For discussion on
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Legislative Council Panel on Health Services

Subcommittee to monitor the implementation of the recommendations of the SARS Expert Committee and the Hospital Authority Review Panel on the SARS Outbreak

The SARS Expert Committee has put forward 46 recommendations in its report (**Annex 1**) to enhance Hong Kong's preparedness against SARS. We have set up a Task Force to coordinate the implementation of these recommendations. The progress made by the Government and the Hospital Authority in taking forward these recommendations is tabulated at **Annex 2**.

2. Members are invited to note and comment on the progress report at **Annex 2**.

Health, Welfare and Food Bureau
October 2003

XVIII. MAIN RECOMMENDATIONS

Organisation of health and healthcare system for the control of an outbreak of communicable disease

1. The organisational structure and the relationship between the Health, Welfare and Food Bureau (HWFB) and the constituent Government Departments under the Bureau in the areas of health, social welfare and food should be reviewed. Consideration should be given to merging the functions of separate departments within the Bureau, headed by the Secretary for Health, Welfare and Food (SHWF), in order to improve the capacity for coordination across the Departments and to facilitate policy-making and commissioning for health protection matters. (See para 6.1)

2. The Government should establish a Centre for Health Protection (CHP), which would have the responsibility, authority and accountability for the prevention and control of communicable diseases. As it develops, this centre would also have the responsibility to advise on all aspects of health protection, including food safety and hygiene, veterinary issues, non-communicable diseases and their risk factors, etc. It would also be responsible for maintaining close working relationships with the main international agencies. (See para 7.1)

3. The Bureau under the leadership of SHWF should consider what changes are necessary to ensure that the necessary systems to coordinate the activities and responsibilities of the Department of Health (DH) and the Hospital Authority (HA) and the private sector are all in place. (See para 6.1)

4. HA has just taken over responsibility for some primary care services formerly provided by DH. In the light of this, consideration should be given to changing the name of HA, eg to the Health Services Authority, in order to reflect its wider responsibilities. (See para 6.5)

Health protection functions

5. CHP should engage in routine surveillance, preparatory response and training with a clear understanding of the functions and skills needed across the healthcare system. (See para 7.1)

6. CHP should ensure there is an adequate infectious disease control system with the following functions: surveillance system, analytic capacity, investigative capacity, training and applied research capacity, surge capacity, health education and evaluation and backup with appropriate statutory powers. (See para 7.1)

7. The Government should ensure that a major outbreak control plan is in place with scenario planning and table-top exercises as appropriate. The control plan should be across the system and include hospitals, regional and cluster level, private and voluntary sectors, and the business sector and territory wide organisations with the following elements in it – (See para 8.2)

   (a) Inclusion of generic plan, site-specific plan and an event-specific plan as well as the international dimensions

   (b) Population-based perspective

   (c) Integrated command management structure

   (d) Infection control team with flexibility in mobilisation of the appropriate expertise

   (e) Information flow, contact tracing, patient management and staff training

   (f) A mechanism for working out research priorities.

8. The adequacy of existing legislation should be reviewed to underpin both public and private sectors, ensuring that there is cooperation and coordination and common purpose in dealing with threat of infectious diseases. (See para 7.2)

Collaboration within the Pearl River Delta region and with the international community

9. Regular data reporting systems and robust collaboration on surveillance need to be developed within the Pearl River Delta region. (See para 9.1)

10. The capacity to establish links and networks and to promote exchanges of professionals, academic, hospital and technical staff between Hong Kong and the Pearl River Delta region in the Guangdong Province needs to be enhanced. (See para 9.1)

11. HWFB/DH/CHP should establish contingent plans and relations with organisations and individuals with outbreak control experience and with capacity to pull together a team of expertise (World Health Organization/ Centers for Disease Control and Prevention in USA/Health Protection Agency in UK). They can then be called upon to help at times of an outbreak. They should be involved now in the preparation of contingency plans and be familiar with Hong Kong's system. (See para 9.2)

Coordination within Hong Kong

12. The working relationships between DH and HA and the private sector, universities and primary care need to be improved. In particular – (See para 8.4)

    (a) Clinical infection control and epidemiological experts should be based in every major hospital, working as employees of DH seconded to HA. These individuals would have responsibility for hospital infection control, pertinent data collection and reporting, and regular liaison between colleagues in HA and DH

    (b) Staff should be encouraged to rotate through the different systems including DH, HA and the universities as appropriate

(c) Resources (staff and funding) should be brought together to deal with a future outbreak on a population basis

(d) 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.

