and more efficient use of the capacity in the private healthcare sector to help it cope with increase in service demand and enhance patient access to clinical services, before the supply of new medical and allied health graduates is able to catch up with the growth in demand of the public healthcare sector.   The key strategic vision is to achieve an overall improvement in both the waiting time and quality of care of patients by bringing together the resources and expertise from both the public and private sectors, promoting

training and sharing of experience and helping ensure the sustainability of our healthcare system.

26.　　　　To do so, the Financial Secretary has pledged in the 2015-16 Budget to allocate to HA a sum of $10 billion as endowment to generate investment return for funding HA's PPP initiatives.

27.　　　　HA would actively explore more clinical PPP opportunities within the strategic vision, try out new concepts with pilot projects and formulate long-term programmes based on the evaluation of the experience and outcome of the pilot projects.

Timetable

28.　　　　The recommendations contained in this Report set out the overall direction to guide HA to reorganise its internal management structure, refine its resources allocation system and improve its human resource management policy, among other things, so that it is better prepared to handle its immediate and future challenges.　　To facilitate HA in implementing these recommendations, the Government has earmarked special allocations where extra resources are called for so that HA can devise detailed plans and operational procedures to implement the recommendations.　　To ensure timely implementation of the recommendations of the Report, HA will prepare an action plan within three months with a view to implementing the recommendations within three years.　　HA will report progress on the implementation of recommendations to the Food and Health Bureau on a regular basis.

CONCLUSION

29.　　　　HA has worked strenuously to look after the health of the public. Over the past two decades, HA has grown in terms of its service scope and capacity, and improved in tandem with the advance in medical technology.　　Their contribution is well recognised and there is growing public expectation on HA. The purpose of the Review is to take stock of HA's work, and to review and refine its management and operation and set new direction for its betterment.　　With the guidance of the views gathered and the recommendations in this Report, we are confident that HA will continue to perform well its role under our twin-track healthcare system as the cornerstone of our public healthcare system and to provide a safety net for all, amid the challenges of an ageing population, increased prevalence of chronic diseases and rapid advance in medical technology.

30.   Lastly, the Chairman of the SC would like to put on record his sincerest gratitude to all Members for their tireless efforts and tremendous inputs in the conduct of this Review.   Without their active participation and invaluable advice, it would not have been possible to come up with this comprehensive Report for the betterment of the public healthcare services.   The Chairman would like to thank all stakeholders who have put forward their views and participated in the Public Engagement Programme.   Their views have provided constructive inputs for the SC to map out the recommendations.   The Chairman is also truly grateful for the unfailing and professional support of HA in the conduct of the Review.   The support from HA, ranging from provision of background information to professional advice on public healthcare services, has been instrumental to the preparation of this Report.

CHAPTER 1   INTRODUCTION

OVERVIEW

1.1   This chapter sets out the background of the Review, and the terms of reference and membership of the SC.

HEALTHCARE SERVICES IN HONG KONG

1.2   Hong Kong has a twin-track healthcare system by which the public and private healthcare sectors complement each other.   The public sector is the predominant provider of secondary and tertiary healthcare services.   As at 31 March 2015, the public hospitals provided about 27,600 hospital beds, accounting for almost 90% of inpatient services (in terms of number of bed days) in Hong Kong.   Apart from hospital services, the public sector also provides medical treatment and rehabilitation services to patients through specialist clinics and outreaching services.   The public healthcare system provides the Hong Kong population with equitable access to healthcare service at highly subsidised rates (e.g. flat rate of $100 per day of hospitalisation for acute general beds, compared to the estimated cost of $4,910 incurred by HA in 2015-16).   As the safety net for all, the public sector focuses its services on four target areas –

      (a)   acute and emergency care;

      (b)   lower-income and under-privileged groups;

      (c)   illnesses that entail high cost, advanced technology and multi-disciplinary professional team work; and

      (d)   training of healthcare professionals.

1.3   The private sector complements the public healthcare system by offering choice to those who can afford and are willing to pay for healthcare services with personalised choices and better amenities.   It provides a variety of choices of healthcare services, including primary care (about 70% of outpatient services in terms of attendance) as well as specialist and hospital care.   In 2014, there were 11 private hospitals in the private sector providing about 3,900 beds in total.

1.4   According to Hong Kong's Domestic Health Accounts 2011-12, total healthcare services were funded roughly equally by public and private sources at $49.3 billion and $52.7 billion respectively. Private healthcare services were mainly financed by household out-of-pocket expenditure (68%) and insurance pay-out (29%, including individually purchased private health insurance and employer-provided private health insurance). Public healthcare services, on the other hand, were predominately financed by public funding from the Government budget.

ESTABLISHMENT OF HA

1.5   Nowadays, HA is providing some 7.0 million SOPC attendances, 8.0 million patient days (including inpatient and day inpatient services) and 2.2 million A&E attendances (2014-15 figures).

1.6   HA's enormous services today have been achieved through the strenuous efforts of many over the past two decades. As a matter of fact, back in 1980s before the establishment of HA, the public hospital service of Hong Kong had been subject to intense pressure from increasing costs, rising community expectations and increasing demand. It suffered from many weaknesses, as manifested by the extensive use of camp beds, variable standards among Government and subvented hospitals, and lack of consistent overall management at senior professional levels. The highly centralised decision-making arrangement then was seen by many critics as the major contributing factor to inflexibility, inefficiency and low staff morale. In 1985, the Government commissioned a management consultant firm, W.D. Scott Pty Company, to review the management of the public hospital system. The outcome of the review was the "Scott Report", which recommended, *inter alia*, the establishment of a statutory HA responsible for the overall management of the Government and subvented hospitals, which were then to become public hospitals with a common fee structure, but otherwise operating with a high degree of developed authority. HA was to be independent of the Civil Service and thus able to practise private sector management and financial methods. The Scott Report also made recommendations to alleviate overcrowding and improve working environment at the public hospitals.

1.7   After the careful study of the Scott Report and thorough public consultation, the Government concluded that an independently administered hospital system, in the form of a statutory HA, should be established to oversee the management of public hospitals and to integrate the then dual system of Government and subvented hospitals. With the Scott Report receiving broad

support, the Government established the Provisional HA in 1988 to consider and make recommendations on matters relating to the establishment of HA. Following preparatory work, the Provisional HA made a report setting out the objectives for the future HA and a number of broad principles for hospital service reforms.   One of such broad principles was the greater delegation of authority to the hospital level so that more effective management could be introduced.

1.8   HA was inaugurated on 1 December 1990 with the enactment of the HA Ordinance (Cap 113).   It formally took over the management and control of all public hospitals a year later.

WORK OF HA AT PRESENT

1.9   Since its establishment, HA has enhanced Hong Kong's public healthcare services and the overall quality of patient care.   It serves as a safety net for the community, particularly the low-income groups and those with illnesses that entail high cost in the treatment.   HA also supports the Government through a well-established emergency preparedness and contingency response mechanism which assists in natural and civil disasters, pandemics and major international events, e.g. providing emergency response support in the ferry collision off Lamma Island in 2012, and sending rescue medical teams in emergency operations outside Hong Kong, etc.

1.10   As a key player in Hong Kong's twin-track healthcare system, HA helps set benchmarks for medical services in the local setting.   It takes the lead to develop evidence-based medicine, family medicine, ambulatory/community-based care and research-oriented Chinese Medicine according to the modern trends of medical development.   In addition, it collaborates with the medical schools of the local universities to provide training to medical students and is the training ground for specialists in various clinical specialties.   As at 28 February 2015, HA employed 70,132[4] staff (full-time equivalent (FTE)), including 5,910 medical staff, 23,721 nurses, 6,891 allied health professionals, 13,665 care-related supporting staff and 19,946 other staff.

1.11   HA is playing these important roles in Hong Kong's healthcare system with the total expenditure of $49.6 billion in 2013-14, representing some 2.3% of Hong Kong's annual Gross Domestic Product[5].   Hong Kong has consistently been rated as having one of the most efficient healthcare systems in

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[4] Figures may not add up due to rounding when calculating FTE manpower.
[5] 2013-14 figure of Gross Domestic Product, Fourth Quarter 2014, Census and Statistics Department

the world[6]. The reliable and high quality services provided by HA and the professionalism displayed by its staff are very well received by Hong Kong people. According to a patient satisfaction survey commissioned by HA and conducted by the Chinese University of Hong Kong in 2013, over 80% of the respondents rated the care provided by HA doctors and nurses as good or very good[7]. On the operational front, our public hospitals have demonstrated remarkable professionalism and resilience in tackling unprecedented threats of infectious diseases pandemics in recent years. At the corporate level, HA received the Directors of the Year Award 2014 and the special recognition of Excellence in Board Diversity from the Hong Kong Institute of Directors.

1.12　　　　Some 18 public hospitals, in a few years' time, have achieved full accreditation status by the Australian Council on Healthcare Standards since 2009. Various public hospitals have received different Asian Hospital Management Awards, which recognise hospitals in Asia for outstanding programmes and best practices. Professionally, renowned medical teams in HA excel in advanced treatment options, for examples, as reflected in breakthroughs in organ transplant and bone marrow transplant operations and robot assisted technology in surgeries, winning international acclaims and more importantly benefiting local patients.

THE REVIEW

1.13　　　　While HA has so far been able to provide a high level of quality healthcare services, the demand for such services will rise further given the ageing population and rising expectations. HA faces the challenges of maintaining and improving the quality and level of services while coping with such a rising service demand, especially in respect of the long waiting time for first consultation in many specialties. There is also a perception that HA's ability to redeploy and optimise resources to tackle the long waiting time problem is hindered by clusters competing for their own interests and putting their own interests before that of HA as a whole. In this connection, the Chief Executive announced in his Policy Address in 2013 that the Government would set up a steering committee to conduct a comprehensive review of the operation of HA to explore viable measures for enhancing the cost-effectiveness and quality of its services.

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[6]　Hong Kong was rated the first and second by Bloomberg in its ranking of the "Most Efficient Health Care Systems in the World" in 2013 and 2014 respectively.

[7]　Hospital-based Patient Experience and Satisfaction Survey 2013 Report, the Jockey Club School of Public Health and Primary Care of the Faculty of Medicine of the Chinese University of Hong Kong, http://www.ha.org.hk/visitor/ha_view_content.asp?Parent_ID=220239&Content_ID=222116&Ver=HTML

1.14   Set up in August 2013, the SC is chaired by the Secretary for Food and Health, and comprises 15 non-official members, five official members (including the Chairman) and two HA representatives.   Non-official members of the SC comprise people from a wide range of backgrounds and interests, including healthcare professionals, academics and representatives from business, welfare sectors, patient groups and front-line staff of HA.   The membership of the SC is at **Annex 1**.

1.15   The Review covers the major areas of HA's operations: management and organisation structure, resource management, staff management, cost effectiveness and service management, and overall management and control.   It aims to improve the operation of HA so that, as the cornerstone of the public healthcare system and the safety net for the public, HA can continue to provide quality services and meet the challenges brought about by social development and ageing population more effectively.

1.16   More specifically, the terms of reference of the SC are as follows –

The SC, in response to the changes in society and the challenges facing HA, such as ageing population, increasing demand for healthcare services, rising medical costs and manpower constraints, is to –

(a)   undertake an overall review of HA's organisation structure and management, cluster arrangement, internal resource management, service levels and overall cost effectiveness;

(b)   identify areas requiring improvements and examine and evaluate possible measures with a view to enabling HA to effectively perform its role as the service provider of public healthcare safety net to the community; and

(c)   make recommendations on ensuring HA will continue to provide quality and effective public healthcare service of high standard under the twin-track healthcare system.

CHAPTER 2   WORK OF THE STEERING COMMITTEE

OVERVIEW

2.1   This chapter introduces the overall work of the SC in conducting the Review.

2.2   The SC had held a total of nine meetings between September 2013 and March 2015.   At the first two meetings, the SC discussed the major challenges faced by HA and identified the following priority areas for review –

    (a)   Management and organisation structure;

    (b)   Resource management;

    (c)   Staff management;

    (d)   Cost effectiveness and service management; and

    (e)   Overall management and control.

2.3   The SC then went through each priority area by examining the present situation and the arrangements/approach being adopted by HA, considering the views of various stakeholders and deliberating areas warranting changes and enhancement and the possible improvement measures.

PUBLIC ENGAGEMENT PROGRAMME

2.4   The services provided by HA understandably touch on every sector of the community.   Engagement of stakeholders like HA staff, patient groups as well as the wider public will help provide useful inputs to the Review.   The SC has conducted, as part of the Review and with the assistance of a consultant, a Public Engagement Programme to gauge the stakeholders' views.

2.5   The Public Engagement Programme ran from January to July 2014. During this period, the SC had conducted a series of activities, namely –

    (a)   SC Members held meetings with four major medical and patients'

groups in January 2014. These stakeholders are the Hong Kong Medical Association, Hong Kong Academy of Medicine (HKAM), Hong Kong Patients' Rights Association of the Society for Community Organisation, and Hong Kong Alliance of Patients' Organisations;

(b) the SC visited HAHO and each of the seven clusters during February to April 2014 to meet with the HA Board, HAHO staff, cluster management and cluster staff;

(c) the SC held stakeholders' fora in March 2014. A total of 27 organisations, comprising five medical bodies, seven nursing bodies, 11 allied health bodies and four patient groups took part in three sessions of fora;

(d) the Public Engagement Programme consultant had luncheon meetings with opinion leaders in May 2014. A total of five sessions of luncheon had been held for opinion leaders including community leaders, academics and researchers, columnists, electronic media programme hosts, and other media professionals;

(e) the Public Engagement Programme consultant conducted focus group sessions with representatives from major stakeholders in June 2014. These major stakeholders came from patient groups, healthcare professional bodies, healthcare related NGOs, and Members of the Hospital Governing Committees (HGC)[8] and the Regional Advisory Committees (RAC)[9] of HA; and

(f) the SC conducted public fora in July 2014 with one held in each of the three regions in Hong Kong Island, Kowloon and the New Territories. A total of 350 members from the public participated in the fora. Participants came from diverse background, including those from Kai Fong Associations, District Councils, patient or concern groups, HA staff and ordinary members of public.

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[8] In accordance with Section 13, paragraph 2(b) of the HA Ordinance (Cap 113), HA has established HGCs to govern public hospitals. HGCs receive regular management reports from HCEs, monitor operational and financial performance of the hospitals, participate in human resources and procurement functions, as well as hospital and community partnership activities.

[9] In accordance with Section 13, paragraph 2(a) of the HA Ordinance (Cap 113), HA has established three RACs, one each for Hong Kong Island, Kowloon and the New Territories. With a focus on their respective regions, each of the RACs is responsible for advising HA on public healthcare service planning; reviewing the performance of public hospitals; monitoring public opinion and suggesting improvements about hospital services; advising HA and public hospitals on allocation of resources; and advising HA on specific matters at the request of HA.

More details of the Public Engagement Programme are available in the programme report at **Annex 2**.

2.6   Having regard to the consideration of the present situation and stakeholders' views, the SC has formulated a set of recommendations to identify the directions towards which HA should refine and improve its operation.   The details are set out in the ensuing chapters.

CHAPTER 3   MAJOR CHALLENGES FACING THE HOSPITAL AUTHORITY

OVERVIEW

3.1   This chapter examines the major challenges facing HA.

MAJOR CHALLENGES

Ageing Population

3.2   While the public hospital services in Hong Kong have been recognised as one of the best in the world, the public healthcare system is facing a major challenge of a rapidly ageing population.   In 1993, 9% of our population was aged 65 or above.   The percentage increased to 15% in 2014 and is expected to rise further to 26% in 2031 and 30% in 2041.   Such a change in composition in our population will impose pressure on the healthcare sector because the demand for healthcare services by elderly is much higher than that by the non-elderly.

Increasing Medical Costs

3.3   With ongoing advances in medical technology, the medical expenditures have been rising rapidly.   The annual drug expenditure for HA, for example, rose by 90% from $2.6 billion in 2007-08 to $4.9 billion in 2013-14.

Increasing Demand for Medical Services

3.4   To cope with the service demand, HA's annual expenditure has increased by about 52% during 2007-08 to 2013-14 and is expected to continue to increase in the years to come.   Compared to the position as of end March 2014, it is estimated that an additional of 2,300 and 8,800 public hospital beds will be needed by 2021 and 2031 respectively as the population ages at an accelerated pace in the next two decades.

Manpower Shortage

3.5   While the demand for public healthcare services is rising rapidly, HA is facing concurrently a severe problem of manpower shortage, especially of doctors.   One of the reasons is a reduction in the number of medical student

intake from some 310 a year in 2001-02 to 280 in 2003-04 and further to 250 in 2005-06 in the aftermath of the Asia financial crisis in the early 2000s. The manpower shortage in HA is further exacerbated by the competing demand for experienced doctors following the rapid expansion of the private healthcare sector in recent years. The situation is expected to improve when the number of medical graduates starts to rise to 320 in 2015 and further to 420 in 2018.

Long Waiting Time

3.6   The high demand on medical services, coupled with the shortage of manpower, has resulted in long waiting time for a number of SOPC services as well as for A&E services. Disparity in waiting time was also observed within HA. The disparity across clusters in some SOPC services such as Ear, Nose and Throat (ENT) and Ophthalmology are particularly conspicuous. The varying waiting time between clusters may be caused by differences in the age profile and demand patterns between different geographical locations. At the same time, there are alleged disparities in resource management and perceived "sectarianism" between clusters. All these have raised concerns and criticisms both in the community as well as within HA despite the fact that HA has initiated pilot cross-cluster referral arrangements for selected SOPC services to partly address the disparity.

High Public Expectation on HA's Role as a Public Healthcare Service Provider

3.7   As a public healthcare service provider, HA is governed by the law and is subject to the principle that no person should be prevented, through lack of means, from obtaining adequate medical treatment. The public has been enjoying highly subsidised and quality healthcare services provided by HA and has high expectation for HA to not only meet the basic demand but to continue to improve its services, e.g. shortening waiting time, introducing new services, expanding the scope of the HA Drug Formulary, etc.

PRIORITY AREAS FOR REVIEW

3.8   Having regard to the present situation and the major challenges faced by HA as set out above, the SC has considered that the following main issues, which have been raised by patient groups, HA staff, the community and other stakeholders, should be the priority areas to be comprehensively examined in the Review.

Management and Organisation Structure

3.9　　A key feature of the management and organisation structure of HA is the cluster arrangement, which aims to establish a clear line of accountability for the operations of all hospitals in the cluster, achieve integration and collaboration amongst various clinical services in the cluster, ensure the most cost-effective use of resources within and between clusters, break the boundaries of services/functions (e.g. human resources, supplies chain, facility management), and develop community-based healthcare services with other healthcare providers in the district, etc.

3.10　　Noting that a major criticism leveled on the cluster arrangement is the perceived "sectarianism" between clusters and that HA has adopted this cluster arrangement for over a decade, the SC reckons that it is necessary to examine whether the existing cluster management structure needs to be refined to ensure the effective delivery of services and discharge of functions and responsibilities.

Resource Management

3.11　　Under the cluster arrangement, HAHO allocates resources to each cluster through a resource management framework that integrates closely with its service planning process, under which resource inputs are linked up with service outputs, targets and quality standard.　The use of resources at the cluster level is then monitored and evaluated by HAHO through a financial and performance reporting system.

3.12　　The SC notes the frequent complaints that clusters with a higher population base are not given an appropriate proportionate share of the overall budget.　It is a fact that resources in HA are not allocated solely based on the population size of the cluster.　It nevertheless gives rise to the questions of whether the present resource allocation model provides an objective and fair means in aligning resources to areas of need, and how it should be improved to facilitate better alignment and balancing of resource allocation to meet service/quality gap across respective clusters.

Staff Management

3.13　　Human resources are the key asset of HA and account for some 70% of its annual expenditure.　A stable and motivated workforce is the foundation for quality healthcare.　The SC considers that there is a need to review if the present staffing policy and structure of HA is optimal for attracting, retaining and motivating staff; and what measures and improvements are needed to optimise the

deployment and use of its human resources in light of the growing demand and rising public expectation.

Cost Effectiveness and Service Management

3.14 In response to the increase in demand for public healthcare services and rising medical costs, the Government has increased its annual subvention for HA. In 2015-16, the Government's recurrent subvention to HA amounts to $49 billion, representing a nearly 50% growth from 2010-11. Putting into context, the Government's recurrent subvention to HA accounts for 92% of Government's recurrent expenditure on health and about 15% of the total government recurrent expenditure[10]. On capital subvention, the Government has allocated about $5 billion for acquisition of equipment, information technology systems and capital works projects in 2015-16. Furthermore, the Government has provided a one-off grant of $13 billion in 2013-14 to fund HA's minor works projects for the coming ten years or so, and $1 billion from that grant is expected to be spent in 2015-16. Comparing with the capital subvention in 2010-11, there is a significant increase of $3 billion. With an ageing population, public healthcare expenditure is set to continue rising. It is necessary to have a system to measure and evaluate the output and the performance of HA to assure the public that funds allocated to HA are well spent and managed.

3.15 Waiting time for SOPC services is an important access issue and concern of the community. The SC recognises the need to examine what can be done in this important area of concern of the public.

Overall Management and Control

3.16 Medical incidents are often regarded as an indicator of the quality and safety of the services provided by HA. It is necessary to examine whether the clinical governance system in place in HA is appropriate and whether it is effective in reducing the risk and to provide the necessary assurance for the quality and safety of services to the community and the patients of HA.

3.17 The SC has examined each of these priority areas, with details set out in Chapter 4 to Chapter 8.
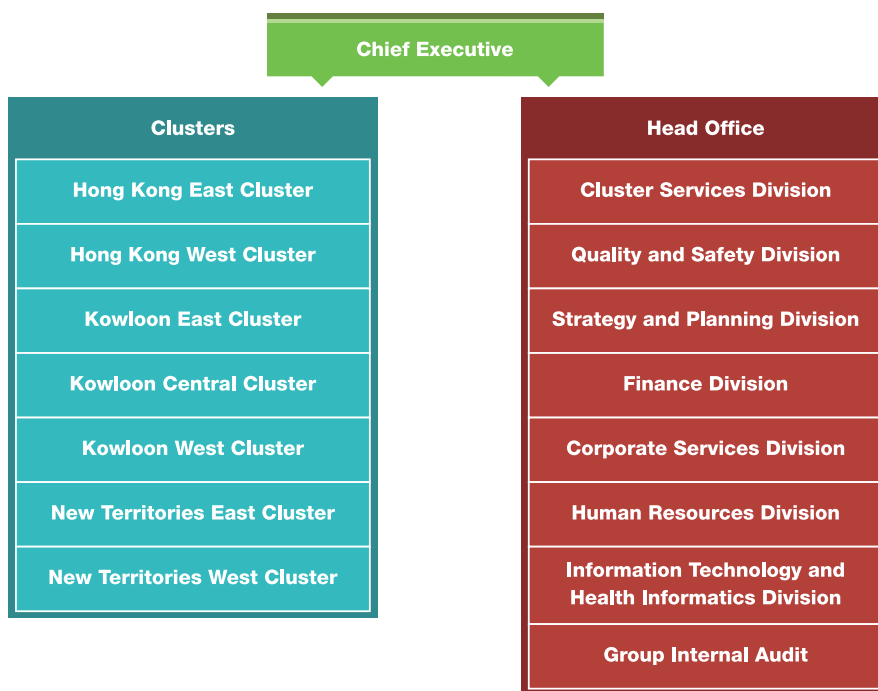
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[10] With the cumulative growth in the Government's recurrent subvention to HA, the share of health in the total government recurrent expenditure has increased to around 17%.

CHAPTER 4 MANAGEMENT AND ORGANISATION STRUCTURE

OVERVIEW

4.1   A key feature of the management and organisation structure of HA is its cluster arrangement.   Under the arrangement, the HAHO primarily plays a leading, policy and strategic planning, coordination and supporting role to the seven clusters and the frontline delivery of healthcare services.   The following chart shows the structure of the cluster arrangement –

Chief Executive	
Clusters	**Head Office**
Hong Kong East Cluster	Cluster Services Division
Hong Kong West Cluster	Quality and Safety Division
Kowloon East Cluster	Strategy and Planning Division
Kowloon Central Cluster	Finance Division
Kowloon West Cluster	Corporate Services Division
New Territories East Cluster	Human Resources Division
New Territories West Cluster	Information Technology and Health Informatics Division
	Group Internal Audit

This structure implements HA's strategy to decentralise management where appropriate.   Accountability is achieved through the setting of agreed objectives and performance measures and the associated reporting and evaluation systems. This chapter reviews HA's management and organisation structure.

4.2   In the 1980s before the establishment of HA, there were no chief executives or general managers in individual Government hospitals, and management responsibilities were highly centralised in the hands of a Government department[11].   Such a centralised arrangement was considered as the main cause

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[11]   The then Medical and Health Department, one of the largest departments in the Government, exercised direct control over 14 Government hospitals and indirect control over 20 Government assisted hospitals in the pre-HA era.

of inefficiency and low staff morale in the then public healthcare system. There was a general call for a more decentralised management system in public hospitals so as to enable healthcare staff to serve patients in a more efficient and effective manner. Against this background, the Government endorsed the following principles[12] concerning the management of public hospitals when establishing HA in 1990 –

(a)   Individual hospitals should enjoy a high degree of autonomy in determining their affairs, subject to certain powers being retained at the HAHO level; and

(b)   There should be a chief executive of each public hospital who should have a high degree of independent management authority for the control of staff and other resources within his hospital.

4.3   The cluster arrangement aims to establish a clear line of accountability for the operation of all hospitals in the cluster, and to achieve integration and collaboration amongst various clinical services within the cluster. On the other hand, it also serves to ensure cost-effective use of resources within and between clusters by eliminating the boundaries of support functions such as human resources, supply chain and facility management across different hospitals/institutions in the same cluster. Cluster arrangement has also facilitated the development of community-based healthcare services in collaboration with other healthcare providers in the district.

CLUSTER ARRANGEMENT

The Clustering Concept

4.4   The clustering concept in HA was introduced in 1992 to address major problems arising from the then three-tier hospital system of regional hospitals, district hospitals and infirmaries. The three types of hospitals were then disorganised and unsatisfactorily coordinated, with some of the regional hospitals supported by up to five to six district hospitals which were widely dispersed in the territory. The three-tier system was reorganised into "acute care" and "extended care" hospitals, delineated by the types of care provided, to better define the roles of and enhance the relationship among hospitals located nearby.

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[12]   Extracted from paragraph 5.1.2 of the Report of the Provisional HA, 1989.

4.5　　　　Later on, the concept of *vertical and horizontal dimensions of service provision* was put forward for organising and coordinating hospital and specialised clinical care services. This aimed to cater for the different needs of patients throughout the course of their illness and to maximise the operational and management efficiency of HA.

4.6　　　　The *vertical dimension* refers to healthcare services provided at different time points in different stages of a patient's illness. This usually follows the sequence of acute care – extended care – community care. This vertical form of service organisation and provision is done by grouping together hospitals which provide different types of healthcare required at different stages in an episode of illness, *i.e., hospital clustering*.

4.7　　　　The *horizontal dimension* refers to the organisation and provision of different specialty services within each of the acute, extended and community care episodes. Within each of the care episodes, it is not uncommon that individual patients need services from multiple clinical specialties. The delivery of certain specialist services may require complex supporting facilities, advanced technological support and special scarce expertise (*i.e. speciality service networking*) which are only available in selected clusters or hospitals. Examples of such services include neurosurgery, oncology, organ transplant and burn management services. The horizontal service integration allows provision of services across clusters and involves organisation of highly specialised services with relatively small demand on a territory-wide basis (tertiary level services).

4.8　　　　A cluster is therefore a network of medical facilities and services grouped together to help HA ensure that patients would receive a continuum of high-quality care within the same geographical setting and throughout their episode of illness – from its acute phase to convalescence and rehabilitation, and community after-care. This is achieved by rationalising the operations of the hospitals within each cluster so that they are capable of providing a comprehensive and complementary range of services to their local population.

4.9　　　　To facilitate effective capital and service planning, each cluster has designated catchment districts demarcated based on the location of the hospitals (primarily the acute hospitals). Medical facilities and services in the clusters are planned and reorganised taking into account the services provided by and the respective roles of the existing hospitals in the cluster, the geographical and demographic considerations of the catchment districts, and service utilisation patterns at that time. Through this process of clustering which involves service rationalisation and reorganisation, continuity of care for each episode of illness is provided to the local population in the cluster.

Current Cluster Organisation and Management Structure

4.10   The HA Board formally adopted the current seven hospital clusters in 2001, following evolution of the early clustering formation in 1994 and the piloting of a new cluster management approach.   The existing seven clusters are –

- Hong Kong East Cluster (HKEC);
- Hong Kong West Cluster (HKWC);
- Kowloon East Cluster (KEC);
- Kowloon Central Cluster (KCC);
- Kowloon West Cluster (KWC);
- New Territories East Cluster (NTEC); and
- New Territories West Cluster (NTWC).
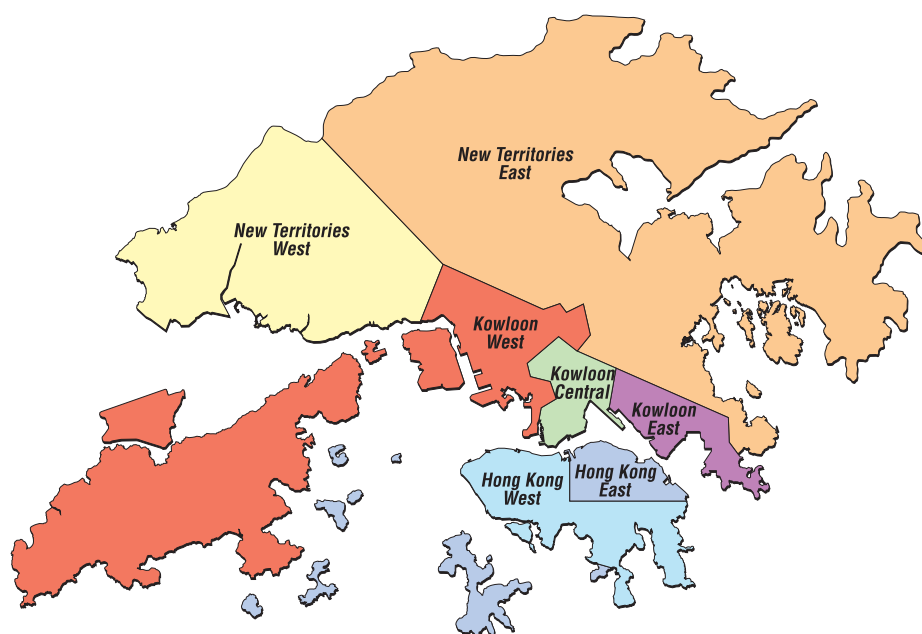
Details of the HA hospitals and institutions in each cluster and the corresponding key statistics are at **Annex 3**.

4.11   Organisationally, each cluster is led by a CCE, who is also the HCE of the major hospital in the cluster (as shown in the following table).

Dual Role of CCE and HCE

CCE of -	Cum HCE of -
HKEC	Pamela Youde Nethersole Eastern Hospital, and Wong Chuk Hang Hospital
HKWC	Queen Mary Hospital, and Tsan Yuk Hospital
KEC	United Christian Hospital
KCC	Queen Elizabeth Hospital and Rehabaid Centre
KWC	Princess Margaret Hospital
NTEC	Prince of Wales Hospital
NTWC	Tuen Mun Hospital

The CCE is responsible for the overall budget and operation of the hospitals and services for the cluster.   The CCE is also part of the Chief Executive/HA's senior management team in the HAHO.

