Healthcare Services (General) Regulations FAQ

Table of Contents

General

1. Where can I find the Healthcare Services (General) Regulations?
• Please refer to (http://www.hcsa.sg) to find out more about the Healthcare Services (General) Regulations (HCSA General Regulations). • Once it is implemented, the Regulations will also be available on Singapore Statues Online at http://sso.agc.gov.sg.

Part III Governance of Licensees

2. Who can be appointed as the licensee?
• Under HCSA, the licensee may be the corporate entity or a natural person (e.g. CEO of the licensable healthcare service). There is no restriction on who may be appointed as the licensee, nor is there any requirement for the licensee to have clinical expertise. • For example, an acute hospital may appoint its CEO as the licensee, or the licence may be held by the corporate entity (e.g. company) that owns the acute hospital. This similarly applies to other services, such as a medical clinic group, a clinical laboratory or a nursing home. In a much simpler business set-up, such as a solo GP clinic, the licensee may be the sole doctor who owns and practises at the clinic.
3. What is the difference between the roles of the Principal Officer (PO) and Key Appointment Holders (KAHs)?
• The role of the PO under HCSA is akin to that of the "manager" under the PHMCA. The oversight provided by the PO is to do with direct day-to-day management of the licensable healthcare service. It is the PO's duty to ensure operational compliance with the regulations and assist the licensee to review any risks to patient safety and welfare. • While the role of the "KAH" is now formalised under the HCSA, it is not a new concept. The KAHs are the governing body and generally the controlling mind and will of the licensee, and to be determined based on the business structure as registered with the Accounting and Corporate Regulatory Authority (ACRA). KAHs generally comprise the Board of Directors (BOD) for companies, the partners for partnerships, or the owner for sole proprietorships. They are responsible for the strategic leadership and corporate management oversight of the organisation, but they have limited direct influence over the day-to-day operations on the ground as compared to the PO. • Examples of typical KAHs in different settings include:

- Board of Directors for acute hospitals and community hospitals, large medical / dental clinic chains, clinical laboratories and large nursing homes, as these are typically complex set-ups owned by companies;
- Partners in partnerships, which typically own less complex set-ups, such as a small multi-doctor clinic;
- The business owner of sole proprietorships, which typically own simple set-ups, such as a solo GP clinic. Where a clinic is owned by an individual and the business is not registered with ACRA as a sole proprietorship, that individual is the KAH.
- For subsidiaries of a corporate entity without their own Board of Directors, e.g. clinical laboratories in a hospital cluster, the Board of Directors of the owner corporate entity are the KAHs of the subsidiaries.

4. Do KAHs have a duty to be involved in day-to-day operational issues?

- KAHs are responsible for approving policies and SOPs for both corporate and clinical aspects of the healthcare service. The PO and, where required, CGO remain responsible for overseeing the day-to-day operational management.
- As such, KAHs should take reasonable steps to apprise themselves of the implementation of policies and SOPs, and to identify any gaps or deficiencies in its implementation.

5. What does "day-to-day" operational management refer to?

- The phrase 'day-to-day' is a broad term, which entails the executive involvement of the PO/CGO, but it does not mean that they are required to be personally or directly involved in every task or function on the ground.
- The PO/CGO may delegate tasks to other personnel deemed competent and suitable for the functions, although the overall responsibility and accountability to ensure operational compliance with HCSA remain with the PO/CGO.
- This is akin to the Chief Executive Officer (CEO) or Chief Operating Officer (COO) retaining executive/operational responsibility over the day-to-day running of their institution even though they are typically supported by a team.

6. Why is there a need to formalise the role of KAHs? Are the KAHs always held accountable in the event of a breach?

- KAHs are the governing body of the licensee responsible for the strategic leadership and general management oversight of the licensable service. However, they do not have statutory roles under the PHMCA. Formalisation of the roles of KAHs under HCSA makes it clear that they are accountable for the directions they give.

- The licensee will always be culpable in the event of the breach. KAHs may not always be culpable whenever there is non-compliance. Their degree of culpability will turn on the facts of each case.

