For Discussion
on 11 May 2009

Legislative Council Panel on Health Services

Interim Review Outcome of Pilot Doctor Work Reform Programmes

PURPOSE

This paper briefs Members on the outcome of the interim review of the pilot doctor work reform programmes implemented by the Hospital Authority (HA).

BACKGROUND

2. At the meeting of the Panel on Health Services held on 10 March 2008, Members noted vide paper CB(2)1266/07-08(03) the recommended strategies on doctor work reform made by the Steering Committee on Doctor Work Hours (the Steering Committee) established by HA. Members also noted the follow-up implementation of pilot programmes in seven hospitals in four clusters[1] starting from the end of 2007.

3. The Steering Committee has been overseeing the implementation of these pilot programmes and has submitted an Interim Pilot Review Report on Doctor Work Reform (the Interim Report) to the HA Board in February 2009 to report the mid-term outcome of the pilot programmes. The executive

[1] The pilot programmes were launched in Pamela Youde Nethersole Eastern Hospital under the Hong Kong East Cluster; United Christian Hospital under the Kowloon East Cluster; Caritas Medical Centre, Princess Margaret Hospital and Yan Chai Hospital under the Kowloon West Cluster; and Alice Ho Miu Ling Nethersole Hospital and North District Hospital under the New Territories East Cluster.

summary of the Interim Report is attached at **Annex** for reference. The full Interim Report is available to the public via HA's internet website.

IMPLEMENTATION AND INTERIM REVIEW OF PILOT PROGRAMMES

4. Doctor work reform is one of HA's key priorities. In implementing the pilot doctor work reform programmes, HA's prime concerns are patient safety and doctors' work-life balance. While the overall direction of reform is to reduce and share out the workload of doctors in public hospitals, it should be emphasized that the reform is not just an exercise to simply rationalize doctors' working hours. The reform also aims to enhance the quality of patient care through better teamwork and explicit sharing of responsibilities, to improve patient safety through risk management, and to attain quality doctor hours for training and patient-centred services.

5. HA set aside $31 million and $77 million in 2007-08 and 2008-09 respectively for implementation of the pilot programmes. The interim review has shown that, in general, the pilot programmes have improved the quality and safety of patient care. The programmes have also helped revamp the existing work patterns of doctors and successfully reduced the workload of frontline doctors and night-time activities. Consequently, doctors are allowed more time to receive training on their core competency which in turn further enhance the quality of care and patient safety.

6. The interim review has also indicated that a number of factors have made the outcome of the pilot programmes vary among different hospitals. These factors include the work flow and set-up of different hospitals, supply of medical graduates, specific roles of each hospital in care delivery under the

hospital cluster arrangement, as well as hospital culture that affects staff acceptance of new modes of operation and service delivery.

7. The outcome of interim review on the major pilot programmes are highlighted as follows -

(a) Deployment of doctors to areas under pressure

To relieve the heavy workload of doctors, HA has increased the number of doctors by 204 from August 2006 to August 2008. Among them, 96 doctors have been deployed to the six specialties where doctors have prolonged work-hour issues[2]. In 2008-09, 47 newly recruited doctors were also deployed to selected specialties to perform duties related to doctor work reform. On the other hand, HA will continue to optimize doctors' workload through various public-private partnership projects and employment of part-time private practitioners.

(b) Re-engineering of emergency operating theatre (EOT) services

Four acute public hospitals have opened extra operating theatre sessions to expand their day-time service capacity on weekdays. The EOT services are also re-engineered in order to clear the backlog of operations, improve patient safety and minimize avoidable night-time activities in the specialties under the surgical stream. While the outcome of this initiative varied among hospitals, the impact was less prominent in acute tertiary hospitals

[2] The six specialties included Neurosurgery, Surgery, Obstetrics & Gynaecology, Paediatrics, Medicine as well as Orthopaedics & Traumatology.

as it is difficult to reduce night-time activities arising from emergency services provided by these hospitals, such as acute trauma and obstetric operations. The utilization rate of EOT time at night, relative to the total EOT time used throughout the whole day, has been reduced by 14% to 45% in these four hospitals in the second quarter of 2008 as compared to the same period in 2007.

