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The Zubin Foundation's Submission on the Regulation of Private Healthcare Facilities
(March 2015)

Introduction to The Zubin Foundation

The Zubin Foundation (TZF)

1 The Zubin Foundation welcomes the regulation of Private Healthcare Facilities in Hong Kong.

2 By way of introduction The Zubin Foundation (TZF) is a non-profit think tank committed to social justice and equality. TZF has charitable status. A key focus area for TZF is the reform of Hong Kong's private hospitals. The overarching objective of TZF for the reform of private hospitals is patient quality of care and safety. This must be achieved through:

a. Regulation of private hospitals in line with Hong Kong's public hospitals and international best practice and in line with Hong Kong's unique circumstances (see paragraph 3 below on Hong Kong's unique circumstances).
b. Transparency and accountability of safety, key clinical indicators, accreditation status with outcomes, audit and investigation outcomes and other information critical to patient decision-making.
c. Other and all reasonable measures to enhance the safety culture of private hospitals.

Hong Kong's unique circumstances

Hong Kong's unique circumstances:

3 Through engagement with patients, TZF understands that there are multiple problems within the current operating mode of private hospitals. These are the principal ones:

a. Private hospitals tend to use "visiting doctors".
b. Private hospitals mostly do not have adequate "hospitalists" or full time hospital-employed doctors who only work at that particular hospital.

c. The legal relationship between the visiting doctor and private hospitals is vague and needs to be clear and legally binding such as one of employer/employee or agency.
d. Resident doctors may be resident at a hospital but actually be visiting with other hospitals at any given time. Even though they are "resident" doctor, this does not guarantee their onsite availability.
e. Private hospitals often market themselves as being open to accidents and emergencies by using wording to suggest so – but do not have full time employed onsite doctors or the teams of expertise to manage such cases.
f. Private hospitals, when they are unable to deal with the medical complexities of the patient, will transfer the patient, sometimes when it is "too late" to the public sector. It is a well-known fact amongst public sector medical doctors that the public hospitals often "clean up the mess of the private hospitals".
g. Nurses, under the current *modus operandi*, will wait for instruction from a patient's visiting doctor before taking action. When the patient's doctor is not available, which is not uncommon, the nurses will not seek or take instruction from any other doctor. This is a problem and puts patient safety at risk.
h. In line with point g above, private hospitals do not currently report on patients that they "transfer out" to public hospitals – even though these may result to a sentinel or adverse event. As such there is no routine account or reporting of these patients and perhaps lessons learned by the hospital from these "transfer out" cases.
i. Private hospitals must not view themselves as "hotels".

4 TZF welcomes collaboration and dialogue with the Food and Health Bureau to further discuss regulation of private hospital and to see how to work together to improve the regulation, governance and management of private hospitals.

5 Below please find specific comments on as well as responses to the Consultation Document of Regulation of Private Healthcare Facilities. Our comments will mainly concern private hospital.

Chapter 1

Existing Regulatory Regime for Private Healthcare

6 TZF agrees that it is necessary to improve the transparency and accountability of private healthcare facilities in particular private hospitals.

7 TZF does not agree that the public should not be "incentivised" to use private healthcare facilities, particular private hospitals, unless the standards of these PHF at least are in line with government/

Facilities

public hospitals, international best practice and are regulated. Specifically:

a. TZF agrees that the current regulation governing private hospital is outdated and is in need of reform. TZF welcomes the review of legislation in Singapore, New South Wales (NSW) Australia and England and Wales and stresses that the principal objective must be patient safety and patient outcomes.
b. TZF believes that Cap. 165 is a weak piece of legislation and agrees that it is in need of overhaul. It must be patient-focused. In addition Cap 165 covers the skeleton required for accommodation, staff and facilities of private hospital. It is incomplete.
c. Cap.165 Code of Practice (CoP) is not legislation– it is a voluntary code of practice. It therefore does not go far enough to protect patients.
d. TZF agrees that there is a need for detailed broad regulation in line with international best practice.
e. TZF agrees that we cannot rely solely on "the ethics and self-discipline of doctors" (Consultation document: 1.12).
f. In light of the above, TZF agrees that there is a genuine and urgent need for reform of private hospital.

Chapter 3

Private Healthcare Facilities to be Regulated

8 TZF agrees that among PHFs, private hospitals provide the widest range of services and entail the highest level of risks (Consultation document: 3.2).

9 TZF agrees to define "hospitals" as 'any healthcare facility primarily for the provision of medical care and/or Chinese medicine practice with continuous medical support and lodging' (Consultation document: 3.5).

