For discussion on
20 June 2016

LEGISLATIVE COUNCIL PANEL ON HEALTH SERVICES

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

PURPOSE

This paper informs Members of the progress of the Hospital Authority (HA) in implementing the recommendations of the Steering Committee on Review of HA. We also take this opportunity to provide supplementary information on HA's management of influenza.

BACKGROUND

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

3. In this connection, the Government established the Steering Committee on Review of HA in 2013 to conduct a comprehensive review of the operation of HA (the Review). The Review sought to explore viable measures for enhancing the cost-effectiveness and quality of the services of HA with a view to providing HA with increased capability to cope with the future challenges. The Steering Committee was chaired by the Secretary for Food and Health. Its members include healthcare professionals, academics and representatives from the welfare sector and patient groups.

4. The Steering Committee published its Report in July 2015 which sets out its findings and recommendations (a full list of the recommendations is at **Annex A**). We briefed Members on the Report (Ref: LC Paper No. CB(2)1907/14-15(01)) on 20 July 2015. We also informed Members of the Action Plan prepared by HA on the implementation of these recommendations (Ref: LC Paper No. CB(2)97/15-16(01)) in October 2015.

PROGRESS REPORT

5. HA plans to implement the recommendations of the Steering Committee within three years. To ensure timely implementation of the recommendations, we have asked HA to prepare regular progress reports. The first progress report prepared by HA in May 2016 is at **Annex B**.

6. In gist, HA has been making good progress in implementing the recommendations. A highlight of the progress is as follows –

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

To rationalise the organisation of service provision, HA is working to re-group Wong Tai Sin and Mong Kok from Kowloon West Cluster (KWC) to Kowloon Central Cluster (KCC) having regard to the supply and demand for healthcare services as well as the hospital development/redevelopment plan in the respective cluster. In essence, Kwong Wah Hospital, Wong Tai Sin Hospital and Our Lady of Maryknoll Hospital will be re-delineated from KWC to KCC. Administrative arrangements for the regrouping is targeted to take effect in December 2016, while budget provision for the three concerned hospitals originally under KWC will be transferred to KCC with effect from 1 April 2017. Re-organisation of care provision in the new KCC and associated changes in KWC will then be implemented by phases thereafter.

HA has engaged the District Councils of Wong Tai Sin, Yau Tsim Mong and Kowloon City in the process, and the District Councils are generally receptive to the re-delineation.

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

The refined population-based resource allocation model serves to enhance transparency and equity in resource management and provide useful information to support service planning. HA has commissioned an external consultancy to help develop and validate the refined population-based resource allocation model. The consultant team has started work in April 2016 and will work out a prototype for further deliberation in HA Board by the

third quarter of 2016. HA will consult stakeholders on the proposed model at the same time.

(c) Staff management and training (Recommendation 6)

HA has set up the Central Training and Development Committee (CTDC) under the Human Resources Committee in November 2015 to strengthen the role of the Board on the central planning and provision of training. CTDC has conducted four meetings since its establishment, and has reviewed the training proposals for 2016-17 and 2017-18, as well as the framework for grade-specific training curriculums for both clinical and non-clinical grades.

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

To address the problem of the particularly long waiting time in orthopaedics and traumatology SOPC, HA has explored the use of family medicine specialist clinics to help attend to routine cases through Low Back Pain clinic in 2015-16. HA plans to further develop the existing model in 2017-18. HA is also employing multi-pronged strategies such as undertaking conversion works to increase consultation rooms to improve the capacity and efficiency of SOPC services in other specialties.

(e) Coordination with relevant specialties to address the serious access block problem in A&E (Recommendation 8(b))

To better manage the access block problem, HA is developing a specific Key Performance Indicator to monitor the situation. HA Head Office is also working jointly with the cluster-based task forces in the two clusters with particularly serious access block problem (namely KCC and New Territories East Cluster) by providing assistance from both policy and resource aspects.

7. HA will continue to report progress on the implementation of the recommendations to the Government on a regular basis. The Government will closely monitor the implementation work to ensure that the recommendations are carried out in a timely manner.

SUPPLEMENTARY INFORMATION ON HA'S MANAGEMENT OF INFLUENZA

8. At the meeting of the Panel on 16 May 2016, the Panel Chairman requested the Administration to provide supplementary information on HA's management of influenza. The ensuing paragraphs set out the relevant information.

9. HA has put in place the clinical guidelines on Antiviral Therapy against Influenza since 2005. Regular reviews have been undertaken by HA with reference to the recommendations from international authorities (such as the World Health Organisation, and the Centres for Disease Control and Prevention). On 16 May 2016, HA conducted consultation through its Task Force on Clinical Management on Infection with infectious diseases experts in both paediatrics and adult medicine and confirmed that the guidelines remain valid. Antiviral treatment is recommended as early as possible for any patient with confirmed or suspected influenza who has severe, complicated, or progressive illness; or is at higher risk for influenza complications. Decisions about starting antiviral treatment should not wait for laboratory confirmation of influenza. This principle is consistent with the latest view of the Hong Kong Medical Association Advisory Committee on Communicable Diseases dated 18 May 2016.

