



醫院管理局
HOSPITAL
AUTHORITY

EXECUTIVE SUMMARY

Doctor Work Reform Recommendation Report by Steering Committee on Doctor Work Hour Hospital Authority

Introduction

- 001 The Hospital Authority (“HA”) is committed to improving the working conditions of public hospital doctors and maintaining a high standard of care for the patients. To promote work-life balance and enhance staff morale, HA continuously strives its best to address the issues related to doctors’ long work hours and excess workload.
- 002 The Steering Committee on Doctor Work Hour (“Steering Committee”), established in October 2006 under the lead of Dr C H LEONG, GBS, JP, former Chairman of HA, is tasked to formulate strategies and implementation plans with a view to **reducing, within 3 years, the work hours of doctors to not exceeding 65 in a week and their continuous work hours to a reasonable level**. Underpinning the Steering Committee, two Advisory Committees have also been formed to solicit feedback from frontline doctors, clinical specialties and cluster administration on the impacts of work reform strategies on doctors’ work, training and ultimately patient care services.

Doctors’ Work – Issues and Recommendations

- 003 Based on the findings from local surveys on doctors’ work hours, on-call structure, duty roster and corporate-wide communication and consultation exercises, the Steering Committee has identified a number of issues of concern with corresponding recommendations for improvement as follows:
- a) **Long weekly work hours**
According to a local survey on doctors’ work hours conducted in September 2006, about 900 HA doctors (i.e. 18%) worked for more than 65 hours in a week. The long work hours were attributable to the voluminous workload and frequent overnight on-site calls shouldered

by a relatively small pool of doctors on rotation. HA is recommended to identify measures to optimize the night activities in all hospitals and reduce the number of overnight on-site doctors required in each hospital while ensuring quality patient care and safety.

b) High intensity activities

It was a general phenomenon that a significant portion of doctors' work hours in most clinical specialties were spent on performing mundane and repetitive technical tasks rather than core patient services. HA is recommended to find ways to reduce avoidable workload, concentrate activities into a few centres and pool doctors to work in specialties / hospitals with highly intensive activities in order to achieve the ultimate goal of delivering quality patient care.

c) Long continuous work hours

Prolonged continuous work hours would jeopardize doctors' clinical decision making and put patients at risk. HA is recommended to work further to shorten doctors' continuous work hours by improving their work pattern, such as replacing overnight on-call duties with a partial shift system and reinforced training.

d) Low staff morale

The low staff morale of doctors could be attributed to pay disparity, unequal work and slow career progression. This was partly reflected in the hastened brain drain of HA doctors to the private sector in recent years. Apart from the two HA-wide doctor-related initiatives, namely, New Career and Pay Structure for Doctors as well as Flexible Employment, HA is recommended to formulate a broad-brush nominal system to recognize doctors' excess work hours and retain well-qualified staff in the organization.

Beliefs and Directions

004 The Steering Committee believes that Doctor Work Reform cannot be taken along without improving staff morale. Corporate reform in the following directions can address the issues related to doctors' excess work hours and boost the morale of HA doctors:

- a) The weekly work hours of doctors should not exceed 65 in general while those currently working for fewer than 65 hours should also be benefited from the reform.
- b) Doctors should not work continuously for more than 16 – 24 hours.
- c) Overtime work of doctors exceeding their conditioned hours should be recognized financially.
- d) Manpower should be rationally increased in certain clinical specialties on a need basis.
- e) Promotion of doctors should be encouraged in HA, taking into consideration their competency, qualifications and years of service.

005 On the other hand, the intrinsic nature of the medical profession entails round-the-clock service and inevitable work at unsocial hours. There is no exception for HA doctors. The Steering Committee fully appreciates the dedication of the frontline doctors in taking on calls out-of-hours and is cognizant of their request to reduce not only their work hours, but their frequency of on-site call during the

unsocial hours as well. Yet, the Steering Committee also believes that HA doctors, as respectable professionals, should pursue medical professionalism and quality patient care rather than meticulous counting of work hours. Their excess work hours should be nominally recognized in a broad-brush approach rather than on an hour-to-hour compensation basis, given the inherent differences in work intensity not only among specialties, but also within the same specialties in different hospital settings. Furthermore, the efficacy of Doctor Work Reform in managing workload and hence doctors' working conditions would need to be verified through various pilot programmes in the organization. Continuous communication and genuine exchanges with stakeholders at all levels on Doctor Work Reform are of paramount importance to taking the leap forward and attaining ultimate success in the long term.

