Implementation of the Recommendations of the Steering Committee on Review of Hospital Authority

Hospital Authority Action Plan

醫院管理局
HOSPITAL AUTHORITY

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CONTENTS

Action Plan on the Role of the Board

On 14 July 2015, the Steering Committee (SC) on Review of Hospital Authority (HA) released 10 recommendations, covering the following five major areas that impact on HA's operation and service provision, to drive for improvements in HA to meet future challenges:

(a) management and organisation structure;

(b) resource management;

(c) staff management;

(d) cost effectiveness and service management; and

(e) overall management and control.

The basket of recommendations includes the very foremost principle as ***Recommendation 1(a)*** under Management and Organisation Structure that:

> ***Recommendation 1(a)***
>
> The HA Board, being the managing board, should play a more active role in leading and managing HA.

1. Fundamentals

1.1 HA is a statutory organisation set up under the HA Ordinance (Cap. 113). As prescribed in the Ordinance, the HA Board[1] is the governing body of the Authority to perform the functions and exercise the powers entrusted in Sections 4 and 5 of the Ordinance. In this respect, the Board gives leadership and strategic direction, controls the organisation and supervises the Executive Management, and reports on HA's stewardship and performance. Under the leadership of the HA Chairman, the Board in discharging its duties is accountable to the Hong Kong Special Administrative Region Government through the Secretary for Food and Health.

[1] Currently 28 members including the Chairman (not being a public officer), 23 non-public officers, three public officers and one principal officer who is the HA Chief Executive, all non-remunerated in the capacity as HA Board Members.

1.2 To effectively perform its functions in leading and managing HA, the HA Board has established 11 Functional Committees, each with clear terms of reference of specific roles and functions as delegated by the Board to advise on specific subject areas.

1.3 The Board emphasises strategic planning to provide overall direction to ensure that HA's operations are effective and efficient in delivering its functions and addressing challenges. The Board has formulated overarching policies to guide and provide boundaries for the Executive Management who are charged with implementing the approved plans and the management of HA's operations. The Board (including its Committees) regularly receives and considers reports from the Management on a wide range of matters including HA's performance, initiatives and plans, changes in the operation environment, internal administration, and risk management and control etc. to support the Board.

1.4 The Board is also adopting an integrated Enterprise Risk Management approach to enable a holistic view and proactive management of enterprise risks facing the Authority. At the Board level, each Functional Committee receives a report on key risks identified in their ambit having regard to last year's results and the corresponding mitigation actions planned ahead for the coming year. At the corporate holistic level, the Audit and Risk Committee considers annual report on the corporate overall Key Enterprise-wide Risks facing HA and the corresponding mitigation action strategies, whereas Executive Committee (EC) considers matters related to risk and facilitates the Board in discharging its responsibilities in this respect.

2. ACTION PLAN

The **Action Plan** will ensure and facilitate the HA Board to play a more active role in leading and managing HA. Key actions and their respective timelines are highlighted below and summarised in the **Annex**.

2.1 Key Action 1 : Strengthen and ensure stewardship by the Board for ongoing strategic focus on corporate governance

2.1.1 For continuous improvement, HA Board conducted a consultancy review on HA overall corporate governance arrangements in 2012 to 2013 through an external professional consultancy firm for the objective of enabling the Authority to better set forward its directions and functions. The review made constructive recommendations on the Board's composition and structure, operation and effectiveness, transparency and disclosure, strategy and planning and enterprise risk management. Implementation on various fronts has been in full swing since then.

2.1.2 The review covers a wide spectrum of recommendations on various corporate governance elements of the Board, collectively as a key enabler for the Board to more actively lead and manage HA. In particular, the respective terms of references of the Functional Committees were reviewed and refreshed. Specifically, the role of the Board's EC is further enhanced to serve as a bridge between the Board, the Functional Committees and the Management, as well as a regular platform for the HA Chairman, Functional Committee Chairmen and the HA Chief Executive to consider and advise on

key strategies, policies, directions and oversight of HA. Through its monthly meetings, EC regularly considers HA's overall policies and directions, long-term strategy and planning, budgets, risk management, governance, performance management and succession planning. Matters reserved for the Board and Delegations of Authority made by the Board are regularly reviewed. EC will also convene as the Emergency Executive Committee in accordance with HA's Emergency Contingency Plan to act for the Board and exercise its powers and functions in managing emergency situations, such as during activation of Serious Response Level (S2) for epidemic threats. EEC was convened in mid-2015 due to the Middle East Respiratory Syndrome outbreak in South Korea as well as in the episodes of H7N9 avian influenza infection threats in 2013 and 2014.

2.1.3 As recommended in the corporate governance review, the HA Board and its Functional Committees are actively involved at the development stage of strategy and planning, providing input on strategy and debating priorities for development and service plans. Long term strategy and planning has become a standing item on the Board's agenda as well the agendas of the Functional Committees

2.1.4 Looking ahead, the Board will continue to reinforce its leading and managing role on HA, including ensuring early engagement of EC in formulation of strategies, directions and policies; strengthening the role and participation of the Functional Committees in setting key standards, driving for best practices and monitoring performance; further strengthening the governance processes of the Board; reinforcing proactive and forward agenda planning in the Functional Committees; and ensuring that the Board is able to make informed discussions and decisions on important issues in HA.

2.2 Key Action 2 : Set up dedicated Task Force to steer action planning & monitor implementation of the recommendations of the HA Review

2.2.1 In anticipation of the SC Report, the HA Board at its meeting held on 25 June 2015 decided that HA should set up a special task force to steer the strategy and monitor implementation of the recommendations at the Board level. This Task Force appointed by the HA Board comprises the Chairman and Chairmen of all the Functional Committees of the Board (except Staff Appeals Committee) in membership.

2.2.2 Specifically, the Task Force actively participates in the formulation of detailed implementation plans by steering and advising on the overall strategies, considering the proposed targets and major issues; and deliberating on the proposed actions and plans. In this respect, the Task Force conducted four intensive discussion meetings in August and September 2015 to examine the detailed proposals on the action plans and targets on each of the recommendations.

2.2.3 In formulating the action plans, the Task Force emphasises the need for concrete targets, including planned deliverables/enhancements and benefits, timetable, actions, roadmap, parties involved etc.; and that due consideration should be given to the required enablers, risk to be managed and stakeholder interests and engagement plan. Post-implementation review or assessment of achievement of target is required, and where appropriate, there should be interim enhancement measures as quick wins particularly for those areas requiring longer term action in implementation

2.2.4 As an integral part of the Board's governance process, the HA Board, including its Functional Committees, will be suitably involved and consulted for views, endorsement or approval as appropriate on the various initiatives under the action plans. For ongoing monitoring, the Task Force will receive and assess progress reports on the implementation, and will submit regular (six-monthly) progress reports to the Food and Health Bureau (FHB).

Action Plan on Cluster Boundaries

The SC made the following recommendation with a view to strengthening governance and rationalising the organisation structure of HA:

Recommendation 1 :

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

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

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

1. Fundamentals

1.1 A HA cluster is a network of medical facilities and services grouped together to help ensure continuity of high-quality care within the same geographical setting throughout a patient's episode of illness, from acute phase to extended, primary and community after-care. It maximises operational and management efficiency through vertical integration of services, including in respect of integration of care at medico-social level particularly in chronic disease management.

1.2 Cross-cluster utilisation of services in HA cannot be entirely avoided given historical development of hospitals (not originally planned on a cluster basis) and due to patients' preference, convenience and proximity (e.g. working population), specialised tertiary services (available only in certain clusters with cross-cluster referrals to ensure concentration of expertise and service quality) etc.

1.3 Re-delineation of cluster boundary will need to be supported by reorganisation of services taking into consideration the supporting network across healthcare services at acute care, extended care, primary care and community care levels for patients. Hence, there will need to be detailed planning, suitable engagement of internal and external stakeholders and phased implementation, through an active and well planned approach, and taking into account the hospital development/redevelopment plans in the respective clusters.

1.4 It is anticipated that with the re-delineation of cluster boundary and the consequent reorganisation of services, cross-cluster service utilisation can be reduced, vertical integration of services for patients in the concerned districts can be facilitated, and the objective of the clustering concept of facilitating patients from local communities to have continuity of care in their residential vicinity can be realised.

2. ACTION PLAN

The **Action Plan** will

- ✧ re-delineate the cluster boundaries of Kowloon West Cluster (KWC) and Kowloon Central Cluster (KCC), thereby reducing cross-cluster service utilisation;

- ✧ enhance the continuity of care for patients through reorganisation of services at acute care, extended care, primary care and community care levels to better match local service demand and supply; and

- ✧ identify and rectify service gaps by building up the necessary capacity progressively through the Annual Planning System (APS) and resource allocation exercises.

Key action plans and their respective timelines are highlighted below, with details of the full action plan outlined in the **Annex**.

2.1 Key Action 1 : Re-group Wong Tai Sin (WTS) district and Mong Kok (MK) area from KWC to KCC

2.1.1 By regrouping WTS district and MK area from KWC to KCC, Kwong Wah Hospital (KWH), Wong Tai Sin Hospital (WTSH) and Our Lady of Maryknoll Hospital (OLMH) will be re-delineated from KWC to KCC to support the new KCC catchment districts which will cover Kowloon City, Yau Tsim Mong (YTM) and WTS Districts.

2.1.2 In support of the regrouping exercise, services will be reorganised taking into consideration the supporting network across healthcare services at acute care, extended care, primary care and community care levels for patients from different catchment districts in the cluster. Besides, infrastructure issues will need to be addressed including staff arrangement, relocation of financial resources and revamp of information systems.

2.1.3 There will be full engagement and consultation of various internal and external stakeholders including staff, governing bodies of the affected hospitals, District Councils, patient groups and the community. The administrative arrangement for the regrouping exercise will be effective by **late 2016** with the associated service reorganisation to take place by phases thereafter, while redevelopment of KWH and the new acute hospital in the Kai Tak area are progressing in parallel.

2.1.4 After the re-delineation of cluster boundary, the objective of the 'Cluster' concept can be better realised. The re-grouping will have the following impact on service:

(a) better balance in population and reduction in cross-cluster utilisation between KCC and KWC:

	Mid 2014		**After re-grouping**	
	KCC	KWC	**KCC**	**KWC**
Population	0.5 million	1.9 million	**1.1 million**	**1.3 million**
Cross-cluster utilisation	62%	13%	**30%**	**9%**

(b) better balance in terms of number of hospital beds per 1000 geographical population of catchment districts:

	KCC	KWC	KEC*
Before re-grouping (bed nos.)	6.6 (3 548)	3.4 (6 629)	2.3 (2 487)
After re-grouping **(bed nos.)**	**4.8** **(5 501)**	**3.5** **(4 676)**	**2.3** **(2 487)**

*KEC stands for Kowloon East Cluster

(c) significant drop in proportion of WTS residents receiving inpatient services in other clusters:

Before re-grouping	68%
After re-grouping	**18%**

(d) more patients in YTM District can receive inpatient services in its designated cluster viz. KCC:

	Before re-grouping	**After re-grouping**
KCC Hospitals	27%	**87% (KCC)**
KWC Hospitals	65%	

2.1.5 Re-evaluate the demand and capacity gaps within KCC, KWC and KEC with special focus on KEC for longer term planning, taking into consideration the impact of cluster boundary realignment and the service demand projection up to 2026. Result to be ready by **3Q 2016** to serve as a guide for facility planning, workforce building, as well as future resource planning and allocation via ongoing annual planning and resource allocation exercises. With the known service gap in KEC, major medical facilities are being planned to expand the cluster's service capacity. These include the United Christian Hospital (UCH) expansion project and the Haven of Hope Hospital (HHH) redevelopment project. Upon the completion of the UCH expansion project, the services currently being provided by KCC for KEC namely oncology, psychiatric and rehabilitation services, will be relocated back to KEC.

2.2 Key Action 2 : Evaluate demand and capacity of other Clusters

2.2.1 Evaluate demand and capacity for the remaining four clusters, with special focus on New Territories East Cluster (NTEC) and New Territories West Cluster (NTWC), with a view to formulating analysis and associated plans by **2Q 2017** to guide facility planning, workforce building, as well as future resource planning and allocation for the clusters. On top of service commissioning of the Tin Shui Wai Hospital (TSWH) by phases starting 2016/17, major medical facilities under planning for NTEC and NTWC to increase the clusters' service capacity include the redevelopment of PWH (Phase 2), the expansion of North District Hospital (NDH), and the extension of the Operating Theatre (OT) Block of Tuen Mun Hospital (TMH).

