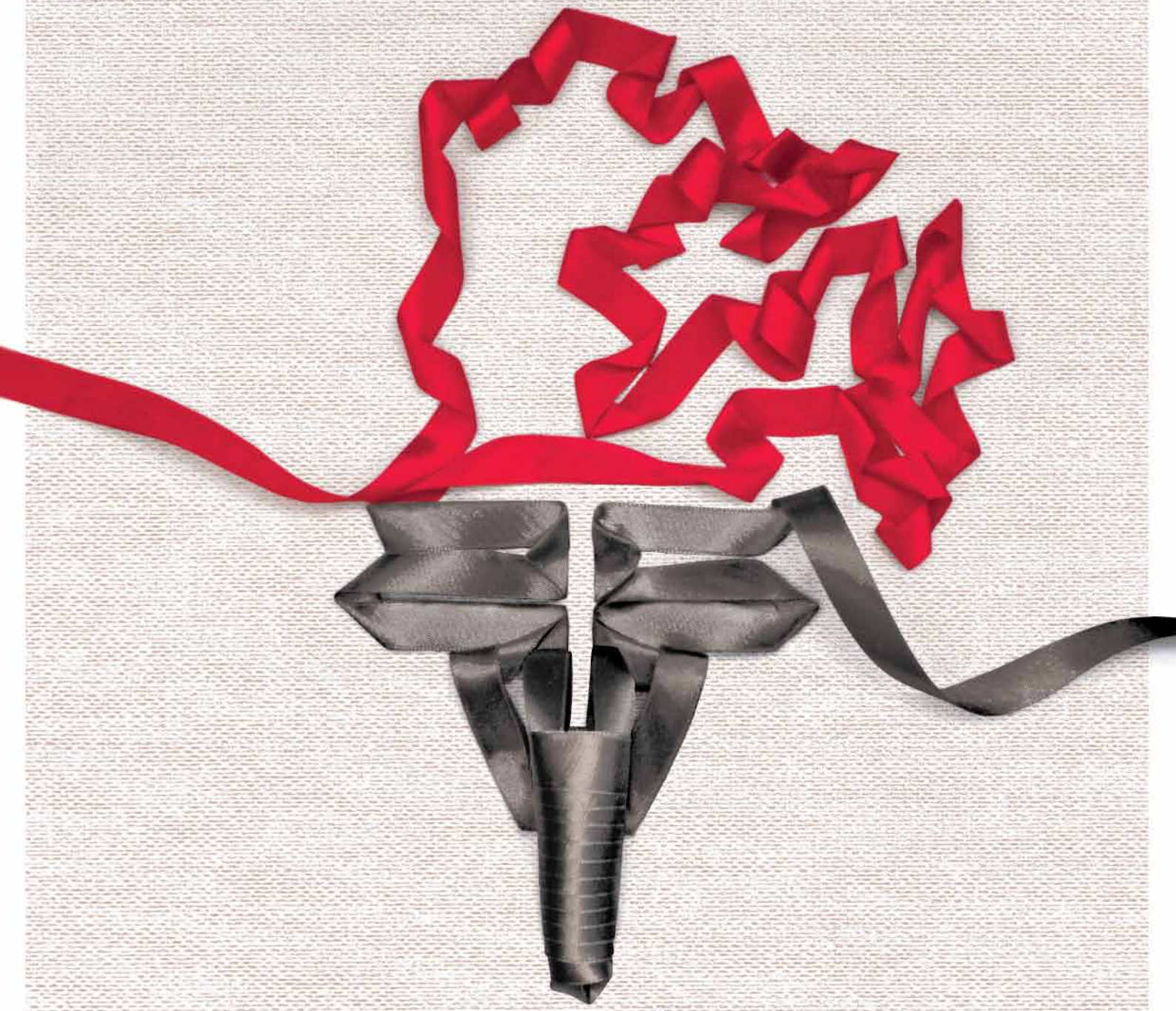
醫院管理局
新界東醫院聯網
Hospital Authority
New Territories East Cluster



# HOSPITAL AUTHORITY
# NEW TERRITORIES EAST CLUSTER

## CLUSTER REPORT

2011/12

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# Hospital Authority Vision, Mission and Values

Guided by the mission of "Helping People Stay Healthy", Hospital Authority will collaborate with community partners to strive for continued success and work towards the vision of "Healthy People, Happy Staff and Trusted by the Community".

The Cluster started to fully adopt HA's vision, mission and values since its introduction.

### Vision

- Healthy People
- Happy Staff
- Trusted by the Community

### Mission

- Helping People Stay Healthy

### Values

- People-centred Care
- Professional Service
- Committed Staff
- Teamwork

## Message from CCE

Dr FUNG Hong

The New Territories East Cluster (NTEC) was formed in 2001 and this is the first year we are producing the Annual Cluster Report. Every year, the public hospital system faces new challenges. We think it is important to keep a record of these challenges and how our frontline colleagues fight against these challenges to keep the public healthy. All the battles are fought under the shared vision, mission and values of the Hospital Authority. This report is dedicated to our staff and patients.

In 2011, we experienced a record high number of deliveries and neonatal admissions. The number of deliveries in Prince of Wales Hospital (PWH) reached 7,400, the highest since the days of the Vietnamese refugees. PWH was the first hospital to stop the booking of Non-entitled Persons for obstetric services. The overall high delivery rate in Hong Kong also led to high occupancy of the Neonatal Intensive Care Unit. Fortunately, the nursing workforce was relatively stable with the injection of additional nurses during the year.

We also experienced a record high number of Accident & Emergency (A&E) attendance and emergency medical admissions during the winter surge in early 2012. A&E attendance increased by around 10% as compared to the previous winter. The bed occupancy rates in medical wards often exceeded 110%. Significant improvements were made to effectively control the emergency patient flow with marked reduction in waiting time for A&E patients and reduction of the access block problem in PWH. The emergency admission wards in North District Hospital (NDH) were re-organized, resulting in improvements in matching ward capacity with the patient demand.

I was also impressed by the continuous improvement in Key Performance Indicators in the Cluster, such as MRSA rate, access to cancer treatment and unplanned readmission rates where the Cluster was already taking the lead. On quality and safety, the Cluster continued our efforts to promote medication safety. The most significant improvement was made on drug administration where the incidence of reported medication incidents dropped by 50% through the concerted efforts of nurses. To enhance communication, we continued to make use of multiple channels and platforms to promote staff engagement and communication. The "iHospital" platform was used extensively by all departments in preparation for accreditation. The new social media platform "YouSay" was launched in March 2011, attracted 173,000 hits over a one year period, averaging 470 hits per day. It became an important platform within the Cluster for sharing hot issues and staff pulse reading.

All the accomplishments of NTEC cannot be made possible without the valuable efforts of all the devoted staff members of the Cluster. I have to thank all NTECians. It is a privilege for me to serve the Cluster.

## Messages from HCEs

Dr Beatrice CHENG

### *Alice Ho Miu Ling Nethersole Hospital & Tai Po Hospital*

The year of 2011/12 has been a dynamic and fruitful one for Alice Ho Miu Ling Nethersole Hospital (AHNH) and Tai Po Hospital (TPH), having our initiatives directed towards the implementation of NTEC strategic plan. Through the coordinated efforts of our diverse professionals, we stay responsive to the heavy demands on acute and rehabilitation services from the local community. I would like to thank our Governing Committee and community partners for their unwavering support. My deepest appreciation also goes to our colleagues, who have made invaluable contributions through their hard work and dedication.

2012 will be a momentous year as we celebrate the 125th anniversary of AHNH and 15th anniversary of the hospital relocation to Tai Po. Time changes but our commitment to serve the sick and needy and to fulfill our healing mission with love, tenderness, and compassion will be passed on. I am confident that we shall, by practising as a cohesive team, continue to deliver holistic and compassionate care and grow from strength to strength in the year ahead.

Dr Theresa LI

### *Bradbury Hospice & Shatin Hospital*

2011 was a challenging and fruitful year for Bradbury Hospice (BBH). A Palliative Day Care Center has been set up at NDH with full collaboration and support from the hospital. We have also established a series of training courses to our volunteers in delivering telephone bereavement service. In line with our mission "add life to days when days cannot be added to life", Bradbury Hospice will continue to provide quality hospice and palliative care to terminally ill patients and their families in NTEC.

2011 was a joyful year for Shatin Hospital (SH). We celebrated our 20th birthday on the theme "Caring for our Carers" and our Fall and Restraint Reduction Team was presented the 2011 HA Outstanding Team Award. As a new member to the hospital, I am most impressed with the agility and team work seen through clinical programs such as Restraint Reduction Program and Personalized Care Program (PCP), with colleagues working to demanding deadlines but delivering concrete and quality results.

Patient safety is fundamentally our priority commitment in Shatin Hospital. In the coming year, we will be focusing on initiatives to enhance our practice and build a safety culture.

Dr Herman LAU

### *Cheshire Home, Shatin*

Though I have only taken up the post of Hospital Chief Executive of Cheshire Home, Shatin (SCH) since April 2011, there have been many sweet memories for me in the past year. We have about 200 staff members and it is a big family with a common goal of serving our patients with dedication and professionalism. Team spirit is everywhere to be seen and care and concern is the motto that we all espouse for service delivery to our patients. Looking ahead, we will strive for continuous quality improvement aiming at providing high quality service to our patients.

Dr MAN Chi Yin

### *North District Hospital*

In 2011, North District Hospital (NDH) witnessed a number of milestone development of new services, in response to the rising demand in the region as well as across the border. We started haemodialysis service and set up a palliative care day centre. We also completed a review of the admission ward system to ensure efficiency of bed utilization and quality of patient care. To improve the quality of food delivered to our patients, the Cook Chill cum Cold Plating Operation was implemented. We will continue to provide a better service to our patients through continuous quality improvement.

## Message from DHCE

Prof Philip LI

### *Prince of Wales Hospital*

Having worked in Prince of Wales Hospital (PWH) since 1985, I really feel home with the Hospital. It is always enjoyable working with all the talented, dedicated and cheerful colleagues with one common goal: helping our patients. The collaboration with CUHK has been most inspiring and rewarding for a clinician like me and I always think that quality of patient care cannot be improved without review and research. This makes PWH as a teaching hospital especially attractive for staff always striving for better care for our patients. With the connection bridge between the Old and New Wing, I actually find myself more chance to say 'Hi' to more staff and that is an enjoyable 'walking' experience, not to mention the opportunity for more exercise. I wish all our colleagues continue to enjoy working in PWH, like you always have been.

# I. Overview of Cluster Performance

The NTE Cluster serves a population of around 1.3 million. A major challenge faced by the Cluster is to meet the pressing service needs from both local residents in the catchment area and cross-border patients. As at March 2012, we were operating 4,185 in-patient beds including 3,333 general, 524 psychiatric and 328 infirmary beds, providing 162,140 in-patient and 81,119 day-patient episodes in 2011/12, representing an increase of 3.5% and 6.6% respectively when compared with 2010/11. There were 402,045 Accident and Emergency (A&E) attendances and 1,032,482 specialist out-patient (SOP) attendances, an increase of 0.9% and 3.1% respectively.

Primary care attendances reached 878,930, which was similar to the attendance last year with a slight reduction of 1.6%. Psychiatric service offered 44,344 day attendances, 8.7% above 2010/11. Community Nursing Service provided 130,280 home visits to support our discharged patients, with throughput increased by 2.1% when compared with the previous year. Total attendances of outreach service for geriatric and psychiatric patients were 78,552 (2.3% less than the previous year) and 33,293 respectively (increased by 52.3% reflecting service expansion as a result of implementation of annual plan programs).

We are facing constant pressure in in-patient and out-patient services due to aging and rising population, especially in SOP, A&E and emergency admission patients. To manage growing demand for SOP consultations, we have rolled out initiatives such as a robust triage mechanism, the setting up of nurse clinics and protocol-based fast track clinics, as well as screening by Family Medicine clinics at our SOP Clinics to shorten the waiting time for patients. Despite these initiatives, waiting time for SOPC routine cases was long in ophthalmology, Ear, Nose and Throat, gynaecology and psychogeriatrics under psychiatry owing to the heavy workload and rising demand. The long waiting list was also attributed to a high turnover of experienced staff, especially in Ophthalmology and Obstetrics & Gynaecology.

On the A&E service, we continued to struggle with the waiting time for Category 3 patients in the A&E department of PWH, due very much to the increase in demand and high turnover of medical staff. On average, only around 70% of the Category 3 patients could be seen within 30 minutes, falling short of the 90% target.

On the other hand, NTEC has attained outstanding performance in many quality indicators. For instance, unplanned readmission rate of 9.6% (HA: 10.3%) and MRSA infection rate of 0.0785 per 1,000 acute patient days (HA: 0.0872). For management of key diseases such as stroke and hip fracture, NTEC had relatively low unplanned readmission rates of 11.8% (HA: 12.9%) and 2.3% (HA: 2.4%) respectively. Completion rate of hip fracture surgery within target time was similar to the HA average, though waiting time has been prolonged with a high turnover of experienced orthopaedic surgeons, especially in North District Hospital. In terms of efficiency in service organization, the day surgery and same day surgery rates for selected procedures at NTEC, we had improved our performance to 54.3 %, (HA: 52.7%).

On cancer management, the percentage of patients receiving radical radiotherapy from decision to treat within 28 days was 94.8% (HA target: 80%). The percentage of patients with colorectal cancer and breast cancer receiving first definitive treatment from diagnosis was similar to the HA average (colorectal cancer: NTEC: 86.1%, HA: 87.9%; breast cancer: NTEC: 91.2%, HA: 92.5%). It is however recognized that some patients referred to our Oncology Centre had already received their primary treatment from the private sector.

The percentage of SOP and GOP diabetic patients under diabetic control, (defined as HbA1c less than target of 7%), was 34.0% and 40% respectively. The percentages were comparable to HA's overall performance of 35.1% and 41.3% for patients under the care of SOP and GOP clinics.

The Cluster continued its efforts in augmenting renal service with the provision of additional Home Haemodialysis (HD) service in NDH and commencement of HD program in AHNH. The measures are proven to be effective, showing that the percentage of patients with end stage renal failure receiving HD has increased from 16.4% in 2010 to 19.6% in 2011 (HA average: 22.5%).

# II. Cluster Governance & Organization

The Cluster continued its efforts to strengthen the governance of the cluster hospitals. Inputs from Hospital Governing Committees (HGC) were strengthened to improve the development and implementation of strategies of the Cluster. The Cluster Strategy Advisory Committee (CSAC) was established in September 2010 with the Chairpersons of all HGCs of the Cluster as members as well as the Cluster Chief Executive as Chairman to advise the Cluster on strategies for the development of hospital services. Two meetings were held in 2011 to discuss and review the key performance, service development, annual plan and budget plan. In addition, members from patient groups continued to serve as members of various HGCs in the Cluster to offer their valuable advice on hospital services.

The Cluster introduced a survey among the HGC members to evaluate our support to the HGCs in executing their expected functions since 2010. The response rate increased from 78% in 2010 to 93% in 2011. Positive feedback and recommendations for improving communication channels were received.

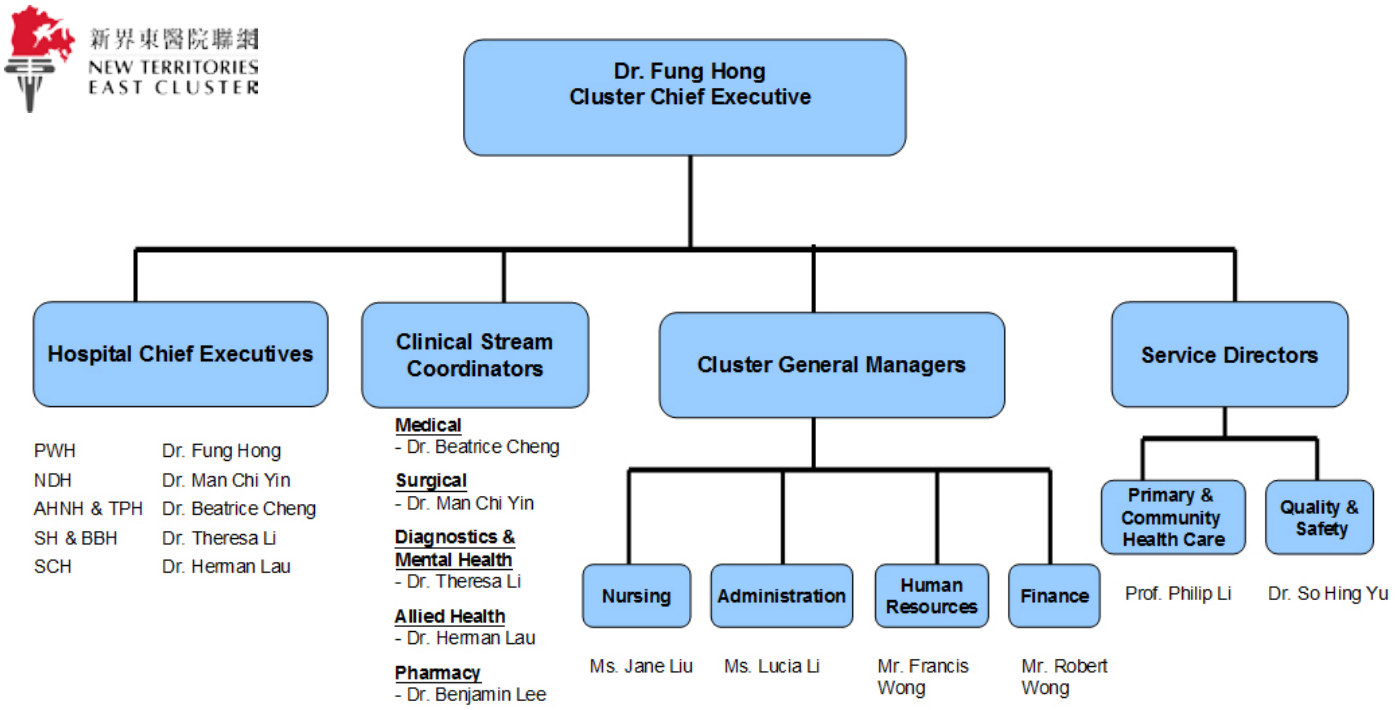
For collaboration and liaison with the Chinese University of Hong Kong, the Cluster Management Committee (CMC) continued its role in advising the directions and strategies for cluster services, organization development, policies as well as priorities in annual planning. The annual CMC Retreat was organized on 22 September 2011. Participants included CMC Members, Cluster Coordinators and Heads of Department of the Cluster. Consensus on future development and priorities of the Cluster was built. The following Consensus Statement was agreed during the Retreat, which formed the basis for the annual planning of 2012/13:

"Given the uncertain political, economic, social and technological environment, we shall maintain our current organization of services while continuing to address service gaps and streamline processes to improve quality and patient safety."

Cluster Strategy Advisory Committee

Cluster Management Team

## Organization Chart of New Territories East Cluster




August 2012

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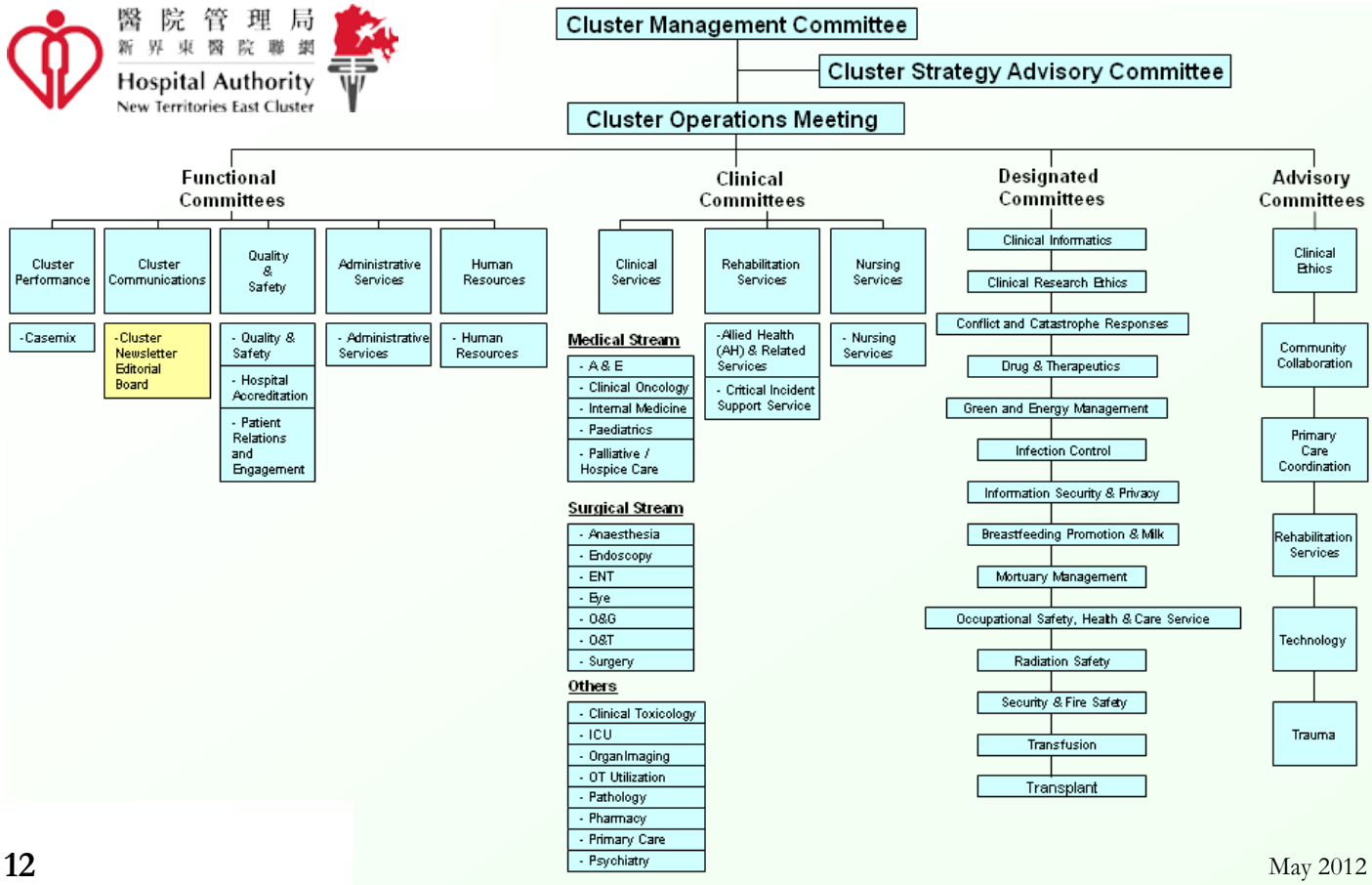
## Committee Structure in New Territories East Cluster




May 2012

# III. Key Achievements of Targets

In response to growing service demand, NTEC opened the PWH Extension Block in October 2010. Major acute and trauma services of the hospital were relocated to the new building with a total gross floor area of 71,500m$^2$. The new facility streamlined and improved patient care processes and alleviated prolonged waiting time for admission in the Accident & Emergency Department. The Comprehensive Acute Stroke Program was also organized to improve the quality of care for stroke patients. At NDH, the Respiratory Collaborative Care Program, a new model of care, was implemented to provide chronically ill patients with an integrated home and discharge support. On the psychiatric service, the Personalized Care Program was developed for patients with severe mental illness with a community-based case management approach.

