CHANGING FOR SUSTAINABILITY

醫院管理局
HOSPITAL
AUTHORITY

Hospital Authority Annual Plan

2002 - 2003

CHANGING FOR SUSTAINABILITY

醫院管理局
HOSPITAL
AUTHORITY

HOSPITAL AUTHORITY

ANNUAL PLAN 2002-2003

TABLE OF CONTENTS

EXECUTIVE SUMMARY 1

PLANNING BACKGROUND 11

1. Introduction 12
2. Review of Progress 16
3. HA's Strengths, Weaknesses, Opportunities & Threats 19
4. Budget Allocation for 2002/03 23

MAJOR DIRECTIONS AND PROGRAMME INITIATIVES FOR 2002/03 HA ANNUAL PLAN 27

5. Six New Directions 28
6. Developing Community Oriented Service Models 29
7. Enhancing Organizational Performance 37
8. Enhancing System Sustainability 41
9. Developing Public-private Interface 46
10. Improving Cost-effectiveness of the Service Delivery System 49
11. Formulating New Human Resource Strategies 56

CLUSTER PLANS 63

12. Hong Kong East Cluster 64
13. Hong Kong West Cluster 66
14. Kowloon East Cluster 68
15. Kowloon Central Cluster 70

16. Kowloon West Cluster 72

17. New Territories East Cluster 74

18. New Territories North Cluster 77

19. New Territories South Cluster 80

APPENDICES 83

Appendix 1: List of Public Hospitals and Institutions 84
Appendix 2: List of Specialist Outpatient Clinics 85
Appendix 3: List of General Outpatient Clinics 86
Appendix 4: Background Information on Hospital Authority 87
Appendix 5: Annual Plan Performance Indicators 90

EXECUTIVE SUMMARY

Funding for 2002/03

1. The recurrent budget allocated from Government to the Hospital Authority (HA) for 2002/03, net of income, is HK$29,881M. The budget is derived from the population-based funding formula introduced in 2001/02 plus additional allocations for new programmes, and less $600M (2% of baseline) as part of the Government's Enhanced Productivity Programme. The organization has for the first time recorded a deficit in the year 2001/02, primarily resulting from high staff cost, low staff turnover rate, and the need to continue recruiting new staff to cope with the ever increasing service demand from the population. Such deficit is expected to worsen for 2002/03, despite the very stringent savings programmes that will be put in place across the organization. This will heavily draw on the HA's reserve accumulated over the years. Within the Authority, there is general consensus that unless the current public-private imbalance in the healthcare system is redressed, the existing system is not sustainable in the long run.

The Environment and Role of HA

2. Hong Kong has experienced unprecedented changes politically, economically and socially in the past few years. The economic downturn has exerted tremendous financial pressure both on society at large and the Government. In turn, the structural deficit of the Government coffer inevitably affects the HA's funding. On the other hand, the continued economic ebb increases demand on public healthcare services, out of proportion to the rate of population increase. Those with means are also crowding into the public hospitals that offer heavily subsidized service (97% subsidy on average). Close to two-thirds of all attendance to emergency rooms that offer completely free service are non-emergent conditions, and in this regard Hong Kong unfortunately boasts the highest emergency room utilization rate per 1,000 population in the world. The proposed charging mechanism should help address the inappropriate use of scarce public resources. Furthermore, there is additional burden of rapidly escalating healthcare cost from new medical technology and procedures. All the demand that is upon the HA in the face of budget constraint translates into overload of the system and the frontline staff, with inevitable tension developing in staff relations.

3. The Government published a consultation document for healthcare reform in 2000, which attracted widespread public debate. Inevitably, such important issue had invited heated discussion in the political arena, but unfortunately not much headway has been made in terms of consensus for the way forward. Indeed, the increasing politicization of policy making has rendered such a big organization as the HA, with such important societal functions, to be an easy political target. While the organization has to adjust to the current political climate, there is all the more reason to refocus on our basic tenet in providing the needed care for those without means, and for catastrophic illnesses.

4. Externally, we will continue contributing our expertise and the extensive information available in our computer systems to support the Government's initiative in healthcare reform. Besides, we will actively explore options of public-private collaboration, including the facilitation of possible insurance schemes that would encourage greater use of the private health market. We have reflected to Government the need for revision in the current fees and charges to curb inappropriate usage of the system, and are awaiting Government directives for the necessary actions. We will also seek to adjust the charges of existing private facilities in the HA to more closely reflect the actual cost and in line with the private market.

5. Internally, we need to further consolidate our service network along the direction of hospital clustering to achieve geographical equity and synergism among different units, as well as reduce duplication of services. In parallel, there is an increasing need to utilize the new mechanisms of technology assessment, evidence-based medicine, and ethical framework to stratify the priority of services that are to be funded by the public purse. Triage of non-urgent service to give priority to those with clinical urgency will be increasingly important. Apart from direct service provision, we will have to continue to shoulder the important mission of providing the largest training ground for healthcare professionals in Hong Kong, and continuously adjust that training to meet the changing needs of society.

SWOT Analysis

6. In mapping out the directions for 2002/03 Annual Planning, we have done an analysis on the Strengths, Weaknesses, Opportunities and Threats (SWOT) of the organization in relation to the environmental challenges.

7. Our strength lies in a track record of improving service over the last decade, which has earned us public confidence and Government support. This is attributable to a progressive managerial environment with a culture of continuous learning and improvement, competent and dedicated staff, as well as a well-established infrastructure in terms of service delivery systems and facilities. On the weakness side, our responsiveness to environmental changes is hampered by limitations in human resource management flexibility and pricing for service. Little control over service demand also reduces our ability in effectively dealing with the volume and access issue. The major threats right now are obviously the incessantly increasing workload coupled with severe budgetary constraints, while the public continues to expect improving level and quality of service, at the same time disagrees to contribute more to the cost, either individually or collectively. On the other hand, such environment has also opened up new opportunities for service re-organization and reform. The realities have made parties concerned, including the community and our professional staff, more amenable to change. These include an evolution towards geographical cluster management, ideas to promote public-private collaboration, as well as innovative business opportunities such as in supporting services.

Major Directions for 2002/03 Planning

8. Taking into account the above elements, we have worked out a new planning framework to provide a new sense of direction for HA for the coming years:

- **Developing community oriented service models** to take advantage of new opportunities and overcome volume and access challenges
- **Enhancing organizational performance** through managerial reform, hospital clustering and service rationalization, as well as governance enhancement
- **Enhancing system sustainability** through assisting and advising Government in healthcare financing reform, revamp of charges, implementation of population-based funding and resource allocation system, and continued generation of productivity savings
- **Developing public-private interface** to redress the imbalance in distribution of workload and improve efficiency in the use of available health resources overall
- **Improving cost-effectiveness of the service delivery system** through territory-wide development of quaternary centres and referral networks, knowledge management initiatives, and focused work on specific diseases and conditions
- **Formulating new human resource strategies** to face environmental challenges, and developing people to enhance performance at all levels

2002/03 Annual Plan Programmes

9. Programme initiatives for the coming year in support of each of the above directions are as follows:

(1) Developing community oriented service models to take advantage of new opportunities and overcome volume and access challenges

10. The Volume and Access issue has been accorded number one priority in the HA's annual planning for two years in a row. Without the ability to adjust pricing of services, the Authority has strived to innovate on numerous other measures to tackle the incessant increase in patient demand. So far, effects have not been long lasting. For the coming few years, new opportunities are opened up in relation to the impact of population-based funding, which has the potential of changing the incentive system of resource allocation from one of competition and maximizing patient numbers at the hospital level, to one of keeping the local population healthy and preventing unnecessary inpatient care at the geographical cluster level. There are also new opportunities associated with Government's decision to put the public general outpatient clinics under the HA. This will encourage HA hospitals to integrate secondary / tertiary care with primary care, with a view to offloading stable patients from the specialist system to the primary care system. It will also enable the further development of cost-effective pluralistic primary care, and supply training ground for the Family Medicine programme.

11. Meanwhile, 366 new beds and 80 day places will be opened to meet the rising population needs in Kowloon and the New Territories, and to account for the additional budget allocation from the population-based formula. On disease prevention, we will coordinate with the Department of Health on its cervical cancer screening programme, and invest in smoking cessation clinics. There will also be initiatives to enhance the interface with the Social Welfare Department, Fire Services Department and the Government Flying Service to improve service organization in elderly services and pre-hospital care of emergency patients.

12. Investments on infrastructure will continue to support clinical service delivery. Major capital works for the coming year include the redevelopment of the Pok Oi Hospital and the establishment of a radiotherapy centre at the Princess Margaret Hospital. The former aims to address the growing population needs in the New Territories, while the latter will cater for the rising number of cancer patients as evidenced by the epidemiological trend. On Information Technology (IT), emphases will be put on full-scale roll-out of the Clinical Management System and the development of electronic Patient Record (ePR) to facilitate information sharing. The related network infrastructure will be upgraded to ensure round-the-clock IT support in the clinical environment.

(2) Enhancing organizational performance through managerial reform, hospital clustering and service rationalization, as well as governance enhancement

13. Tremendous strides have been made in 2001/02 in organization reform at HA Head Office, and in the implementation of a cluster management structure at hospital level. So far, the top management team has been revamped to comprise the Chief Executive, five Directors who share out all the central portfolios, and Cluster Chief Executives (CCE). Three CCEs have been appointed in 2001/02 for two intermediate clusters (Hong Kong East and Kowloon East), and one mega-cluster (New Territories East). They are in charge of the performance of all hospitals and service units within the geographical drainage areas, and accountable for the total resources allocated.

14. The HA Board has reviewed the early experience of cluster management, and endorsed its full-scale roll-out to the remaining clusters within 2002/03. A significant portion of new initiatives in this Annual Plan is therefore devoted to the numerous improvement and rationalization programmes at the cluster level. Across the organization, the clinical specialty-based services as well as supporting services will increasingly be planned and reorganized along the ultimate five mega-cluster framework. Such reorganization will serve the purpose of reducing duplication, improving cost-effective use of resources, facilitating training, and leveraging on economy of scale.

(3) Enhancing system sustainability through assisting and advising Government in healthcare financing reform, revamp of charges, implementation of population-based funding and resource allocation system, and continued generation of productivity savings

15. Faced with a deficit budget and awaiting fruition of major system-wide healthcare reform, the HA nevertheless has to be proactive in seeking to facilitate change on the one hand, and continue to improve internal efficiency on the other.

16. The Government's consultation document 'Lifelong Investment in Health' published in 2000 proposes a revamp of the fee structure with the objective of targeting public subsidies at areas of greatest needs. As follow-up work along this direction, we will be providing support to the Health and Welfare Bureau to conduct studies on fees and charges, feasibility of the proposed Health Protection Account, and a willingness-to pay survey. We will also be submitting to the Government proposals on restructuring private charges in HA facilities to more closely reflect the current cost of such services, in line with the principle of full cost recovery for private patients. We will also step up our effort to educate the public on the rationale and need to revise fees and charges for public healthcare services.

17. Major work will be done on a new formula for population-based internal resource allocation in accordance with the five mega-cluster model, and to dovetail with the Government's new funding mechanism to the HA. This will need to address the age-adjusted population needs in each cluster, cross-cluster utilization of services, and cross charging for tertiary/quaternary referrals according to agreed protocols.

18. For the rapidly emerging and often expensive new medical technologies, we will refine our central mechanisms to examine the clinical evidence, coordinate the experience, as well as consider the ethical and financial aspects regarding their introduction. This will not only ensure safety of patients, but also evolve ethical and value-based considerations to guide the prioritization of and subsidy level for those with proven efficacy. In this context, the current outdated list of Privately Purchased Medical Items will have to be revised.

19. Continuous effort will be made to enhance system productivity and generation of savings. We will continue to endeavor on administrative downsizing, and maximize the use of available manpower to take on new programme initiatives as far as possible. Savings will also be generated through cluster-based rationalization of services, central purchasing, process re-engineering and 'Invest-to-Save' programmes. In this respect, we will also support initiatives in environmental protection. Apart from generation of savings through judicious use of energy and resources, we will promote staff awareness and commitment to environmental practices through corporate events.

(4) Developing public-private interface to redress imbalance in distribution of workload and improve efficiency in the use of available health resources overall

20. There is consensus in both the public and private sectors that the current imbalance in utilization between the two, which represents mal-distribution of both workload and use of available health resources, should be redressed as a matter of priority. Following the initiation by the Secretary for Health and Welfare, a number of forums have been kick-started to bring together public and private colleagues to discuss possible collaborative opportunities. In the coming year, hospital clusters will work with the local private practitioners and hospitals on referral guidelines and protocols, as well as facilitation of information on price and services of private providers to be passed on to public patients. We will also experiment with legal sharing of patient information in one cluster, in addition to participation in the Government's Hong Kong Health Information Infrastructure project. Centrally, we will adopt public-private collaborative models in service provision when opportunities arise, such as in the introduction of Positron Emission Tomography service and on taking over of general outpatient clinics from the Department of Health.

21. For the long term, we will propose for Government consideration new financing / insurance schemes for specific population groups to promote public-private interface and to allow more choices for Hong Kong citizens

(5) Improving cost-effectiveness of the service delivery system through territory-wide development of quaternary centres and referral networks, knowledge management initiatives, and focused work on specific diseases and conditions

22. While Continuous Quality Improvement (CQI) has always been integral to our provision of services, the emphasis for the coming year will be increasingly put on system-wide considerations of cost-effectiveness in view of the new environment and challenges. Meanwhile, the important on-going effort in clinical audits and development of clinical guidelines and protocols to ensure the standard of care will continue.

23. To dovetail with the new clustering arrangement and the population-based resource allocation mechanism, there is a need to substantially speed up the development of tertiary and quaternary clinical service networks. Medical services of high complexity and low volume, requiring specialized expertise and sophisticated equipment, will be concentrated at designated centres to ensure efficiency and effectiveness in service delivery. The various Specialty Services Coordinating Committees will be charged with the responsibility of working out such network arrangements, as well as agreeing on referral protocols and cross charging mechanisms.

24. Focused improvement programmes will be implemented for diseases and conditions of high incidence rate, including Cancer, Ischaemic Heart Disease, Stroke, Renal Disease and Mental Illness. In addition, rehabilitation service and long term care for the growing elderly population will be enhanced.

25. In line with our effort in judicious introduction and application of new technology, we will commence Positron Emission Tomography service, implement Nucleic Acid Test to enhance the safety of blood transfusion, and conduct biomedical screening for Down Syndrome to reduce unnecessary fetal loss compared to the traditional method. We will also establish a mechanism to review and monitor research activities in HA hospitals.

26. An HA-wide infection surveillance programme will be launched to reduce the risk of hospital acquired infection. Our electronic knowledge gateway (eKG) will be extended to seven additional specialties to facilitate the use of best evidence in clinical decision-making. We will also explore ways to give healthcare professionals outside the HA accessibility to the eKG service.

27. In line with the Government directive and principles laid down by the HA Board, we will develop a research oriented model for setting up Chinese Medicine clinics in the HA to help establish evidence and standards of practice in Chinese Medicine. Such clinics will be backed up by standardized Chinese Medicine dispensing service, appropriate IT infrastructure, and a central database on the toxicity of Chinese herbs.

(6) Formulating new human resource strategies to face environmental challenges, and developing people to enhance performance at all levels

28. Faced with a demanding and rapidly changing environment, we need to build up a team of dedicated workforce with professional competence and versatility in order that we can meet the numerous challenges ahead.

29. To meet the rising service need and to alleviate the workload of frontline staff particularly the doctors, we will enhance our workforce by recruiting 270 doctors, 400 nurses, 135 allied health professionals and 1000 care assistants. Besides, we will continue the initiative of recruiting 1920 personal care and ward supporting staff which started in 2001/02.

30. Realizing the need for new HR strategies to meet environmental challenges, we have conducted an organization-wide HR review. In the coming year, we will take forward the recommendations to better support the HR functions at cluster level, enhance the competency of HR professionals and re-engineer our HR administrative processes. Major work will go into grade reform for the nursing, pharmacy and a number of allied health grades. In the light of changes in the Government's funding formula to the HA and new environmental challenges, and in line with modern HR practices, we will review the approach of remuneration for new staff.

31. On-going effort will be made on professional and managerial training, including specific programmes to enhance the leadership and management capabilities of our executives to tackle the complex organizational issues. We will also be organizing our 10th anniversary HA Convention to exchange experience and ideas within ourselves and with the international healthcare management community.

32. On staff advocacy, we will continue to promote 'Care for the Carers', including initiatives in occupational safety and health, as well as a new centre for psychological support for staff in need. With additional staff and innovative roster arrangements, we aim to alleviate the long working hours of our frontline doctors. Efforts will also be made to strengthen the management of the HA Provident Fund Scheme and the HA Mandatory Provident Fund Scheme to ensure that our staff's retirement benefits are safeguarded.

