8 Coordination within Hong Kong

What have we heard?

- ❑ Complicated organisational structure of Government hindered communication across departments and between Government and other sectors of the community
- ❑ Unclear division of responsibility among Government officials and departments
- ❑ Insufficient communication between DH and HA
- ❑ Insufficient communication among different hospitals of HA
- ❑ Poor coordination between HA and private sector

INTRODUCTION

8.1 Emergencies such as communicable disease outbreaks will often highlight not only deficiencies in communication, but also weaknesses in organisational arrangements. The Committee was told of a variety of problems that arose during the course of the epidemic at all levels of the health service in Hong Kong, some of which were inherent in existing organisational or management arrangements. However, the Committee is aware too of many examples where good communication helped to overcome the overwhelming crisis that faced Hong Kong.

BETWEEN HWFB, DH AND HA

8.2 Effective communication is vital at every level when dealing with a major outbreak. This requires a common understanding of who is responsible for what at each level within the health services. There must be clear lines of responsibility between HWFB and DH; between DH and HA; between DH head office and the regional offices; and between regional offices and hospital clusters or individual hospitals. There should be close liaison between hospitals and the staff of the regional offices of DH. This should include greater clarity about their roles and responsibilities in managing the public health aspects of communicable disease and in managing outbreaks from a population-based perspective. There needs to be an authoritative visible spokesperson.

8.3 Several submissions suggested that the complicated organisational structure of the Government hindered communication during the epidemic, and that there was unclear division of responsibility among different officials and departments. For example, without a designated spokesperson who could disseminate public information about the outbreak in a consistent manner, the general public was left with the impression that the Government was hiding something when conflicting messages surfaced from different departments and sectors. Another example was that both DH and HA issued guidelines to homes for the elderly, but the guidelines contained differing advice about infection control measures.

8.4 The Committee notes that a number of measures were taken to mitigate the problems, such as through establishing multi-sectoral coordination bodies at the highest level of Government. This involved establishing three ad hoc, interim bodies –

- The HWFB Task Force
- The Chief Executive's Steering Committee (CESC)
- The Inter-departmental Action Co-ordinating Committee (IACC).

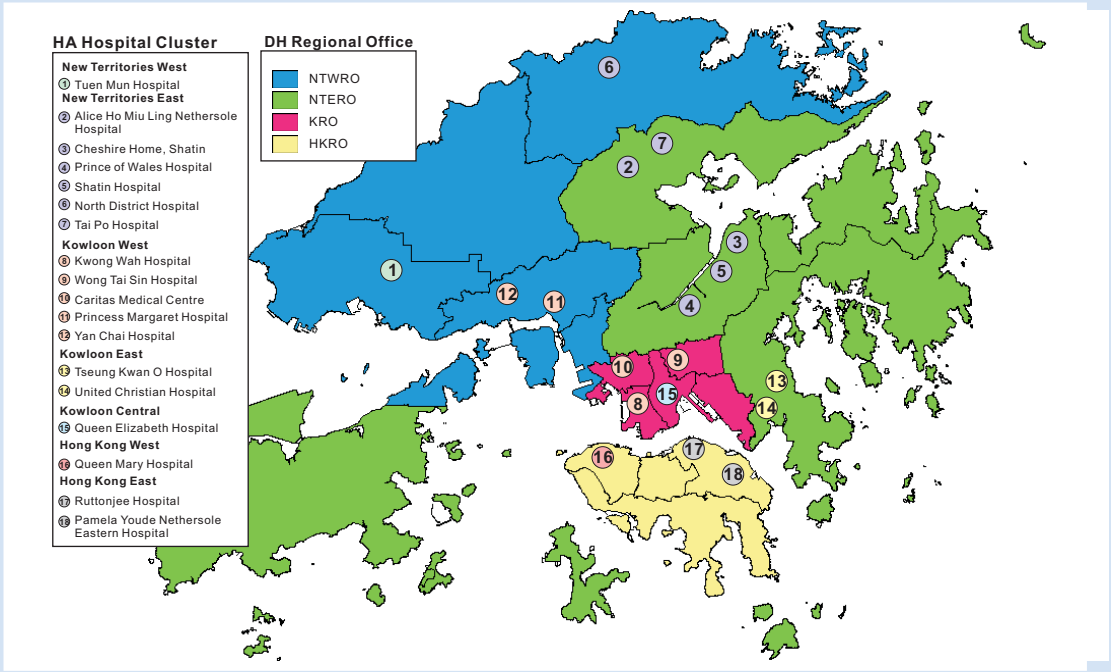
8.5 The HWFB Task Force was convened by SHWF on 14 March 2003 in response to the outbreak at Prince of Wales Hospital. It was chaired by SHWF, and included experts in public health, respiratory medicine and microbiology from DH, HA, local universities and WHO, as well as officials from DH and executives from HA. It met six times, before it was superseded by the CESC on 25 March 2003. This was chaired by the Chief Executive and involved the relevant Principal Officials of policy bureaux which took part in dealing with the epidemic. It was intended to ensure better coordination of the Government's response and to ensure that the necessary manpower and financial resources were made available. SHWF remained responsible for coordinating the health sector response. The IACC, which was chaired by the Permanent Secretary for Health, Welfare and Food, included members of over 25 bureaux, departments and public bodies and was formed to coordinate the implementation of decisions made by the CESC and SHWF. The IACC was responsible for, among other things –

- The isolation and evacuation of Amoy Gardens Block E
- The identification, conversion and management of vacant public housing blocks as temporary quarters for frontline healthcare staff
- The implementation of home confinement scheme
- The implementation of port health measures to prevent the importation or exportation of SARS
- The operation to provide assistance to a Malaysian-registered vessel with suspected SARS-infected crew members on board.