Reform Objectives

006 The key objectives of Doctor Work Reform are as follows:

- a) Quality patient care through team work
- b) Risk management for enhanced patient safety
- c) Quality doctor hours for service and training

Local Reform Model Founded on Wide Consultation

007 The Steering Committee is mindful to formulate a rational reform model to cater for local needs by way of wide consultation and engagement of stakeholders and professional organizations. A Strategic Planning Workshop involving more than 40 frontline staff and 9 specialties was held on 23 March 2007. Views of the participants had been incorporated to form the discussion framework in the consultation paper, which was sent to every HA doctor and the Hong Kong Academy of Medicine on 9 May 2007. The final round of consultation with the two Advisory Committees on Doctor Work Hour, all cluster and hospital chiefs and senior executives of the HA Head Office started on 3 September 2007 and all feedback received has been incorporated or addressed in this Recommendation Report.

The Steering Committee's Recommendations

008 I. **Work Hours – What & How? (Chapter 5)**

- a) The Steering Committee recommends that all HA doctors should not work for more than 65 hours in a week on average. HA may consider counting the weekly work hours of doctors as an average over a period of 26 consecutive working weeks. Should doctors' average weekly work hours exceed 65 hours, HA is recommended to look into the work arrangements and identify ways to rectify the situation. [See Para 522 items (a), (e) & (h)]

- b) HA may consider fully counting doctors' time involved in rostered on-site clinical care, administrative duties, intervening meals and commuting as well as urgent called-back on-site clinical duties during an off-site call as work hours. [See Para 522 items (b) & (d)]
- c) HA may consider counting official release and paid study leave as work for the purpose of assessing doctors' average weekly work hours. For simplicity and consistency in calculation, a broad-brush approach is recommended to count the duty hours. [See Para 522 items (c)]
- d) HA may consider counting doctors' time involved in an off-site call from home as one equivalent on-site work hour. Out-of-hour commuting time taken by doctors for each called-back on-site duty may also be counted as one equivalent on-site work hour. [See Para 522 items (b) & (d)]
- e) HA may consider gradually reducing the continuous work hours of doctors towards the **target of 16 on weekdays and 24 at weekends and holidays** in the long term. HA is recommended to arrange no more than 5 consecutive night shifts for doctors under the new work hour arrangements. [See Para 528, 529 & 732 item (a)]

[For interim recommendations on continuous work hours and time-off arrangements, please refer to Para 013 item B2.2 below for details.]

II. Reform Strategies

A. Optimizing Total Workload (Chapter 6)

009 Strategy A1 - Managing Workload at Macro Level

- A1.1 HA may consider establishing **Emergency Medicine Wards** in selected acute hospitals with 24-hour Accident and Emergency services as a gatekeeper to reduce avoidable hospital admissions, curtail duplication of work and optimize night activities in clinical departments. [See Para 623 item (a)]
- A1.2 HA may consider employing **part-time private practitioners** through a contemporaneous Flexible Employment strategy to partially relieve the workload of doctors in certain overstretched departments. [See Para 634]
- A1.3 HA may consider exploring the extension of **Telephone Nursing Consultation Service** to all hospital clusters to further reduce avoidable admissions. [See Para 623 item (b)]

010 Strategy A2 - Treat-and-transfer among Hospitals

- A2.1 HA may consider delineating the roles and scope of services of different hospitals in each cluster and **concentrating selected emergency admissions into tertiary hospitals** in order to optimize patient access to emergency services currently provided by a limited number of HA doctors. [See Para 653 item (a)]

