立法會
Legislative Council

LC Paper No. CB(2)1101/15-16
(These minutes have been seen by the Administration)

Ref : CB2/PL/HS

Panel on Health Services

Minutes of meeting
held on Monday, 21 December 2015, at 4:30 pm
in Conference Room 2 of the Legislative Council Complex

Members present	:	Prof Hon Joseph LEE Kok-long, SBS, JP, PhD, RN (Chairman) Hon Albert HO Chun-yan Hon Vincent FANG Kang, SBS, JP Hon WONG Ting-kwong, SBS, JP Hon CHAN Kin-por, BBS, JP Hon CHEUNG Kwok-che Hon Albert CHAN Wai-yip Hon YIU Si-wing, BBS Hon CHAN Han-pan, JP Hon Alice MAK Mei-kuen, BBS, JP Dr Hon KWOK Ka-ki Dr Hon Fernando CHEUNG Chiu-hung Dr Hon Helena WONG Pik-wan Hon POON Siu-ping, BBS, MH
Members absent	:	Dr Hon LEUNG Ka-lau (Deputy Chairman) Dr Hon Elizabeth QUAT, JP Hon Christopher CHUNG Shu-kun, BBS, MH, JP
Public Officers attending	:	Items III to V Prof Sophia CHAN Siu-chee, JP Under Secretary for Food and Health

Item III

Mr Chris SUN Yuk-han, JP
Head, Healthcare Planning and Development Office
Food and Health Bureau

Dr Cindy LAI Kit-lim, JP
Deputy Director of Health

Dr Amy CHIU Pui-yin, JP
Assistant Director of Health

Item IV

Miss Linda LEUNG
Principal Assistant Secretary for Food and Health (Health)2

Dr CHEUNG Wai-lun
Director (Cluster Services)
Hospital Authority

Ms Clara CHIN
Director (Finance)
Hospital Authority

Dr HUNG Chi-tim
Cluster Chief Executive, New Territories East Cluster
Hospital Authority

Item V

Miss Linda LEUNG
Principal Assistant Secretary for Food and Health (Health)2

Dr Rebecca LAM
Chief Manager (Patient Safety & Risk Management)
Hospital Authority

Vivien CHUANG
Associate Consultant, Chief Infection Control Officer Office
Hospital Authority

Clerk in attendance : Ms Maisie LAM
Chief Council Secretary (2) 5

Staff in attendance	:	Ms Janet SHUM Senior Council Secretary (2) 5 Ms Priscilla LAU Council Secretary (2) 5 Ms Louisa YU Legislative Assistant (2) 5

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I. Information paper(s) issued since the last meeting
[LC Paper No. CB(2)439/15-16(01)]

Members noted that a referral from the Public Complaints Office of the Legislative Council ("LegCo") Secretariat on the policy and regulation for tobacco control had been issued since the last meeting.

II. Items for discussion at the next meeting
[LC Paper Nos. CB(2)470/15-16(01) and (02)]

2. Members agreed to receive a policy briefing by the Secretary for Food and Health on the Chief Executive's 2016 Policy Address in respect of the portfolio of health services at the next regular meeting scheduled for 18 January 2016 at 4:30 pm. Members also agreed to discuss the item "An update on public hospital development" at the next regular meeting.

III. Proposed creation of two supernumerary directorate posts in the Department of Health for the review of regulation of private healthcare facilities
[LC Paper No. CB(2)470/15-16(03)]

3. Under Secretary for Food and Health ("USFH") briefed members on the proposed creation of two supernumerary directorate posts in the Department of Health ("DH") for three years, namely, one Consultant (D4/D3/D2) post to head the new Office for Regulation of Private Healthcare Facilities ("ORPHF") and one Principal Medical and Health Officer ("PMO") (D1) post (i.e. PMO(PHF)2) to head the new Planning and Development Section under ORPHF, details of which were set out in the Administration's paper (LC Paper No. CB(2)470/15-16(03)).

