Elderly Commission

Minutes of the 63rd Meeting

Room 2005, 20/F, Murray Building, Garden Road, Central
9:30 a.m., 6 May 2010 (Thursday)

Present:

Chairman

Dr the Honourable LEONG Che-hung, GBS, JP

Vice-chairman

Prof CHAN Cheung-ming, Alfred, BBS, JP

Members

Mr CHAN Chi-yuk, Kenneth

Mr CHAN Han-pan

Dr CHAN Hon-wai, Felix

Dr CHENG Kam-chung, JP

Dr CHEUNG Moon-wah

Prof CHIU Fung-kum, Helen

Dr CHONG Ming-lin, Alice

Ms FUNG Yuk-kuen, Sylvia

Rev LAU Wai-ling, Dorothy, BBS, JP	
Mr MA Chan-hang, Leo	
Mr MA Ching-hang, Patrick, BBS	
Mr MA Kam-wah, Timothy	
Dr WONG Yee-him, John	
Prof Jean WOO	
Mr WU Moon-hoi, Marco, SBS	
Dr YAM Yin-chun, Loretta, BBS	
Ms LEE Suk-yee, Sandra, JP	Permanent Secretary for Food and Health
Mr TANG Kwok-wai, Paul, JP	Permanent Secretary for Labour and Welfare
Mr NIP Tak-kuen, Patrick, JP	Director of Social Welfare
Dr CHAN Wai-man, JP	Representative of Director of Health
Mr HSU Kam-lung	Representative of Secretary for Transport and Housing / Director of Housing
Dr Daisy DAI	Representative of Chief Executive of Hospital Authority

<u>In attendance</u>:

Ms YOUNG Bick-kwan, Irene	Deputy Secretary for Labour and Welfare
Ms HO Siu-ping, Betty	Principal Assistant Secretary for Labour and Welfare
Mrs NG MA Kam-han, Kathy, JP	Assistant Director Social Welfare Department

Mr NGAN Man-por	Chief Social Work Officer Social Welfare Department
Miss Sheila KONG	Chief Social Work Officer Social Welfare Department
Mr LAM Ding-fung	Chief Social Work Officer Social Welfare Department
Miss LAM Ching-wa, Nora	Senior Social Work Officer Social Welfare Department
Mr HEUNG Wing-keung	Senior Social Work Officer Social Welfare Department
Ms CHAN Sau-ming	Senior Social Work Officer Social Welfare Department
Ms LEUNG Mei-wah	Senior Social Work Officer Social Welfare Department
Ms KWAN Yuen-yuk, Rosemary	Senior Social Work Officer Social Welfare Department
Dr NG Ping-sum, Sammy	Senior Medical and Health Officer Department of Health
Dr LAM Chau-kuen, Yonnie	Senior Medical and Health Officer Department of Health
Mr HA Kwok-fung, Bryan	Assistant Secretary for Labour and Welfare
Miss LEE Wing-tung, Jessica	Assistant Secretary for Labour and Welfare
Mr LO Chun-hang, Simpson	Assistant Secretary for Labour and Welfare
Miss LAM Chin-kiu, Crystal	Assistant Secretary for Labour and Welfare
Miss MOK Tik-shan, Elizabeth	Chief Executive Officer

	Labour and Welfare Bureau
Ms LI Wing-hang, Amanda	Executive Officer Labour and Welfare Bureau
Mr LUK Kar-kin, Bruno	Principal Assistant Secretary for Food and Health [Agenda Item 3]

Absent with apologies:

Mr YAU How-boa, Stephen, BBS, JP

Secretary

Mrs CHAN CHOY Bo-chun, Polly	Principal Assistant Secretary for Labour and Welfare

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Dr LEONG Che-hung, the Chairman, welcomed Members to the meeting. He reminded Members to make a disclosure of interests when they had a potential conflict of interest with the matters to be discussed.

Agenda Item 1: Confirmation of the minutes of the 62nd meeting

2. As Members had not proposed any amendments to the Chinese and English versions of the draft minutes issued by the Secretariat on 22 and 28 April respectively, the minutes were confirmed.