Various initiatives were implemented to improve service quality and safety in NTEC. A major program was launched to promote medication safety, including an interactive electronic platform for staff engagement. The number of reported medication incidents continued to drop during the year. Safe surgery checklist was successfully rolled out to all three acute hospitals in the Cluster. An audit conducted in 2010 showed an overall compliance rate of 98.8%. The surgical "Checklist 123" was also introduced to non-operating theatre settings.

NTEC also put continuous emphasis on building up the People First culture. Traditional staff communication platforms of CCE/HCE visits and staff forums, staff lunch gatherings, as well as workshops and events were organized to foster a caring culture and team spirit. The Cluster intranet platform was further strengthened to promote staff engagement and communication.

## A. "Implement a Planned Response to Manage Growing Service Demand"

### *1.Opening of Main Clinical Block & Trauma Centre*

The Main Clinical Block and Trauma Centre was constructed on the areas of helipad and tennis court of the Prince of Wales Hospital (PWH). The new Centre occupied a floor area of 75,650(m$^2$) and provided around 800 in-patient beds for various specialty services, 16 operation theatres, a comprehensive trauma and emergency centre as well as an intensive care unit (ICU).

The Centre was officially opened on 28 June 2011. Officiating Guest of the HKSAR Chief Executive Mr Donald Tsang, remarked that "With the new facilities, I hope the 4,000 staff in PWH will work and collaborate much better, continue to serve patients wholeheartedly and set new standards for the medical services in Hong Kong."

The Main Clinical Block and Trauma Centre was equipped with the advanced medical facilities and built to the standards of a modern tertiary acute hospital, with patient-oriented setting that improved patient comfort, achieved operational efficiency, and met the challenges of clinical and technological advances in the healthcare service.


New Clinical Block and Trauma Centre opened by HKSAR Chief Executive Mr Donald TSANG

### *2. Comprehensive Acute Stroke Treatment Program*

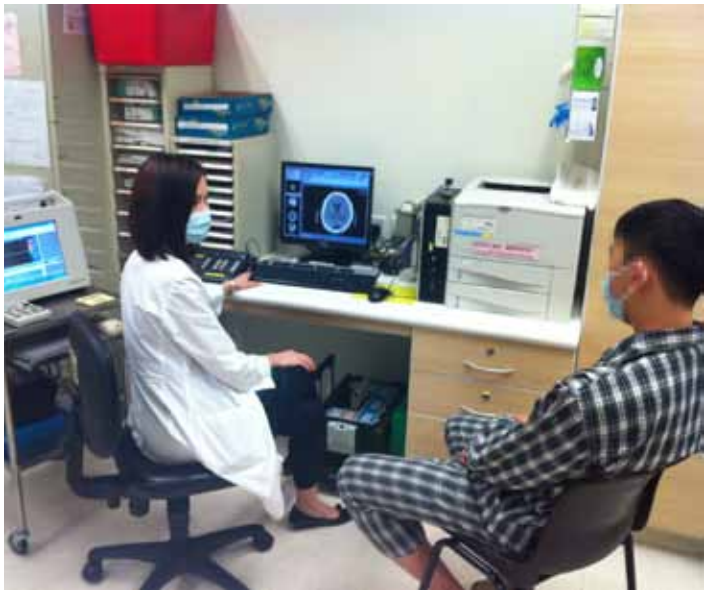
Thrombolytic therapy significantly improves the clinical outcome of ischemic stroke by alleviating neurological disability and enhancing the chance of independence of stroke patients. Thrombolytic treatment, therefore, diminishes the overall cost and demand for rehabilitation and institutional care.

The therapeutic time-window of stroke thrombolysis is narrow and treatment efficacy is highly time-dependent. In order to support an emergency 24-hour neurology service, neurologists in PWH collaborated with Hong Kong Polytechnic University and piloted a computer-aided mobile system that allowed instantaneous patient assessment. Neurologists can now examine stroke patients in real-time and review CT images and medical records with no restriction in time and location through iPhone and iPad.

A total of 25 patients were treated in 2011/12 (from 8am to 8pm during weekdays). Trial run of 24-hour service was started since 26 March 2012 and the outcome was satisfactory. The number of patients receiving the treatment are expected to increase after introduction of the 24-hour service.

Also, PWH sets up the first Transient Ischemic Attack (TIA) Clinic in Hong Kong. Instead of admission to hospital, patients with TIA or minor strokes are now promptly triaged as out-patients at the TIA Clinic. While timely diagnosis and institution of treatment reduce the risk of stroke recurrence, the facility also relieves the burden of in-patient care.

With the help from some volunteers, stroke talks are conducted to promote the Chinese version of "FAST", an acronym for common stroke symptoms (Facial weakness, Arm weakness, Speech problem, Timely attendance to A&E), in the community of New Territories East Cluster.



Transient Ischemic Attack Clinic

Option of Intra-Arterial Tissue Plasminogen Activator During Day Time


Stroke Awareness Program

### *3. COPD Program for Enhancing Integrated Home & Discharge Support*

The Respiratory Collaborative Care Team is a multidisciplinary team which was established at North District Hospital. It empowered chronic obstructive pulmonary disease (COPD) patients with disease knowledge and self-management ability to facilitate their transition from hospitalization to community living.

Systematic patient education begins with a patient's hospital journey. Once stabilized, nurses would teach the patient and/or carer various inhaler techniques. Occupational Therapist taught breathing coordination during basic activities of daily living (ADL). Further breathing, coughing and huffing techniques as well as exercise training were introduced by physiotherapist. Before discharge, medical and nursing staff would instruct patients/carers on when and how to use a crisis management pack of antibiotics and steroids when symptoms of exacerbation recur.

After discharge, patients were encouraged to report their symptoms through self-administered COPD Assessment Tests (CAT) transmitted electronically to a tele-monitored website. Whenever help is needed, respiratory nurse can be contacted via a telephone hotline.

Early hospital discharge was supported by a multidisciplinary Hospital-at-Home (H@H) team backed by respiratory physicians. Community nurses provided education and supervision on drug treatment. Community occupational therapists ensured that patients resumed domiciliary ADL despite breathing limitations. Bronchial hygiene and rehabilitative training were provided by community physiotherapist who also tele-monitored patients on oxygen therapy or non-invasive ventilation.

Under a service program partnership, students of Institute of Vocational Education (IVE) were trained to conduct a series of home visits to COPD patients. This special bonding enabled many COPD patients to preserve exercise regimens and widen their social interactions.

It is not surprising to encounter NDH COPD patients requesting for repeated prescriptions of crisis packs. These patient avoided hospitalization through early self-initiated treatment. However, to prevent overuse, side effects of antibiotics and steroids were repeatedly emphasized during patient education. Furthermore, courses on crisis pack taken would be recorded in hand-held COPD patient passports.

Multi-disciplinary team in action

Occupational therapist showed patient energy conservation technique during dressing

Physiotherapist encouraged oxygen-dependent patient to mobilize

COPD patient and daughter inspired by the visit of student volunteers

Community nurse instructed patient on use of tele-monitoring device

### *4. Personalized Care Program for Severe Mental Illness*


Shatin Personalized Care Program team photo

Shatin Personalized Care Program (PCP) Team set out to serve 1,450 patients with Severe Mental Illness (SMI). Our team adopted a community-based case management approach which is recovery-oriented, encompassing physical, psychological and social needs of patients. A Case Manager (CM) will be assigned for each referred patient and he/she will establish a close service relationship with the patient to develop an individual care plan having regard to the patient's need and risk profile. Recovery focused practice includes illness management, relapse prevention and pursuing of personal goals – common themes being the pursuit of health and wellness, a shift of emphasis from pathology and disability to health and strengths; hope and belief in positive change; social inclusion including housing, work, education and leisure; and patient empowerment. CMs will encourage active participation of patients and carers. PCP develops flexible strategies aiming at preventing any negative event from occurring or, if this is not possible, minimising the harm caused. CMs provide timely crisis intervention if indicated. Fostering a close connection to community resources and non-governmental organizations is also within our service framework.

CCE joint-visit with CM

Drug education at patient's home

Job-hunting talk by CM

Bowling outing

The program has excelled in providing quality service to its pledge. A year after its launch, 23 CMs conducted a total of 11,597 outreach visits. Notably, the Shatin PCP has established a unique multidisciplinary team (doctors, nurses, therapists and social workers), which created an enriched workplace where cross-discipline integration, supervision, skill transfer all occur in a synergistic manner. Indeed, special skills of our CMs are matched with the needs of our patients, which facilitate their journey to recovery.

Pain management class

Skin care tutorial

Visit to Noah's Ark

First-aid tutorial

In the coming year, we will consolidate our workforce, strengthen our collaboration with other community partners and share our experience in NTEC. Evidence-based research will be incorporated to analyse the service utilization, clinical outcomes and cost-effectiveness.

## B. "Improve Continuously Service Quality & Safety"

### *1. Medication Safety*

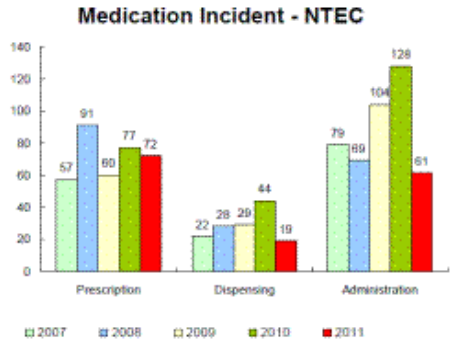
Medication safety remains the top priority of patient safety in NTEC. Since the "CCE Forum: Medication Safety – Yes We Can!" in 2010, a series of activities had been organized to improve medication safety. In 2011, the theme for medication safety was "Medication Safety – Be Safe, Be Smart, Yes We Have!"

4 cluster-wide programs were launched. These included 1) promotion of Safety Culture "有疑必問盡我本份"; 2) rollout of "NTEC Drug Book"; 3) review of Medication Administration Record (MAR); 4) revision of 3 Checks 5 Rights (3C5R) Protocol. These programs were implemented successfully in all 7 hospitals.

In addition, 4 medication safety programs were implemented: Smart Prescription project was led by Physicians, risk reduction for Look Alike Sound Alike (LASA) medications was led by Pharmacy, Protected Time for Drug Administration project and Standardization of Drug Scheduling was led by Central Nursing Division. We shared the programs outcomes in NTEC Medication Forum in October 2011.

Sharing and learning through Risk Watch meetings and iSMART pamphlet continued in 2011. Number of reported medication incidents decreased by 39%, when compared with 2010 (prescription incident decreased by 6.5%, dispensing incident decreased by 59%, and drug administration incident decreased by 52%). The result was encouraging, which reflected the efforts paid by all staff of the Cluster. We shall continue the momentum in the coming years.

NTEC Quality & Safety Forum 2011

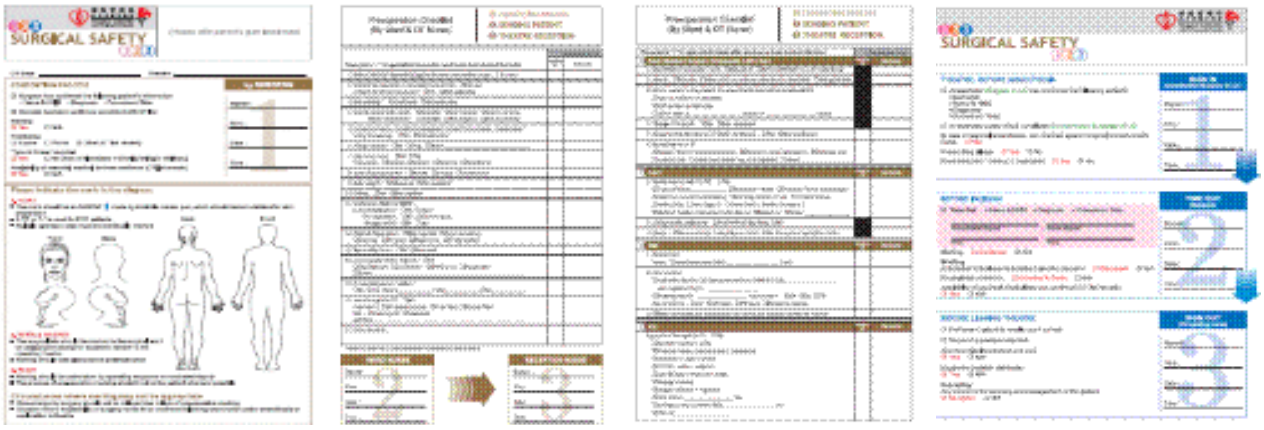




## *2. Surgical Safety*

Safe surgery is another important focus in patient safety for NTEC. A standardized NTEC Safe Surgery 123 Checklist was implemented since August 2010 to improve communication between various parties involved in a surgery and facilitate an integrated surgical checking procedure. An audit on its compliance showed an improvement from 98.4% in 2010 to 99.7% in 2011.

In December 2012, 9 Safety Checklists for Minor Operations / Interventional Procedures in interventional suites were implemented. Promulgation of these checking procedures in minor operating and intervention suites were smooth.

Phase III of Surgical Safety Program involved bedside procedures for all clinical areas (a total of 140 wards) and 2 checklists were designed, one for chest tapping, drainage and pleurocentesis, and the other for insertion of intravascular catheter with the use of guide wire. The procedures were promulgated on 15 August 2011. Similar to phases I and II, the roll out was smooth. An audit will be conducted in early 2012.




Surgical Safety Program – Phase I

Surgical Safety Program - Phase II

Surgical Safety Program - Phase III

### *3. 2D Barcode for Unique Patient Identification*

The use of 2D barcode to ensure correct patient identification was implemented in all NTEC wards in 2008. The result was excellent and incidents related to wrong labeling dropped by 94%. The system was subsequently tried out in AED, NDH in 2010 and proved to be successful in preventing labeling errors. In June 2011, AED, PWH also started to use the 2D barcode system and achieved a similar success. AED, AHNH will also implement the system in 2012.

Use of 2D barcode

### *4. Patient Relations and Engagement*

We witnessed an enhancement of patient partnership and engagement in 2011. NTEC Patient Relations and Engagement (PR&E) Service nurtured the seed of a patient engagement culture in the heart of our frontline staff. Through various programs and events, e.g. the Annual PR&E Forum, Patient-centred Care Video and Access Literacy etc, staff was made more aware of the importance of collaboration with our patients and their carers in provision of high quality healthcare services.

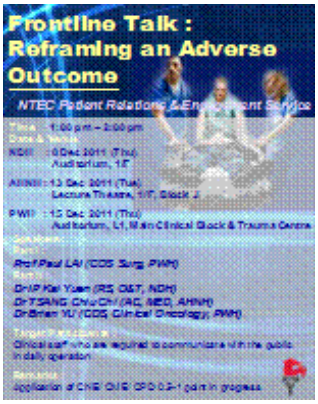
To proactively solicit feedback from service users, NTEC initiated an Inpatient Satisfaction Survey in three acute hospitals. A one-page questionnaire in three service areas was developed to collect patients' comments. Survey results were uploaded to websites for staff and public scrutiny on a quarterly basis. The cluster also actively engaged patient representatives to participate in the governance of hospitals. Four patient representatives were invited to sit in the Hospital Governing Committee or its subcommittee in the cluster hospitals.



338 participants, including 10 patient groups, attended the Annual PR&E Forum in June 2011. Feedback from the audience of the event was found to be enthusiastic.

Frontline staff were trained and educated on effective communication with patients and conflict resolution through multi-media learning tools, e.g. "Frontline Talks", interactive videos showing recommended solutions for difficult scenarios in the "High Temperature Theatres", regular PR&E's newsletter "iPartners", various training courses on complaint management for different ranks of staff, etc. Staff were equipped with better communication, mediation and conflict resolution skills.






A total of 1,056 staff attended 3 Frontline Talks conducted in acute hospitals in 2011

The networking between Patient Relations Officers (PRO) and clinical staff was also enhanced. PR&E teams paid visit to clinical departments on a regular basis to review complaints' statistics and cases specific to the department. Through discussion about the skills and experience in managing complaints and patient safety incidents, both PROs and clinical staff became more familiar with the roles and functions of each other. This paves the way for a better collaboration in the future.

PR&E Team joined departmental meetings to review the complaints' statistics and share skills and experience in managing complaints and incidents

## C. "Build People First Culture"

### *1. Staff Communication through Intranet Platform*

NTEC added an electronic discussion forum – "YouSay" to the suite of social media communication tools like CCE blog which has already been in place for a few years.

YouSay is an open forum allowing real-time posting from all users who have an intranet email account, which practically means the entire cluster community. As the platform is set up with a mission to facilitate conversation and crowd-sourcing, it has embraced the key web 2.0 operating rules of having minimal guidelines, multidirectional flow and dis-mediation. Since its launch in March 2011, more than 3,000 postings have been received from users and the 22 invited contributors from members of the cluster management. Total hit count has exceeded 200,000. Post content is diversified ranging to issues close to home to organization buzz. Sometimes the debates could get rather heated and the forum has attracted criticisms of bearing out conflicts too glaringly.

Nevertheless, a recent user survey has proved that YouSay has established itself as one of the stickiest platforms in the cluster. Many users have found it interesting, informative and considered it a breakthrough

in organization communication practice, reflecting the Cluster's values of putting people first and driving innovation and achieving excellence with the wisdom of the crowd.

Apart from discussion forum, the staff portal has been further revamped with new content and layout. A column was added for different hospitals to upload important information and news from their end with much more ease, and the regular webcasting program "CCE Dialogue" has also been enhanced with a thematic treatment. Staff from different grades and ranks and external guests are lined up to share their best practice and insights on different themes. It is believed that the authenticity and strong visual impact will engage staff interest and subtly encourage positive work values.


NTEC started a first-of-its-kind discussion forum YouSay on its staff portal in 2011.

Dr Alex YU, ex-COS (Med) of the Alice Ho Miu Ling Nethersole Hospital shared his insights with Dr FUNG Hong, Cluster Chief Executive, in the webcast " CCE Dialogue".



Hot topics on YouSay reflected staff's voices and areas of concern.

# IV. Key Achievements of Cluster Functions

## A. Administrative Services

2011/12 has been a challenging yet fulfilling year for the administrative services. Despite facing many difficult changes and an increasing workload, important achievements have been made. One of the most memorable examples was the taking up of the building day-to-day maintenance of PWH Extension Block by the existing staff of the Hospital Planning and Facility Management Division before the formation of the Technical Management Services (Building Works) (TMS-BW) Group.

### *Facilities Management*

Since the withdrawal of the Property Services Branch of the Architectural Services Department (ArchSD) in 2003, the day-to-day building maintenance of PWH had all along been provided by the Electrical and Mechanical Services Trading Funding (EMSTF). In 2010, EMSTF announced that the day-to-day building maintenance services to all HA hospitals were to cease in March 2012. As such, EMSTF declined to take up the day-to-day building maintenance of the Extension Block.

The Extension Block was completed and handed over to the hospital in June 2010 by ArchSD. Gross floor area of the building was 71,500 $m^2$, which exceeded that of AHNH (65,100 $m^2$) and NDH (66,200 $m^2$). With such a large floor area, a high demand on building repair services was expected.

The new day-to-day building maintenance team had not yet been established by then and the existing manpower of the PWH Local Facility Management Office was very limited, comprising of one Manager, one Assistant Manager, one Senior Foreman and two Foremen. They faced a challenging task of overseeing all corrective and preventive building maintenance works of the new building. During this period, the facility managers were on-call round-the-clock to provide emergency support to the maintenance works.

This task-oriented arrangement was relieved when a dedicated Building Maintenance Team was finally established on 1 April 2012. On a final count, the team had handled over 5,000 repair orders of different kinds for the new building.

Looking back on the experience of this challenging 17 months, the provisional arrangement had not only enhanced the technical knowledge of all members of the team, but also trained up a strong back-up team for handling the day-to-day building maintenance of NTEC as a whole. It was a worthwhile journey.

