For discussion on
15 January 2018

LEGISLATIVE COUNCIL PANEL ON HEALTH SERVICES

Progress updates: reviews on Hospital Authority and on Healthcare Manpower Planning and Professional Development

PURPOSE

This paper updates Members of the progress of (i) the Hospital Authority (HA) in implementing the recommendations of the Steering Committee on Review of HA and (ii) the Food and Health Bureau in implementing the recommendations of the Steering Committee on the Strategic Review on Healthcare Manpower Planning and Professional Development (the Strategic Review).

THE REVIEW OF HOSPITAL AUTHORITY

2. With the rapid ageing population and increased aspiration for healthcare services in Hong Kong, the demand for quality public healthcare services has been increasing. HA has been facing the double challenges of the increasing cost of providing hospital care due to advance in medical technology and rising demand of an ageing population with changes in diseases pattern such as increased prevalence of chronic diseases.

3. In this connection, the Government established the Steering Committee on Review of HA in 2013 to conduct a comprehensive review of the operation of HA (the Review). The Review sought to explore viable measures for enhancing the cost-effectiveness and quality of the services of HA with a view to providing HA with increased capability to cope with the future challenges. The Steering Committee was chaired by the Secretary

for Food and Health. Its members included healthcare professionals, academics and representatives from the welfare sector and patient groups.

4. The Steering Committee published its report in July 2015 which set out its findings and recommendations (a full list of the recommendations is at **Annex A**). We briefed Members on the report at the Panel meeting held on 20 July 2015 and informed Members of the Action Plan prepared by HA on the implementation of these recommendations (Ref: LC Paper No. CB(2)97/15-16(01)) in October 2015. We last updated Members on the implementation progress in June 2016 (Ref: LC Paper No. CB(2)1740/15-16(01)). The latest progress report prepared by HA is at **Annex B**. The major progress is highlighted in the ensuing paragraphs.

(a) Re-delineation of cluster boundary (Recommendation 1)

To rationalise the organisation of service provision, having regard to better matching of the supply and demand for healthcare services as well as the hospital development / redevelopment plan in the respective clusters, HA has re-grouped Wong Tai Sin district and Mong Kok area from Kowloon West Cluster (KWC) to Kowloon Central Cluster (KCC) since 1 December 2016. The objective is to maximise coherence on vertical integration of services for the patients in the concerned districts and to facilitate patients from local communities to have continuity of care in their residential vicinity.

Subsequent re-organisation of service provision in the new KCC and associated changes in KWC would be continued, following a phased approach and formulated around the building blocks of acute-convalescent care; primary and community services; and direct patient care including clinical supporting services. Any service gap will be addressed through subsequent annual planning exercises. Communication with and engagement of staff and other stakeholders on the development are ongoing.

(b) Development of a refined population-based resource allocation model (Recommendation 3)

Through an external consultancy completed in September 2017, HA has developed the Refined Population-based Model (Refined Model) to inform resource allocation. The Refined Model, which has taken into account various factors that impact healthcare utilisation (e.g. population size, demographics, socioeconomic factors, chronic disease burden, distance from hospitals, supply), as well as the impact of 13 Designated Services and cross-cluster flow of patients on individual clusters' resources, aims to provide analytical tools to analyse and model population healthcare needs, and is not a direct funding formula. The Refined Model enables analyses from multiple perspectives and time points to facilitate the understanding of Cluster resources and to identify the relative needs of Clusters in aligning with population development.

Starting with the 2018-19 planning cycle, the analysis along with other relevant factors such as HA's strategic priorities, service directions, and implementation timeline would be considered comprehensively for service and capacity planning in short and longer terms, which would in turn inform resource allocation to the clusters. Infrastructure and capacity take time to develop and existing services must not be disrupted. Changes will be incremental according to the timeline and phasing of capacity building and services development.

(c) Staff management and training (Recommendations 5 and 6)

HA has set up the Central Training and Development Committee (CTDC) as a dedicated committee under the Human Resources Committee of the HA Board, to advise on policy issues relating to training and consider priorities of training initiatives and programmes.

The CDTC includes co-opted Members from the universities, Hong Kong Academy of Medicine and Civil Service Training and Development Institute. A structured mechanism for identification of training needs was developed to meet operational requirements.

Training programmes for both clinical and non-clinical grades covering a variety of subject matters have been supported from 2015-16 to 2017-18 with the support of the $300 million of designated training fund from the Government. Training opportunities were increased, with enhanced quality and safety and improved job performance noted. The designated training fund has also provided additional manpower support for training relief. Recurrent funding will be sought via the annual Resource Allocation Exercise to continue with the necessary training programmes. HA is also conducting active discussions with external professional bodies and universities to strengthen current collaboration platforms with a view to enhancing training capacity and capability.

Through an external consultancy, HA conducted a corporate-wide staff survey in 2016-17 to enhance staff communication and gauge staff feedback with a view to driving for improvements. Having regard the findings of the staff survey, HA is implementing a basket of strategies and actions plans to enhance staff communication as well as training and development initiatives to meet staff's aspirations, including many targeting for the younger generation staff groups.

(d) Implementation of comprehensive plan to shorten waiting time for specialist outpatient clinics (SOPCs) (Recommendation 8(a))

HA has refined the service models to address the waiting time for SOPCs, particularly for the high pressure areas in

Orthopaedics & Traumatology by diverting routine cases to Family Medicine Specialist Clinics. Further extension/ customisation of the model to other appropriate specialties will be explored for relieving SOPC workload.

HA will continue to further develop its service models to address the waiting time issues. The multidisciplinary teams are enhanced to cope with the rapid increase of demand for mental health services. HA is also employing multi-pronged strategies such as undertaking conversion works to increase consultation rooms to improve the capacity and efficiency of SOPC services in other specialties. Efforts have been made to align practices of different clusters, minimise cross-cluster variance in waiting time and facilitate patients to make informed decisions in this regard.