PLANNING BACKGROUND

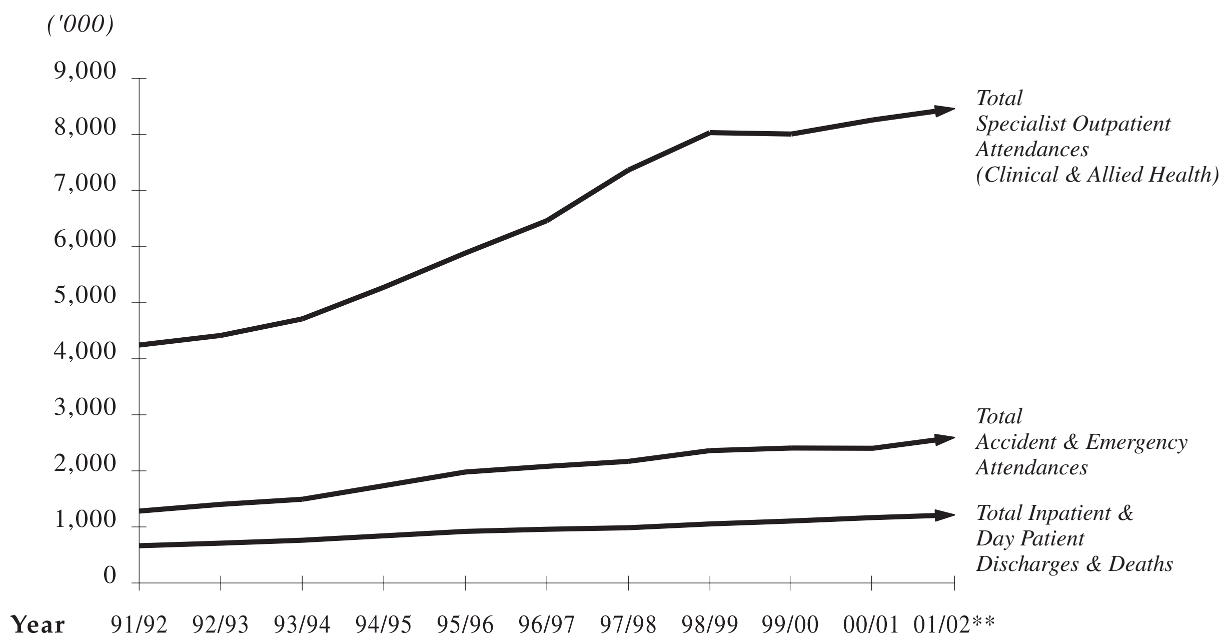
Chapter 1
INTRODUCTION

Simple Facts and Statistics about HA

1.1 HA is responsible for delivering a comprehensive range of hospital, specialist outpatient and community-based services through its network of healthcare facilities. As at 31 December 2001, we managed 44 public hospitals / institutions (Appendix 1), 49 specialist outpatient clinics (Appendix 2) and 13 general outpatient clinics (Appendix 3). We also managed 29,022 hospital beds, representing around 4.2 public hospital beds per 1,000 population, and employed 49,692 full-time and 98 part-time staff. For 2002/03, our recurrent expenditure budget from Government, net of income, is HK$29,881M.

1.2 There has been resurgence in the growth of HA activities in 2001/02 after two years of relative slowing in the rate of activity growth. There have been increases in total inpatient and day patient discharges and deaths, total accident and emergency attendances and total specialist outpatient attendances. The activity trend of HA since 1991/92 is shown in the chart below:

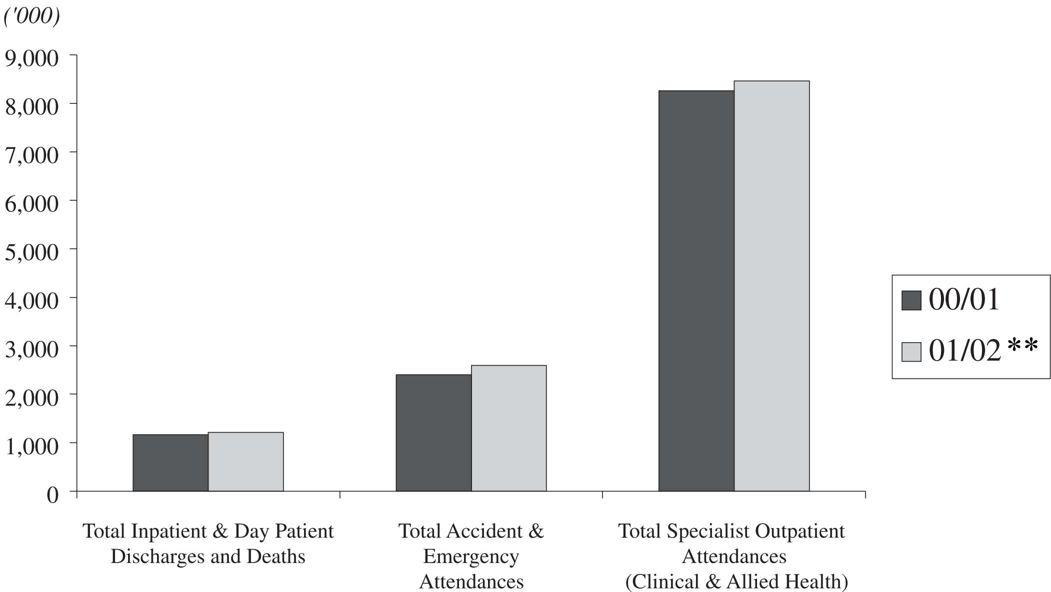
1991/1992 to 2001/02 HA Activities



** Projected figures

1.3 In 2001/02, there were around 1,213,600 inpatient and day patient discharges and deaths, 2,594,700 accident and emergency attendances, 8,461,500 specialist outpatient attendances and 938,800 general outpatient attendances. A comparison of HA's activities between 2000/01 and 2001/02 is as follows:

Comparison between 2000/01 and 2001/02



** Projected figures

1.4 Of all the staff employed by HA as at 31 December, 2001, 69.59% were on direct patient care:

	Staff Strength	
Direct Patient Care (69.59%)	**as at 31.12.2001**	**% of total staff**
Medical	4,454	8.95
Nursing	19,674	39.51
Allied Health	4,593	9.22
General Services Assistant (Care-related), Technical Services Assistant (Care-related), Health Care Assistants & Ward Attendants	5,928	11.91
Subtotal	**34,649**	**69.59**
Indirect Patient Care (30.41%)		
Other Professionals/Management	1,001	2.01
Other Supporting Staff (Clerical, Secretarial, Workmen, Artisan, etc)	14,140	28.40
Subtotal	**15,141**	**30.41**
Total	**49,790**	**100**

Evolution of HA's Annual Planning Process

1.5 We have been publishing our Annual Plan since 1992/93 as part of our commitment to enhance accountability and transparency to the community. Annual Planning provides us with a structured mechanism to turn corporate vision and directions into strategies, goals and operational targets. HA's corporate vision and strategies are detailed in Appendix 4.

1.6 Over the years, the planning process has evolved taking into account the experience gained, input from staff and public, and the service needs of the community. For the past 2 years, our emphases have been to maintain our service level and improve service quality despite the growing financial constraints and the incessant increase in service demand through focused efforts on the following 6 priority areas of work:

- Volume and Access
- Enhanced Productivity Programme (EPP)
- Financing and Resource Allocation System
- Distribution Network and Infrastructure
- Care Process and Quality; and
- Human Resource Capabilities and Management

1.7 With the political, social and economic development unfolding in Hong Kong, it becomes likely that we will continue to face the challenges of budgetary difficulties, increasing workload and system sustainability for a period of time. To maintain and further improve our services commensurate with developments in modern healthcare, a more proactive approach is needed. In the 2002/03 HA Annual Planning process, after revisiting the corporate vision, assessing the environment and analyzing our strengths, weaknesses, opportunities and threats, we have further adapted the 6 priority areas into a new framework to meet our current needs. Based on the new framework, programme initiatives for 2002/03 were formulated. For clinical programmes, input was mainly obtained from the Specialty Services Coordinating Committees as modified at the Service Management Meetings. Input for functional programmes was mainly from Head Office Divisions as modified at Policy Group Meetings while cluster programmes were discussed at Cluster Management Meetings. During the process, comments raised by District Councils and Regional Advisory Committees on HA services were also taken into account.

Chapter 2
REVIEW OF PROGRESS

2.1 The 2001/02 Annual Plan described a total of 249 targets. Of these 249 targets, 235 (94.4%) were achieved according to schedule and 241 (96.8%) were achieved within the year. Details of individual targets not achieved by year end are illustrated below:

Deferred Targets

- *Formulate a service networking plan for optimal utilization of cardiac catheterization laboratory facilities, and conduct clinical audit on Percutaneous Transluminal Coronary Angioplasty (PTCA) and other cardiac interventional procedures:*
  A preliminary survey on cardiac services and definition of outcome indicators has been conducted. The survey indicated a need to develop agreed protocol / guidelines and common definitions of outcome indicators to enable effective audits. To prepare for future audits, an HA-wide survey on current percutaneous coronary interventions (PCI) practices will be conducted in 2002/03 to identify priority areas for clinical guideline development and the generation of a minimal data set. Another review exercise aiming at formulating a rationalization plan for cardiac intervention within HA will also be conducted in the coming year.

- *Commission Positron Emission Tomography (PET) service in HA:*
  Installation of the equipment was deferred to 1Q03. While the service networking plan has been agreed, the project schedule is postponed for a number of reasons: complexity of the tendering process of radioisotopes, rapidly evolving technology for the scanner and dependence of the business model on charging arrangement. Options for the latter are now being formulated.

- *Improve hospital-based Family Medicine training in Ophthalmology, Ear, Nose, Throat (ENT) and Dermatology by centralizing in the form of regional and grouped attachment to selected training centres:*
  This programme has been deferred to 2002/03. The ENT and Ophthalmology programmes are now scheduled to begin in July, 2002 while attachment on Dermatology is being arranged.

Revised Target

- *Implement action plan for consolidation of neurosurgical service into 4 collaborative centres:*
  Target revised to dovetail with the cluster-based management reform. We have reviewed the originally endorsed direction of collaboration. Instead of 4 centres, neurosurgical service will be reorganized into 5 collaborative centres ie. one per mega-cluster. Rationalization is in good progress.

- *Enhance ambulatory service in internal medicine by (i) increasing medical day cases by 5% and (ii) enhancing ambulatory care for patients requiring gastronintestinal endoscopic procedures, chemotherapy, haemological investigations, diabetic stabilization, and diagnostic cardiac procedures:*
  Medical cases suitable for ambulatory care are already done as day cases or at outpatient setting as far as feasible. As accurate quantification of medical day cases is difficult in view of the different definitions adopted, this target has been modified for further pursuit in the coming year.

Suspended Targets

- *Commission 20 beds in Cheshire Home, Shatin through conversion of 4 chalets to cater for the young severely disabled patients:*
  This project was suspended to make way for the parent organization of Cheshire Home, Shatin to engage in a redevelopment plan for the whole of the chalet portion of the institution.

Partially Achieved Targets

- *Conduct 9 critical appraisal skills workshops, 2 meta-analysis workshops and 2 health technology assessment courses & symposium:*
  The target was partially achieved as 2 of the 9 critical appraisal workshops have to be deferred to 2002/03 due to the difficulty in identifying overseas trainers willing to travel.

- *Enhance cluster collaboration on both surgical and paediatric services to assure care standards in Kowloon West:*
  This target was partially achieved. Integration of surgical services between Kwong Wah Hospital and Our Lady of Maryknoll Hospitals has been worked out, and will be implemented in May 2002. Clustering of paediatric services will be conducted on a mega-cluster basis.

Targets Achieved Ahead of Schedule

2.2 The following targets were achieved ahead of schedule:

- *Complete lighting retrofit for energy conservation in a further 9 hospitals in 1Q02*

- *Relocate Yan Chai Hospital Laundry equipment to Tuen Mun Hospital Laundry as replacement for existing worn-out tunnel washer in 1Q02*

- *Roll out automatic dispatching system to Prince of Wales Hospital and Kwong Wah Hospital in 1Q02*
- *Review and monitor performance indicators in 1Q02 as agreed between HA and the government on the implementation of population-based funding in 01/02*
- *Employ 1900 workers by 1Q02 to help alleviate workload to frontline healthcare professionals in support of the Government's Initiative for Wider Economic Participation Programme*
- *Install and commence Magnetic Resonance Imaging service in United Christian Hospital in 1Q02*
- *Implement early intervention programme for young persons with psychotic illness in Castle Peak Hospital in 1Q02*
- *Implement community psychiatric service in North District Hospital in 1Q02*
- *Implement community geriatric service in North District Hospital in 1Q02*
- *Enhance the outreach service of Siu Lam Hospital in 4Q01*
- *Extend the service hours of Magnetic Resonance Imaging service in Tuen Mun Hospital in 4Q01*
- *Commission the Tuen Mun Ambulatory Care Centre in 3Q01*

Chapter 3
HA'S STRENGTHS, WEAKNESSES, OPPORTUNITIES & THREATS

The Environment

3.1 Hong Kong has experienced unprecedented changes in the past few years. Economically and socially, the continued economic ebb has exerted tremendous financial pressure both on society at large and the Government. While the structural deficit of the Government coffer affects funding to the HA, the economic climate also affects consumers' behaviour, including private spending on healthcare. Demand on public healthcare services continues to rise, and out of proportion to the rate of population increase. Those with means are also crowding into public hospitals that offer heavily subsidized service (97% subsidy on average). Close to two-thirds of all attendance to emergency rooms that offer completely free service are non-emergent conditions. In this regard, Hong Kong unfortunately boasts the highest emergency room utilization rate per 1,000 population in the world. Unless the proposed charging mechanism is put into place, such phenomenon will continue to signify inefficient use of scarce public resources. Apart from the increased workload, the liberalization of medical knowledge, particularly through the Internet, has added pressure to the frontline healthcare professionals. Their accountability, both in terms of competence and ethical responsibilities, has been put under closer scrutiny of the community. All such demands upon the HA in the face of budget constraints translate into overload of the system, leading to tension in staff relations as well.

3.2 Politically, the growing politicization in public policy making inevitably subjects the HA to more political considerations in decision-making and service planning. Indeed, HA, with its important societal functions, is prone to be an easy political target. Our response to Government directives and public demand has increasingly become a major area of deliberation not only internally within the Authority but also externally in the legislature and community. The consultation document on healthcare reform titled "Lifelong Investment in Health", published by the Government last year in response to the growing concern on the sustainability of the healthcare system against an environment of aging population, super-specialization and escalating cost of new technology attracted widespread public debate. The issue has invited heated discussion in the political arena but unfortunately, not much headway has been made in terms of consensus for the way forward. As a result, we still have to feel our way to adjust to the current political climate.

HA's Roles

3.3 Given the unfavorable environment, there is all the more reason to refocus on our basic tenet, which is to provide the needed care for those without means, and for catastrophic illnesses. Our 2002/03 annual plan programmes are therefore formulated along these lines.

3.4 Externally, we will continue to contribute our expertise and the extensive information available in our information systems to support Government's initiatives in healthcare reform. We will also actively explore options of public-private collaboration, including the facilitation of possible insurance schemes that would encourage greater use of the private market. We will also adjust the fees and charges of existing private facilities in the HA to more closely reflect the actual cost in line with the private market.

3.5 Internally, we need to further consolidate our service network along the direction of hospital clustering to achieve geographical equity and synergism among different units, as well as reduce duplication of services. In parallel, there is an increasing need to utilize the new mechanisms of technology assessment, evidence-based medicine, and ethical framework to prioritize services that are to be funded by the public purse. Triage of patient referrals to give priority to those with clinical urgency will be increasingly important. Apart from direct service provision, we will have to continue to shoulder the important mission of providing the largest training ground for healthcare professionals in Hong Kong, and continuously adjust that training to meet the changing needs of society.

SWOT Analysis

3.6 In mapping out the directions for 2002/03 Annual Planning, we have analyzed the strengths, weaknesses, opportunities and threats (SWOT) of the organization in relation to the organization challenges.

Strengths

3.7 Our track record of service improvement over the last decade has earned us public confidence and Government support. We have strong assets, both hardware and managerial "software". On the hardware side, we have established infrastructure in the form of service distribution network, physical facilities, information technology and equipment. On the software side, we have sound managerial processes, competent and dedicated staff, and a well-developed culture of continuous learning and improvement. Indeed, we provide the major training ground for healthcare professionals and health executives in Hong Kong. We have developed considerable experience in healthcare management theories and practices that are internationally recognized. We have also established good connections with the Mainland and the international healthcare communities through our annual HA Convention and other activities.

Weaknesses

3.8 Limitations in human resource management flexibility and pricing for our service, and the complicated governance structure and processes have hampered our system's responsiveness to environmental changes. Little control over service demand reduces our ability to tackle the volume and access issue effectively. In addition, professional dominance in swaying public opinion particularly on the use of glamorous technology, together with the industrial lobby, often puts us on the defensive. The relatively weak business expertise has prevented us from capitalizing and leveraging on our assets to generate revenue, exploit business opportunities, or overcome the public-private barrier more effectively.

Opportunities

3.9 Developments in primary and community-based care, together with the experience gained in knowledge management and the use of clinical protocols, have laid good foundation for more cost-effective service organization and disease management. In addition, changes in the labor market have improved the supply of good caliber staff and enabled us to retain a high quality work force. All these, together with the prevailing environmental factors, have opened up new opportunities for service reform. The realities have made parties concerned, including the community and our professional staff, more amenable to change that includes evolution towards geographical cluster management, promotion of public-private collaboration, as well as innovation on business opportunities.

Threats

3.10 The greatest threats right now are obviously the incessantly increasing workload coupled with severe budgetary constraints. The public continues to expect improvements in the level and quality of service, at the same time disagrees to contribute more to the cost, either individually or collectively. The sluggish staff turnover, as a result of the poor job market, also constitutes a threat to the organization as this affects staff's promotion prospect and even the intake of trainees. With rising workload, growing public expectation and uncertain career prospect, staff burnout and staff relation issues will need to be addressed.