HAHO's Role and Structure

4.12   The HAHO, led by the Chief Executive/HA, supports the HA Board and plays a strategic role in leading corporate development, aligning corporate values and directions, and supporting hospital clusters and the frontline delivery of healthcare services.

4.13   HAHO aligns corporate values and directions through interactive collaboration of its seven divisions, namely Cluster Services; Corporate Services; Finance; Human Resources; Information Technology & Health Informatics; Quality & Safety; and Strategy & Planning.   Collectively, the seven divisions in HAHO undertake the functions of leading and planning, policy and standards setting, alignment of values and practices, resource management and control, external reporting and relationship building with key stakeholders.   HAHO also provides a range of centralised and agency services such as business support services, capital works planning and information technology services, designed to attain economies of scale, increase consistency and improve cost-efficiency.

EVALUATION ON CLUSTER ARRANGEMENT

Cluster Arrangement in General

4.14　　　Through hospital clustering, HA has achieved the overall objective of decentralising the direct management of individual hospitals closer to users of the services.　At the same time, HA has identified and rectified service gaps and duplications in different specialties through, for example, integration of pathology, radiology, ENT, renal, psychiatric support, pharmacy and allied health services in clusters.　HA has also fostered additional integration and collaboration among various clinical services through, for example, the establishment of cluster-based services such as diabetes mellitus, geriatric care and stroke management. Collaboration between HA and other community partners has also been enhanced in the development of more cluster-based ambulatory and community care programmes.

4.15　　　Given HA's large and complex environment, decision-making at operational level needs to be made close to patients so as to enable hospital staff to serve the patients in a more efficient and effective manner.　The principle of decentralised management of public hospitals, which was formulated in 1990 at the time when HA was set up, remains equally applicable today, if not more, given the growing network of public hospitals and the expanding services both in volume and types.

Views from the Public Engagement Programme

4.16　　　In the Public Engagement Programme, stakeholders generally recognised the need for cluster arrangement for a large organisation like HA. During the SC's visits to HA, while some staff raised the need for refinement of the cluster arrangement, they cautioned against any drastic revamp of the existing structure or boundary.　They pointed out that frontline staff have taken a long time to develop and operate the referral and service coordination arrangement under the existing clustering system.　Any substantial changes in cluster delineation would affect integrated service provision, involving referral for follow up treatment, rehabilitation services, and outreaching support, etc. for patients after discharge from hospitals.　Some stakeholders considered that the role of HA Board, being a managing board, should be enhanced in order to have a more effective management of the organisation.

Geographical Boundaries of Clusters

4.17   HA's longer term objective is that the local population of the respective clusters can seek public secondary hospital services within the cluster where they reside.   In implementing the hospital clustering concept, it is recognised that there is unevenness among the clusters in terms of population, demographics, demand for public healthcare, as well as the level and scope of services, facilities and expertise available.   This is because the portfolio of hospitals was not originally planned on a cluster basis and not all clusters started at the same level.   Such unevenness inevitably results in certain level of overlap in individual service provision in some clusters.

4.18   On the other hand, some specialised tertiary services are available only in certain clusters to ensure concentration of expertise and economies of scale and patients may choose to attend any of HA's hospitals and clinics regardless of which cluster they reside in.   These factors have resulted in cross-cluster utilisation of services.

4.19   Unevenness among clusters and cross-cluster utilisation is particularly visible in Kowloon.   As shown in the following table, the size of KWC (comprising eight public hospitals including five acute hospitals) is larger than the other two Kowloon clusters in terms of catchment districts as well as patient load.

Cross-cluster Utilisation in Kowloon

	Hospitals/institutions	No. of hospital beds (as at 31.3.2014)	No. of staff (on FTE basis) (as at 31.3.2014)	2013-14 Budget ($Mn)	Proportion of the Cluster's Inpatient Discharge Episodes^ Utilised by Patients Living Outside the Districts in 2013-14	Catchment districts For Planning Purposes
KWC	Princess Margaret Hospital*, Kwong Wah Hospital*, Caritas Medical Centre*, North Lantau Hospital*, Yan Chai Hospital*, Kwai Chung Hospital, Our Lady of Maryknoll Hospital, Tung Wah Group of Hospitals Wong Tai Sin Hospital	6,629	14,955	9,716	13%	Mongkok, Wong Tai Sin, Sham Shui Po, Kwai Tsing, Tsuen Wan, Lantau Island
KCC	Queen Elizabeth Hospital*, Hong Kong Buddhist Hospital, Hong Kong Eye Hospital, Kowloon Hospital, Hong Kong Red Cross Blood Transfusion Service, Rehabaid Centre	3,548	9,307	5,843	62%	Kowloon City, Yau Tsim
KEC	United Christian Hospital*, Tseung Kwan O Hospital*, Haven of Hope Hospital	2,487	6,960	4,490	10%	Kwun Tong, Sai Kung

^ Referring to discharges and deaths
* with A&E Department

4.20   Some districts receive services from more than one cluster despite the presence of geographical boundaries of the catchment districts.   The services from various clusters might not be always well coordinated or integrated.   For example, Yau Tsim Mong districts are served by KWC (for Mongkok district) and KCC (for Yaumatei and Tsimshatsui districts).   Separately, as shown in the following map, while the Wong Tai Sin district is part of KWC, it tends to be closer to KCC in physical location with the majority of the acute patients there

seeking services at the Queen Elizabeth Hospital in KCC. Yet, when these patients are discharged from hospitals, they will be followed up by community care teams from KWC. As the hospitals and community care teams are from different clusters under such arrangement, communication between them can be at times less than perfect and this might impede seamless continuum of care. Relating to a range of factors and partly reflecting the seriousness of cross-cluster utilisation, 63% of KCC's patients are in fact residing outside the cluster's catchment districts.
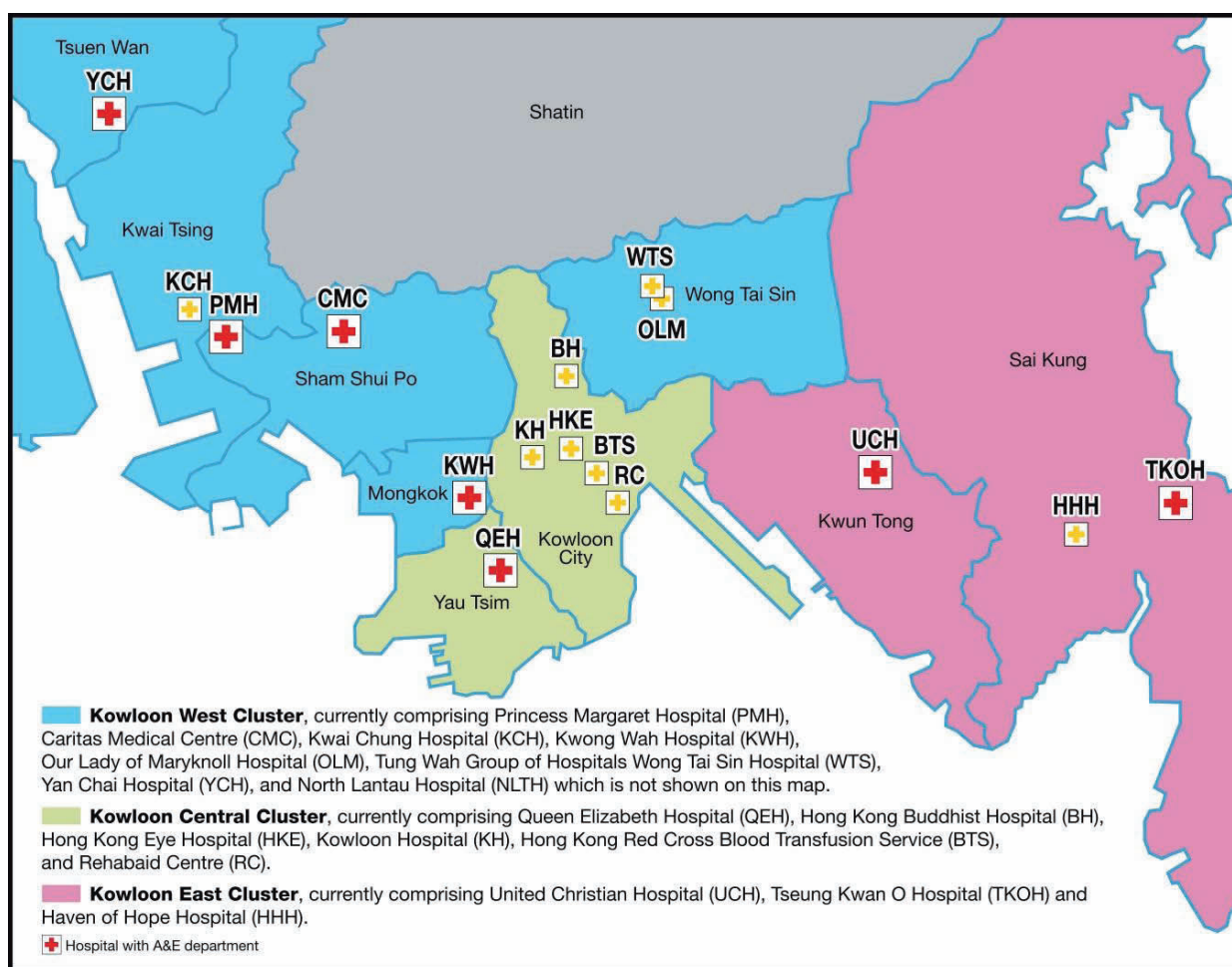
Views from the Public Engagement Programme

4.21 During the Public Engagement Programme, no particular adverse comments were raised regarding the cluster boundary in the New Territories and Hong Kong Island. However, noting the disparity in size and number of hospitals as well as the high level of cross-cluster activities in the three clusters in the densely populated Kowloon region, there were calls for reviewing the clustering arrangement for the three clusters concerned. In particular, the Wong Tai Sin District Council has been urging the Government to review the cluster

boundary so as to provide more rationalised and better coordinated services in the region.

4.22   High cross-cluster utilisation was a concern not only of the District Council or the patients, but also HA staff.   During the SC's visits to clusters and the staff consultation, some staff considered that there was mismatch of services in the three clusters in Kowloon causing problems in referrals and follow-up of cases. They suggested that the geographical boundary there be reviewed to rationalise services and enhance vertical integration of services.

SC's Considerations

4.23   The SC in general agrees to the need of a cluster structure for a complex and large organisation like HA.   The HA Board, being the managing board, should play a more active role in leading and managing HA.   There is also a consensus on maintaining the present arrangement of having seven clusters. Members share the view that the existing cluster delineation for Hong Kong Island and the New Territories does not present any significant problem.   On the other hand, the SC considers that the existing cluster organisation in the Kowloon region is not conducive to facilitating patients from local communities to have continuity of care in their residential vicinity.   The high percentage of cross-cluster patients in KCC also casts doubts whether the cluster boundary and resource allocation are optimal.   Especially   with   the   ageing   population   and   changing   demographic characteristics of the districts, the roles and demarcation of the different acute and convalescent hospitals and community service network in these clusters have to be re-examined, and the present high percentage of cross-cluster patients in KCC and the coordination on service provision to Wong Tai Sin population need to be redressed.   Re-delineating Wong Tai Sin district from KWC to KCC by adjusting the cluster boundaries of KWC and KCC may bring about greater benefits and convenience to the patients.   The review should take into account any upcoming hospital development/redevelopment which will have a bearing on the supply of services in the locality.

4.24   **Recommendation 1:** the SC **recommends** that –

(a)   The HA Board, being the managing board, should play a more active role in leading and managing HA.

(b)   The existing arrangement of having seven clusters should be maintained;

(c)   The   delineation   of   cluster   boundary,   particularly   those   of   the

Kowloon clusters, should be refined having regard to the supply and demand for healthcare services as well as the hospital development/redevelopment plans in the respective cluster; and

(d) In reviewing the cluster boundary, opportunities should be taken to maximise coherence on vertical integration of services to ensure continuity of care for patients within the same cluster.

EVALUATION ON COORDINATION OF SERVICES

4.25 While the existing cluster arrangement should be maintained, further improvement is warranted in certain areas. One of the perceived shortcomings of the current cluster arrangement is "sectarianism". As a decentralised cluster arrangement is characterised by allowing individual clusters a reasonable level of autonomy in service provision so as to cater for the needs in the respective districts, the types and format of service provision may not necessarily be uniform throughout the territory. Patients may feel confused or consider it unfair to be accorded with different types or format of services in different clusters despite having similar clinical conditions.

4.26 HA is not unaware of the problem. There has been the set-up of COC and CC to coordinate various services. The setup of COCs was first endorsed by the HA Board in 1991. At its inception, there were 12 COCs which mirrored the inaugural colleges at HKAM. At present, the COCs, in conjunction with the later developed service-oriented CC, have become the platforms where clinical leaders deliberate issues including manpower, training, services, quality, technology and therapeutics. Playing the important leading and advisory role in HA for their respective specialty/service, COCs/CCs set HA's clinical standards and advise on strategic service planning. In order to continuously improve professional care, COCs/CCs also perform a crucial role in conducting clinical audits, pursuing best practice and developing innovative quality improvement programmes. The current list of COCs/CCs in HA is appended in **Annex 4**.

Views from the Public Engagement Programme

4.27 Despite the work of COCs/CCs, patient organisations have raised concerns on inconsistent practices in service provision in different clusters. Some HA staff also opined that all acute hospitals should be equipped with comparable facilities to provide the same basic and standard services to serve the local community, notwithstanding that some acute hospitals were smaller than the others.

4.28   There were different views expressed on the dual role of CCE as the head of the cluster and HCE of the major acute hospital therein, citing concerns of possible perception of greater advantages enjoyed by large hospitals in resource allocation.   There were, however, also views that a CCE without the portfolio of a HCE might lack hands-on experience in hospital management and this was not conducive to the CCE's discharge of management responsibilities.

SC's Considerations

4.29   The SC considers that there is a need for HAHO to play a greater role in central coordination to ensure consistency in service provision and to coordinate the adoption of new treatment and highly specialised technology among clusters. It is necessary to further strengthen the central management role of HAHO and the central coordination role of COCs and CCs to guard against "sectarianism" or to address perceived conflict of interest.

4.30   To achieve better division of labour and better alignment of service provision at cluster level with organisation goals, the SC considers that the CCEs, being part of the HAHO senior management team, should strengthen their participation in central management rather than merely focusing on cluster management and operation.   This should also help bring the CCEs more in line with the corporate management goals and service targets of HA as a whole and minimise potential "sectarianism".

4.31   Some SC Members also opine that the domination of COCs by Chief of Services (COS) of major hospitals has resulted in the interests of smaller hospitals not adequately reflected.   Also the large number of COCs and CCs have increased the workload of clinical staff and delayed the management decision process.   These concerns further link to the allocation of resources within and among the clusters.   As hospitals are of different scale, there are also perceptions that HCE of smaller hospitals have less power.   The SC reckons the need for role differentiation so that different hospitals within a cluster can play complementary roles to support each other.

4.32   **Recommendation 2:** the SC **recommends** that –

(a)   HAHO should strengthen overall coordination on service provision to minimise inconsistencies among clusters while exercising control over the development and introduction of highly specialised services and advanced technology to ensure well-coordinated development of

services among clusters;

(b)   To ensure better division of labour, more effective support in cluster management, as well as better alignment of service provision at cluster level consistent with organisation goals, HA should –

    (i)   re-examine the overall cluster management structure, focusing on and streamlining the roles of the CCE, HCE, COC/CC, etc.; and

    (ii)   strengthen CCEs' participation in the overall management of HA, particularly on staffing, resources and services planning; and

(c)   To enhance cooperation, coordination and role differentiation of hospitals within the cluster, HA should consider –

    (i)   where appropriate, grouping two or more hospitals under the management of one HCE to bring the scope of duties of all HCEs to a comparable level and to facilitate job rotation among HCEs; and

    (ii)   delineating the role of individual hospitals within a cluster so as to ensure the coordinated and planned development of all hospitals within the cluster and between clusters.

CHAPTER 5   RESOURCE MANAGEMENT

OVERVIEW

5.1   As the largest subvented organisation in Hong Kong, HA manages some $50 billion a year to provide public healthcare services for the community. While the amount of fund available to HA is significant, resources are always finite and the way to manage them effectively and equitably is an important area that needs to be looked into. In addition, while the concept of organising the delivery of frontline clinical services into seven clusters would enable HA to be more able to respond to the demand and demographic characteristic of the local population, it also means that the resource management system inside HA has to address the public, patients and staff perception of fairness, equity and transparency between clusters and to some extent between hospitals within the cluster. This chapter sets out the background of the resources available to HA, the development of internal resource allocation models within HA, and the SC's observations on the models and recommendations for improvement.

5.2   Like many other healthcare providers around the world, HA strives to manage the ever-rising service demand with limited resources. To cope with the continuous emergence of challenges and the changing healthcare service environment, HA's resource management has been evolving over the past 20 years to align resource allocation with areas of need on the basis of three major principles –

(a)   ***Government Healthcare Policy***
To ensure no person should be prevented, through lack of means, from obtaining adequate medical treatment[13];

(b)   ***Government Funding Arrangements***
To tie in with the Government's funding arrangements for HA; and

(c)   ***Corporate Strategy on Internal Resource Allocation***
To ensure public resources are used effectively to provide services of the highest possible standard within resources obtainable[14], as well as to deliver output/outcome-focused care.

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[13]   Principle quoted from HA Ordinance (Cap 113), Section 4 (d).
[14]   HA Ordinance (Cap 113), Section 4 (c)(i).

5.3   To fulfill its statutory obligation in providing the highest possible standard of care within resources obtainable, HA strives to uphold its key values in resource management – to facilitate service provision not only to achieve continuum of care within the same geographical proximity for patients seeking medical support, but also to optimise effectiveness of care for patients receiving medical services at HA.

5.4   To this end, HA provides local communities with a comprehensive range of core primary and secondary care services organised into cluster networks of facilities and services. Such services include 24-hour A&E care, inpatient services supported by different specialties, day services, outpatient services and rehabilitation and community services.

5.5   To optimise the effectiveness of medical services from a professional viewpoint, it is also necessary to allocate and utilise resources for the betterment of total patient care. Within each care episode, individual patients may require services from a number of clinical specialties. To cater for patients' multiple needs throughout the course of their illness, different specialty services are organised and provided within each of the acute, extended and community care episodes. Some highly specialised services which require advanced technological support and special scarce expertise (i.e. specialty service networking) are operating across clusters on a territory-wide basis (tertiary level services). These services are centralised at designated centres with a view to facilitating effective pooling of expertise and resources. Examples of such services are neurosurgery, oncology, organ transplants (kidney, liver, heart, lung), bone marrow transplant and burn management services, as well as the Hong Kong Children's Hospital being developed at the Kai Tak Development Area.

5.6   To drive better clinical outcome and efficiency gain, some medical services have also been put under the management of a single cluster to serve the whole Hong Kong population, such as the Blood Transfusion Service at KCC (for ensuring sufficient supply of safe and high-quality blood and blood components for all hospitals' use), and the Infectious Disease Block at KWC (constructed following the 2003 Severe Acute Respiratory Syndrome (SARS) epidemic to better prepare Hong Kong for any future emergent infectious diseases).

5.7   All in all, HA's objectives of resource management are to –

(a)   ensure efficient use of the public resources as stipulated in the HA Ordinance (Cap 113)[15];

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[15]   HA is under a statutory duty to "use hospital beds, staff, equipment and other resources efficiently to provide

(b)　　provide necessary funding to meet cluster/hospital operating commitments;

(c)　　support HA and its development to serve the community, in short-term and long-term, through -

　　(i)　　achieving annual planning and targets committed to the Government under the Resource Allocation Exercise;

　　(ii)　　timely modernisation of facilities and equipment to meet evolving healthcare needs of the population;

　　(iii)　　building and retaining a quality healthcare workforce for HA[16] and for Hong Kong at large;

　　(iv)　　advising the Government of the needs of the public for hospital services and of the resources required to meet those needs[17];

(d)　　support incentives to drive quality, efficiency and parity across public hospitals; and

(e)　　provide relevant and timely information for monitoring against planned performance, and evaluating the role of resource allocation in driving and incentivising organisational goals.

FUNDING SOURCES OF HA[18]

5.8　　In 2013-14, the total available resources to HA amounted to $53.7 billion, which came from two major sources, namely the Government funding and the income generated by HA as depicted below –

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hospital services of the highest possible standard within the resources obtainable;" (HA Ordinance, Cap 113, Section 4 (c) (i)).

[16]　HA is under a statutory duty to "attract, motivate and retain qualified staff;" (HA Ordinance, Cap 113, Section 4 (c) (iv)).

[17]　HA Ordinance, Cap 113, Section 4 (b).

[18]　As financial results for 2014-15 are not yet finalised at the time when this report is under preparation, all financial information provided in paragraphs 5.8 to 5.17 are based on the 2013-14 fiscal year.

92%

8%

- Government funding
  (Recurrent Funding ($45.7 billion) &
  Capital Subvention ($3.6 billion))

- Income generated by HA
  (Hospital/Clinic Fees and Charges ($3.2 billion) &
  Other Income ($1.2 billion))
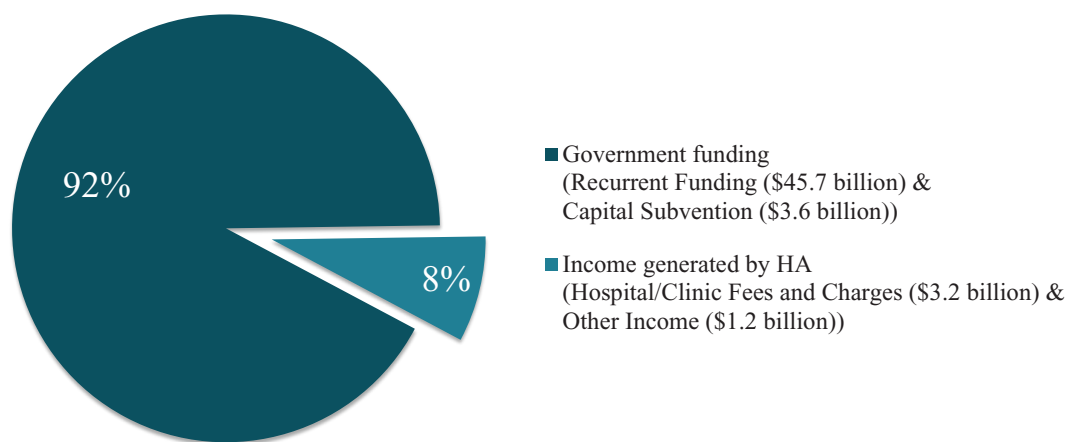
(a) Government Funding

5.9   The Government funding comprises recurrent funding and capital subvention.

5.10   Recurrent funding to HA is provided primarily to meet its day-to-day operational needs.   In 2013-14, the Government's recurrent subvention to HA was $45.7 billion.

5.11   Capital subvention to HA is provided mainly in the form of block votes for infrastructure and initial set up, acquisition of equipment, introduction of information technology/systems, and implementation of facility maintenance and improvement work projects, etc.   These votes include the Equipment Block Vote, the Information Systems Block Vote, the Capital Works Reserve Fund – Works, Furniture & Equipment and Improvement Works.   In 2013-14, the total capital subvention amounted to approximately $3.6 billion, with breakdown as follows –

Capital Subvention	**2013-14 Actual**
Equipment Block Vote	$0.4 billion
Information Systems Block Vote	$0.2 billion
Capital Works Reserve Fund –Works, Furniture & Equipment	$2.3 billion
Capital Works Reserve Fund – Improvement Works	$0.7 billion

(b) Income Generated by HA

5.12   In addition to Government funding, HA also generates its own income which comprises hospital/clinic fees and charges and other income.

Hospital/Clinic Fees and Charges

5.13   In 2013-14, HA reported a total of $3.2 billion[19] in hospital/clinic fees and charges, including income from drugs self-financed by patients and medical fee income.

5.14   Medical fees of HA are determined and published in the Gazette according to the HA Ordinance (Cap 113) under two categories, namely public charges and private charges.   Public charges, which are in general set on an all-inclusive basis[20], cover both Eligible Persons and Non-eligible Persons[21].   All Eligible Persons utilising HA's public services are charged at highly subsidised rates without any means testing required.   The fees have not been revised for 12 years (not even to take into account the impact of price inflation), the overall subsidy rates have since increased from a range of 77% - 100% to 84% - 100% today. Medical fees for Eligible Persons were last revised in April 2003. Non-eligible Persons are charged on a cost-recovery basis.   Medical fees for Non-eligible Persons, together with private charges, were last revised in April 2013.   In contrast with the all-inclusive public charges, private services are charged on a maintenance fee and itemised charge basis, where the charges are set on the higher of cost or market price for respective services.   HA is also responsible for providing medical services to civil servants and their eligible dependants either free of charge or at concessionary rates.

5.15   To dovetail with Government's healthcare policy that no person should be prevented, through lack of means, from obtaining adequate medical treatment, patients who are recipients of Comprehensive Social Security Assistance (CSSA) are eligible to receive full waiver of public medical charges. Other patients with financial difficulties in paying the public medical charges can

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[19]   Net of waivers.

[20]   A flat rate is charged to cover, in general, medical consultation, drugs other than self-financed items, operation, procedures and investigations, etc.

[21]   Patients falling into the following categories are eligible for the highly subsidised rates applicable to "Eligible Persons" –

(i)   holders of Hong Kong Identity Card issued under the Registration of Persons Ordinance (Chapter 177), except those who obtained their Hong Kong Identity Card by virtue of a previous permission to land or remain in Hong Kong granted to them and such permission has expired or ceased to be valid;

(ii)   children who are Hong Kong residents and under 11 years of age; or

(iii)   other persons approved by Chief Executive/HA.

Other patients are subject to the rates applicable to "Non-Eligible Persons".

also apply for non-CSSA waivers (Medical Social Worker Waivers)[22]. In 2013-14, the total waiver amount in HA was about $527 million.

Other Income

5.16   HA's other income, consisting mainly of non-medical fee income such as interest income and donation, amounted to $1.2 billion in 2013-14.

RESOURCE UTILISATION IN HA

5.17   Healthcare is a labour-intensive service industry and about 69% of HA's expenditure (2013-14)[23] was spent on staff cost.   Technology advancement is another driving force for health expenditure, for example, drugs, medical supplies and equipment together accounted for more than 14% of HA's total expenditure in 2013-14.   Indeed, they grew at an average rate of 8% in the past 16 years, which is much higher than economic growth or HA's funding growth.

Evolution of Internal Resource Allocation Model within HA

5.18   In the Review, the SC noted that the internal resource allocation model of HA has evolved over time having regard to the social, economic and healthcare service environment at the time.

(a) Hospital Plan-Based Resource Allocation Model (Prior to 2001-02)

5.19   Prior to the establishment of HA in 1990, funds to individual hospitals were largely allocated on historical basis, focusing primarily on the resource needs of respective hospitals (input-based).

5.20   Following the inception of HA, a corporate strategy of developing output/outcome-focused care was established with a view to developing a resource allocation model that would progressively move from an input-based towards an output/outcome-based approach by linking resource consumption to output performance and/or outcome.   Recognising resource allocation was an integral part of the organisation's business planning process, HA entered the era of Hospital Plan-Based Resource Allocation.   Under this arrangement, hospital service agreements were formulated to specify the scope and level of services to

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[22]   Waivers issued by Medical Social Workers of HA / Social Welfare Department, or Social Workers of Integrated Family Service Centres / Family & Child Protective Services Units of the Social Welfare Department.
[23]   HA's total operating expenditure for 2013-14 amounted to $49.6 billion.

be provided (i.e. the annual service plan of hospitals) and resources were allocated to respective hospitals according to the service level at agreed level of prices.

5.21   Three key features were developed to complement each other to facilitate the implementation of this model in driving efficiency: (i) Specialty Costing; (ii) Patient Related Groups; and (iii) Productivity Gain.

5.22   Specialty Costing measures the average cost of HA services for treating a patient within a clinical specialty.   It was developed as an interim tool to provide a common unit of cost measurement for allocating resources according to agreed service levels.   The concept of Specialty Costing was first applied in 1992-93 for allocating additional drug expenditure, and its use was subsequently extended to allocate up to 40% of the 11 acute hospitals' resources by the late 1990s.   To link resource input with output/outcome, HA pioneered the development of a locally customised patient classification system, the Patient Related Groups.   The Patient Related Groups complemented the Specialty Costing in accounting for variations in the mix of cases and the level of care among hospitals.

5.23   A mechanism of productivity gain was also introduced, where "productivity savings" from hospitals were pooled for further redistribution to encourage hospitals to optimise efficiency and to provide hospitals with funding source for new and improved services.   This mechanism was first applied in 1993 at 1% of HA funding and subsequently increased to as high as 3% of the funding, amounting to a total of $2.1 billion savings over the six years period from 1993-94 to 1998-99.

Limitations

5.24   While the use of Specialty Costing and the Patient Related Groups information in allocating resources under this output/outcome-based model had helped reduce variation in unit cost among major acute hospitals, and the concept of productivity gain had facilitated steady growth in the share of ambulatory and extended care services to better meet the needs of the community, this model had a perceived drawback of favouring hospitals experiencing volume growth.   This gave rise to the unintended consequential effect of encouraging hospitals to vie for volume growth.   In 1998-99, HA refined the model so that "productivity savings" were no longer pooled for redistribution and the hospitals concerned could keep their savings for service improvement.   The role of Specialty Costing and the Patient Related Groups information had also been altered to serve as references for subsequent resource allocation.

5.25   Another shortfall of the model was its fragmented approach of service planning and resource allocation based primarily on individual hospital's service plan.   With its limited regard to the overall picture of the society's service need and the low level of central coordination, this model had not been conducive to HA's efforts in directing its resources to meet the population's greatest need.   Its unintended effect on encouraging volume growth also offered little incentive for hospitals to achieve better efficiency and effectiveness in resource utilisation.

(b) Population-Based Resource Allocation Model (2001-02 to 2008-09)

5.26   In the late 1990s, HA began to formulate rationalisation and integration plans to move its medical services from an inpatient setting towards the ambulatory and community mode with a view to achieving better productivity. This change in service delivery mode implied a need to review the then internal resource allocation model adopted by HA.

5.27   Against this background, HA commenced the development of its population-based internal resource allocation model in early 2000's.   The objectives of this new model were –

(a)   To provide resources based on the needs of the community served – equality in resources for equal needs (equity principle); and

(b)   To provide incentives to hospitals for improving the organisation and delivery of services within the hospital clustering environment.

5.28   Under this model, resources were allocated to each cluster according to the headcount and age profile of the population of the catchment districts (demarcated based on the location of hospitals within that cluster's administration), and adjustments were made to take into account the cross-cluster flow of patients. Clusters/hospitals were responsible for assuring that service needs were met either within their own cluster or from other clusters.   They were given the flexibility to rationalise their services provision/mix to meet the needs of their local population. They were also encouraged to improve both internal service coordination between clusters and external collaboration with primary care/private sector providers, as well as to pursue technical efficiency.

5.29   The introduction of this population-based resource allocation model in 2001-02 coincided with the Government's Enhanced Productivity Programme implemented across the public sector to achieve the best value-for-money in Government expenditure while maintaining and improving the quality of public services.   As a result of this programme drive and other efficiency savings

measures implemented up to 2005-06, HA delivered a total of around $3.5 billion savings during the six-year period from 2000-01 to 2005-06. This might have somehow posed some challenges to the implementation of the population-based resource allocation model in HA in the relevant years. Notwithstanding the Enhanced Productivity Programme drive and efficiency savings measures, the Government continued to provide additional recurrent funding of about $2.3 billion (on top of the annual recurrent subvention) to HA to cope with the population growth and service needs during the same period.

