

立法會
Legislative Council

LC Paper No. CB(2)3061/03-04

Ref : CB2/PS/1/03

**Paper for the Panel on Health Services
Meeting on 19 July 2004**

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

Purpose

This paper reports on the deliberations of the Subcommittee to monitor the implementation of the recommendations of the SARS Expert Committee and the Hospital Authority Review Panel on the SARS Outbreak (the Subcommittee).

Background

2. Following the publication of the Report of the SARS Expert Committee on 2 October 2003, the Panel on Health Services (the Panel) decided to set up a subcommittee to monitor the implementation of the recommendations of the SARS Expert Committee by the Government and the Hospital Authority (HA) on 9 October 2003.

The Subcommittee

3. The terms of reference and the membership list of the Subcommittee are in **Appendices I and II**.

4. Under the chairmanship of Hon Cyd HO, the Subcommittee has held a total of six meetings, including five with the Administration, and made a visit to the isolation facilities at the Pamela Youde Nethersole Eastern Hospital on 13 July 2004. The Subcommittee has also received a total of 13 submissions from private hospitals and doctors' associations as listed in **Appendix III**.

Deliberations of the Subcommittee

Management of the implementation of the recommendations of the SARS Expert Committee by the Government and HA

5. A member is of the view that the Administration should adopt a project management approach in implementing the 46 recommendations of the SARS Expert Committee, having regard to the varying timings for implementing these recommendations which are inter-related.

6. The Administration has advised that a Task Force, chaired by the Secretary for Health, Welfare and Food (SHWF), has been set up to coordinate the implementation of the 46 recommendations of the SARS Expert Committee. Under such a setup, Chief Executive, HA, for instance, is responsible for following up those recommendations which fall within his purview and will submit a report on the progress made to the Task Force periodically. The Task Force will see to it that there is no conflict in the implementation of these recommendations. For instance, the setting up of the proposed Centre for Health Protection (CHP) within the Department of Health (DH) will give due regard to the eventual re-organisation of the departments under the Health, Welfare and Food Bureau (HWFB). Moreover, progress made on the implementation of these recommendations will be overseen by a monitoring committee comprising outside experts.

Contingency mechanisms to deal with possible resurgence of SARS

7. Members are generally satisfied with the contingency mechanisms put in place by the Administration, including HA, to combat the possible return of Severe Acute Respiratory Syndrome (SARS). They, however, are particularly concerned about HA's strategy for communicating with its staff in the event of an outbreak, and that of DH and HA to keep doctors and other healthcare professionals in the private sector effectively informed during the outbreak.

8. The Administration has advised that one of the problems which HA has identified during the last SARS outbreak with its staff was over-reliance on the HA Intranet as a communication tool. HA is committed to overcome this weakness by developing new channels of communication. These include the appointment of internal communication co-ordinators at hospital level, the establishment of 24-hour staff help desks during times of crises, and displaying up-to-date information and important messages about outbreaks of infectious disease and measures for effective infection control through the terminals of HA's clinical management system. HA is also developing plans to strengthen staff groups communication. Apart from the aforesaid, HA will continue its practice of disseminating up-to-date information and important messages about outbreaks of infectious disease and measures for effective infection control

through putting up notices and posters in the hospitals and circulating a newsletter, the HASLINK Express, to all staff members via email, in hard copies and through postings on notice boards in hospital compounds. Consideration will also be given, as far as practicable, to make more use of media devices as short films and electronic signboards to disseminate information, as suggested by some members.

9. As regards keeping the private sector effectively informed before and during the outbreak, the Administration has advised that HA has recently reached a consensus with the private sector, including private hospitals and doctors' associations and the Hong Kong Medical Association, on ways to enhance communication. These measures include both sides, namely, HA and the private sector, say, a doctors' association, appointing designated contact officers to act as the focal liaison points, and all private hospitals are required to submit to DH contingency plans, which will be tested by drills. Apart from these, a section of the DH's official website is dedicated to communication with the registered private hospitals and healthcare institutions. HA will also designate a section in its website for public-private interface. All relevant outbreak information and feedback will be placed in this section. The web address for this section will be publicised to all private hospitals and doctors' associations. Seminars on relevant subjects such as infection control have been and will be conducted on a need basis to provide information and advice.

10. A member has suggested that in addition to relying on doctors' associations to disseminate information, HA should also make use of the correspondence list kept by DH to disseminate information to private medical practitioners.