13. The role of the private sector for disease surveillance should be enhanced by - (See para 8.5)

(a) Making the "Visiting Medical Officer" (VMO) scheme permanent to provide support and care to the elderly in residential care homes and to assist in disease surveillance

(b) Involving family medicine and traditional Chinese medicine (TCM) practitioners in sentinel surveillance

(c) Exploring the development of a web-based system for electronic notification by private practitioners and providing regular updates of surveillance results to private practitioners.

14. Laboratories in Government, HA and universities should share information for clinical, epidemiological and research purposes - (See para 10.1)

(a) To initiate discussion and reach agreement as far as possible on a set of protocol arrangements amongst laboratories

(b) To enable contingency planning on operating procedures including health safety issue to limit spread amongst laboratory workers, and backup arrangement with overseas laboratories.

15. Discussions leading to agreements as far as possible should be initiated amongst the clinical academic community on randomised control trials (RCTs), protocols and information sharing before the next outbreak. This should cover all aspects of the management of an epidemic, including clinical treatment, staff and patient protection, including personal protection equipment (PPE). These discussions should embrace public health research across all sectors. (See para 12.2)

The management of an epidemic, including surge capacity

16. The surge capacity should be reviewed, and where appropriate preparedness enhanced in the following areas – (See paras 11.3 - 11.4)

    (a) Hospital: intensive care unit beds, adequate staffing for such beds including the provision of specialised respiratory intensive care facilities as appropriate, hospital ventilation, isolation facilities, including where appropriate provision of negative pressure rooms. The advisability of designating one acute hospital in each cluster for the primary reception of SARS patients and other infectious disease patients should be considered. Such a hospital will need to have adequate intensive care facilities, including access to specialised respiratory intensive care advice. The appropriate arrangements for step down wards or other facilities within each cluster need to be determined

    (b) Public health: laboratory capacity, epidemiology, surveillance and infectious disease control, contact tracing and quarantine and isolation centres

    (c) Supplies: drugs, vaccines, PPE etc.

17. Discussions should be held with private practitioners on their involvement at times of outbreak, including backup services to be provided by the private sector, support services required by them, and roles and responsibilities. (See para 11.5)

18. The services of the voluntary sector, organisations such as Auxiliary Medical Service (AMS), Civil Aid Service (CAS) and non-government organisations, should be drawn on to provide backup services at times of outbreak. (See para 11.5)

19. The command and control structure to manage an outbreak or epidemic needs to be clear. Consideration should be given to the establishment of a small command group, chaired by SHWF, with a limited number of personnel, such as the Permanent Secretary of the Bureau, the Director of Health, the Head of CHP and the Chief Executive of HA. This body should be responsible for taking all major decisions, such as invoking public health legislation, closure of hospitals, and quarantine of residential areas. There should be clarity established beforehand, as to what decisions are taken at what level and by whom during an epidemic,

in a major incident plan. The authority and responsibilities of DH/CHP in all aspects of epidemiological management, including surveillance and contact tracing, need to be clearly understood and adhered to by all parties. (See para 6.2)

20. Clear policies for isolation and the period of quarantine for both affected individuals and their contacts in hospital and the community need to be established. (See para 8.2)

21. Contingency plans should be established to take account of the possibility that people whose roles are important in the management of an epidemic may themselves become victims. Nominated and trained deputies should be clearly identifiable for each of these key positions. (See para 8.2.)

22. HA needs to develop clarity over the role of its own Board during the management of an epidemic or outbreak and the role of the Board of individual hospitals. Consideration should be given to the value of utilising the experience and skills of Board members in communicating with staff, patients and local populations. (See para 6.5)

Communications

23. The overall responsibility for devising a communications strategy in advance of a communicable disease outbreak should be given to DH/ CHP. (See para 14.2)

24. In times of epidemic the public need to be kept informed. Capacity to communicate effectively and regularly must be described, available and understood. (See para 14.2)

25. DH/CHP should be responsible for the coordination and implementation of the communications strategy. They need to match the purpose, the message, the medium and the audience and to use multiple modes of communication. (See para 14.2)

26. DH/CHP should ensure adequate training is provided. This should include special training on how best to communicate risk and uncertainty. External consultancy to support this development should be considered. (See para 14.2)

27. HA should develop policies for communicating with the media that includes coordination with DH, and details of respective responsibilities of HA head office and individual hospitals, taking into account matters such as work priorities and the level of information available at HA head office and hospitals. (See para 14.2)

