Hong Kong College of Health Service Executives

Newsletter Issue 3 2016/17

Council Members

Past and Upcoming Events

APR

Seminar on "ISACA: Myths and Facts" Impact to Health Services

Speaker : Mr. Raymond CHAN Kwan Tak
Program Director
ISACA China Hong Kong Chapter
Date : 26 April 2017 (Wednesday)
Time : 18:30 - 20:30
Venue : Seminar Room 1
M/F, Hospital Authority Building
147B Argyle Street, Kowloon, Hong Kong

MAY

Seminar on "Communications at Good or Bad Times"

Speaker : Ms. Anita Yuen Mei Fung BBS, JP
Date : 25 May 2017 (Thursday)
Time : 18:30 - 22:00
Venue : Craigengower Cricket Club,
188 Wong Nai Chung Road,
Happy Valley, Hong Kong

JUL

HKCHSE Annual Conference

Theme : Invest in Health, Create Wealth
Date : 22 July 2017 (Saturday)
Time : 14:00 - 22:30
Venue : Cordis, Hong Kong
555 Shanghai Street, Mongkok

SEP

ACHSM/ACHS Joint Conference

Theme : The Winds of Change – Adjust Your Sails
Date : 27 - 29 September 2017
Time : 18:30 - 20:30
Venue : Hilton Sydney, Australia

Message from the President

20/20 Leaders of Healthcare

Demographic changes, burden of chronic diseases, increasing pressure for accountability, emerging technologies that revolutionize care delivery model .... and pace of these changes can be dizzying.

The role of our College is to ensure that leaders of tomorrow should be ready for the future we can see coming and prepared to adapt to the innovations we cannot even dream of today. In these new model of health care, we are building teams centered on the needs of the patient so that the collective expertise and wisdom of the inter-disciplinary team work can determine the best care. Increasing inter-professional activities focus on better understanding what a holistic approach to patient care means. It goes without saying that, just like any of us, healthcare executives are being recognized not only as key drivers for organizational performance but also the catalytic factor that are affecting our patient's life and health.

We embrace the vision of excelling in healthcare management for better serving the people in Hong Kong. The College Council in October 2016 has been deliberating the implementation of a continuing professional enhancement that would promote increased self-awareness, responsibility of self assessment, engineering specific knowledge, skill and attitude relevant to professional practice. Such a systematic development would allow our members to achieve a deeper understanding of the competencies underpinning effective performance.

Figure 1: Relationship between Domains

The Council considers that ACHSM MASTER HEALTH SERVICE MANAGEMENT COMPETENCY FRAMEWORK[1] has articulated the capability and behavior that HKCHSE wishes to encourage within its members. This competency framework is a method of attribute based guide that should not be confused with performance assessment. Its benefits should be gained through experience and interaction and are cultivated, matured and honored through professionalism incorporated within a holistic approach to lifelong learning.

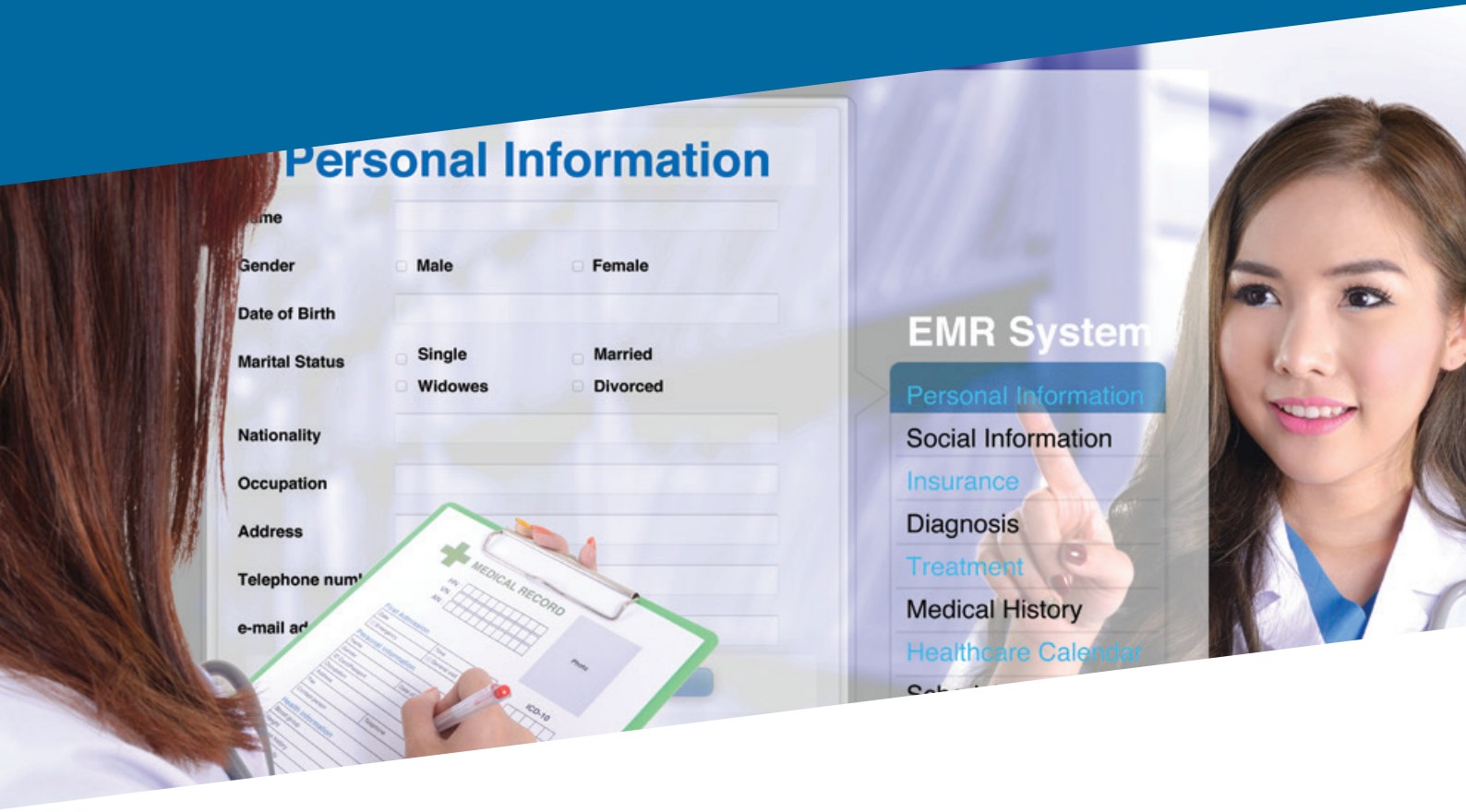
The ACHSM Master Competency Framework captures the core competencies that are considered important for health service managers and leaders. This Framework, summarized in Figure 1, uses the five domains of health service management competency adopted by the Global Consortium and the International Hospital Federation[2]. The Domains consist of a core leadership competency and 4 interlinked areas in health care environment, business skills, communication and professional responsibility. Our College will take reference from this document to guide refinement in our Fellowship program and organization of future CPD programs. Periodic review of its applicability in the local healthcare scene will be conducted.