11. HA and DH have agreed to work out ways to ensure that the dissemination of information to the private sector is well-coordinated to avoid repetition and overproviding.

12. Some members have pointed out that one of the weaknesses identified from the last SARS outbreak was the inability of HA Head Office to deploy staff to cope with the outbreak. They have asked whether this problem has now been addressed.

13. The Administration has advised that HA has built into its contingency plans at different levels staff deployment plans. The sequence in which staff should be deployed is as follows -

- (a) staff with expertise and experience on the required specialist skills;
- (b) staff trained in the field or a closely related field; and

- (c) staff of a less affected specialty.

Staff across all ranks are deployed under the same principles, unless there are demonstrable overriding essential needs in other clinical areas. All staff deployed must receive training on infection of relevance to the local setting before they are put to full duties. Individual clusters are now working out detailed staff deployment plans in consultation with their staff and within corporate parameters.

Manpower requirement for combating SARS

14. A number of members have raised queries as to whether recruitment for epidemiologists and virologists by DH would mainly focus on candidates from overseas.

15. The Administration has assured members that all eligible applicants would be assessed on the same basis, regardless of where they come from. The reason why recruitment for these specialist posts is also made from overseas is because of the limited number of suitable candidates in Hong Kong.

16. Responding to members' enquiry on whether the new posts created by DH and HA to combat SARS and other infectious diseases are permanent ones, the Administration has advised that these posts would be required on a long term basis, with the exception of the 12 diagnostic radiographer posts under HA.

17. Regarding the some 400 contract staff employed by DH to carry out control measures at all border control points, members have asked whether any structured training on infection training has been provided to these staff, and what are their duties and working hours.

18. The Administration has advised that structured training on infection control, such as correct way of using personal protective equipment and proper disinfection procedures, has been provided by DH during the induction course for the contract staff being employed to carry out health screening measures on travelers at various border control points. The duties of these contract staff include -

- (a) checking of Health Declaration Forms;
- (b) screening travelers' body temperature by using different temperature devices as appropriate;
- (c) giving health advice to travelers;

- (d) making referrals for symptomatic travelers;
- (e) compilation of statistical returns and operational reports; and
- (f) disinfection of equipment and medical posts.

In terms of working hours, they are required to work 48 hours per week on a roster basis, covering the full operating hours of different border control points.

19. Members urge DH and HA not to reduce or curtail existing services and/or raise fees and charges in order to come up with savings to meet the recurrent costs for new additional staff hired to combat infectious diseases.

20. The Administration has explained that the recurrent costs for the new additional staff hired by DH to combat infectious diseases would first be met by redeployment of resources within the Department, as most of these staff would be deployed to work for the Centre for Health Protection (CHP) to be established under DH. As the Hong Kong Jockey Club has pledged a sum of \$500 million to fund the establishment of the CHP, DH would deploy part of the money to fund any shortfall in meeting the recurrent costs for new additional staff where necessary. In the meantime, SHWF would discuss with the Financial Secretary on the possibility of allocating additional funding to HA and DH to meet the additional recurrent staff costs for combating SARS and other infectious diseases. The Administration has also assured members that in line with established practice, the public would be consulted on any proposed changes to public hospital services and fees and charges before deciding on the way forward.

Communications

21. Responding to an enquiry raised by a member about the criteria adopted by the Administration and HA in selecting which staff to attend a radio phone-in programme and which radio phone-in programme to attend, the Administration has advised that staff most knowledgeable about the subject matter to be discussed, and preferably from a senior rank, are normally selected. There is no preference on which radio phone-in programme to attend. The only consideration is whether to do so would be in the public interest.

22. Another member has suggested that DH and HA should respectively appoint a staff whose sole duty is to act as the spokesperson in times of outbreak, so as not to repeat the mistake of overburdening staff who had his own duties to perform during the last SARS outbreak.

23. The Administration does not consider it necessary for DH or HA to designate a staff whose sole duty is to act as the spokesperson in times of outbreak. Nevertheless, in view of the time needed for staff to prepare themselves before attending media briefings, several staff will take turn to attend such. Arrangements will also be made for other staff to take up some of the normal duties of those staff chosen to attend media briefings.

Surveillance, information and data management

24. Noting the Administration's plan to develop a syndromic surveillance system, which would not require a definitive diagnosis of an infectious disease pathogen to be made, so to recognise new disease threats and identify outbreaks early, a member has raised concern about its feasibility. This is because to do so would entail a paradigm shift on how western medicine-trained practitioners conduct diagnosis.