Staff of TMS(BW) handled minor installation work for end-user

Staff of the Repair Office repaired broken chairs

Staff of TMS(BW) repaired door hinge

Staff of TMS(BW) checked the source of water leakage

Apart from the achievement by the Hospital Planning and Facility Management Division, we have also attained notable results in many other administrative service areas:

***Health Information and Records Management***

- Developed computerized medical report tracking system "iMR" to improve the workflow efficiency in completing medical reports
- Achieved 99.6% attendance rate on data security training

***Procurement and Materials Management***

- Enhanced equipment management plan for timely disposal of replaced asset
- Reduced and replaced aging critical medical equipment with unit cost below $0.15Mn
- Introduced continuous quality improvement plan to enhance product quality on Total Solution for supply of general consumables

*Food Services*

- Implemented cook chill cum cold plating operation in NDH
- Implemented "No Diet" and "Food Waste Decomposer" Program for food waste management. Food waste rate decreased from 29.1% in 2006 to 22.5% in 2011

*Transport Services*

- Introduced fixed routes for in-patient transfer to shorten patient waiting time for NEATS
- Extended a more direct and hygienic transportation service for skin tissue from Lo Wu to PWH

*General Support Services*

- Reduced incidents on workplace violence by 13%
- Enhanced staff awareness on fire safety by organizing talks, fire ambassador course, web-based and VCD training, fire drill, etc
- Launched new initiatives to improve linen services, including friendly visits to wards, album with photos on all linen items, working group discussion to standardize the practices across the cluster and introduced new linen items to suit operation and maximize resources utilization
- Implemented Octopus-payment to streamline cash-handling in library
- Shared library resources through book acquisitions
- Catalogued acquired books in the library system

*Committee Secretariat*

- Organized the survey on evaluation of HGCs to review the support to all HGCs in the Cluster in executing their expected functions.
- Provided business support to clinical departments in the relocation exercise from old block to the new extension block of PWH.

With the conjoint effort of all administrative staff, we have witnessed very fruitful results in 2011/12 and it will undoubtedly become the motivation for our service to attain greater achievements in future.

## B. Communications

Apart from modernizing the internal communication tools, the Cluster has continued to put heavy emphasis on engagement with external stakeholders, aiming to ensure that two-way symmetrical communication is maintained with them to foster mutual understanding. During the year, a key focus of public attention has been the pressure caused by mainland pregnant ladies crossing the border to give births, sometimes taking the risk of gate-crashing at the Accident and Emergency Departments. Being nearest to the border, the hospitals in the cluster have borne the brunt of the phenomenon and its spillover effects, including manpower brain-drain, additional workload, impact on quality and safety etc. They underpinned the stakeholders' concern for the year past.

To address the concern, cluster representatives have participated in 9 district council meeting sessions and provided 45 written replies to the councilors to explain the hospitals' response

measures as well as to proactively brief council members of hospital's service developments. 5 Ad-hoc discussion and hospital visits have also been arranged to facilitate direct communication.

On the media relation side, the Cluster values the contribution of the media as a direct stakeholder and has provided timely response to media enquiries in the form of 90 written replies and many more verbal response and explanation. Visits to pressure areas like the obstetric wards, AEDs and neonatal ICU and paediatric ICU were also arranged to engender a first-hand understanding.

Apart from addressing the stakeholders' concern on various topical issues, the Cluster has also organized some 200 media interviews to publicize the achievements and work of the hospital during the year.

Meeting legislative and district council members to discuss issues of community concern

The Cluster is also keenly aware of the need to directly communicate with members of the public via strategic touchpoints. Last year, we held a number of on-site events to engage the public who may not have had direct experience with hospital services before. On the occasion of the grand opening of PWH's new Main Clinical Block and Trauma Centre in June, a two-month photo exhibition was held in the new building to showcase the images of hospital life in the old block taken by the veteran photojournalist Mr Alex NG. The photos have realistically captured the health care workers' professional spirit and dedication to their vocation. Viewers' comments were overwhelmingly very positive. An electronic display and open exhibition in the Jockey Club Creative Arts Centre (JCCAC) soon followed.

In Jan 2012, the Cluster solicited the help from the students of the Department of Nursing and Health Sciences of the Tung Wah College to arrange a two-day public health-check-cum-exhibition titled "'Tips for Combating Stroke' in the Wo Che Plaza to dovetail with the cluster Annual Plan initiative of introducing '24-hour thrombolytic treatment'. More than 1,000 members of the community participated in the health check and many more viewed the health education panels.

A photo exhibition captured the professional spirit of the health care workers.

Members of the community were given tips on how to combat stroke

Cluster Chief Executive Dr FUNG Hong briefed the press on the Cluster's new service developments

Health beat reporters visited the Bradbury Hospice and were given a briefing on narrative therapy

## C. Finance

In financial management, NTEC achieved good governance by balancing the budget and optimizing the use of public resources for the benefits of our patients.

### *Governance*

The Budgetary Control Framework is a tool to support the three main principles of Openness, Integrity and Accountability. Although the framework has existed since the establishment of the cluster, it was not formally documented until this year. The framework which defines the structure and key components of budgetary controls received formal approval from the Cluster Management and was presented at each of the seven Hospital Governing Committee Meetings.

### *Modernization through Systems*

We have been supporting the development and implementation of new systems since 2007. The list of systems includes: General Ledger, Procurement, Accounts Payable, Inventory Control Systems, Fixed Assets, Paperless Shared Care Compensation and the Human Capital Management. In 2011/12, we worked on Hyperion, PBRC (Patient Billing Revenue Collection) and the PHS (Pharmacy System) to prepare for their implementation in the fiscal year of 2012/13.

Our experiences with systems development gave us a better understanding on how to collaborate efficiently with Cluster IT and the stakeholders. We co-developed and implemented the iAnnual Plan system in less than three months. Its key benefits/features include a secure web-based tool that streamlined process flow (completeness and accuracy), highlighted by a paperless workflow and approval process. The iAnnual Plan system captured around 440 program submissions and reduced time spent to submit, review, and approve the Annual Plan proposals.

### *People*

The key ingredient for any department is people. We face a challenging task of recruiting a "right" person to perform well in public sector accounting. We are pleased that this year we managed to successfully fill all of our professional accounting posts, which was an achievement not many clusters have been able to attain.

We aim at attracting highly qualified staff and providing structured training and development opportunities for retaining good staff. We recruited students twice each year, with a view to give them real working experience to open their minds to consider starting a career in Hospital Authority. We established linkage with them through visits, social gatherings or meeting each other on Facebook.

We worked on enhancing internal communications. Emphasis was placed on strengthening our basic skills and enhancing our quality through teamwork. We enjoyed a Team Building exercise held at Breakthrough Youth Village during the year.

Team Building

Financial Accounting Team

Financial Management Team

iAnnual Plan Celebration

## D. Human Resources

### *Staff Engagement*

The cluster management team continued to invest time and effort to engage staff through various channels. Departmental visits were held in which CCE and the senior executives visited each department within the cluster once every year. A total of 47 visits was arranged in 2011/12. The management team met departmental representatives from different staff categories and levels; and to share departmental performance and issues and to listen to staff concerns. Immediate feedback would normally be offered or otherwise subject officers would follow up with the various issues raised.

HCEs of individual hospitals also conducted walk rounds to each department to meet frontline staff at their workplace to understand their needs and problems. Imminent concerns of staff were gauged through regular luncheon meetings with different staff groups.

CCE Staff forums were conducted in PWH (video-conferenced to SH & SCH), AHNH and NDH bi-monthly. The style of forum would vary to encourage staff participation, e.g. by inviting relevant doctors and nurses to sit on stage to talk with audiences on current hot issues. Topics discussed included "Walking through the Patient Journey"; "Reflections on Medical Incidents". The forum on "Accreditation" adopted an on-site Questions and Answers approach. Individual HCEs also held regular staff forums at their own hospitals.

There were also online forums to enable staff to express their views. Our YouSay has attracted widespread attention for allowing staff to give their voices through an intranet platform. In 2011/12, this newly created platform attracted many hits. We made use of this to communicate management philosophy through issues of concerns.

To enhance staff engagement, we organized the first Cluster Allied Health Day, Administrative & Supporting Staff Fun Day and Doctors' Day on 23 September 2011, 20 January & 30 March 2012 respectively to recognize contributions of each of these staff groups and to celebrate their achievements and successes. These activities were organized building on the success of the Nurses' Day which was organized every year on 12 May.

During the celebrations, video episodes were shown to enhance understanding and appreciation on each others' work. We also took the opportunity to recognize staff who had received compliments from our patients in the past year.

A Cluster Sports Fun Club was formed to foster relations between staff through an informal social network linking their common interest in sports and other hobbies. The Clubs strengthened staff's' bondage by participation in various teams' social activities and competitions, which cultivated a norm of sharing and participation. One of our major joyful achievements was the Cluster's participation in HA New Year Run, resulting in winning the Overall Cluster Championship. We also have performed very well in dragon boat races.

## NTEC Nurses Day



A


## NTEC Allied Health Day

B


C

A) The 1st Cluster Allied Health Day
B) Awardees of the most senior AH staff
C) Toasting Guests

# Cluster Administrative & Supporting Staff Day






A) Staff marched into the Auditorium
B) Champion Slogan in Slogan Competition
C) Karate performance by Supporting Staff
D) Kick off ceremony during the celebration
E) 300 staff participated in lunch time celebration

# NTEC Doctors' Day






A) Prof Ellis HON & Prof Johnny CHAN doctor sing & play guitar
B) Doctors' Day @ AHNH & TPH
C) Doctors' Day @ SH & SCH
D) & E) NTEC Doctors' Day (simultaneously held during lunch time in PWH, SH, AHNH & NDH)

# NTEC Staff Forums & CCE Staff Luncheons





A) CCE monthly luncheons with different staff groups in PWH, AHNH & NDH
B) CCE bi-monthly Staff Forums

## Cluster Sports Fun Club


A), B) & C) NTEC Solo & Group singers won awards in HA Singing Contest 2012


## NTEC Won Overall Championship In HA New Year Run

A) Mr Anthony WU and Dr PY LEUNG presented the Overall Championship to NTEC athletes
B) NTEC won the Overall Championship in HA New Year Run 2012
C) Dr CH LEONG and Dr FUNG Hong joined our Pupil Nurses in cheering team

## PWH Spring Reception Dinner



A) Er hu & singing performance
B) Director of Finance and HGC Chairman & members joined in toasting with PWH staff
C) Beer drinking contest



## Teambuilding Workshop for SCH CND

## SH & BBH CND TEAMBUILDING WORKSHOP IN BREAKTHROUGH VILLAGE


## STAFF COACHING WORKSHOP FOR WARD MANAGERS BY HK CHRISTIAN SERVICES

## MEDICO-LEGAL SEMINAR FOR DOCTORS & NURSES BY JSM PARTNERS

### *Staff Training*

To enhance nursing leaders' people skills, all 100 Ward Managers in the cluster attended 2-days training on "Conflict Resolution" and "Coaching". Retired senior nurses were invited to share insights on communication, teamwork and accountability with frontline RNs.

Besides, hospital management also organized hospital strategic planning workshops to share their respective development and execution plans. Various departments also conducted team building workshops to enhance team cohesion and mutual understanding at work.

One-staff-one-plan training courses were rolled out to doctors in mid-2011 after its implementation in nurses, allied health, supporting staff and administrators in the past four years. Medico-legal seminars and talks on Equal Opportunities were amongst the most popular classes.

## E. Information Technology

### *Filmless Hospitals*

After the rollout of "Filmless HA project" in NDH and PWH Extension Block, the project was further extended to PWH old block, LKS Specialist Outpatients Clinics and Cancer Centre in 2011-12.

In an inpatient ward, computers-on-wheels (COW) running in wireless network were installed to support the doctors and nurses to readily access online patients' X-ray, CT or related images in their ward round. Wall-mounted workstations were also setup and monitors of existing workstations were upgraded to high-grade monitors for reading diagnostic imaging.

An army of COWs is ready to go!

PWH and NDH installed hospital local lossless servers (LLW) to support the contingency plan and ensured no interruption of imaging services.

### *Mobility Engagement*

Mobile is not simply another device for IT to support. Rather, mobile is a new system of engagement that helps to empower our patients, partners and employees.

With the new implementation of the "PWH Internet One-Touch 一點通" and "PWH Internet One-Click 一站通", online information related to visiting hours, transportation, admission procedures, patients literacy videos, application for patients information and so forth are accessible via Smartphone.


Try the new PWH One-Click on iPhone and iPad

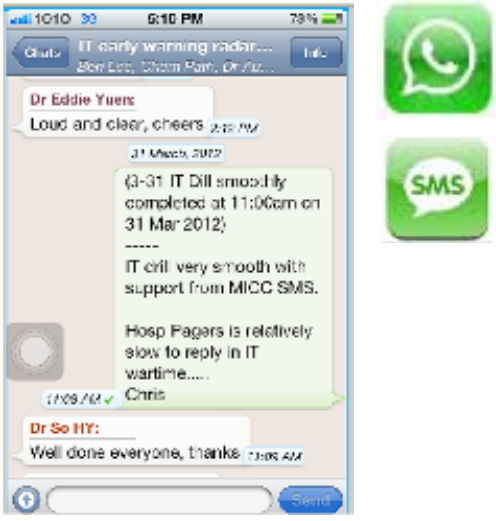
NTEC colleagues can use their own personal Smartphone like iPhone, iPad or Blackberry to connect to NTEC email server. As at 31 Mar 2012, there were over 120 pilot users.

Mobile CMS operating in 3G broadband and notebooks was setup to support Community Psychiatry program and Child Care Development Service (CCDS) in this year. Doctors can bring their notebooks with 3G/4G tokens to access their patients' ePR or other clinical information in Clinical Management System (CMS) at outreaching clinics or GOPCs.

### *Preparedness for IT Disaster*

"331 Drill" for IT contingency plan was conducted on 31 March 2012. It raised staff's awareness on communication, readiness of department contingency plans and use of manual forms if CMS was down. All AHNH, NDH and PWH department CMS coordinators attended the drill and the debriefing results was shared.

And the "IT pre-alert" in WhatsApp or SMS was also adopted as a pilot in issuing earlier IT warning radar to IT key management. So, a quick response which minimizes adverse impacts of IT disaster can be achieved.



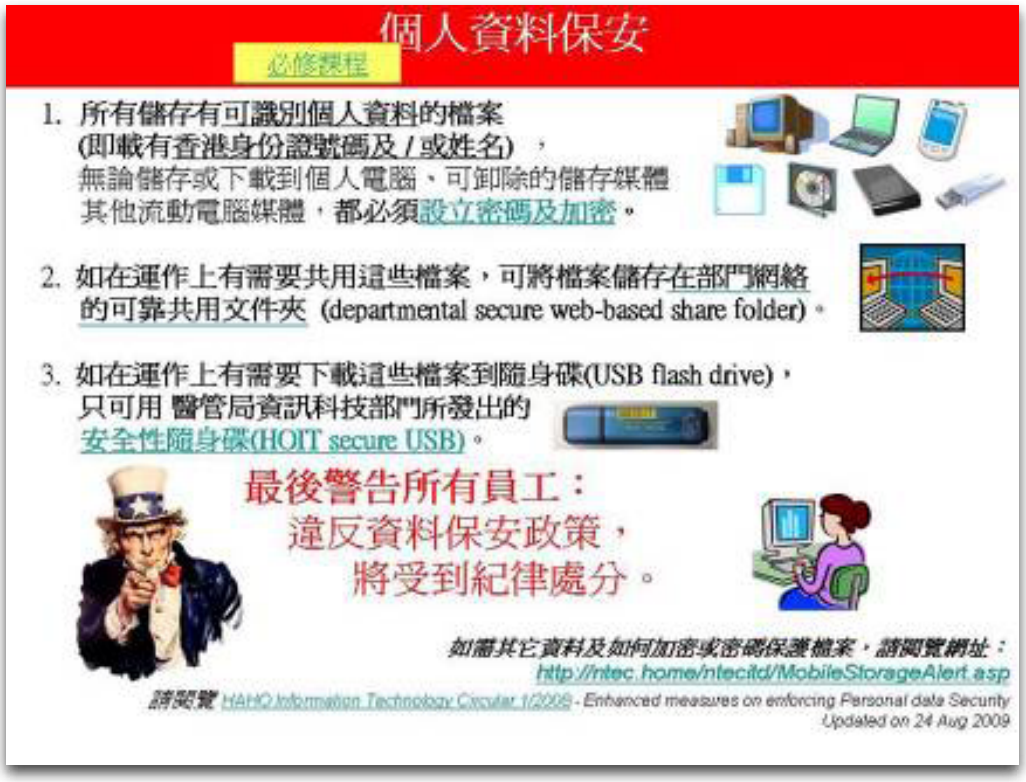

"IT pre-alert" in WhatsApp or SMS


"331 Drill" for IT contingency plan was conducted on 31 Mar 2012

### *Protecting Personal Data*

The Cluster puts a very strong emphasis on staff's awareness and adherence of protecting personal data. Our programs in 2011-12 cover:

- Mandatory training to all NTEC staff
- Information portal accessible in NTEC intranet @iNTEC
- Use of secure web folders in each dept web @iHosp
- Distribution of secure USBs flash disc for each department
- Endpoint encryption software installed in all NTEC notebooks




Highlights of Personal Data Security / 個人資料保安

# V. KEY ACHIEVEMENTS OF HOSPITALS 11/12

## A. Alice Ho Miu Ling Nethersole Hospital & Tai Po Hospital

### *1. Enhancement of Renal Services*

The Hospital made a great stride in patient empowerment with the establishment of Nocturnal Home Haemodialysis (NHHD) Training Centre, providing NHHD services for patients in the whole New Territory region. Commencing the service in early 2011, patients who have completed training managed to improve their quality of life whilst on self-performed dialysis at home.

As an initiative for service enhancement to meet the growing needs of renal service, AHNH has increased the number of chronic haemodialysis patients, Automated Peritoneal Dialysis (APD) patients and hospital haemodialysis. Additional fixtures and equipments were also in place to accommodate service augmentation.

Opening Ceremony of Nocturnal Home Haemodialysis Training Centre

Expansion of home haemodialysis and in-hospital haemodialysis to serve the growing needs of the population

### *2. Celebration of Doctors' Day*

In collaboration with the Doctors' Association of Alice Ho Miu Ling Nethersole Hospital (AHNH) and Tai Po Hospital, AHNH organized the first-ever "Doctors' Day" on 30 March 2011 to appreciate the numerous achievements and efforts of our doctors made. In order to tie in with the theme of "We care, we serve and we appreciate", a greeting-card game was designed to gain staff participation and facilitate communication, care and concern among staff members. A doctor and a chaplain jointly composed a theme song to commemorate this special event. The event was concluded with

a ceremony. A series of activities, including presentation of awards to the most popular doctor nominated by each clinical department and patients, was arranged. The event was widely supported by the frontline staff and a total of 129 doctors attended the ceremony. The celebration was further embarked on a cluster level with the participation of health care professionals in NTEC in 2012.

"We care, we serve, we appreciate", celebration of Doctors' Day was well received


Awards were presented at the ceremony to show our appreciation

### *3. Establishment of Serene Teen - New Holistic Child & Youth Wellness Centre to Nourish Healthy Growth and Development of Children*

With a donation of HK$8.35 million from Li Ka Shing Foundation and funds from the Hospital Authority, AHNH has established the "Serene Teen" - a Holistic Child and Youth Wellness Centre cum Training Centre in addressing mental health problems of children and adolescents in NTEC.

Working closely with community partners to create an all-round synergy platform for holistic care and support, the centre delivered a seamless spectrum of services, including prevention education, early identification, prompt intervention, assessment and therapy and rehabilitation, with the support of a multi-disciplinary team of different expertise.

A soft launching ceremony was held on 22 March 2012. The scheme will be fully implemented in mid-2013, expecting that AHNH will be able to handle 400 paediatric psychiatric outpatients per year from 120/year in 2010. Number of patients served will be increased six-fold to 2,200. For multi-disciplinary professional medical care such as clinical psychiatric services, occupational and speech therapy, the number of cases handled is expected to rise from 90/year in 2010 to 5,000/year.

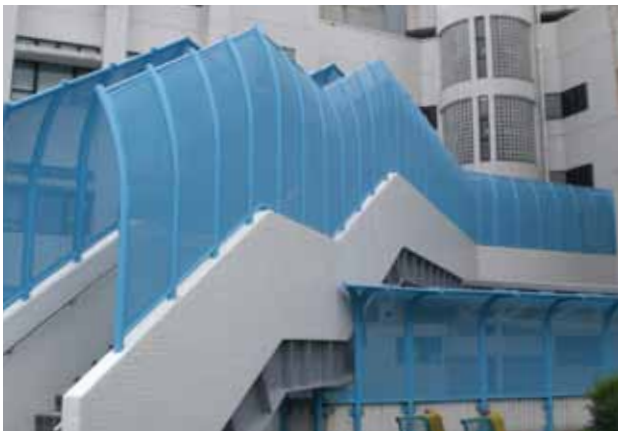
Launching Ceremony for the Development of Holistic Child and Youth Wellness Centre cum Training Centre on 22 March 2012

Our committed team delivered holistic care and support for the "Serene Teen" project

### *4. Modernization of Mental Health Services - Official Launch of Model Ward, Access to Rehabilitation Garden and Psychiatric Day Centre*

TPH has laid out a detailed plan to modernize its mental health services, in an attempt to provide a safe and pleasant environment for psychiatric patients as well as adequate support for patients, carers and staff members. The plan outlines three key elements, including the enhancement of facilities, provision of leisure activities for in-patients and implementation of long term rehabilitation programs. On 10 Jan 2011, the Hospital held a launching ceremony to exhibit its sustained commitment to modernize the service delivery, present the newly renovated ward, the shielded stairway bridging the psychiatric ward to the rehab garden and the day activity area for psychiatric inpatients.

