

二零一四年八月二十二日
葵青區議會
社區健康服務工作小組
第一次會議(二零一四年)

服務推行及監察

目的

本文件旨在向各委員報告社區重點項目的推行時間表，以及邀請委員就服務協議及服務監察機制提出意見。

背景

2. 立法會財務委員會已於 2014 年 7 月 12 日批准葵青區社區重點計劃的撥款，其中 3,690 萬元用以提供牙科護理服務、620 萬元提供眼科護理服務、3,690 萬元提供其他社區健康及支援服務、770 萬元設置社區健體設施及健康資訊站、280 萬元進行相關宣傳、400 萬元聘請民政處非公務員合約員工。另外，政府已計劃提供餘下的 550 萬元為儲備金，將用於延展服務項目及／或增設健體設施及健康資訊站。

3. 葵青民政事務處現正就各項服務推行擬定具體工作計劃。首要的工作包括與兩間非牟利機構擬定項目推行時間表、簽訂服務協議及制定服務監察機制。相關工作載於下文第 4 段至第 7 段，供委員考慮。

推行時間表

4. 項目各主要部分，即(i)社區健康服務、(ii)社區健體設施及健康資訊站，以及(iii)宣傳活動的推行時間表載於附件一。有關各項目之開展日期，計劃如下：

- (i) 社區健康服務：就社區健康服務，葵青民政事務處預計在 9 月底與兩間合作機構(仁濟醫院(下稱「仁濟」)及葵青安全社區及健康城市協會(下稱「協會」))簽訂服務協議。各項服務預計可於簽訂服務協議後的 6 至 15 個月內逐步開展。由協會提供的眼科護理服務，預計可於 2015 年第一季開展。同期，兩間社區健康資源中心亦會開始投入服務。兩間中心所提供的服務包括流感疫苗注射及健康教育。此外，外展服務亦預計會於 2015 年第一季或第二季開展。至於流動健康站及其餘三間社區健康資源中心預計將於 2015 年下半年投入服務。牙科護理服務方面，仁濟提供的兩所流動牙科診所預計會於 2016 年第一季或之前開始投入服務。
- (ii) 社區健體設施及健康資訊站：自 2014 年 6 月起，葵青民政事務處正就有關資訊站和健體設施的設計、建造和安裝、購置設備等安排進行前期準備工作。計劃中，將於 2014 年年底進行招標，並在 2015 年中逐批正式啟用。有關細節將於「社區健康設施及社區健康宣傳計劃工作小組」的會議上討論。(詳情載於社區健康設施及社區健康宣傳計劃工作小組 3/2014 號文件。)
- (iii) 宣傳活動：宣傳活動將陸續分階段展開，以配合各項服務開展及設施啟用時進行推廣。首項大型活動將會是 2014 年 9 月 28 日的「攜建共融 健康社區」葵青社區重點項目巴士巡遊活動。有關細節將於「社區健康設施及社區健康宣傳計劃工作小組」的會議上討論。(詳情載於社區健康設施及社區健康宣傳計劃工作小組 2/2014 號文件。)

服務協議

5. 葵青民政事務處已就服務協議的各項條款與仁濟及協會進行協商，亦已向律政司諮詢法律意見及向其他有關部門諮詢意見，包括財務安排、採購、資產管理、處理個人資料事宜及版權及知識版權之事宜。如各委員欲參閱服務協議的擬稿(只有英文版)，請聯絡秘書處。

服務監察

6. 根據草擬中的服務協議第 7.2 項，合作機構須每兩個月提交進度報告。葵青民政事務處現就各服務項目所需報告的事項擬定了有關要求，進度報告擬稿請見附件二(只有英文版)。請各委員就報告的內容提出意見。此外，葵青民政事務處亦會就服務監察制訂機制及程序，例如到服務地點進行巡察、制訂收集意見及投訴機制。上述服務協議亦已包含有關監督的條款。

7. 當然，我們歡迎亦期望各位區議員能透過其地區網絡，廣泛而直接監察兩間機構的服務，並收集居民的意見，確保項目的順利開展和服務質素。

徵詢意見

8. 請各位委員考慮上文第 4 段至第 7 段所述的推行時間表、服務協議及服務監察的安排。

社區健康服務工作小組秘書處

二零一四年八月

**Bi-monthly Progress Report No. __ for
K&T's Signature Project
Kwai Tsing Safe Community and Healthy City Association**

Period Covered From: _____ To: _____ Date of Submission: _____
(DD/MM/YY) (DD/MM/YY)