10 In line with the definition in 9 above, TZF agrees that special attention must be paid to the words *"continuous support"* including but not limited to:

a The responsibility of the hospital when the 'visiting doctor' is not present or available, which can be much of the time.
b Mandatorily requiring all private hospitals to ensure that the patient is provided with continuous support from medical practitioners who are required to be onsite at all times.
c The practitioner in charge could still be the visiting doctor but in cases where s/he cannot be contacted and/or available onsite within a "reasonable' timeframe (as per regulation), the hospitalist and/or next visiting doctor on the roster would become the practitioner required to make decisions.
d TZF Recommendation (TZF Recommendation 1): In order for private hospital to ensure that patient risks are mitigated,

private hospitals to have full time doctors on staff and a roster of specialist doctors' available at all times.

e Similar to the situation in the United States, Hong Kong may consider having private hospitals employ "hospitalist". In the US, hospitalists were introduced specifically because a visiting doctor cannot be in two places at one time. Hospitalists are full time doctors employed by the private hospital. As per, Next Step in Care, A campaign of United Hospital Fund in US, a hospitalist is usually:

i. Doctors who have been trained in internal medicine (internists). Others have been trained in family practice, pediatrics, or a few other specialties.
ii. Some hospitalists have advanced training in managing critical illnesses and are leaders in patient safety and high quality care.
iii. Available 24 hours a day, with doctors rotating in shifts – can respond quickly to a patient's danger signs.
iv. Work in teams with nurses and other assistants. The hospitalist is in charge (- in Hong Kong perhaps when the visiting doctor is not available).
v. Hospital communicates with the patient's primary care doctor and other specialists in most cases.
vi. Hospitalists work directly for a hospital, a hospital corporation, or a health care system.

f The British Medical Association, found that NHS patients who were admitted to hospital on Saturday or Sunday were significantly more likely to die than those admitted during the week. In addition they found that hospitals with higher levels of senior medical staff present at weekends are associated with lower mortality rates. (See *Seven-day services in the NHS*, BMA, http://bma.org.uk/working-for-change/doctors-in-the-nhs/seven-day-services). This makes the case clearly that onsite staffing makes a significant impact on mortality rates.

g In Singapore, all private hospitals with 50 or more beds are required to have at least one medical practitioner on duty at all times.

h In the UK, NICE (National Institute for Health and Care Excellence) has recently published two sets of guidelines,one on nursing levels, another on midwifery and they are currently working on medical practitioners at the moment. There are legal duties of care and not having staff (e.g. an A&E department not having a qualified A&E consultant) would doubtless be a breach of this.

j. In Hong Kong, although some private hospital may have resident doctors, it is the experience of TZF that the current arrangement is less than satisfactory due to the following

reasons:

i. The resident doctor, is not guaranteed to be onsite at all times and will often have her/his own medical clinic elsewhere as well as be a visiting doctor in other private hospitals. Therefore resident doctors are not always present.

ii. The term "resident doctor" is a misnomer and wrongly suggests to the patient that the resident doctor will be available onsite as s/he lives there. With the way things currently stand in Hong Kong, this sends the wrong message to patients.

iii. Nursing care needs to be strengthened in private hospitals and the nursing ethos changed to reflect that patient risk is paramount and the ultimate responsibility of the patient is with the hospital not the visiting doctor , who may not be present or not contactable. Nurses must be empowered to activate escalation procedures even if the visiting doctor is not available or present.

Chapter 5 Board of Governors (proposed by WG4)

Corporate Governance

11 WG4 proposal: Establishment of Board of Governors (the "Board") mandatory. Minimum requirements on the composition of the Board, their functions and responsibilities should be stipulated, and the regulatory authority should be empowered to, as and when necessary, require private hospitals to submit information concerning the set up and operation of the board of governors as required under the CoP.

12 TZF response: TZF agrees to WG4 proposal. TZF believes that private hospitals should not be exempt from good governance.

13 In addition, in the largest research conducted amongst hospital boards in USA, found that hospital boards may play a large role in influencing the quality of care in hospitals. In addition the research finds a positive relationship between board governance and performance of hospitals.
(*Hospital Governance And The Quality of Care – by* Ashish Jha and Arnold Epstein, Harvard School of Public Health, *http://content.healthaffairs.org*)

14 In line with this, TZF proposes the following as regulation:

a. The Board is responsible for the quality of care in the hospital. As per paragraph 13 above, the research conducted by the Harvard School of Public Health shows clearly that quality of

care and board governance are closely linked.
Furthermore, in research *Governance in large Nonprofit Health System,* Commonwealth Centre Governance Studies http://www.hallrender.com/library/articles/1220/Governance_booklet.pdf) research into board governance in non-profit hospital boards in USA, uses in their benchmark of board governance an indicator that shows clearly that the board has overall responsibility of patient care and safety.