25. The Administration has pointed out that there is no cause for the concern mentioned in paragraph 24 above, as the sentinel surveillance system now operated by DH not only conducts surveillance on statutorily notifiable diseases but other infections of public health significance based on syndromes. At present, 50 private medical practitioners and the general out-patient clinics managed by HA participating in the sentinel surveillance system would report to DH influenza-like-illness, acute diarrheal disease, acute conjunctivitis and hand-foot-mouth disease amongst their patients. It, however, should be noted that in order to recognise new disease threats and identify outbreaks early, there is a need to expand the existing coverage of the sentinel surveillance system and automate the reporting and analysis of the syndromes reported.

26. The member is of the view that to only monitor syndromes from the four types of diseases mentioned in paragraph 25 above would not be sufficient, having regard to the rapid emergence of new disease threats. Collaboration should be made with local universities in developing a more comprehensive syndromic surveillance system which is capable of capturing a wider range of significant syndromes. The member urges that the Administration, in its review of the Quarantine and Prevention of Disease Ordinance (Cap. 141) (QPDO), to also address how a disease defined by syndromes and not by pathogen could be made a statutorily notifiable disease.

27. Members also note the Administration's plan to develop an electronic infectious disease surveillance system comprising two phases. The first phase of the infectious disease surveillance system will be a case notification system whereby all medical practitioners, including those of the private sector and private hospitals, will be able to notify DH of statutorily notifiable diseases when such was identified, and the second phase will be a syndromic surveillance system. Although the entire surveillance system is expected to be

completed in 2006-07, the case notification system is expected to be completed first in 2004.

28. Some members consider that, in order to minimise risk to public health, priority should be given to completing the syndromic surveillance system over the case notification system, as the existing manual reporting of statutorily notifiable diseases to DH has been working smoothly.

29. The Administration has explained that both the case notification system and the syndromic surveillance system could be developed in parallel. The reason why the case notification system could be completed earlier is because the system would only entail automating the existing well-established manual reporting of statutorily notifiable diseases. A longer time, however, is needed to develop the syndromic surveillance system, as the system would involve the wider participation of various sectors of the community.

Review of existing legislation for the control of infectious diseases

30. Members are of the view that the Administration should expeditiously conduct a comprehensive revamp of the QPDO, having regard to the inadequacy of the legal powers provided under the Ordinance to combat infectious diseases. For instance, persons arriving in Hong Kong by land transport currently are not required to provide information on their health to a health officer, but are dealt with administratively.

31. Taking into account members' comments made at the Subcommittee meeting on 15 December 2003, the Administration has further looked into the adequacy of the QPDO in the combat against infectious diseases. Having consulted the Department of Justice, the Administration has come to a view that the powers conferred upon the Administration in the QPDO and the various disease prevention and control measures in place already provide sufficient and comprehensive safeguard for public health. The Administration has pointed out that although persons arriving in Hong Kong by land transport are currently not required by law to declare their health, they are generally very co-operative in completing the health declaration forms.

32. Nevertheless, the Administration has advised that it is also aware of the need to modernise the Ordinance, and more importantly, to bring it in line with the development of the overall control mechanism for communicable diseases in Hong Kong and international best practices. To this end, the Administration considers it appropriate to undertake a comprehensive revamp of the QPDO. The exercise would take into account the statutory powers to be vested upon the CHP to enable its effective operation and the impending review of the International Health Regulations, the principles of the which the enactment of the QPDO are based, by the World Health Organization. Opportunity would

also be taken to modernise the Ordinance and to make necessary amendments to other public health legislation. The Administration should be in a position to seek the Panel's views on the revamp of the QPDO in the next legislative session.

33. Members urge the Administration to expeditiously transfer the statutory powers under the QPDO from D of H to Head of the CHP, to avoid delaying and complicating the decision-making process in the fight against infectious diseases. This is particularly pertinent in times of major outbreak. A member also considers that the post of the Head of the CHP should be a political appointment, given that the functions and role of the CHP are to protect public health.

Engaging the community in times of outbreak

34. A member is of the view that HA should work out with the private sector the compensation arrangements for relieving the latter's staff to work for HA in future outbreaks. The member has pointed out that many private healthcare professionals had ended up not being able to provide services to HA during the last SARS outbreak because of HA's failure to reach an agreement compensating their employers for relieving them to work for HA temporarily to combat the disease.