10. HA maintains on average a stock of two-month consumption of antiviral drugs (including Tamiflu and Relenza) in all acute hospitals and general outpatient clinics. 24-hour pharmacy services are available in 11 acute hospitals, and overnight drug stock (including Tamiflu) is accessible during night time in the other five acute hospitals. Clinicians could seek assistance from the on-call pharmacists for drug supplies and other pharmacy support where necessary.

11. To enhance the service for urgent testing for severe influenza cases outside office hours, HA has designated two laboratories with 24 hours service in the Prince of Wales Hospital and Queen Mary Hospital to handle urgent requests starting from 6 June 2016. Reverse transcription – polymerase chain reaction (RT-PCR) test for Influenza A and B will be performed and the test result will be made available within 8 to 12 hours. Clinicians can request urgent RT-PCR test for influenza virus directly through the existing electronic platform. Samples from other hospitals outside office

hours (17:00 – 09:00) will be sent to the two designated centres for urgent test according to the referral arrangement at **Annex C**.

ADVICE SOUGHT

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

Food and Health Bureau
Hospital Authority
June 2016

Annex A

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

Management and Organisation Structure

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

Recommendation 1

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

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

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

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

Recommendation 2

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

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

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

etc.; and

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

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

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

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

Resource Management

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

Recommendation 3

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

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

Recommendation 4

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

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

Staff Management

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

Recommendation 5

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

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

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

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

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

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

Recommendation 6

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

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

Cost Effectiveness and Service Management

- ***Providing better services***

Recommendation 7

(a) The HA Board, being a managing board, should play a more active role in setting key standards and targets to –

(i) monitor the overall performance and service provision for public accountability; and

(ii) facilitate management decision to improve performance and drive best practices; and

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

Recommendation 8

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

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

Recommendation 9

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

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

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

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

Overall Management and Control

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

Recommendation 10

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

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

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

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

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

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

Annex B

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

Hospital Authority Action Plan – Progress Update (position as at 31 May 2016)

Strategic Goal & Target	Key milestones of individual action items
Recommendation 1	
The Hospital Authority (HA) Board, being the managing board, to play a more active role in leading and managing HA	• The Board continues to reinforce its leading and managing role on HA. Subject Directors/Heads are engaging the Executive Committee of the Board at early stages in formulation of strategies, directions and policies. The role and participation of the functional committees are strengthened in setting key standards, driving for best practices and monitoring performance. Actions are in hand to further strengthen the governance processes of the Board through proactive and forward agenda planning in the functional committees; and facilitating informed discussions and decisions by the Board/Committees. • To assist the Board in closely monitoring the implementation progress, the Management has arranged quarterly progress reports to the Executive Committee, followed by six-monthly progress report to the Board which would then be submitted to the Food and Health Bureau. In parallel, the respective subject officers will submit progress report to the relevant functional committees for advice and support as appropriate. The first half-yearly report was considered by the Board in April 2016.

Strategic Goal & Target	Key milestones of individual action items
Re-grouping of Wong Tai Sin (WTS) district and Mong Kok (MK) area, involving Kwong Wah Hospital (KWH), Wong Tai Sin Hospital (WTSH) and Our Lady of Maryknoll Hospital (OLMH) from Kowloon West Cluster (KWC) to Kowloon Central Cluster (KCC)	• The regrouping exercise needs to be supported by a number of service re-organisation initiatives in order to ensure that effective service integration, collaboration and networking can be achieved. To start with, active preparations are in progress to implement the associated administrative arrangements, which mainly involve change of cluster identity and line of accountability for the affected hospitals and staff, by December 2016. Non-clinical functional services in respect of Human Resources (HR), Finance, Information Technology (IT), procurement functions, etc for the affected hospitals will be transferred from KWC to KCC with effect from April 2017. Re-organization of care provision in the new KCC and associated changes in KWC will then be implemented by phases, depending on the readiness of the supporting functions and infrastructure. The phased approach is to ensure minimal disruption to patient services. Internal and external engagement and communication are underway, and will continue. The preliminary implementation plan on re-delineation of cluster boundary will be presented to the Board in June 2016 for comment. • In connection with the clinical service reorganization, demand and capacity gap analysis for the three Kowloon clusters is being conducted. Capacity gaps, taking into account completion of the re-developed and new hospital facilities in the Kowloon region, will be identified. Capacity building, where necessary, will be addressed through the annual planning exercises which may go beyond the three-year implementation timeframe set for the HA Review Action Plan. That said, concrete action plan is in place to guide and pursue the entire implementation process. • Results of the capacity-demand gap analysis for the Kowloon clusters will be presented to the Board in 3Q 2016. Similar analysis will be conducted for the remaining clusters in 1Q2017.

