CHAPTER 6 STAFF MANAGEMENT

OVERVIEW

6.1 HA is a large and complex organisation with a total of 70,132 staff (FTE as at 28 February 2015). It is the largest public organisation in Hong Kong outside the Government, with staff size exceeding one third of that of the civil service.

6.2 Healthcare service is a human service the delivery of which rests with people. In order to deliver quality public healthcare services, a comprehensive and effective staff management system is indispensable. This chapter reviews HA's staffing and training arrangement.

6.3 HA has, according to the HA Ordinance (Cap 113)[25], the authority to determine -

(a) the remuneration, and the terms and conditions of employment of its employees; and

(b) the standards of work and conduct of its employees, and matters relating to their suspension or dismissal from office.

The employment terms and conditions and relevant staff management matters are set out in HA's Human Resources (HR) Policy Manual, as approved by the HA Board. HA has also laid down further guidance on HR policies and procedures in its HR Administration Manual.

6.4 As stated in Chapter 5.1.2 of the Report of the Provisional HA, the management principle advocated during the formative years of HA is to allow "individual hospitals to enjoy a high degree of autonomy in determining their affairs". In line with this, HA has adopted a decentralised management structure along with the principle that operational decision is encouraged to be made as close to the patients as possible. While HR policies are developed and set by HAHO, clusters/hospitals are responsible for implementing such policies.

6.5 In accordance with the schedules of delegations made by HA pursuant to section 6 of the HA Ordinance (Cap 113), the authority for hiring and firing HA employees in a hospital generally rests with the HCE, who is the overall

[25] Paragraph 10 of Schedule 3 to the HA Ordinance (Cap 113).

manager of the hospital. To support HCEs in exercising these and other HR functions, the HR Policy Manual and the HR Administration Manual provide guidance for the exercise of such functions and authority across HA. Moreover, each cluster has a Cluster HR Department headed by a Cluster General Manager (HR). HA operates a single HR and payroll system for all staff, and this system also supports other functions such as manpower planning, rostering, leave management and training.

THE HA WORKFORCE

6.6 HA's large workforce comprises six main groups with over 300 grades and ranks of staff. These six main groups of staff, together with the corresponding number of staff in each group, are as follows –

Group of Staff	**Number (FTE as at 28 February 2015)**
Medical	5,910
Nursing	23,721
Allied Health	6,891
Care Related Supporting	13,665
Management/Administration (e.g. Executive Officers, Hospital Administrators, Finance & Accounting, System Analysts, etc.)	2,421
Others (e.g. Operation Assistants, Clerical & Secretarial, Workmen, Executive Assistants, Information Technology Assistants, etc.)	17,525
Total	**70,132**[26]

The majority of the workforce is involved in direct patient care delivery providing a wide range of services to patients. These healthcare staff groups, including doctors, nurses, allied health professionals, care-related supporting staff, and their respective numbers are outlined in **Annex 5**.

[26] Figures may not add up due to rounding when calculating FTE manpower.

THE CURRENT STAFFING SYSTEM

Recruitment, Selection and Appointment Process

6.7 Under the decentralised management structure, creation of posts and recruitment of staff to deliver patient services are at the discretion of CCE – the overall senior executive in charge of the cluster. Appointment and promotion exercises are normally initiated and carried out by the hospitals in which the vacancies exist.

6.8 HA adopts an open appointment system. The objective is to uphold equity and fairness in its recruitment and appointment processes. Appointment will be based on the candidate's merits rather than seniority with a view to appointing the most suitable candidate with the highest calibre for the job. Any person, including incumbent employee of HA, who considers that he/she meets the entry requirements of a post advertised, may submit an application for appointment. Selection of candidates for appointment (including the recruitment process, and the use of selection board and interviews to assist in the selection process) is governed by relevant policies and guidelines specified in HA's HR Policy Manual and HR Administration Manual respectively.