References:

(1) ACHSM MASTER HEALTH SERVICE MANAGEMENT COMPETENCY FRAMEWORK (2016).http://achsm.org.au/Documents/Education/Competency%20framework/2016_competency_framework_A4_full_brochure.pdf

(2) International Hospital Federation. Leadership Competencies for Healthcare Services Managers. Bernex, Switzerland: IHF; 2015.

Dr LIU Shao Haei



Clinical Handover Practice in a Clinical Department - Change Management

Background

Clinical Handover

Clinical Handover refers to transfer of information, responsibility and accountability between individuals and teams, within the local context of workflow and structure of the care system.[1,2] It involves transfer of patient information between individuals and groups and is an integral part of patient care.

Clinical handover is essential for ensuring continuity in patient care. Use of a standardized process for clinical handover was shown to improve patient safety because important information is more likely to be communicated and acted upon.[3]

Poor handover may lead to breakdown in information transfer. Study has identified that poor communication of clinical information contributed to serious adverse events and was a preventable cause of patient harm[4]. It leads to unnecessary delay in diagnosis or treatment; repeated tests, missed/delayed communication of investigation results, incorrect treatment or mediation errors.

In 2006, the World Health Organization (WHO) identified communication of patient information as one of the five areas of patient safety concern in the Action on Patient Safety Projects: High 5s[5]. Since then, different regulatory bodies and professional societies have published guidelines to promulgate clinical handover practice.[2,6-8]

In Hong Kong, there is no published guideline from regulatory bodies or professional societies. Clinical handover, a conventional practice in Operating Theatre, Intensive Care Unit and Accident & Emergency Department, only received increased attention by other specialties recently. The corporate wide Hospital Accreditation Project jointly organized by Hospital Authority (HA) and The Australian Council on Healthcare Standards (ACHS) catalyzed the emphasis on this practice. An electronic handover (e-Handover) system was implemented to facilitate handover practice within the organization.

Local Contextual Background

i) **Under-utilization of the e-Handover system**

Electronic clinical handover tool (e-Handover) was implemented in Caritas Medical Centre in January 2014. This system was promulgated in different specialties to facilitate the handover process. Initial response to this system was encouraging in the first eight months. Ongoing statistics showed the system was under-utilized (Figure 1). Though its significance was well understood, handover practice varied among specialties. This might be related to heterogeneity in staff mix, workflow and environment. Another key factor was lack of prevailing culture and practice. Quality and Safety (Q&S) Unit of the hospital has recognized the need to strengthen the handover practice.

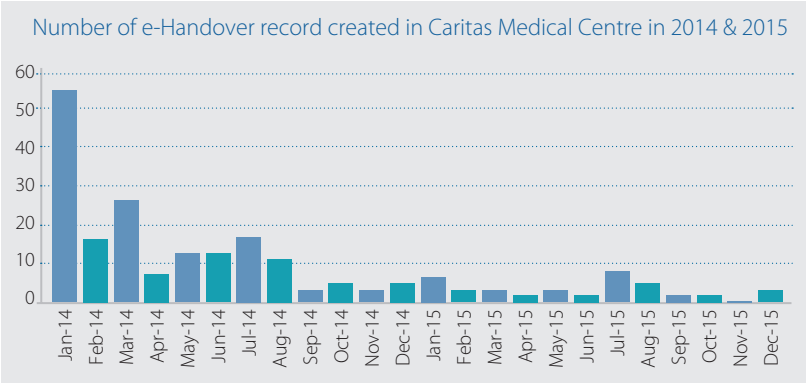


Figure 1: Number of e-Handover records created in Caritas Medical Centre in 2014 and 2015

ii) The "critical situation" in Department of Medicine and Geriatrics

More than 10 new graduates joined the Department of Medicine and Geriatrics (M&G Department) in July 2015. It accounted for about 18% of department's manpower. They lacked sufficient clinical experience in managing complicated or critically ill patients. The call roster had been modified in recent years as a measure to retain staff. Longer shift duties were replaced by shorter ones which were staffed by junior colleagues. They took up 80% of these calls. We recognized the need to provide more supervision to these colleagues.

Out of the 1046 beds in the hospital, 434 beds are under M&G Department. There are 292 are acute beds and 142 rehabilitation beds distributed in nine different wards. Number of acute admission ranges from 1576 to 2082 per month. Four doctors provide on-call services each day. In addition to their day-time clinical duties, two physicians take up the ***short-call*** duty which ends at 23:00. The ***night-shift*** physician has a short break between 17:00 to 23:00 and resumes the night shift duty at 23:00. The ***ward-call*** physician has to work continuously for up to 36 hours.

Faced with more inexperienced staff and more shift duties, we recognized the compelling need to strengthen the handover practice to ensure delivery of quality and safety care to our patients.

Project Objectives and Scope

Q&S Unit chose Department of Medicine and Geriatrics as the pilot site to develop a new handover system after consideration of their compelling need to strengthen the handover practice and after SWOT analysis.

The scope of this project is to build a handover culture in our newly recruited colleagues, and change the prevailing culture and practice in the existing staff. This new system should be tailored to the specific need, workflow and context of M&G Department, with minimal disruption to the existing workflow and with minimal additional workload.

Table 1: SWOT analysis suggested M&G Department is a favourable pilot site for new handover system

Strength	Opportunities
1. Supportive Chief-Of-Services and senior staff	1. Influx of significant number of new staff provides an opportunity for culture and behavioral change
2. A significant proportion of colleagues have prior clinical handover experience during their ICU rotation	2. Anticipated continued influx of junior staff as new graduate will replace retired consultant in the workforce. Momentum for change can be maintained in subsequent years
3. Staff experienced in clinical handover (ICU Senior) act as facilitator (role model) in initial run-in phase to coach/ train clinical handover technique	3. Periodic Review of ACHS will be carried out in late 2016 (urgency to improve handover practice within the department)
4. The relationship between staff is close and supportive in this small department.	
5. Implementation of handover system in the M&G Department, if successful, will result in significant impact to the hospital (41.4% in-patients)	
Weakness	**Threat**
1. Staff may be engaged in out-patient clinics or other clinical duties (Time constraint)	1. New arrangement may not be accepted by some of the middle level staff
2. MG Department is the busiest department especially during the winter surge	2. Loss of momentum and lack sustainability

Project Planning and Execution

i. **Explain the project plan to key stakeholders and empowerment from top administrators**

A meeting with Chief of Services (COS) and Consultant of Quality and Safety (Q&S) Unit was arranged to explain the reason of initiating this new project to enhance the handover practice. We defined our goal as cultivating handover culture & behavior in new staff and changing prevailing concept and practice of existing staff.