Name of Grantee: _____

Project Name: _____ Project Ref. No.: _____

Before services launch

Please fill in the table below

Milestone	Starting Date (preparation work)		Completion Date		
	Expected	Actual	Expected (last report)	Expected (this report)	Actual
Influenza Vaccination					
- Staff recruitment					
1. Enrolled Nurse (FET)					
2. Program Assistant (FET)					
<i>Other milestones to be inserted or added as appropriate</i>					
Outreach Services					
- Confirmation of collaborating organizations/ schools					
- Signing preliminary agreement with collaborating organizations/ schools					
- Signing formal agreement with collaborating organizations/ schools					
- Volunteer recruitment					
- Staff recruitment					
1. Service Master (Part-time)					
2. RN -0.25 FTE					
3. Program Assistant 0.25 FTE					
<i>Other milestones to be inserted or added as appropriate</i>					
Community Health Centers x3					
- Location confirmation of community health centers					
- Commencement of health center construction					
1. General construction					
2. TCM clinic					
3. Nurse clinic					
4. Pain clinic					
- Purchasing equipment (<i>please provide the name and number of equipment purchased in the space below</i>)					

1.					
2.					
3.					
4.					
- Staff recruitment					
1. Music Therapist (sessional)					
2. TCM x 0.2 FTE					
3. PTI x 0.2 FTE					
4. RN x 0.5 FTE					
5. Healthcare Assistant					
<i>Other milestones to be inserted or added as appropriate</i>					
Collaborative Community Health Centers x2					
- Confirmation of collaborating organizations/ schools					
- Signing preliminary agreement with collaborating organizations/ schools					
- Signing formal agreement with collaborating organizations/ schools					
- Location confirmation of community health centers					
- Commencement of health center construction					
1. General construction					
2. TCM clinic					
3. Nurse clinic					
4. Pain clinic					
- Purchasing equipment (<i>please provide the name and number of equipment purchased in the space below</i>)					
1.					
2.					
3.					
4.					
- Staff recruitment					
1. Music Therapist (sessional)					
2. TCM x 0.2 FTE					
3. PTI x 0.2 FTE					
4. RN x 0.5 FTE					
5. Social Worker					
6. Healthcare Assistant					
7. Office Assistant					
<i>Other milestones to be inserted or added as appropriate</i>					
Health Education					
- Staff recruitment					
1. RN – 0.25 FET					

2. Program Assistant					
<i>Other milestones to be inserted or added as appropriate</i>					
Mobile Health Station					
- Tender preparation					
- Tender publishing					
- Confirmation of motor vehicle supplier					
- Signing preliminary agreement with motor vehicle supplier					
- Signing formal agreement with motor vehicle supplier					
- Purchasing motor vehicle					
- License application for two mobile dental clinics					
- License confirmation from Highway Department					
- Accessories and fixture of the motor vehicle					
- Notebook and software support ready					
- Purchasing equipment <i>(please provide the name and number of equipment purchased in the space below)</i>					
1.					
2.					
3.					
4.					
- Staff recruitment					
1. RN x 0.5 FTE					
2. Optometrist x 0.5 FTE					
3. Program Assistant x 0.5 FTE					
4. Driver x 1 FTE					
5. Relief Driver					
- Final operation readiness testing					
<i>Other milestones to be inserted or added as appropriate</i>					
General Admin					
- Staff recruitment					
- Hardware IT system ready					
- Software IT system ready					
<i>Other milestones to be inserted or added as appropriate</i>					
Commencement of Operation					
Ophthalmic Care Services					
Influenza Vaccination					
Outreach Services					
Community Health Center					
Mobile Health Station					
Health Education					

2. Please discuss the **barriers** (internal and external) identified for the preparation of the project so far

3. Please devise the **solutions** in response to the aforementioned barriers

4. Please briefly sum up all factors and provide an assessment on the potential delay to overall project programme, if any

After services launch

Part A. Information on Activities under the *Ophthalmic Care Services*

1. Please fill in the following table

Activities	Target no. of service users (Two months)	Actual no. of service users served # (Two months)		Referrals (if applicable) (Two months)		Accumulative total	
		No. of service users	Attendance rate* (%)	Total no. of referrals	Please indicate the number of referrals to each of the referral places	Referrals (No.)	Service users (No.)
Free preliminary ophthalmic check (mobile health station)							
Comprehensive ophthalmic check (ICHC)							
Eye consultation and diagnosis							
Prescription of corrective glasses							
Subsidy for cataract surgeries							

*Attendance rate = actual number of attendance/ number of booking

Please submit the name list/ attendance record of the Ophthalmic Care Services along with this report