Agenda Item 2: Matters arising

Paragraph 4 of the minutes of the 62nd meeting

3. With the aid of a powerpoint presentation, the Chairman briefed Members on the visit of the Elderly Commission (EC) to Sydney, Australia during the period from 28 to 30 April. The itinerary included visits to government departments, quasi-government agencies and service operators there which were responsible for residential and community care for the elderly, accreditation for residential care homes for the elderly (RCHEs) and promotion of active ageing. He summarised observations from the visit as follows:

(a) In Australia, financial resources for residential and community care for the elderly were mainly from government revenue, although elders had to pay part of the expenses with their retirement benefits;

(b) as financial resources for elderly care services were mainly from government revenue, development of the private service market was very limited; and

(c) the Australian government had appointed an independent accreditation body to assess the quality of RCHEs. RCHEs had to pass quality accreditation before they could receive government subsidies. The accreditation body would not further rank the RCHEs according to their service quality.

4. Prof Alfred CHAN, the Vice-chairman, considered that a possible reason for Australians residing in RCHEs was that they were used to live independently, and thus might not want to live with their children at their old age. Mr Paul TANG, Permanent Secretary for Labour and Welfare, said that most elders in Australia might not wish to move into RCHEs until they reached the final stage of their lives when their physical conditions had deteriorated to the extent that they were no longer fit for home care services. Since

Australians were accustomed to living in detached houses, it was understandable that elders did not want to live in RCHEs of smaller size.

5. Other Members who took part in the visit expressed the following views:

(a) The Australian government had a set of established criteria in planning elderly services (e.g. the provision of 113 RCHE places for every 1 000 elders aged above 70). However, the government department concerned failed to explain the rationale behind such criteria and whether the existing criteria could meet elders' demand;

(b) elders in Australia were encouraged to continue to work. Recently, the Australian government even proposed that employers made MPF contributions for employees aged 70 to 74;

(c) consideration should be given to the co-payment approach adopted by Australia (and other countries such as Denmark). If elders preferred care services of a higher quality, the Government could provide subsidies, but elders themselves would need to share part of the expenses;

(d) Australia could invest more resources in elderly care services because of its high tax rate, policies on deferred retirement age and user co-payment, etc. By comparison, Hong Kong's ability to provide diversified elderly care services in the context of a low-tax regime indicated that we were better in resource utilisation; and

(e) drug handling arrangements adopted by some RCHEs in Hong Kong were more advanced than those in Australia. This showed that Hong Kong was

no worse than overseas countries in terms of the quality of elderly care services.

6. In conclusion, the Chairman said that there were some areas of elderly care in Australia to which Hong Kong might draw reference. However, respective services in the two places had their own merits and characteristics. The Secretariat would in due course prepare a detailed report on the visit for reference and record purposes.

[Post-meeting note : The visit report was issued to Members on 21 October 2010.]

Paragraph 7 of the minutes of the 62nd meeting

7. The Vice-chairman said that EC had commissioned the consultant team led by Dr Ernest CHUI of the Department of Social Work and Social Administration, The University of Hong Kong, to conduct a study on community care services for the elderly. The consultant team had initially decided on the study methodology, and would soon commence a questionnaire survey.

Paragraph 24 of the minutes of the 62nd meeting

8. The Chairman said that The Hong Kong Society for the Aged, having considered Members' views, had proposed to change the English name of the elderly portal to "eElderly". Besides, the kick-off ceremony for the portal would be held at the East Point City on 13 June. The Financial Secretary and the Secretary for Labour and Welfare would officiate.

Paragraph 28 of the minutes of the 62nd meeting

9. The Chairman said that EC wrote to the Transport and Housing Bureau (THB) earlier to follow up on the request of the Kwai Chung Estate Resident's Right Concern Group

for the construction of lifts/escalators at paths or staircases on slopes in Kwai Chung Estate. Subsequently, EC was informed that THB had already conducted an assessment on this proposed project. After considering the priorities of different projects, however, THB was unable to take forward the Kwai Chung Estate project for the time being.