This project was initiated by the Q&S coordinator of the department (i.e. the author) and was jointly owned by M&G Department and Q&S Unit. This project was fully supported by our Hospital Chief Executive (HCE), COS and other consultants in the department.

Stakeholders were approached in the preparation phase to explain the underlying rationale to start this new project. They included fellows and frontline colleagues in the department, General Manager (Administration) (GM(Adm)), Information Technology Department, department Secretary and Ward Manager.

ii. **Define roles and responsibilities**

A small project team consisted of COS, Consultant of Q&S Unit and Q&S coordinators was formed. As the project manager, I was responsible for liaising with different stakeholders for resource and designing the workflow. I needed to oversee the project in planning, execution and evaluation phases in order to accomplish the project objectives. COS and Consultant of Q&S Unit were sponsors of this project. Roles of other stakeholders were listed in Table 2.

Table 2: Stakeholders of this project were identified and approached

Stakeholders	Involved in	Roles in this project
HCE/ Q&S Unit	All phases	Hospital Governance
COS of MG Department	All phases	Sponsor of this project. Empower and authorize this project. Governance issue.
Seniors/Fellows	Planning, Execution Phase	Daily operation in the new Senior led Clinical Handover arrangement
Frontline colleagues	Planning, Execution Phase	Direct participation in the new handover arrangement
GM (Adm)	Planning Phase	Resource input (Installation of computer based SMS message system)
IT Department	Planning Phase	Resource input (installation of additional of CMS station and data port)
Department secretary	Planning, Execution Phase	Sending SMS to on-call colleagues; coordinate Senior to attend handover round
Ward Manager/Clerk	Planning, Execution Phase	Daily maintenance and preparation of meeting room for handover round

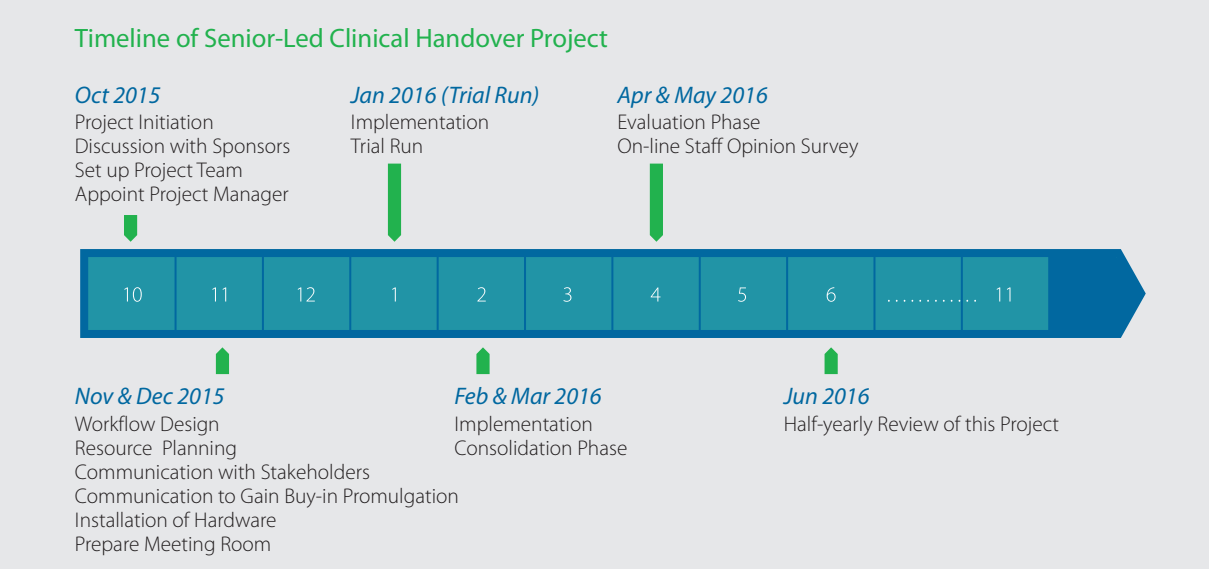


Figure 2: Timeline of this new Senior-Led Clinical Handover Project in M&G Department

Table 3: Findings from on-line survey, direct communication with colleagues and literature review

Feedback and suggestions from direct face-to-face communication with staff

1. Senior on-call may not be able attend a designated handover round in view of the time constraint and competing clinical duties
2. Staff expressed their worry and concern on sustainability and accountability issue.
3. Staff suggested a protected time for clinical handover.

Result and conclusion from on-line opinion survey carried out in the MG Department (Appendix 1)

1. Eighteen of 58 (31%) doctors in the department completed the evaluation form.
2. 61% of the respondents were basic or advanced trainees with overnight duty and 39% were seniors without overnight duty.
3. The important findings were summarized

Opinion on clinical handover practice in patient management	*% agreed or strongly agreed*
a. Handover is beneficial for patient management and it helped clinicians get prior information on unstable cases.	84
b. Handover is useful for managing the cases during their on-call duties.	78
c. Structured handover format is needed	72
d. Input from experienced clinicians on managing difficult cases or scenarios is essential	83
e. Handover should be short and precise, with clear instruction and direction on patient management.	78

Electronic handover tool

a. 67% of the respondents had used e-handover in CMS for less than 5 times
33% had never used the system.
b. 55% commented the system was not user-friendly
c. 61% agreed or strongly agreed that using the system was time consuming.
d. 77% agreed or strongly agreed that activation/deactivation of e-handover was a barrier for its use.

Conclusion

This survey showed that our colleagues had positive attitude towards clinical handover.

Senior input on patient management was welcomed by most colleagues.

Electronic platform/tool, when available, should be user-friendly and not created extra workload.

Literature review on staff survey on clinical handover (overseas experience)

1. Senior participation in handover round improved juniors' management skill on patient care through better communication of the patient information[9]. Junior doctors expected senior colleague participation for guidance.[10]
2. Strict adherence to meeting time frame improved the efficiency and was viewed positively by the participants.[9, 10]
3. The junior participants viewed the handover round as an educational event. This approach helped keeping the system sustainable and enhanced adherence to the system.[9]
5. Clearly defined rules and template avoided variation in practice and was expected by juniors.[10]
6. Face-to-face handover allowed clarification of information and was preferred.[10]
7. Computers allowing rapid access to clinical information and knowledge database enhanced attendees' satisfaction.[9]

External evaluation report on the National Clinical Handover Initiative Pilot Program initiated by Australian Commission on Safety and Quality in Health Care (ACSQHC)[11]

Experience from successful pilot projects:

1. The handover tool or process was tailored for the specific handover environment, was practical and an improvement on current practice.
2. The organizational environment was supportive and conductive. The change was made an organizational priority and embedded in routine structure and process.
3. Successful change was driven by influential people. A dedicated project manager to drive the change day-to-day was essential.
4. There was a demonstrable and positive outcome resulting from the change, e.g. statistics showing reduction in adverse events, or staff perception of improved efficiency or communication, etc.
5. Sustainability and spread of practice: Perceived by users as helpful and perceived by management as efficient and beneficial. Sponsors support was essential.

iii. **Design and revise workflow on a new clinical handover system**

To design a new handover system which is both practical and acceptable, we carried out an on-line staff opinion survey (Appendix 1) to investigate staffs' opinion on handover practice and the existing e-Handover system. I also arranged face-to-face direct communication with each colleague. Not only could I use these opportunities to explain and introduce this project, I also listened to their worry and concern and to clarify the policy to avoid misunderstanding. Their suggestions and feedback were acknowledged and some were used to design and refine our new handover system. Literature search was also performed to incorporate the key success factors from overseas experience.