7. Why are KAHs required to have clinical expertise?

- At least one KAH is required to have clinical qualifications and experience relevant to the healthcare service(s), to ensure appropriate clinical oversight and guidance for the service(s) being provided. This is especially the case as there is no requirement for the licensee or the PO to have such clinical qualifications or experience.
- However, to provide greater flexibility for healthcare service providers, the clinical qualification/governance requirements for the KAH will be waived if these clinical requirements are met instead by the PO, or where there is a mandatory appointment of a Clinical Governance Officer (CGO) for the licensee's service.
- Please refer to the consultation slides for the Code of Practice for KAHs and its FAQs for more details.

8. Can one person be appointed as the CGO for more than one licensee or licensable service?

- Yes, a person with suitable skills and competencies can be appointed as the CGO for several licensees or licensable services simultaneously, subject to them meeting the specific requirements on skills and competencies of the CGO stipulated in the specific service regulations.
- However, in appointing such persons as the CGO, licensees are responsible for taking into consideration their bandwidth and capacity as part of assessing their suitability and ability for the role.

9. If the PO consults the CGO for clinical matters but eventually makes a decision that deviates from the CGO's advice, who would be held responsible if a non-compliance occurs?

- Under HCSA, the licensee is ultimately responsible for safeguarding patient safety and welfare and ensuring compliance with the Act and Regulations. The licensee is the default party that will be culpable for non-compliance with HCSA.
- However, if MOH investigates and determines that key officeholders such as the PO and CGO are also responsible for the non-compliance, MOH may also hold these other officeholders accountable. Their degree of culpability will depend on the specific facts of the case.
- Using the above example, the investigation will look into, among others, the nature of the non-compliance, and whether the licensee, PO and/or CGO are reasonably expected to identify and avoid or rectify the non-compliance based on their respective competencies, to ascertain their culpability.

10. [Updated on 9 Jun 2021] Does the PO report to the licensee?
• Under HCSA, the PO should be sufficiently empowered in his role to assist the licensee in ensuring operational compliance with the regulations, while remaining accountable to the licensee since the latter is ultimately responsible. The organisation can determine the reporting structure and arrangements that will allow this outcome to be best achieved.

Part IV Employees of licensees

11. What are the things a licensee should do to meet the requirements to ensure adequate supervision of employees?
• The licensee could have an organisation chart that clearly states the reporting line of every employee. • The licensee could also put in writing (e.g. Letter of Appointment) the responsibilities, duties and reporting line of each employee. • The licensee can have an appraisal system, which institutes systematic and regular review of the performance of the employees by the supervisors. Discussions during the appraisals should be documented. • The head of the group of employees or the supervisors may be held accountable if the employee's performance is not up to standard due to the lack of supervision.

Part V Committees appointed by licensees

12. Can I appoint a QAC for a service that is not listed in the HCSA General Regulations?
• Yes, the licensee can appoint a QAC for any service, and take reference from the QAC requirements stipulated under HCSA, in the interests of ensuring quality and safety. • However, please note that the protection from personal liability offered under HCSA section 55 is not applicable to such QACs, as the licensee is not legally required to set these up.
13. [Updated on 9 Jun 2021] Can a hospital have one hospital-level QAC to cover all QAC requirements for the various services provided by the hospital, including renal dialysis, nuclear medicine, day surgery, blood transfusion etc.?
• Licensee can choose to have separate QACs (with different member compositions) for each service or have the same QAC cover all services. The

licensee will need to ensure that the QAC(s) meet all the requirements for the various services and that the composition is appropriate for the areas covered.

14. [Updated on 9 Jun 2021] Do clinical laboratories offering laboratory genetic testing require at least one Mortality and Morbidity (M&M) QAC?

- No, clinical laboratories offering genetic testing do not need M&M QAC at this juncture.

15. What is the definition of "clinical appropriateness" that a QAC is responsible for?

- Appropriateness of clinical care is determined by the extent to which the relevant and required clinical care plans and procedures are executed properly; patients are subject to healthcare resources and procedures based on evidence that such resources and procedures can help the patients subjected to them; and healthcare practices with proven benefits to patients are employed, as required.

16. Can I appoint individuals who are not employed by the licensee as QAC members?

- Yes, the licensee can appoint non-employees who are assessed to be appropriate to be a QAC member.