Day activity area for inpatients



Stairway connecting the Psychiatric ward to rehab garden

Rehab Garden

Model Ward

## B. Bradbury Hospice & Shatin Hospital

### *1. Life Honouring Project – Application of Narrative Therapy in Psychosocial Care of Terminal Patients*

The Medical Social Service Unit in Bradbury Hospice has been collaborating with Hong Kong Polytechnic University in applying Narrative Therapy in patient group context at Day Hospice. This is a pilot scheme named as 「死去、活來：生命的再思」 in local palliative care setting.

Three rounds of patient group sessions have been organized, with family interviews arranged for patients outside the group sessions. Social workers helped each group of patients to produce their life portfolio and presented their memorial work at the end of the group sessions. In connection with this, an event was organized on 17 September 2011 at HAHO for the community to share the experience of this project.

The event comprised of workshop, exhibition and book publication. Around 300 people from health care setting and community organizations participated in the event. From the participants' feedback, they felt the event inspiring and the average satisfaction score was high. The book with the title 「死去、活來：生命的再思」 jointly written by the social workers of Bradbury Hospice and lecturers of the Hong Kong Polytechnic University was published.

With the purpose of life and death education, displaying the exhibition materials in our cluster hospitals will be arranged. Besides, Medical Social Service Unit also planned to continue the implementation of narrative groups for patients, and enhance the psychosocial care through application of various practices and methods of narrative therapy.

Narrative Group for patients

Exhibition of Narrative Project at BBH

### *2. Person-centred Care - Safety without Restraint*

Frail elderly are often instructed to stay in bed or to put on restraint to minimize possible injury related to fall during hospitalization. At Shatin Hospital, we believe that use of restraint is inhumane and has no proven benefits.

The Fall and Restraint Reduction (FARR) Team of Shatin Hospital (SH) was set up to start a new page in taking care of the elderly. The Team composed of doctors, nurses, physiotherapists and occupational therapists of the Medical and Geriatric Department. Programs launched were aimed at enhancing patient rehabilitation, improving service quality and allowing staff to better understand patient needs and manage delirium and falls appropriately. Alternatives such as enhanced observation, patient monitoring devices and low electric beds were adopted to achieve the aims.

Results were highly satisfactory as restraint rate dropped from 32% in 2005 to below 1% in 2010 - with no increase in fall rate. A restraint-free and safe environment was promoted and independence level of the elderly patients during rehabilitation was enhanced. It was a great honor for the Team to receive the Hospital Authority Outstanding Teams Award 2011, which was a remarkable recognition of their efforts in continuously improving the holistic care provided to patients.

The project was widely publicized in various means of media, including newspapers, television and radio.

In acknowledgement of the work of SH to provide a safe and therapeutic environment for patient rehabilitation, the Hong Kong Jockey Club Charities Trust has donated HK$8 million in December 2011 for implementing the project "Person-centred Care: Safety without Restraint".

Fall Prevention Alarm System - Bed pad sensor

Electric Low Bed

Fall Prevention Alarm System
- Set of easy release

HA Outstanding Team 2011, Fall and Restraint Reduction (FARR) Team


### *3. Celebration of 20th Anniversary*

Shatin Hospital celebrated its 20th birthday in 2011. An array of celebrating activities was organized to care for our carers and promote the physical as well as mental health of staff. Staff were encouraged to lead a balanced life throughout the year. Lots of staff responded to the call and started their first 6km run during the Chinese New Year, conducted body check in the Carnival, participated in exercise sessions under the guidance of physiotherapists, took part in football matches and equipped with self-care skills from talks on Chinese Medicine and Workplace Happiness.

Academically, the Hospital collaborated with the International Association of Gerontology and Geriatrics (IAGG) and the Chinese University of Hong Kong to organize IAGG Institutional Care of Older Adults Conference in May 2011 with over 170 participants attended the Conference.

The celebration culminated in a dinner ceremony on 2 December, which was also the birthday of the hospital. Over 550 participants joined the banquet including many old colleagues who left the hospital for more than a decade.

While meeting old friends and looking at photographs capturing the precious moments, lots of sweet memories were recapped. The seemed-to-be forgotten memories were retrieved again. These memories were imprinted in our mind and being part of our life.

Carnival 26.2.2011


IAGG Institutional Care of Older Adults Conference 4 - 5.5.2011

Football Match with HK Movie Star Sports Association Charities Ltd 5.11.2011

Anniversary Dinner 2.12.2011

## C. Cheshire Home, Shatin

### *1. Celebration of 20th Anniversary*

To the colleagues and residents of Cheshire Home, Shatin, Year 2011 conveyed a special meaning for them. The passing of February 2011 ushered in our 20th Anniversary.

Celebration activities were held in each season of the year. There were the anniversary kick-off ceremony and the couplet design competition in March, the games day in July, the walkathon in November and the participation in the 50th anniversary dinner of the Hong Kong Cheshire Home Foundation in February 2012.

The kick-off ceremony was the curtain raiser. Our Kitchen colleagues prepared a birthday cake sprinkled with strawberries in the shape of our logo. The event was participated by some Hospital Governing Committee members to share the happiness.

Another highlight was the games day in summer. Our residents competed in the boccie tournament. Their adroit skills won the applause of all the participants. There was also the image on the wheelchair contest. We had Mother Teresa, a singer, etc. coming to our hospital.

With the arrival of autumn came the walkathon. It was a rendezvous of our residents, their relatives and our colleagues. We walked in high spirits within the hospital compound to appreciate the beautiful scenery.

To mark the closing of our celebration activities, we joined the gala dinner of the 50th anniversary of our Foundation. It was an once-in-a-lifetime event for the Cheshire Home family in Hong Kong. Not only was the food sumptuous, but also a golden opportunity for reminiscence.

Our staff members happily welcomed the arrival of our 20th anniversary

Kick-off ceremony for 20th anniversary celebration activities

Games day in summer

Walkathon on November 11, 2011

Our colleagues in high spirits during the walkathon

### *2. Fall Rate Reduction and Workplace Safety*

Sharing the same vision of providing safe and quality service, our colleagues are united in their determination to reduce the fall rate of our patients. We set up a multi-disciplinary team to achieve this task. Their input has brought about gigantic changes and we have achieved a 58% decrease in the fall rate as compared with last year.

In our quest to excel in our service, we also take good care of our colleagues. We have adopted various measures to provide a safe workplace for them. There are regular rounds by the Occupational Safety & Health Team in our hospital to identify good practices and also room for improvement. Besides, whenever there is an injury on duty (IOD) case, the above team will conduct investigation to promptly unravel the cause(s) and take necessary remedial action. The annual IOD figures have dropped by almost 50% after implementing the measures.

Our Critical Incidents Support Team (CIST) also plays a crucial role to walk with our colleagues in times of distress. Their support goes beyond critical incidents and they are here to show their care and support whenever need arises.

Autumn picnic with overwhelming response from colleagues

Writing of spring scrolls to herald the arrival of Chinese New Year

Our participation in the HA New Year Run

Occupational Safety & Health Round

### *3. Nursing Supporting Team Project*

The idea of setting up a nursing supporting team in SCH dedicated to bathing patients surfaced during a Hospital Chief Executive round to a ward about six months ago. Since most of our patients are physically compromised or bedridden, bathing duty is one of the ward routines. It is a task of great importance and our colleagues performing it are prone to injury.

Therefore, the suggestion of assigning certain colleagues to be specialized in bathing patients is a challenge to us. It is a practice adopted by some overseas hospitals with satisfactory outcomes. Despite that, effecting the above change requires a reorganization of the duties of our ward colleagues and we are unflustered to translate the idea into action. We have the conviction that it will be beneficial for both our patients and colleagues.

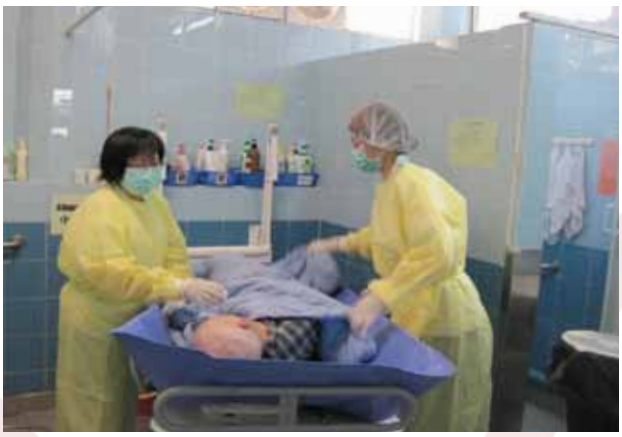
As a starting point, we engaged various disciplines including Physiotherapy Department, Occupational Therapy Department and ward management to form a taskforce to embark on this new project. Meticulous planning and thorough communication are essential to pave the way for its eventual success.

The project was on board in December 2011. It has so far run its course as anticipated. Everyone involved is pleased to see its progress. We will conduct a review later and roll out the project to all the wards subsequently.

Physical assessment

Daily exercise

Kick-off Ceremony



Patient bathing

## D. North District Hospital

### *1. Admission Ward System Revamp*

For acute patients admitted through AED, "Bed available. Care should be provided" signified the ABC primary objective that staff always kept during every review of admission system in NDH. The 4th review of admission system was started in December 2010. Staff asked "Why change?" "Why our ward?" "Why….?" Facing this challenging task, we worked in unity and collaboration of all the departments was achieved in overcoming the problem. A era of new admission system started in September 2011. With the mutual understanding and cooperation of all departments and staff, we can definitely overcome the everlasting winter surge.

### *2. Renal Haemodialysis Day Service*

Renal Haemodialysis (HD) day service in 3D ward of NDH started in September 2011. The objectives are to provide chronic HD service to accommodate the expanding End Stage Renal Failure (ESRF) population at NTEC and patients with acute renal failure complicating other medical and surgical problems. 5 day beds were provided for serving patients and out-patients requiring HD services. Moreover, renal nurses also educated patients and their families on pre-dialysis management to ensure patients received sufficient information regarding the nature of ESRF and options of the treatment.

Commencement of Renal Haemodialysis Day Service in September 2011

### *3. Hospice Day Centre*

A hospice day centre was set up in December 2011, which offered a wide spectrum of services, including doctors/nurses consultations, counselling, rehabilitation, chaplaincy and spiritual support with volunteers participation. The centre is designed with a homely atmosphere and serves as a hub for extending hospice care to patients of NDH. Staff training and clinical support have been strengthened. Comfort rooms in various wards and a family room in A&E are also established.

Opening of Hospice Day Centre in December 2011


Opening of Hospice Day Centre in December 2011

### *4. Implementation of Cook Chill cum Cold Plating Operation*

The new Cook Chill cum Cold Plating Operation was successfully launched in NDH in June 2011. With the new Patient Meal Serving System, both the quality and safety of patient meal have been improved. Besides, since food is plated cold, large cooking is no longer required. Hot holding equipment dissipating heat to the environment is reduced to a minimal. The work environment for our staff has improved a lot.

System activated

Meals ready

Meal served to patient

Meal tray with hot & cold items

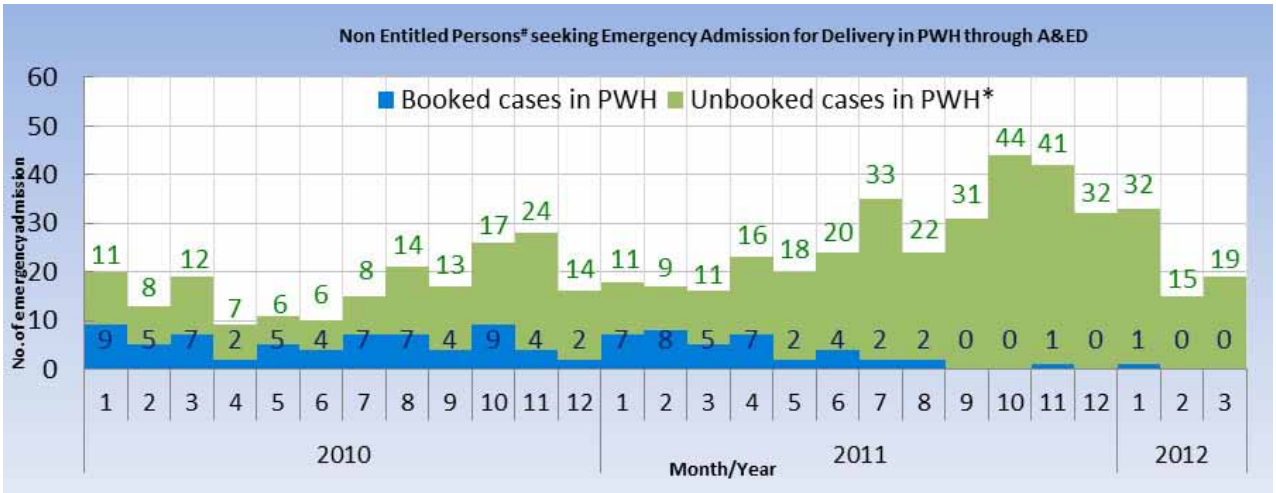
Meal service at ward

## E. Prince of Wales Hospital

### *1. Record High Deliveries*

PWH faces a great demand for its services not only from local residents, but also from residents living across the border.

Apart from the demand by local pregnant women, Non-eligible Persons (NEPs) also made arrangement for deliveries in PWH. In 2011, a vast numbers of mainland pregnant women (over 450% as compared with 2010) rushed to the Accidents and Emergency Department (A&E) for delivery without making appointment, which overloaded the A&E. During peak season, there were more than 1 NEPs seeking emergency admission for delivery at A&E each day.




# Non-entitled Persons here included Mainland China and other nationalities (3% for other nationalities)
* Non-booked cases in PWH included those booked cases in other HA or private hospitals

In 2011, the number of deliveries reached a record high of 7,400. There was also a concomitant increase in the demand for neonatal intensive care service as the number of babies born in Hong Kong went up. Occupancy rate of Neonatal Intensive Care Unit had increased by more than 20% when compared to 2010.

In light of the progressive increase in demand by local pregnant women in 2012 & 2013, Hospital Authority announced the suspension of obstetric service booking by non-local pregnant women in 2013 and a revision of NEPs obstetric package charge for non-booked cases complemented the stepped-up border control and law enforcement by the Government. It proved to be effective in discouraging the undesirable and high-risk behavior of NEPs seeking last-minute hospital admission before delivery through A&E and ensure that priority be given to local pregnant women for the use of obstetric services.

### *2. Opening of Integrated Oncology Clinic and Expansion of Ambulatory Cancer Care Centre*

Setting up of Integrated Oncology Clinic (IOC) was made possible with a generous donation from the Hong Kong Cancer Fund and support from the Hospital Authority. The renovation took 10 months to complete and opening of the clinic took place on 6 December 2011.

IOC was designed to serve cancer patients requiring multidisciplinary consultation and integrated treatment with surgery, chemotherapy and radiotherapy. In the Clinic, oncologists, surgeons, radiologists and other specialists jointly devised the optimal treatment plan for patients with different types of cancer, including breast cancer, head and neck cancer, brain tumors and skin cancer, etc.

The Clinic offered a one-stop holistic service to meet the special needs of cancer patients. Doctors, nurse specialists and radiation therapists offered patient counseling on coping skills, cancer education and care of treatment's side effects.

IOC's spacious waiting areas, cheerful color scheme and open registration counter provided a pleasant environment to cheer up the patients which maintain their positive attitude in fighting against their diseases.

Opening Ceremony of the Integrated Oncology Clinic

Reception and waiting hall of the Integrated Oncology Clinic

In line with the opening of IOC, the centre is now equipped with a total of 5 linear accelerators with state-of-the-art technology to deliver real-time image-guided and motion-compensated high precision radiotherapy. It improves the radiotherapy of lung, liver, prostate, brain and head and neck cancers. Commissioning of the last replacement machine was completed and put to full clinical service in 2011/12. In 2011, the Centre provided Image Guided Radiotherapy (IGRT) and Intensity Modulated Radiotherapy (IMRT) to 88 and 348 patients respectively.

Service at the Ambulatory Cancer Care Centre (ACCC) was also expanded with an increased capacity for chemotherapy. ACCC currently offered 44 day places (28 chairs + 16 beds) and 2 treatment rooms for patients receiving chemotherapy, radioimmunotherapy, biologic therapy, stem cell collections and day procedures. In 2011, there were 16,636 chemotherapy treatment attendances, which is 4.1% higher than the attendances of 2010.

The 5th Linear Accelerator

### *3. Launching of Filmless Radiology*

Prince of Wales Hospital Filmless Radiology service had successfully rolled out on 1 January 2011 to transform traditional film based operation to a fully digital medical imaging era.

Planning of the filmless project started in 2009 with representatives from different disciplines working as team members for the project. Under this project, the Radiology Department undergone the process of upgrading the radiology equipment to Digital Imaging and Communications in Medicine (DICOM) standards and installation of the Picture Archiving and Communication System (PACS). Great effort had also been made to integrate PACS to Electronic Patient Record (ePR) for image distribution.

A large scale of computer hardware installation was conducted for this project. Totally, 38 Computer On Wheels (COW), 99 wall mount workstations and over 500 medical grade review monitors were installed in wards, Li Ka Shing Specialist Outpatient Department (LKS SOPD) and General Outpatient Clinic (GOPC). Clinicians, nurses and ward staff could view and share instantly every medical image in everywhere and at anytime.

All clinical departments are benefited by the filmless project and about 1.5 million manual film loan and return transactions is saved every year. Around 90% of hard copy films can also be reduced. The Filmless Project will be further rolled out to other NTEC hospitals in 2012/13 and 13/14. The digital imaging network will cover all 7 hospitals, SOPDs and GOPCs at NTEC eventually.

Introduction of the Computer On Wheel (COW) of the Filmless Radiology Service to HKSAR Chief Executive Mr Donald TSANG

# VI. APPENDICES



## A. Key Achievements of Cluster Committees

### *1. Functional Committees*

#### a. Cluster Performance Committee

i. Standardized management reports to Hospital Governing Committee, Cluster Operations Committee, Hospital Management Committees and to Department Heads. Objectives of the report would be to facilitate service planning and monitoring of key performance and prompt response to service gaps.

ii. Monitored the casemix data and prepared reports to facilitate departments in the monitoring of service performance as well as preparation of care plans for disease groups which constitute significant disease burden in our Cluster.

iii. Helped to identify pressure areas of the NTEC clinical services, and raise the problem to management for strategic prioritization. Key findings were also presented at the Cluster Strategy Advisory Committee and annual planning meetings.

#### b. Casemix Committee

i. Implemented a list of actions to increase staff's awareness on data accuracy such as conducting more than 20 clinical document seminars, development and implementation of department specific diagnosis and procedure list.

ii. Developed management reports such as quarterly management and annual management reports to assist departments in improving their performance.

iii. Monitored the performance of departments by reviewing special reports such as un-groupable reports and audits reports.

### c. Cluster Communications Committee

i. Reorganized the Cluster Communication Committee with revised membership and terms of reference.

ii. Introduced online discussion forum YouSay.

iii. Engaged patient group representatives in annual planning.

### d. Cluster Newsletter Editorial Board Committee

i. Positioned Net East as staff-oriented newsletter to promote staff communication and to report staff news.

ii. Promoted staff understanding of senior management through CCE/HCE Column.

iii. Promoted sense of belongings for NTEC staff through better knowledge on the Cluster and participation of activities.

### e. Quality & Safety Committee

i. Endorsed and implemented 6 cluster wide policies / protocols (4 concerning medication safety and 2 concerning safe surgery).

ii. Launched 4 cluster wide improvement programs for medication (safe culture, e-drug information, review MAR, and reaffirm 3C5R procedure) with positive response.

iii. Developed and implemented 2 Checklists for Bedside Procedures (Phase III Safe Surgery) in all clinical wards in NTEC; the audit was good.

### f. Hospital Accreditation Steering Committee

i. Established the governing structure for accreditation, i.e. cluster level and hospital based Steering Committee / Project Committee with the support from Hospital Coordinators and Quality Officers.

ii. 2,106 PPGs (policy / protocol / guideline) were registered in iHospital from all departments which demonstrated the clinical / service standards and preparation for accreditation.

iii. Conducted Quality Workshops and Walkrounds in the Cluster to review the standards and identify areas for improvement.

### g. Patient Relations and Engagement Committee

i. Enhanced patient partnership and engagement through organization of programs and events in the Cluster.

ii. Trained and educated frontline staff on effective communication with patients and conflict resolution by employing multi-media.

iii. Enhanced support and communication between Patient Relations Office and clinical departments.

h. Administrative Services Committee

i. Took up building day-to-day (DTD) maintenance of PWH Extension Block by existing staff of Hospital Planning & Facility Management (HPFM) Division before the formation of Technical Management Services (Building Works) (TMS-BW) Group.

ii. Launched new initiatives on improving linen service including friendly visits to wards, album with photos on all linen items, setting up working group to standardize practices across the Cluster and introducing new linen items.

iii. Achieved 99.6% attendance rate on data security training.

i. Human Resources Committee

i. Established a Workgroup for One Doctor One Plan training program.

ii. Continued to explore the set up of survey to collect staff opinion.

iii. Piloted the reactivation of Healthy Staff Program in NDH.

### *2. Clinical Committees*

a. Accident & Emergency (A&E) Service Committee

i. Augmented the training of inter-facility transportation of obstetric patients.

ii. Collaborated with obstetrician for management of obstetric emergencies in NDH A&E Department.

iii. Implemented 'Team Triage' in PWH A&E with a senior doctor working in triage for targeted hours.

b. Clinical Oncology Service Committee

i. Opened the Integrated Oncology Clinic to serve cancer patients requiring multidisciplinary consultation and integrated treatment on surgery, chemotherapy and radiotherapy.

ii. The TrueBeam radiotherapy machine, one of the most advanced linear accelerator models was donated by the Li Ka Shing Foundation on 18 January 2012.

c. Internal Medicine Service Committee

i. Extended the service hours of providing tissue plasminogen activator (tPA) to stroke patients at PWH from 8:00 am to 8:00 pm from Monday to Friday since 1 July 2011. Up to 28 March 2012, a total of 25 patients were given tPA in 2011/2012.

ii. Enhanced renal service in NTEC with provision of service to 10 home haemodialysis patients, 12 home automated peritoneal dialysis (APD) patients and 11 additional hospital haemodialysis patients.

iii. In order to cope with the increase in service demand during winter surge, extra beds were opened in medical wards and hospitals to pilot the provision of fast track investigation, intervention and procedures in day wards to reduce the burden to inpatient beds.