Strategic Goal & Target	Key milestones of individual action items
Interim measures for quick enhancement	• HA has rolled out catch-up improvement plan in Kowloon East Cluster (KEC), New Territories East Cluster (NTEC) and New Territories West Cluster (NTWC) by mobilising the additional three-year funding of $300 million to address known deficiencies in their service capacity. • Additional beds were opened in KEC (36 beds), NTEC (71 beds) and NTWC (122 beds including 40 convalescent beds) in 2015/16. Capacity will be further enhanced in the 3 clusters through subsequent annual planning exercises. • For enhancing services in WTS district, resources were allocated to improve the provision of medical services for residents of WTS District over the past three years, including enhancement of Computerized Tomography (CT) service and orthopaedic service in OLMH. In 2015/16, additional manpower and resources were allocated to WTSH. Resources were also allocated to OLMH in 2015/16 to enhance its endoscopy service and day service. Besides, the general outpatient service of OLMH has been augmented with the provision of service during public holidays. • Refurbishment of Hong Kong Buddhist Hospital is in progress. The target completion date is 3Q 2019. • A pilot project to rationalise the acute-rehabilitation service arrangement for Queen Elizabeth Hospital (QEH)/WTSH and KWH/Kowloon Hospital (KH) was implemented in early August 2015 where WTSH and KH have each designated medical rehabilitation beds for cases referred by QEH and KWH respectively. Under this new patient-flow arrangement, target patients from WTS and Yau Tsim Mong Districts can receive acute-rehabilitation services in hospitals under the same cluster. Outcome of this pilot cross-cluster service collaboration will be reviewed with a view to extending the arrangement. • Refinement of geographical boundaries for ambulance catchment areas through continuing review on the Kowloon ambulance catchment areas is ongoing.

Strategic Goal & Target	Key milestones of individual action items
Recommendation 2	
Set up a mechanism for selection of centres for provision of highly specialised services	• A Task Group on Mechanism for Introduction of Highly Specialized Services was set up. A preliminary framework on introduction of highly specialised services to HA was formulated and the framework including the training requirement and arrangement will be refined and consultation with staff and Coordinating Committees (COCs) / Central Committees (CCs) will commence.
Refine the cluster management structure	• The roles and responsibilities of Cluster Chief Executives (CCEs) are being reviewed. Input from CCEs on their current involvement and possible enhancements in the overall management of HA have been sought and are being reviewed. • COCs/CCs will be engaged to enhance their roles and responsibilities in clinical governance under R10.
Regroup hospitals under one Hospital Chief Executive (HCE) to make HCE job portfolios comparable	• The proposal (on the recommendation of an external consultancy) and implementation plan on regrouping of hospitals were endorsed by the Board in December 2015. The re-grouping of hospitals in Hong Kong East Cluster (HKEC) and KEC was completed in January 2016. HCE(Pok Oi Hospital / Tin Shui Wai Hospital) is under recruitment and will be in post in 4Q 2016 to tie in with the commencement of services of Tin Shui Wai Hospital. The remaining proposals will be taken forward in a phased approach. Deputy HCE positions were created for hospitals where the HCEs have to manage more than one hospital. Recruitment of Deputy HCEs for different hospitals is in progress. A HR circular on Deputy HCE arrangement was issued in May 2016. Job rotation between Chief Managers and HCEs are being arranged when opportunity arises.
Delineate the roles of hospitals within cluster	• HA has delineated the roles and functions of hospitals for Hong Kong West Cluster (HKWC), KEC and NTEC respectively through the development of a Clinical Services Plan (CSPs) for each of the clusters. • The CSP for KCC is under review having regard to the regrouping of hospitals and will be refined by 4Q 2016. • The development of NTWC CSP has commenced in 2Q 2016.

Strategic Goal & Target	Key milestones of individual action items
Recommendation 3	
Develop refined population-based resource allocation model	• HA is actively developing a refined population-based resource allocation model, which will incorporate factors to reflect the differential need of local populations for public hospital services and address unique requirement of individual clusters for resources, such as arising from the provision of designated services and demand generating from cross-cluster movement of patients. An initial analysis on hospital services utilisation by patient residence down to small local communities was conducted to understand the magnitude and pattern of cross-cluster flow. It was also agreed that for the purpose of internal resource allocation analysis, designated services would be carved out from the population-based resource utilisation analysis such that the remaining core hospital and clinic services were more comparable in terms of scope, nature, and the target population (i.e. within the cluster's catchment locations) intended to serve. • According to the action plan, HA has commissioned an external consultancy through tender to help develop and validate the "refined population-based resource allocation model". The consultant team has started work in April 2016 and the next target is to propose the conceptual framework and methodology so as to come up with a prototype for further deliberation in HA Board by the third quarter of 2016. At the same time, a consultation document would be published to engage and collect stakeholders' view. • Looking ahead, the refined model will provide the basis and methodology for an analysis to compare resource need and utilization among the clusters. Clusters which are found to be relatively disadvantaged in resources provision will be given priority in catch up plans, via submission of plans to the Annual Planning exercise for beefing up the under-provided areas. • Pending the development of a refined population-based resource allocation model, analyse will be conducted on cluster resource utilization to inform decision-making in service planning.
Communication and stakeholder engagement	• For communication and stakeholder engagement, two rounds of sharing with clusters on the model and development progress were held in August to September 2015 and January to March 2016 respectively. Each cluster has also designated a single liaison point to facilitate communication among clusters, the project team and the external consultant. HA will also publish a consultation paper to solicit views on the model from frontline in 3Q 2016.

