

CHAPTER 1

**Labour and Welfare Bureau
Social Welfare Department**

**Provision of long-term care services
for the elderly**

**Audit Commission
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PROVISION OF LONG-TERM CARE SERVICES FOR THE ELDERLY

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PROVISION OF LONG-TERM CARE SERVICES FOR THE ELDERLY

Executive Summary

1. Hong Kong is facing an ageing population. In 1997, the Chief Executive of the Hong Kong Special Administrative Region (HKSAR) has made “Care for the Elderly” a Strategic Policy Objective of the Government of the HKSAR. The objective is to improve the quality of life of our elderly population and to provide them with a sense of security, a sense of belonging and a feeling of health and worthiness.

2. The Government’s long-term care (LTC) policy is to promote ageing in place and subsidised LTC services are provided by the Social Welfare Department (SWD), through community care services (CCS) and residential care services (RCS), to the elderly citizens (aged 65 and above) with proven needs as assessed under a standardised care need assessment mechanism (“assessment mechanism”) it operates. There is no means test for these subsidised LTC services. If subsidised care places are not readily available, eligible elderly persons are put on the Central Waiting List for subsidised LTC services (CWL) to wait for their turn of admission. The CWL allocates the subsidised places on a first-come-first-served basis according to the applicants’ registration dates and their preferences.

3. In 2013-14, recurrent expenditure on subsidised CCS and RCS amounted to \$4.38 billion. In addition, the Government has from time to time applied for funds from the Lotteries Fund (LF) to finance the development of elderly services. These included funds for the construction and setting-up of contract residential care homes for the elderly (RCHEs) and for the implementation of various time-limited welfare projects/schemes for the elderly (e.g. \$380 million approved for the first phase of the Pilot CCS Voucher Scheme for the Elderly). Non-governmental organisations (NGOs) may also apply for grants from LF to meet the capital costs of works projects in connection with elderly services provided by them. The Audit Commission (Audit) has recently conducted a review on the SWD’s provision of subsidised LTC services for the elderly and its regulation of RCHEs.

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Growing demand for subsidised long-term care services

4. ***Long waiting lists and waiting times.*** With the ageing population and the longer life expectancy of Hong Kong people, the demand for subsidised LTC services is growing rapidly. Although the Government has strived to cope with the increasing demand, the long waitlisting situation remains. For CCS, the numbers of elderly on the waiting lists for both day care and home care services were generally rising. The uneven waiting times for CCS in different districts also call for concern. For RCS, against a capacity of some 23 000 “care and attention” (C&A) places and 3 000 nursing home (NH) places, as at end-August 2014, the SWD reported a waiting list on the CWL of 24 250 elderly awaiting subsidised C&A places and 6 440 elderly awaiting subsidised NH places, and the average waiting time was 36 months for subsidised C&A places in subvented/contract RCHEs, 7 months for purchased C&A places in private RCHEs and 32 months for subsidised NH places (paras. 2.11, 2.13 to 2.15 and 2.17).

5. Audit further noted the following:

- (a) ***6 800 elderly persons on the CWL not included as a result of their “inactive” status.*** The waitlisting information reported on RCS by the SWD to the Legislative Council (LegCo) and posted onto the SWD’s website did not reflect, among others, the number of “inactive” cases on the CWL. For example, the reported number of 30 690 (24 250 + 6 440) applicants on the CWL awaiting C&A or NH places as at end-August 2014 had not included a total of 6 800 “inactive” elderly who had been assessed as “RCS only” or “dual option” (i.e. either RCS or CCS is equally appropriate for the applicant) but were meanwhile using CCS. Given that these 6 800 “inactive” elderly can opt at any time for RCS (with their priority on the CWL not being affected by the “inactive” status), they represent a hidden, but not negligible, demand which should have been disclosed when reporting the waiting list and suitably taken into account in service planning (para. 2.18(a));
- (b) ***SWD statistics relating to elderly persons on the CWL.*** Based on SWD statistics, the number of elderly on the CWL who had passed away while waiting for RCS places had increased from “4 000 to 4 500” a year before 2010 to 5 700 in 2013-14 (para. 2.18(b)); and

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- (c) *Need for reviewing the assessment mechanism.* The SWD assessment mechanism is used to assess elderly persons' level of impairment which will be matched with appropriate subsidised LTC services. It acts as the "Gate-keeper" and plays a very important role in the Government's provision of LTC services. Audit has however found a number of issues warranting a review of the assessment mechanism. Among others, Audit noted that although there were about 2 700 accredited assessors as at June 2014, only 1 800 of them were recorded as active ones. An analysis further revealed that: (i) only 47% of the 1 800 active assessors had been involved in conducting assessments in the 12 months ended June 2014; and (ii) 70% of the assessment work was conducted by 36 accredited assessors of the five regional Standard Care Need Assessment Management Offices (Elderly Services) of the SWD. The extremely uneven output may affect the quality and efficiency of the assessments which determine the appropriate LTC services to be provided and may also have accounted for why the SWD has kept on taking longer time to complete the care need assessments (paras. 2.19 and 2.21).
6. *Marginal increase achieved in the capacity of subsidised RCS places.* On the supply side, although the Administration has made great efforts to increase the provision of RCS places over the years, the overall increase in the number of subsidised RCS places was not significant. The number of subsidised RCS places had only increased by 20% in 14 years, i.e. from 21 600 as at end-March 2000 to 26 000 as at end-March 2014. In particular, although some 10 000 RCS places previously provided by 74 homes for the aged and self-care hostels were converted to some 6 100 C&A places in order to provide the elderly residents with continuum of care, the Administration was not able to offset the reduction in number of subsidised RCS places by increasing timely the supply at a greater pace (paras. 2.23 to 2.26).
7. *Need to maximise the effective use of limited subsidised RCS places available.* Given the growing service demand and the constraints faced by the Government in bringing forth more rapid expansion of the subsidised RCS capacity (see paras. 4 to 6 above), the Administration should make good efforts to maximise the optimum use of the limited subsidised places available, as each subsidised RCS place cost the Government \$7,900 to \$15,600 a month in 2013-14. Audit has however found inadequacies in the provision, allocation and monitoring of the limited RCS places, as follows:

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- (a) ***Purchase and allocation of Enhanced Bought Place Scheme (EBPS) places.*** As at end-March 2014, 30% of the subsidised RCS places were provided by RCHEs participating in one of the Government's purchase schemes, namely, the EBPS. In 2013-14, the SWD spent \$673 million on the purchase of 7 660 EBPS places. Audit however found that 39 (32%) of the 121 private RCHEs participating in the EBPS could not achieve the 92% enrolment rate set by the SWD. Among them, ten RCHEs had an average enrolment rate between 50% and 80%, and three below 50%. On average, some 550 to 590 EBPS places had remained vacant in 2012-13 and 2013-14 (para. 2.30(a));
- (b) ***Allocation, matching and admission of RCS places.*** Audit noted various inefficiency and wastage in the allocation of, and admission to, subsidised RCS places, including: (i) late reporting by RCHEs of discharge cases (including temporary discharge of elderly residents); (ii) no time pledge set for SWD placement referrals; (iii) delay in admissions of applicants by RCHEs; and (iv) lack of laid-down procedures for handling late reporting of RCS vacancies and reliance on an honour system for reporting RCS vacancies (para. 2.34);
- (c) ***Management of agency quota (AQ) places.*** Although the SWD has implemented the CWL since 2003 to centralise under its control all applications for subsidised LTC services, Audit has however found that among the 16 460 subsidised RCS places provided by subvented RCHEs, 1 812 (or 11%) AQ places were managed and allocated by NGOs outside the CWL and beyond the SWD's control, so long as the elderly taking up the AQ places had been subject to care need assessment under the SWD's assessment mechanism. These 1 812 AQ places are fully subsidised by the Government at some \$25.5 million a month. Audit considers that the SWD needs to critically review the possibility of clawing back the AQ places for central allocation under the CWL taking into consideration, among others, the following: (i) the growing demand for, and the acute shortfall of, subsidised RCS places the Government is facing today and the 100% subvention provided for the AQ places; (ii) the admission of elderly by NGOs outside the CWL may provide opportunities for inequitable allocations; (iii) the commitment made by the Administration to LegCo in March 1995 that NGOs operating subvented RCHEs would not be given any discretion to admit applicants other than those on the

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SWD's waiting list; and (iv) the low enrolment rate for AQ places allocated by NGOs themselves as a whole (paras. 2.37, 2.38, 2.45 to 2.50); and

- (d) *Utilisation of subsidised infirmary unit (IU) places.* RCHEs have been taking care of infirm elderly while the latter are waiting for infirmary placement in public hospitals. As at end-June 2014, 19 subvented RCHEs were running 29 IUs providing a total of 580 IU places, which cost the Government some \$52 million in 2013-14. Audit has however found that 62 (11% of 580) IU places had, on average, been vacant for at least five years, with the vacancy reaching 22% to 53% for five RCHEs (paras. 2.51, 2.52 and 2.54).

Provision of community care services for the elderly

8. The Government provides a wide range of subsidised CCS to assist the elderly to age in the community. They include centre-based day care services and home-based home care services which are essentially operated by NGOs with subventions or service fees from the Government. In 2013-14, the Government spent some \$970 million on the provision of subsidised CCS for the elderly (paras. 3.2 and 3.5).

9. *Monitoring of CCS places.* In 2013-14, it cost the Government about \$7,100 a month for a day care service place and about \$3,700 a month for a home care service place. Owing to the limited CCS places available, timely reporting of discharge cases and timely admission of elderly to services are both important. Audit has however found that there is scope for improvement in these respects (paras. 3.9 and 3.12).

10. *Implementation of the Pilot CCS Voucher Scheme.* The Scheme, launched in September 2013 with a \$380 million grant from LF, adopts a "money-follows-the-user" approach and provides subsidy directly to service users (instead of service providers) in the form of service vouchers. Audit has noted that as at August 2014 (one year after implementation), some 310 out of 1 200 elderly users still participating in the Scheme had not commenced using the services, with vouchers issued to some 180 elderly users having become void (paras. 3.16 and 3.20(a)).

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11. *Need for a more strategic approach to implement CCS.* According to the Elderly Commission, effective CCS can encourage the elderly to age in place and avoid premature and unnecessary institutionalisation. Since 2000, the SWD has launched various pilot schemes at different times to supplement the regular CCS. No concrete plan has however been drawn up to properly integrate, rationalise or re-engineer them to provide effective CCS for the frail elderly. For example, the Enhanced Home and Community Care Services (EHCCS), the Integrated Home Care Services (IHCS) and the Pilot Scheme on Home Care Services for Frail Elders, which were launched in 2001, 2003 and 2011 respectively, provide similar services yet they differ in various ways in their operational modes (paras. 3.4, 3.25 and 3.27).

Provision of residential care services for the elderly

12. As at end-March 2014, there were 748 RCHEs providing 75 000 (26 000 subsidised and 49 000 non-subsidised) RCS places for the elderly. Subsidised RCS places are provided by subvented/contract RCHEs and private/self-financing RCHEs participating in the Government's two purchase schemes, whereas non-subsidised RCS places are provided by private and self-financing RCHEs. In 2013-14, the Government spent \$3.41 billion on the provision of the 26 000 subsidised RCS places (paras. 4.2 and 4.3).

13. *Varying quality standards of different types of RCHEs.* Apart from the provision of subsidised RCS, the SWD also regulates RCHEs through a licensing system it operates. Although 424 private RCHEs not offering any subsidised RCS places formed the majority of the RCHEs, Audit noted that their service quality varied and most of them differed from the other types of RCHEs which offered subsidised places, with obvious disparities in their spacing and staff provision. Many of these private RCHEs just met the statutory minimum requirements. Many of the RCHEs in the private sector had high vacancy rates too, despite the high demand for subsidised RCS places. Audit noted that more warning letters on non-compliance with licensing requirements were issued against RCHEs in the private sector. For example, although these RCHEs accounted for only 57%

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of total RCHEs in the sector, in 2013-14, 284 (81%) of 351 warning letters issued by the SWD were issued against them. It is understood that high rentals and manpower shortage are two major problems facing many of these RCHEs in the private sector. This might also have explained why the Administration had been slow in upgrading the statutory minimum requirements which had not been revised in the past 18 years (paras. 4.5 and 4.7 to 4.14).

14. ***Many elderly opted not to stay in private RCHEs under EBPS.*** Although 30% of the 26 000 subsidised RCS places were provided by the two purchase schemes (including the EBPS), applicants on the CWL who were willing to take up EBPS places had decreased from 7% as at end-March 2009 to 5% as at end-March 2014. As mentioned in paragraph 7(a) above, some 550 to 590 EBPS places were vacant in 2012-13 and 2013-14, indicating that good value has not been realised for some \$50 million spent a year. Audit also noted a case when the demand for more subsidised RCS places in a particular private RCHE could not be entertained because of the “50% cap” requirement set by the SWD since 2003 on the number of subsidised places to be purchased (paras. 4.16 to 4.19).

15. ***Granting of sites by private treaty for RCHE purpose.*** The Government may grant sites at nominal premium to NGOs for welfare purposes. Based on the SWD records, some 50 private treaty grants (PTGs) had been granted to NGOs for operating subvented and/or self-financing RCHEs. Based on an examination of a number of such PTGs, Audit found that in two cases (both involving self-financing RCHEs which did not provide subsidised RCS places), the SWD had not exercised its rights reserved in the PTGs to agree with the grantees on the admission quotas to be provided to the Government (para. 4.25).

16. ***Granting of premium concession for RCHE purpose.*** To encourage developers to provide RCHEs in new private developments, in July 2003, the Administration launched the Premium Concession Scheme, under which eligible premises will be exempted from assessment of premium for various types of land transactions, subject to meeting certain conditions for the delivery of the RCHE premises. Audit however found that as at June 2014, no RCHE under the Premium Concession Scheme had come into service and the SWD had not conducted any review to assess the effectiveness of the Scheme (paras. 4.28 and 4.29).

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17. *Inspections of RCHEs.* To ensure that all RCHEs have complied with the licensing requirements, the SWD monitors them by conducting inspections. It conducts several surprise inspections of each RCHE a year and has adopted a risk-based approach in conducting such inspections. Over the five years from 2009-10 to 2013-14, 35 RCHEs had been successfully prosecuted, involving 46 offences. Among these 46 offences, 29 offences were related to non-compliance with requirements on staff employment, and 13 related to non-compliance with requirements on health matters such as drug management and use of physical restraints. Audit examination of the SWD's records revealed that: (a) its inspection targets had not always been achieved; and (b) for 24 (71%) of 34 RCHEs which had been assessed as high risk ones, follow-up inspections were not conducted within the target timeframe (paras. 4.31 to 4.35).

Way forward

18. *Government initiatives more recently taken.* Each year, the Government spends substantial public resources on providing subsidised LTC services to the elderly. To cope with the ageing population and the rising demand for LTC services, the Government has launched various initiatives in more recent years. These include, for example: (a) the launching of a Special Scheme in September 2013 by inviting welfare NGOs to submit proposals to make better use of the land they owned, through in-situ expansion or redevelopment, to provide welfare facilities (including elderly facilities); and (b) tasking the Elderly Commission to prepare an Elderly Services Programme Plan within two years (para. 5.2).

19. *Challenges ahead.* Various challenges are lying ahead for the Government in the provision of subsidised LTC services for the elderly. These include, for example, the need to expand the subsidised CCS and RCS to keep pace with the rising demand and the need to timely and effectively implement the various Government initiatives (para. 5.3).

Audit recommendations

20. **Audit recommendations are made in PART 5 of this Audit Report. Only the key ones are highlighted in this Executive Summary. Audit has recommended that the Director of Social Welfare should, in collaboration with the Secretary for Labour and Welfare:**

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- (a) **continue striving to expand the subsidised CCS and RCS to meet the rising demand, shorten the waiting lists and reduce the waiting times for subsidised LTC services;**
- (b) **disclose the methodology used for calculating the waiting list and waiting time when reporting the waitlisting information to LegCo and/or posting the information onto the SWD website, including the proper disclosure of those “inactive” cases on the CWL;**
- (c) **review and fine-tune the SWD’s care need assessment procedures taking into account the various inadequacies Audit identified in the effectiveness of the SWD assessment mechanism;**
- (d) **address the various inadequacies mentioned in paragraphs 7 and 14 above with a view to maximising the effective use of the limited subsidised RCS places available, including the need to:**
 - (i) **improve the effectiveness of the EBPS by optimising the use of the places and minimising the number of vacant places;**
 - (ii) **explore how the procedures for the allocation, matching and admission of the limited RCS places can be fine-tuned to minimise the lead time;**
 - (iii) **critically review the possibility of clawing back the AQ places for central allocation under the CWL; and**
 - (iv) **take measures to follow up on the 11% vacancy of the limited IU places available and review, in close collaboration with the Director of Health, how the IU places in subvented RCHEs can more effectively be used;**

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- (e) **step up the SWD’s monitoring of the allocation and admission of limited subsidised CCS places available, and fine-tune the procedures in the SWD Manual;**

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- (f) **continue monitoring the effectiveness of the Pilot CCS Voucher Scheme;**
- (g) **formulate a long-term strategy for the provision of better and integrated CCS to meet the genuine needs of the frail elderly who prefer ageing in place, including exploring how EHCCS and IHCS can be properly integrated;**

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- (h) **address the disparities in quality standards of different types of RCHEs as far as possible, paying particular attention to the acute manpower shortage in the RCHE sector;**
- (i) **examine all PTGs granted for operating RCHEs to ascertain if there are similar cases when the SWD's right to nominate persons for admission to the RCHEs has not been exercised;**
- (j) **conduct an effectiveness review of the Premium Concession Scheme and explore appropriate measures to improve it;**
- (k) **ensure that the inspection targets for individual RCHEs are met, and carry out more timely follow-up inspections of RCHEs with higher risk; and**

Way forward

- (l) **address the various challenges ahead, including the monitoring of the various pilot CCS and RCS voucher schemes, and the Special Scheme for in-situ expansion or redevelopment of privately owned sites for welfare uses.**

Response from the Administration

21. The Director of Social Welfare, with the support of the Secretary for Labour and Welfare, agrees with the audit recommendations. The Secretary for Labour and Welfare has also undertaken to forward Audit's findings and recommendations to the Elderly Commission for it to take into account as it deems appropriate when formulating the Elderly Services Programme Plan.

PART 1: INTRODUCTION

1.1 This PART describes the background to the audit and outlines the audit objectives and scope.

Government policy on provision of subsidised elderly care services

1.2 Like many other economies, Hong Kong is facing an ageing population. In 2013, the number of elderly people aged 65 and above stood at about one million, representing 14% of our population. According to the Government's projection, the number of elderly people will increase to 1.45 million by 2021, representing 19% of our population. Concurrently, the life expectancy of Hong Kong's population has also continued to increase. On average, men and women in Hong Kong today are expected to live 81 years and 86 years respectively.

1.3 In 1997, the Chief Executive of the Hong Kong Special Administrative Region (HKSAR) has made "Care for the Elderly" a Strategic Policy Objective of the Government of the HKSAR. The objective is to improve the quality of life of our elderly population and to provide them with a sense of security, a sense of belonging and a feeling of health and worthiness (Note 1). A wide spectrum of subsidised community care services (CCS) and residential care services (RCS), collectively termed long-term care (LTC) services, are provided by the Social Welfare Department (SWD) to the elderly citizens with proven needs as assessed by it under an assessment mechanism which it operates (see para. 1.6). There is no means test for these subsidised LTC services. Through the provision of subsidised LTC services to the frail elderly, the Administration aims to enable them to stay at home and remain living in the community for as long as possible, before admitting

Note 1: *Apart from the long-term care services for the elderly provided by the SWD (the subject of this Audit Report — see para. 1.19), the Government has provided multifarious types of other elderly services. These include, for example, the Senior Citizen Card Scheme, the old age living allowance, priority public housing rental schemes for the elderly, public transport fare concessions and the Elderly Health Care Voucher Scheme. These other services are not covered in this review. A separate Audit Report on the provision of health services for the elderly is included in Chapter 2 of the Director of Audit's Report No. 63.*

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them to be taken care of in licensed residential care homes for the elderly (RCHEs). In the RCHE sector, the majority of the RCHEs are run by private operators.

1.4 The Government's LTC policy is underpinned by the following three principles:

- (a) it is the Government's policy to promote "ageing in place as the core, institutional care as back-up". By "ageing in place", the Government aims to encourage the elderly to age at home, which is also their preference (Note 2), and to support their families to take care of them by providing appropriate support and care services (Note 3);
- (b) the Government aims to promote a continuum of care (CoC) in subsidised RCS. By providing residential care places with CoC, the elderly can stay in the same RCHE and continue to receive care services even when their health conditions have deteriorated; and
- (c) given the ageing population and limited public resources, elderly who are most in need should have priority in using subsidised care services.

1.5 Within the Government, the Labour and Welfare Bureau (LWB) is the policy bureau overseeing the provision of LTC services for the elderly. Under the LWB, the SWD is responsible for implementing the Government's elderly services. Like most other welfare services in Hong Kong, LTC services are not directly provided by the Government. Instead, the Government funds the non-governmental organisations (NGOs) and service operators in both the CCS and RCS domains to provide the services, with service quality monitored by the SWD. Within the SWD, the Elderly Branch (see Appendix A) oversees the operation of the CCS and RCS.

Note 2: *In our predominantly Chinese society, ageing in place is often the common wish of our elderly citizens.*

Note 3: *With elderly persons living in the community, some of them have the support of private care services, e.g. foreign domestic workers and local paid domestic helpers/carers, and some may make use of services provided by private health professionals. Family support is always an important pillar. A considerable number of elderly persons are being taken care of by family members.*

Standardised care need assessment mechanism

1.6 The long-term care services delivery system (LDS) operated by the SWD is a single-entry point for application established for all applicants who wish to seek for subsidised LTC services. To apply for the services, elderly persons have to apply through responsible/referring workers (collectively termed “RWs”) in referring units authorised by the SWD (Note 4). Since 2000, the SWD has implemented a standardised care need assessment mechanism (“assessment mechanism”) to determine the LTC services to be provided for elderly of moderate or severe level of impairment, with other health problems, coping problems and/or environmental risks to be assessed. The assessments are conducted by accredited assessors who may include social workers, nurses, physiotherapists and occupational therapists. The assessment tool adopted is internationally recognised, namely Minimum Data Set-Home Care (MDS-HC). Assessors are required to undergo necessary training and pass examination for accreditation to ensure the level of knowledge and skills attained.

1.7 Based on the assessment results, the elderly persons will be matched with the appropriate subsidised LTC services, which include “RCS only”, “CCS only” or “dual option” (i.e. either RCS or CCS). If subsidised places are not readily available, eligible elderly persons are put on the Central Waiting List for subsidised LTC services (CWL) to wait for their turn of admission.

Central Waiting List

1.8 The SWD has implemented since 2003 the CWL for the registration and allocation of subsidised LTC services. With the implementation of the CWL, the elderly can apply to a single-entry point for subsidised LTC services and appropriate services will be arranged to them according to the assessment results. The CWL is intended to achieve the following:

Note 4: *Such authorised referring units refer to welfare/elderly service units of the SWD, NGOs and the Hospital Authority. They include, for example, the Medical Social Services Units under the SWD and the Hospital Authority, integrated family service centres of NGOs and SWD, district elderly community centres, neighbourhood elderly centres/social centres for the elderly of NGOs.*

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- To centralise and streamline the application process in that the elderly no longer need to indicate a specific service or approach different NGOs for different services;
- To secure better coordination of service allocation. With assessment conducted for the elderly at the time when they apply for LTC services, those assessed to have care needs (i.e. impairment level at moderate or above) will be registered in the CWL and provided with or waitlisted for the appropriate services as applicable. Elderly assessed to have no care needs (i.e. no or mild impairment level) will be referred to other district-based support services as necessary;
- To target resources at elderly with LTC needs. The CWL can facilitate more effective service planning and resource management; and
- To encourage ageing in place, an elderly who wish to stay at home will be given the choice of CCS, even if matched to any RCS.