### d. Paediatric Services Committee

i. Relocated the Paediatric General Ward and Day Ward to 11/F Clinical Sciences Building, PWH to improve isolation facilities for paediatric wards and to relieve the overcrowding conditions of Special Care Baby Unit (SCBU) at PWH.

ii. Adopted measures to handle the high demand from cross-border patients. The total number of in-patient and day-patient D&D increased from 20,920 in 2010 to 21,231 in 2011. The in-patient bed occupancy rate of Neonatal Intensive Care Unit (NICU) also increased from 104.3% in 2010 to 124.8% in 2011.

iii. Completed renovation work at the paediatric day ward of AHNH.

### e. Palliative & Hospice Service Committee

i. Oversaw and supported the new palliative care services programs for end stage renal failure patients, and end-of-life care for terminally ill patients in the Cluster.

ii. Provided advice to the development of hospice day centre and services in NDH.

iii. Promoted training and education on palliative care & care of the dying by:
- Co-organising NTEC Care of Dying Forum on 24 April 2012.
- Co-organising a certificate course on end-of-life-care with CUHK.

### f. Anaesthesia Service Committee

i. PWH, NDH, AHNH were approved as training sites by Australian and New Zealand College of Anaesthetists (ANZCA).

ii. Dr. Jerry Wong won the Renton Prize awarded by ANZCA.

iii. Successfully trained and revised job responsibilities of health care assistants to take up the role of Anaesthetic Assistant in NDH Operating Theatre.

### g. Endoscopy Service Committee

i. Piloted Nurse Colonoscopist Program.

ii. Organized Colorectal Cancer Flagship Project.

### h. Ear, Nose and Throat (ENT) Service Committee

i. With a series of successful serial internal promotion exercise of medical staff and upgrading of an Advanced Practice Nurse post to a Ward Manager post, staff morale was improved. Core members of the team were now stable and ENT service was well maintained.

ii. Improvements in the area of head and neck cancer surgery included increased operating time and throughput and reduced waiting time. The median waiting time for oral and non-oral surgeries improved from 35 to 20 days and 60 to 32 days respectively (October 2009 to September 2010 vs October 2011 to February 2012).

### i. Ophthalmology Service Committee

i. Turnover rate of medical staff in 2011/2012 was lower than that in 2010/2011 (24% vs 43%).

ii. Compliance rates of cataract operations performed for Priority I (Urgent – within 2 months) and Priority II (Early – within 1 year) in 2011/2012 were higher than that in 2010/2011.

iii. Rate of day surgery in 2011/2012 was higher than that of 2010/2011.

### j. Obstetrics & Gynaecology (O&G) Service Committee

i. Introduced new surgical techniques of single port hysterectomy and hysteroscopic sterilization in July 2011 and February 2012 respectively to expedite recovery, enable early discharge and accomplish better cosmetic outcomes.

ii. Introduced radiofrequency umbilical cord ablation in discordant monochorionic twin pregnancies. The Department was the first center in Hong Kong to introduce this safe and technically easy method for fetocide in complicated monochorionic twin pregnancies where the fetus with major abnormalities might jeopardize the health and survival of the normal co-twin.

iii. Launched Down's screening using maternal serum fetal DNA in 2012. The technology was jointly developed by the Department of O&G and the Department of Chemical Pathology to avoid the use of invasive procedures in screening Down's syndrome.

### k. Orthopaedics & Traumatology (O&T) Service Committee

i. Introduced i-hospitalized rehabilitation clinical pathway and completed benchmarking pathway for accreditation.

ii. Back pain triage program won the Best Poster Award in HA Convention 2011.

iii. Identified access block for home discharge of fracture hip patients.

### i. Surgical Service Committee

i. Achieved significant reduction in utilization of big gun antibiotics.

ii. Achieved significant increase in the "rate of day surgery" and "same day surgery" (from 71% in 2009/2010 to 81% in 2010/2011).

### m. Clinical Toxicology Services Committee

i. Prince of Wales Hospital Poison Treatment Centre (PWHPTC) provided regular in-patient and out-patient service to patients with poisoning in PWH. For 2011/2012, 287 in-patients and 70 out-patients were treated at PWHPTC. Phone consultations to patients in all HA hospitals with poisoning and adverse drug reactions were also accepted through a hotline during office hours.

ii. Organized regular meetings and conferences for healthcare professionals with emphasis on serious or fatal poisonings.

iii. Established collaboration with the Guy's & St Thomas' Poisons Unit, St. Thomas' Hospital, London, UK.

### o. Intensive Care Services Committee

i. Resumed hospital beds to 22 in PWH Intensive Care Unit (ICU).

ii. Resumed hospital beds to 14 in NDH ICU.

### p. Diagnostic Radiology & Organ Imaging Committee

i. Implemented PWH Filmless Project.

ii. Commenced the service of Biplane Angio-suite in NDH.

### q. Utilization of Operation Theatres (OT) Services Committee

i. Added 6 extra OT sessions to shorten waiting time for targeted operations such as Head & Neck (H&N) Cancer Surgery, Brain Tumour, Cardiac Surgery & Eye Surgery.

ii. Implemented 5-day work week in PWH and AHNH Operation Theatre to enhance staff morale.

iii. Improved same day admission rate.

### r. Pathology Services Committee

i. Introduced a high-throughput Total Laboratory Automation (TLA) System for Chemical Pathology in performing 12,800 tests per hour. This online TLA provided a "one-stop" sample entry, processing, analysis and storage management. The concept of one-stop operation minimizes operator intervention, reduces human errors in sample processing, thereby enhancing the quality of the analytical cycle which is facilitative for quality patient care.

ii. Implemented the Blood Bank Automation to perform analysis of pre-transfusion testing. It performed 60 samples per hour and brought all of the discrete activities of compatibility testing into a SINGLE PLATFORM process, interfaced to the Laboratory Information System (LIS). It could standardize the technique for antibodies detection, documentation of pre-transfusion analysis to minimize transcriptional error during processing.

iii. Implemented a series of molecular test investigations to enhance laboratory service for treatment of chronic hepatitis and cancer.

## s. Pharmacy Service Committee

i. Clinical Pharmacists at AHNH and PWH joined the clinical teams at specialist out-patient clinics (renal & respiratory) and in-patients (paediatrics, neonatal ICU and oncology) for medication management reviews. This had further enhanced patient safety through more appropriate, rational and cost-effective drug use.

ii. Extended the pharmacy service hours at AHNH and NDH to 11pm daily in October and November 2011 respectively. This helped to improve medication safety with reduced workload for nurses and also increased convenience for A&E patients.

## t. Primary Care Services Committee

### General Outpatient Clinic (GOPC)

i. Improved the clinical workflow and service provision by strengthened infrastructural support with additional space in Fanling Family Medicine Centre, Lek Yuen General Outpatient Clinic and Yuen Chau Kok General Outpatient Clinic.

ii. Further enhanced the Chronic Disease Management for NTEC patients by implementing Integrated Mental Health Program, Diabetic Retinopathy Screening (DMR) and Smoking Cessation Counseling Program in GOPCs, as well as involving multidisciplinary teams in the services.

iii. Enhanced Primary Care service by providing additional episodic quota so as to improve the access indicators for target groups i.e. elderly (>65 years old) and Comprehensive Social Security Assistance (CSSA) patients.

### Community Outreach Services Team (COST) Service

i. Implemented the Integrated Care and Discharge Support (ICDS) to High Risk Elders Program supporting services to the high-risk elderly patients having difficulties in taking care of themselves after discharge.

ii. Provided 2543 discharge planning, substantial community support to 488 discharged elderly patients with 1862 home visits to enhance patients' quality of life, and reduce unplanned readmission to hospitals.

## u. Psychiatric Service Committee

i. Monitored the drug expenditures of psychiatric service in NTEC. Measures implemented successfully balanced the drug expenditures in some hospitals.

ii. Enhanced service at various areas on psychiatric service:

- Child psychiatry – The quota for patients with Autism Spectrum Disorder (ASD) and Attention Deficient Hyperactivity Disease (ADHD) were increased.
- Adult psychiatry – Personalized Care Program (PCP), Intensive Care Team and Extension of Early Assessment Service for Young person with psychotic disorders (EASY-EX) Program were launched to extend the coverage.
- Psycho-geriatrics – The coverage of outreach services for private old aged homes (OAHs) in NTEC had been extended to 33 OAHs.

### v. Rehabilitation Services Committee

i. Volunteer Service, Rehabilitation Shops and Health Resource Centres (VRH) focused on enhancing community partnership through a variety of disease based programs and our team won the Hospital Authority Outstanding Team Award 2012.

ii. Allied Health Services participated successfully in different programs in GOPC e.g. Dietitians and Podiatry in Risk Assessment & Management Program (RAMP) for diabetic patients, physiotherapy and occupational therapy in Nurse & Allied Health Clinic for respiratory programs and enhancement of Primary and Public Care services for musculoskeletal conditions.

iii. Physiotherapy, Occupational Therapy and Dietetic departments started the work-based training to enhance the competence of the Allied Health Professionals through skill transfer and bedside training.

### x. Critical Incident Support Service (CISS) Committee

i. Promoted CISS and recruited new members.

ii. Organized Team Building Workshop led by Oasis on an experiential workshop " Dialogue in the Dark 黑暗中對話".

iii. Collaborated with NTEC Patient Relations & Engagement (PR&E) Team in the role play of frontline talk "Facing Sudden Death - Clinician and Patient Family."

### y. Nursing Services Committee

i. Implemented medication safety program including review of Dangerous Drug (DD) guidelines, promotion of safe practice in DD handling and administration, building drug knowledge database, reinforcement of protected time for drug administration and standardization of drug administration scheduling.

ii. Developed a system on credentialing of nursing procedures of high risk and high volume in 1Q 2012.

iii. Enhanced caring culture for nurses with the implementation of new policy on "Exemption of Night Duty for Pregnant Nurses with 32 Weeks of Gestation" with effect from 1 September 2011.

### *3. Designated Committees*

#### a. Clinical Informatics Committee

i. Implemented Consultation@inbox (eReferral) in all specialties in PWH. This avoided tedious paper works like completing forms and fax, fostered personal data privacy protection for having the referral made within CMS, and allowed flexibility in obtaining more clinical data from CMS or ePR before the process.

ii. Set up wireless (3G) broadband CMS computers in Lek Yuen Maternal & Child Health Centre (PAED, O&G, PSY) to support cross-specialty consultation in using CMS in DH clinics by eligible HA staff where HA network was not available to facilitate patient care.

iii. Organized the 3-31 IT disaster drill on 31 March 2012 (involving PWH, AHN and NDH).

#### b. Clinical Research Ethics Committee

i. Vetted 623 nos of new clinical research applications in Year 2011.

ii. Renewed 705 nos of approved research projects in Year 2011.

iii. Monitored the adverse effects of 569 cases arising from clinical research.

#### c. Drug & Therapeutics Committee

i. Maintained rational and cost-effective NTEC drug formulary with reference to the latest recommendation from HA Drug Formulary.

ii. Facilitated the implementation of various guidelines and policies from HA or hospital to ensure medication safety.

iii. Reviewed prescribing practice and ensured safe and cost-effective use of drugs.

#### d. Green and Energy Management Committee

i. Awarded the 2009/2010 Carbonless certificate for NDH.

ii. Completed the carbon audit for NDH for renewal of the Carbonless certificate for 2010/2011.

iii. Completed the carbon audit for AHNH, BBH and SCH for new applications of Carbonless certificate for 2010/2011.

#### e. Cluster Infection Control Committee

i. Improved overall hand hygiene compliance from 78% in 2010 to 84% in 2011.

ii. Improvements were observed among all ranks of staff and all types of indications in the compliance of hand hygiene.

#### f. Information Security & Privacy Committee

i. Implemented a list of actions to raise staff awareness on data security such as conducting more than 60 seminars to train 9516 (99.6%) staff, developing in-house DVD training

program / data security website, conducting annual walk around audit in 7 NTEC hospitals with 91% compliance rate and conducting annual CMS access log audit.

ii. Reviewed guidelines such as "Incident Report Mechanism of Misplacement / Lost Sensitive Personal Data" and "NTEC Guidelines on Transmission of Confidential Document by Facsimile Machine" in NTEC.

iii. Adopted measures such as end-point encryption on portable competing device, Cluster file server and Privacy Impact Assessment Guidelines to improve data security.

### g. Breastfeeding Promotion & Milk Committee

i. Reviewed and updated the communication flow during Safety Alert of Nutrition Products (including Infant Formula and Teats) in June 2011.

ii. Prepared for potential crisis related to decline of use of the rotation brand "Snow Brand Ready-to-feed formula" manufactured in Japan by postnatal mothers after the 3.11 earthquake from August to November 2011.

iii. Performed the "Milk Safety Drill on Recall of Infant Formula Product" on 21 December 2011.

### h. Mortuary Management Committee

i. Implemented of Radio-frequency Identification (RFID) in NDH Mortuary.

ii. Commenced service of Smokeless Joss Furnace in AHNH, NDH and SH.

iii. Renovated the Ceremony Room in PWH and SH.

### i. Occupational Safety, Health & Care Service Committee

i. Injury On Duty cases in NTEC in 2011 dropped by 11% when compared with the figures of 2010.

ii. "The Chemical Safety Enhancement Program of PWH" won the merit award of the Safety Enhancement Program Award 2011 organized by the OSH Council.

iii. Launched "Staff Fall Prevention Program" in AHNH/TPH with remarkable success.

### j. Cluster Radiation Safety Committee

i. Uploaded the documents regarding the compliance with the Radiation Ordinance to iOSH@NTEC.

ii. Adopted a proactive approach to matters related to radiation safety in NTEC.

### k. Security & Fire Safety Committee

i. Formulated the fire safety strategy for NTEC covering training, fire drills, fire services, installations, etc. to ensure safety of our colleagues, patients and visitors.

ii. 3 security staff members won the best security personnel award bestowed by Hong Kong Police for their meritorious performance.

iii. Filled up the manpower gap of TPH and AHNH with reference to the benchmark set by the Central Committee on Hospital Security of HAHO to enhance security service of the above hospitals.

l. Transfusion Committee

i. Established Cluster Transfusion Committee to deal with blood transfusion within the Cluster.

ii. Developed policy of handling blood units accompanying the patient upon transfer to other cluster hospital.

iii. Developed and promulgated the policy on informed consent.

m. Transplant Committee

i. Prepared and promulgated the guidelines on organ donation.

### *4. Advisory Committees*

a. Community Collaboration Committee

i. Set up a good channel to deliberate on the strategies in developing Community Collaboration programs in NTEC with related health care sectors (NGOs) in NTEC district.

b. Primary Care Coordination Committee

i. Piloted Chronic Disease Management Shared Care Program under Resources Allocation Exercise.

ii. Updated posters at Accident Emergency Department, Specialist Outpatient Clinic and General Outpatient Clinic.

iii. Updated General Practitioners (GP) list by districts.

c. Technology Committee

i. Implemented corporate wide programs on Single Use Devices, Medical Devices, and Minor Minor Equipment Replacement Exercise.

ii. Piloted mechanism for introduction of new technology in Operating Theatre of PWH.

iii. Explored new framework for allocation of resources for equipment.

d. Trauma Committee

i. Developed and implemented Massive Blood Transfusion Protocol.

ii. Outcome of performance in terms of adjusted survival rate was the best among 5 trauma centre.

iii. Successfully applied research grant from the Government and completed project on "Long term assessment of functional outcome in patients sustaining moderate and major trauma".

## B. Key Performance Indicators & Statistical Reports

### Service Statistics (up to Mar 2012) - New Territories East Cluster

| | YTD (prior year) A | YTD (current year) B | YTD target (current year) C | Variance (from target) D =(B–C) or (B-C)/C | Variance (from prior year) E =(B–A) or (B-A)/A |
|---|---|---|---|---|---|
| **No. of hospital beds (as at month end)** | | | | | |
| Available | 4,514 | 4,514 | 4,514 | 0 | 0 |
| In-use | 4,161 | 4,185 | 4,181 | + 4 | + 24 |
| **Inpatient services** | | | | | |
| No. of IP discharges and deaths | 156,483 | 162,140 | 156,617 | + 3.5% | + 3.6% |
| Bed occupancy rate(%) - noon | 85% | 83% | N.A. | N.A. | - 1.5%pt |
| Bed occupancy rate(%) - midnight | 84% | 83% | 84% | - 0.2%pt | - 0.9%pt |
| Average length of stay (days) for general inpatients | 6.2 | 6.0 | 6.1 | - 1.5% | - 3.2% |
| **Day patient services** | | | | | |
| No. of DP discharges & deaths | 77,848 | 81,119 | 76,101 | + 6.6% | + 4.2% |
| **Accident & emergency services** | | | | | |
| No. of attendances | 392,585 | 402,045 | 398,385 | + 0.9% | + 2.4% |
| % of A&E patients within target waiting time | | | | | |
| - Triage I (critical cases – 0 minutes) | 100% | 100% | 100% | 0%pt | 0%pt |
| - Triage II (emergency cases < 15 minutes) | 96.3% | 96.1% | 95% | + 1.1%pt | - 0.2%pt |
| - Triage III (urgent cases < 30 minutes) | 81.3% | 83.9% | 90% | - 6.1%pt | + 2.6%pt |
| **Outpatient services** | | | | | |
| No. of specialist outpatient attendances (clinical) * | 1,036,075 | 1,032,482 | 1,001,079 | + 3.1% | - 0.3% |
| Median waiting time of patients booking new cases (week) | | | | | |
| - First priority patients | < 1 | < 1 | 2 | - 2 | 0 |
| - Second priority patients | 4 | 4 | 8 | - 4 | 0 |
| No. of general outpatient attendances # | 837,546 | 828,190 | 780,248 | + 6.1% | - 1.1% |
| **Rehabilitation & palliative care services** | | | | | |
| No. of home visits by community nurses | 127,590 | 130,280 | 132,222 | - 1.5% | + 2.1% |
| No. of allied health (outpatient) attendances | 331,361 | 335,508 | 339,238 | - 1.1% | + 1.3% |
| **Geriatric services** | | | | | |
| No. of geriatric outreach attendances | 80,366 | 78,552 | 77,595 | + 1.2% | - 2.3% |
| No. of visiting medical officer attendances | 22,750 | 22,232 | 22,521 | - 1.3% | - 2.3% |
| **Psychiatric services** | | | | | |
| No. of psychiatric outreach attendances | 21,858 | 33,293 | 36,320 | - 8.3% | + 52.3% |
| No. of psychiatric day hospital attendances | 40,780 | 44,344 | 40,655 | + 9.1% | + 8.7% |
| **Quality Indicators** | | | | | |
| | (up to Feb 2011) | (up to Feb 2012) | (up to Feb 2012) | | |
| Unplanned readmission rate (%) for general in-patients^ | 9.7% | 9.6% | 10.5% | - 0.9%pt | - 0.1%pt |

* include nurse clinic attendances (NURS) ; exclude FMSC attendances (FMSC)

# include nurse clinic attendances (NURG)

^ New definition is applied in 2011/12. The time lag for data available is 2 month. (i.e 2011/12 data will be available on 11/5/2012)

**Blue** > 5% above target / prior year
> 3% pt above target / prior year (for bed occupancy rate)
> 3% pt above prior year (for A&E waiting time)
> 1% pt above target / prior year (for unplanned readmission rate)

**Green** > 5% below target / prior year
> 3% pt below target / prior year (for bed occupancy rate)
> 3% pt below prior year (for A&E waiting time)
> 1% pt below target / prior year (for unplanned readmission rate)

**Brown** Below COR target (for A&E waiting time)

## KPIs for Service Performance - Part A (Apr 2011 - Mar 2012)

| | | | NTEC | | |
|---|---|---|---|---|---|
| | | | Current Year | Prior Year | |
| | | | YTD Mar 2012 | YTD Mar 2011 | Variance |
| | | | A | B | C = (A - B) or (A - B) / B |
| **Service Growth in response to Population Change & Ageing Effect** | | | | | |
| Service capacity (as at 31.03.2012) | K | * No. of geriatric day places | 145 | 120 | 25 |
| | | * No. of psychiatric day places | 185 | 185 | 0 |
| Inpatient services | K | * No. of patient days (IP BDO) | | | |
| | | General - Acute | 948,693 | 944,529 | 0.4% |
| | | Mentally Ill | 133,967 | 135,557 | -1.2% |
| | | Infirmary | 99,028 | 101,484 | -2.4% |
| | | Overall | 1,181,688 | 1,181,570 | 0.01% |
| Accident & Emergency (A&E) services | K | * No. of First Attendances for: | | | |
| | | Triage I (Critical cases) | 2,702 | 2,965 | -8.9% |
| | | Triage II (Emergency cases) | 6,944 | 6,301 | 10.2% |
| | | Triage III (Urgent cases) | 96,439 | 97,828 | -1.4% |
| Primary care services | K | * No. of family medicine specialist clinic attendances (FM) | 57,700 | 55,864 | 3.3% |
| | K | * # Total no. of primary care attendances (including nurse clinic attendance) | 885,890 | 893,410 | -0.8% |
| Day services | K | * # No. of rehabilitation day & palliative care day attendance (RDP-ANA) | 6,307 | 6,055 | 4.2% |
| | K | * # No. of geriatric day attendance (GDH) | 27,507 | 27,554 | -0.2% |
| Community & outreach services | K | * # No. of allied health (community) attendances | 10,166 | 8,794 | 15.6% |
| | K | * # No. of geriatric elderly persons assessed for INF care service | 244 | 253 | -3.6% |
| | K | * # No. of psychogeriatric outreach attendances (including: PGT: no. of outreach attendances: total + PGT: total no. of home visits + PGT: total no. of consultation-liaison attendances) | 16,085 | 15,130 | 6.3% |