The new regulatory regime for private healthcare facilities

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Objective of and way forward for the review

4. Noting that a major function of the new ORPHF was to support the legislative exercise to revamp the regulatory regime for private healthcare facilities ("PHFs"), Mr YIU Si-wing asked whether the new regulatory regime would take into account that the future introduction of the Voluntary Health Insurance Scheme ("VHIS") would facilitate a greater use of private healthcare services as an alternative to public services. Mr Albert CHAN sought clarification as to whether the new regulatory regime was aimed to facilitate the introduction of more public-private partnership initiatives and VHIS. Mr WONG Ting-kwong enquired about the way forward pursuant to the public consultation on regulation of PHFs which ended in March 2015. Pointing out that the existing Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165) and Medical Clinics Ordinance (Cap. 343) had undergone no substantive amendments since 1960s, Dr Fernando CHEUNG urged for the early implementation of the proposed new regulatory regime for PHFs.

5. USFH advised that to meet the public demand and better safeguard public health, the Government had conducted a root-and-branch review of the regulatory regime for PHFs with a view to strengthening regulation and enhancing standards. The proposed new regulatory regime for the three classes of PHFs (i.e. private hospitals, ambulatory facilities providing high-risk medical procedures and medical clinics operated by incorporated bodies), which comprised a host of requirements pertaining to corporate governance, clinical quality, price transparency, etc. with a view to, among others, enhancing consumers' confidence in using private healthcare services, had received broad public support. Mr Albert HO sought elaboration as to whether the new regulatory regime would contribute to enhancing protection for consumers against unscrupulous medical groups operated by non-medical investors or managers in the form of incorporated bodies. Assistant Director of Health ("ADoH") responded that facilities providing medical services under the management of incorporated bodies would be subject to regulation under the new regulatory regime for PHFs.

6. Noting from the Consultation Document on Regulation of PHFs that the original plan of the Administration was to introduce the relevant bill into LegCo in the current legislative session, Dr Fernando CHEUNG asked whether the Administration had confidence in forging consensus amongst the stakeholders and introducing the bill into LegCo in the 2016-2017 legislative session according to its latest schedule. USFH advised that the Administration would endeavour to introduce the bill into LegCo in the 2016-2017 legislative session.

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Regulation of private hospitals

7. Mr Albert HO asked whether the setting of the regulatory standards for services of private hospitals would make reference to that of public hospitals or international best practices. ADoH responded that the review sought to align the regulatory regime with international best practices, with local adaptation on the advice of professional bodies such as the Hong Kong Academy of Medicine ("HKAM"). In response to Dr Fernando CHEUNG's enquiry about whether private hospitals would be required to participate in hospital accreditation in the long run under the new regulatory regime, USFH replied in the positive.

8. Mr CHAN Kin-por expressed support for revamping the regulatory framework for PHFs. Noting that the Planning and Development Section of the new ORPHF would review the existing Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes ("CoP") in keeping with the enhanced regulation of private hospitals, he asked whether the new regulatory regime would provide legal backing and penalties for the new CoP to achieve a deterrent effect. USFH responded that private hospitals failing to comply with the regulatory requirements would be subject to sanctions commensurate with the seriousness of the offence.

9. Mr CHAN Kin-por was of the view that while the new regulatory regime for PHFs included various measures to enhance price transparency, they alone could not lead to a reduction in the price level of private hospital services if medical inflation was not well managed through increasing the number of private hospital beds and healthcare manpower supply. Miss Alice MAK expressed a similar view, adding that the development of more non-profit making private hospitals, such as the Chinese University of Hong Kong Medical Centre ("CUHKMC"), could provide the public with more choices of high quality private hospital services.

10. USFH advised that the proposed regulatory requirements that private hospitals had to provide fee schedules and quotations, offer, where available, recognized service packages to patients and disclose historical bill sizes statistics could enhance price transparency of private healthcare services. In addition, the expansion and redevelopment projects of existing private hospitals and the new private hospital developments would help enhancing private healthcare capacity in the coming years. The review conducted by the Steering Committee on Manpower Planning and Professional Development ("the Steering Committee"), which was expected to be completed in the first half of 2016, would shed light on ways to ensure an adequate supply of healthcare professionals for meeting future healthcare needs. Mr CHAN Kin-por remarked that the expected increase in the

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number of private hospital beds was far from adequate to achieve a significant reduction in the price level of private hospital services.

11. Miss Alice MAK asked whether the new regulatory regime would strengthen the power of the regulatory authority to investigate complaints and medical incidents relating to private hospitals. ADoH advised that it was proposed that a two-tier complaints handling system with an Independent Committee on Complaints against Private Hospitals be set up under the new regulatory regime to handle complaints lodged by the public against the service of private hospitals and against how complaints were handled by private hospitals, and private hospitals would be required to establish a comprehensive sentinel events management system.