(e) Coordination with relevant specialties to address the serious access block problem in Accident and Emergency (Recommendation 8(b))

HA Head Office has been working jointly with KCC and New Territories East Cluster (NTEC), the two clusters with particularly noticeable access block problem, by providing input and support for cluster strategies from both policy and resource aspects.

The access block problem is indeed a phenomenon resultant from issues in service capacity with shortage of bed and manpower resources which requires considerable lead time to fill the capacity gap through annual planning and resources allocation exercises. For short and medium terms, both KCC and NTEC have strengthened intra-cluster bed coordination to facilitate patient flow for more efficient use of beds among hospitals in the clusters. At the same time, HA will continue building up the service capacity of both clusters by opening additional beds by phases through subsequent annual planning

exercises. A key performance indicator has also been developed to continue monitor the situation and to reflect the progress of the improvement measures being taken.

5. HA will continue to work on the on-going and continuous initiatives for the ultimate goal of bringing better healthcare services to Hong Kong. The Government will continue to monitor the implementation progress to ensure that the HA Review Action Plan can be timely completed by the second half of 2018. As indicated in the Policy Address announced in October 2017, the Government undertakes to increase the recurrent funding for HA progressively on a triennium basis, having regard to population growth rates and demographic changes. This will enable HA to address the challenges in public healthcare provision, including staffing and service demands, arising from the growing and ageing population in a more effective and sustained manner.

Supplementary Information on Provision of Specialist Outpatient Service for Elderly Patients by HA

6. The opportunity is taken to provide information on issues relating to the provision of SOPCs for elderly patients, which were among the various items referred to the Panel for follow-up by the Public Accounts Committee.

7. In essence, in Chapter 2 (provision of health services for the elderly) of the Director of Audit's Report No. 63 released in October 2014, the Audit Commission has made a number of recommendations which include, among others, recommending HA to –

(a) conduct a comprehensive review of the appointment scheduling practices of SOPCs;

(b) in the light of the results of the review, implement measures to optimise the use of the earliest available appointment slots in scheduling appointments for patients;

(c) take action to ensure that the appointment slots from cancelled appointments are timely released and are put to effective use as far as possible; and

(d) disseminate the good practices for clearing backlog of routine cases, and encourage SOPCs to adopt such good practices.

8. HA completed the comprehensive review of the appointment scheduling practices of SOPCs and has identified good practices on scheduling appointments for patients in order to optimise the use of the earliest available slots. Such good practices have been incorporated into the SOPC Operation Manual which was issued to all SOPCs on 1 January 2016. HA will continue to monitor the effectiveness of this measure in managing the waiting time of SOPCs. The SOPC Phone Enquiry System, first piloted in the Queen Elizabeth Hospital in KCC, facilitates patients in giving advance notice to SOPCs of intention to cancel or reschedule their appointments. HA has extended the system to the other six clusters since 2015-16. With the full implementation of the system in all clusters, cancelled appointments can be put to effective use and the released quotas can be fully utilised.

HEALTHCARE MANPOWER PLANNING AND PROFESSIONAL DEVELOPMENT

9. The Government published the report of the Strategic Review of Healthcare Manpower Planning and Professional Development in June 2017. We are taking forward the recommendations of the Strategic Review with a view to planning ahead for the long-term manpower demand and making adjustment to manpower supply as well as fostering professional development.

10. On healthcare manpower training, the Government has substantially increased the number of University Grants Committee (UGC)-funded degree places healthcare disciplines by about 60% over the past decade. The Government will consider further increasing the number of

UGC-funded healthcare training places for those disciplines (including doctors, dentists, nurses and relevant allied health professionals) which will still be facing manpower shortage in the medium to long term in the 2019-20 to 2021-22 triennium. We will count on the self-financing sector to provide training to help meet part of the increasing demand for healthcare professionals. We will also kick-start a new round of manpower projection exercise to update the demand and supply projection of healthcare manpower.

11. Healthcare professionals in the public sector are of utmost importance. HA will recruit all qualified locally trained medical graduates and provide them with relevant specialist training. There will be over 2 000 medical graduates[1] becoming registered doctors in the coming five years. HA will put in place a structured mechanism to ensure that there is sufficient training relief as well as adequate training time and opportunities for our healthcare professionals, in particular frontline healthcare professionals. As regards planning for specialist training, HA will take into account factors including operational service needs, specialty development, long-term service development and manpower situation.

12. HA will spare no efforts in retaining existing healthcare professionals, rehiring retired doctors and engaging private doctors to serve in public hospitals in order to meet imminent service needs. Without affecting the employment and career prospects of locally trained doctors, HA will proactively recruit non-locally trained doctors under limited registration.

13. The Government introduced the Medical Registration (Amendment) Bill 2017 into the Legislative Council (LegCo) in June 2017. One of the objectives of the Bill is to extend the validity period and renewal period of limited registration from not exceeding one year to not exceeding three years. The Government will strive to facilitate the scrutiny of LegCo in order to secure an early passage of the Bill. We hope that the extension of the validity period and renewal period could facilitate HA to recruit more

[1] For 2018-2022, there will be about 420 medical graduates becoming doctors with full registration annually. From 2023, there will be about 470 medical graduates becoming doctors with full registration annually.

qualified non-locally trained doctors under limited registration to meet imminent service needs.

14. Multi-disciplinary healthcare professional teams can be utilised more effectively in our public healthcare system. HA will set up more nurse clinics and enhance the services of existing ones in particular in urology and rheumatology, and expand perioperative nurse clinics so as to facilitate patients' early access to treatment and continuity of care. HA will also recruit more pharmacists to improve its clinical pharmacy services for patients (including oncology and paediatric services) and help reduce the workload of doctors. In addition, the Government will study how to make better use of resources to improve pharmacy services for the elderly living in elderly homes.