b. The Board is responsible for designing, assessing and reporting on clinical governance in the private hospital as per CoP 165 2.5.2 and 2.5.3.
c. Mandatory training for all Board members on quality of care. Research as per *Hospital Governance and The Quality of Care* and *Governance in large Nonprofit Health System*s, cited in paragraph 13 above, states that board training is an effective way to enhance better board governance. TZF sees mandatory training as "low hanging fruit" which can have a substantial impact on quality of care of patients and patient safety.
d. The composition of the Board should include both executive and independent non-executive directors. Non-executive directors to include those individuals with standing and integrity in the community who come from diverse stakeholder groups.
This recommendation is also as per *Governance in large Nonprofit Health System*, Commonwealth Centre Governance Studies,
http://www.hallrender.com/library/articles/1220/Governance_booklet.pdf).
Closer to home in Hong Kong, boards of listed companies in Hong Kong are required to have one third of their boards be independent non executive directors. At a minimum, Hong Kong's private hospitals, should be complying with this.
e. The composition of the board should also include a clearly defined percentage of medical and nursing professionals.
This recommendation allows for the views of both medical and nursing staff, critical stakeholders to hospitals, to be included at the leadership governance level.
This is also in line with what is recommended in *Governance in large Nonprofit Health System*, Commonwealth Centre Governance Studies,
http://www.hallrender.com/library/articles/1220/Governance_booklet.pdf)
f. The frequency and duration between meetings should be stated and mandatory.
This is in line with good corporate governance globally and is

also recommended by "*Governance in large Nonprofit Health System"*, Commonwealth Centre Governance Studies*,* http://www.hallrender.com/library/articles/1220/Governance_booklet.pdf

g. The terms of the Board should be written and clearly communicated to all board members including the written terms of all the various sub committees of the board.
This is in line with good corporate governance globally and is also recommended by *Governance in large Nonprofit Health System*, Commonwealth Centre Governance Studies *,* http://www.hallrender.com/library/articles/1220/Governance_booklet.pdf

h. The role of the Chair of the Board to be kept separate from the Person-in-charge or PIC (or Executive Director or CEO of the private hospital) in line with good corporate governance, where the Chair is able to view the private hospital at "arms length".

i. The board should be diverse in terms of gender, background and other factors. Reference should be drawn from the Hong Kong Stock Exchange with regard to diversity of boards -see *Appendix 14 Corporate Governance code and corporate governance report*, HKEx, https://www.hkex.com.hk/eng/rulesreg/listrules/mbrules/documents/appendix_14.pdf).

j. This recommendation is also consistent with good corporate governance globally and is also recommended by *Governance in large Nonprofit Health System*, Commonwealth Centre Governance Studies *,* http://www.hallrender.com/library/articles/1220/Governance_booklet.pdf

k. The names, terms, functions of the Board should be transparent and made clear and visible on the hospital website.

l. The Board should be responsible for monitoring the progress of all complaints received at the private hospital.

15 **Establishing a Nominations Committee (TZF Recommendation 2)**

TZF proposes: A nominations committee of the Board must be mandatory. The purpose of the nomination committee is to ensure that board candidates are recruited professionally, widely and fairly and succession planning is being addressed.
The process of identifying and selecting board candidates should be transparent and available. This is not dissimilar to what is required from companies listed on the HKSE (see *Appendix 14*

Corporate Governance code and corporate governance report, HKEx, https://www.hkex.com.hk/eng/rulesreg/listrules/mbrules/documents/appendix_14.pdf)

16 **Establishing an Quality, Audit and Compliance Committee (TZF Recommendation 3)**

TZF proposes: A quality, audit and compliance committee should be a Board committee and be mandatory. The role of the audit and compliance committee should ensure that quality standards are upheld, reporting requirements are met and regulation is complied with. Given the increase in requirements of private hospitals post regulation, this Committee would have overall responsibility for :

a. Compliance with regulation
b. Internal audits
c. Communications and reporting to the regulatory authority
d. Accreditations
e. Clinical Audit System (CAS)
f. Preparing a dashboard of quality of care for the hospital and ensuring that the board is made aware of this at each board meeting.

17 **Appointment of Person-in-charge (PIC) (A1)**

18 FHB proposal: Mandatorily requiring the appointment of a person-in-charge for each regulated PHF.

19 TZF response**:** TZF welcomes the idea of appointing a person-in-charge for the overall management of private hospitals.

20 TZF recommends that it the PIC is in charge of patient safety and clinical governance at the private hospital. This is in line with the regulation in New South Wales, Australia, where the Private Health Facilities Act stipulates that the “licensee (i.e. the PIC) should ensure that reasonable standards of patient care and safety are maintained at the facility. (Private Health Facilities Act, Division 3, 12.2(e))

21 In addition, the PIC should be required to live onsite, or as close as possible.

22 Furthermore and in case of his/her temporary absence for any reason, it should be made mandatory that there is an acting PIC that immediate takes the role of the PIC.

23 The PIC performance should be evaluated taking into account her/his performance on quality care and safety indicators (See: *Hospital Governance And The Quality of Care,* Ashish Jha and Arnold Epstein Health Affairs *http://content.healthaffairs.org/com*)

Accountability of PIC (WKG4 Recommendation 6)

24 WKG4 Proposal: PIC should be accountable (and liable to penalty if the offence is substantiated) for breaches or non-compliance that would seriously affect the safety or integrity of hospital services
25 which s/he should be reasonably in control when appropriately discharging his responsibilities under the new regime.