3.11 Faced with the rapid and unprecedented environmental changes, there is a great need for changes and innovative solutions at various levels of the organization so that the challenges can be overcome.

Chapter 4
BUDGET ALLOCATION FOR 2002/03

Funding from Government

4.1 The recurrent budget allocated from Government to the HA for 2002/03, net of income, is HK$29,881M. The budget is derived from the population-based funding formula introduced in 2001/02 plus additional allocations for new programmes, and less $600M (2% of baseline) as part of the Government's Enhanced Productivity Programme. In addition, the Government will provide us with $395M for information technology development and the purchase of additional or replacement equipment and vehicles.

HA's Overall Financial Position

4.2 The organization has for the first time recorded a deficit in the year 2001/02, primarily resulting from high staff cost, low staff turnover rate, and the need to continue recruiting new staff to cope with the ever increasing service demand from the population. Such deficit is expected to worsen for 2002/03 and extend into 2004/05, despite the very stringent savings programmes that will be put in place across the organization. This will heavily draw on the HA's reserve accumulated over the years. The main contributing factors for such deficits are:

- Staff turnover is low under the current economic environment. Savings generated from staff turnover are insufficient to cover the additional 'creep' for existing staff moving to higher points of their pay scales. The latter amounts to some $535M in 2002/03, for which there is no separate funding from Government.

- Some $600M is deducted from the HA budget as part of the Government's Enhanced Productivity Programme.

- Income for 2002/03 is projected to fall short of the budget by $137M, mainly because of the prevailing low interest rate.

- Despite the projected deficit, HA still needs to increase intake of clinical staff to cope with the rapid growth in service demand including opening of new beds and facilities in line with the population-based new allocations, and specifically funded new programmes. In addition, HA needs to improve the long working hours of doctors through recruiting new staff, as well as provide training to new graduates of the various healthcare professions.

4.3 The projected deficits will have to be covered by our revenue reserve and cash flow management in the interim. In parallel, we will continue to enhance productivity in the system by administrative downsizing and business support initiatives. The move towards cluster management should be able to generate system-wide efficiency gain in human resources and material management. With further effort on demand management and review of our human resource policies and practices, it is projected that the unfavorable budgetary situation will reverse in 2005/06, assuming that additional funding will continue to be allocated to HA in accordance with the agreed population-based formula.

Resource Allocation for Existing Services and New Projects

4.4 Most of the funding is to maintain the existing level, scope and volume of services provided by HA hospitals and institutions. In 2002/03, hospitals are expected to use 98% of their resource allocation baseline to fund existing services. We plan to open 366 new beds in the Kowloon, North District, Tai Po, United Christian and Tuen Mun Hospitals. In addition, 80 day places will be opened in the North District Hospital.

4.5 We are allocated new monies through the Government's resource allocation exercise (RAE) for the ongoing development and extension of the ambulatory and outreach services for the mentally ill, the enhancement of psychiatric services through a pilot Extended care patients Intensive Treatment Early diversion and Rehabilitation Stepping-stone (EXITERS) projects, the strengthening of smoking cessation services, the introduction of elderly suicide prevention programme, and the development of Chinese Medicine outpatient services. In addition, funding is provided to commission the opening of the Fanling Health Centre, and to prepare for the future management transfer of the remaining general outpatient clinics from the Department of Health.

4.6 We are participating for the second year in Government's Initiatives for Wider Economic Participation as announced in the HKSAR Chief Executive's 2000 Policy Address with the objectives of meeting community needs for healthcare and creating 2,500 jobs in 2001/02 and 2002/03. Following the 2001 Policy Address, we will also participate in this Government initiative to create an additional 1,000 jobs to strengthen extended care services in 2002/03. An additional amount is also allocated to HA for the creation of 428 jobs to commence in 2002/03.

Government Funding 2002/03

4.7 The table below outlines the Government funding and projected income for HA for 2002/03:

	Government Funding $Mn
Recurrent Expenditure	
Personal Emoluments	17,311
Staff On-Cost	7,669
Sub-Total	24,980
Drugs, Medical Supplies & Instruments	2,640
Other Charges	3,262
Sub-Total	5,902
Total Recurrent Expenditure	**30,882**
Income	
Medical	766
Non-Medical	235
Total Income	**1,001**
Recurrent Expenditure Net of Income	**29,881**

MAJOR DIRECTIONS AND PROGRAMME INITIATIVES FOR 2002/03 HA ANNUAL PLAN

Chapter 5
SIX NEW DIRECTIONS

5.1 Taking into account the environmental factors and the SWOT analysis, we have further adapted the 6 priority areas of work for the past two years to a new context to meet our current needs. The revised framework, comprising the following directions, will provide a new sense of direction for HA for the coming years.

- **Developing community oriented service models** to take advantage of new opportunities and overcome volume and access challenges

- **Enhancing organizational performance** through managerial reform, hospital clustering and service rationalization, as well as governance enhancement

- **Enhancing system sustainability** through assisting and advising Government in healthcare financing reform, revamp of charges, implementation of population-based funding and resource allocation system, and continued generation of productivity savings

- **Developing public-private interface** to redress the imbalance in distribution of workload and improve efficiency in the use of available health resources overall

- **Improving cost-effectiveness of the service delivery system** through territory-wide development of quaternary centres and referral networks, knowledge management initiatives, and focused work on specific diseases and conditions

- **Formulating new human resource strategies** to face environmental challenges, and developing people to enhance performance at all levels

Chapter 6
DEVELOPING COMMUNITY ORIENTED SERVICE MODELS

to take advantage of new opportunities and overcome volume and access challenges

6.1 The Volume and Access issue has been accorded number one priority in the HA's annual planning for the past two years. Without the ability to adjust pricing of services, the Authority has strived to innovate on numerous other measures to tackle the incessant increase in patient demand. For the coming year, we will continue to make use of technology assessment and evidence-based medicine to prioritize services, and improve on the triage system, so that priority will be given to patients with clinical urgency.

6.2 At the macro level, new opportunities are opened up in relation to the impact of population-based funding. It has the potential of changing the incentive system from one of competition and maximizing patient numbers at the hospital level, to one of keeping the local population healthy and preventing unnecessary inpatient care at the geographical cluster level. There are also new opportunities associated with Government's decision to put the public general outpatient clinics under the HA. This will encourage HA hospitals to integrate secondary / tertiary care with primary care. Stable patients can be offloaded from the specialist system to the primary care system, while better primary care keeps people healthier and away from the specialist system. This will also enable the further development of cost-effective pluralistic primary care, and supplies training ground for Family Medicine.

Opening of New Beds and Facilities

6.3 To meet the rising service demand particularly in Kowloon and the New Territories where the population is ageing and expanding, and to account for the additional budget allocation from the population-based formula, we will increase our service capacity by opening new beds and day places, as well as enhancing our clinical services in clusters / hospitals.

- *Provide 366 additional beds:*
  - *68 acute general beds in United Christian Hospital* 2Q02
  - *23 convalescent beds in United Christian Hospital* 3Q02
  - *9 hospice beds in Tuen Mun Hospital* 3Q02
  - *4 Intensive Care beds in North District Hospital* 3Q02
  - *100 infirmary beds in Pok Oi Hospital (Tin Ka Ping Centre)* 2Q02
  - *162 psychiatric beds in Kowloon Hospital* 4Q02

- *Provide 80 additional day places in North District Hospital* 4Q02

- *Implement day hospice programme in two more clusters (New Territories South & Hong Kong East)* 4Q02

- *Deploy clinical staff to enhance the Otorhinolaryngology (ENT), Pathology and Neurosurgical services of Tuen Mun Hospital* 3Q02

Takeover of General Outpatient Clinics from Department of Health

6.4 The Government has decided to put the public general outpatient clinics under the HA. Following the completion of the pilot transfer of the first five clinics in 2001/02, we are working with the Government on the takeover of the remaining 59 general outpatient clinics from the Department of Health.

- *Develop an implementation plan including staff transfer, infrastructure enhancement and financial accounting system for taking over of general outpatient clinics from Department of Health* 1Q03

Service Rationalization between General Outpatient and Hospital Cluster Services

6.5 Specialist outpatient and Accident and Emergency services are the major sources of our service demand. We will improve the coordination and inter-referral between general outpatient, specialist outpatient and accident and emergency services to manage patient volume and prioritize care according to clinical needs.

- *Set up cluster-based management structure to provide training in primary care and coordinate general outpatient clinic and integrated clinic services* 4Q02

- *Formulate referral and clinical practice guidelines for selected disease and patient groups across the general outpatient, specialist outpatient and Accident & Emergency services* 4Q02

- *Formulate triage guidelines for specialist outpatient new cases and inter-specialty referrals* 3Q02

Development of Pluralistic Primary Care Services

6.6 To integrate secondary / tertiary care with primary care with a view to achieving an optimal balance between the specialist and primary care systems, we will further develop the cost-effective primary care system. We will also enhance the delivery of community care and interface with other providers in the community.

- *Recruit 100 trainees for Family Medicine training in 2002-2003* — 3Q02
- *Pilot 8 community-based healthcare projects with emphasis on the health / welfare interface* — 4Q02
- *Extend post-discharge community allied health service teams to 4 hospitals and develop mutual referral and training among community nursing teams and community allied health teams* — 4Q02

Development of Cost-effective Nurse-led Services

6.7 To improve the cost-effectiveness of and access to care, nurse-led clinics were piloted in ten HA hospitals in the past three years. Under the system, Nurse Specialists or nurses with advanced nursing competency and clinical experiences provide patient services according to protocols with doctor back-up. Because of the positive feedback on the pilots, the service will be extended to more hospitals in the coming year. Multi-skilled community outreach nursing service will also be implemented for the chronically and terminally ill.

- *Enhance midwifery-based maternity service in New Territories East Cluster* — 2Q02
- *Establish nurse-led Diabetes Mellitus clinics in Our Lady of Maryknoll Hospital, Tung Wah Eastern Hospital & Tseung Kwan O Hospital, stoma / wound care in Pamela Youde Nethersole Eastern Hospital, continence care in Tung Wah Group of Hospitals Wong Tai Sin Hospital and North District Hospital and primary care in 5 pilot general outpatient clinics* — 1Q03
- *Implement multi-skilled community outreach nursing service to patients for rehabilitation (fracture hip, stroke and hospice) in the community* — 4Q02

Implementation of Cost-effective Programmes in Disease Prevention

6.8 To improve the health status of the population, we will coordinate with the Department of Health on specific disease prevention programmes. Health education and promotion materials will also be produced.

• *Assess impact on HA services arising from Department of Health's cervical cancer screening programme and to coordinate service planning with Department of Health*	1Q03
• *Establish 10 hospital and community-based smoking counselling and cessation centres beginning 2002 and conduct smoking cessation sessions for 2,500 smokers per year*	1Q03
• *Empower 1,500 independent elderly and 2,500 informal carers through the Smart Elderly Programme*	1Q03
• *Formulate overall strategy for development of volunteer services in HA*	4Q02
• *Design and produce 20 sets of health education and promotion materials for patients and the public in coordination with different Specialty Services Coordinating Committees*	1Q03

Enhancement of Interface with Government Departments Involved in Service Delivery

6.9 For more effective service organization, we will, as a continuous effort, enhance our interface with various Government departments. We will also contribute to the training of healthcare professionals for the welfare sector as commissioned by the Government.

• *Agree with Social Welfare Department the future development directions for role delineation of Medical Social Workers in clinical and community settings*	1Q03
• *Rectify the mixed provision situation of Medical Social Workers by recruiting new Medical Social Workers in 9 Schedule II hospitals to replace the outgoing Medical Social Workers from Social Welfare Department*	3Q02
• *Collaborate with Fire Services Department and the Government Flying Service to streamline pre-hospital care & to improve communication with Accident & Emergency Departments*	1Q03

- *Recruit and train 100-120 students per year for two intakes in the Higher Diploma Nursing Programme for the welfare sector as commissioned by Government to be commenced in September 2002* 3Q02

- *Organize training programmes for community healthcare professionals for the welfare sector* 1Q03

Development of HK Health Information Infrastructure

6.10 The Government, in the 'Lifelong Investment in Health' consultation document published in 2000, proposed to develop a computer-based Health Information Infrastructure (HII). It will encompass both public and private healthcare sectors to enable the sharing of medical knowledge for improving patient care, and subject to individual patient's wishes, for sharing patient records. As we have already developed comprehensive information systems to assist clinical management, and are working towards electronic patient records for our patients, initial HII activities will focus on the public sector. We were commissioned by the Health and Welfare Bureau to carry out the Project Definition Study (PDS) for the HII project in 2001/02 and will continue to contribute to the development of the infrastructure.

- *Provide assistance to the Government in preparation of the Health Information Infrastructure Project* 1Q03

Infrastructure Enhancement

6.11 Investment in infrastructure will continue to support clinical service delivery. On capital works, we are planning and constructing new facilities to meet the increasing healthcare needs arising from an ageing and expanding population. The planning of new facilities will cater for improvements and trends for modern healthcare delivery. These include the shift from inpatient to ambulatory and community care, meeting basic customer needs and the requirements for technologically advanced diagnostic, treatment and supporting facilities. The major capital works for the coming year include the redevelopment of the Pok Oi Hospital and the Radiotherapy Centre at the Princess Margaret Hospital to meet the medical care needs of the rising population in the Yuen Long and Tin Shui Wai districts and the rising number of cancer patients as evidenced by the epidemiological trend.

6.12 On information technology (IT), developments will be focused on the full-scale roll-out of the Clinical Management System and the development of electronic Patient Record (ePR) to facilitate information sharing. IT infrastructure and capabilities will also be upgraded to facilitate the streamlining of processes and to ensure effective round-the-clock IT support in the clinical environment. Besides, we will also assist in the IT development of the Prince Philip Dental Hospital through consultancy arrangement.

- *Commence the site formation and foundation works of the redevelopment of Pok Oi Hospital* — 2Q02
- *Commence the demolition of Block H for establishment of a radiotherapy centre at Princess Margaret Hospital* — 4Q02
- *Conduct an assessment on the demand and supply of hospital beds & ambulatory care facilities in HA* — 1Q03
- *Implement and upgrade corporate information systems and equipment in the new hospital blocks of Caritas Medical Centre, Kowloon Hospital Phase I, Ruttonjee Hospital renovation, Castle Peak Hospital new block* — 1Q03
- *Continue to implement the Clinical Management System (Outpatient) core functions within the specialist outpatient departments of 10 non-acute hospitals* — 1Q03
- *Establish the IT infrastructure and implement the necessary information systems in Fanling Clinic and commence the preparation infrastructure work for the clinics planned to be taken over in 2003* — 1Q03
- *Enhance the Clinical Data Analysis & Reporting System (CDARS) Phase 1 and implement in all hospitals* — 1Q03
- *Enhance the content of the electronic Patient Record (ePR) by extracting and transforming data from clinical systems, including allergy, attendance & admission history, Laboratory Information System, Radiology Information System* — 1Q03

• *Enhance the functionality of Clinical Management System Phase II by developing and implementing the following:* - *Generic Clinical Request (GCR) module* - *Generic Result Reporting (GRR) module* - *Medication Decision Support (MDS) module* - *Clinical Data Framework (CDF) module* - *Rehabilitation Outcome (RO) module*	1Q03
• *Carry out a study on infrastructure design on the adoption of Public Key Infrastructure (PKI) and implementation for pilot projects*	1Q03
• *Implement the Electronic Data Interchange (EDI) engines for setting up patient data interface in 6 hospitals*	1Q03
• *Continue the implementation of the HA Network Strategy Phase 1 in 3 acute hospitals and 10 non-acute hospitals and institutions*	1Q03
• *Continue enhancement of midrange (Unix) computing environment for mission critical clinical systems in terms of service availability, management and security*	1Q03
• *Continue to replace the Laboratory Information System from the Delphic version to the corporate ECPath version for the remaining 3 hospitals*	1Q03
• *Acquire hosting services for existing and additional IT/IS equipment and facilities for mission critical clinical applications, new IT development and initiatives to overcome current constraints*	2Q02
• *Upgrade the Internet infrastructure to enhance the Internet access services and security*	1Q03
• *Enhance operating environment of the corporate data centre at Hospital Authority Building for mission critical clinical applications by:* - *Replacing uninterruptible power supply (UPS) system* - *Upgrading air-conditioning system*	1Q03
• *Replace the uninterruptible power supply (UPS) system and install parallel redundant UPS at Queen Mary Hospital data centre*	1Q03

- *Further enhance HA IT Call Centre infrastructure* — 1Q03
  - *Enhance Call Centre web site to include knowledge management*
  - *Integrate Problem Management System with telephony equipment*

- *Enhance the Radiology Information System core modules to support cluster initiatives and link up non-acute hospitals to the major acute hospitals* — 1Q03

- *Implement the Radiology Information System - Nuclear Medicine module in 1 hospital* — 1Q03

- *Relink the Laboratory Information System of the North District Hospital from New Territories North Cluster to New Territories East cluster* — 1Q03

- *Develop the corporate version of the antenatal record system (ARS) and extend it to North District Hospital and Alice Ho Miu Ling Nethersole Hospital of New Territories East Cluster as a pilot* — 1Q03

- *Enhance the Medical Records Tracing System (MRTS) to support cluster-wide medical record management; and improve performance measurement indicators on the medical record services* — 1Q03

- *Enhance Outpatients Appointments System (OPAS) to interface with electronic money collection machines and develop the Patient Billing Revenue Collection (PBRC) interfaces* — 1Q03

- *Assist IT development in Prince Philip Dental Hospital through consultancy arrangement* — IQ03

Chapter 7
ENHANCING ORGANIZATIONAL PERFORMANCE
through managerial reform, hospital clustering & service rationalization, as well as governance enhancement

7.1 Tremendous strides have been made in 2001/02 in organization reform at HA Head Office, and in the implementation of a cluster management structure at hospital level. So far, the top management team has been revamped and three Cluster Chief Executives have been appointed. In the coming year, we will aim at strengthening the leadership role of the top management team with the full-scale roll-out of the cluster management structure. To facilitate planning and organization of our services, we will enhance our interface with Government departments involved in the delivery of healthcare services. We will also improve our clinical governance at both the corporate and cluster levels.