10. As for the request of the Concern Group for the provision of an elderly centre inside Kwai Chung Estate, Mrs Kathy NG, Assistant Director of Social Welfare, said that the District Social Welfare Office of Social Welfare Department (SWD) had discussed the feasibility of different options with the Concern Group, relevant welfare service units in the district and local groups. The District Social Welfare Officer would meet with the Concern Group on 20 May to further discuss the matter. She would update Members at the next meeting.

Paragraph 30 of the minutes of the 62nd meeting

11. Mr MA Kam-wah, Chairman of the Working Group on Active Ageing (WGAA), said that the WGAA agreed at its meeting on 22 April to set up a task force to coordinate the pre-retirement planning event. Prof CHAN Cheung-ming, Dr CHEUNG Moon-wah and Dr CHENG Kam-chung had joined the task force in addition to Mr MA himself. The task force would convene a meeting as soon as possible to commence work.

Agenda Item 3: Briefing on the Shared Care Programme in the New Territories East Cluster of the Hospital Authority

12. With the aid of a powerpoint presentation, Mr Bruno LUK, Principal Assistant Secretary for Food and Health, briefed Members on the Shared Care Programme (the Programme) implemented in the New Territories East Cluster of the Hospital Authority (HA).

13. The Chairman said that the Programme aimed to provide effective, comprehensive and continuous care for chronic disease patients through promoting public-private partnership. He was glad to note that public healthcare services would not be reduced as a result of the Programme, which only offered more flexible choices of private services for patients. Patients could revert to the public healthcare system for specialist out-patient services if necessary.

14. The Chairman and Members raised the following questions and views:

(a) In what way was the Programme directly relevant to elders?

(b) How much resource was involved in the entire programme? Could the Government save healthcare expenditure by implementing the Programme?

(c) How could participating patients actually use the annual subsidy of up to $1,400? For example, could patients use all subsidy in one single consultation? Could the above subsidy be used together with the annual subsidy of $250 granted under the Elderly Health Care Voucher Pilot Scheme?

(d) If a patient suffered from both diabetes mellitus (DM) and hypertension (HT), could he receive double subsidies (i.e. maximum $2,800 per year)?

(e) Under the Programme, the Government would provide a quality incentive to participating doctors to encourage them to provide treatment to patients according to specified process indicators. What were the process indicators?

(f) Only patients who had started receiving care for DM and HT at public specialist out-patient clinics at least two years ago would be invited to join

the Programme. This seemed unfair to those who had been receiving treatment from private doctors.

(g) The Programme required each participating patient to receive treatment from the same private doctor for at least one year. After that, patients with good cause might request to change private doctors. This requirement seemed too stringent because there might be "incompatibility" between patients and doctors, or patients might be discontent with the fees charged by the doctors. However, in such cases, patients still could not change doctors as they wished.

(h) The Programme only targeted at DM and HT patients. Elders might however misunderstand that all patients could receive the subsidy. It was therefore necessary for the Government to explain clearly the eligibility criteria to the public.

(i) The Programme could not benefit patients with multiple chronic diseases, those with financial difficulties or receiving Comprehensive Social Security Assistance (CSSA). These patients could not afford extra consultation fees and drug fees charged by private doctors.

(j) The drug fees charged by private doctors were relatively high in general. This might discourage interested patients from participating in the Programme.

(k) Was there any estimate on the number of DM and HT patients in the New Territories East Cluster who would benefit from the Programme?

(l) It was suggested that in future, the Government should consider including patients suffering from dementia and elderly depression, etc. in the Programme.

(m) The Programme would be piloted in Tai Po and Shatin. Would it be extended to other districts later?

(n) What were the initial responses of private doctors in Tai Po and Shatin to the Programme? Would they need to open electronic health care voucher accounts for participating patients?

15. Ms Sandra LEE, Permanent Secretary for Food and Health, and Mr LUK responded as follows:

(a) At this stage, the Programme targeted at DM and HT patients receiving treatment in the public healthcare system and assessed to be in a more stable condition. Although no age limit had been set, the proportion of elders was higher in these two types of patients.