Strategic Goal & Target	Key milestones of individual action items
Monitor progress and utilisation of catch-up funding	• The time-limited funding of $300 million for three financial years from 2015/16 to 2017/18 will be used to enhance existing services and address under provision areas according to the needs identified by KEC, NTEC and NTWC. Budget was allocated to the three clusters in 3Q 2015 to implement catch-up plans and $56 million was utilised in 2015/16. Around 70% of the funding was used to hire additional staff (including nursing and supporting staff) while the remaining amount will mainly be used to purchase medical equipment. • Implementation progress of the catch-up plans in 2015/16 and refinement planned for 2016/17 were reviewed in December 2015. A budget of $125 million will be allocated for implementing the 2016/17 catch-up plans in the three clusters.
Recommendation 4	
Improve and simplify the procedures of resources bidding	• Training workshops for frontline users to consolidate the workflow in the Annual Planning System were conducted in January 2016 and March 2016. Over 100 colleagues participated. • Enhancements to the functionality of the Annual Planning System were completed and launched on 16 January 2016.
Enhance transparency of the resource bidding and allocation processes	• The Manual on Annual Planning, outlining the structure and process of resource bidding in HA was reviewed with updates promulgated. Sharing sessions on the annual planning process were conducted. • Annual planning proposals formulated by COC/CCs, Head Office and Clusters were submitted and were presented in the respective Forums on 11 March 2016, 1 April 2016 and 6 May 2016. • Two briefing sessions to explain the rationale and considerations behind the final decisions and allocation results were held on 1 February 2016 and 5 February 2016 for COC/CC members, clusters and HA Head Office (HAHO) subject officers. Around 350 colleagues attended the briefing.
Recommendation 5	
Enhance central system to monitor creation and deletion of selected levels of senior positions	• The existing central mechanism for the creation of senior positions has been extended to cover Deputy HCE posts. A more formalized structure to monitor the creation and deletion of senior positions is being developed. Consultation with key stakeholders is in progress.

Strategic Goal & Target	Key milestones of individual action items
Enrich HAHO representation in cluster selection boards	• A Working Group on Enriching HAHO Representation in Cluster Selection Boards was formed with representatives from cluster Human Resources departments. The Working Group has developed some preliminary proposals. Comments and inputs from Grade Managers on the preliminary proposals have been solicited with a view to developing a framework for consideration by the Management, targeting for completion by 4Q 2016.
Develop and enhance rotation programmes	• A formal document on the job rotation arrangements for senior executives, including CCE/HCE/Chief Manager/Senior Manager/ Cluster General Manager is under preparation. Endorsement by the Human Resources Committee of the Board will be sought in September 2016. • To facilitate intra-specialty rotation of clinical staff, central funded posts (11 additional central funded training places on top of 28 existing places are supported in 2016/17) are provided. The allocation principles and proposal were deliberated in December 2015. The budget for 2016/17 has been allocated to clusters. • For cross specialty trainee rotation, a cluster-based rotation programme is being considered. A meeting of the Taskforce on Medical Workforce Review chaired by the Chief Executive was held on 27 January 2016 and rotation arrangements of trainees for all specialties were reviewed respectively. • A rotation mechanism is being developed for training of clinical staff in different grades/hospitals on the use of new healthcare technology/equipment when such are introduced into HA. A proposal has been formulated and will be discussed in the Training & Development Executive Group meeting in 2016/17.
Strengthen alignment of HR practices and implementation of HR policies across clusters	• To enhance consistency in HR practice, more regular communication forums have been arranged with clusters HR, and senior HR executives in clusters are involved to lead corporate-wide HR projects. • A framework for HR audit and standard protocols for policy formulation and implementation is under preparation.

Strategic Goal & Target	Key milestones of individual action items
Enhance HA staff communication	• In order to enhance staff communication and engagement, a series of mobile "Apps" on staff related functions, e.g. leave application, enquiry on own health records, staff clinic appointment booking, etc. are being developed. Three modules of the HR Apps were piloted at five hospitals in March 2016. They will be further rolled out to two other hospitals in June 2016. • Hay Group has been commissioned in May 2016 to conduct a corporate-wide staff survey in HA in September 2016 to gauge staff's concerns and views to facilitate the development of future strategies for staff engagement. • Staff Communication Framework was in place and the first Draft of the Staff Communication Guidebook outlining the staff communication strategies, framework, practical tools and checklists is under preparation.
Formulate central staff deployment plan in emergency situations	• A framework of proposed central deployment mechanism to cope with staffing needs in emergency situations is being developed. Grade managers have been engaged to work on the details. • The proposal to standardize format and signatory of HA's appointment letter are being developed with a view to reinforcing the "one HA" spirit, and a standardized central deployment clause will be included in appointment letters highlighting the need for deployment by HA in case of need.
Central recruitment of Resident Trainees	• Specialty-based central selection panels for Paediatrics and Psychiatry were conducted in March 2015. 22 Resident Trainees (RTs) were selected for specialty training in Paediatrics and 22 RTs for specialty training in Psychiatry according to service and training needs as well as candidates' priorities. • Specialty-based central selection panels have been rolled out to all specialties with 16 specialty-based central selection panels formed. Cluster HRs were designated to support the respective COCs to conduct the specialty-based central selection boards. Selection and appointment processes will be completed by 2Q 2016.