2.3 Key Action 3 : Interim measures for quick enhancements

2.3.1 Enhancing services in WTS district

(a) WTSH: injected additional manpower and resources in **2015/16** to enhance its capacity to serve additional patients residing in WTS.

(b) OLMH: allocated resources in **2015/16** to enhance its endoscopy service and day service, augmented general outpatient service via provision of service during public holidays.

(c) Refurbishment of Hong Kong Buddhist Hospital (HKBH) to be completed by **2019** and the planned redevelopment of OLMH will further increase the service capacity for residents of the WTS district.

2.3.2 Rationalise acute-rehabilitation service arrangement

(a) launched in **August 2015** a pilot project to provide same district medical rehabilitation service for target patients residing in WTS and YTM after they have stabilised in acute hospitals. This is a new acute-rehabilitation patient-flow arrangement for Queen Elizabeth Hospital (QEH)/WTSH and KWH/Kowloon Hospital (KH) where WTSH and KH have each designated medical rehabilitation beds for cases referred by QEH and KWH respectively. We will review the results of this collaboration in six months' time with a view to considering expanding and extending the reorganisation subject to outcome of the review.

2.3.3 Ongoing review of geographical boundaries for ambulance catchment areas in collaboration with Fire Services Department (FSD)

(a) continue to work with FSD to conduct regular review on the Kowloon ambulance catchment areas with a view to exploring improvement opportunities for refinement to enable more speedy access to patient care in the districts.

2.3.4 Roll out catch up improvements in KEC, NTEC and NTWC in **2015/16 to 2017/18**

(a) mobilise the additional three-year funding of $300 million for catch-up plans in KEC, NTEC and NTWC to address known deficiencies in service capacity, with the first year priority plans in 2015/16 focusing on enhancement of their manpower shortfall particularly in respect of nursing, allied health and supporting staff.

(b) In the meantime, service capacity for KEC, NTEC and NTWC is being built up. In 2015/16, 36 beds are added to Tseung Kwan O Hospital (TKOH), 71 beds to PWH and a total of 122 beds to TMH and Pok Oi Hospital (POH). Arrangements are also being made to commission the service of TSWH in 2016/17. At the same time, resources are put aside / planned under Minor Works Projects forward renovation of hospitals in the clusters to increase the clusters' physical capacity to accommodate more hospital beds.

Action Plan on Management and Organisation Structure

The SC made the following recommendation with a view to further strengthening the central management and coordination role of Hospital Authority Head Office (HAHO) to ensure consistency in service provision in different clusters, and achieve better division of labour and better alignment of service provision at cluster level with organisational goals.

Recommendation 2 :

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

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

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

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

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

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

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

1. Fundamentals

1.1 Through hospital clustering, HA over the years has achieved the objective of decentralising the direct management of individual hospitals closer to users of the services, allowing individual clusters a reasonable level of autonomy in service provision so as to cater for the needs in the catchment districts of the respective clusters. As such, the type and format of service provision may not necessarily be uniform throughout the territory.

1.2 Under the decentralised cluster structure, HAHO plays a strategic role in leading corporate development, aligning corporate values and directions, and supporting hospital clusters and frontline delivery of healthcare services. At the hospital level, CCEs are responsible for the overall budget and operation of the hospitals and services for the respective cluster, and are also part of the HA Chief Executive's senior management team in HAHO.

1.3 Some specialised tertiary services are available only in certain clusters with cross-cluster patient referrals to ensure concentration of expertise and service quality. COCs and CCs are established to coordinate various services for the respective specialty/clinical grade and service, establishing specialty service networks through the coordination by HAHO.

2. ACTION PLAN

The **Action Plan** will

- ensure a fair mechanism for selection of centres for highly specialised services with training needs of staff being well taken care of;
- refine the cluster management structure and delineate and reinforce the roles and responsibilities of CCEs and strengthen their participation at HA corporate level;
- ensure that HCE portfolios are comparable, thus facilitating job rotation and career advancement; and
- clearly define, delineate the roles of hospitals, align services to meet local service needs, and minimise inconsistencies in practice among hospitals and across clusters.

Key action plans and their respective timelines are highlighted below, with details of the full action plan outlined in the **Annex**.

2.1 Key Action 1 : Set up a mechanism for selection of centres for provision of highly specialised services

2.1.1 A mechanism will be devised by **1Q 2017** for selection of centres for provision of highly specialised services to ensure that service provision is well coordinated for optimal service efficiency and effectiveness, and that equitable access to services is provided to patients from different clusters over the territory. The mechanism will be transparent in the selection process with clearly defined definition of highly specialised services, and parameters for evaluation and decision purposes. The mechanism will also ensure appropriate training opportunities for staff, including those outside the cluster or centre providing the service, to facilitate career development of staff and service enhancement by HA.

2.2 Key Action 2 : Refine the cluster management structure

2.2.1 HAHO will continue to actively involve the CCEs in the work of various management committees where corporate decisions on staffing, resources management and service planning are made. In parallel, we will revisit the cluster management structure, with particular regard to the roles and responsibilities of CCEs and HCEs, to propose enhancements to the Board by **1Q 2017** for strengthening the participation of CCEs in central management and ensuring that CCEs are in line with HA's corporate management goals and service targets.

2.2.2 We will also engage the COCs/CCs to enhance their roles and responsibilities in clinical governance, specifically in setting service standards, developing clinical practice guidelines, education and training, conducting clinical audits, clinical risk management and introduction of new technology and service development. This will be elaborated further under the action plan for Recommendation 10.

2.3 Key Action 3 : Regroup hospitals under one HCE to make HCE job portfolios comparable

2.3.1 Based on the recommendations of a professional external consultancy review, we are formulating, taking into account views from engagement of relevant stakeholders including the hospitals concerned (including their ex-governing bodies where applicable), a final proposal on regrouping of hospitals for seeking the Board's endorsement by **December 2015**. Through implementation by phases in the coming three years having regard to staffing arrangements, the regrouping aims to enhance operational synergy and improve patient journey/experience, as well as to enrich solid HCE portfolios with comparable complexity and exposure to facilitate rotation and prepare HCEs for career advancement.

2.4 Key Action 4 : Delineate the roles of hospitals within a cluster

2.4.1 HAHO will work closely with individual Clusters to formulate **Clinical Services Plan**[Note] **(CSP)** for the respective clusters to set out the clinical strategies and service directions for the cluster and to further delineate the role of individual hospitals within the cluster to ensure coordinated and planned development of all hospitals within the cluster and between clusters. CSPs for Hong Kong West Cluster (HKWC), KEC and NTEC have been completed and published. CSP for KCC is under preparation and take into account the action plan in respect of the cluster boundary under Recommendation 1. HA will strive to complete the remaining CSPs, viz. for NTWC, Hong Kong East Cluster (HKEC) and KWC in phases in the next three years.

[Note: A CSP is a document formulated with active participation of clinicians. It maps out the clinical strategies, models of care, future service development, and role of hospitals within a cluster. It also informs and guides the conceptual design of a future hospital.]

Action Plan on Resource Management

The SC made the following recommendations with a view to enhancing equity and transparency in resource management in HA.

Recommendation 3 :

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

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

Recommendation 4 :

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

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

Separately, the Government also plans to allocate a time-limited funding of $300 million for the next three years from 2015/16 to 2017/18 to enhance the existing services of NTWC, NTEC and KEC pending the implementation of the refined population-based funding model.

1. Fundamentals

1.1 To fulfill its statutory obligation in providing the highest possible standard of care within resources obtainable, HA strives to uphold its key values in resource management – to facilitate service provision to achieve continuum of care within the same geographical proximity for patients seeking medical support, and also to optimise effectiveness of care for patients receiving medical services at HA.

1.2 Over the years, resource management of HA have progressively evolved from addressing the activity/service volume of individual hospitals, which was in use prior to the establishment of HA, to networking hospitals (into seven clusters) for integrated health care strategies and service planning by a population-based perspective. While residential population is the prime determinant of demand for healthcare, and hence, resource requirement of individual clusters, there are other relevant factors affecting service designation and utilisation across the public hospitals in Hong Kong that HA needs to adjust so as to ensure allocating resources to the right areas and drive development towards the desired direction. It should be noted that the patient load of a cluster is subject to influence by factors like (i) population demographics, which is a key determinant of disease burden, (ii) specialised services designated or centralised in particular hospitals to serve population beyond the local area, (iii) population mobility due to work and other reasons that would affect healthcare seeking behavior and utilisation across clusters, and (iv) economic status of the regions and its effect on the relative utilisation of public and private health services.

1.3 While the refined population-based model lays the basic understanding for parity of resource allocation between clusters at a macro level, it is not sufficient by itself for ensuring comparable service provision and performance at the cluster and hospital level. It is equally important for HA to monitor accessibility to care across Hong Kong (such as waiting time and access block) and to evaluate efficiency at the cluster and hospital level.

1.4 Resource allocation does not exist in a vacuum. It is to a large extent linked to the existing infrastructure (viz. facilities, equipment, work force and the organisation of care delivery, etc.), and hence the scale of service provision and pattern of utilisation cannot be drastically changed overnight. Under the refined population-based model, measures will be taken incrementally through various planning activities (including capital works planning, equipment planning, workforce planning, and new service initiatives at the annual planning exercises) in time to bring in more parity between clusters. In particular, clusters found to be relatively disadvantaged in resources will be given additional support to catch up. Resource management is not static but a continuous process that must address both current and future needs, and therefore, HA must take into consideration current and future populations, as well as the lead time required to execute planned changes.

2. ACTION PLAN

The **Action Plan** will

- ✧ adopt a refined population-based resource allocation model, which will incorporate factors to reflect the differential need of local populations for public hospital services and address unique requirement of individual clusters for resources, such as arising from the provision of designated services and demand generating from cross-cluster movement of patients. The objective is to facilitate service planning in addressing the healthcare needs of the present and future population under the cluster framework for delivering public hospital services;

- ✧ enable time-trend analysis of cluster resource utilisation so as to shed light on whether resource management in HA is improving parity between clusters;

- ✧ facilitate promulgation of information on resource analysis, resource management and upcoming planning strategies to stakeholders such as HA staff and the public where appropriate;

- ✧ improve and simplify the procedures of resource bidding; and

- ✧ enhance transparency of the resource bidding and allocation process.

Key action plans and their respective timelines are highlighted below, with details of the full action plan outlined in the **Annex**.

2.1 Key Action 1 : Develop refined population-based resource allocation model and perform analysis to aid service planning

2.1.1 HA will undertake the necessary groundwork to prepare for model building through (a) analysing public healthcare utilisation of local communities by the cluster framework, and identifying pattern of cross-cluster utilisation of care; and (b) setting up governance to build consensus for designated services to be counted and the related costing methodologies. We aim at developing a prototype model for consideration by the Board by **3Q 2016**. The prototype model will be fine-tuned and validated by an external consultant, and the finalised model will be ready by **1Q 2017**. HAHO will hold biannual meetings with each cluster to share ideas on model development and potential application of analysis findings.

2.1.2 With the refined model, we will then compare resource utilisation of clusters and perform time trend analysis of cluster resource need and utilisation. Clusters found to be relatively disadvantaged in resources (beyond the degree of certainty within the model) will be given priority to catch up through submission of plans to the annual planning exercise to beef up the under-provided areas. Preliminary results of resource allocation analysis will be reported to the Board by **1Q-2Q 2017**. Subject to feedback and endorsement, analysis will be incorporated into the HA annual planning exercise by **3Q 2017**, i.e. for the 2018/19 planning cycle onwards, whereby parity of cluster resources will be one of the key considerations for vetting resource biddings.

2.1.3 We are discussing with NTWC, NTEC and KEC on allocation of topping up funding to help them to build up the capacity progressively to serve the growing population demand in their catchment districts before the switch over to the proposed refined model. Catch up plans for **2015/16 to 2017/18** have been formulated with the three clusters, mainly to enhance staff mix in nursing, pharmacy, different disciplines of allied health professionals and other supportive functions, as well as to acquire/upgrade medical equipment. The implementation of the catch-up plans is now in progress, and we will monitor progress and utilisation of the catch-up funds and to dovetail in the annual planning exercise.

2.2 Key Action 2 : Simplify the procedures of resource bidding and enhance transparency of the resource bidding and allocation process

2.2.1 HA has introduced the APS since 2014/15 to enable online submission of resource requirement for annual plan proposals covering manpower, equipment, capital works and other costs. Training workshops will be organised in **1Q 2016** to help frontline users to better understand the APS workflow to prepare for the next planning cycle. We are formulating plans to enhance the APS by **1Q 2017** by adding additional functionalities to further reduce the administrative work of frontline clinical staff in the resource bidding process.