28. HA should develop a communications strategy for its staff, which includes face-to-face communication and avoids over-reliance on posting information on the intranet, which may exclude some groups of staff. (See para 14.3)

29. HA should make use of information and video technology to facilitate communication between patients and their families during isolation. (See para 14.3)

30. The Government should develop partnerships with the media through regular contact, communicable disease training initiatives, and other means. (See para 14.2)

Surveillance, information and data management

31. The enhanced data management system (comprising e-SARS, MIIDSS, and SARS-CCIS) should be made a permanent part of the infrastructure to support the control of communicable diseases. (See para 10.3)

32. The enhanced data management system should be extended to link up with other sectors, including the private sector and community clinics. (See para 10.3)

33. DH should formulate and promulgate a clear policy of privacy of information that balances public and private interests. (See para 10.3)

Clinical practice

34. HA should update, on a regular basis, treatment guidelines based on the best laboratory and clinical evidence available locally and overseas. (See para 12.2)

Research and training

35. The Government and HA should work with universities and research funding providers to ensure that research places due emphasis on public health and that priority is given to projects that need to be undertaken urgently in order to prepare for any future outbreak of SARS. (See para 13.3)

36. Further research should be conducted on – (See para 13.3)

    (a) Improved diagnostic techniques

    (b) Clinical management of SARS, including therapeutics and role of traditional Chinese medicine

    (c) Transmission risks of SARS

    (d) Most appropriate hospital infection control measures for SARS

    (e) Seroprevalence of SARS in defined populations and communities

    (f) Cost and clinical effectiveness of community infection control measures for SARS

    (g) Long-term consequences of SARS.

37. Cross-boundary research within the Pearl River Delta region should be actively encouraged. Advantage should be taken of the readiness of the international research community to work in collaboration with their colleagues in Hong Kong. (See para 13.3)

38. The Government should give a policy commitment to public health training and ensure that priority is accorded in allocation of resources. (See para 13.5)

39. The Government, HA, universities, training institutes, and private sector employers should ensure that all healthcare workers get basic and

ongoing training in infection control and have an understanding of fundamental epidemiology and public health principles. (See para 13.5)

40. DH, HA and the universities should establish joint academic and clinical appointments of public health staff to work across the health and healthcare system. (See para 13.3)

Engaging the community

41. A population-based framework should be devised for times of outbreak – (See para 15.5)

    (a) To coordinate services across all sectors (hospital, public health and social services), taking particular account of the vulnerable populations

    (b) To fully utilise the skills of nurses and other healthcare professionals in caring for the needs of vulnerable groups (children, elderly and chronically ill patients) and in sentinel surveillance

    (c) To involve private practitioners in providing services

    (d) To involve the voluntary sector, organisations such as AMS and CAS and non-government organisations in providing care not only for those who are affected, but also for those who are chronically ill

    (e) To engage the community in health promotion activities and health campaigns.

42. A contingency fund for public relief supported by contributions from the Government and the community should be considered. (See para 15.5)

Occupational health

43. HA should review its occupational health services and put in place a comprehensive package of occupational health services, led by professionally trained occupational health staff, which will support physical and psychological health and promote safety at work for healthcare staff. (See para 12.5)

Post-SARS environment and its impact

44. HA should assess the medical and psychological needs of recovered SARS patients and develop a programme to cater for their needs. (See para 16.2)

45. Social Welfare Department should assess the needs of the families of deceased SARS patients and offer follow-up support as appropriate. (See para 16.2)

46. A study should be undertaken to assess the extent and impact of discrimination against former SARS patients, their families and contacts. Appropriate support for those discriminated against should be considered. (See para 16.2)

Annex 2

Panel on Health Services

Subcommittee to monitor the implementation of the recommendations of the SARS Expert Committee and the Hospital Authority Review Panel on the SARS Outbreak

Progress on the implementation of the recommendations of the SARS Expert Committee as at 27 October 2003

	Recommendation	Progress
I. Organisation of health and healthcare system for the control of an outbreak of communicable disease		
1.	Review organizational structure and the relationship between HWFB and the constituent Government Departments under HWFB to improve the capacity of coordination across the Departments and facilitate policy-making and commissioning for health protection matters	A review of the organizational structure of the departments under HWFB has already started.
2.	Establish a Centre for Health Protection (CHP)	An Advisory Committee on CHP is being set up to advise on the various aspects relating to the setting up of a CHP in Hong Kong. The membership of the Committee will include academics, medical professionals and relevant officials. The first meeting of the Committee is scheduled to be held in early November. To discuss the initial proposed framework of the CHP.
3.	HWFB to ensure that necessary systems are in place to coordinate activities and responsibilities of DH, HA and private sector for the control of an outbreak of communicable disease	Systems being reviewed continuously. Some coordination systems are already in place and in use.