(c) Refined Model under the Pay-for-Performance Concept (2009-10 to 2012-13)

5.30   To drive further improvement in its resource management, both in terms of the baseline resources of clusters and their additional new funding received each year, HA refined its resource allocation model by adopting the concept of Pay-for-Performance in 2009. This refinement aimed to modernise patient care processes through directing more focus on quality and outcome, and to better link resource utilisation with output/outcome. At the same time, the model strived to further promote productivity while ensuring resources are deployed to targeted areas of need through a transparent mechanism.

5.31   Recognising the need for a tool to promote clusters' productivity, a baseline budget redistribution mechanism was built to measure efficiency among clusters. This mechanism involved the application of a modest efficiency adjustment to clusters' baseline resources based on their acute inpatient throughput measured using Casemix[24]. A cluster's actual cost in producing a certain level of throughput was compared against HA's average cost expected to produce the same level of throughput, with the difference being the efficiency variance. Clusters with higher than expected costs would be asked to improve their efficiency by reducing their baseline resources and/or increasing their throughput. Resources would be redistributed from the "over-funded" clusters to the "under-funded" ones according to casemix-adjusted costs.

5.32   To ensure that additional new funding was directed towards priority areas under the Pay-for-Performance concept, new resources were deployed to clusters across three strategic performance areas –

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[24]   The Casemix model adapted by HA is built upon an internationally-adopted patient classification system, namely the Diagnosis Related Groups system. Through classifying acute inpatient admissions into the Diagnosis Related Groups, hospitals' workload can be measured, and compared against each other, by the number of cases they treat and adjusted by their complexity.

(a)   Service growth in areas of greatest need such as high demand pressure areas and expansion of treatment for life threatening conditions;

(b)   Improvement in patient safety and quality; and

(c)   Initiatives that enhance services through training and retention of staff, and adoption of advanced technologies and treatment.

5.33   As another key focus under the Pay-for-Performance concept, improvement in quality was also emphasised with the introduction of a three-year Quality Incentive Pilot Programme.   Through consultation with relevant clinical groups, strategic priority areas were identified and a set of quality performance indicators were developed for measurement.   In recognising clusters' performance in quality improvement, financial incentives were rewarded to clusters for either achieving the pre-set targets, or for demonstrating improvement for each indicator.

5.34   Following the principle of "same service, same price" under this Pay-for-Performance concept, unit costs of respective clinical services formed the basis for allocating new resources to strategic areas of service needs.   In formulating this "purchasing unit price", Specialty Costing as well as casemix information (for acute inpatient services) had been used to measure and reflect the resource requirements of the hospitals.

Strengths

5.35   The use of Casemix information under this model gave due considerations of complexity in the inpatient services provided by clusters and it had been a significant step for HA in refining its resource allocation.   Such information had also facilitated public and stakeholders' understanding of HA resource requirements.

5.36   The establishment of the baseline budget redistribution mechanism as an efficiency measurement had also successfully raised clusters' awareness of and incentives to drive efficiency improvement.

5.37   The strategic drive of resources towards targeted performance areas had enabled HA to systematically optimise and broaden the use of its resources over a multi-dimensional focus that not only met the growing demand from rising and ageing population, but also addressed resource needs to facilitate improvements in technology, quality and safety as well as the workforce.

Limitations

5.38   Despite the benefits this model could offer, it had the following underlying deficiencies that had undermined its effectiveness -

(a)   Clusters' perception of inequality of the baseline budget redistribution mechanism due to its confined focus on acute inpatient service alone;

(b)   The approach of redistributing baseline resources at the cluster level had not been effective in facilitating the identification of specific areas at hospital level or services with efficiency issue requiring management attention;

(c)   Driving for activity growth given the prevailing market shortage in healthcare professional had further exacerbated the workload of HA; and

(d)   Focusing primarily on resource need and service throughput was not conducive to delivering outcome-focused medical care.

5.39   In light of the above observations, both the baseline budget redistribution mechanism as well as the purchasing arrangement for new services (i.e. at respective "unit price") had been put aside since 2012-13 to avoid further drive for unnecessary activity growth given the manpower shortage.   In the same year, the Quality Incentive Pilot Programme had completed its three-year trial period and its scope had been well incorporated by the emerging and ongoing development of other quality initiatives.

(d) Current Framework (from 2012-13)

5.40   At present, HA's service planning determines how resources are allocated across the organisation.   This is further reinforced through the structured service planning framework to ensure the best use of public resources in the delivery of quality care services.

(i) Resource Allocation to Cluster

5.41   In 2012, HA published its latest Strategic Plan 2012 – 2017 to set out its strategies and priorities for the next five years. The development of this document was led by the HA Board and involved extensive consultation and discussion with both internal and external stakeholders.   Through extensive

environmental scanning of HA's internal and external context, key outstanding issues and gaps across different aspects of the organisation, such as service needs, patients' expectation, medical technology and facilities requirement, etc., were identified. Noting that many of the gaps revealed could only be addressed over a period of time in a progressive manner, HA drew up medium term strategies and directions accordingly with a view to aligning and balancing these service/quality gaps across respective clusters while addressing the relevant challenges of maintaining an adequate workforce, managing growing service demand, ensuring service quality and safety, and enhancing corporate governance. These medium term priorities would be implemented and monitored through appropriately redistributing existing or allocating additional resources to targeted areas of need during the Annual Planning process.

5.42   The Annual Planning process itself is a participative exercise with bottom-up and top-down contributions throughout the organisation. Views are collected from frontline clinical staff and cluster management to HAHO executives. Every year, resource requirements for new services and specific pressure areas are deliberated at the Annual Planning fora with inputs from stakeholders across all clusters.

5.43   Through the above Annual Planning process, HA formulates its Annual Plan, incorporating all new programmes that are approved for implementation for the year, including territory-wide and specialty-based programmes, as well as cluster/hospital/department-specific initiatives, with set targets to be achieved and reported.

5.44   Upon the Government's notification of its total recurrent funding to HA for the year, resource allocation to clusters (including manpower, equipment, facilities and other operating needs) will be determined based on the following considerations –

(a)   the resources needed to sustain the baseline operations of respective clusters, including their core primary and secondary services as well as any centralised services under their management;

(b)   additional resources required to deliver the new services that have been supported during the annual service planning process; and

(c)   any other resources needed to address specific pressure areas/gaps.

(ii) Resource allocation within clusters

5.45   Charged with the responsibility to ensure operational efficiency while delivering the targets set under the Annual Plan, respective cluster management will likewise work out its cluster's service plan according to the baseline need, new services supported and pressure areas of its hospitals/departments, and make necessary service reorganisation and rationalisation to ensure that there is optimal deployment of resources to targeted areas of need.   To ensure transparency in resource allocation, relevant stakeholders are engaged throughout each cluster's resource allocation process to prioritise new initiatives from hospitals within the cluster and agree on a service plan, based on which the clusters will prepare a viable budget plan to balance the financial requirements with the resources available.

5.46   In parallel with the evolution of different internal resource allocation model as detailed above, the Government's subvention has been increasing over the years.   In the ten years from 2006-07 to 2015-16, the Government's recurrent subvention to HA has increased from $27 billion to about $49 billion, representing an increase of nearly 80% or about $22 billion.   It is high time for HA to ensure a better and more efficient allocation of this increased baseline provision.

EVALUATION ON RESOURCE MANAGEMENT

Resource Allocation Model

Views from the Public Engagement Programme

5.47   Resource management is understandably a contentious issue. Various parties, including HA's cluster management and frontline staff as well as stakeholders outside HA, have expressed their views on the subject when meeting with the SC.

5.48   In summary, the SC received quite a significant number of views expressing concerns on the existing resource allocation model and showed support for a population-based approach.   The general perception was that the present resource allocation model was unfair as the resources allocated to a cluster were not commensurate with service demand which was considered to be related to the number of patients and population in a cluster.   For example, the resources allocated to KEC were the least among the seven clusters on a per capita basis. Kwun Tong and Sai Kung districts covered by KEC accounted for 15.1% of Hong Kong's overall population in 2013.   While 15.5% of HA's patients had ever used

KEC service, KEC was only allocated with 10.7% of the total recurrent funding allocated to clusters for the year 2013-14. There were also criticisms that the present model often focused only on new money for implementing new services, leaving the inherent "unfairness" in baseline provision among clusters unaddressed. Many expressed comments that a population-based model would provide a fair and transparent mechanism in allocating resources. It would allow resources to match the prevailing service needs rather than historical provision.

5.49   However, the SC also noted that there were concerns about a resource allocation model solely based on population size. Specifically, there were worries that a pure population-based model would not be able to take into account the territory-wide tertiary and quaternary services provided by certain hospitals in selected clusters, the inflow demand for cross-cluster services experienced by certain clusters and the special role of certain hospitals (e.g. teaching hospitals shouldering teaching duties on top of service provision). For example, the Queen Mary Hospital provided liver transplant services for patients throughout the territory. It also served as a teaching hospital of the University of Hong Kong. The same applied to the Prince of Wales Hospital as a teaching hospital for the Chinese University of Hong Kong. The Hong Kong Eye Hospital at KCC, as another example, served a large number of patients from other clusters. Moreover, the resident population in a district did not truly reflect patients' behaviour in seeking medical services as one might choose to receive services from clusters other than the one he/she resided after considering factors like the distance from the workplace, transportation convenience reasons and personal preference.

SC's Considerations

5.50   Members of the SC appreciate the limitations of the existing resource allocation model in which the resources allocated for certain clusters do not appear to be commensurate with the corresponding population. Recognising that population is a key factor in generating workload and thus resources requirement for a cluster/hospital, the SC agrees that the concept (with sufficient refinement – see below) of a population-based model should be most able to address the public concern and perception of equality, equity and transparency.

5.51   However, members of the SC hasten to point out the risk of going to the extreme of allocating resources through simplistic arithmetic by following one and only one single factor, namely population. Taking such a simplistic model will disregard the centralised and/or tertiary and quaternary services provided in certain clusters as well as the demand generated in the cross-cluster services. In particular, service demand in a cluster where A&E services are provided is to a

certain extent determined by the proximity of the cluster with the location of the incident, there are bound to be cases where patients are sent to clusters outside their residential area to receive A&E and consequential services (hospital admission via A&E and related outpatient services). The SC considers that a refined population-based model should take due account of the resource requirements of clusters and hospitals concerned for undertaking centralised and/or tertiary and quaternary services and providing services to patients residing in other clusters.

5.52   **Recommendation 3:** the SC **recommends** that –

(a)   HA should adopt a refined population-based resource allocation model by reviewing the present approach and taking into consideration the demographics of the local and territory-wide population. The refined population-based model should take into account the organisation of the provision and development of tertiary and quaternary services, and hence the additional resources required by selected hospitals or clusters, as well as the demand generated from cross-cluster movement of patients; and

(b)   HA should develop the refined population-based resource allocation model and implement through its service planning and budget allocation process within a reasonable timeframe. To avoid unintentional and undesirable impact on the existing baseline services of individual clusters, HA should consider appropriate ways to address the funding need of clusters identified with additional resources requirement under the new model, while maintaining the baseline funding to other clusters.

Procedures in Resource Allocation

Views from the Public Engagement Programme

5.53   During the Public Engagement Programme, some HA staff raised concerns on the tedious and complicated procedures involved for bidding new resources. Some were particularly uneasy with the requirement to obtain clearance from various committees and hierarchies at hospital, cluster and HAHO level for implementing a new initiative, and the requirement to repeat the whole process again next year if the bid in the current year failed. All these have added to the workload of frontline clinical staff. Some, however, appreciated the merits of clearing the proposals with relevant COCs to ensure consistency and coherence in service provision at the corporate level.

5.54   Some staff were also concerned that the decision-making process of the internal resource allocation was not as transparent as they expected and they did not have a full picture on the rationale and methodology adopted.   There was perception that large hospitals might enjoy greater advantages as COC chairmen normally came from large hospitals.   Some claimed that the amount of resources actually allocated to frontline services was less than the original approved amount and thus became inadequate, alleging that part of the sum had been used to meet the supporting functions of HAHO and cluster management.

SC's Considerations

5.55   Members of the SC note the general sentiments of frontline staff on the process of resource allocation.   While managing an annual funding of some $50 billion for an organisation comprising 42 hospitals/institutions with some 70,000 staff is a mammoth exercise and certain degree of flexibility is inevitable in order to meet local operational needs at the cluster/hospital level, there is room to improve the logistics and enhance transparency in the process to alleviate staff's concerns.

5.56   **Recommendation 4:** the SC **recommends** that –

(a)   HA should work to improve and simplify the procedures of bidding new resources by clusters for new or improved services at the next resource allocation exercise (in 2016-17), with a view to streamlining and expediting the process and minimising the administrative workload of frontline clinical staff, balancing the need for efficiency and accountability; and

(b)   HA should enhance transparency of the resource bidding and allocation processes through better internal communication with clusters and within clusters on the methodologies, priorities and selection criteria.   For the same reason, HA should explain the rationale and considerations behind the final decisions and allocation result starting with the next resource allocation exercise (in 2016-17) so that clusters can have a better understanding of how priorities are being determined and how resources are being allocated within the whole organisation.

CHAPTER 6   STAFF MANAGEMENT

OVERVIEW

6.1   HA is a large and complex organisation with a total of 70,132 staff (FTE as at 28 February 2015).   It is the largest public organisation in Hong Kong outside the Government, with staff size exceeding one third of that of the civil service.

6.2   Healthcare service is a human service the delivery of which rests with people.   In order to deliver quality public healthcare services, a comprehensive and effective staff management system is indispensable.   This chapter reviews HA's staffing and training arrangement.

6.3   HA has, according to the HA Ordinance (Cap 113)[25], the authority to determine -

  (a)   the remuneration, and the terms and conditions of employment of its employees; and

  (b)   the standards of work and conduct of its employees, and matters relating to their suspension or dismissal from office.

The employment terms and conditions and relevant staff management matters are set out in HA's Human Resources (HR) Policy Manual, as approved by the HA Board.   HA has also laid down further guidance on HR policies and procedures in its HR Administration Manual.

6.4   As stated in Chapter 5.1.2 of the Report of the Provisional HA, the management principle advocated during the formative years of HA is to allow "individual hospitals to enjoy a high degree of autonomy in determining their affairs".   In line with this, HA has adopted a decentralised management structure along with the principle that operational decision is encouraged to be made as close to the patients as possible.   While HR policies are developed and set by HAHO, clusters/hospitals are responsible for implementing such policies.

6.5   In accordance with the schedules of delegations made by HA pursuant to section 6 of the HA Ordinance (Cap 113), the authority for hiring and firing HA employees in a hospital generally rests with the HCE, who is the overall

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[25]   Paragraph 10 of Schedule 3 to the HA Ordinance (Cap 113).

manager of the hospital. To support HCEs in exercising these and other HR functions, the HR Policy Manual and the HR Administration Manual provide guidance for the exercise of such functions and authority across HA. Moreover, each cluster has a Cluster HR Department headed by a Cluster General Manager (HR). HA operates a single HR and payroll system for all staff, and this system also supports other functions such as manpower planning, rostering, leave management and training.

THE HA WORKFORCE

6.6   HA's large workforce comprises six main groups with over 300 grades and ranks of staff. These six main groups of staff, together with the corresponding number of staff in each group, are as follows –

Group of Staff	Number (FTE as at 28 February 2015)
Medical	5,910
Nursing	23,721
Allied Health	6,891
Care Related Supporting	13,665
Management/Administration (e.g. Executive Officers, Hospital Administrators, Finance & Accounting, System Analysts, etc.)	2,421
Others (e.g. Operation Assistants, Clerical & Secretarial, Workmen, Executive Assistants, Information Technology Assistants, etc.)	17,525
Total	**70,132**[26]

The majority of the workforce is involved in direct patient care delivery providing a wide range of services to patients. These healthcare staff groups, including doctors, nurses, allied health professionals, care-related supporting staff, and their respective numbers are outlined in **Annex 5**.

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[26]   Figures may not add up due to rounding when calculating FTE manpower.

THE CURRENT STAFFING SYSTEM

Recruitment, Selection and Appointment Process

6.7   Under the decentralised management structure, creation of posts and recruitment of staff to deliver patient services are at the discretion of CCE – the overall senior executive in charge of the cluster. Appointment and promotion exercises are normally initiated and carried out by the hospitals in which the vacancies exist.

6.8   HA adopts an open appointment system. The objective is to uphold equity and fairness in its recruitment and appointment processes. Appointment will be based on the candidate's merits rather than seniority with a view to appointing the most suitable candidate with the highest calibre for the job. Any person, including incumbent employee of HA, who considers that he/she meets the entry requirements of a post advertised, may submit an application for appointment. Selection of candidates for appointment (including the recruitment process, and the use of selection board and interviews to assist in the selection process) is governed by relevant policies and guidelines specified in HA's HR Policy Manual and HR Administration Manual respectively.

Staff Transfer and Deployment Process

6.9   The SC notes that transfers of staff between hospitals are arranged on the staff's initiative and with mutual agreement of the hospitals concerned. Management postings initiated by HAHO, which were commonly practised in Government hospitals before the takeover by HA, are limited. Although HAHO does reserve the right to transfer staff to meet special operational needs, such authority is seldom exercised and when exercised, for temporary relief only.

Role of HAHO

Central Recruitment for entry ranks for certain grades

6.10   The SC notes that notwithstanding the decentralised recruitment and appointment system, HAHO plays a central agency role in certain circumstances. For example, in the annual intake of graduate doctors, nurses and allied health professionals to entry ranks of these grades, HAHO coordinates central recruitment actions in collaboration with Cluster HR Departments in the aspects of posts allocation, conducting selection interviews and matching of applicants' preferences to posts available. HAHO's involvement ensures that the relevant process is procedurally proper. Selection of candidates for relevant clusters

depends largely on the choice of the candidates as well as clusters' line managers. It is observed that HAHO only has minimal influence on directing and deploying appointees to other areas even if there is higher demand in those areas.

Recruitment of other positions

6.11   Recruitment of other entry level/promotional positions in clusters is carried out by the hospitals in which the vacancies/posts exist. HAHO's involvement in local selection boards is relatively limited. The SC appreciates that if HAHO was to send representatives to attend all selection boards of individual posts in clusters as well as the consequential vacancies generated therefrom, the manpower requirement on the part of HAHO would have been substantial. In this respect, HA's HR Policy Manual requires inclusion of HAHO representative only in selection boards of senior posts (e.g. Consultants) in clusters. HAHO representation is either not required or not mandatory for the lower rank posts. Most posts in clusters are filled by candidates with significant local characteristics, often geared specifically towards the requirement of the particular job concerned.

Cross-Cluster Promotion

6.12   The SC notes that most of the promotion cases (over 90%) were from within the cluster. As illustrated in **Annex 6**, the overall proportion of cross-cluster promotion of clinical professionals (i.e. doctors, nurses, allied health professionals) in the past five years was low, ranging from 10% in 2009-10 to 9% in 2013-14.

6.13   Among the professional groups, there is a slightly higher percentage of cross-cluster promotion for doctors (8% - 14%). Nurses have a comparatively lower cross-cluster promotion rate (4% - 9%) over the years.

6.14   Whilst it is acknowledged that serving members of a team are more likely to have an edge over other competitors in the promotion process as they are more familiar with the job requirements and working environment and have established working networks, the general resultant phenomenon of promotion from within the cluster/team has gradually (and unintentionally) created silos. This leads to the perception of "sectarianism" and forms a possible barrier to cross-fertilisation of expertise and deployment of people resources across cluster to meet needs at critical times.

Cross-Cluster Staff Movement/Deployment

6.15   Horizontal movement of staff between hospitals/clusters is mainly left to the discretion and initiation of the staff concerned.   For example, the staff concerned is free to apply for transfer to another hospital/cluster subject to –

(a)   the agreement of the two departments or hospitals concerned; and

(b)   the availability of vacancies for placement.

Alternatively, the staff member may follow the recruitment process and apply for appointment to fill an advertised vacancy in another cluster.

6.16   Although HAHO does reserve the right to transfer staff horizontally to meet special operational needs, such authority is seldom exercised.   Even when it is exercised, it is often fraught with difficulties due to the overall manpower shortage in HA.

THE MANPOWER SHORTAGE ISSUE

6.17   With an ageing population, advances in medical technology and increasing demand for healthcare services in the community, the manpower requirement of HA for service provision has grown considerably.   In particular, there has been a significant shortfall of doctors in recent years due to the reduced number of local medical graduates as explained in paragraph 3.5 and the competition from a more vibrant private healthcare sector.

6.18   HA has been closely monitoring the attrition rate of staff and is committed to improving the manpower situation of doctors.   For this purpose, a basket of measures with a view to strengthening the medical workforce and boosting staff morale has been put in place.   These include recruitment of non-local doctors through limited registration, employment of part-time doctors through enhanced pay package, enhancement of promotion prospect, enhanced recognition through honorarium scheme, reduction in workload through introducing care technician service support and improving working conditions (more details of these measures are at **Annex 7**).

Current Attrition Position

6.19   Upon implementation of these measures, HA has recorded improvement in staffing position.   As can be seen from the diagram below, the

attrition rate of full-time doctors has declined from 4.9% in 2010-11 to 3.9% in 2013-14. The attrition rate of nurses is also on the decline from 5.2% in 2010-11 to 4.7% in 2013-14, while attrition rate of allied health professional has remained steady and lower than that of doctors and nurses.

Hospital Authority Manpower and Attrition (Wastage) Rate (%) of Doctors, Nurses & Allied Health Professionals

	2010-11	2011-12	2012-13	2013-14
Full-Time Doctors	4.9%	4.4%	4.4%	3.9%
Full-Time Nurses	5.2%	5.2%	4.9%	4.7%
Full-Time Allied Health	3.3%	3.9%	3.4%	3.4%
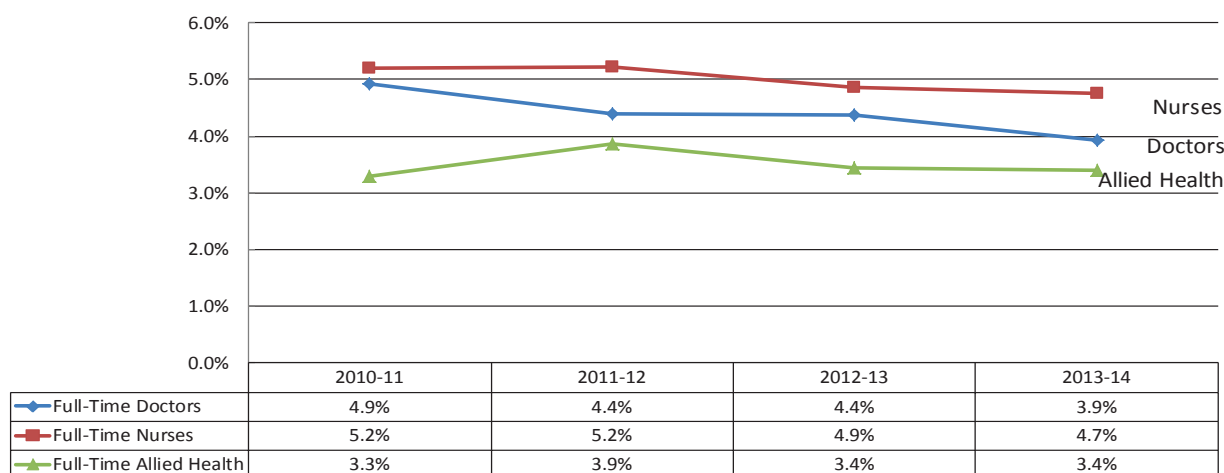
FTE Strength

Doctors	5,052	5,165	5,260	5,376
Nurses	20,102	20,901	21,816	22,759
Allied Health	5,618	5,944	6,302	6,609

Part-Time Doctors	63	88	111	125

Note:
(1) Doctors exclude Interns and Dental Officers.
(2) Attrition (Wastage) includes all types of cessation of service from HA for full-time permanent and full-time contract staff on Headcount basis
(3) Rolling Attrition (Wastage) Rate = Total no. of full-time staff left HA in the past 12 months /Average strength in the past 12 months x 100%
(4) Manpower on FTE includes all full-time and part-time permanent, contract and temporary staff in HA's workforce

Current Manpower Position

6.20 While it is fair to say that the overall strength of HA's manpower and staff wastage have been improved, the overall manpower shortage problem remains due to the fast growing service demand. In 2014, the shortfall of doctor in HA was around 340 and the shortfall is expected to continue in the next few years. Similar challenges exist in nurses and allied health professionals though in a smaller magnitude.

6.21 In the past two years, there is a rising attrition of care related supporting staff. Heavy workload, work nature and the labour market competitive force drive the attrition rate from 13.9% in 2011-12 to 15.7% in

2013-14. These have added to the pressure at the frontline and become a risk factor on quality of care.

6.22 All in all, the manpower shortage issue undoubtedly has a bearing on HA's flexibility in managing staff.

EVALUATION ON STAFF MANAGEMENT

6.23 Over the years, HA has noticed a number of HR management and staff morale issues including the following –

(a) There are allegations of favouritism in the appointment/promotion process with perception of less-able persons being promoted ahead of more competent ones;

(b) The difficulties experienced by staff in cross-cluster transfers, as well as the difficulties and limitations in deploying people resources across HA have hindered optimal utilisation especially at critical periods;

(c) The general phenomenon of promotion from within the cluster/team has gradually created silos and has formed barriers to cross-fertilisation of expertise and development of lateral thinking for staff; and

(d) Inconsistencies in the interpretation and application of HA's HR policies at local level have created perceived unfairness amongst staff and caused adverse impact on staff sentiment and morale.

HA's Recent Endeavours

6.24 The SC notes that HAHO has been taking a more proactive lead in recent years in staffing issues, examples of which are set out in the ensuing paragraphs.

Advancement of Clinical Consultants

6.25 HAHO conducts the advancement exercise for clinical Consultants from Directorate ranks D1/D2 to D3 and from D3 to D4, taking into consideration overall service needs, professional development of the specialties and career development of individual doctors. HAHO has put in place consistent

assessment criteria and considerations for advancement, unified appointment date and centrally coordinated prior communication of such to individual doctors to improve transparency and enhance trust building between management and staff.

Creation of Directorate Positions

6.26   Instead of vesting the authority to cluster management which has resulted in lack of coordination and variation in management structure among clusters, creation of Directorate positions (e.g. clinical Consultant posts in clusters) is now deliberated at and determined by a CC led by HAHO on an annual basis, where both local needs as well as HA's overall needs can be considered and balanced.

Alignment of weekly conditioned work hours of HA employees

6.27   To align the conditions of work of HA staff, HAHO has reduced the weekly conditioned work hours of all junior supporting grades employees (around 20,000 employees or 30% of HA's total work force) from 45 net per week (i.e. excluding lunch break) to 44 gross per week (i.e. including lunch break) with effect from 1 May 2013.   All HA employees now have the same number of conditioned work hours per week.

Central acquisition and allocation to clusters of phlebotomist support and clerical support

6.28   HA implemented in 2012-13 an initiative to centrally acquire and allocate to clusters phlebotomist support and clerical support to help relieve manpower shortage.   Through the initiative, HA has recruited an additional of 280 Clinical Assistants (phlebotomists) to provide 24-hour phlebotomy support service to all acute hospitals.   HA has also provided 315 clerical staff members to relieve frontline healthcare professionals from administrative duties.

Executive Development and Succession Planning

6.29   HA takes succession planning of senior management across HA seriously.   A central Executive Succession Committee chaired by the Chief Executive/HA has been formed to oversee and monitor the succession management of strategic leadership positions, e.g. CCEs, HCEs, selected Chief Managers, Cluster General Managers or equivalent.   This Committee is tasked to review nominations against defined criteria and decide who are to be admitted to the succession pools.   Cluster Succession Committees are also established to manage and monitor the succession management of operational leadership

positions such as COS, Department Operation Managers, Department Managers, General Managers or equivalent.

6.30 HA has designed and implemented an in-house tailor-made leadership development programme, the Executive Leadership Programme, for those in the succession pools. This is a 12-month programme that covers workshop, seminars on critical business skills, coaching, boardroom sessions and projects. Overseas training and short-term attachment will also be arranged for those who have already participated in the Executive Leadership Programme.

Rotations of HCE, CCE and Chief Managers

6.31 In 2008, HA had initiated the HCE rotation scheme. Under this scheme, HCEs who had been in current positions for six years or more and were more than three years from retirement would be invited to join the rotation scheme.

6.32 CCEs are also recommended for similar job rotation. CCEs who are in post for three years or more would be invited for lateral transfer should the opportunity arise.

6.33 In 2011, job exchanges amongst selected Chief Managers were also implemented on a voluntary basis to widen exposure in general management at corporate level. HA has introduced a more structured job rotation scheme between Chief Managers (at Executive Manager/Senior Executive Manager rank) and relevant HCEs in 2014 for exposure and development purposes for the benefit of the organisation.

Streamlined administrative duties

6.34 HAHO provides leadership, policy steer, central planning and performance management in a large organisation with a total workforce of over 70,000 operating under a decentralised environment. Apart from its strategic role in leading corporate strategies and development, aligning corporate values and directions, HAHO also shoulders the responsibilities of an array of important corporate functions such as corporate governance, administration, finance, HR management, information technology systems development and operations, quality and standards, as well as other essential central supporting services including procurement, drug management, corporate communication, external relations and legal support. This organisation of work through HAHO also supports the hospital clusters in the delivery of healthcare services and alleviates the administrative tasks of the clusters. It also facilitates alignment of corporate

policies and direction, standardization, quality improvement, as well as effective structure and operation in HA.

6.35 HA is very conscious of the need to streamline any necessary administrative duties and support its clinical staff so that they can focus on their clinical duties. As mentioned in paragraph 6.28 above, additional clerical staff have been provided to the clinical departments of the clusters, and information technology has been utilised, and will continue to be developed, where practicable, to streamline and standardise administration of systems and practices to help alleviate clinical professionals from mundane administrative duties.

Views from the Public Engagement Programme

6.36 Despite HA's recent endeavours above, the general sentiments from frontline staff gathered during the Public Engagement Programme were that there was still room for improvement. Inconsistencies in HR practices among clusters were still found. For example, some pointed out that different clusters had different arrangements in the granting of study leave and creation of posts. Some considered that HAHO should be equipped with greater authority in coordinating resource deployment and setting direction. In particular, to enhance the collaborative culture within the organisation, HA should consider more staff rotations. HAHO should also attend and oversee the promotion boards of individual clusters to ensure transparency and fairness.

6.37 While different hospitals in the same cluster would perform different roles, some considered that a more flexible flow of staff between clusters/hospitals would provide staff with more training opportunities and exposure and this would help attract and retain staff.

6.38 Some also thought that at present, the spirit of cooperation in providing staff support between clusters or hospitals was not strong enough in meeting *ad hoc* requirements for additional manpower. There should be some central coordination in deploying staff across clusters to meet short-term service needs, particularly during crisis or contingent situations.

6.39 Acknowledging the fact that certain specialties might be more popular among medical graduates than others, some opined that more central coordination was needed in the allocation of Resident Trainees to address manpower shortage in these specialties.