ADVICE SOUGHT

15. Members are invited to note the content of this paper.

Food and Health Bureau
Hospital Authority
January 2018

Annex A

The full set of the recommendations made by the Steering Committee on Review of Hospital Authority

Management and Organisation Structure

- ***Strengthening governance and rationalising the organisation structure***

Recommendation 1

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

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

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

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

Recommendation 2

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

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

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

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

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

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

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

Resource Management

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

Recommendation 3

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

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

Recommendation 4

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

(b) HA should enhance transparency of the resource bidding and allocation processes through better internal communication with clusters and within clusters on the methodologies, priorities and

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

Staff Management

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

Recommendation 5

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

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

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

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

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

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

Recommendation 6

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

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

Cost Effectiveness and Service Management

- ***Providing better services***

Recommendation 7

(a) The HA Board, being a managing board, should play a more active role in setting key standards and targets to –
   (i) monitor the overall performance and service provision for public accountability; and
   (ii) facilitate management decision to improve performance and drive best practices; and

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

Recommendation 8

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

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

Recommendation 9

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

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

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

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

Overall Management and Control

- ***Enhancing the safety and quality of services***

Recommendation 10

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

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

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

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

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

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

Annex B

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

Hospital Authority Action Plan – Progress Update (position as at December 2017)

Strategic Goal & Target	Key milestones of individual action items
Recommendation 1	
The Hospital Authority (HA) Board, being the managing board, to play a more active role in leading and managing HA	1. The HA Board continues to reinforce its leading and managing role on HA. Subject Directors/Heads are engaging the Executive Committee of the Board at early stages in formulation of strategies, directions and policies. The role and participation of the functional committees are strengthened in setting key standards, driving for best practices and monitoring performance. Actions have been taken to further strengthen the governance processes of the HA Board through proactive and forward agenda planning in the functional committees; and facilitating informed discussions and decisions by the HA Board/Committees. 2. To assist the HA Board in closely monitoring the implementation progress of the HA Review Action Plan, the Management has arranged quarterly progress reports to the Executive Committee of the HA Board, followed by six-monthly progress report to the HA Board which would then be submitted to the Food and Health Bureau (FHB). In parallel, the respective subject officers have been submitting progress reports to the relevant functional committees for advice and support as appropriate. So far, eight quarterly and four half-yearly reports were submitted to Executive Committee and the HA Board/FHB respectively.
Re-grouping of Wong Tai Sin (WTS) district and Mong Kok area, involving Kwong Wah Hospital (KWH), Tung Wah Group of Hospitals Wong Tai Sin Hospital (WTSH) and Our Lady of Maryknoll Hospital (OLMH) from Kowloon West Cluster (KWC) to Kowloon Central Cluster (KCC)	3. The administrative arrangement which involved mainly the change of cluster identity from KWC to KCC for the concerned staff, hospitals and services units was implemented smoothly on 1 December 2016. Complete cut-over for non-clinical support services, together with the transfer of budget and manpower, took place on 1 April 2017. 4. A high level plan for reorganisation of clinical services by phases in KCC was developed with reference made to the KCC Clinical Services Plan (CSP). A phased approach for implementation and spanning across years taking the opportunity of the planned commissioning of the New Acute Hospital in the Kai Tak Development Area, would be adopted in the reorganisation. Enabling factors in realising future service collaboration with the refined partnering hospitals in the long run would include capacity

Strategic Goal & Target	Key milestones of individual action items
	and resource planning, enhanced clinical governance, and aligned hospital management structure. 5. KWC has also developed her high level plan for reorganisation of clinical services by phases. During the development process, strategies for different scenarios are set out. Future service directions will be mapped out in the upcoming KWC's CSP. 6. Both KCC and KWC have adopted a phased approach for the service reorganisation which was formulated around the building blocks of acute-convalescent care; primary and community services; and direct patient care including clinical supporting services. A platform involving the management of both clusters has been set up to review and prioritise the service for reorganisation jointly. Staff and other stakeholders will continue to be updated on the development. 7. In connection with the clinical service reorganisation, demand and capacity gap analysis for various clusters have been conducted. Capacity building, where necessary, will be addressed through the annual planning exercises which will go beyond the three-year implementation timeframe set for the HA Review Action Plan. That said, concrete action plan is in place to guide and pursue the entire implementation process.
Interim measures for quick enhancement	8. HA has rolled out catch-up improvement plan in Kowloon East Cluster (KEC), New Territories East Cluster (NTEC) and New Territories West Cluster (NTWC) by mobilising the additional three-year funding of $300 million to address known deficiencies in their service capacity. From 2015-16 to 2017-18, time-limited funding has been allocated to the three clusters to enhance their manpower, particularly for nursing, allied health and supporting staff. 9. Additional 229 beds were opened in KEC, NTEC and NTWC in 2015-16. Total of 187 beds were opened in KEC, NTEC and NTWC in 2016-17. For 2017-18, total of 175 beds are planned to be opened in KEC, NTEC and NTWC by phases. Capacity will be further enhanced in the three clusters through subsequent annual planning exercises. 10. Resources were allocated to improve the provision of medical services for residents of WTS district over the past three years, including enhancement of computerised tomography service and orthopaedic service in OLMH. In 2015-16, additional manpower and resources were allocated to WTSH. Resources were also allocated to OLMH in 2015-16 to enhance its endoscopy service and day service. Besides, general out-patient service of OLMH has been augmented with the provision of service during public holidays.