Regulation of ambulatory facilities providing high-risk medical procedures

12. Dr KWOK Ka-ki expressed support for enhancing regulation of PHFs. He, however, considered that the new regulatory regime should provide for a licensing system for beauty services companies providing high-risk medical procedures for beauty purpose.

13. USFH stressed that most of the practices of the beauty industry were non-intrusive and involved no or very little health risks that called for direct regulatory intervention. USFH and ADoH added that the new regulatory regime would provide for a statutory registration system for ambulatory facilities providing high-risk medical procedures, such as endoscopy, which were currently not covered under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance and the Medical Clinics Ordinance. The Administration planned to introduce an administrative listing system for these facilities before statutory registration came into effect. In addition, it was proposed that high-risk procedures would be required to be performed only in regulated ambulatory facilities or hospitals by qualified health professionals. The regulated ambulatory facilities would be subject to a set of core facility standards and requirements that covered the management of the facility, physical conditions, service delivery and care process, infection control and resuscitation and contingency.

14. Mr Albert HO considered that the new regulatory regime should enhance DH's role in monitoring illegal practice of medicine. Dr KWOK Ka-ki sought information about the enforcement actions taken by DH under the existing legislative framework against those beauty services companies improperly providing high-risk medical procedures.

15. ADoH advised that DH had issued advisory note to the beauty industry, advising providers to refrain from performing those procedures classified as medical treatment if they were not themselves registered

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medical practitioners or registered dentists. It had also stepped up public education on the risks involved in cosmetic procedures via various media channels. During the period of October 2012 to 14 December 2015, DH had screened more than 30 000 advertisements, which involved some 2 000 advertisements from about 100 beauty services companies, relating to the provision of cosmetic procedures with potential safety concerns. A total of 18 cases of suspected illegal medical or dental practice related to beauty services had been referred to the Police for further investigation. Two of the cases had pleaded guilty so far. These apart, DH had followed up on cases referred to by the Consumer Council in relation to complaints on adverse effects arising from cosmetic procedures since October 2012. A total of 116 cases had been referred to DH in this regard. In addition, from October 2012 to December 2015, DH issued more than 700 warning letters against advertisements of beauty centres that had contravened the Undesirable Medical Advertisements Ordinance (Cap. 231). It should be noted that the Customs and Excise Department would also take enforcement actions against beauty centres engaging in unfair trade practices under the Trade Descriptions Ordinance (Cap. 362).

Proposed directorate and non-directorate support for ORPHF

16. Mr WONG Ting-kwong sought elaboration about the reason why the new ORPHF and its Planning and Development Section, which would support DH in the legislative exercise on regulation of PHFs, had to be headed by medical professionals. Dr Fernando CHEUNG raised a similar enquiry. Mr Albert CHAN said that he did not see the need that holders of the two proposed supernumerary directorate posts had to be medical professionals. In his view, non-medical personnel with ample administrative or healthcare services management experiences, such as Administrative Officers or chief executive of private hospitals, could be right persons for the two posts. Dr Helena WONG considered that high calibre non-medical personnel who were rich in local or overseas hospital management experience could take up the positions.

17. USFH advised that expertise on the subject was required, as the two post holders would need to provide professional input in ironing out the regulatory standards required of PHFs through engagement with various stakeholders, such as HKAM, so as to ensure that the legislative exercise and the relevant preparatory work could be completed smoothly. Dr Fernando CHEUNG urged the Administration to engage patient groups in working out the regulatory details. USFH responded that the Administration would take into account the views expressed by patient groups during the consultation exercise in mapping out details of the new regulatory regime. Mr Albert CHAN and Dr Helena WONG said that they remained unconvinced of the

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justifications provided by the Administration so far. Mr Albert CHAN said that he would object the staffing proposal.

18. Noting that the time-limited PMO post holder would mainly be responsible for assisting in the legislative exercise, implementing interim measures and undertaking preparatory work for the new regulatory regime of PHFs, Dr KWOK Ka-ki asked whether it would be necessary to retain the post after 2018-2019. Referring to the Administration's proposal to create 20 additional non-directorate civil service posts for the new ORPHF for three years till 2018-2019, Mr POON Siu-ping asked whether these posts would, in addition to the 40 existing non-directorate staff of ORHI who would be transferred to the Licensing Section of the new ORPHF, become part of the permanent establishment of ORPHF after the three-year period.