35. HA has explained that it is HA's policy to engage all the outside help it needed to meet its manpower requirement in times of outbreak. Although HA could not accede to all the demands of the private practitioners who offer assistance during the outbreak, HA would strive to satisfy these demands as far as practicable within its human resources policy. HA does not see the need to formulate a policy on compensating the employers of the healthcare practitioners who offer to work for HA in times of outbreak, having regard to the varying circumstances. HA considers it more important and effective to enhance communication with private organisations, such as private hospitals and healthcare professional groups, so that better collaboration in terms of providing services to one another, among others, could be effected during times of outbreaks. To this end, a point-to-point communication mechanism has been established between the senior officers of HA and these private organisations.

36. Another member has suggested that the Administration should appoint a quasi-governmental body to coordinate resources from the community to combat infectious diseases.

37. The Administration considers that a high level inter-departmental committee formed under the Government to coordinate resources from the community in times of outbreak might be a better option, as it is questionable whether a single government or quasi-governmental body could do the job

effectively given the wide scope of resources in the community. By setting up an inter-departmental committee, effective coordination of resources from the community could be better ensured by harnessing member departments' well-established connections with the trades concerned. A case in point is the high-level inter-departmental meeting chaired by the Secretary for Health, Welfare and Food on 8 January 2004 to formulate cross-department precautionary measures to prevent the return of SARS in Hong Kong. A major objective of this interdepartmental meeting was to ensure effective co-ordination of resources from the community with those of the Government by harnessing member departments' well-established connections with the trades concerned. For instance, as a contribution to that meeting, the Tourism Commission sought the commitment of the hotel industry to step up hygiene improvement measures and cleaning frequency in public corridors and communal areas within hotel complexes, reinforced surveillance on health conditions of staff and reinforced management control on relevant work procedures.

38. Responding to a member's enquiry about compensating volunteers who contracted SARS in the course of helping to contain the outbreak last year, the Administration has advised that they may apply for assistance under the Trust Fund for SARS. The Administration would, in the light of the operational experience gained through the Trust Fund for SARS and discussion within the Administration, consider the idea of a general contingency fund to provide public relief as proposed in the Report of the SARS Expert Committee.

39. On the support which has been provided by DH in preventing RCHE staff from contracting infectious disease at work, the Administration has advised that apart from providing these staff with comprehensive skills training and professional advice so as to reduce their risk of contracting infectious diseases at work, DH has provided the Infection Control Officers (ICOs) and other staff of RCHEs with training on infection control through 15 one-day workshops in November 2003. Apart from organising workshops, DH also reaches out to individual RCHEs and provides them with additional training through the Visiting Health Teams. The Visiting Health Teams target its efforts particularly on those RCHEs identified by DH to require more intensive support in a comprehensive on-site assessment conducted between August and October 2003. During the visits, the Visiting Health Teams would provide professional advice on infection control in accordance with the specific situation of each RCHE and the training needs of its staff. The Teams have also adopted a train-the-trainer approach, under which the ICOs of the RCHEs who receive training from the Visiting Health Teams would be responsible for keeping other RCHE staff updated on the latest information/guidelines on infection control and for providing orientation to new staff on these guidelines.

40. Responding to a member's suggestion of providing assistance to RCHEs for setting up isolation facilities, the Administration has advised that the Social

Welfare Department (SWD) has obtained a grant of \$17.8 million from the Lotteries Fund to assist RCHEs to improve their infection control facilities. All subvented and non-subvented RCHEs in Hong Kong can apply for the one-off subsidy, which is provided on a reimbursement basis and will cover basic material and installation cost of a prescribed set of building and building services installation fittings/items, covering toileting and bathing facilities, partitions, exhaust fans and emergency call bell. SWD has issued letters to all RCHEs in mid-November 2003 to inform them of the subsidy scheme. The improvement works are required to be completed within three months of the commencement of the scheme, i.e. by mid-February 2004.

Latest position of the progress of implementation of the recommendations of the SARS Expert Committee

41. Members note that progress has been made by the Administration on the implementation of the recommendations of the SARS Expert Committee, details of which are provided in the two progress reports prepared by the Administration in **Appendices IV and V**.

Advice sought

42. Members are invited to note the deliberations of the Subcommittee.

Council Business Division 2
Legislative Council Secretariat
13 July 2004

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Legislative Council

Ref : CB2/PS/1/03

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**

Terms of reference

To deliberate, monitor and review the work of the Government and the Hospital Authority in implementing the recommendations of the SARS Expert Committee and the Hospital Authority Review Panel on the SARS Outbreak.