Enhancement of Interface with Government

7.2 The roles amongst the Department of Health, Social Welfare Department and HA on the provision of health and welfare services are evolving. To facilitate planning, monitoring and organization of HA services, we will improve our liaison with the Health and Welfare Bureau and other parties concerned. We will also be providing consultancy support to the Prince Philip Dental Hospital (PPDH) on its management reform.

- *Align and clarify working relations among executives, HA Board and Secretary for Health & Welfare through a series of workshops and memorandum of administrative arrangement* — 4Q02
- *Enhance coordination in planning process with Health & Welfare Bureau, Department of Health and Social Welfare Department through structured planning meetings and agreed format* — 3Q02
- *Revamp quarterly report review process with Health & Welfare Bureau and propose new performance monitoring parameters in line with the population-based funding mechanism* — 3Q02
- *Strengthen liaison and support to the Research Office and policy formulation role of Health & Welfare Bureau* — 3Q02
- *Provide consultancy support on the management reform of Prince Philip Dental Hospital (PPDH) upon request by the PPDH Board* — 2Q02

Organization Reform & Strategic Repositioning of HA Head Office

7.3 We have revamped our top management structure in 2001/02 with the top management team now comprising the Chief Executive, Directors and the Cluster Chief Executives. With the full-scale roll-out of the formal cluster management structure, we will continue to strengthen the roles of Head Office in leading the Authority to meet the challenges ahead.

- *Revamp top management leadership team with establishment of formal decision-making structure comprising Chief Executive, the newly appointed Directors and Cluster Chief Executives* 3Q02

- *Strengthen Head Office's roles in strategic leadership, policy setting, managerial innovations, and as clearing house for cluster initiatives through new mechanism* 2Q02

Implementation & Evolution of Formal Cluster Management Structure

7.4 Currently, the HA hospitals are organized into eight clusters. Under the mega-cluster management structure, all HA hospitals will ultimately be grouped into five mega-clusters in 2-3 years as follows:

- Hong Kong East and West combined to form the *Hong Kong Cluster*
- Kowloon East and Central combined to form the *Kowloon East Cluster*
- Kowloon West and New Territories South combined to form the *Kowloon West Cluster*
- The *New Territories East Cluster* has been formed
- The present New Territories North will be re-titled *New Territories West Cluster*

7.5 Apart from achieving economy of scale by leveraging on automated processes and facilitating more cost-effective use of resources, the new structure will enable further integration and collaboration within and amongst various clinical services and hospitals to improve care. It can also provide better training and career development opportunities for staff in the cluster as well as facilitate community-based healthcare services through collaboration with other healthcare providers within the local community.

7.6 Three Cluster Chief Executives have been appointed in 2001/02 for two intermediate clusters (Hong Kong East and Kowloon East), and one mega-cluster (New Territories East). They are in charge of the performance of all hospitals and service units within their geographical drainage areas, and accountable for the total resources allocated. The HA Board has reviewed the early experience of cluster management, and endorsed its full-scale roll-out to the remaining clusters within 2002/03. In line with the new structure, clinical specialty-based services as well as supporting services will increasingly be planned and reorganized along the ultimate five mega-cluster framework.

- *Roll out formal cluster management structure to all clusters with the appointment of Cluster Chief Executives for remaining clusters* — 1Q03

- *Conduct job evaluation and review for senior managerial posts under the cluster management arrangement* — 1Q03

- *Formulate cluster performance measurement at the corporate level and cluster level to dovetail with population-based resource allocation, and development of community-based care model* — 1Q03

- *Evaluate cluster management approaches and cluster management structure, with the view to arrive at recommendation on the future model* — 1Q03

Cluster-based Organizational Development and Service Rationalization

7.7 A significant portion of the new initiatives under the 2002/03 Annual Plan is on the improvement and rationalization programmes at the cluster level. Such programmes are mainly centred around managerial and administrative functions as well as clinical services in the clusters. Detailed programme initiatives for individual clusters are listed in the individual cluster plans in Chapters 12 to 19.

Evolution of Governance at Corporate and Cluster Levels

7.8 As a responsible and accountable organization, it has always been our concern to strengthen the governance structure at different levels in the HA. At the corporate level, we will enhance our governance oversight over issues of ethical concern, which have increasingly become subjects of debate in the community. We will also improve our public complaints system and strengthen the function of internal audit in the organization's governance framework. At the cluster level, we will review the governance structure and functions in the light of cluster management development.

• *Establish a Clinical Ethics Committee to oversee issues requiring ethical considerations in service delivery*	2Q02
• *Establish international standards for Research Ethics Committee to oversee the protection of human subjects involved in clinical research activities*	1Q03
• *Employ the risk management approach to address issues arising from complaints so as to bring about system enhancements, and to improve the feedback process of the Public Complaints Committee*	2Q02
• *Revise Internal Audit policy to position this function as an integral part of HA's governance framework*	2Q02
• *Review governance structure and functions in the light of cluster management development*	4Q02

Chapter 8
ENHANCING SYSTEM SUSTAINABILITY

through assisting & advising Government in healthcare financing reform, revamp of charges, implementation of population-based funding & resource allocation system, & continued generation of productivity savings

8.1 Sustainability of the HA system has become a growing concern of society. Hong Kong is undergoing demographic transition similar to most developed countries with a rapidly ageing population. It is anticipated that those aged 65 or above, who constituted about 11% of the population in 2001, will rise to about 13% in 2016. This, together with the life-style of a cosmopolitan city, has resulted in an increase in illnesses like diabetes mellitus, stroke and heart diseases that require long term care. Added to this is the escalating healthcare cost particularly for the advanced, but often expensive medical technology, as well as the budgetary issues that we are now faced with. We have therefore to take a proactive role in seeking to facilitate change on the one hand, and continue to improve internal system efficiency on the other.

Provision of Support to Government on Healthcare Financing Reform

8.2 The Government's consultation document 'Lifelong Investment in Health' published in 2000 proposed a revamp of the fee structure with the objective of targeting public subsidies at areas of greatest needs. Towards this end, we have been managing, on behalf of the Government, a study on the relationship between fee levels and the utilization of public healthcare services. Following the completion of the study, we will assist in the consultation process and take steps to implement the short term recommendations as directed by the Government. The consultation document also proposes that a study be carried out on the Health Protection Account. We will therefore also provide input and analysis to the Government in this aspect. We will also be studying the feasibility of insurance products in public healthcare services in collaboration with the insurance industry. This is aimed to further promote the public-private interface and will also allow more choices in healthcare services for the citizens of Hong Kong.

- *Provide support to Health & Welfare Bureau in developing the Fees & Charges Consultancy Study results into policy options and plans* — 1Q03
- *Assist the Health & Welfare Bureau in conducting studies for the proposed 'Health Protection Account' by providing support in utilization analysis and financial projections* — 1Q03
- *Condutc a 'Willingness to pay' study for private insurance benefits among the general public* — 1Q03

- *Examine strategies and options of creating new financing / insurance schemes to promote public-private interface, and to allow more choices for Hong Kong citizens* 4Q02
- *Prepare for implementation of new charges for Accident and Emergency service and specialist outpatient medication, pending Government direction* 1Q03
- *Conduct feasibility study for insurance options in the use of public funds on service provision* 1Q03

Revamp of Private Charges in line with No Subsidy Principle

8.3 A review of private charges in 2001/02 has suggested that our private ward services are being subsidized as the fee level has not caught up with the rise in service cost. We will therefore be submitting to Government proposals on restructuring private charges in HA facilities to more closely reflect the current cost of such services, in line with the principle of full cost recovery for private patients.

- *Develop costing information for the major procedures and services* 1Q03
- *Submit to Government the proposed direction for restructuring of private charges* 4Q02

Review to Rationalize Different Levels of Subsidy for New Technology and Alternative Treatment Modalities

8.4 For the rapidly emerging and often expensive new medical technologies, we will refine our central mechanisms to examine the clinical evidence, coordinate the experience, as well as consider the ethical and financial aspects regarding their introduction. This will not only ensure safety of patients, but also evolve ethical and value-based considerations to guide the prioritization of and subsidy level for those technology or modalities with proven efficacy. In this context, the current outdated list of Privately Purchased Medical Items will need to be revised.

- *Plan for the establishment of a central mechanism to consider the ethical and financial aspects regarding the introduction of and subsidy levels for new diagnostic and therapeutic modalities and treatment of patients' own choice* 1Q03
- *Propose to Government to revise the list of Privately Purchased Medical Items* 1Q03

Deliberation on Population Funding Mechanism with Government

8.5 The population-based funding formula for Government allocation to HA was implemented in 2001/02, and will be subject to review every three years. We will undertake a review of the assumptions within the funding formula in the light of financial projections and the experience of application.

4Q02

- *Review the agreement with Government on the implementation of performance reporting related to population-based funding*

Formulation of Population-based Internal Resource Allocation System

8.6 Major work will be done on a new formula for population-based internal resource allocation in accordance with the five mega-cluster model, and to dovetail with Government's new funding mechanism to the HA. We will take into account the age-adjusted population needs in each cluster, cross-cluster utilization of services, and cross charging for tertiary / quaternary referrals according to agreed protocols. The new system will encourage cost-effective use of resources, appropriate care, volume management, development of ambulatory and community care, and implementation of public-private partnership initiatives. In addition to developing the resource allocation system for recurrent funding, strategies on capital funding will also be explored.

1Q03

- *Develop a working model for population-based resource allocation framework with parameters and cross charging methodology for quaternary, tertiary and secondary services defined and agreed*

1Q03

- *Define and agree on cross-cluster quaternary referral conditions and protocols through the work of Specialty Services Coordinating Committees*

1Q03

- *Develop information systems to support new resource allocation mechanism*

1Q03

- *Develop costing methodology and coordinate costing by clusters*

4Q02

- *Explore strategies on budget allocation to hospitals for capital items*

Continuous Enhancement of System Productivity & Generation of Savings

8.7 We have been subject to Government's Enhanced Productivity Programme (EPP) since 2000/01. Under the programme, our recurrent funding from Government is adjusted downward by 5% for three years until 2002/03. This is on top of the over 11% productivity gain already achieved by us prior to the EPP period, and in spite of the huge increase in service volume in recent years. To address the issue, we will continue to leverage on initiatives proven in past years which include rationalization of services in clusters (detailed programmes in Chapters 12 to 19), central purchasing, process re-engineering and 'Invest-to-Save' programmes. Under the 'Invest-to-Save' programme, funding is set up to facilitate investments by hospitals to implement productivity saving projects, which can generate real money savings. Since its introduction in 2000/01, over 100 projects totaling HK$329M have been approved. Nearly 35% of the projects are on energy conservation while others are on kitchen and catering, laboratory and other automation ventures. So far, 28 projects have been completed, yielding a total annual saving of HK$11.3M. Savings will also be generated through administrative downsizing and the maximized use of available manpower to take on new programme initiatives as far as possible.

- *Implement energy conservation projects to reduce energy costs by $13M through roll-out of energy conservation measures in 13 Hospitals* — 1Q03
- *Achieve productivity savings of $12M from electrical & mechanical and biomedical engineering services through Electrical and Mechanical Services Trading Fund (EMSTF) to provide new services for 02/03* — 1Q03
- *Leverage on economy of scale in centralized purchasing and acquisition of services to generate savings:*
  - *Pilot "total solution" contract for supply, distribution & logistics support of general consumables and stationery* — 4Q02
  - *Pilot "flexible contracting" with bulk leverage discount with technology upgrades for supply of Linear Accelerators and Anaesthesia Machines* — 1Q03
  - *Develop 16 standard contract specifications for bulk purchase of common medical equipment* — 4Q02
  - *Arrange bulk outsourcing of the maintenance of 4000 items of medical equipment with value-added services for Schedule II hospitals* — 4Q02
  - *Implement centralized purchasing and supplies management in hospital clusters* — 4Q02

1Q03

- *Further enhance the e-procurement functions and services provided to HA hospitals:*
  - *Enhance Purchase Requisition Information System (PRIS) to provide clustering procurement support, and*
  - *Expand Electronic Data Interchange (EDI) to include messaging for delivery, inventory and invoice information for bulk contracts* 1Q03

- *Achieve ISO 9000 accreditation for Biomedical Engineering Service* 1Q03

- *Develop a business solution and contract specification for provision of centralised food production service through a public-private-partnership project* 3Q02

- *Enhance Asset Management System and generate exception report on equipment utilization* 1Q03

- *Develop tools to monitor and review management and support staff mix* 1Q03

- *Redeploy staff from within HA to meet service needs for new beds and services* 1Q03

- *Achieve a further 5% reduction in Head Office headcount and expenditure*

Implementation of Environmental Friendly Practices

8.8 The hospital industry is a significant concern in environmental protection circles world-wide. We feel obliged to continue our effort on protecting the environment. Apart from the judicious use of energy and resources that can generate savings, we will promote staff awareness and commitment to environmental practices through corporate events. 1Q03

- *Implement Waste Wise Scheme in HA hospitals in partnership with the Hong Kong Productivity Council & Environmental Protection Department in promoting reduction, reuse and recycling for paper, aluminium cans and printing toners*

2Q 02

- *Strengthen staff awareness and commitment through corporate events:*
  - *Dedicated session in HA Convention 2002 to discuss environmental protection in healthcare* 1Q 03 1Q 03
  - *Corporate Environmental Protection Campaign* 4Q 02
  - *Tree Planting Day*
  - *Web page on environmental protection initiatives*

Chapter 9
DEVELOPING PUBLIC-PRIVATE INTERFACE

to redress the imbalance in distribution of workload & improve efficiency in the use of available health resources overall

9.1 HA's patient volume has ever been increasing since its establishment. In the past two years, we contributed to about 94% of the total inpatient days in Hong Kong. There is consensus in both the public and private sectors that the current imbalance in utilization between the two should be redressed as a matter of priority. The imbalance represents mal-distribution of both workload and use of available health resources. It is critically affecting the sustainability of the healthcare system in Hong Kong. Following the initiation by the Secretary for Health and Welfare, a number of forums have been kick-started to bring together public and private colleagues to discuss possible collaboration opportunities. The Government's consultation document on Healthcare Reform talks about 3 kinds of barriers between the public and private sectors i.e. information, clinical and financial barriers. We will focus our efforts on strengthening and building the information and clinical bridges, and actively support the Government and other parties on all three.

Protocol Driven Public-private Collaboration

9.2 As an important pillar of the clinical bridge, hospital clusters will work with the local private practitioners and hospitals on referral guidelines and protocols. Shared care will also be explored. We will also facilitate the passing of information on price and services of private providers to public patients.

- *Formulate cluster-based referral protocols with private practitioners for selected clinical conditions* — 3Q02

- *Explore feasibility of shared care in cataract surgery* — 3Q02

- *Explore partnership with local practitioners on discharge planning for patients with asthma* — 4Q02

- *Explore feasibility of partnership between Precious Blood Hospital and Caritas Medical Centre in hospice care* — 4Q02

Collaborative Models on Service Provision with Private Sector

9.3 We will experiment on public-private collaborative models on service provision ranging from primary care to specialized services.

- *Introduce Positron Emission Tomography service through collaboration with private provider of isotopes* 1Q03
- *Introduce sessional private practice in selected general outpatient clinics* 1Q03
- *Explore cluster-based collaborative schemes with private hospitals in human resources* 1Q03
- *Explore bulk purchase leverage in the combined purchase of drugs for both public and private hospitals* 1Q03

Training and Education Initiatives for Private Practitioners

9.4 To support the clinical bridge, we will capitalize on our professional expertise and knowledge infrastructure to provide training and education to private practitioners. We will also explore ways for healthcare professionals outside the HA to access our electronic knowledge gateway (eKG) service.

- *Provide 2 structured Continuous Medical Education (CME) programmes for practising doctors who are not taking CME programme for specialists co-organised by Hong Kong Medical Association and Kwong Wah Hospital / Queen Elizabeth Hospital* 2Q02
- *Provide Continuous Medical Education (CME) programmes for practising doctors who are not taking CME programme for specialists to pirvate practitioners* 2Q02
- *Offer skills training courses for private practitioners in Obstetrics & Gynaecology* 4Q02
- *Pilot collaboration with private ophthalmologists in training* 3Q02

Building of Information Linkage to Facilitate Public-Private Shared Care

9.5 To provide the information bridge, we will experiment with legal sharing of patient information in one cluster, in addition to participation in Government's Hong Kong Health Information Infrastructure project.