- A2.2 HA may consider establishing **Escort Medicine Teams** in different clusters by phases, with all necessary care protocols and transfer guidelines, to support inter-hospital treat-and-transfer of stabilized critically-ill patients. [See Para 653 item (b)]
- A2.3 HA may consider forming **service networks** for certain clinical sub-specialties across clusters and setting up task forces to formulate a clear timetable for service networking. [See Para 653 item (c)]

011 *Strategy A3 - Optimizing Night Activities in All Hospitals*

- A3.1 HA may consider **restricting emergency operations after 22:00 hours** to patients with life, limb or sight-threatening conditions only and expanding the operating theatre capacity in the extended day on weekdays in all hospital clusters. [See Para 674]
- A3.2 HA may consider enhancing the professional role of nurses in the patient care process and planning for provision of **24-hour care technician service** to carry out blood-taking, intravenous cannulation, electrocardiogram recording and / or other activities as appropriate, so as to allow on-site doctors to re-focus their time and work on core clinical decision making and communication with patients and their relatives. [See Para 682 item (a)]
- A3.3 HA may consider the role of **admission wards** and explore their potentials for concentrating resources and staffing to handle emergency admissions as per the prevailing conditions in different hospitals. [See Para 687]
- A3.4 HA may consider reinforcing the overall clinical diagnostic system support and plan for **expanding computerized tomography service to the extended day** in selected acute hospitals, subject to manpower availability. [See Para 698 item (a)]

B. Change in Existing Doctors' Work Pattern (Chapter 7)

012 *Strategy B1 - Building Core-competency Call Teams*

- B1.1 HA may consider working out **a system** to design, update and promulgate both **intra- and inter-departmental clinical protocols** involving multi-disciplinary professionals in order to ensure seamless and quality patient care through teamwork. [See Para 717 item (a) & 819 item (c)]
- B1.2 HA may consider optimizing the number of overnight on-call doctors required in hospitals by extending **doctors on general call to cover sub-specialty calls in their respective departments**. [See Para 717 item (b)]
- B1.3 HA may consider exploring further the option of competency-based patient care after 22:00 hours on weekdays and throughout weekends and holidays, complemented by subsequent ward rounds by specialists, to ensure quality care and patient safety. If the introduction of **core-competency call teams** is agreed, the teams can be phased in after staff training on core skills and competencies within the local departments. [See Para 717 item (c)]

013 *Strategy B2 - Shift System Replacing Overnight On-call Duties*

- B2.1 HA may consider gradually implementing a **shift system** to replace overnight on-call duties to address the issue of long continuous work hours of doctors. HA is recommended to attain the target of reducing doctors' **continuous work hours towards 16 on weekdays and 24 at weekends as well as public and statutory holidays** in the long term. [See Para 528 & 732 item (a)]
- B2.2 HA may consider, in the interim, attaining **100% compliance with post-call half-day time-off** granted to doctors on overnight on-site call. [See Para 531 & 732 item (b)]
- B2.3 HA may consider arranging **mutual-cover sleep time for 4 consecutive hours**, recommended to be counted as work hours, for doctors on overnight on-site call duties exceeding 24 hours, subject to service sustainability and regular monitoring. [See Para 531 & 732 items (b)]

014 *Strategy B3 - Structured and Comprehensive Multi-disciplinary Handover*

- B3.1 HA may consider putting in place a **structured and comprehensive multi-disciplinary handover system** for critically ill and unstable patients to ensure patient safety and continuity of care. [See Para 740 item (b) & 819 item (b)]

015 **C. Training under the New Work Hour Arrangements (Chapter 8)**

- C1 HA may consider following the prevailing study leave policy and administrative procedures to facilitate and encourage doctors' training, subject to service requirements, operational practicability and resource availability. [See Para 819 item (a)]
- C2 HA may consider making more use of **simulation and scenario-based training sessions** to supplement the contemporaneous training framework for doctors. [See Para 819 item (d)]
- C3 HA may consider exploring with the Hong Kong Academy of Medicine to introduce **cluster-based training programmes** with rotation of trainees among hospitals. [See Para 819 item (e)]
- C4 HA may consider creating **part-time doctor service posts** for consistently overstretched specialties to concentrate resources for enhanced doctors' training. [See Para 819 item (f)]
- C5 HA may consider adopting a **common ward language** (e.g. MEWS – Modified Early Warning Score) among non-medical staff to facilitate identification of critical patient conditions for timely specialist intervention. [See Para 819 item (g)]