1.9 Under the CWL, all applications for LTC services must be referred by the RWs in authorised referring units (see para. 1.6). The RWs support the elderly by making applications for LTC services to the Standardised Care Need Assessment Management Offices (Elderly Services) (SCNAMO(ES)s) of the SWD (see Appendix A), keeping in view their conditions and welfare needs while they are waitlisting for LTC services and explaining the assessment result to them and following up their welfare needs. Allocation of care services, arranged by the LDS Office (in the case of RCS) and by the SCNAMO(ES)s (in the case of CCS), is based on the applicants' priority on the CWL and their indicated preferences for the matched services. In general, applicants with restrictive preferences have to wait for a longer time.

Subsidised community care services

1.10 Subsidised CCS are allocated on a district basis and are essentially provided by NGOs with subventions or service fees from the Government. As at March 2014, some 27 000 elderly were receiving CCS funded by the Government. Subsidised CCS include “centre-based” day care services and “home-based” home care services, as shown below:

Types of the Government's subsidised community care services

I. “Centre-based” day care services

- Services, implemented since 1980s, cover personal care, nursing care, meal services, rehabilitation exercises, health education, and social activities for the frail elderly. They serve frail elderly of 60 or above in age and who have no family member or lacking the care from family members during daytime.
- As at March 2014, there were 67 day care centres/units providing 2 750 places in total. While 58 day care centres were operated by NGOs and funded by the Government under Lump Sum Grant (LSG) subventions, 9 day care units attached to contract RCHEs were operated by NGOs/home operators and funded by the Government by service fees.

II. “Home-based” home care services

- Services cover basic and special nursing care, personal care, rehabilitation exercises, home-making and meal delivery services, escort services, as well as carer support services. Such services are mainly provided by the following two schemes:
 - (a) Enhanced Home and Community Care Services (EHCCS — introduced in 2001), which are operated by NGOs and funded by the Government by service fees. As at March 2014, there were 24 teams serving 5 580 frail elderly of 65 or above in age (or aged between 60 and 64 if there is a proven need); and
 - (b) Integrated Home Care Services (IHCS), which were formed in 2003 by re-engineering various home help, home care and meal teams previously in operation. IHCS are operated by NGOs and funded by the Government under LSG subventions. As at March 2014, there were 60 IHCS teams serving 1 120 frail elderly and 17 300 elderly of no or mild impairment and of 60 or above in age.

Source: SWD records

Introduction

Subsidised residential care services

1.11 In the RCS domain, there exists a mix of public and private modes. In fact, the private market is providing the majority of the RCS places. As at March 2014, some 61 200 elderly were receiving RCS, with some 40% of them taking up subsidised RCS places. Subsidised RCS places are provided by subvented/contract RCHEs or by purchase of places from private/self-financing RCHEs (Note 5) which participated in the Government's Enhanced Bought Place Scheme (EBPS) and Nursing Home Place Purchase Scheme (NHPPS).

1.12 In essence, there are two types of RCS places, namely "care and attention" (C&A) places and nursing home (NH) places. C&A places are provided for elderly persons assessed to be moderately impaired under the assessment mechanism whereas NH places are provided for those assessed to be severely impaired. Elderly residents at C&A places are provided with, among others, limited nursing care whereas residents staying at NH places are provided with regular basic medical and nursing care. An overview of the types of the Government's subsidised RCS is shown below.

Note 5: *Self-financing RCHEs refer to those non-profit-making RCHEs which have not received Government subvention to support their operations.*

Types of the Government's subsidised residential care services

Subsidised RCS provide residential care and facilities for elderly of 65 or above in age (or aged between 60 and 64 if there is a proven need) who, for personal, social, health or other reasons, cannot be adequately taken care at home.

I. Subvented RCHEs

Subvented RCHEs, started as early as the 1970s, are operated by NGOs and funded by Government under LSG subventions. As at March 2014, there were 127 subvented RCHEs providing some 14 790 C&A places, 1 570 NH places and 100 home for the aged (H/A) places.

II. Contract RCHEs

Contract RCHEs, introduced since 2001, are purpose-built premises set up by the Government. Once built, they are awarded to be operated by NGOs/home operators through competitive bidding. Each contract awarded lasts for five years, extendable for another five years. As at March 2014, there were 22 contract RCHEs providing 210 C&A and 1 460 NH places.

III. Enhanced Bought Place Scheme (EBPS)

The EBPS was introduced in 1998 to replace the previous Bought Place Scheme. Under the EBPS, the Government purchases RCS places from private RCHEs which are paid monthly subsidies for the places purchased. As at March 2014, there were 135 private RCHEs which participated in the Scheme, providing 7 660 C&A places. There are two categories of EBPS places, namely EA1 and EA2 places, with the former of higher quality in terms of space and staffing.

IV. Nursing Home Place Purchase Scheme (NHPPS)

The NHPPS was introduced in 2010-11. The Government purchases NH places from self-financing RCHEs. As at March 2014, four self-financing RCHEs were participating in the Scheme, providing 160 NH places.

Source: SWD records

Remarks: There are also some 49 000 non-subsidised RCS places in the RCHE sector. As at March 2014, these places were occupied by 36 000 residents, including 25 700 residents who were receiving Comprehensive Social Security Assistance allowances (see para. 2.10).

Introduction

Use of LTC services by the elderly

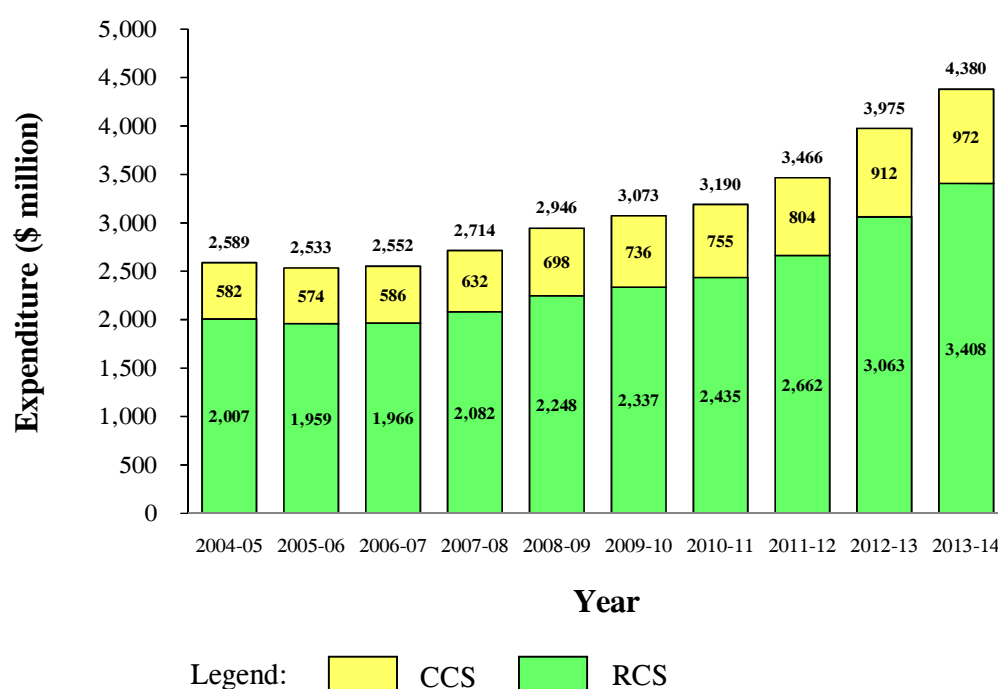
1.13 According to the 2014 Policy Address, to uphold the spirit of respecting, loving and caring for the elderly, the Government is committed to promoting the well-being of the elderly in all aspects of their life by providing them with services which will enable them to remain members of the community for as long as possible and, by making available RCS for those in need. Against an elderly population of one million in 2013 (see para. 1.2), during the year 2013-14, some 14 000 frail elderly had received subsidised CCS and some 30 000 frail elderly had received subsidised RCS.

Expenditure on provision of subsidised CCS and RCS

1.14 All along, the Administration has allocated substantial resources every year under the Government General Revenue for the provision of elderly services. In 2013-14, the SWD spent \$4.38 billion for the provision of subsidised CCS (\$0.97 billion) and RCS (\$3.41 billion) to the elderly, an increase of 69% as compared with \$2.59 billion spent in 2004-05 (see Figure 1).

Figure 1

**Recurrent expenditure on the provision of subsidised CCS and RCS
(2004-05 to 2013-14)**



Source: SWD records

1.15 In addition, the Government has from time to time applied for funds from the Lotteries Fund (LF) to finance the development of elderly services. These included funds for the construction and setting-up of contract RCHEs and for the implementation of various time-limited welfare projects/schemes for the elderly (e.g. \$380 million for implementing the first phase of the Pilot CCS Voucher Scheme for the Elderly). NGOs may also apply for grants from LF to meet the capital costs of works projects in connection with elderly services provided by them (Note 6). In September 2013, the Administration further launched a Special Scheme by inviting welfare NGOs to submit proposals to provide the necessary welfare facilities, in particular elderly and rehabilitation facilities, through in-situ expansion or redevelopment of the land they owned, and undertook to finance out of LF the capital costs for feasible projects under the Special Scheme. The Government would provide targeted assistance for land owners during the planning or development process. To ensure sufficient resources are available for the purpose, the Legislative Council (LegCo) Finance Committee (FC) approved in February 2014 fund transfer of \$10 billion from the General Revenue to LF.

Regulation of RCHEs

1.16 The Residential Care Homes (Elderly Persons) Ordinance (Cap. 459 — the RCHE Ordinance) and its subsidiary legislation, the Residential Care Homes (Elderly Persons) Regulation (Cap. 459A — RCHE Regulation) have provided for the regulation of RCHEs through a licensing system administered by the SWD (Note 7). The purpose of the RCHE Ordinance is to ensure that the services received by residents in RCHEs are of standards that are beneficial to them physically, emotionally and socially. The SWD has also issued a Code of Practice under the RCHE Ordinance setting out the principles, procedures, guidelines and standards for the management and operation of RCHEs.

Note 6: *Under section 6(4) of the Government Lotteries Ordinance (Cap. 334), the Financial Secretary has the authority to approve payments from LF to finance the support and development of social welfare services. In 2012-13 and 2013-14, LF funds of some \$1.4 billion had been approved to finance various projects on elderly services.*

Note 7: *All RCHEs are licensed under the RCHE Ordinance, with the exception of RCHEs offering only NH places, which are regulated by the Department of Health under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165).*

Audit review

1.17 In 2002, the Audit Commission (Audit) conducted a review on RCS for the elderly, with the results published in the Director of Audit's Report No. 38 (March 2002). After examining that Audit Report, in July 2002, the Public Accounts Committee (PAC) made, among others, the following conclusions and recommendations:

- (a) the PAC expressed concern that there were significant disparities in the service levels between subvented RCHE places and RCHE places under the EBPS, and that the waiting time for admission to subvented RCHEs was 34 months whereas that for EBPS places was 10 months only; and
- (b) the PAC urged the Director of Social Welfare to take further actions to reduce the disparities in the waiting time and the level of services mentioned in (a) above.

1.18 In his 2014 Policy Address, the Chief Executive of HKSAR has announced that he would task the Elderly Commission (which advises the Government on elderly policy matters) to prepare within two years an Elderly Services Programme Plan. In April 2014, the LWB informed LegCo that given the combined effect of an ageing population and increasing longevity, there would be a pressing need for the Government to enhance its medium to long-term planning for elderly services, while at the same time exploring a viable model for subsidised LTC services. In this connection, the Elderly Commission has also been tasked to conduct a study on the feasibility of a pilot scheme on RCS voucher.

1.19 In April 2014, Audit commenced a review on the SWD's provision of LTC services for the elderly. Focus was placed on the waitlisting situation, the expansion and effective use of the limited subsidised LTC places available and the regulation of RCHEs. Audit notes that the disparities in waiting time and service levels between subvented RCHE places and EBPS places, as commented by the PAC in 2002 (see para. 1.17), still exist. This Audit Report will cover the following PARTs:

- (a) growing demand for subsidised long-term care services (PART 2);
- (b) community care services (PART 3);
- (c) residential care services (PART 4); and
- (d) way forward (PART 5).

Audit has found that there is room for improvement in various areas and has made recommendations to address the issues.

Acknowledgement

1.20 Audit would like to acknowledge with gratitude the full cooperation of the staff of the LWB and SWD during the course of the audit review.

PART 2: GROWING DEMAND FOR SUBSIDISED LONG-TERM CARE SERVICES

2.1 This PART examines the growing demand for subsidised LTC services and the multi-pronged approach taken by the Administration to tackle the growing demand. Against the background set out in paragraphs 2.2 to 2.10, the following issues are covered:

- (a) long waiting lists and waiting times (paras. 2.11 to 2.22);
- (b) marginal increase achieved in the capacity of subsidised RCS places (paras. 2.23 to 2.28); and
- (c) need to maximise the effective use of limited subsidised RCS places available (paras. 2.29 to 2.60).

Long-term care services delivery system

Central Waiting List

2.2 As mentioned in paragraph 1.8, the SWD implemented in 2003 the CWL for the registration and allocation of subsidised LTC services. An elderly person may apply for LTC services through RWs of authorised referring units in the SWD, NGOs and the Hospital Authority (HA). The SWD only accepts requests for care services on a referral basis. The elderly persons are required to undergo care need assessments under the standardised assessment mechanism operated by the SWD (formerly known as the “Gate-keeping Mechanism”). Such assessments are conducted by accredited assessors (Note 8) who are trained up and accredited by the SWD. Based on the assessment results, elderly persons may be matched with appropriate LTC services. Eligible elderly persons are put on the CWL for the services according to the options recommended in the assessments.

Note 8: *The accredited assessors, who have to complete training in the use of the MDS-HC assessment tool, are professionals from various disciplines such as social workers, nurses, occupational therapists and physiotherapists of the SWD, HA or NGOs.*

Growing demand for subsidised long-term care services

2.3 Appendix B shows the procedures for processing applications for LTC services from the time requests are made by applicants until their admission to service. Before an applicant is included for waitlisting on CWL, the SWD arranges care need assessment to be conducted by accredited assessors and quality checks (QCs) to be conducted by the regional SCNAMO(ES)s to ensure the accuracy of the assessment (see Steps (a) to (h) at Appendix B). The result of an assessment is only valid for 12 months. Re-assessment of the applicants is required prior to admission to services if the 12-month validity period of the assessment results has expired. The allocation of care services is on a first-come-first-served basis determined according to the applicants' LTC dates (Note 9) and their preferences (such as specific districts or RCHEs, religious background and diet provision of RCHEs).

2.4 Because the assessment results determine the applicants' eligibility for different types of subsidised care services, the SWD assessment mechanism acts as the "Gate-keeper" and plays a very important role in the Government's provision of subsidised LTC services.

Subsidised community care services

2.5 In line with the Government's "ageing in place" policy, applicants who wish to continue to stay at home are encouraged to accept CCS offers, even if they are matched to any RCS. According to the Elderly Commission, effective CCS could encourage the elderly to age in place and thus avoid premature or unnecessary institutionalisation, and CCS should be further developed to help the elderly stay at home. In ten years' time, the CCS capacity for frail elderly had increased by 80% from 5 260 places in 2003-04 to 9 450 places in 2013-14.

Note 9: *Effective from January 2013, the SWD has adopted the registration date (i.e. the date of receiving the RW's application for arranging care need assessment of the elderly) as the LTC date. Before 2013, the assessment completion date was taken as the LTC date.*

Growing demand for subsidised long-term care services

2.6 In 2013-14, the Government spent \$970 million on the provision of various types of subsidised CCS (see para. 1.14). According to the SWD Controlling Officer's Reports, in 2013-14, the cost to the Government for CCS was about \$7,100 a month for a place receiving day care services, about \$3,700 a month for EHCCS and about \$1,600 a month for IHCS. For day care services, elderly users have to pay standard rates of \$900 to \$1,000 a month whereas the fee for home care services varies, depending on the elderly user's household income and service usage (e.g. \$12.6 to \$18.6 for meal delivery and \$5.4 to \$19.0 per hour for home making).

2.7 On the other hand, elderly with no or mild impairment can apply for services under the IHCS (Ordinary Cases). They are however not required to be assessed by the SWD assessment mechanism and the NGOs which operate the IHCS maintain their own waiting lists for these ordinary cases.

Subsidised residential care services

2.8 At present, some 75 000 RCS places in the territory are provided by 748 RCHEs (see details in para. 4.2). Of the 75 000 RCS places provided, 26 000 are subsidised ones (some 23 000 for subsidised C&A places and some 3 000 for subsidised NH places). For these 26 000 subsidised RCS places, approximately two-third are provided by the subvented and contract RCHEs whereas the other one-third is provided by private/self-financing RCHEs participating in the EBPS and the NHPPS.

2.9 In 2013-14, the Government spent \$3.41 billion on providing the subsidised RCS (see para. 1.14). The cost per subsidised RCS place to the Government ranged from \$7,900 to \$15,600 a month (Note 10). An elderly user also has to pay \$1,600 to \$2,000 a month for the services received.

Note 10: *According to the SWD Controlling Officer's Reports, in 2013-14, it cost the Government \$7,900 a month for an EBPS place, \$13,200 a month for a subsidised C&A place in a subvented RCHE, \$12,700 a month for a C&A/NH place in a contract RCHE and \$15,600 a month for an NHPPS place or an NH place in a subvented RCHE.*

Growing demand for subsidised long-term care services

2.10 In addition, in 2013-14, the Government spent another \$2.1 billion (Note 11) on payments under the Comprehensive Social Security Assistance (CSSA) Scheme of the SWD to 25 700 elderly (aged 60 or above) living in non-subsidised RCS places in RCHEs. That is, apart from providing the 26 000 subsidised RCS places (see para. 2.8), the Government was also subsidising indirectly another 25 700 elderly who were living in non-subsidised RCS places in RCHEs, some 8 250 of whom were on the CWL (Note 12).

Long waiting lists and waiting times (para. 2.1(a))

2.11 On the demand side, with the ageing population and the longer life expectancy of Hong Kong people, the demand for subsidised LTC services is growing rapidly. Although the Government has strived to cope with the increasing demand, the long waitlisting situation remains.

Subsidised community care services

2.12 Against a capacity of some 7 010 to 9 450 places (an increase by 35%) over the five years from 2009-10 to 2013-14, the number of waiting cases for CCS had increased by 84%, rising from 2 330 to 4 280 for the same period. According to the SWD's records, the waitlisting situation for CCS was as follows:

Note 11: *Based on the average monthly CSSA payments of \$6,953 a month for 25 700 elderly CSSA recipients living in non-subsidised RCS places in RCHEs as at March 2014, the Government spent some \$2.1 billion ($\$6,953 \times 12 \times 25\,700$) on such CSSA payments to the elderly.*

Note 12: *The LWB informed LegCo in January 2014 that among the 29 000 applicants on the CWL as at end-September 2013, some 8 250 applicants were elderly CSSA recipients living in non-subsidised RCS places in RCHEs.*

Growing demand for subsidised long-term care services

- (a) *The numbers of elderly on the waiting lists for day care and home care services compared to the CCS capacity:*

As at end-March of	Day care services		Home care services (Note)		Total	
	Capacity (a)	No. of waiting cases (b)	Capacity (c)	No. of waiting cases (d)	Capacity (a) + (c)	No. of waiting cases (b) + (d)
2010	2 310	1 580	4 700	750	7 010	2 330
2011	2 330	1 970	4 700	1 340	7 030	3 310
2012	2 560	2 260	6 200	910	8 760	3 170
2013	2 670	2 170	6 700	1 250	9 370	3 420
2014	2 750	2 100	6 700	2 180	9 450	4 280

Source: SWD records

Note: Home care services cover EHCCS and IHCS (Frail Cases), both of which provide similar services. In fact, elderly choosing these two types of services are on the same waiting list.

- (b) *The average waiting time for the two types of CCS over the past five years:*

Financial year	Average waiting time (Month)	
	Day care services	Home care services
2009-10	6.8	2.5
2010-11	8.0	4.0
2011-12	9.3	4.5
2012-13	8.8	2.6
2013-14	8.5	5.3

Source: Audit analysis of SWD records

Growing demand for subsidised long-term care services

2.13 It can be seen that the numbers of elderly on the CCS waiting lists were generally rising and waiting times were long, reflecting a need for the Administration to keep the CCS capacity under regular review and expand it if appropriate, given the increasing demand on CCS arising from the ageing population. In October 2014, the SWD informed Audit that the waitlisting situation would improve in 2014-15 as it had planned to increase an additional 1 500 home care service places in March 2015 and these 1 500 additional places would be allocated to districts in accordance with their different demands.

2.14 As mentioned in paragraph 1.10, subsidised CCS are allocated on a district basis and are essentially provided by subvented NGOs through their centres/teams in 18 districts where the elderly live. Hence in service planning, it is important to take into account the number of waiting cases and waiting time of each district. Audit has found that:

- (a) **Day care services:** Against an average of 7.7 months for day care services for the quarter ended June 2014, the average waiting time in a few districts (mostly in the New Territories) was particularly high (approaching or even exceeding 12 months) whereas that for a few districts was as low as two months or below, as shown below:

District	Average waiting time for quarter ended June 2014 (Month)
NT1	20.7
NT2	18.7
NT3	14.1
NT4	12.6
NT5	11.6
NT6	11.1
KLN1	2.3
HK1	1.6
KLN2	1.4

Source: Audit analysis of SWD records

Growing demand for subsidised long-term care services

- (b) **Home care services:** Against an average of 7.3 months for home care services for the quarter ended June 2014, the average waiting time for a number of districts was particularly high whereas, in contrast, that for a few districts was quite low, as follows:

District	Average waiting time for quarter ended June 2014 (Month)
KLN3	11.6
NT7	10.1
HK2	9.7
NT3	9.5
KLN4	9.4
NT4	5.7
KLN5	2.2

Source: Audit analysis of SWD records

2.15 According to the SWD, different waiting time for different districts is reflective of a combination of factors, including the increasing population in certain districts, the number of centre/home places available, the turnover of day/home care places and the availability of premises for setting up new day care centres/units, and some of these factors are beyond the control of the Administration. The uneven waiting time for CCS in different districts however calls for concern. Whilst noting that the SWD has applied certain measures to reduce the waiting time in certain districts, such as: (a) introducing flexibility by allowing the provision of cross-district services in newly set-up day care centres; and (b) redistributing the EHCCS places among the cluster teams, Audit considers that the SWD needs to continue making more effective planning in its provision of CCS.

2.16 Unlike RCS for which the waitlisting information was regularly posted onto the SWD website (see para. 2.17), the SWD did not publicise the waitlisting information for CCS. Given the Government policy of ageing in place, the SWD needs to consider publicising the waitlisting information for CCS on its website.

Growing demand for subsidised long-term care services

Subsidised residential care services

2.17 The allocation of RCS places is on a territory-wide basis. As mentioned in paragraph 2.16, the SWD posted the RCS waitlisting information monthly onto its website. The Administration also reported to LegCo from time to time the number of applicants on the CWL and, on occasions, the waiting time for different types of subsidised RCS. The following waitlisting situation for RCS was reported/published as at different dates:

- (a) ***Waiting list (against a capacity of some 23 000 C&A places and 3 000 NH places):***

Subsidised services	No. of applicants on the CWL (Note 1) as at end of		
	March 2008 (i)	March 2011 (ii)	August 2014 (iii)
C&A places (Note 2)	16 700	20 340	24 250
NH places (Note 3)	6 230	6 410	6 440
Total	22 930	26 750	30 690

Source: SWD records

Note 1: Most of the elderly on the CWL were staying at home or at non-subsidised RCS places in RCHEs while waiting for subsidised RCS places.

Note 2: The C&A places were mainly provided by subvented RCHEs and private RCHEs participating in EBPS.

Note 3: The NH places were mainly provided by subvented and contract RCHEs.

Growing demand for subsidised long-term care services

(b) *Waiting time:*

Subsidised places	Average waiting time (months)		
	for the three months ended		
	March 2008 (i)	March 2011 (ii)	August 2014 (iii)
C&A places			
• Subvented/contract RCHEs	32	32	36
• EBPS in private RCHEs	9	8	7
Overall	21	22	20
NH places	43	39	32 (Note)

Source: SWD records

Note: As explained by the SWD, there was a reduction in the waiting time for NH places mainly because additional NH places had been provided in the 12 months to end-August 2014.