Remarks:

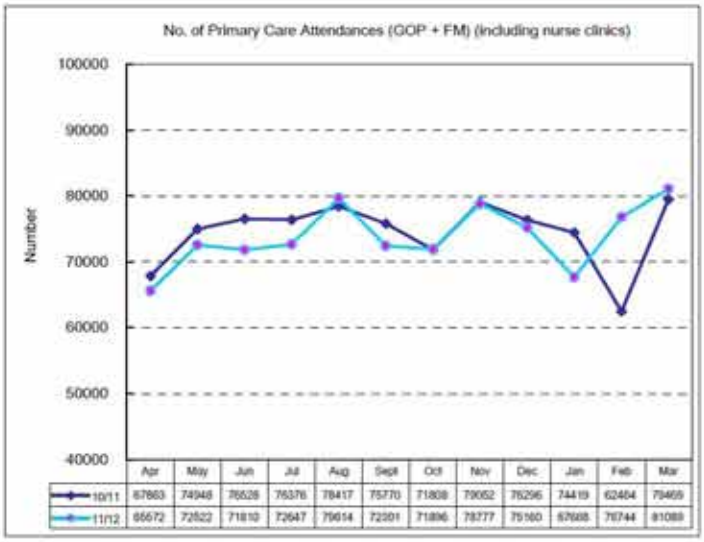
* with graph presented

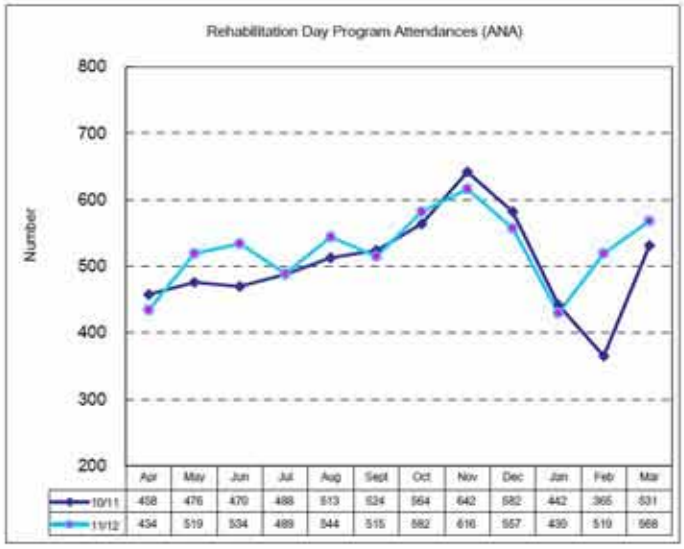
Blue > 5% above prior year

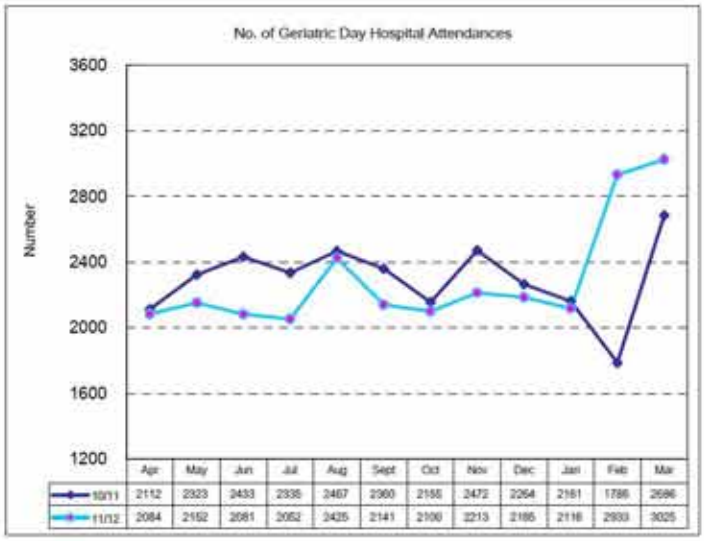
Green > 5% below prior year

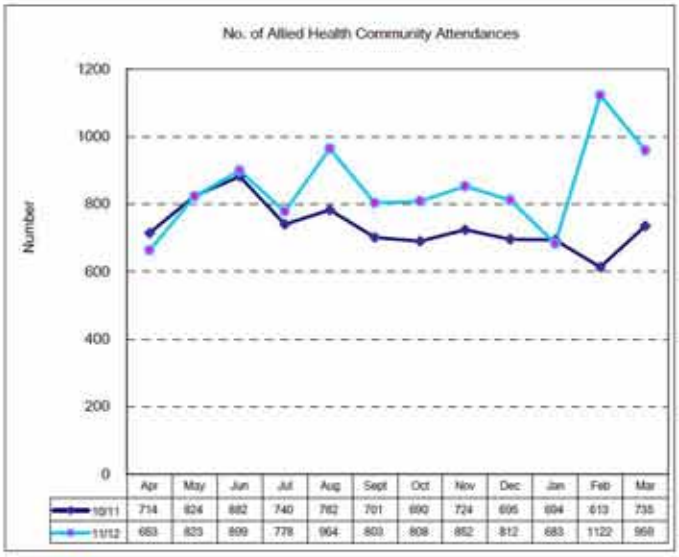
K KPI
Q QPI
* COR item

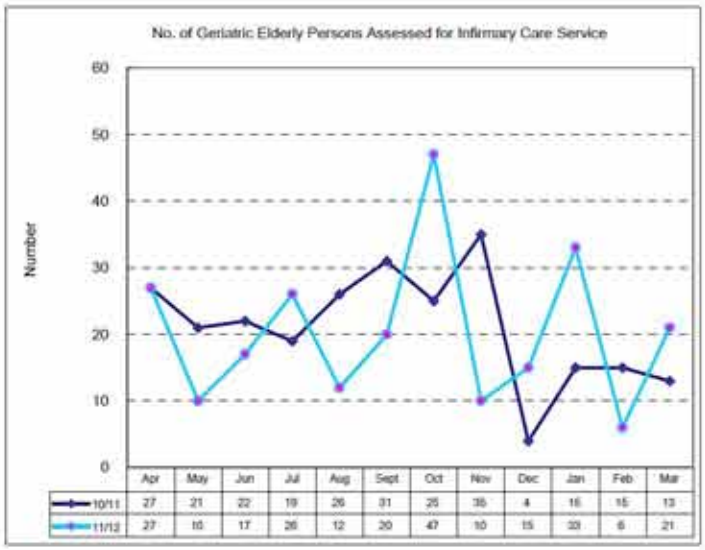
## Service Growth in response to Population Change & Ageing Effect (cont'd)

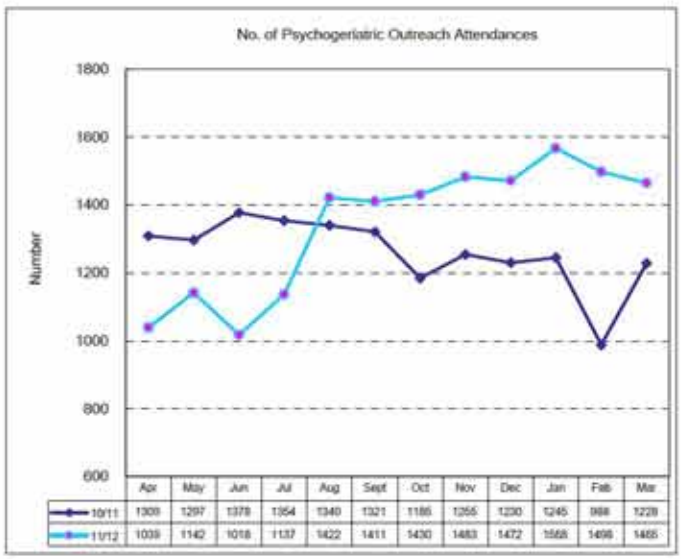


## KPIs for Service Performance - Part B (Apr 2011 - Mar 2012)

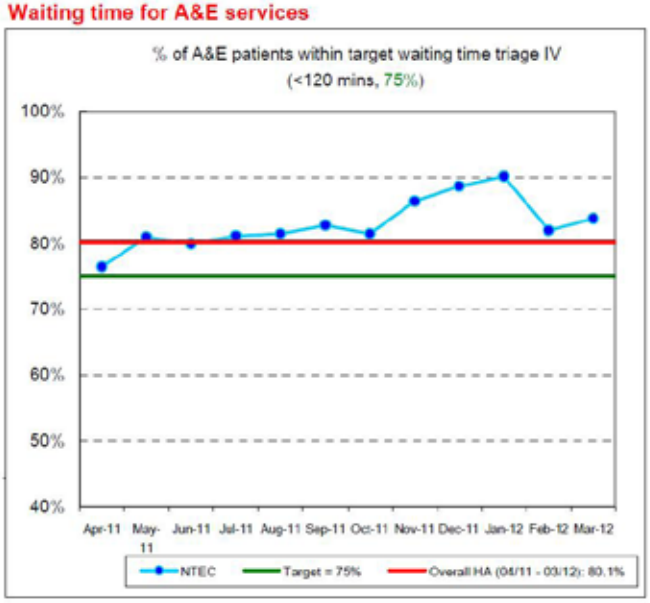
| Service Improvement as a result of Technology Advancement or Implementation of New Service Quality & Access initiatives | | | | Current period | | Previous period | |
|---|---|---|---|---|---|---|---|
| | | | | NTEC | Overall HA | NTEC | |
| | | | | Apr 2011 - Mar 2012 | | Apr 2010 - Mar 2011 | Variance |
| | | | | A | B | C | D = (A - C) or (A - C) / C |
| **Waiting time for A&E services** | | | **% of A&E Patients within Target WT** | | | | |
| | K | * | Triage I (Critical cases - 0 minutes, 100%) | 100% | 100% | 100% | 0%pt |
| | K | * | Triage II (Emergency cases- <15 minutes, 95%) | 96.1% | 97.8% | 96.3% | -0.2%pt |
| | K | * | Triage III (urgent cases- <30 minutes, 90%) | 83.9% | 90.5% | 81.3% | 2.6%pt |
| | K | # | Triage IV (Semi-urgent cases- <120 minutes, 75%) | 82.9% | 80.1% | 78.3% | 4.6%pt |
| **Waiting Time for SOP New Case Bookings** | | | **Median waiting time for 1st appointment at specialist clinics** | | | | |
| | | | **Overall** | | | | |
| | K | * | 1st priority patients ( ≤ 2 weeks) | <1 | <1 | <1 | 0 |
| | K | * | 2nd priority patients ( ≤ 8 weeks) | 4 | 5 | 4 | 0 |
| | | | **ENT** | | | | |
| | K | | % of patients seen within 2 weeks for 1st priority patients | 96.8% | 97.9% | 96.7% | 0.1%pt |
| | K | | % of patients seen within 8 weeks for 2nd priority patients | 97.6% | 96.7% | 97.3% | 0.3%pt |
| | K | # | 75th percentile of waiting time of routine cases (weeks) | 68 | 40 | 65 | 4.6% |
| | | | **Gynaecology** | | | | |
| | K | | % of patients seen within 2 weeks for 1st priority patients | 94.0% | 94.6% | 95.2% | -1.2%pt |
| | K | | % of patients seen within 8 weeks for 2nd priority patients | 94.5% | 97.4% | 97.8% | -3.3%pt |
| | K | # | 75th percentile of waiting time of routine cases (weeks) | 59 | 36 | 47 | 25.5% |
| | | | **Medicine** | | | | |
| | K | | % of patients seen within 2 weeks for 1st priority patients | 97.2% | 97.9% | 97.8% | -0.6%pt |
| | K | | % of patients seen within 8 weeks for 2nd priority patients | 97.3% | 97.9% | 98.2% | -0.9%pt |
| | K | # | 75th percentile of waiting time of routine cases (weeks) | 59 | 47 | 52 | 13.5% |
| | Q | | (QPI Target: < 52 weeks) | | | | |
| | | | **Ophthalmology** | | | | |
| | K | | % of patients seen within 2 weeks for 1st priority patients | 96.1% | 98.3% | 97.8% | -1.7%pt |
| | K | | % of patients seen within 8 weeks for 2nd priority patients | 97.8% | 97.1% | 98.2% | -0.4%pt |
| | K | # | 75th percentile of waiting time of routine cases (weeks) | 101 | 45 | 60 | 68.3% |
| | | | **Orthopaedics & Traumatology** | | | | |
| | K | | % of patients seen within 2 weeks for 1st priority patients | 98.9% | 98.9% | 99.0% | -0.1%pt |
| | K | | % of patients seen within 8 weeks for 2nd priority patients | 98.1% | 98.3% | 97.9% | 0.2%pt |
| | K | # | 75th percentile of waiting time of routine cases (weeks) | 81 | 77 | 69 | 17.4% |
| | Q | | (QPI Target: < 52 weeks) | | | | |
| | | | **Paed. & Adolescent Med.** | | | | |
| | K | | % of patients seen within 2 weeks for 1st priority patients | 97.0% | 98.4% | 96.0% | 1.0%pt |
| | K | | % of patients seen within 8 weeks for 2nd priority patients | 99.0% | 98.3% | 95.8% | 3.2%pt |
| | K | # | 75th percentile of waiting time of routine cases (weeks) | 29 | 20 | 25 | 16.0% |
| | | | **Psychiatry** | | | | |
| | K | | % of patients seen within 2 weeks for 1st priority patients | 94.1% | 95.9% | 96.6% | -2.5%pt |
| | K | | % of patients seen within 8 weeks for 2nd priority patients | 96.4% | 98.0% | 98.3% | -1.9%pt |
| | K | # | 75th percentile of waiting time of routine cases (weeks) | 60 | 27 | 53 | 13.2% |
| | Q | | (QPI Target: < 52 weeks) | | | | |
| | | | **Surgery** | | | | |
| | K | | % of patients seen within 2 weeks for 1st priority patients | 96.3% | 97.3% | 96.6% | -0.3%pt |
| | K | | % of patients seen within 8 weeks for 2nd priority patients | 95.1% | 98.2% | 96.3% | -1.2%pt |
| | K | # | 75th percentile of waiting time of routine cases (weeks) | 59 | 59 | 55 | 7.3% |
| | Q | | (QPI Target: < 52 weeks) | | | | |

Remarks:
* with graph presented
K KPI
Q QPI
* COR item

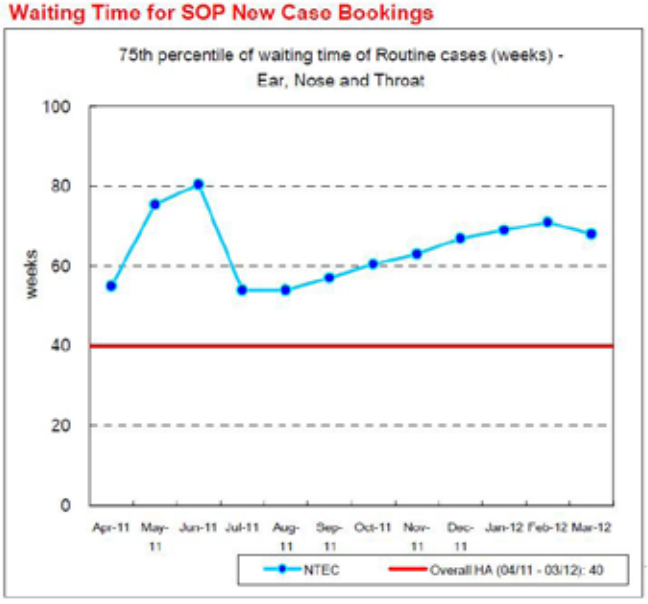
Blue > 5% above previous period
Green > 5% below previous period

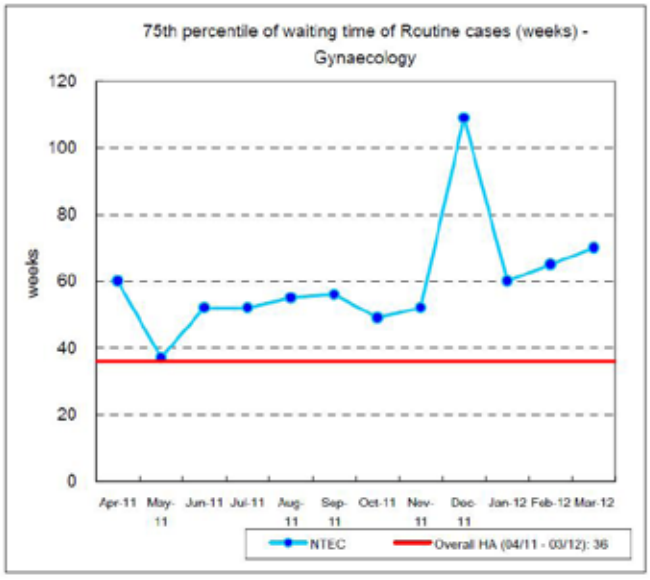
## Service Improvement as a result of Technology Advancement or Implementation of New Service Quality & Access initiatives (cont'd)