016 **D. Targeted Deployment of Resources (Chapter 9)**

HA may consider strategically deploying resources to the following areas in order to protect the safety and health of both doctors and patients:

- D1 Enhancing operating theatre capacity, setting up Emergency Medicine wards, deploying care technicians with extended roles and enhancing diagnostic imaging support for patient care

D2 Employing more doctors for selected specialties without pre-empting implementation of other re-engineering and reform initiatives

017 E. Enhanced Honorarium System (Chapter 10)

E1 HA may consider exploring a sound and appropriate enhanced honorarium system to recognize the excess work hours of doctors in a **broad-brush and nominal approach** to deter over-rostering of doctors and self-generating overwork. [See Para 1024]

Pilot Implementation

018 HA may consider pilot implementing selected strategies of Doctor Work Reform in the hospital clusters and allocate resources strategically. Moreover, HA may consider providing incentives for clusters to roll out pilot projects of proven benefits, such as employing care technicians, employing part-time doctors to help out in specialist outpatient clinics, opening extra operating theatre sessions and training of core-competency call teams. Besides, HA may consider putting in place a monitoring system to ensure that the reform programmes are implemented for the intended outcome.

The Way Forward

019 Doctor Work Reform is the business of everyone in HA rather than just the pilot sites. To make the reform a success, the Steering Committee recommends HA to **continually communicate with all stakeholders** and implement changes gradually and strategically. HA may consider conducting qualitative and quantitative assessments in order to show that Doctor Work Reform is beneficial to both doctors and patients. Though additional funding is required for certain reform initiatives, HA is recommended to continually strive for further process re-engineering and lead changes within the bound of available resources.

*Steering Committee on Doctor Work Hour
Hospital Authority
November 2007*



HA's Response Statement on Doctor Work Reform Recommendation Report

The Hospital Authority (HA) convened its Administrative and Operational Meeting today (29 November 2007, Thursday) and discussed the Doctor Work Reform Recommendation Report (Report) submitted by the Steering Committee on Doctor Work Hour (Steering Committee). The following is HA's response to the Report.

I. Overall Response

2. HA welcomes the recommended work reform strategies of the Steering Committee and supports the directions of reform in general.

3. Doctor Work Reform is a key priority area under HA's "People First" Strategy. It carries the three-fold objectives of quality patient care through teamwork, risk management for enhanced patient safety as well as quality doctor hours for service and training.

4. Issues that HA's Doctor Work Reform seeks to resolve are multi-faceted and intricate, including doctors' work and training, service mode and volume, roles and functions of hospitals, system support and, above all, accountability for providing quality and safe patient services. The road of reform is daunting and confounded by different challenges, like frugal public healthcare expenditure, manpower constraint, increasing turnover of clinical staff in recent years and uncertainties about the future mode of healthcare financing. Mere injection of resources, provision of additional doctors or any piecemeal remedial action cannot by themselves solve nor revert the looming situation. HA needs a total work reform to address the issues.

5. HA appreciates the Steering Committee's efforts in formulating a local reform model by way of wide consultation and engagement of stakeholders and professional organizations. The recommendations are all made with due consideration of patient safety, workability, rationality, affordability as well as service sustainability. The proposed strategies are targeted to improve not only patient care and safety, but also doctors' working conditions and morale.

6. The Report has brought in new perspectives and pragmatic ways of delivering patient services and work arrangements across disciplines, set the right direction of reform and provided HA with a menu of possibilities to tackle the workload issues while ensuring the

quality of service. The right care can thus be given to the right patients at the right time in public hospitals.

7. HA extends its sincere thanks to the Steering Committee under the lead of Dr C H LEONG, GBS, JP, former Chairman of HA, for its dedicated work and tremendous contribution to the corporate reform. The Report is the outcome of constructive exchanges and concerted efforts of all. Stakeholders' engagement and opinions have played a crucial part in shaping the reform strategies. HA is particularly grateful for the precious views and suggestions of all frontline doctors, Doctors' Associations and Unions, clinical heads, the nursing profession, management colleagues as well as the Hong Kong Academy of Medicine and its constituent Colleges to make the reform possible and successful in future.