17. [Updated on 9 Jun 2021] Must the QAC include external parties?

- QACs are not required to have external members.
- In the case of a conflict of interest when a case being reviewed by the QAC involves a QAC member, the licensees should put in place processes to resolve the conflict of interest, and ensure transparency and fairness, including requiring the implicated person to recuse himself from the QAC review, and appoint another qualified person to take over that role in fulfilling the QAC obligations.

18. How does a licensee ensure the QAC carries out its functions and duties when the members are appointed by the licensee and there may be conflict of interests?

- It is the QAC's duties and responsibilities to evaluate and monitor the quality, safety and clinical appropriateness of the licensable healthcare service provided by the licensee in a fair manner.
- The licensee must appoint a QAC supervisor, who may or may not be a member of the QAC, to oversee the QAC activities and ensure the QAC's duties and responsibilities are fulfilled.
- In case of a conflict of interest when a case being reviewed by the QAC involves a QAC member, the licensees should put in place processes to resolve the conflict of interest, and ensure transparency and fairness, including requiring the implicated person to recuse himself from the QAC review, and appoint another qualified person to take over that role in fulfilling the QAC obligations.

19. [Updated on 26 Jan 2021] What is the requirement of qualifications and competencies for the QAC Supervisor? Can a CGO be the QAC Supervisor?

- The licensee can also appoint a member of the QAC or an independent person as the QAC Supervisor. This can be the CGO if the licensee deems it appropriate. The licensee should assess whether the person could effectively perform the role of a QAC Supervisor, taking into consideration his/her qualification, competencies and experience.

20. I'm a licensee of a service for which QAC is not mandated. Why do I need to participate in the QAC activities?

- A non-QAC licensee may be directed by the Director to participate in the QAC activities of a QAC licensee, or to provide information as requested by the Director. This will ensure an independent review of the clinical quality of the non-QAC licensee.

21. Why is it necessary to have both QAC and key officeholders such as KAH/PO/CGO?

- The appointment of key officeholders strengthens the governance of the licensee and is applicable to all licensees. They ensure organisational processes of the licensee comply with all laws and regulations, including day-to-day operations and various aspects of the clinical services.
- On the other hand, QACs are set up to evaluate and monitor the quality and appropriateness of the healthcare services provided by the licensee and are only required for prescribed licensees. QACs review incidents such as Serious Reportable Events (SREs) and recommend corrective actions.
- The requirements on key officeholders and the QAC complement each other to enhance patient safety.

22. Can key officeholders such as the KAH/PO/CGO take on concurrent appointments in the QAC?

- Yes, key officeholders can be appointed as members of the QAC.
- The QAC members are required to carry out their reviews impartially. If the QAC is reviewing incidents that involve any QAC members, the implicated member should recuse himself from the review. Under HCSA Section 40(6), if there are reasonable grounds to believe that a QAC member is not performing any function or discharging any duty in a proper or satisfactory manner, the DMS may direct the licensee to (a) remove or replace any member of that committee; (b) appoint one or more additional members to that committee; or (c) dissolve that committee and appoint another such committee in its place.

23. [Updated on 9 Jun 2021] If I operate a medical practice as a solo practitioner (e.g. private specialist), am I required to assemble a QAC for the healthcare service(s) I provide?

- If you are not providing any licensable healthcare service(s) prescribed in the General Regulations that require a QAC, you are not required to establish a QAC. However, you may set up processes or engage qualified individuals to review the clinical quality of the service(s) provided.
- However, if you are offering special licensable healthcare services that require a QAC, a QAC must be appointed as a pre-condition to offering these services, as this is deemed necessary to ensure quality and safety for patients. You are allowed to tap on relevant existing QACs. This can be appointed by the hospital involved in the patient's care, or by another licensee. Multiple services can be overseen by the same QAC if the members of the QAC are appropriate for the evaluation of the healthcare services under its purview.

Part VI Licensed premises and licensed conveyances

24. Why is the licensee accountable for any misconduct/mistreatments by the co-located non-licensed healthcare service provider?

- The aim of the HCSA and its Regulations is to safeguard patient safety and welfare. Therefore, if licensees wish to have non-licensed services co-located within the same premises as licensed services, the licensee remains responsible for ensuring that patient safety and welfare are not compromised by any of these services.