6.40 Having said the above, the SC noted that the views on the existing staffing arrangements were not one-sided. Some saw the merits of allowing

individual clusters or hospitals to retain the authority to select staff so as to build their own team. In general, supporting grades were more cautious to centrally-coordinated promotion or transfer as they might not wish to work in other clusters due to possible concerns on transportation and the need to adapt to new working environment.

SC's Considerations

6.41   The SC appreciates that central coordination and decentralisation have their respective pros and cons. There is no single right model that lasts forever for any organisation. The challenge to a large organisation like HA is to strike the appropriate balance to suit its stage of development at the specified time.

6.42   One of the main purposes of establishing clusters in HA was to improve efficiency through decentralisation. In this connection, despite the perception of "sectarianism" under the current decentralised arrangement, the SC is mindful that any changes should avoid going to the other extreme of centralisation like that during the pre-HA era where all personnel issues were in the single hand of the then Medical and Health Department. The key is to strike a *right* balance between central coordination and decentralisation to ensure consistency and alignment of practices in HA.

6.43   The SC considers that HAHO should enhance its coordinating role in staff management to ensure that there would be greater consistency, fairness and parity in human resources practices at the cluster and hospital levels. To cater for the special needs and features in different disciplines, HA should enhance the coordinating and monitoring role of the COC in this connection in different specialties. Furthermore, HAHO should strengthen its staff development programme for senior managerial and clinical staff whereby senior staff will be given wider exposure through rotation to different postings. HA should also strengthen the rotation arrangement for trainees as part of their training programme. HAHO should, in particular, enhance its central coordinating role in time of crisis in order to deal with any contingent situation effectively. It is important to instill in staff the notion that they are staff of the HA family, rather than merely staff of individual cluster or hospital.

6.44   While HAHO is playing the central agency role in the annual recruitment exercise of Resident Trainees, the SC is of the view that such function is not performed strongly enough. Individual hospital departments virtually conduct the recruitment exercise on their own by inviting interns to attend informal departmental interviews arranged by themselves and make informal indications to offer Resident Trainee positions to interns considered suitable in

these informal departmental interviews prior to the official central selection interviews. This often leads to certain interns accepting informal offers from more than one department. Hospitals' manpower plans thus remain uncertain until the very end of the recruitment period. Strengthened central coordination in this aspect is called for.

6.45 SC Members also notice the existence of occasional inconsistencies among clusters and hospitals in HR practices resulting from different interpretation of HAHO's rules. For example, leave for training is granted in one cluster but not necessarily in another under the same circumstance. To address such inconsistencies, Members see a need for HAHO to enhance transparency and strengthen internal communication on staff management issues. Clear guidelines on the foci of representative from HAHO and/or representative from HKAM (in case of doctors) in selection boards may also be considered.

6.46 **Recommendation 5:** the SC **recommends** that –

(a) While there is a need to draw a right balance between central coordination and decentralisation on matters relating to recruitment, promotion and deployment of staff to take into account the cluster-based organisational structure of HA, HAHO should enhance its coordinating role to ensure greater consistency, fairness and parity in human resources management and practices in and between the clusters. In particular, HA should exercise greater central coordination in the annual recruitment of Resident Trainees and their placement to different specialties to promote a corporate identity and spirit;

(b) Transparency in staff promotion and transfer processes should be enhanced through involvement of HAHO. HA should also enhance transparency in promotion with clear criteria and guidelines and well defined foci of representatives from HAHO and/or HKAM as appropriate;

(c) HAHO should strengthen its staff development programme for senior managerial and clinical staff whereby senior staff will be given wider exposure through different postings. HA should also strengthen the rotation arrangement for trainees as part of their training programme;

(d) HAHO should be able to assume the central coordinating role of staff deployment within the organisation when situation so warrants, such as in response to a large emergency situation, staff shortage or surge

in service demand;

(e) To address the needs of specific disciplines and maintain consistency in practices between hospitals, HA should enhance the coordinating role of COC in different specialties; and

(f) Regular communication and reporting between clusters and HAHO should be established to ensure common understanding on corporate personnel policies.

TRAINING

Background

6.47 Training is one of the important elements of staff management, particularly for the healthcare sector in which service quality and patient safety are at stake and where staff retention is crucial for addressing the prevailing problem of manpower shortage. In fact, promoting, assisting and taking part in "*the education and training of persons involved or to be involved in hospital services or other services relevant to the health of the public*" is one of the functions of HA stipulated in Section 4 of the HA Ordinance (Cap 113). Training of healthcare professionals, as set forth by the Secretary for Food and Health in the report "*Building a Healthy Tomorrow*" in 2005, is also one of the four priority areas directed by the Government for HA to focus on.

6.48 The overall aim of HA's training programmes is to ensure that the healthcare workforce has the right skills and is of the right numbers to maintain the standard of care, improve patient outcomes and lead to greater job and career satisfaction for staff.

6.49 HA is therefore committed to supporting the healthcare workforce with high quality training, including providing specialty training for doctors, nurses and allied health professionals, and scholarships for overseas training.

6.50 HA's education and training programmes mainly fall under three categories –

(a) Professional Training – HA provides professional training for medical staff, nurses and allied health professionals. For instance, HA supports clinical teaching for medical students (Years 4 to 6) through collaboration with the medical schools of the two local

universities.   HA offers the majority of specialist medical training in Hong Kong (such as on-the-job training, training rotation and simulation training) based on the guidelines of HKAM.   HA also runs nursing schools to provide Registered Nurses and Enrolled Nurses training;

(b)   Post Graduate and Specialised Service Training – given the rapid medical developments, HA is committed to providing service related professional training.   It has established the Institute of Health Centre in 1998 to coordinate and organise clinical professional training for healthcare professional at all levels; from beginner's level for new graduates to advanced or specialty level for specialist practitioners.   HA also provides overseas training programmes and sponsorship schemes to help build up a competent workforce; and

(c)   Soft Skills – HA has put in place a number of competency-based training programmes to reinforce its four corporate values, namely People-centred Care, Professional Service, Committed Staff and Teamwork.   Examples of these programmes, which focus on the soft side of a healthcare worker's skills, include "Better Patient Communication", "On-the-job Coaching", "The 7 Habits of Highly Effective People", and "Building Wellness at Work".

Resources for Training and Development

6.51   Along with its strategic direction to support staff through high quality training and development (*HA Strategic Plan 2012-17*), HA has allotted significant resources to healthcare professional and service related training. Much of this is "On-the-job training" that integrates with HA service provision and associated budgets.   This makes full quantification of resources utilised for such training and development purposes within HA difficult.

6.52   As a reference, additional funding from Government specifically allocated to HA for training[27] totalled around $300 million in 2011-12, and reached $500 million in 2012-13 and $600 million in 2013-14 cumulatively.

6.53   Another indication on the extent of training and development activities undertaken by HA can also be obtained from the following statistics-

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[27]   Using 2010-11 as base year

	Internal Training Days	**Local Training Days**	**External Training Days**	**Total Training Days**	**Total Training Days per Head count**
Medical	5,367	5,367	23,690	34,424	5.86
Nursing	121,085	14,690	5,996	141,771	5.95
Allied Health	32,622	3,302	2,938	38,862	5.85
Management	3,894	979	575	5,448	2.38
Others	31,383	1,643	224	33,250	1.09
Total	**194,351**	**25,981**	**33,423**	**253,755**	**3.67**

Note:

- Statistics of 2013-14
- Internal training days – official release to attend internal classroom training recorded in HA's e-Learning Centre.
- Local and Overseas training days - study leave taken recorded in HR records.
- Excludes internal training not recorded in e-Learning Centre and "On-the-job training"

OBSERVATIONS ON HA'S TRAINING WORK

6.54   Promoting, assisting and taking part in the education and training of healthcare professionals is a statutory function of HA, and supporting staff through high quality training is a key focus area.   To this end, HA takes a leading role in the training and development of Hong Kong's healthcare workforce and has, together with its training partners, put in tremendous efforts to establish structured programmes of professional training to ensure that healthcare professionals are competent and skilled.   Taking opportunities to further enhance these programmes will help HA continue to support the healthcare workforce with high quality training and to meet the service related challenges going forward.

Training Opportunities

6.55   As stated in paragraph 6.17 – 6.22 above, HA faces the challenges of shortage of doctors, nurses and allied health professionals (though with a smaller magnitude for the latter two).

6.56   The unmatched supply of clinical professionals has made it difficult for HA to cope with the escalating service demand.   This naturally creates a sub-optimal situation, adversely impacting both service delivery and training. Decisions on staff release for training must be balanced with service needs.   The

duration of the training, particularly for overseas training, is also reduced.

6.57   Staff shortages also mean fewer available trainers can spare time for conducting training activities, especially during office hours. This adversely impacts HA's training capacity.   All along, HA will consider opening up training opportunities to non-HA clinical professionals if the training is of benefit to clinical service providers outside HA and its internal training requirements are fulfilled.   With the reduced training capacity as mentioned earlier, HA has to reserve the training opportunities to cater for HA's internal demand and therefore resulting in less training opportunities available to external partners.

6.58   The staffing situation is expected to begin to improve when the number of annual local medical graduates increases to 320 in 2015 and further to 420 in 2018.   Besides, there is also increased number of graduates in nursing and allied health professionals in recent years and the situation will improve similarly. It is therefore anticipated that training opportunities will increase in the following years.

Views from the Public Engagement Programme

6.59   While not being the main area of concerns in the Public Engagement Programme, stakeholders, both within and outside HA, did express different views on HA's work on training.   Staff raised their concerns on the shorter training time, fewer overseas training opportunities and the lack of transparency in the selection process.   There were also views that HA should strengthen collaboration with its strategic partner, e.g. HKAM, in planning and developing training programmes and that sufficient resources should be earmarked for performance of training duties as well as facilitating staff relief.

6.60   Some considered that the current operation in HA over-emphasised service delivery but overlooked the need to upgrade professionalism.   There was a need to enhance training so as to improve the quality of services provided by healthcare staff.   To enhance emphasis on training, some suggested the establishment of a committee on training under the HA Board and a dedicated budget on training.

SC's Considerations

6.61   Members note HA's work on training and also the stakeholders' views on the subject.   While the SC acknowledges that the current manpower shortage inevitably imposes limitation on HA's ability to increase training opportunities substantially in the near future, there exist areas for improvement.

These include better planning for training programmes taking into account the development needs of different disciplines and/or specialties, as well as providing greater parity in the selection process for training.

6.62   **Recommendation 6:** the SC **recommends** that –

(a)   HA plays a key role in training and developing future generations of healthcare professionals in Hong Kong.   To ensure it performs this function effectively, HA should enhance its role in central planning and provision of training.   More specifically, HA should set up a high-level central training committee under the HA Board to set overall training policy, allocate designated resources for training, and oversee implementation of the policy within HA; and

(b)   Mechanism on selection of candidates for training should be put in place to enhance transparency and facilitate career development.

CHAPTER 7   COST EFFECTIVENESS AND SERVICE MANAGEMENT

OVERVIEW

7.1   As a statutory body providing public hospital services in Hong Kong, HA is required, under section 4c(vi) of the HA Ordinance (Cap 113), to ensure its accountability to the public for the management and control of the public hospitals system.   How to deliver service at a cost-effective manner and manage service through an optimal service delivery model are therefore important topics for HA to address.   This chapter reviews the approaches adopted by HA on cost effectiveness and service management.

COST EFFECTIVENESS

Background

7.2   HA is the major healthcare service provider in Hong Kong, providing over 90% of inpatient medical care and 31% of primary care[28].   In 2013-14, of the 7.2 million population in Hong Kong, around 3.1 million used HA's services. With its key role in the Hong Kong healthcare system, HA's total expenditure amounted to $49.6 billion in 2013-14 which represented some 2.3% of the Gross Domestic Product of Hong Kong. Hong Kong is rated as the most efficient healthcare system among the 48 economies covered in a study conducted by Bloomberg in 2013.   Hong Kong compares favourably with other developed countries in important health indices such as infant mortality rate and life expectancy at birth[29].

7.3   HA has put in place performance management mechanisms to ensure its accountability to the public for the management and control of the public hospitals system as required under the HA Ordinance (Cap 113).   HA has accordingly developed appropriate performance management tools to -

(a)   measure service performance;

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[28]   Based on "Thematic Household Survey Report No. 50" Census & statistics Department, January 2013.

[29]   Based on "Demographic Trends in Hong Kong 1981 – 2011" published by Census & Statistics Department, (http://www.censtatd.gov.hk/hkstat/sub/sp150.jsp?productCode+B1120017), Hong Kong's infant mortality rate in 2011 was 1.3 while that for Singapore, Sweden, Switzerland and Germany was 2.0, 2.1, 3.8 and 3.6 respectively.   The life expectancy at birth for Hong Kong for both sexes in 2011 (80.5 years for male and 86.7 years for female) also compare favourably to advanced economies such as Japan and Sweden.

(b)   identify areas with effective and efficient performance as well as areas requiring improvement; and

(c)   provide reference on service planning and resource allocation.

7.4   There are three major performance monitoring tools in HA –

(a)   *COR*:   The Controlling Officer's Report (COR) of the annual Estimates of Expenditure for the Health Branch of FHB, which forms part of the Government's annual Estimates of Expenditure, sets out HA's key activity targets and indicators in support of policy objectives related to public healthcare services.   In this respect, HA's performance is measured against pre-set targets and, where applicable, performance pledges.

(b)   *KPIs*:   HA has a wide range of quantitative KPIs.   They reflect the outcome of major initiatives taken and drive service improvement through performance benchmarking.   More details about the KPIs are covered in the ensuing section.

(c)   *Performance monitoring of funded programmes*: Performance outcome of initiatives receiving funding is measured against pre-set targets or deliverables formulated through the annual planning exercise.

7.5   There are both internal and external aspects of performance monitoring in HA.   Internal performance monitoring measures include the following –

(a)   *At Board level*: Quarterly reports on the achievement of annual plan targets are submitted to the HA Board at its open meetings, while progress reports on KPIs are submitted to the HA Board at monthly interval.

(b)   *At HAHO level*: KPIs, including service targets covered in the COR of FHB, are reported to the Directors' Meeting [30] at monthly intervals.

(c)   *At Cluster level*: Quarterly reports on the performance of KPIs and funded programmes are submitted to the Cluster Management

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[30]   The Directors' Meeting is a weekly forum for HA's top management to discuss and consider matters of strategic and significant implications in HA. It is chaired by the Chief Executive/HA with all Directors and Heads and CCEs as members.   It is also attended by the HA Chairman.

Meeting[31], which is the major platform for HAHO to monitor cluster performance.

7.6   Externally, HA provides FHB with a Quarterly Progress Review Report which summarises HA's service performance on KPIs and progress of funded programmes.   To the public, apart from the service targets covered in FHB's COR, HA also publishes its targets for major funded programmes in the HA Annual Plan.   The HA Annual Report also provides an overview on HA's performance for the year under report.   Moreover, as a major public organisation, HA is answerable to enquiries from the legislature, district councils, media and members of the public concerning service performance.

KPIs

Major objectives of the KPI System

7.7   Before the formal establishment of HA's KPI framework, performance monitoring in HA was primarily based on the service targets contained in the COR which reflected HA's input, output and cost of the services. In order to define and measure progress towards organisational objectives and priorities, HA developed a set of KPIs in 2008 to measure service performance, particularly in the aspects of quality and efficiency.

7.8   The major objectives of HA's KPIs are to –

(a)   provide a mechanism for strategic monitoring, taking into consideration corporate priorities;

(b)   identify areas to drive service improvement continuously; and

(c)   enhance accountability on resources spent.

The KPI Framework

7.9   As illustrated in the diagram below, there are three pillars under HA's KPI framework, namely clinical services, human resources and finance.

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[31]   Cluster Management Meeting is a meeting chaired by the Chief Executive/HA with individual cluster to monitor its performance and advise on strategic or priority issues in relation to cluster's services.
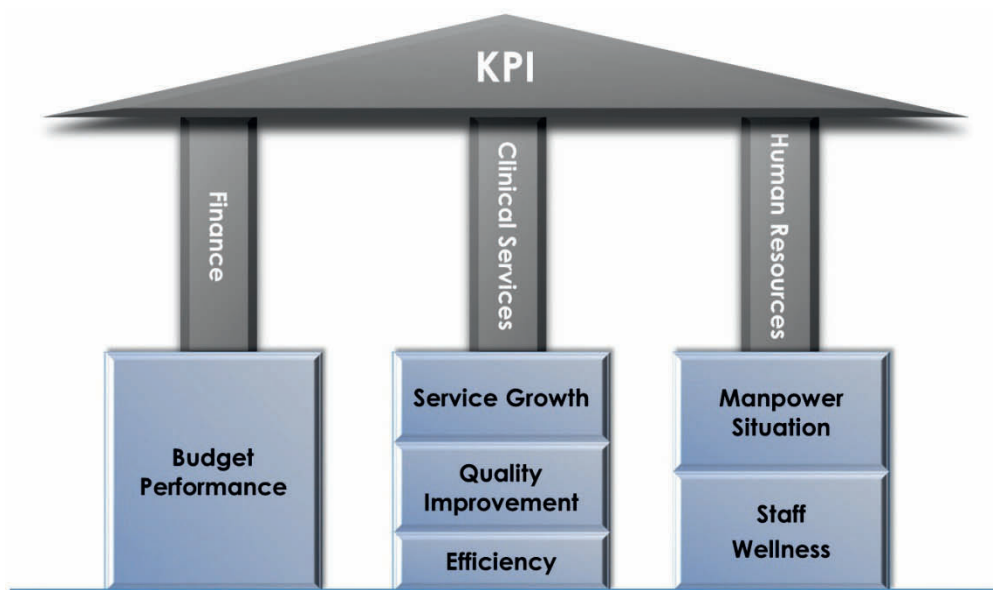
7.10   For clinical services, the three key dimensions for monitoring are service growth, quality improvement and efficiency, which are regarded as the fundamental elements for assessing clinical service performance. For human resources management, the major dimensions are manpower situation and staff wellness which can help HA track the human resources situation so that a stable workforce can be maintained for effective delivery of services. For finance, the major dimension for monitoring is budget performance which ensures that HA's spending is contained within resources obtained. A list of the KPIs is at **Annex 8**.

7.11   Each of the three pillars is supported by a collection of KPIs. HA selects the KPIs with regard to a number of criteria, including the availability of automated data that is reliable and comparable across clusters, relevance to the overall KPI framework, impact on service outcome and cost efficiency, and burden of diseases in clinical services. The KPIs can be broadly classified into three types according to their functions –

    (a)   KPIs with pledge and target, e.g. waiting time for A&E attendance for Triage categories I, II and III;

    (b)   KPIs to benchmark and drive improvement across clusters, e.g. waiting time for treatment of different diseases (like Cancer and Cataract Surgeries), outcome of treatment (like percentage of diabetes mellitus and hypertension patients with specified clinical conditions); and

    (c)   KPIs to reflect outcomes of major initiatives for monitoring and reporting, e.g. average length of stay for psychiatric inpatients,

waiting time for total joint replacement and cataract surgeries.

Interpretation of KPI reports and Driving for service improvement

7.12　　　KPIs provide important management information that sheds light on HA's performance in key service areas by facilitating self and cross-cluster comparison.　This helps identify areas that warrant deliberation and formulation of enhancement and improvement plans by management teams at hospital cluster and HAHO levels.

7.13　　　Experience shows that the KPIs have brought about reductions of performance variation between clusters, as well as improvement on HA's overall services.　Some examples are illustrated below –

(a) *Percentage of patients indicated for surgery on hip fracture with surgery performed ≤ 2 days after admission through A&E*
The cluster with the lowest performance improved from 50.0% for the period from July 2008 to June 2009 to 66.1% for the period from April 2013 to March 2014; and the HA overall average improved from 63.0% to 70.7% in the same period; and

(b) *Percentage of Diabetes Mellitus patients with HbA1c[32] < 7%*
The cluster with the lowest performance improved from 29.0% for the period from July 2008 to June 2009 to 56.8% for the period from April 2013 to March 2014; and the HA overall average improved from 33.8% to 48.9% in the same period.

7.14　　　To ensure that the KPI framework and the KPIs selected are kept abreast of service directions and priorities, HA conducts regular review of the framework and individual KPIs[33].　HA has also conducted an internal audit on its KPI Framework in late 2013 and found that it has adopted an appropriate and systematic approach in the development of its KPIs.　This approach, combined with the established structures and processes for consultation, reporting and monitoring, helps ensure that HA's KPI system has largely achieved its stated objectives.

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[32] HbA1c refers to glycosylated haemoglobin which is a form of haemoglobin to measure the level of blood glucose over prolonged period of time.　It is an important measurement for the effective control of blood glucose level for diabetes mellitus patients.

[33] A KPI Review Working Group chaired by HA's Director (Cluster Services) was established in 2010 to conduct such regular review.

EVALUATION ON COST EFFECTIVENESS

Views from the Public Engagement Programme

7.15   During the Public Engagement Programme, stakeholders who have expressed views on the subject generally agreed that it was important to have a mechanism to ensure cost effectiveness of HA's operation.   Some considered that the role of HA Board should be enhanced as a managing board in order to manage and monitor HA's performance more effectively.   Some clinical staff, on the other hand, voiced concerns that KPIs had added burden to their workload with many reporting requirements and administrative duties so generated.

SC's Considerations

7.16   The SC notes HA's efforts in performance management and the major performance monitoring tools in place including COR, KPIs, and the performance outcome monitoring of funded programmes.

7.17   SC Members consider that the purpose of drawing up KPIs is to drive improvement and achieve corporate goals.   In order for the KPIs to be useful, the SC sees the importance for the HA Board to play an active role in setting key standards and targets and monitor the performance.   This is particularly the case when the HA Board is a managing board which has to lead HA's operation and continuously drive better performance.

7.18   While the SC agrees that the KPI system has been useful for driving service improvements and facilitating alignment in cluster performance, some Members comment that the quantitative nature of some individual KPIs might inadvertently encourage comparison, and at times competition, across clusters thereby causing stress on frontline staff in attaining the KPI targets.

7.19   Members also note that while the COR focuses on HA's key activity targets and indicators in support of policy objectives and measures throughput and cost of HA's services, KPIs are introduced to measure *key* performance aspects in terms of quality and efficiency through performance benchmarking.   As KPIs are intended to measure *key* performance aspects, they should be limited in number and general in nature for easy comprehension for both staff and the community. While HA could develop more sophisticated indicators like dashboards to facilitate internal management, it should have a simple set of KPIs for overall performance monitoring and public accountability purposes.

7.20   In particular, the KPIs should be refined and enhanced so as to help inform the management on areas for examination and improvement to better

address service demand and management, as well as facilitate service planning and resource allocation.

7.21   On the whole, the SC considers that HA's existing KPI system is a useful and essential performance monitoring tool, though there is room to refine individual KPIs to better address service demand and management, facilitate service planning and resource allocation, and drive best practices.

RECOMMENDATION

7.22   **Recommendation 7:** the SC **recommends** that –

(a)   The HA Board, being a managing board, should play a more active role in setting key standards and targets to –

(i)   monitor the overall performance and service provision for public accountability; and

(ii)   facilitate management decision to improve performance and drive best practices; and

(b)   HA should enhance and refine the KPIs in 2015 to better address service demand and management, facilitate service planning and resource allocation, and drive best practices among various specialties, hospitals and clusters.

SERVICE MANAGEMENT

Background

7.23   The volume of services provided by HA is enormous, with annual attendance at A&E amounting to 2.2 million, SOPC 7.0 million and number of patient days (including inpatient and day inpatient services) 8.0 million in 2014-15. Apart from the need to ensure cost effectiveness of HA operation, the SC also recognises the importance to consider the way HA manages its service given the enormity in volume as well as coverage.   This includes, in particular, the way HA ensures the quality of the service and the effectiveness of the service delivery mode in the light of the changing service needs and medical development.

Service Quality

7.24 *"To use hospital beds, staff, equipment and other resources efficiently to provide hospital services of the highest possible standard within the resources obtainable"* is the commitment of HA enshrined in section 4 of the HA Ordinance (Cap 113). Continuous improvement of professional and service quality is therefore one of HA's missions.

7.25 To this end, HA established the Division of Quality and Safety in 2006 at HAHO level to explicitly lead the development of clinical quality assurance systems and coordinate their implementation across HA. Clusters have also set up mirroring structures in the following years to drive the implementation of safety and quality systems and improve the quality of care in their respective hospitals.

7.26 HA's overall strategies and approach in ensuring professional and service quality focus on the following domains –

    (I)   People
    (II)   Facilities
    (III) Technology
    (IV) Systems
    (V)   Service Access

(I) People

7.27 HA commits to delivering quality healthcare service through supporting its workforce with education and training opportunities. HA is the major training ground for undergraduates and interns of medical, nursing, and allied health disciplines. It also collaborates with HKAM to provide accredited training for both basic and higher medical trainees. For nurses and other clinical professions, HA provides the platform for clinical practicum offered by universities and other tertiary institutes. Details of HA's work on training have been set out in Chapter 6.

Clinical Management Teams

7.28 Through its well-structured clinical management teams, HA executes robust clinical governance for continuously assuring and improving the quality and standards of its services.

7.29 A clinical management team is a structured assembly of multi-disciplinary healthcare professionals providing medical services to patients

under a team approach.   Such an approach allows close supervision of staff in their daily practices as well as provides a mechanism for peer review of performances, based on which duties can be assigned according to an individual's experience and competence.   The clinical management team is also responsible for conducting quality assurance activities such as mortality and morbidity meetings and clinical audits.

7.30   The heads of all clinical management teams within an individual clinical specialty are represented in their respective HA-wide COC, which, together with CC, work to improve professional care.   One notable example of how COCs/CCs take the lead in clinical governance is the Surgical Outcome Monitoring and Improvement Programme.   That programme is an organisation-wide clinical outcome monitoring programme conducted annually under the leadership of COC(Surgery).   Audits and evaluations of different kinds are also conducted in other specialties, e.g. outcome evaluation of Integrated Discharge Support Programme for Elderly Patients led by the Geriatrics Subcommittee under COC(Internal Medicine), Management of Intensive Care Unit Services audit led by COC(Intensive Care Unit), etc.   Clinical indicators that can help inform the level of performance and draw attention to areas warranting improvement are also developed by COCs/CCs and some have subsequently been incorporated into HA's KPIs, e.g. HbA1c level in diabetic care.

Credentialing

7.31   Modern healthcare has become increasingly complex and technology laden and many of the latest interventions demand sophisticated skills and competence.   Credentialing is considered another valuable tool to ensure service quality on top of the existing clinical governance system.

7.32   Credentialing refers to the formal process used to verify the qualifications, professional training, clinical experience and other relevant professional attributes of healthcare professionals for the purpose of forming a view about their competence and professional suitability to provide safe, high quality healthcare.   The defining of the scope of practice follows credentialing. It refers to the mechanism to define an individual healthcare professional's practice based on credentials, competence and performance.

7.33   In April 2014, the Medical Services Development Committee of the HA Board endorsed the proposed framework for credentialing and defining scope of practice in HA to promote patient safety and professional competence.   The framework outlines HA's approach of adopting activity-based credentialing, under which specific procedures/intervention will have their credentialing criteria, in terms of qualifications and training and experience requirements.   Professional

staff fulfilling the relevant criteria will be allowed to perform the concerned procedures/intervention independently. Given their established role in clinical governance, there is an advantage for COCs/CCs to be actively engaged in selecting procedures for credentialing and designing credentialing requirements, while HAHO sets the policy, prioritises procedures for credentialing and approves credentialing submissions at corporate level.

7.34　　　　With the above framework developed in due course, HA will engage professional staff and work with cluster credentialing committees to develop priorities and agenda of credentialing. HA is also maintaining communication with HKAM and the Professional Colleges during the process.

(II)　Facilities

7.35　　　　People aside, HA also continuously improves its facilities to serve the community better and to cater for the foreseeable increase in demand and service needs.

Increasing Capacity, Hospital Redevelopment and Construction

7.36　　　　HA modernises its facilities and increases the bed capacity having regard to factors such as the growing and ageing population in Hong Kong, changes in demand for public healthcare services, the standards required of modern medical equipment and the wear and tear of existing healthcare facilities. The number of beds provision in HA has increased from 27,041 in 2010-11 to 27,645 in 2014-15, mainly in pressure areas like KEC and NTWC.

7.37　　　　Apart from increasing bed capacity, HA also plans for and pursues redevelopment of existing hospitals. HA reviews the conditions of the structures and facilities of its public hospitals annually. The outcome of the annual review informs the order of priority and estimates of expenditure for implementing minor maintenance and improvement works in the coming years. Over the years, funding approvals were obtained from the Legislative Council to carry out a number of major capital works in public hospitals, such as expansion, redevelopment and refurbishment of existing hospitals including the Queen Mary Hospital, United Christian Hospital, Kwong Wah Hospital and Caritas Medical Centre. Moreover, projects to construct new hospitals, such as the Tin Shui Wai Hospital and the Hong Kong Children's Hospital, are underway. The Government has also announced in the 2015 Policy Address that it would pursue the construction of a new acute general hospital in the Kai Tak Development Area.

High Volume Centres

7.38　　　New facilities can bring new concepts that could better serve the community.　For public services with high demand, such as cataract surgery, the specialty of Ophthalmology has worked to find measures to shorten waiting time for the service.　Amongst these was the development of designated Cataract Surgery Centres.　The first Cataract Surgery Centre set up at the Grantham Hospital is equipped with a purpose-built operating theatre designed to cater for operations performed in an ambulatory setting.　The unique design of the facility allows significant reduction in the turnover time between operations, resulting in efficiency gain and increased throughput.　With the success of the Grantham Hospital Cataract Surgery Centre, the second centre was set up at the Tseung Kwan O Hospital.

7.39　　　The total joint replacement centres at the Hong Kong Buddhist Hospital and the Yan Chai Hospital were set up under the same high volume centre concept.　In light of the success of these centres and to cater for the increasing demand for joint replacement surgery, a third centre at the Pok Oi Hospital was established in 2014-15, and a fourth one at the Alice Ho Miu Ling Nethersole Hospital will be set up in 2015-16.

Other Facility Enhancements

7.40　　　Enhancing facilities for patients with special needs is another focus of HA's service quality improvement.　To comply with the United Nations Convention on the Rights of Persons with Disabilities, HA has improved its barrier free access in all newly constructed facilities, as well as existing facilities with major renovations designed and completed after December 2008.

7.41　　　Additionally, after the epidemic of SARS in 2003, HA has worked to ensure that isolation facilities within its hospitals are up to standard to prevent transmission of infectious diseases that are airborne in origin.　As of December 2014, HA has 680 isolation rooms with a capacity of 1,457 isolation beds.

(III)　Technology

7.42　　　HA strives to modernise technology to improve patient care through more precise diagnosis, less invasive intervention and more effective treatment. The SC reckons that technological enhancement can also help increase HA's productivity and efficiency.

Novel Technologies

7.43   The SC notes that HA has introduced many novel technologies over the last decade.   These include Robotic-Assisted Prostatectomy, Spine Navigation Surgery, and frameless radiotherapy.   Moreover, HA also conducts ongoing reviews and efforts to reinforce its Drug Formulary to include new drugs that are more effective and with less side effects.   Examples include target treatment for cancer patients, new generation epileptic drugs, etc.

Digital Medicine

7.44   Apart from medical science, there are other areas of technological advancement that contributes to quality improvement in HA's clinical care.   For example, the Filmless HA project which adopts the latest digital technology allows clinicians to view radiological images via the Clinical Management System and Electronic Patient Records platform.   Benefits are multi-fold –

(a)   overall operational efficiency is increased and the turn-around time is shortened, thereby reducing patients' waiting time;

(b)   improved image availability and capability provides better support for making clinical decisions; and

(c)   occupational safety is enhanced as the conventional labour intensive processes associated with older technologies could now be eliminated.