2.2.2 To ensure transparency in the resource allocation process, we will reinforce the annual briefing forums to explain the rationale and considerations behind the final decisions and allocation result of submitted proposals. Feedback on the submitted proposals will be conveyed to stakeholders including COC/CC members, clusters and HAHO subject officers. In addition, the existing Manual on Annual Planning, which is available to all staff via the HA intranet, will also be reviewed and updated for promulgation to all stakeholders in **4Q 2015 – 1Q 2016**.

Action Plan on Staff Management

The SC made the following recommendation with a view to strengthening staff management in HA.

Recommendation 5 :

The SC considers that HAHO should enhance its coordinating role in staff management to ensure greater consistency, fairness and parity in Human Resources (HR) management across clusters. Internal communication on staff management issues should also be strengthened. In particular, the SC's recommendations on HA's staff management are as follows :-

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

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

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

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

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

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

Separately, in order to address the manpower shortage problem and encourage transfer of knowledge and experience, the Government will allocate to HA a time-limited funding of $570 million for 2015/16 to 2017/18 to re-employ suitable retirees of those grades and disciplines which are facing a severe staff shortage problem, for a specific tenure period to be considered by HA.

1. Fundamentals

1.1 HA is a large and complex organisation with total workforce exceeding 70 000 staff in 300 grades and ranks, being the largest in Hong Kong's public organisations other than the civil service.

1.2 HA adopts a decentralised management structure along with the principle that operational decision-making should be encouraged as close to the patient as possible, and one of the main purposes of establishing clusters in HA was to improve efficiency through decentralisation. Any changes to the existing system should avoid going to the other extreme of centralisation; we need to strike a proper and careful balance between enhancing the central coordination role of HAHO whilst retaining sufficient authority and autonomy at the cluster level.

1.3 Strengthening central coordination in various HR functions (e.g. creation and deletion of senior posts, central staff deployment, HAHO representation in cluster selection board) may be perceived as tightening up authority or limiting the flexibility in operation. Extensive staff consultation and communication will need to be arranged to manage possible staff sentiments.

1.4 HA's manpower shortage issues will continue to have a significant bearing on the Authority's flexibility in staff management.

2. ACTION PLAN

The **Action Plan** will

- ✧ strike an appropriate balance between central coordination and decentralisation to ensure greater consistency, transparency, fairness and equity in staff management throughout HA;
- ✧ promote the concept of "one-HA" in order to address the perception of 'sectarianism' and instill in staff the notion of being a member of the HA family rather than merely staff of individual cluster or hospital;
- ✧ strengthen staff communications and foster a collaborative culture to help improve staff morale and engagement to support HA's service and development; and
- ✧ re-employ suitable retirees to address manpower needs.

Key action plans and their respective timelines are highlighted below, with details of the full action plan outlined in the **Annex**.

2.1 Key Action 1 : Enhance central coordination

2.1.1 HA will take forward the following initiatives to enhance the coordinating role of HAHO to ensure greater consistency, fairness and parity in HR management and practices in and between the clusters :

(a) Instead of vesting the authority to cluster management, HA has recently introduced a central panel led by HAHO to manage the creation and deletion of directorate positions (e.g. clinical Consultants) and Nursing Consultant positions so that a more balanced consideration can be given to both local needs as well as HA's overall needs. The mechanism will be formalised into a structured approach to manage the creation and deletion of senior posts. The enhanced mechanism will be piloted in a specific grade in **2016/17** with subsequent further extension to other grades and ranks as appropriate.

(b) HAHO representation in cluster selection boards will be strengthened by **4Q 2016** with expanded positions requiring HAHO representation (e.g. General Managers), expanded pool of HAHO representatives to include cluster senior staff (e.g. HCEs, Cluster General Managers), and clear role delineation of HAHO and other representatives in selection boards.

(c) Communication and partnership between HAHO and cluster HR departments are being strengthened to minimise inconsistencies in practices in implementation of HR policies. In the longer term, a system for HR audit will be established to look into the policies, guidelines, procedures, and practices in selected disciplines of the HR functions, with a view to identifying any gaps and improvement areas for risk prevention; and mechanism and standard protocols will be developed to guide HR policy formation, implementation and monitoring with a view to sustaining consistency and quality assurance.

(d) To strengthen central coordination and involvement of COC in recruitment of Resident Trainees, specialty-based central selection panels currently being piloted in Paediatrics and Psychiatry will be rolled out to all specialties in **2016/17**.

2.2 Key Action 2 : Promote the concept of "One-HA"

2.2.1 HA will reinforce rotation of senior management and clinical staff to broaden exposure and facilitate mutual understanding between staff and other clusters:

(a) Structured job rotation arrangement will be developed for positions at Chief Executive Officer (CEO) rank and above with clear objectives, selection criteria, and approval process by **3Q 2016**.

(b) HA will facilitate intra-specialty rotation for clinicians by provision of central funded posts. For cross specialty trainee rotation, cluster-based rotation programme will be piloted in **2016/17** to enhance staff's exposure with a view to better support to HA's service. The developed mechanism can serve as a useful reference for other clinical grades. A rotation mechanism will be developed in consultation with COCs and Clinical Technology Management team by **2017/18** for training of staff in different grades/hospitals on the use of new technology/equipment when such are introduced into HA.

2.2.2 HA will develop a structured approach by **2016/17** to enable central coordinated authority for activating central deployment plan to cope with emergencies, with guidelines on delineating the roles and responsibilities at cluster and corporate levels in staff deployment and the triggering factors for cluster based and HA wide crisis.

2.2.3 In parallel, the format and signatory of HA's appointment letter will be standardised to emphasis the "one-HA" family culture and the authority for deployment by HA in case of need.

2.3 Key Action 3 : Strengthen staff communication

2.3.1 HA will develop HR mobile solutions to modernise staff communication. The plan is to pilot the development of modules for staff health records, leave application, and staff welfare in **1Q 2016** followed by rollout of other modules for staff training, retirement benefits and job opportunities in **2016/17**. A Staff Communication Guidebook outlining the staff communication strategies, framework, practical tools and checklists will be produced in **2016** to provide a useful guide to enhance staff communication. At the same time, a staff survey will also be conducted in **2016/17** to gauge staff's concerns and views to develop staff engagement strategies.

2.4 Key Action 4 : Re-employ suitable retirees

2.4.1 As approved by the Board, and using the time-limited funding of $570 million for **2015/16 to 2017/18**, re-employment schemes (with detailed eligibility criteria, selection process, post creation arrangement and implementation plans) for suitable retirees are being implemented for clinical doctors, nurses, allied health and supporting grades staff retiring in 2015/16 and 2016/17 to help address manpower shortage and facilitate knowledge transfer. As at 30 September 2015, arrangements have been made to re-employ 60 retiring doctors. Recruitment for retiring nurses and allied health is in progress and over 110 nurses and allied health professionals are expected to be recruited by **4Q 2015**. As for supporting grades staff, recruitment process is still in progress, and around 460 retiring supporting grades staff have so far been recommended for re-employment.

Action Plan on Strengthening Training & Development

The SC made the following recommendation on enhancing the training of healthcare professionals with a view to sustaining the Hong Kong's healthcare system and continued improvement of healthcare services.

Recommendation 6

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

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

Separately, a time-limited funding of $300 million for the next three years from 2015/16 to 2017/18 will be allocated to HA for enhancing staff training which includes strengthening of training support, especially for clinical staff, through scholarship, commissioned training programmes, staff rotation development programmes, simulation training courses and additional manpower support for training relief.

1. Fundamentals

1.1 Promoting, assisting and taking part in the education and training of healthcare professionals is a statutory function of HA, and training of healthcare professionals is of paramount importance to supporting professional development of staff and sustaining Hong Kong healthcare system and continued improvement of healthcare services. In this regard, HA takes a leading role in providing training and development (T&D) to local healthcare workforce. However, given the current shortage in the supply of clinical professionals, training also adversely affected apart from service delivery.

1.2 For holistic T&D of HA's workforce, apart from the well-structured training curriculums in place for clinical professionals such as doctors, nurses, allied health and pharmacists, training and development for professionals on non-clinical fronts such as information technology (IT), HR, finance and business administration fields, who play an essential role in supporting frontline clinical staff to discharge their daily work, is equally important.

1.3 Enhanced training opportunities will promote greater job and career satisfaction of staff and thereby help in staff attraction and retention.

2. ACTION PLAN

The **Action Plan** will

- ✧ strengthen the role of the Board in central planning and provision of training with a view to aligning practices of individual clusters in selection and funding arrangements for training opportunities, and ensuring the workforce has the right skills and is of the right numbers to maintain the standard of care and improve patient outcomes;

- ✧ develop a mechanism to ascertain the training needs of HA for development of training programmes/activities for the whole workforce in a more structured manner; and

- ✧ strengthen collaboration with external parties to enhance HA's overall training capacity and capability.

Key action plans and their respective timelines are highlighted below, with details of the full action plan outlined in the **Annex**.

2.1 Key Action 1 : Strengthen governance on training

2.1.1 At the Board level, HA will set up a Central T&D Committee under the Board's Human Resources Committee (HRC) in **4Q 2015** to oversee all training elements in HA. The Central T&D Committee will advise on training policies to ensure consistency, parity and transparency in allocation of training resources and opportunities among different clusters, and consider priorities of training initiatives/programmes. It will also monitor the utilisation of the one-off funding of $300 million from the Government for enhancing staff training and will report the progress of implementation to HRC on a regular basis.

2.1.2 At the second tier, the Central T&D Committee will be supported by a T&D Executive Group co-chaired by Director (Cluster Services) and Head of Human Resources with grade/ functional heads as core members, as the executive arm of the Committee to consolidate the organisation's training needs and make recommendations on the priorities of training initiatives/programmes.

2.2 Key Action 2 : Ascertain organisation training needs and development of training activities

2.2.1 We will systematically identify the training needs of non-clinical staff and come up with a structured programme for development of training activities for different grades of non-clinical staff. Grade-specific training needs for different disciplines/grades of staff for non-clinical professional grades will be consolidated, and relevant training curriculums will be formulated in **4Q 2015 – 3Q 2016** to facilitate career development and professional growth.

2.2.2 Through a stock-taking exercise on current practices in the clusters, HA will also develop a structured mechanism in **2016** for adoption by the seven clusters for identification of individual staff development needs to meet operation requirement.

2.2.3 Training plans for relevant grades of staff will be incorporated when new technology or medical service are introduced in HA. The training arranged for medical staff is now confined to the department/hospital concerned. A rotation mechanism for training of staff in different grades/hospitals on the use of new technology/equipment will be developed in **1Q 2018**. Further, training activities for highly specialised services in HA will also be centrally coordinated.

2.2.4 Through a phased approach, HA will enhance and integrate its training information management system to provide comprehensive and accurate training-related information (e.g. training records, training days, training expenses, etc.) for monitoring, control and future planning. As an initial step, we will set up a system in **4Q 2015** to track key training activities sponsored by designated training funds. A participatory project will be launched in **early 2016** for user consultation and engagement, to be followed by planned pilot of some key modules of the new IT system in **4Q 2017**.

2.3 Key Action 3 : Strengthen collaboration with external partners

2.3.1 To enhance training capacity and capability, HA will conduct active discussions with external parties e.g. the Medical Council of Hong Kong, HKAM, and the Universities to strengthen current collaboration platforms by **4Q 2016**. There will be well-defined priority of areas of collaboration such as bringing in external expertise for programme enrichment, organising joint programmes with external parties or procuring training places from external professional training organisations.

2.4 Key Action 4 : One-off additional funding of $300 million to enhance training

2.4.1 HA will make use of the additional funding of $300 million from the Government to increase training opportunities for staff and provision of additional manpower support for training relief. Training proposals are being formulated to strengthen training support for staff, especially clinical staff, through scholarship, commissioned training programmes, staff rotation development programmes, simulation training courses and overseas training. Emphasis will also be placed on

increasing overseas training opportunities for staff to learn and acquire best practices from other countries. For the initial year, 11 new and scale-up training programmes are rolled out in **2015/16**. Also, a structured Healthcare Services Management Training Curriculum with 52 e-learning modules are being developed to help enhance core business knowledge of senior executives.

2.4.2 Funding support for training relief is also incorporated to maintain service operation through the special retire and rehire schemes, engagement of temporary staff, part-timers or the Special Honorarium Scheme while selected staff members are on training. In the long run, consideration will be given to training requirement of staff for future manpower planning to enhance training opportunities.

Action Plan on Cost Effectiveness and Service Management
(Key Performance Indicators)

The SC made the following recommendation with a view to strengthening the role of the HA Board in setting key standards and targets and enhancing and refining HA's Key Performance Indicators (KPIs).