(c) Establishment of Emergency Medicine Wards (EMWs)

HA has established pilot EMWs in three acute hospitals to improve the quality of care for short-stay patients and efficiency in handling admission of acute patients. On the whole, the programme is considered effective in providing care for selected short-stay patients without compromising the quality of care and patient safety. The interim review has shown that the programme has contributed to reducing acute patient bed days by 2.9% to 26.3% in the three acute hospitals in the period from November 2007 to August 2008, when compared to those from November 2005 to August 2006. The variation in the outcome among hospitals is due to the factors mentioned in paragraph 6 above.

(d) Support to doctors by trained non-medical staff

HA has recruited and provided training to 91 Technical Services Assistants (Care Assistant) to provide 24-hour blood-taking, electrocardiogram and intravenous cannulation services for patients in six acute hospitals with an aim to relieve the workload of frontline doctors and nurses. From May to October 2008, an average of around 11,000 doctor work hours were saved each month under this pilot programme. With this initiative, more

timely and better services can be provided by the Technical Services Assistants, while doctors can focus more on their core clinical decision making and professional duties.

(e) Other initiatives

These include phased implementation of a common ward language with integrated observation charting and a unified communication approach for multi-disciplinary communication, training programmes to enhance the core competency of healthcare professionals, as well as an electronic handover system piloted in selected acute hospitals. These pilot programmes commenced at various junctures in 2008 and early 2009. Their efficacy in reducing doctors' workload while ensuring the quality of care and patient safety will be assessed in due course.

8. Apart from the seven hospitals where pilot programmes have been launched, other HA hospitals have also attained various degrees of success in reducing their frontline doctors' work hours in the past year. This was made possible by determined clinical leadership, change in the conventional on-site call system as well as a cultural change among the frontline doctors. As a result, doctors' continuous work hours could be reduced, thereby reducing their average weekly work hours as well.

WAY FORWARD

9. In 2009-10, HA will continue to implement the pilot reform programmes as highlighted in paragraph 7 above. To further relieve the heavy workload of frontline doctors, HA will deploy 23 additional Residents under specialist training to pressurized specialties and enhance the roles of

experienced nurses to strengthen their support in patient management in selected acute hospitals.

10. The Steering Committee will continue to oversee the implementation of the pilot programmes. It will compile a final review report to the HA Board in early 2010 to evaluate the efficacy of the pilot programmes and recommend strategies for rolling out the pilot programmes in other public hospitals.

11. In the course of implementing the pilot programmes, HA will maintain close communication with frontline staff and other relevant stakeholders to obtain feedback on the programmes. HA will continue to collaborate with the Hong Kong Academy of Medicine to improve doctors' training as well.

12. On doctor work hours, as recommended by the Steering Committee, HA's target is to reduce the average weekly work hours of doctors to not more than 65 by the end of 2009; and to gradually reduce their continuous work hours on weekdays and at weekends and holidays to 16 and 24 hours respectively in the long term. HA has started monitoring doctor work hours systematically since January 2009 and would continue to improve doctors' work patterns in different specialties in order to attain the work-hour target by the end of 2009.

Advice Sought

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

Hospital Authority
May 2009

醫院管理局
HOSPITAL AUTHORITY

EXECUTIVE SUMMARY

Interim Pilot Review Report on Doctor Work Reform
by
The Steering Committee on Doctor Work Hour
Hospital Authority

INTRODUCTION

001 Doctor Work Reform of the Hospital Authority ("HA") carried 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. The Steering Committee on Doctor Work Hour ("Steering Committee") submitted the Doctor Work Reform Recommendation Report to the HA Board on 29 November 2007 for deliberation. HA welcomed the work reform strategies recommended by the Steering Committee and supported the directions of reform in general. While the overall direction of Doctor Work Reform was to reduce and share out the total workload of public hospital doctors through a variety of reform strategies, it was HA's target to reduce all public hospital doctors' average weekly work hours to not exceeding 65 by the end of 2009 and their continuous work hours to a reasonable level in the long term.