Strategic Goal & Target	Key milestones of individual action items
Develop and implement re-employment schemes for suitable retirees to help address manpower shortage and encourage knowledge transfer [One-off funding of $570 million]	• Recruitment exercises for rehiring of staff retiring in 2015/16 and 2016/17 were completed with the following results: (a) Doctors : 2 rounds of recruitment exercises completed; 62 doctor rehires (b) Nurses : 102 posts created; 48 nurses rehires (c) AH & Pharm staff : 12 posts created for AH while no needs for Pharm staff; 9AH staff rehires (d) Supporting Grade staff : 884 recommended for re-employment • In view of the recent staff shortage in Anatomical Pathology, a one-off recruitment exercise for rehiring specialists in Anatomical Pathology retiring in 2015/16 and 2016/17 is being conducted to help alleviate the critical manpower situation. The recruitment exercise is targeted to be completed by end June 2016.
Recommendation 6	
Strengthen governance on training	• A two-tier governance structure for training was set up in 4Q 2015. The Central Training & Development Committee (CTDC) newly set up under the Human Resources Committee has commenced its work. CTDC comprises Board Members, external experts and representatives from external stakeholders including the Hong Kong Academy of Medicine (HKAM), The University of Hong Kong, The Chinese University of Hong Kong and The Hong Kong Polytechnic University. CTDC is supported by the T&D Executive Group which is co-chaired by Director (Cluster Services) and Head (Human Resources). It has so far conducted four meetings from October 2015 to May 2016.

Strategic Goal & Target	Key milestones of individual action items
Develop mechanism to ascertain organisation training needs and development of training activities	• For the purpose of developing a grade-specific training curriculum, a task group with members from four major non-clinical grade/functional heads (i.e. Business Support Services, Finance, Human Resources, and Information Technology) was formed in December 2015. Head Office T&D Team has been working closely with the four grades. Work has been done to review their core competency sets, and identify core skill sets for each competency. • In order to establish a structured mechanism for clusters to ascertain training needs, a task group with members from Cluster General Manager (HR)s [CGM(HR)] was set up in November 2015 to help review the current practices and formulate a new structured mechanism on training needs identification. A survey to stock-take the current practices of clusters was completed in end-December 2015 and meetings with CCEs and CGM(HR)s were held in January/February 2016 to solicit views/inputs on the new mechanism. The draft mechanism will be presented to T&D Executive Group in June 2016 for comments. • Training plans for relevant grades of staff will be incorporated when new technology or medical services are introduced in HA. To this end, clinical grades have revisited the existing mechanism of new technology / services training with inputs from Central Technology Office and Quality & Standards Department using an example on Robotic surgery development. A proposed mechanism was discussed by the T&D Executive Group Meeting in December 2015. It was agreed to further study the feasibility of implementation through consultation.
Develop system for effective training information management and planning	• A tracking system for training programmes under the $300 million designated training fund has been developed and presented to T&D Executive Group and CTDC. Ongoing refinement to this mechanism will be made as and when appropriate subject to endorsement by the T&D Executive Group. • A new IT system to facilitate planning, monitoring and reporting on staff training is under development. A task group with members from IT, clinical grade and non-clinical grade representatives was formed to follow up on the related matters.

Strategic Goal & Target	Key milestones of individual action items
Strengthen collaboration with external parties to enhance overall training capacity and capability	• To enhance training capacity and capability, HA will continue to conduct active discussions with external parties, e.g. the Medical Council of Hong Kong, HKAM, local universities and colleges to strengthen current collaboration platforms. There will be well-defined priority of areas of collaboration such as bringing in external expertise for programme enrichment, organizing joint programmes with external parties or procuring training places from external professional training organisations.
Utilise one-off additional funding of $300 million to enhance training	• For 2015/16, the 11 new and scale-up training programs were implemented and progress reports were made via the Internal Resource Allocation monitoring mechanism. With support and endorsement of the T&D Executive Group and CTDC, most of the training programmes will continue in 2016/17. • Training proposals for 2016/17 and 2017/18 were endorsed by CTDC. A total of 15 and 23 training proposals amounted to $56.47 million and $78.52 million for 2016/17 and 2017/18 respectively were supported. A variety of training programmes in form of in-house training, overseas training, simulation training, commissioned training, e-Learning etc. will be offered to clinical and non-clinical staff at different levels to address training needs derived from service development/provision, professional development, and job/operation requirements.
Recommendation 7	
Enhance the role of the HA Board in Key Performance Indicator (KPI) performance review and KPI development process	• KPI reporting mechanism is strengthened. As from 4Q 2015, the relevant functional committees of the Board are tasked to discuss and review matters relating to KPIs. Views and comments received will be highlighted for the Board's attention as appropriate.

Strategic Goal & Target	**Key milestones of individual action items**
Enhance HA's KPIs	• New KPIs to reflect capacity-demand gap and service efficiency on the key pressure areas were endorsed by the Board in February 2016 for phased implementation in 2016/17. The new KPIs are: (a) Capacity and throughput for Specialist Out-patient (SOP) services - No. of SOP first attendances per doctor full-time equivalent (FTE) - No. of SOP follow-up attendances per doctor FTE - Growth of waiting list against throughput (b) Capacity and utilization of Operating Theatre (OT) services - Indicator to reflect the utilization of scheduled elective OT sessions (c) Access block monitoring - Indicator to reflect the frequency and magnitude of the access block problem
Enhance utilisation of KPI information to drive best practices	• An information system is being developed for phased implementation within three years to facilitate dissemination of KPI information, and retrieval by different levels of staff. This will promote and facilitate organisation learning and sharing of best practices.