We adopted a stepwise strategic approach, first to build a habitual handover culture and behavior. We proposed a new structured Senior-led face-to-face clinical handover system tailored to department's need. The initial step was to set up regular handover rounds during weekday at 16:45. It was targeted to handover information of unstable patients or patients expected to deteriorate in the next 24 hours. Essential information on patient's active problems, management plan, and follow-up action were communicated. To facilitate communication, department secretary sent a simple SMS message (with names of on-call doctors and their hospital mobile phone number) to our colleagues at 12:00 noon. By one simple touch on the smartphone screen, primary team doctors could contact the on-call colleagues to handover before 16:45. The on-call team of doctors (4 on-site doctors and the on-call senior) gathered in a designated meeting room equipped with computer facilities (with access to both clinical information/management system (CMS) and knowledge databases). The meeting started at 16:45 and ended sharply at 17:00. To ensure punctuality, department secretary sent a reminder SMS message at 16:30. Strict time control of 15 minutes was implemented to enhance the efficiency. On-call team of doctors reviewed the clinical information on CMS and the senior would give suggestions on the subsequent management. Selected cases would be reviewed by the same on-call senior at 20:00. Simple documentation of the handover cases onto a log-book was implemented during the initial phase. A standby facilitator of senior grade would lead the round in case the on-call senior was engaged in other activities as backup measure. Starting from February 2016 onwards, the on-call team was encouraged to enter the reported cases into e-handover system on voluntary basis for better documentation.

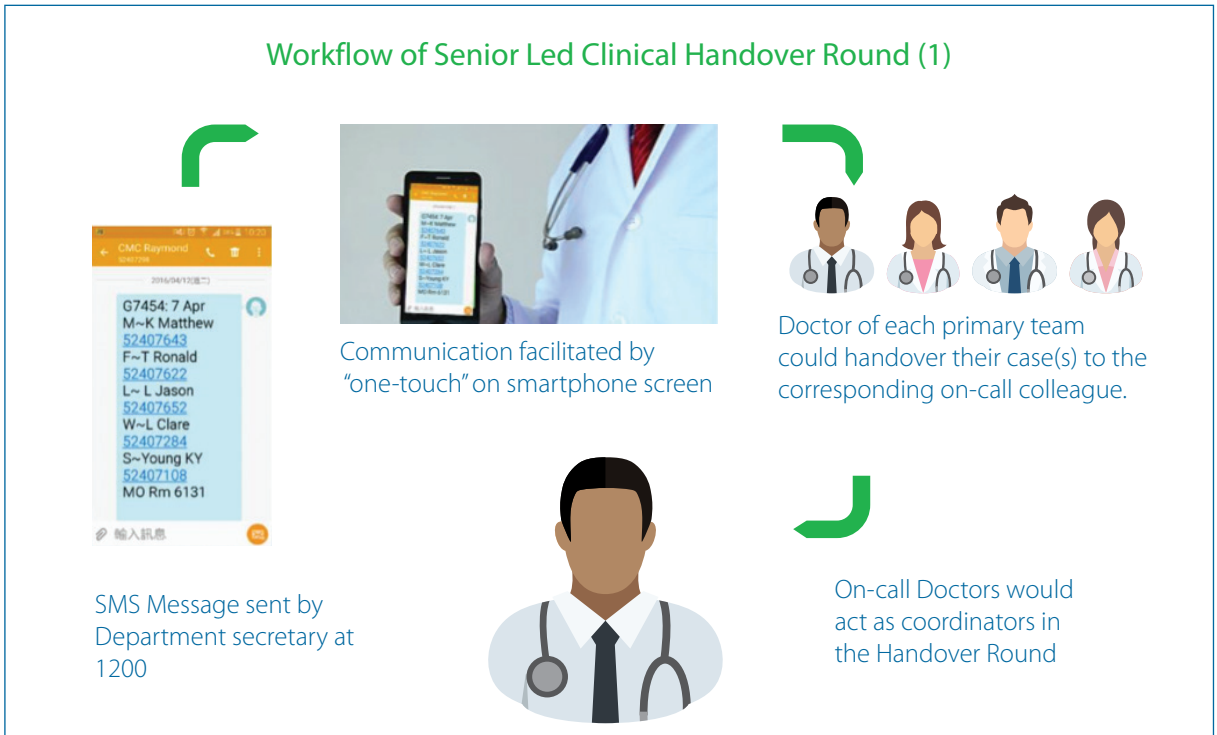


Figure 3a: Workflow of Senior Led Clinical Handover Round

Workflow of Senior Led Clinical Handover Round (2)

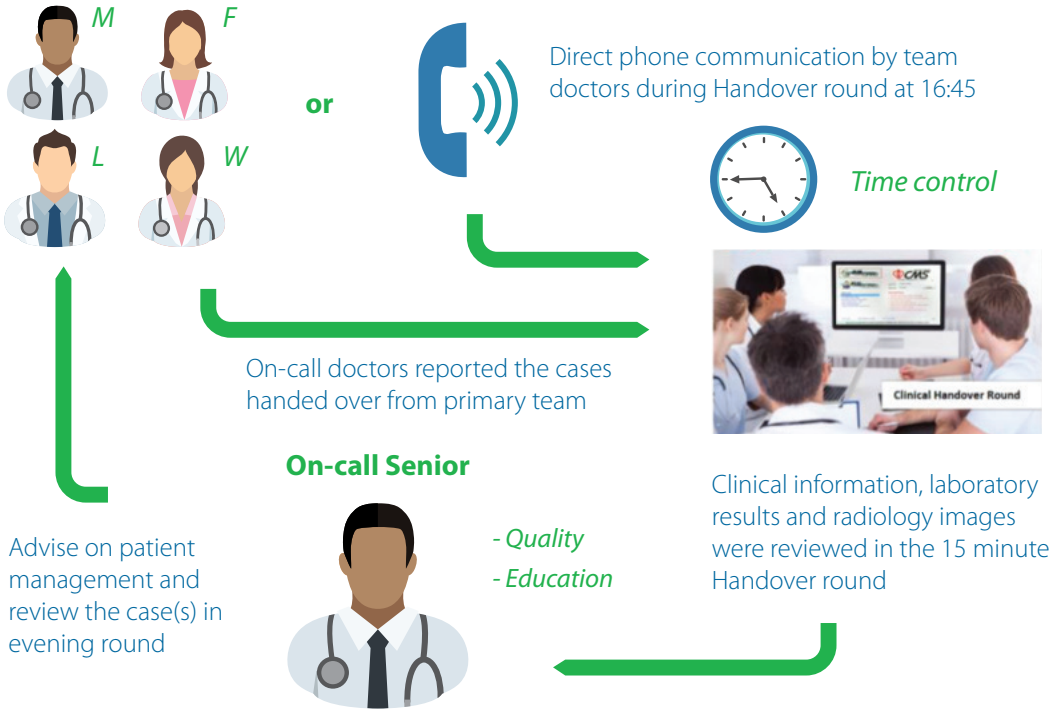
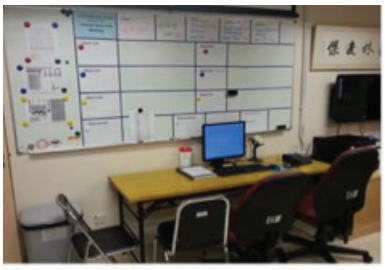