25. [Updated on 9 Jun 2021] Are TCM and allied healthcare services able to be co-located with a clinic?

- The following non-licensable healthcare services (stipulated in the Fifth Schedule of the General Regulations) can be co-located with a licensed service, without the need for specific approval from MOH:
- Healthcare services provided by healthcare professionals registered under the following Acts:
- Nurses and Midwives Act
- Pharmacists Registration Act
- Optometrists and Opticians Act
- Traditional Chinese Medicine Practitioners Act
- Healthcare services provided by the Allied Health Professionals listed in the Second Schedule of the Allied Health Professions Act:
- Occupational Therapist / Ergotherapist

- Physiotherapist / Physical Therapist
- Speech Therapist / Speech Pathologist
- Radiation Therapist / Therapeutic Radiographer
- Radiographer / Diagnostic Radiographer / Radiologic Technologist
- For any other non-licensable healthcare services not listed above, MOH's prior approval is required before they can be co-located with a licensed service.

26. [Updated on 9 Jun 2021] Would dietician services require specific licensing?

- Under HCSA, dietetic service is not a licensable healthcare service, and thus a licence is not required. However, if it is being provided as part of another licensable service, e.g. in a clinic or hospital, the licensee is responsible for ensuring the appropriate provision of the service.

Part VII Handling of medicinal products, health products and specimens

27. Whose responsibility is it if the specimen is compromised/destroyed during the transport? Licensee or the outsourced transportation provider (e.g. the courier)?

- Licensees should have protocols in place to ensure safe packaging, handling and transport of specimen.
- Licensees should also take steps to ensure there is no mix-up or contamination of the specimen, as well as proper labelling of the nature of the specimen to ensure public safety is not compromised.
- If the specimen is compromised/destroyed during transport, MOH will investigate and hold the licensee culpable if it has not complied with HCSA's requirements.

28. [Updated on 9 Jun 2021] Are medical practitioners required to record the specified dose prescribed to patients?

- As required by both the HCSA General Regulations and the Health Products Regulations 2016, medical practitioners should record details including the product name, amount supplied and dose instructions to patients to ensure that the appropriate dose has been prescribed and dispensed or administered to the correct individual. Patient's medication records should contain adequate, accurate and relevant information to ensure clear documentation, and safe and appropriate use of the product by the patient.

Part VIII Service standards

29. There are requirements for licensees to ensure patients are protected from abuse and negligent, but how can licensees protect their staff from being abused by patients/family members?

- Protection of staff is governed under the Protection from Harassment Act (POHA), and there is also recourse available under the Penal Code against the abusive patients/family members.
- HCSA focuses on safeguarding the safety and welfare of patients, including protecting them from abuse and neglect.

30. What information must be given to patients to help them make an informed decision?

- Licensees must ensure that patients are adequately informed of their conditions and options for treatment, and also put in place systems to obtain the corresponding consent from patients thereafter.
- These requirements complement existing requirements stipulated in the Directive on Consent Taking Practices for Procedures Performed by All Registered Medical Practitioners issued by MOH in 2016, as well as the guidelines on consent taking set out by the Ethical Code and Ethical Guidelines published by Singapore Medical Council (SMC ECEG).

Part IX Price transparency

31. How detailed do I need to be when displaying the "common charges" on the premises or websites? I may be providing many services, and there are too many to be displayed.

- Licensees should ensure price transparency by providing information on fees and charges to patients and/or their representatives. The purpose is to facilitate informed decision-making. Therefore, common charges (e.g. consultation) and fees of treatments/procedures that are relevant to a significant segment of patients of the service must be prominently displayed on the premises/conveyance or website.
- MOH will provide further guidance on the details of common charges to be displayed in different services at a later date.

32. Am I required to always provide an itemised bill to patients?

- Licensees are required to provide a bill that itemises the charges minimally by the generic categories stipulated in the General Regulations.
- Licensees that are able to generate a more detailed line item bill may also choose to do so, as appropriate.