Strategic Goal & Target	Key milestones of individual action items
	11. Refurbishment of Hong Kong Buddhist Hospital is in progress. The target completion date is the third quarter of 2019. 12. A pilot project to rationalise the acute-rehabilitation service arrangement for Queen Elizabeth Hospital (QEH)/WTSH and KWH/Kowloon Hospital (KH) was implemented in early August 2015 where WTSH and KH have each designated medical rehabilitation beds for cases referred by QEH and KWH respectively. Under this new patient-flow arrangement, target patients from WTS and Yau Tsim Mong Districts can receive acute-rehabilitation services in hospitals under the same cluster. Outcome of this pilot cross-cluster service collaboration will be reviewed with a view to extending the arrangement. 13. Refinement of geographical boundaries for ambulance catchment areas through continuing review on the Kowloon ambulance catchment areas is ongoing.
Recommendation 2	
Set up a mechanism for selection of centres for provision of highly specialised services	14. HA Head Office (HAHO) has strengthened its role in central coordination to ensure consistency in service provision and to coordinate the adoption of new treatment and highly specialised technology among clusters. A new mechanism for introduction of highly specialised services in HA with emphasis on central coordination and training was approved by the HA Board on 23 March 2017.
Refine the cluster management structure	15. To achieve better division of labour and better alignment of service provision at cluster level with organisation goals, HA had reviewed the current roles and responsibilities of Cluster Chief Executives (CCEs) and their involvement and possible enhancements in the overall management of HA. In this respect, HA has strengthened the role of CCEs in corporate management functions through job rotation and participation in corporate decision making, and planning and budgetary processes. Meanwhile CCE's role as a link person between corporate and cluster has been enhanced through his early engagement in corporate policy development process beyond his role as a cluster head.
Regroup hospitals under one Hospital Chief Executive (HCE) to make HCE job portfolios comparable	16. To enhance cooperation, coordination and role differentiation of hospitals within the cluster, arrangements have been made to group 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. Regrouping of hospitals is largely completed with the remaining one to be completed by 2018.

Strategic Goal & Target	Key milestones of individual action items
	17. Deputy HCE positions were created for hospitals where the HCEs have to manage more than one hospital. Recruitment of Deputy HCEs for different hospitals is in progress. A human resources (HR) circular on Deputy HCE arrangement was issued in May 2016. Job rotation between Chief Managers and HCEs are being arranged when opportunity arises.
Delineate the roles of hospitals within cluster	18. HAHO has worked closely with individual clusters to formulate CSPs to set out the clinical strategies and service directions for the cluster. Through this process, HA delineates the role of individual hospitals within the cluster to ensure coordinated and planned development of all hospitals within the cluster and between clusters. So far, CSPs for Hong Kong West Cluster, KCC, KEC, NTEC and NTWC were completed and promulgated. Formulation of CSP for KWC has been initiated in third quarter of 2017 and that for Hong Kong East Cluster will follow.
Recommendation 3	
Develop refined population-based resource allocation model	19. HA commissioned an external consultancy in April 2016 to develop the Refined Population-based Model (Refined Model) to inform resource allocation. The Refined Model provides analytical tools to analyse and model population healthcare needs objectively, and a starting point to facilitate understanding through transparent information. In addition to population size and demographics, the Refined Model has taken into account other factors that impact healthcare utilisation (e.g. socioeconomic factors, chronic disease burden, distance from hospitals, supply) as well as the impact of 13 Designated Services and cross-cluster flow of patients on individual clusters' resources. It is not a direct funding formula as infrastructure and capacity take time to develop and existing services must not be disrupted. 20. Analyses from multiple perspectives and time points were conducted to generate business intelligence to facilitate the understanding of cluster resources and to identify the relative needs of clusters in aligning with population development, so as to inform capacity and facility planning in the longer term. Cluster resource analysis showed clusters' expenditure was broadly comparable with respect to their scale of services (within ±0.5% in 2012-13 to 2015-16). 21. Starting with the 2018-19 planning cycle, the analysis along with other relevant factors such as HA's strategic priorities, service directions, and implementation timeline would be considered comprehensively for service and capacity planning in short and longer terms, which would in turn inform resource allocation to clusters. Changes would be incremental according to the timeline and phasing of capacity building and services development. The

Strategic Goal & Target	Key milestones of individual action items
	consequential changes in patients' health seeking behaviour, and hence the clusters' workload, would take time to take place. 22. The consultant's final report was endorsed by the HA Board in September 2017.
Communication and stakeholder engagement	23. Throughout model development, different levels of stakeholders (e.g. senior executives, clinical leaders and frontline staff) have been engaged. Starting from the third quarter of 2015, project team had communicated regularly with frontline to share ideas and groundwork; and progress of model development through cluster forums. In addition, by June 2016, the external consultant had started to conduct hospital visits and met with various stakeholders and frontline to solicit feedbacks on the concept and approach of the Refined Model. In November and December 2016, the project team briefed different stakeholders through various platforms including staff fora for all seven clusters. Feedbacks from these engagement activities in November and December 2016 with clinical frontline and various stakeholders were duly considered by the consultant. 24. The consultant's final report has been uploaded onto HA corporate website and Intranet.
Monitor progress and utilisation of catch-up funding	25. Budget was allocated to KEC, NTEC and NTWC to implement catch-up plans. In 2015-16 and 2016-17, $56 million and $109 million were utilised in the three clusters respectively. Implementation progress of catch-up plans would be kept under review. 26. For 2017-18, a budget of $123 million had been allocated for implementing the catch-up plans in the three clusters.
Recommendation 4	
Improve and simplify the procedures of resources bidding	27. Training workshops for frontline users to consolidate the workflow in the Annual Planning System were conducted in January 2016. 28. Enhancements to the functionality of the Annual Planning System with more analysis functions and data reports were completed and launched in the first quarter of 2017.
Enhance transparency of the resource bidding and allocation processes	29. The internal deliberation for the Resource Allocation Exercise (2018-19 planning cycle) started in the first quarter of 2017. Clinical Coordinating Committees (COC) and Central Committees (CCs) Annual Planning Forum were organised on 9 March 2017 for frontline professionals to present proposed clinical programmes. HAHO Annual Planning Forum was held on 21 March 2017 at which HAHO subject officers presented programme proposals that