Figure 3b: Workflow of Senior Led Clinical Handover Round

Senior Led Clinical Handover Round



Dedicated handover meeting room with CMS computer facility

1. Inclusion criteria : required review within the same day for
   a. clinical reassessment; or
   b. review of radiological/ laboratory results; or
   c. anticipated clinical deterioration; or
   d. delicate issues such as "complaint case"
2. Exclusion criterion: DNA CPR case(s)
3. Protected meeting time for all on-call doctors (4 trainees and the on-call senior)

Senior led Clinical Handover Round

Figure 3c: Workflow of Senior Led Clinical Handover Round

iv. Staff planning and resource planning

Our new system involved installation of a computer based SMS system and a new CMS workstation. After liaison with the General Manager (Administration) and the Information Technology Department, the hardware was installed in one month.

On-call seniors might sometimes be engaged in other clinical tasks. Liaison was made with the consultants (who are responsible for the call roster) to make adjustment so as to facilitate seniors' attendance in the handover rounds.

A meeting room was prepared for these rounds and the venue was maintained by a ward manager and a ward clerk. A backup plan was devised in case the ward clerk or department secretary was on leave.

v. Outcome and evaluation

In first four month of implementation, number of cases reported in handover round ranged from 26 to 45 cases per month (Figure 4a). The attendance rate was approximately 90% on average (Figure 4b).

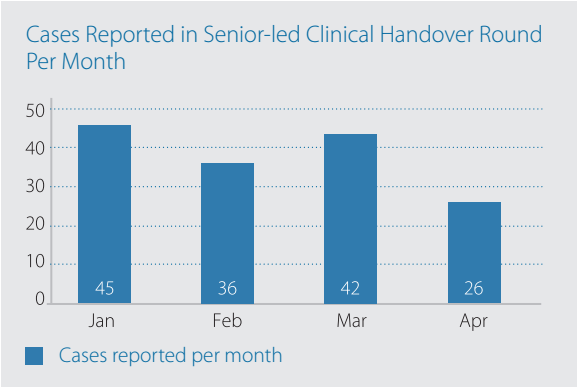


Figure 4a: Cases reported in the new Senior-Led Clinical Handover Round

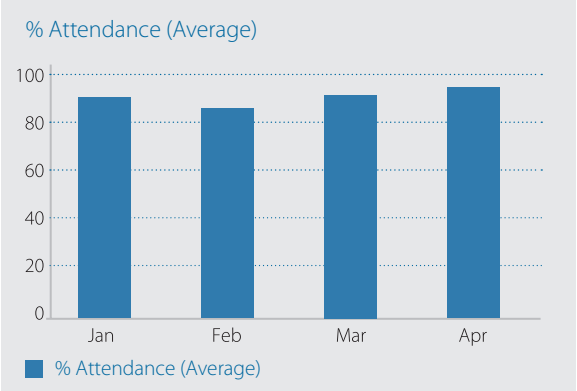


Figure 4b: Attendance rate in the new Senior-Led Clinical Handover Round

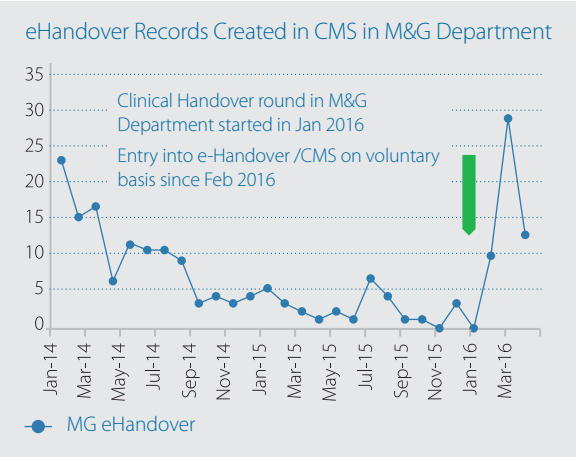


Figure 4c: Number of e-Handover records created in CMS system by M&G Department

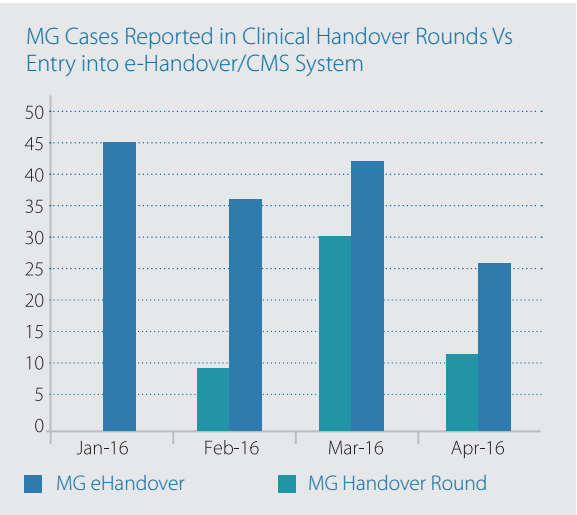


Figure 4d: Number of cases reported in Senior-led Clinical Handover Rounds was compared with number of records created in e-Handover system by M&G Department

From second month onwards, voluntary entry into existing e-Handover system by on-call team was encouraged. This was an additional measure not initially planned but the resistance was minimal. Though not all reported cases were entered into the e-Handover system, it already showed marked improvement as compared with 2015 (Figure 4c and 4d).

The project team continued to monitor the related statistics. Monthly reports will be submitted to COS and Consultant of Q&S Unit. Half yearly report will be submitted to HCE for review. The project team will continue to oversee the progress of this project. An online opinion survey will be carried out in May 2016 to review staffs' belief and opinion on handover practice. Since change of culture and practice is an ongoing and evolving process, time is needed for the behaviour to be consolidated. With time, it is anticipated that the handover practice will become habitual among our staff.