33. Is financial counselling required for every service and visit?

- Financial counselling will be mandated for licensees providing selected licensable services which will be listed in General Regulations during their respective implementation phases (notwithstanding that, licensees of services not within the list may also carry out financial counselling if deemed appropriate.).
- In general, the licensee should verify whether the patient is aware of the charges, and counsel or re-counsel the patient if the fee information is new to the patient.
- Some examples of when financial counselling should be carried out:
    a. During the first visit or consultation for a particular care episode
    b. When the patient is advised on a treatment or procedure for the first time
    c. For longer-term care, when there is a change in fee or estimated charge range earlier counselled to the patient (e.g. the price of doctor's consultation or treatment has increased from $x to $y with effect from a certain date)

34. Am I expected to provide the historical and national price ranges for all my services and charge items?

- The provision of historical and national price ranges is mandated if they are published by MOH, such as on MOH's website for fee benchmarks and bill amount information for surgeon fees, inpatient bill sizes, and dental fees.
- In such instances, licensees may include these published price ranges in the financial counselling process, e.g. by informing patient of the relevant diagnosis-related group (DRG) or table of surgical procedures (TOSP), or point their patient to the website where they can access the information.

Part X Infection control, incident management and emergency preparedness

35. [Updated on 17 Aug 2021] Why is vaccination against measles and diphtheria incorporated as requirements under HCSA? Will MOH be including other vaccination as requirement under HCSA?

- Measles and diphtheria are serious infectious diseases, and vaccinations against the two diseases are mandated under the Infectious Diseases Act for all children residing in Singapore.
- There is a need to ensure high vaccination coverage or immunity among workers in healthcare, to minimise the risk of disease outbreak and spread of the diseases to patients, and other healthcare workers.

- The measles outbreaks in 2019 globally further point at the vulnerability of not being protected against the disease. It is important to ensure that all healthcare workers who are clinically eligible for the vaccines are protected against these serious infectious diseases through vaccination.

36. [Updated on 17 Aug 2021] Can self-declaration of immunity or vaccination be accepted?

- No, self-declaration is not accepted as proof of immunity.
- For measles, acceptable evidence of immunity includes documented proof of vaccination (completion of a course of vaccination involving 2 doses given at least 4 weeks apart); serological evidence of immunity or laboratory confirmation of past infection.
- For diphtheria, acceptable evidence of immunity includes documented proof of vaccination with tetanus toxoid, reduced diphtheria toxoid and acellular pertussis ("Tdap") or tetanus and diphtheria toxoids ("Td") in the last 10 years.

37. [Updated on 17 Aug 2021] We understand that there are exemptions whereby certain age groups need not be vaccinated. Who is exempted/not exempted? Why are there such age-group exemptions?

- Healthcare workers who do not have evidence of immunity against measles will have to be vaccinated against measles. The exception is if they are Singaporeans or Permanent Residents (PRs) born in Singapore before 1 January 1975. Serological studies have shown that there is a high level of immunity against measles (~100%) in these cohorts.
- There is no age-group exemption for the diphtheria vaccination requirement. All workers in healthcare who do not have evidence of immunity against diphtheria will have to be vaccinated against diphtheria.

38. [Updated on 17 Aug 2021] Why is the age-group exemption (Singaporeans or PRs born before 1975 are exempted) not extended to foreigners or Singaporeans or PRs not born in Singapore?

- The immunity of these persons/groups of persons cannot be established a priori.

39. [Updated on 31 Oct 2021] I am an SC/PR born in Singapore before 1975 and should be exempted from the measles immunity requirement. However, my institution/clinic insists that I should be vaccinated against measles or provide documentary proof that I am immune. Why is this so?

- While SC/PR born in Singapore before 1975 are exempted from the measles immunity requirement, licensees may put in place additional appropriate measures based on their risk assessment to ensure that there is no risk of spreading the disease.

40. [Updated on 17 Aug 2021] On measles vaccination, for staff who have taken one dose, can they continue working while waiting to take the second dose?

- Yes, they can continue working while waiting for the second dose.
- The dose interval for the measles vaccine is 4 weeks. Staff who have taken one dose should take the second dose based on the minimum dose interval between the first and second doses.

41. [Updated on 17 Aug 2021] How can the licensees assess whether the exemption criteria are met?

