Hong Kong College of Health Service Executives

Newsletter Issue 1 2011/12

Council Members

Message from the President

The public healthcare sector of Hong Kong all along has a reputation of being highly efficient - spending only around 2.5% of the gross GDP to support around 90% of inpatient service and 30% of outpatient consultations. It also takes care of nearly all major public health responsibilities, including quarantine, population vaccination, disease surveillance, field epidemiological studies and treatment of patients suffering from infectious diseases. However, this glory appears to be fading rapidly.

The most frequently cited reason is imported inflation related to the depreciation of the Hong Kong currency which is pegged to the US dollar. A retrospective review of the Hong Kong dollar showed a depreciation of around 35% against the RMB in the past 4 years. There is also a world-wide rise in the price of most commodities which is the result of increase in demand from countries with rapid economic development combined with the "quantified easing" in the supply of money in most developed countries in response to the recent financial tsunami. However, I think the most important factor for the marked cost inflation of public healthcare is due to high pressure for take-home pay of most professionals. This in turn is related to the booming private health insurance market and the flooding of pregnant women from Mainland China to Hong Kong for delivery.

The skyrocketing number of pregnant women from Mainland China coming to Hong Kong for delivery is the product of two population policies, one imposed by the Mainland and the other adopted by Hong Kong SAR. The "one-child policy" of the Mainland drives many couples who want to have a second or even a third child to come to Hong Kong where the Hong Kong SAR Government grants permanent resident status to all babies born at Hong Kong. The demand for obstetric care is so huge that the Government as a deterring measure has to impose a heavy charge for the Mainland expectant mothers if they choose to give birth to their children at Hong Kong public hospitals. This in turn facilitates the private sector to mark an even higher hospital fee for similar service. Despite the high-price policy the number of incoming of expectant Mainland mothers keeps on mounting. The final result is that obstetricians and paediatricians in the private sector are making astronomical incomes. When their peers in other specialties in the private sector noted such phenomenon, they also raised their fee so as to narrow the gap. This is some how facilitated by the growing acceptance of private health care service by the middle class through private health care insurance. The private hospitals also make enviable profits in connection to all these price races. The result is gross price inflation in the private healthcare sector.

When demand for healthcare in the private sector increases allowing doctors to make very attractive income, the incentive for doctors working in the public sector to join the private market becomes very high. As a result there is significant manpower drift from the public sector to the private sector. This also applies to nurses and some allied health professionals. The workload on the remaining healthcare workers of the public sector becomes heavier every day. So they expressed their discontent in the form of rallies and demonstrations demanding attention from the Food and Health Bureau and Hospital Authority. In order to pacify the healthcare professionals so as to retain them in the public sector, various financial incentives have been introduced. The result is that the overall healthcare expenditure is rising rapidly.

My worry is that there may be a time when the cost for private healthcare service is beyond the affordability of most people, including those who have purchased private health insurance or have employer provided insurance coverage as part of their employment benefit. This will force more people to come back to the public sector, and the latter may crumble because of less and less professionals staying behind. By then I envisage the public healthcare sector will require a total overhaul and hopefully the SAR government will review its population policy with support from the Central Government of China.

Dr H C MA

2011 Annual Conference cum Annual General Meeting

12th March 2011 Langham Place Hotel, Kowloon

Fellowship Conferment Ceremony

Our New Fellows

Congratulations to the following who passed the recent Fellowship examination and were conferred as fellows of the College at the AGM cum fellowship conferment ceremony

Terence CHAM	*Pearl CHAN*	*CHUNG Lai Ha*	*Cindy TSE*
Cecilia CHAN	*Leo CHEUNG*	*Wendy HO*	*Macky TUNG*
Joseph CHAN	*Liza CHEUNG*	*Ellen KU*	*Eddie YUEN*
CHAN Kam Hoi	*CHEUNG Wai Yee*	*TANG Fung Ki*	*Connie WAN*

Patient Empowerment Program - A New Approach to an Old Problem

The management of chronic diseases is a growing burden in many countries and Hong Kong is no exception. It is estimated that Hong Kong has over 700,000 persons with diabetes mellitus and that many more have not been diagnosed nor seeking treatment. Health care systems such as the Hospital Authority of Hong Kong that relies heavily on public funding is under enormous pressure to try to tackle this problem, not only to significantly reduce costs but more so to improve access and quality. In the past two years, The Hospital Authority of Hong Kong has found an innovative approach to address an old problem by realizing the potential of the third sector- delivering patient empowerment programs through Non Government Organization.

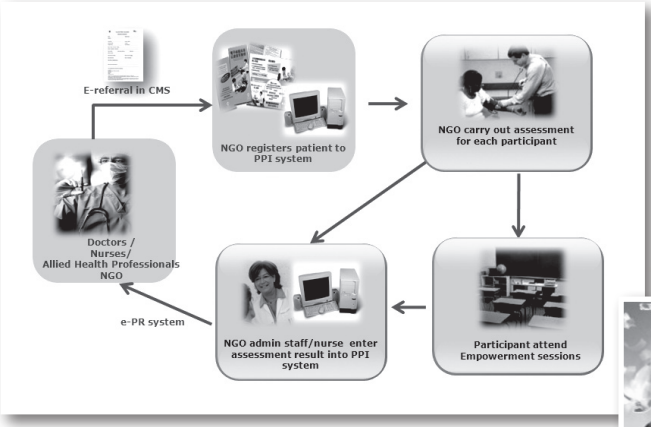
Here are some ways that the author believes will make Patient Empowerment Programs work:

Think Big

When we first had the idea of implementing patient empowerment programs on a big scale, we discussed with several people and many laughed at us for trying to think big. We were told " it's not going to work, Hong Kong people are too busy and they will not attend lectures or education talks". Others commented that patients in Hong Kong are too passive, and that there is a difference between being educated and being empowered for self management. Yet, it would not be possible to attain any level of success if we keep running small individual programs. So when we had the opportunity, we put in a bid to the Government for resources to provide patient empowerment programs to 32,000 patients in 3 years. In fact, we are happy to note that the Mckinsey Institute shared this same idea and in an article on making chronic disease management programs work, the idea of being big was cited as being one of the most important elements in making chronic disease management programs work. "Large disease management programs are more likely to be successful than small programs because they benefit from economies of scale: resources can be pooled, and costs can be amortized across many patients. As a result, it is often easier to achieve net savings. Large programs are also more likely to improve their processes regularly, because they are usually better able to mine the data they are collecting and use those analyses to refine their processes."