II. Response to Work Reform Recommendations

8. HA will follow the recommendations of the Steering Committee in relation to optimizing total workload, change in existing doctors' work pattern, training under the new work hour arrangements and targeted deployment of resources. HA will roll out different reform strategies in phases, subject to the outcome of pilot programmes, to improve doctors' working conditions and enhance the quality of patient care. While the Report will form the blueprint for reform implementation in the entire organization, HA is committed to attaining specific milestones of reform under the aforesaid constraints, and will continuously collaborate with the concerned professional groups and the training institutions on reform implementation.

A) Improving Doctors' Working Conditions

9. HA is committed to reducing doctors' average weekly work hours to not exceeding 65 by the end of 2009. HA will implement reforms as to gradually reduce the continuous work hours of doctors to a reasonable target of 16 on weekdays and 24 at weekends and during public and statutory holidays in the long term. In the interim, HA will look to the arrangement of granting post-call half-day time-off to doctors on overnight on-site calls and 4 consecutive hours of mutual-cover sleep time to doctors taking on overnight on-site call duties exceeding 24 hours, subject to exigencies and service sustainability.

10. According to an HA-wide self-reporting Survey on Doctor Work Hour in September 2006, it was estimated that 18% of all HA doctors were working for more than 65 hours in a week on average. HA will strive to attain the stated target of 65 hours through different reform strategies in the coming years, subject to compliance monitoring, while those who are currently working for fewer than 65 hours in a week will also be benefited from the reform. As for the Steering Committee's recommendations on continuous work hours, it will take time for HA to attain the stated targets, given the manpower constraint and readiness of other supportive measures at present. However, HA will facilitate the proposed interim measures so that doctors can work in vigilance and freshness at night.

11. HA is aware of frontline doctors' request for reviewing the honorarium system in recognizing their excess work hours. HA agrees to the Steering Committee's recommended principle of nominal recognition in a broad-brush approach. With the implementation of the

New Career and Pay Structure for Doctors in October 2007, frontline doctors' concern over "equal work and unequal pay" has been significantly alleviated. In particular, the pay point for new doctors has been raised by 3 pay points to attract new comers; the salary of 2,000 serving doctors who joined HA after April 2000 will have a pay rise by 15% – 38%; and the ceiling of doctors' pay scale has been lifted by 8 pay points with a view to retaining specialists in the public hospital system. Besides, doctors who have passed specialist examinations will have pay increments; and HA will offer a nine-year employment contract to retain doctors undergoing specialist training. Under this new initiative, HA has committed an annual recurrent expenditure of more than \$350 million to retain well qualified specialists in the public sector. Despite the financial commitment and the stringent financial position, HA will actively communicate with the frontline and the concerned stakeholders to explore a sound and appropriate honorarium system so as to address the concerns of frontline doctors.

B) Improving Patient Safety

12. Since its inception, HA has devoted great attention to patient safety which is also a key focus of the Steering Committee's recommended reform strategies. To this end, a number of strategies will be implemented in phases, viz. (a) continual facilitation and encouragement of doctors' training, (b) gradual reduction of overnight on-site call hours / frequency, (c) enhancement of clinical protocols and care pathways to streamline patient management, (d) pilot running of call teams with enhanced core-competency in selected hospitals as well as (e) development of a common ward language to identify potentially critical patient conditions for timely specialist intervention.

13. With regard to the Steering Committee's recommendation on core-competency call teams, HA agrees with the Steering Committee that the aims of setting up these call teams are to reduce the number of doctors required to be on on-site call in the hospital and improve the provision of emergency care for patients through enhancing the core competencies of doctors. Doctors will be geared up with the core-competency skill sets, i.e. the requisite knowledge and skills in recognizing, assessing and managing patients with critically ill and unstable conditions in both emerging and urgent situations, so that the call teams will be competent to handle the majority of emergency conditions that require immediate attention at night. In the event that cases require a higher level of expertise, the team can readily access stand-by multi-disciplinary specialists' support within a reasonable time frame.