Technology Assessment

7.45   The rapid development in medical research has resulted in proliferation of new technologies in the areas of equipment, drugs, medical devices and digital medicine.   New health technologies have great potential benefits but not all such technologies are evidence-based and cost-effective. Inappropriate introduction and use of new technologies may create risk and burden to patients.   They can also often be expensive, imposing a heavy strain on healthcare resources.

7.46   HA has therefore put in place a robust assessment mechanism to support evidence-based decision-making in considering whether a new technology should be adopted.   There are technology committees under COCs and at the cluster level to provide a platform to deliberate safety and efficacy issues, the strategy of technology adoption and the procurement of suitable medical equipment.   HAHO plays a coordinating role in these discussions.

(IV) Systems

7.47　　　　HA has also put in place systems to identify, analyse and manage risk.

Clinical Risk Assessment

7.48　　　　HA implemented the Sentinel Event Policy in 2007 to strengthen the reporting and management of serious medical incidents.　This Policy was extended into the Sentinel and Serious Untoward Event Policy in 2010.　The Policy defines sentinel event as an "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof" and serious untoward event as an "unexpected occurrence which could have led to death or permanent harm".

7.49　　　　Sentinel events, serious untoward events and other medical incidents are reported through HA's Advance Incident Reporting System, a web-based electronic platform which has streamlined the capture, analysis and follow-up of such incidents.　With the support of the Advance Incident Reporting System, incident demographics and other related data can be analysed to identify opportunities to prevent recurrences of the incidents.

7.50　　　　All sentinel events/serious untoward events are investigated.　HA will set up a Root Cause Analysis panel to identify root causes and contributing factors of reported incidents, and make recommendations for improvement and risk management.　Being an accountable and transparent organisation, HA reports all sentinel event/serious untoward events in a quarterly newsletter that is available to both staff and the public.　HA also organises half-yearly Patient Safety Forums for staff to foster mutual learning and sharing.

Complaint Handling

7.51　　　　HA has a two-tier complaint system to handle patient complaints. All complaints are handled initially by the hospital/clinic concerned. Complainants who are not satisfied with the outcomes could appeal to the central Public Complaints Committee of the HA Board for review.

7.52　　　　The Public Complaints Committee is responsible for deciding all appeal cases.　It comprises members from different sectors of the community, who are non-executives and are not employees of HA.　By virtue of its independence, the Public Complaints Committee handles all complaints fairly and impartially and would also make recommendations to HA.　Details of the complaint handling system and relevant statistics are published in the Annual

Report on Public Appreciation, Feedback & Complaints Management for public information.

Hospital Accreditation

7.53　　　　HA launched the Pilot Scheme of Hospital Accreditation (Pilot Scheme) in 2009 in collaboration with The Australian Council of Healthcare Standards, an international accrediting agent.　The Pilot Scheme (first phase) was completed in 2011 with five public hospitals attaining full accreditation.　The Pilot Scheme laid the foundation for HA's development of a set of internationally accredited Hong Kong standards and the nurturing of the first batch of local surveyors for accreditation.　HA has launched the second phase of the Pilot Scheme and expects that a total of 20 HA hospitals will be accredited upon its completion by 2015.

7.54　　　　Hospital accreditation has helped HA modernise and benchmark itself against international best practices on many fronts.　One notable improvement was in the area of instrument disinfection and sterilisation.　Others include the phasing out of the practice of reusing higher risk single use devices, the introduction of document control, surgical instrument tracking and tracing, and care planning and evaluation.

(V)　Service Access

7.55　　　　Timely access to clinical services is an issue of clinical as well as community concern.　As far as the domain of service access is concerned, waiting time for A&E, elective surgeries, radiological investigations, cancer treatment and SOPC are amongst the areas attracting the greatest attention among the community.

Demand Problems

7.56　　　　Waiting time is essentially the result of demand and capacity imbalance.　The increasing healthcare demand is attributed to Hong Kong's ageing population and rising prevalence of chronic illnesses.　Inadequate gatekeeping at the primary care level also adds pressure on the public hospital system in Hong Kong.

Capacity Issues

7.57　　　　Medical manpower shortage remains a crucial factor for the existing waiting time problem concerning HA services.　Although the situation will begin to alleviate when the number of local medical graduates increases from 250 to 320

and 420 in 2015 and 2018 respectively, the shortage will likely remain in certain specialties such as ophthalmology and anaesthesia, where the staff turnover rate is high. Moreover, by 2020, the projected number of retiring doctors in HA will increase to around 70, which is three times as much as around 20 in 2014. Sub-specialisation in modern medicine has also brought along new demand-capacity imbalance in, for example, the field of clinical genetics and infertility treatment.

Governance and Monitoring

7.58   HA currently monitors waiting time through the COCs of relevant specialties. HAHO plays a coordinating role and oversees the development of strategies and their implementation. Waiting time statistics are included in HA's KPIs, reportable to and monitored by Cluster Management Meeting and the HA Board. Those with significant disease burden and public concern are also required to be reported to FHB under the COR.

Measures to Manage Waiting Time

7.59   HA has been implementing measures to manage waiting time, including the following –

(a)   *Retention and Attraction of Medical Staff:* HA has introduced initiatives for staff retention including implementation of new career structure; enhancement of promotion prospects; enhancement of training opportunities; and recognition of excessive overnight call duties. Supporting workforce including phlebotomist services and clerical support have also been strengthened to alleviate the workload of medical staff.

(b)   *Temporising Measures:* HA has engaged about 330 part-time clinicians to assist in providing services as of March 2014. The Special Honorarium Scheme has also been enhanced to facilitate operation of extra service sessions to meet operational needs of individual hospitals. Since 2012, HA has commenced the recruitment of non-local doctors to practise with limited registration in HA as one of the additional measures to address the manpower shortage.

(c)   *Designated Centres:* As mentioned before, by setting up designated high volume centres for cataract surgery and total joint replacement, the notional waiting time for cataract surgery in HA has been reduced from over 44 months to below 16 months and the number of joint

replacement operations per year has increased by 75% to about 2,800 cases from 2008-09 to 2013-14.

(d) *PPP:* By using a co-payment model, HA first adopted PPP in 2008 for patients requiring cataract surgeries and has been successful in bringing down the cataract surgery waiting time. The Tin Shui Wai Primary Care Partnership Project engages private practitioners in the region to provide primary care services for HA patients in the locality. This successful model is now being extended to other parts of Hong Kong under the General Outpatient Clinic PPP (GOPC PPP) Programme. Piloted in Kwun Tong, Wong Tai Sin and Tuen Mun since the first quarter of 2014, the GOPC PPP Programme aims to help HA manage demand for GOPC service, enhance patient access to primary care services, provide choice to patients for receiving primary care services from the private sector, promote family doctor concept, and foster the development of the territory-wide electronic health record. Meanwhile, the Pilot Project on Enhancing Radiological Investigation Services through collaboration with the private sector allows patients to have radiological scans in chosen private service providers to expedite their care process. The programme is well received and the eligibility coverage has been extended from four to eleven cancer groups. The Haemodialysis PPP increases HA's dialysis service capacity and enhances patients' choices of location for receiving treatment. In 2014-15, 200 HA patients received the service in six community haemodialysis centres.

(e) *Enhance Transparency:* HA recognises the importance of enhancing transparency in waiting time to enhance public accountability and confidence. HA has by phases uploaded SOPC waiting time information on HA's website, covering all eight major specialties (namely ENT, Gynaecology, Medicine, Ophthalmology, Orthopaedics & Traumatology, Paediatrics, Psychiatry and Surgery) since 30 January 2015. The information will facilitate patients' understanding of the waiting time situation in HA and assist them to make informed decisions when considering whether they should pursue cross-cluster treatment.

(f) *Cross-Cluster Collaboration:* To let more patients benefit from cross-cluster referral arrangement according to patients' preferences, HA has reminded frontline staff to accept new case bookings from patients residing in other clusters. In February 2015, HA has launched a poster on the procedures and practice on the booking of first appointment at SOPC for the information of both the public and

staff.   Apart from allowing patients to voluntarily book appointments at SOPCs in other clusters, HA has, since 2012, enhanced cross-cluster collaboration by establishing a centrally coordinated mechanism to facilitate pairing-up patients in clusters of longer waiting time with clusters of shorter waiting time.   Patients with appropriate clinical conditions waiting in a suitable specialty of a cluster will be invited to attend SOPC in another cluster with shorter waiting time.   So far, the cross-cluster collaboration is being implemented in the specialties of ENT, Gynaecology, and Ophthalmology.

(g)   *Collaboration with Family Medicine:*   Noting that many patients referred to SOPC could indeed be dealt with at primary care level, HA explored using Family Medicine to help attend to these patients. One successful example is the Low Back Pain clinic.   Patients referred to SOPC suffering from low back pain are screened and managed by Family Medicine Specialists.   Using protocolised care, many patients can be discharged within a few visits, while those with sinister conditions are referred to SOPC in an expedited manner.

(h)   *Improved Management Tool:*   HA has developed an electronic referral system to facilitate clinicians in making referrals to SOPC. The information collected also helps better business analytics and keeping track of patient needs.   To help improve queue management in each SOPC, HA has also developed a new management tool to provide comprehensible visual analysis of the queuing pattern.

Evaluation on Service Quality

Views from the Public Engagement Programme

7.60   In the Public Engagement Programme, the area that stakeholders were most interested in as far as service quality is concerned was the level of or accessibility to services.   Some considered that the long waiting time, particularly for SOPC services, was the most important problem of HA.   Others found A&E and inpatient services insufficient as well and the resulting long time that a patient had to wait at A&E departments before getting admitted into an inpatient ward (the "access block" problem) was unsatisfactory.   Some attributed the difficulties in alleviating the waiting time problem to the lack of coordination and the perceived "sectarianism" among specialty services or clusters.

7.61   In the public fora, attendees raised a number of specific views on HA's services, ranging from the telephone appointment system in GOPC to the

drug dispensary services. Generally speaking, while they appreciated the quality of services provided by HA, they called for enhanced level of services in various aspects in order to meet the rising demand.

SC's Considerations

7.62   The SC notes that HA is already taking measures on professional and service quality and the initiatives are comprehensive covering the relevant key aspects of people, facilities, technology, system and service access. However, Members receive the clear views raised by stakeholders on waiting time and access block and their strong request for improvement measures. In particular, the long waiting time for SOPC services in selected specialties and the disparity of the waiting time among clusters have been an ongoing concern of the public. For instance, the 90th percentile waiting time for routine cases in Orthopaedics and Traumatology is more than two years and has often been cited as an area of concern. SC Members have also got first-hand experience of the waiting situation and congestion in certain hospitals when they conducted visits to the seven clusters and selected public hospitals during the Public Engagement Programme. The SC considers that variance in waiting time among clusters may have aggravated the perception of "sectarianism". The SC thus identifies service access as one of the top priority issues that HA should address.

7.63   All in all, while HA's efforts to improve the quality and level of services are commendable, the SC is of the view that there are areas on waiting time and access block that HA needs to do more.

Recommendation

7.64   **Recommendation 8:** the SC **recommends** that –

(a)   HA should implement a comprehensive plan to shorten waiting time for SOPC and A&E services with a view to enabling timely access to medical services and minimising cross-cluster variance in waiting time; and

(b)   HA should coordinate with relevant specialties to address the serious access block problem in A&E Departments in concerned hospitals.

Mode of Service Delivery

7.65   The comprehensive spectrum of acute, rehabilitation and community healthcare services of HA are delivered mostly by multi-disciplinary teams and spanning different stages of care, from primary care and specialist care through to

end-of-life care and across different settings.   The key services include the
following –

(a)   *Primary Care* – primary care services are delivered mainly through
       HA's GOPCs and Community Health Centres developed in recent
       years.   As at December 2014, 71 GOPCs and two newly launched
       Community Health Centres (in Tin Shui Wai and Tung Chung) are in
       operation.   The services are primarily targeted at the elderly, low
       income families, and patients with chronic illnesses.

(b)   *SOPCs* – there are currently 47 SOPCs delivering specialist
       consultation, treatment and investigation for patients referred by
       GOPCs or private practitioners as well as patients discharged after
       in-patient care.   All cases newly referred to SOPCs are triaged to
       ensure that patients with urgent conditions requiring early
       intervention are treated with priority.

(c)   *Hospital Care* – there are currently 42 public hospitals/institutions in
       HA supplying a total of around 27,600 beds mainly for the delivery
       of acute and convalescent care.   Among these, 17 are acute hospitals
       each with an A&E Department to provide consultation and treatment
       to patients requiring emergency service.

(d)   *Community Care* – HA also delivers a range of community-based
       outreach services to provide support for discharged patients, in
       particular elderly patients, to help them recover in the community.
       These include the Community Nursing Service, Community Geriatric
       Assessment   Team   Service,   Community   Psychiatric   and
       Psycho-geriatric Services, and Community Allied Health Services.

Key Challenges in Service Delivery

7.66   Two major trends in the demographic structure and disease
epidemiology of Hong Kong are posing great challenges to HA in its service
delivery.   These two key challenges are ageing population and rising incidence of
chronic diseases.

Ageing Population

7.67   Our population is ageing fast.   In 1993, 9% of our population was
aged 65 or above.   The number increased to 15% in 2014 and is expected to rise
further to 26% in 2031 and 30% in 2041.

7.68   The impact of the fast growing elderly population on HA services is illustrated below –

(a)   Older people require more healthcare services, particularly the public services which are highly subsidised.   In 2012, elderly people (aged 65 or above) made up around 14% of the Hong Kong population, yet they accounted for about 37% of the GOPC attendances and around 50% of all hospital bed days in HA;

(b)   The relative risk of an elderly person being hospitalised in general specialties is about four times that of a non-elderly person according to HA data;

(c)   Elderly patients have longer cumulative hospitalised days than non-elderly patients.   For general specialties' inpatient services, the average hospitalised days is 14.2 per year for elderly patients and 6.0 per year for a non-elderly patient; and

(d)   Total resources spent on elderly patients (aged 65 or above) amounted to around 46% of HA's total expenditure in 2013-14.

7.69   Given the above, the SC notes that the demand for and cost of HA services will rise as the number of older patients continues to increase, particularly for inpatient services.

Burden of Chronic Diseases

7.70   Concomitant with population ageing is an increasing occurrence of chronic illnesses.   Analysis of leading causes of death indicates that cancer, diseases of the heart, pneumonia, cerebrovascular diseases, respiratory diseases, and renal diseases are the main causes of mortality in the elderly population, accounting for almost 80% of deaths in this age group in 2013[34].   In addition, diabetes mellitus and hypertension are two other chronic diseases that are common risk factors for heart disease and stroke and contribute to a large proportion of inpatient days.   All of these, save for pneumonia, are chronic conditions, and they pose a major burden to the healthcare system.

7.71   It is projected that between the period from 2012 to 2017, the number of patients treated for diabetes mellitus in HA will increase by 29% from 427,000 to 549,000; the increase for those with hypertension is 29%, from 1,163,000 to

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[34]   Source: "Number of Deaths by Leading Causes of Death by Sex by Age in 2013", website of the Centre for Health Protection http://www.chp.gov.hk/en/data/4/10/27/340.html

1,498,000. For patients with coronary heart disease, the projected increase is 26%, from 205,000 to 258,000.

Service Models in Response to Ageing Population

7.72   To ensure the service delivery could be innovated and improved to be more attuned to meeting the expanding and evolving needs of the ageing population, HA has formulated a Strategic Service Framework for Elderly Patients to guide the future development and delivery of healthcare services for older persons.

Risk-stratified Care

7.73   Formulated through a highly interactive and broad engagement approach and published in 2012, the Strategic Service Framework for Elderly Patients emphasises wellness of patients. It aims at minimising the need for hospital admission and readmission as the new models of medical care for older patients. This involves strengthening of multi-disciplinary integrated care, patient and carer empowerment, and collaboration with community stakeholders. The focus is on providing appropriate care based on the stratified risk of individual patients according to their conditions –

(a)   For the large volume of older patients with early, mild and stable chronic diseases, the focus of healthcare delivery is on supported self-care through patient education and empowerment.   HA has also reserved elderly quotas for GOPC services for patients aged 65 or above to cater for their episodic illnesses and to enhance their accessibility to primary care services;

(b)   As regards older patients with multiple chronic diseases, more holistic and structured care is provided through an integrated disease management approach.   This entails the development of coordinated services for multidisciplinary management of the chronic conditions with discharge support and regular follow-up at an ambulatory or outpatient setting; and

(c)   For the comparatively smaller group of highly complex older patients who have severe impairments arising from complications, more intensive care is delivered through enhanced care coordination in the form of case management.   This involves the coordination of a wide spectrum of healthcare, social care, and support services for high risk patients requiring multi-professional intervention, as elaborated in the following paragraphs.

Integrated Care for High Risk Older Patients

7.74   HA has developed an "integrated care model" that enables targeted use of resources on elderly patients identified with high risk and those with complex needs requiring more intensive management.   Coordinated care and support will be provided on need basis.   Key components of the model are as follows –

(a)   Early comprehensive assessment of older patients admitted to Medical wards is conducted by designated staff (usually nurses) so as to identify their care and social support needs.   High risk older patients who are likely to have unplanned readmission are also identified;

(b)   The designated staff will perform early discharge planning and formulate individualised care plans for the high risk older patients with multi-disciplinary input so that post-hospital support would be delivered in subacute, ambulatory and community settings based on the patients' needs;

(c)   For patients suffering from functional decline (e.g. as a result of stroke or falls) and in need of more intensive rehabilitation and comprehensive geriatric care, they may be referred to the Geriatric Day Hospitals for rehabilitation therapy, medical consultation and nursing care as required through a multi-disciplinary approach.   As for patients who require continual intensive rehabilitation and care at home after discharge, community-based allied health and nursing services will be arranged to deliver them with comprehensive and coordinated outreach services based on a case management approach;

(d)   For older patients who require social support upon discharge, HA has partnered with NGOs through contractual arrangement for the latter to provide timely home support services.   Services include personal care, home-making and modification, provision of meals, transportation, "elder sitter" services, escort, and transitional residential respite care;

(e)   For patients living in old age homes who are frail and at high risk of unplanned readmission, the Community Geriatric Assessment Teams will provide outreach services of comprehensive multi-disciplinary care at the old age homes.   Community Geriatric Assessment Teams

will also provide training and support to the old age home staff to enhance their skills in taking care of the elderly residents;

(f)   HA has also taken measures to engage older patients and their carers to enable them to participate and make shared decisions related to their care.   This is achieved through supported self-management (e.g. medication management) via the Community Health Call Centre and SmartPatient website; and by working with NGOs to provide patient education and empowerment; and

(g)   There are also improved service networks with community partners, including General Practitioners, NGOs, the Department of Health's Elderly Health Service, and the Social Welfare Department to enhance service continuity and appropriate transitional care for older patients.

Service Models in Response to Burden of Chronic Diseases

7.75   Recognising that poorly controlled chronic diseases will lead to complications while optimal management will delay disease progression and improve the quality of life for patients and carers, HA has adopted a chronic diseases management model focusing on the following inter-linked elements –

(a)   Proactive multi-disciplinary teams for provision of comprehensive care based on disease-based protocols;

(b)   Self-management support for better health outcomes by empowering patients to manage their own health; and

(c)   Mobilising community resources to meet the needs of patients.

Multidisciplinary Team Providing Protocol-driven Care

7.76   HA has set up multi-disciplinary teams comprising nurses and allied health professionals at selected GOPCs in all clusters to identify early complications and delay disease progression for chronic disease patients, particularly those with diabetes mellitus and hypertension.   Patients will receive structured assessment, risk stratification and targeted interventions by the multi-disciplinary teams led by primary care doctors.   The assessment and intervention process, known as the Multi-disciplinary Risk Factor Assessment and Management Programme, is guided by disease-based protocols developed for standardisation of care.   Programme evaluation has revealed positive clinical outcome and greater satisfaction among patients.   HA will extend this service

delivery model to cover chronic disease patients attending the SOPCs in the coming years.

Self-management Support

7.77   HA collaborates with NGOs in the delivery of a patient empowerment programme to improve chronic disease patients' knowledge of the diseases and enhance their self-management skills.   A multi-disciplinary team of healthcare professionals has developed different sets of teaching aids and materials for common chronic diseases and provided training for the staff of participating NGOs to organise and deliver the patient empowerment programme. The programme currently covers high prevalence chronic illnesses like diabetes mellitus and hypertension.   HA is considering extending it to cover other common chronic diseases such as heart disease and chronic respiratory disease.

Mobilisation of Community Resources

7.78   HA has established collaborative networks with local NGOs and community partners to provide comprehensive care support for chronically ill and older patients who are living in the community.   For example, besides providing telephone support for disease monitoring, the Community Health Call Centre facility at the Tang Shiu Kin Hospital also links high risk older patients and chronic disease patients to ambulatory and community care services, including primary care clinicians and NGOs.   The programme currently covers older patients and those patients with diabetes mellitus.   HA will continue to explore the use of Community Health Call Centre service to support patients with other types of chronic disease so as to optimise its role.

7.79   As mentioned in paragraph 7.59(d) among the PPP initiatives, HA also implements a new GOPC PPP Programme on a pilot basis in Kwun Tong, Wong Tai Sin and Tuen Mun to subsidise clinically stable patients having hypertension with or without hyperlipidemia, and later diabetes mellitus patients who are currently under the care of GOPCs, to have their chronic conditions and episodic illnesses followed up by private doctors participating in the programme. Through this programme, patients can be looked after by a chosen family doctor in the community for monitoring of disease and continuity of care.   HA will explore to extend the programme to other needy districts based on evaluation results of the programme.

Capacity Development to Cater for Growing Service Demand

7.80   It is projected that HA has to increase its service throughput by an average of at least 2% every year in order to cater for the increasing demand. Compared to end March 2014, it is estimated that an additional of 2,300 and 8,800 public hospital beds will be needed by 2021 and 2031 respectively as the population ages at an accelerated pace in the next two decades.

7.81   In response, HA has increased the provision of around 580 additional beds in the three years from 2012-13 to 2014-15. With the one-off grant of $13 billion approved by the Legislative Council Finance Committee in late 2013 for HA to improve and upgrade its facilities through minor works projects over the next ten years, HA will provide an additional of around 800 beds in the coming years.

7.82   At the same time, HA has been implementing and planning a number of hospital development and redevelopment projects as mentioned in paragraph 7.37.

Cluster Clinical Services Plans

7.83   To guide the hospital development and redevelopment projects, HA formulates Clinical Services Plans on a cluster basis to map out the respective future service delivery models of a cluster and delineate the roles of each hospital within the cluster. HA has taken the opportunities to incorporate new service models to respond to population ageing and increasing burden of chronic diseases, as well as to minimise the need for unnecessary hospitalisation.

7.84   HA prepares Clinical Services Plans through a structured and extensive process of staff engagement and consultation. It takes due account of the special features and environment of each cluster and set out their clinical strategies and service models. Clinical Services Plan was first drawn up for HKWC in 2013, and then for KEC in 2014, while clinical services planning is currently underway for KCC and NTEC.

7.85   Using the HKWC Clinical Services Plan as an example, the new service models emphasise a major shift in service delivery towards ambulatory care services such as day surgery. It also highlights the merits of enhancing subacute care to help reduce the need for acute services.

Ambulatory Care Model

7.86 Ambulatory care model embodies a new philosophy that complex, sophisticated health services can be provided in ambulatory settings that are more orientated to the needs of patients. The evolution of minimally invasive procedures and the technologies enable complex procedures to be performed without the need for an overnight admission.

7.87 Under the ambulatory care model, services are organised in such a way that individual patients can see their healthcare team in a single visit, or at the very least during the course of one day, and that their multiple health issues can be addressed by a multidisciplinary approach. In addition to assessment, treatment and investigation, a team may also offer advice on self-management such as fall prevention, exercise, nutrition, vision, degenerative joint disease, etc. which will contribute to better management of diseases and minimising unnecessary hospitalisation.

Subacute Care

7.88 As transpired in the completed Clinical Services Plan for HKWC, there is also an orientation towards subacute or step-down care such as convalescent and rehabilitation services for patients who no longer require acute care. This direction on the one hand helps relieve the pressure on acute hospitals, and on the other hand highlights the importance to have a clear definition of roles of various hospitals within a cluster, particularly with regard to subacute care like rehabilitation services and palliative services.

7.89 For example, in the HKWC Clinical Services Plan, the role of Tung Wah Hospital and Grantham Hospital with regard to the provision of subacute services for their respective districts has been enhanced which would help alleviate the workload pressure of Queen Mary Hospital being the major acute hospital in the cluster. Tung Wah Hospital is positioned as a subacute hospital for the Central and Western District with a focus on rehabilitation for patients with multiple morbidities as well as ambulatory services. As for Grantham Hospital, it will serve as an academic ambulatory care centre and will provide subacute services for the Southern District.

7.90 Ward patients in Queen Mary Hospital who no longer require acute care but still need a certain extent of inpatient medical attention and nursing intervention will be transferred to Tung Wah Hospital or Grantham Hospital depending on their district of residence. Other suitable patients in need of subacute care may also be transferred directly to these two hospitals from the Medical Assessment and Planning Unit to be set up in Queen Mary Hospital,

which is a short-stay unit providing rapid assessment and, if necessary, acute intervention for emergency patients presenting to the A&E department. This arrangement will help facilitate early discharge from acute care and reduce the need for unnecessary admission to an acute hospital.

Evaluation on Mode of Service Delivery

Views from the Public Engagement Programme

7.91   Stakeholders in general found that it was necessary for HA to consider ways to manage the significant demand for healthcare services. Some considered that ageing population and increasing chronic diseases highlighted the need for HA to enhance its work on rehabilitation services and extended care services. HA could also strengthen step-down care and community partnership such as collaboration with the welfare sector to minimise the need for admissions to hospitals. Enhancing patient support through, for example, services of day centres or home visits could facilitate early discharge of patients with stable medical condition and alleviate the overcrowded Medical wards. Some considered that the collaboration should be extended to the private sector so as to make use of the capacity of the latter through introduction of more PPP programmes.

7.92   Some found that GOPC services should be enhanced so as to alleviate the pressure on A&E Departments. HA should draw up plans to monitor the service demands in different point of service delivery and adjust and enhance service capacity as appropriate. New service delivery model through, say, reviewing the arrangement for acute and convalescent wards, should also be considered to cater for the medical needs of elderly patients. Meanwhile, the working relationship between HA and the Department of Health should be strengthened so as to provide better services for the public.

SC's Considerations

7.93   The SC notes that the model of service delivery adopted by HA has been evolving and that HA has been mindful of the need to adjust and develop the model in response to the changing environment, particularly the key challenges of population ageing and increasing burden of chronic diseases. Facing with these challenges, the SC reckons that there are areas that HA could work on further.

7.94   SC Members consider that it is important to have a plan to provide comprehensive medical care for patients. This is particularly important for elderly patients as there has already been a very high utilisation of public hospital services at present and that elderly patients are more prone to hospitalisation

which usually lasts for a longer period than that of non-elderly patients.   In this connection, the SC is of the view that HA should explore ways to provide a coordinated step-down care at the community level for easing the burden of public hospital services.   Members also note the importance of more coordination and cooperation among public (notably HA and the Department of Health) and private healthcare service providers as well as the welfare sector with a view to tapping any spare capacity in the private sector and ensuring holistic support for discharged patients in general and elderly patients in particular.   Also, PPP programmes are areas where HA should explore more in order to utilise the capacity of the private sector in easing the burden on public sector.

7.95   To assess whether HA's services are sufficient or effective, the views of the service recipients (i.e. patients) are indispensable.   The SC considers that HA should put in place effective mechanisms to take into account patients' feedback in formulating its service plans as well as improvement measures where necessary.

Recommendation

7.96   **Recommendation 9:** the SC **recommends** that –

(a)   HA should enhance its service capacity and review its service delivery model to better prepare itself to meet the challenges of the ageing population;

(b)   Specifically, HA should enhance step-down care, strengthen ambulatory services, and enhance partnership with non-governmental organisations and the private sector with a view to providing comprehensive healthcare and support for patients, in particular elderly patients;

(c)   HA should actively work with the Department of Health and the welfare sector on healthcare services to promote and enhance primary care and rehabilitation services in non-hospital setting.   The objective of this new model of care is not only to make better use of the resources but also to address the needs and provide better care for patients, in particular elderly patients, in an ageing society; and

(d)   HA should ensure an effective mechanism is in place to take into account patients' feedback for service planning and improvement.

CHAPTER 8   OVERALL MANAGEMENT AND CONTROL

OVERVIEW

8.1   The primary function of HA, as set out in section 4 of the HA Ordinance (Cap 113), is to *manage and control* public hospitals in ways which are conducive to, among other things, using resources efficiently to provide hospital services of the highest standard within the resources obtainable.   Apart from the aspects of cost effectiveness and service management which have been covered in Chapter 7, it is also essential for HA to establish an effective risk management and internal control system to ensure that quality public healthcare services are provided as per HA's objectives.   This chapter reviews HA's overall management and control arrangement, focusing on risk management and ensuring effective system of internal control.

8.2   Since its establishment in 1991, HA has put in place a framework of measures (the Framework) through which it directs, controls and holds the organisation accountable.   This Framework, which has been refined to meet the ever changing environment and rising public expectation over the years, comprises the following three key elements –

   (a)   **Structure** – a proper organisation structure established at all levels with clearly defined roles and responsibilities, delegation of authority and accountability;

   (b)   **Systems/Processes** – systems and processes for cost-effective control of key results areas and risks; and

   (c)   **People** – competent and committed people are held accountable for the results and systems.

THE FRAMEWORK

I.   Structure

8.3   The overall structure established by HA on management and control covers three key components at different levels -

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(a)   at the corporate governance level, the HA governing body, namely the HA Board and its committees, is responsible for giving leadership and strategic direction, controlling the organisation, supervising the executive management, and reporting on stewardship and performance of HA;

(b)   at the management and operations level, the executive management of HA led by the Chief Executive/HA, with delegated responsibilities and authority from the HA Board, is responsible for managing HA's operations for the purpose of fulfilling HA's stipulated functions and achieving its objectives; and

(c)   to provide independent assurance, both internal and external auditors monitor HA's compliance with relevant legal requirements and policy objectives and provide independent oversight on various aspect of HA operation including financial statements and other key performance information.

II.   Systems and Processes

8.4   The HA Board has established systems and processes to direct and control HA's operations.

Planning

8.5   Strategic planning in HA plays an important role in providing the overall direction to address key challenges and to ensure that HA's operations are effective and efficient.   The Five-Year Strategic Plan 2012 – 2017 provides the framework for clinicians and executives to align their programme initiatives in the service planning process, and guides the development of HA's annual plans within the five-year period.

8.6   As discussed in Chapter 5, HA prepares an Annual Plan each year to support the actions outlined in the Strategic Plan.   The Annual Plan sets out key objectives, service priorities and programme targets and provides a basis for detailed services, resources and budget planning.   Both the Annual Plan and the associated budget, which are approved by the HA Board at the beginning of each financial year, serve as an important management tool for subsequent performance monitoring.

Policies and Procedures

8.7   The HA Board establishes overarching policies to guide and provide boundaries for the executive management to implement the approved plans and manage HA's operations.   Examples of these overarching policy frameworks include the HR Policy Manual; the Financial Accounting Manual; the Procurement and Materials Management Manual; and the Capital Works Procedural Manual.   HA will conduct periodic review to ensure that the existing policies remain relevant and appropriate.   HA will also develop new policies where necessary.