002 In the past year, HA had embarked on various pilot reform programmes in order to verify the efficacy of the reform strategies. Communication with public hospital staff and external stakeholders continued in order to enlist buy-in and draw in the wisdom of the stakeholders for refinement of the reform strategies. In 2008, 110 internal communication sessions had been organized with more than 2,600 staff attendances while close liaison was being kept with the Hong Kong Academy of Medicine, patient groups, community leaders and the Panel on Health Services of the Legislative Council.

003 HA had delegated the Steering Committee to oversee the pilot reform programmes and report the outcomes to the HA Board at intervals. This Interim Pilot Review Report on Doctor Work Reform ("Interim Report") laid out the mid-term outcome and recommended the rollout strategies for various pilot reform programmes. Review of these programmes would continue in the coming year in order to improve doctors' working conditions while ensuring the quality of care and patient safety.

PART I PILOT DOCTOR WORK REFORM

1 Pilot Reform Strategies

004 HA had continually injected new manpower and resources to launch various Doctor Work Reform strategies and relieve the heavy workload of doctors in pressurized clinical specialties. $31 million and $77 million were set aside in 2007/08 and 2008/09 respectively for all reform-related programmes. A total of 348 new posts were supported, including 38 doctors. Besides, the total number of doctors rose by 204 from August 2006 to August 2008 and the six pressurized specialties with prolonged work hour issues also recorded a net increase of 96 doctors in the same period. HA also allocated 47 newly recruited doctors to selected clinical specialties in 2008/09 for reform-related purposes. On the other hand, public-private partnership was still considered to be the cornerstone for optimizing HA's workload, although under the earlier boom in the private market, difficulties were encountered in recruiting part-time private practitioners to relieve the workload of surgeons in the pilot hospital.

005 Four acute public hospitals had expanded their day-time operating theatre capacity on weekdays and re-engineered their emergency operating theatre (EOT) services in order to clear their backlog operations, improve patient safety and minimize avoidable activities in the surgical stream specialties at night. The performance varied among hospitals but the reform impact was more conspicuous in acute secondary than acute tertiary hospitals. The utilization ratio of EOT time at night was reduced by 14% – 45% in the pilot phase.

006 Three acute public hospitals piloted the Emergency Medicine Ward (EMW) service to improve the quality of short-stay patient care and the efficiency in handling acute patient admissions. In a study conducted from November 2007 to August 2008, EMWs were found to have contributed to a standardized reduction of acute patient days by 2.9% – 26.3% in the pilot hospitals. The varied outcome was attributable to different modes of operation and resource injections for running the EMWs and various limiting factors that the pilot hospitals were faced with in the study period. On the whole, EMW service was an effective means of caring for selected acute patient conditions; and the right care could be given to the right patients at the right place. Despite the teething problems and room for further collaboration between the emergency departments and other clinical specialties, the quality of care and patient safety were maintained in the pilot EMWs.

007 A total of 91 care technicians were recruited and trained to provide 24-hour blood-taking, electrocardiogram and intravenous cannulation for patients in six acute hospitals so as to relieve the workload of frontline doctors and nurses. Around 11,000 doctor work hours were saved in the pilot hospitals per month on average and the programme was in general welcomed by both doctors and nurses. Patients would also benefit from more timely and fast-track services while on-site doctors could refocus their time on core clinical decision making and professional duties, thereby enhancing the quality of care and patient safety. No critical incident was reported after implementation of the pilot programme.

008 Some early observations showed improved quality of care and sustained patient safety after implementation of the pilot reform programmes. No increase in critical incidents had been observed so far. Both frontline doctors' workload and night activities had also been reduced. The work hours of frontline doctors could thus be reduced in certain clinical specialties. Besides, the core competency of doctors and nurses was enhanced, while a pool of care technicians were trained up to relieve both doctors and nurses in providing basic patient care.

009 On the other hand, an electronic handover system was being developed to improve multi-disciplinary teamwork in patient management and ensure the continuity of care. Besides, a Central Doctor Work Hour Monitoring System, coupled with a doctor work hour calculator, was being set up to facilitate monitoring of doctor work hour. Finally, to give extra protection for staff performing emergency duties and improve their morale, HA extended the employment compensation coverage for its employees traveling for called-back duties beyond their normal duty hours.

010 An "Interim Outcome at a Glance" on Doctor Work Reform was prepared at the annex to the Executive Summary for ease of reference.