Staff Transfer and Deployment Process

6.9 The SC notes that transfers of staff between hospitals are arranged on the staff's initiative and with mutual agreement of the hospitals concerned. Management postings initiated by HAHO, which were commonly practised in Government hospitals before the takeover by HA, are limited. Although HAHO does reserve the right to transfer staff to meet special operational needs, such authority is seldom exercised and when exercised, for temporary relief only.

Role of HAHO

Central Recruitment for entry ranks for certain grades

6.10 The SC notes that notwithstanding the decentralised recruitment and appointment system, HAHO plays a central agency role in certain circumstances. For example, in the annual intake of graduate doctors, nurses and allied health professionals to entry ranks of these grades, HAHO coordinates central recruitment actions in collaboration with Cluster HR Departments in the aspects of posts allocation, conducting selection interviews and matching of applicants' preferences to posts available. HAHO's involvement ensures that the relevant process is procedurally proper. Selection of candidates for relevant clusters

depends largely on the choice of the candidates as well as clusters' line managers. It is observed that HAHO only has minimal influence on directing and deploying appointees to other areas even if there is higher demand in those areas.

Recruitment of other positions

6.11 Recruitment of other entry level/promotional positions in clusters is carried out by the hospitals in which the vacancies/posts exist. HAHO's involvement in local selection boards is relatively limited. The SC appreciates that if HAHO was to send representatives to attend all selection boards of individual posts in clusters as well as the consequential vacancies generated therefrom, the manpower requirement on the part of HAHO would have been substantial. In this respect, HA's HR Policy Manual requires inclusion of HAHO representative only in selection boards of senior posts (e.g. Consultants) in clusters. HAHO representation is either not required or not mandatory for the lower rank posts. Most posts in clusters are filled by candidates with significant local characteristics, often geared specifically towards the requirement of the particular job concerned.

Cross-Cluster Promotion

6.12 The SC notes that most of the promotion cases (over 90%) were from within the cluster. As illustrated in **Annex 6**, the overall proportion of cross-cluster promotion of clinical professionals (i.e. doctors, nurses, allied health professionals) in the past five years was low, ranging from 10% in 2009-10 to 9% in 2013-14.

6.13 Among the professional groups, there is a slightly higher percentage of cross-cluster promotion for doctors (8% - 14%). Nurses have a comparatively lower cross-cluster promotion rate (4% - 9%) over the years.

6.14 Whilst it is acknowledged that serving members of a team are more likely to have an edge over other competitors in the promotion process as they are more familiar with the job requirements and working environment and have established working networks, the general resultant phenomenon of promotion from within the cluster/team has gradually (and unintentionally) created silos. This leads to the perception of "sectarianism" and forms a possible barrier to cross-fertilisation of expertise and deployment of people resources across cluster to meet needs at critical times.

Cross-Cluster Staff Movement/Deployment

6.15 Horizontal movement of staff between hospitals/clusters is mainly left to the discretion and initiation of the staff concerned. For example, the staff concerned is free to apply for transfer to another hospital/cluster subject to –

(a) the agreement of the two departments or hospitals concerned; and

(b) the availability of vacancies for placement.

Alternatively, the staff member may follow the recruitment process and apply for appointment to fill an advertised vacancy in another cluster.

6.16 Although HAHO does reserve the right to transfer staff horizontally to meet special operational needs, such authority is seldom exercised. Even when it is exercised, it is often fraught with difficulties due to the overall manpower shortage in HA.

THE MANPOWER SHORTAGE ISSUE

6.17 With an ageing population, advances in medical technology and increasing demand for healthcare services in the community, the manpower requirement of HA for service provision has grown considerably. In particular, there has been a significant shortfall of doctors in recent years due to the reduced number of local medical graduates as explained in paragraph 3.5 and the competition from a more vibrant private healthcare sector.