2.18 The waiting list and waiting time reported/published by the SWD as shown in paragraph 2.17(a) and (b) respectively however did not reflect the number of “inactive” cases on the CWL and the processing time taken for assessment. The methodology for calculating the waiting time, and revisions thereof, was also not properly documented. Taking for example, with the waiting list and waiting time reported as at end-August 2014 (see para. 2.17(a)(iii) and (b)(iii)), Audit noted the following:

Waiting list

- (a) *6 800 elderly persons on the CWL not included as a result of their “inactive” status:*

Growing demand for subsidised long-term care services

- (i) Before 5 November 2012, elderly cases which had been assessed as “RCS only” but were using CCS while waiting for RCS places were considered as “active” cases and included in waiting list for reporting. However, with effect from 5 November 2012, such elderly cases were reclassified as “inactive” in status and excluded from counting in reporting the number of elderly on the waiting list. Such revision in status was however not disclosed when reporting the number of elderly cases on the waiting list. The SWD Manual of Procedures (SWD Manual — Note 13) had also not been suitably revised to reflect such revision in “inactive” status for “RCS only” elderly cases;
- (ii) the reported number of 30 690 applicants on the CWL awaiting C&A or NH places as at end-August 2014 (see para. 2.17(a)(iii)) did not include a total of 6 800 “inactive” elderly cases which had been assessed as “RCS only” (see (i) above) or “dual option” but were meanwhile using CCS (Note 14); and
- (iii) given that the 6 800 “inactive” elderly in (ii) above can opt at any time for RCS (with their priority on the CWL not being affected by the “inactive” status), they represent a hidden, but not negligible, demand which should have been disclosed (say, by footnote) when reporting the waiting list and should have been suitably taken into account in service planning. In fact, Audit found that during January to August 2014, 560 (16%) of 3 400 RCS admissions under the CWL in the eight months were related to such “inactive” elderly cases which had reactivated their applications for RCS;

Note 13: *The SWD Manual on registration and allocation of subsidised LTC services is drawn up for use by all accredited assessors, RWs, RCHEs and all centre/service operators. The relevant parties are expected to observe the procedures laid down in the Manual.*

Note 14: *As explained by the SWD, elderly cases which had been assessed as “RCS only” but were receiving CCS before 5 November 2012 were continued to be classified as active cases in the CWL. As for elderly cases which had been assessed as “dual option” (i.e. either RCS or CCS is equally appropriate for the applicant) but were receiving CCS, they had all along been classified as “inactive” cases and excluded from reporting.*

Growing demand for subsidised long-term care services

- (b) ***SWD statistics relating to elderly persons on the CWL:*** Based on SWD statistics, for 2013, elderly still awaiting subsidised RCS places in the CWL had an average life span of 83 years whereas elderly staying in subsidised RCS places (NH/C&A places) had an average life span of 87 years. Besides, the number of elderly on the CWL who had passed away while waiting for RCS places had increased from “4 000 to 4 500” a year before 2010 to 5 700 in 2013-14 (1 800 while waiting for NH places and 3 900 while waiting for C&A places);

Waiting time

- (c) ***Methodology and revisions not properly documented:*** Audit found that the SWD did not maintain proper records of the methodology it used. Upon Audit’s enquiry, the SWD explained that in calculating the waiting time, the average number of days between the waitlist date and the admission date (see Steps (i) to (o) at Appendix B) for admitted cases in the past three months was taken. Even though Audit was informed by the SWD that it had revised in December 2013 the methodology for calculating the waiting time by excluding the complicated admission cases (e.g. those with history of reactivating the “inactive” status) from its calculations, the justifications for the revision and the extent to which the resultant waiting time would be affected were not properly documented; and
- (d) ***Processing time for assessment not taken into account:*** Although assessment is required before an eligible elderly is included in the CWL, the processing time for assessment had not been taken into account in calculating the waiting time. Such processing time includes the time taken for care need assessment after the elderly had given his/her consent for applying for LTC services and accepting the conduct of an assessment (see Steps (b) to (h) at Appendix B). According to the SWD, there may be time when it has to wait for the applicant’s confirmation of his/her wish to be put on the CWL even after he/she had given his/her consent for assessment. According to the SWD Manual, a care need assessment, not including the time taken by SCNAMO(ES) for QC, should normally be completed within three weeks (or 21 days). Apparently because the assessment workload has kept on increasing

Growing demand for subsidised long-term care services

(Note 15), coupled with the over-concentration of the assessment workload on the accredited assessors of the SCNAMOs (ES)s (see para. 2.21(b)), the five regional SCNAMOs (ES)s had taken longer time in recent years to complete the assessments. In 2013-14, they had taken, on average, 27 days to complete an assessment, as compared with an average of 7 days in 2009-10, with detailed breakdown shown below:

Financial year	Average processing time for a care need assessment					
	Office 1	Office 2	Office 3	Office 4	Office 5	Overall
	(No. of days)					
2009-10	6	10	6	7	7	7
2010-11	7	10	7	13	7	9
2011-12	12	12	7	17	9	11
2012-13	12	17	8	28	20	17
2013-14	24	19	14	36	42	27

In particular, Audit noted that:

- (i) of 4 700 applications received in the first three months of 2014 with assessments completed by mid-August 2014, half were completed beyond 21 days, with many completed even beyond two months;
- (ii) after assessment, QC is required to be conducted by SCNAMOs (ES)s (see Step (e) at Appendix B) to ascertain if there are any inconsistencies or irregularities in the assessments. Against the standard of two weeks for QC as stipulated in the SWD Manual, Audit however found that as at mid-August 2014, QC for 16% of the assessments received in the first three months of 2014 were completed in more than two weeks, with some completed even in more than two months; and
- (iii) as at end-July 2014, the SCNAMOs (ES)s had accumulated a backlog of some 2 900 cases awaiting eligibility assessment and re-assessment.

Note 15: Comparing with the workload some five years ago (2008-09) of receiving 1 500 applications a month, the SWD received 2 500 applications a month in 2013-14.

Need for reviewing the assessment mechanism to cope with the growing demands

2.19 As mentioned in paragraph 1.6, the SWD has implemented a standardised care need assessment mechanism to help assess elderly persons' level of impairment which will be matched with appropriate subsidised LTC services, including "RCS only", "CCS only" or "dual option". As the assessment mechanism determines the applicants' eligibility for different types of care services, it acts as the "Gate-keeper" and plays a very important role in the Government's provision of subsidised LTC services.

2.20 Assessment results obtained from the SWD assessment mechanism have also enabled the RWs and the RCHEs/centre operators to design care plans for individual elderly according to their needs and make appropriate referrals for specialists' intervention.

2.21 Audit has however found a number of issues warranting a review of the SWD assessment mechanism, as follows:

- (a) ***Old version of assessment tool in use.*** The MDS-HC assessment tool currently in use for assessment and service matching is version 2.0 which has been employed for use since November 2000 (over 13 years). In July 2013, the SWD obtained funds from LF to commission a local university to, among others, review and update the assessment tool from version 2.0 to version 9.1 which would:
 - (i) facilitate the Government to better decide how subsidised LTC services could be matched according to the need and urgency of elderly applicants and provide a more detailed assessment on the health status of the elderly persons, based on, for example, their levels of functional impairment, cognition (e.g. consistency in thoughts), communication, pain and mood as well as social support and environmental risk; and
 - (ii) allow the elderly care service operators to have a more precise understanding of the services required for taking care of elderly persons with different levels of frailty.

Growing demand for subsidised long-term care services

In September 2014, the SWD informed Audit that the local university was commissioned under a three-year project to update the assessment tool as well as to develop a more effective standardised assessment system for better service matching. However, the tool updating process would only be completed by early 2016;

- (b) ***Low percentage of accredited assessors involved in assessments.*** According to the LDS computer system, as at June 2014, there were about 2 700 accredited assessors, but only 1 800 of whom were recorded as active ones (Note 16). An analysis of the assessments completed for the 12 months ended June 2014 as captured in the computer system however revealed that only 850 (47%) of these 1 800 active assessors had been involved in conducting assessments in the 12 months. This casts doubt on whether the other 950 (53%) accredited assessors were still active in assessment work. Another analysis revealed that 70% of the 6 800 assessments completed by mid-August 2014 in relation to applications received during the first quarter of 2014 were conducted by 36 (2% of 1 800) accredited assessors of the five regional SCNAMO(ES)s (Note 17). The low percentage of accredited assessors who are still active in assessment work and the over-concentration of the assessment workload on the 36 accredited assessors of the SCNAMO(ES)s call for concern. The extremely uneven output may affect the quality and efficiency of the assessments which determine the appropriate LTC services to be provided. They may also have accounted for why the SWD has kept on taking longer time to complete the care need assessments (see para. 2.18(d)); and

Note 16: *As at June 2014, these 1 800 accredited assessors (classified as active ones) were in relevant assessment-related posts in the SWD, NGOs and HA, with the majority of them stationed in the SWD (about 1 000) and NGOs (about 650). The five regional SCNAMO(ES)s under the SWD had 47 accredited assessors in post.*

Note 17: *In September 2014, the SWD informed Audit that due to division of work, the SCNAMO(ES)s had shouldered much of the assessment workload, but the situation would improve with the provision, effective from October 2014, of increased manpower to NGOs for their operation of district elderly community centres and the neighbourhood elderly centres which would share more assessment workload.*

- (c) **Limited random QCs conducted.** In line with the recommendations made by the Independent Commission Against Corruption (ICAC — Note 18) in 2009, the SWD has laid down the requirement that effective from November 2010, each regional SCNAMO(ES) would conduct, in addition to paper check for confirming the results of each assessment (see para. 2.18(d)(ii)), random QCs of a few cases by home visits or interviews in each quarter, in order to deter and detect inaccurate assessments. In this review, Audit has however found that over the 3.5 years from 2011 to 2014 (up to June 2014), only 36 random QC visits (i.e. some 10 visits a year) had been conducted by the five regional SCNAMO(ES)s, with one office not having conducted any random QC visits over the years and another office having conducted only one random QC visit (in 2011). With the growth of assessment workload in recent years (coming up to some 25 000 assessments a year), the adequacy of conducting only 10 random QCs a year should be reviewed.

2.22 Given the “Gate-keeper” role of the assessment mechanism, the SWD needs to review how the assessment procedures can be fine-tuned, with appropriate checks and balances strengthened. In September 2014, the SWD informed Audit that as part of its upcoming LDS redevelopment project and the three-year project for enhancing the infrastructure of LTC in Hong Kong (see para. 2.21(a) above and para. 5.8), the Department will review the assessment mechanism with a view to improving its efficiency and accuracy.

Marginal increase achieved in the capacity of subsidised RCS places (para. 2.1(b))

2.23 On the supply side, the Administration has continuously allocated substantial resources to the provision of LTC services to cope with the rising demands, particularly for RCS. For many years, the Chief Executive of HKSAR in his Policy Addresses has indicated the need to provide more subsidised RCS places for the elderly and various Government initiatives have been implemented in recent years to increase the provision of RCS places, including the following:

Note 18: *In October 2009, the ICAC completed an assignment review of the SWD’s administration of the CWL for subsidised LTC services for the elderly.*

- **2010-11 Policy Address:** To provide additional places by building new RCS homes and making full use of the space in existing homes, and to increase the supply of higher-quality places under the EBPS.
- **2011-12 Policy Address:** To buy more RCS places to help relieve the pressure on subvented and contract homes.
- **2013 Policy Address:** To increase the number of subsidised RCS places for the elderly through a multi-pronged approach:
 - in the short run, the Government would purchase places from private RCHes through EBPS and make better use of space in subvented homes for provision of more subsidised places;
 - for the medium-term, the Government would build new contract RCHes to increase the number of subsidised places, particularly places providing a higher level of nursing care; and
 - in the long run, the Government would identify sites for new homes, and would explore the feasibility of incorporating RCS facilities into redevelopment projects, and convert vacant buildings into RCHes.

From 2013 to 2015, the SWD would provide over 1 700 new subsidised places. The Government had also earmarked sites in 11 development projects for new contract RCHes.

- **2014 Policy Address:** The Government would continue to increase the supply of subsidised RCS places for the elderly through a multi-pronged approach that included, among others, the Special Scheme on privately owned sites for welfare uses. The Government would purchase RCS places from an elderly home run by a Hong Kong NGO in Shenzhen to provide an option for the elderly on the CWL for subsidised RCS places. The Government was also discussing similar arrangements with another elderly home in Zhaoqing run by a Hong Kong NGO. The Government had also earmarked about \$800 million to meet the expenses incurred in issuing a total of 3 000 RCS vouchers in three phases from 2015-16 to 2017-18.

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2.24 There has been a steady increase in the capacity of CCS over the past five years (see para. 2.12(a)). In the case of RCS, although the Administration has made great efforts to increase the provision of RCS places over the years, including the adoption of a multi-pronged approach to increase the number of subsidised RCS places, Audit however noted that the overall increase in the number of subsidised RCS places was not significant. As shown below, the number of subsidised RCS places had only increased by 20% in 14 years, i.e. from 21 600 as at end-March 2000 to 26 000 as at end-March 2014, with trend over the years shown at Appendix C:

Type of RCHEs	No. of subsidised RCS places	
	End-March 2000	End-March 2014
(a) Subvented RCHEs	18 330	16 460
(b) Contract RCHEs	(Not yet come into operation)	1 670
(c) Private/Self-financing RCHEs participated in EBPS or NHPPS	3 250	7 820
Total	21 580 (say 21 600)	25 950 (say 26 000)

Reasons for not achieving significant increase in the number of subsidised RCS places are examined below.

2.25 *Service quality enhanced, but number of places reduced after conversion.* There had been a significant reduction in the number of RCS places provided by homes for the aged (H/As) and self-care (S/C) hostels (Note 19). Since 2005-06, the SWD has launched a conversion programme to upgrade RCS places in H/As and S/C hostels to C&A places providing CoC. According to the SWD, it is the Government's policy to promote CoC in subsidised RCS in order to enable

Note 19: *Elderly residing in H/As are assessed to be of no or mild impairment by the assessment mechanism, while elderly residing in S/C hostels need not be assessed by the assessment mechanism. Since 2005, the Administration had aimed to phase out H/A and S/C hostel places so that the resources could be redirected to provide more LTC services for the elderly. No new H/As and S/C hostels had been built since 1998 and 1992 respectively.*

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elderly residents to stay in the same RCHE even when their health conditions deteriorate (see para. 1.4(b)). Because of the conversion programme, some 10 000 RCS places previously provided by 74 H/As and S/C hostels were converted to some 6 100 C&A places with CoC.

2.26 To make up for the reduction of the RCS capacity by 3 900 (10 000 less 6 100) RCS places as a result of the conversion programme, the Administration should have exerted greater efforts to increase the overall RCS capacity. Audit has however found that the Administration was not able to increase timely the supply at a greater pace:

- (a) ***Limited number of subsidised RCS places provided by contract RCHEs:***
- (i) While noting that the time taken to construct a contract RCHE is not entirely under the control of the SWD, it generally took a long time (could be over 10 years) to construct a contract RCHE after a suitable site had been identified until the contract RCHE commenced operation. However, while it took a long time to set up an RCHE, the 22 contract RCHEs currently in operation could only provide in total 1 670 subsidised RCS places. Although seven new contract RCHEs are expected to commence service from 2014-15 to 2016-17 and 11 sites had been earmarked for the construction of new contract RCHEs, the SWD's preliminary estimation indicated that they could only provide additional 2 000 RCS places (subsidised and non-subsidised) over a nine-year period; and
 - (ii) the capital cost for setting up a contract RCHE (which is usually purpose-built) is high (Note 20) and, as mentioned in (i) above, contract RCHEs usually took many years to set up. Under the open-tender contracts awarded, the home operators are allowed to provide a certain ratio of non-subsidised places in the RCHEs (Note 21). Since 2009, the SWD has generally adopted a ratio of

Note 20: *For example, the estimated construction cost of a contract RCHE with 100 RCS places and 20 day care places in Kwun Tong was \$65 million.*

Note 21: *Operators for contract RCHEs need to seek approval of the SWD on the fees to be charged, or for any revisions thereof, on the non-subsidised RCS places they provide.*

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“6:4” for newly-built contract RCHEs for their subsidised and non-subsidised places provided. As at end-June 2014, ten contract RCHEs were operating at a ratio of “6:4”. Audit however found that the contract RCHEs which had been in full year operation in 2013-14 had in total 95 (9%) vacant non-subsidised places (with one to 19 vacant places in each of the contract RCHEs). This indicates that there might be spare capacity in some of the contract RCHEs. However, in practice, the SWD only adjusted the ratio of subsidised places to non-subsidised places on contract extensions/renewals (which did not occur frequently). In view of the growing demand for subsidised LTC services and given the high capital cost for setting up a contract RCHE, there is a need for the SWD to take measures to secure the optimum use of the places (subsidised and non-subsidised) of each contract RCHE, including exploring the feasibility of incorporating suitable flexibility in future tenders/contracts on the ratio of subsidised to non-subsidised places; and

(b) ***Target numbers of EBPS and NHPPS places to be purchased not achieved/sustained:***

- (i) In the ten years to end-March 2014, the SWD had substantially completed six rounds of EBPS purchase targeting to purchase a total of 2 290 to 2 390 places to supplement the original 5 840 EBPS places as at end-March 2003. However, by end-March 2014, there was only a net addition of 1 820 EBPS places (76% to 79% of the target). According to the SWD’s records, over the years, there were cases when the home operators had ceased to operate or decided to withdraw from the EBPS. The SWD had also reduced the number of places purchased from several operators as a means of sanction for operators not complying with conditions in the EBPS purchase agreements. Furthermore, in the more recent rounds of purchases, a few operators applying for participating in the EBPS did not accept the SWD’s offer even after their applications had been approved;

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- (ii) the same applied to the NHPPS which was launched in 2010. Although the SWD intended to purchase from some 40 self-financing RCHEs (see para. 4.2(e)) a total of 380 NH places which would come in service by 2011-12, it transpired that the SWD could only purchase a total of 161 NH places (42% of 380) from four self-financing RCHEs. Audit however noted that the overall enrolment rate for non-subsidised places in these 40 RCHEs was only around 75% as at end-March 2014, indicating that there was still scope for the SWD to purchase additional NH places from them; and

- (iii) the “50% cap” requirement set by the SWD since 2003 (Note 22) on the number of EBPS places to be purchased from individual RCHEs may also call for review because there were occasions when the RCHEs had vacant non-subsidised places, but the SWD could not purchase additional EBPS places from the RCHEs concerned because of the “50% cap” requirement, despite that there were demands for such subsidised places in the RCHEs concerned (paras. 4.19(c) and 4.20(c) are both relevant).

2.27 Although the Administration had made great efforts to increase the number of subsidised RCS places and to improve their service quality, Audit has however noted that it took a long time to achieve results and the results were not always apparent. Given the ageing population and the growing demand for subsidised LTC services, the marginal increase in the total number of subsidised RCS places provided as reported in paragraph 2.24 is a cause for concern. Although the elderly are encouraged to age in place, some frail ones still need institutional care for health or family reasons. Therefore, it remains a challenge for the Government to cope with the growing demand. More recently, a Special Scheme on privately owned sites for welfare uses was launched (see para. 1.15). According to the Administration, if all proposals received from welfare NGOs under the Special Scheme for in-situ expansion and redevelopment of land they owned could be implemented smoothly, a substantial number of additional elderly service places would be provided. However, the Scheme would take some time to develop and there are challenges ahead in its implementation (see para. 5.6).

Note 22: *Before 2003, the SWD would purchase up to 70% of the EBPS places from individual RCHEs. According to the SWD, the reduction of the capping percentage of purchased places from 70% to 50% since 2003 aimed to allow more private RCHEs to participate in EBPS, which helped enhance the quality of the RCHEs in the private sector.*

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2.28 With the long waiting list and waiting time for subsidised RCS places and with the constraints faced by the Government in increasing the supply, Audit has however noted that RCHEs in the private sector which are providing the bulk of the RCS places (see para. 4.2(c) and (d)) have an overall vacancy rate of 26% (Note 23) for their non-subsidised places. It appears that there may possibly be spare capacity in these RCHEs. In this connection, the Government's initiative of issuing RCS vouchers as stated in the 2014 Policy Address (see para. 2.23) may be a way in future to allow the elderly to choose for living in self-financing and private RCHEs which provide non-subsidised places that operate up to a standard to the satisfaction of the SWD.

Need to maximise the effective use of limited subsidised RCS places available (para. 2.1(c))

2.29 Given the substantial Government resources spent on the provision of LTC services each year, coupled with the growing service demand and the constraints faced by the Government in bringing forth more rapid expansion of the RCS capacity, the Administration should make good efforts to maximise the optimum use of the limited subsidised places available, as each subsidised RCS place cost the Government \$7,900 to \$15,600 a month (see para. 2.9). Taking the 26 000 subsidised RCS places currently available, Audit has found the following inadequacies in the provision, allocation and monitoring of the limited RCS places:

- (a) purchase and allocation of EBPS places (paras. 2.30 and 2.31);
- (b) allocation, matching and admission of RCS places (paras. 2.32 to 2.36);
- (c) management of agency quota places (paras. 2.37 to 2.50); and
- (d) utilisation of subsidised infirmary unit places (paras. 2.51 to 2.60).

Note 23: *The vacancy rate for non-subsidised places of an RCHE is calculated by deducting from its licensing capacity (for private RCHEs not participating in the EBPS)/actual capacity (for private RCHEs participating in the EBPS) the number of subsidised places (if any) and the number of residents residing in non-subsidised places of the RCHE.*

Purchase and allocation of EBPS places (para. 2.29(a))

2.30 As at end-March 2014, 30% of the subsidised RCS places were provided by RCHEs participating in the EBPS. Each year, the SWD spent substantial resources on the purchase scheme. For example, in 2013-14, the SWD spent \$673 million on the purchase of EBPS places. Audit however noted that:

- (a) among 121 RCHEs participating in the EBPS as at end-March 2014 (excluding 14 RCHEs which had involved place purchase and case intake by phases in 2013-14), 39 (32% of 121) RCHEs could not achieve the 92% enrolment rate set by the SWD (see para. 4.19(a)). Among them, 13 RCHEs had relatively low enrolment rates, with ten of them having an average enrolment rate between 50% and 80%, and three below 50%. On average, some 550 to 590 of 7 660 EBPS places had remained vacant in 2012-13 and 2013-14; and

- (b) the SWD had introduced a place reduction mechanism since April 2012 by reducing the number of EBPS places to be purchased in the renewal of the purchase agreement if an RCHE had not achieved an average enrolment rate of 92% in its previous agreement period (Note 24). According to the SWD, resources so released could be directed to purchase of places from RCHEs with higher demand. Of the 39 RCHEs which had failed to achieve the 92% enrolment rate set by the SWD, 25 RCHEs were subject to EBPS place reductions in their 2014-16 purchase agreements. However, for the 25 RCHEs, some 140 vacant EBPS places were still found in the first three months of their renewed agreements (April to June 2014) and with 11 of the 25 RCHEs still having an enrolment rate below 90%.

2.31 According to the SWD, the objective of the EBPS is to upgrade the service standard of private RCHEs and to reduce the elderly's waiting time for subsidised C&A places. The EBPS places have remained essential to meet the RCS needs of those on the CWL. Nonetheless, it can be seen that although the EBPS has helped increase substantially the number of subsidised RCS places provided by the

Note 24: *The place reduction mechanism did not apply to RCHEs which joined the EBPS after April 2012 and RCHEs with additional EBPS places purchased after April 2012.*

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Government, there is however scope for optimising the use of the EBPS places. This will be examined in more detail in PART 4.

Allocation, matching and admission of RCS places (para. 2.29(b))

2.32 As mentioned earlier, in 2013-14, each RCS place cost the Government \$7,900 to \$15,600 a month, i.e. some \$260 to \$520 per day for a place. To ensure optimum use of the RCS places, the SWD has required an RCHE to meet a target yearly enrolment rate ranging from 92% to 97% (which is to be calculated on the end day of each month). To facilitate the CWL matching and placement allocation, the SWD has also set up a “small pool” mechanism which aims to ensure that eligible applicants are placed to a matched RCHE promptly once vacancies are expected to be available soon (see Steps (j) to (l) at Appendix B). If a matched applicant has accepted an offer of a particular RCHE place, the LDS Office will arrange for his/her placement admission once the vacancy is available. In addition, the SWD has laid down in its Manual the lead time allowed for different stages of processing, e.g. two working days allowed for an RCHE to notify the SWD of the discharge of an elderly resident and six weeks allowed for an RW to confirm an elderly’s acceptance of a call for admission to RCS small pool.