(b) The Government had earmarked about $200 million for the Programme, which would be sufficient to provide approximately 20 000 places. Through the Programme, the Government aimed to provide patients with more effective, comprehensive and continuous care, encourage them to pay attention to their own health, and reduce their need for hospital admissions, thus indirectly reducing government expenditure on hospital services. However, public healthcare services would not be reduced as a result of the implementation of the Programme. The public healthcare system would continue to provide support for participating patients.

(c) The Government would open an electronic health care voucher account for each participating patient, and deposit into this account a subsidy of $1,200 each year and an incentive of up to $200 each year in the form of electronic health care vouchers. The Programme required private doctors to provide no less than four consultations a year for patients; as such, patients could not exhaust the subsidy of up to $1,400 per year in one single consultation. Besides, participants aged 70 or above who had participated in the Elderly Health Care Voucher Pilot Scheme could use the subsidy under the Programme together with the health care vouchers of $250 a year during consultations.

(d) Given that many patients suffered from both DM and HT, the annual subsidy of up to $1,400 would be used to subsidise patients' consultation fees and drug fees paid for treating these two diseases. As the Programme targeted at patients who were assessed to be in a stable condition, doctors would not prescribe too many types of drugs for the patients. Private doctors in the pilot districts of the Programme (i.e. Shatin and Tai Po) also agreed that the amount of subsidy (i.e. up to $1,400 per year) was reasonable.

(e) The process indicators referred to the procedural guidelines for compliance by participating doctors in providing treatment to patients, such as requirements on annual referral of patients to HA for health risk re-assessment, regular measurement of blood pressure, etc. The Administration had consulted local private doctors in developing such indicators to ensure their practicability.

(f) Under the prevailing government policies, all Hong Kong residents could obtain healthcare services in public hospitals and clinics, or choose services from private hospitals or doctors on their own. As for the requirement that patients had to be receiving treatment in the public healthcare system for at least two years, this was mainly to ascertain the suitability of the patients for participation in the Programme and continuous treatment at the primary care level based on their medical history and health risk assessment.

(g) To ensure continuous treatment for participating patients, the Administration encouraged them to receive treatment from the same private doctor for at least one year. After that, patients with good cause might change private doctors. However, HA would set up a joint review panel comprising representatives from HA, patients and private doctors to allow patients to change doctors on a case-by-case basis.

(h) Only DM and HT patients who were assessed to be in a stable condition and suitable for continuous treatment at the primary care level would be invited to participate in the Programme. Patients with multiple chronic diseases would not be eligible to participate.

(i) CSSA recipients might not be interested in participating in the Programme as they were already exempted from medical fees by HA. However, the Programme could still attract patients who could afford part of the consultation fees and drug fees or preferred greater flexibility in consultation time.

(j) A list of drugs required for the two diseases under the Programme had been compiled by HA and private doctors in Shatin and Tai Po. It covered basic

drugs currently prescribed by HA. The annual subsidy of up to $1,400 provided by the Government aimed to subsidise patients to purchase drugs on the list. If patients wanted to use alternative drugs, they would have to pay the additional fees specified upfront by the private doctors.

(k) The number of chronic disease patients suffering from both DM and HT in Shatin and Tai Po was about 20 000 and 8 000 respectively. The Administration expected that about 1 000 patients would participate in the Programme in the first year of implementation.

(l) Apart from the Programme, the Government had launched the following primary care pilot projects in phases to enhance support for chronic disease patients:

(i) Multi-disciplinary Risk Assessment and Management Programme;

(ii) Patient Empowerment Programme;

(iii) Nurse and Allied Health Clinics;

(iv) the purchase of haemodialysis services from the private sector or non-governmental organisations (NGOs) for end stage renal disease patients currently under the care of public hospitals; and

(v) the provision of subsidies to specific groups of patients under the care of the general out-patient clinics for primary healthcare services in Tin Shui Wai.