Strategic Goal & Target	Key milestones of individual action items
	were coordinated at the corporate level or were initiated by HAHO. Cluster Annual Planning Forums were organised on 11 and 12 May 2017 for cluster management to propose initiatives that aimed at addressing the service needs of individual clusters, in particular the key pressure areas. All the proposals presented at the forums were put forward for prioritisation by the Service and Budget Planning Committee chaired by the Chief Executive of HA and involving all Directors/Heads/CCEs as members.
Recommendation 5	
Enhance central system to monitor creation and deletion of selected levels of senior positions	30. The enhancement on the central mechanism for creation and deletion of senior positions was implemented in the first quarter of 2017 to enhance consistency.
Enrich HAHO representation in cluster selection boards	31. A proposed framework for enriching HAHO representation in cluster selection boards in recruitment/appointment exercises was presented to the Human Resources Committee (HRC) of the HA Board on 20 June 2017 for implementation in phases in 2017-18 and 2018-19. To facilitate smooth implementation and thorough understanding of the proposed framework and relevant implementation logistics by the concerned parties, briefings for clinical COCs, Grade Managers, Functional Heads and Cluster General Managers have been arranged. Further consultation with Medical Grade Manager, COCs of various specialties and Doctors Staff Group Consultative Committee will be arranged in the latter half of 2018-19 to assess the readiness for implementation of the proposed central recruitment framework in different specialties and invite the more ready specialties for pilot implementation.
Develop and enhance rotation programmes	32. HA has put in place measures to reinforce rotation of senior management and clinical staff to broaden exposure and facilitate mutual understanding between staff and other clusters. A rotation mechanism is being developed for training of clinical staff in different grades/hospitals on the use of new healthcare technology/equipment introduced into HA. 33. To facilitate intra-specialty rotation of clinical staff, central funded posts (11 additional central funded training places on top of 28 existing places are supported in 2016-17) are provided. The allocation principles and proposal were deliberated. The budget for 2017-18 has been allocated to clusters. 34. Review of clinical staff rotation programmes (intra and cross specialty) is in progress. Consultations with COCs and the Taskforce on Medical Workforce Review were completed in November 2016. Resident Trainees (RTs) were invited through CCEs and Doctors Staff Group Consultative Committee to

Strategic Goal & Target	Key milestones of individual action items
	participate in focus group discussions conducted in December 2016. The progress update and the way forward were discussed in March 2017 and enhancement of the rotation arrangement of Trainees would be pursued. In 2016-17, two additional central funded training places were supported in Intensive Care Unit (ICU) to pilot the cluster-based/cross-cluster rotation of Trainees between ICU and Anaesthesiology departments.
Strengthen alignment of HR practices and implementation of HR policies across clusters	35. To enhance consistency in HR practice, more regular communication forums have been arranged with clusters HR, and senior HR executives in clusters are also involved in leading corporate-wide HR projects. 36. An HR Quality Assurance Programme has been formulated to look into policies, guidelines, procedures and practices in selected disciplines of HR functions with a view to identifying gaps and improvement areas. The framework together with the three-year rolling plan commenced in the second quarter of 2017.
Enhance HA staff communication	37. A series of measures have been taken to enhance communication and foster a collaborative culture to help improve staff morale and engagement with staff, including mobile applications (app), staff communication guidebook, etc. The HR App has been rolled out to all staff since March 2017 and over 40 000 staff had downloaded the app as at November 2017. A staff communication guidebook, serving as a useful reference for HR professionals to formulate communication plan for different purposes, e.g. consultative, informative, persuasion and mediation, has been developed and uploaded onto the HA Intranet in late June 2017. 38. Separately, the HA Staff Survey was conducted and the results as well as follow-up actions were presented to the HA Board on 23 March 2017 and to various Staff Groups Consultative Committees in the second quarter of 2017. A Project Committee (PC) with representatives from both the HAHO and clusters was set up to steer and monitor the implementation of the survey. The PC will also monitor the progress of implementation of the action plans and the progress of work was reported to HRC in September 2017.
Formulate central staff deployment plan in emergency situations	39. Proposed enhancements for facilitating central staff deployment during emergency including standardisation of HA's appointment letters with inclusion of central deployment clause and establishment of central staff deployment mechanism was endorsed on 3 January 2017 and promulgated for implementation with effect from 1 April 2017.
Central recruitment of Resident Trainees	40. With an aim to identify areas for improvement in the Annual Recruitment Exercise for RTs, an ad-hoc group was formed by HAHO Medical Grade Department in 2014 with representatives