2.33 RCHE residents will be discharged from the LTC services under the following circumstances:

- (a) self-withdrawal of the elderly resident;
- (b) when an elderly resident’s health conditions has improved and he/she is no longer eligible for or in need of RCS;
- (c) the elderly resident has been transferred to other services with his/her consent or that of his/her designates; or
- (d) death of the elderly resident.

According to the SWD Manual, when an RCHE resident has been discharged from LTC services, the RCHE concerned should inform the LDS Office of the SWD within 2 working days after the discharge. After matching of placement against the CWL, the LDS Office will issue a placement referral to the RCHE concerned which

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should contact the elderly as soon as possible and arrange for his/her admission within 3 weeks.

2.34 From an examination of the SWD records, Audit notes the following inefficiency and wastage in the allocation of, and admission to, subsidised RCS places which call for improvement:

- (a) ***Late reporting of discharge cases by RCHEs:*** Although the RCHEs are required under the SWD Manual to inform the SWD within 2 working days of the discharge of an elderly resident, an analysis of some 300 ordinary discharge cases reported by RCHEs to the LDS Office with admission placements effected in April 2014 identified many cases which had not complied with the “2 working days” requirement. Some 50 discharge cases were reported, without explanations given, more than 7 days after the discharge, with 11 cases reported more than one month after the discharge. Among these 11 cases, in one extreme case, the SWD was notified almost two years after the discharge. There was however no evidence indicating that the SWD had taken any follow-up actions (e.g. seeking explanations and/or issuing advisory letters) on the RCHEs’ belated reporting of the discharge;

- (b) ***No time pledge set for SWD placement referrals:*** As mentioned earlier, the SWD has operated a “small pool” mechanism to facilitate the CWL matching and placement allocation. The applicant should have given, during the “small pool” screening (Note 25), his/her consent for admission and have possessed valid assessment results. Once the SWD receives a vacancy notification from an RCHE, it will arrange for referring an applicant to fill the vacancy (i.e. placement referral). In the absence of any performance pledge on the processing time allowed for placement referral, Audit examined all 174 placement referrals made by the SWD to subvented and contract RCHEs in April 2014 and found that 42 (24% of 174) placement referrals were made more than one week, with seven of them made more than one month after receiving the vacancy notifications. On enquiry with staff of the LDS Office, Audit

Note 25: *During the “small pool” screening, an applicant may choose not to accept a matched offer and will be removed from the “small pool”. If he/she has met certain circumstances as defined in the SWD Manual, he/she is allowed to continue to be waitlisted under the CWL (see Step (l) at Appendix B).*

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was informed that earlier placement admissions could not be made very often because of the time taken to await the results of pre-admission re-assessment (Note 26);

- (c) ***Delay in admissions of applicants by RCHEs:*** As mentioned in paragraph 2.33, once the SWD has made a placement referral, an RCHE is expected to contact the elderly as soon as possible and arrange for his/her admission within 3 weeks. An analysis of the admission cases reported by the RCHEs, as captured in the LDS computer system, revealed that 29% (1 353 out of 4 666 admission cases handled for the 12 months to June 2014) were admitted to services more than one month after the SWD's placement referral, with 89 cases admitted two to six months thereafter:

Time for admission	No. of admission cases
> 2 months to 3 months	81
> 3 months to 4 months	4
> 4 months to 5 months	3
> 5 months to 6 months	1 (involving a time lag of 177 days)
Total	89

Again, there was no evidence indicating that the SWD had taken any follow-up actions (e.g. seeking explanations and/or issuing advisory letters) on the late admission of the cases;

- (d) ***Late reporting of temporary discharge cases by RCHEs:*** According to the SWD Manual, an RCHE should discharge an elderly resident on a temporary basis when: (i) he/she has been hospitalised for 2 or more months and no foreseeable discharge date can be fixed; or (ii) he/she is away from Hong Kong for one or more months and has no definite return date. Under the circumstances, the RCHE needs to notify the LDS Office to arrange for admission placement and, again, when the date of return for the temporarily discharged elderly is confirmed for re-admission.

Note 26: *As mentioned in paragraph 2.3, assessment results are only valid for 12 months and because of the long waiting time, re-assessment is required. Besides, the SWD had accumulated a backlog of cases awaiting assessment (see para. 2.18(d)(iii)).*

Audit examined all 38 notifications of temporary discharge received by the LDS Office between January and July 2014, and found that many notifications were submitted late by the RCHEs, including 11 (29% of 38) notifications received by LDS Office some 2.5 to 10 months after the temporary discharge, with no explanations given. Among these 11 late notifications of temporary discharge cases, except for one case which was related to an elderly resident who was away from Hong Kong (and was reported after the lapse of five months), all the other 10 cases were related to hospitalisation of the elderly residents. There was however no evidence indicating that the SWD had taken any follow-up actions (e.g. seeking explanations and/or issuing advisory letters) on the late notification of the temporary discharge cases; and

- (e) ***Lack of laid-down procedures for handling late reporting of RCS vacancies and reliance on an honour system for reporting RCS vacancies:*** Vacancies may arise from discharge of service users, from newly purchased places, or from additional places created as a result of in-situ expansion of the RCHE. The SWD Manual has however not laid down the procedures for handling late reporting of vacancies as well as the follow-up actions to be taken. Besides, the SWD does not maintain a proper system to keep track of the utilisation of the subsidised RCS places provided by individual RCHEs. Although RCHEs providing subsidised RCS places are required to achieve a yearly enrolment rate (e.g. 95% for subvented RCHEs), the SWD relies on the RCHEs to report accurately and timely any RCS vacancies arising. Proper checks and balances have not been put in place to ensure no non-reporting of vacancies.

2.35 As mentioned earlier, the number of subsidised RCS places is limited and such places are costly to the Government. The “small pool” mechanism, together with the target enrolment rates set by the SWD for individual RCHEs, help optimise the use of the subsidised RCS places. However, as reported in paragraph 2.34(a) to (d), Audit has found occasions when the SWD had taken longer time to arrange for admission placement while the RCHEs had also taken longer time to report vacancies and to arrange for the admission of applicants. The situation calls for improvement. In particular, the SWD needs to explore how the procedures for allocation, matching and admission of the limited RCS places can be fine-tuned to minimise the lead time, including the incorporation of appropriate checks and balances to facilitate more effective monitoring.

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2.36 In response to Audit’s enquiries, the SWD informed Audit in October 2014 that it would implement the following measures, starting from November 2014, to improve the current situation:

- (a) issuing notifications to the RCHEs, reminding them to timely report the discharge and temporary discharge of elderly residents to the LDS Office in accordance with the timeframe stipulated in the SWD Manual;
- (b) putting in place an acknowledgement system to ensure that the LDS Office has received the discharge notifications from the RCHEs for timely referral of cases for admission;
- (c) demanding for written explanations from relevant parties on overdue replies and belated notifications on discharge of residents for study of areas for improvement;
- (d) organising sharing sessions for relevant parties to facilitate their compliance in completing the admission procedures within the timeframe stipulated in the SWD Manual; and
- (e) putting in place a bring-up system as well as incorporating appropriate check-and-balance functions to facilitate more effective monitoring in the coming redevelopment of the LDS computer system.

Management of agency quota places (para. 2.29(c))

2.37 As mentioned in paragraph 1.8, the SWD has implemented the CWL since 2003 to centralise under its control all applications for subsidised LTC services. This streamlines the application and placement procedures, and avoids the need for the elderly to approach different organisations to apply and waitlist for different services. It also facilitates effective service planning and resource management. Audit has however found that among the 26 000 subsidised RCS places available as at June 2014, 1 812 subsidised RCS places were managed and allocated by the NGOs outside the CWL (Note 27). It involved 30 NGOs operating

Note 27: *The number of 1 812 “agency quota” places had not included another 230 H/A places which were occupied as at end-June 2014 by residents admitted under AQ and would be deleted after completion of the conversion programme mentioned in paragraph 2.25.*

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74 subvented RCHEs. These 1 812 places, representing 11% of the 16 460 subsidised RCS places provided by the subvented RCHEs, are known as “agency quota” (AQ) places.

2.38 Whilst these 1 812 AQ places are 100% subsidised by the Government at some \$25.5 million a month (Note 28), NGOs are given full autonomy to decide when to accept/register applications for admission to such AQ places, so long as the elderly taking up the AQ places have been subject to the care need assessment under the SWD assessment mechanism. That is, only elderly found suitable for admission to RCS under the SWD assessment mechanism are allowed to take up the AQ places.

2.39 *Historical developments leading to the provision of AQ places to NGOs.* According to the SWD records, in the early days, RCHEs were operated by NGOs largely using their own resources. Placement admissions were then solely allocated by the NGOs. With gradual expansion of RCS for the elderly, the SWD took over the full funding responsibility for most of these RCHEs. Gradually, the SWD was approached by a large number of elderly people for admission to RCHEs, and subvented RCHEs were asked to admit cases from the SWD’s waiting list (now known as the CWL). The NGOs operating these subvented RCHEs were also allocated separate quota, termed “AQ”, for admitting their own cases (Note 29). The AQ arrangement was generally laid down as follows:

- (a) it was stipulated as a private treaty grant (PTG) condition for RCHEs that a minimum of 80% of the RCHE capacity would be reserved for applicants to be nominated by the SWD (“80% SWD quota”)(Note 30);
or

Note 28: *Based on the SWD Controlling Officer’s Report for 2014-15, it cost the Government \$14,100 a month for a subsidised C&A place in a subvented RCHE. The cost of 1 812 AQ places was \$25.5 million ($\$14,100 \times 1\,812$) a month.*

Note 29: *In October 2014, the SWD informed Audit that the provision of AQs to NGOs was a historical arrangement and served as an acknowledgement of the financial contribution of NGOs to the capital cost for setting up the RCHEs at that time.*

Note 30: *According to the Lands Administration Office Instruction (issued before 1998) which governed PTGs for RCHEs, although a special condition was set for a minimum of 80% of the home capacity to be reserved for nomination by the SWD, it was also stated that the reserved places might not always be taken up.*

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- (b) for RCHEs located in public housing estates, the AQ was agreed in correspondence between the SWD and the NGOs which had successfully bid for hiring the Housing Authority premises for operating RCHEs.

2.40 To encourage NGOs to build and operate RCHEs, the Administration sometimes provided them with land on PTGs. The NGOs could also apply for grants from LF to defray part of the building and other capital costs of setting up the RCHEs. However, the SWD had also made it clear in its correspondence with the NGOs that the SWD quota would not automatically commit the NGOs to any subventions or LF capital grants for the operation of the RCHE. The SWD emphasised in its correspondence with the NGOs that separate application for LF grants and/or other types of SWD subventions should be made as and when appropriate and would be considered on their own merits. The provision of AQ places and the funding of such places are therefore two separate issues, and this was further confirmed in the legal advice obtained by the SWD on two occasions (Note 31). Thus the SWD had no obligation to grant or continue to grant subvention for the AQ places, and taking back the subvention for the AQ places would not constitute a breach of the PTG. The same applied to the AQ places granted to NGOs for RCHEs located in public housing estates.

2.41 *ICAC review in 2005.* In an assignment review conducted in June 2005, the ICAC had expressed concerns on the risks in the admission procedures for the AQ places, particularly concerns about possible abuse in making priority placements and manipulating the waiting lists. In that review, the ICAC found that there were 3 165 AQ places and the waiting time in 2004 for the latest placement of AQ places for six (out of nine) NGOs it visited was less than one year (Note 32), with only one visited NGO having opened up its AQ places to members of the public. The ICAC made recommendations to the SWD to step up the controls, including the need for the NGOs to adopt the SWD assessment mechanism to process applications for admission to the AQ places.

Note 31: *The SWD sought legal advice in 2001 on the allocation of AQ places and again in 2004 on the deletion of the AQ places previously granted to H/As and S/C hostels (see para. 2.44).*

Note 32: *It seems that this compared favourably with the average waiting time in 2004-05 of 30 months for C&A places for applicants then on the CWL.*

2.42 Following the ICAC assignment review, the SWD issued guidelines in June 2006 for NGOs with AQ places to follow. According to the SWD guidelines (which are still in force), each NGO may set the admission criteria with reference to its mission, vision, values and service strategies. While some NGOs may open up their AQ places to the elderly of the public, some may continue to admit cases referred by directors or donors, family members or relatives of staff, members of service units of the agency and elderly with the same religion as the agency, on the basis of admission criteria laid down by the NGOs.

2.43 In line with the SWD guidelines, effective since April 2008, each NGO is required to submit yearly a standard agency-based “Self-assessment Form” to the SWD to confirm compliance with its operational manual for allocation of the AQ places in the preceding financial year and state the action plan to be taken for any non-compliance and specify the timeframe for completing the actions. In other words, the SWD has adopted an honour reporting system (Note 33) and relies largely on the NGOs’ own governance to manage the AQ places.

2.44 *Conversion of H/A and S/C hostel places into C&A places providing CoC.* With the phasing out of H/A and S/C hostel places since 2005 (see para. 2.25), Aqs previously accorded to NGOs for these places had ceased to exist once the RCHEs kick-started conversion under the conversion programme. During the conversion programme, the SWD had also encouraged RCHEs participating in the conversion to return all or part of their C&A places under the AQ to the SWD for allocation to elderly on the CWL. With the cessation of AQ places previously accorded to H/As and S/C hostels, coupled with the voluntary return of some AQ places by a few subvented RCHEs, as at June 2014, there were 1 812 AQ places available.

Note 33: *Other than the annual reporting requirement, NGOs are not required to submit to the SWD copies of their operational manuals, including information on their admission criteria, criteria for priority placement, waitlisting and monitoring mechanisms adopted for the allocation of AQ places.*

Audit findings

2.45 *The appropriateness of granting AQ places outside the CWL with full subsidy.* The introduction of the CWL since 2003 has provided a single-entry point for the elderly to apply for subsidised LTC services. As mentioned earlier, the number of subsidised RCS places is limited and there is always a long waiting list on the CWL. The fact that the SWD has allowed some 1 800 subsidised RCS places to be allocated outside the CWL and beyond its control may have undermined the central mechanism adopted for the allocation of RCS places.

2.46 Because the AQ allocations are managed by the NGOs/RCHes concerned and are separate from the CWL, some elderly waiting on the CWL may approach different RCHes to queue up for AQ allocations. There are even RCHes which have set the requirement that an applicant applying for their AQ allocations must at the same time apply for LTC services under the CWL of the SWD. The allocation of AQ places outside the CWL might provide an added advantage to some applicants who applied for AQ places more recently, but might have been admitted RCS places ahead of other needy elderly still on the CWL (Note 34). This may provide opportunities for inequitable allocations. Audit research of the websites of selected NGOs with quite a large number of AQ places for their RCHes further found that many of the NGOs had not posted information on the availability of AQ or their latest turn of placement for AQ places onto their websites.

2.47 Audit examined copies of all 29 AQ admission forms received by the SWD in April 2014 from different NGOs. It was found that the majority (72% or 21 cases) of the elderly involved in these 29 AQ admissions were also on the CWL of the SWD. This is not in line with the Government's LTC policy of centralising all applications for subsidised LTC services under the CWL. According to the SWD guidelines, NGOs with AQ places are allowed to lay down their own admission criteria and waitlisting mechanism (see para. 2.42).

Note 34: *As mentioned in paragraph 2.3, the allocation of care services for the elderly on the CWL is on a first-come-first-served basis determined according to the applicants' LTC dates and their preferences.*

Growing demand for subsidised long-term care services

2.48 *Commitment made to LegCo FC in 1995.* As early as March 1995, the Administration informed the LegCo FC (Note 35) that the Government would play an active role in monitoring the admission of elderly people into RCHEs and NGOs which operated the subvented RCHEs would not be given any discretion to admit applicants other than those on the waiting list managed by the SWD. However, Audit noted that the Administration had still granted AQs, without keeping LegCo informed, to 25 subvented RCHEs (Note 36) which were planned before 1995 but commenced operation between 1995 and 2002. As at June 2014, they together were providing 607 (33% of 1 812) AQ places. Although the Administration has ceased granting AQs for subvented RCHEs planned after 1995, it had continued allowing all RCHEs already granted with AQs to allocate their AQ places outside the CWL (see para. 2.37).

2.49 *Under-utilisation of AQ places.* As mentioned in paragraph 2.38, as at June 2014, 1 812 AQ places were allocated by NGOs outside the CWL, but they were fully subsidised by the Government. According to the SWD records, Audit noted that as at June 2014, among the 1 812 AQ places available:

- Only 1 275 (70%) of the 1 812 AQ places were successfully allocated by the NGOs themselves (with AQ enrolment rates for individual RCHEs ranging from 17% to 100%).
- Another 344 (19%) AQ places had been informally “loaned” to the SWD for taking up applicants on the CWL on a one-off basis (Note).
- The remaining 193 (11%) AQ places were not utilised.

Note: These subvented RCHEs are required under the Funding and Service Agreements they entered with the Government to keep an overall enrolment rate of not less than 95% within one year for their subvented places, including AQ places. There were occasions when the RCHEs requested for referrals from the CWL to fill some of their vacant AQ places, in order to meet the agreed 95% enrolment rate.

Note 35: Approval was then sought for a grant of \$83.8 million from LF to one NGO (which had committed to shoulder 20% of the total project cost) for setting up a new NH for the elderly.

Note 36: The 25 subvented RCHEs included six NHs. AQ places were granted to these NHs on a one-off basis at the commencement of their operation in 1998 and 1999, but were phased out upon discharge of residents occupying these places.

Growing demand for subsidised long-term care services

Audit further noted that some RCHEs had, in particular, a relatively high percentage of vacant AQ places even after the one-off deployment of AQ places to the CWL. Three examples are shown in Table 1:

Table 1
SWD quota and agency quota places in three subvented RCHEs
(end-June 2014)

RCHE	Subsidised RCS places					
	SWD quota		Agency quota (AQ)			
	No. of places (a)	No. enrolled under CWL (b) (% of (a))	No. of places (c)	No. enrolled		
				No. allocated by RCHEs (d) (% of (c))	No. loaned to SWD on a one-off basis (e) (% of (c))	Total (f) = (d) + (e) (% of (c))
1	130	130 (100%)	25	7 (28%)	10 (40%)	17 (68%)
2	154	154 (100%)	36	18 (50%)	8 (22%)	26 (72%)
3	97	95 (98%)	20	8 (40%)	5 (25%)	13 (65%)

Source: SWD records

It can be seen from Table 1 that the three subvented RCHEs had achieved enrolment rates of 100%, 100% and 98% for their SWD quota places. However, the enrolment rates for their AQ places could be as low as 28%, 50% and 40% respectively if they had not loaned some of their AQ places to the SWD. In fact, in the past few years, some of the subvented RCHEs (including the above three RCHEs) reported to the SWD that they had failed to achieve the agreed 95% yearly enrolment rate, as stipulated in the Funding and Service Agreements (FSAs), for their subvented RCS places (i.e. SWD quota places plus AQ places), with one of the reasons being the under-enrolment of their AQ places.

Growing demand for subsidised long-term care services

2.50 The 193 AQ places still left unfilled as at end-June 2014 involved wastage of recurrent Government subvention of \$2.7 million a month (\$14,100 × 193 — see Note 28 to para. 2.38). Given the acute shortfall of subsidised RCS places the Government is facing, the situation is far from satisfactory. Audit considers that the SWD needs to approach the NGOs more proactively to request the latter to deploy their unfilled AQ places to the CWL and critically review the possibility of clawing back the AQ places for central allocation under the CWL, taking into consideration the following:

- (a) the growing demand for, and the acute shortfall of, subsidised RCS places the Government is facing today and the 100% subvention provided for the AQ places;
- (b) the admission of elderly by NGOs outside the CWL may provide opportunities for inequitable allocations (see para. 2.46);
- (c) the commitment made by the Administration to the LegCo FC in March 1995 that NGOs operating subvented RCHEs would not be given any discretion to admit applicants other than those on the waiting list managed by the SWD, i.e. the CWL now in operation (see para. 2.48);
- (d) the legal advice obtained by the SWD that the latter had no obligation under the PTG to grant or continue to grant subvention for the AQ places, and taking back the AQ subvention would not constitute a breach of the PTG or the AQ commitment as agreed with the NGOs in correspondence (see para. 2.40); and
- (e) the enrolment rate of 70% for AQ places allocated by NGOs themselves as a whole, as compared with the overall target 95% yearly enrolment rate set for these subvented RCHEs (see para. 2.49).

In response, the SWD has agreed to monitor the utilisation of the AQ places closely and will request the NGOs to deploy their unfilled AQ places to the CWL. It will also review critically the possibility of clawing back the AQ places for central allocation under the CWL (see para. 5.11(m)).

Utilisation of subsidised infirmary unit places (para. 2.29(d))

2.51 As at end-June 2014, 19 subvented RCHEs were running 29 infirmary units (IUs) providing a total of 580 IU places (included as subsidised C&A places in paras. 4.2 and 4.3). The cost to the Government for these 580 IU places amounted to some \$52 million in 2013-14.

2.52 RCHEs have been taking care of infirm elderly while the latter are waiting for infirmary placement in public hospitals (Notes 37 and 38). Since 1986, IUs have been established in various subvented RCHEs with additional nursing staff provision to take care of elderly residents who have become so frail as to require infirmary care while staying in the RCHEs. According to the Administration, providing infirmary care services for medically-stable infirm elderly in a non-hospital setting will ensure that hospital-based infirmary care services are targeted for patients most in need, including elderly patients, in the long term. It will also help increase the supply of and shorten the waiting time for infirmary care places for the frail elderly.

2.53 To enhance support, the Administration has also introduced since 1996 the provision of infirmary care supplement (ICS) to RCHEs to enable them to use the supplements to employ additional staff to enhance the care for needy elderly staying in subsidised RCS places. In 2013-14, the amount of ICS was \$70,539 per case a year. In the same year, a total of \$95 million had been paid to 88 subvented RCHEs and 37 private RCHEs participating in the EBPS. Due to limited resources, ICS was allocated to RCHEs, under a quota system, in proportion to their numbers of eligible elderly as confirmed by the HA every year (Note 39).

Note 37: *The HA provides general infirmary services to elderly whose health conditions require long-term medical care in hospital setting which are beyond the level of care provided in welfare (i.e. non-hospital) setting. Applicants have to be assessed by the HA Community Geriatric Assessment Teams before eligible ones are put on the Central Infirmary Waiting List for placement in infirmary beds of HA hospitals.*

Note 38: *As at March 2014, the number of HA infirmary beds available for eligible applicants on the Central Infirmary Waiting List was 1 234, but there were 2 400 applicants waiting. As informed by the HA, in 2013-14, the average waiting time for admission to these places was 27 months and some 800 eligible applicants on the waiting list passed away while waiting.*

Note 39: *The eligibility of elderly for ICS has to be assessed by the Community Geriatric Assessment Teams of the HA.*

Audit findings

2.54 As mentioned earlier, there were only 580 IU places. On one hand, Audit has found that 62 (11% of 580) IU places had, on average, been vacant for at least five years, with the vacancy particularly high for five RCHEs. Each of the five RCHEs had 4 to 14 vacant IU places, representing 22% to 53% of their IU capacity.

2.55 On the other hand, Audit noted that as at end-August 2014, some 1 290 applicants awaiting RCS places on the CWL had been assessed as in need of care at “Beyond NH”. In view of the limited IU places available and given the long waiting list of infirm elderly on the CWL, the fact that 11% of the 580 IU places were continuously unoccupied calls for review.

2.56 The high vacancy of IU places in five RCHEs (see para. 2.54) could be due to the restrictive eligibility criteria set by the SWD for admission to IU places, as follows:

- (a) the infirm elderly must be existing residents of the subvented RCHEs or have taken up EBPS places in private RCHEs;
- (b) they must have been certified by the Community Geriatric Assessment Teams of the HA to be in a condition requiring infirmary placement; and
- (c) they must not have been registered for ICS (see para. 2.53).