Part B. Information on *Influenza Vaccination*

1. Please fill in the following table

Activities	Target no. of service users (Two months)	Actual no. of service# users served (Two months)		Type of service users (No.) (Two months)		Accumulative total		
		No. of service users	Attendance rate* (%)	Age group of 50 to 64	Pregnant	Total service users (No.)	Age group of 50 to 64 (No.)	Pregnant (No.)
Influenza vaccination								

*Attendance rate = actual number of attendance/ number of booking

Please submit the name list/ attendance record of the Influenza Vaccination along with this report

Part C. Information on Activities under *Outreach Services*

Item	Number of volunteers# trained/ service users served in past two months	Accumulative number of volunteers trained/ service users served
Volunteers		
Home visits		
Home Cleansing		
Minor Repairs		
Home safety appliance		
Outdoor exercise classes		

Please submit the name list of the volunteers trained along with this report

Please fill in the following table according to the services provided in the past two months

Date & Time (dd/mm/yyyy)	Activities <i>(Please describe the purpose, nature, target clients, etc. of the activity)</i>	Service district(s)/ location(s)	Name of collaborating organization(s) /school(s), if any	Target no. of households	Actual no. of households served	Detailed feedback from the service users

Part D. Information on community health centers and mobile health station

Please fill in the following table

Centers & Mobile Health Station	Target no. of sessions and service users (Two months)	Actual no. of sessions and service users served # (Two months)	Referrals (if applicable) (Two months)		Accumulative total	
			Total no. of referrals	Number of referrals to each corresponding services <i>(e.g. register nurses, Chinese medicine practitioners, physiotherapists)</i>	Referrals (No.)	Service users (No.)
Community Health Centers and Collaborative Community Health Centers						
Health assessment						
Nurse clinic						
Chinese medicine clinic						
Pain clinic						
Rehabilitation class						
Music therapy class						
Health education						
Patient groups						
Volunteer training						
Career training						
Mobile Health Stations						
Health assessment						
Preliminary eye check						
Health counseling						
Drug advice						

Please submit supporting document on actual no. of sessions and service users served along with this report

Part E. Information on activities under health education

Program	In the past two months		Accumulative	
	Number of program organized	Number of service users served	Number of program organized	Number of service users served
Health Education Program				
Chronic Disease Program				
OLE Program				
Health Ambassadors				

Please submit supporting document on actual no. of programs and service users served along with this report

Please fill in the following table according to the services provided in the past two months

Date & Time (dd/mm/yyyy)	Activities <i>(Please describe the purpose, theme, target clients, etc. of the activity)</i>	Service district(s)/ location(s)	Information about the presenter <i>(e.g. name, qualification, organization)</i>	Target no. of service users	Actual no. of service users served	Detailed feedback from the service users

1. What were the characteristics of the target service users so far (e.g. age group, health status, socioeconomic status)?

2. Please describe the **project process** according to the proposed timetable

3. Please provide the **feedback** of the project from service users so far

4. Please describe and discuss those issues affecting the progress, e.g. the **problems encountered** (internal and external) and **solution devised**

5. Please briefly sum up all factors and provide an assessment on the potential delay to overall project programme, if any

6. What was Association's evaluation plan on each of the services in the past two months? (*Please attach the sample of evaluation tools/forms if any*)

7. Please list out the **forecast major activities** and/or **achievements** envisaged in the next two months

8. Other detailed comments

Part F. Income and Expense Statement

***Please fill in the excel as attached

Part G. Overall comment on Signature Project of Kwai Tsing District

1. How closely the actual implementation of the Signature Project of Kwai Tsing District met the planned criteria so far? Please select (☑) one below.

No criteria met	Somewhat met	Moderately met	Mostly met	All met

2. Please provide reason(s) in the space below

3. Please provide suggestion(s) to improve the Signature Project's efficacy, effectiveness and/or impact.

Part H. Declarations

I certify that all information contained in the financial statements and project performance report as stated above are true and correct. I also confirm that the Association has executed and complied with all the terms and conditions spelt out in the Agreement signed between the Association and the Government of the Hong Kong Special Administrative Region, as well as all relevant guidelines on implementing projects under The Signature Project Scheme as published at the website of the Home Affairs Department and at the webpage of the Enhancement of Community Healthcare Service.