Recommendation 7 :

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

  (i) monitor the overall performance and service provision for public accountability; and
  (ii) facilitate management decision to improve performance and drive best practices; and

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

1. Fundamentals

1.1 HA's KPI framework is an important management tool for regular tracking and monitoring of its performances internally by the HA Board and HAHO, as well as externally by the FHB and the public.

1.2 HA's KPI framework comprises the three pillars of Clinical Services, HR and Finance, each supported by a collection of specific KPIs selected based on a number of well-considered criteria, including relevance to the overall corporate priorities and organisational objectives, availability of related automated data that is reliable and comparable across clusters, materiality in affecting managers and clinicians' behavior, impact on service outcome and cost efficiency, and the burden of diseases involved for KPIs of clinical services.

1.3 Apart from ongoing monitoring of KPI performances, HA regularly reviews and updates its KPIs through annual review by the KPI Review Working Group, with participation from HAHO Divisions and clusters, as well as input from relevant COCs and CCs on clinical services. The review recommendations are put forward to the HA Board for deliberation and endorsement to ensure that the KPIs are in line with current corporate priorities and service directions.

2. ACTION PLAN

The **Action Plan** will

- ✧ strengthen the Board's review and monitoring mechanism for HA's KPI performance with greater and in-depth involvement of the Board's functional committees; and

- ✧ develop additional KPIs to reflect capacity and service efficiency to facilitate management decision to improve performance and drive best practices.

Key action plans and their respective timelines are highlighted below, with details of the full action plan outlined in the **Annex**.

2.1 Key Action 1 : Enhance the role of the HA Board in KPI performance and KPI development process

2.1.1 HA will implement an enhanced mechanism for KPI performance review with effect from **4Q 2015** to actively involve the respective functional committees to support the HA Board in reviewing and monitoring HA's performance. Specifically, KPI reports of the Clinical Services KPIs will be submitted to the Board's Medical Services Development Committee (MSDC), HR KPIs to HRC, and Finance KPIs to Finance Committee for scrutiny and in-depth discussion. With the expertise of the respective functional committees, HA's performance will be more critically and effectively reviewed and analysed, and issues of concern or outlying performance will be brought up to the Board for attention and focused discussion with a view to driving for improvements.

2.1.2 Through the enhanced mechanism and reporting platform, and with the support of the functional committees, the Board's role in steering the development of KPIs will be strengthened, including in identification of strategic areas for KPI development and setting of targets and standards. With such enhancement, the Board will be able to proactively drive best practices for cost effectiveness, quality and service management.

2.2 Key Action 2 : Develop KPIs to reflect capacity and efficiency gaps

2.2.1 HA is developing additional KPIs on capacity and service efficiency. Through capacity KPIs, HA should be able to ascertain the service gaps between capacity and demand, and such KPIs can provide direction for capacity building and resource allocation. By developing efficiency KPIs, HA can facilitate performance benchmarking across clusters and amongst peers. This in turn will drive best practices and help the organisation develop efficient models of operation, leading to overall service improvement.

2.2.2 Priority focus will be on the key pressure areas of access to Specialist Outpatient Clinic (SOPC) and OT services, and the access block problem. Proposals are targeted for submission to the Board for endorsement in **1Q 2016**, and for implementation and commencement of reporting in **2016/17.**

(a) For SOPC service, indicators will be developed to reflect adequacy of existing capacity in matching the new case demand and the efficiency in the allocation of resources for the service through analysing the related input, throughput and output.

(b) On OT service, indicators will be explored to reflect the utilisation of the existing OT facilities and give insight on the potentials for further optimising and maximising the utilisation of the OT resources.

(c) For access block, indicators will be developed to monitor the access block situation and to reflect the effectiveness of measures in managing demand and organising supply.

2.3 Key Action 3 : Enhance utilisation of KPI information to drive best practices

2.3.1 HA will develop an IT system with different functional modules for phased implementation within three years to improve dissemination of KPI information so that KPIs and their detailed supporting information relevant to different levels of staff can be made easily accessible within the organisation. This will promote and facilitate organisation learning and sharing of best practices.

Action Plan on Cost Effectiveness & Service Management : Waiting Time

The SC made the following recommendation for improving timely access to medical services and minimising cross-cluster variance in waiting time.

Recommendation 8(a) :

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

1. Fundamentals

1.1 Waiting time for SOPC service and A&E service is essentially the result of demand and capacity imbalance, with increasing healthcare demand due to Hong Kong's ageing population and rising prevalence of chronic illnesses.

	HA SOPC attendances / new case bookings in 2012/13 – 2014/15		
	2012/13	**2013/14**	**2014/15**
First attendance (a)	682 000	705 000	713 000
Follow up attendances (b)	6 203 000	6 336 000	6 479 000
Total attendances (a) + (b)	6.9 million	7.0 million	7.2 million
New case bookings	808 000	829 000	843 000

Year	**Elderly people aged 65 and above**	**Proportion of the total population**
2012	0.98 million	13.7%
2031 projection	2.16 million	26.5%

Year	**Visits to A&E Departments**	
2004	2.07 million visits	5 666 attendances per day
2009	2.20 million visits	6 029 attendances per day
2014	2.23 million visits	6 200 attendances per day

1.2 Inadequate gatekeeping at the primary care level also adds pressure to Hong Kong's public hospital system. Medical manpower shortage is also a crucial factor contributing to the existing waiting time problems in HA services.

1.3 HA will strive to address pressure on SOPC service in all specialties, with priority to Orthopaedics and Traumatology (O&T) and Psychiatry (PSY) which warrant special attention given their much prolonged waiting time and rapidly escalating demand.

	Waiting Time (weeks)					
	2012/13		**2013/14**		**2014/15**	
	Median	**90th Percentile**	**Median**	**90th Percentile**	**Median**	**90th Percentile**
O&T	52	107	55	124	60	133
PSY	16	70	20	88	22	87

1.4 HA has implemented a triage system for new SOPC referrals to ensure that urgent conditions requiring early intervention are treated with priority. Under the triage system, referrals of new patients are triaged into priority 1 (Urgent), priority 2 (Semi-urgent) and Routine categories. So far, we have been able to meet the target of keeping Urgent and Semi-urgent categories within two weeks and eight weeks respectively, and will strive our best to sustain this service target against the rising demand, ageing population etc. The SOPC waiting time challenge is primarily among the Routine cases.

1.5 A&E service serves to deliver a high standard of service for critically ill or injured persons who need urgent medical attention, as well as medical support for victims of disasters. Through a triage system which classifies A&E patients into the five categories of Critical, Emergency, Urgent, Semi-urgent and Non-urgent according to their clinical conditions, patients with more serious conditions are ensured higher priority in medical treatment. The proportion of Semi-urgent and Non-urgent patients attending A&E Departments in Hong Kong is higher than that in some developed countries. It may be explained by the fact that some patients perceive A&E as a good choice for medical attendance as they are conveniently located, available 24-hour round-the-clock, has good value for money with one-stop and provides all-inclusive service including x-ray, laboratory test and treatment.

1.6 HA in recent years has implemented an array of measures to manage the lengthening SOPC and A&E waiting time. We enhanced public primary care services to reduce the demand, and launched specific annual plan programmes for services enhancements on pressure points to relieve SOPC caseload such as in Ear, Nose and Throat (ENT), Eye, and O&T, services. Public-Private Partnership (PPP) opportunities are explored. We constantly strive to enhance clinical manpower, both full time and part time and by various means and have introduced a special supporting session programme to recruit additional medical and nursing staff from other departments to work in A&E Departments. We have enhanced the transparency of waiting time information to facilitate patient choice and improved management tools for monitoring. Various local measures have been implemented at A&E Departments by different hospitals during peak seasons, including enhanced gatekeeping to reduce unnecessary admissions. Given the ever increasing demand, we need more measures on top of the ongoing efforts.

1.7 HA will engage the views, support and concerted efforts of our partners in the clusters, clinical specialties and the COCs/CCs for exploring initiatives and formulating annual plan proposals to address waiting time problems.

2. ACTION PLAN

The **Action Plan for SOPC waiting time** will

- ✧ refine the service models to address the waiting time for SOPC, particularly for the high pressure areas in O&T and PSY SOPC;
- ✧ manage SOPC referral sources;
- ✧ employ multi-pronged strategies to improve capacity and efficiency; and
- ✧ align practices of different clusters and minimise cross-cluster variance in waiting time and facilitate patients to make informed decisions in this regard.

Key action plans and their respective timelines are highlighted below, with details of the full action plan outlined in the **Annex**.

2.1 Key Action 1 : Utilise Family Medicine Specialist Clinic (FMSC) to relieve pressure on O&T SOPC service

2.1.1 In **2015/16**, HA is actively exploring using FMSCs to help attend a proportion of O&T patients triaged as Routine cases, e.g. the setting up of Low Back Pain (LBP) clinics as a pilot. HA will build on and refine the existing model to prepare for expansion of this programme in KEC and NTEC through the **2017/18** annual planning exercise.

2.1.2 In light of the operational experience, HA will explore customising the model for other appropriate specialties / clusters with a view to diverting routine SOPC cases in pressure areas to FMSCs to relieve SOPC workload.

2.1.3 HAHO will also strengthen its role on central coordination in formulating annual plans for a consistent service model in the clusters to cope with SOPC pressure areas and to align and share best practices across clusters, including efficient triage of new referrals, appropriate use of FMSCs, and avoiding excessive sub-specialisation.

2.2 Key Action 2 : Employ new multi-disciplinary strategy to relieve pressure on PSY SOPC service

2.2.1 We will increase the service capacity by using trained psychiatric nurses and allied health professionals under supervision of psychiatrists to address the

manifestation of imbalance between service demand and supply in the child and adolescent (C&A) psychiatric SOPC service. This strategy of nurse and allied health clinics is being implemented in KWC, NTEC and KEC. In KWC for example, the overall 90th percentile waiting time of new case bookings for Routine cases had significantly dropped from 92 weeks in 2013-14 to 64 weeks in 2014-15 after enhancement of its multidisciplinary team. We aim to similarly enhance C&A teams in HKWC and NTWC in **2016/17** subject to availability of resources.

2.2.2 Recurrent follow-up appointments of the large volume of chronic cases with common mental disorders (CMD) are another pressure point. To manage the waiting time problem, we are enhancing the multidisciplinary teams in PSY departments in KWC in **2015/16** and will consider the same for other clusters in subsequent years through annual planning exercise. The development of close case criteria could help discharge those who have satisfactorily completed the programme with no further specialist needs.

2.2.3 We will attempt cross-cluster booking in PSY by piloting a corporate-coordinated system in **4Q 2015** to enable suitable patients with CMD from other clusters to attend KWC's CMD clinic with a view to minimising cross cluster variance in the waiting time. We will examine the effectiveness and result of the pilot after the first year of this initiative and consider further rolling out to other clusters by phase in subsequent years.

2.3 Key Action 3 : Manage SOPC referrals

2.3.1 Around 70% of new case bookings in SOPC are referrals from within HA, mainly from General Outpatient Clinics (GOPCs) and A&E Departments. We shall exert more efforts to better manage referrals to SOPCs from the sources. We will regularly review and refine specialty-based referral guidelines and clinical protocols to facilitate and encourage referring medically stable patients to receive follow-up primary health care services instead of at SOPCs.

2.3.2 An electronic referral (eReferral) system is being developed to improve the quality of referrals and facilitate the triage process by creating structured templates for entry of relevant referral information with reference to established clinical guidelines and protocols. HA will further promote the utilisation of the standardised electronic referral template for 12 common symptoms / diseases, such as back pain and neck pain**.**

2.4 Key Action 4 : Employ multi-pronged strategies to generally improve SOPC capacity and efficiency

2.4.1 We will adopt multi-pronged strategies in improving the capacity of SOPC service and enhancing its efficiency. Key actions include:

- Expanding the physical capacity and facilities of SOPCs through a number of redevelopment/expansion projects, including the refurbishment of HKBH, reprovisioning of Yau Ma Tei SOPC, redevelopment/expansion of KWH, UCH and Kwai Chung Hospital (KCH);

- Extending the GOPC PPP programme, which has been piloted in Kwun Tong (KT), WTS and Tuen Mun (TM) in 2014, to the remaining 15 districts by phases in three years' time, i.e. **2016/17 to 2018/19**; and

- Introducing new KPIs in **2016/17** to reflect service efficiency and capacity to facilitate management decision to improve performance and drive best practices.

2.5 Key Action 5 : Align practices of different clusters and minimise cross-cluster variance in waiting time

2.5.1 HA is extending the SOPC Phone Enquiry System, which has been piloted in KCC/QEH, to all other clusters in **2015/16** to enhance utilisation of SOPC quotas by reducing the number of default cases.