	Recommendation	Progress
4.	To consider changing the name of HA to reflect its wider responsibilities	The HA Board will discuss this recommendation. HWFB will also consider this recommendation, taking into account legal and other implications.
II. Health protection functions		
5.	CHP to engage in routine surveillance, preparatory response and training	Will take into account in working out a framework of the CHP. DH has started recruiting overseas epidemiologist and virologist to help designing training program and providing field epidemiology and microbiology training.
6.	CHP to ensure an adequate infectious disease control system	DH has developed protocols for investigation and control for infectious diseases of public health importance. The organization of the CHP is being mapped out to further strengthen infectious disease surveillance and control systems.
7.	Ensure a major outbreak control plan in place with scenario planning and table-top exercises	SARS contingency plan in place for DH including the response to different scenarios. DH has collaborated with HA in two SARS drills in October. Further table-top exercises are being planned.
8.	Review the adequacy of existing legislation to underpin both public and private sectors, ensuring that there is cooperation and coordination and common purpose in dealing with threat of infectious diseases	Having regard to the overall operational experience in relation to the handling of the SARS epidemic and the proposed revision of the International Health Regulations, preparatory work is currently underway to take forward legislative amendments to the Quarantine and Prevention of Disease Ordinance (Cap. 141).
III. Collaboration within the Pearl River Delta region and with the international community		
9.	Develop regular data reporting systems and collaboration on surveillance within the Pearl River Delta region	There are regular meetings with officials from Guangdong Province and Macao. Infectious diseases surveillance data exchange platform has been established. Monthly reports of designated infectious diseases are received from Guangdong Province and Macao, since June 2003. Guangdong Province, Hong Kong and Macao agreed in August 2003 to expand the scope of notification mechanism to include statutory notifiable diseases of each place.
10.	Enhance the capacity to establish links and networks and to promote exchanges of professionals, academic, hospital and technical staff between Hong Kong and the Pearl River Delta region in Guangdong Province	Agreed in principle to exchange expertise among Guangdong Province, Hong Kong and Macao. Details of the exchange program will be discussed later.
11.	HWFB/DH/CHP to establish contingent plans and relations with organizations and	Contacts have been initiated with CDC, HPA and other international health authorities to arrange contingent plans and relations. Visits are being planned to

	Recommendation	Progress
	individuals with outbreak control experience and with capacity to pull together with a team of expertise (e.g. World Health Organization / Centers for Disease Control and Prevention in USA / Health Protection Agency in UK)	these organizations.
IV. Coordination within Hong Kong		
12.	Improve working relationships among DH, HA, private sector, universities and primary care sector	
	(a) Clinical infection control and epidemiological experts to be based in every major hospital, working as employees of DH seconded to HA	DH will arrange a meeting with HA in end October to discuss details.
	(b) Rotation of staff in DH, HA and universities	Discussion about the rotation of staff among the health care and academic institutes has already started.
	(c) To bring together resources for dealing with a future outbreak on a population basis	To be considered in the overall context of collaboration among DH, HA and the different institutions.
	(d) Re-examine the geographic boundaries defining DH regions and HA hospital clusters	Public health teams in DH will be realigned to match with HA hospital clusters.
13.	Enhance the role of private sector for disease surveillance	
	(a) Making the VMO scheme permanent	HWFB is considering how best to implement this recommendation. Meanwhile, the scheme is continuing. HA has recruited 100 VMOs to provide regular visits and consultations to old aged homes (OAHs). These VMOs will work in close collaboration with Community Geriatric Assessment Teams in enhancing medical surveillance and reducing hospital admissions of elders in OAHs.