26 TZF response: TZF agrees with this recommendation of WKG4.

Establishment of Medical Advisory Committee (MAC) (A2)

27 FHB proposal: Mandatorily requiring the establishment of MAC for private hospital.

28 TZF response: TZF agrees with the proposal of mandatorily requiring the establishment of MAC for all private hospitals. However the FHB proposal does not go far enough. TZF proposes that the MAC is a sub-committee of the Board and represents directly to the Board.

Drawing from good practice, including from NSW (private health facilities Act, Part 3, 39) and Singapore (Private Hospital and Medical Clinics Act, Ch 248, Section 22, Part 1A, 12A), TZF proposes the following.

Composition:

a. Medical practitioners including at least one with no direct/indirect relationship with the hospital. This may include an overseas medical practitioner who may be more likely to offer alternative views.
b. Nursing staff.
c. Administrative and ancillary staff of the private hospitals
d. The PIC of the hospital could be a member of the MAC, however, should not be the chair of the committee.
e. Member(s) from the Quality, Audit and Compliance Committee (TZF Recommendation 3).

Functions and Responsibilities:

a. Monitoring and evaluating the overall quality and appropriateness of the patient care that is provided, and the practices and procedures that are carried out by the private

hospital.

b. Advising on and monitoring and evaluating the accreditation of practitioners (not just medical doctors) that provide services at the private hospital and the delineation of their clinical responsibilities.
c. Advising on matters concerning clinical practice and monitoring and evaluation of clinical practice.
d. Advising on matters concerning patient care and safety.
e. Oversight of patient complaints at hospitals, their impact on medical practices and practitioners and improvement and action required in light of medical complaints.
f. Overall responsibility of sentinel events management system.
g. Report sentinel and adverse events (see paragraphs 68-69 below) as well as all transfers out to public hospitals and deaths to regulatory authority.
h. Review of all sentinel events, adverse clinical incidents, transfers to public hospitals, complaints of all medical and nursing practitioners and audit reports (as per Cap 165 CoP 2.6.4)

Complaints Management System (A3)

29 FHB proposal: Establishing a two-tier complaints management system for hospitals; and a streamlined complaints management system for other regulated PHFs. For private hospital, the first tier would be the private hospital and the second tier would be a centralised and independent body.

30 TZF response: TZF agrees to the proposal of the FHB with specific details as follows:

The first tier is the hospital:

a. The Board should have overall responsibility and oversight of complaints
b. First tier complaints made about medical practitioners related to doctors and nurses should be directed to tier 2 immediately.
c. First tier complaints made about medical procedures should be directed to tier 2 immediately.
d. All first tier complaints should be directed to tier 2 if unresolved after a defined reasonable period of time, to be defined by the regulation.

The second tier is the independent external body, an Independent Committee on Complaints Against Private Hospitals (ICCAPH) to be empowered by regulation and cover the following but not limited

to:

a. Investigate all complaints against medical practitioners and nurses and medical procedures filed with regard to private hospitals s stated above.
b. Investigate all unresolved complaints filed at private hospitals under the first tier.
c. Seek alternate opinions from medical practitioners both locally and overseas.
d. Make recommendations to the various bodies based on investigation. These bodies may include:
    i. Private hospital concerned
    ii. Regulatory body
    iii. Medical Council with regard to specific doctors
    iv. Relevant nursing and other professional bodies
e. Make public with monthly updates on their website on numbers of complaints received by hospital and general nature of complaints.

31 It is critical that complaints against medical doctors whilst at service in the private hospitals be filed with the ICCAPH. .

32 An independent body set up in the interest of the public, not in the best interest of the medical fraternity, must be empowered to investigate and make complaints with regard to the severity or not of the medical practitioner conduct.

Establishment of an Information System Connectable with the Electronic Health Record Sharing System (eHRSS) (A4)

33 FHB proposal: Hospitals should, in time, establish an information system connectable with eHRSS

34 TZF response**:** TZF agrees establishing an information system connectable with the electronic health record sharing system will benefit both the hospital and patient. A clearly defined timetable must be set forth and made clear to the public.

Maintenance of Hospital Accreditation Status (A5)

35 FHB proposal: Consideration should be made to require any established hospitals to participate in hospital accreditation and keep the regulatory authority informed of any change in the accreditation status.

36 TZF response**:** TZF proposes that all hospitals must be accredited by same the accredited body (or bodies) chosen by the regulator.

The accreditation body should not be chosen by the individual private hospitals.

37 In addition, accreditation scores with regard to specific indicators should be made public through the private hospital websites. This will give patients access to safety and clinical information necessary to make informed decisions on which private hospital to chose.