19. Deputy Director of Health ("DDoH") advised that the Administration would review the workload and consider the manpower needs and the future operation mode of ORPHF in 2018-2019 in accordance with the established procedures. On the responsibilities of the PMO post holder, DDoH advised that other than providing professional and research inputs to the legislative exercise, the post holder would need to liaise with relevant stakeholders in developing the regulatory standards and assist PHFs previously not under regulation in getting ready for the new regulatory requirements in order to ensure smooth transition from the existing regulatory regime to the revamped regime. In response to Miss Alice MAK's enquiry about whether the 20 additional non-directorate civil servants would conduct inspection against PHFs, ADoH advised that the Licensing Section of the new ORPHF, which was in essence the existing ORHI, would continue to oversee the existing licensing and inspection functions.

Conclusion

20. The Chairman concluded that the majority of Panel members were supportive of the Administration's submission of its proposal to create one Consultant post and one PMO post in DH for three years to the Establishment Subcommittee for consideration.

[Note: At this juncture, the Chairman informed members of his decision to extend the meeting for 15 minutes beyond its appointed time to allow more time for discussion.]

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IV. Hospital Authority's private patient services
[LC Paper Nos. CB(2)470/15-16(04) and CB(2)1907/14-15(04)]

21. Members noted the paper provided by the Administration (LC Paper No. CB(2)470/15-16(04)) and the background brief prepared by the LegCo Secretariat (LC Paper No. CB(2)1907/14-15(04)) on the subject under discussion.

Rationale for the provision of private patient services at public hospitals

22. Dr KWOK Ka-ki was of the view that the provision of private patient services at public hospitals would adversely affect the public healthcare services. Dr Helena WONG said that she did not see the rationale for providing private patient services in public hospitals which were financed by public funds. She queried whether there was a call from the affluent class for the provision of these services by the Hospital Authority ("HA") to obviate their need to wait in the long queue for public healthcare services and to provide them with a choice of doctor, or there was a call from doctors of HA for them to earn additional income through the provision of private patient services at public hospitals.

23. USFH explained that the practice of providing private patient services at public hospitals could be traced back to the time of the former Medical and Health Department and continued in HA after its establishment in 1990. The main rationale for the provision of private patient services at public hospitals was for the public to access, by means of such services, specialized expertise and facilities in the public healthcare sector, notably in the two teaching hospitals (i.e. the Queen Mary Hospital ("QMH") affiliated with the University of Hong Kong ("HKU") and the Prince of Wales Hospital ("PWH") affiliated with the Chinese University of Hong Kong ("CUHK")), which were not generally available in the private sector. Director (Cluster Services), HA ("D(CS), HA") supplemented that the charges for private patient services in HA were set on the higher of cost or market price. Hence, the provision of private patient services at public hospitals on a small scale would provide an alternative to those affordable patients who wished to remain in the public healthcare system to seek consultation from HA doctors of their choice, thereby optimizing the resources for the highly subsidized public healthcare services. The waiting time of individual private clinics would depend on the supply of and demand for the services concerned. Given that the number of patients waiting for private services was smaller than that for public services, the waiting time for the former would be shorter.

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24. Dr Helena WONG remained unconvinced and urged the Administration to review the practice of providing private patient services at public hospitals, which were available for both local residents, or referred to as eligible persons in the context of fee-charging by HA, and non-eligible persons. Holding the view that HA's primary role should be a public healthcare service provider for the underprivileged, Dr Fernando CHEUNG considered that private patient services should only be provided in public hospitals if they were proved to be of value to the teaching and research of the clinical professors concerned. He expressed concern that there were views from private hospitals that HA should not compete with them by providing private patient services in public hospitals. In addition, there was a media report in August 2015 that the emergency surgery at QMH had been unduly affected due to the deployment of an HA doctor by a clinical professor of HKU for the performance of an elective surgery for a private patient.