Systems

8.8   There exists an array of systems to support HA's operations, minimise risks and achieve its objectives.   For example, as discussed in Chapter 7, HA has established a system of clinical governance for the continuous assuring and improvement of quality and standards of services.   The COCs and CCs set HA's clinical standards, advise on strategic service planning and perform a crucial role in conducting clinical audits, pursuing best practice and developing innovative quality improvement programmes.   The COS, on the other hand, is the overall manager of a clinical specialty department responsible for service delivery and development, planning and budgeting, quality assurance and staff development.

8.9   As another example, HA has progressively developed sophisticated information technology systems and an extensive network supporting its corporate-wide operations throughout the territory.   These information technology systems serve not only as enablers driving efficient use of resources through automation, but also as tools to facilitate more effective control by minimising manual interventions and providing timely and relevant information support for performance monitoring.

Monitoring and Reporting

8.10   To ensure that services are delivered in line with its strategies and goals, HA has drawn up monitoring and reporting mechanisms.   Such mechanisms help generate reference information for performance monitoring which facilitates identification of areas warranting improvements.   Examples of such mechanisms include an HA-wide Patient Satisfaction Survey and Sentinel and Serious Untoward Events reporting.   There are also other regular accountability reports on specific subject matters, such as Report on the Operation of Samaritan Fund, and the HA Provident Fund Scheme Governance Report.

Auditing

8.11   Clinical auditing plays a significant role in the overall management and control framework.   It seeks to improve patient care and outcomes through systematic review.   It is a standard-based tool, measuring the patient care and services provided against evidence-based standards.   Wherever there is a gap between existing practice and the best practice, HA works to narrow it.   In areas without agreed good practice criteria, HA will adopt an outcome measurement approach (outcome-based).   Being a peer review activity under the umbrella of clinical governance, clinical audits are conducted by clinicians at the hospital/cluster level, and through COCs and CCs at the HA-wide level.

8.12   In HA's largely decentralised environment, the monitoring component of the Framework is reinforced by an independent internal audit function.   HA's Internal Audit Unit conducts a planned programme of audits to evaluate and improve the effectiveness of internal controls, risk management, and governance processes across the organisation.

III. People

8.13   HA has established processes to ensure that staff employed are with the right competencies and experience, and are provided with appropriate training to develop their skills and keep pace with the ever advancing technology and increasing sophistication of service delivery.   In addition to technical competencies, HA also promulgates and promotes its core values – People-centred care, Professional service, Committed staff, Teamwork – to support its vision, shape the corporate culture and instil these values to staff.   A culture of patient safety and quality improvement is among the critical components in HA's continuous drive to improve healthcare quality.

8.14   HA also attaches importance to integrity and ethical behaviour of its staff and has accordingly established a Code of Conduct applicable to all HA staff. The Code describes how the organisation and individual staff should behave in work relationships, dealings with external organisations and in the use of public funds.   Compliance with the Code is an integral part of HA's employment terms.

Credentialing

8.15   As covered in Chapter 7, HA has drawn up a framework for credentialing to verify the qualifications, clinical experience, professional training and other relevant professional attributes of healthcare professionals to assess their competence, performance and professional suitability to provide safe and quality services.   Under this system, only professional staff fulfilling the credentialing criteria will be allowed to perform the procedures/intervention independently to ensure the safety and quality of healthcare services provided.   HA will engage professional staff to develop priorities and agenda of credentialing.

INTERNAL CONTROL AND RISK MANAGEMENT

Systems of Internal Control

8.16   As can be seen from the Framework above, HA has established internal control systems and they collectively provide reasonable assurance on the achievement of the objectives; reliability of internal and external reporting; and compliance with applicable laws and regulations and internal policies.

8.17   In addition to the Internal Auditor who conducts independent audits within HA, HA also engages external consultants from time to time to conduct reviews that help it strive for continuous improvement.   Relevant recent reviews include a review of HA's Management and Control Framework in 2011; a review of the overall Corporate Governance arrangements in 2011-12; and a review of Clinical Governance in 2012.

Risk Management

8.18   Aside from system of internal control, risk management is another important aspect in the overall management and control in HA.

8.19   All activities involve risk that must be managed.   This is particularly true for healthcare organisations, where risks are inherent and the stake is high. It pervades every element of the service chain, both clinical and non-clinical.   In this respect, HA's risk management goals are to –

      (a)   minimise the likelihood of possible events that have negative consequences for patients, staff and the organisation;

(b)   minimise the risk of death, injury and/or disease for patients, employees and others as a result of the services provided;

(c)   enhance patient outcomes;

(d)   manage and protect resources effectively; and

(e)   support legislative compliance and ensure organisational development.

8.20   The SC notes that HA's risk management journey commenced over ten years ago with the introduction of a high level risk framework and accompanying policy.   There have been ongoing enhancements since then, contributing to the establishment of HA's risk management culture and with the first HA-wide risk profile compiled.

8.21   HA's current risk management model comprises clinical risk management (e.g. medication incidents, etc.) and non-clinical risk management (e.g. finance, information technology, facilities, treasury, etc.).   In both aspects of the management model, there are systems in place to identify, analyse and manage risk, often at departmental level.   As discussed in Chapter 7, staff report incidents through the Advance Incident Reporting System.   And with the alert messaging function now introduced, more speedy and timely notification of sentinel and serious untoward events for reporting to the senior management is enabled. "Near Miss" event reporting has also been added since early 2013 to identify issues with potential harm to facilitate early intervention.

8.22   HA will aggregate risks identified at department level to produce hospital/cluster-wide risk registers and develop risk profiles for reporting to the respective HGC.   At the corporate level, HA develops a consolidated organisation-wide risk profile showing its key corporate risks for reporting to the respective committees of the HA Board.   Such information also forms the basis for the establishment of important risk reduction programmes to implement corrective strategies.

EVALUATION ON OVERALL MANAGEMENT AND CONTROL

Views from the Public Engagement Programme

8.23   Stakeholders from both within and outside HA were interested in the overall management and control arrangement.   Those outside, notably patients

and the general public, were particularly concerned about the clinical outcome. They expected safer services and fewer medical incidents.

8.24   Those within HA, while concerned about the outcome, also provided views on the process.   Some frontline staff pointed out that while COS in some specialties carry out merely administrative functions, others adopt a more proactive role in clinical monitoring and governance.   The different approach by individual COS would affect training and adoption of advanced technology and treatment protocol in different specialties in different hospitals.   They considered that the role of COS should be clearly defined particularly in clinical governance given the team work nature of many clinical duties.

8.25   During the meetings with staff, some expressed concerns over the layering of specialties/services committees including COC/CC/HAHO level committees and the HA Board committees.   They considered that such arrangement resulted in time consuming process and more administrative work for clinical staff in seeking endorsement from each of these layers before any service proposals could be implemented.   Clinicians saw some scope for streamlining the consultation process to facilitate clinical service development in HA.

SC's Considerations

8.26   The SC notes that HA's overall control framework to support its operations and minimise risks to achieve its objectives through structure, systems/processes and people is generally robust and elaborate.   Members also note that COCs play a significant role in ensuring professional service quality, including setting standard of services, preparing clinical guidelines, conducting clinical risk assessment and advising on technology adoption and enhancement.

8.27   Despite the key role of COCs, SC Members find that the clinical governance functions of individual COCs vary in different specialties, and clinical governance practices might also differ among clusters.   Given the size and many functional units of HA, Members reckon that the audit and control functions of HA and the role of COCs in clinical governance should be strengthened to ensure service quality and safety.   Some Members also suggest that the role of COS should be reviewed with greater emphasis on clinical governance.

8.28   Noting that modern healthcare has become increasingly complex and technology laden, Members share the view that apart from performance monitoring, it is also important for HA to put in place proper and standardised credentialing arrangement.   The COCs, with their established role in clinical governance on their respective disciplines, should have a strengthened role in

identifying procedures for defining scope of practice and setting standards and aligning requirements.

8.29 The SC agrees that clinical auditing contributes positively to the overall management and control framework and in improving patient care and outcomes through systematic review. In this connection, the SC appreciates that HA has been undertaking useful initiatives like the Surgical Outcome Monitoring and Improvement Programme to monitor clinical outcome. As service quality is a major aspect of HA's overall management and control, the SC considers that there is room for enhancement in the assessment and monitoring of clinical competence and service outcome, e.g. through peer review process in different specialties, in order to attain further service quality improvement.

8.30 While the number of medical incidents is relatively small compared to HA's overall service throughput, any occurrence of such incidents is a great concern to the public. The incidents may also reflect possible systemic problem in certain area. While the SC supports HA's existing approach in carrying out investigations into the root cause of medical incidents, it recommends enhancing the learning and sharing culture within HA with a view to preventing repeated occurrence of medical incidents. And such learning should not just be confined to the clinical aspect; other aspects like communication with and support for patients should also be strengthened where appropriate.

Recommendations

8.31 **Recommendation 10:** the SC **recommends** that –

(a) HA should strengthen the roles of COCs on clinical governance, including the development of clinical practice guidelines, services standards, introduction of new technology and service development plan for its respective specialty to achieve more standardised service quality and treatment and to ensure safety;

(b) HA should review the role of COS with greater emphasis on clinical governance;

(c) HA should review the inter-relationship of COC/CC and various services committees with a view to streamlining internal consultation on annual resource planning and clinical service development. HA should address the concerns of frontline clinical staff and review their administrative workload to ensure they can concentrate focus on their core duty of providing care for the patients;

(d)   HA should, through COCs, develop a system of credentialing and defining scope of practices to ascertain professional competence and to ensure patient safety;

(e)   HA should step up the implementation of clinical outcome audits as a tool to assess and monitor clinical competence and service outcome for seeking service quality improvement; and

(f)   In examining the root cause for the occurrence of a medical incident, HA should strengthen the sharing of lessons learnt among clusters to minimise the possibility of its recurrence, and consider measures to enhance communication with and support for patients.

CHAPTER 9   CONCLUSION

OVERVIEW

9.1   This chapter sets out the deliberations of the SC and the Government on the implementation of the review findings.

9.2   The SC observes that patients and many other stakeholders in general appreciate HA's professional services and quality.   They are however most concerned about the stringent capacity of HA in meeting the public demand for service.   There are strong requests for urgent means to cut the long waiting time at various pressure areas such as the GOPC, SOPC and A&E admissions.   The HA staff, particularly the frontline ones and many other healthcare professionals, also point to the manpower shortage faced by HA which cannot be eased within a short period of time.   They however consider that HA should take measures to streamline the administrative procedures and resource allocation process, enhance transparency and fairness in human resources management, and last but not least, provide better training and career development for staff.   This would alleviate the work pressure on the staff and help retain the talents and maintain the morale in HA.

9.3   With the above in mind, the SC comes up with a list of recommendations to drive HA to improve its operation towards the direction that meet the expectation and needs of patients, stakeholders and staff.   The SC is also mindful that HA should be allowed the flexibility to formulate specific and detailed measures for implementing the recommendations, with suitable engagement with its staff at appropriate stages.   The SC therefore looks to HA to come up with an action plan in no slow time and to the Government to jumpstart the implementation and monitor the progress.

Ultimate Goal : Benefits to the Public Healthcare system

9.4   The purpose of the Review is to find ways to improve the service and operation of HA for the ultimate goal of bringing better healthcare services to Hong Kong.   The most important stakeholders for public healthcare services are undoubtedly HA staff and patients who are the respective providers and ultimate users of the services.   The SC is keen to see that the Review and the implementation of the recommendations would bring about the following benefits –

For Patients

- Better services with shorter waiting time

- Increased service capacity to meet the growing public demand of services

- More efficient use of resources, greater choices and more diverse modes of service delivery to cater for different needs

- More consistent service provision among clusters

- Enhanced safety and quality of services

- Increased sustainability of the development of our healthcare system amid the challenges of increasing cost and ageing population

For HA Staff

- More equitable and transparent resource allocation

- Provision of additional manpower support and resource to pressure areas

- Streamlined administrative and resource allocation procedures

- Greater transparency, consistency and fairness in staff management practices

- Better training and staff development

- Improved clinical governance and more advance service development

IMPLEMENTATION OF RECOMMENDATIONS OF THE REPORT

9.5   In making the above recommendations, the SC is mindful that the recommendations should provide HA with the directions towards which it should implement enhancement measures to improve its operation. HA should be allowed the flexibility to formulate specific action plans for implementing the recommendations, with suitable engagement with its staff at appropriate stages. As proposed by the SC, the Government has set aside additional time-limited resources totalling $1,170 million for 2015-16 to 2017-18, on a one-off basis, on

areas where further financial support would be necessary to facilitate HA in implementing the recommendations, as described in paragraphs 9.6 to 9.13 below.

Enhanced allocation of resources

9.6　　The SC recommends HA to adopt a refined population-based resource allocation model by reviewing the present approach and refining it to take into account the different age groups within the population, as well as the patient population served by HA.　The SC appreciates that it would take time and detailed deliberations to develop and agree on an appropriate methodology for incorporating relevant factors into the refined population-based model.

9.7　　To assess the impact of the proposed change of funding model, HA should conduct an initial review of the population distribution, demographics and healthcare utilisation pattern of difficult clusters to identify those clusters which would receive a higher allocation of resources under the proposed new refined population-based model.　This is to enable the early planning and formulation of catch-up plans to lessen the impact on individual clusters when the change in resource allocation model is implemented in future years.　As a first step, it is found that there is a priority need for topping up funding for three clusters, namely NTWC, NTEC and KEC, so that they can build up the capacity progressively now to serve the growing population demand in their catchment districts before the switch over to the proposed refined population-based funding model.　This echoes the concerns expressed at some staff consultation fora on the under-provision of resources for some hospitals in these three clusters.

9.8　　The Government plans to allocate a time-limited funding of $300 million for the next three years from 2015-16 to 2017-18 to enhance the existing services of these three clusters pending the implementation of the refined population-based funding model.

Enhanced manpower

9.9　　The Government fully shares the concern of the SC and the general public on the insufficient level of services with manpower shortage being a major cause.　Indeed, the successful implementation of a number of recommendations made by the SC (e.g. Recommendation 5 concerning staff deployment, Recommendation 6 concerning training, Recommendation 8 concerning the reduction in waiting time, and Recommendation 9 concerning the enhanced service capacity) hinges on, among other things, a sufficient supply of manpower.

9.10   HA's manpower projection shows that 1,244 of its staff are due for retirement in 2015-16.   In order to address the manpower shortage problem and encourage transfer of knowledge and experience, the Government would allocate to HA a time-limited funding of $570 million for 2015-16 to 2017-18 to re-employ suitable retirees of those grades and disciplines which are facing a severe staff shortage problem, for a specific tenure period to be considered by HA.   For retiring medical staff, it is proposed that they would only be re-employed for clinical duties and not management role, so as to help relieve the staff shortage at the service front without blocking normal career progression.   The re-employment of retirees would also help retain experienced staff for coaching of new recruits, provide staff relief for training and enhance staff training.

9.11   For the longer term, in line with the Government's strategy, HA has adopted a higher retirement age of 65 for new recruits commencing employment on or after 1 June 2015.   For HA staff whose employment commenced before 1 June 2015, their retirement age will remain unchanged at 60.   They can apply for HA jobs in compliance with prevailing recruitment policies, practices and selection process should they wish to continue working for HA after retirement at 60.

Enhanced staff training

9.12   Recommendation 6 sets out that HA should enhance its role in central planning and provision of training.

9.13   The Government agrees that training of healthcare professionals is of paramount importance to sustaining the Hong Kong healthcare system and continued improvement of healthcare services, and that implementation of this recommendation should be given priority.   For this purpose, the Government would allocate a time-limited funding of $300 million for the next three years to HA for enhancing staff training, including strengthening of training support for staff, especially clinical staff, through scholarship, commissioned training programmes, staff rotation development programmes, simulation training courses and provision of additional manpower support for training relief.

PPP

9.14   The Government encourages HA to actively explore measures to reduce the long waiting time in certain specialties.   HA should also review its service delivery model in order to meet the challenges of the ageing population. To this end, the Government would facilitate HA to expand and roll out more PPP programmes to make better and more efficient use of the capacity in the private healthcare sector to help it cope with increase in service demand and enhance patient access to clinical services, before the supply of new medical and allied health graduates is able to catch up with the growth in demand of the public healthcare sector.   The key strategic vision is to achieve an overall improvement in both the waiting time and quality of care for patients by bringing together the resources and expertise from both the public and private sectors, promoting training and sharing of experience and helping to ensure the sustainability of our healthcare system.

9.15   To do so, the Financial Secretary has pledged in the 2015-16 Budget to allocate to HA a sum of $10 billion as endowment to generate investment return for funding HA's PPP initiatives.

9.16   HA would actively explore more clinical PPP opportunities within the strategic vision, try out new concepts with pilot projects and formulate long-term programmes based on the evaluation of the experience and outcome of the pilot projects.

Timetable

9.17   The recommendations contained in this Report set out the overall direction to guide HA to reorganise its internal management structure, refine its resources allocation system and improve its human resource management policy, among other things, so that it is better prepared to handle its immediate and future challenges.   To facilitate HA in implementing these recommendations, the Government has earmarked special allocations where extra resources are called for so that HA can devise detailed plans and operational procedures to implement the recommendations.   To ensure timely implementation of the recommendations of the Report, HA will prepare an action plan within three months with a view to implementing the recommendations within three years.   HA will report progress on the implementation of recommendations to the Food and Health Bureau on a regular basis.

CONCLUSION

9.18   HA has worked strenuously to look after the health of the public. Over the past two decades, HA has grown in terms of its service scope and capacity, and improved in tandem with the advance in medical technology.   Their contribution is well recognised and there is growing public expectation on HA. The purpose of the Review is to take stock of HA's work, and to review and refine its management and operation and set new direction for its betterment.   With the guidance of the views gathered and the recommendations in this Report, we are confident that HA will continue to perform well its role under our twin-track healthcare system as the cornerstone of our public healthcare system and to provide a safety net for all, amid the challenges of an ageing population, increased prevalence of chronic diseases and rapid advance in medical technology.

9.19   Lastly, the Chairman of the SC would like to put on record his sincerest gratitude to all Members for their tireless efforts and tremendous inputs in the conduct of this Review.   Without their active participation and invaluable advice, it would not have been possible to come up with this comprehensive Report for the betterment of the public healthcare services.   The Chairman would like to thank all stakeholders who have put forward their views and participated in the Public Engagement Programme.   Their views have provided constructive inputs for the SC to map out the recommendations.   The Chairman is also truly grateful for the unfailing and professional support of HA in the conduct of the Review.   The support from HA, ranging from provision of background information to professional advice on public healthcare services, has been instrumental to the preparation of this Report.

Membership of the
Steering Committee on Review of Hospital Authority

Chairman
Secretary for Food and Health (Dr KO Wing-man, BBS, JP)

Non-official Members
Professor Alfred CHAN Cheung-ming, SBS, JP
Professor Andrew CHAN Chi-fai, SBS, JP
Ms CHAN Lai-hung
Dr Pierre CHAN (since 7 July 2014)
Dr Kenneth FU Kam-fung (up to 3 July 2014)
The Hon LAM Woon-kwong, GBS, JP
Dr LAU Ka-hin
Ms Connie LAU Yin-hing (up to 14 March 2014)
Professor LO Chung-mau, JP
Dr Kim MAK Kin-wah, BBS, JP
Mr PANG Chak-hau
Mr Tim PANG Hung-cheong
Professor Joseph SUNG Jao-yiu, SBS, JP
Ms Deborah WAN Lai-yau, BBS, JP
Ms Gilly WONG Fung-han (since 24 March 2014)
Mr Jason YEUNG Chi-wai
Dr Andrew YIP Wai-chun

Official Members
Permanent Secretary for Food and Health (Health) (Mr Richard YUEN Ming-fai, JP)
Director of Health (Dr Constance CHAN Hon-yee, JP)
Secretary for Financial Services and the Treasury (or representative) (Ms Esther LEUNG Yuet-yin, JP)
Secretary for Labour and Welfare (or representative) (Miss Annie TAM Kam-lan, JP)

Hospital Authority
Chairman of the Hospital Authority
    (Mr Anthony WU Ting-yuk, GBS, JP (up to 30 November 2013);
    Professor John LEONG Chi-yan, SBS, JP (since 1 December 2013))
Chief Executive of the Hospital Authority (Dr LEUNG Pak-yin, JP)

Report of the Public Engagement Programme

Part One: Introduction

1.1   The services provided by HA touch on every sector of the community. Engagement of stakeholders like HA staff, patient groups as well as the wider public will help provide useful inputs to the review of HA. The SC has therefore conducted a Public Engagement Programme to gauge the public views on HA.

1.2   A consultant has been engaged to assist in the conduct of the Public Engagement Programme through meetings, visits, focus group discussions, individual engagement sessions and public fora.

1.3   This report sets out the process of and the views collected in the Public Engagement Programme.   Part Two of the report outlines the scope of the programme, Part Three summarises the views collected and Part Four gives the final remarks.

Part Two: Scope of the Public Engagement Programme

Engagement Activities

2.1   The Public Engagement Programme ran from January to July 2014. During this period, the SC had conducted a series of activities, namely –

(a)   SC Members held meetings with four major medical and patients' groups in January 2014.   These stakeholders are the Hong Kong Medical Association, HKAM, Hong Kong Patients' Rights Association of the Society for Community Organisation, and Hong Kong Alliance of Patients' Organisations;

(b)   the SC visited HAHO and each of its seven clusters to meet with the HA Board, HAHO staff, cluster management and cluster staff from February to April 2014;

(c)   the SC held stakeholders' fora in March 2014.   A total of 27 organisations, comprising five medical bodies, seven nursing bodies, 11 allied health bodies and four patient groups took part in three sessions of fora;

(d)   the Public Engagement Programme consultant had luncheon meetings with opinion leaders in May 2014.   A total of five sessions of luncheon had been held for these opinion leaders including community leaders, academics and researchers, columnists, electronic media programme hosts, and other media professionals;

(e)   the Public Engagement Programme consultant conducted focus group sessions with representatives from major stakeholders in June 2014. These major stakeholders came from patient groups, healthcare professional bodies, healthcare related NGO, the HGC and the RAC of HA.   In view of the large number of the major stakeholders of HA, we had adopted a stratified random sampling method to select participants for each focus group within the pool of major stakeholders (please see **Appendix A** for details).   A total of 42 representatives from seven patients groups, 12 healthcare professional bodies, ten healthcare related NGOs, and ten Members of HGC and RAC had separately joined four sessions of focus group discussions; and

(f)   the SC conducted public fora in July 2014 with one held in each of

the three regions in Hong Kong Island, Kowloon and the New Territories. A total of 350 members from the public participated in the fora. Participants came from diverse background, including those from Kai Fong Associations, District Councils, patient or concern groups, HA staff and ordinary members of public.

The full list of the engagement activities is in **Appendix B**.

2.2　　　We have undertaken a simple questionnaire survey in the public fora to gauge the participants' overall views on HA. According to the survey, respondents gave a score of 6.3 and 7.0, out of 10.0, for the quality of healthcare services and professionalism of healthcare programme respectively, showing their general positive view of HA's services. The detailed findings of the questionnaire survey are at **Appendix C**[35].

2.3　　　To publicise the Public Engagement Programme and to invite public participation, we have prepared a number of publicity activities –

　　　(a)　　leaflets distributed in public hospitals;

　　　(b)　　advertisements placed in major newspapers;

　　　(c)　　posters displayed in public hospitals, District Offices and Community Halls; and

　　　(d)　　dedicated page under the FHB's website.

2.4　　　We have also received comments from certain stakeholders through emails, petitions, and letters direct, which have been duly incorporated together with views gathered in the engagement activities in this report.

2.5　　　The full list of stakeholders who have provided written views to us is at **Appendix D**.

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[35]　It should be noted that there were constraints in the conduct of the survey through this questionnaire. Firstly, participants in the fora were not a random sample selected to represent the general public. Secondly, the possibility that a respondent might have attended more than one forum and returned the questionnaire more than once could not be precluded. As such, the findings from this survey should be interpreted with caution.

Part Three: Analysis of Views Received

3.1   We have broadly classified the views received during the Public Engagement Programme into the following six areas, which are in line with the priority areas of review of the SC –

      (a)   Management and organisation structure;

      (b)   Resource management;

      (c)   Staff management;

      (d)   Cost effectiveness and service management;

      (e)   Overall management and control; and

      (f)   Others

Management and Organisation Structure

3.2   The first area of stakeholders' views is the management and organisation structure, which is mainly characterised by the HA Board and the cluster arrangement.   HA Board governs HA and the cluster arrangement serves as a system under which HAHO plays a leading, policy, coordination and supporting role to its seven clusters and the frontline delivery of healthcare services.

Cluster Arrangement

3.3   Some stakeholders considered that the role of the HA Board, being a managing board, should be enhanced in order to have a more active and effective management of the organisation.

3.4   Stakeholders generally recognised the need for a cluster arrangement for a large organisation like HA.

3.5   However, noting the disparity in size and number of hospitals as well as the high level of cross-cluster activities in the three clusters in the densely populated Kowloon region, there were calls for reviewing the clustering arrangement for the three clusters concerned.   Some considered that, in drawing up the cluster boundary, HA should take into account the geographical size of the catchment areas, the demographic characteristics of the population as well as the development of healthcare facilities in the areas.

3.6   In particular, the Wong Tai Sin District Council had been urging the Government to review the cluster boundary so as to provide more rationalised and better coordinated services in the region.

3.7   High cross-cluster utilisation was a concern not only of the District Council or the patients, but also of HA staff.   Some staff considered that there was mismatch of services in the three clusters in Kowloon causing problems in referrals and follow-up of cases.

3.8   While some HA staff raised the need for refinement of the cluster arrangement, they cautioned against any drastic revamp of the existing structure or boundary.   They pointed out that frontline staff have taken a long time to develop and operate the referral and service coordination arrangement under the existing clustering system.   Any substantial changes in cluster delineation would affect integrated service provision, involving referral for follow up treatment, rehabilitation services, and outreaching support, etc. for patients after discharge from hospitals.

Coordination of Services

3.9   Patient organisations raised concerns on the inconsistent practices in service provision in different clusters.   Some HA staff opined that all acute hospitals should be equipped with comparable facilities to provide the same basic and standard services to serve the local community, notwithstanding that some acute hospitals were smaller than the others.   There were also views that the communication between HAHO, the clusters as well as hospitals should be enhanced to ensure smooth implementation of corporate-wide policies.

3.10   Some HA staff expressed opinions on the dual role of CCE as the head of the cluster and HCE of the major acute hospital therein, citing concerns of possible perception of large hospitals enjoying greater advantages in resource allocation.   There were, however, also views that a CCE without the portfolio of a HCE might lack hands-on experience in hospital management and this was not conducive to the CCE's discharge of management responsibilities.

3.11   Some suggested that HA should strengthen its coordination role and enhance communication with clusters and hospitals to ensure consistent standard of service and better manpower deployment across clusters/hospitals.

Resource Management

3.12   The second area of stakeholders' views is resource management. HA manages some $50 billion a year and stakeholders have expressed various views on the way such resources should be managed.

Resource Allocation Model

3.13   There were quite a significant number of views expressing concerns on the existing resource allocation model and showing support for a population-based resource allocation approach.   The general perception was that the present model was unfair as the resource allocated to a cluster were not commensurate with service demand which was considered to be related to the number of patients and population in a cluster.   For example, the resources allocated to KEC were the least among the seven clusters on a per capita basis. Kwun Tong and Sai Kung districts covered by KEC accounted for 15.1% of Hong Kong's overall population in 2013.   While 15.5% of HA's patients had ever used KEC service, KEC was only allocated with 10.7% of the total recurrent funding allocated to clusters in 2013-14.

3.14   Some considered that the present resource allocation model often focused only on new money for implementing new services, leaving the inherent "unfairness" in baseline provision among clusters unaddressed.   Many thought that the population-based resource allocation model would provide a fairer and more transparent mechanism in allocating resources.   It would allow resources to match the prevailing service needs rather than historical provision.

3.15   Others however had concerns about a resource allocation model solely based on population size.   Specifically, some were worried that a pure population-based model would not be able to take into account the territory-wide tertiary and quaternary services provided by certain hospitals in selected clusters, the inflow demand for cross-cluster services experienced by certain clusters and the special role of certain hospitals (e.g. teaching hospitals shouldering additional teaching duties on top of service provision).   For example, Queen Mary Hospital provided liver transplant services for patients throughout the territory.   It also served as a teaching hospital of the Faculty of Medicine of the University of Hong Kong.   The same applied to the Prince of Wales Hospital as a teaching hospital for the Chinese University of Hong Kong's Medicine Faculty.   The Hong Kong Eye Hospital at KCC, as another example, served a large number of patients from other clusters.

3.16   Moreover, the resident population in a district did not truly reflect patients' behaviour in seeking medical services as one might choose to receive services from clusters other than the one he/she resided after considering factors like the distance from the workplace, transportation convenience reasons and personal preference.

3.17   Some considered that the resource allocation for the two clusters in the New Territories should take into account the service demand for healthcare services from the cross-border patients.

Procedures in Resource Allocation

3.18   Some HA staff raised concerns on the tedious and complicated procedures involved in bidding new resources.   Some were particularly uneasy with the requirement to obtain clearance from numerous committees and hierarchies at hospital, cluster and HAHO levels for implementing a new initiative, and the requirement to repeat the whole process again next year if the bid in the current year failed.   All these have added to the workload of frontline clinical staff.   Some, however, appreciated the merits of clearing the proposals with the COC for the relevant specialty to ensure consistency and coherence in service provision at the corporate level.

3.19   Some staff were also concerned that the decision-making process of resource allocation was not as transparent as they expected and they did not have a full picture on the rationale and methodology adopted.   There was perception that large hospitals might have advantage as COC chairmen normally came from large hospitals.   Some claimed that the amount of resources actually allocated to frontline services was less than the original approved amount and thus became inadequate, alleging that part of the sum had been used to meet the supporting functions of HAHO and cluster management.

Staff Management

3.20   The third area of stakeholders' views concerns with staff management.   HA has some 70,000 staff and the way HA deals with its human resources management has attracted a number of views, particularly from its staff.

Staff management

3.21   The general sentiments from frontline staff were that there was room for improvement in HR practices.   For example, inconsistencies in HR practices among clusters were observed.   Some pointed out that different cluster had

different arrangement for the granting of study leave and creation of posts. Some considered that HAHO should be equipped with greater authority in coordinating resource deployment and setting direction. In particular, to enhance the collaborative culture within the organisation, HA should consider more staff rotations. HAHO should also attend and oversee the promotion boards of individual clusters to ensure transparency and fairness.

3.22 While different hospitals in the same cluster would perform different roles, some considered that a more flexible flow of staff between clusters/hospitals would provide staff with more training opportunities and exposure and this would help attract and retain staff.

3.23 Some also thought that at present, the spirit of cooperation in providing manpower support between clusters or hospitals was not strong enough in meeting *ad hoc* requirements for additional manpower. There should be some central coordination at HAHO level in deployment of staff across clusters to meet short-term service needs, particularly during crisis or contingent situations.

3.24 Acknowledging the fact that certain specialties might be more popular among medical graduates than others, some opined that more central coordination was needed in the allocation of Resident Trainees to address manpower shortage in these specialties.

3.25 Some, however, saw the merits of allowing individual clusters or hospitals to retain the authority to select staff for them to build their own team. In general, supporting grades were more cautious to centrally-coordinated promotion or transfer as they might not wish to work in other clusters due to possible concerns on transportation and the need to adapt to a new working environment.