(m) If the Programme went well in Tai Po and Shatin, the Food and Health Bureau would consider extending it to other districts.

(n) Before launching the Programme, the Government had already thoroughly discussed and forged a consensus with doctors in the Tai Po and Shatin Networks of the Hong Kong Medical Association. HA had set up a dedicated office to open electronic health care voucher accounts for patients participating in the Programme.

16. In sum, the Chairman said that the Programme was worth supporting in principle. The Administration could review its operational details after a period of implementation and extend it to other districts as soon as possible.

Agenda Item 4: Interim Report on the Integrated Discharge Support Trial Programme for Elderly Patients

17. The Chairman invited Dr Daisy DAI, Chief Manager of HA, to brief Members on the Interim Report on the Integrated Discharge Support Trial Programme for Elderly Patients (IDSP).

18. With the aid of a powerpoint presentation, Dr DAI introduced the objectives of IDSP, the three hospitals and organisations participating in the pilot projects, the service flow, the distribution of participating patients by age and risk group, statistics on the number of participants, and the types of services provided by the Home Support Teams (HSTs). She said that participating patients showed significant improvement in terms of health, quality of life and physical functioning, etc., and the stress levels of their carers were also significantly reduced. Furthermore, their Accident and Emergency (A&E) attendance, hospital admission

rate via A&E and utilisation of A&E beds were reduced over a 90-day post-discharge period. Some of the patients were referred to rehabilitation hospitals for appropriate services.

19. In view of the positive outcomes mentioned above, Dr DAI looked forward to the extension of IDSP to the whole territory. She considered that IDSP was particularly suitable for elderly dischargees assessed to have a medium risk of hospital readmission. Besides, she suggested that if IDSP was to be further rolled out, services provided by HSTs should not overlap with other existing community care services, but should integrate with mainstream services. She pointed out that IDSP, if extended to all 15 acute hospitals in Hong Kong, was expected to provide assessment service and discharge planning for about 32 500 elderly dischargees every year, of whom about 8 500 would be referred to HST services after discharge.

20. The Chairman said that the Government had invested more than $90 million in this three-year trial programme which covered three hospitals. The interim report had highlighted some quantitative benefits of the programme.

21. Members raised the following questions and views on the interim report on IDSP:

(a) IDSP was considered effective in enhancing collaboration between NGOs and HA. It succeeded in identifying dischargees in need of home support and providing them with appropriate home support in the critical six-week period after discharge. These helped reduce their chance of readmission to hospitals. It was hoped that the report could provide more details, say, on the effectiveness of IDSP on patients at different risk levels.

(b) It was suggested that elderly dischargees be recruited to join IDSP according to their risk of readmission, so as to further enhance the results and the cost-effectiveness of the programme.

(c) Upon analysis of the chart on quality of life, it was suggested that dischargees with better mental health be supported through the provision of training for their carers and telephone follow-up service, while the services of geriatric day hospitals and HSTs be focused on dischargees with poorer physical functioning. Besides, it was suggested that the basic duration of HST services be shortened to 28 days and, if necessary, extended by 14 days. The above suggestions should be able to effectively enhance the cost-effectiveness of the programme.

(d) It was agreed that discharge planning should start right after admission. However, if the programme was to be extended to the whole territory, consideration should be given to the availability of ancillary professional staff, for example, whether the supply of nurses was adequate. Besides, it was suggested that the scope and content of services be clearly specified in future tendering exercises for HST services to ensure that the support services could be effectively integrated with mainstream services.

(e) Were there control groups under IDSP to compare the differences between service users and other patients? Had death figures been taken into account to better reflect the relevance between the reduction in the number of readmitted patients and IDSP?

(f) The report did not mention whether IDSP could reduce the percentage of elderly dischargees admitted to RCHEs, and whether there were participants

who needed to receive transitional residential care before they could go home. Having learnt that United Christian Hospital provided post-discharge transitional residential care services, it was suggested that Dr LEUNG Man-fuk of that hospital be invited to share his experience with Members.