- As a first step, Licensees should review the records of staff who are employed or engaged by them, or volunteer with them, to ascertain if they fall within the scope of any of the exemptions in the licensing terms and conditions.
- In respect of other staff that are not employed or engaged by them, or who do not volunteer with them (such as external vendors), they should take appropriate steps to satisfy themselves that the exemption criteria are met. For example, one possibility would be to include the immunity requirements and requirements for proof in relation to exemptions in their contracts with vendors. They should also ensure that they are able to access relevant records of immunity of such staff upon request.
- The intent behind the immunity requirements is to ensure that staff are not a conduit of spread of diseases to patients (and healthcare workers) in the healthcare setting. Staff whose work does not involve direct interaction with patients and who do not work within any premises of a healthcare institution which provides services that involve direct interaction with patients do not have to meet the immunity requirement. To illustrate, staff who work in a testing laboratory would not have to meet the immunity requirements, if the laboratory is not located within the physical site of a healthcare institution which provides services involving direct interaction with patients (such as hospitals and clinics). If, however, the laboratory is located within the physical site of such a healthcare institution, it would be considered to be within its premises, and the immunity requirement would apply for the laboratory's staff.
- In addition, staff who are clinically not suitable for the vaccination (i.e. they have been certified permanently medically unfit for vaccination) also do not have to meet the immunity requirement.

42. [Updated on 17 Aug 2021] How should persons who refuse the vaccinations be managed?

- Licensees should implement appropriate measures to ensure that high vaccination coverage is maintained, in keeping with the intent of the requirements. For example, licensees may require new hires to comply with

immunity requirements imposed by these licensing terms and conditions as part of their employment contracts.

- Licensees should also proactively encourage existing staff who do not have acceptable evidence of immunity to be vaccinated. For example, for older staff who may be concerned about vaccine side-effects, a vaccinated individual of around the same profile could be asked to provide reassurance. For staff who decline vaccination, the licensee may consider redeploying such staff to settings which do not involve direct interaction with patients (in the interests of patient safety), while continuing to engage such staff on their concerns and encouraging them to be vaccinated.

43. [Updated on 22 Jan 2021] Will this vaccination requirement among healthcare workers be extended to COVID-19 vaccination?

- For now, COVID-19 vaccination is voluntary for healthcare workers. However, healthcare workers are at high risk of exposure to the disease in their workplace. It is, therefore, important that they are protected from the disease, so that they can in turn protect their loved ones and their patients. Healthcare workers are therefore, strongly encouraged to be vaccinated.

44. [Updated on 17 Aug 2021] What is the timeline for licensees who are transiting to HCSA in the other Phases (i.e. Phases 2 and 3) to meet the measles and diphtheria vaccination requirements?

- MOH plans to introduce the vaccination requirements via the HCS General Regulations and PHMC LTCs, which are planned to be issued on 3 January 2022. Licensees will be required to ensure their staff have undergone the measles and diphtheria vaccinations by 3 January 2022 unless they have been exempted.
- PHMC licensees will be subjected to the vaccination requirements through the PHMC LTCs until they transit to HCSA in their respective phases (e.g. Phase 2 for clinics and Phase 3 for hospitals), after which the HCS General Regulations will apply.

45. [Updated on 17 Aug 2021] We have outsourced partners and vendors, volunteers, who provide services in our premises at various frequencies. For example, air conditioner servicing is done quarterly, while couriers enter our premises either daily or weekly. Are the vaccination requirements applicable to such volunteers, outsourced partners and vendors?

- Staff from outsourced partners/vendors, and volunteers will need to be vaccinated if they do not fall within the scope of the exemptions in the licensing terms and conditions, and do not have acceptable evidence of immunity.
- This applies to all staff of partners and vendors which provide services(e.g. maintenance of equipment, infrastructure, couriers etc.) as well as volunteers, save where such partners, vendors and volunteers provide services or volunteer

on only a one-off basis (for example, providing catering services for, or organising a one-off event).

- Licensees should ensure that they put in place measures to ensure that they comply with their obligations to ensure that staff of outsourced partners/vendors as well as volunteers have, or acquire the required immunity under the licensing terms and conditions. These may include, for example, stipulating the requirements for immunity and vaccination in their contractual agreements with such partners and vendors.