Training

3.26 Some staff raised their concerns on the shortened training time and reduced overseas training opportunities and the lack of transparency in the selection process. There were also views that HA should strengthen collaboration with its strategic partner, e.g. HKAM, in planning and developing training programmes and that sufficient resources should be earmarked for performance of training duties as well as facilitating staff relief.

3.27 Some considered that the current operation in HA over-emphasised service delivery but overlooked the need to upgrade professionalism. There was a need to enhance training so as to improve the quality of services provided by

healthcare staff. To enhance planning on training matters, some suggested the establishment of a committee on training under the HA Board and a dedicated budget for training purposes.

Cost Effectiveness and Service Management

3.28   The fourth area of stakeholders' views concerns with cost effectiveness and service management. Some stakeholders expressed a number of views on the appropriate way for HA to deliver services at a cost-effective manner and manage services through an optimal service delivery model.

Cost Effectiveness

3.29   Stakeholders who expressed views on the subject agreed in general that it was important to have a mechanism to ensure cost effectiveness of HA's service delivery.

3.30   Some considered that the role of HA Board should be enhanced as a managing board in order to manage and monitor HA's performance more effectively. Some clinical staff, on the other hand, voiced concerns that KPIs had added burden to their workload with many reporting requirements and administrative duties so generated.

Service Quality

3.31   As far as service quality was concerned, the area that stakeholders were most interested in was the level of or accessibility to services. Some considered that the long waiting time, particularly in SOPC, was the single most important problem of HA. Others found A&E and inpatient services insufficient as well and the resulting long time that a patient had to wait at A&E departments before getting admitted into an inpatient ward (the "access block" problem) was unsatisfactory.

3.32   Some attributed the difficulties in alleviating the waiting time problem to the lack of coordination and sectarianism among specialty services or clusters.

3.33   Some patients considered that the telephone appointment system for GOPC was not easy to use, particularly for elderly patients. The quota for GOPC was not sufficient to cater for the demand of the public either.

3.34   Some were concerned with the long waiting time for drug dispensing in pharmacies.

3.35   All in all, stakeholders called for enhanced level of services in various aspects in order to meet the rising demand.

Mode of Service Delivery

3.36   Stakeholders in general found that HA had to consider an appropriate way to manage the growing demand for healthcare services.   Some considered that HA should enhance its work on rehabilitation services and extended care services in view of the ageing population and increasing chronic diseases.

3.37   Some considered that HA should consider strengthening step-down care and community partnership such as collaboration with the welfare sector to minimise the need for admissions to hospitals.   Enhancing support through, for example, services of day centres or home visits to patients could facilitate early discharge of patients with stable medical condition and alleviate the overcrowded Medical wards in hospitals.   Some considered that HA should collaborate with the private sector so as to make use of the spare capacity of the latter through more PPP programmes.

3.38   Some found that the GOPC services should be enhanced so as to alleviate the pressure on A&E departments.   HA should draw up plans to monitor the service demands in different point of service delivery and adjust and enhance service capacity as appropriate.   New service delivery model through, say, reviewing the arrangement for acute and convalescent wards, should also be considered to cater for the medical needs of elderly patients.   Meanwhile, the working relationship with the Department of Health should be strengthened so as to provide holistic and better services for the public.

3.39   Some suggested that HA should enhance communication with patients and strengthen mechanism to engage patients for feedbacks in order to facilitate service planning and improvement.

Overall Management and Control

3.40   The fifth area of stakeholders' views is overall management and control.   This is related to how HA maintains its risk management and internal control system to ensure that quality public healthcare services are provided.

3.41   Some members of the public were concerned with the medical incidents that happened from time to time. They called for a more transparent and stringent clinical governance system to ensure the quality and safety of services.

3.42   Some clinical staff pointed out that while the COS in some specialties carried out merely administrative functions, others adopted a more proactive role in clinical monitoring and governance. The different approach by individual COS would affect training and adoption of advanced technology and treatment protocol in different specialties in different hospitals. They considered that the role of COS should be clearly defined particularly in respect of clinical governance given the team work nature of many clinical duties.

3.43   Some expressed concern over the layering of specialties/services committees including COC/CC/HAHO level committees and the Board committees. Such arrangement resulted in time consuming processes and more administrative work for clinical staff in seeking endorsement from each of these layers before any service proposals could be implemented. Clinicians saw some scope for streamlining the consultation process to facilitate timely clinical service development in HA to take account of changing service needs and/or medical technology.

Other Views

3.44   During the Public Engagement Programme, stakeholders have raised a wide range of views concerning policy matters relating to the healthcare system in Hong Kong as well as operational matters of HA (please see **Appendix E** for a summary of such views). While not all these views fall within the scope of the Review by the SC, we have taken note of them and will make reference to them when considering the respective policy areas. And for views related to the specific operational aspects in HA, we have relayed them to HA for consideration as appropriate.

Part Four: Final Remarks

4.1   Throughout the Public Engagement Programme, stakeholders, both within and outside HA, have been enthusiastic in voicing their views on HA. While they have pointed out a number of areas for further improvement, most stakeholders appreciated the efforts of HA in providing a wide range of healthcare services to the public at a low cost.

4.2   We thank the views of all stakeholders and have taken due account of their views in formulating the recommendations in the Review on HA.

The Mechanism in Forming the Focus Group

Objective of Focus Group Discussions

We have held focus group discussions to solicit the in-depth views of major stakeholders on HA.

2. In view of the large number of major stakeholders of HA, we have adopted a stratified random sampling method to select participants for each focus group. The sampling method involved partitioning the population of major stakeholders into strata (or homogenous groups) and selecting samples randomly within each stratum to ensure a balanced representation.

Sampling Procedures

3. We first drew up four lists of major stakeholders with frequent interface with HA as follows –

(A) 7 patient groups;

(B) 48 healthcare related professional bodies;

(C) 30 NGOs with close working relations with HA; and

(D) Chairpersons of all 32 HGC and Members of all three RAC of HA.

We also divided the lists into sub-groups as follows –

Groups of Major Stakeholders	Subgroups	No. of Stakeholders in each subgroup
(A) Patient groups	(A1) Alliance of patient groups	3
	(A2) Individual patient groups	4
(B) Healthcare related professional bodies	(B1) Medical professional groups	9
	(B2) Nursing professional groups	13
	(B3) Allied health professional groups	26

Groups of Major Stakeholders	Subgroups	No. of Stakeholders in each subgroup
(C) NGOs with close working relations with HA	(C1) Composite bodies	22
	(C2) Rehab and hospice services	4
	(C3) Specific diseases/disabilities	4
(D) Chairpersons of HGCs and Members of RACs of HA	(D1) HGC chairpersons of hospitals with A&E Service under Schedule 1 to the HA Ordinance (Cap 113)	9
	(D2) HGC chairpersons of hospitals with A&E Service under Schedule 2 to the HA Ordinance (Cap 113)	6
	(D3) HGC chairpersons of hospitals without A&E Service under Schedule 1 to the HA Ordinance (Cap 113)	4
	(D4) HGC chairpersons of hospitals without A&E Service under Schedule 2 to the HA Ordinance (Cap 113)	12
	(D5) Members of Hong Kong RAC*	14
	(D6) Members of Kowloon RAC*	21
	(D7) Members of New Territories RAC*	16

* excluding members who are concurrently HGC Chairpersons.

4.   We then drew up ten to 14 participants from each group for focus group discussions along the ways in the ensuing paragraphs.

(A) Patient groups

5.   We invited two representatives from each of the alliance of patient groups (sub-group (A1)) and one representative from each of the individual patient groups (sub-group (A2)) to attend the focus group discussion on 6 June 2014.   The detailed distribution of invitees and attendees is as follows –

Name of organisations	No. of representatives invited	No. of representatives attended
(A1) Alliance of patient groups		
(1) Hong Kong Alliance of Patients' Organisations	2	2
(2) Patients' Alliance on Healthcare Reform	2	2
(3) Rehabilitation Alliance Hong Kong	2	2
(A2) Individual patient groups		
(1) Hong Kong Patients' Rights Association of the Society for Community Organisation	1	1
(2) Alliance for Renal Patients Mutual Help Association	1	1
(3) New Life Psychiatric Rehabilitation Association	1	1
(4) Mental Health Association of Hong Kong	1	1
Total no. of participants	**10**	**10**

(B) Healthcare related professional bodies

6.   We randomly selected four organisations under each of the three subgroups of healthcare related professional bodies and invited one representative from each organisation to attend the focus group discussion on 13 June 2014.   The detailed distribution of invitees and attendees is as follows –

Name of organisations	No. of representatives invited	No. of representatives attended
(B1) Medical professional groups		
(1) HKAM	1	1
(2) Public Consultant Doctors Group	1	1
(3) Li Ka Shing Faculty of Medicine, The University of Hong Kong	1	1
(4) Faculty of Medicine, The Chinese University of Hong Kong	1	1
(B2) Nursing professional groups		
(1) Association of Hong Kong Nursing Staff	1	1

Name of organisations	No. of representatives invited	No. of representatives attended
(2) Nursing Council of Hong Kong	1	1
(3) Nurses Branch, Hong Kong Chinese Civil Servants' Association	1	1
(4) Hong Kong Public Nurses Association	1	1
(B3) Allied health professional groups		
(1) Hong Kong Radiographers' Association	1	1
(2) Government Medico-Radiological Equipment Technical Staff Association	1	1
(3) Hong Kong Society of Certified Prosthetist-Orthotists	1	1
(4) Union of Hong Kong Speech Therapists (Medical)	1	1
Total no. of participants	**12**	**12**

(C) NGOs with close working relations with HA

7.   We invited four organisations from each of the subgroups of NGOs with close working relations with HA and invited one representative from each organisation to attend the focus group discussion on 20 June 2014. The detailed distribution of invitees and attendees is as follows –

Name of organisations	No. of representatives invited	No. of representatives attended
(C1) NGOs as composite bodies		
(1) Methodist Centre	1	1
(2) Aberdeen Kai-fong Welfare Association Social Service Centre	1	1
(3) Po Leung Kuk	1	1
(4) Evangelical Lutheran Church Social Service - Hong Kong	1	1
(C2) NGOs as rehab and hospice service		
(1) Hong Kong Cheshire Home Foundation	1	1
(2) The Hong Kong Society for Rehabilitation	1	1
(3) Rehabaid Society	1	1
(4) Society for the Promotion of Hospice Care	1	1

Name of organisations	No. of representatives invited	No. of representatives attended
Care		
(C3) NGOs on specific diseases/disabilities		
(1) The Hong Kong Tuberculosis, Chest and Heart Diseases Association	1	0
(2) Lions Kidney Education Centre and Research Foundation, Chan Wong Sau Wah Memorial Renal Dialysis Centre	1	1
(3) Hong Kong Kidney Foundation, Jockey Club Dialysis Centre	1	0
(4) Society for the Relief of Disabled Children	1	1
Total no. of participants	**12**	**10**

(D) Chairpersons of HGCs and Members of RACs

8.   We randomly selected two representatives from each of the seven subgroups of HGC chairpersons and RAC members to attend the focus group discussion on 27 June 2014.   The detailed distribution of invitees and attendees is as follows –

Subgroups	No. of Members invited	No. of Members attended
(1) HGC Chairperson of 9 Schedule 1 hospitals with A&E service	2	2
(2) HGC Chairperson of 6 Schedule 2 hospitals with A&E service	2	2
(3) HGC Chairperson of 4 Schedule 1 hospitals without A&E service	2	2
(4) HGC Chairperson of 12 Schedule 2 hospitals without A&E service	2	2
(5) 14 Members of Hong Kong RAC (excluding Chairpersons of HGC)	2	1
(6) 21 Members of Kowloon RAC (excluding Chairpersons of HGC)	2	1
(7) 16 Members of New Territories RAC (excluding Chairpersons of HGC)	2	0
Total no. of participants	**14**	**10**

List of Activities in the Public Engagement Programme

A) Meetings with Stakeholders

1. 13 January 2014   Hong Kong Medical Association
2. 13 January 2014   HKAM
3. 21 January 2014   HA Board
4. 21 January 2014   Staff of HAHO
5. 29 January 2014   Hong Kong Patients' Rights Association of the Society for Community Organisation
6. 29 January 2014   Hong Kong Alliance of Patients' Organisations

B) Visits to Clusters of HA

1. 24 February 2014
   Session I   NTWC Management
   Session II   NTWC Staff
2. 7 March 2014
   Session I   HKWC Management
   Session II   HKWC Staff
3. 13 March 214
   Session I   KEC Management
   Session II   KEC Staff
4. 14 March 2014
   Session I   NTEC Management
   Session II   NTEC Staff
5. 25 March 2014
   Session I   KCC Management
   Session II   KCC Staff
6. 31 March 2014
   Session I   HKEC Management
   Session II   HKEC Staff
7. 1 April 2014
   Session I   KWC Management
   Session II   KWC Staff

C) Fora for Stakeholders

1. 6 March 2014
   Session I   Medical professionals bodies
   - (a) Association of Private Medical Specialists of Hong Kong
   - (b) Frontline Doctors' Union
   - (c) Hong Kong Doctors Union
   - (d) Hong Kong Public Doctors' Association
   - (e) Public Consultant Doctors Group

   Session II   Nursing professionals bodies, Allied health professionals bodies and patient group

   - (a) Association of Hong Kong Nursing Staff
   - (b) Midwives Council of Hong Kong
   - (c) Nursing Council of Hong Kong
   - (d) Hong Kong Pharmacists (Public Service) Association
   - (e) Hong Kong Physiotherapy Association
   - (f) Hong Kong Physiotherapists' Union
   - (g) AIDS Concern

2. 24 March 2014   Nursing professionals bodies, Allied health professionals bodies and patient groups

   - (a) Nurses Branch, Hong Kong Chinese Civil Servants' Association
   - (b) Hong Kong Nurses General Union
   - (c) College of Nursing, Hong Kong
   - (d) The Provisional Hong Kong Academy of Nursing
   - (e) Division of Clinical Psychology, The Hong Kong Psychological Society
   - (f) Hong Kong Radiographers' Association
   - (g) Hong Kong Dietitians Association
   - (h) Hong Kong Clinical Psychologists Association
   - (i) Hong Kong Occupational Therapy Association
   - (j) Hong Kong Association of Medical Physics
   - (k) Hong Kong Society of Audiology
   - (l) Association of Scientific Officers (Medical)
   - (m) Rehabilitation Alliance Hong Kong
   - (n) Patients' Alliance on Healthcare Reform
   - (o) The Patients and Healthcare Professionals Rights Association

D) Luncheon Meetings

1. 5 May 2014   6 print media columnists
2. 9 May 2014   6 media professionals
3. 16 May 2014   5 opinion/community leaders
4. 26 May 2014   6 electronic media programme hosts
5. 29 May 2014   6 academics and researchers

E) Focus Groups

1. 6 June 2014   Patient groups

     (a)   Hong Kong Patients' Rights Association of the Society for Community Organisation
     (b)   Hong Kong Alliance of Patients' Organisations
     (c)   Patients' Alliance on Healthcare Reform
     (d)   Rehabilitation Alliance Hong Kong
     (e)   Alliance for Renal Patients Mutual Help Association
     (f)   New Life Psychiatric Rehabilitation Association
     (g)   Mental Health Association of Hong Kong

2. 13 June 2014   Healthcare related professional bodies

     (a)   HKAM
     (b)   Public Consultant Doctors Group
     (c)   Li Ka Shing Faculty of Medicine, The University of Hong Kong
     (d)   Faculty of Medicine, The Chinese University of Hong Kong
     (e)   Association of Hong Kong Nursing Staff
     (f)   Nursing Council of Hong Kong
     (g)   Nurses Branch, Hong Kong Chinese Civil Servants' Association
     (h)   Hong Kong Public Nurses Association
     (i)   Hong Kong Radiographers' Association
     (j)   Government Medico-Radiological Equipment Technical Staff Association
     (k)   Hong Kong Society of Certified Prosthetist-Orthotists
     (l)   Union of Hong Kong Speech Therapists (Medical)

3. 20 June 2014   NGO with close working relations with HA

     (a)   Methodist Centre
     (b)   Aberdeen Kai-fong Welfare Association Social

Service Centre
(c) Po Leung Kuk
(d) Evangelical Lutheran Church Social Service - Hong Kong
(e) Hong Kong Cheshire Home Foundation
(f) The Hong Kong Society for Rehabilitation
(g) Rehabaid Society
(h) Society for the Promotion of Hospice Care
(i) Lions Kidney Education Centre and Research Foundation, Chan Wong Sau Wah Memorial Renal Dialysis Centre
(j) Society for the Relief of Disabled Children

4. 27 June 2014   Chairpersons of Hospital Governing Committees and Members of Regional Advisory Committees of HA

F) Public Fora

1. 7 July 2014   Forum in Kowloon
(held in Henry G. Leong Yau Ma Tei Community Centre, Multi-purpose Hall, 1/F., 60 Public Square Street, Yau Ma Tei)
154 individuals attended

2. 14 July 2014   Forum in New Territories
(held in Tai Po Community Centre, Multi-purpose Hall, 1/F., 2 Heung Sze Wui Street, Tai Po)
118 individuals attended

3. 19 July 2014   Forum on Hong Kong Island
(held in Causeway Bay Community Centre, Multi-purpose Hall, 3/F., 7 Fook Yum Road, North Point)
78 individuals attended

Findings of the Questionnaires at Public Fora

Introduction

To gauge the general views of the participants of the public fora, we invited all participants to fill in a questionnaire (a copy of which is at Enclosure). In addition to the general demographics and the frequency of visits to HA facilities, the questionnaire asks respondents to give a score to indicate their satisfaction levels of HA's performance in various areas. Respondents may also provide written views in response to an open-ended question in the questionnaire.

2. Out of the 350 participants, we have received a total of 204 copies of returned questionnaires.

3. It should be noted that the findings of the survey should be looked at with care. The participants in the fora were not a random sample drawn to represent the general population, and hence the views of the former revealed from the survey should not be regarded as representative of that of the latter.

Findings

(a) Respondents' Basic Demographics and Usage of HA Services

4. Respondents' demographic information is shown in the following charts –

Basic Demographics of Respondents (Home District)

Respondents' Usage of HA Facilities (As a patient or visitor/family of a patient) Number of Times in a Year on Average
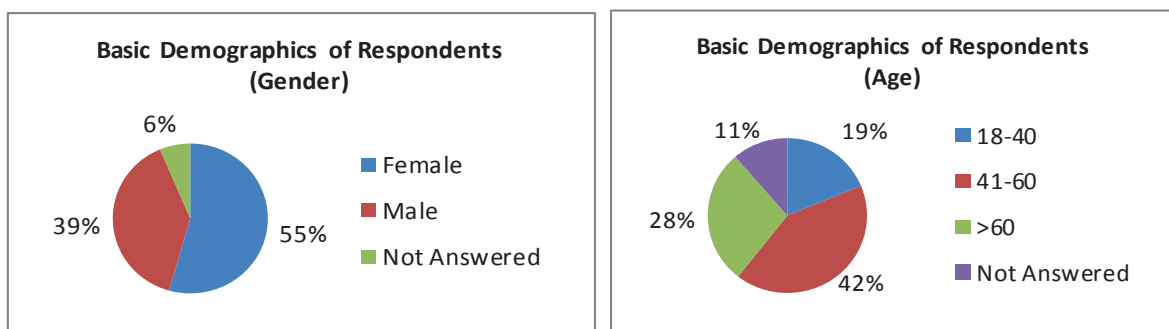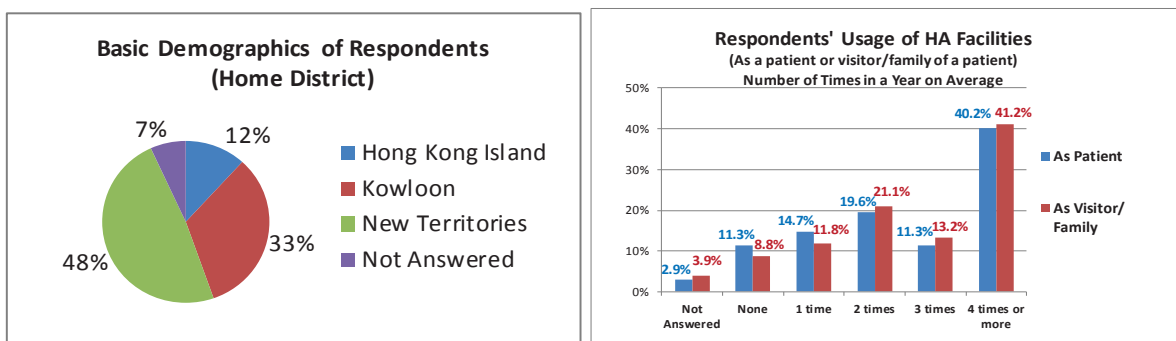
5.　　　　It may be noted that more than 70% of respondents have themselves visited or used HA's facilities twice or more in a year.　In a way this shows that the respondents are informed users who have first-hand experience when commenting on HA's services.

(b) Respondents' Satisfaction Levels of Various Aspects of Services

6.　　　　The average scores on the satisfaction level of HA's services on seven service aspects are as follows –

Service Aspects	Average Scores
(a) Quality of Healthcare Services	6.3
(b) Professionalism of Healthcare Personnel	7.0
(c) Attitude of Healthcare Personnel	6.2
(d) Level of Fees & Charges	7.5
(e) Medicine Provided	6.5
(f) Waiting Time for Services	3.5
(g) Delineation of Clusters in HA	5.2

Note: 0 indicates very unsatisfactory, 5 average and 10 very satisfactory

7.　　　　Most aspects record an average score of greater than 5, showing that the respondents generally find HA's services satisfactory.　Among the seven aspects covered in the questionnaire, "Professionalism of Healthcare Personnel" and "Level of Fees & Charges" have the highest average scores (7.0 and 7.5 respectively).

8.　　　　"Waiting Time for Services", on the other hand, has recorded a score of 3.5 and is the only aspect with a score that is below average.　This shows that waiting time is an aspect where respondents are most dissatisfied with.

(c) Respondents' Satisfaction Levels of Various Types of Services

9.   The average scores on the satisfaction level of HA's types of services are as follows –

Types of Services	Average Scores
(a) GOPC services	5.4
(b) SOPC services	5.9
(c) A&E services	5.0
(d) Inpatient services	6.6
(e) Ambulatory services	6.4
(f) Community Nursing services	5.8

Note: 0 indicates very unsatisfactory, 5 average and 10 very satisfactory

10.   All types of services record an average score of 5.0 or above, indicating that the respondents in general are satisfied with HA's services.   It may be noted that while respondents are more satisfied with inpatient services and ambulatory services (with a score of 6.6 and 6.4 respectively), they are less so with A&E services (with an average score of 5.0).

(d) Respondents' Comments on the Open-ended Question

11.   Out of the 204 questionnaires received, 110 responded to the open-ended question, giving a total of 190 comments.   The areas to which the comments are related may be classified as follows –

Areas	Number of Comments
Management & Organisation Structure	6
Resource Management	5
Staff Management	35
Cost Effectiveness and Service Management	118
Overall Management & Control	0
Others	26
Total	**190**

12.   Cost effectiveness and service management, including the service level and accessibility, is an area that most respondents commented on.   In this area, respondents have called for improvement in waiting time, GOPC services, elderly services and mental health services, etc.

13.　　　　Staff management is an area which receives the second largest number of written comments.　Respondents have expressed concerns on the manpower shortage which HA is encountering and have made suggestions for HA to improve the working conditions to attract and retain staff.

14.　　　　In other areas, a handful of respondents have mentioned about the need to review the delineation of clusters and improve resource allocation within HA.

HA Review Public Forum - Questionnaire

Sex：_____ Age：_____

Home District：_____ Work District：_____

Part One: Your opinion on services of Hospital Authority

1）In general, are you satisfied with the performance of HA in the following areas?

  Rate in scale of 0 to 10 0 for very unsatisfactory 5 for average
             10for very satisfactory X for no comment or not applicable

    (a) Quality of healthcare services
    (b) Professionalism of healthcare personnel
    (c) Attitude of healthcare personnel
    (d) Level of fees and charges
    (e) Medicine provided
    (f) Waiting time for services
    (g) Delineation of clusters in HA

2）Are you satisfied with the following types of services provided by HA?

  Rate in scale of 0 to 10 0 for very unsatisfactory 5 for average
             10for very satisfactory X for no comment or non-applicable

    (a) General Out-patient services
    (b) Specialist Out-patient services
    (c) Accident and Emergency services
    (d) Inpatient services
    (e) Ambulatory services
    (f) Community nursing services

3）Do you have any other comments on the services of HA?

_____

_____

Part Two: Your personal experience in using HA services

4）On average how many times a year do you, as a patient, use the services of HA?
  ☐ None
  ☐ Once
  ☐ Twice
  ☐ 3 times
  ☐ 4 times or more

5）On average how many times a year do you, as a visitor, attend to the facilities
  of HA to visit or accompany your family or friends to undertake treatment?
  ☐ None
  ☐ Once
  ☐ Twice
  ☐ 3 times
  ☐ 4 times or more

List of Stakeholders who have Submitted Written Views

1. AIDS Concern
2. Association of Hong Kong Nursing Staff
3. Coalition of Civil Servants on Medical and Dental Benefits for Civil Service Eligible Persons
4. Concern Group of Medical Resources (NTW) & Tin Shui Wai Community Development Alliance
5. DAB Kwun Tong Branch
6. DAB Yau Tsim Mong Branch
7. HKAM
8. Hong Kong Alliance of Patients' Organisations
9. Hong Kong Doctors Union
10. Hong Kong Medical Association
11. Hong Kong Patients' Rights Association of the Society for Community Organisation
12. Hong Kong Pharmacists (Public Service) Association
13. Hong Kong Physiotherapy Association
14. Joint Conference of Hong Kong Health Care Professional Organisations
15. KEC Staff
16. KWC - Our Lady of Maryknoll Hospital Frontline Staff
17. NTEC - Alice Ho Miu Ling Nethersole Hospital Staff
18. NTEC Staff
19. Patients' Alliance on Healthcare Reform
20. Public Consultant Doctors Group
21. Rehabilitation Alliance Hong Kong
22. Tai Po District Council Member – Ms WONG Pik-kiu, MH, JP
23. Victoria Harbour Association
24. Wong Tai Sin District Council
25. 4 members of the public

Summary of Other Views Collected
in the Public Engagement Programme

During the Public Engagement Programme, in addition to subjects covered under the current Review, stakeholders have raised a wide range of views concerning policy matters relating to the overall healthcare system in Hong Kong as well as operational matters of HA. A summary of these views are set out in the ensuing paragraphs.

Views concerning wider Healthcare Issues

Healthcare System

2.   There were views that Hong Kong should have a long term healthcare policy. Noting the increasing burden on public healthcare sector particularly the hospital services, some suggested that the Government should adjust the healthcare policy and resources to enhance the primary care services and give more focus on health promotion, prevention and medical rehabilitation. The Government should also review the optimal way in delivering primary care, having regard to the roles of the Department of Health, HA and the private sector.

3.   Some suggested that the Government should evaluate the demand on healthcare manpower and facilities for long-term planning to cater for the ageing population and the disease development.

Funding for HA

4.   Some considered that the Government should provide more resources for HA to improve its services. Instead of an annual funding, the Government might consider allocating funding for a longer period to facilitate HA's service planning. Some opined that the Government should set aside a fund for use as medical expenditure by HA to meet the increasing medical cost arising from ageing population.

Fees and Charges for Public Healthcare Services

5.   Some suggested that the Government might consider reviewing the fees and charges for public medical services in order to manage demand. For instance, the fees for A&E services should be increased to discourage abuse of A&E services.

Views concerning the Operational Matters of HA

Terms of Employment

6.　　　　Various grades of staff have voiced concerns on specific measures to improve their working conditions. For example, some opined that the pay and working conditions of certain grades of staff in HA were inferior to those of their counterparts in the private sector, making it difficult for HA to recruit and retain manpower. They suggested various improvement measures, such as reducing the working hours, enhancing pay, improving the over-time allowance and creating more promotion opportunities.

7.　　　　Some thought that the medical benefits of HA staff was inferior to those of civil servants and that the services of the staff clinic at HA should be improved. Some suggested that HA should consider allowing staff to retire not on a specified age but within a range of ages to suit the individual needs of staff and also to solve the manpower shortage problem.

Equipment and Facilities

8.　　　　There were views that HA should streamline its procurement practices so as to ensure that obsolete medical equipment was replaced and new equipment would be purchased timely. In particular, some considered that the medical equipment (such as Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) scanner) was not up-to-date and failed to meet the technological advancement and expectation of the public.   Some considered that hospitals did not have sufficient resources to replace obsolete equipment.

9.　　　　Some staff expressed concerns on HA's existing practice of accepting the offer with the lowest price during the procurement process as it might result in acquisition of outdated equipment. They suggested that flexibility should be allowed in the procurement process.

10.　　　　Some staff raised concerns about space constraints in selected hospitals which hampered installation of new equipment and smooth operation of clinical services. They called for expedited improvement and maintenance works to enhance operational efficiency.

Clustering of Hospitals and Institutions

Table 1   Seven Clusters – Facilities and Budget (as at 31.3.2014)

Cluster	No. of hospitals/ institutions	No. of hospital beds	No. of GOPCs	No. of staff (FTE)	2013-14 Budget ($Mn)
HKE	7 (2)	3,031	12	7,596	4,631
HKW	7 (1)	3,142	6	7,442	4,804
KC	6 (1)	3,548	6	9,307	5,843
KE	3 (2)	2,487	8	6,960	4,490
KW	8 (4)	6,629	23	14,955	9,716
NTE	7 (3)	4,518	10	10,557	6,910
NTW	4 (2)	4,085	8	8,942	5,558

Figures in brackets refer to number of general acute hospitals (inclusive) with 24 hour A&E services, but excluding St. John Hospital, as well as North Lantau Hospital which extended its A&E service to 24 hours with effect from 25 September 2014.