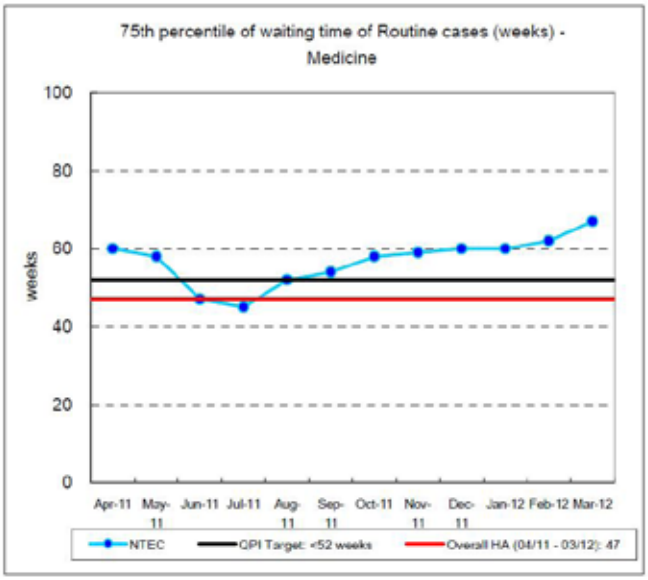
### Waiting time for A&E services

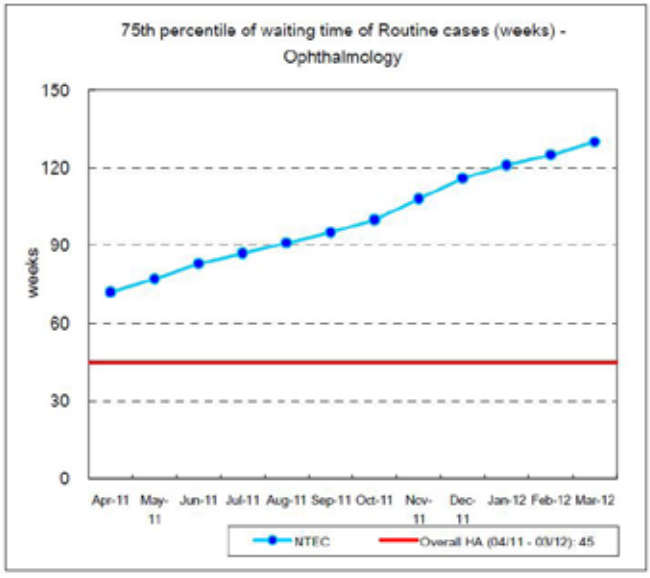



### Waiting Time for SOP New Case Bookings



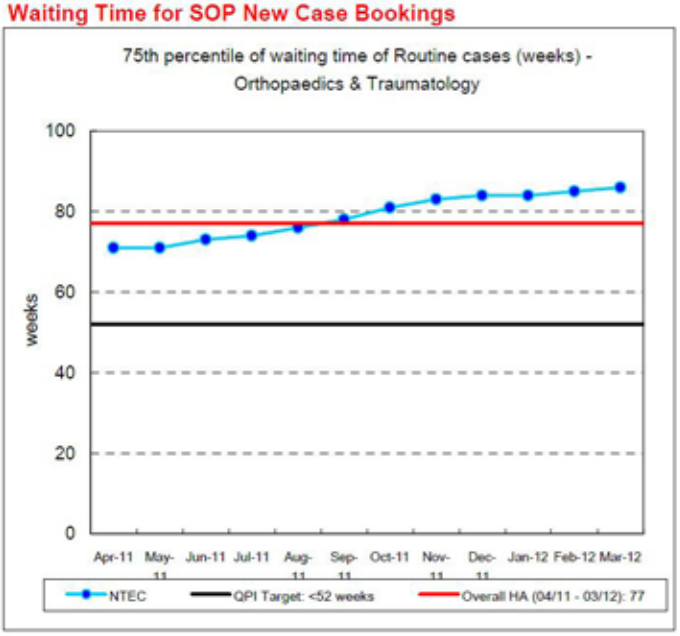



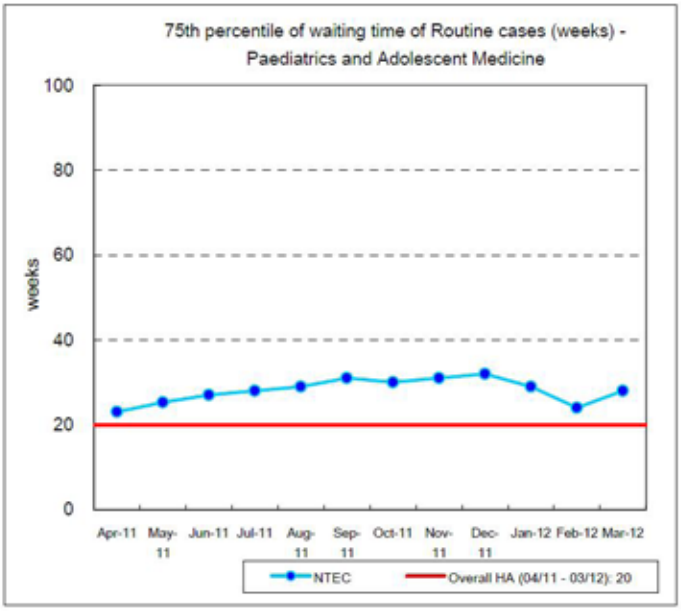



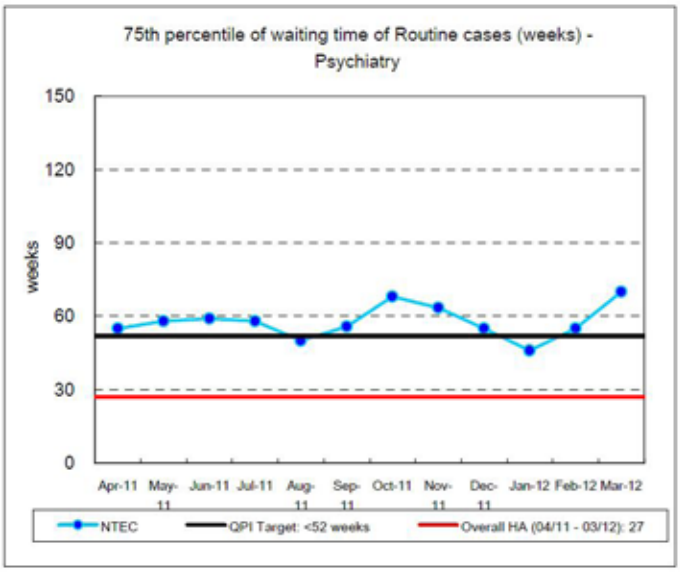



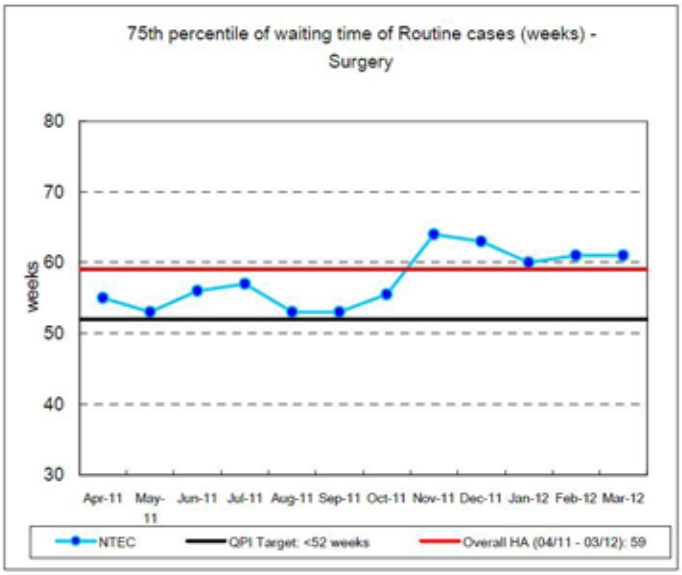
## Service Improvement as a result of Technology Advancement or Implementation of New Service Quality & Access initiatives (cont'd)

### Waiting Time for SOP New Case Bookings



## KPIs for Service Performance - Part C (Jan - Dec 2011)

| Service Improvement as a result of Technology Advancement or Implementation of New Service Quality & Access initiatives (cont'd) | | | | Current period | | Previous period | |
|---|---|---|---|---|---|---|---|
| | | | | NTEC | Overall HA | NTEC | |
| | | | | Jan - Dec 2011 | | Jan - Dec 2010 | Variance |
| | | | | A | B | C | D = (A - C) or (A - C) / C |
| **Waiting time for elective surgery** | | | **Waiting time for cataract** | (Nov 2010 - Oct 2011) | | (Nov 2009 - Oct 2010) | |
| | K | # | % of patients provided with surgery within 2 months for Priority 1 (P1) patients (Internal compliance target : 80%) | 94.4% | 89.4% | 92.8% | 1.5%pt |
| | K | # | % of patients provided with surgery within 12 months for Priority 2 (P2) patients (Internal target : 90%) | (Jan 2010 - Dec 2010) 97.4% | 96.1% | | |
| **Waiting time for diagnostic radiological investigations** | | | **Waiting time of CT, MRI, ultrasound and mammogram cases (days)** | | | | |
| | | | **CT** | | | | |
| | K | # | 90th percentile | 138 | 108 | 127 | 8.7% |
| | | | **MRI** | | | | |
| | K | # | 90th percentile | 501 | 318 | 442 | 13.3% |
| | | | **Ultrasound** | | | | |
| | K | # | 90th percentile | 258 | 225 | 219 | 17.8% |
| | | | **Mammogram** | | | | |
| | K | # | 90th percentile | 555 | 455 | 578 | -4.0% |
| **Appropriateness of care** | | | **Standardized admission rate for A&E patients** | 25.7% | 26.2% | 25.3% | 0.4%pt |

Remarks :
# with graph presented
K KPI
Q QPI
* COR item

Blue » 5% above previous period
Green » 5% below previous period

Not all data shown above are updated due to updated data is not available in data source (KPI website).

## Service improvement as a result of Technology Advancement or Implementation of New Service Quality & Access Initiatives (cont'd)

### Waiting time for elective surgery

% of patients provided with surgery within 2 months for Priority 1 (P1) patients (cataract)

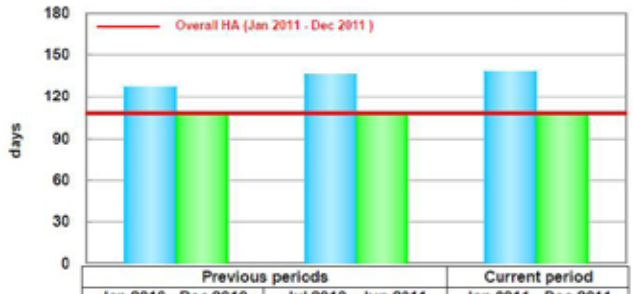

| | Previous periods | | Current period |
|---|---|---|---|
| | Nov 2009 - Oct 2010 | May 2010 - Apr 2011 | Nov 2010 - Oct 2011 |
| NTEC | 92.8% | 94.4% | 94.4% |
| Overall HA | 86.6% | 89.1% | 89.4% |

% of patients provided with surgery within 12 months for Priority 2 (P2) patients (cataract)


| | Previous periods | | Current period |
|---|---|---|---|
| | Sep 2009 - Jun 2010 | Oct 2009 - Sep 2010 | Jan 2010 - Dec 2010 |
| NTEC | 96.1% | 97.8% | 97.4% |
| Overall HA | 94.4% | 95.6% | 96.1% |

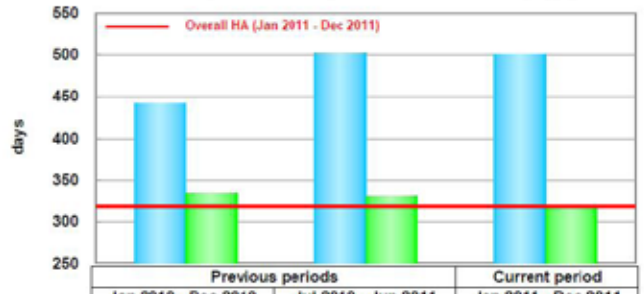
### Waiting time for diagnostic radiological investigations

Waiting time for 90th percentile of CT cases (days)



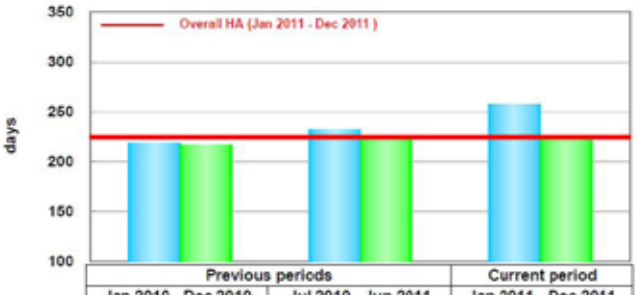

| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 127 | 136 | 138 |
| Overall HA | 106 | 108 | 108 |

Waiting time for 90th percentile of MRI cases (days)




| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 442 | 502 | 501 |
| Overall HA | 335 | 330 | 318 |

Waiting time for 90th percentile of Ultrasound cases (days)




| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 219 | 232 | 258 |
| Overall HA | 217 | 222 | 225 |

Waiting time for 90th percentile of Mammogram cases (days)


| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 578 | 606 | 555 |
| Overall HA | 439 | 436 | 455 |

Remarks :
Not all data shown above are updated due to updated data is not available in data source (KPI website).

## KPIs for Service Performance - Part C (Jan - Dec 2011)

| Service Improvement as a result of Technology Advancement or Implementation of New Service Quality & Access initiatives (cont'd) | | | | Current period | | Previous period | |
|---|---|---|---|---|---|---|---|
| | | | | NTEC | Overall HA | NTEC | |
| | | | | Jan - Dec 2011 | | Jan - Dec 2010 | Variance |
| | | | | A | B | C | D = (A - C) or (A - C) / C |
| | | | | (Jan 2011 - Nov 2011) | | (Jan 2010 - Dec 2010) | |
| Safety | K | * | Unplanned Readmission Rate within 28 days for general in-patients (%) | 9.7% | 10.4% | 9.7% | 0%pt |
| | | | Infection rate | | | | |
| | | | MRSA | | | | |
| | | | | (Oct 2011 - Dec 2011) | | (Oct 2010 - Dec 2010) | |
| | K | | MRSA bacteraemia per 1000 patient days | 0.0781 | 0.0921 | 0.0681 | 14.7% |
| Disease specific quality indicators | | | Stroke | | | | |
| | K | # | % of adult acute stroke patients with CT/MRI scan of brain performed within 12 hours of A&E registration | 94.2% | 92.8% | 92.4% | 1.8%pt |
| | K | # | Unplanned readmission rate | 11.7% | 12.9% | 12.4% | -0.8%pt |
| | K | # | ALOS (days) - overall (all care types) | 23.7 | 23.0 | 23.7 | 0.1% |
| | | | Hip fracture | | | | |
| | KQ | # | % of patients indicated for surgery on hip fracture with surgery performed <=2 days after admission through A&E (QPI Target : >70%) | 68.7% | 72.6% | 75.7% | -7.0%pt |
| | K | # | Unplanned readmission rate | 2.2% | 2.6% | 2.1% | 0.1%pt |
| | K | # | ALOS (days) - overall (all care types) | 30.3 | 28.9 | 29.4 | 3.0% |
| | | | Cancer | | | | |
| | K | # | % of cancer patients requiring radical radiotherapy (RT) started RT within 28 days from decision to treat (DTT) ( ≤ 28 days, 80%) (PWH) | 94.3% | 94.4% | 87.9% | 6.5%pt |
| | | | | (Jul 2010 - Jun 2011) | | (Jul 2009 - Jun 2010) | |
| | K | # | % of patients with colorectal cancer with time < 60 days from diagnosis to first definitive treatment (< 60 days, >90%) (Remarks : Surgery treatments performed in both main theatre and day surgery centre are included in the calculation.) | 85.0% | 87.3% | 90.1% | -5.1%pt |
| | | | | (Jul 2010 - Jun 2011) | | (Jul 2009 - Jun 2010) | |
| | K | # | % of patients with breast cancer with time < 60 days from diagnosis to first definitive treatment (< 60 days, >90%) (Remarks : Surgery treatments performed in both main theatre and day surgery centre are included in the calculation.) | 90.1% | 92.6% | 91.5% | -1.3%pt |
| | | | DM | | | | |
| | K | # | % of DM patients followed up in SOPC with HbA1c checked in same 12-month period | 96.0% | 94.5% | 95.7% | 0.3%pt |
| | K | # | % of SOP DM patients with HbA1c < 7% | 35.1% | 36.7% | 44.2% | -9.1%pt |
| | | | Renal | | | | |
| | K | # | % of ESRD patients receiving HD treatment | 19.6% | 22.5% | 16.4% | 3.1%pt |
| | K | # | No. of ESRD receiving HD treatment | 207 | 1212 | 155 | 33.5% |

Remarks :
# with graph presented
K KPI
Q QPI
* COR item

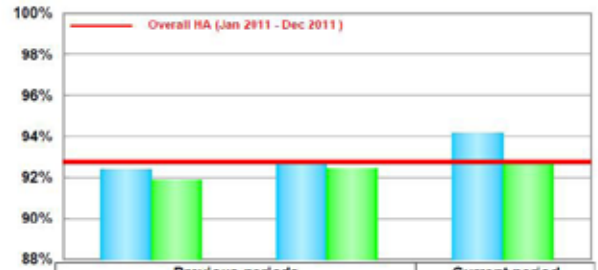
Blue > 5% above previous period
Green > 5% below previous period

Not all data shown above are updated due to updated data is not available in data source (KPI website).

## Service improvement as a result of Technology Advancement or Implementation of New Service Quality & Access Initiatives (cont'd)

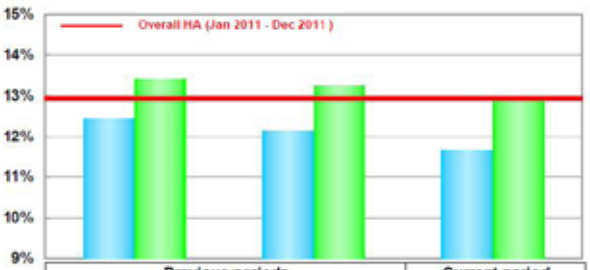
### Disease specific quality indicators - Stroke

% of adult acute stroke patients with CT/MRI scan of brain performed within 12 hours of A&E registration




| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 92.4% | 92.7% | 94.2% |
| Overall HA | 91.9% | 92.4% | 92.8% |

Unplanned readmission rate




| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 12.4% | 12.1% | 11.7% |
| Overall HA | 13.4% | 13.2% | 12.9% |

Average length of stay (days) (overall)

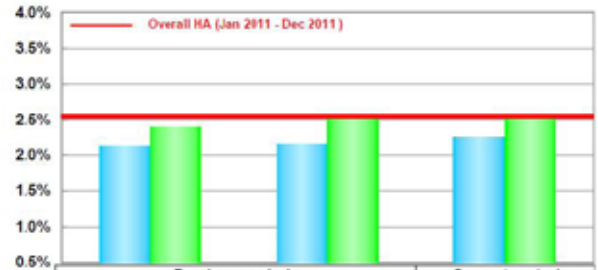

| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 23.7 | 23.7 | 23.7 |
| Overall HA | 22.9 | 23.0 | 23.0 |

### Disease specific quality indicators - Hip fracture

% of patients indicated for surgery on hip fracture with surgery performed ≤ 2 days after admission through A&E

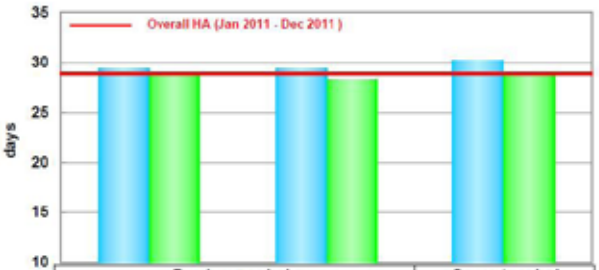

| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 75.7% | 69.2% | 68.7% |
| Overall HA | 73.9% | 73.5% | 72.6% |

Unplanned readmission rate




| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 2.1% | 2.2% | 2.2% |
| Overall HA | 2.4% | 2.5% | 2.6% |

Average length of stay (days) (overall)




| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 29.4 | 29.4 | 30.3 |
| Overall HA | 28.8 | 28.3 | 28.9 |

Remarks :

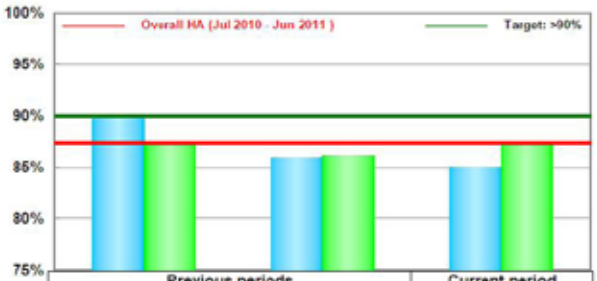
Not all data shown above are updated due to updated data is not available in data source (KPI website).

## Disease specific quality indicators - Cancer

% of cancer patients requiring radical radiotherapy (RT) started RT within 28 days from decision to treat (DTT) (PWH)

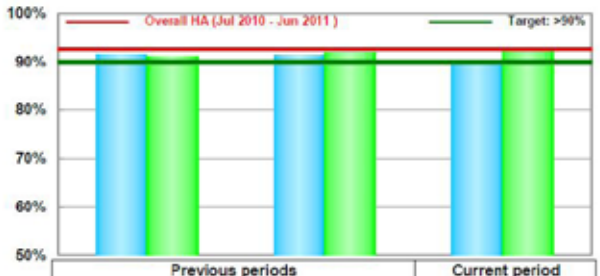

| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 87.9% | 93.2% | 94.3% |
| Overall HA | 89.4% | 93.9% | 94.4% |

% of patients with colorectal cancer with time < 60 days from diagnosis to first definitive treatment




| | Previous periods | | Current period |
|---|---|---|---|
| | Jul 2009 - Jun 2010 * | Jan 2010 - Dec 2010 * | Jul 2010 - Jun 2011 |
| NTEC | 90.1% | 85.9% | 85.0% |
| Overall HA | 87.1% | 86.1% | 87.3% |

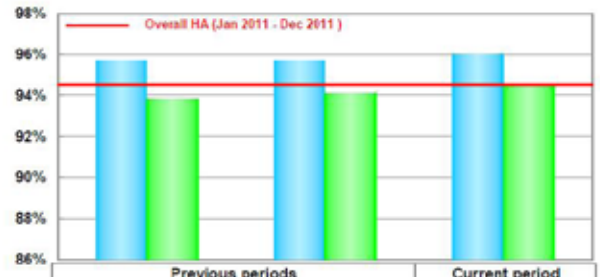
% of patients with breast cancer with time < 60 days from diagnosis to first definitive treatment




| | Previous periods | | Current period |
|---|---|---|---|
| | Jul 2009 - Jun 2010 * | Jan 2010 - Dec 2010 * | Jul 2010 - Jun 2011 |
| NTEC | 91.5% | 91.4% | 90.1% |
| Overall HA | 91.2% | 91.8% | 92.6% |

## Disease specific quality indicators - DM

% of DM patients followed up in SOPC with HbA1c checked in same 12-month period



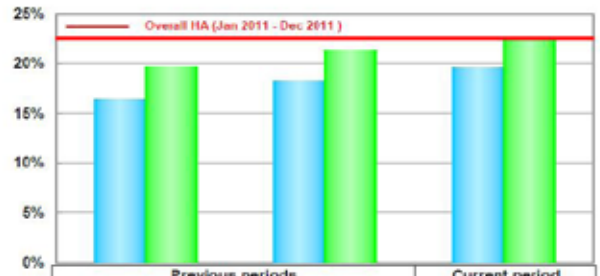

| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 95.7% | 95.7% | 96.0% |
| Overall HA | 93.8% | 94.1% | 94.5% |

% of SOP DM patients with HbA1c < 7%


| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 44.2% | 31.3% | 35.1% |
| Overall HA | 36.0% | 32.2% | 36.7% |

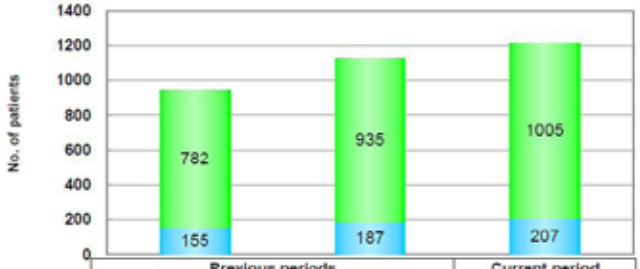
## Disease specific quality indicators - Renal

% of ESRD patients receiving HD treatment




| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 16.4% | 18.3% | 19.6% |
| Overall HA | 19.7% | 21.4% | 22.5% |

No. of ESRD patients receiving HD treatment




| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 155 | 187 | 207 |
| Sum of other clusters | 782 | 935 | 1005 |

Remarks :

* Data revised due to change of definition.

Not all data shown above are updated due to updated data is not available in data source (KPI website).