	Recommendation	Progress
	(b) Involve family medicine and traditional Chinese medicine practitioners in sentinel surveillance	• Sentinel surveillance for some 50 private doctors already in place. We will review and consider expanding this surveillance network. • The issue of involving Chinese medicine practitioners in sentinel surveillance had been raised at the Practitioners Board of the Chinese Medicine Council held on 27 October 2003 and members opined that implementation of the recommendation would need to be further explored.
	(c) Develop a web-based system for electronic notification by private practitioners and provide regular updates of surveillance results to them	• Establish a development platform by early November 2003. • Web-based electronic notification form for SARS will be ready by November 2003. • Develop web-based surveillance system for other 27 statutory notifiable diseases by end September 2004. • Please refer to Appendix for details.
14.	Share laboratory information among Government, HA and universities for clinical, epidemiological and research purposes	
	(a) Initiate discussion and reach agreement as far as possible on a set of protocol arrangements amongst laboratories	A task force comprising members from the laboratories of Queen Mary Hospital, Prince of Wales Hospital, Princess Margaret Hospital, Queen Elizabeth Hospital, Tuen Mun Hospital and the Government Virus Unit (GVU), has discussed protocol for PCR, testing methods, strategy, interpretation and turn-around-time as well as quality and biosafety issues. In particular, GVU was designated as the reference centre to confirm positive PCR tests and organize external quality assessment programme.
	(b) Enable contingency planning on operating procedures	The six laboratories providing SARS testing are engaging in active dialogue with a view to agreeing on the turn-around-time of providing test service during outbreak, the mechanism for urgent testing outside office hours and the procedures for confirming positive test results. These laboratories are capable of conducting confirmatory tests for diagnosis of SARS virus in accordance with the standards of WHO, and are able to provide the surge capacity for laboratory testing services needed during an outbreak.

	Recommendation	Progress
15.	Initiate discussion and reach agreement as far as possible amongst the clinical academic community on randomized control trials (RCT), protocols and information sharing to cover all aspects of management of an epidemic and embrace public health research across all sectors	Through the commissioning process of the Research Fund for the Control of Infectious Diseases (RFCID), discussion on a portfolio of basic, epidemiological, public health and clinical research on emerging infectious diseases with the participation of the academic institutions and HA had been initiated.
V. The management of an epidemic, including surge capacity		
16.	Review surge capacity and enhance preparedness	
	(a) Hospital: ICU beds, ventilation, isolation facilities	Conversion works is on-going in 14 public acute hospitals to provide over 1,500 isolation beds, including 70 ICU beds. The isolation beds will be placed in isolation rooms which will have the following features – • negative pressure gradient; • provision of 100% fresh air; • dilution of bio-load in sufficient air change rates; and • installation of high efficiency air particulate filters to filter out droplets and aerosols. 900 isolation beds ready in October/November. Another 600 will be completed in batches between December 2003 and January 2004. Planning for the construction of three infectious disease blocks in three major public acute hospitals is under way.
	(b) Public health: laboratory capacity, epidemiology, surveillance and infectious disease control, contact tracing and quarantine and isolation centres	DH will recruit extra manpower for public health control of infectious diseases. Advertisements have been placed in major medical journals to recruit experienced field epidemiologists to establish a training program.
	(c) Supplies: drugs, vaccines, personal protection equipment (PPE)	**<u>For use by Government departments:</u>** In addition to identifying drugs suppliers for rapid placement of orders and deliveries should situation warrants, DH has also agreed with the Government Logistics Department on the coordination of the supplies of drugs, vaccines and PPE for government. An adequate stock of PPE for at least six months is kept for activities and operations initiated by DH. **<u>For use by hospitals:</u>**

	Recommendation	Progress
		Drugs – There is immediate stock for oral antiviral drugs on hand sufficient for at least 200 SARS patients. For antibiotics, a normal stock of 2 months is kept. HA maintains close monitoring and liaison with suppliers in case there is urgent additional requirement. Delivery lead time is approximately 1 – 2 weeks. **Vaccines** – HA distributed flu vaccines for high risk group patients and health care workers in hospitals in late September. The second batch of 100,000 vaccines to cover high risk elderly patients on CSSA attending GOPCs has arrived and distribution of the first lot of 33,620 will begin on 28 October. The remaining 66,380 vaccines will be delivered as and when required. HA has established a close monitoring and liaison mechanism with the supplier in case of additional demands. **PPE** - HA has built up a 3-month stock (at peak usage rate) of PPE and other essential consumables.
17.	Discuss with private practitioners on their involvement at times of outbreak	Forum with private hospitals and associations was held on 16 October. All private hospitals were requested to submit their SARS contingency plans to DH by 31 October 2003. Further liaison with private practitioners being pursued (see also 41(c) below).
18.	Draw on voluntary sector (e.g. Auxiliary Medical Service (AMS), Civil Aid Service (CAS) and non-government organisations (NGOs)) to provide backup services at times of outbreak	At their recent meeting with DH, AMS and CAS pledged their continued support for the provision of backup services at times of outbreaks. CSB and DH will also jointly organize briefing sessions in late November 2003 to all government departments and CAS/AMS in this regard.
19.	Make clear the command and control structure to manage an outbreak or epidemic	A clear command structure is in place as outlined in the checklist of measures announced in end September 2003.
20.	Establish clear policies for isolation and quarantine	Home confinement protocol in place.
21.	Establish contingency plans for deputies to take over responsibilities of key positions	All departments and HA have been asked to incorporate this element in their contingency plans.
22.	HA to develop clarity over the role of HA Board during the management of an epidemic or outbreak and role of the Board of individual hospitals	The HA Planning Committee has set up a Working Group on Governance to review the existing governance practices of HA and make recommendations for improvement to the HA Board.