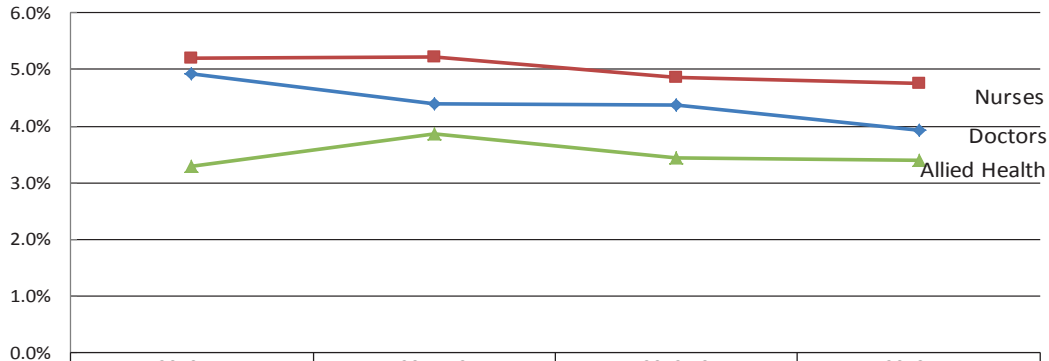
6.18 HA has been closely monitoring the attrition rate of staff and is committed to improving the manpower situation of doctors. For this purpose, a basket of measures with a view to strengthening the medical workforce and boosting staff morale has been put in place. These include recruitment of non-local doctors through limited registration, employment of part-time doctors through enhanced pay package, enhancement of promotion prospect, enhanced recognition through honorarium scheme, reduction in workload through introducing care technician service support and improving working conditions (more details of these measures are at **Annex 7**).

Current Attrition Position

6.19 Upon implementation of these measures, HA has recorded improvement in staffing position. As can be seen from the diagram below, the

attrition rate of full-time doctors has declined from 4.9% in 2010-11 to 3.9% in 2013-14. The attrition rate of nurses is also on the decline from 5.2% in 2010-11 to 4.7% in 2013-14, while attrition rate of allied health professional has remained steady and lower than that of doctors and nurses.

Hospital Authority Manpower and Attrition (Wastage) Rate (%) of Doctors, Nurses & Allied Health Professionals



	2010-11	2011-12	2012-13	2013-14
Full-Time Doctors	4.9%	4.4%	4.4%	3.9%
Full-Time Nurses	5.2%	5.2%	4.9%	4.7%
Full-Time Allied Health	3.3%	3.9%	3.4%	3.4%

FTE Strength				
Doctors	5,052	5,165	5,260	5,376
Nurses	20,102	20,901	21,816	22,759
Allied Health	5,618	5,944	6,302	6,609
Part-Time Doctors	63	88	111	125

Note:
(1)Doctors exclude Interns and Dental Officers.
(2)Attrition (Wastage) includes all types of cessation of service from HA for full-time permanent and full-time contract staff on Headcount basis
(3)Rolling Attrition (Wastage) Rate = Total no. of full-time staff left HA in the past 12 months /Average strength in the past 12 months x 100%
(4)Manpower on FTE includes all full-time and part-time permanent, contract and temporary staff in HA's workforce

Current Manpower Position

6.20 While it is fair to say that the overall strength of HA's manpower and staff wastage have been improved, the overall manpower shortage problem remains due to the fast growing service demand. In 2014, the shortfall of doctor in HA was around 340 and the shortfall is expected to continue in the next few years. Similar challenges exist in nurses and allied health professionals though in a smaller magnitude.

6.21 In the past two years, there is a rising attrition of care related supporting staff. Heavy workload, work nature and the labour market competitive force drive the attrition rate from 13.9% in 2011-12 to 15.7% in

2013-14. These have added to the pressure at the frontline and become a risk factor on quality of care.