Strategic Goal & Target	Key milestones of individual action items
	from Medical Policy Group and HAHO HR Division. After extensive consultations and deliberations, specialty-based centrally-coordinated RT recruitment was conducted for Psychiatry and Paediatrics/Hong Kong Children's Hospital in 2015-16 and rolled out to all specialties in 2016-17. In 2016-17, 16 specialty-based Central Selection Panels were formed by all COCs to replace cluster-based selection interviews. The above process enhanced transparency on the applicants' selected specialties for recruiting departments, thereby reducing the number of informal interviews and over-commitment on preliminary RT offers. After three rounds of centrally coordinated specialty-based interviews, a total of 363 RTs were recruited in the 2016-17 Annual Recruitment Exercise for RTs, with the number of RT recruited in departments with acute manpower needs, e.g. Accident and Emergency (A&E) Departments and Obstetrics and Gynaecology Departments, increased from 35 and 13 in 2015-16 to 40 and 21 in 2016-17 respectively.
Develop and implement re-employment schemes for suitable retirees to help address manpower shortage and encourage knowledge transfer [One-off funding of $570 million]	41. To help alleviate manpower issues, and to retain suitable expertise for training and knowledge transfer, 61 clinical doctors, 45 nurses, 8 allied health staff and 787 supporting grades staff retired in 2015-16 and 2016-17 were rehired under the Special Retired and Rehire Scheme. For 2017-18, the HA Board approved a similar scheme at its meeting held on 19 January 2017, and recruitment is in progress.
Recommendation 6	
Strengthen governance on training	42. A two-tier governance structure for training was set up in the fourth quarter of 2015. The Central Training & Development Committee (CTDC) newly set up under HRC has commenced its work. CTDC comprises HA Board Members, external experts and representatives from external stakeholders including the Hong Kong Academy of Medicine (HKAM), The University of Hong Kong, The Chinese University of Hong Kong, The Hong Kong Polytechnic University and Civil Service Training and Development Institute. CTDC is supported by the Training and Development (T&D) Executive Group which is co-chaired by Director (Cluster Services) and Head (Human Resources). It has so far conducted 11 meetings since October 2015.
Develop mechanism to ascertain organisation training needs and development of training activities	43. HA has developed a structured mechanism for adoption by the seven clusters for identification of training needs to meet operational requirements. The mechanism has been rolled out by phases in 2017-18. Grade-specific training curriculums for Finance, HR, Hospital Administrators and IT grades have been finalised. The curriculums are implemented in 2017-18 with regular review and fine-tunings by individual grades.

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Develop system for effective training information management and planning	44. HA is enhancing its training information management system to provide comprehensive and accurate training-related information for monitoring control and future planning. Phase I development including users and system requirements formulation, prototype development and feasibility testing was completed in 2016-17. Currently, system development is being made with a target to pilot a number of selected training management reports at corporate level by December 2017. This new IT system will provide useful training data and reports to management and training organisers to facilitate service planning, foster professional development and support daily operation. 45. A tracking system for training programmes under the $300 million designated training fund has been developed and presented to T&D Executive Group and CTDC. Ongoing refinement to this mechanism will be made as and when appropriate subject to endorsement by the T&D Executive Group.
Strengthen collaboration with external parties to enhance overall training capacity and capability	46. Medical, Nursing, Allied Health and Pharmacy Grades have each established formal liaison platforms/forums with external training partners in 2016. For doctors, HA and HKAM have agreed on the priority areas and the respective action plans on the facilitation of HKAM Constituent College examinations in HA hospitals and simulation training collaboration between HA and HKAM. Nursing, Allied Health and Pharmacy Grades have worked with local tertiary education institutions and the potential areas of collaborations spanning from alignment of undergraduate programme curriculum and clinical placement to postgraduate programmes collaboration as well as development of staff appointment mechanism between academic institutions and HA to help further build up training capability of all parties, and research capabilities among HA staff and conduction of healthcare operational and clinical research.
Utilise one-off additional funding of $300 million to enhance training	47. With the additional $300 million, HA has organised new training programmes and scale up programmes as well as time-limited training programmes to support HA's strategic directions and operational needs. 48. Eleven and 17 programmes had been implemented in 2015-16 and 2016-17 respectively. Another 21 programmes are planned in 2017-18. Some of the training programmes are repeated each year owing to service needs and the size of the target population. 49. With the designated training fund in place, increased training opportunities, enhanced quality and safety and improved job performance are noted. The designated training fund has also provided additional manpower support for training relief.

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	Recurrent funding will be sought via the annual Resource Allocation Exercise to continue those necessary programmes. 50. HA has stepped up training relief support for both trainers and trainees joining selected programmes sponsored by the designated training fund, e.g. Corporate Scholarship and Simulation Training for Clinical Professionals. In the interim, HA engages part-timers and temporary staff or uses Special Honorarium Scheme to address the operation needs arisen from manpower shortage. Similar practices are applied for training relief with the designated training fund. A tracking mechanism has been developed to monitor utilisation of the designated training fund including the expenditure on training relief.
Recommendation 7	
Enhance the role of the HA Board in Key Performance Indicator (KPI) performance review and KPI development process	51. KPI reporting mechanism is strengthened. As from the fourth quarter of 2015, the relevant functional committees of the HA Board are tasked to discuss and review matters relating to KPIs with a view to enhancing the role of HA Board in KPI performance review and KPI development process.
Enhance HA's KPIs	52. New KPIs to reflect capacity-demand gap and service efficiency on the key pressure areas were endorsed by the HA Board in February 2016 for phased implementation in 2016-17. The new KPIs are: (a) Capacity and throughput for specialist outpatient (SOP) services - Number of SOP first attendances per doctor - Number of SOP follow-up attendances per doctor - Growth of waiting list against throughput (b) Capacity and utilisation of Operating Theatre (OT) services - Utilisation rate of scheduled elective OT sessions (%) - Ratio of scheduled to expected elective OT session hours (%) (c) Access block monitoring (via exception reporting) - Number / percentage of patients with access block time more than [4 hours, 12 hours]
Enhance utilisation of KPI information to drive best practices	53. An information system (Hospital Authority Management Information System, "HAMIS") is being developed for phased implementation to facilitate dissemination of KPI information, and retrieval by different levels of staff. The system will be ready for report production in March 2018 followed by access to report archives and release of the report at the new platform. This will promote and facilitate organisation learning and sharing of best practices. Ad hoc enquiries and other enhanced function of HAMIS will be further developed by phases.