	Recommendation	Progress
VI. Communications		
23.	Give DH/CHP the overall responsibility to devise communications strategy in advance of a communicable disease outbreak	• DH has revised the communication strategy and communication plan for disease control. • DH to identify suitable staff for further training on communication skills. • DH has initiated search for overseas courses on risk communication and organize relevant in-house training courses for its staff and relevant parties. • DH to conduct a detailed study for creating an enhanced communication mechanism and devising comprehensive communication strategies.
24.	Capacity to communicate effectively and regularly with the public in times of epidemic must be described, available and understood	
25.	DH/CHP to coordinate and implement the communications strategy	
26.	DH/CHP to ensure adequate training on communication, including special training on how best to communicate risk and uncertainty	
27.	HA to develop policies for communicating with the media	HA is developing an overall strategy. In developing the strategy, HA will solicit support from external experts who will work side by side with HA's Public Affairs team on the strategy as well as provide assistance in implementation and skill transfer. HA is also working with the Government on improving the overall coordination in communicating with the public and the media. The overall strategy will not only focus on information release but also on educating the public on pertinent health concept and practice. It is expected to be completed by end 2003.
28.	HA to develop communications strategy for its staff	HA has put in place an internal communication strategy, with internal communication co-ordinators identified, 24-hour staff help desk ready and staff group formal and informal communications strengthened. Crisis communication training has also been arranged for managers and frontline staff and several other communications training programmes are under development.
29.	HA to facilitate communication between patients and their families during isolation	HA has identified a number of possible options for communication purpose for patients in the isolation wards. These systems should be put in place in the next epidemic when the restricted visiting policy is implemented.
30.	Develop partnerships with the media through regular contact, communicable disease training initiatives, etc.	Contacts being enhanced and other initiatives being planned.

VII. Surveillance, information and data management		
31.	Make the enhanced data management system a permanent part of the infrastructure to support the control of communicable diseases	Please refer to Appendix.
32.	Extend the enhanced data management system to link up with other sectors, including private sector and community clinics	Please refer to Appendix.
33.	DH to formulate and promulgate a clear policy of privacy of information that balances public and private interests	Please refer to Appendix.
VIII. Clinical practice		
34.	HA to update treatment guidelines regularly based on the best laboratory and clinical evidence available locally and overseas	HA has set up the HA SARS Collaborative Group to hold regular meetings with clinicians to discuss treatment options with a view to formulating update treatment recommendations. Clinicians have agreed on a few potentially beneficial treatment options and the approach to conduct clinical trials during future outbreaks.
IX. Research and training		
35.	The Government and HA to work with universities and research funding providers to ensure that research places due emphasis on public health and priority is given to urgent projects that need to be undertaken urgently in order to prepare for any future outbreak of SARS	• DH to plan collaborative research on public health with universities. • Thematic priority on public health had been built into the current call for grant application for Health and Health Services Research Fund (HHSRF) and RFCID.
36.	Conduct further research on (a) improved diagnostic techniques (b) clinical management of SARS (c) transmission risks of SARS (d) most appropriate hospital infection control measures for SARS (e) seroprevalence of SARS in defined populations and communities	HA has organized a series of scientific meetings to bring together experts from universities, DH and HA to share findings on existing projects and ideas on these potential research areas. **Progress on specific areas** (a) <u>improved diagnostic techniques</u> • DH has completed evaluation of real-time PCR commercial kits and serology based on immuno-chromatography as well as ELISA. • DH will collaborate with other centres to continue to search for better, faster