Name of responsible officer:

Name : _____

Post : _____

Signature : _____

Contact Tel. No. : _____

Date : _____

Official Chop

**Bi-monthly Progress Report No. __ for
K&T's Signature Project
Yan Chai Hospital**

Period Covered From: _____ To: _____ Date of Submission: _____
(DD/MM/YY) (DD/MM/YY)

Name of Grantee: _____

Project Name: _____ Project Ref. No.: _____

Before services launch

Please fill in the table below

Milestone	Starting Date (preparation work)		Completion Date		
	Expected	Actual	Expected (last report)	Expected (this report)	Actual
Dental Care Services					
- Tender preparation					
- Tender publishing					
- Confirmation of motor vehicle supplier					
- Signing preliminary agreement with motor vehicle supplier					
- Signing formal agreement with motor vehicle supplier					
- Purchasing motor vehicle					
- License application for two mobile dental clinics					
- License confirmation from Transport Department					
- Accessories and fixture of the motor vehicle					
- Notebook and software support ready					
- Purchasing equipment (<i>please provide the name and number of equipment purchased in the space below</i>)					
1.					
2.					
3.					
4.					
- Staff recruitment					
2 full-time or part-time dentists					
3 dental hygienists					
1 senior dentist for consulting purpose					
2 executive officers					
1 part-time accounts clerk					

2 part-time drivers					
2 part-time clerks					
- Final operation readiness testing					
<i>Other milestones to be inserted or added as appropriate</i>					
Health Care Education					
- Confirmation of collaborating organizations/ schools					
- Signing preliminary agreement with collaborating organizations/ schools					
- Signing formal agreement with collaborating organizations/ schools					
General Admin					
- Staff recruitment					
- Hardware IT system ready					
- Software IT system ready					
<i>Other milestones to be inserted or added as appropriate</i>					
Commencement of Operation					
Dental Care Services					
Health Care Education					

1. Please discuss the **barriers** (internal and external) identified for the preparation of the project so far

2. Please devise the **solutions** in response to the aforementioned barriers

3. Please briefly sum up all factors and provide an assessment on the potential delay to overall project programme, if any

After Services Launch

Part A. Information on Activities under Dental Care

Please fill in the following table

Services provided	Target no. of service users (Two months)	Actual no. of service users served # (Two months)	Attendance rate* %	Referrals (Please indicate the number of referrals to each of the referral places) (Two months)	Accumulative total	
					Referrals (No.)	Service users (No.)
Oral Examination						
X-Ray						
Scaling (Full mouth)						
Temporary Restoration, Pus Drainage						
Extraction						
Restoration Composite/ Restoration Amalgam						
Denture						
Denture Repair						
Endodontic Treatment						
Dental Bridge						

* Attendance rate = actual number of attendance/ number of booking

Please submit the name list/ attendance record of the Dental Care services along with this report

Part B. Information on activities under health education

Program	In the past two months		Accumulative	
	Number of program organized#	Number of service users served	Number of program organized	Number of service users served
Oral Hygiene and oral health care				
Chinese Medicine Health Care				
Health Eating and Lifestyle				
Women Health				
Eye Care				
Mental Health				

Please provide supporting document actual no. of programs and service users served along with this report

Please fill in the following table according to the services provided in the past two months

Date & Time (dd/mm/yyyy)	Activities <i>(Please describe the purpose, theme, target clients, etc. of the activity)</i>	Service district(s)/ location(s)	Information about the presenter <i>(e.g. name, qualification, organization)</i>	Target no. of service users	Actual no. of service users served	Detailed feedback from the service users

1. Please describe the **project process** according to the proposed timetable

2. Please provide the **overall feedback** of the project from service users so far

3. Please describe and discuss those issues affecting the progress, e.g. the **problems encountered** (internal and external) and **solution devised**

4. Please briefly sum up all factors and provide an assessment on the potential delay to overall project programme, if any

5. What was Yan Chai Hospital's evaluation plan on the services provided in the past two months? *(Please attach the sample of evaluation tools/forms if any)*

6. Please list out the **forecast major activities** and/or **achievements** envisaged in the next two months

7. Other detailed comments

Part C. Income and Expense Statement

****Please fill in the excel as attached*

Part D. Overall comments on Signature Project of Kwai Tsing District

1. How closely the actual implementation of the Signature Project of Kwai Tsing District met the planned criteria so far? Please select (☑) one below.

No criteria met	Somewhat met	Moderately met	Mostly met	All met

2. Please provide reason(s) in the space below

3. Please provide suggestion(s) to improve the Signature Project's efficacy, effectiveness and/or impact.

Part E. Declarations

I certify that all information contained in the financial statements and project performance report as stated above are true and correct. I also confirm that the Association has executed and complied with all the terms and conditions spelt out in the Agreement signed between the Association and the Government of the Hong Kong Special Administrative Region, as well as all relevant guidelines on implementing projects under The Signature Project Scheme as published at the website of the Home Affairs Department and at the webpage of the Enhancement of Community Healthcare Service.

Name of responsible officer:

Name : _____

Post : _____

Signature : _____

Contact Tel. No. : _____

Date : _____

Official Chop