Structure, Structure and More Structure

When we ask patients with diabetes if they have ever attended educational talks, most of them will say yes. However, the level of knowledge that they have attained varies and many will tell us that they cannot remember what they have heard or that they do not understand what they have learned. From our conversations with organizations with experience in providing chronic disease management programs, we found that some programs were too focused on the disease aspects whereas others were more generic and tried to emphasize too much on self-empowerment without giving participants background knowledge of the disease nor equipping patients with the necessary skills to deal with the disease. Hence, when we had the opportunity to start afresh, we created a new service model which was structured around



two essential components, a basic disease specific component and a generic component featuring self management and coping skills. The critical part was to give structure to something fluid and to make sure that all the specifics were written into the contracts so that service providers could understand what they had to deliver. It was equally important to keep things simple so that it is not overwhelming to the patients. Easy to understand messages delivered in a lively and interactive manner tend to be more useful. A well written service contract with clearly defined roles and responsibilities for both the purchaser and provider is the first step towards success.

Find out what's happening in the field

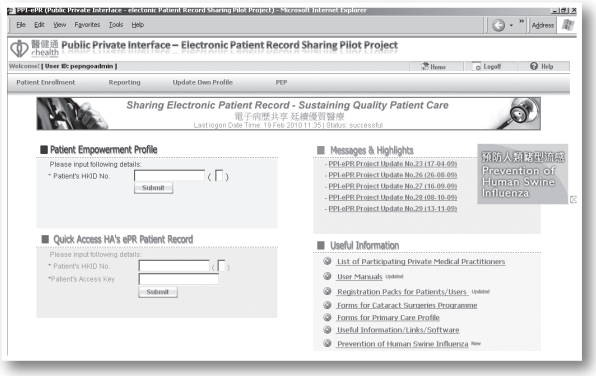
It would be disastrous if we had created a nicely written service tender document but there was nobody in the field who would be interested to help us deliver the programme. We spent some time talking to NGOs in the field to gauge their interest and their capability to deliver what we had in mind. Briefing sessions were organized and there was some level of interest and capability resting with our NGOs and this gave us the confidence to move on.

Create Incentives

Giving providers and patients incentives work. For the NGOs, we wrote into the service contracts incentive or extra payment scheme and extra funds were given if they fulfilled certain criteria written in the service contracts. We found that this actually incentivized our NGO partners to think of ways to attract patients to the programs and as purchasers of the service, we did not have to worry if there were enough patients attending the programs and the ball was, so to speak, in the providers' court! Incentives breed incentives. Our service partners had innovative ways to bring patients to their programs. Some used gift vouchers, others offered free transportation and yet others used a membership scheme.

Leverage on IT

In this day and age, IT is an essential component of any new program development. We created a new IT platform which could track all the components of the program and acted as an interface between the referring physician and the NGO provider. Doctors in our primary and specialist clinics could refer patients through the PEP module and at a click of a button, the information in the e-referral would be passed to our NGOs partners and they would then commence the whole process of recruiting patients, enrolling them into the respective programs, conducting pre-program assessments, planning the time schedule of the classes, delivering the programs and classes, conducting post- evaluation assessments and finally performing regular telephone follow up. All information at the various stages of the program



would be captured through the IT system and at the end of the program, a discharge summary would be generated to provide feedback to the referring physician. By leveraging on IT, a complex process could be broken down into several small components to ensure that information would not be lost throughout the patient's journey.

Listen, review and make changes

No program would be perfect at day one. It was important to engage our providers and listen to their concerns. In the beginning, there were several hiccups encountered in the work flow and in the IT system. We took note of the problems, worked with our NGO partners and our IT counterparts, found appropriate solutions and made the necessary changes, either to the work flow or to the system. By listening to our partners and instituting changes, where possible, we created win-win- win solutions for all parties. At the same time, it was also important to listen to the patients and make sure that the programs address their needs. Stay in touch with the patients and the providers to make sure that the programs continue to be relevant to both parties is an important element for success.

Publicize and make use of the media

Social marketing is a tool that has not been used very much by health care providers and in a new program that will have potential to impact on the lives of many thousands; we thought it was time that we engaged in some marketing gimmicks to help push the program through. We used various media, ranging from print, radio and even had our Programm logo embossed in recycle bags which we distributed freely.

Conclusion

We rolled out the Patient Empowerment Program by contracting Non Government Organisations to provide the service in all seven clusters of the Hospital Authority. The first contract was signed in March 2010 and initially two hospital clusters were involved. By the end of 31st March 2011, around 9000 patients were enrolled into the program and everything was running fairly smoothly. An interim independent evaluation was conducted by two academic institutions looking at the quality of care and patient satisfaction. The interim results were encouraging though the long term impact that this program will have on health care utilization and on the management of chronic diseases is yet to be confirmed. In sum, this project points to the fact that we need not rely on our own all the time. We need to tap the potential of our community partners such as NGOs and interact with them to produce programs that can be easily accessed by many patients. The real challenge often is not knowing what to do but how to do it right. With chronic diseases raising its ugly head all over the place, it is time that health care organization adapt old ways of doing things to try to find the winning formula that can reap benefits for all. Nothing is new under the sun but we can always make them "look and feel new".

Margaret TAY

Meeting with Chiefs

The College held its annual Fellows Night on 12 March 2011 and invited Dr Leung Pak Yin, Chief Executive of Hospital Authority and Dr Lei Chin Ion, the Director of Government of Macau SAR Health Bureau to share with us some insights on leadership and leading. Here are some of words of wisdom from our leaders:

" Be in the company of those who are better than yourself so you can constantly improve yourself "

" Learn to relax and take care of your health "

" Do not try to lead in all situations. In certain situations, be the little brother and you can totally relax."

" The true leader is able to assess the situation and makes appropriate decisions, fast and rapid response needed for critical times and deliberated and well thought out decisions during peace times."

" Do not overkill by trying to accomplish too much. This may not be the best strategy for winning the battle."

" Maintain a balanced perspectives on life and work - learn to do things outside of your own comfort zone"

" Teamwork is important - No leader can accomplish everything but the leader can learn to use the abilities of his team to accomplish a lot"

Besides the sharing from our leaders, members and fellows enjoyed a relaxing evening and let's hope that there will be another fellows night next year!