	(f) cost and clinical effectiveness of community infection control measures for SARS (g) long-term consequences of SARS	and reliable testing methods to detect SARS at earlier stage. (b) <u>clinical management</u> • HA has drawn up protocols for clinical trials of therapeutic agents and laboratory study of hyperimmune globulin for post-exposure prophylaxis for implementation. (c) <u>transmission risks of SARS</u> • findings of ongoing studies by universities and DH have been shared with a view to specifying focuses of future research. (d) <u>hospital infection control measures</u> • the protocols for collaborative study with universities on equipment and practices are being refined. (e) <u>seroprevalence of SARS in defined populations and communities</u> • DH's collaborative study with HKU on close contacts of SARS cases is in progress. (f) <u>cost and clinical effectiveness of community infection control measures for SARS</u> • DH has commissioned the Social Science Research Centre of the HKU to undertake the population survey personal and environmental hygiene. A draft questionnaire for the survey is being developed. (g) <u>long-term consequences of SARS</u> • the scheme for following up the physical and psychosocial consequences of recovered SARS patients has already started.
37.	Actively encourage cross-boundary research within the Pearl River Delta region	• A research project to map out the HIV pattern in Guangdong Province is being planned by DH. • Funding support will be provided to encourage research on the control of infectious diseases in Mainland China. • RFCID encourages, facilitates and supports collaborative, cross-boundary research on the control of infectious diseases.
38.	The Government to give policy commitment to public health training and to ensure that priority is accorded in allocation of resources	$130 million has been earmarked under the Training and Welfare Fund for the HA to set up an Infectious Disease Control Training Centre under the Hospital Authority Institute of Health Care and to finance various infection control training programmes for HA staff across all disciplines. DH has also strengthened infection control training and organised SARS-specific courses for nurses working in DH

		and FEHD since September 2003.
39.	Ensure all healthcare workers get basic and ongoing training in infection control and have an understanding of fundamental epidemiology and public health principles	• In-house infection control training courses in progress, and development of guidelines/ protocols under planning. • First round of SARS courses for DH medical and nursing staff to be completed in December 2003; for other DH paramedical staff in January 2004. • Training courses on infection control and epidemiology for healthcare personnel outside DH will also be organized.
40.	DH, HA and universities to establish joint academic and clinical appointments of public health staff to work across the health and healthcare system	DH will have a meeting with HA in end October.
X. Engaging the community		
41.	Devise population-based framework for times of outbreak	
	(a) Coordinate services across all sectors (hospital, public health and social services), taking particular account of the vulnerable populations	• Issue a new guideline on prevention of communicable diseases to all elderly home before end October. • The Social Welfare Department (SWD) has issued a letter on 7 October asking all elderly homes to designate an infection control officer (ICO). Training programmes will be organized for ICOs – workshops will commence in November. • An enhanced information exchange system has been set up among DH, HA, SWD and the elderly home to delineate procedures and roles of relevant parties during outbreaks. • Set up an enhanced information exchange system for infectious diseases among parties involved in community care services for elders.
	(b) Fully utilise the skills of nurses and other health care professionals in caring for the needs of vulnerable groups and in sentinel surveillance	DH nurses have completed comprehensive on-site assessment as regards the infection control measures in all elderly homes to identify possible areas that require improvement and facilitate the planning of necessary training. Meanwhile, DH and SWD are engaged in active discussion with a view to identifying collaborating elderly homes as sentinel surveillance sites.
	(c) Involve private practitioners in providing services	HA has initiated discussion with private hospitals and medical associations on enhancing collaboration between the public and private sector in the event of resurgence of SARS. The initiatives being considered are –

		(a) training on infection control and staff protection; (b) sharing of scientific information and professional guidelines on SARS; (c) establishment of referral channel and sharing of referral guidelines; (d) sharing of information on patient referred from private sector; (e) provision of service information from private sector to facilitate private sector in sharing the patient load.
	(d) Involve voluntary sector, organisations such as AMS and CAS and non-governmental organisations in providing care for those who are affected and chronically ill	In addition to strengthening the communication network with voluntary sector and organizations providing care for those who are affected and chronically ill, DH will assist non-health sectors to revise and update sector-specific guidelines in preparation for any possible comeback of SARS.
	(e) Engage the community in health promotion activities and health campaigns	• DH is working with the travel sector on disseminating health advice for SARS prevention to travelers. A briefing session on guidelines for the prevention of SARS was conducted for hotel staff. 13,000 pocket size booklets on SARS prevention were distributed to inbound tour guides via the Hong Kong Association of Registered Tour Coordinator and the Travel Industry Council of Hong Kong. • Two pamphlets on personal and environmental hygiene were produced for new arrivals to Hong Kong. 23,000 copies of these pamphlets were sent to Lo Wu border control point for distribution. • Two pamphlets on personal and environmental hygiene were produced for domestic staff. About 28,000 copies were sent to the Employee Retraining Board, Home Affairs Department (HAD), relevant NGOs and community centres for distribution. The pamphlets are also being translated into Tagalog, Bahasa Indonesia and Thai. • Messages on personal and environmental hygiene were incorporated in the publication, "Your Guide to Services in Hong Kong" produced by Home Affairs Bureau, which is available for free collection at the airport, the Public Enquiry Service Centres of the HAD, the Immigration Tower at Wan Chai and NGOs servicing ethnic groups.
42.	Consider a contingency fund for public relief	We plan to seek FC's approval for the setting up of a Trust Fund for SARS on 7 November 2003.
XI. Occupational health		