14. HA realizes the frontline's concern for cross-specialty coverage at night. HA agrees that cross-specialty coverage is not applicable to Obstetrics and Gynaecology, Paediatrics and Psychiatry. Doctors in the medical and surgical service streams of service, given their fundamentally different requisite skills and core competencies in patient management, cannot cross cover. However, HA will re-focus on the core competency skill sets of overnight on-site call doctors, and continue to facilitate training of doctors and collaborate with the Academy in order to improve the foundation training of junior doctors. In the meantime, HA will plan for a system of formulating and promulgating intra- and inter-departmental clinical protocols to streamline patient management. Besides, HA will, as an initial step, facilitate doctors on general call to cover their respective sub-specialty on-site calls at night and consider piloting core competency call teams in certain district hospitals where services are not highly sub-specialized.

C) Improving the Quality of Patient Care

15. HA has all along been emphasizing delivery of quality patient care through teamwork. HA supports the Steering Committee's recommendations for delivering protocol-based care with enhanced multi-disciplinary collaboration. Besides, HA has identified great potentials for improved care and more efficient use of resources in various reform strategies proposed by the Steering Committee, including (a) establishment of Emergency Medicine wards to reduce avoidable admissions, (b) expansion of service capacity during daytime and evening to reduce unnecessary activities at night, e.g. opening of extra operating theatre sessions on weekday evenings, (c) set-up of a structured and comprehensive multi-disciplinary handover system for critically ill and unstable patients to ensure continuity and safety of patient care, (d) extension of roles of non-medical staff in patient care and (e) enhancement of diagnostic imaging support for services.

16. Service volume remains the major issue of concern for HA. HA will keep on reviewing the role and scope of service provided by different hospitals within clusters and identify ways to manage workload through service re-organization, process re-engineering and enhanced public-private interface programmes, so that the scarce professional resources can be better utilized to deliver the best care for the patients. HA will study the feasibility of further service networking and rationalization among specialties in different hospital clusters in the long term.

III. The Way Forward

17. To facilitate gradual rollout of reform to all public hospitals, HA will embark on a number of pilot programmes in 7 hospitals of 4 clusters, commencing the end of 2007, to verify the efficacy of the reform strategies. The Kowloon West Cluster will be the major site for pilot reform whereas individual pilot programmes will be implemented in the Hong Kong East, Kowloon East and New Territories East Clusters. Apart from \$19 million already allocated for development of Emergency Medicine wards in 4 public hospitals, HA has further deployed \$12 million in 2007 / 08 to run four pilot programmes, namely, (a) opening of extra weekday operating theatre sessions, (b) establishment of Emergency Medicine wards, (c) introduction of 24-hour Technical Care Assistant service, and (d) employment of part-time doctors to help out in specialist out-patient consultations and other clinical duties. The pilot programmes will be run for 6 to 9 months.

18. Additional manpower, including Associate Consultants, Residents, nurses, allied health and supporting staff, will be recruited. HA will monitor the resource utilization and assess the impacts of reform on doctors' work hours, distribution of workload, service operation and patient outcome. Extra resources will be injected for sustaining and rolling out successful reform programmes to other HA hospitals in 2008/09 through the Annual Planning process.

19. HA has delegated the Steering Committee to oversee the pilot programmes and report the outcomes to the HA Board at intervals, as its Members have already mastered the underlying issues of reform and had thorough understanding of the local health system. The Steering Committee has all along been steering the reform strategy formulation and will definitely provide valuable input to the implementation of reform throughout the pilot phase.

20. HA believes that Doctor Work Reform strategies will evolve with the changing needs and service priorities over time. HA will continue to liaise with the Government on the resource requirement. Despite the stringent workforce, financial constraints as well as other confounding factors and uncertainties ahead, HA will keep on communicating with stakeholders at all levels and plan for further reform rollout to other hospital clusters in order to bring forth the intended outcome and take the entire organization another leap forward.

21. Doctor Work Reform is the business of everyone in HA. HA will make the Report available to the concerned parties. All staff and the general public may access the Report via HA's intranet and internet websites respectively for reference.