Discussion – Role as a Health Services Executive

i. Challenges and barriers

Prevailing culture and behavior were difficult to change especially when it involved long tradition and the participants were professional. M&G department did not have on-call team concept and there was no explicit format to handover patient care responsibility and accountability. With prior unpleasant experience from the e-Handover platform, we anticipated staff sentiment on the handover practice. Some staff might view handover as additional tasks and stress as they were packed with tight schedule. Seniors might lack experience in handover practice while juniors might need time to learn the skill.

To motivate and engage them, they were involved early in the preparation phase. I used two months to approach each colleague to explain the objective of this project. Their worries and concerns were listened. Besides incorporating key success factors from overseas experience and literatures, valuable suggestions from staff were incorporated to design and refine our workflow. Workflow was explained and misunderstandings were clarified by face-to-face communication and emails. During the promulgation phase, ground rules were set among colleagues. We accepted under-reporting and over-reporting phenomenon. A no-blame culture was adopted for cases that missed reporting as everyone took time to learn the practice.

As project manager, I participated in all the handover rounds in first month, both as a facilitator and as a role model to illustrate the handover process. I also acted as a quality controller to make sure relevant information was transferred and recommendation was conveyed to juniors. I was there to solve any un-anticipated difficulties and problems. Examples of cases that benefited from this handover practice were shared to create short term win and keep the momentum going. In subsequent months, I continued to join the meeting at regular intervals, to show my participation and support to them and to make sure that the expected quality, time control and other arrangement were carried out as planned.

ii. The Change Management and the leadership skill/ knowledge involved

Kotter's change management approach was employed.[12] The Q&S Unit observed the under-utilization of the e-Handover system. COS of M&G Department also realized the compelling need to strengthen the handover practice without much persuasion by the Q&S team (*the urgency*). A small project team was formed to lead the change and I was appointed as the project manager. Having worked in the department for 20 years, having been the ex-chairman of doctors' association and having been teaching newly recruited staff for many years, I had the advantage of having good interpersonal connection and relationship with administrative staff, colleagues and the HCE. Other project team members were also committed to drive the change (*build the guiding team*). The team took a strategic and stepwise approach in driving the change as we realized that changing culture and behavior would be an ongoing, slow and evolving process. We targeted the objective at fostering a handover culture and behaviour in new staff and changing prevailing culture and practice in existing staff. With handover practice in place, transferred information would be utilized to benefit patient management (***get the vision right***). It would be more appropriate if we first make the handover habitual and accepted by staff before we moved on targeting at quality of the handover and use of electronic handover tools.

Recognizing the importance of communication, I used two months to communicate with each colleague face-to-face. I used these opportunities to explain the rationale of the new system, to explain the workflow and to listen to their worries and concern. Valuable suggestions were taken and used to design and refine our new system. Misunderstanding was clarified and negative emotion was handled promptly. I also communicated with different stakeholders to gain buy-in (*Communicate for buy-in*).

Communication did not end after the preparation phase. During the process, successful stories were shared. They were shared via emails and discussion in the handover meetings. This created short-term win and the effort of the colleagues could be recognized. This measure was important to keep the momentum going (*Create Short-term win and Empower action*). When we designed and refined the workflow, we tried to remove the obstacles that might hinder the transformation. In our project, the "one-touch on smartphone" and "daily reminder SMS message" approach saved our colleagues' time to find out who would be on-call and their hospital smartphone numbers. Call list adjustment and coordination was arranged to remove obstacles in the organization so that seniors' presence in the handover was facilitated and secured. Both sponsors' expectation (better supervision, better quality care to patients) and frontline's worries and suggestions (no excessive workload, no major change in workflow, better guidance from seniors and anticipated educational value of handover) were balanced to create win-win situation.

The project team did not declare victory too soon with the initial success as most projects would enjoy a honeymoon period at the beginning. We understood that transformation took not months but years. We should make use of the credibility from short term win to keep the momentum going and to consolidate the cultural and behavioural change. The project team would continue to evaluate the progress at regular intervals by repeating staff opinion survey and monitoring the related statistics (*Don't Let Up*). This project was the initial step. We would like to root this handover practice in our colleagues' norm and shared value (*Make change stick*). In future, we would like to promulgate the changes further in M&G Department (e.g. including weekend handover, night shift handover) and other clinical specialties.

Resistance to change is the largest obstacle that change leaders have to face. From Bridges' transition model[13], 3 phases of emotional reaction are identified: (1) *ending and losing of the old situation,* (2) the *neutral zone* and (3) the *new beginning with emotional commitment to the new state*. People went through the transition at different speeds and in different ways. Some might find themselves moving back and forth between the phases. As a leader of change, my role was to support and encourage our staff with my skill in communication and listening. I needed to coach them when difficulties are encountered. Fortunately, our department had a supportive culture among staff. We have a group of seniors who come together, have shared commitment to improve performance through change.

iii. The management Lesson learned

Change management was not easy to achieve. It went through a series of phases and required a considerable length of time. Critical mistake in any phase could have negative impact; slow the momentum or negating hard-won gains. I have learned from the e-Handover example that just providing a handover tool did not produce satisfactory results in transformation of practice. Modifying the prevailing belief and behavior was the cornerstone for change. One had to catch the opportunity to create a sense of urgency among the stakeholders, to ignite the transformation process and to drive people out of their comfort zone to change. One should realize that no two organizations are similar in structure, workflow and staff mix. A universal handover tool was only a complementary element in the practice. Driving change in handover should be coupled with the specific concerns and workflow tailored to context of the organization.

The use of electronic handover platform should be viewed as a complimentary tool for facilitating transfer and documentation of information. It could not replace the normal clinical handover process. E-Handover platform enhancement and promulgation will be the future direction of Hospital Authority. Our project was just an initial step targeting at building culture and modifying behavior. One should targeted at implanting the seeds of handover in our juniors, making them incorporating it as quality and safety practice while incorporating e-Handover as complimentary tool.

Clear vision helped painting a picture of future to enhance communication and to convince stakeholders to join the transformation. Credible communication is the backbone in the process and we adopted both top-down and bottom-up approach. Both sponsors' and other stakeholders' perspectives were balanced to achieve a win-win situation. Good planning, efficient time management, integration management and quality management were the key factors for a successful project. Last but not the least, a committed project team, supportive culture of co-workers, and leadership skill contributed to success in change management.