Strategic Goal & Target	Key milestones of individual action items
Recommendation 8	
Utilise Family Medicine Specialist Clinic (FMSC) to relieve pressure on Orthopaedics & Traumatology (O&T) SOPCs	• Based on the experience in the existing model of using FMSC to help attend to O&T patients triaged as Routine cases through Low Back Pain clinic in 2015/16, the model is being further developed, in consultation with the concerned COCs, for roll out to KEC and NTEC. • The arrangement will be protocol driven and cases for diversion to FMSC (new cases triaged and screened by O&T) will mainly be those patients suffering from back problems which are of low risk nature and do not involve surgical intervention but only functional rehabilitation. A rough estimate will be around 20% - 30% of low back pain cases may be transferrable to FMSCs for consultation. • There have been active discussions among the concerned COCs to pursue this O&T/FM collaboration service model, building on the existing model to divert new routine O&T SOPC cases in pressure areas to FMSCs. Arrangements have also been made to enhance the triage process and improve the quality of referrals, by enhancing the referral practices at source. That includes refining the structured disease templates on back pain and neck pain in the electronic referral system with specific reference to the established clinical guidelines and protocols. • HA has been preparing a proposal in 2016 for implementation of the programme in KEC and NTEC through the 2017/18 Annual Planning Exercise for implementation by mid-2017. • In considering that over sub-specialisation may also be a factor in contributing to long waiting time of new case appointment at O&T SOPCs, corresponding arrangement has been made to address the issue by ensuring adequate capacity of general consultations in the Department upfront.

Strategic Goal & Target	Key milestones of individual action items
Employ new multidisciplinary strategy to relieve pressure on Psychiatric SOPCs	• HA has enhanced the multidisciplinary teams to cope with the rapid increase of service demand for mental health services. The use of trained psychiatric nurses and allied health professionals under supervision of doctors is proved to be effective in improving treatment outcome, and the development of criteria for closing cases also helps discharge those who have satisfactorily completed the care plan developed by doctors. This service delivery model enables the availability of more doctor consultation sessions for new cases with a view to shortening the SOPC waiting time. Taking KWC as an example, with the enhancement of its multi-disciplinary team, the overall waiting time of new case booking for routine cases has dropped from some 60-70 weeks to some 40-50 weeks. HA will further enhance the multidisciplinary teams of psychiatric SOPCs in KEC (for patients with common mental disorder), and in HKWC and NTWC (for child and adolescent patients) in 2016/17.
Employ multi-pronged strategies to generally improve the capacity and efficiency	• Conversion works to increase five additional consultation rooms in Yung Fung Shee Memorial Centre were completed in December 2015. Works to expand physical capacity for SOPC service are progressing in on-going projects and projects under planning, including Reprovisioning of Yaumatei SOPC at QEH; redevelopment of KWH, Kwai Chung Hospital and OLMH; expansion of United Christian Hospital; and New Acute Hospital in Kai Tak. • The "Specialty-based SOPC Waiting Time Analysis Charts" is now available in Management Information Portal (MIPo). • Indicators on SOPC service throughput and capacity have been developed. On 25 February 2016, the HA Board endorsed to adopt them as HA's KPI in 2016/17 by phases. • The General Outpatient Clinic Public-Private Partnership (GOPC PPP) Programme will continue with implementation closely monitored. HA has completed an interim review on the Programme in the first quarter of 2016. The interim review report was presented to the Board on 28 April 2016, and will be submitted to the Food and Health Bureau for consideration and endorsement in the second quarter of 2016. Taking into account the Government commitment, initial positive feedback from the medical professional bodies, patients, private doctors, and staff as well as the strong community call, the Programme is planned to be further rolled out to 18 districts in the coming three years starting from 2016/17.

Strategic Goal & Target	Key milestones of individual action items
Align practices of different clusters and minimise cross-cluster variance in waiting time	• By April 2016, the SOPC phone enquiry systems were extended to Pamela Youde Nethersole Eastern Hospital, Queen Mary Hospital, United Christian Hospital, Princess Margaret Hospital, Prince of Wales Hospital and Tuen Mun Hospital. • HA has conducted a comprehensive review of appointment scheduling practices of SOPC and issued a SOPC Operation Manual to align different practices on 1 January 2016 for clinics' reference. • To facilitate patient-initiated cross-cluster new case booking, HA has enhanced transparency of SOPC waiting time information. Effective from 30 January 2015, SOPC waiting time information for all eight major specialties is available on HA's website, with updates on a quarterly basis. • HA has piloted a mobile App to facilitate patients' choice on cross-cluster new case booking. The mobile App for SOP new case booking in the specialty of gynaecology was launched on 8 March 2016.
Ensure Accident & Emergency (A&E) patients with pressing medical needs received timely medical treatment	• HA has implemented a new model namely "Rapid Assessment and Treatment Model" in QEH in 1Q 2016. Through re-engineering the work process in A&E Department, it allows early assessment of Category III patients by a team led by a senior doctor who is able to make a competent initial assessment and define a care plan. • HA will continue to closely monitor the manpower situation in A&E departments and make appropriate arrangements in light of service needs and operational requirements. In 2016-17, for doctors, HA plans to recruit 42 RTs to A&E departments. For nurses, HA plans to recruit 47 nurses to A&E departments for replacement of attrition and for providing new services.
Improve the waiting time of Category IV and Category V patients in A&E departments	• The smartphone App namely "PWH AE Aid 威院急症先 phone" was piloted and released to the public in 4Q 2015/1Q 2016. Real-time waiting status is provided in the mobile application. An engagement meeting to share the tentative roll-out plan with A&E Departments (AEDs) will be held in June 2016.. • The A&E support session programme was further extended to all AEDs with effective from 1 November 2015. In 2016-17, AEDs plans to operate support sessions at a total of around 20,000 hours (equivalent to 5,000 4-hour sessions).