Margaret TAY

Patient Flow Variability Management in Emergency Department

Abstract

Efficiency in the healthcare system has been a topic of particular concern in recent years as we have been putting in an escalating amount of resources into the healthcare system despite a falling quality of care. The study of patient flow has gained its momentum as a result. Variability Management is a relatively new concept. The proper name should be **Patient Flow Variability Management**. As the name suggest, it tackles the problem of patient flow within the healthcare system.

The methodology behind this is the separation of artificial and natural variability. Each type of variability is then sub-divided and further analyzed using scientific method. This is followed by a 'smoothing' procedure where the healthcare processes are reengineered to generate the optimal efficiency.

The Local Problem

The use of Patient Flow Variability Management will be illustrated in a local acute district hospital, where the manpower was not of optimal standard and access block in Emergency department was a daily occurrence. The hospital in question is a 450 bed medium size acute district hospital, 200 of those bed are designated for the medical specialty. The problem locally is the nighttime coverage. As patient arrive emergency department at random, so will be the admission of patients to the medical wards. There have been occasions that minimal number of staff is left in the middle of night to deal with a sudden influx of acute medical admission, up to 6 in one hour. The inadequate staffing coverage also will eventually reduce the efficiency of the system and affect the turnover of patient, as exemplified by the lengthening average length of stay (ALOS) in recent years. This will push up the bed occupancy rate, to well over 100% at times. Access block starts to appear in emergency department when bed occupancy rise over 85%. Access block becomes more frequent at 95% bed occupancy rate and will become constant features when it is over 105%.

Patient Flow Variability

The concept of variability comes into the spotlight as lean management and other logistic flow apparatus come into trend in recent years. This is mainly due to the falling in the standard of healthcare provided despite the injection of an escalating amount of resources (financial and manpower) into the healthcare system. The reduction in quality of healthcare has been exemplified by the limited access to healthcare as in the overcrowding situation in the Accident and Emergency Department (A&E) globally, access block (patient waiting for beds) in A&E, excessive patient waiting times in almost all function of the system and heavy workloads for nurses and other staff. The problem of patient flow has been scrutinized in the United States. The U.S. General Accountability Office, the investigative arm of the U.S. Congress, highlighted the importance of the patient flow concept in their two introduction reports in 2003[1] and 2009[2]. The Joint Commission published a Leadership standard for managing patient flow report in 2004 and recommended hospital leaders to *"develop and implement plans to identify and mitigate impediments to efficient patient flow"* throughout the hospital[3].

There are two main types of variability that impede on the efficiency of the health care system, the natural and artificial variability. Natural variability occurs by nature and follow random statistical model. Artificial variability is purely man-made, whether intentionally or not.

Management of Variability

Artificial variability should be eliminated at the outset. In order to address the issue, we should understand the scope of the problem. This is done by using a chart displaying changes in a metric (for example, volume) over time. The variation over time is then classified as either natural or artificial variability. A simple statistical test of randomness can be helpful to assign whether variation in the metric is random and thus naturally occurring. When there is no apparent natural reason for the variability, it is likely to be Artificial. Variability that is nonrandom and at the same time not predictable is clearly artificial. We next quantified the variability and established the variance from the ideal expected pattern. We finally eliminate or reduce the artificial variability through system redesign and manage any remaining natural variability.

Separation of homogenous subgroups is the cornerstone in the management of natural variability. The separation can be based on clinical and/or operational characteristics. Separation of patient flows into homogenous groups allows for higher efficiency for that group, which in turn enables higher overall efficiency of the system. This is exemplified in some A&E, where homogenous subgroup is fast-track versus high-acuity patients. Some subgroup of patients has with lower acuity issues that require less testing and more routine treatment. They have a clearly distinct clinical profile from that of the higher-acuity patients. Therefore, assigning these patients to a fast-track system can significantly increase provider efficiency and patient flow efficiency for these patients as well as for the A&E overall.

Patient Flow Redesign: The Three Phrase Approach

This starts with the classification and separation of flows. Dedicated resources should be set aside for urgent and semi-elective flows, and in unit with significant mix of elective and non-elective patients, like operating theatre and cardiac catheterization laboratory. The reason for the separation of resources is that the management objectives are different for each of these flows. The most important goal for the urgent and semi-elective flows is timely access to services while that for the elective flow is the maximization of efficiency and volume. Likewise, the day-surgery cases are separated from the inpatient.

The next phrase involves redesign of the flows by smoothing the daily demand pattern from the designated unit, like operating theatre or catheterization laboratory, while taking into account variation in LOS, so as to reduce the day-to-day variability in the number of admissions. The smoothing maximizes the utilization of inpatient resources and minimizes the competition between elective flows and A&E admissions for inpatient beds. We finally determine the bed and staffing level for the new flow approach.

The three-phase approach can be applied to any major source of admissions to a hospital, such as the operating theatre and the cardiac catheterization laboratory; it is not limited to those areas. Artificial variability can be found throughout the health care system, e.g. clinics, laboratories, and procedural areas. The three-phrase approach is applicable to these areas as well.