38 Although apparently most private hospitals in Hong Kong have been accredited internationally (see:*私院聯會：新規定對業界影響不大*, Now.com, 15 December 2014), TZF strongly suggests that the government should:

a. Review the current accreditation by the Australian Council on Healthcare Standards (ACHS) as 10 of the 11 private hospitals are accredited by July 2014 to determine whether in fact this is the "best" accreditation scheme for Hong Kong'
b. Make reference to the Joint Council International (JCI) which currently accredits 738 hospitals in 64 countries including but not limited to Australia, Singapore, UK, USA, Abu Dhabi and Germany. It is important to note that IHH Healthcare in Singapore is accredited by the JCI and IHH Healthcare has entered into a joint venture with The University of Hong Kong School of Medicine to set up the Gleneagles Hong Kong Hospital.

Chapter 6 Premises Management (B6)

Standard of Facilities

39 FHB proposal: Effective premises management hinges on proper management and maintenance of physical assets such as buildings, equipment, power and water supply with a view to ensuring the quality of services provided.

40 TZF response**:** Although this is not an area of expertise of TZF, in principle we agree to the highest possible standards being adopted for Hong Kong's private hospitals. TZF urges the government to take reference from overseas standards and in light of Hong Kong's unique circumstances.

Physical Conditions (B7)

41 FHB proposal: Include but not limited to the state of repair, ventilation, lighting, and periodical maintenance of a PHF

42 TZF response: TZF recognizes the importance of the physical conditions to patient safety. Although this is not an area of

expertise of TZF, in principle we agree to the highest possible standards being adopted for Hong Kong's private hospitals. TZF urges the government to take reference from overseas standards and in light of Hong Kong's unique circumstances.

Infection Control (B8)

43 FHB proposal: PHFs should devise mechanism regarding infection control on diagnosis, treatments, operations and other medical procedures, etc. performed in regulated facilities (for example, documentation procedures to ensure staff have complied with relevant protocols)

44 TZF response: Although this is not the area of expertise of TZF, in principle we agree to the highest possible standards being adopted for Hong Kong's private hospitals. TZF urges the government to take reference from overseas standards and in light of Hong Kong's unique circumstances. TZF also suggests that reference here is to work done by the World Health Organisation (WHO) on infection control. (World Health Organisation , Infection Control, http://www.who.int/topics/infection_control/en/)

Chapter 7 **Service Delivery and Care Process (C9)**

Clinical Quality

45 FHB proposal: Prescribing standards on service delivery and care process for compliance of all PHFs

46 A. FHB proposal: Sufficient number of qualified staff on duty at all times;

47 TZF response: TZF agrees to this. For patients to receive sufficient care at private hospital, TZF suggests private hospitals should have a clear human resource plan where the focus is on patient care and patient safety.

48 Particular attention should be paid to private hospitals and:

i. "24 hour care' centres at hospitals (marketing themselves as accident and emergency centres). These should be required to have the same service delivery and care process as public hospitals offering the same "services", This would include staff required for the provision of A&E, its subsidiary services and intensive care units
ii. Private hospitals to have doctors onsite at all times and a roster of specialist doctors' available at all times. These doctors must have a legally binding relationship with the hospital such as employer/employee or agency.
iii. The general mindset needs to change. The current mindset

is that "the patient belongs to the visiting doctor". The correct mindset is "the patient belongs to the hospital".

iv. The (full time) doctor patient ratio should be defined by regulation by specialty.

v. Nursing care needs to be strengthened in private hospitals and the nursing ethos changed to reflect that patient risk is paramount and the ultimate responsibility of the patient is with the hospital because the visiting doctor may not be present or not contactable. Nurses must be empowered to activate escalation procedures even if the visiting doctor is not available or present.

vi. Doctor in charge names must be clearly visible to patients at all times.

49 B. FHB proposal: Patients are duly informed of the recommended interventions for treatment and/ or care;

50 TZF response**:** Although this is not an area of expertise of TZF, in principle we agree to the highest possible standards being adopted for Hong Kong's private hospitals. TZF urges the government to take reference from overseas standards and in light of Hong Kong's unique circumstances. TZF also suggests that reference here is made to work done by the World Health Organisation (WHO) on Patient Care. (See: *IMAI District Clinician Manual: Hospital Care for Adolescents and Adults*, Guidelines for the management of common illnesses with limited resources, World Health Organization http://www.who.int/influenza/patient_care/DCM_Volume_1.pdf?ua=1)

51 C. FBP proposal: A properly managed medical record system to ensure all medical records are accurate and up-to-date and are kept in a secure and confidential manner;

52 TZF response**:** Although this is not an area of expertise of TZF, in principle we agree to the highest possible standards being adopted for Hong Kong's private hospitals. TZF urges the government to take reference from overseas standards and in light of Hong Kong's unique circumstances.

53 D. FHB proposal: Policy to protect patients' rights such as privacy, confidentiality of their medical records, informed consent before medical intervention, and a safe care environment; and

54 TZF response**:** Although this is not an area of expertise of TZF, in principle we agree to the highest possible standards being adopted for Hong Kong's private hospitals. TZF urges the

government to take reference from overseas standards and in light of Hong Kong's unique circumstances.

55 E. FHB proposal: suitable support services, such as laboratory services, sterilization facility and waste management, available whenever necessary.

