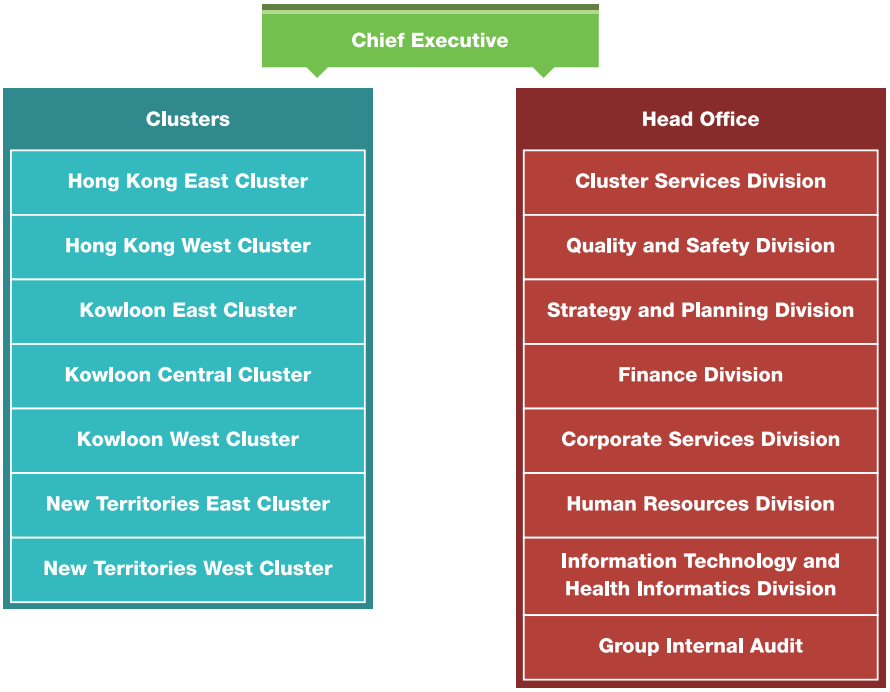
CHAPTER 4 MANAGEMENT AND ORGANISATION STRUCTURE

OVERVIEW

4.1 A key feature of the management and organisation structure of HA is its cluster arrangement. Under the arrangement, the HAHO primarily plays a leading, policy and strategic planning, coordination and supporting role to the seven clusters and the frontline delivery of healthcare services. The following chart shows the structure of the cluster arrangement –



This structure implements HA's strategy to decentralise management where appropriate. Accountability is achieved through the setting of agreed objectives and performance measures and the associated reporting and evaluation systems. This chapter reviews HA's management and organisation structure.

4.2 In the 1980s before the establishment of HA, there were no chief executives or general managers in individual Government hospitals, and management responsibilities were highly centralised in the hands of a Government department[11]. Such a centralised arrangement was considered as the main cause

[11] The then Medical and Health Department, one of the largest departments in the Government, exercised direct control over 14 Government hospitals and indirect control over 20 Government assisted hospitals in the pre-HA era.

of inefficiency and low staff morale in the then public healthcare system. There was a general call for a more decentralised management system in public hospitals so as to enable healthcare staff to serve patients in a more efficient and effective manner. Against this background, the Government endorsed the following principles[12] concerning the management of public hospitals when establishing HA in 1990 –

(a) Individual hospitals should enjoy a high degree of autonomy in determining their affairs, subject to certain powers being retained at the HAHO level; and

(b) There should be a chief executive of each public hospital who should have a high degree of independent management authority for the control of staff and other resources within his hospital.

4.3 The cluster arrangement aims to establish a clear line of accountability for the operation of all hospitals in the cluster, and to achieve integration and collaboration amongst various clinical services within the cluster. On the other hand, it also serves to ensure cost-effective use of resources within and between clusters by eliminating the boundaries of support functions such as human resources, supply chain and facility management across different hospitals/institutions in the same cluster. Cluster arrangement has also facilitated the development of community-based healthcare services in collaboration with other healthcare providers in the district.