The Three Phrase Model in Patient Flow Variability Management

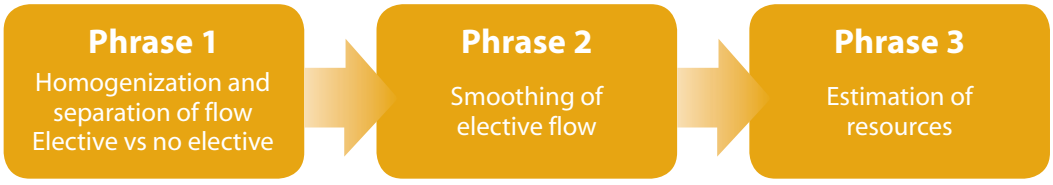


Figure 5

The Local Solution: the Variability Smoother

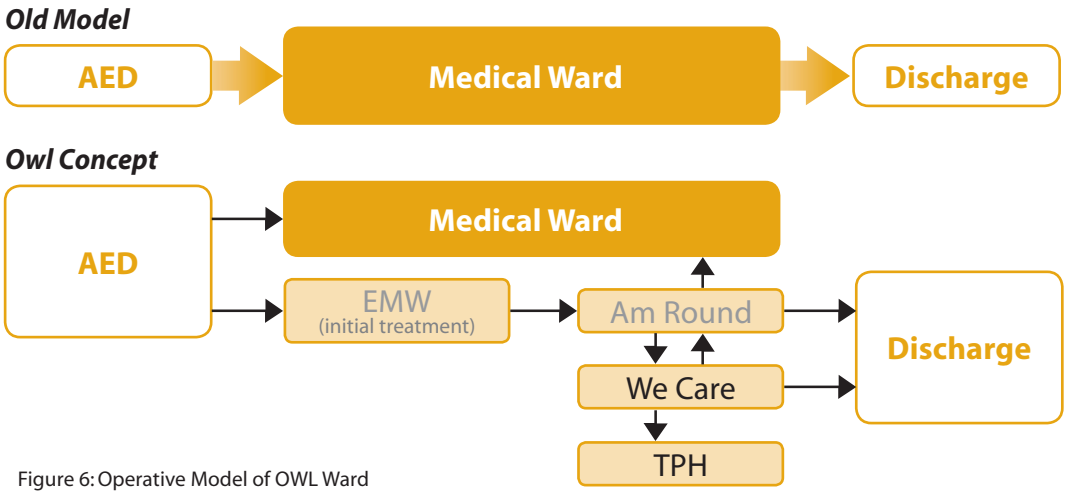


Figure 6: Operative Model of OWL Ward

The OWL ward concept is pioneered locally. As the name OWL suggests, it operates during the night time. It focuses on the provision of acute medical care during the night time only. It aims to admit most of the medical admission during the night period and the case will be assessed the next day by senior A&E specialist and geriatrician for the need of transfer to medical bed or direct discharge. The admission to medical bed will be reduced drastically during the night time. The natural variability is tackled as patient is now admitted to an alternative facility, rather than the medical ward.

Results

The OWL ward was opened with a view to control the variability in patient flow, through its 'smoothing' effect in minimizing overnight admission to acute medical ward. The first six-month analysis showed a 50% drop in overnight acute medical admission. A drop of 33% was noted in the daily acute medical admission. Access block has become an ancient history. This also served as a platform for collaborative care. There has been a valued added feature in doctors work reform. The reduced workload also paved way for a revamp of the on-call system in the medical team and the objective of weekly work hour of less than 65 hours has been achieved.

Conclusion

The use of patient flow variability management has reduced the sporadic workload in the acute clinical setting. It has provided an opportunity for collaborative care. The strategies in patient flow management and the methodology of variability management can be applied to other area and specialties as well, like ambulatory and overnight surgical and urological surgeries, which are the pressure area in the territories.

References

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Dr Eddie YUEN

Palliative Care Centre – The Path from Commissioning to Service Delivery

Abstract

This thesis centers around reflection on the journey of setting up a Palliative Care Centre (PCC) serving cancer & non-cancer end stage organ failure patients in an Extended Care health care institution. The key perspectives deliberated include an account of executive functions involved in the path from commissioning to service delivery.

The path commenced upon conceiving the future vision leveraged on the success of an existing clinical service when a charitable organization extended an invitation to submit proposal for sponsorship. Apart from elaborating the strategic planning process, the author retrospectively explored essential perspectives on the engagement of stakeholders at various levels, seeking approval from various governance bodies, fiscal feasibility, options appraisal, and deliverables. Defining the business case for clinical service delivery & ascertaining approval for clinical governance forms important ground works for building support.

Subsequent descriptions center on executive experience consolidated in project planning and execution. The author collaborated closely with facility management colleagues and project consultants in planning the "dream premise". The comprehensive Palliative Care Centre took shape through integrating vision with clinical experience, delineating the schedule of accommodation (SoA), functional brief, setting up, procurement; with strong adherence to budget control and time management milestones. The approach to delineate the blueprint for clinical service delivery was deliberated.

Third part of the thesis focused on organizational involvement and collaborative leadership to engage clinical colleagues in change. The author highlights strategies employed for alignment of expectations at various levels, the importance of ascertaining staff competency and readiness, and the pursuit for the status of specialist-led service. Towards the end, the author reflects on lessons learned, converging on the strategic planning process, domain of governance, value of project management, change management, and participatory decision making.

Strategic Planning & Perspectives of Governance

In 2001, the author's clinical management team (CMT) responded to the invitation from BMCPC, a charity organization, to submit proposal for a major sponsorship in expansion projects of existing hospice care for the local population.

The hospital management and the CMT revisit the philosophy of the service in ***strategic planning*** meetings. ***SWOT analysis*** was conducted on current developments and identified key issues faced in the future. The aging population impacts on future service volume and direction. There was increasing evidence on adopting Palliative Care approach in caring aged clients suffering from non-cancer organ failure diseases. Although the service was highly valued by clients and relatives, space was a major limitation to further service expansion, especially the ambulatory care component.

Reaffirming values and beliefs of Palliative Care service, CMT envisaged future ***vision*** being "Reaching Nature, Resting Home" (親近自然 則

久遠安和矣：優游家舍 必內外康泰焉), and from this, delineated the mission statement and objectives of the improvement plan. The author developed the main frame of the proposal brief, fiscal estimation & layout of facilities. The proposal covered aims & objectives, breakdowns of one-off expenses, suitable details of constructions, provisions of furniture & equipment; but excluded commitments on expenses of recurrent nature. In 2002, BMCPC confirmed in principle the approval of HK$30M. It also set a ceiling to the expenditure on furniture & equipment; & ensured commitment of TWGHs to meet shortfall of the budget estimation of HK$37.2M. The hospital would commit to delivering service of 26 hospice beds, and to seek BMCPC's approval for variations from the proposal.

Governance of a non-profit making organization, relates to consistent management, cohesive policies, guidance, processes and decision-rights for a given area of responsibility. The Governing Board also has the principal responsibility for strategic planning. In the case of a hospital, the Governing Board guides the development of the plan consistent with the hospital's mission, philosophy and values. Hospital Management of WTSH secured support from its Governing Board, which has the roles in strategic planning process including:

- Approval of the hospital's vision, mission statement and goals
- Suggestion and considerations of strategies
- Approval of the strategic plan and its implementation
- Monitoring and updating the plan and its implementation

The hospital management also secured support & guidance from its parent governing bodies: Board of TWGHs & Hospital Authority via cluster management authorities. Engaging the ***Hospital Chief Executive's*** commitment to the business case is crucial. As leader of the Hospital Management Committee, HCE plays an important role in maintaining connection with the governing bodies through phases of consolidation of the business case. From conception of vision to clinical service delivery, the project stretched across a time frame of nearly 8 years. Dr Daisy DAI supported the conception of vision. Dr C. C. LUK steered the engagement with BMCPC & parent governing bodies, as well as guided refinement of the business proposal from its sketch. Dr Lawrence TANG subsequently guided project planning and execution.