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Recommendation 8	
Utilise Family Medicine Specialist Clinics (FMSCs) to relieve pressure on Orthopaedics & Traumatology (O&T) SOPCs	54. In October 2017, KEC and NTEC commenced the 2017-18 annual plan proposal on using FMSCs to attend O&T routine new SOPC cases. The arrangement is protocol driven and cases for diversion to FMSCs are mainly patients suffering from back problems which are of low risk nature and do not involve surgical intervention but only functional rehabilitation. A rough estimate will be around 20% to 30% of low back pain cases may be transferrable to FMSCs for consultation.
Employ new multidisciplinary strategy to relieve pressure on Psychiatric SOPCs	55. HA has enhanced the multidisciplinary teams to cope with the rapid increase of service demand for mental health services. The use of trained psychiatric nurses and allied health professionals under supervision of doctors is proved to be effective in improving treatment outcome, and the development of criteria for closing cases also helps discharge those who have satisfactorily completed the care plan developed by doctors. This service delivery model enables the availability of more doctor consultation sessions for new cases with a view to shortening the SOPC waiting time. Taking KWC and KEC as example, with the enhancement of their multi-disciplinary teams, the 90th percentile waiting time of patients booking new cases at the adult psychiatric SOPCs triaged into routine cases in KWC decreased from 61 weeks in June 2015 (before the enhancement) to 57 weeks in September 2017 while in KEC, the waiting time decreased from 97 weeks in May 2016 (before the enhancement) to 43 weeks in September 2017. 56. HA further enhanced the multidisciplinary teams of psychiatric SOPCs in NTEC (for patients with common mental disorder (CMD)) in 2017-18. 57. The pilot on corporate-coordinated cross-cluster booking for suitable patients with CMD in KWC and KEC commenced in the fourth quarter of 2015 and third quarter of 2016 respectively. Up to 31 March 2017, a total of 501 cross-cluster referrals had been received.
Employ multi-pronged strategies to generally improve the capacity and efficiency	58. Works to expand physical capacity for SOPC service are progressing via on-going projects and projects under planning, including construction of Hong Kong Children's Hospital; redevelopment of KWH, Kwai Chung Hospital and OLMH; expansion of United Christian Hospital and North District Hospital; and New Acute Hospital at Kai Tak Development Area. Yaumatei SOPC has been reprovisioned in the Ambulatory Care Centre (Extension) / Block T at QEH. SOPC services in the new Tin Shui Wai Hospital commenced on 9 January 2017.

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	59. HA has been taking active steps to seek collaboration with the private sector to deliver public healthcare services to strengthen the primary care. The General Outpatient Clinic Public-Private Partnership Programme (GOPC PPP) has currently been rolled out to 16 districts. The Programme will be further rolled out to the two remaining districts (Yau Tsim Mong District and North District) in 2018-19.
Align practices of different clusters and minimise cross-cluster variance in waiting time	60. The SOPC Phone Enquiry Systems, aiming to answer patient enquiries and enhance utilisation of SOPC quotas by facilitating rescheduling and cancellation of appointments, were implemented in all seven clusters by 2015-16. In 2016-17, the systems were further extended to six other hospitals, including Hong Kong Eye Hospital, Tseung Kwan O Hospital, Caritas Medical Centre, KWH, Yan Chai Hospital and Alice Ho Miu Ling Nethersole Hospital. 61. HA launched a mobile booking app "BookHA" on 8 March 2016 to provide patients of major specialties (namely Ear, Nose and Throat, Gynaecology, Cardiothoracic Surgery, Medicine, Neurosurgery, Ophthalmology, O&T and Surgery) with a more convenient means of making SOPC new case booking, apart from coming to clinics in person or sending in application by facsimile. Up till 30 September 2017, the total app downloads exceeded 150 000 times while booking requests submitted via BookHA exceeded 51 000 times. The app would be further rolled out to Obstetrics and Paediatrics by the first quarter of 2018.
Ensure A&E patients with pressing medical needs received timely medical treatment	62. In order to ensure timely medical treatment for Category III (Urgent) patients with pressing medical needs and to improve the waiting time of Category IV (Semi-urgent) and Category V (Non-urgent) patients in A&E department, HA has implemented a new model "Rapid Assessment and Treatment Model" in QEH in the first quarter of 2016. Through re-engineering the work process in A&E department, it allows early assessment of Category III patients by a team led by a senior doctor to make a competent initial assessment and define a care plan. 63. HA will continue to closely monitor the manpower situation in A&E departments and make appropriate arrangements in light of service needs and operational requirements. In 2016-17, HA recruited 40 RTs and 75 nurses to A&E departments for replacement of attrition and new services. In 2017-18, HA also recruited 33 RTs to A&E departments while the recruitment of nurses are on-going and continuous.
Improve the waiting time of Category IV and Category V patients in A&E departments	64. The A&E support session programme, which recruits additional medical and nursing staff (including those from non-A&E departments), to handle semi-urgent and non-urgent cases, has been further extended to 17 A&E departments since 1 November 2015.

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	In 2016-17, A&E departments have operated support sessions at a total of around 17 700 hours, equivalent to around 4 400 four-hour sessions. The A&E support sessions programme will continue in 2017-18. 65. HA has also standardised the waiting time information of A&E departments in the third quarter of 2016 and released A&E waiting time information to public via the HA website, smartphone app (HA Touch) and at registration counter of A&E departments on 20 December 2016.
Strengthening of HAHO's input and enhancement of intra-cluster collaboration	66. HAHO is working jointly with the cluster-based task forces in KCC and NTEC, which are led by the respective CCEs, to formulate cluster strategies and action plans for improving the access block situation, by providing inputs and assistance from policy and resource allocation levels. Proposals to build up capacity will be submitted through the annual planning process. Besides, HAHO will continue to enhance system to provide information on access block situation. The Hospital Bed Management Dashboard has been enhanced to include the information down to "sub-specialty" level with effect from 20 April 2017 to facilitate better coordination for acute and convalescent beds.
Building up of capacity/ management of service demands	67. Both KCC and NTEC had a noticeable improvement in the last winter surge period (December 2016 – May 2017) when compared with the year before. For KCC, the access block problem is being managed and the result has sustained during the last winter surge period. The access block problem in NTEC has improved in terms of frequency and intensity, though some fluctuations have been observed. Observation on access block situation will be continued through the regular KPI monitoring. 68. The major direction for KCC in addressing the access block problem is to improve bed usage and facilitate patient flow through better coordination among its cluster hospitals. With OLMH and WTSH joining KCC after cluster boundary re-delineation, there will be a more flexible use of convalescent beds in the cluster to facilitate patient flow. 69. To alleviate the access block problem, NTEC strives to build up its capacity by opening more beds as stated in 2017-18 Annual Plan, including 20 Surgery acute beds and six Medicine day beds in Prince of Wales Hospital, 12 Orthopaedics acute beds in Alice Ho Miu Ling Nethersole Hospital and 20 Medicine convalescent beds in North District Hospital. The progress and key measures of HA in managing access block problem was last reported to the HA Board on 27 July 2017.