2.5.2 We also conduct a comprehensive review of the appointment scheduling practices of SOPC and will publish a SOPC Operation Manual by **2015/16** to align different practices in SOPC.

2.5.3 We will continue to enhance transparency on SOPC waiting time to facilitate patients' understanding of the waiting time situation in HA to make informed decisions in their choice of SOPC for appointment while HA will take due account of individual patients' clinical condition and nature of service required.

2.5.4 HA will pilot a mobile App in **March 2016** to facilitate patients' choice on cross-cluster new case booking in Gynaecology.

3. ACTION PLAN

The **Action Plan for managing A&E waiting time** will

✧ ensure timely medical treatment for Category III (Urgent) patients with pressing medical needs; and

✧ improve the waiting time of Category IV (Semi-urgent) and Category V (Non-urgent) patients in A&E Departments.

Key action plans and their respective timelines are highlighted below, with details of the full action plan outlined in the **Annex**.

3.1 Key Action 1 : Ensure A&E patients with pressing medical needs received timely medical treatment

3.1.1 We will implement a new model named "Rapid Assessment and Treatment Model" in **1Q 2016** and onwards by re-engineering the work process in A&E Departments to enable early assessment of Category III patients by a team led by a senior doctor who is able to make a competent initial assessment and define a care plan. The aim is to shorten the waiting time for Category III patients (target pledge of 90% within 30 minutes) and improve patient outcome and their experience in A&E Departments.

3.1.2 To address the manpower issue, we will deploy additional medical and nursing manpower to pressure specialties, including A&E Departments, alongside the projected growth of service demand and workload as well as the forecasted turnover rate. This will help sustain the operations in A&E Departments and improve the waiting time for Category III patients.

3.2 Key Action 2 : Improve the waiting time of Category IV and Category V patients in A&E Departments

3.2.1 We will develop a transparent mechanism and an open platform on electronic means for releasing estimated waiting time to the public.

3.2.2 Accessibility of estimated waiting time information on Semi-urgent (Category IV) and Non-urgent (Category V) cases now available at the A&E Departments will be further extended to the public via an electronic platform being developed. Information on nearby clinics will also be provided with a view to encouraging patients to consider alternative mode of medical service that best suits their needs locally. The programme is planned to be rolled-out by phases, commencing from **2016/17**.

3.2.3 We will further expand the scale and coverage of the "A&E Support Session Programme" in **2016/17** to recruit additional medical and nursing staff, including those from non-A&E Departments, to handle Semi-urgent and Non-urgent cases and shorten waiting time in A&E Departments.

Action Plan on Cost Effectiveness & Service Management : Access Block

The SC made the following recommendation with a view to addressing the serious access block problem in A&E Departments in concerned hospitals.

Recommendation 8(b) *:*

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

1. Fundamentals

1.1 'Access Block' refers to the situation where patients requiring and decided for hospital admission are unable to be admitted to appropriate hospital beds within a reasonable duration of time and have to wait at A&E Departments, causing delay in hospital admission and overcrowding at A&E Departments.

1.2 The access block problem indeed reflects issues in patient management during the entire course of patient flow. There may be bottleneck(s) in one or more intersection point(s) of the patient journey between A&E service, acute inpatient service, convalescent/rehabilitation inpatient service and patient discharge (often dependent on availability of community support upon discharge), as a result of imbalance between service capacity and demand, or because of service efficiency issues. The root causes will need to be identified in order to ensure that the issue can be effectively addressed.

1.3 Currently, access block problem is most noticeable in QEH of KCC and PWH of NTEC particularly during the winter surge periods.

	Patients waited for > 8 hours at A&E before admission (January 2015)
QEH	49.0%
PWH	49.8%

2. ACTION PLAN

The **Action Plan** will

- ✧ develop KPI to monitor the access block problem;
- ✧ strengthen HAHO's input and enhance intra-cluster collaboration to address the problem;
- ✧ build up capacity and eliminate service bottlenecks; and
- ✧ manage service demands.

Key action plans and their respective timelines are highlighted below, with details of the full action plan outlined in the **Annex**. HA has initiated priority to execute the actions by end **1Q 2016**. Any capacity and efficiency gaps so identified will be addressed through subsequent annual planning exercises. Through implementation of the action plan, the aim is to achieve significant improvement in terms of intensity and frequency of access block by **2018**, with the ultimate goal of eliminating the access block problem.

2.1 Key Action 1 : Develop KPI to monitor the access block problem

2.1.1 We are developing a new KPI to monitor the access block situation and to reflect the effectiveness of measures taken in managing demand and organising supply. This KPI will be ready by **1Q 2016**.

2.2 Key Action 2 : Strengthen HAHO's input and enhance intra-cluster collaboration

2.2.1 Using a multi-pronged approach, HAHO will actively provide input to the cluster-based task forces in KCC and NTEC and will provide support to the clusters from the policy and resource allocation levels. The task forces, to be led by the respective CCEs, will enhance intra-cluster collaboration and mobilise resources at cluster level to address the access block problem of QEH and PWH. Detailed proposals are being formulated for submission to the Board by **1Q 2016** for support and subsequent progress update.

2.3 Key Action 3 : Build up capacity and eliminate service bottlenecks

2.3.1 We will continue building up the service capacity of KCC and NTEC. In **2015/16**, manpower resources are added to QEH while 71 beds are being opened in PWH. More beds are planned to be opened in both clusters in **2016/17**. With the completion of the refurbishment project for HKBH, and the Minor Works Projects planned for QEH, KH, Alice Ho Miu Ling Nethersole Hospital (AHNH), PWH and Shatin Hospital (SH), the inpatient service capacity of the two clusters will be increased. On top of these, major medical facilities such as the new acute hospital at the Kai Tak Development

Area and the redevelopment of PWH (Phase 2) are being planned to meet the growing service demand in the two clusters.

2.4 Key Action 4 : Further manage service demand

2.4.1 Targeted measures will be implemented in **2016/17** to manage the service demand from elderly patients to ease access block pressure in public hospitals particularly during winter surge periods. Liaison with the community geriatric assessment service at A&E level will be enhanced to address the inpatient service demand from old aged homes.

2.4.2 Other key measures in the pipeline include development of alternative care paths to reduce hospital admission at A&E level, through enhancing access to day care services and establishing fast track clinics for patients who otherwise would need hospital admission. Length of stay will be shortened by setting up a mechanism to facilitate medical decisions for patient admission, discharge or transfer based on clinical needs. Ward rounds and discharges on Saturdays, Sundays and public holidays as well as discharge planning are being strengthened to facilitate patient discharge. Clinical supporting services will also be enhanced to speed up patient assessment and recovery. The target is to commence this by **2016/17**.

2.4.3 A dashboard will be developed by **1Q 2016** to provide real time information on access block and bed utilisation status to facilitate patient flow management, thereby maximising utilisation of hospital beds.

Action Plan on Enhancement of Service Capacity and Service Delivery Model

The SC made the following recommendation with a view to enhancing HA's service capacity and providing better services and strengthening cost effectiveness to better prepare HA to meet upcoming challenges, in particular the ageing population.

Recommendations 9 :

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

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

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

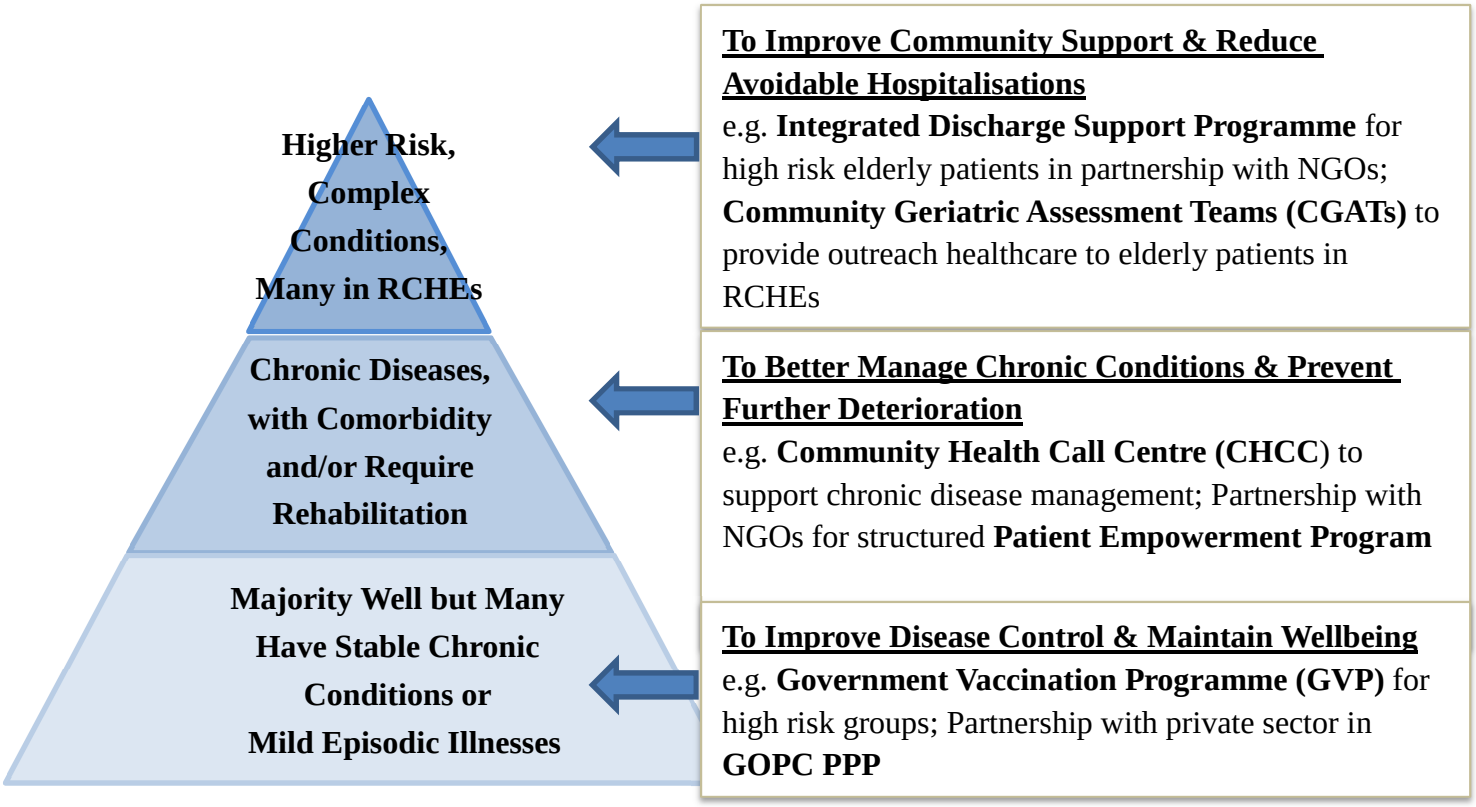
(d) HA should ensure an effective mechanism is in place to take into account patients' feedback for service planning and improvement.

1. Fundamentals

1.1 HA is facing great challenges in its service delivery due to the ageing population and rising prevalence of chronic diseases in Hong Kong. In general, older people require more healthcare services, and the situation is particular significant in public hospital services which are highly subsidised. Elderly people (aged 65 or above) accounted for around 50% of all hospital bed days in HA. The relative risk of an elderly person being hospitalised in general specialties is about four times that of a non-elderly person. Many elderly patients have complex health problems and higher chances of prolonged hospital stay or unplanned readmission.

1.2 Managing the growing service demand of an ageing population has been a priority area of HA. In this connection, HA has formulated a Strategic Service Framework for Elderly Patients in 2012 to guide the future development and delivery of healthcare

services for older persons through a systematic approach. Strategies have been translated into actions with an aim to providing appropriate level of care based on the stratified risks and needs of individual patients, as described below in the "Pyramid of Healthcare Needs of the Elderly Population" :



[Note : RCHEs stands for Residential Care Homes for the Elderly]

1.3 Primary care is the first point of contact for individuals and families in a continual healthcare process. Effective primary care can improve the health of individuals in the community, reduce their need for more expensive healthcare services especially specialist and hospital services, and contribute to the health of the population.

2. ACTION PLAN

The **Action Plan** will be taken forward alongside the above overarching strategies. In particular, we will

- ✧ increase the capacity of healthcare services for an ageing population;
- ✧ review and develop service delivery models in collaboration with related partners with more focus on step-down care, ambulatory care and primary care to provide more comprehensive care and facilitate ageing and care in-place; and
- ✧ strengthen patient empowerment and engage patients as partnership in healthcare.

Key action plans and their respective timelines are highlighted below, with details of the full action plan outlined in the **Annex**.