Strategic Goal & Target	Key milestones of individual action items
Strengthening of HAHO's input and enhancement of intra-cluster collaboration	• HAHO is working jointly with the cluster-based task forces in KCC and NTEC, which are led by the respective CCEs to formulate cluster strategies and action plans for improving the access block situation, by providing inputs and assistance from policy and resource allocation levels. Proposals to build up capacity will be submitted through the Annual Planning Process. Regular progress updates on the access block situation are being submitted to the Board.
Building up of capacity	• HA is making continued efforts to increase service capacity in KCC and NTEC though addition of beds, refurbishment projects, minor works projects and planning of major medical facilities to meet service demand of the clusters. Capacity gap revealed during the process will be addressed through annual planning exercise.
Management of service demands	• HA has implemented measures to reduce avoidable hospital admissions of elderly patients. e.g. by deploying community geriatric assessment service at A&E level, enhancing day care services, fast track clinics, etc. • Weekly reports on process indicators showing the use of acute medical beds and the related supporting convalescent / rehabilitation beds are being sent to clusters to facilitate better coordination on the use of hospital beds. • A dashboard has been put into use from 1Q 2016 to provide real time information to facilitate bed coordination in 16 acute hospitals to speed up patient flow. • Arrangement, initiated for winter surge monitoring, has been launched to send out daily alert emails on A&E cases with long waiting time in admission to senior executives to facilitate them to closely monitor the situation and promptly attend to problems identified.

Strategic Goal & Target	Key milestones of individual action items
Recommendation 9	
Increase service capacity	• GOPC quotas in various clusters was increased by 55,000 (77 000 Full Year Effect) in 2015/16 as pledged. HA plans to provide 27 000 additional quotas in GOPCs across different clusters in 2016/17. The implementation of quota addition for 2016/17 has started as planned and in good progress. • The 250 beds planned for 2015/16 have been opened and HA plans to open 231 additional hospital beds in 2016/17. • HA plans to recruit 420 doctors, 1 720 nurses and 480 allied health professionals in 2016/17. • HA is actively implementing PPP programmes for services such as cataract surgery, radiology, primary care, infirmary and haemodialysis services with qualified service providers in the community. • Through annual planning for 2016/17, HA aims to cover an addition of around 40 Residential Care Homes for the Elderly (RCHEs) by Community Geriatric Assessment Teams (CGATs) to support frail elderly patients living in RCHEs.

Strategic Goal & Target	Key milestones of individual action items
Review and develop service delivery models and strengthen partnership with community partners	• HA has put in place enhanced services in collaboration with Department of Health to provide influenza vaccination to patients with chronic disease and elderly living in the community. HA clinics will continue to provide vaccines to eligible target groups till the exhaustion of stock to enhance vaccination rate among target groups. • HA is working with Non-Governmental Organisations (NGOs), Social Welfare Department and Food and Health Bureau to develop a collaborative service model with enhanced geriatric support in a large-scale old age home in Lam Tei to facilitate ageing in place and reduce unnecessary hospitalization. HA has provided input on the service model, staff skill-mix and infrastructure required for better support the care of elderly in the large-scale old age home. • In line with the Government's policy direction and the benefits of developing a social infirmary service in the longer-term, HA has been exploring collaboration with NGOs to enhance the choices of infirmary care services for patients on the Central Infirmary Waiting List managed by HA. An Infirmary Service PPP Programme is about to be implemented on a pilot basis, through contracting with an NGO to operate infirmary services at Wong Chuk Hang Hospital with a maximum capacity of 64 beds for three years and a possibility of extension by two years subject to evaluation. The service is expected to commence in the second half of 2016. • Starting from 4Q 2015, CGATs have worked in partnership with Palliative Care Team and NGOs to improve medical and nursing care to elderly patients living in RCHEs facing terminal illness and to provide training for RCHE staff. • Structured training programme on palliative care for nurses working in non-palliative care setting was organized in 4Q2015. Training course for medical social workers providing support to patients who require palliative care commenced in 1Q2016. • HA has further developed the Community Health Call Centre service to provide telephone advice and support to diabetes mellitus patients in Medical SOPCs on disease management. The initiative has commenced in KEC, NTEC and NTWC as from 3Q 2015.