46. [Updated on 17 Aug 2021] If vaccination is needed, are the vaccinations subsidised by MOH? If not, will the staff be eligible for the National Adult Immunisation Schedule (NAIS) subsidy for the measles and diphtheria vaccination?

- All Singapore Citizens (SCs) and Permanent Residents (PRs) for whom vaccination is recommended under the NAIS are eligible for subsidies for the relevant vaccinations. Under the NAIS, measles vaccination (as part of the Measles Mumps and Rubella vaccine) is recommended for adults who have not been previously vaccinated, or lack evidence of past infection or immunity, while Tdap is recommended for pregnant women during 16-32 weeks of each pregnancy. Licensees may also further subsidise the remaining cost of vaccinations for staff, at their discretion.

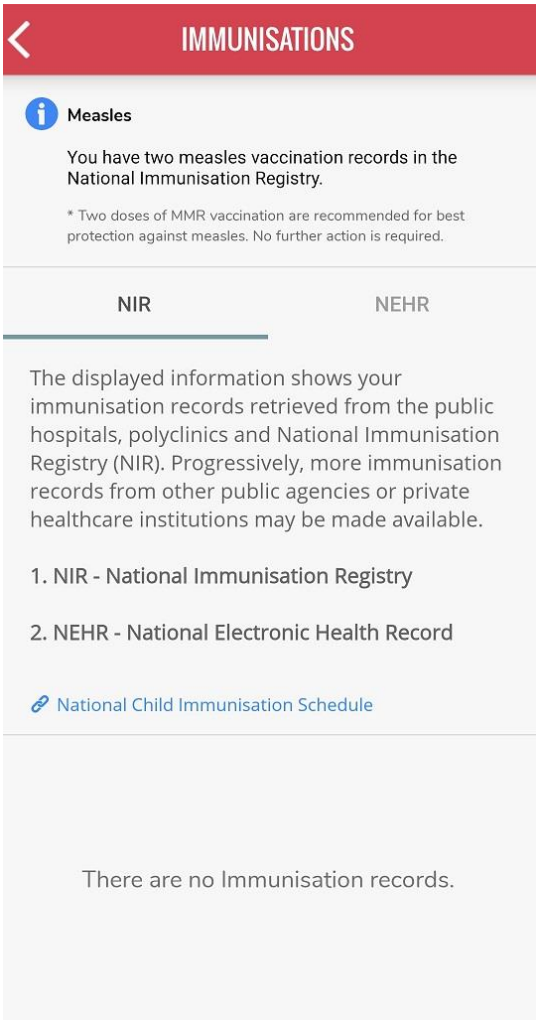
47. [Updated on 17 Aug 2021] After proof of immunity has been obtained, do we need to submit the supporting documents (e.g. vaccination records) to MOH?

- Licensees are not required to submit the documents to MOH. However, licensees should keep such records minimally for the period specified in the licensing terms and conditions. Such records may be subject to inspection and audit by MOH.
- Licensees should note that there are requirements to notify vaccinations involving vaccines in the National Childhood Immunisation Schedule and National Adult Immunisation Schedule to the National Immunisation Registry following administration and comply with any applicable requirements.

48. [Updated on 17 Aug 2021] Where can I retrieve past vaccination records, if available?

- Singaporeans who are born in 1996 and after can access their past vaccination records via HealthHub with their SingPass.
- Singaporeans born before 1996 will be able to access their vaccination records via HealthHub for vaccinations under the National Adult Immunisation Schedule, taken on or after 1 Nov 2017.
- Some Singaporeans born before 1996 may also have records of the measles vaccination administered before 1 Nov 2017 shown in HealthHub. An example

of such a record, which will be acceptable as proof of vaccination, is shown in the screenshot attached.



- Persons whose records are not available in Healthhub may request for the proof of immunity from the healthcare providers where they had received the vaccination or, in the case of measles only, where they were diagnosed.

Part XI Miscellaneous

49. If my clinic specialises in treating a certain disease, can I include the disease in the name of my clinic? Do I need to apply for special permissions to do such?