Defining the Business Case of the Palliative Care Centre

A business case answers the question: "What happens if we take this course of action?" Managers at all levels create business cases for all manner of decisions, to initiate actions, or to obtain resources for an initiative.

This ***"business opportunity"*** was defined in a ***position paper*** for the Palliative Care Centre initiative, and ***a position (opportunity) statement*** summarized the ***stance*** & described the ***benefits.*** The statement emphasized on several key elements: maintaining a learning and creative organization; pursuing evidence-based practice; striving to escalate on the platform of palliative care and venture into managing terminal organ failure and cancers, in partnership with TCM specialist in palliation and research."

The position paper formed the ***basis for building support with internal & external stakeholders.*** It covered: objectives; philosophy and service differentiation; service projection, staging & expected time frames; the option of TCM – WM Integrative Model; *deliverables*, namely: facilities, service model, population served (coverage of the Kowloon West Cluster), service volume per annum; *funding* requirement; multidisciplinary staff ***skill mix*** requirement for a *specialist-led* service, *manpower planning* , & staff development. ***Evaluation of impacts*** potentially incurred from committing to the initiative was discussed. The ***author's role*** focused on data preparation for compilation of this paper, providing input in clinical service delineation of department and its impact on service delivery, nursing manpower requirement projection & planning and preparation for staff competency readiness, both for palliative care & in-patient ***Traditional Chinese Medicine-Western Medicine*** (TCM-WM) integrative model.

TCM-WM ***Integrative Mode***l for in-patient Palliative Care services was a ***new initiative within the existing paradigm of healthcare delivery*** in Hospital Authority. Reference was made against the HAHO Operation Circular (July 2008), expressing it stance to promote positive interactions between TCM and WM practitioners, and provide guidance in interface issues confronted.

WM adopts a scientific analysis approach, whilst TCM's approach is that of a philosophical construct. ***Foundation on evidence-based medicine (EBM)*** is also being viewed as ***"the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients"***. In this connection, TCM & WM may not be mutually exclusive. ***"Best current evidence"***, ***"do no harm" & "informed option"*** form the basis of conscientious practice in TCM-WM Integrative Model.

Other than seeking support from internal clients of the hospital, the ***business case*** was communicated to the Kowloon West Cluster (KWC) Palliative Cancer Care Coordinating team to elicit support. Related cluster ***service statistics*** for cancer deaths by residence (existing & projection) was deliberated; and ***service gaps*** identified collaboratively.

- cluster serving a population of 545,323 (at mid 2000)
- Growing oncology service and changing cancer population movement in KWC
- Palliative Care beds in deficit
- Community based care under provided, &
- Day Care and consultative service of different service provision characteristics

Moreover, ***benefits of the business initiative*** from capturing the opportunity were explored, including: cross specialty synergy in service outcome & mutual support, avoiding unnecessary competitions, & cross-breeding of talents & clinical specialty experts. The discussion consolidated a ***governance structure for KWC Palliative Cancer Care***. The structure was headed by Cluster Chief Executive with a Clinical Service Director, 3 site leaders, including one in WTSH; & six service coordinators: Oncology treatment, Home care service, Clinical psychology service, Medical social welfare service, Surgical & NGO, and Pain service. These are the partners as well as stakeholders of the business initiative on a cluster-wide basis.

The CMT also identified ***alternative options*** of service provision for the BMCPC Board to ***appraise***. In July 2003, economic downturn brought about by the impact of the SARS epidemic result in considerable savings in the original budget estimate, mainly from building costs. Finally, the Board endorsed a comprehensive Palliative Care (PC) Centre fulfilling future development needs. From the original 26 PC beds for cancer cases

& an open garden on roof top; to ***additional deliverables*** of 40 palliative organ failure care beds, an ambulatory care cum resource centre; bereavement and counseling facilities, & stress relieve facilities for staff. Dr William HO, ***Chief Executive of Hospital Authority***, endorsed the finalized proposal.

The ***functional brief*** was delineated and ***blueprint of the layout*** of the Palliative Care Centre was developed. The brief was conducive to realization of the vision, projects the theme of the Centre, and essential for Facilities Management and the Project Architectural Consultant to work out design details. As a key member of the clinical Management Team, the author worked with frontline supervisors and medical colleagues on this intensively. Clinical activities, operational circulation requirement, & patients' flow were elaborated to facilitate defining of the layout plan of the future premise.

Project Planning & Execution

Project governance was two-tiered. A Steering Committee as well as a Work Group on Project Management was set up to govern & manage the following three aspects: ***resource & budget management, scope of works involved and time management.***

The Steering Committee provided directions, guidance and final endorsement on the line to take in case variations & discrepancies occurring on the way. ***The Project Working Group*** involved stakeholders at the hospital level. Its functions were more on ensuring the actual planning, implementation of the construction works and procurement procedures were aligned with clinical operational requirements and service need. The author, as a key stakeholder of the clinical service, was actively engaged in ***project execution*** in the Project Working Group. The key roles and challenges were defining the scope of works for construction works & setting up; schedule of accommodation (SoA), change management, staff engagement and decanting arrangement. In close collaboration with FMD colleagues, building service requirements, procurement management; integration of communication technology in enhancement of clinical operation were worked out.

Blue Print of Clinical Service Delivery

The author and the CMT worked on the blueprint for clinical service delivery, which form the basis to enhance clinical governance in ***quality and risk management***. Clinical operation manuals were compiled to help depict the collective efforts of multidisciplinary clinical service.

In the ***structure domain***, mission statement, conceptual framework of service, integrated model of care delivery, interdisciplinary approach, nursing care delivery model, and discharge planning formed the core. Important elements of ***continuous quality improvement*** and ***proactive risk management*** inherent to the nature of the service were indispensable. ***Care pathways*** were compiled to facilitate expression of the domains of care across the time frame adopting an interdisciplinary approach. It also set the scene for orientation and induction of staff, baseline to measure against for continuous quality improvement activities, facilitating future variance tracking activities. The ***process domain*** depicted work processes for in-patient, ambulatory care as well as discharge support services. It delineated a clear picture for effective communication between the various intra-hospital and inter-hospital stakeholders. ***International best current practices*** for ***care processes*** were adopted, like Liverpool Protocol for End of Life Care and the

Protocol of "Care of dying". Standard of practices on Palliative Care recommended by corporate & KWC Palliative Care were referenced. ***Advance care planning*** was incorporated in the care process. Patients, their health care providers, their families & important others; communicate regarding the kind of care that will be considered appropriate when the patient cannot make decision. The senior doctor in-charge and nurse-in-charge offer sufficient & accurate information to facilitate informed decision making to patients and relatives who expressed wish to make an advance refusal of life-sustaining treatment and enhance symptom relieve treatment.