CLUSTER ARRANGEMENT

The Clustering Concept

4.4 The clustering concept in HA was introduced in 1992 to address major problems arising from the then three-tier hospital system of regional hospitals, district hospitals and infirmaries. The three types of hospitals were then disorganised and unsatisfactorily coordinated, with some of the regional hospitals supported by up to five to six district hospitals which were widely dispersed in the territory. The three-tier system was reorganised into "acute care" and "extended care" hospitals, delineated by the types of care provided, to better define the roles of and enhance the relationship among hospitals located nearby.

[12] Extracted from paragraph 5.1.2 of the Report of the Provisional HA, 1989.

4.5 Later on, the concept of *vertical and horizontal dimensions of service provision* was put forward for organising and coordinating hospital and specialised clinical care services. This aimed to cater for the different needs of patients throughout the course of their illness and to maximise the operational and management efficiency of HA.

4.6 The *vertical dimension* refers to healthcare services provided at different time points in different stages of a patient's illness. This usually follows the sequence of acute care – extended care – community care. This vertical form of service organisation and provision is done by grouping together hospitals which provide different types of healthcare required at different stages in an episode of illness, *i.e., hospital clustering*.

4.7 The *horizontal dimension* refers to the organisation and provision of different specialty services within each of the acute, extended and community care episodes. Within each of the care episodes, it is not uncommon that individual patients need services from multiple clinical specialties. The delivery of certain specialist services may require complex supporting facilities, advanced technological support and special scarce expertise (*i.e. speciality service networking*) which are only available in selected clusters or hospitals. Examples of such services include neurosurgery, oncology, organ transplant and burn management services. The horizontal service integration allows provision of services across clusters and involves organisation of highly specialised services with relatively small demand on a territory-wide basis (tertiary level services).

4.8 A cluster is therefore a network of medical facilities and services grouped together to help HA ensure that patients would receive a continuum of high-quality care within the same geographical setting and throughout their episode of illness – from its acute phase to convalescence and rehabilitation, and community after-care. This is achieved by rationalising the operations of the hospitals within each cluster so that they are capable of providing a comprehensive and complementary range of services to their local population.

4.9 To facilitate effective capital and service planning, each cluster has designated catchment districts demarcated based on the location of the hospitals (primarily the acute hospitals). Medical facilities and services in the clusters are planned and reorganised taking into account the services provided by and the respective roles of the existing hospitals in the cluster, the geographical and demographic considerations of the catchment districts, and service utilisation patterns at that time. Through this process of clustering which involves service rationalisation and reorganisation, continuity of care for each episode of illness is provided to the local population in the cluster.

Current Cluster Organisation and Management Structure

4.10 The HA Board formally adopted the current seven hospital clusters in 2001, following evolution of the early clustering formation in 1994 and the piloting of a new cluster management approach. The existing seven clusters are –

- Hong Kong East Cluster (HKEC);
- Hong Kong West Cluster (HKWC);
- Kowloon East Cluster (KEC);
- Kowloon Central Cluster (KCC);
- Kowloon West Cluster (KWC);
- New Territories East Cluster (NTEC); and
- New Territories West Cluster (NTWC).

Details of the HA hospitals and institutions in each cluster and the corresponding key statistics are at **Annex 3**.

4.11 Organisationally, each cluster is led by a CCE, who is also the HCE of the major hospital in the cluster (as shown in the following table).

Dual Role of CCE and HCE

CCE of -	Cum HCE of -
HKEC	Pamela Youde Nethersole Eastern Hospital, and Wong Chuk Hang Hospital
HKWC	Queen Mary Hospital, and Tsan Yuk Hospital
KEC	United Christian Hospital
KCC	Queen Elizabeth Hospital and Rehabaid Centre
KWC	Princess Margaret Hospital
NTEC	Prince of Wales Hospital
NTWC	Tuen Mun Hospital

The CCE is responsible for the overall budget and operation of the hospitals and services for the cluster. The CCE is also part of the Chief Executive/HA's senior management team in the HAHO.