- *Pilot IT enabled public-private shared care in Prince of Wales Hospital* 4Q02
- *Pilot patient health record in general outpatient clinics* 2Q02
- *Collaborate with the private sector in development of the Hong Kong Health Information Infrastructure project* 1Q03

Chapter 10

IMPROVING COST-EFFECTIVENESS OF THE SERVICE DELIVERY SYSTEM

through territory-wide development of quaternary centres & referral networks, knowledge management initiatives, and focused work on specific diseases & conditions

10.1 Continuous Quality Improvement (CQI) has always been integral to our organization and provision of services. Taking into account the new environment and challenges, emphasis will increasingly be put on system-wide considerations of cost-effectiveness, while the important on-going efforts in clinical audits and development of clinical guidelines and protocols to ensure the standard of care will continue.

Development of Quaternary Service Networks in Clinical Specialties and Management / Referral Protocols

10.2 Over the years, we have developed an effective service distribution system through horizontal networking of specialty services and vertical clustering of hospitals. To build on the strength of the existing system, we will continue to streamline the operation of the existing network. To dovetail with the new clustering arrangement and the population-based resource allocation mechanism, there is a need to speed up the development of tertiary and quaternary clinical service networks. Medical services of high complexity, low volume and requiring specialized expertise and sophisticated equipment will be concentrated at a limited number of designated centres to ensure quality and cost-effectiveness. The various Specialty Services Coordinating Committees will be charged with the responsibility of working out such network arrangements, as well as agreeing on referral protocols and cross charging mechanisms.

Intensive Care Service:

- *Develop admission and discharge guidelines for intensive care service and establish service networking to facilitate inter-cluster transfer of critically-ill patients who are in need of intensive care* — 2Q02

Internal Medicine:

- *Initiate comprehensive review on cardiac services and formulate rationalization plan for cardiac intervention services* — 1Q03

- *Develop an integrated model comprising microbiologists and infectious disease physicians in the clinical management of infectious disease* — 4Q02

• *Designate Grantham Hospital and Kowloon Hospital as Multi-drug Resistant Tuberculosis (TB) centres*	4Q02
• *Establish network arrangements on haematological service*	4Q02
Neurosurgery:	
• *Re-organize current arrangement for neurosurgical coverage to dovetail with mega-cluster structure (North District Hospital from Tuen Mun Hospital to Prince of Wales Hospital (2Q02); United Christian Hospital from Prince of Wales Hospital to Queen Elizabeth Hospital (1Q03)*	1Q03
• *Enhance Neurosurgical network to support admission of acute neurosurgical patients from Accident & Emergency Departments to hospitals with on-site neurosurgical service*	4Q02
Paediatrics:	
• *Review / rationalize paediatric intensive care / neonatal intensive care service / beds*	1Q03
Pathology:	
• *Establish a toxicology reference laboratory in Princess Margaret Hospital for herbal product poisoning and substance abuse patients*	1Q03
Surgery:	
• *Develop thoracic surgery network to ensure specialist coverage in all mega-clusters*	1Q03
• *Develop referral criteria and protocols for the 3 designated Paediatric Surgery Centres*	4Q02
• *Designate specialized centres for managing major trauma*	3Q02
• *Formulate disaster plan and networking arrangement for managing major burns disaster*	1Q03

Focused Improvement Programmes on Specific Disease Conditions

10.3 In 2000, the five major killers in Hong Kong were Malignant Neoplasm, Heart Diseases, Pneumonia, Cerebrovascular Disease, and Injury and Poisoning. They collectively accounted for 74% of the total deaths in Hong Kong and took up about 28% of the patient days of HA. There has also been increasing concern on the high incidence rate of renal diseases and the substantial morbidity and even mortality associated with mental health problems in the community. We will implement focused improvement programmes, most being inter-specialty and inter-disciplinary in nature, for some of the above disease conditions. We hope these efforts will contribute to improve the overall health status of the community.

Cancer:

- *Review provision of services and treatment for cancer patients* — 1Q03
- *Develop inter-specialty clinical protocols for colorectal and breast cancer* — 1Q03
- *Survey the existing practice of administration of chemotherapy among different specialties* — 1Q03
- *Review 3 newly introduced cancer chemotherapeutic agents* — 4Q02

Chronic Renal Failure:

- *Explore the feasibility of setting up a community-based self-care haemodialysis programme in collaboration with the private sector to offer additional choices for patients with chronic renal failure* — 1Q03

Diabetes Mellitus:

- *Pilot diabetic complication screening programme in 5 general outpatient clinics* — 1Q03

Ischaemic Heart Disease:

- *Survey HA-wide practices / protocols in percutaneous coronary interventions (PCI) and collaborate with Specialty Services Coordinating Committees to plan audit on PCI outcomes* — 1Q03

- *Increase the provision of cardiac revascularization (vascular bypass) operations for patients with coronary heart diseases* — 1Q03

Mental Illness:

- *Provide intensive rehabilitation to appropriate extended care patients in group homes set up in 3 psychiatric hospitals (EXITERS Programme)* — 1Q03
- *Establish Elderly Suicide Prevention Programme by setting up fast track clinics to identify and treat elderly with suicidal risks* — 4Q02
- *Establish a pilot network with non-Government organizations in Sham Shui Po to facilitate screening and early detection of mental disease, timely provision of psychosocial assistance, and referrals to appropriate specialists for continual care* — 2Q02

Stroke:

- *Facilitate the delivery of stroke management service via clinical practice guidelines development* — 1Q03
- *Set up acute stroke units in 4 acute hospitals* — 1Q03

Enhancement of Rehabilitation Service and Long Term Care for the Elderly and Chronically Ill

10.4 There has been a rising demand for rehabilitation and long term care services for the aged, chronically ill and disabled. We will continue to adopt an inter-disciplinary, inter-specialty, and inter-sectoral approach to provide care and support to these patients and their carers.

- *Extend the Back Clinic Programme led by Physiotherapy and Orthopaedics & Traumatology to 5 more hospitals* — 3Q02
- *Standardize and audit nursing care in pressure sore and fall prevention. Establish benchmark references on pressure sore and patient fall for improvement action* — 3Q02
- *Establish tele-linkages between community nurses serving remote areas in North Lantau with Princess Margaret Hospital and pilot tele-linkage between Kwong Wah Hospital (2Q02) / Caritas Medical Centre (1Q03) and selected elderly homes* — 1Q03

- *Enhance interface with social welfare sector in long term care through use of the Standardized Care Needs Assessment tool in assessing elderly patients for community support services on hospital discharge* — 3Q02

Safe and Cost-effective Use of New Technology

10.5 There has been an ever increasing need to apply advanced technology in clinical services. The HA Mechanism for the Safe Introduction of New Procedures (HAMSINP) was implemented in 2001/02 to ensure that emerging technologies / interventions were introduced to the HA system in a safe and coordinated manner. Apart from new technologies, we see the equally important need for a structured mechanism to review and monitor research activities in HA hospitals.

- *Explore mechanism to review and monitor research activities in HA hospitals* — 1Q03

- *Provide Positron Emission Tomography (PET) service for 1500 patients per annum under agreed clinical protocols* — 1Q03

- *Replace 2 computed tomographic scanners at Queen Elizabeth Hospital and Pamela Youde Nethersole Eastern Hospital, and 3 linear accelerators at Tuen Mun Hospital and Queen Elizabeth Hospital in accordance with master development plan* — 1Q03

- *Implement biochemical screening for Down Syndrome to reduce foetal loss as compared to traditional screening based on maternal age* — 1Q03

Risk Management and Quality Standards

10.6 Risk management and continuous service improvement are integral parts in clinical care and service organization. They are the main tools to minimize mishaps, improve standard of care and support professional growth and organizational learning. In the coming year, we will continue the ongoing efforts in clinical audits and protocol formulation. Specific programmes will be introduced to reduce risk in donated blood and hospital acquired infection. We have also done risk scanning and planned to introduce initiatives over specific clinical, administrative and organizational areas of concern.

- *Develop a programme to audit and improve the utilization of Point of Care Testing (POCT) equipment* — 1Q03

- *Implement Nucleic Acid Test (NAT) screening for Human Immunodeficiency Virus (HIV) and Hepatitis C Virus (HCV) for all blood donations to improve safety* — 1Q03

• *Establish a framework for HA-wide infection surveillance programme to improve clinical practice and reduce the risk of hospital acquired infection*	4Q02
• *Review and upgrade quality standards in Section III of hospital annual plan for continuous service improvement, and to facilitate self-assessment of performance using the new standards*	4Q02
• *Review options for Authority-wide insurance strategies*	3Q02
• *Review the current process, organize educational workshops, and propose a framework for the development & implementation of clinical practice guidelines*	3Q02
• *Organize centrally coordinated audits in surgery*	1Q03
• *Develop a Clinical Data Policy Manual to strengthen the protection of clinical data confidentiality*	1Q03

Implementation of Knowledge Management Initiatives

10.7 The key objectives in knowledge management are to facilitate the use of best evidence in clinical decision-making and to support healthcare professionals in lifelong learning. Access to evidence-based professional knowledge and practice is improved through the development of the electronic knowledge gateway (eKG). By 1Q03, all HA hospitals will have free access to the service.

• *Enrich the contents of the existing electronic knowledge gateway (eKG) on 8 specialties and to cover 7 additional specialties by 2003*	1Q03
• *Explore sharing of electronic knowledge gateway (eKG) and Evidence/Evidence in Practice with other sectors*	1Q03
• *Put electronic knowledge gateway (eKG) on the Internet for use by HA staff*	1Q03

Development of Evidence for Chinese Medicine Practice

10.8 In line with the Government directive of introducing Chinese Medicine outpatient services in public hospitals, we will be looking at suitable models for setting up Chinese Medicine clinics according to the principles adopted by the HA Board. We will develop a research oriented model for setting up Chinese Medicine clinics in the HA. Such clinics will be backed up by standardized Chinese Medicine dispensing service, appropriate IT infrastructure, and a central database on the toxicology of Chinese herbs.

- *Provide research oriented Chinese Medicine outpatient clinics in pilot sites* 1Q03
- *Establish the IT infrastructure and implement the necessary information systems in the newly introduced Chinese Medicine Clinics* 1Q03
- *Set up Central HA-Chinese Medicine Committee to monitor and steer selection and funding of all submitted applications for Chinese Medicine research* 1Q03
- *Establish and promulgate standards of practice on dispensing service and procurement service to Chinese Medicine dispensaries in HA* 3Q02
- *Establish interface guidelines for Western / Chinese medical practitioners* 1Q03
- *Establish Chinese Medicine clinical toxicology service network* 1Q03

Chapter 11

FORMULATING NEW HUMAN RESOURCE STRATEGIES

to face environmental challenges, and developing people to enhance performance at all levels

11.1 Faced with a demanding and rapidly changing environment, we need to build up a team of dedicated workforce with professional competence and versatility to meet the numerous challenges ahead.

Enhancement of Workforce in Frontline Patient Care Units

11.2 To meet the rising service need and to alleviate the workload of frontline staff, we will enhance our workforce by recruiting additional doctors, nurses, allied health professionals and supporting staff.

• *Recruit 270 doctors for training in various clinical specialties (including 100 family medicine trainees)*	1Q03
• *Recruit 400 qualified nurses to meet service needs*	1Q03
• *Recruit 135 allied health professionals*	1Q03
• *Employ 1920 additional personal care and ward supporting staff starting from 2001/02 to assist the doctors, nurses and other healthcare professionals in patient care*	1Q03
• *Employ 1000 care assistants to strengthen the provision of extended care services in public hospitals*	1Q03

Follow-up Work on Recommendations of Organization-wide Human Resource (HR) Review & Restructuring of HR Functions in Head Office & Clusters

11.3 Realizing the need for new HR strategies to meet environmental challenges, we have conducted an organization-wide HR review. In the coming year, we will take forward the recommendations to better support the HR functions at cluster level, enhance the competency of HR professionals and re-engineer our HR administrative processes.

- *Create core competency set for HR professional staff and organize HR management development programmes to address competency gaps* — 3Q02

- *Decentralize and transfer HR expertise to clusters and develop cluster HR structure to facilitate organization development, foster people management and rationalize administration* — 4Q02

- *Review and streamline key HR processes and procedures covering recruitment process, allowance and leave administration* — 2Q02

- *Review HR policies and practices to introduce greater flexibility in view of changing circumstances and organizational needs* — 1Q03

Implementation of Grade Reform Plans

11.4 Following the implementation of the new staff structure for doctors, we have rolled out the grade reform to other job families. We have completed the review in support services grades and implemented a new structure to facilitate the broad-banding of jobs and multi-skilling of staff. We have also completed the review in nursing grade and selected grades in the allied health profession including pharmacist, radiographer and medical laboratory technician. In 2002/03, we will work out plans to implement the new structure for these grades and will continue to roll out grade reform to other grades.

- *Pilot Allied Health Graduate Clinical Training programmes in 4 allied health grades covering Prosthetist-Orthotist, Diagnostic Radiographer, Therapeutic Radiographer and Medical Laboratory Technician.* 3Q02
- *Implement grade reform in the radiographer grade* 3Q02
- *Implement grade reform for Medical Laboratory Technicians* 4Q02
- *Conduct grade review for 4 allied health grades covering Optometrist, Orthoptist, Clinical Psychologist and Medical Physicist* 1Q03
- *Implement a new staff structure for the Pharmacist grade* 2Q02
- *Communicate & consult on a new staffing structure for the Nursing grade* 1Q03

Formulation of Long Term Plans for Medical Grade to Enhance Training & Coordination with Service

11.5 HA provides the largest training ground for doctors in Hong Kong. Having adequate number of specialists with appropriate competence is also the backbone of our service. We therefore have to ensure that adequate training programmes are developed for the various clinical specialties including Family Medicine. However, with the changing economic environment, there has been decreasing turnover amongst the medical staff in the HA. Under the prevailing financial condition, budgetary considerations of different hospitals may override the training imperative, making it even more difficult to provide sufficient training positions for new graduates. Hence, more centrally coordinated manpower planning for the medical grade is needed to ensure effective service provision and optimal training opportunities. A framework to centralize the resources of Medical Officers and Residents is being developed to facilitate HA-wide coordination of specialist training with reference to service needs, to establish structured programme for Residents on recruitment, posting and assessment of their training progress, to promote specialist-led services with adequate supply of trained doctors, and to maximize resources available to provide specialist training opportunities to junior doctors and new graduates.

- *Centralize the organization and budgeting for medical specialist training* — 3Q02
  - *Centralize budget management for Medical Officers and Residents of all hospitals*
  - *Establish central mechanisms to coordinate manpower planning, specialist training programmes and posting of staff*
  - *Establish cluster-based mechanisms to optimize the use of total allocated resources to meet service and training needs*

- *Introduce a structured rotation training programme for basic surgical trainees involving General Surgery, Orthopaedics & Traumatology, Urology, Neurosurgery, Cardiothoracic Surgery, Plastic Surgery, Paediatric Surgery, Otorhinolaryngology (ENT) and Emergency Medicine* — 2Q02

- *Facilitate the development of training programmes for community paediatricians and establish training venues in collaboration with the Department of Health* — 1Q03

Continuous Emphasis on Professional and Managerial Training

11.6 We are committed to staff training and continuous education to ensure that knowledge, practice and skills of staff are in line with service requirement. Tailored training programmes will continue to be organized for medical and various staff groups. Specific programmes will be organized to enhance the leadership and management capabilities of our executives to tackle the complex organizational issues. We will also be organizing our 10th anniversary HA Convention to exchange experience and ideas within ourselves and with the international healthcare management community.

- *Sponsor 200 nurses and 150 Enrolled Nurses to take up conversion course in tertiary education institutions in 02/03* — 1Q03
- *Organize competence enhancement programmes for 9000 nurses and advanced competence for 500 nurses. Provide on-line resources for delivery of 10 selected in-service enhancement programmes* — 1Q03
- *Review, develop and pilot competency-based Staff Development Review for Enrolled Nurses* — 1Q03
- *Formulate continuous professional education framework and set up e-training record system for Diagnostic Radiographers, Physiotherapists, Occupational Therapists, Medical Laboratory Technicians and Prosthetists & Orthotists* — 4Q02
- *Pilot competency-based Staff Development Review for Diagnostic Radiographers, Medical Laboratory Technicians, Medical Social Workers, Prosthetists & Orthotists and Therapeutic Radiographers* — 4Q02
- *Develop a continuous professional education framework to achieve credit recognition with tertiary institutions and / or professional bodies for courses organised by Institute of Healthcare* — 1Q03
- *Organize strategic people management programmes to enable key managers at corporate and cluster level to effectively address critical people issues in support of organization transformation* — 1Q03
- *Conduct training programmes on hospice and rehabilitation nursing for 150 Community Nurses* — 4Q02

- *Organise and co-ordinate team building programmes at corporate and cluster levels in support of organisational transformation* 3Q02

- *Develop and organise Chinese Medicine awareness / training programmes for frontline healthcare professionals* 1Q03

- *Obtain accreditation for training programmes in Administrative Medicine and organize programme-based training for trainees* 2Q02

- *Implement rotation and succession planning for key managerial positions in Head Office and hospital clusters to enhance managerial exposure and capabilities* 1Q03

- *Organise the 10th Anniversary HA Convention with the theme of "Knowledge, Partnership & Sustainable Healthcare" to promote a knowledge-based organisation culture and explore the future direction of corporate environment* 2Q02

Communication and Caring for Staff

11.7 As a caring organization, it has always been our prime concern to ensure that our staff work safely and healthily. To this end, Staff Health Ambassadors were appointed in 2001/02 and in the coming year, the concept of 'Care for the Carers' and occupational safety and health will be further promoted. We aim to reduce unnecessary workload and occupational hazards and risks, work smarter and provide psychosocial support to staff members.