2.57 The SWD informed Audit that the setting up of IUs in subvented RCHEs was a stop-gap measure to tackle the acute demand for infirmary places until there was an adequate supply of infirmary places. The SWD also informed Audit that residents already registered for ICS were not entitled to take up IU places in order to avoid double subsidy. Furthermore, the LWB informed Audit that the provision of IU places is part of the CoC policy and not a substitute for direct admission of elderly awaiting NH places in the CWL.

Growing demand for subsidised long-term care services

2.58 Audit further found that elderly awaiting NH places could not be directly accepted to take up the IU places because all 19 RCHEs with IUs had not been registered with the Department of Health (DH) which regulates the infirmary care services under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (see Note 7 to para. 1.16 and Note 40). Most of the elderly currently taking up the IU places are residents previously occupying subsidised C&A places in the 19 subvented RCHEs, but their health conditions have deteriorated to the extent that they are found to be in need of infirmary care as assessed by the HA.

2.59 The provision of infirmary care services for medically stable infirm elderly in a non-hospital setting is a good initiative. It serves as a stop-gap measure and helps relieve the demand for hospital-based infirmary care services. However, there are indications that the initiative had not been effectively implemented. Audit considers that the SWD needs to review, in close collaboration with the LWB and DH, and fine-tune the existing arrangement.

2.60 As early as 2004, the SWD informed LegCo that it would launch a trial scheme to provide subsidised infirmary care services for medically stable frail elderly in purpose-built RCHE premises. However, taking into account the opinion of the welfare sector, the Administration considered that upgrading some of the places in existing subvented RCHEs to provide infirmary care services might be more cost-effective. As a result, the trial scheme was kept on hold. However, the SWD had not yet reported back to LegCo the development on this matter and the implementation of the scheme was still included as an outstanding item to be followed up by the LegCo Panel on Welfare Services.

Note 40: *As explained by the SWD, the welfare sector had indicated that they were not able to employ adequate nurses to fulfil the DH's requirements for registration under the Cap. 165 Ordinance.*

PART 3: COMMUNITY CARE SERVICES

3.1 This PART examines in more detail the provision of CCS by the SWD.

Community care services provided for the elderly

3.2 The Government provides a wide range of subsidised CCS to assist the elderly to age in the community. These services are essentially operated by NGOs with subventions or service fees from the Government. For CCS (Note 41), they are mainly provided by day care centres/units (for centre-based services) or at the elderly's homes by the respective services teams (for home-based services):

Centre-based services

- (a) *Day care centres/units.* They serve elderly who have been assessed as being in a state of either moderate or severe level of impairment by the SWD assessment mechanism and are suitable for day care services. These centres/units provide personal care, nursing care, rehabilitation exercises and social activities for frail elderly (Note 42);

Home-based services

- (b) *Enhanced Home and Community Care Services (EHCCS) and Integrated Home Care Services (IHCS)(Frail Cases).* Both EHCCS and IHCS provide a comprehensive package of services for frail elderly, including care management, basic and special nursing care, personal care, rehabilitation exercises, counselling services, 24-hour emergency services, day respite services, home-making services, meal delivery services, escort

Note 41: *Besides CCS, the SWD also finances NGOs for operating 211 elderly centres, including district elderly community centres, neighbourhood elderly centres and social centres for the elderly, for providing community support services for the elderly and their carers at district and neighbourhood levels.*

Note 42: *The services provided by a day care centre and a day care unit are largely the same, except that usually the former is a stand-alone service unit while the latter is attached to an RCHE or a district elderly community centre.*

Community care services

services and support services to the carer. Similar to day care centres/units, elderly have to be assessed as being in the state of either moderate or severe level of impairment by the SWD assessment mechanism in order to be eligible for the services; and

- (c) ***IHCS (Ordinary Cases)***. It serves elderly who suffers from no or mild level of impairment and does not form part of the Government's subsidised LTC services. Unlike the above-mentioned services, elderly are not required to be assessed by the assessment mechanism. IHCS (Ordinary Cases) cover personal care, simple nursing care, meal delivery services, escort services and household cleaning. The NGOs which operate this service keep their own waiting lists for the ordinary cases.

3.3 As at end-March 2014, the numbers of day care centres/units and home care service teams, and the numbers of subsidised places they provided under CCS are shown below:

Service	No. of day care centres/units or home care teams	No. of subsidised places provided
Day care	67	2 750
EHCCS	24	5 580
IHCS (Note)	60	1 120 (for frail elderly)

Source: SWD records

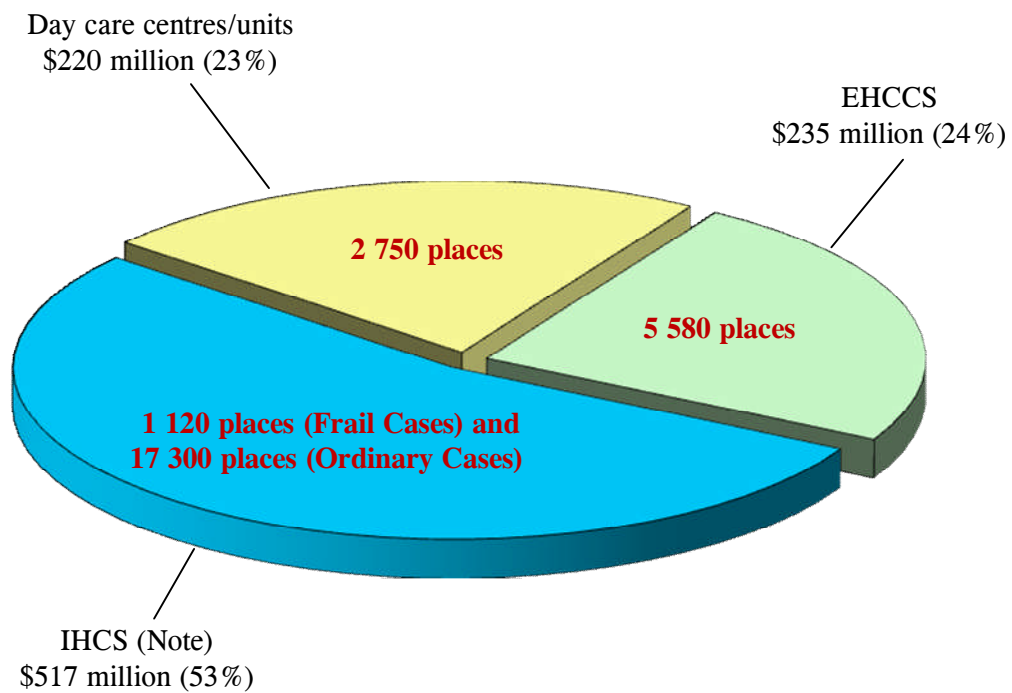
Note: Each IHCS team serves both frail and ordinary cases. There is no service capacity for IHCS (Ordinary Cases). Elderly of ordinary cases need not be assessed by the SWD assessment mechanism. The NGOs support about 23,000 elder ordinary cases each year.

3.4 It is the Government's policy to encourage the elderly to age in place (see para. 1.4(a)). According to the Elderly Commission, effective CCS can encourage the elderly to age in place and avoid premature and unnecessary institutionalisation (see para. 2.5). In a 2011 study report on CCS commissioned by the Elderly Commission, it stated that effective CCS could reduce or delay institutionalisation, improve the physical functions of elderly service users and reduce the decline in cognitive status. It was also commented in a study report on RCS of 2009 that there

had been a tendency for older people (or their family members) to opt for RCS instead of CCS, which could be attributable to the inadequacy of subsidised CCS and the relative immaturity of the private CCS as compared with the subsidised market, resulting in that the older people and their family caregivers had no alternatives, but to choose RCS. Therefore, the 2009 study report recommended the promotion of CCS so as to enable the older people to remain living in their familiar community to be provided with sufficient quality service and support.

3.5 In 2013-14, the Government spent some \$970 million on the provision of subsidised CCS for the elderly. Figure 2 below shows the cost breakdown for 2013-14.

Figure 2
Expenditure on the provision of CCS
(2013-14)



Source: SWD records

Note: As at end-March 2014, IHCS (Ordinary Cases), which does not form part of the Government's subsidised LTC services, was serving 17 300 elderly with no or mild impairment and some 5 000 elderly were waiting for such services. As mentioned earlier, elderly users of IHCS (Ordinary Cases) need not be assessed by the SWD assessment mechanism.

Community care services

Government initiatives in recent years

3.6 As mentioned in paragraph 3.2, CCS is mainly provided by day care centres/units and by home-based teams under EHCCS and IHCS. In recent years, the Government has launched a number of other time-limited, but one-off schemes to supplement the existing CCS. For example:

- (a) the three-year Pilot Scheme on Home Care Services for Frail Elders (with funding amount of \$72 million) which was launched in March 2011 to provide home-based care and support services to the elderly who have been assessed as severely impaired by the assessment mechanism and are waiting for subsidised NH places. The Scheme was extended for one year to end by February 2015 and would subsume thereafter under EHCCS;
- (b) the four-year Pilot Scheme on CCS Voucher for the Elderly (Pilot CCS Voucher Scheme — see para. 3.7(b)) which involved funding amount of \$380 million for the first phase of two years. It is a new form of CCS, launched in September 2013, which aims to enable eligible elderly to choose CCS that suit their individual needs freely and flexibly through the use of vouchers; and
- (c) the District-based Trial Scheme on Carer Training, a community support scheme launched in October 2007, under which a one-off seed money of \$50,000 was provided to each participating elderly centre to partner with community organisations in selected districts to provide basic training in elderly care skills and carer services at district and neighbourhood level. The Scheme was extended to all districts since 2009 and renamed as District-based Scheme on Carer Training. In total, 119 elderly centres have participated in the Scheme (with funding amount of \$6 million). The Scheme has been regularised in 2014-15 with funding amount of some \$6.7 million per year.

Audit findings

3.7 The following audit issues are examined in this PART:

- (a) monitoring of CCS places (paras. 3.8 to 3.15);

- (b) implementation of the Pilot CCS Voucher Scheme (paras. 3.16 to 3.22); and
- (c) need for a more strategic approach to implement CCS (paras. 3.23 to 3.27).

Monitoring of CCS places

Discharge from services

3.8 According to the SWD Manual, service operators are required to inform the SWD within 2 working days after discharge of the service users. An audit analysis of the reporting of discharge cases during the 12 months from July 2013 to June 2014 shows the following results:

No. of days after discharge	No. of discharge cases reported to SWD	
	Day care services	Home care services
Within 5	1 117 (85%)	1 691 (82%)
>5 to 10	112 (8%)	278 (13%)
>10 to 20	56 (4%)	78 (4%)
>20	35 (3%) (Note)	23 (1%) (Note)
Total	1 320 (100%)	2 070 (100%)

Source: Audit analysis of SWD records

Note: For 7 cases (5 for day care services and 2 for home care services), the service operators had taken more than 60 days to report the discharge of the service users, with the longest of 230 days for day care services and 78 days for home care services.

Community care services

3.9 Whilst the majority of the discharge cases could be reported to the SWD within five days (after allowing a few grace days to the standard of two working days as stipulated in the SWD Manual), the fact that some service operators had taken more than 20 days, with seven cases taking more than 60 days, to report the discharge is far from satisfactory. The number of CCS places is limited (see para. 2.12). As mentioned in paragraph 2.6, it cost the Government about \$7,100 a month in 2013-14 for a day care service place and about \$3,700 a month for a home care service place under EHCCS. Timely reporting of discharge cases is therefore important. The SWD needs to find out the reasons for the late reporting and take action to improve the situation. In September 2014, the SWD informed Audit that it would strengthen the current mechanism to acknowledge receipt of notifications of discharge to ensure timely and accurate information on availability of places.

Admission to services

3.10 According to the SWD Manual, service operators are required to admit an elder to services normally within 7 working days after receiving a placement referral from the SWD. An audit analysis of the admissions to day care services during the 12 months from July 2013 to June 2014 shows the following results:

No. of days after SWD placement referral	No. of admissions to day care services
Within 15	831 (52%)
> 15 to 30	561 (35%)
> 30 to 60	193 (12%)
> 60	23 (1%) (with the longest of 144 days)
Total	1 608 (100%)

Source: Audit analysis of SWD records

Against the standard of 7 working days allowed for admissions, it can be seen that nearly half of the admissions were effected more than two weeks after receiving the SWD placement referrals. This indicates that there is scope for improvement.

3.11 Audit further found that as at 30 June 2014, some 148 admissions to day care services were still outstanding, i.e. SWD placement referrals had been received by the service operators but, due to one reason or another, the elderly had not yet been admitted to take up the CCS places. An ageing analysis of these 148 outstanding admissions revealed that 61 (41%) placement referrals had been outstanding for more than 15 days, as follows:

No. of days after SWD placement referral	No. of outstanding admissions to day care services
> 15 to 30	44 (72%)
> 30 to 60	11 (18%)
> 60	6 (10%) (with the longest of 164 days)
Total	61 (100%)

Source: Audit analysis of SWD records

Against the standard of 7 working days allowed for admissions, it can be seen that about 30% of the SWD placement referrals had been outstanding for more than one month, with six cases even outstanding for more than two months.

3.12 As mentioned in paragraph 2.12(b), the waiting time for day care services was long. Owing to the limited CCS places available, timely admission is important. Upon Audit's enquiries with the SWD, Audit was given the explanations that on many occasions, the elderly were not timely admitted because they and/or their relatives were difficult to contact, they had been away from Hong Kong, they were sick or had been hospitalised, and sometimes time was required to persuade them for admissions and/or to arrange for the transportation to/from centres. Audit considers that the SWD needs to explore, in close collaboration with the service operators, on how earlier admissions can be arranged. In September 2014, the SWD informed Audit that it would strengthen the current mechanism for earlier admission of new cases to fill up the vacant day care places.

Community care services

3.13 For home care services provided for the 12 months from July 2013 to June 2014, whilst the service operators could effect most of the SWD placement referrals on a timely basis, Audit still noted a few cases for which the services could not be effected after the lapse of one month.

3.14 According to the SWD Manual:

- (a) after a placement referral has been made, the SWD should issue a reminder if no reply is received from the service operator within 7 working days;
- (b) if the elderly cannot be contacted within 14 working days after placement referral, the service operators should liaise with the RWs for the elderly for clarifying his/her conditions; and
- (c) if the elderly still fails in admission, the service operators should return the relevant documents of the case, with reasons, to the SWD. If admission cannot be proceeded because the elderly is hospitalised without a proposed date of discharge, is away from Hong Kong or cannot be contacted, the SWD will suspend the case for a period of up to three months automatically. The suspended case will be closed if the RW for the elderly does not provide any further information within the 3-month suspension period.

For the long outstanding cases identified in paragraphs 3.10 and 3.11, Audit has found no evidence that the SWD had taken timely actions to follow up with the service operators on the progress of the admission cases or to suspend the cases (see Case 1 as an illustration). Given the acute shortfall of subsidised CCS places, there is a need for the SWD to step up its monitoring of the allocation and admission of CCS places, including enhancing its communication with the service operators.

Case 1

1. Audit selected a placement referral from the SWD records to ascertain its follow-up actions with a day care centre to ensure that the elderly had timely taken up the vacant place. Audit found that although the SWD referral was effected in early March 2014, the elderly only commenced using the day care services four months later, i.e. in early July 2014.

2. Firstly, the SWD sent out its placement referral by mail, but the service operator only received the referral one week later. Due to one reason or another, the service operator was only successful in arranging a meeting with the elderly in late May 2014, which was more than two months after the SWD referral. In the event, the elderly started using the day care services after the lapse of another one month and ten days, i.e. in early July 2014.

Audit comments

3. In handling this placement referral, the SWD had not timely followed up its placement referral with the service operator or with the RW for the elderly, as laid down in the SWD Manual, e.g. taking steps to ensure that the placement referral had been timely received by the service operator for action, making enquiries to ascertain the progress of the placement referral and, if necessary, suspend the case and make another placement referral.

Source: SWD records

3.15 In October 2014, the SWD informed Audit that it would improve the allocation, matching and admission of CCS places by implementing with effect from November 2014 similar measures as those to be adopted for RCS (see para. 2.36(a) to (e)). These include, among others, the issue of notifications to CCS service providers to remind them of the need to timely report discharge of service users to the SCNAMO(ES)s, and to require written explanations from them for overdue replies and belated notifications on discharge of service users.

Implementation of the Pilot CCS Voucher Scheme

3.16 The Pilot CCS Voucher Scheme was to be implemented in two phases over a period of four years. The first phase, which will last for two years, was launched in September 2013 with a \$380 million grant from LF. The Scheme adopts a “money-follows-the-user” approach and provides subsidy directly to service users (instead of service providers) in the form of service vouchers. Each voucher value is set at \$6,000 per month. Eligible elderly (Note 43) may choose the service provider, the type of service and the service package that suit their individual needs. The recognised scope of services under the Scheme is similar to that provided by the day care centres and EHCCS under the CCS.

3.17 There were 62 recognised service providers providing services to the voucher holders. They were operated by 29 NGOs and two social enterprises. Service providers can seek reimbursement of the Government subsidy for services provided on a quarterly basis.

3.18 For monitoring, the SWD has set up a review programme for conducting review visits, random checks (with or without prior notice) of service providers to audit all relevant records and files of individual voucher holder, records on payment and service hours of the individual voucher holder, fee-charging, complaint investigations and compliance with 16 service quality standards.

Audit findings

3.19 The SWD planned to issue 1 200 vouchers in the first phase. The target was achieved in early April 2014. By August 2014, some 1 600 elderly had participated in the Pilot CCS Voucher Scheme. Audit notes the following characteristics in the Scheme which differ from the conventional CCS schemes implemented:

Note 43: *In the first phase, eligible elderly are those who: (i) have been assessed by the SWD assessment mechanism as moderately impaired and are waiting for CCS and/or RCS on the CWL; and (ii) live in one of ten districts of the territory.*

- (a) the Scheme aims at testing the viability of a new funding mode, whereby the Government has adopted a “money-follows-the-user” approach and provides subsidy directly to the service users (instead of service providers) in the form of service vouchers;
- (b) eligible elderly persons may choose the service provider, the type of service and the service package that suit their individual needs; and
- (c) whilst the services provided under the Scheme are subsidised by the Government, a sliding scale of co-payment has been put in place with five levels of Government subsidy, so that the less the user can afford, the more the Government will pay. To determine the level of co-payment made by the voucher holders, the SWD takes into account the holders’ household incomes. Voucher holders receiving CSSA allowances may apply for a special grant under the CSSA Scheme to cover part of the co-payment.

3.20 As at September 2014, the Pilot CCS Voucher Scheme had only been implemented for one year. Given the short time it has developed, Audit has not conducted a comprehensive review of its operation. Nonetheless, Audit has noted the following which may call for the SWD’s attention:

- (a) ***Vouchers issued, but not yet put into use by some of the voucher holders.*** As at August 2014, some 310 out of 1 200 elderly users still participating in the Scheme had not commenced using the services. For some 180 of these 310 participants, vouchers were issued to them more than three months ago and should have become void; and
- (b) ***Elderly users withdrawn from the Scheme.*** By August 2014, 433 (27% of 1 600) elderly users had withdrawn from the Scheme. Among them, 164 withdrew because they would be/had been admitted to other types of LTC services and 135 withdrew because they could not find suitable service providers/service packages.

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3.21 In this regard, the SWD informed Audit in October 2014 that:

Vouchers issued, but not yet put into use by some of the voucher holders (para. 3.20(a))

- (a) it is aware that some voucher holders have not yet used their vouchers. Yet, under the “money-follows-the-user” funding mode, government subsidies will be disbursed to recognised service providers only after they have provided services to the voucher holders;
- (b) apart from sending reminders to the RWs and the voucher holders/carers in April 2014, the SWD had contacted them directly to find out the reasons for not using the vouchers yet and encouraged them to use the vouchers. The SWD will continue making efforts to assist the voucher holders in using the vouchers;

Elderly users withdrawn from the Scheme (para. 3.20(b))

- (c) it is also aware that 27% of the voucher users had withdrawn from the Scheme. However, given the principle of fairness in service allocation, invitation to applicants must start from the beginning of the CWL. It is understandable that applicants having a much earlier LTC date may withdraw from the Scheme shortly after their participation in the Scheme when (i) subvented RCS is offered; or (ii) they are admitted to private RCHEs due to deteriorating health; and
- (d) the SWD has commissioned a local university to conduct an evaluation study of the Pilot CCS Voucher Scheme which will examine, among others, the voucher holders’ reasons for withdrawal. The findings of the study will be useful for the design of the second phase of the Scheme.

3.22 The Pilot CCS Voucher Scheme has adopted an innovative funding mode which is quite new in social service. It will take time to develop. Audit welcomes the SWD’s initiative and its efforts to prepare for the second phase of the Scheme by commissioning a case mix study on CCS as well as a formative and outcome evaluation of the first phase of the Scheme. Subject to the outcome of the university’s study, the SWD will fine-tune the Scheme before proceeding onwards.

Need for a more strategic approach to implement CCS

3.23 As at March 2014, community care and support services were provided by 86 NGOs which operate some 360 service units to provide multifarious types of services, including day care services (67 centres), home care services (24 EHCCS teams and 60 IHCS teams) and education, social and recreational services (211 elderly centres).

3.24 As early as 2000, the Administration commissioned a consultant to review the provision of community care and support services for the elderly living in the community. The consultant observed a number of problems, including service fragmentation, inadequate co-ordination and service duplication in the then community elderly care infrastructure. In 2003, in line with the consultant's recommendations, the Administration re-engineered the community care and support services for the elderly through upgrading elderly centres and re-engineering various home help, home care and meal teams to form the IHCS teams.

3.25 Since then, the SWD has launched various pilot schemes at different times to supplement the regular CCS in order to meet the needs of the elderly living in the community. They include the Pilot Scheme on Home Care Services for Frail Elders, and the more recent Pilot CCS Voucher Scheme (see para. 3.6(a) and (b)). Most of these schemes were however introduced at different times on a pilot/time-limited basis, e.g. for a number of years, at selected districts, or for specific elderly groups. No concrete plan has been drawn up to properly integrate, rationalise or re-engineer them to provide effective CCS for the frail elderly. In the long term, there is a need to formulate a proper strategy to provide at one-stop all the services and support required by a family which looks after a frail elderly at home.

3.26 On one hand, the Administration has made great efforts to try out different types of new CCS. On the other hand, Audit notes that similar CCS are provided to the frail elderly under three different schemes, namely the EHCCS, the IHCS and the Pilot Scheme on Home Care Services for Frail Elders, which were launched in 2001, 2003 and 2011 respectively. Although the three schemes provide similar services, they differ in various ways in their operational modes (see Table 2).

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Table 2
Comparison of EHCCS, IHCS and
Pilot Scheme on Home Care Services for Frail Elders

Scheme	EHCCS (Note 1)	IHCS (Note 1)	Pilot Scheme on Home Care Services for Frail Elders (Note 2)
Effective date	April 2001	April 2003	March 2011
Implementation period	Ongoing	Ongoing	Four years (March 2011 to February 2015)
Funding source	General Revenue	General Revenue	LF
Funding mode	Service fee	Recurrent subventions by LSG	One-off grant
Monitoring	Contract Management Section of Elderly Branch of SWD	Subventions Branch of SWD	Contract Management Section of Elderly Branch of SWD and overseen by a Steering Committee (Note 3)
Service operator (Note 1)	24 teams from 14 NGOs	60 teams from 24 NGOs	3 NGOs
Capacity	1 453 places (April 2001) 5 579 places (March 2014) 7 079 places (March 2015)	1 120 places for frail elderly since April 2003	300 places since March 2011
Coverage	18 districts	18 districts	8 districts
Target users	Elderly assessed to be moderate or severely impaired by the SWD assessment mechanism		Severely impaired elderly waiting for NH places on the CWL
Services	Essentially the same for all three Schemes. Services include care management, basic and special nursing care, personal care, rehabilitation exercises, day respite services and carer support.		