## KPIs for Service Performance - Part C (Jan - Dec 2011) (cont'd)

| | | | | Current period | | Previous period | |
|---|---|---|---|---|---|---|---|
| | | | | NTEC | Overall HA | NTEC | |
| | | | | Jan - Dec 2011 | | Jan - Dec 2010 | Variance |
| | | | | A | B | C | D = (A - C) or (A - C) / C |
| **Efficiency in the Use of Funding Resources** | | | | | | | |
| **Bed management** | K | * | **Bed Occupancy Rate (%) (IP Overall Mid-night)** | | | | |
| | | | General - Acute & Convalescent (excl. PSY/MH/INF) | 85.0% | 83.1% | 86.5% | -1.5%pt |
| | | | Mentally Ill | 69.1% | 76.5% | 72.3% | -3.2%pt |
| | | | Infirmary | 82.2% | 87.9% | 85.8% | -3.6%pt |
| | | # | **Overall** | **82.6%** | **82.5%** | **84.5%** | **-1.9%pt** |
| | K | * | **Average Length of Stay (days)** | | | | |
| | | # | General - Acute & Convalescent (excl. PSY/MH/INF) | 6.1 | 5.6 | 6.2 | -1.6% |
| | | | Mentally Ill | 35.1 | 70.2 | 34.6 | 1.5% |
| | | | Infirmary | 312.0 | 119.7 | 272.0 | 14.7% |
| | | | **Overall** | **7.3** | **7.3** | **7.5** | **-2.1%** |
| **Day surgery services** | K | # | **Rate of day and same day surgery for selected procedures** | **53.6%** | **52.5%** | **52.4%** | **1.2%pt** |
| | | | | (Apr 2011 - Sep 2011) | | (Apr 2010 - Sep 2010) | |
| **Productivity** | K | # | **Performance in total weighted episodes (WEs)** | **107,909** | **676,088** | **109,055** | **-1.1%** |
| | | | | (Oct 2010 - Sep 2011) | | (Oct 2009 - Sep 2010) | |
| | K | # | **No. of inpatient episodes per general bed** | **66.8** | **69.8** | **65.3** | **2.4%** |

Remarks:

\# with graph presented
K KPI
Q QPI
* COR item

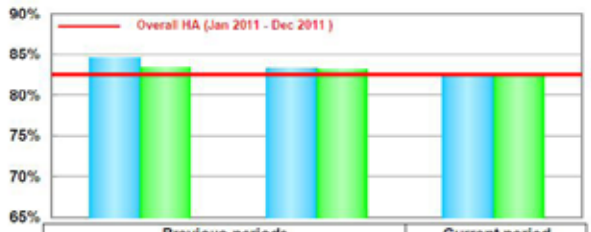
Blue > 5% above previous period
Green > 5% below previous period

Not all data shown above are updated due to updated data is not available in data source (KPI website).

## Efficiency in the Use of Funding Resources (cont'd)

### Bed management

Bed occupancy rate (%) (IP mid-night) - Overall



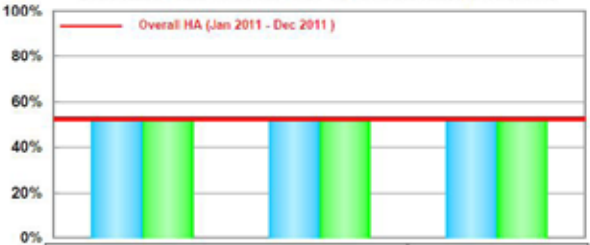

| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 84.5% | 83.3% | 82.6% |
| Overall HA | 83.4% | 83.2% | 82.5% |

ALOS (days) - general (acute & Convalescent) (excl. PSY/MH/INF)


| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 6.2 | 6.2 | 6.1 |
| Overall HA | 5.7 | 5.7 | 5.6 |

### Day surgery services

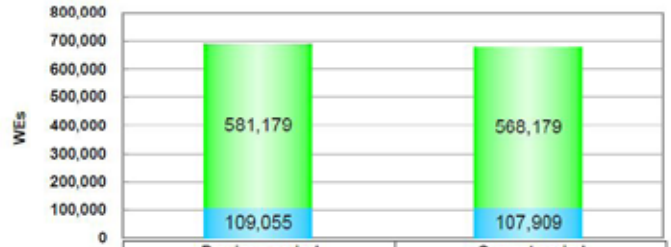
Rate of day and same day surgery for selected procedures




| | Previous periods | | Current period |
|---|---|---|---|
| | Jan 2010 - Dec 2010 | Jul 2010 - Jun 2011 | Jan 2011 - Dec 2011 |
| NTEC | 52.4% | 53.1% | 53.6% |
| Overall HA | 52.3% | 52.8% | 52.5% |

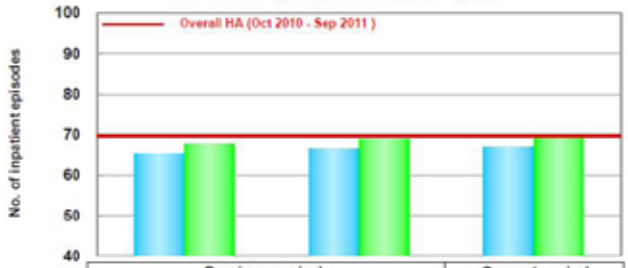
### Productivity

Performance in total weighted episodes (WEs)




| | Previous period | Current period |
|---|---|---|
| | Apr 2010 - Sep 2010 | Apr 2011 - Sep 2011 |
| NTEC | 109,055 | 107,909 |
| Sum of other clusters | 581,179 | 568,179 |

No. of inpatient episodes per general bed




| | Previous periods | | Current period |
|---|---|---|---|
| | Oct 2009 - Sep 2010 | Apr 2010 - Mar 2011 | Oct 2010 - Sep 2011 |
| NTEC | 65.3 | 66.3 | 66.8 |
| Overall HA | 67.8 | 68.9 | 69.8 |

Remarks :

Not all data shown above are updated due to updated data is not available in data source (KPI website).

## C. Human Resources Report

*1. Number of Full-time Equivalent (FTE) Staff (as at 31.3.2012)**

| Hospital | Medical | Nursing | Allied Health | Others | Total |
|---|---|---|---|---|---|
| AHN | 145 | 508 | 175 | 638 | 1466 |
| BBH | 3 | 28 | 5 | 23 | 58 |
| NDH | 166 | 603 | 151 | 668 | 1589 |
| NTE Cluster Office | 1 | 10 | 1 | 403 | 415 |
| PWH | 523 | 1552 | 493 | 1732 | 4299 |
| SCH | 1 | 83 | 8 | 121 | 213 |
| SH | 39 | 296 | 69 | 390 | 794 |
| TPH | 43 | 307 | 61 | 427 | 838 |
| Total | 922 | 3386 | 963 | 4401 | 9672 |

*including permanent, contract and temporary staff

*2. Turnover Rates in NTEC in 2011/12 with Comparison to 2010/11 and Overall HA 2011/12 (Including resignation, retirement and completion of contract, excluding transfer and rehire without a break)*

| Staff Group | NTEC Turnover Rate (%) (Apr 2010 to Mar 2011) | NTEC Turnover Rate (%) (Apr 2011 to Mar 2012) | Overall HA Turnover Rate (%) (Apr 2011 to Mar 2012) |
|---|---|---|---|
| Medical | 6.8% | 5.4% | 4.8% |
| Nursing | 4.8% | 4.4% | 5.3% |
| Allied Health | 2.7% | 3.4% | 3.9% |
| Mgt/Admin | 9.0% | 9.1% | 6.2% |
| Supporting (care-related) | 11.0% | 14.3% | 13.9% |
| Others | 8.9% | 8.8% | 9.8% |
| Overall | 6.9 % | 7.4% | 7.8% |

Including intern but excluding temporary staff

## D. Financial Report

The Cluster reported a balanced budget for the year, with expenditures matching the Government subvention and fees and charges collected by the Cluster during the year.

The Cluster's expenditures increased from approximately $6 billion to $6.6 billion over the previous fiscal year. Half of 10% increase is caused by staff annual pay adjustments and general inflation for other expenditures. The remaining increase represents a real increase in hospital funding in keeping with the Government's pledge to target health care spending to 17% of the Government annual expenditures. The increase in resources is primarily related to staffing, drugs and medical equipment.

Some of the more significant events that impacted finances are set out below:

### *Non-eligible Persons ("NEP") Obstetric services*

In order to provide Hong Kong people with sufficient Obstetric services, the Cluster ceased providing advance pre-booking Obstetric services to the NEP in September 2011. The number of NEP booked cases fell from around 1500 to less than 550. This measure reduced cluster resources by approximately $17 million, as a result of the corresponding reduction in NEP revenue.

### *Manpower*

Chronic nursing shortages were met with intensive manpower planning measures including: hiring part-time staff, increasing reliance on student nurses, leave encashment, paying compensation off/ Continuous Night Shift Scheme and Special Honorarium to augment nursing numbers during critical peak period.

There were also unplanned vacancies in Supporting and Allied Health staff. Under spending from this area was ploughed back into hospital services, by purchasing urgently needed one-off equipment for the hospitals.

### *Drugs*

In previous years, the Cluster encountered some difficulties in containing drug expenditures within the budget. However, with a combination of both Government and Cluster support to increase the drug budget by approximately $70 million to cover both existing demands and widen the drug formulary, the Cluster was able to work within the budget for the first time in many years.

### *Winter Surge costs higher than budgeted*

The impact of influenza like illnesses continues to increase year-on-year. Although the Cluster budgeted for a 13.5% increase in expenditures over the previous year, the current year's actual expenditures were $19 million over the budget coming in at about $78 million for the December to March period. The higher than budgeted costs were primarily offset by under spending in manpower and drugs.

## New Territories East Cluster
## Balance Sheet at 31 March 2012

| | Note | 2012<br>*HK$'000* | 2011<br>*HK$'000* |
|---|---|---|---|
| **Current Assets** | | | |
| Inventories | 2 | **157,034** | 121,924 |
| Accounts receivable | 3 | **22,101** | 23,579 |
| Other receivables | | **3,188** | 2,536 |
| Deposits and prepayments | 4 | **11,257** | 5,639 |
| Amount due from the Head Office | | **293,279** | 297,952 |
| Cash | 5 | **27,849** | 21,346 |
| | | **514,708** | 472,976 |
| **Non-Current Assets -** Property, plant and equipment | 6 | **599,700** | 585,701 |
| **Total Assets** | | **1,114,408** | 1,058,677 |
| **Current Liabilities** | | | |
| Creditors and accrued charges | | **470,365** | 413,608 |
| Deposits received | | **20,464** | 41,211 |
| | | **490,829** | 454,819 |
| **Non-Current Liabilities** - Deferred income | 7 | **23,879** | 18,157 |
| **Capital subventions and donations** | 8 | **599,700** | 585,701 |
| **Total Liabilities and Capital subventions and donations** | | **1,114,408** | 1,058,677 |

## New Territories East Cluster
## Statement of Income and Expenditure for the year ended 31 March 2012

| | Note | 2012<br>*HK$'000* | 2011<br>*HK$'000* |
|---|---|---|---|
| **Income** | | | |
| Recurrent Government subvention | | **5,878,826** | 5,240,567 |
| Capital Government subvention | | **129,800** | 155,812 |
| Hospital/clinic fees and charges | | **489,033** | 499,450 |
| Transfers from: | | | |
| Designated donation fund | 7 | **16,536** | 17,620 |
| Capital subventions | 8 | **97,046** | 82,471 |
| Capital donations | 8 | **9,251** | 9,108 |
| Other income | | **55,856** | 50,576 |
| | | **6,676,348** | 6,055,604 |
| **Expenditure** | | | |
| Staff costs | | **(4,763,314)** | (4,348,310) |
| Drugs | | **(662,568)** | (601,467) |
| Medical supplies and equipment | | **(341,486)** | (259,130) |
| Utilities charges | | **(171,769)** | (162,150) |
| Repairs and maintenance | | **(217,345)** | (180,673) |
| Building projects funded by the Government | | **(129,237)** | (155,683) |
| Operating lease expenses - office premises and equipment | | **(4,867)** | (24,609) |
| Depreciation and amortisation | 6 | **(106,297)** | (91,279) |
| Other operating expenses | | **(279,465)** | (220,881) |
| | | **(6,676,348)** | (6,044,182) |
| **Surplus for the year** | | **-** | 11,422 |

## 1. Basis of preparation of financial statements

The Cluster's financial statements have been prepared in accordance with the Hospital Authority Financial and Accounting Manual as appropriate to public hospitals and clinics under the management and control of Hospital Authority.

The financial statements have been prepared under an accrual basis of accounting. These draft financial statements are subject to the Head Office's final adjustments which are expected no later than July 2012. At this time management does not anticipate any material adjustments to the draft financial statements.

Surpluses or deficits for the year are transferred to the Head Office accounts in the year they arise and are consolidated at the Head Office. As a result, Reserves do not form part of the Cluster's financial accounts.

## 2. Inventories

| | 31 March 2012 HK$'000 | 31 March 2011 HK$'000 |
|---|---|---|
| Drugs | **109,358** | 85,495 |
| Medical consumables | **39,770** | 30,627 |
| General consumables | **7,906** | 5,802 |
| | **157,034** | 121,924 |

## 3. Accounts receivable

| | 31 March 2012 HK$'000 | 31 March 2011 HK$'000 |
|---|---|---|
| Bills receivable [note 3(a)] | **22,688** | 25,020 |
| Accrued income | **3,917** | 4,017 |
| | **26,605** | 29,037 |
| Less: Provision for doubtful debts [note 3(b)] | **4,504** | 5,458 |
| | **22,101** | 23,579 |

### (a) Aging analysis of bills receivable:

| | 31 March 2012 HK$'000 | 31 March 2011 HK$'000 |
|---|---|---|
| **Past due by:** | | |
| 0-30 days | **17,446** | 20,040 |
| 31-60 days | **2,313** | 3,149 |
| 61-90 days | **838** | 518 |
| Over 90 days | **2,091** | 1,313 |
| | **22,688** | 25,020 |

## 3. Accounts receivable (Continued)

### (a) Aging analysis of bills receivable (Continued):

The policy in respect of patient billing is as follows:

(i) Patients attending outpatient and accident and emergency services are required to pay fees before services are performed.

(ii) Private patients and non-eligible persons are required to pay deposit on admission to hospital.

(iii) Interim bills are sent to patients during hospitalisation. Final bills are sent if the outstanding amounts have not been settled on discharge.

(iv) Administrative charge is imposed on late payments of medical fees and charges for medical services provided on or after 1 July 2007. The administrative charge is imposed at 5% of the outstanding fees overdue for 60 days from issuance of the bills, subject to a maximum charge of HK$1,000 for each bill. An additional 10% of the outstanding fees are imposed if the bills remain outstanding 90 days from issuance of the bills, subject to a maximum additional charge of HK$10,000 for each bill.

(v) Legal action will be instituted for outstanding bills where appropriate. Patients who have financial

### (b) Movements in the provision for doubtful debts are as follows:

| | 2012<br>*HK$'000* | 2011<br>*HK$'000* |
|---|---|---|
| At beginning of year | **5,458** | 3,580 |
| Provision for impairment of receivables | **2,627** | 6,792 |
| Uncollectible amounts written off | **(3,581)** | (4,914) |
| At end of year | **4,504** | 5,458 |

The maximum exposure to credit risk at the reporting date is the fair value of receivable mentioned above. The Cluster does not hold any collateral as security.

## 4. Deposits and prepayments

| | 31 March 2012<br>*HK$'000* | 31 March 2011<br>*HK$'000* |
|---|---|---|
| Utility and other deposits | **284** | 282 |
| Prepayments to Government departments | **4,608** | 3,603 |
| Maintenance contracts and other prepayments | **6,365** | 1,754 |
| | **11,257** | 5,639 |

The above balances do not contain impaired assets. The maximum exposure to credit risk at the reporting date is the fair value of the assets mentioned above. The Group does not hold any collateral as security.

## 5. Cash

| | 31 March 2012 | 31 March 2011 |
|---|---|---|
| | *HK$'000* | *HK$'000* |
| Cash at bank and in hand | **17,395** | 14,926 |
| Bank deposits with maturity within three months | **10,454** | 6,420 |
| | **27,849** | 21,346 |

Cash is deposited to the bank in accordance with the Head Office's Treasury guideline on Bank Accounts and Fund Management.

## 6. Property, plant and equipment

**1 April 2011 - 31 March 2012**

| | Building and improvements | Furniture, fixtures and equipment | Motor vehicles | Computer equipment | Total |
|---|---|---|---|---|---|
| | *HK$'000* | *HK$'000* | *HK$'000* | *HK$'000* | ***HK$'000*** |
| **Cost** | | | | | |
| At 1 April 2011 | 206,212 | 1,247,549 | 20,682 | 10,738 | **1,485,181** |
| Reclassifications | - | (4,639) | - | - | **(4,639)** |
| Additions | - | 124,935 | - | - | **124,935** |
| Disposals | - | (89,565) | (423) | - | **(89,988)** |
| At 31 March 2012 | 206,212 | 1,278,280 | 20,259 | 10,738 | **1,515,489** |
| **Accumulated depreciation** | | | | | |
| At 1 April 2011 | 59,687 | 814,987 | 14,643 | 10,163 | **899,480** |
| Charge for the year | 4,124 | 99,655 | 2,324 | 194 | **106,297** |
| Disposals | - | (89,565) | (423) | - | **(89,988)** |
| At 31 March 2012 | 63,811 | 825,077 | 16,544 | 10,357 | **915,789** |
| **Net book value** | | | | | |
| At 31 March 2012 | 142,401 | 453,203 | 3,715 | 381 | **599,700** |

**1 April 2010 - 31 March 2011**

| | Building and improvements | Furniture, fixtures and equipment | Motor vehicles | Computer equipment | Total |
|---|---|---|---|---|---|
| | *HK$'000* | *HK$'000* | *HK$'000* | *HK$'000* | ***HK$'000*** |
| **Cost** | | | | | |
| At 1 April 2010 | 206,212 | 1,067,261 | 20,204 | 10,481 | **1,304,158** |
| Reclassifications | - | 5,215 | - | - | **5,215** |
| Additions | - | 274,881 | 1,031 | 257 | **276,169** |
| Disposals | - | (99,808) | (553) | - | **(100,361)** |
| At 31 March 2011 | 206,212 | 1,247,549 | 20,682 | 10,738 | **1,485,181** |
| **Accumulated depreciation** | | | | | |
| At 1 April 2010 | 55,563 | 829,738 | 12,972 | 9,989 | **908,262** |
| Charge for the year | 4,124 | 84,757 | 2,224 | 174 | **91,279** |
| Disposals | - | (99,508) | (553) | - | **(100,061)** |
| At 31 March 2011 | 59,687 | 814,987 | 14,643 | 10,163 | **899,480** |
| **Net book value** | | | | | |
| At 31 March 2011 | 146,525 | 432,562 | 6,039 | 575 | **585,701** |

## 6. Property, plant and equipment (Continued)

### (a) Capitalisation of property, plant and equipment

(i) The following types of assets which give rise to economic benefits have been capitalised:

Building projects costing HK$250,000 or more; and

All other assets costing HK$100,000 or more on an individual basis.

The accounting policy for depreciation of property, plant and equipment is set out in note 6(b).

(ii) Expenditure on furniture, fixtures, equipment, motor vehicles and computer hardware is capitalised (subject to the minimum expenditure limits set out in note 6(a)(i) above) and the corresponding amounts are credited to the capital subventions and capital donations accounts for capital expenditure funded by the Government and donations respectively.

### (b) Depreciation

Property, plant and equipment are stated at cost less accumulated depreciation. Additions represent new or replacement of specific components of an asset. An asset's carrying value is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount.

The historical cost of assets acquired and the value of donated assets are depreciated using the straight-line method over the expected useful lives of the assets as follows:

| | |
|---|---|
| Buildings | 20-50 years |
| Furniture, fixtures and equipment | 3-10 years |
| Motor vehicles | 5-7 years |
| Computer equipment | 3-6 years |

The useful lives of assets are reviewed and adjusted, if appropriate, at each balance sheet date.

The gain or loss arising from disposal or retirement of an asset is determined as the difference between the sales proceeds and the carrying amount of the asset and is recognised in the statement of income and expenditure.

Capital expenditure in progress is not depreciated until the asset is placed into commission.

## 7. Deferred income

| | Designated donation fund |
|---|---|
| | *HK$'000* |
| At 1 April 2010 | **27,799** |
| Additions during the year | **7,978** |
| Utilisation during the year | **(17,620)** |
| At 31 March 2011 | **18,157** |
| Additions during the year | **22,258** |
| Utilisation during the year | **(16,536)** |
| At 31 March 2012 | **23,879** |

The movement in deferred income represents the opening balance of donation funds available for use plus donations received less donations used during the year.

## 8. Capital subventions and donations

| | Capital subventions | Capital donations | Total |
|---|---|---|---|
| | *HK$'000* | *HK$'000* | ***HK$'000*** |
| At 1 April 2010 | 230,713 | 165,183 | **395,896** |
| Additions during the year | 275,803 | 5,581 | **281,384** |
| Transfers to consolidated statement of income and expenditure | (82,471) | (9,108) | **(91,579)** |
| At 31 March 2011 | 424,045 | 161,656 | **585,701** |
| Additions during the year | 115,703 | 4,593 | **120,296** |
| Transfers to consolidated statement of income and expenditure | (97,046) | (9,251) | **(106,297)** |
| At 31 March 2012 | 442,702 | 156,998 | **599,700** |

The movement in capital subventions and donations represents the opening balance of the capital assets plus capital funding received and less the annual depreciation charge for the year.

## E. Staff e-polling results on Top Ten Events of NTEC in 2011

1. Surge of Mainland women deliveries via AED after suspension of NEP delivery bookings in PWH.

2. Various medical incidents and patient complaints in public hospitals attracted wide media coverage and public concern.

3. HA submitted applications to recruit non-local doctors on limited registration to ease manpower strain.

4. NTEC launched YouSay online communication platform where staff can freely share their opinions, suggestions and insights to facilitate understanding.

5. HA put forward ten initiatives to improve working conditions to retain doctors.

6. A PWH house officer wrongly prescribed medications to an elderly patient who later passed away.

7. PWH Main Clinical Block and Trauma Centre officially opened by HKSAR Chief Executive Mr Donald Tsang.

8. A CUHK doctor brought a postgraduate student into PWH Operating Theatre to observe the operation without prior approval.

9. Implementation of new grading and salary structure for GSA and TSA.

10. Sewer blockage in PWH AED caused spillage to waiting hall.

醫院管理局
新界東醫院聯網
Hospital Authority
New Territories East Cluster