011 On the whole, Doctor Work Reform should not be seen as simply an added cost to the healthcare system. Many of the pilot reform programmes that had been piloted were about more efficient use of the workforce (e.g. care technicians) or the system (e.g. EMW and electronic handover). Quality initiatives, like re-engineering of emergency theatre services, could also reduce cost by reducing complications, re-admission and infection rates and by reducing patients' length of stay in hospitals. Given that doing the right things right was the most cost-effective, it could be expected that Doctor Work Reform would invest to save and contribute to reducing cost to the public healthcare system.

2 Key Success Factors to Improve Work Hours

012 Despite the varied outcome of the same reform strategy launched at different pilot sites, the key success factors to bring down frontline doctors' work hours in the clinical departments, be they pilot reform sites or not, included determined clinical leadership in changing doctors' existing call patterns, implementing supportive reform strategies to reduce the overall workload and a cultural change among the frontline doctors to accommodate new modes of operation and service delivery.

013 Clinical departments attained different degrees of success in bringing down the average weekly and continuous work hours of frontline doctors in the past year. The supportive reform strategies had trimmed the workload and created an environment conducive to revamping the work patterns and on-site call structure of doctors in various clinical specialties. This was made possible by reducing avoidable activities and redistributing workload among the clinical specialties, reshuffling non-emergency activities at night to the extended day and sharing out part of doctors' technical duties to the other trained personnel in wards.

014 Moreover, additional doctors were deployed to pressurized areas to alleviate the workload and improve the morale of frontline doctors. Furthermore, certain clinical departments piloted various pragmatic means of operation, like fewer on-site doctors for an optimized workload, partial shift system, short-call system, mutual call coverage among the on-site doctors, combined call layers with stronger off-site specialist support, on-call mode of operating theatre support services as well as post-call time-off arrangement for doctors on overnight on-site duties exceeding 24 hours. All these were proven effective in reducing frontline doctors' frequency of overnight on-site call duties and their continuous work hours in stages, hence their average weekly work hours as well, without compromising the quality of care and patient safety.

3 The Next Step

015 Following an interim review of the pilot reform programmes and other supportive reform measures, the Steering Committee recommended HA to take the following steps in the coming year :

a) To continue the existing pilot reform programmes and roll out successful ones to other public hospitals at appropriate time points, taking into account staff wastage in different specialties and supply of medical graduates in the market

b) To continue collaborating and communicating with the stakeholders in order to gradually instill a culture of change, enlist buy-in for reform and modernize the healthcare profession for the benefit of patients and the community

c) To closely monitor doctors' working conditions and drive for clinical determination and leadership to make necessary changes in the work arrangement so that all public hospital doctors would work for fewer than 65 hours per week on average by the end of 2009

016 The Hong Kong Academy of Medicine also supported in general the recommendations made by the Steering Committee in this Report for rolling out the pilot reform programmes.

PART II RECOMMENDATIONS

A Rollout of Pilot Reform Programmes

017 Following an interim review of the pilot reform programmes and other supportive reform measures, the Steering Committee made the following recommendations to HA:

018 A1 Deployment of Doctors to Pressurized Areas

a) HA to consider reviewing the effectiveness of deploying additional doctors in reducing doctor work hour at different pilot reform sites and pressurized clinical specialties [See Para 420 item (a)]

b) HA to consider continually exploring further means of collaboration with the private sector so as to alleviate the workload and improve the quality of care and patient safety in public hospitals, like employment of part-time private practitioners through the Flexible Employment Strategy to help out the General Outpatient Departments, dovetailing with redeployment of newly employed doctors to pressurized clinical specialties via the established resource allocation mechanisms [See Para 420 item (b)]

c) HA to consider continually reviewing its manpower level, work arrangements and call patterns in order to identify any possible room for optimizing workload, streamlining work procedures and improving doctors' working conditions [See Para 420 item (c)]