6.22 All in all, the manpower shortage issue undoubtedly has a bearing on HA's flexibility in managing staff.

EVALUATION ON STAFF MANAGEMENT

6.23 Over the years, HA has noticed a number of HR management and staff morale issues including the following –

(a) There are allegations of favouritism in the appointment/promotion process with perception of less-able persons being promoted ahead of more competent ones;

(b) The difficulties experienced by staff in cross-cluster transfers, as well as the difficulties and limitations in deploying people resources across HA have hindered optimal utilisation especially at critical periods;

(c) The general phenomenon of promotion from within the cluster/team has gradually created silos and has formed barriers to cross-fertilisation of expertise and development of lateral thinking for staff; and

(d) Inconsistencies in the interpretation and application of HA's HR policies at local level have created perceived unfairness amongst staff and caused adverse impact on staff sentiment and morale.

HA's Recent Endeavours

6.24 The SC notes that HAHO has been taking a more proactive lead in recent years in staffing issues, examples of which are set out in the ensuing paragraphs.

Advancement of Clinical Consultants

6.25 HAHO conducts the advancement exercise for clinical Consultants from Directorate ranks D1/D2 to D3 and from D3 to D4, taking into consideration overall service needs, professional development of the specialties and career development of individual doctors. HAHO has put in place consistent

assessment criteria and considerations for advancement, unified appointment date and centrally coordinated prior communication of such to individual doctors to improve transparency and enhance trust building between management and staff.

Creation of Directorate Positions

6.26 Instead of vesting the authority to cluster management which has resulted in lack of coordination and variation in management structure among clusters, creation of Directorate positions (e.g. clinical Consultant posts in clusters) is now deliberated at and determined by a CC led by HAHO on an annual basis, where both local needs as well as HA's overall needs can be considered and balanced.

Alignment of weekly conditioned work hours of HA employees

6.27 To align the conditions of work of HA staff, HAHO has reduced the weekly conditioned work hours of all junior supporting grades employees (around 20,000 employees or 30% of HA's total work force) from 45 net per week (i.e. excluding lunch break) to 44 gross per week (i.e. including lunch break) with effect from 1 May 2013. All HA employees now have the same number of conditioned work hours per week.

Central acquisition and allocation to clusters of phlebotomist support and clerical support

6.28 HA implemented in 2012-13 an initiative to centrally acquire and allocate to clusters phlebotomist support and clerical support to help relieve manpower shortage. Through the initiative, HA has recruited an additional of 280 Clinical Assistants (phlebotomists) to provide 24-hour phlebotomy support service to all acute hospitals. HA has also provided 315 clerical staff members to relieve frontline healthcare professionals from administrative duties.

Executive Development and Succession Planning

6.29 HA takes succession planning of senior management across HA seriously. A central Executive Succession Committee chaired by the Chief Executive/HA has been formed to oversee and monitor the succession management of strategic leadership positions, e.g. CCEs, HCEs, selected Chief Managers, Cluster General Managers or equivalent. This Committee is tasked to review nominations against defined criteria and decide who are to be admitted to the succession pools. Cluster Succession Committees are also established to manage and monitor the succession management of operational leadership

positions such as COS, Department Operation Managers, Department Managers, General Managers or equivalent.

6.30 HA has designed and implemented an in-house tailor-made leadership development programme, the Executive Leadership Programme, for those in the succession pools. This is a 12-month programme that covers workshop, seminars on critical business skills, coaching, boardroom sessions and projects. Overseas training and short-term attachment will also be arranged for those who have already participated in the Executive Leadership Programme.

Rotations of HCE, CCE and Chief Managers

6.31 In 2008, HA had initiated the HCE rotation scheme. Under this scheme, HCEs who had been in current positions for six years or more and were more than three years from retirement would be invited to join the rotation scheme.

6.32 CCEs are also recommended for similar job rotation. CCEs who are in post for three years or more would be invited for lateral transfer should the opportunity arise.

6.33 In 2011, job exchanges amongst selected Chief Managers were also implemented on a voluntary basis to widen exposure in general management at corporate level. HA has introduced a more structured job rotation scheme between Chief Managers (at Executive Manager/Senior Executive Manager rank) and relevant HCEs in 2014 for exposure and development purposes for the benefit of the organisation.