HAHO's Role and Structure

4.12 The HAHO, led by the Chief Executive/HA, supports the HA Board and plays a strategic role in leading corporate development, aligning corporate values and directions, and supporting hospital clusters and the frontline delivery of healthcare services.

4.13 HAHO aligns corporate values and directions through interactive collaboration of its seven divisions, namely Cluster Services; Corporate Services; Finance; Human Resources; Information Technology & Health Informatics; Quality & Safety; and Strategy & Planning. Collectively, the seven divisions in HAHO undertake the functions of leading and planning, policy and standards setting, alignment of values and practices, resource management and control, external reporting and relationship building with key stakeholders. HAHO also provides a range of centralised and agency services such as business support services, capital works planning and information technology services, designed to attain economies of scale, increase consistency and improve cost-efficiency.

EVALUATION ON CLUSTER ARRANGEMENT

Cluster Arrangement in General

4.14 Through hospital clustering, HA has achieved the overall objective of decentralising the direct management of individual hospitals closer to users of the services. At the same time, HA has identified and rectified service gaps and duplications in different specialties through, for example, integration of pathology, radiology, ENT, renal, psychiatric support, pharmacy and allied health services in clusters. HA has also fostered additional integration and collaboration among various clinical services through, for example, the establishment of cluster-based services such as diabetes mellitus, geriatric care and stroke management. Collaboration between HA and other community partners has also been enhanced in the development of more cluster-based ambulatory and community care programmes.

4.15 Given HA's large and complex environment, decision-making at operational level needs to be made close to patients so as to enable hospital staff to serve the patients in a more efficient and effective manner. The principle of decentralised management of public hospitals, which was formulated in 1990 at the time when HA was set up, remains equally applicable today, if not more, given the growing network of public hospitals and the expanding services both in volume and types.

Views from the Public Engagement Programme

4.16 In the Public Engagement Programme, stakeholders generally recognised the need for cluster arrangement for a large organisation like HA. During the SC's visits to HA, while some staff raised the need for refinement of the cluster arrangement, they cautioned against any drastic revamp of the existing structure or boundary. They pointed out that frontline staff have taken a long time to develop and operate the referral and service coordination arrangement under the existing clustering system. Any substantial changes in cluster delineation would affect integrated service provision, involving referral for follow up treatment, rehabilitation services, and outreaching support, etc. for patients after discharge from hospitals. Some stakeholders considered that the role of HA Board, being a managing board, should be enhanced in order to have a more effective management of the organisation.

Geographical Boundaries of Clusters

4.17 HA's longer term objective is that the local population of the respective clusters can seek public secondary hospital services within the cluster where they reside. In implementing the hospital clustering concept, it is recognised that there is unevenness among the clusters in terms of population, demographics, demand for public healthcare, as well as the level and scope of services, facilities and expertise available. This is because the portfolio of hospitals was not originally planned on a cluster basis and not all clusters started at the same level. Such unevenness inevitably results in certain level of overlap in individual service provision in some clusters.

4.18 On the other hand, some specialised tertiary services are available only in certain clusters to ensure concentration of expertise and economies of scale and patients may choose to attend any of HA's hospitals and clinics regardless of which cluster they reside in. These factors have resulted in cross-cluster utilisation of services.

4.19 Unevenness among clusters and cross-cluster utilisation is particularly visible in Kowloon. As shown in the following table, the size of KWC (comprising eight public hospitals including five acute hospitals) is larger than the other two Kowloon clusters in terms of catchment districts as well as patient load.