- *Facilitate the setting up of committees or work groups at hospital / cluster level and to drive staff health and wellness strategies and programmes to promote "care for carers" culture across HA hospitals* 4Q02

- *Review effectiveness of critical incident support teams in pilot hospitals* 1Q03

- *Further improve the working hours of frontline doctors through re-scheduling of work, recruitment of additional doctors and enhanced communication* 1Q03

- *Develop occupational safety and health guideline and checklist to be piloted in selected workplaces at North District Hospital, Queen Elizabeth Hospital, Pamela Youde Nethersole Eastern Hospital and Princess Margaret Hospital* 4Q02

- *Conduct personal development programmes including therapeutic groups and educational talks in the newly established 'Centre for Personal Growth and Crisis Intervention' for 1000 HA staff to enhance their psychological wellness* 1Q03

Strengthened Management for Staff Retirement Benefit

11.8 To ensure continued viability of the HA Provident Fund Scheme, there is a need to revise the terms of the existing trust deed. The management of both the HA Provident Fund Scheme and the HA Mandatory Provident Fund Scheme will also be strengthened to safeguard the retirement benefit of our staff.

- *Strengthen management of HA Provident Fund Scheme through the work of full time Director of Investment Supervision, review on investment strategy, and enhanced performance monitoring on fund managers and investment consultant* 3Q02

- *Plan for necessary changes of trust deed and introduction of members' choice in the HA Provident Fund Scheme* 1Q03

- *Establish a mechanism to monitor the performance of the HA Mandatory Provident Fund Scheme* 2Q02

CLUSTER PLANS

Chapter 12
HONG KONG EAST CLUSTER

12.1 The Hong Kong East Cluster serves the population of Wanchai and Eastern District of the Hong Kong Island as well as Cheung Chau. The estimated population of these districts is around 0.90M. There are six hospitals in the cluster providing full range of comprehensive inpatient, ambulatory and community-based healthcare services to these communities:

- Pamela Youde Nethersole Eastern Hospital: An acute regional hospital providing full range of specialist services
- Ruttonjee & Tang Shiu Kin Hospitals: A community hospital providing acute, extended and community care services, as well as specialized tuberculosis and chest services
- Tung Wah Eastern Hospital: An Ophthalmic Centre in addition to its role as the provider of rehabilitation services.
- Wong Chuk Hang Hospital and Cheshire Home (Chung Hom Kok): They provide infirmary services for patients requiring long term care
- St John Hospital: It serves the population of Cheung Chau

12.2 As at 31 December, 2001, there were a total of 3,258 beds, with 1,566 for acute care, 1082 for convalescent, rehabilitation, infirmary and hospice care and 610 for mentally ill.

Future Challenge & Major Initiatives

12.3 The major challenge to the Cluster is to ensure sustainable healthcare service to the population of the Cluster. The key strategies are to enhance ambulatory and community-based care and to develop closer collaboration with other social and healthcare providers in the community.

12.4 In support of the Cluster's direction, large scale remodeling works is in progress at the Ruttonjee & Tang Shiu Kin Hospitals to accommodate the planned relocation of the accident and emergency services from the Tang Shiu Kin Hospital to Ruttonjee Hospital and the conversion of the Tang Shiu Kin Hospital into an ambulatory and community-based care centre for the Cluster. Renovation work is also being done at the Tung Wah Eastern Hospital to convert part of the nurses quarters into a Diabetic Centre.

12.5 With the formal establishment of the cluster management structure in June, 2001, many initiatives have been undertaken to integrate and rationalize clinical, nursing, allied health, business supporting, administrative and financial services in the Cluster to enhance efficiency. In line with the clustering initiative, there will be more opportunities for staff training and development through rotation of professional and managerial staff amongst the cluster hospitals.

Major Cluster-based Programme Initiatives:

Rationalization of managerial & administrative functions:

- *Develop cluster human resources structure in Hong Kong East Cluster to facilitate organization development, foster people management and streamline human resources administration* — 2Q02
- *Establish effective structures to enhance managerial capabilities in risk management and infection in Hong Kong East Cluster* — 2Q02
- *Establish cluster-based financial management centre* — 2Q02
- *Establish procurement centre for Hong Kong East Cluster and reorganize supply chain management* — 2Q02
- *Maximize production of cook chill food products to support the requirement of Hong Kong East Cluster* — 2Q02
- *Rationalize facilities management in Hong Kong East Cluster to achieve economy of scale* — 1Q03

Rationalization of clinical services:

- *Integrate clinical pathology services in Hong Kong East Cluster under one coordinator and rationalize laboratory services to enhance efficiency* — 3Q02
- *Rationalize provision of radiology services in the cluster* — 1Q03
- *Integrate speech therapy, podiatry and prosthetic-orthotic services into single teams in the cluster* — 2Q02
- *Rationalize the distribution of extended care and infirmary beds in the cluster* — 1Q03

Chapter 13
HONG KONG WEST CLUSTER

13.1 The Hong Kong West Cluster serves the population of the Central, Western and Southern Districts of the Hong Kong Island. The estimated population of these districts is around 0.57M. There are eight hospitals in the cluster providing full range of comprehensive inpatient, ambulatory and community-based healthcare services to these communities:

- Queen Mary Hospital: A major acute hospital that is also the teaching hospital for the University of Hong Kong's medical school
- Tsan Yuk Hospital: With its obstetrics and paediatric services moved to Queen Mary Hospital, it will be turned into a community health centre
- Grantham Hospital: A specialized hospital offering cardiothoracic services including organ transplant, paediatric cardiology, and rehabilitation services
- Duchess of Kent Children's Hospital: It offers specialized orthopaedic and paediatric services
- Tung Wah Hospital: It supports Queen Mary Hospital in some acute services and in extended care
- MacLehose Medical Rehabilitation Centre and Tung Wah Group of Hospitals (TWGHs) Fung Yiu King Hospital: Both offer extended care and rehabilitation services
- Nam Long Hospital: It provides hospice care

13.2 Apart from providing a full spectrum of specialist outpatient services, the cluster also runs a geriatric day hospital at the TWGHs Fung Yiu King Hospital, a day rehabilitation centre at the Tung Wah Hospital and a psychogeriatric day hospital at the David Trench Rehabilitation Centre. As at 31 December, 2001, there were a total of 3,695 beds, with 2,610 for acute care, 993 for convalescent, rehabilitation, infirmary and hospice care and 92 for mentally ill. Apart from serving the local population, the Cluster also serves a large number of patients from the other districts. In fact, about 18% of the patients treated in this cluster reside in Kowloon and the New Territories.

Future Challenge & Major Initiatives

13.3 The major challenge is to ensure cost-effective use of resources to meet the cluster needs. To achieve this, a number of cluster-based integration and rationalization programmes have been implemented in various clinical, allied health and supporting services in the past two years. These reorganization initiatives have set the stage for the new cluster management structure through which the Cluster will continue to explore opportunities to achieve further integration and collaboration following the disease management concept. The forthcoming population-based resource allocation method presents even greater challenges and more pressing need for the Cluster to develop a long term plan to further streamline service provision for efficient care delivery and optimal utilization of resources.

Major Cluster-based Programme Initiatives:

Rationalization of managerial & administrative functions

- *Appoint Cluster Chief Executive* — 4Q02
- *Develop plans to rationalize the managerial structure for clinical, administrative and supporting functions across hospitals in the Hong Kong West Cluster* — 4Q02

Rationalization of clinical services

- *Implement cluster-based hospital infection control and monitoring* — 4Q02
- *Establish cluster-based radiology service* — 4Q02
- *Integrate anaesthesiology service of Queen Mary Hospital, Tung Wah Hospital, Duchess of Kent Children's Hospital and Grantham Hospital* — 4Q02
- *Integrate pathology service of Queen Mary Hospital & Grantham Hospital* — 1Q03
- *Consolidate and streamline services following the 'disease management' concept and a cluster-wide perspective in target service areas* — 4Q02

Chapter 14
KOWLOON EAST CLUSTER

14.1 The Kowloon East Cluster serves the population of Kwun Tong, Sai Kung and Tseung Kwan O. The estimated population of these districts is over 0.84M. There are three hospitals in the Cluster.

- United Christian Hospital and Tseung Kwan O Hospital: Both are acute hospitals
- Haven of Hope Hospital: It provides extended care and rehabilitation services

14.2 As at 31, December, 2001, there were a total of 2,142 beds in the Cluster, with 1,676 for acute care, 436 for convalescent, rehabilitation, infirmary and hospice care and 30 for mentally ill. The mission of the Cluster is 'To develop a healthy community, with healthy hospitals and healthy staff, through cluster collaboration and partnership with other healthcare providers'.

Future Challenge & Major Initiatives

14.3 The greatest challenge to the Cluster is to make the best use of the resources available to provide cost-effective service, with the ultimate aim of improving the health of the local community. The cluster management structure, which started in October 2001 and emphasizes collaboration and allows flexibility, provides an opportunity to gear up the Cluster to meet the challenge.

14.4 To improve cost-effectiveness, the roles of the cluster hospitals will be better delineated so that they will complement each other. Economy of scale will be maximized in suitable areas by centralization of services. Plans will be worked out to keep the community healthy and minimize unnecessary use of HA services. A three-pronged approach will be adopted: to improve post-discharge ambulatory care, to channel more cases to primary care providers and the private sector and to improve the quality of service of primary care providers and caring institutions. The above will be achieved through service reorganization, improved liaison with other healthcare providers and empowerment of staff, patients and carers.

14.5 For the management structure to work effectively, a good team of staff is essential. Team building programmes to care for the carers will be carried out. A paradigm shift in the organization culture is needed. To empower staff, communication will be improved with emphases on openness, trust and respect.

Cluster-based Programme Initiatives:

Rationalization of managerial & administrative functions

- *Organize cluster training programmes for medical and nursing professionals* 4Q02
- *Centralize Central Sterile Supply Delivery (CSSD) service from Haven of Hope Hospital to Tseung Kwan O Hospital* 3Q02
- *Establish cluster financial management centre* 2Q02
- *Establish cluster procurement centre* 2Q02
- *Review cluster human resources services to facilitate organization development, foster people management and rationalize administration* 4Q02

Rationalization of clinical services

- *Appoint cluster coordinators for all major services* 2Q02
- *Integrate the following departments under one Chief of Service: the Obstetrics & Gynaecology Departments of United Christian Hospital and Tseung Kwan O Hospital and the Radiology Departments of Tseung Kwan O Hospital and Haven of Hope Hospital* 2Q02
- *Extend allied health integrated rehabilitation model of Tseung Kwan O Hospital to Haven of Hope Hospital under one manager* 2Q02
- *Integrate the Community Nursing Service of Kowloon East into a single cluster team* 4Q02
- *Rationalize service and form cluster subspecialty teams for the Surgical Departments of Tseung Kwan O Hospital and United Christian Hospital* 2Q02

Chapter 15
KOWLOON CENTRAL CLUSTER

15.1 The Kowloon Central Cluster serves the population of Yau Ma Tei, Tsim Sha Tsui, Mongkok and Kowloon City. The estimated population of these districts is around 0.60M. There are six hospitals / institutions in the cluster.

- Queen Elizabeth Hospital: A major acute hospital providing 24-hour comprehensive services
- Kowloon Hospital: An extended care hospital providing rehabilitation and psychiatric services
- Buddhist Hospital: A community hospital with some general and extended care services
- Hong Kong Eye Hospital: A specialized Ophthalmic Centre
- Hong Kong Red Cross Blood Transfusion Service: It provides blood and blood products to all hospitals in Hong Kong
- Rehabaid Centre: It provides specialized community-based rehabilitation services

15.2 As at 31 December, 2001, there were a total of 3,529 beds in the Cluster, with 2,197 for acute care, 1,181 for convalescent, rehabilitation, infirmary and hospice care, and 151 for mentally ill. With the opening of the Kowloon Hospital Rehabilitation Building in 2001/02, the Cluster also provides extended care support to the Kowloon East Cluster.

Future Challenge & Major Initiatives

15.3 Major challenges include managing the volume and access issue, and preparing for the future mega-cluster formation as well as impact of the population-based resource allocation model. Queen Elizabeth Hospital, being the largest hospital in Hong Kong, attracts patients from all over the territory, and as a result is confronted with significant problems in management of service volume and waiting lists. Work flow and human resource management in such a large and complex organization also require sustained effort to achieve streamlining and synergy.

15.4 At the cluster level, there is a need to enhance service rationalization and inter-hospital cooperation to further improve efficiency and productivity. Completion of capital work projects in Kowloon Hospital will give additional capacity for the necessary expansion of services to cater for the increasing demand. With the hospital already providing convalescent support to the Kowloon East Cluster, and the plan to finally merge the two clusters into a mega-cluster, there is a need to start high level discussions on future modes of operation among hospitals of the two clusters. This will also be relevant in the context of the future resource allocation model.

15.5 To dovetail with the mega-cluster development, surgical service at the Buddhist Hospital will be rationalized and surgical patients will be redirected to the Queen Elizabeth and Tseung Kwan O Hospitals. Neurosurgical service coverage from Queen Elizabeth Hospital will be provided to the Kowloon East Cluster and spinal cord rehabilitation beds at the Kowloon Hospital will receive referrals from other hospitals in the Kowloon region.

Cluster-based Programme Initiatives:

Rationalization of managerial & administrative functions

- *Appoint Cluster Chief Executive* — 4Q02
- *Rationalize Central Sterile Supplies Departments (CSSD) service between Kowloon Hospital and Buddhist Hospital* — 1Q03
- *Establish cluster-based training programme for Internal Medicine* — 3Q02
- *Establish a cluster-based Staff Health & Wellness Committee* — 4Q02
- *Establish a staff rotation programme among allied health staff in Kowloon Central Cluster for better exposure and professional development* — 4Q02

Rationalization of clinical services

- *Integrate radiology service for outpatients between Kowloon Hospital and Buddhist Hospital* — 2Q02
- *Rationalize surgery service at Buddhist Hospital with redirection to Queen Elizabeth Hospital and Tseung Kwan O Hospital* — 2Q02
- *Provide Neurosurgical cover to Kowloon East Cluster* — 1Q03
- *Establish cluster-based infection control service at Kowloon Central* — 4Q02

Chapter 16
KOWLOON WEST CLUSTER

16.1 The Kowloon West Cluster serves the population of Mongkok and Wong Tai Sin districts. The estimated population of these districts is around 0.58M. It is projected that by 2010, 14.6% of the Cluster's population will be aged 65 or above, as against the territory average of 11.5%. There are three hospitals in the Cluster:

- Kwong Wah Hospital: A major regional hospital providing a comprehensive range of acute services
- Our Lady of Maryknoll Hospital: A community hospital providing general services
- Tung Wah Group of Hospitals (TWGHs) Wong Tai Sin Hospital: An extended care hospital providing rehabilitation and tuberculosis and chest services

16.2 As at 31 December, 2001, there were a total of 2,692 beds in the cluster, comprising 1,667 acute care and 1,025 convalescent, rehabilitation, infirmary and hospice beds.

Future Challenge & Major Initiatives

16.3 Rising patient volume has remained a challenge, especially when most patients are socially deprived and aged, and most of the outpatient service is free. A multi-pronged approach is adopted: seamless and cluster-based operation, effective triage of incoming referrals, active development of ambulatory care (eg ambulatory ward for patients in diabetes mellitus) and collaborative projects with community carers (eg. Telelinking selected elderly homes).

16.4 Following the integration of management and governance of Kwong Wah Hospital and TWGHs Wong Tai Sin Hospital in 2001/02, major efforts will be on integrating various clinical and non-clinical functions in 2002/03. Many of these integrations will be extended to encompass the Our Lady of Maryknoll Hospital. We are also preparing for the formation of the future mega-cluster, including rationalization of liaison psychiatric service from Kowloon Hospital to Kwai Chung Hospital. There will also be closer collaboration between Kwong Wah Hospital and Caritas Medical Centre in Pathology and Orthopaedic Rehabilitation services.

16.5 The cluster will actively take part in the development of pluralistic primary care services and evidence for Chinese Medicine practices. A cluster-based approach is adopted for the former emphasizing the interface between primary care and specialist care, interface with community providers and training of Family Medicine trainees. Kwong Wah Hospital will implement a tri-partite model i.e. with Tung Wah Group of Hospitals and Chinese University of Hong Kong, in the provision of a research oriented Chinese Medicine clinic.