25. D(CS), HA advised that HKU and CUHK ("the two Universities") and HA had set up a Private Service Review Working Group ("the Working Group") in 2014 to, among others, identify priority areas for improvement in the administration of private services. In particular, the Working Group agreed that there was a need to make it clear that the offering of private patient services at the two teaching hospitals should strictly be based on the rationale for the public to access, by means of these services, specialized expertise and facilities in the public healthcare sector which were not generally available in the private sector. In response to the Chairman's enquiry, D(CS), HA advised that other than the two teaching hospitals, private patient services at other HA hospitals were of an even smaller scale. The private patient services at the Queen Elizabeth Hospital mainly served the civil service eligible persons who were entitled to private inpatient accommodation by HA at a specific fee and charges.

26. Mr POON Siu-ping noted that the total number of private beds in public hospitals was capped at no more than 379 beds, which represented 1.37% of HA's total number of beds. He asked whether HA had any plan to turn these private beds to general beds given the foreseeable increase in the capacity of private hospital services with the development of CUHKMC which would be a non-profit making private hospital.

27. Mr YIU Si-wing held another view, adding that the continuous provision of private patient services in public hospitals could help to relieve some pressure on public healthcare services. Referring to a case whereby an HA patient with chronic disease had difficulty to obtain referral from the clinical professor concerned for transferring to private ward even the patient found the private services affordable and wished to use those services, and given the fact that private bed-days only stood at 0.6% of total bed-days in

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HA in 2013-2014 and 2014-2015, he enquired about the reason why HA adopted such a high threshold for providing private inpatient services.

28. D(CS), HA responded that at present, only 299 out of the 379 private beds in public hospitals were in use and the utilization rate of these beds was 60%. The reduction in the supply of private beds and the low utilization rate was partly due to the reason that measures would be put in place by HA to reduce the private ward services during influenza peak seasons, so that healthcare personnel could focus on serving public patients in need. The number of private beds to be provided by HA in the future would depend on the relevant demand from members of the public. D(CS), HA added that patients of HA who wished to receive private inpatient services provided by designated clinical doctors or professors had to obtain prior consent of the clinical doctors or professors concerned. As regards those cases without designation of attending doctors, the availability of private inpatient services would depend on the number of private beds available for use.

Impact on public healthcare services

29. Dr KWOK Ka-ki expressed concern that the arrangement to allow clinical professors of the two Universities, who were appointed as honorary staff of HA for their practice on public patients in the two teaching hospitals, to conduct private clinical practices would result in their having less time devoted to public patients and in turn created heavier workload for other doctors, in particular junior doctors, employed by HA. Miss Alice MAK asked whether mechanism was in place to ensure that the waiting time for public healthcare services at HA hospitals would not be prolonged as a result of the provision of private patient services.

30. USFH responded that there was no cause for such concern, as clinical professors of the two Universities were allowed to provide private patient services in accordance with a set of formal governance and management procedures. There was a limit on the number of sessions (or hours of work) that the clinical professors were permitted to conduct private clinical practices. D(CS), HA supplemented that to HA's understanding, it was the requirement of the two Universities that the time spent by their clinical professors on private clinical practices should not exceed the equivalent of one working day per week. It should be noted that HA and the two Universities, which were funded by Government recurrent subventions under different heads of expenditure, had both been contributing resources to the two teaching hospitals. In particular, the two Universities had to assume responsibilities in the areas of clinical services, teaching and research. Past studies revealed that clinical professors of the two Universities would spend about 55% of their time on clinical services, and about 45% of their time on teaching and research.

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31. As regards the internal control measures to govern the provision of private patient services at public hospitals, Cluster Chief Executive, New Territories East Cluster, Hospital Authority ("CCE(NTEC), HA") advised that the relevant Heads of Department of HA would monitor the time spent by staff of HA as well as honorary staff from the two Universities on private patient services and public clinical services. The clinical professors were also required to report their time and place of private practices to the medical faculty concerned. Dr KWOK Ka-ki cast doubt about the effectiveness of the above measure, as the Heads of Departments of HA might also be clinical professors of the two Universities providing private patient services at public hospitals. CCE(NTEC), HA clarified that many Departments of PWH were currently headed by doctors of HA. In addition, participation in private services by honorary staff from the two Universities required not only the approval of the Faculty Deans of the two Universities, but also that of the Hospital Chief Executive concerned.

Fees and charges for private services in HA hospitals

32. Miss Alice MAK sought information about the setting of fees and charges for private services in HA hospitals, including whether the charge for blood tests was at the level of about $2,000. D(CS), HA advised that the fees and charges for private services in HA hospitals, which were abided by the Gazette, were set on the higher of cost or market price for the respective services. The cost of private consultations in public hospitals could be attributed to two main factors, namely, the level of medical expertise required in the provision of the service and the complexity of the patients' clinical conditions. As regards blood tests, the charges varied according to the complexity of the tests.