Source: Audit analysis of SWD records

Note 1: In 13 districts, the same NGOs are operating both EHCCS and IHCS, with seven EHCCS teams residing in the same premises as their associated IHCS teams.

Note 2: The Scheme will be integrated with EHCCS upon its expiry in February 2015.

Note 3: The Steering Committee comprises staff of the SWD, LWB, DH, HA and the Hong Kong Council of Social Service.

3.27 Table 2 shows that although the three CCS schemes are similar in the scope of services they provide, they are operating in different modes. Audit notes that the Administration has plans to subsume the Pilot Scheme on Home Care Services for Frail Elders under EHCCS in 2015 (see para. 3.6(a)). A survey conducted as early as 2002 had established that EHCCS was effective in that it could lower the demand for RCS for the elderly, especially those who preferred living with their family members to being sent to RCHEs. However, as both the EHCCS and the IHCS have already been operated for over ten years, they are due for review. In order to help frail elderly living in the community to achieve ageing in place, the Administration needs to consider how to provide them with better and integrated CCS, including, among other things, how EHCCS and IHCS can be properly integrated and how their service content can be enriched, taking into consideration other factors including the funding mode and the availability of other forms of CCS in the private market (such as helpers and carers).

PART 4: RESIDENTIAL CARE SERVICES

4.1 This PART examines in more detail the provision of RCS for the elderly.

4.2 As at end-March 2014, there were 748 RCHEs providing 75 000 RCS places, with breakdown as follows:

Type of RCHE	No. of RCHEs	No. of subsidised places (A)	No. of non-subsidised places (B)	Total ((C) = (A) + (B))
(a) Subvented RCHEs (Note 1)	127	16 460	340	16 800
(b) Contract RCHEs (Note 2)	22	1 670	1 200	2 870
(c) Private RCHEs participated in EBPS (Note 3)	135	7 660	7 560	15 220
(d) Other RCHEs in the private sector	424	—	36 310 (Note 4)	36 310
(e) Self-financing RCHEs				
(i) participated in NHPPS (Note 5)	4	160	360	520
(ii) others	36	—	3 460	3 460
Total	748	25 950 (say 26 000)	49 230 (say 49 000)	75 180 (say 75 000)

Note 1: Subvented RCHEs, providing mainly NH places or C&A places, are operated by NGOs which receive LSG subventions from the SWD.

Note 2: These are purpose-built RCHEs with operating contracts awarded through open tenders to NGOs/private organisations by the Government.

Note 3: The EBPS, implemented since 1998, involves the purchase of places from private RCHEs with the aims of increasing the provision of subsidised places and encouraging the private homes to improve their quality of care.

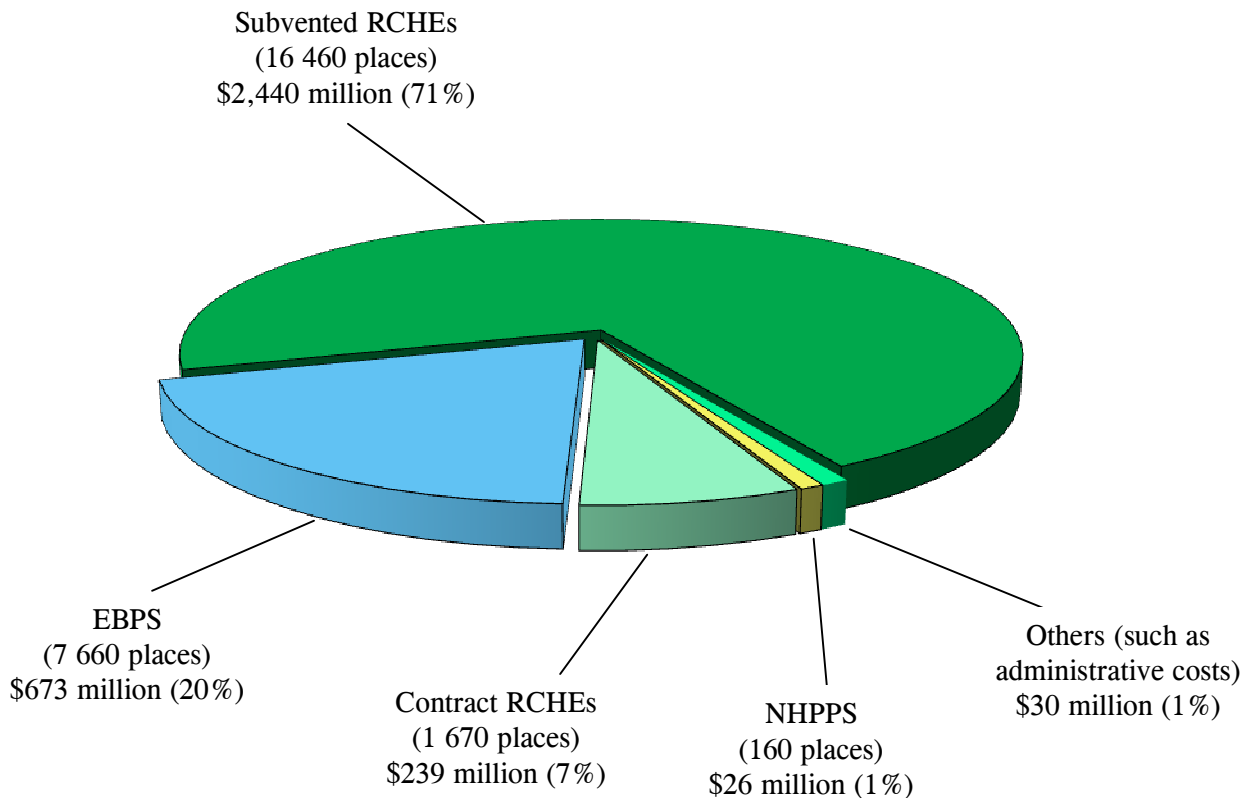
Note 4: This is the licensed capacity of the RCHEs. As at end-March 2014, they were actually providing 31 000 places only.

Note 5: The NHPPS, implemented since 2010, involves the purchase of places from self-financing RCHEs with an aim to increase the provision of subsidised places for elderly persons of severe impairment.

Figure 3 shows how the 2013-14 expenditure of \$3.41 billion (see para. 1.14) was spent to provide the 26 000 subsidised RCS places.

Figure 3

**Expenditure on provision of RCS
(2013-14)**



Source: SWD records

Residential care homes provided for the elderly

4.3 These 748 RCHEs (see para. 4.2) together provided some 75 000 places, of which some 26 000 were subsidised by the Government (23 000 for C&A places and 3 000 NH places). As at end-March 2014, these 748 RCHEs were serving 61 200 elderly. RCHEs in the private sector (see para. 4.2(c) and (d)) however had an overall vacancy rate of 26% for their non-subsidised places.

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4.4 As mentioned in paragraph 1.14, in 2013-14, the Government spent out of the Government General Revenue \$3.41 billion on the provision of RCS. This had not taken into account:

- (a) the substantial capital expenditure incurred by the Government out of LF for setting up the contract RCHEs or renovating the subvented RCHEs in paragraph 4.2(a) and (b). For example, in 2013-14, some \$82 million were paid out of LF; and
- (b) another \$2.1 billion a year spent by the Government on allowance payments under the CSSA Scheme of the SWD to another 25 700 elderly living at non-subsidised places of RCHEs, which were receiving subsidies from the Government in another form (see para. 2.10).

4.5 Among the 748 RCHEs:

- (a) 713 RCHEs are licensed and regulated by the SWD under the RCHE Ordinance (see para. 1.16);
- (b) 10 RCHEs, which provide NH places only, are registered with the DH under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165); and
- (c) 25 RCHEs, which provide both C&A and NH places, are subject to the licensing and registration requirements of both Ordinances in (a) and (b) above.

Audit findings

4.6 Against the background that the SWD provides subsidised RCS places for the elderly as well as regulates all RCHEs licensed under the RCHE Ordinance, the following issues are examined in this PART:

- (a) varying quality standards of different types of RCHEs (see paras. 4.7 to 4.15);

- (b) many elderly opted not to stay in private RCHEs under EBPS (paras. 4.16 to 4.20);
- (c) operation of RCHEs in premises subject to deed of mutual covenant (paras. 4.21 to 4.24);
- (d) granting of sites and premium concessions for RCHE purpose (paras. 4.25 to 4.29); and
- (e) inspections of RCHEs (paras. 4.30 to 4.35).

Varying quality standards of different types of RCHEs

4.7 As shown in paragraph 4.2, RCHEs in the private sector which did not offer subsidised places formed the majority of the RCHEs in the territory. Audit noted that their service quality varied and most of them differed from the other types of RCHEs which offered subsidised places (see para. 4.2(a) to (c) and (e)(i)), with obvious disparities lying in their space and staff provision, as shown in the Table 3 below.

Table 3

Spacing and staffing provisions in RCHEs providing C&A places

	RCHEs offering subsidised places			RCHEs <u>not</u> offering subsidised places	
	Subvented RCHEs (para. 4.2(a))	Contract RCHEs (para. 4.2(b))	Private RCHEs in EBPS (Note 1) (para. 4.2(c))	Private RCHEs <u>not</u> in EBPS (para. 4.2(d))	Self-financing RCHEs (para. 4.2(e)(ii))
Average net floor area per resident	17.5 m ²	20.8 m ²	8.9 m ² (EA1: 9.9 m ² EA2: 8.3 m ²)	7.5 m ²	17.1 m ²
Average number of staff per 100 residents					
Nurse	5.1	7.7	2.6	0.2	3.2
Health worker	2.8	4.6	5.8	3.4	4.6
Care worker	16.3	18.7	14.7	8.4	15.2
Ancillary worker	12.8	8.7	7.0	3.0	9.8
Other staff (Note 2)	3.2	2.6	1.9	1.3	2.2
Total	40.2	42.3	32.0	16.3	35.0

Source: Audit analysis of SWD records

Note 1: There are two types of EBPS places, namely EA1 and EA2 places. EA1 places are of higher quality and are more costly to the Government.

Note 2: RCHEs also employ other types of staff, such as home managers, social workers, occupational therapists and physiotherapists. According to the SWD, relief workers are commonly hired by private RCHEs, but they are not included in the figures.

4.8 The disparities in quality standards (e.g. spacing and staffing requirements), as shown in Table 3, have arisen because different types of RCHEs are subject to different service quality requirements, as follows:

Type of RCHEs	Service standards to be met
Subvented/contract RCHEs (see para. 4.2(a) and (b))	In addition to the statutory minimum standards as stipulated in the RCHE Ordinance, subvented/contract RCHEs are required to meet enhanced standards in the FSAs or service contracts signed between the home operators and the Government.
Private RCHEs offering EBPS places (see para. 4.2(c))	In addition to the statutory minimum standards, RCHEs offering EBPS places are required to meet enhanced standards as stipulated in the purchase agreements. A major characteristic of the EBPS is that once a private RCHE has participated in the Scheme, the same enhanced standards apply to the entire home (including non-subsidised places), regardless of the number of places purchased by the Government.
Private/self-financing RCHEs not providing any subsidised places (see para. 4.2(d) and (e)(ii))	RCHEs in the private sector are required to meet only the statutory minimum standards.

Service standards and quality of RCHEs in the private sector

4.9 Appendix D shows in detail the differences in spacing and staffing requirements for C&A places between those stipulated in the RCHE Ordinance and those set by the SWD in planning for subvented/contract RCHEs, or for EBPS places to be purchased from private RCHEs.

4.10 As at end-March 2014, there were 424 RCHEs in the private sector, which did not participate in EBPS, providing some 31 000 non-subsidised RCS places (see Note 4 to para. 4.2(d)). Unlike subvented/contract RCHEs which are

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set up in areas located in public housing estates or purpose-built complex provided by the Government, many of these private RCHEs are located in commercial or residential buildings which are relatively less spacious but more expensive in rental cost. According to the SWD records, many of these RCHEs just met the statutory minimum requirements, as follows:

(a) **Spacing requirement:** 91 (21%) of them provided a net floor area above 8 m² (up to 24 m²) per resident, but 333 (79%) of them provided a net floor area of “6.5 m² to 8.0 m²” per resident which, albeit meeting the minimum statutory level of “6.5 m²”, was far below par as compared with “16 m² to 18 m²” for a subvented/contract RCHE or with “8 m² to 9.5 m²” for a private RCHE offering EBPS places (see Appendix D); and

(b) **Staffing requirement:** Many of them could only meet the statutory minimum staffing level requirement. For instance, the RCHE Regulation requires that:

- unless a health worker is present, there should be one nurse for every 60 residents or part thereof from 7 am to 6 pm; or
- unless a nurse is present, there should be one health worker for every 30 residents or part thereof from 7 am to 6 pm.

Based on their returns to the SWD, these 424 RCHEs had only employed a total of 61 nurses and 1 085 health workers, indicating that:

- a great percentage of these RCHEs had not employed any nurse as it is not a mandatory requirement under the RCHE Ordinance; and
- on average, only 1.05 health workers were employed for every 30 residents ($1\ 085 \times 30 \div 31\ 000$) at each RCHE, which has just met the statutory minimum requirement of “one health worker for every 30 residents” in an RCHE.

Many of the RCHEs in the private sector had high vacancy rates too, despite the high demand for subsidised RCS places.

4.11 Audit also noted that more warning letters on non-compliance with licensing requirements were issued against RCHEs in the private sector. For example, in 2013-14, 284 (81%) of 351 warning letters were issued by the SWD against these RCHEs, although they accounted for only 57% ($424 \div 748 \times 100\%$) of total RCHEs in the sector.

4.12 In October 2014, the SWD informed Audit that it had worked to upgrade the quality standards of private RCHEs through the EBPS. Measures taken to improve the EBPS have included the following:

- (a) since 2011-12, the places to be purchased from private RCHEs have been confined to EA1 level only;
- (b) since 2011-12, increased subsidy had also been provided for EA1 places to include physiotherapy service;
- (c) two exercises were conducted in 2012 and 2014 respectively to upgrade EA2 places to EA1 places; and
- (d) the unit subsidy of all EBPS places was increased in 2014-15 to strengthen the care and support of these homes for elderly persons.

4.13 The RCHE Ordinance aims to ensure the elderly residents in the RCHEs will receive services of acceptable standards that are of benefit to them physically, emotionally and socially (see para. 1.16). Under the Ordinance, the SWD has also issued a Code of Practice for RCHEs to ensure that the premises, design, staffing, operation, management, etc. of licensed RCHEs complied with the licensing requirements and that the RCHEs has the necessary resources to attend to the care needs of their residents and provide a safe hygienic living environment for them. Whilst the SWD had implemented various measures to upgrade the service quality of RCHEs, including the introduction of enhanced service standards for subvented/contract RCHEs and for RCHEs participating in the purchase schemes, and the issuing of an updated Code of Practice in 2013, Audit however noted that the statutory minimum requirements in the RCHE Ordinance (such as the spacing and staffing requirements) had not been revised in the past 18 years.

4.14 It is understood that high rentals and manpower shortage are two major problems facing many RCHEs in the private sector, which are not easy to overcome. This might also have explained why the Administration had been slow in upgrading the minimum requirements set in the RCHE Ordinance, although the Office of The Ombudsman recommended the SWD in March 2012, among others, to conduct timely and regular reviews of the relevant legislation, in particular the statutory minimum requirements in respect of RCHEs. In its progress report of October 2012 on follow-up of The Ombudsman's recommendations, the SWD said that it had reviewed the statutory minimum requirements from time to time and any proposal to introduce major changes to the Ordinance must be fully justified and must have the support of the stakeholders and the community at large.

4.15 Audit notes the SWD's commitment to keep the Ordinance under review, but is particularly concerned with the acute staffing shortage in the RCHE sector. The more recent initiative of allowing private RCHEs participating in EBPS to employ, effective since April 2014, imported care workers to serve elderly residents taking up non-subsidised RCS places could help alleviate the staffing shortage in the sector. However, the Labour Advisory Board (Note 44) needs to be consulted on individual applications for imported care workers. With the growing demand for LTC services, the Government needs to critically review how to address the root of the problem.

Many elderly opted not to stay in private RCHEs under EBPS

4.16 As mentioned earlier, 30% of the 26 000 subsidised RCS places were provided by the two purchase schemes, namely the EBPS and the NHPPS, with the latter still implemented on a very small scale (see para. 4.2(c) and (e)(i)). According to the Administration, the EBPS (or the Bought Place Scheme before 1998), apart from increasing the supply of subsidised C&A places, helps enhance the quality of RCHEs in the private sector because, once a private RCHE has

Note 44: *The Labour Advisory Board, chaired by the Commissioner for Labour, is a non-statutory body to advise the Commissioner on labour matters.*

participated in the Scheme, the same standards will apply to the entire RCHE. As at end-March 2014, there were 7 660 EBPS places, comprising 4 090 EA1 places and 3 570 EA2 places (Note 45). In 2013-14, cases of admission to EBPS places had accounted for 45% of all admission cases.

4.17 Although improved quality standards have been set for EBPS places (see paras. 4.7 and 4.10), they are still not on par with the quality standards set for subvented or contract RCHEs (see para. 4.7 and Appendix D). Probably as a result, the percentage of applicants on the CWL who had indicated their willingness to take up EBPS places had decreased from 7% as at end-March 2009 to 5% as at end-March 2014, and the waiting time for an EBPS place was seven months, which was much shorter than the waiting time for a subvented/contract RCHE place (see para. 2.17(b)).

4.18 Although RCHEs participating in EBPS had achieved in 2013-14 an overall enrolment rate of 95% for their EA1 places and 91% for their EA2 places, Audit noted that 13 (11% of 121) of these RCHEs had a low enrolment rate of below 80% with three below 50% (as low as 32%). Over the two financial years of 2012-13 and 2013-14, some 550 to 590 of 7 660 EBPS places purchased by the Government had remained vacant, which means that good value has not been realised for some \$50 million spent a year.

4.19 Audit also noted the following which might have affected the effectiveness of the EBPS:

- (a) *Place reduction mechanism introduced since April 2012 (see para. 2.30(b))*: To address the issue of vacant EBPS places, the SWD introduced a place reduction mechanism since April 2012. Under the mechanism, all private RCHEs which had been offering EBPS places in April 2012 were required to achieve an average enrolment rate of 92% during the two-year agreement period from April 2012 to March 2014. If

Note 45: *In 2013-14, it cost the Government some \$8,800 a month for an EA1 place and \$6,600 for an EA2 place in the urban, and \$8,000 and \$6,000 a month for the same in the New Territories.*

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the actual average enrolment rate was below 92%, the number of places purchased would be proportionally reduced in the succeeding 2-year agreement period (i.e. from April 2014 to March 2016). A total of 143 EBPS places, involving 25 RCHEs, had been reduced under the place reduction mechanism. Audit however noted that there was still room for further improvement. For example, in the case of one RCHE with 190 EBPS places purchased before April 2014, although the number of EBPS places purchased had been reduced to 175 places effective from April 2014, there were still 33, 35 and 41 vacant places for the three months ended June 2014, representing 19% to 23% of the 175 EBPS places purchased. In September 2014, the SWD informed Audit that the place reduction mechanism has been continuously in force under the current two-year service agreements. The SWD would closely monitor the enrolment position of the EBPS places with a view to achieving better utilisation of public resources;

- (b) *Use of vacant EBPS places for residential respite services:* In March 2012, the SWD introduced a measure to utilise vacant EBPS places for residential respite services for the elderly (Note 46). Audit however found that the utilisation of vacant EBPS places for such service was not high. In 2013-14, only 486 respite cases were reported, with the length of stay in each case ranging from one to 85 days. The utilisation of the vacant EBPS places for residential respite services only accounted for 6% of the total vacant EBPS places in the period. More promotion work may be required to publicise the measure; and

- (c) *Need for review of the “50% cap” requirement (see para. 2.26(b)(iii)):* According to the SWD, the “50% cap” requirement was set in 2003 to allow participating private RCHEs to run their non-subsidised part of business in the same RCHE, and enables more RCHEs to participate in EBPS so as to enhance the service standard of private homes as far as possible. As mentioned earlier, the “50% cap” requirement may call for review given the long waiting time in the CWL. Case 2 is an example showing the need to have the “50% cap” requirement kept under review.

Note 46: *Residential respite service is a form of temporary or short-term residential care service for the elderly. It serves the objective of providing temporary relief for family members or relatives who are the main caregivers of the elderly requiring a certain degree of personal care whilst residing in the community.*

Case 2

1. One RCHE (RCHE 4) has a capacity of 430 places and the SWD has purchased 50% of the places, i.e. 215 places from the RCHE. As at 31 March 2014, all EBPS places in RCHE 4 were fully enrolled, but 20 non-subsidised places were vacant.

2. According to the CWL as at March 2014, 37 elderly had indicated preference for admission to this RCHE. These 37 elderly were aged between 64 to 101, all of whom had been waiting for 2 to 15 months.

3. Because of the “50% cap” requirement, the SWD could not purchase additional places from RCHE 4 concerned notwithstanding that vacant non-subsidised places were available.

Source: SWD records

4.20 In October 2014, the SWD informed Audit that:

- (a) the objective of the EBPS is to upgrade the service standard of private RCHEs and to reduce the elderly’s waiting time for subsidised C&A places. The EBPS places have remained essential to meet the RCS needs of those on the CWL;
- (b) it was making strenuous efforts in pushing the private RCHEs participating in the EBPS to achieve a higher enrolment rate to ensure proper use of public resources (see (c) below). Though only 5% of the applicants on the CWL as at end-March 2014 opted for admission to EBPS places (see para. 4.17), 45% of the total admission cases in 2013-14 were admitted to EBPS places; and
- (c) with a view to enhancing the attractiveness of the EBPS to both the home operators and the elderly applicants, the SWD has implemented various means, including increasing the purchase price of the EBPS places in 2014-15 and launching exercises to upgrade existing EA2 places to EA1 places in 2012-13 and 2014-15. While strenuous efforts are being made to push private RCHEs with EBPS places to achieve a higher enrolment rate, the SWD considers it too early to lift the “50% cap” requirement

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mentioned in paragraph 4.19(c) and would examine the issue in tandem with the future development of the Pilot Voucher Scheme for RCS, the feasibility of which is now being studied by the Elderly Commission (see paras. 5.2(b)(ii) and 5.5).

Audit notes the SWD's comments in (c) above and considers that the SWD needs to continue keeping the "50% cap" requirement under regular review.

Operation of RCHEs in premises subject to deed of mutual covenant

4.21 The majority of the RCHEs in Hong Kong belonged to private RCHEs (see para. 4.2(c) and (d)). As reported by the Administration to LegCo in June 2003, many of the private RCHEs were located in commercial or residential buildings under co-ownership and governed by deed of mutual covenant (DMC).

4.22 On the advice of the Elderly Commission, the Lands Department had expressly disallowed since February 2001 the prohibition of RCHEs in DMCs for new residential developments where commercial uses are normally permitted in the lowest three floors. In June 2003, the Administration informed LegCo of a High Court judgment in which the incorporated owners of a building were granted an injunction refraining the operator from using the premises in the building as RCHE on the basis of a provision in its DMC. In this court case, the Judge concluded that the RCHE was a boarding house within the meaning of "boarding house" as stated in the relevant DMC. Arising from the court case, the Administration informed LegCo that as a long-term objective, RCHEs should preferably operate in purpose-built premises. In relation to a case when there was legal conflict over DMC upon the change of tenancy from one RCHE to another at a particular premises, the SWD further obtained legal advice in 2012 that the enforcement of DMC was not among the objects of the RCHE Ordinance and, even if evidence was available to show that there was a clear breach of the DMC, the SWD was not legally obliged to refuse an application for an RCHE licence.

4.23 It is noted that another government department, the Home Affairs Department (HAD), has also operated a largely similar licensing regime for the operation of hotels and guesthouses in buildings subject to DMC. The Licensing Authority is not empowered under the relevant law to consider the compliance of the

hotel/guesthouse operation with the terms of the DMC when processing a licence application for operation of a hotel or guesthouse in a building subject to DMC. Since April 2014, the Office of the Licensing Authority under the HAD has implemented a notification system by issuing letters to the owners' corporation, residents' organisation and/or property management company of the building concerned, as appropriate, thus allowing time for them to consider whether they would initiate any legal actions for any breach of the DMC. Before the licence application is approved, the Office of the Licensing Authority will issue another round of letters to the parties concerned. Meanwhile, the Administration is also reviewing the licensing requirement for hotels and guesthouses under the relevant law.