56 TZF response**:** Although this is not an area of expertise of TZF, in principle we agree to the highest possible standards being adopted for Hong Kong's private hospitals. TZF urges the government to take reference from overseas standards and in light of Hong Kong's unique circumstances.

Resuscitation and Contingency (C10)

57 FHB proposal: Hospitals and facilities providing high-risk medical procedures in ambulatory setting should comply with standards on the availability and readiness of essential resuscitation equipment (such as monitoring device and defibrillator) and guidelines as well as contingency planning

58 TZF response**:** TZF agrees with importance of setting up mandatory requirement on resuscitation and contingency on both software (trained staff) and hardware (emergency lighting and power supply, etc.). TZF suggests private hospitals should submit reports and records of clinical risk management work to the regulatory authority for inspection regularly and when required. Although this is not the area of expertise of TZF, in principle we agree to the highest possible standards being adopted for Hong Kong's private hospitals. TZF urges the government to take reference from overseas standards and in light of Hong Kong's unique circumstances.

Standards Specific to Procedures Performed (C11)

59 FHB proposal: Prescribing standards embracing requirements on the premises, equipment and staffing for high-risk procedures the administration of which is confined to regulated facilities

60 TZF response**:** TZF agrees with the proposal that PHF should be required to comply with additional standards for each of the selected procedures intended to be performed in the facilities to ensure patient safety. However, the additional standards need to be prescribed clearly and updated periodically. Although this is not an area of expertise of TZF, in principle we agree to the highest possible standards being adopted for Hong Kong's private

hospitals. TZF urges the government to take reference from overseas standards and in light of Hong Kong's unique circumstances.

Credentialing of Visiting Doctors (C12)

61 FHB proposal: Mandatorily requiring hospitals to implement policies in relation to the credentialing of visiting doctors

62 TZF response**:** TZF proposes that the standard of staffing (credentialing) is regulated by law and not by the private hospitals. This would be similar to Singapore, England and NSW, Australia. Similar to the UK and NSW, Australia, TZF proposes that the regulation sets forth that each private hospital recruits a sufficient number and quality of staff to be employed by the hospital and to be on duty at all times. This would apply to all staff. Furthermore, TZF proposes that Chapter 4 of the Cap 165 CoP, is made regulation with regard to each private hospital having a Human Resource Management.

Establishment of Clinical Audit System (C13)

63 FHB proposal: The introduction of a set of basic requirements, as prescribed by the regulatory authority, for establishing a well-structured clinical audit system should be made mandatory for private hospitals.

Private hospitals should submit reports on audit findings and implementation progress to the regulatory authority for inspection as and when required. Specifically, private hospitals should be required to develop policies to review and record clinical audits performed and improve service performance based on audit findings.

64 TZF response**:** TZF welcomes the idea of private hospitals having to establish a Clinical Audit System to ensure the clinical quality of private hospitals. The requirements should go beyond being "basic" and should instead be in line with best practice internationally.

65 Reports should be submitted to the regulatory authority regularly and as per regulation.

66 Responsibility of the Clinical Audit System should rest with the Quality, Audit and Compliance Committee (TZF Recommendation 3 above paragraph 16) , a sub-committee of the Board of Governors.

Sentinel Events Management (C14)

67 FHB proposal: Hospitals should establish a comprehensive sentinel events management system to strengthen internal quality assurance and enable the regulatory authority to gain access to relevant information for regulatory purposes.

68 TZF response**:** TZF strongly agrees that it should be mandatory that private hospitals have a comprehensive sentinel events management system.

69 TZF proposes that the regulatory authority consider the following:

a. The definition of sentinel events- to include adverse events as well. This is in line with Singapore, Malaysia and England
b. The definition to include details of all "transfers out" to public hospitals. As is unique to Hong Kong, private hospitals will "transfer out" patients to public hospitals in cases which they themselves cannot resolve. TZF knows from public sector hospital administrators that often the "public sector cleans up the mess of the private hospitals". Those cases that were taken on by the private hospital that ultimately got transferred to a public hospital must also be in the reporting of the private hospital.
c. Sentinel events to go beyond the nine classifications as per Department of Health website and also include serious untoward events (see: *Reportable Sentinel Events and Serious Untoward Events for Private Hospitals*, Department of Health, http://www.dh.gov.hk/english/main/main_orhi/reportable_ph.html)
d. TZF agrees that the regulatory authority should be empowered to prescribe reporting requirement, and to gain access to records and documents kept by hospitals in connection with sentinel events including information and reports on the investigation and recommendations of the MAC.
e. Confidentiality vs. Public safety. TZF agrees that the primary purpose of reporting of sentinel events is that improvements are made and mistakes are learned from and a fine balance needs to be reached between confidentiality (and encouraging reporting) and public safety.
f. However, TZF also believes that the public should have access to selected information which could help them make better decisions. This may include hospital name and brief nature of event.
g. At the private hospital level, there needs to be independent

investigation conducted by a root cause analysis team, which could be appointed by/under the MAC of all sentinel events as per the regulation in New South Wales, Australia.

h. In addition, the MAC should be in charge of establishing and reporting on all sentinel events and the Chair of the Board of member of the MAC together with the PIC must sign off on every sentinel report submitted to the regulatory authority which includes full information about the event itself plus next steps to be taken by the private hospital in light of the event.
i. All sentinel report information at the private hospital level must also feed into their Clinical Audit System so that continuous improvements are made.
j. TZF does agree to protect the confidentiality of information and documents produced in the course of root cause analysis by hospitals except for those that involve legal disputes, civil or criminal proceedings and reckless or purposeful unsafe acts.
k. It is critical that in any legal proceedings or disputes, all information is made available.