Limitation of this Project

We reported the experience of a change management project in a clinical department. The strategy and approach might not be directly applicable to other clinical departments or hospitals. Understanding that the structure, workflow and staff-mix in clinical departments were different, one might consider using different approach in planning, communication, workflow design and implementation. This was the so-called flexible standardization approach suggested by Australian Commission on Safety and Quality in Health Care. The essence was to create a structured format for handover tailored-made to the local context and specific clinical settings. In this article, we only reported the outcome in terms of number of reported cases per month and the attendance rate in the initial phase of execution. Ongoing progress and outcome have to be monitored and reported to ensure sustainability. Ideally, measurement of safety and quality in handover requires consideration of the transfer of three aspects: system/context, responsibility/accountability and information transfer. Policy, process and outcome of these aspects should be evaluated. Quality of handover practice, such as accuracy of information transferred or percentage of missed handover leading to adverse events was not reported in this report. When the system matures, one should report these surrogate measures that address the quality and performance of handover practice.

Conclusion

Clinical Handover refers to the transfer of information, responsibility and accountability between individuals and teams, within the context of workflow and structure of the care system. Though it significance is well understood, the handover practice varies between specialties. Introducing electronic tools for clinical handover without tackling the prevailing the culture and practice resulted in under-utilization of the new tool. After reviewing the literature and opinion from our colleagues, we implemented a new senior-led clinical handover arrangement with initial satisfactory results. As a healthcare executive participated in this project, I recognized the importance of planning, communication skills and other associated leadership capacity in project management. In implementing new change, we have to recognize the variation in context, workflow and staff mix before we tailor the change to meet the specific need of an organization.

CHEUNG Wai Man

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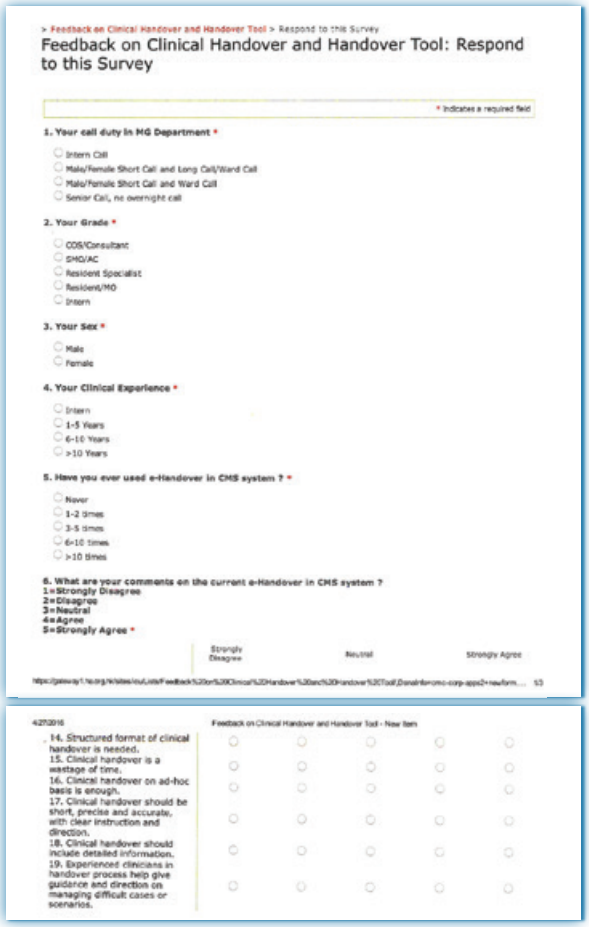
Appendix 1 (Online Staff Opinion Survey on Clinical Handover and Handover Tool)

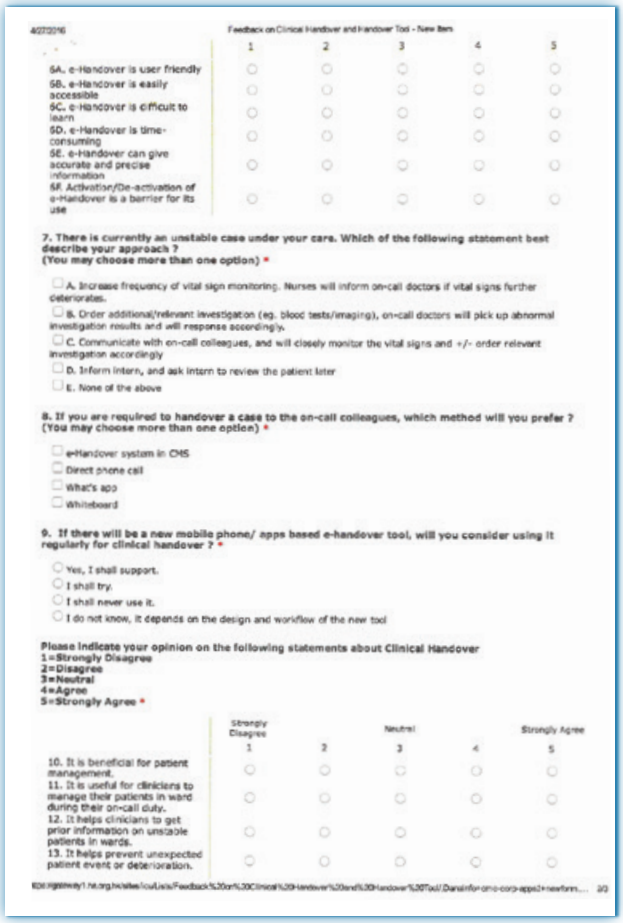


Feedback on Clinical Handover and Handover Tool: Respond to this Survey

* Indicates a required field

1. Your call duty in MG Department *
   - Intern Call
   - Male/Female Short Call and Long Call/Ward Call
   - Male/Female Short Call and Ward Call
   - Senior Call, no overnight call
2. Your Grade *
   - CDS/Consultant
   - SMO/AC
   - Resident Specialist
   - Resident/MO
   - Intern
3. Your Sex *
   - Male
   - Female
4. Your Clinical Experience *
   - Intern
   - 1-5 Years
   - 6-10 Years
   - >10 Years
5. Have you ever used e-Handover in CMS system ? *
   - Never
   - 1-2 times
   - 3-5 times
   - 6-10 times
   - >10 times
6. What are your comments on the current e-Handover in CMS system ?
   1=Strongly Disagree
   2=Disagree
   3=Neutral
   4=Agree
   5=Strongly Agree *

	Strongly Disagree				Strongly Agree
14. Structured format of clinical handover is needed.					
15. Clinical handover is a wastage of time.					
16. Clinical handover on ad-hoc basis is enough.					
17. Clinical handover should be short, precise and accurate, with clear instruction and direction.					
18. Clinical handover should include detailed information.					
19. Experienced clinicians in handover process help give guidance and direction on managing difficult cases or scenarios.					