Cross-cluster Utilisation in Kowloon

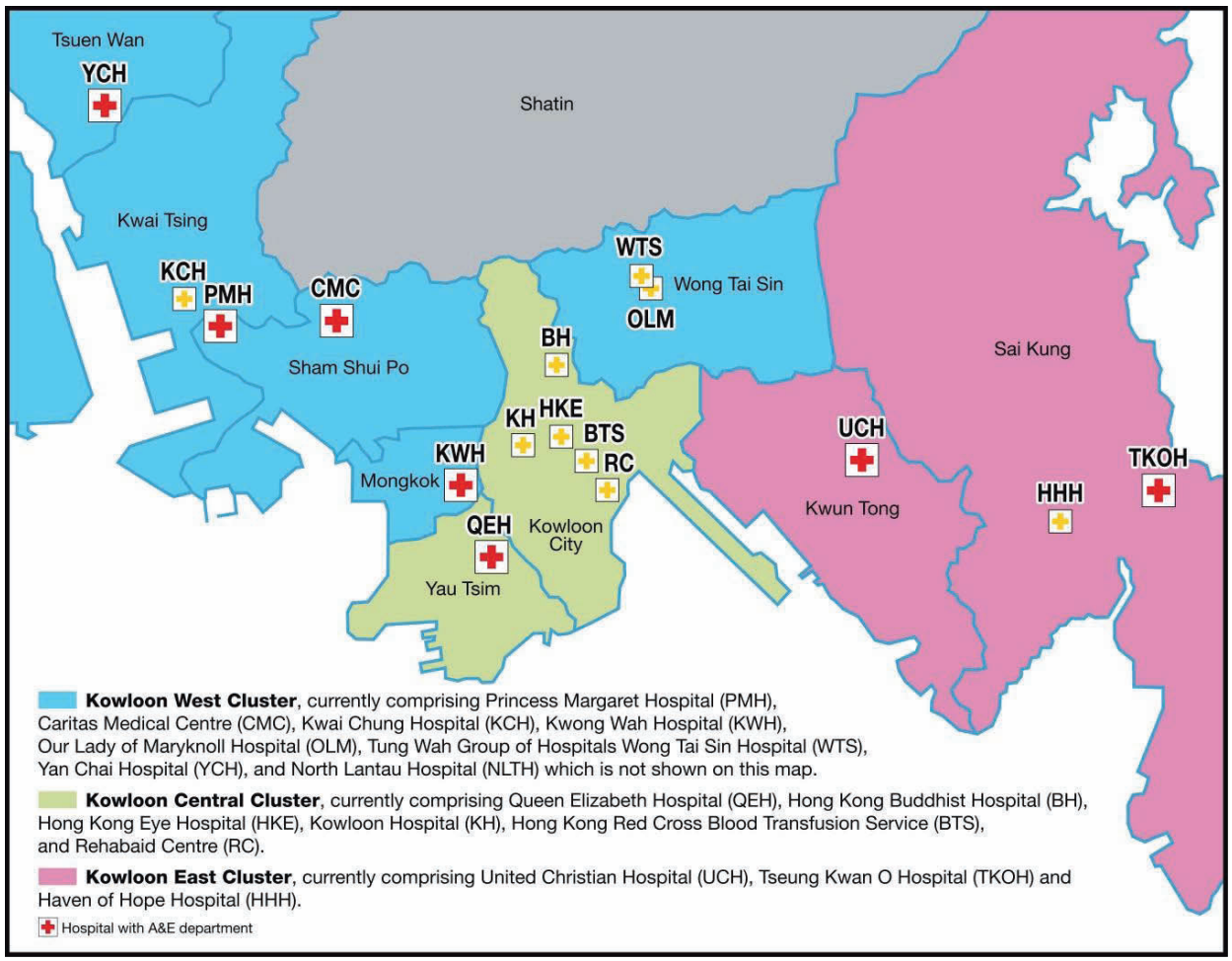
	Hospitals/institutions	No. of hospital beds (as at 31.3.2014)	No. of staff (on FTE basis) (as at 31.3.2014)	2013-14 Budget ($Mn)	Proportion of the Cluster's Inpatient Discharge Episodes^ Utilised by Patients Living Outside the Districts in 2013-14	Catchment districts For Planning Purposes
KWC	Princess Margaret Hospital*, Kwong Wah Hospital*, Caritas Medical Centre*, North Lantau Hospital*, Yan Chai Hospital*, Kwai Chung Hospital, Our Lady of Maryknoll Hospital, Tung Wah Group of Hospitals Wong Tai Sin Hospital	6,629	14,955	9,716	13%	Mongkok, Wong Tai Sin, Sham Shui Po, Kwai Tsing, Tsuen Wan, Lantau Island
KCC	Queen Elizabeth Hospital*, Hong Kong Buddhist Hospital, Hong Kong Eye Hospital, Kowloon Hospital, Hong Kong Red Cross Blood Transfusion Service, Rehabaid Centre	3,548	9,307	5,843	62%	Kowloon City, Yau Tsim
KEC	United Christian Hospital*, Tseung Kwan O Hospital*, Haven of Hope Hospital	2,487	6,960	4,490	10%	Kwun Tong, Sai Kung