Though ***outcome measurement*** often projected an impression of quantitative objective measurable for easy benchmarking and comparison, it is always important to note that qualitative descriptions and expressions are indispensible parameters for the nature of the Palliative Care service. To help capture clients' subjective evaluation, the Palliative Performance Scale (PPS), pain score, M.D. Anderson Symptom Inventory (MDASI), and Quality of Life (EORTC QLQ-C30 version 3) are validated tools adopted. Yet, it is important to balance the wish to capture data versus respecting the clients' and relatives' need to alleviate their physical and psychological distress.

Staff Engagement & Empowerment

Staff engagement began with project commissioning. Clinical leaders at various levels were identified and involved in the project management team. Their view and expectations were integrated into the blueprint of the future service. To communicate progress of development, ***a Hospital Chief Executive (HCE) Forum*** was conducted to address the concerns of frontlines. Apart from announcing the launch of the Project, decanting plan, strategies to contain possible risks and nuisances were deliberated. To capture the audience, the author illustrated relationships of the essential elements of the project in form of milestones for important changes. Core members of the Project Working Group, including the author, addressed to concerns and suggestions of frontline, like staff development and manpower readiness.

To further engage staff of various disciplines, a ***"Vision Journey"*** was launched. In this event, the vision, mission & objectives of the Centre were represented in form of tangible experiences & activities booths. Elements of the new service were displayed to engage staff involvement in the domains of knowledge, clinical skills & affects. Through experiencing modalities displayed in the booths, colleagues get to know how complementary therapy, Traditional Chinese Medicine (TCM), spiritual support and therapeutic group activities ***synergize*** with the Palliative Care Service we used to deliver for cancer patients, and be extended to suffering clients with end-stage organ failure.

Staff empowerment involved engaging multidisciplinary in domains of knowledge, skills and affect. It began with a ***pilot of the service model*** while the capital works were taking place to capture experience, especially on adopting the Palliative Care approach for end stage organ failure patients. ***Area of competence*** developed and sustained included palliative care for cancer and organ failure; palliative communication for end of life care, pain management, concepts of Integrated model of Traditional Chinese Medicine and Western Medicine, and concepts on contemporary oncology. There is also on-going promulgation of the culture and value at the organizational level to consolidate application and synthesis. The Centre achieved it's objectives as a ***specialist-led service centre***, and is working towards accreditation as Palliative specialty

training centre. The proportion of specialty trained colleagues is consistently proliferating.

Reflections

The ***strategic planning process*** from conception of the vision of an Integrated Palliative Care Centre to actual service delivery determined what the Hospital Management & Clinical Management Team wanted to position its Palliative Care in the future and how it will get there. It is different from short-term or operational planning, and must be established to position the hospital/health system in a rapidly changing environment.

The whole process embarked with various stakeholders who acted as ***sources of governance*** providing guidance, policy and direction. These included the BMCPC, Board of TWGHs, Hospital Governing Board, Hospital Management, Project Steering Committee, KWC Cluster Management, KWC Co-ordinating Committee for Palliative Cancer Care; last but not the least, the Hospital Authority Head Office and Chief Executive. In terms of ***clinical governance***, executives adopted ***quality and risk management*** approaches and practice guidelines stipulated by Hospital Authority Head Office, Cluster Clinical Management and other best practices currently identified. Procurement procedures observed corporate and cluster expectation and policies. Organization of clinical service adopts ***proactive management of risk*** in alignment with clinical service expectations.

In this business case of the Palliative Care Centre, important ***project management*** concepts were identified and adhered to. It included: stakeholder identification, risk identification and planning, defining requirements and scopes; and controlling changes. Project plans in various domains served as guides for execution; and focused on scope, time, and cost / resources. Apart from capital works, project plans included other areas of concern such as risk, quality, communications, and procurement. In this project, changes were monitored effectively and provided decisions support information to project stakeholders.

Project governance in terms of leadership, budgetary control and time management is crucial. Leadership of hospital management evolved over time. Inevitably, engaging the new incumbency was essential to secure commitment and success. The socio-economic environment affected strategic planning process and project execution, especially in fiscal feasibility considerations. The SARS epidemic and economic downturn in 2003 had benefited budget estimation and the ***opportunity was captured*** to allow expansion of the project scope. Yet, changes in global economic situations lead to inflation in 2006/07 & escalation of capital project cost. As a result, some items of relatively lower priority for immediate service provision were deferred as improvement items.

The scale of this business case and its far fetched nature for potential impact on staff perception warranted tactful ***expectation and change management***. Various communication strategies and participation decision making were employed to engage stakeholders. Despite concerted efforts, there still exist some hidden corners and grey areas being identified in current situations. For example, staff participation in Hospital Chief Executive forum provided a good commencement point. Alignment of staff expectation does not end when capital works or staff training was concluded. Staff engagement & empowerment warrants continuous effort and asked for proactive sensitivity of the executive to identify information gaps early.

Ivy TANG

A Year of Learning and Sharing for the College

Last year was indeed a fruitful year for the College with the participation of over 200 persons who attended six talks organized by the College. Topics of the talks vary and they range from the field of healthcare which we are all familiar with to some territory-wide hot issues such as education reform and development of high speed railway in Hong Kong. These were thoughtfully arranged to keep members abreast of the development in healthcare industry as well as the society as a whole. It was encouraging to see members' active participation in exchanging views with the guest speakers who are either specialists in healthcare management or senior government officials.

8 November 2010, Monday

"Preparing for LegCo Meetings, a No-kidding Job"

by Ms. Pauline NG, Secretary General of the Legislative Council:

Following an introductory overview on the composition, powers and functions of the LegCo, Ms. NG shared with members the gist of preparing for the panel meetings of LegCo. The talk provided valuable hints and tips for those who may need to prepare for Legco meetings, indeed a *No-kidding Job*.