4.24 In the light of the more recent "guesthouse" development as mentioned in paragraph 4.23, Audit considers that the SWD needs to keep under close review, in collaboration with the LWB, the existing RCHE licensing requirements and assess, when appropriate, the possible impact of the "guesthouse" development on RCHEs. In response, the SWD has said that RCHEs are very different from guesthouses, in terms of business, clientele, neighbourhood acceptance, turnover of service users, etc. and are monitored under a different legislation, namely the RCHE Ordinance and a different licensing regime. According to the SWD, in the past three years, it had not encountered any case of RCHE closure due to conflicts arising from DMC. Nonetheless, the SWD indicates that it will keep close watch of the "guesthouse" development and result of the HAD review of, and possible legislative amendments to, the Hotel and Guesthouse Accommodation Ordinance (Cap. 349) concerning DMC and will assess, when appropriate, the possible impact of the development on RCHEs with reference to the legal framework and licensing regime for monitoring RCHEs.

Granting of sites and premium concessions for RCHE purpose

Granting of sites by private treaty

4.25 The Government may grant sites at nominal premium to NGOs for welfare purposes. Based on SWD records, some 50 PTG sites had been granted to NGOs for operating subvented and/or self-financing RCHEs (see para. 4.2(a) and (e)). Audit examined a number of such PTGs and found in two cases that the SWD had not exercised the rights reserved in the PTGs to nominate persons for admission

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to the RCHEs established on the sites (Note 47). In these two PTGs, the SWD was allowed to nominate persons for admission in accordance with the quota to be agreed between the SWD and the grantee. The two RCHEs were self-financing ones and did not provide subsidised RCS places (an example is shown in Case 3).

Case 3

1. In January 2005, a remote site was granted by private treaty at nominal premium for operating a non-profit-making RCHE (RCHE 5). RCHE 5 commenced operation in August 2007. The PTG has stipulated, among others, that the SWD shall have the right to nominate persons for admission to the RCHE in accordance with the criteria for admission and a quota both agreed or to be agreed by the Director of Social Welfare and the grantee, and such persons nominated shall be admitted to the RCHE.

2. Based on the SWD records, RCHE 5 was a self-financing RCHE which provided 88 non-subsidised RCS places. Audit has however found that no record was available showing that the SWD had agreed with the grantee on the quota for nominating persons for admission to the RCHE.

3. Based on the SWD records, RCHE 5 had an enrolment rate of only 61% to 68% for the five financial years from 2009-10 to 2013-14.

4. In September 2014, the SWD informed Audit that since all RCS places provided by RCHE 5 were non-subsidised ones, it had not exercised the right to nominate persons for admission to the RCHE.

Audit comments

5. Given that the site was granted at nominal premium, the 30% vacancy rate of RCHE 5 is a cause for concern. In view of the acute shortfall of subsidised RCS places the Government is facing (as reported in PART 2), the SWD should also explore how to make better use of the site for the provision of additional RCS places and, in particular, agree with the grantee on the admission quota to be provided to the Government.

Source: SWD records

Note 47: *For one of the two PTGs, there was evidence that the RCHE had before 1996 admitted a small number of elderly persons nominated by the SWD, but the latter had not agreed with the grantee on the quota in accordance with the lease condition.*

4.26 In the light of the audit findings, the SWD needs to review all PTGs granted to ascertain if there are similar cases when its right to nominate persons for admission to the RCHEs has not been exercised and explore with the grantees on how the PTG sites can be better used including, but not limited to, using the sites for the provision of additional RCS places and other elderly facilities.

4.27 In September 2014, the SWD informed Audit that it had not lost sight of the satisfactory operation of the welfare facilities on the PTG sites concerned and had been contemplating an enhanced mechanism to step up the monitoring of sites held by NGOs under PTG including, but not limited to, those operating RCHEs.

Premium Concession Scheme

4.28 To encourage developers to provide RCHEs in new private developments, in July 2003 the Administration launched the Premium Concession Scheme, under which eligible premises will be exempted from assessment of premium for various types of land transactions (such as lease modifications, land exchange and PTGs), subject to meeting certain conditions for the delivery of the RCHE premises, such as a maximum limit of 5 400 m² for gross floor area.

4.29 When the Scheme was first introduced, the Administration undertook to keep it under review and would assess its effectiveness in due course. It was then estimated that the first RCHE under the Scheme would become available in 2006-07. Audit however found that although ten years had elapsed after the Scheme was launched, as at June 2014, no RCHE under the Scheme had come into service. Only three applications had been received and the Lands Department had only approved one application and the RCHE concerned should commence to operate within 54 months from the date of the subject land lease (i.e. before mid-2017). There was no evidence indicating that the SWD had conducted any review to assess the effectiveness of the Scheme and to improve the operation of the Scheme. As informed by the SWD in October 2014, it had plans to conduct a review on the Scheme.

Inspections of RCHEs

4.30 Under the RCHE Ordinance, all RCHEs (see para. 4.5) must be duly licensed. They have to comply with the licensing requirements relating to the RCHE's management and staffing, facilities and equipment, location, structure and design of the premises, building safety, fire precautions, health and sanitation, etc. The RCHE Ordinance also empowers the SWD to monitor RCHEs by inspecting them, directing remedial measures and ordering them to cease operation if the person employed is not a fit person to operate or manage the RCHEs, the premises of the RCHEs are not fit for the purpose, the premises do not comply with any requirements, or the RCHE is operated in a manner contrary to the public interest.

4.31 Within the SWD, there is the Licensing Office of RCHEs (LORCHE). Its duties include handling applications for licences/renewal of licenses for RCHEs, monitoring the operation of RCHEs on an ongoing basis and providing guidance and advice to the operators of RCHEs to ensure that all RCHEs continuously comply with the licensing requirements stipulated in the RCHE Ordinance, the RCHE Regulation and the Code of Practice (see para. 1.16). LORCHE comprises four professional inspectorate teams with 41 staff, including officers seconded from the Buildings Department and the Fire Services Department. They conduct inspections in building safety, fire safety, health and care, and social work.

4.32 LORCHE conducts several surprise inspections of each RCHE per year, and has adopted a risk-based approach in conducting inspections, i.e. the frequency of inspection would be adjusted based on the risk level of individual RCHEs to render closer monitoring of high risk RCHEs (e.g. more inspections for these RCHEs). RCHEs are required by LORCHE to rectify irregularities detected during inspections. Depending on the severity of the irregularities, advisory/warning letters or directions requiring remedial measures under the RCHE Ordinance will be issued to non-compliant RCHEs, and prosecution actions will be taken if needed. For the five years from 2009-10 to 2013-14, 35 RCHEs had been successfully prosecuted, involving 46 offences. Among the 46 offences, 29 offences (63%) were related to non-compliance with requirements on staff employment and 13 offences (28%) were related to non-compliance with requirements on health matters such as drug management and use of physical restraints.

Audit findings

4.33 *Inspection targets have not always been achieved.* For example:

- (a) LORCHE has set a target of conducting building safety inspections (i.e. inspections on matters such as structure and design of the premises and building safety) around once a year for each RCHE. During the 39-month period from January 2011 to March 2014, LORCHE had conducted some 2 300 such inspections. On average, LORCHE was able to meet its target, i.e. conducting three inspections for each RCHE during the period. For some RCHEs requiring attention, LORCHE conducted more than three inspections (up to seven inspections). Audit however noted that during the 39-month period, 84 RCHEs had only been inspected twice or, in the case of seven RCHEs, only once;
- (b) LORCHE has set a target of conducting fire safety inspections (i.e. inspections on matters relating to fire precautions) around once a year for each RCHE. During the 39-month period from January 2011 to March 2014, LORCHE had conducted some 2 600 such inspections. On average, LORCHE was able to meet its target, i.e. conducting three inspections for each RCHE during the 39-month period. For some RCHEs requiring attention, LORCHE conducted more than three inspections (up to eight inspections). Audit however noted that during the 39-month period, 72 RCHEs had only been inspected twice or, in the case of three RCHEs, only once; and
- (c) LORCHE has set a target of conducting one non-office hour inspection for each private RCHE every year. In 2013-14, LORCHE had conducted 582 such inspections. On average, LORCHE was able to meet its target. However, Audit noted that non-office hour inspections had not been conducted for 132 private RCHEs in operation during the year.

In October 2014, the SWD informed Audit that it adopts a risk-based approach to inspections of RCHEs and accords priority in handling complaints. It agrees that while on average the numbers of building safety and fire safety inspections as well as non-office hour inspections have exceeded the targets, inspections of individual RCHEs were not evenly distributed. It undertakes to make efforts to improve the

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situation by evening out the number of inspections, so that the annual check for individual RCHEs can be better achieved and the different inspection targets can be met while taking into consideration the risk level of individual RCHEs and other operational needs.

4.34 *Follow-up inspections to RCHEs of higher risk not conducted in a timely manner.* After inspection of an RCHE, LORCHE assesses the risk level of the RCHE with reference to the number and nature of the non-compliant items identified. The risk level of an RCHE can be classified into high, medium or normal. Examples of severe non-compliant items that would lead to high risk assessment include staff employment not complying with the licensing requirements and unsatisfactory specialised nursing procedures. Once an RCHE is assessed by LORCHE as high or medium risk, inspection will be conducted more frequently to ensure that the non-compliant items have been rectified in a timely manner. Furthermore, for all the RCHEs assessed as high risk, the SWD would issue warning letters to formally require them to make rectifications on the non-compliant items, which would be followed up by unannounced inspections. The RCHEs have to make rectifications and be ready for follow-up inspections to be conducted anytime afterwards. If irregularity is identified again in the follow-up inspection, LORCHE would escalate actions which include taking prosecution actions as appropriate.

4.35 Audit examined the LORCHE records for 2013-14 of follow-up inspections to RCHEs which had been assessed as high risk ones and found that:

- (a) 34 RCHEs had been assessed as high risk ones;
- (b) in only 10 (29%) cases, follow-up inspections were conducted within the target timeframe; and
- (c) in the remaining 24 (71%) cases, follow-up inspections were not conducted within the target timeframe with delays ranging from one to three months.

The SWD has undertaken to make efforts to conduct follow-up inspections within the target timeframe in future.

PART 5: WAY FORWARD

5.1 This PART takes stock of the Government initiatives more recently taken on LTC services, identifies the challenges ahead and makes audit recommendations on the way forward.

Government initiatives more recently taken

5.2 Each year, substantial public resources are spent on providing subsidised LTC services to the elderly. To cope with the ageing population and the rising demand for subsidised LTC services, the Government has launched various initiatives in more recent years. They are as follows:

- (a) launching of the Special Scheme in September 2013 by inviting welfare NGOs to submit proposals to make better use of the land they owned, through in-situ expansion or redevelopment, to provide welfare facilities including elderly facilities (see paras. 1.15 and 2.27). The Government undertook to support the capital costs for feasible projects under the Scheme;
- (b) as mentioned in paragraph 1.18, tasking the Elderly Commission to:
 - (i) prepare an Elderly Services Programme Plan within two years; and
 - (ii) conduct a feasibility study of introducing an RCS voucher scheme. In this connection, the Government has earmarked \$800 million to meet the expenses incurred in issuing a total of 3 000 RCS vouchers in three phases from 2015-16 to 2017-18;
- (c) the implementation in mid-2014 of the Pilot Residential Care Services Scheme in Guangdong to provide about 400 RCS places at two RCHes situated at Guangdong province and operated by Hong Kong NGOs. The Scheme aims to provide an additional option (in addition to the EBPS, etc.) for the elderly on the CWL for subsidised C&A places;

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- (d) provision of \$172 million in the 2014-15 Estimates to provide an additional 1 500 home-based CCS places under the EHCCS to supplement the 5 600 EHCCS places then available; and
- (e) the LWB would allocate additional resources to NH places to provide CoC as announced in the 2014 Policy Address.

Challenges ahead

5.3 Despite the vigorous efforts exerted by the Administration in recent years to tackle the long waiting lists and waiting times posed by an ageing population and growing demand, Audit notes the following challenges ahead for the Government in its provision of subsidised LTC services for the elderly:

- (a) need to expand the subsidised CCS and RCS to keep pace with the rising demand (in particular, the long waiting lists and waiting times);
- (b) need to strengthen CCS with a view to encouraging the elderly to age in place and avoid their premature or unnecessary institutionalisation;
- (c) need to improve the efficiency and reduce wastage in the provision, matching and allocation of subsidised CCS and RCS places;
- (d) need to cope with the acute labour shortage in the RCHE sector (see para. 4.15);
- (e) need to upgrade the service standards and quality of RCHEs in the private sector which provides the bulk of RCS places, and tap on the spare capacity in the private market (see paras. 2.28 and 4.10);
- (f) need to draw experience from the implementation of the pilot CCS Voucher Scheme (see para. 3.22) and explore the feasibility of introducing an RCS voucher scheme (see para. 5.2(b)(ii));
- (g) need to formulate the long-term strategy for the provision of better and integrated CCS, taking into consideration the need to properly integrate EHCCS, IHCS and other pilot/time-limited schemes in place, in order to meet the genuine needs of the elderly (see para. 3.27);

- (h) need to timely and effectively implement the various Government initiatives recently embarked (see para. 5.2) to meet their intended objectives (paras. 5.4 to 5.8 are also relevant); and
- (i) need to enhance the LDS computer system to effectively support the registration and allocation of LTC services under the CWL (see para. 5.9).

5.4 *Pilot Residential Care Services Scheme in Guangdong (see para. 5.2(c)).* With the implementation of this Scheme in Guangdong, which is estimated to involve annual recurrent cost of \$32.64 million on the basis that about 400 RCS places could be provided in the two RCHEs, it aims to provide an alternative choice for elderly who choose to retire in the Mainland. Upon the launching of the Scheme in late June 2014, the SWD had sent out 7 000 invitations. As informed by the SWD, the Administration had well taken note of the possible concerns of the elderly persons and their family, and had already paid special attention on the provision of healthcare service in designing the service package under the Scheme.

5.5 *Pilot Voucher Schemes for CCS and RCS (see paras. 3.16 and 5.2(b)(ii)).* The Administration has implemented the Pilot CCS Voucher Scheme since September 2013, targeting at eligible frail elderly who are on the CWL and are living in 10 of the 18 districts. It helps test the viability of a new funding mode, whereby the Government adopts a “money-follows-the-user” approach and provides subsidy directly to the service users (instead of service providers) in the form of service vouchers. Subject to the outcome of a case mix study and an evaluation of the first phase of the Scheme (see para. 3.22), the SWD will fine-tune the Scheme for its second-phase implementation in two years’ time. The experience to be gained from the implementation of the Pilot CCS Voucher Scheme will also be useful for the Administration to proceed with the implementation of the RCS voucher scheme, the feasibility study of which is underway by the Elderly Commission. Nonetheless, the Administration needs to be conscious of the different characteristics between the RCS and the CCS.

5.6 *Special Scheme on privately owned sites for welfare uses (see para. 5.2(a)).* The LWB informed LegCo in February 2014 that the response of welfare NGOs to the Special Scheme was overwhelming and preliminary proposals were received from about 40 welfare NGOs involving more than 60 in-situ

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expansion, redevelopment or development projects. According to the Administration, based on the rough estimation of the applicant NGOs, there can be an increase of a maximum of about 9 000 RCS and CCS places if all the proposals received could be implemented smoothly. Audit welcomes the Special Scheme which, if successfully implemented, can considerably relieve the pressure on service demand and shorten the waiting time. Nonetheless, there are various challenges ahead in its implementation, e.g. the Scheme may take some time to achieve results. As the Administration informed LegCo FC in February 2014, it might take several years or even longer to implement the projects given the time required to complete the necessary development and planning procedures (e.g. outline zoning plan amendment, planning permission or lease modification). Close monitoring is therefore required. Guidelines are also needed to be developed to facilitate the welfare NGOs to implement their projects under the Special Scheme to be funded by LF, including how to liaise with different Government departments and optimise the use of the sites.

5.7 *Contract RCHEs to be constructed on 11 earmarked sites (see para. 2.26(a)).* The difficulties faced in the Special Scheme similarly apply to the construction of contract RCHEs on 11 sites earmarked for the purpose. Given the long lead time taken in the past for setting up contract RCHEs and to bring them into operation, how to ensure that the new contract RCHEs can be timely set up, and can come into operation and bring to optimum use as soon as possible are again challenges ahead for the Administration.

5.8 *Project on enhancing the infrastructure of LTC services.* As mentioned in paragraph 2.21(a), the Administration had commissioned a local university in 2013 to implement a three-year project to, among others, review and update the care need assessment tool and develop better service matching, assessment and coordination systems for LTC services, with a view to enhancing the LTC infrastructure.

5.9 *The LDS computer system is overdue for redevelopment.* The existing LDS computer system, implemented in 2003, supports the registration and allocation of LTC services for the elderly. Its users include the five regional SCNAMO(ES)s of the SWD, LWB and HA. Although the system is mission-critical, it is not that efficiently and effectively operated. Both the hardware

and system software have become obsolete and the application work flow is complex (Note 48). There is an urgent need to redevelop the computer system (e.g. a web-based one) to more effectively support the registration and allocation of LTC services under the CWL (Note 49). As informed by the SWD in October 2014, a feasibility study for the redevelopment was completed in March 2012 and it would commence redevelopment of the LDS computer system in November 2014.

Audit recommendations and response from the Administration

PART 2: Growing demand for subsidised long-term care services

5.10 **Audit has recommended that the Director of Social Welfare should, in collaboration with the Secretary for Labour and Welfare:**

- (a) **continue striving to expand the subsidised CCS and RCS to meet the rising demand, shorten the waiting lists and reduce the waiting times for subsidised LTC services (see paras. 2.12 to 2.15 and 2.17);**
- (b) **continue to make more effective planning in the provision of CCS in different districts (see para. 2.15);**
- (c) **publicise the waitlisting information for CCS on the SWD website (see para. 2.16);**
- (d) **disclose the methodology used for calculating the waiting list and waiting time when reporting the waitlisting information to LegCo and/or posting the information onto the SWD website, including the proper disclosure of those “inactive” cases on the CWL (see para. 2.18(a)) and the need for suitably taking such “inactive” cases into account in service planning (see para. 2.18(a)(iii));**

Note 48: *For example, the five regional SCNAMO(ES)s of the SWD have to manually input extensive data into the computer system based on the applications/information received from RWs, home/service operators, NGOs and HA and have to communicate with them in paper forms (e.g. by facsimile).*

Note 49: *The SWD obtained funding approval of \$9.7 million in February 2013 to redevelop the LDS computer system, which was originally scheduled to be in live run in December 2014, but deferred more recently to early 2016.*

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- (e) **maintain proper records of the methodology used for calculating the waiting time, and make proper disclosure of revisions made to the methodology (see para. 2.18(c));**
- (f) **review and fine-tune the SWD's care need assessment procedures taking into account the various inadequacies Audit identified in the effectiveness of the SWD assessment mechanism (see para. 2.22);**
- (g) **explore the feasibility of incorporating suitable flexibility in future tenders/contracts on the ratio of subsidised to non-subsidised RCS places and take measures to ensure the optimum use of individual contract RCHEs (see para. 2.26(a)(ii)); and**
- (h) **address the various inadequacies mentioned in paragraphs 2.30 to 2.60 with a view to maximising the effective use of the limited subsidised RCS places available, including the need to:**
 - (i) **improve the effectiveness of the EBPS by optimising the use of the places and minimising the number of vacant places (see para. 2.30(a) and (b));**
 - (ii) **explore how the procedures for the allocation, matching and admission of the limited RCS places can be fine-tuned to minimise the lead time, including the incorporation of appropriate checks and balances to facilitate effective monitoring (see paras. 2.34 and 2.35);**
 - (iii) **approach the NGOs more proactively to request them to deploy their unfilled AQ places to the CWL and critically review the possibility of clawing back the AQ places for central allocation under the CWL (see para. 2.50);**
 - (iv) **take measures to follow up on the 11% vacancy of the limited IU places available and review, in close collaboration with the Director of Health, how the IU places in subvented RCHEs can more effectively be used as a stop-gap measure to tackle the acute demand for infirmary places (see paras. 2.54 and 2.59); and**

- (v) **report back to LegCo the development of providing infirm care to elderly in non-hospital setting as proposed by the SWD in 2004 (see para. 2.60).**

5.11 *Response from the Administration.* The Director of Social Welfare, supported by the Secretary for Labour and Welfare, agrees with the audit recommendations. In addition, she has said that:

- (a) the Administration notes that Hong Kong is facing an ageing population and a rapidly rising trend in the demand for CCS and RCS for the elderly. Strenuous efforts have been made by the Government to increase both CCS and RCS places;

For CCS:

- (b) the capacity has increased by 35% over the five years from 2009-10 to 2013-14 (see para. 2.12(a)). The Pilot CCS Voucher Scheme launched in September 2013 had provided 1 200 CCS places and had attracted different types of service providers to enter the market, thereby further developing the capacity of CCS. The SWD is planning to conduct the second phase of the Pilot Scheme targeting more frail elderly persons by September 2015. It has also planned to increase an additional 1 500 EHCCS places in 2014-15;
- (c) the SWD will continue to make effective planning in the provision of CCS in different districts. It has taken various measures to expand the provision of CCS in different districts to meet the high service demand, including:
 - (i) introducing flexibility by allowing the provision of cross-district services in two newly set-up day care centres in 2012 (see para. 2.15(a));
 - (ii) allowing recognised service providers in selected districts to provide services for cross-district voucher users under the first phase of the Pilot CCS Voucher Scheme which commenced in September 2013; and

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- (iii) re-distributing the EHCCS places among three cluster teams upon contract variation in March 2014 (see para. 2.15(b)) and allocating the new 1 500 EHCCS places in accordance with the demands in different districts in 2014-15 (see para. 2.13);
- (d) the SWD has reserved various development sites, including some of the districts with high service demand, for setting up new day care centres/units;
- (e) the SWD plans to upload the average waiting time and number of waiting cases of day care and home care services onto the SWD website by November 2014;

For RCS:

- (f) there were over 1 600 additional subsidised places from 2012 to 2014. The SWD plans to increase about 530 subsidised RCS places through new contract RCHEs (which would also provide about 270 subsidised day care places) from 2014-15 to 2016-17 and has earmarked sites in 11 development projects (see para. 5.7) for the construction of new contract RCHEs for provision of about 710 subsidised RCS places (and also about 310 subsidised day care places);
- (g) the Special Scheme launched since September 2013 would provide a maximum of about 9 000 RCS and CCS places if all the proposals received could be implemented smoothly;
- (h) as announced in the 2014 Policy Address, the Elderly Commission will conduct a study on the feasibility of introducing an RCS voucher scheme (see para. 5.5). If it is considered feasible, the scheme will provide a total of 3 000 RCS vouchers in three years' time;
- (i) the Pilot RCS Scheme in Guangdong introduced in June 2014 (see para. 5.2(c)) provides an additional option for the elderly who are on the CWL for subsidised C&A places to choose to live in two RCHEs operated by Hong Kong NGOs in Guangdong;

- (j) regarding the reflection of the number of “inactive” cases on the CWL and the processing time taken for assessment when reporting the waiting time, and the disclosure of the methodology used for calculating the waiting list and waiting time when reporting the waitlisting information (see paras. 2.18 and 5.10(d) and (e)), it is the SWD’s view that:
 - (i) the methodology used in calculating the waiting time is well known in the sector. To better report the waitlisting information, the SWD will post additional notes to explain the methodology in calculating the waiting time, including the exclusion of “inactive” cases on the CWL;
 - (ii) the adoption since November 2012 of the “inactive” status for elderly cases which had been assessed as “RCS only” but were receiving CCS (see para. 2.18(a)(i) to (iii)) was made in response to the appeal of the elderly applicants after extensive consultation with stakeholders, such that their applications for RCS could be handled in the shortest time when there is a need in future (Note 50). Documentation was kept on the consultation and endorsement process; and
 - (iii) in the coming redevelopment of the LDS computer system (see para. 5.9), the SWD will consult stakeholders on the methodology in calculating the waiting time and the information required to be generated from the system for better reporting and service planning;
- (k) regarding the need to review and fine-tune the SWD’s care need assessment procedures (see para. 5.10(f)), the SWD has already secured a LF grant in July 2013 to commission a local university to implement a three-year project to, among others, update the assessment tool and revise the Clinical Assessment Protocols as well as a set of updated service matching decision making tree to facilitate better service matching (para. 5.8 is also relevant);

Note 50: *RCS applicants with “active” status would have the chance of being called for admission to “small pool” from time to time and their applications might be closed if they reject a placement offer at the “small pool” stage (except under certain circumstances). However, if such RCS applicants are reclassified as “inactive” ones on the CWL (as currently adopted), they will not be called for admission until they reactivate their applications with priority on the CWL not being affected.*

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- (l) the SWD will put in place measures in the LDS computer system about to be redeveloped to monitor the reporting by the SCNAMO(ES)s of the conduct of random QCs on a quarterly basis (para. 2.21(c) is relevant);
- (m) the SWD will monitor the utilisation of the AQ places closely and will request the NGOs to deploy their unfilled AQ places to the CWL. The SWD will also review critically the possibility of clawing back the AQ places for central allocation under the CWL. The SWD has further indicated that providing AQs to subvented RCHEs is a historical arrangement and serves as an acknowledgement of the financial contribution of NGOs to the capital cost for constructing and setting up the RCHEs at that time. The Administration has ceased granting AQ for subvented RCHEs planned after 1995 and has already taken measures to get back some of the AQ places in the past years, such as phasing out all H/A and S/C hostel places under AQ once the RCHEs kick-started conversion under the conversion programme (see para. 2.44). As mentioned in Note 36 to paragraph 2.48, the AQ places granted on a one-off basis to six subvented NHs had been phased out upon discharge of residents occupying these places;
- (n) as mentioned in paragraph 2.57, the setting up of IUs in subvented RCHEs was a stop-gap measure to enable the frail elderly to continue receiving care services before infirmary placement by the HA is available. The SWD has issued a circular letter to all subvented RCHEs and private RCHEs participating in EBPS in April 2014 to promote the IU services and will continue with such promotion on a regular basis. To better interface the mechanism of application for IU and infirmary care supplement (ICS — see para. 2.53) and to optimise the utilisation of the IU places, the SWD will explore a measure to proactively offer IU places, where available, to elderly residents in subsidised RCS place whose need for infirmary care is confirmed by the Community Geriatric Assessment Teams of the HA prior to allocation of ICS to the RCHEs which are taking care of the elderly concerned; and
- (o) the Administration will report back to LegCo on the development of providing infirmary care to elderly in non-hospital setting as proposed by the SWD in 2004 (see para. 2.60).