Clinical Indicators (WGB Proposal)

70 WKG 4 Proposal: Private hospitals should be mandated to collect more in-depth and comprehensive clinical indicators and perform review and analysis regularly and submit to the regulatory authority quarterly.

71 Private hospitals should be encouraged, at the earliest convenience, to adopt a systematic approach (e.g. electronic information system) to collect and analyse clinical indicators and an effective and efficient manner.

72 TZF response: TZF agrees

Clinical Effectiveness

73 WKG 4 Proposal: Private hospitals should have in place and implemented written policies and guidance on clinical effectiveness.

74 TZF Response: TZF agrees

Chapter 8 Price Transparency

Provision of Fee Schedule (D15)

75 FHB proposal: Fee schedules, covering all chargeable items, should be publicly available at all regulated PHFs

76 TZF response: TZF agrees.

Provision of Quotation (D16)

77 FHB proposal: Hospitals should ensure that patients are provided with the estimated total charges for the whole course of investigative procedures or elective, non-emergency therapeutic operations/ procedures for known diseases on or before admission

78 TZF response: TZF agrees.

Provision of Recognised Service Packages (D17)

79 FHB proposal: Encouraging all PHFs to provide Recognized Service Packages which are identically and clearly defined standard services provided at packaged charge

80 TZF response: TZF agrees.

Disclosure of Historical Bill Sizes Statistics (D18)

81 FHB proposal: Mandatorily requiring hospitals to publish key historical statistics on their actual bill sizes for common treatments/procedures as prescribed by the regulatory authority.

82 TZF response: TZF agrees.

Chapter 9 Sanctions

83 TZF response: TZF agrees with the proposal here to increase the maximum penalties for hospitals.

Chapter 10 Powers of the Regulatory Authority

84 FHB proposal: The regulatory authority/ Government should be vested with powers to issue and amend regulations/code of practice- the regulations and/or code of practice should set out the principles, procedures, guidelines and standards for the operation and management of PHFs and provide practical guidance.

85 TZF response: TZF welcomes the idea of providing flexibility for the regulatory authority to issue and amend the regulatory standard and we propose that there is no ambiguity with regard to statutory nature of codes of practice. Either the Code of Practice should be mandated by law or regulation itself. As it currently stands, with the Code of Practice (Cap 165 CoP), the Department of Health has no statutory power to impose penalties on private hospitals for non-compliance with the existing CoP. which is voluntary. This is unsatisfactory and we recommend that penalties

are imposed and reporting of non-compliance is made available to the public through the regulator's website.

86 FHB proposal: The regulatory authority/ Government should be vested with powers to inspect, collect and publish information for the purposes of
(a) monitoring and/or investigating whether this Ordinance, any regulations and/or code of practice made under this Ordinance has been or is being contravened
(b) assessing the quality and standard of the facilities and services provided and the practices and procedures being carried out at the regulated PHFs;
(c) investigating complaints/ sentinel events/ medical incidents relating to the regulated PHFs.

87 TZF response: TZF agrees with (a) and (c) above.
For (b), TZF suggests conducting an annual inspection and one ad-hoc inspection for each private hospital annually, during which, surprise checks on patients' medical records, facilities and equipment management records, selected service areas or department are covered. This is in line with the current practice. (See: Audit Commission, "Chapter 3" (2012), page 6-7, http://www.aud.gov.hk/pdf_e/e59ch03.pdf).

88 TZF also suggests the regulatory authority should consider, like the Care Quality Commission in UK, developing clear ratings and inspection standards. In addition, findings would be made available on the regulatory authority website with a detailed inspection report. (See: http://www.cqc.org.uk/content/hospitals).

89 FHB proposal: The regulatory authority should also be empowered to have access to records and documents in the custody of regulated PHFs, including information and reports on the investigation, findings and recommendations of the Medical Advisory Committee (MAC) and other relevant committees. Such powers enable the regulatory authority to access the necessary information to monitor and assess whether the regulated PHFs comply with the standards and requirements.

90 TZF response: TZF agrees

91 FHB proposal: It is suggested to treat the information or documents provided by PHFs in the course of root cause analysis as confidential, unless the disclosure is made for prosecution of a criminal offence or for making or investigating a complaint against registered health professional for sanctionable behaviour. Private

hospitals may appeal to an Independent Review Committee on Regulatory Actions to review the regulatory authority's decision in respect of collection and disclosure of information.