Cluster-based Programme Initiatives:

Rationalization of managerial & administrative functions

• *Appoint Cluster Chief Executive for the Kowloon West mega-cluster (encompassing the current Kowloon West Cluster and the New Territories South Cluster)*	4Q02
• *Rationalize Medical Social Service in the cluster to be provided only by HA medical social workers*	2Q02
• *Implement total integration of finance, IT/IS, business support, human resources and occupational safety and health functions of Kwong Wah Hospital and TWGHs Wong Tai Sin Hospital*	2Q02
• *Implement cluster-based capital works function*	1Q03
• *Establish cluster financial management centre*	1Q03

Rationalization of Clinical Services

• *Integrate surgical services between Kwong Wah Hospital and Our Lady of Maryknoll Hospital*	2Q02
• *Implement cluster-based pathology service*	2Q02
• *Integrate Dietetic, Pharmacy, Speech Therapy, and some other allied health services between Kwong Wah Hospital and TWGHs Wong Tai Sin Hospital*	2Q02
• *Enhance cluster-based respiratory medicine service*	1Q03
• *Rationalize liaison psychiatry service to be provided by Kwai Chung Hospital instead of Kowloon Hospital*	2Q02
• *Implement cluster-based ambulatory occupational therapy service*	3Q02

Chapter 17
NEW TERRITORIES EAST CLUSTER

17.1 The New Territories East Cluster serves the population of Shatin, Tai Po and North District. The estimated population of these districts is around 1.33M. There are seven hospitals in the cluster:

- Prince of Wales Hospital: A major acute hospital that is also the teaching hospital for the Chinese University of Hong Kong's medical school
- Shatin Hospital and Cheshire Home (Shatin): Both are extended care hospitals in Shatin
- Bradbury Hospice: It provides inpatient and community outreach hospice services
- Alice Ho Miu Ling Nethersole Hospital: An acute general hospital in Tai Po
- North District Hospital: An acute general hospital in Fanling
- Tai Po Hospital: An extended care hospital in Tai Po

17.2 They together provide acute, convalescent, rehabilitation and extended care services to the cluster. As at 31 December, 2001, there were a total of 4,434 beds in the cluster, with 2,555 for acute care, 1,271 for convalescent, rehabilitation, infirmary and hospice care and 608 for mentally ill.

Future Challenge & Major Initiatives

17.3 The major challenges confronting the Cluster are:

- Budget constraints
- Duplication and compartmentalization of services
- Mismatch of service demand, facilities and resources amongst the cluster hospitals
- Concerns of the local community, individual Hospital Governing Committee and staff on organization and service transformation
- Increasing demand from communities

17.4 To address the above issues, the Cluster will restructure its administrative and finance functions through integration of finance, business support, human resource and facility management to achieve savings. Web-based information technology framework will be set up to ensure staff's access to the latest developments of the Cluster. Efforts will also be made to contain the cluster expenditure within its budget.

17.5 Clinical services will also be reorganized with each clinical service to be integrated into one functional team across the Cluster. Nursing services will also be rationalized through reclassification of beds and redefinition of manpower requirement according to care level. All allied health services will be fully integrated across hospitals into one functional team for each discipline to facilitate the mobilization of manpower and resources. Efforts will also be made to develop cost- effective services to take advantage of new opportunities and overcome volume and access challenges through the opening of beds, setting up of pilot schemes of pluralistic primary healthcare services, enhancement of cardiothoracic surgery service and enhancement of the Cluster's otorhinolaryngology service.

Cluster-based Programme Initiatives:

Rationalization of managerial & administrative functions

- *Integrate administrative services namely finance, supply chain management, human resources and facility management to achieve savings through economy of scale and to enhance administrative support to clinical departments* — 2Q02
- *Set up web-based information technology framework to ensure staff's access to latest developments in the Cluster* — 2Q02
- *Realize a cluster budget with measures for its containment* — 1Q03

Rationalization of clinical services

- *Integrate each clinical service into one functional team across the Cluster to enhance the provision of effective healthcare to the cluster population* — 3Q02
- *Rationalize and integrate nursing service and Healthcare Assistants across the Cluster through reclassification of beds and redefinition of manpower requirement according to care level* — 1Q03
- *Integrate all allied health services across cluster hospitals into 1 functional team for each discipline to facilitate mobilization of manpower and resources to tie in with service need of the Cluster* — 2Q02

- *Develop cost-effective services to take advantage of new opportunities and overcome volume and access challenges through:*
    - *Opening of new psychiatric & infirmary beds* 1Q03
    - *Opening of geriatric & psychiatric day beds* 4Q02
    - *Opening of additional intensive care beds* 3Q02
    - *Setting up of a pilot scheme of pluralistic primary healthcare services* 4Q02
    - *Enhancement of Cardiothoracic Surgery Service* 3Q02
    - *Enhancement of the Cluster's Otorhinolaryngolgy (ENT) service* 2Q02

Chapter 18
NEW TERRITORIES NORTH CLUSTER

18.1 The New Territories North Cluster serves the population of Tuen Mun and Yuen Long Districts. The estimated population of these districts is around 1M. It is expected that the cluster population will grow to 1.22M by 2010. There are four hospitals in the cluster:

- Tuen Mun Hospital: An acute general hospital providing a comprehensive range of acute, ambulatory and community services
- Pok Oi Hospital: It is undergoing major redevelopment and is currently providing rehabilitation and infirmary services
- Castle Peak Hospital: A psychiatric hospital
- Siu Lam Hospitals: A specialized hospital for the severely mentally disabled adult patients

18.2 The North District Hospital, originally clustered under New Territories North, was re-clustered to New Territories East in October, 2001 in accordance with the mega-cluster management structure. As at 31 December, 2001, there were a total of 4,054 beds in the Cluster, comprising 1,405 acute, 316 convalescent, rehabilitation, infirmary and hospice care and 2,333 mentally ill / mentally handicapped beds.

Future Challenge & Major Initiatives

18.3 With a growing population, a wide geographical spread and inadequate medical facilities before the completion of Pok Oi Hospital redevelopment, the Cluster faces many challenges in the coming years. Besides, with the re-clustering of the North District Hospital to New Territories East in October 2001, the cluster hospitals in New Territories North have to reorganize their services.

18.4 It is envisaged that reaching out to the community and developing ambulatory and community services will be the major areas for development in the Cluster. Additionally, the Cluster will work in close collaboration with primary care and private practitioners to develop new models of shared care. As the Tuen Mun Hospital has taken over the Yan Oi General Outpatient Clinic in December 2001 and the Castle Peak Hospital will set up the Institute of Mental Health, there are ample opportunities for the cluster to explore the development of community-based services.

18.5 Ongoing efforts will be put in the integration of clinical and administrative services in 2002/03. Most clinical departments of the Pok Oi Hospital will be integrated with the clinical departments of the Tuen Mun Hospital. A financial management centre will be set up to serve the whole Cluster and allied health and administrative services such as human resources, procurement and transportation will be further streamlined. The Psychiatric Department of the Tuen Mun Hospital will be integrated with that of the Castle Peak Hospital and to meet the increasing workload of the Cluster, the Tuen Mun Hospital will open nine hospice beds whereas the Pok Oi Hospital will increase its infirmary beds.

18.6 Apart from the short and medium term efforts to meet the demand of the Cluster, there are also longer term development projects in the Cluster. The redevelopment of the Pok Oi Hospital is making good progress and is targeted for completion in 2006. The Castle Peak Hospital has just completed its Phase II Stage I redevelopment and will complete the final phase of its redevelopment by 2004. The Cluster is also looking forward to the commencement of works of the Tuen Mun Hospital Rehabilitation Block and will continue to plan for the redevelopment of the older facilities in the Cluster such as the Siu Lam Hospital.

Cluster-based Programme Initiatives:

Rationalization of managerial & administrative functions

- *Appoint Cluster Chief Executive* — 4Q02
- *Establish financial management centre in the cluster* — 1Q03
- *Implement cluster-based procurement service in the cluster on 1.4.02* — 2Q02
- *Rationalize human resources services by setting up cluster human resources team* — 1Q03

Rationalization of clinical services

- *Establish nurse-led primary care in Yan Oi General Outpatient Clinic* — 3Q02
- *Rationalize hospice service of the cluster by integrating the hospice service of Pok Oi Hospital and Tuen Mun Hospital* — 2Q02
- *Rationalize psychiatric service by relocating long stay beds from Tuen Mun Hospital to Castle Peak Hospital and integrating the Psychiatric Departments of Tuen Mun Hospital and Castle Peak Hospital* — 3Q02

• *Rationalize Obstetric & Gynaecology service of New Territories North by integrating Obstetric & Gynaecology Departments of Pok Oi Hospital and Tuen Mun Hospital on 1.4.02*	2Q02
• *De-link pathology service of Tuen Mun Hospital from North District Hospital and reorganize pathology service for New Territories North Cluster*	2Q02
• *De-link neurosurgical service of Tuen Mun Hospital from North District Hospital*	2Q02
• *Rationalize allied health services of New Territories North by clustering physiotherapy, occupational therapy, clinical psychology and prosthetic & orthotic services in the cluster*	1Q03

Chapter 19
NEW TERRITORIES SOUTH CLUSTER

19.1 The New Territories South Cluster serves the population of Sham Shui Po, Kwai Chung, Tsing Yi, Tsuen Wan and the Tung Chung New Town. The estimated population of these districts is around 1.18M with 12.3% aged 65 or above. It is expected that by 2010, the Cluster's population will grow to 1.42M with 12.3% at 65 or above. There are four hospitals in the cluster:

- Princess Margaret Hospital: A major regional hospital providing a comprehensive range of acute services
- Yan Chai Hospital: A community hospital providing general and rehabilitation services
- Caritas Medical Centre: A general hospital providing acute, extended care and community care services
- Kwai Chung Hospital: A psychiatric hospital

19.2 As at 31 December, 2001, there were a total of 5,439 beds in the Cluster, comprising 2,668 general beds, 1,522 psychiatric beds, 949 convalescent, rehabilitation, infirmary and hospice beds and 300 beds for the mentally handicapped.

Future Challenge & Major Initiatives

19.3 The greatest challenge to the Cluster is to meet the needs of the growing population in the most cost-effective manner. Rationalization of services will be a major theme for 2002/03.

19.4 Following the successful experience in integrating pathology and financial management services between the Yan Chai and Princess Margaret Hospitals, the momentum to rationalize clinical, supporting and administrative services in the Cluster will continue. The Radiology and Accident and Emergency Departments of the Princess Margaret and Yan Chai Hospitals will be integrated to achieve optimal sharing of expertise and resources, better training opportunities for professionals and enhanced capability for handling disasters. Other major initiatives on integrating supporting and administrative services include integration of pharmacy service between the Kwai Chung and Princess Margaret Hospitals, and integration of in-house supporting, IT and financial management services amongst the Yan Chai, Princess Margaret and Kwai Chung Hospitals.

19.5 The physical construction of Phase I redevelopment of the Caritas Medical Centre has been completed and the new building will be commissioned in 2Q02. This will improve the physical environment and treatment facilities for acute patients, as well as the functional flow and operational efficiency of acute services. Ambulatory and rehabilitation services will be decanted into the remaining vacant space for optimal service delivery during planning and preparation for Phase II redevelopment.

19.6 Use of information technologies and partnership with other healthcare providers will be the key strategies for the development of community-based rehabilitation service in the Cluster. Efforts to explore opportunities to establish protocol driven public-private collaboration will continue. There will also be various initiatives to improve clinical care, risk management and interface between primary care, specialist outpatient and accident and emergency services.

19.7 In preparation for the formation of the future mega-cluster, opportunities for service rationalization and realignments are being explored with hospitals in the Kowloon West Cluster. There will be increasing collaboration between the Caritas Medical Centre and the Kwong Wah Hospital in orthopaedic rehabilitation and the Kwai Chung Hospital will take over the Kowloon Hospital in the provision of liaison psychiatric service to the Kowloon West Cluster.

Cluster-based Programme Initiatives:

Rationalization of managerial & administrative functions

- *Appoint Cluster Chief Executive for the Kowloon West mega-cluster (comprising the current Kowloon West Cluster and New Territories South Cluster)* — 4Q02

- *Integrate finance and IT supporting services among Yan Chai Hospital, Kwai Chung Hospital and Princess Margaret Hospital* — 1Q03

Rationalization of clinical services

- *Rationalize and integrate Radiology and Accident & Emergency services between Princess Margaret Hospital & Yan Chai Hospital* — 2Q02

- *Rationalize and integrate Pharmacy services in Princess Margaret Hospital & Kwai Chung Hospital* — 2Q02

- *Enhance hospice care of New Territories South by developing hospice day service and augmenting inpatient service in Caritas Medical Centre* 1Q03

- *Provide 10 orthopaedic rehabilitation beds in Caritas Medical Centre to patients referred from Kwong Wah Hospital* 2Q02

- *Provide liaison psychiatric services to Kowloon West Cluster* 3Q02

APPENDICES

LIST OF PUBLIC HOSPITALS AND INSTITUTIONS

(as at 31 December, 2001)

Alice Ho Miu Ling Nethersole Hospital (AHNH)
Bradbury Hospice (BBH)
Caritas Medical Centre (CMC)
Castle Peak Hospital (CPH)
Cheshire Home, Chung Home Kok (CCH)
Cheshire Home, Shatin (SCH)
Duchess of Kent Children's Hospital (DKCH)
* Fanling Hospital (FH)
Grantham Hospital (GH)
Haven of Hope Hospital (HHH)
Hong Kong Buddhist Hospital (BH)
Hong Kong Eye Hospital (HKEH)
Hong Kong Red Cross Blood Transfusion Service (BTS)
Kowloon Hospital (KH)
Kwai Chung Hospital (KCH)
Kwong Wah Hospital (KWH)
\# Lai Chi Kok Hospital (LCKH)
MacLehose Medical Rehabilitation Centre (MMRC)
Nam Long Hospital (NLH)
North District Hospital (NDH)
Our Lady of Maryknoll Hospital (OLMH)
Pamela Youde Nethersole Eastern Hospital (PYNEH)
Pok Oi Hospital (POH)
Prince of Wales Hospital (PWH)
Princess Margaret Hospital (PMH)
Queen Elizabeth Hospital (QEH)
Queen Mary Hospital (QMH)
Rehabaid Centre (RC)
Ruttonjee Hospital (RH)
Shatin Hospital (SH)
Siu Lam Hospital (SLH)
St. John Hospital (SJH)
Tang Shiu Kin Hospital (TSKH)
Tai Po Hospital (TPH)
Tsan Yuk Hospital (TYH)
Tseung Kwan O Hospital (TKOH)
Tuen Mun Hospital (TMH)
Tung Wah Eastern Hospital (TWEH)
Tung Wah Group of Hospitals Fung Yiu King Hospital (FYKH)
Tung Wah Group of Hospitals Wong Tai Sin Hospital (WTSH)
Tung Wah Hospital (TWH)
United Christian Hospital (UCH)
Wong Chuk Hang Hospital (WCHH)
Yan Chai Hospital (YCH)

* The services of Fanling Hospital have been integrated with those of North District Hospital.

\# Lai Chi Kok Hospital has now been converted into a long stay care home for patients with chronic mental illness under the subvention of Social Welfare Department.

LIST OF SPECIALIST OUTPATIENT CLINICS

(as at 31 December, 2001)

Hospitals with Specialist Outpatient Clinic

Alice Ho Miu Ling Nethersole Hospital
Bradbury Hospice
Caritas Medical Centre
Castle Peak Hospital
Cheshire Home, Shatin
Duchess of Kent Children's Hospital
Grantham Hospital
Haven of Hope Hospital
Hong Kong Buddhist Hospital
Hong Kong Eye Hospital
Kowloon Hospital
Kwai Chung Hospital
Kwong Wah Hospital
MacLehose Medical Rehabilitation Centre
Nam Long Hospital
North District Hospital
Our Lady of Maryknoll Hospital
Pamela Youde Nethersole Eastern Hospital
Pok Oi Hospital
Prince of Wales Hospital
Princess Margaret Hospital (including South Kwai Chung Jockey Club Polyclinic)
Queen Elizabeth Hospital
Queen Mary Hospital
Rehabaid Centre
Ruttonjee Hospital
Shatin Hospital
St. John Hospital
Tai Po Hospital
Tang Shiu Kin Hospital
Tsan Yuk Hospital
Tseung Kwan O Hospital
Tuen Mun Hospital
Tung Wah Eastern Hospital
Tung Wah Group of Hospitals Fung Yiu King Hospital
Tung Wah Group of Hospitals Wong Tai Sin Hospital
Tung Wah Hospital
United Christian Hospital
Yan Chai Hospital

Standalone Specialist Clinics

David Trench Rehabilitation Centre
East Kowloon Polyclinic
Ngau Tau Kok Jockey Club Clinic
Pamela Youde Polyclinic
Southorn Centre
Tang Chi Ngong Specialist Clinic
Tuen Mun Polyclinic
Yaumatei Jockey Club Polyclinic
Yaumatei Specialist Clinic Extension
Yuen Long Yung Fung Shee Ophthalmic Centre
Yung Fung Shee Memorial Centre

LIST OF HOSPITALS WITH GENERAL OUTPATIENT SERVICE

(as at 31 December, 2001)

Caritas Medical Centre
Hong Kong Buddhist Hospital
Kwong Wah Hospital
North District Hospital
Our Lady of Maryknoll Hospital
Pok Oi Hospital
St. John Hospital
Tung Wah Eastern Hospital
Tung Wah Hospital
Yan Chai Hospital

List of General Outpatient Clinics with Management Transfer from Department of Health

(as at 31 December, 2001)

Cheung Sha Wan Jockey Club General Outpatient Clinic
(under Caritas Medical Centre)

East Kowloon General Outpatient Clinic
(under Our Lady of Maryknoll Hospital)

Yan Oi General Outpatient Clinic
(under Tuen Mun Hospital)

* Tseung Kwan O Jockey Club General Outpatient Clinic
(under Tseung Kwan O Hospital)

* Sai Ying Pun Jockey Club General Outpatient Clinic
(under Queen Mary Hospital)

* Planned management transfer in February and March, 2002

BACKGROUND INFORMATION ON HOSPITAL AUTHORITY

Background on Hospital Authority

The Hospital Authority was established in December, 1990 under the Hospital Authority Ordinance to manage all the public hospitals in Hong Kong. It is a statutory body that is independent of, but accountable to, the Hong Kong Government through the Secretary for Health and Welfare. It is charged with the responsibility of delivering a comprehensive range of secondary and tertiary specialist care and medical rehabilitation services through its network of healthcare facilities at an affordable price which ensures access by every citizen.