Streamlined administrative duties

6.34 HAHO provides leadership, policy steer, central planning and performance management in a large organisation with a total workforce of over 70,000 operating under a decentralised environment. Apart from its strategic role in leading corporate strategies and development, aligning corporate values and directions, HAHO also shoulders the responsibilities of an array of important corporate functions such as corporate governance, administration, finance, HR management, information technology systems development and operations, quality and standards, as well as other essential central supporting services including procurement, drug management, corporate communication, external relations and legal support. This organisation of work through HAHO also supports the hospital clusters in the delivery of healthcare services and alleviates the administrative tasks of the clusters. It also facilitates alignment of corporate

policies and direction, standardization, quality improvement, as well as effective structure and operation in HA.

6.35 HA is very conscious of the need to streamline any necessary administrative duties and support its clinical staff so that they can focus on their clinical duties. As mentioned in paragraph 6.28 above, additional clerical staff have been provided to the clinical departments of the clusters, and information technology has been utilised, and will continue to be developed, where practicable, to streamline and standardise administration of systems and practices to help alleviate clinical professionals from mundane administrative duties.

Views from the Public Engagement Programme

6.36 Despite HA's recent endeavours above, the general sentiments from frontline staff gathered during the Public Engagement Programme were that there was still room for improvement. Inconsistencies in HR practices among clusters were still found. For example, some pointed out that different clusters had different arrangements in the granting of study leave and creation of posts. Some considered that HAHO should be equipped with greater authority in coordinating resource deployment and setting direction. In particular, to enhance the collaborative culture within the organisation, HA should consider more staff rotations. HAHO should also attend and oversee the promotion boards of individual clusters to ensure transparency and fairness.

6.37 While different hospitals in the same cluster would perform different roles, some considered that a more flexible flow of staff between clusters/hospitals would provide staff with more training opportunities and exposure and this would help attract and retain staff.

6.38 Some also thought that at present, the spirit of cooperation in providing staff support between clusters or hospitals was not strong enough in meeting *ad hoc* requirements for additional manpower. There should be some central coordination in deploying staff across clusters to meet short-term service needs, particularly during crisis or contingent situations.

6.39 Acknowledging the fact that certain specialties might be more popular among medical graduates than others, some opined that more central coordination was needed in the allocation of Resident Trainees to address manpower shortage in these specialties.

6.40 Having said the above, the SC noted that the views on the existing staffing arrangements were not one-sided. Some saw the merits of allowing

individual clusters or hospitals to retain the authority to select staff so as to build their own team. In general, supporting grades were more cautious to centrally-coordinated promotion or transfer as they might not wish to work in other clusters due to possible concerns on transportation and the need to adapt to new working environment.

SC's Considerations

6.41 The SC appreciates that central coordination and decentralisation have their respective pros and cons. There is no single right model that lasts forever for any organisation. The challenge to a large organisation like HA is to strike the appropriate balance to suit its stage of development at the specified time.

6.42 One of the main purposes of establishing clusters in HA was to improve efficiency through decentralisation. In this connection, despite the perception of "sectarianism" under the current decentralised arrangement, the SC is mindful that any changes should avoid going to the other extreme of centralisation like that during the pre-HA era where all personnel issues were in the single hand of the then Medical and Health Department. The key is to strike a *right* balance between central coordination and decentralisation to ensure consistency and alignment of practices in HA.

6.43 The SC considers that HAHO should enhance its coordinating role in staff management to ensure that there would be greater consistency, fairness and parity in human resources practices at the cluster and hospital levels. To cater for the special needs and features in different disciplines, HA should enhance the coordinating and monitoring role of the COC in this connection in different specialties. Furthermore, HAHO should strengthen its staff development programme for senior managerial and clinical staff whereby senior staff will be given wider exposure through rotation to different postings. HA should also strengthen the rotation arrangement for trainees as part of their training programme. HAHO should, in particular, enhance its central coordinating role in time of crisis in order to deal with any contingent situation effectively. It is important to instill in staff the notion that they are staff of the HA family, rather than merely staff of individual cluster or hospital.