(g) HA had launched the "Community Health Call Centre" service to provide telephone follow-up service for frail elderly dischargees so as to reduce their chance of readmission. It was suggested that IDSP could cooperate with this Centre to reduce overlapping of services. Besides, it was suggested that rehabilitation wards of hospitals could teach carers some nursing skills and ways to reduce stress.

(h) It was suggested that the review report on IDSP should cover comments from service users (including patients and their family members).

(i) What were the similarities and differences between the target users of IDSP and those of home care services for frail elders to be launched by SWD? How would the two schemes complement each other?

(j) It was suggested that apart from training and support in groups, consideration could be given to adopting individual training modes which were more flexible and carer-friendly.

(k) It was suggested that elders be enquired about their needs/wishes for admission to RCHEs at their hospital admission, and before and after their discharge to assess whether IDSP could effectively encourage elders to age in place.

(l) The programme had filled the gaps in the existing transitional care services for elderly dischargees, thus should be further taken forward.

22. Dr DAI's responses to Members' views were as follows:

(a) There were control groups under IDSP. However, it was hard to identify patients with exactly the same conditions (e.g. age, illness and risk) for comparison. Hence, no detailed analysis was made in the report. In reviewing the effectiveness of IDSP in reducing the number of readmitted patients/use of healthcare services, statistical methods had been adopted to discount the death factor so as to figure out more accurately whether the reduced use of healthcare services was related to IDSP.

(b) The evaluation report would include whether participating elders would choose to live in RCHEs. However, given the many different factors that would affect their decisions, it was hard to ascertain whether IDSP was the reason which saved elders from the need to live in RCHEs.

(c) In assessing IDSP, the hospitals had enquired users about their level of satisfaction. She would provide the relevant information after the meeting.

23. Mr Patrick NIP, Director of Social Welfare, said that the Government was about to launch a pilot project to provide home care services for frail elders waiting for nursing home (NH) places. SWD was collating views on the service content. He agreed to study how the above home care services could integrate with IDSP to enable elderly dischargees to stay in the community.

24. Mr Paul TANG added that the above two schemes were similar in concept. However, IDSP mainly focused on the provision of relatively intensive services for elders

during the most critical period after discharge, whereas the home care services to be launched by SWD aimed to provide long-term care services for severely impaired elders. He agreed to further examine together with HA how to find out whether IDSP could reduce the RCHE admission rate of elderly dischargees, with a view to encouraging ageing in place.

25. After consolidating Members' views, the Chairman said that EC supported in principle the continuous implementation of IDSP, and hoped that the Government would allocate resources to extend the Programme to the whole territory.

Agenda Item 5: Evaluation of the Care Enhancement Pilot Project for Aged Care

26. With the aid of a powerpoint presentation, the Vice-chairman briefed Members on the review report on the Care Enhancement Pilot Project for Aged Care. First of all, he thanked HA for participating in the project, Mr CHAN Chi-yuk, Kenneth for his assistance in offering placements in private RCHEs under the pilot project, as well as Dr WONG Chun-por and his team from Ruttonjee Hospital for their assistance in carrying out the review of the pilot project.

27. The Vice-chairman said that participating trainees, RCHE operators, elders living in RCHEs and their family members, and Visiting Advanced Practice Nurses (VAPNs) generally considered that, apart from trainees' knowledge and skills, the pilot project could enhance health workers' capability and confidence, as well as the overall quality of care and service standard of RCHEs. However, the review results showed that there were few chances for the trainees to practise "Two Tubes and One Injection" in RCHEs, and that "Two Tubes and One Injection" was not the most important part of the entire project. Meanwhile, participating trainees, management of RCHEs and VAPNs were of the view that it was not an opportune time to entrust health workers with the duties of "Two Tubes and One Injection".