33. Noting that an income of $349 million and $379 million was generated from private patient services in HA in 2013-2014 and 2014-2015 respectively, Mr POON Siu-ping sought information about whether there was default on payment by private patients. D(CS), HA advised that to minimize default, private patients of non-emergency cases were required to pay a deposit upon admission. During their hospitalization, interim bills would be issued to the patients concerned on a weekly basis. Those patients who did not settle the fees would be transferred to general wards. Director (Finance), HA supplemented that the amount of payments for private services in default was $0.7 million in 2014-2015, representing about 0.2% of the total charges for private services in HA in that year.

Income sharing between HA and the two Universities

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34. Dr KWOK Ka-ki considered that the fee sharing arrangement between the two Universities and HA for consultation and procedures involved in private patient services provided at public hospitals, which was at the ratio of 75:25, should be reviewed given the contribution of HA in providing the relevant facilities for the services. He surmised that at present, some clinical professors might earn an annual income of $4 million from the provision of such services.

35. USFH advised that for the provision of supporting services for private patients at public hospitals, such as radiology investigation and laboratory tests, the revenue generated was shared by the University concerned and HA in the ratio of 25:75. D(CS), HA supplemented that there was room for review of the above fee sharing arrangement between the two Universities and HA, which had been adopted prior to the establishment of HA. However, the way the two Universities handled their shares of revenue from private services was outside the jurisdiction of HA.

Review on private patient services

36. Dr KWOK Ka-ki enquired about the timeframe for taking forward the five priority areas identified by the Working Group as set out in paragraph 14 of the Administration's paper for improving the administration of private patient services and the processing of related revenue in the two teaching hospitals. D(CS), HA advised that the recommendations of the Working Group would be considered by the Teaching Hospital Committee with a view to implementing the recommendations in early 2016. The Chairman requested the Administration to revert to the Panel on the way forward for implementing the recommendations of the Working Group.

[Note: At this juncture, the Chairman proposed and members agreed that the meeting be further extended for fifteen minutes.]

V. Patient safety management in HA

[LC Paper Nos. CB(2)470/15-16(05) and (06)]

37. Members noted the paper provided by the Administration (LC Paper No. CB(2)470/15-16(05)) and the background brief prepared by the LegCo Secretariat (LC Paper No. CB(2)470/14-15(06)) on the subject under discussion.

Resources and manpower of HA

38. Holding the view that the current medical manpower constraint of HA might be the root cause for some recent clinical incidents in public hospitals,

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such as the one on Alkaline Phosphatase reference range deviation at Tuen Mun Hospital ("the TMH incident"), Miss Alice MAK asked about the progress of the strategic review conducted by the Steering Committee. Mr Albert HO held the view that some clinical incidents were caused by the heavy work pressure and workload of frontline healthcare personnel. He urged HA to ensure that there was a reasonable establishment of healthcare personnel to maintain quality service. Dr KWOK Ka-ki considered that disparities in manpower as well as resource allocation due to sectarianism among hospital clusters, and the increase in the number of experienced doctors in HA switching to private sector had adversely affected patient safety, in particular surgical safety, in public hospitals.

39. USFH advised that the Steering Committee was expected to complete its review in the first half of 2016. In the meantime, it was expected that the medical manpower shortage problem would improve when the number of medical graduates started to go up to 420 in 2018. Apart from the supply of local medical graduate, the Administration had worked with the Medical Council of Hong Kong ("MCHK") on ways to facilitate more overseas-trained doctors to practise in Hong Kong. In addition, HA had in recent years introduced a number of measures to attract and retain its healthcare professionals. These included, among others, enhancement of promotion prospects and training opportunities, improvement of working conditions and re-employment of suitable retirees in grades and disciplines which were facing a severe staff shortage problem.

40. On the perceived sectarianism among hospital clusters, USFH advised that the action plan formulated by HA to follow up on the recommendations of the Steering Committee on Review of HA included, among others, strengthening the roles of the Coordinating Committees and that of the Chief of Service in clinical governance, arranging rotation among Cluster Chief Executives, and enhancing the central coordinating role of the HA Head Office in staff deployment within the organization when situation so warranted. Chief Manager (Patient Safety & Risk Management), HA ("CM(PS&RM), HA") assured members the various systems and procedures put in place by HA to ensure high clinical standards as set out in paragraphs 4 to 20 of the Administration's paper were applied across-the-board to all hospital clusters.