43.	HA to review its occupational health services and put in place a comprehensive package of occupational health services	HA is reviewing existing occupational safety and health accountability and structure with the intention to substantially enhance the level of professional expertise in regard to policy setting and training.
XII. Post-SARS environment and its impact		
44.	HA to assess and address the medical and psychological needs of recovered SARS patients and develop a programme to cater for their needs	A comprehensive follow-up scheme is in place for recovered SARS patients. In the scheme, recovered patients will be interviewed by professionals on their functional impairments and psychosocial wellbeing. Blood tests and magnetic resonance imaging examination will also be conducted. Patients will receive intensive physical and psychosocial care according to the findings.
45.	SWD to assess the needs of the families of deceased SARS patients and offer support	• SWD has already contacted each and every of the 287 families of the deceased SARS patients (299 altogether). 53 families have declined assistance. • SWD has also rendered assistance through its service units and administered the We Care Education Fund, emergency financial assistance etc. • SWD will set up a core team to support the operation of the proposed Trust Fund for SARS which provides, amongst others, ex-gratia relief payment to families with deceased SARS patient. • SWD will ensure that continuous follow-up support is available to the families with deceased SARS patients, including those who have refused assistance earlier on. A checklist has been developed to ensure that there is a comprehensive assessment of their needs.
46.	Conduct study to assess the extent and impact of discrimination against former SARS patients, their families and contacts and consider providing appropriate support for those discriminated against	EOC collaborated with CUHK in July 2003 to conduct an opinion survey about the impact of SARS on our community, the findings of which assisted the Commission to refine strategies on information dissemination, public education and promotion of different aspects of communicable diseases control. EOC has also embarked on the initial steps to disseminate information about dealing with different scenarios related to SARS. We are discussing with EOC on how to better take forward this recommendation.

Appendix

Progress report on the development of Information Systems for the Centre for Health Protection
As at 27 October 2003

Timeline and Progress

Items	Progress	Expected date of completion
(A) Planning		
1. Finalisation of development plan on information systems for CHP	Plan on short term, medium term and long term has been drafted. Will finalised by end of October	End of October
(B) IT exchange framework		
1. Drafting assignment brief on development on IT exchange framework	Assignment brief is being drafted	End of October
2. Award of professional service on IT exchange framework		First week of November
(C) IT system for DISEASE NOTIFICATION SYSTEM		
1. Defining scope on online real time notification system	Working group with Disease Prevention and Control Division (DPCD) has been formed. Scope being defined	End of October
2. Finalisation of specifications on notification system	Finalising with DPCD professional input	End of October
3. Drafting assignment brief	Will be part of the assignment brief on IT exchange framework	End of October
4. Award of assignment		First week of November
5. Development of Exchange Infrastructure and exchange modules for 28 notifiable diseases, and electronic notification forms		End of January 2004
(D) IT systems for EMERGENCY RESPONSE CENTRE		
1. Defining scope on IT requirement on ***Emergency Response Centre***	Working group will be formed in early November	Early December

2. Drafting of ***specifications*** of a) IT systems on ***Geographical Information System*** to track location of infection cluster	Working group has been formed. Potential systems are being under study.	Late February 2004
b) IT systems on ***syndromic surveillance*** on alert generation	Working group has been formed. Potential systems are being under study.	Late February 2004
c) IT systems on ***real time situation reporting***, including epidemic curve and cluster map, update statistical reports	Working group has been formed.	Late February 2004
d) ***Integrated messaging and communication system*** which provide logging on incoming and outgoing messages; and alerts on outstanding messages	Working group will be formed by mid November	Late February 2004
(E) IT systems for other surveillance systems/programmes		
The IT systems for surveillance system will integrate with Public Health Information System (PHIS). Enhancement will be made on PHIS.		The timeline will follow the timeline of PHIS.