6.44 While HAHO is playing the central agency role in the annual recruitment exercise of Resident Trainees, the SC is of the view that such function is not performed strongly enough. Individual hospital departments virtually conduct the recruitment exercise on their own by inviting interns to attend informal departmental interviews arranged by themselves and make informal indications to offer Resident Trainee positions to interns considered suitable in

these informal departmental interviews prior to the official central selection interviews. This often leads to certain interns accepting informal offers from more than one department. Hospitals' manpower plans thus remain uncertain until the very end of the recruitment period. Strengthened central coordination in this aspect is called for.

6.45 SC Members also notice the existence of occasional inconsistencies among clusters and hospitals in HR practices resulting from different interpretation of HAHO's rules. For example, leave for training is granted in one cluster but not necessarily in another under the same circumstance. To address such inconsistencies, Members see a need for HAHO to enhance transparency and strengthen internal communication on staff management issues. Clear guidelines on the foci of representative from HAHO and/or representative from HKAM (in case of doctors) in selection boards may also be considered.

6.46 **Recommendation 5:** the SC **recommends** that –

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

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

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

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

in service demand;

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

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

TRAINING

Background

6.47 Training is one of the important elements of staff management, particularly for the healthcare sector in which service quality and patient safety are at stake and where staff retention is crucial for addressing the prevailing problem of manpower shortage. In fact, promoting, assisting and taking part in "*the education and training of persons involved or to be involved in hospital services or other services relevant to the health of the public*" is one of the functions of HA stipulated in Section 4 of the HA Ordinance (Cap 113). Training of healthcare professionals, as set forth by the Secretary for Food and Health in the report "*Building a Healthy Tomorrow*" in 2005, is also one of the four priority areas directed by the Government for HA to focus on.

6.48 The overall aim of HA's training programmes is to ensure that the healthcare workforce has the right skills and is of the right numbers to maintain the standard of care, improve patient outcomes and lead to greater job and career satisfaction for staff.

6.49 HA is therefore committed to supporting the healthcare workforce with high quality training, including providing specialty training for doctors, nurses and allied health professionals, and scholarships for overseas training.

6.50 HA's education and training programmes mainly fall under three categories –

(a) Professional Training – HA provides professional training for medical staff, nurses and allied health professionals. For instance, HA supports clinical teaching for medical students (Years 4 to 6) through collaboration with the medical schools of the two local

universities. HA offers the majority of specialist medical training in Hong Kong (such as on-the-job training, training rotation and simulation training) based on the guidelines of HKAM. HA also runs nursing schools to provide Registered Nurses and Enrolled Nurses training;

(b) Post Graduate and Specialised Service Training – given the rapid medical developments, HA is committed to providing service related professional training. It has established the Institute of Health Centre in 1998 to coordinate and organise clinical professional training for healthcare professional at all levels; from beginner's level for new graduates to advanced or specialty level for specialist practitioners. HA also provides overseas training programmes and sponsorship schemes to help build up a competent workforce; and

(c) Soft Skills – HA has put in place a number of competency-based training programmes to reinforce its four corporate values, namely People-centred Care, Professional Service, Committed Staff and Teamwork. Examples of these programmes, which focus on the soft side of a healthcare worker's skills, include "Better Patient Communication", "On-the-job Coaching", "The 7 Habits of Highly Effective People", and "Building Wellness at Work".

Resources for Training and Development

6.51 Along with its strategic direction to support staff through high quality training and development (*HA Strategic Plan 2012-17*), HA has allotted significant resources to healthcare professional and service related training. Much of this is "On-the-job training" that integrates with HA service provision and associated budgets. This makes full quantification of resources utilised for such training and development purposes within HA difficult.