	1	2	3	4	5
6A. e-Handover is user friendly					
6B. e-Handover is easily accessible					
6C. e-Handover is difficult to learn					
6D. e-Handover is time-consuming					
6E. e-Handover can give accurate and precise information					
6F. Activation/De-activation of e-Handover is a barrier for its use					

7. There is currently an unstable case under your care. Which of the following statement best describe your approach ? (You may choose more than one option) *
   - A. Increase frequency of vital sign monitoring. Nurses will inform on-call doctors if vital signs further deteriorates.
   - B. Order additional/relevant investigation (eg. blood tests/imaging), on-call doctors will pick up abnormal investigation results and will response accordingly.
   - C. Communicate with on-call colleagues, and will closely monitor the vital signs and +/- order relevant investigation accordingly
   - D. Inform intern, and ask intern to review the patient later
   - E. None of the above
8. If you are required to handover a case to the on-call colleagues, which method will you prefer ? (You may choose more than one option) *
   - e-Handover system in CMS
   - Direct phone call
   - What's app
   - Whiteboard
9. If there will be a new mobile phone/ apps based e-handover tool, will you consider using it regularly for clinical handover ? *
   - Yes, I shall support.
   - I shall try.
   - I shall never use it.
   - I do not know, it depends on the design and workflow of the new tool

Please indicate your opinion on the following statements about Clinical Handover
1=Strongly Disagree
2=Disagree
3=Neutral
4=Agree
5=Strongly Agree *

	Strongly Disagree		Neutral		Strongly Agree
	1	2	3	4	5
10. It is beneficial for patient management.					
11. It is useful for clinicians to manage their patients in ward during their on-call duty.					
12. It helps clinicians to get prior information on unstable patients in wards.					
13. It helps prevent unexpected patient event or deterioration.					

Brief Summary of Leadership in Public Administration - Challenges and Lessons

We were honored to have Mr. Patrick Nip, the Permanent Secretary for Food and Health (Health) of HKSAR as our guest speaker of the Distinguished Leader Series of the College in March. The event was held on 30th March and the topic was "Leadership in Public Administration – Challenges and Lessons". Over forty fellows of the College and guests from the public and private markets attended the event and had a fruitful night at the YMCA of TST.

In the event, Patrick briefly introduced the current healthcare systems adopted in Hong Kong, latest development of the industry as well as the updated public health policies. He also shared his valuable experience at different positions of 15 government departments along his career path over past 30 years.

With the experience of handling different crisis including SARS and, he summarized his experiences for handling various incidents. It is important to identify the core issues, stakeholders and objectives for each incident. Multiple angles of thinking with consideration of consistency, political consequences and cost effectiveness would be essential to evaluate those possible solutions. Last but not the least, listening to opinions of team members and respecting their ideas would often bring the best outcomes.

Patrick also shared his 10 tips for leaders:

1.	***Leadership*** matters
2.	It is about ***Commitment*** to serve with heart and passion
3.	It is about ***Process***
4.	It is about ***Value*** and ***Culture***
5.	It is about ***People***
6.	It is about ***Team Work***
7.	A ***bird's eye*** perspective
8.	Be ***part of it***
9.	It is about ***Empathy***
10.	It is about ***Communication***

Leo LUI

Updated Member List in HKCHSE Website

Dear Fellow Members,

I am delighted to inform you that our College had started to upload all the paid up Fellow names, either dual fellows of ACHSM & HKCHSE or local fellows of HKCHSE, at our College website with effective from 31/3/2017. You can first log-in the "About the College" icon of our College website (http://www.hkchse.org), then go the "Member List" where you will find all the paid up Fellows of our College. Such College Fellow names list will be updated on March 31st and September 30th each year.

Honorary Secretary,

HKCHSE

投資健康 創造財富

Invest in Health Create Wealth

Hong Kong College of Health Service Executives
Annual Conference 2017

Date : 22 July 2017 (Saturday) **Time :** 2pm – 9pm
Venue : Shanghai Room, Level 8, Cordis Hong Kong, 555 Shanghai Street, Mongkok, Kowloon (Mongkok station exit C3 or E1)

Officiating Guests:

- **Dr KO Wing Man, BBS , JP**
  Dr LEI Chin Ion, MMP

Speakers: (in alphabetical order)

- **Ms Elaine CHAN**
  Chief Health Officer, Zurich Insurance Company Limited
- **Ms Eleanor KAM**
  Head of Ageing Innovation, New World Development Company Limited
- **Mr Alex LAM**
  Chairman, Hong Kong Patients' Voices
- **Dr Walton LI**
  Medical Superintendent, Hong Kong Sanatorium & Hospital
- **Mr Albert Wong**
  Chief Executive Officer, Hong Kong Science and Technology Parks Corporation
- **Mr John WONG**
  Regional President, Boston Consulting Group

Moderator

- **Mr Stephen LEUNG**
  Country Manager, Pfizer Corporation Hong Kong Limited

Programme Rundown

1:30pm	Registration (Shanghai Room, Level 8)
2:00pm	Opening Ceremony
2:15pm	Annual Conference
5:15pm	AGM & Fellowship Conferment
6:00pm	Dinner Reception (Star Room, Level 42)
7:00pm	Annual Dinner

Registration fee (including dinner)

Paid-up member	HK$500
Non-member	HK$1,000

Deadline for registration: 22 June 2017 (Thursday)

Language

Cantonese (Supplement with English)

Please send the registration form and a cheque payable to
"**Hong Kong College of Health Service Executives Ltd**" to
FMSHK, 4/F Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai
Enquiry: (Tel) 2527 8898 (Fax) 2865 0345 (Email) eva.tsang@fmshk.org
Conference Secretariat: The Federation of Medical Societies of Hong Kong
Please visit www.hkchse.org for update

Application Form

Hong Kong College of Health Service Executives
香港醫務行政學院
Year 2017-2018 New Membership Application / Renewal Form

Title : Prof / Dr / Mr / Ms / Mrs

Name:

_____ _____

(Surname) (Other name)

❖ please ✓in the appropriate box

☐ Please RENEW my membership (please fill up area of any changes that apply ONLY)

☐ Please consider my NEW membership application (please fill up all the below items)

HKID No.: ☐☐ – ☐☐☐ X X X (X) Sex : M / F

Professional Qualification : _____

_____

Qualification in Health Care Management : _____

_____

Work Position Held : _____

Place of Work : _____ _____

(Department / Division) (Organization / Institution)

Nature of Organization : ☐ HA ☐ Government Department ☐ Private Hospital
☐ Academic Institute ☐ Other Public Organization
☐ Commercial Organization

Correspondence Address : _____

_____

_____

Contact No. : (Off) _____ (Mobile) _____

Email : _____

Membership Type	Annual Membership Fee			
	HK Membership (HKCHSE)		Dual Membership (HKCHSE and ACHSM)	
Fellow *	HK$500	☐	HK$2,200	☐
Associate Fellow **	HK$300	☐	HK$2,000	☐
Associate	HK$200	☐	N/A	☐

* Fellow membership only applied to those who have been conferred Fellowship by HKCHSE.

** Qualification for Associate Fellowship: holding a degree in management or a full time managerial position.

Please send this application with cheque payable to **"Hong Kong College of Health Service Executives Ltd."** to **P.O. Box No. 70875, Kowloon Central Post Office, Hong Kong**

For Enquiry:
http://www.hkchse.org