Motion on
"Establishing an Independent Statutory Office
of the Health Service Ombudsman"
moved by Hon Andrew CHENG Kar-foo
at the Legislative Council Meeting on 30 November 2011

Progress Report

Purpose

This report sets out the actions taken by the Administration in respect of the captioned Motion. The Motion carried by the Legislative Council is enclosed at Annex.

Progress

2. The Government attaches great importance to the quality of healthcare services and patient safety. Having an effective mechanism for handling medical incidents and medical complaints is an integral part of quality patient care. Currently, patients have various channels to express their dissatisfaction with medical services. These channels include lodging complaints directly to medical institutions or regulatory bodies of the professions concerned. Depending on the nature of complaints or medical incidents, patients can also lodge their complaints to the Office of the Ombudsman or take legal actions. Continuing efforts are under way to enhance the quality of our healthcare services and to ensure patient safety.

Report of medical incidents in public hospitals

3. HA has put in a place a mechanism and guidelines for medical and health staff to report medical incidents and take follow-up actions timely and properly.

4. In October 2007, with reference to international practice, HA implemented the Sentinel Event Policy to make mandatory the reporting of nine categories of incidents, with standardized definition of sentinel events and process for their reporting, investigation and management in the public hospitals. HA further improved the reporting mechanism in

January 2010 by mandating the reporting of two additional categories of serious untoward events, namely, medication error and misidentification that could have led to death or permanent harm.

5. Under the Policy, public hospitals are required to report all sentinel and serious untoward events to the HA Head Office within 24 hours. The hospitals are also required to handle the incidents in accordance with established procedures to minimize harm and provide necessary support to patients, family and staff involved.

6. Each and every sentinel event and serious untoward event will be investigated by an expert panel. The hospital involved will submit a report on the incident to the HA Head Office within eight weeks' time. Improvement measures will be implemented at the hospital level to avoid recurrence of similar incidents, while the HA Head Office will coordinate the implementation of improvements on systems and work procedures at corporate level as appropriate.

Review of clinical governance structure in HA

7. Since its establishment, HA has established a clinical governance structure for safeguarding the standard of care and sustaining improvement of service quality and professional accountability.

8. For medical services, HA adopted the Clinical Management Team and Chief of Service (COS) framework to emphasize specialist-led services and peer review of clinical competency. The specialists in clinical departments are responsible for providing training, guidance and direct supervision to junior doctors for maintaining professional standards. The COS of each clinical department is accountable for upholding clinical service quality in the department and reports to the top management of the hospital.

9. HA has also set up Quality and Safety (Q&S) teams in clusters and hospitals to promote patient safety culture among clinical staff and implement programmes to reduce risk and enhance service quality. When a medical incident is reported, the Q&S team of the relevant cluster will take necessary action to assess the risk, support investigation of the incidents and coordinate communication with internal and external

stakeholders.

10. To further enhance clinical governance of public hospitals and ensure patient safety, the Secretary for Food and Health has tasked HA to conduct a review of its clinical governance system with reference to international best practices and to identify room for further improvement. The review will commence in early 2012.

Handling of medical incidents and complaints in private hospitals

11. Under the sentinel event reporting system of Department of Health (DH), all private hospitals are required to report to DH medical incidents falling into specific categories of sentinel events within 24 hours of occurrence, and to submit a detailed report on the incident to DH within four weeks. Private hospitals are also required to develop their own policies and mechanisms to identify, report and manage sentinel events and take prompt actions to ensure that the safety and well-being of patients are safeguarded.

12. DH also requires private hospitals to put in place a mechanism for handling complaints. Upon receipt of a complaint against a private hospital, DH will investigate into the case and request the management of the hospital concerned to provide explanation and give an account of its handling of the complaint. Private hospitals will be required to take appropriate actions if management problems are identified.