2.1 Key Action 1 : Increase service capacity

2.1.1 We will increase the total capacity of primary care to address the anticipated growing service demand. We will continue to renovate the existing GOPCs to create more space for capacity increase. Active planning of new GOPCs/Community Health Centres in districts including North District, Shek Kip Mei and MK are in progress to tackle the rising service demand. To this end, GOPC quotas will be increased by 55 000 (77 000 for full year effect [FYE]) and 27 000 (49 000 for FYE) in **2015/16** and **2016/17** respectively. We will closely monitor the service utilisation and demand to plan for future service enhancement.

2.1.2 We have been taking active steps to engage collaboration with the private sector including NGOs to deliver public healthcare services to strengthen the primary care, especially for patients with chronic diseases. We launched the GOPC PPP in three districts viz. KT, WTS and TM, whereby GOPC patients with specific chronic diseases and in stable clinical condition are given a choice to receive treatment in private clinics. We will extend the GOPC PPP Programme to the remaining 15 districts by **2018/19** to enhance primary care capacity for the management of patients with chronic diseases.

2.1.3 We will strengthen the CGAT service in RCHEs to provide timely assessment and appropriate management for high-risk elderly. At present, the overall coverage of RCHEs by CGATs is around 90%. Through the annual planning for **2016/17**, we aim to cover an addition of around 40 RCHEs, allowing us to cover around 95% of RCHEs in the territory.

2.1.4 To cope with the growing service demand for elderly patients with higher chances of hospitalisation, we will open 250 beds in **2015/16**, and plan to increase another 200 beds in **2016/17**. Looking further ahead, with the planned commissioning of TSWH (**late 2016** onwards), refurbishment of HKBH (completion by **Q3 2019**), HA's overall bed capacity will be further enhanced in the near future. In addition, planning of new hospitals are underway, including the development of a new acute hospital in the Kai Tak Development Area with a total bed capacity of about 2 400, and phase two redevelopment of the PWH as well as the expansion of the Lai King Building in Princess Margaret Hospital to provide about 900 and 400 beds respectively.

2.2 Key Action 2 : Review and develop service delivery models and strengthen collaboration with related partners in the community

2.2.1 HA actively participates in and supports the GVP to protect the health of the high risk populations. Currently, two-thirds of the vaccinations in the territory were delivered by HA, mainly through GOPCs. Along the Government's direction to enhance the coverage of GVP for 2015/16, we will continue to work closely with DH to further strengthen our role through the increase in provision of influenza vaccination to more patients with chronic diseases and elderly living in the community starting from **4Q 2015**.

2.2.2 We have been exploring, in collaboration with the Government and NGOs, practicable ways to reduce unplanned hospital re-admissions as well as premature or unnecessary institutionalisation of elders so as to put into effect the policy objective of promoting "ageing in place". We are working together with NGO, Social Welfare Department (SWD) and the FHB to develop a collaborative service model for a large-scale RCHE in Lam Tei of TM District with enhanced geriatric services. HA will proactively provide input into this new service model development in **2016/17**.

2.2.3 For elderly patients or severely disabled persons requiring long term institutional care, apart from being cared in HA infirmaries, we believe that those with relatively stable clinical conditions can be taken care of by the NGOs or other healthcare organisations. As such, we are developing a service model that involves partnership with NGO or other healthcare organisation to provide infirmary service. This pilot Infirmary Service PPP project is anticipated to provide up to 64 infirmary beds located in the Wong Chuk Hang Hospital (WCHH) starting from **2017**.

2.2.4 Over the years, HA has strengthened palliative care services to patients with terminal illness and their family members. To improve the quality of care for elderly patients living in RCHEs who are facing terminal-illness and to reduce their unnecessary hospitalisations, HA's CGATs will work together with the Palliative Care teams and NGOs to enhance these patients' medical and nursing care and to provide training for RCHEs staff starting from **4Q 2015**. We will also strengthen the structured palliative care training for different healthcare disciplines.

2.2.5 HA's CHCC is a community-based service model to help high-risk elderly patients stay healthy after discharge from hospital, and to support chronic disease management of diabetes mellitus (DM) patients in primary care. Built on the successful experiences, we will expand the CHCC service to provide telephone advice and support to DM patients follow up in SOPCs. We plan to extend the service to KEC, NTEC and NTWC starting from **3Q 2015** and subject to the results, we will further roll out to other clusters in due course.

2.3 Key Action 3 : strengthen patient empowerment and engagement

2.3.1 We are committed to empowering and engaging our patients, their carers as well as the community at large, with a view to enriching their knowledge on service and care options, self-management skills for care at home, and participation and role in decision-making process for navigating the system of care efficiently. On this front, we will

- ✧ revamp HA's Smart Patient Website by **1Q 2016** to provide more information to support carers of elderly;

- ✧ refine the service model and contractual partnership with the NGOs on the Patient Empowerment Programme in **2016/17** to better support patients with DM or hypertension and enhance service quality;

- ✧ strengthen the role of HA's Patient Resource Centres as a platform to coordinate community partners and patient groups by **2016/17**, and to help strengthen the participation of patient groups;

- ✧ continue to conduct the corporate Patient Experience and Satisfaction Survey (PESS) Programme to collect patient feedback on HA services and identify areas and drive for improvement. The programme will cover in the coming years inpatient services in **2015/16**; A&E services in **2016/17**, and hospital-based PESS in **2017/18**; and

- ✧ further increase patient representatives' participation in formal platforms by **1Q 2016** to provide views and feedback to HA on service development and patient care.

Action Plan on Overall Management & Control

The SC made the following recommendation with a view to enhancing safety and quality of service.

Recommendation 10 :

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

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

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

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

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

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

1. Fundamentals

1.1 The volume of services provided by HA is enormous. In 2014/15, annual attendances to its A&E Departments amounted to 2.2 million, SOPC 7 million, and total number of patient days (including inpatient and day inpatient services) reached some 8 million. Maintaining quality and safety is an essential core business in HA, and yet with challenges given the volume, varieties, and complexities of its patient services.

1.2 HA places quality and safety as top priorities in the planning and running of its patient-centred services by establishing governance structure and systems to ensure high clinical standards. Broadly speaking, key elements in HA's clinical accountability structure include the Clinical Management Team and COS framework, and COC (mainly specialty-based) and CC (mainly service-based) framework, building on the foundation of specialist led services and peer reviews with competency of staff assured through professional supervision and continuous training. We have established a system of multi-disciplinary multi-specialty disease-based clinical audit across HA. Besides, HA has active monitoring of clinical indicators for enhancing service quality, and a well-established Sentinel Event Policy (also including Serious Untoward Events) for the reporting and management of serious medical incidents.

1.3 Clinical audits are initiated, led and conducted by clinicians at hospital settings as part of the continuous quality improvement initiatives to generate informative results for driving quality and safety enhancements. The HA Board has also commissioned an Independent Clinical Governance Review in 2012 to assess the suitability, effectiveness and sustainability of HA's clinical governance and patient safety measures, systems, and processes.

2. ACTION PLAN

The **Action Plan** will

- ✧ strengthen quality and safety structure to integrate different elements of clinical governance;
- ✧ enhance the role of professional committees (COC/CC) and COS on clinical governance;
- ✧ develop a system of credentialing and defining scope of practices;
- ✧ enhance performance monitoring and management; and
- ✧ enhance incident learning.

Key action plans and their respective timelines are highlighted below, with details of the full action plan outlined in the **Annex**.

2.1 Key Action 1 : Strengthen the roles of COC on clinical governance

2.1.1 We will engage the COCs/CCs to enhance their roles in setting service standards, developing clinical practice guidelines, education and training, conducting clinical audits, clinical risk management and introduction of new technology and service development. We will specify these via a set of standardised Terms of Reference to be issued and promulgated in **3Q 2016**, through which individual COC/CC will be entrusted and required to carry out

the said tasks in express terms. We will evaluate the results through self-assessment by the COCs/CCs in **3Q 2017** to identify areas for improvement.

2.2 Key Action 2 : Enhance the role of COS with greater emphasis on clinical governance

2.2.1 We will engage COSs and doctor groups on the enhanced role of COS, particularly in quality of patient care and patient safety by **2Q 2016**. We will also specify COS management functions as related to clinical governance in the COS appointment and staff appraisal procedure by **1Q 2017**.

2.3 Key Action 3 : Refine COC/CC/service committees relationship with a view to reducing their administrative work in annual resource planning and clinical service development

2.3.1 We will streamline the annual planning process by **1Q 2016** with a view to reducing the administrative work of clinical staff in annual resource planning and clinical service development. We will engage key stakeholders in COCs/CCs through training workshops and feedback processes to better utilise the annual planning cycle for prioritisation of resource bids put forward by hospital service units so as to reduce abortive work at frontline level.

2.4 Key Action 4: Develop a system of credentialing and defining scope of practices

2.4.1 HA has been working on a framework for credentialing and defining scope of practice since 2014 for high risk activity-based credentialing, under which specific procedures/intervention will set out appropriate credentialing criteria in terms of qualifications, training and experience requirements. We are actively engaging the COCs/CCs in selecting procedures for credentialing and setting credentialing requirements. We will develop a framework to guide implementation and reporting of credentialing in hospitals, with a view to setting professional standards and assuring staff competency in performing the procedures.

2.4.2 We aim to implement the vetting mechanism of credentialing activities on medical procedures with qualifications, training and professional standards set by COC/CCs and endorsed by HA's Central Credentialing Committee by **1Q 2016**. By **4Q 2016**, we will develop a mechanism for defining the scope of practice, maintenance of staff lists and regular reporting of HA endorsed credentialing activities in collaboration with the Cluster Credentialing Committees.

2.4.3 We will maintain ongoing communication with HKAM on HA's credentialing development and discuss the future development.

2.5 Improve clinical outcomes and patient care through clinical audit activities

2.5.1 We will reinforce clinical audit as an essential and integral part of clinical governance, and enhance the role of COC/CC in performing clinical audit activities with a view to improving clinical outcomes and patient care. We will also refine and update the clinical audit guidelines by **1Q 2016** to guide clinical specialties in performing clinical audits.

2.5.2 Riding on the experience of Surgical Outcomes and Improvement Program in providing an appraisal to hospitals based on risk-adjusted outcomes, we are supporting COC (Intensive Care Unit (ICU)) to develop a local risk adjusted model for intensive care outcome monitoring program by **4Q 2016**, which we anticipate will effectively drive for quality and safety improvement measures in patient care outcomes.

2.5.3 HA will continue to develop specific sets of clinical indicators to facilitate tracking of critical processes and outcomes over time and among peers for service quality improvement. Developing clinical indicators provides an opportunity to re-examine standards of care in specific areas, and stimulate changes to overcome perceived inadequacies.

2.6 Strengthen medical incident sharing

2.6.1 We have established an effective incident reporting mechanism and a sharing culture from reaping the benefits of root cause analysis on medical incidents. For further improvement, HA will develop an electronic platform by **1Q 2017** to strengthen the sharing of lessons learnt among clusters to minimise the chance of recurrence. To reinforce the learning process of preventing recurrence of incidents, we will continue to publish the HA Risk Alert and annual report, and organise incidents sharing sessions at HAHO, cluster forums and COCs.

2.6.2 For promoting a patient-centred culture among staff, staff are encouraged to report medical incident in a timely and open manner. Through the issuance of the Clinical Incident Management Manual, HA will further strengthen and standardise the reporting, management and monitoring of medical incidents, with focus of communication with and support for patients by **2Q 2016**.

2.6.3 At the same time, we will continue to integrate proven quality and safety practices into the education and training of interns and junior doctors by inoculating patient safety in their training curricula for building and consolidating the culture of safety.