6.52 As a reference, additional funding from Government specifically allocated to HA for training[27] totalled around $300 million in 2011-12, and reached $500 million in 2012-13 and $600 million in 2013-14 cumulatively.

6.53 Another indication on the extent of training and development activities undertaken by HA can also be obtained from the following statistics-

[27] Using 2010-11 as base year

	Internal Training Days	Local Training Days	External Training Days	Total Training Days	Total Training Days per Head count
Medical	5,367	5,367	23,690	34,424	5.86
Nursing	121,085	14,690	5,996	141,771	5.95
Allied Health	32,622	3,302	2,938	38,862	5.85
Management	3,894	979	575	5,448	2.38
Others	31,383	1,643	224	33,250	1.09
Total	**194,351**	**25,981**	**33,423**	**253,755**	**3.67**

Note:

- Statistics of 2013-14
- Internal training days – official release to attend internal classroom training recorded in HA's e-Learning Centre.
- Local and Overseas training days - study leave taken recorded in HR records.
- Excludes internal training not recorded in e-Learning Centre and "On-the-job training"

OBSERVATIONS ON HA'S TRAINING WORK

6.54 Promoting, assisting and taking part in the education and training of healthcare professionals is a statutory function of HA, and supporting staff through high quality training is a key focus area. To this end, HA takes a leading role in the training and development of Hong Kong's healthcare workforce and has, together with its training partners, put in tremendous efforts to establish structured programmes of professional training to ensure that healthcare professionals are competent and skilled. Taking opportunities to further enhance these programmes will help HA continue to support the healthcare workforce with high quality training and to meet the service related challenges going forward.

Training Opportunities

6.55 As stated in paragraph 6.17 – 6.22 above, HA faces the challenges of shortage of doctors, nurses and allied health professionals (though with a smaller magnitude for the latter two).

6.56 The unmatched supply of clinical professionals has made it difficult for HA to cope with the escalating service demand. This naturally creates a sub-optimal situation, adversely impacting both service delivery and training. Decisions on staff release for training must be balanced with service needs. The

duration of the training, particularly for overseas training, is also reduced.

6.57 Staff shortages also mean fewer available trainers can spare time for conducting training activities, especially during office hours. This adversely impacts HA's training capacity. All along, HA will consider opening up training opportunities to non-HA clinical professionals if the training is of benefit to clinical service providers outside HA and its internal training requirements are fulfilled. With the reduced training capacity as mentioned earlier, HA has to reserve the training opportunities to cater for HA's internal demand and therefore resulting in less training opportunities available to external partners.

6.58 The staffing situation is expected to begin to improve when the number of annual local medical graduates increases to 320 in 2015 and further to 420 in 2018. Besides, there is also increased number of graduates in nursing and allied health professionals in recent years and the situation will improve similarly. It is therefore anticipated that training opportunities will increase in the following years.

Views from the Public Engagement Programme

6.59 While not being the main area of concerns in the Public Engagement Programme, stakeholders, both within and outside HA, did express different views on HA's work on training. Staff raised their concerns on the shorter training time, fewer overseas training opportunities and the lack of transparency in the selection process. There were also views that HA should strengthen collaboration with its strategic partner, e.g. HKAM, in planning and developing training programmes and that sufficient resources should be earmarked for performance of training duties as well as facilitating staff relief.

6.60 Some considered that the current operation in HA over-emphasised service delivery but overlooked the need to upgrade professionalism. There was a need to enhance training so as to improve the quality of services provided by healthcare staff. To enhance emphasis on training, some suggested the establishment of a committee on training under the HA Board and a dedicated budget on training.

SC's Considerations

6.61 Members note HA's work on training and also the stakeholders' views on the subject. While the SC acknowledges that the current manpower shortage inevitably imposes limitation on HA's ability to increase training opportunities substantially in the near future, there exist areas for improvement.

These include better planning for training programmes taking into account the development needs of different disciplines and/or specialties, as well as providing greater parity in the selection process for training.

6.62 **Recommendation 6:** the SC **recommends** that –

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

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