019 A2 Re-engineering of Emergency Operating Theatre (EOT) Services

a) HA to consider re-engineering the EOT services in all acute hospitals with 24-hour emergency services in order to clear the backlog of emergency operations and optimize patients' access to emergency services currently provided by a limited number of HA doctors – Different modes of operating theatre services could be introduced after 22:00 hrs to support the night emergency operations. Additional funding, if any, could first be allocated to acute secondary hospitals to expand their operating theatre capacity in the extended day. [See Para 528 item (a)]

i) For acute hospitals shouldering acute trauma, obstetric and neurosurgical services, HA to consider running two concurrent EOT sessions with back-up arrangement for conducting another emergency operation at night

ii) For acute hospitals shouldering obstetric and / or neurosurgical services, HA to consider keeping one EOT session with back-up arrangement for conducting another emergency operation at night

iii) For less busy acute hospitals, HA to consider running on-call theatre services (i.e. Anaesthetists and theatre nurses being put on-call for ad hoc emergency operations) or transferring patients with high risk of potential deterioration to another acute hospital in the cluster for emergency operations at night

b) HA to consider addressing the issues of inadequate day-time operating theatre capacity in order to clear the backlog elective operations and avoid the exploitation of EOT slots for non-emergency operations [See Para 528 item (b)]

c) HA to consider reviewing the work practice and instilling a cultural change in the surgical stream specialties in order to optimize the need for operation at night, improve patient safety by operating in the extended day, and reduce the number of overnight on-site call doctors in public hospitals [See Para 528 item (c)]

d) HA to consider delineating the roles and service scopes of different hospitals, exploring further room for service re-arrangements, formulating acute trauma and neurosurgical diversion mechanisms and developing protocol-based escort medicine service in all hospital clusters in order to ensure patient safety and support the treat-and-transfer arrangement [See Para 528 item (d)]

e) HA to consider continuing to collaborate with the Hong Kong Academy of Medicine and its Specialty Colleges in order to enhance the core competency training of frontline doctors on emergency care [See Para 528 item (e)]

f) HA to explore the feasibility of providing general resident call coverage for patients who were physiologically unstable in the surgical stream specialties with reference to the global trend and the practice in the private healthcare market [See Para 528 item (f)]

020 **A3 Establishment of Emergency Medicine Wards**

a) HA to consider exploring different models of emergency care for acutely admitted patients and address various limiting factors, like availability of hospital beds, training for a competent workforce, system support and a gradual change for closer cross-specialty collaboration, which were vital to the success of the EMW initiative [See Para 635 item (a)]

b) For those acute hospitals that had already set up an EMW, HA to consider continuing to refine the service model in order to reduce avoidable hospital admissions, alleviate the workload of clinical specialties and improve the quality and safety of patient care [See Para 635 item (b)]

c) In view of the evolving mode of EMW service and the lead time required for addressing the aforementioned limiting factors, HA to consider reviewing the pilot EMW initiative for a longer period and analyzing more performance and outcome data before determining the detailed rollout plan for EMW service [See Para 635 item (c)]

d) HA to consider enhancing the core competencies of doctors through structured training and staff rotations among hospital clusters and clinical specialties in order to improve patient care and maximize the benefits of the EMW initiative for both patients and doctors [See Para 634 item (d)]

021 **A4 Introduction of Care Technician Service**

a) HA to consider extending round-the-clock care technician service to all acute hospitals in order to improve patient services and relieve doctors and nurses from mundane and repetitive tasks, especially after hours, so that they might refocus their time on core clinical decision making and professional duties. Regular review of care technicians' scope of service, coupled with periodic safety monitoring and competency-based refresher training, were recommended to ensure quality patient care and meet the evolving healthcare needs of the society over time. [See Para 726 item (a)]

i) For major acute hospitals, a team of 17 – 25 care technicians, with 2 staff running on night-shift, was recommended for provision of blood-taking, electrocardiogram and intravenous cannulation for patients.

ii) For small to medium-sized acute hospitals, a team of 15 – 18 care technicians, with 1 staff running on night-shift, was recommended for provision of blood-taking, electrocardiogram and intravenous cannulation for patients.