8.6 The SARS epidemic demonstrated the importance of a mechanism to coordinate the response of Government departments to a public health emergency. Although the IACC has now been stood down, there should be a standing arrangement to ensure a coordinated response to any future public health emergency. This should be capable of being promptly activated and should comprise members from HWFB, DH/CHP, and other relevant Government bureaux, departments and agencies.

- The Government should ensure that HWFB, DH and HA each have in place (at every level) a major outbreak control plan that –
  - Explains the circumstances in which it will be activated
  - Describes how an outbreak control team will be convened
  - Specifies the responsibilities of key individual team members
  - Takes a population-based perspective
  - Defines the respective roles of HWFB, DH and HA, and explains clearly the chain of command at all levels: operational, tactical and strategic
  - Describes the mechanisms for coordinating the outbreak response across all sectors in the health system
  - Includes coordination of activities with the private, voluntary and business sectors
  - Addresses key areas such as staff training, information flow, patient management, contact tracing, quarantine and isolation
  - Identifies resources that can be rapidly mobilised and shared across organisational boundaries, including arrangements for seconding staff
  - Incorporates arrangements for replacing key staff with appropriately trained deputies, should they become unavailable
  - Embraces generic plans, site-specific plans and event-specific plans.
- The HWFB plan should include arrangements for convening an Inter-departmental Action Coordinating Committee to coordinate the actions of relevant Government bureaux and departments.
- Plans should be developed in collaboration with the CHP and regularly tested at all levels by means of desktop exercises and drills and communicable disease outbreaks should be viewed as an integral part of contingency planning.

Figure 8.1 DH Regional Offices and HA Hospital Clusters



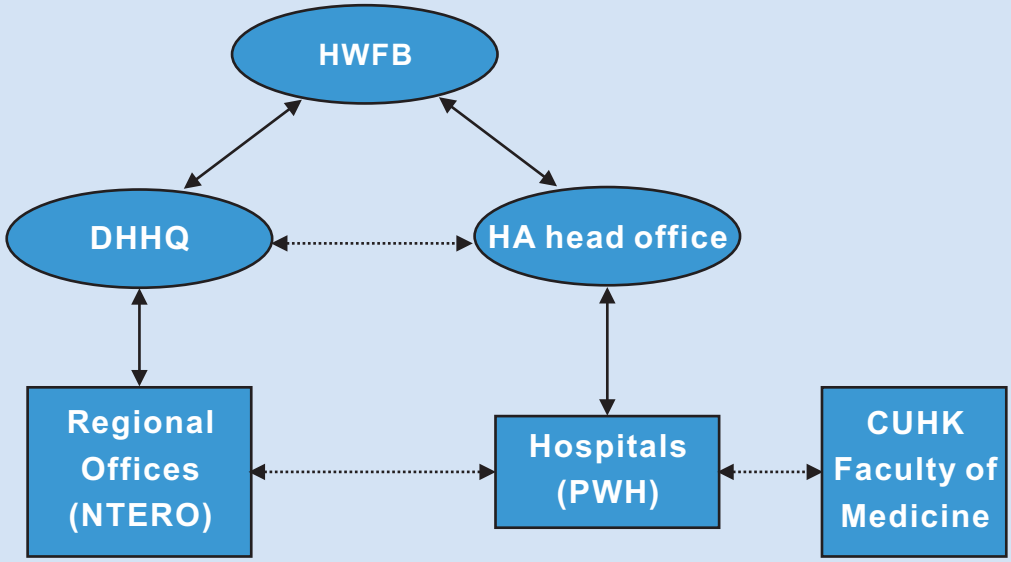
BETWEEN AND WITHIN DH AND HA

8.7 The Committee heard criticisms of insufficient communication between DH and HA. During the epidemic, the two bodies cooperated on various issues: DH was represented on the HA's Working Group on Severe Community-Acquired Pneumonia set up in February 2003; DH promptly deployed staff to assist with managing the PWH outbreak; the e-SARS system was developed jointly; DH's public health laboratories worked together with laboratories in the universities and HA to coordinate specimen sharing; and DH issued infection control guidelines to healthcare workers. However, at times there was confusion over responsibilities and a failure in the system to enable full appreciation of the interaction between the hospital and the community. There were problems with communication within HA. Decisions made by senior management were not communicated adequately to frontline staff, and frontline staff were seldom consulted when policy guidelines were drawn up.