Hospital Accreditation

13. To further improve hospital service quality and uphold patient safety, the Government launched in 2009 a Pilot Scheme on Hospital Accreditation. A set of common hospital accreditation standards for measuring the performance of both public and private hospitals in Hong Kong has been developed. By end 2011, five public hospitals and seven private hospitals[1] were awarded full accreditation. With the successful implementation of the Pilot Scheme, the Government is supportive of

[1] The five public hospitals are Pamela Youde Nethersole Eastern Hospital, Queen Elizabeth Hospital, Caritas Medical Centre, Tuen Mun Hospital and Queen Mary Hospital; the seven private hospitals are Hong Kong Sanatorium & Hospital, Shatin International Medical Centre Union Hospital, Hong Kong Baptist Hospital, Hong Kong Adventist Hospital, Tsuen Wan Adventist Hospital, Matilda Hospital and Canossa Hospital (Caritas).

rolling out the hospital accreditation scheme to more Hong Kong hospitals. HA will be implementing the Phase II Hospital Accreditation programme in 15 public hospitals in the coming five years.

Strategic Review on Manpower Planning and Professional Development

14. In Hong Kong, the medical and healthcare professions are regulated by the respective independent statutory bodies under the principle of professional autonomy. The regulation covers registration, practising qualifications, practising conduct, professional ethics and disciplinary matters of the healthcare professions. These statutory bodies are also responsible for handling complaint cases, conducting disciplinary inquiries and imposing disciplinary sanctions.

15. To ensure the healthy and sustainable development of our healthcare system, the Government has set up a high-level steering committee to conduct a strategic review on manpower planning and professional development. The first meeting of the Steering Committee was held in January 2012. The assessment of manpower and professional development needs aside, the review will also cover the regulatory frameworks for the healthcare professions and mechanisms for upholding professional standards and maintaining continuing competence. The Steering Committee will put forth recommendations on how to cope with the anticipated demand for healthcare manpower, strengthen professional training and facilitate professional development having regard to the findings of the strategic review.

Food and Health Bureau
February 2012

(Translation)

Motion on
"Establishing an independent statutory Office of the Health Service Ombudsman"
moved by Hon Andrew CHENG
at the Council meeting of 30 November 2011

Motion as amended by Dr Hon PAN Pey-chyou, Hon Paul CHAN and Hon CHAN Hak-kan

That, with the increasing needs and pressure of public and private health services in Hong Kong, medical incidents in public and private health services have occurred frequently in recent years, but there is a current lack of a uniform, credible and highly transparent mechanism for handling health service complaints from members of the public, causing the public to feel helpless; in this connection, this Council urges the Administration to, without violating the principle of professional autonomy, establish an independent statutory Office of the Health Service Ombudsman to ensure that complaints targeting at health service are properly handled and transparency in the handling of complaints is enhanced, thereby improving the quality of health service; the functions of the Office should include:

(a) to centralize the receipt of public complaints against all public and private health service providers registered in Hong Kong;

(b) to conduct investigations into the complaints received, with statutory powers to request the relevant parties to provide related information, such as medical files and internal investigation reports, for facilitating investigations, and inform the complainants and the parties under complaint of the investigation results within a reasonable time frame;

(c) to assist complainants in obtaining independent professional advice on their cases;

(d) to assist the two sides in communicating with each other on an equal footing, and to conduct conciliation and handle compensation matters with their mutual consent;

(e) to provide complainants in need with information about further actions on ascertaining liability through judicial means as well as professional liability proceedings and investigation, and offer reasonable assistance to complainants for instituting such procedures;

(f) to regularly announce to the public the statistics on complaint cases and the handling of medical complaints, so as to enable the public to know the trend of complaints about health services; and

(g) to promote civic education to enable the public to understand the causes of medical incidents and complaints, so as to deepen public awareness of health service risks, and prompt health service providers to improve the quality of health services;

at the same time, the Administration should review the composition of the Medical Council of Hong Kong, consider introducing the participation of more independent lay members of credibility to enhance the strength of public monitoring and safeguarding public interest, and consider raising the proportion of lay member participation in handling complaint cases regarding misconduct in a professional respect, so as to further ensure that the investigation into and the handling methods and procedures for such cases are fair, just and impartial; the Administration should also study establishing an emergency financial assistance mechanism for medical incidents modelled on the Traffic Accident Victims Assistance Scheme, so as to offer timely assistance to families with financial difficulties arising from medical incidents.