^ Referring to discharges and deaths

* with A&E Department

4.20 Some districts receive services from more than one cluster despite the presence of geographical boundaries of the catchment districts. The services from various clusters might not be always well coordinated or integrated. For example, Yau Tsim Mong districts are served by KWC (for Mongkok district) and KCC (for Yaumatei and Tsimshatsui districts). Separately, as shown in the following map, while the Wong Tai Sin district is part of KWC, it tends to be closer to KCC in physical location with the majority of the acute patients there

seeking services at the Queen Elizabeth Hospital in KCC. Yet, when these patients are discharged from hospitals, they will be followed up by community care teams from KWC. As the hospitals and community care teams are from different clusters under such arrangement, communication between them can be at times less than perfect and this might impede seamless continuum of care. Relating to a range of factors and partly reflecting the seriousness of cross-cluster utilisation, 63% of KCC's patients are in fact residing outside the cluster's catchment districts.



Views from the Public Engagement Programme

4.21 During the Public Engagement Programme, no particular adverse comments were raised regarding the cluster boundary in the New Territories and Hong Kong Island. However, noting the disparity in size and number of hospitals as well as the high level of cross-cluster activities in the three clusters in the densely populated Kowloon region, there were calls for reviewing the clustering arrangement for the three clusters concerned. In particular, the Wong Tai Sin District Council has been urging the Government to review the cluster

boundary so as to provide more rationalised and better coordinated services in the region.

4.22 High cross-cluster utilisation was a concern not only of the District Council or the patients, but also HA staff. During the SC's visits to clusters and the staff consultation, some staff considered that there was mismatch of services in the three clusters in Kowloon causing problems in referrals and follow-up of cases. They suggested that the geographical boundary there be reviewed to rationalise services and enhance vertical integration of services.

SC's Considerations

4.23 The SC in general agrees to the need of a cluster structure for a complex and large organisation like HA. The HA Board, being the managing board, should play a more active role in leading and managing HA. There is also a consensus on maintaining the present arrangement of having seven clusters. Members share the view that the existing cluster delineation for Hong Kong Island and the New Territories does not present any significant problem. On the other hand, the SC considers that the existing cluster organisation in the Kowloon region is not conducive to facilitating patients from local communities to have continuity of care in their residential vicinity. The high percentage of cross-cluster patients in KCC also casts doubts whether the cluster boundary and resource allocation are optimal. Especially with the ageing population and changing demographic characteristics of the districts, the roles and demarcation of the different acute and convalescent hospitals and community service network in these clusters have to be re-examined, and the present high percentage of cross-cluster patients in KCC and the coordination on service provision to Wong Tai Sin population need to be redressed. Re-delineating Wong Tai Sin district from KWC to KCC by adjusting the cluster boundaries of KWC and KCC may bring about greater benefits and convenience to the patients. The review should take into account any upcoming hospital development/redevelopment which will have a bearing on the supply of services in the locality.