28. The Vice-chairman continued to say that the evaluation results revealed that elders residing in RCHEs and in a relatively stable health condition needed care services provided by enrolled nurses (ENs). He was glad to note that The Open University of Hong Kong (OU) would launch EN training programmes in September 2010, which would include internship training in community and residential care services. He suggested discussing with the Education Bureau how to incorporate entry requirements for health workers and ENs into a Qualification Framework to develop a professional ladder so as to attract more young people to join the health worker profession. Besides, the steering committee on the pilot project also recommended SWD including more care management elements in training programmes for health workers or other RCHE staff in future so as to enhance the overall quality of care services provided by RCHEs.

29. Members raised the following views and questions:

(a) The service quality of RCHEs was closely related to the training and grade structure of front-line care staff. As such, the promotion prospect of front-line care staff in the grade should be addressed whilst enhancing their skills. The pilot project allowed front-line care staff to understand the industry's professional development path and their important role in the overall development of residential services.

(b) HA offered EN training programmes again in 2008. The first class of 350 trainees would graduate this year (2010). It was estimated that a total of more than 900 ENs would be trained within three years. Coupled with about 150 trainees per year to be trained by OU's EN training programmes, the number of ENs was expected to increase significantly in the next few years.

Also, there were cases in the past where HA's Technical Services Assistants transferred to be ENs, and ENs transferred to be registered nurses.

(c) Training provided to frontline care staff under the pilot project emphasised the need to provide comprehensive care to patients in accordance with the "people-oriented" principle to meet different needs of patients. This was worth appreciation.

(d) There was little demand for "Two Tubes and One Injection" in RCHEs probably because of the lack of manpower to provide such service in RCHEs at present, resulting in their reluctance to admit patients in need of such services. However, if sufficient manpower and support became available for the service in future, it might help expand the service scope of RCHEs.

(e) The title of "Advanced Practice Nurse" in the nurse grade suggested respect for the rank and helped enhance the image of nursing staff. In view of this, it was suggested that apart from bridging the qualifications of care staff, consideration should be given to enhancing the professional recognition of the grade so as to attract more young people to join the profession.

30. Mrs Kathy NG added that to ease the manpower shortage of nurses in the welfare sector and enhance the quality of care services, SWD had since 2006 commissioned HA to run a two-year full-time EN training programme of eight classes tailored for the welfare sector. Among these, three classes of trainees had graduated and about 90% of them had joined the welfare sector. SWD was discussing with HA to organise future eighth and ninth classes, with a view to helping resolve the manpower shortage of nurses.

Agenda Item 6: Any other business

Work Progress of the Working Group on Long Term Care Model

31. The Chairman said that the Working Group on Long Term Care Model was preparing for the establishment of a task group to examine support services provided for demented patients.

Work Progress of the WGAA

32. The Chairman said that the WGAA was inviting Radio Television Hong Kong to produce a new Golden Age series. Members' views on the content of the programme were welcome.

Consultation Paper on Long-term Social Welfare Planning in Hong Kong of the Social Welfare Advisory Committee (SWAC)

33. Mr Paul TANG briefed Members on the Consultation Paper, and advised that the focus of discussion was on the overall long-term planning, guiding principles and strategic objectives of social welfare in Hong Kong. He invited Members to attend the coming open consultative forums or send their views in writing to the Secretariat. The Secretariat would consolidate all the views and submit them to SWAC upon EC's endorsement. [Post-meeting note: The Secretariat did not receive any views from Members during the consultation period. With the Chairman's consent, SWAC was informed that EC had no comment on the Consultation Paper.]

34. Mr Timothy MA, who was a member of SWAC, added that the Consultation Paper also noted issues such as resource utilisation and the Government's affordability of welfare

expenditure in future, and encouraged the public to share part of the welfare responsibilities and explore long-term welfare planning from a new perspective.

Consultation Paper on "2011 Population Census – Consultation on Definition, Questioning Approach and Classification of Data Topics"

35. Members noted the above Consultation Paper and did not raise any comments.

Briefing on "Professional Pharmaceutical Services for Old Age Homes" of the Pharmaceutical Society of Hong Kong

36. Members noted the content of the briefing.

Date of the next meeting

37. The next meeting was tentatively scheduled for 27 October 2010.

Time of Adjournment

38. The meeting was adjourned at 12:05 p.m.

September 2010