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**

Membership List

Chairman	Hon Cyd HO Sau-lan
Members	Dr Hon David CHU Yu-lin, JP Hon CHAN Yuen-han, JP Hon Andrew CHENG Kar-foo Dr Hon LAW Chi-kwong, JP Hon LI Fung-ying, BBS, JP Hon Michael MAK Kwok-fung Dr Hon LO Wing-lok, JP
	(Total : 8 Members)
Clerk	Miss Mary SO
Legal Adviser	Miss Monna LAI
Date	1 July 2004

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**

List of private hospitals and doctors' associations

- Consumer Council
- Department of Nursing Studies of the University of Hong Kong
- Faculty of Medicine of the University of Hong Kong
- Hong Kong Association of Dental Surgery Assistants
- Hong Kong Baptist Hospital
- Hong Kong Doctors Union
- Hong Kong Infection Control Nurses' Association
- Hong Kong Sanatorium & Hospital
- Hong Kong Society for the Aged
- Hong Kong Society for Nursing Education Limited
- Society for Community Organization
- St. Paul's Hospital
- Tsuen Wan Adventist Hospital

**Legislative Council Panel on Health Services
Subcommittee to Monitor the Implementation
of the Recommendations of the SARS Expert Committee**

**Progress of Implementation of the
Recommendations of the SARS Expert Committee**

Purpose

This paper provides an overview of the latest progress concerning implementation of the recommendations made by the SARS Expert Committee (EC).

Background

2. In its report to the Chief Executive in October 2003, the SARS EC put forward 46 recommendations to enhance the preparedness of Hong Kong for future outbreak of infectious diseases. An internal Task Force chaired by the Secretary for Health, Welfare and Food (SHWF) with representatives from the Health, Welfare and Food Bureau (HWFB), Department of Health (DH) and Hospital Authority (HA) was set up to coordinate implementation of the recommendations.

3. A Monitoring Committee (MC)¹ was established to oversee the implementation of the recommendations of the EC Report. The first MC meeting was held on 19 January 2004 to review progress of implementation. SHWF, Director of Health, and Chief Executive of HA attended the meeting to report progress and discuss areas of further efforts. The MC also visited the Public Health Laboratory Centre and Princess

¹ The MC was co-chaired by Sir Cyril Chantler and Professor Sian Griffiths who were also Co-Chairs of the EC. Other members of the MC are Dr the Hon Lo Wing-lok, Professor Lee Shiu-hung and Professor Rosie Young.

Margaret Hospital, and met with the recovered SARS patients and bereaved families. To enhance transparency of the MC's work, the discussion materials produced for the MC meeting, the meeting minutes and other relevant correspondences have been uploaded to the MC's website at www.sars-monitoring.com.gov.hk.

Progress of Implementation

4. The following provides a stock-take of the latest progress of implementation of the recommendations of the EC Report. Latest developments on those in relation to engaging the community are set out in a separate paper.

Organization Review

5. The organization review on the interface between HWFB and its departments is underway. The starting point is the setting up of the Centre for Health Protection (CHP) which by itself forms part of the reorganization. The CHP will centralize responsibilities, authority and accountability for prevention and control of communicable diseases initially.

6. Upon the establishment of CHP and when it further develops, the CHP may take on other aspects of health protection covering non-communicable diseases, food safety and hygiene, veterinary issues, etc.

Centre for Health Protection

7. Having regard to the health needs and circumstances of the local population, the recommendations of the EC and the views of an advisory committee comprising healthcare professionals and academics, we have drawn up an organization structure with six functional branches¹ and a phased implementation approach for the CHP. The CHP will be

¹ The six functional branches are Surveillance and Epidemiology Branch (SEB), Infection Control Branch (ICB), Public Health Laboratory Services (PHLS), Public Health Services (PHS), Programme Management and Professional Development Branch (PMPDB) and Emergency Response and Information Branch (ERIB).

established by mid-2004. Initial attention will be paid to the development of the Surveillance and Epidemiology Branch (ESB) and Infection Control Branch (ICB). With the commencement of operation of these two branches, there will be enhancement and integration of resources to strengthen disease surveillance and standardization of infection control protocols in various settings. All six branches will be fully developed in 2005.