92 TZF response: TZF agrees to protect the confidentiality of information and documents produced in the course of root cause analysis by hospitals except for those that involve legal disputes, civil or criminal proceedings and reckless or purposeful unsafe acts.

93 It is critical that in any legal proceedings or disputes, all information is made present.

94 FHB proposal: The regulatory authority/ the Government should be vested with powers to suspend the use of all or part of a facility/service/use of equipment to enable a proportionate response to manage an immediate and serious risk to patient safety.

95 TZF response: TZF agrees with the proposal and would like to suggest FHB to consider having a clear guideline on when to use the power of suspension so that both the PHF and the authority know when and how do so and avoid ambiguity.

96 FHB proposal: The regulatory authority/ the Government should be vested with powers to appoint committees advising on the regulation of PHFs such as the Advisory Committee on Regulation of Private Healthcare Facilities – to advise on issues in respect of registration, compliance and other matters of concern that relate to regulation of PHFs

97 TZF response**:** TZF agrees and suggests greater clarification on composition, functions and responsibilities of the committee. TZF suggests members should be diverse and represent a cross section of stakeholders of private healthcare facilities and not just medical practitioners.

98 FHB Proposal: The regulatory authority/ the Government should be vested with powers to appoint committees advising on the regulation of PHFs such as Independent Review Committee on Regulatory Actions – to handle appeals lodged by regulated PHFs or any person who is aggrieved by regulatory decisions (e.g. refusal of registration) or enforcement actions (e.g. order of service suspension) taken by the regulatory authority;

99 TZF response**:** TZF agrees and would suggest greater clarity is provided about the composition, functions and responsibilities. TZF

suggests the committee members should represent a cross section of stakeholders and not just medical practitioners.

100 FHB Proposal: The regulatory authority/ the Government should be vested with powers to appoint committees advising on the regulation of PHFs such as Independent Committee on Complaints against Private Hospitals – to handle complaints lodged by the public against the service of private hospitals or against how complaints are handled by private hospitals.

101 TZF response**:** TZF agrees and suggests considering including both overseas medical practitioners to avoid conflicts (Hong Kong's medical community is close knit and small) plus laypeople.

102 FHB Proposal: The regulatory authority/ the Government should be vested with powers to appoint committees advising on the regulation of PHFs such as a Committee to devise, review and update the Scope and Standards of Regulation for *High-risk Medical Procedures/Practices*– to devise, review and update the scope and standards of regulation of high-risk medical procedures/practices so that the regulatory regime can keep up with the advancement in technology and medical services.

103 TZF response: TZF agrees with the proposed item.

Further recommendations on the role of the regulator as per TZF

104 TZF Proposal (TZF Recommendation 4): The regulator to collect clinical outcome data and make it accessible to the public. From this, regulators can more easily identify where there are patient safety issues. Thus, hospitals operate under far greater scrutiny. Clinical outcome data collected would include, but not be limited to, readmission rates, morbidity and mortality rates, lengths of stay, infection rates, etc such that policy makers and other stakeholders could all gain sight of what is really going.

105 TZF recommends that FHB look at best practice globally including from England and Japan around clinical outcome indicators against which private hospitals must report.
See the *State of Care* report in the UK:
http://www.cqc.org.uk/sites/default/files/documents/cqc_soc_report_2013_lores2.pdf
And read one of the CQC inspection report:
http://www.cqc.org.uk/sites/default/files/new_reports/AAAB8931.pdf for reference

106 TZF Proposal (TZF Recommendation 5): The regulator to standardise processes, procedures and medical equipment required for the most common medical interventions at private hospitals- or require the private hospitals to. The aim is to reduce risk to patients

107 In USA, the Mayo Clinic, for example has undertaken to standardize its care processes or care pathways with the aim of bringing "mistakes down to zero". See *Global Perspectives of Clinical Governance* by KPMG, 2013.

Chapter 12 Interim Measures

108 FBH Proposals:

A. Implemented/ On-going Interim Measures
   i. Alignment of Reporting Criteria of Sentinel Events between Public and Private Sectors
   ii. Standard on Credentialing of Doctors

B. Interim Measures to be Adopted

109 TZF Proposal: In the interim between now and the enactment of new legislation TZF proposes that the current Cap 165 CoP be made mandatory.

TZF Additional Thoughts

110 Without proper and complete regulation of private hospitals:

a. The Government is exposing itself to risk by asking the public to move from public to private sector pay when the clinical standards required of private hospitals is much lower.
b. And specifically not having doctors onsite at all times (as per ratio determined by the regulator) enhances the risk to patients. This potentially increases the insurance premiums for patient healthcare and hospital indemnity insurance. Patient safety is in the best interest of all parties.

Enquiries:

111 For further information and discussion, please contact:

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112 TZF agrees that the FHB may publish the names and views in this submission for public viewing.