Table 2   Seven Clusters – Patients and Outputs

Cluster	Patients & Output in 2013-14				Catchment Districts for Planning Purposes
	Total Inpatient & Day Patient Discharge Episodes*	Total A&E Attendances	Total SOPC Attendances	Proportion of the Cluster's Inpatient Discharge Episodes* Utilised by Patients Living Outside the Districts	
HKE	177,500	243,850	792,008	14%	Eastern, Wan Chai, Islands (excl. Lantau Island)
HKW	186,007	131,577	844,024	31%	Central & Western, Southern
KC	202,593	195,280	1,016,873	62%	Kowloon City, Yau Tsim
KE	168,030	323,703	766,997	10%	Kwun Tong, Sai Kung
KW	370,586	595,085	1,634,502	13%	Mongkok, Wong Tai Sin, Sham Shui Po, Kwai Tsing, Tsuen Wan, Lantau Island
NTE	262,448	394,271	1,099,139	11%	Sha Tin, Tai Po, North
NTW	202,167	357,240	887,340	5%	Tuen Mun, Yuen Long

*   Referring to discharges and deaths

Table 3   Hospitals Included in Individual Clusters

(a) HKEC (*Catchment Districts*: Eastern, Wan Chai, and Islands excluding Lantau Island)

Hospitals/Institutions	No. of beds (as at 31.3.2014)	Remarks
Pamela Youde Nethersole Eastern Hospital	1,633	An acute regional hospital providing a full range of specialist services
Ruttonjee Hospital	633	An acute general hospital providing A&E and selected specialist services
Tang Shiu Kin Hospital		
Tung Wah Eastern Hospital	278	A community hospital providing primary services and selected specialist services
Cheshire Home, Chung Hom Kok	240	Both providing infirmary services to patients requiring long-term care
Wong Chuk Hang Hospital	160	
St. John Hospital	87	Located at Cheung Chau providing primary and emergency services
12 GOPC		

(b) HKWC (*Catchment Districts*: Central & Western and Southern)

Hospitals/Institutions	No. of beds (as at 31.3.2014)	Remarks
Queen Mary Hospital	1,702	An acute regional hospital and teaching hospital. Also a territory-wide tertiary and quaternary referral centre for many complex and advanced services
Grantham Hospital	372	A major referral centre providing comprehensive medical treatment of adult heart and lung diseases, palliative medicine and acute geriatrics services
MacLehose Medical Rehabilitation Centre	110	Provides comprehensive rehabilitation services
The Duchess of Kent Children's Hospital at Sandy Bay	133	A tertiary specialist hospital specialised in Paediatric Orthopaedics, Spinal Surgery, Paediatrics to patients in the territory
Tsan Yuk Hospital	3	A community family health centre
Tung Wah Group of Hospitals Fung Yiu King Hospital	272	An extended-care hospital providing geriatric services, rehabilitation and convalescence services
Tung Wah Hospital	550	Provides acute and extended inpatient care, ambulatory and day surgery services, and renal services
6 GOPC		

(c) KCC (*Catchment Districts*: Kowloon City and Yau Tsim)

Hospitals/Institutions	No. of beds (as at 31.3.2014)	Remarks
Queen Elizabeth Hospital	1,844	An acute regional hospital providing 24-hour comprehensive services
Hong Kong Buddhist Hospital	324	A community hospital with general and extended care services
Hong Kong Eye Hospital	45	A specialised Ophthalmic Centre
Kowloon Hospital	1,335	A multi-specialty hospital providing acute and extended care services in psychiatry, rehabilitation, respiratory medicine, as well as convalescent care
Hong Kong Red Cross Blood Transfusion Service	-	An institution providing blood and blood products to all hospitals in Hong Kong
Rehabaid Centre	-	An institution providing specialised community-based rehabilitation services
6 GOPC		

(d) KEC (*Catchment Districts*: Kwun Tong and Sai Kung)

Hospitals/Institutions	No. of beds (as at 31.3.2014)	Remarks
United Christian Hospital	1,403	An acute regional hospital providing secondary services for Kwun Tong district and tertiary services for the entire Cluster area
Tseung Kwan O Hospital	623	An acute general hospital providing secondary services for Tseung Kwan O district
Haven of Hope Hospital	461	An extended-care hospital providing subacute, rehabilitation and infirmary services for the Cluster
8 GOPC		

(e) KWC (*Catchment Districts*: Mongkok, Wong Tai Sin, Sham Shui Po, Kwai Tsing, Tsuen Wan and Lantau Island)

Hospitals/Institutions	*No. of beds (as at 31.3.2014)*	*Remarks*
Princess Margaret Hospital	1,753	An acute regional hospital providing a comprehensive range of acute services, which also serves as the Cluster's trauma and oncology centre, as well as HA's infectious diseases centre and toxicology reference laboratory
Caritas Medical Centre	1,203	An acute general hospital providing acute, extended and hospice care services, plus a developmental disability unit for children
Kwai Chung Hospital	920	A mental health hospital with acute and outreach psychiatric care services
Kwong Wah Hospital	1,206	A acute regional hospital providing comprehensive acute services
North Lantau Hospital	-	HA's newest hospital (commenced services in phases since September 2013) providing A&E service, Community Health Centre, SOPC as well as community outreach services
Our Lady of Maryknoll Hospital	236	A community hospital providing general medical and hospice care services
Tung Wah Group of Hospitals Wong Tai Sin Hospital	511	An extended care hospital providing rehabilitation, tuberculosis and chest services
Yan Chai Hospital	800	An acute general hospital providing acute and rehabilitation services
23 GOPC		

(f) NTEC (*Catchment Districts*: Sha Tin, Tai Po and North)

Hospitals/Institutions	*No. of beds (as at 31.3.2014)*	*Remarks*
Prince of Wales Hospital	1,518	An acute regional hospital and the teaching hospital for the medical school of the Chinese University of Hong Kong
Alice Ho Miu Ling Nethersole Hospital	536	An acute general hospital in Tai Po
North District Hospital	589	An acute general hospital in North District
Shatin Hospital	553	An extended-care hospital providing convalescent, rehabilitation and psychiatric inpatient care
Cheshire Home, Shatin	304	An extended-care hospital providing infirmary care for the severely disabled and patients from the central infirmary waiting list
Bradbury Hospice	26	A specialised palliative care centre providing inpatient and community outreach hospice services
Tai Po Hospital	992	An extended-care hospital providing convalescent, rehabilitation and psychiatric inpatient care
10 GOPC		

(g) NTWC (*Catchment Districts*: Tuen Mun and Yuen Long)

Hospitals/Institutions	*No. of beds (as at 31.3.2014)*	*Remarks*
Tuen Mun Hospital	1,862	An acute regional hospital providing a comprehensive range of acute, ambulatory and community services
Pok Oi Hospital	567	An acute general hospital providing A&E service and selected specialist and ambulatory care services
Castle Peak Hospital	1,156	A full range of psychiatric services, including the quaternary forensic psychiatric service
Siu Lam Hospital	500	A specialised facility that receives severely mentally handicapped adult patients from throughout the territory
8 GOPC		

List of Coordinating Committees and Central Committees
(as at 1 April 2015)

	COC/CC
COCs of Specialties (with Colleges under HKAM)	COC in A&E
	COC in Anaesthesiology
	COC in Clinical Oncology
	Sub-Committee for Radiation Therapy
	Sub-Committee for Medical Physics
	COC in Family Medicine
	COC in Intensive Care
	COC in Internal Medicine
	Geriatrics Subcommittee
	COC in Obstetrics & Gynaecology
	COC in Ophthalmology
	Sub-Committee for Optometry & Orthoptics
	COC in Orthopaedics & Traumatology
	COC in Ear, Nose & Throat / Otorhinolaryngology
	Sub-Committee for Audiology
	COC in Paediatrics
	COC in Pathology
	Allied Health Committee of Pathology
	COC in Psychiatry
	COC in Radiology
	Sub-Committee for Diagnostic Radiography
	COC in Surgery
	COC in Neurosurgery
CC on Training	Committee on Surgical Training
	Committee on Internship

	COC/CC
COC on Allied Health / Nurses	COC – Grade (Nursing)
	COC – Grade (Clinical Psychology)
	COC – Grade (Dietetics)
	COC – Grade (Medical Social Service)
	COC – Grade (Occupational Therapy)
	COC – Grade (Pharmaceutical Services)
	COC – Grade (Physiotherapy)
	COC – Grade (Podiatry)
	COC – Grade (Prosthetics & Orthotics)
	COC – Grade (Speech Therapy)
CC on Disease Group	CC on Cancer Service
	CC on Cardiac Service
	Central Renal Committee
	CC on Diabetic Service
	CC on Stroke Service
	CC on Genetic Services
	CC on Chronic Obstructive Pulmonary Disease
CC on Service Type	Committee on Chinese Medicine Services
	CC on Palliative Care
	CC on Rehabilitation Services
	CC on Transplant Services
	CC on Trauma Service
	CC on Transfusion Service
CC on Quality & Safety	CC on Infectious Diseases & Emergency Response
	Committee on Quality & Safety
	CC on Toxicology Services
	Committee on Complaints Management & Patient Engagement
	Committee on Major Incident Response
CC on IT	CC on Information Technology

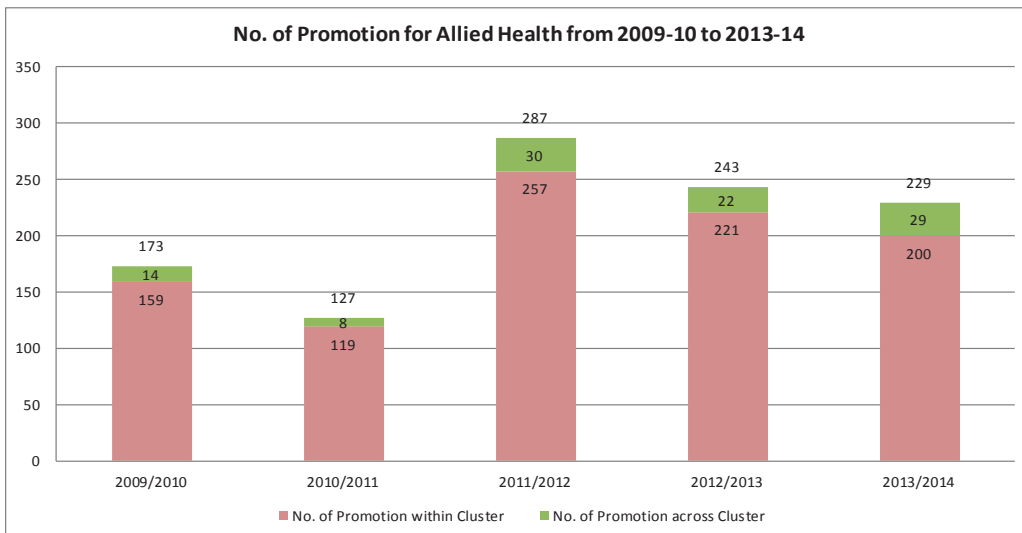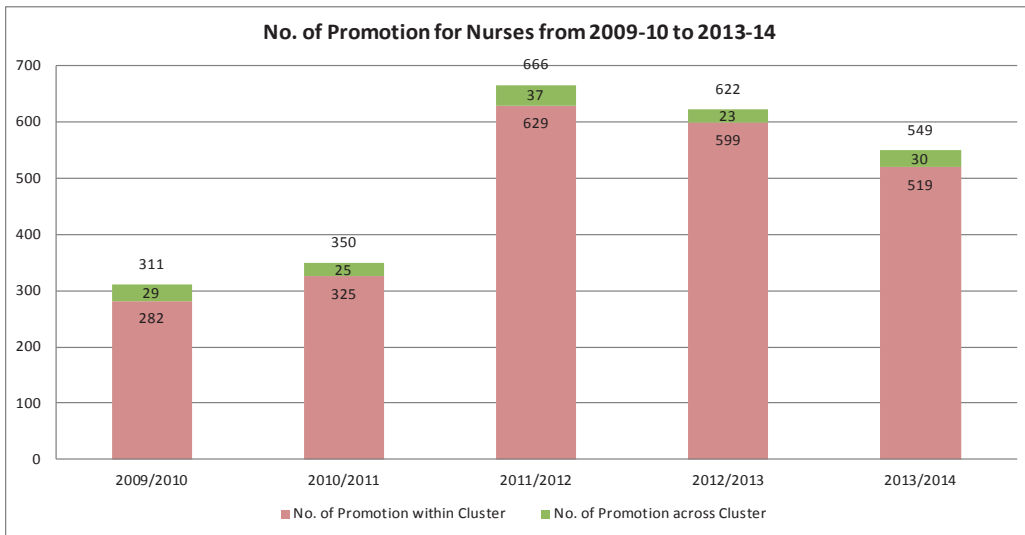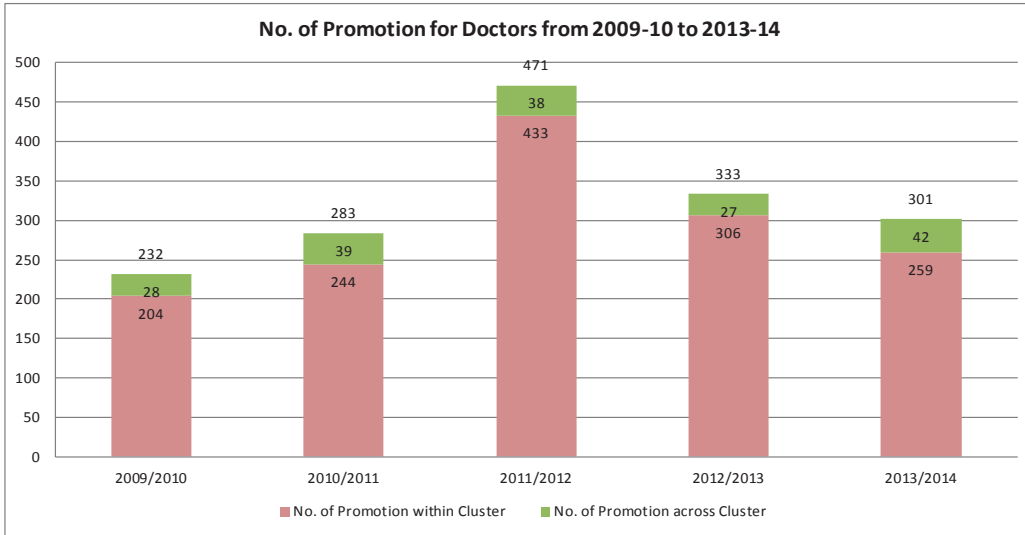**Direct Patient Care Staff Groups (figures as at 28 February 2015)**

Staff Group	Description	No. of Staff[1]
Medical ranks	Consultant	798
	Senior Medical Officer/Associate Consultant	1,779
	Medical Officer/Resident	2,925
	Intern	401
	Dental Officer	8
Medical Total		5,910
Nursing ranks	Department Operation Manager / Senior Nursing Officer and above	361
	Advanced Practice Nurse / Nurse Specialist / Nursing Officer/ Ward Manager	4,641
	Registered Nurse	15,095
	Enrolled Nurse/Others	3,062
	Trainees	562
Nursing Total		23,721
Allied Health groups	Audiology Technician	6
	Clinical Psychologist	155
	Dietitian	140
	Dispenser	1,184
	Medical Technologist/Medical Laboratory Technician	1,351
	Mould Technologist/Mould Laboratory Technician	26
	Optometrist	67
	Orthoptist	15
	Occupational Therapist	732
	Pharmacist	573
	Physicist	73
	Physiotherapist	886
	Podiatrist	39
	Prosthetist & Orthotist	135
	Diagnostic Radiographer/Radiation Therapist	1,021
	Scientific Officer (Medical)	81
	Speech Therapist	91
	Medical Social Workers	314
	Dental Technician	3
Allied Health Total		6,891

Care Related	Health Care Assistant	2,198
Supporting	Ward Attendant	252
groups	Patient Care Assistant	10,274
	Ambulanceman	3
	Artisan	397
	Dental Surgery Assistant	10
	Laboratory Attendant	141
	Mortuary Officer/Technician/Attendant	93
	Occupational Therapy Assistant	122
	Operating Theatre Assistant	144
	Other Hospital Supporting Staff	31
Care Related Supporting Total		13,665
DIRECT PATIENT CARE TOTAL		**50,186**[2]

(1) Manpower on FTE basis including permanent, contract and temporary staff in HA's workforce.

(2) Figures may not add up due to rounding when calculating FTE.

Figures for Promotion within and outside Clusters

No. of Promotion for Doctors from 2009-10 to 2013-14

	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
Total	232	283	471	333	301
No. of Promotion across Cluster	28	39	38	27	42
No. of Promotion within Cluster	204	244	433	306	259

■ No. of Promotion within Cluster ■ No. of Promotion across Cluster

No. of Promotion for Nurses from 2009-10 to 2013-14

	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
Total	311	350	666	622	549
No. of Promotion across Cluster	29	25	37	23	30
No. of Promotion within Cluster	282	325	629	599	519

■ No. of Promotion within Cluster ■ No. of Promotion across Cluster

No. of Promotion for Allied Health from 2009-10 to 2013-14

	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
Total	173	127	287	243	229
No. of Promotion across Cluster	14	8	30	22	29
No. of Promotion within Cluster	159	119	257	221	200

■ No. of Promotion within Cluster ■ No. of Promotion across Cluster

No. of Promotion across Cluster by Staff Group by Rank Group 2009-10 to 2013-14

Staff Group	DetailSubGroup	No. of Promotion across Cluster(3)					Total No. of Promotion(1)				
		2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
Doctors	Consultant	5	10	11	4	11	57	78	100	66	63
	Senior Medical Officer/Associate Consultant	23	29	27	23	31	175	205	371	267	238
Doctors Total		28	39	38	27	42	232	283	471	333	301
		12%	14%	8%	8%	14%					
Nursing	DOM/SNO and above	3	2	5	4	4	22	17	78	62	47
	APN/NS/NO/WM	26	23	32	19	26	289	333	588	560	502
Nursing Total		29	25	37	23	30	311	350	666	622	549
		9%	7%	6%	4%	5%					
Allied Health	Audiology Technician								2		
	Clinical Psychologist					1			5		2
	Dietitian		1	1		1		2	2		2
	Dispenser			3	4	2	12	11	32	44	16
	Medical Laboratory Technologist	5		4	3	11	30	36	40	46	68
	Medical Social Worker				1		2	2	1	1	1
	Occupational Therapist	1	2	9	3	4	34	21	62	38	34
	Optometrist						1		1		
	Orthoptist			2					6		
	Pharmacist	2		2			5	3	12	5	4
	Physicist				1				3	1	1
	Physiotherapist	2	1	1	3	1	41	22	60	48	49
	Podiatrist				1	1			3	2	1
	Prosthetist-Orthotist			1		1	4		6	6	7
	Diagnostic Radiographer	3	3	4	4	5	32	26	41	40	37
	Radiation Therapist	1		2	2	2	9	2	11	12	6
	Speech Therapist						1	1			
Allied Health Total		14	8	30	22	29	173	127	287	243	229
		8%	6%	10%	9%	13%					
Grand Total		71	72	105	72	101	716	760	1424	1198	1079
		10%	9%	7%	6%	9%					

Note:

(1) Manpower on headcount basis includes permanent, contract staff in HA's workforce excluding eHR staff.

(2) Refers to cases of appointment to higher rank with higher maximum pay point or take home pay. Other staff movement cases such as

(3) Refers to cases of promotion to difference clusters. Promotion cases hospitals within same cluster not included.

Legend :
APN : Advance Practice Nurse
DOM : Department Operation Manager
NO : Nursing Officer
NS : Nursing Specialist
SNO : Senior Nursing Officer
WM : Ward Manager

Measures to Strengthen Medical Workforce and Boost Staff Morale

(A) Recruitment of Doctors

Active recruitment of full-time doctors

HA has over the years actively recruited doctors from both local and overseas sources.   During 2010 to 2014, HA in a year could recruit on average about 240 local graduates (about 95% of total graduates in a year), 15 to 30 overseas graduates who have passed the Licentiate Medical Examination and 10 doctors from private sector.   Since 2012, HA has commenced recruitment of non-local doctors to practise in HA through limited registration with the Medical Council of Hong Kong, as one of the additional measures to address the doctors' manpower shortage.   As of March 2015, the Medical Council of Hong Kong has altogether approved in total 23 applications of non-local doctors under limited registration submitted by HA.   Currently, there are 13 non-local doctors working in HA hospitals under that scheme.

Employment of part-time doctors

2.   HA has introduced an enhanced and unified pay package for employment of part-time doctors in all specialties, and has made proactive efforts to retain some of the doctors who have retired or resigned to work part time for the organisation.   As a result, the number of part-time doctors has increased from 129 in 2010 (48 FTE) to 349 as at February 2015 (129 FTE).

(B) Retention of Doctors

Enhancement of promotion prospect

3.   Since 2011-12, HA has launched a centrally coordinated additional promotion mechanism for Associate Consultant to recognise and reward meritorious doctors who have served HA for five years or more after obtaining fellowship.   Under the mechanism, additional Associate Consultants will be appointed to meet the operational needs while improving the promotion prospects for doctors.   Since inception of the exercise in 2011, a total of 325 specialist doctors as at April 2015 have been selected for appointment as Associate Consultants.

Enhanced recognition to doctors through improved honorarium schemes

4.　　　　Since 2012, HA has enhanced its Fixed-rate Honorarium Scheme which is applicable to doctors to recognise their need to work consistently long hours by nature of their duties.　　The revised Fixed-rate Honorarium Scheme has raised the honorarium of the existing two tiers from $1,750 and $3,500 to $2,750 and $4,750 respectively, and introduced a third tier rate of $5,750 to compensate those doctors who work in departments with exceptionally frequent overnight on-site call duties.　　In addition, the Special Honorarium Scheme (hourly rate), which aims to address short term manpower constraint issues, has also been enhanced to facilitate operation of extra service sessions to meet operational needs of individual hospitals under special projects.

Exemption of pregnant doctors from overnight on-site duties

5.　　　　HA has since 2011 effected exemption to pregnant doctors from overnight on-site calls during the advanced stage of their pregnancy from the 32nd week of pregnancy as far as possible.

Enhanced training support with standardisation in granting of examination leave and reimbursement of examination fees

6.　　　　To enhance provision of training support to doctors, HA has standardised the practice of granting full pay study leave to doctors sitting for higher qualification examination, and provided reimbursement of examination fees to eligible doctors.

Enhancement of training opportunities

7.　　　　HA attaches great importance to the training and development of its doctors.　　Continuous efforts are made in enhancing professional training opportunities for medical staff, including commissioned training as well as overseas training programmes, sponsorships etc. to enhance professional competence and clinical skills and keep abreast of rapid medical developments and technological advancements.　　As an example, intensive courses of simulation training are provided to doctors engaged in the provision of high-risk clinical services as well as team-based patient care.

(C)   Reduce Workload of Doctors

Introduction of care technician service support

8.   As a strategy to relieve doctors and nurses from technical tasks and mundane activities, HA has been recruiting care technicians since 2008 and training more care technicians to provide round-the-clock blood-taking, electrocardiogram and intravenous cannulation service. These additional staff are now available in all acute public hospitals.

Improvement of working conditions

9.   All HA employees are conditioned to work a fixed number of hours per week. Because of the need to provide round-the-clock continual care to patients, doctors are required to perform on-call duties and work additional hours from time to time.

10.   Various doctor work reform programmes were implemented in 2007 and as a result, there have been significant improvements in doctor's working conditions both in terms of average weekly work hours and continuous work hours. The proportion of doctors working for more than 65 hours per week on average has dropped from 18% in December 2006 to 4.6% by the end of December 2013. As an ongoing effort to monitor the working conditions of doctors, HA has established a corporate mechanism and adopted a structured, broad-brush and prospective approach in monitoring doctors' rostered hours of on-site work over a 26-week reporting cycle.   Full-scale monitoring of doctors' working hours for all specialties has been conducted from July to December every alternate year since 2009.

List of Key Performance Indicators for 2015-16

A. Clinical Services KPIs
(COR items are marked with *)

A1 Service Growth in response to Population Change & Ageing Effect

A1.1   Service Capacity (as at month end)
*   No. of hospital beds (total)
*   No. of community nurses
*   No. of geriatric day places
*   No. of community psychiatric nurses
*   No. of psychiatric day places

A1.2   Service Throughput (year-to-date)
Inpatient Services
*   No. of inpatient discharge episodes (overall)
*   No. of patient days (overall)
*   No. of day patient discharge episodes
Accident & Emergency (A&E) Services
*   No. of attendances
    No. of first attendances for
*   -   triage I (critical cases)
*   -   triage II (emergency cases)
*   -   triage III (urgent cases)
Specialist Outpatient Services
*   No. of specialist outpatient (clinical) new attendances
*   No. of specialist outpatient (clinical) follow-up attendances
*   Total no. of specialist outpatient (clinical) attendances
Primary Care Services
*   No. of general outpatient (GOP) attendances
*   No. of family medicine specialist clinic attendances
*   Total no. of primary care attendances
Allied Health Outpatient (AHOP) Services
*   No. of allied health (outpatient) attendances
Day Hospital Services
*   No. of rehabilitation day & palliative care day attendances
*   No. of geriatric day attendances
*   No. of psychiatric day attendances
Community & Outreach Services
*   No. of home visits by community nurses
*   No. of allied health (community) attendances

* No. of geriatric outreach attendances
* No. of geriatric elderly persons assessed for infirmary care service
* No. of VMO attendances
* No. of psychiatric outreach attendances
* No. of psychogeriatric outreach attendances

A2 Quality Improvement as a result of Technology Advancement or Implementation of New Service Quality & Access Initiatives

A2.1   *Waiting time for A&E services*
    % of A&E patients seen within target waiting time for
*   -   triage I (critical cases - 0 minute)
*   -   triage II (emergency cases - 15 minutes)
*   -   triage III (urgent cases - 30 minutes)
    -   triage IV (semi-urgent cases - 120 minutes)

A2.2   *Waiting time for Specialist Outpatient new case bookings*
    Median waiting time for 1st appointment at specialist outpatient clinics for
*   -   P1 patients
*   -   P2 patients
    For each of ENT, GYN, MED, OPH, O&T, PAED, PSY & SURG
    -   % of patients seen within 2 weeks for P1 patients
    -   % of patients seen within 8 weeks for P2 patients
    -   Waiting time (week) for 90th percentile of 'Routine' cases

A2.3   *Waiting time for AHOP new case bookings*
    For each of OT & PT
    -   % of patients seen within 2 weeks for P1 patients
    -   % of patients seen within 8 weeks for P2 patients
    -   Waiting time (week) for 90th percentile of 'Routine' cases

A2.4   *Waiting time for elective surgery*
    Waiting time for Total Joint Replacement
    -   Waiting time (month) at 90th percentile of patients receiving the treatment of Total Joint Replacement
    Waiting time for cataract
    -   % of patients provided with surgery within 2 months for P1 patients
    -   % of patients provided with surgery within 12 months for P2 patients
    Waiting time for TURP
    -   % of patients provided with surgery within 2 months for P1 patients
    -   % of patients provided with surgery within 12 months for P2 patients

A2.5   *Waiting time for diagnostic radiological investigations*
    % of urgent cases with examination done within 24 hours for CT, MRI and US cases
    Median waiting time for P1 patients for CT, MRI, US and Mammogram cases
    Median waiting time for P2 patients for CT, MRI, US and Mammogram cases

Waiting time (day) for 90th percentile of 'Routine' cases for CT, MRI, US and Mammogram cases

A2.6 Access to General Outpatient Clinic (GOPC) episodic illness service

% of IVAS call-in elderly patients offered with GOP appointment in 2 working days

% of IVAS call-in elderly, Comprehensive Social Security Assistance (CSSA) and non-CSSA waiver patients offered with GOP appointment in 2 working days

A2.7 Appropriateness of care

Standardised admission rate for A&E patients

* Unplanned readmission rate within 28 days for general inpatients

Breastfeeding rate on discharge

A2.8 Infection rate

MRSA bacteraemia in acute beds per 1,000 acute patient days

A2.9 Service coverage

% of RCHEs covered by CGATs or VMOs under CGATs

A2.10 Disease specific quality indicators

Stroke
- % of stroke patients ever treated in Acute Stroke Units
- % of acute ischaemic stroke patients received IV tPA treatment

Hip fracture
- % of patients indicated for surgery on hip fracture with surgery performed ≤ 2 days after admission through A&E

Cancer
- Waiting time (day) from decision to treat to start of radiotherapy for 90th percentile of cancer patients requiring radical RT
- Waiting time (day) at 90th percentile for patients with colorectal cancer receiving first definitive treatment after diagnosis
- Waiting time (day) at 90th percentile for patients with breast cancer receiving first definitive treatment after diagnosis
- Waiting time (day) at 90th percentile for patients with nasopharynx cancer receiving first definitive treatment after diagnosis

Diabetes Mellitus (DM)
- % of DM patients with HbA1c < 7%

Hypertension (HT)
- % of HT patients treated in GOPCs with Blood Pressure < 140/90mmHg

Renal
- % of end-stage renal disease patients receiving Haemodialysis treatment

Mental Health
- Average Length of Stay (ALOS) of acute inpatient (IP) care (with LOS ≤ 90 days)

Cardiac

- % of acute myocardial infarction patients prescribed with Statin at discharge
- % of ST elevation myocardial infarction patients received primary Percutaneous Coronary Intervention

A2.11 Technology
% of medical equipment with age beyond the expected life

A3 Efficiency in Use of Resources

A3.1 Bed management
* Bed occupancy rate (%) (IP overall midnight)
* ALOS (day) for general inpatients

A3.2 Day surgery services
Rate of day surgery plus same day surgery for selected procedures

A3.3 Productivity
Total weighted episodes (WEs) of acute inpatient services
Growth index for non-acute inpatient services
Growth index for ambulatory / community care services

B. Human Resources KPIs

B1 Manpower Situation

B1.1 Manpower Position
Manpower Position
- By Staff Group

B1.2 Attrition (Wastage) Rate/Resignation
5 Years Trend Attrition (Wastage) Rate
- By Cluster
- By Staff Group
No. of resignations (Medical Staff)
- No. of resignations
- No. of resignations per 100 staff (Resignation rate)
No. of resignations (Nursing Staff)
- No. of resignations
- No. of resignations per 100 staff (Resignation rate)
No. of resignations (supporting (Care-related) Staff)
- No. of resignations
- No. of resignations per 100 staff (Resignation rate)

B2 Staff Wellness

B2.1   Sick Leave
Average Sick Leave Days taken per staff
- By Staff Group

Percentage of staff with Sick Leave taken $\geq$ 50 days
- By Staff Group

B2.2   Injury on Duty (IOD)
No. of IOD Cases per 100 FTE staff
- By Staff Group

No. of IOD Leave Days per 100 FTE staff
- By Staff Group

C. Finance KPIs

C1 Budgetary Performance

C1.1   Budgetary Performance
Budget Performance Report
Report on Capital Expenditure
Untaken Leave Balance
Drug Stock Balance and Stock Holding Period

Legend: CGAT - Community Geriatric Assessment Team
            CT - Computed Tomography
            ENT - Ear, Nose & Throat
            GYN - Gynaecology
            IVAS - Interactive Voice Appointment System
            MED - Medicine
            MRI - Magnetic Resonance Imaging
            MRSA - Methicillin-resistant Staphylococcus aureus
            O&T - Orthopaedics & Traumatology
            OPH - Ophthalmology
            OT - Occupational Therapy
            P1 - Priority 1
            P2 - Priority 2
            PAED - Paediatrics & Adolescent Medicine
            PSY - Psychiatry
            PT - Physiotherapy
            RCHEs - Residential Care Homes for the Elderly
            SURG - Surgery
            TURP - Transurethral Resection of the Prostate
            US - Ultrasound
            VMO - Visiting Medical Officer

ABBREVIATIONS

A&E	Accident and Emergency
CC	Central Committee
CCE	Cluster Chief Executive
COC	Coordinating Committee
COR	Controlling Officer's Report
COS	Chief of Services
CSSA	Comprehensive Social Security Assistance
ENT	Ear, Nose and Throat
FHB	Food and Health Bureau
FTE	Full-Time Equivalent
GOPC	General Outpatient Clinic
HA	Hospital Authority
HAHO	Hospital Authority Head Office
HCE	Hospital Chief Executive
HGC	Hospital Governing Committee
HKAM	Hong Kong Academy of Medicine
HKEC	Hong Kong East Cluster
HKWC	Hong Kong West Cluster
HR	Human Resources
KCC	Kowloon Central Cluster
KEC	Kowloon East Cluster
KPI	Key Performance Indicator
KWC	Kowloon West Cluster
NGO	Non-Governmental Organisation
NTEC	New Territories East Cluster
NTWC	New Territories West Cluster
PPP	Public-Private Partnership
RAC	Regional Advisory Committee
SARS	Severe Acute Respiratory Syndrome
SC	Steering Committee on Review of Hospital Authority
SOPC	Specialist Outpatient Clinic