B Improving Quality of Care and Patient Safety

022 B1 Enhancing the Roles of Nurses

a) HA to consider piloting in phases and evaluating the efficacy of enhancing the clinical, professional and leadership roles of experienced nurses in providing protocol-driven, competency-based and after-hour coverage across clinical specialties in selected acute hospitals in order to improve patient assessment, ensure timely intervention for high-risk patients and enhance the safety and continuity of patient care [See Para 820 item (a)]

b) HA to consider continuing to organize commissioned clinical skill enhancement training for nurses in acute settings in order to enhance their professional competency in care coordination, patient assessment, responsiveness and emergency stabilization, and to develop the local training resource for improving the core competency of nurses in acute patient care. [See Para 820 item (b)]

023 B2 Introducing Common Ward Language

a) HA to consider extending the common ward language to other public hospitals as appropriate and establishing a uniform approach in multi-disciplinary communication, so as to ensure timely specialist intervention for potentially critical patient conditions and improve patient safety [See Para 905 item (a)]

024 B3 Extending Protocol-driven and Evidence-based Patient Care

a) HA to consider continuing to formulate, update and promulgate both intra- and inter-departmental clinical management protocols involving multi-disciplinary professionals, coupled with regular clinical audits, in order to ensure seamless and quality patient care through teamwork. [See Para 1004 item (a)]

025 B4 Formulating Structured and Comprehensive Multi-disciplinary Handover

a) HA to consider piloting and evaluating the efficacy of the newly developed electronic handover system in order to facilitate structured and comprehensive handover between shifts for critically ill and unstable patients, ensure continuity and safety of patient care and enhance after-hour clinical supervision [See Para 1108 item (a)]

C Attaining Quality Doctor Hours for Service and Training

026 C1 Monitoring Doctor Work Hour

a) HA to consider monitoring the work hours of public hospital doctors in a broad-brush approach and on the principle of prospective counting of rostered work in all situations, except their called-back duties during an off-site call and endorsed unrostered work [See Para 1226 item (a)]

b) HA to consider putting in place a mechanism to recognize unrostered work beyond the rostered duty hours in unforeseen circumstances and justified by demonstrable clinical needs [See Para 1226 item (b)]

c) HA to consider monitoring the work hours of frontline doctors at regular and appropriate time points in order to keep watch on their working conditions and for workforce planning purpose – For clinical specialties that were unable to meet the corporate target of reducing doctors' average weekly work hours to not exceeding 65 by the end of 2009, HA to consider reviewing their manpower level, work arrangement and duty patterns at half-yearly intervals in order to improve doctors' working conditions while ensuring the quality of care and patient safety [See Para 1226 item (c)]

027 C2 Changing Doctors' Existing Work Pattern

a) HA to consider continuing to explore new ways of operation and work out viable solutions to change doctors' existing work pattern with the ultimate aims of enhancing their work-life balance and morale without compromising the quality of care and patient safety [See Para 1317 item (a)]

b) HA to consider gradually implementing a modified on-call system in order to reduce their continuous work hours towards the long-term target of 16 on weekdays and 24 at weekends as well as public and statutory holidays [See Para 1317 item (b)]

c) In the interim, HA to consider attaining 100% compliance with post-call half-day time-off granted to all doctors on overnight on-site call and arranging mutual-cover sleep time for 4 consecutive hours for those who were on overnight on-site duty exceeding 24 hours, subject to adequate workforce, operational practicability and service sustainability [See Para 1317 item (c)]

028 **C3 Enhancing Doctors' Core Competency**

a) HA to consider continuing to encourage and facilitate doctors' training and set in different supportive measures and modes of training in order to strengthen the core competency of frontline doctors and ensure the quality of care and patient safety [See Para 1411 item (a)]

b) HA to consider enhancing the core competency of junior doctors in acute clinical care management by organizing refresher training courses in collaboration with different Specialty Colleges in order to enhance both the core competency skill sets of overnight on-site call doctors and the quality of patient care [See Para 1411 item (b)]

c) HA to consider continuing to collaborate with the Hong Kong Academy of Medicine in evaluating the impacts of work reform on the standard of doctors' training in the post-pilot period [See Para 1411 item (c)]

D Targeted Deployment of Resources

029 HA to consider prudently utilizing the frugal healthcare resources in reconfiguring its hospital services, enhancing the service quality and improving the morale of healthcare personnel, while taking into account equity, right incentives and service sustainability in the long term [See Para 1511 item (a)]

030 Realizing the financial stringency under the current financial turmoil, HA to consider appropriate resource injection and manpower deployment in the light of the need and the scale of launching various work reform strategies in different public hospitals [See Para 1511 item (b)]