Hospital Authority
November 2007

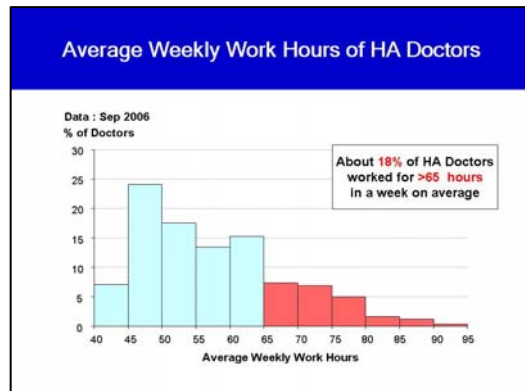
Doctor Work Reform

Fact Sheet (November 2007)

Background

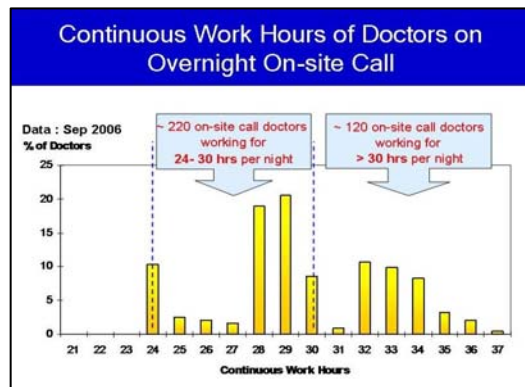
Doctor Work Reform (“DWR”) is a key priority area under HA’s “People First” Strategy.

The Steering Committee on Doctor Work Hour (“Steering Committee”), established in October 2006 under the lead of Dr C H LEONG, GBS, JP, Former Chairman of HA, is tasked to reduce, within 3 years, the work hours of doctors to not exceeding 65 hours per week and their continuous work hours to a reasonable level.



Reform Objectives

- A. Quality Patient Care through Teamwork
- B. Risk Management for Enhanced Patient Safety
- C. Quality Doctor Hours for Service and Training



Local Reform Model Founded on Wide Consultation

- A. Consultation Paper
 - All HA doctors and HK Academy of Medicine
- B. Communication Forums
 - HA staff (3rd round with 61 sessions and more than 1,100 doctor attendances)
 - Specialty Coordinating Committees (1 round)
 - HK Academy of Medicine (4 briefings)
 - General Manager (Nursing) Forum (3 briefings)
- C. Workshops
 - Strategic Planning Workshop (frontline inputs)
 - Hospital Chief Executive Workshop
- D. DWR Recommendation Report
 - Cluster Administration & Specialty Advisory Committee on Doctor Work Hour
 - Doctors Staff Group Consultative Committee



Doctor Work Reform

Quality Care
Patient Safety
Teamwork
Quality Hours

Strategies

Quality Patient Care

- A. To establish Emergency Medicine wards to reduce avoidable admissions
- B. To expand service capacity during daytime and evening to reduce unnecessary activities at night
- C. To set up a structured and comprehensive multi-disciplinary handover system for critically ill and unstable patients
- D. To extend the roles of non-medical staff in patient care
- E. To enhance diagnostic and imaging support for services in the extended day

Patient Safety

- A. To facilitate and encourage doctors' training for enhanced competency
- B. To gradually reduce overnight on-site call hours / frequency for betterment of patient care
- C. To enhance clinical protocols and care pathways to streamline patient management
- D. To set up call teams with enhanced core-competency in selected hospitals
- E. To develop a common ward language for early detection of potentially critical patient conditions and timely specialist intervention

Doctor Work Hours

- A. All HA doctors should not work for more than 65 hours in a week on average
- B. Doctors' continuous work hours should be gradually reduced to 16 on weekdays and 24 at weekends and holidays in the long term

The Way Forward

- A. DWR pilot programmes will be implemented as from end of 2007 with regular monitoring
- B. HA will continually communicate with stakeholders at all levels

Doctor Work Reform is the Business of Everyone in HA!

The full report is accessible via HA's internet and intranet



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