Strategic Goal & Target	Key milestones of individual action items
Recommendation 9	
Increase service capacity	70. HA continues to raise the capacity of priority services of HA, particularly for high demand services having regard to the projected demand arising from a growing and ageing population, and roll out service enhancements within the resource constraints. For 2017-18, HA will open a total of 229 additional beds to meet the growing demand arising from population growth and ageing. It will continue to commission services in Tin Shui Wai Hospital in phases and make preparation for the commencement of services in the Hong Kong Children's Hospital in phases from 2018. It will also continue to enhance the services provided by the HA's Community Geriatric Assessment Team for terminally ill patients living in residential care homes for the elderly, and increase capacity for SOPCs and GOPCs. HA also aims at sharing out the demand with community partners. 71. HA has been taking active steps to seek collaboration with the private sector to deliver public healthcare services to strengthen the primary care, including the implementation of GOPC PPP.
Review and develop service delivery models and strengthen partnership with community partners	72. HA has been exploring practicable ways to alleviate the anticipated overburdened hospital services and to facilitate "ageing in place". To this end, HA is working with Pok Oi Hospital Board of Directors to develop a collaborative service model for a large-scale residential care home for the elderly in Lam Tei. The construction is scheduled to be completed in 2020-21 the earliest and its service is planned to commence in phases. 73. HA has developed a service model that involves partnership with non-governmental organisations or other healthcare organisations to enhance the choices of infirmary care services for applicants on the Central Infirmary Waiting List managed by HA. A pilot Infirmary Service PPP project (with 64 infirmary beds in Wong Chuk Hang Hospital) has been launched. 74. HA is also strengthening palliative care services to patients with terminal illness and their family members, and has further developed the Community Health Call Centre services to provide telephone advice and support to diabetes mellitus patients in Medical SOPCs on disease management.
Strengthen patient empowerment and engagement	75. HA is committed to empowering and engaging its 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. Patient Empowerment Programme has been refined to better support patients with diabetes mellitus or hypertension. Collaboration

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	projects were launched involving collaboration between patient groups, Patient Resource Centres and the clinical teams of HA. The content and accessibility of the HA's Smart Patient Website were enhanced. Patient Experience and Satisfaction Surveys will continue to be conducted to proactively engage patients for feedback on services and identify areas for improvement.
Recommendation 10	
Strengthen the roles of COCs on clinical governance	76. HA has enhanced the roles and responsibilities of COCs 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. A standardised set of Terms of Reference was promulgated to COCs in August 2016. COCs are required to include the following standing agenda items in COC meetings by the first quarter of 2017: (a) Standard of clinical service and care; (b) Workforce and training; (c) Quality and safety; and (d) Technology, therapeutics and information technology.
Enhance the role of COS with greater emphasis on clinical governance	77. HA has engaged COSs and doctor groups on the enhanced role of COS, particularly in quality of patient care and patient safety. COSs and senior doctors are encouraged to complete the Quality and Safety modules in Healthcare Service Management Training e-Course (which provides concise learning information on an array of quality and safety subject matters such as accreditation; clinical incident management) which was released in the second quarter of 2016. 78. HA has specified the management functions of COS as related to clinical governance in COS appointment and staff appraisal procedure. Management functions related to clinical governance are specified in the job description and key responsibilities in Vacancy Notification Circular for COS. This enhancement and the emphasis of the COS's role on clinical governance were communicated to CCEs/HCEs, Cluster Human Resources and COCs.
Develop a system of credentialing and defining scope of practices	79. On the development of a system of credentialing and defining scope of practices, the second batch of the three procedures from three specialties, namely clinical oncology, obstetrics and gynaecology and radiology was endorsed in March 2017 as HA credentialing activities.

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Improve clinical outcomes and patient care through clinical audit activities	80. Updated Clinical Audit Guidelines are being shared through eKG platform. 81. To develop a local risk adjusted model for intensive care outcome monitoring programme, HA has supported COC in ICU in developing a local risk adjusted model for intensive care outcome monitoring programme with the assistance from the Chinese University of Hong Kong. The model and findings were presented and accepted by COC in ICU in the fourth quarter of 2016. 82. HA has developed specific sets of clinical indicators for service quality improvement. A Working Group on Clinical Indicators with representations from different stakeholders is overseeing the selection, development and review process of clinical indicators. As at August 2017, 22 clinical indicators have been established while one is under the development (Turnaround time for rapid test for influenza A&B).
Strengthen medical incidents sharing	83. HA publicised and implemented Clinical Incident Management Manual in July 2015. In the first quarter of 2016, the Manual was promulgated on various platforms, including Staff Sharing Forum on Sentinel and Serious Untoward Events (SE & SUE), COCs and CCs, with focus of communication and support for patients. 84. HA will continue to publish Risk Alert on a quarterly basis (latest one released on 27 October 2017) and Annual Report on SE & SUE. Regular incident sharing sessions are held at HAHO, clusters and COCs, e.g. in the third quarter of 2017, two sessions were held in HAHO, and five sessions in clusters with video conferencing to other hospitals within the same cluster. Training in patient safety, including medication safety, has been incorporated into orientation programmes for interns and junior doctors.

Hospital Authority
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