Annex

Implementation of the Recommendations of the Steering Committee on Review of Hospital Authority

Hospital Authority Action Plan

Strategic Goal and Target	Action	Timeline
Management and Organisation Structure **Strengthening governance and rationalising the organisation structure**		
Recommendation 1		
The HA Board, being the managing board, to play a more active role in leading and managing HA	1. Continue to strengthen stewardship by the Board along the directions of the recommendations of its corporate governance review and for ongoing strategic focus on corporate governance	Ongoing and continuous
	2. Set up dedicated Task Force to steer action planning for the implementation of the various recommendations of the HA Review	Task Force proactively set up by HA Board and conducted 4 meetings in August and September 2015
	3. HA Board to closely follow through implementation of the various action plans and monitor progress	Ongoing and continuous in the coming three years
Re-grouping of WTS district and MK area (KWH, WTSH and OLMH) from KWC to KCC	4. Consult stakeholders, both internal (staff, governing bodies of concerned hospitals, etc.) and external (District Councils, patients groups, community, etc.)	2015/16
	5. Effect administrative arrangement for the re-grouping exercise	Late 2016
	6. Re-organise care provision within the new KCC and implement associated changes in KWC, having regard to • service planning and coordination, taking into consideration supporting network across healthcare services at acute care, extended care, primary care and community care levels • service alignment with partners beyond HA, e.g. FSD and NGOs • associated staff arrangement, relocation of resources • infrastructure issues	Seek HA Board's endorsement on detailed implementation plan in 3Q 2016 Implement by phases from 4Q 2016 onwards, taking into account KWH redevelopment (target 2023) and the new acute hospital in Kai Tak area (Phase 1 target 2021)
	7. Evaluate demand and capacity gap in KCC, KWC and KEC, taking reference to service demand projection up to 2026	Result of analysis for Board's endorsement in 3Q 2016; and implementation through subsequent annual planning exercises

Strategic Goal and Target	Action	Timeline
Demand and capacity evaluation of the remaining clusters	8. Conduct capacity-demand gap analysis on NTEC, NTWC, HKWC and HKEC	Seek HA Board's endorsement in 2Q 2017; and implement plans from 3Q 2017 onwards
Interim measures for quick enhancement (a) Catch up improvements for KEC, NTEC, and NTWC	9. Mobilise the additional 3-year funding for catch-up plans for KEC, NTEC and NTWC to help address known deficiencies in service capacity	2015/16 – 2017/18
	10. Continue to enhance service capacity in KEC, NTEC and NTWC, including additional 36 beds to TKOH, 71 beds to PWH and a total of 122 beds to TMH and POH in 2015/16; TSWH in 2016/17; and other initiatives to enhance physical capacity of the 3 cluster	2015/16 and ongoing
(b) Enhancing services in WTS District	11. Additional resources to WTSH and OLMH	2015/16
	12. Refurbishment of HKBH	Project ongoing with a view to target completion by 3Q 2019
(c) Rationalise acute-rehabilitation service arrangement	13. Pilot project to drive for better vertical integration between acute and rehabilitation service for target patients residing in WTS and YTM Districts	August 2015 launched
(d) Refine geographical boundaries for ambulance catchment areas	14. Fine-tune the Kowloon ambulance catchment areas to enable more speedy access to patient care in the districts	Ongoing
Recommendation 2		
Set up a mechanism for selection of centres for provision of highly specialised services	15. Establish mechanism to define highly specialised services, formulate selection criteria, and set parameters for highly specialised services	Seek HA Board's endorsement on the mechanism by 1Q 2017
	16. Mechanism to cover planning of training to build up clinical expertise as well	
Refine the cluster management structure	17. Revisit cluster management structure with particular regard to roles and responsibilities of CCEs	Submit findings and proposals to HA Board by 1Q 2017
	18. Actively engage CCEs in HAHO management functions e.g. service planning in HA's Service Budget and Planning Committee, allocation of doctor posts to clusters etc.	
	19. Engage the COCs/CCs to enhance their roles and responsibilities in clinical governance under Recommendation 10	

Strategic Goal and Target	Action	Timeline
Regroup hospitals under one HCE to make HCE job portfolios comparable	20. Implement the regrouping proposals and follow up on consequential appointment of Deputy HCEs to support HCE of grouped hospitals	Seek HA Board's endorsement on the final regrouping proposals in December 2015 and implement the changes by phased approach in three years, taking into account tenure of service of current incumbents, as well as to dovetail with cluster boundaries
	21. Arrange job rotations for HCEs	
Delineate the roles of hospitals within cluster	22. Develop cluster CSP (CSP for HKWC, KEC and NTEC completed) and delineate the roles and functions of hospitals within cluster	KCC CSP under preparation and will be finalised and published within three months after the Board's approval of the cluster boundary revision; and formulation of CSPs for NTWC, HKEC and KWC will commence in phases within next three years
Resource Management **Enhancing equity and transparency in resource management**		
Recommendation 3		
Develop refined population-based resource allocation model	23. Undertake the necessary groundwork to prepare for model building • Analyse healthcare utilisation of local communities to study cross-cluster flow patterns and to assess impact of different strategies for refining the cluster boundary (under Recommendation 1) • Set up governance to build consensus for designated services to be counted, and conduct technical review of their costing methodologies	3Q 2015 – 2Q 2016
	24. Develop prototype model and submit to HA Board for deliberation/endorsement	Report to HA Board in 3Q 2016
	25. Engage an external consultant to validate the approach and framework of the model	Early 2016 – 1Q 2017
	26. Finalise prototype model	1Q 2017
Analyse cluster resource utilisation to inform decision- making in service planning	27. Compare resource utilisation of clusters by the refined population-based resource allocation model (i.e. with relevant adjustments)	Report preliminary findings to HA Board in 1Q 2017 – 2Q 2017

Strategic Goal and Target	Action	Timeline
	28. Perform time trend analysis of cluster resource need and utilisation	Analysis ready by 3Q 2017, for incorporation into the 2018/19 annual planning exercise and thereafter
Communication and stakeholder engagement	29. Hold biannual meetings with each cluster to share ideas on model development and potential application of analysis findings	Starting 3Q 2015 onwards
	30. Publish a consultation paper to solicit views on the model from frontline	3Q 2016
	31. Publish a report on the results of cluster resource utilisation analysis	1Q 2017 – 2Q 2017
Monitor progress and utilisation of catch-up funding	32. Formulate catch-up plans for KEC, NTEC and NTWC to address under-provisioned areas	Catch up plans for 2015/16 to 2017/18 were formulated in 2Q-3Q 2015
	33. Review progress of 2015/16 catch-up plans to facilitate refinement of 2016/17 catch-up plans if necessary	Progress review of 2015/16 catch-up plans in 1Q 2016
	34. Review progress of 2016/17 catch-up plans to facilitate refinement of 2017/18 catch-up plans if necessary	Progress review of 2016/17 catch-up plans in 1Q 2017 Overall review of 3-year catch-up plans in 3Q 2018
Recommendation 4		
Improve and simplify the procedures of resources bidding	35. Training workshops will be organised for frontline users to consolidate the workflow in the APS	1Q 2016
	36. Over 10 system enhancements will be implemented to the APS to improve system functionality, facilitate automation and reduce administrative work	1Q 2017
Enhance transparency of the resource bidding and allocation processes	37. The Manual on Annual Planning, outlining the structure and process of resource bidding in HA, will be reviewed and updated for promulgation to all stakeholders	4Q 2015 – 1Q 2016
	38. Annual planning proposals formulated by clinicians with input from cluster management are deliberated and prioritised by the Service and Budget Planning Committee, membership of which includes all seven CCEs	Ongoing, every 1Q – 3Q

Strategic Goal and Target	Action	Timeline
	39. Briefing forums will be reinforced to • explain the rationale and considerations behind the final decisions and allocation result of submitted proposals. Feedback concerning the submitted proposals will be given to stakeholders involved. The target groups for the forums are COC/CC members, clusters and HAHO subject officers; and • share with colleagues about HA's service development and annual plan proposal submission procedures for the next planning cycle	Ongoing in every 1Q
Staff Management **Enhancing consistency in staff management and strengthening staff development**		
Recommendation 5		
Enhance central system to monitor creation and deletion of selected levels of senior positions	40. Formalise current mechanism for the creation and deletion of directorate positions (e.g. clinical Consultants) and Nursing Consultant positions, and extend to other grades/ranks	Ongoing and 2016/17
Enrich HAHO representation in cluster selection boards	41. Extend posts requiring mandatory HAHO representation as well as the pool of representatives with role delineation	4Q 2016
Develop and enhance rotation programmes	42. Formulate job rotation arrangements for CEO rank and above with clear objective, selection criteria, proper selection and endorsement process, funding arrangement, roles delineation	3Q 2016
	43. Expand central funded training places to facilitate intra-specialty rotation of clinical staff	2016/17
	44. Pilot cluster-based rotation programme for cross specialty rotation of clinical staff	2016/17
	45. Set up a rotation mechanism for training of clinical staff in different grades/hospitals when introducing new healthcare technology/equipment	2017/18
Strengthen alignment of HR practices and implementation of HR policies across clusters	46. Strengthen existing communication and enhance partnership with cluster HR in policy development and implementation	4Q 2015 – ongoing
	47. Establish system of HR audit on system and practice and standard protocols for policy formation and implementation	

Strategic Goal and Target	Action	Timeline
Enhance HA staff communication	48. Develop HR mobile solution with phased rollout	1Q 2016 – 2016/17
	49. Produce a Staff Communication Guidebook	2016
	50. Conduct Staff Survey	2016/17
Formulate central staff deployment plan in emergency situations	51. Establish a structured approach and relevant guidelines to enable central coordinated authority for activating central deployment plan to cope with staffing needs in emergency situations	2016/17
Central recruitment of Resident Trainees	52. Conduct specialty-based central selection panels for Paediatrics and Psychiatry	2015/16
	53. Roll out specialty-based central selection panels to all specialties to replace cluster-based selection in 2016/17 Resident Trainee recruitment and allocation exercise	2016/17
Develop and implement re-employment schemes for suitable retirees to help address manpower shortage and encourage knowledge transfer [One-off funding of $570 million]	54. Develop and implement three Special Schemes respectively for (1) clinical doctors; (2) supporting grades staff; and (3) nurses, allied health and pharmacy staff retiring in 2015/16 and 2016/17	2Q 2015 – 2017/18
Recommendation 6		
Strengthen governance on training	55. Set up a 2-tier governance structure for training with a dedicated committee under HRC for overall policy and steer on training	4Q 2015
Develop mechanism to ascertain organisation training needs and development of training activities	56. Develop grade-specific training curriculums	4Q 2015 – 3Q 2016
	57. Establish a structured mechanism for clusters to ascertain training needs	2016
	58. Include training plan for staff when introducing new technology / services and develop a rotation mechanism for staff of different grades/hospitals other than the concerned hospital where the technology/service is introduced (Items 16 & 45 also refer)	1Q 2017 – 1Q 2018
Develop system for effective training information management and planning	59. Develop a tracking system for training programmes under the designated training fund	4Q 2015
	60. Pilot a few key modules of a new IT system to facilitate planning, monitoring and reporting on staff training	1Q 2016 – 4Q 2017

Strategic Goal and Target	Action	Timeline
Strengthen collaboration with external parties to enhance overall training capacity and capability	61. Develop regular liaison platforms and forums with external training partners with defined priority areas of collaboration	2016
Utilise one-off additional funding of $300 million to enhance training	62. Implement 11 new and scale-up training programmes (including scholarships, commissioned training, overseas training and simulation training) in 2015/16	4Q 2015 – 1Q 2016
	63. Endorse training plans and programmes of 2016/17 and 2017/18 by the Central T&D Committee	1Q 2016 – 2Q 2016
	64. Funding support for training relief to maintain service operation	2015/16 and ongoing
Cost Effectiveness and Service Management **Providing better services**		
Recommendation 7		
Enhance the role of the HA Board in KPI performance review and KPI development process	65. KPI reports will be presented to functional committees for in-depth discussion with issues of concern highlighted to the Board for focused discussion. Through this enhanced reporting platform, the Board will be able to identify key areas for KPI development, and setting of targets and standards to drive best practices in HA services	Mechanism endorsed by EC of the HA Board in June 2015 and will be implemented in 4Q 2015
Enhance HA's KPIs	66. Develop and refine KPIs to reflect capacity-demand gap and service efficiency on the key pressure areas, including access to SOPC service, OT service and access block at A&E Departments	Potential indicators will be identified by 4Q 2015, for endorsement by the HA Board in 1Q 2016. Upon the HA Board's endorsement, the KPIs will be implemented and reporting will commence in 2016/17
Enhance utilisation of KPI information to drive best practices	67. Develop an IT system with functional modules to facilitate dissemination of KPI information so that KPIs and their detailed supporting information relevant to different levels of staff can be made accessible to relevant levels of staff, including the frontline within the organisation	Phased implementation in 2015/16 to 2017/18