8.8 The basis of epidemic control lies with taking a population-based approach in which both DH and HA should work together. To do this, a greater understanding of the relative roles, responsibilities and accountabilities is required and these need to be spelt out explicitly. In addition, more needs to be done to break down the barriers between the different sectors and hospital clinicians and managers. There should also be greater appreciation that since patients and staff are drawn from the

Communications: the weakest link?

The communications between DH, HA and the Faculty of Medicine of the Chinese University of Hong Kong during the initial period of the Prince of Wales Hospital outbreak followed the traditional pattern tacitly observed by the various parties. This communication pattern, which was characterised by the autonomy and independence of each in the three-some, is illustrated below.



While the lines of communication worked well during ordinary times, they might have given rise to distorted perception in this episode of heightened emotions. The concerned parties might not have communicated clearly their expectations or sought clarifications from each other when in doubt. Misunderstanding added to the frustration and anxiety of the various parties already overwhelmed by the scale of the outbreak.

community, communicable disease incidents in the hospital may have wider implications for the community at large.

- For outbreak control, a population-based approach is needed, in which DH will take the lead, regardless of whether the outbreak occurs in hospitals or in the community, and work together with HA as appropriate with agreed protocols.

8.9 DH's role is underlined by the fact that its officers are, in law, empowered to exercise various statutory powers and enforce legislation on infectious diseases. DH requires appropriate expertise and resources to properly fulfill this function. From a community and population-based perspective, hospitals will need to communicate hospital-acquired infection to DH. Part of the current problem stems from a lack of standing of public health staff among clinical colleagues. It is essential that staff in the public health service are properly trained and supported to carry out their work.

8.10 At the operational level, there needs to be good working relationships between public health staff and clinicians, particularly

hospital microbiologists and infectious disease clinicians. To help foster this, it is important that hospital infection control services are developed. Whilst public health staff will not be directly involved in the day-to-day management of hospital infection, they should be involved at the strategic and policy-making level, eg through membership of hospital or hospital cluster infection control committees.

8.11 For the purpose of bringing a population-based perspective and ready resource to manage any future outbreak, what is needed is a system of management and infection control that communicates and is shared by clinicians, public health staff, and policymakers alike. One way that could improve understanding and communication is embedding epidemiologists in HA who is DH employed and work across academic systems as well. There should also be better relationships in day-to-day activity, getting properly trained expertise out into the system, into the community and working together.

- The following should be done to improve collaboration between DH and HA –
  - Infection control and epidemiological experts should be based in every major hospital, working as employees of DH seconded to HA. These individuals will have responsibility for hospital infection control, data collection and reporting, and regular liaison between colleagues in HA and DH
  - Staff should be encouraged to rotate through the different systems including DH, HA and the universities as appropriate
  - Resources (staff and funding) should be brought together to deal with future outbreaks from a population-based perspective
  - The geographic boundaries defining DH regions and HA hospital clusters should be re-examined with the aim of making the geographic areas of responsibility co-terminous
  - There should be closer day-to-day working relationships between public health professionals and clinical colleagues in hospitals and primary care
- There should be better collaboration between hospitals, and between the hospital, primary care and public health service sectors particularly in respect of disease surveillance and infection control.

BETWEEN PUBLIC AND PRIVATE SECTORS

8.12 The Committee heard allegations that HA was reluctant to transfer patients to private sector for fear of losing patients to the latter, that private practitioners needed to compete with HA to purchase masks and protective gear, and that the public sector alone could not

adequately deal with SARS. Conversely, there was the view that private hospitals could not have coped with SARS without HA's backup. The grievance expressed by the private sector against HA is a reflection of a long-standing problem regarding the structure and emphasis of the current healthcare system, on which the Committee understands the Government is already working through healthcare reforms.

8.13 The Committee notes that there were attempts to initiate joint initiatives between DH, HA and the private sector. Private hospitals were invited to report severe community-acquired pneumonia cases to DH from February onwards, and the DH laboratory sought to involve the private sector in the surveillance of infectious disease. DH had also disseminated information and guidelines about SARS to community doctors, pharmacists and traditional Chinese medicine practitioners. To minimise the need for hospitalisation, HA strengthened its Community Geriatric Assess-ment Team service and launched a Visiting Medical Officer scheme with help from the Hong Kong Medical Association to offer medical and triage services to residential care homes for the elderly. However, the interface between public and private sectors could be further strengthened.

- In order to enhance the role of the private sector in communicable disease control –
  - The private sector (private hospitals, private laboratories, family medicine and traditional Chinese medicine practitioners) should be more fully involved in communicable disease surveillance
  - The development of a web-based system for electronic notification by private practitioners and for providing regular updates of surveillance results to private practitioners should be explored
  - DH/CHP should promote better standards of infection control in primary care and the residential care services
  - The Visiting Medical Officer scheme should be made permanent to provide support and care to the elderly in residential care homes and to assist in disease surveillance.