24 November 2010, Wednesday

"Health Insurance"

by Professor Gabriel LEUNG, Under Secretary for Food and Health:

Professor LEUNG introduced the government-regulated health insurance (the Health Protection Scheme) which aimed to ensure protection of public health with a sustainable healthcare system in Hong Kong in facing the challenges of a rapidly ageing population and rising medical cost. Views on the Scheme features, key success factors, engagement of the industry and incentives to attract public participation were exchanged.

24 January 2011, Monday

"Managing Healthcare Finances – An Art or Science?"

by Ms. Nancy TSE, Director of Finance in Hospital Authority:

While in most people's mind healthcare financing falls within the discipline of science, Ms. TSE led members through the journey from budgeting to costing and internal control from state-of-mind and perspective of art. And that has made all the difference.

29 March 2011, Tuesday

"High Speed Railway – Development Imperative or Nightmare for Environment?"

by Mr. YAU Shing Mu, Under Secretary for Transport & Housing:

The society's impression on High Speed Railway was seemingly scarred by the opposing post-80s who surrounded the LegCo building the night when the budget was approved. Mr. YAU helped members clear the noises by presenting to us the positive side of the Project including the strategic connotation, potential economic gain and cost benefits to the society.

13 April 2011, Wednesday

"Education Reform – Change for Better or Status Quo in Disguise?"

by Mr. Kenneth Wei-on CHEN, Under Secretary for Education:

Mr. CHEN introduced to members the new Senior Secondary Curriculum (NSS) which aimed to help students acquire a broad knowledge base and equip them with the ability to understand contemporary issues at the personal, community, national and global levels. Many members who are also caring parents actively exchanged views especially on the choices and the multiple pathways the NSS can offer.

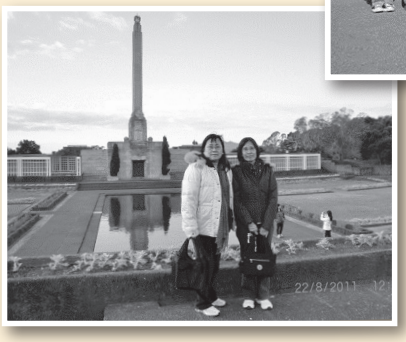
Benjamin LEE

New Zealand Study Tour cum the 2011 International Congress of Australaisan College of Health Service Management

Journey to Rotorua 21 - 28 August 2011

The Hong Kong College of Health Service Executives (HKCHSE) organized the New Zealand study tour cum the 2011 International Congress of Australaisan College of Health Service Management (ACHSM) in August 2011. Under the leadership of Dr. H C Ma and Dr. S H Liu, the study tour delegation embarked on the journey to New Zealand on 21 August with a total of 23 participants (20 College members, 1 non-member and 2 family members). In summary, the one-week study tour was a most memorable, educational and rich cultural experience which was exceedingly fruitful and rewarding for the delegates.

21-22 August 2011
- Arrive Auckland. Free Day for City Tour



After the overnight flight on 21 August, the study tour delegation arrived at Auckland airport in noon time of 22 August. The group received the greeting from the local guide as well as the warm welcome of New Zealand by its cloudless sky with shining blue and light breeze. The group's journey in NZ was started with its three-hour city tours of Auckland, New Zealand's biggest city. The study group first visited the famous Auckland landmark of Mount Eden which is a dormant volcano whose summit offers excellent panoramic views of the city and harbours.

The second spot was the Michael Joseph Savage Memorial on Takaparawha which is a memorial to the first Labour Prime Minister of New Zealand and the founder of the Welfare State, it overlooks the Waitemata Harbour and offers panoramic views of it.

Then the group travelled over the Tamaki Drive which is the road along the coast. It hugs the coastline from the central bus iness district, through bays and past beaches to St Heliers 10 kilometres away. While not strictly a park, Tamaki Drive is most certainly a playground for Aucklanders and their visitors with all beautiful attractions on either side of the road along the way. The weather was beautiful during the sight-seeing. The group returned to the hotel after a joyful trip.

23 Aug 2011
- Fellowship Conferment Ceremony in Rotorua

After one day's stay in Auckland, the group moved on the journey and travelled by coach to Rotorua, the final destination of the study tour. On arrival, the group had their lunch at Skyline

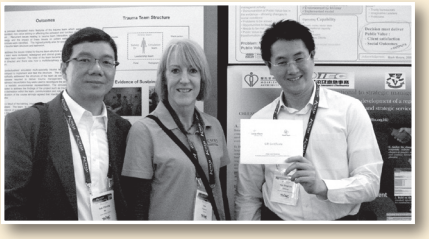
The first evening in Rotorua started off with the network drinking and fellows dinner at Mitai Maori Village. Mitai had offered its guests an authentic hangi meal that was cooked in the earth oven known as 'the hangi pit'. Following the succulent Hangi meal was the spectacular cultural experience. All participants were enthralled by the natural bush setting during the guided bush walk, the group saw warriors in traditional dress paddle an ancient warrior canoe (waka) down the Wai-o-whiro stream, and they had their only opportunity in the Rotorua area to see glow worms in their natural habitat. The cultural performance was a fascinating performance full of emotion and power enabled audiences to learn Maori's past, carvings and ta moko (tattoo art). The evening at Mitai gave all delegates an authentic introduction to Maori culture leaving them amazed and in awe.

Gondola which was conveniently located just minutes from Rotorua's City centre, high on the side of Mount Ngongotaha. The Gondola carried the delegates to 487 metres above sea level to a stunning environment which provided panoramic views of Rotorua City, Lake Rotorua and the surrounding area. The greatest time finally came for all the 2011 new fellows in the afternoon – ACHSM's Fellowship Conferment Ceremony. A good number of twelve Hong Kong new fellows travelled all the way to Rotorua for this memorable moment. Moreover, it was delighted and encouraging that our new fellow Dr. Eddie Yuen was granted with "The Dr. Geoffrey Lieu and Dr. David Briggs Award for his excellence in the 2011 HKCHSE Fellowship Examinations". One can envisage excitement and joyful moment as shown in the pictures.