PART 3: Community care services

5.12 **Audit has recommended that the Director of Social Welfare should, in collaboration with the Secretary for Labour and Welfare:**

- (a) **step up the SWD's monitoring of the allocation and admission of limited subsidised CCS places available, and fine-tune the procedures, including revision, if required, of the SWD Manual, in close collaboration with the NGOs operating the day/home care services (see para. 3.14);**
- (b) **continue monitoring the effectiveness of the Pilot CCS Voucher Scheme, taking note of the fact that 27% of the elderly users had withdrawn from the Scheme within the first year of operation (see para. 3.20(b)); and**
- (c) **formulate a long-term strategy for the provision of better and integrated CCS to meet the genuine needs of the frail elderly who prefer ageing in place, including the need to explore how EHCCS and IHCS can be properly integrated (see paras. 3.25, 3.27 and 5.3(g)).**

5.13 ***Response from the Administration.*** The Director of Social Welfare, supported by the Secretary for Labour and Welfare, agrees with the audit recommendations. She has said that:

- (a) similar measures as those for RCS will be implemented for CCS commencing November 2014 to improve the allocation, matching and admission of CCS places (see paras. 2.36 and 3.15);
- (b) the SWD has commissioned a local university to conduct an evaluation study on the Pilot CCS Voucher Scheme which will examine, among others, the voucher holders' reasons for withdrawal (see para. 3.21(d)); and
- (c) the SWD will explore the feasibility of integrating IHCS and EHCCS, but this has to be handled with care. Owing to historical development of the two services, IHCS includes both ordinary cases and frail cases whereas EHCCS covers only frail cases. The care need of the non-frail cases has to be examined carefully in any planning for integration.

PART 4: Residential care services

5.14 **Audit has recommended that the Director of Social Welfare should, in collaboration with the Secretary for Labour and Welfare:**

- (a) **address the disparities in quality standards of different types of RCHEs as far as possible, paying particular attention to the acute manpower shortage in the RCHE sector (see paras. 4.10 and 4.15);**
- (b) **endeavour to improve the effectiveness of the EBPS and optimise the use of the EBPS places, including keeping under regular review the “50% cap” requirement (para. 5.10(h)(i) is also relevant);**
- (c) **keep under close review the more recent development of the Government’s regulation of hotels and guesthouses in premises subject to DMC and assess, when appropriate, the possible impact of the development on RCHEs (see paras. 4.23 and 4.24);**
- (d) **examine all PTGs granted for operating RCHEs to ascertain if there are similar cases when the SWD’s right to nominate persons for admission to the RCHEs has not been exercised, and explore with the grantees on how the PTG sites can be better used including, but not limited to, using the sites for the provision of additional subsidised RCS places (see para. 4.26);**
- (e) **conduct an effectiveness review of the Premium Concession Scheme which has been launched for over ten years and explore appropriate measures to improve it (see para. 4.29); and**
- (f) **ensure that the inspection targets for individual RCHEs are met, and carry out more timely follow-up inspections of RCHEs with higher risk (see paras. 4.33 to 4.35).**

5.15 *Response from the Administration.* The Director of Social Welfare, supported by the Secretary for Labour and Welfare, agrees with the audit recommendations. She has said that:

- (a) the SWD will work closely with relevant bureaux and departments to continue addressing the manpower shortage problem. In this regard, the Administration has taken various measures to tackle the problem, including the following:
 - (i) the Steering Committee on Strategic Review on Healthcare Manpower Planning and Professional Development under the Chairmanship of the Secretary for Food and Health is conducting a strategic review of healthcare manpower planning and professional development in Hong Kong;
 - (ii) with the support of the University Grants Committee, the student intakes for occupational therapy, physiotherapy and nursing programme have been substantially increased in the 2012-15 triennium;
 - (iii) a “first-hire-then-train” pilot scheme under LF was launched in 2013 to recruit young persons to provide care services at RCHEs while receiving on-the-job training, with subsidies from the Government to pursue a two-year part-time diploma course;
 - (iv) a project named “Navigation Scheme for Young Persons in Care Services”, providing an additional 1 000 places in phases from 2015-16 will be implemented;
 - (v) the SWD will continue with the Enrolled Nurse Training Programme for the Welfare Sector which seeks to provide over 900 places in the coming years. The training fee is fully sponsored by SWD and all trainees have to sign an undertaking to work for the welfare sector for at least two years after satisfactory completion of the training; and

Way forward

- (vi) the Training Sponsorship Scheme was launched through funding support for NGOs so that they could sponsor students enrolled in a two-year entry level Master in Occupational Therapy/Master in Physiotherapy programme. These students have to undertake serving the sponsoring NGOs for no less than two consecutive years immediately after graduation;

- (b) in addition to measures taken to optimise the use of EBPS places as mentioned in paragraphs 4.19 and 4.20, the SWD will continue the promotion work on residential respite service available in different types of subsidised places, including those in private RCHEs joining the EBPS;

- (c) as mentioned in paragraph 4.24, the SWD will keep close watch of the development and result of the review of and possible legislative amendments to the Hotel and Guesthouse Accommodation Ordinance concerning DMC and will assess the possible impact of the development on RCHEs with reference to the legal framework and licensing regime for monitoring RCHEs;

- (d) the SWD has been working on an enhanced mechanism to step up the monitoring of sites held by NGOs under PTG including, but not limited to, those operating RCHEs;

- (e) the SWD plans to conduct a review on the Premium Concession Scheme (see para. 4.29); and

- (f) as mentioned in paragraphs 4.33 and 4.35, the SWD, adopting a risk-based approach, undertakes to even out the number of inspections and conduct follow-up inspections within the target timeframe.

PART 5: Way forward

5.16 Audit has recommended that the Director of Social Welfare should, in collaboration with the Secretary for Labour and Welfare:

- (a) address the various challenges identified in paragraphs 5.3 to 5.8, including the monitoring of the various pilot CCS and RCS voucher schemes, the Special Scheme for in-situ expansion or redevelopment of privately owned sites for welfare uses, and the setting up of contract RCHEs on 11 sites;**
- (b) redevelop the LDS computer system as early as possible to enable it to more effectively support the registration and allocation of LTC services under the CWL (see para. 5.9); and**
- (c) keep on monitoring the waiting lists and waiting times for LTC services from time to time to ensure that the situation has not deteriorated.**

5.17 Audit has also recommended that the Secretary for Labour and Welfare should take on board the audit findings and recommendations in this Audit Report in formulating and implementing the Elderly Services Programme Plan which is meanwhile under preparation by the Elderly Commission (see para. 1.18).

Response from the Administration

5.18 The Director of Social Welfare, supported by the Secretary for Labour and Welfare, agrees with the audit recommendations. She has said that:

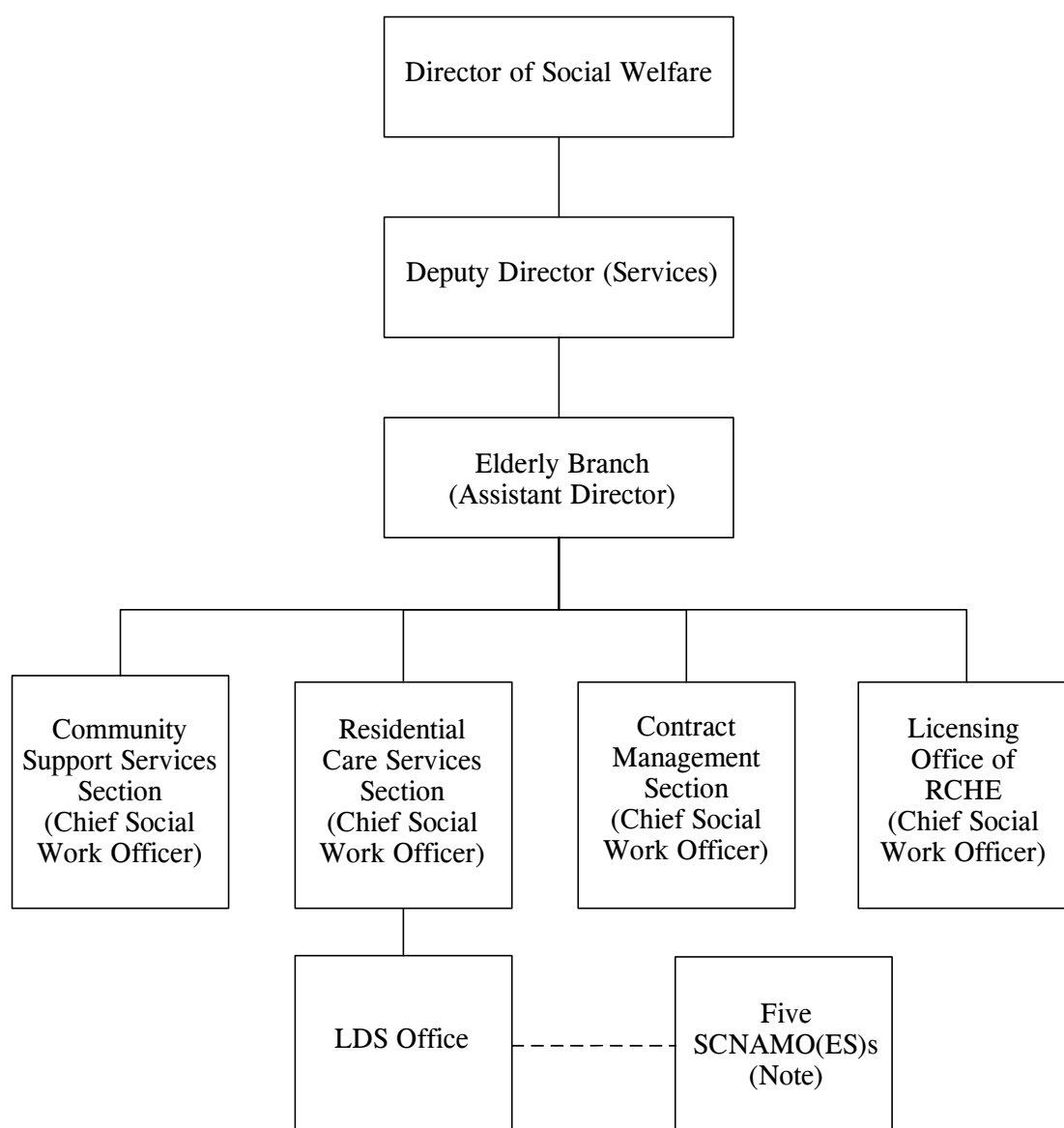
- (a) the SWD will keep in view the findings of the evaluation study on the Pilot CCS Voucher Scheme and the consultancy study on RCS voucher scheme;**

Way forward

- (b) for the Special Scheme on privately owned sites for welfare uses, the SWD will continue to liaise with the applicant NGOs and departments concerned closely to ensure that the use of the sites will be optimised and comply with relevant requirements for provision of the welfare facilities and that the projects be completed as soon as practicable;
- (c) the SWD will make every effort to streamline the work procedures with a view to bringing the new contract RCHEs (see para. 5.7) into operation as soon as possible; and
- (d) the LDS redevelopment project has been scheduled to commence in November 2014 with the areas of improvement including, among others, proper tracking and record of form submission, e-form transmission and workflow enhancement to strengthen compliance in processing applications and service allocation in accordance with the manual of procedures and business rules, etc.

5.19 Regarding the audit recommendation in paragraph 5.17, the Secretary for Labour and Welfare has said that the Elderly Commission is currently in the process of engaging stakeholders and interested parties in setting the scope of the Elderly Services Programme Plan. He has undertaken to forward Audit's findings and recommendations to the Elderly Commission for it to take into account as it deems appropriate when formulating the Programme Plan.

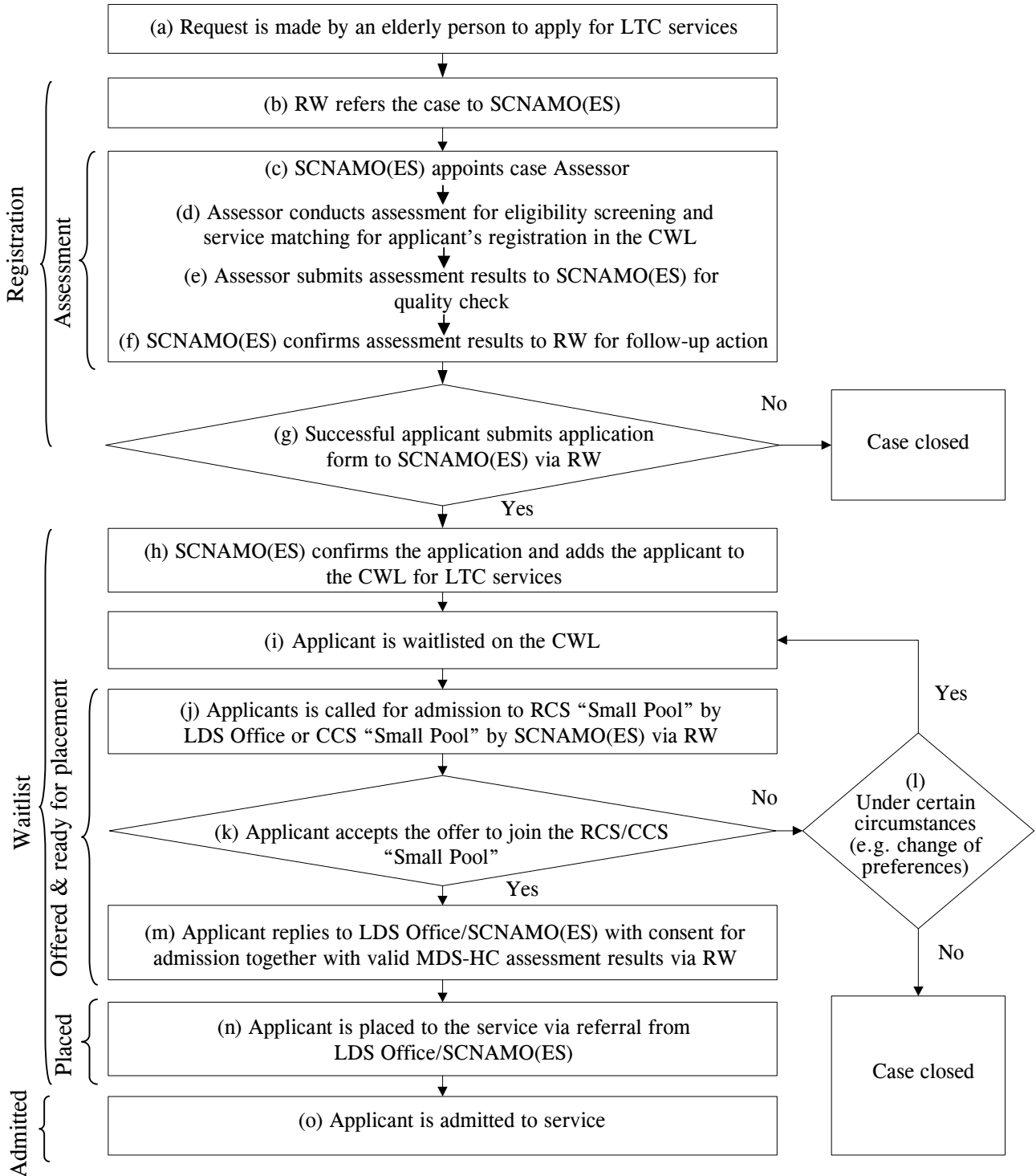
**Elderly Branch of Social Welfare Department
Organisation Chart (extract)
(31 August 2014)**



Source: SWD records

Note: The five SCNAMO(ES)s serve the regions of Hong Kong, East Kowloon, West Kowloon, New Territories East and New Territories West of the SWD. They are responsible for the monitoring of the operations of the assessment mechanism.

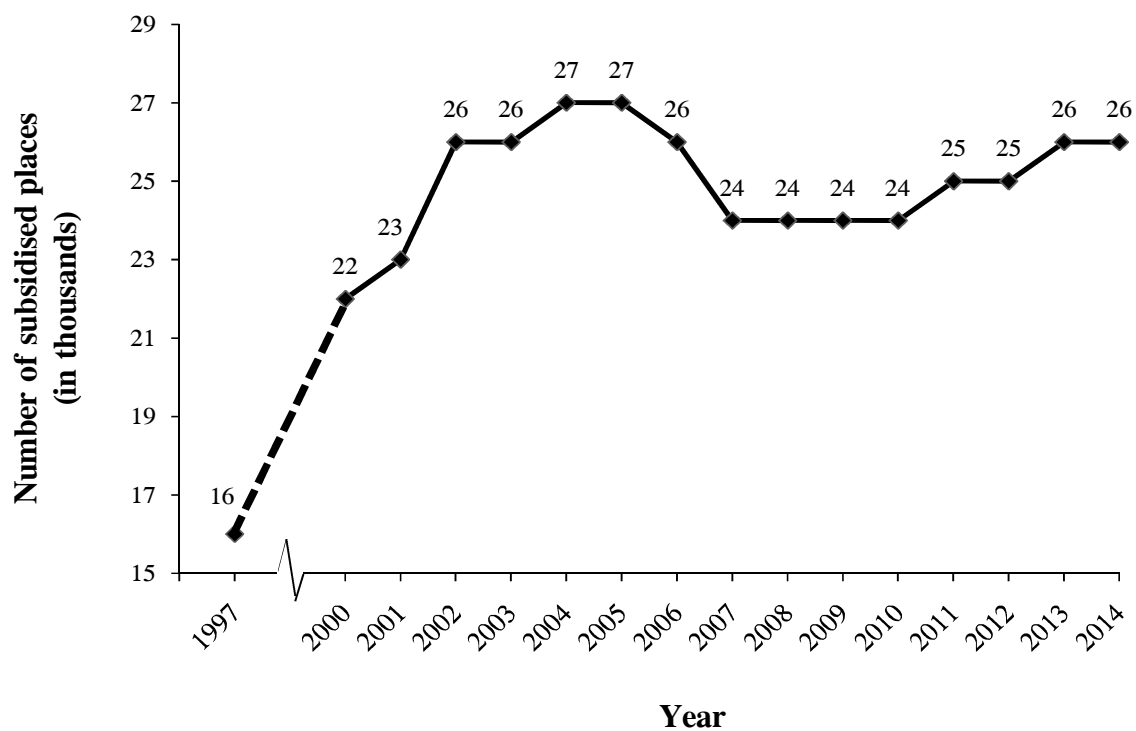
**Simplified work flow for processing applications
 under the Central Waiting List**



Source: SWD records

Remarks: Applicant may request, through the RW, for re-assessment to update his/her latest care need and for change, if required, of LTC services.

**Trend in the number of subsidised RCS places
provided by the Government over the years from 2000 to 2014**



Source: SWD records

**Spacing and staffing level requirements of different types
of RCHEs for providing “care and attention” places**

Spacing	Subvented/ Contract RCHE	Private RCHE participating in the EBPS providing EA1 places	Private RCHE participating in the EBPS providing EA2 places	Statutory minimum requirements for RCHE providing C&A places
Net floor area per resident	16 m ² to 18 m ²	9.5 m ²	8 m ²	6.5 m ²
Staffing level	Notional staffing requirement for a 40-place C&A home	Staffing requirement with reference to a 40-place C&A home on the basis of 8 working hours per staff member per day		A minimum of two shifts of workers. Number of working hours of each staff member subject to employer-employee agreement.
Home Manager	1	1	1	1
Registered/ Enrolled Nurse	4	2	Not required	(unless a health worker is present) 1 for every 60 residents or part thereof (7 am to 6 pm)
Health Worker	Not required	2	4	(unless a nurse is present) 1 for every 30 residents or part thereof (7 am to 6 pm)
Care Worker	9	8	8	— 1 for every 20 residents or part thereof (7 am to 3 pm) — 1 for every 40 residents or part thereof (3 pm to 10 pm) — 1 for every 60 residents or part thereof (10 pm to 7 am)
Ancillary Worker	8	8	6	1 for every 40 residents or part thereof (7 am to 6 pm)
Total	22	21	19	

Source: SWD records

Acronyms and abbreviations

AQ	Agency quota
Audit	Audit Commission
CCS	Community care services
CoC	Continuum of care
CSSA	Comprehensive Social Security Assistance
CWL	Central Waiting List for subsidised LTC services
C&A	Care and attention
DH	Department of Health
DMC	Deed of mutual covenant
EBPS	Enhanced Bought Place Scheme
EHCCS	Enhanced Home and Community Care Services
FC	Finance Committee
FSA	Funding and service agreements
H/A	Home for the aged
HA	Hospital Authority
HAD	Home Affairs Department
HKSAR	Hong Kong Special Administrative Region
ICAC	Independent Commission Against Corruption
ICS	Infirmiry care supplement
IHCS	Integrated Home Care Services
IU	Infirmiry unit
LDS	Long-term care services delivery system
LegCo	Legislative Council
LF	Lotteries Fund

Appendix E
(Cont'd)

LORCHE	Licensing Office of RCHEs
LSG	Lump Sum Grant
LTC	Long-term care
LWB	Labour and Welfare Bureau
MDS-HC	Minimum Data Set-Home Care
NGO	Non-governmental organisation
NH	Nursing home
NHPPS	Nursing Home Place Purchase Scheme
PAC	Public Accounts Committee
PTG	Private treaty grant
QC	Quality check
RCHE	Residential care home for the elderly
RCS	Residential care services
RW	Responsible worker/Referring worker
SCNAMO(ES)	Standardised Care Need Assessment Management Office (Elderly Services)
S/C	Self-care
SWD	Social Welfare Department