031 HA to consider continuing to explore a sound and appropriate enhanced honorarium system in order to recognize the excess work hours or overnight on-site calls of doctors in a broad-brush and nominal approach and deter over-rostering of doctors and self-generating overwork – This could be supplemented by the established special honorarium system to recognize frontline doctors' contribution to ad hoc clinical activities [See Para 1511 item (c)]

Steering Committee on Doctor Work Hour
Hospital Authority
26 February 2009

Annex

Interim Outcome at a Glance
Doctor Work Reform, Hospital Authority

I. Overview of Pilot Reform Outcome

- Quality of care improved
- Safe care
- Reduced workloads of doctors
- Enhanced training on core competency of doctors and nurses
- Improved doctor work hour in some clinical specialties

II. Pilot Doctor Work Reform Strategies

A1 Deployment of Doctors to Pressurized Areas

- Additional funding of $31 million in 2007/08 and $77 million in 2008/09 to create a total of 348 new posts for Doctor Work Reform related programmes
- Net increase of 96 doctors in specialties with prolonged work hour issues

Specialty	Aug 2006	Aug 2007	Aug 2008	2008 vs 2006
Neurosurgery	77	77	87	+10 (+13%)
Surgery	455	470	484	+29 (+6%)
Obstetrics & Gynaecology	211	218	221	+10 (+5%)
Paediatrics	308	319	320	+12 (+4%)
Medicine	1,127	1,139	1,157	+30 (+3%)
Orthopaedics & Traumatology	301	306	306	+5 (+2%)
All specialties	5,041	5,122	5,245	+204 (+4%)
	2006/07	**2007/08**	**2008/09 (Projected)**	
Doctors leaving HA	302	310	274	

A2 Re-engineering of Emergency Operating Theatre (EOT) Service

- Utilization ratio of emergency operating time at night (22:00 hours till 08:00 hours the next day) against total reduced by 14% – 45% (2Q08 vs 2Q07)

A3 Establishment of Emergency Medicine Wards (EMWs)

- Standardized acute patient days (workload) reduced by 3%-26%
- Standardized acute admissions to Medicine specialty reduced by up to 6.5%
- Patient survey showing 273 out of 300 discharged patients from the 3 pilot EMWs (91%) agreed that EMW service improved the quality of care in terms of timeliness of service and shortened hospital stay

A4 Introduction of Care Technician Service

- Around 11,000 doctor hours / month saved by the care technician teams (91 care technicians) providing round-the-clock blood-taking, electrocardiogram and intravenous cannulation in 6 pilot hospitals, thereby allowing on-site call doctors to refocus their time on core clinical care processes

Other Supportive Reform Programmes

1. Common Ward Language

- Phased implementation in 6 hospitals with progress put under scrutiny

2. Enhanced Core Competency of Healthcare Professionals

- Pilot cluster-based training conducted to enhance the core competency of around 40 basic surgical trainees from three hospital clusters in the Kowloon Region in November 2008
- Commissioned training programmes organized in June and November 2008 to enhance the clinical skills of 200 experienced nurses with positive response with a local trainer team of 10 built

3. Electronic Handover System

- Trial version of electronic handover system to be implemented at 3 selected hospital sites in the first quarter of 2009 with subsequent evaluations and refinements

4. Monitoring of Doctor Work Hour

- A Central Doctor Work Hour Monitoring System being set up with a locally developed doctor work hour calculator to facilitate doctor work hour capturing and management reporting

5. Extra Staff Protection

- HA's employee compensation extended to cover employees traveling for called-back duties beyond their normal duty hours for extra protection

III. Impacts on Doctor Work Hours

- Pilot reform sites : Varying degrees of success in revamping the conventional on-site call system and reducing doctors' continuous (e.g. from 28/29 hrs to 14/16 hrs) and average weekly work hours (i.e. from over 65 hrs/wk to fewer than 65 hrs/wk) in certain clinical specialties piloting Doctor Work Reform
- Non-pilot sites : Some success in reducing doctor work hours in certain clinical specialties through determined clinical leadership and a cultural change in accepting pragmatic ways of revamping the on-site call system