The Authority took over the management of 38 public hospitals and the related institutions and their 37,000 staff on 1 December, 1991.

Mission of Hospital Authority

The Government's policy is to safeguard and promote the general health of the community as a whole and to ensure the provision of medical and health services for the people of Hong Kong so that no one should be prevented, through lack of means, from obtaining adequate medical attention. This includes particularly that section of the community which relies on subsidized medical attention. In keeping with this policy, the Mission of the Authority is:

(a) To meet the different needs of the patients for public hospital services, and to improve the hospital environment for the benefit of the patients;

(b) To serve the public with care, dedication and efficiency, and to encourage community participation in the system, resulting in better care and more direct accountability to the public;

(c) To provide rewarding, fair and challenging employment to all its staff, in an environment conducive to attracting, motivating and retaining well-qualified staff;

(d) To advise the Government of the needs of the community for public hospital services and of the resources required to meet these needs, in order to provide adequate, efficient, effective and value for money public hospital services of the highest standards recognized internationally within the resources obtainable; and

(e) To collaborate with other agencies and bodies in the healthcare and related fields both locally and overseas to provide the greatest benefit to the local community.

Corporate Vision and Strategies

To fulfill its mission, the Authority has established the following Corporate Vision:

> ' The Hospital Authority will collaborate with other healthcare providers and carers in the community to create a seamless healthcare environment which will maximize healthcare benefits and meet community expectations.'

The above corporate vision is accomplished through the following five corporate strategies:

(a) Develop Outcome Focused Healthcare to maximize health benefits and meet community expectations;

(b) Create Seamless Healthcare by reorganizing medical services in collaboration with other providers and carers in the community;

(c) Involve the Community as Partners in health in the decision-making and caring process;

(d) Cultivate Organization Transformation and Effectiveness through a multi-disciplinary team approach to holistic patient care and continuous quality improvement; and

(e) Promote Corporate Infrastructure Development and Innovation to support service improvement

The above strategies have all along been the guiding principles for HA's Annual Plans. As the planning process evolved, and taking into account the environmental changes, the above five strategies were crystallized into the following six priority areas in the 2000/01 and 2001/02 HA Annual Plans.

(a) Volume and Access;

(b) Enhanced Productivity Programme;

(c) Financing and Resource Allocation System;

(d) Distribution Network and Infrastructure;

(e) Care Process and Quality; and

(f) Human Resource Capabilities and Management

In the 2002/03 HA Annual Planning Process, the above six priority areas were further adapted into a new planning framework, comprising the following six major directions:

(a) **Developing community oriented service models** to take advantage of new opportunities and oversee volume and access challenges;

(b) **Enhancing organizational performance** through managerial reform, hospital clustering and service rationalization, as well as governance enhancement;

(c) **Enhancing system sustainability** through assisting and advising Government in healthcare financing reform, revamp of charges, implementation of population-based funding and resource allocation system, and continued generation of productivity savings;

(d) **Developing public-private interface** to redress the imbalance in distribution of workload and improve efficiency in the use of available health resources overall;

(e) **Improving cost-effectiveness of the service delivery system** through territory-wide development of quaternary centres and referral networks, knowledge management initiatives, and focused work on specific diseases and conditions

(f) **Formulating new human resource strategies** to face environmental challenges, and developing people to enhance performance at all levels

The above framework will provide a new sense of direction for HA for the coming years.

Performance Indicators for Annual Plan

	2000		
I) Health Improvement			
i) Natality			
• Life expectancy at birth (year)			
– Male	77.0		
– Female	82.2		
• Life expectancy at age 65 (year)			
– Male	16.5		
– Female	20.1		
ii) Mortality			
• Still birth rate (per 1000 births)	5.6		
• Perinatal mortality rate (per 1000 births)	6.8		
• Infant mortality rate (per 1000 live births)	3.0		
• Standardised death rate from all causes (per 1000 population aged 15-64)	1.8		
• Standardised death rate from all causes (per 1000 population aged 65 and over)	34.6		
• Crude death rates (per 1000 population) for selected cause of death:			
– Malignant neoplasm	1.7		
– Heart diseases, including hypertension heart diseases	0.8		
– Cerebrovascular diseases	0.5		
• Suicide rates (Death cases per 1000 population)			
– Up to age 64	0.1		
– Age 65 and above	0.3		
• Death rate from accidents (per 1000 population)	0.1		
	2000/01 (Actual)	2001/02 (Estimate)	2002/03 (Plan)
II) Fair Access			
i) Access to professional services in HA (As at 31st March)			
• No. of doctors per 1000 population	0.6	0.6	0.6
• No. of qualified nurses per 1000 population	2.6	2.8	2.8
• No. of allied health professionals per 1000 population	0.6	0.7	0.7
ii) Access to public hospital services (As at 31st March)			
• No. of beds per 1000 population			
– General	2.9	2.9	2.9
– Infirmary (per 1000 population aged 65 and over)	3.3	3.7	3.7
– Mentally ill	0.8	0.7	0.7
– Mentally handicapped	0.1	0.1	0.1

	2000/01 (Actual)	2001/02 (Estimate)	2002/03 (Plan)
iii) Access to ambulatory service			
• No. of specialist outpatient doctor sessions per 1000 population	60.2	62.6	62.6
• No. of psychiatric day places per 100,000 population (as at 31st March)	9.2	9.7	10.2
• No. of geriatric day places per 100,000 population aged 65 and over (as at 31st March)	68.7	67.6	70.9
iv) Access to community services (as at 31st March)			
• No. of nurses for Community Nursing Service per 100,000 population	4.9	5.1	5.3
• No. of nurses for Community Psychiatric Nursing Service per 100,000 population	1.2	1.3	1.4
III) Effective Delivery of Appropriate Healthcare			
• Unplanned readmission rate within 28 days (including day patients)			
– General	7.1%	7.3%	7.3%
– Mentally ill	3.7%	4.1%	4.1%
• Accident & emergency admission rate (to own hospital) (as % of accident & emergency first attendance)	21.8%	21.7%	21.7%**
• Accident & emergency re-attendance rate (<48 hours) (as % of accident & emergency first attendance)	3.3%	3.4%	3.4%
IV) Efficiency			
i) Utilization of services			
Accident and emergency			
• Accident & emergency attendance per 1000 population	346.5	371.1	371.1**
Inpatient services			
• Inpatient & daypatient discharges & deaths per 1000 population	168.1	173.6	175.0
• Bed occupancy rate (inpatient only)	84.6%	85.0%	85.0%
• Average length of stay (days) (inpatient only) *			
– General	6.6	6.5	6.5
– Infirmary	112.0	128.9	128.9
– Mentally ill	178.7	171.7	171.7
– Mentally handicapped	326.5	326.1	326.1
– Overall	10.0	9.8	9.8
• Day patients as % of total discharges and deaths	24.4%	25.0%	25.0%

	2000/01 (Actual)	2001/02 (Estimate)	2002/03 (Plan)
Outpatient services			
• General outpatient attendances per 1000 population	117.3	134.3	189.3
• Specialist outpatient attendances (clinical) per 1000 population ***	845.7	864.0	879.3
• Specialist outpatient attendances (allied health services) per 1000 population	345.4	346.3	342.3
Community services			
• No. of home visits by community nurses (per 1,000 population)	91.3	97.3	102.5
• No. of home visits by community psychiatric nurses (per 1,000 population)	7.0	7.6	7.9
• No. of psychiatric day hospital attendances (per 1,000 population)	23.3	25.4	25.9
• No. of geriatric day hospital attendances (per 1,000 population aged 65 and over)	159.7	159.2	166.8
• No. of outreach services attendances by Community Psychiatric Teams (per 1,000 population)	1.2	2.2	2.2
• No. of outreach services attendances by Psychogeriatric Teams (per 1,000 population aged 65 and over)	40.7	49.6	48.9
• No. of outreach services attendances by Community Geriatric Assessment Teams (per 1,000 population aged 65 and over)	341.2	423.4	413.0
• No. of elderly cases assessed for infirmary care services by Community Geriatric Assessment Teams (per 1,000 population aged 65 and over)	2.8	3.6	3.5
ii) Maximising use of resources			
Unit costs (based on total HA costs)($)			
• Cost per patient discharged (including day patients)			
– General	15985	16341	16253
– Infirmary	189250	194173	193291
– Mentally ill	136042	143237	151540
– Mentally handicapped	499657	521881	521881
• Cost per specialist outpatient attendance	661	679	667
• Cost per accident & emergency attendance	571	556	551**
• Cost per home visit by community nurse	346	339	328
• Cost per home visit by community psychiatric nurse	1041	1000	1012
• Cost per psychiatric day hospital attendance	893	905	919
• Cost per geriatric day hospital attendance	1513	1571	1553

	2000/01 (Actual)	2001/02 (Estimate)	2002/03 (Plan)
V) Patient / Carer Experience			
• % of accident & emergency cases with the target waiting time			
– Triage I (critical cases - 0 minute)	100%	100%	100%
– Triage II (emergency cases - <15 minutes)	97%	95%	95%
– Triage III (urgent cases - <30 minutes)	90%	90%	90%
• Median waiting time for first appointment at specialist clinic (weeks)	4	5	6
• Average queuing time for consultation at specialist clinic (minutes)	<60	<60	<60
Patient satisfaction			
• No. of patient appreciation per 1000 discharges and deaths	23.2	24.3	24.3
• No. of patient complaints per 1000 discharges and deaths	1.4	1.3	1.3
VI) Health Outcomes			
• Number of neo-natal deaths per 1000 live births in HA	2.1	1.8	1.8

Notes:

1. * For general and overall inpatient service, the average length of stay is derived by dividing the sum of length of stay of inpatients discharged by the corresponding no. of inpatients discharged.
   For mentally ill, mentally handicapped, infirmary, the average length of stay is derived by dividing the sum of length of stay of inpatients discharged in respective specialties by the corresponding number of inpatients treated.

2. ** Figures may change if government approves implementation of the proposed charging scheme during the year to reduce misuse of service.

3. *** No. of integrated clinic attendances is included.

4. Population covers usual, mobile residents and transients. For 2000, the mid year estimates published by Census & Statistics Department is adopted. For 2001 and 2002, the projected population from "Hong Kong Population Projections 2000-2029 (1999 base)" is adopted (including marine population):

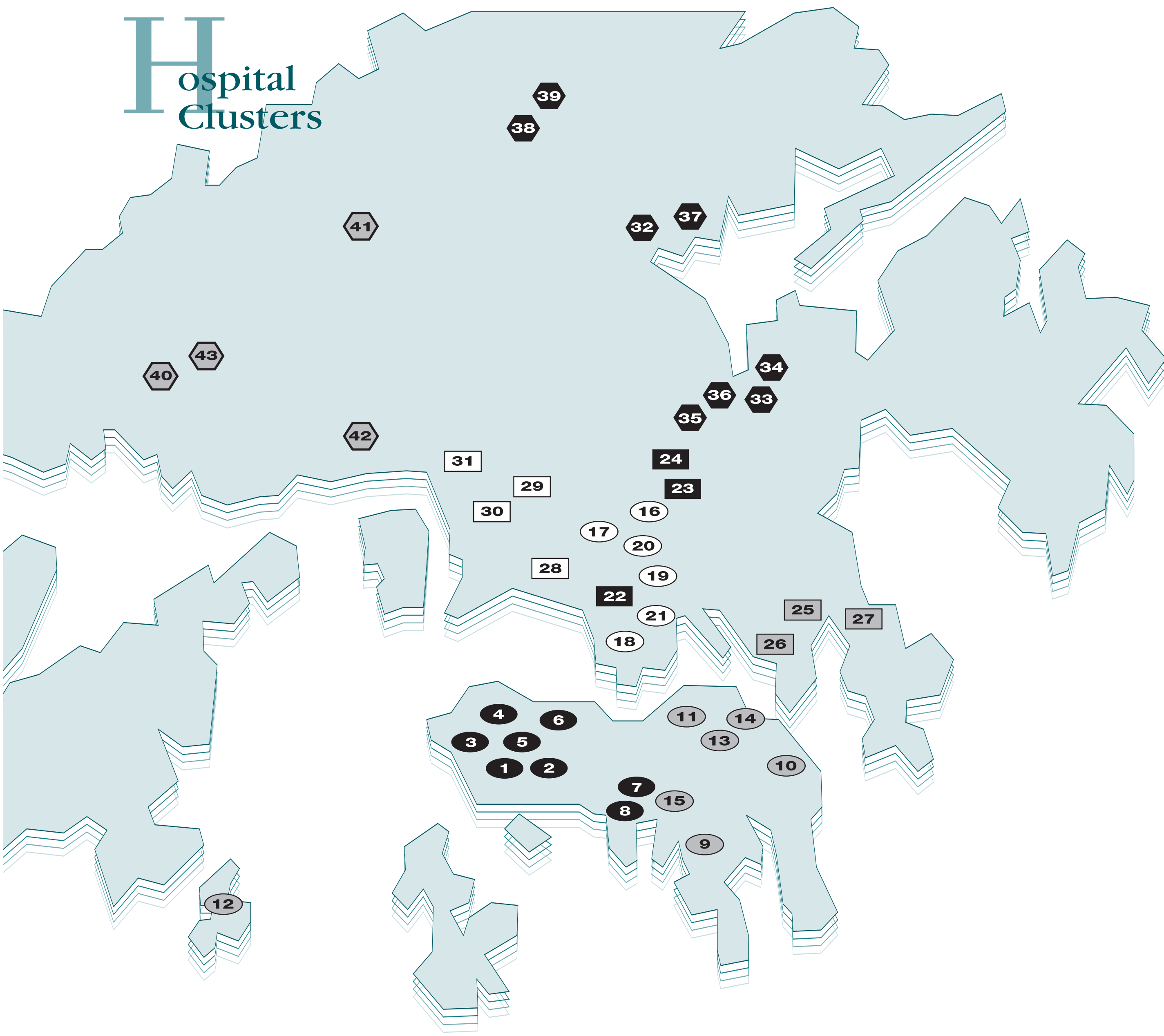
Age group	Mid 2000	Mid 2001	Mid 2002
0 - 14	1,173,500	1,150,200	1,134,000
15 - 64	4,994,500	5,061,300	5,140,400
65+	766,600	779,900	799,600
All Age Groups @	6,934,600	6,991,400	7,074,000

@ may not add up to total due to rounding.

5. The 2001/02 activity data is estimated based on the actual performance from April 2001 to September 2001, taking into account addition or deletion of facilities or expected changes in service output.

6. The 2002/03 activity data is estimated based on either the general growth in the population in Hong Kong or the expected addition or deletion of facilities or services.

Hospital Clusters



HONG KONG WEST

1. Duchess of Kent Children's Hospital at Sandy Bay
2. MacLehose Medical Rehabilitation Centre
3. Queen Mary Hospital
4. Tsan Yuk Hospital
5. Tung Wah Group of Hospitals Fung Yiu king Hospital
6. Tung Wah Hospital
7. Grantham Hospital
8. Nam Long Hospital

HONG KONG EAST

9. Cheshire Home, Chung Hom Kok
10. Pamela Youde Nethersole Eastern Hospital
11. Ruttonjee Hospital
12. St.John Hospital
13. Tang Shiu Kin Hospital
14. Tung Wah Eastern Hospital
15. Wong Chuk Hang Hospital

KOWLOON CENTRAL

16. Hong Kong Buddhist Hospital
17. Kowloon Hospital
18. Queen Elizabeth Hospital
19. Hong Kong Eye Hospital
20. Rehabaid Centre
21. Hong Kong Red Cross Blood Transfusion Service

KOWLOON WEST

22. Kwong Wah Hospital
23. Our Lady of Maryknoll Hospital
24. Tung Wah Group of Hospitals Wong Tai Sin Hospital

KOWLOON EAST

25. Haven of Hope Hospital
26. United Christian Hospital
27. Tseung Kwan O Hospital

KOWLOON SOUTH

28. Caritas Medical Centre
29. Kwai Chung Hospital
30. Princess Margaret Hospital
31. Yan Chai Hospital

NEW TERRITORIES EAST

32. Alice Ho Miu Ling Nethersole Hospital
33. Bradbury Hospice
34. Cheshire Home, Shatin
35. Prince of Wales Hospital
36. Shatin Hospital
37. Tai Po Hospital
38. Fanling Hospital
39. North District Hospital

NEW TERRITORIES NORTH

40. Castle Peak Hospital
41. Pok Oi Hospital
42. Siu Lam Hospital
43. Tuen Mun Hospital

We welcome your suggestions on the
Hospital Authority Annual Plan.
Please forward your suggestion to:

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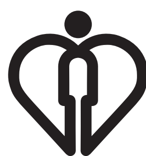

醫院管理局
HOSPITAL
AUTHORITY

HA-COR-02-05/2