- Generally, the name must accurately reflect the service(s) that the licensee is licensed to provide. It should not contain terms that may misrepresent the licensee's capability, or purport to be a different specialty or licensable service.
- In the same vein, the name of the licensed service(s) should not include mention of disease conditions or treatments that the licensee is not qualified and/or competent to manage or provide. For example, at least one medical/dental

practitioner working in that licensed service must be a specialist (certified by SAB or DSAB) for that disease condition or treatment, or the medical/dental practitioner is credentialed by a professional body to provide treatment for that disease condition, where they are mentioned in the licensed name.

- During the evaluation of licence applications, or if complaints are lodged against licensees with alleged inaccurate names, MOH can require licensees to furnish proof of their competency/credentials to provide treatment for that particular disease condition. There is no need to specially apply for permission for naming of the service.

50. [Updated on 9 Jun 2021] Is the term "aesthetic" allowed for use in a clinic name?

- The business name for the licensed service should accurately reflect the services it is licensed to provide as well as its capabilities, and not be misleading. As such, the term "aesthetic" is allowed where it accurately reflects the services provided at the clinic.
- Additionally, a recognised specialty may only be reflected in the business name if there is at least one specialist for that specialty registered by SMC or SDC. This specialist must be actively practising in the clinic.

51. As businesses who have built brands around their names may lose brand equity, will there be grandfathering of existing providers with names that will not be approved under the HCSA?

- Existing licensees will be exempted and may continue to use their present name.
- However, this exemption will cease where there is a transfer of ownership or substantial change in the governing body (e.g. Board of Directors) of the licensee.

52. [Updated on 9 Jun 2021] Do we have to change our clinic names which may be deemed inappropriate under the new HCSA?

- Existing licensees are grandfathered and may continue to use their present names until there is a change in their licence, such as where there is a transfer of ownership, a substantial change in the governing body (e.g. ≥ 50% of the Board of Directors) of the licensee, or the name of the business or institution.

53. [Updated on 9 Jun 2021] How detailed must the business continuity plans (BCP) be?

- Given that the risk and impact of disruptions, and the corresponding need for business continuity plans vary based on the business structure, size and services involved, the regulations are not intended to prescribe exactly what licensees should do in developing such plans.
- Rather, they are intended as a general obligation for licensees to think about the actions to be taken in case of service disruption, which may again vary

depending on the services involved. For instance, in dealing with a power failure, clinics may decide to stop operating, whereas acute hospitals may require the procurement and activation of back-up power sources.

- Generally, where the licensee decides to continue with the service, the licensee should consider what needs to be in place for the service to continue despite the disruptions in question.
- Compliance with the BCP requirements will be checked as part of the inspection process. While large and complex set-ups (e.g. acute and community hospitals, nursing homes, clinic chains, laboratories) should have documented BCPs, smaller set-ups (e.g. those involving solo practitioners) may not need to do so. Regardless of the need for documentation, licensees must be clear on the actions to be taken in case of service disruption, to ensure continuity of care for the patients.

54. If I outsource a licensable healthcare service, do I need to ensure the facilities and equipment used by outsourced service providers meet the requirements? Who is responsible if the requirements are not met?

- Where the outsourced service is a licensable healthcare service, the contracted provider that the licensee engages must be a HCSA licensee holding a licence for that service. The contracted service provider is responsible for ensuring its facilities and equipment meet requirements under HCSA and its various Regulations.
- The licensee should also implement measures to ensure the outsourced service provider meet the requirements under HCSA, as the licensee retain overall oversight for any outsourced service and remain ultimately responsible for compliance with HCSA. This could be done via a formal contractual agreement which clearly states the obligations of the outsourced service provider. Licensees may also wish to consider random audits and checks by the on the facilities, equipment, and services by the contracted service provider.
- In case of a breach, both licensee and the contracted provider (who is also a licensee) remain accountable, and degree of culpability will turn on the facts of each case.
- For completeness, outsourced services cannot be contracted to foreign providers unless expressly permitted under the Service Regulations.

55. [Updated on 9 Jun 2021] Is sending genetic testing panels to an overseas accredited laboratory considered outsourcing?

- Yes, that is considered outsourcing. There will be provisions stipulated in the service regulations to allow outsourcing to overseas labs. The overseas labs must be accredited by the list of accreditation authorities that MOH accepts.