24 - 25 Aug 2011 AM
- Congress Program & Congress Dinner

In the two days from 24 August to 25 August 2011, the group attended the international congress jointly organized by the Australasian College of Health Service Management (ACHSM) and the New Zealand Institute of Health Management (NZIHM) which was officially opened on 24 August by the Minister of Health, Hon. Tony Ryall. The main theme this year was "World Class Health Management – Kicking for Goal'. The aim of this Congress was to present new thinking on the main challenges faced by health managers and health facility designers and planners. All participants were engaged in exploring new approaches to health management that would be a better fit for the times. According to Sue Thomson of ACHSM, this was the first time that the congress had been held outside Australia. They had delegates from Australia, New Zealand, Malaysia and, of course, the delegation of HKCHSE from Hong Kong. This forum had typically brought together different professional groups - health managers and health facility designers and planners working

across the sectors, public, private, NGOs and across the disciplines making up healthcare - who were able to learn from each other by comparing respective roles and responsibilities and sharing knowledge and experiences. The sessions were organized according to four strands – strategic/policy focus; hands-on/how to focus, research/case studies/ innovation and clinical leadership session. The 2011 HKCHSE new fellows were very excited at being able to participate in this great learning and networking opportunity – bringing together health managers from all around the region and shared with them the amazing and highly memorable Maori culture like kappa haka, hongi and hangi which had been shaped by the traditions of its rich culture heritage. Dr. Cissy Choi, Ms. Wendy Ho, Ms. Macky Tung and Mr. Leo Cheung from the delegation also had their own oral or poster presentation on their research papers or projects. It was encouraging that Mr. Leo Cheung was granted with the outstanding poster presentation award by the ACHSM.



The group joined the Congress Dinner on 25 August 2011 which was a very unique evening of Kiwi. The event had very much focused on the culture and hospitality of the Kiwi hosts. Delegates were also welcomed to go dressed in their own national costume. The climax of the dinner was the haka dance (Maori War Dance) performed by ACHSM's Council members, affiliates and guests from different countries. The organizers and all delegates took this great opportunity to relax and socialize and it was a great way to mingle around with delegates from countries over the world. Experiences were shared and friendships were made with them, it was a joyful and funny evening filled with laughter.

26 Aug 2011
- Health Services Site Visit Rotorua Hospital and Korowai Aroha Trust

On 26 August, the group joined the closing session of the International Congress in the morning and, being accompanied by Ms. Kate Copeland, the President of ACHSM, the delegation of HKCHSE had managed to visit the health services facilities in Rotorua – Rotorua Hospital and Korowai Aroha of Lakes District Health Board. The group received the warm welcome by Ms. Cathy Cooney, the Chief Executive of Lakes DHB upon arrival at Rotorua Hospital. Ms. Cooney briefed the delegation background of Lakes DHB which was established in year 2001 and it is responsible for providing and funding healthcare services for 102,000 people who live in the Lakes region. Rotorua and Taupo Hospitals are the two hospitals operated by Lakes DHB in the region. Rotorua Hospital provides a range of services to the people of the Lakes district and has started its hospital redevelopment program since year 2009. The delegation mainly visited the new Rotorua Hospital building programme included the new three-level Rotorua Hospital building which was just officially opened on in July 2011, other clinical services like ICU/CCU, the Medical Unit, the Surgical and Orthopaedic Units which were still under its relocation to the new

building during August 2011. The hospital staff stated that Hospital would continue to redevelop the Emergency Department, expanding the area from 15 cubicles to 32. till the end of 2011. The hospital also provided a range of community services - in homes, at centres away from the hospital and in other community settings. The group continued with their visit to kaupapa Mäori health care provider Korowai Aroha Trust after the hospital visit.

Korowai Aroha is a Mäori centre providing primary health care services to people in the Rotorua and surrounding districts. Its focus is on Mäori health and wellbeing. Its mission statement is "To provide accessible, affordable quality service that allows for the cultural values of the Mäori people." It offers a General Medical practice (GP and nursing services), Advocacy for Mothers and their Pepi, Asthma Management, Aukati Kai Paipa, Cervical Screening, Diabetes Management, Mobile Mäori Nursing, an Outreach service, Whänau Ora and Home Based Support Services. After the visit to local health services providers, the group was impressed by DHB's dedicated efforts to promote the health of Lakes population there (32 per cent Maori population).

27 Aug 2011
- Free Day for Hobbiton Movie Set and Farm Tour

The group departed Rotorua and proceeded to Hobbiton Movie Set and Farm Tour in the morning. The Hobbiton Movie Set is located on a real New Zealand farm, there on the most picturesque private farmland near Matamata in the North Island of New Zealand, the group had visited the remnants of the original Hobbiton Movie Set from The Lord of the Rings movie trilogy in a fascinating guided tour. There were spectacular views across to the Kaimai Ranges from the rolling green hills of the movie set, which is still a working sheep and beef farm. The farm owner specifically offered the group an authentic and unforgettable sheep farm experience by seeing how the shearer cleverly handles the sheep. Then they took the opportunity to cuddle and bottle feed the pet lambs. All had relaxed and soaked up the unique atmosphere with a delicious meal and a great meal cup of coffee in The Shires Rest Cafe. After the joyful trip to Hobbiton, the group travelled back to Auckland in the afternoon and this also denoted a perfect full stop to the entire study tour. The group returned to Auckland in the evening on 27 August, set off to the airport and took 13:20 flight to Hong Kong on 28 August.

With such fruitful and eye-opening Rotorua study group program, on behalf of all the sixteen 2011 new fellows, I would like to express our gratitude to Dr. H C Ma, Dr. S H Liu, Ms Tammy So, all other Council members and the mentors for their unfailing effort made for the fellowship program and the study tour. The objective of the delegation was successfully reached particularly when being part of this very special and rich cultural experience.

I am eagerly looking forward to the coming ACHSM International Congress 2012 which will be heading back to the Gold Coast, Australia, from 15-17 August 2012 (tentative). Please mark your diary and don't miss this exciting event in coming year!

Liza CHEUNG

Application Form

Hong Kong College of Health Service Executives
香港醫務行政學院

Membership Application / Renewal Form (with effect from 1 Aug2011)

A. Name:

(Family Name / other name)

Title : Prof / Dr / Mr / Ms / Mrs HKID No.: ☐☐☐☐☐☐☐ – ☐ 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

Email : _____

B. Correspondence Address :

C. Contact Information:

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

D. Membership Type: (please ✓ in the appropriate box) (New Renewal)

Membership Type	Annual Membership Fee			
	HK Membership ** (HKCHSE)		Dual Membership (HKCHSE and ACHSE)	
Fellow *	HK$500	☐	HK$3,300	☐
Associate Fellow ***	HK$300	☐	HK$3,100	☐
Associate	HK$200	☐	N/A	☐

* Fellow membership only applied to those who have been conferred Fellow by the College
** If you are life member of the HKSHSE, you still need to pay full membership fee annually w.e.f. 2008/09.
*** 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.**