Strategic Goal & Target	Key milestones of individual action items
Strengthen patient empowerment and engagement	• A New Smart Elders platform with enhancement on carer information on Smart Patient Website was launched on 1 March 2016. • The service model and contractual partnership with NGOs on the Patient Empowerment Programme to support patients with diabetes mellitus or hypertension was reviewed. The enhanced model under new service contract has been implemented since 1st April 2016 with more emphasis on personalization. • The application for 2nd phase Pilot Scheme of Collaborative Project aiming at building partnership with patient groups in supporting patients/carers and enhancing the community integration of patients was closed. Announcement of successful application is expected in 3Q 2016. • HA will continue to implement Corporate Patient Experience and Satisfaction Survey (PESS) Programme to collect patient feedback. The rolling plans are as follow: (1) Inpatient Service in 2015/16; (2) A&E Service in 2016/17; and (3) Hospital-based in 2017/18 • Four additional patient members were appointed as members in various Hospital Governing Committees. The appointment took effect on 1 April 2016. • To enhance patients' understanding of HA service and facilitate their engagement at various levels in hospitals and Head Office, a structured training programme Patient Partnership in Action for patient leaders nominated through the Hong Kong Alliance of Patients' Organizations and cluster hospitals was organized from 3Q 2015 to 1Q 2016. A total of 24 leaders had completed the programme.
Recommendation 10	
Strengthen the roles of COCs on clinical governance	• A standardised set of Terms of Reference of COCs/CCs was developed for adoption by COCs/CCs and their supporting Chief Managers. • Group Internal Audit, COCs/CCs and their supporting Chief Managers will be involved in the evaluation on implementation of enhanced roles and responsibilities in 4Q 2017.

Strategic Goal & Target	Key milestones of individual action items
Enhance the role of COS with greater emphasis on clinical governance	• Chief of Services (COSs) and senior doctors are encouraged (via COSs) to complete the Quality and Safety modules in Healthcare Service Management Training e-Course (e.g. accreditation; clinical incident management) which would be released in 2Q 2016. • Action plan is in hand to specify COS management functions as related to clinical governance in COS appointment and staff appraisal procedure. The target implementation date is 4Q 2016 to 1Q 2017.
Refine COC/CC/service committees relationship with a view to reducing their administrative work in annual resource planning and clinical service development	• To improve and simplify the annual planning process, training workshops were organised alongside with the IT system enhancement to HA's Annual Planning System in January 2016. In particular, two briefing forums were held on 1 February and 5 February 2016 for COC/CC members, cluster and HAHO subject officers with around 350 participants. Information concerning the rationale and considerations behind the decision on submitted proposals for 2016/17 were disseminated.
Develop a system of credentialing and defining scope of practices	• The first batch of five high risk and complicated procedures from three specialties, with comments from HKAM incorporated, was endorsed as HA credentialing activities in December 2015 as follows: Specialty — Procedure Anaethesiology — Cardiac Anaesthesia Cardiology — Left Atrial Appendage Occlusion (LAAO) Percutaneous Coronary Intervention (PCI) Transcatheter Aortic Valve Implantation (TAVI) Surgery — Robotic Assisted Laparoscopic Radical Prostatectomy • Central Credentialing Committee with representatives from Cluster Credentialing Committees had finalised the implementation mechanism in developing lists of credentialed staff and hospital to perform the HA credentialing activities and verifying staff's credentials at clusters/hospitals. Supporting IT platform will be ready for shadow run in June 2016.

Strategic Goal & Target	Key milestones of individual action items
Improve clinical outcomes and patient care through clinical audit activities	• Updated Clinical Audit Guidelines are being shared through eKG platform. • A local risk adjusted model for intensive care outcome monitoring programme is being developed with the assistance of the Chinese University of Hong Kong (CUHK). First set of data was sent to CUHK in February 2016 and preliminary risk adjusted model will be developed for further refinement. • A Working Group on Clinical Indicators with representations from different stakeholders is overseeing the selection, development and review process of clinical indicators (CIs). There are 10 active CIs and 13 CIs under the development pipeline.
Strengthen medical incidents sharing	• Arrangement is being made to develop an electronic platform (e.g. mobile App) for staff communication on medical incidents. • The Clinical Incident Management Manual was published and implemented in July 2015. In 1Q2016, the Manual was promulgated in various platforms (e.g. Staff Sharing Forum on Sentinel and Serious Untoward Events (SE&SUE), COC/CCs, etc.), with focus of communication with and support for patients. • HARA (HA Risk Alert) and SE & SUE Annual Reports are published quarterly and annually respectively. The latest HARA with highlights of SE & SUE in 4Q2015 was published in April 2016. • There are regular incident sharing sessions at HAHO, cluster forums and COCs. In 1Q 2016, two sessions were held in HAHO and three sessions were held in clusters (with video conferencing to various hospitals in the same cluster). In 2Q 2016, two more sessions will be held in clusters. In 3Q 2016, another round of incident sharing sessions will be conducted. • Training in patient safety, including medication safety, has been incorporated into orientation programmes for interns and junior doctors.

Annex C

Specimen Referral Mechanism of Urgent Request for Influenza Testing Outside Office Hours (17:00-09:00)

Designated centre	Referring clusters / hospitals
Hong Kong West Cluster Queen Mary Hospital	Hong Kong East Cluster Pamela Youde Nethersole Eastern Hospital Ruttonjee Hospital Kowloon Central Cluster Queen Elizabeth Hospital Kowloon West Cluster Kwong Wah Hospital
New Territories East Cluster Prince of Wales Hospital	Kowloon East Cluster Tseung Kwan O Hospital United Christian Hospital Kowloon West Cluster Caritas Medical Centre North Lantau Hospital Princess Margaret Hospital Yan Chai Hospital New Territories East Cluster Alice Ho Miu Ling Nethersole Hospital North District Hospital New Territories West Cluster Pok Oi Hospital Tuen Mun Hospital Tin Shui Wai Hospital