41. Mr POON Siu-ping asked how frequent the major domains for safety management as identified by HA would be subject to organization-wide risk assessment. CM(PS&RM), HA advised that risk assessment in respect of medication, surgical and device safety as well as infection control would be carried out by the committees and clinical departments concerned on a regular and need basis. Reference would be made to international trends in quality and safety management in conducting the risk assessment. For

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instance, HA's Central Coordinating Committee in Pathology had discussed measures to prevent recurrence of the TMH incident, which included, among others, the setting up of an electronic platform for cross-checking entries of the laboratory reference ranges to avoid transcription error. The above apart, the clinical management teams of public hospitals would regularly conduct clinical audits to ensure that any event affecting patient care would be looked into as appropriate.

42. Referring to a Serious Untoward Event in the North District Hospital in November 2015 whereby a patient who had been given an incorrect infusion rate of morphine infusion by a student nurse had subsequently died, Mr POON Siu-ping expressed concern about how the work of student nurses could be effectively monitored to ensure patient safety. USFH responded that student nurses of HA worked under the supervision of registered nurses and ward managers.

43. Mr Albert HO called on HA to allocate more resources to enhance its capacity in advanced diagnostic investigations to shorten the waiting time of patients in this regard, and improve access to 24-hour emergency percutaneous coronary intervention service which was currently mainly available in QMH.

44. USFH advised that the waiting time for diagnostic investigations would depend on the clinical conditions of individual patients. It should also be noted that the introduction of the Pilot Project on Enhancing Radiological Investigation Services through Collaboration with the Private Sector by HA had shortened patients' waiting time for cancer radiological investigation services. CM(PS&RM), HA supplemented that the availability of sufficient healthcare workforce was a pre-requisite for extending the operating hours of the percutaneous coronary intervention surgery service. At present, HA had piloted by phases to extend the operating hours of the service in the regional hospitals of the seven hospital clusters. At the request of the Chairman, the Administration was requested to provide after the meeting information on the timeframe for the provision of 24-hour emergency percutaneous coronary intervention service in all hospital clusters.

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Clinical incident management

45. Mr YIU Si-wing sought information about the respective proportion of clinical incidents in public hospitals which were caused by human errors and system and process factors. USFH responded that similar to overseas experience, local clinical incidents were mainly caused by system and process factors rather than mere human error. In response to Mr YIU Si-wing's enquiry about whether HA had set a target to reduce the number of clinical incidents, CM(PS&RM), HA stressed that given the complex healthcare settings, it would be difficult for hospitals to attain zero incidents.

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The objective of HA's Sentinel Event and Serious Untoward Events Policy was to, among others, avoid the recurrence of similar events in future through improvements to the relevant systems and work procedures.

46. Dr Fernando CHEUNG asked whether the Administration would consider setting up an independent body to handle medical incidents in both public and private sectors to ensure impartiality of the investigations. USFH responded that there was no cause for concern about the impartiality of the investigations conducted by HA, as the investigation panels concerned would comprise, among others, independent members and experts. HA would review and consider the appropriate follow-up actions having regard to the circumstances of individual cases, including, where appropriate, referring to MCHK for following up cases about professional conduct of registered medical practitioners. As regards private hospitals, the Administration had proposed in the Consultation Document on Regulation of PHFs that private hospitals should establish a comprehensive sentinel events management system to strengthen internal quality assurance.

Monitoring the performance of service contractors

47. Referring to the incident in QMH whereby the patient linen items supplied by the Shum Wan Laundry Centre was confirmed as the source of the contamination, Miss Alice MAK called on HA to step up its efforts to monitor the performance of service contractors. CM(PS&RM), HA advised that HA had been, and would continuously be, doing so. At present, the operation of Shum Wan Laundry Centre had been suspended. HA would follow up with the service contractor of Shum Wan Laundry Centre on the liability issues in accordance with the contractual terms.

VI. Any other business

48. There being no other business, the meeting ended at 6:53 pm.

Council Business Division 2
Legislative Council Secretariat
16 March 2016