4.24 **Recommendation 1:** the SC **recommends** that –

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

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

(c) The delineation of cluster boundary, particularly those of the

Kowloon clusters, should be refined having regard to the supply and demand for healthcare services as well as the hospital development/redevelopment plans in the respective cluster; and

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

EVALUATION ON COORDINATION OF SERVICES

4.25 While the existing cluster arrangement should be maintained, further improvement is warranted in certain areas. One of the perceived shortcomings of the current cluster arrangement is "sectarianism". As a decentralised cluster arrangement is characterised by allowing individual clusters a reasonable level of autonomy in service provision so as to cater for the needs in the respective districts, the types and format of service provision may not necessarily be uniform throughout the territory. Patients may feel confused or consider it unfair to be accorded with different types or format of services in different clusters despite having similar clinical conditions.

4.26 HA is not unaware of the problem. There has been the set-up of COC and CC to coordinate various services. The setup of COCs was first endorsed by the HA Board in 1991. At its inception, there were 12 COCs which mirrored the inaugural colleges at HKAM. At present, the COCs, in conjunction with the later developed service-oriented CC, have become the platforms where clinical leaders deliberate issues including manpower, training, services, quality, technology and therapeutics. Playing the important leading and advisory role in HA for their respective specialty/service, COCs/CCs set HA's clinical standards and advise on strategic service planning. In order to continuously improve professional care, COCs/CCs also perform a crucial role in conducting clinical audits, pursuing best practice and developing innovative quality improvement programmes. The current list of COCs/CCs in HA is appended in **Annex 4**.

Views from the Public Engagement Programme

4.27 Despite the work of COCs/CCs, patient organisations have raised concerns on inconsistent practices in service provision in different clusters. Some HA staff also opined that all acute hospitals should be equipped with comparable facilities to provide the same basic and standard services to serve the local community, notwithstanding that some acute hospitals were smaller than the others.

4.28 There were different views expressed on the dual role of CCE as the head of the cluster and HCE of the major acute hospital therein, citing concerns of possible perception of greater advantages enjoyed by large hospitals in resource allocation. There were, however, also views that a CCE without the portfolio of a HCE might lack hands-on experience in hospital management and this was not conducive to the CCE's discharge of management responsibilities.

SC's Considerations

4.29 The SC considers that there is a need for HAHO to play a greater role in central coordination to ensure consistency in service provision and to coordinate the adoption of new treatment and highly specialised technology among clusters. It is necessary to further strengthen the central management role of HAHO and the central coordination role of COCs and CCs to guard against "sectarianism" or to address perceived conflict of interest.

4.30 To achieve better division of labour and better alignment of service provision at cluster level with organisation goals, the SC considers that the CCEs, being part of the HAHO senior management team, should strengthen their participation in central management rather than merely focusing on cluster management and operation. This should also help bring the CCEs more in line with the corporate management goals and service targets of HA as a whole and minimise potential "sectarianism".

4.31 Some SC Members also opine that the domination of COCs by Chief of Services (COS) of major hospitals has resulted in the interests of smaller hospitals not adequately reflected. Also the large number of COCs and CCs have increased the workload of clinical staff and delayed the management decision process. These concerns further link to the allocation of resources within and among the clusters. As hospitals are of different scale, there are also perceptions that HCE of smaller hospitals have less power. The SC reckons the need for role differentiation so that different hospitals within a cluster can play complementary roles to support each other.

4.32 **Recommendation 2:** the SC **recommends** that –

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

services among clusters;

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

(i) re-examine the overall cluster management structure, focusing on and streamlining the roles of the CCE, HCE, COC/CC, etc.; and

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

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

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

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