Strategic Goal and Target	Action	Timeline
Recommendation 8		
Utilise FMSC to relieve pressure on O&T SOPCs	68. Build on the existing model to divert routine O&T SOPC cases in pressure areas to FMSCs to prepare for expansion of programme in KEC and NTEC. In the light of operational experience, will explore customising the model for other appropriate specialties / clusters with a view to relieving SOPC workload	Commenced preparation. Through 2017-18 annual planning exercise
	69. HAHO will strengthen its role on central coordination in formulating annual plans for a consistent service model in clusters	Ongoing
Employ new multidisciplinary strategy to relieve pressure on Psychiatric SOPCs	70. Through annual plan bidding, HA will enhance and strengthen the multidisciplinary teams of psychiatric SOPC for child and adolescent service and patients with CMD	Commenced in 2015/16 with further roll-out in coming few years
	71. HA will pilot a corporate-coordinated cross-cluster booking for suitable patients with CMD from others clusters to be attended at the CMD clinic of KWC	Commencing by 4Q 2015
Manage SOPC referrals	72. To manage O&T SOPC referral sources in particular, HA will engage A&E, FM and O&T on enhancement and utilisation of the referral guidelines and electronic referral system (eReferral) template on neck / back pain	Ongoing with regular update and promulgation
	73. Enhancement and promulgation of eReferral	Ongoing with enhancements and utilisation regularly monitored
Employ multi-pronged strategies to generally improve the capacity and efficiency	74. HA will carry out various renovation and redevelopment/expansion projects to expand physical capacity for SOPC service	Ongoing
	75. Production of "Specialty-based SOPC Waiting Time Analysis Charts" in Management Information Portal for easy retrieval and timely access to most up-to-date analysis	2015/16
	76. Indicators are being developed to assist the monitoring of SOPC service throughput, new case booking pattern, service demand and supply relationship. SOPC service throughput indicators on SOPC attendances per doctor ratio will be explored to become HA's KPIs	2016/17

Strategic Goal and Target	Action	Timeline
	77. Subject to results of the GOPC PPP Interim Review, to extend the Programme to all 18 districts in phases (Item 95 also refers)	2016/17 to 2018/19
Align practices of different clusters and minimise cross-cluster variance in waiting time	78. Further to the pilot run in QEH, the SOPC Phone Enquiry System will be implemented in the other six clusters	2015/16
	79. HA will conduct a comprehensive review of appointment scheduling practices of SOPC and publish a SOPC Operation Manual to align different practices in SOPC	2015/16
	80. To facilitate patient-initiated cross-cluster new case booking, HA has enhanced transparency of SOPC waiting time information, which will facilitate patients' understanding of the waiting time situation in HA and assist them to make informed decisions in treatment choices and plans	Ongoing with quarterly update on waiting time information
	81. HA will pilot a mobile App to facilitate patients' choice on cross-cluster new case booking in the specialty of gynaecology. Upon review, the application will be further rolled out to other appropriate specialties	Commencing by 1Q 2016
Ensure A&E patients with pressing medical needs received timely medical treatment	82. Re-engineer the work process for Category III patients aiming for early assessment and intervention	Commencing in 1Q 2016
	83. Deploy additional medical and nursing manpower to pressure specialties including A&E Departments to sustain the operation of A&E Departments and improve the waiting time for Category III patients	Ongoing
Improve the waiting time of Category IV and Category V patients in A&E Departments	84. Develop a transparent mechanism and an open platform for releasing the estimated waiting time to public	Commencing in 2016/17
	85. Further expand the scale and coverage of A&E Support Session Programme	Commencing in 2016/17

Strategic Goal and Target	Action	Timeline
Development of KPI to monitor access block problem	86. Develop an Access Block KPI to monitor the access block problem	KPI proposal to be ready by 1Q 2016 for HA Board's endorsement
Strengthening of HAHO's input and enhancement of intra-cluster collaboration	87. HAHO to actively provide input and support for cluster strategies from policy and resource allocation levels to cluster-based task forces in KCC and NTEC	Commence by 1Q 2016
	88. Cluster-based task forces to coordinate intra-cluster collaboration and mobilise cluster resources to address the problem	
Building up of capacity	89. Continued efforts in increasing service capacity in KCC and NTEC through addition of beds, refurbishment projects, minor works projects, and planning of major medical facilities to meet service demand of the clusters	Commence by 2016/17
	90. Capacity gap revealed during the process to be addressed through annual planning exercises	
Management of service demands	91. Implement measures to reduce avoidable hospital admissions of elderly patients, e.g. community geriatric assessment service at A&E level, enhancing day care service, fast track clinics	Commence by 2016/17
	92. Reduce length of stay for patients for better service demand management	
	93. Dashboard to provide real time information to facilitate bed coordination	1Q 2016
Recommendation 9		
Increase service capacity	94. Continue to enhance the capacity of primary care services provided by HA	Increase GOPC quotas by 55 000 (77 000 FYE) in 2015/16; and aim to increase GOPC quotas by 27 000 (49 000 FYE) in 2016/17 through annual planning
	95. Strengthen partnership with the private sector on primary care via extension in phases of the GOPC PPP to enhance primary care capacity for the management of patients with chronic diseases and provide choice to patients (Item 77 also refers)	Extend in phases the GOPC PPP to all 18 districts by 2018/19 (Subject to results of the interim review)
	96. Increase the capacity to support elderly patients in RCHEs through the CGAT service	Through annual planning for 2016/17, HA aims to cover an addition of around 40 RCHEs

Strategic Goal and Target	Action	Timeline
	97. Increase the capacity of hospital beds	Increase hospital beds by 250 in 2015/16; and aim to increase hospital beds by around 200 in 2016/17 through annual planning
Review and develop service delivery models and strengthen partnership with community partners	98. Enhance services in collaboration with the DH to provide influenza vaccination to patients with chronic disease and elderly living in the community	Strengthen the role of public clinics in the GVP GVP starting from 4Q 2015
	99. Work with NGO, SWD and FHB to develop a collaborative service model with enhanced geriatric support in a large-scale old age home in Lam Tei to facilitate ageing in place and reduce unnecessary hospitalisation	Provide HA's input into collaborative service model development by 2016/17
	100. Partner with NGO to provide infirmary service to persons requiring long term institutional health and social care via the pilot Infirmary Service PPP	Pilot the Infirmary Service PPP in 2017 in WCH
	101. CGATs work in partnership with Palliative Care teams and NGOs to improve medical and nursing care to elderly patients living in RCHEs facing terminal illness, and to provide training for RCHEs staff	Start in RCHEs supported by the CGATs of RH, FYKH, PWH and TMH from 4Q 2015
	102. Strengthen the structured palliative care training for different healthcare disciplines	Develop more structured training programmes (e.g. seminars, workshops, attachment programmes) on palliative care for multidisciplinary staff in 2015/16 and 2016/17
	103. Further develop the CHCC service to provide telephone advice and support to DM patients in Medical SOPCs on disease management	Commence in KEC, NTEC and NTWC from 3Q 2015
Strengthen patient empowerment and engagement	104. Revamp the Smart Patient Website to provide more information to support carers of the elderly	1Q 2016
	105. Review and refine the service model and contractual partnership with the NGOs on the Patient Empowerment Programme to support Patients with DM or Hypertension and enhance service quality	Renew contract with NGOs incorporating service refinement in 2016/17
	106. Review and strengthen the role of Patient Resource Centres as a platform to coordinate community	2016/17

Strategic Goal and Target	Action	Timeline
	partners and patient groups, and to help strengthen the participation of patient groups	
	107. Continue to implement Corporate PESS Programme to collect patient feedback on HA services and identify areas for improvement	PESS rolling plan: inpatient services in 2015/16; A&E services in 2016/17 and hospital-based PESS in 2017/18
	108. Further increase patient representatives' participation in formal platforms to provide advice and feedback on service development and patient care	2016 and ongoing
Overall Management and Control **Enhancing the safety and quality of services**		
Recommendation 10		
Strengthen the roles of COCs on clinical governance	109. Require COCs/CCs to enhance their roles and responsibilities in clinical governance, specifically in setting service standards, developing clinical practice guidelines, education and training, conducting clinical audits, managing clinical risk management and introduction of new technology and service development	1Q 2016
	110. Promulgate standardised set of Terms of Reference of COCs/CCs	3Q 2016
	111. Evaluate the implementation by inviting COCs/CCs to conduct self-assessment on their enhanced roles and areas for improvement	3Q 2017
Enhance the role of COS with greater emphasis on clinical governance	112. Engage COSs and doctor groups on the enhanced role of COS, particularly in quality of patient care and patient safety	2Q 2016
	113. Specify COS management functions as related to clinical governance in COS appointment and staff appraisal procedure	1Q 2017
Refine COC/CC/service committees relationship with a view to reducing their administrative work in annual resource planning and clinical service development	114. Improve the annual planning process to further reduce the administrative work in annual resource planning. Key stakeholders in COCs/CCs will be engaged through training workshops and feedback processes to better utilise the annual planning cycle for prioritisation of resource bids put	1Q 2016

Strategic Goal and Target	Action	Timeline
	forward by hospital service units so as to reduce abortive work at frontline level	
Develop a system of credentialing and defining scope of practices	115. Implement the established vetting mechanism of credentialing activities in HA through the COCs/CCs, Central and Cluster Credentialing Committees	1Q 2016
	116. In collaboration with Cluster Credentialing Committees, develop mechanism of defining scope of practice, maintenance of staff lists and regular reporting of HA endorsed credentialing activities	4Q 2016
	117. Communicate with HK Academy of Medicine on HA's credentialing development and discuss the future development	Ongoing
Improve clinical outcomes and patient care through clinical audit activities	118. Enhance and update the clinical audit guidelines to guide clinical specialties in performing clinical audits	1Q 2016
	119. Support COC (ICU) to develop a local risk adjusted model for intensive care outcome monitoring programme	4Q 2016
	120. Develop specific sets of clinical indicators for service quality improvement	Ongoing
Strengthen medical incidents sharing	121. Develop an electronic platform for staff communication on medical incidents	1Q 2017
	122. Publicise and implement the Clinical Incident Management Manual, with focus of communication with and support for patients	2Q 2016
	123. Publish HA Risk Alert (HARA) and annual report and organise incidents sharing sessions at HAHO, cluster forums and COCs	Ongoing
	124. Continue to integrate patient safety in training to interns and junior doctors	Ongoing

Abbreviation list

A

A&E	Accident and Emergency
AHNH	Alice Ho Miu Ling Nethersole Hospital
APS	Annual Planning System

C

C&A	Child and Adolescent
CC	Central Committee
CCE	Cluster Chief Executive
CEO	Chief Executive Officer
CGAT	Community Geriatric Assessment Team
CHCC	Community Health Call Centre
CMD	Common Mental Disorders
COC	Coordinating Committee
COS	Chief of Service
CSP	Clinical Services Plan

D

DH	Department of Health
DM	Diabetes Mellitus

E

EC	Executive Committee
eReferral	Electronic Referral
ENT	Ear, Nose and Throat

F

FHB	Food and Health Bureau
FSD	Fire Services Department
FM	Family Medicine
FMSC	Family Medicine Specialist Clinic
FYE	Full Year Effect
FYKH	TWGHs Fung Yiu King Hospital

G

GOPC	General Outpatient Clinic
GVP	Government Vaccination Programme

H

HA	Hospital Authority
HAHO	Hospital Authority Head Office
HCE	Hospital Chief Executive
HHH	Haven of Hope Hospital
HKAM	Hong Kong Academy of Medicine
HKBH	Hong Kong Buddhist Hospital
HKEC	Hong Kong East Cluster
HKWC	Hong Kong West Cluster
HR	Human Resources
HRC	Human Resources Committee

I

ICU	Intensive Care Unit
IT	Information Technology

K

KCC	Kowloon Central Cluster
KCH	Kwai Chung Hospital
KEC	Kowloon East Cluster
KH	Kowloon Hospital
KWC	Kowloon West Cluster
KPI	Key Performance Indicator
KT	Kwun Tong
KWH	Kwong Wah Hospital

L

LBP	Low Back Pain

M

MK	Mong Kok

N

NGO	Non-Governmental Organisation
NTEC	New Territories East Cluster
NTWC	New Territories West Cluster

O

OLMH	Our Lady of Maryknoll Hospital
OT	Operating Theatre
O&T	Orthopaedics & Traumatology

P

PAC	Patient Advisory Committee
PESS	Patient Experience and Satisfaction Survey
POH	Pok Oi Hospital
PPP	Public-Private Partnership
PMH	Princess Margaret Hospital
PSY	Psychiatry
PWH	Prince of Wales Hospital

Q

QEH	Queen Elizabeth Hospital

R

RCHEs	Residential Care Homes for the Elderly
RH	Ruttonjee Hospital

S

SC	Steering Committee on Review of Hospital Authority
SH	Shatin Hospital
SOPC	Specialist Outpatient Clinic
SWD	Social Welfare Department

T

T&D	Training and Development
TKOH	Tseung Kwan O Hospital
TM	Tuen Mun
TMH	Tuen Mun Hospital
TSWH	Tin Shui Wai Hospital

U

UCH	United Christian Hospital

W

WCH	Wong Chuk Hang Hospital
WTS	Wong Tai Sin
WTSH	Wong Tai Sin Hospital

Y

YTM	Yau Tsim Mong