8. The CHP will be operationally headed by a Controller, CHP who will report to the Director of Health. The Legislative Council Finance Committee endorsed the creation of the Controller post on 27 February 2004. A post-holder for the Controller is expected to be appointed before end April. Most branch heads/directorate officers of the CHP and their supporting staff have been identified through resources redeployed from DH and HA. There will be about 200 additional staff to support the operations of the CHP upon its full establishment in 2005.

9. The organization structure and scope of work of the CHP would need to be continuously reviewed and updated. In the light of a post-establishment review to be conducted in 2005, we will consider the need for the CHP to expand into other health protection areas. We will continue to draw on the views of local and overseas healthcare experts and other relevant stakeholders in mapping out future development plans for the CHP.

Contingency Plan and Emergency Response

10. The SARS contingency mechanism² is underpinned by detailed contingency plans developed by DH and HA, the two operational agencies with the most involvement in the anti-SARS battle. DH's contingency plan features sections on case definitions, command structure,

² Central to this contingency mechanism is a three-level response system to ensure expeditious and effective interventions for various SARS emergencies:

- **Alert Level Response** is activated when there is a laboratory-confirmed SARS cases outside Hong Kong or a SARS Alert in Hong Kong;
- **Level 1 Response** is activated when there are one or more laboratory-confirmed SARS cases in Hong Kong occurring in a sporadic manner; and
- **Level 2 Response** is activated when there are signs of local transmission of the disease.

staff deployment, communication protocols, port health and quarantine measures, operational guidelines on isolation, evacuation and disinfection of building premises, and field investigation protocols for various SARS scenarios involving flights, hospitals, general practitioners, elderly homes, schools, etc. Included in HA's contingency plan are an outbreak definition, a three-tier response framework applicable to hospital setting, and a checklist of responses covering collation and dissemination of epidemiological information, infection control and outbreak management, decanting and mobilization of patients, human resources deployment, supplies of drugs, consumables and equipment, clinical management and communication. In addition, some 40 departments/agencies other than DH and HA have developed contingency plans to combat SARS in accordance with objectives and guidelines laid down by HWFB.

11. Over the past eight months, HA organized over 40 drills in the hospital setting to assess the effectiveness of its contingency plans and to ensure that responsible officers are able to put the plans into practice. HWFB and DH have also co-organized a major exercise in late 2003 to strengthen inter-agency communications and collective capacity and confidence in coping with SARS-related emergencies in the community setting. A total of ten government bureaux/departments/agencies took part in that exercise. DH further conducted a drill with a private hospital in February 2004. Private hospitals are encouraged to conduct internal drills.

12. Meetings have been held by DH, HA and private sectors to exchange outbreak information and coordinate surveillance and response. A section of DH's official website is dedicated to communicate with the registered private hospitals and healthcare institutions. All private hospitals have prepared contingency plans on SARS. They have conducted or are planning to conduct drills within hospital and/or in collaboration with DH.

13. The above SARS contingency measures constitute useful building blocks towards the development of a major disease outbreak control plan. The tasks ahead are to add more building blocks and knit

them together into a totality that can cater for different circumstances of public health significance to the local population. The Emergency Response and Information Branch (ERIB) of the CHP to be established by September 2004 will assume a leading role in developing the overall outbreak control plan. It will draw up contingency plans for different communicable disease scenarios and organize exercises/drills to enhance collective preparedness and capacity to handle the various scenarios.

Communications

14. We recognize that communication is an essential component of outbreak management. We will vest the overall responsibility for devising a communication strategy with the CHP. The ERIB of the CHP will be responsible for, amongst others, the formulation and regular updating of a communication strategy for use in times of an infectious disease outbreak. Pending the formal establishment of the CHP, HWFB, DH and HA have already mapped out the outline of a government-wide communication strategy to implement the EC's recommendation in this respect and to meet the immediate need to maintain close communication with the public over possible resurgence of SARS and outbreak of other infectious disease in the interim. We have reported the outline of the communication strategy to this Sub-committee in an earlier paper issued in December 2003 [Paper No. CB(2)476/03-04(02)]. When alert to the risk of SARS/other infectious disease is heightened, HWFB will monitor developments and decide on communication plans to keep the community closely informed. The messages to give out include the risk assessment, precautionary and preventive measures that the public health sector and other sectors have taken/will take, and preventive measures that the general public should take. If and when there are actual cases, there will be joint DH and HA daily updates of the situation provided to the public and the media. The frequency of these media briefings will be increased if and when necessary. There will be full co-ordination amongst the different parties in delivering their messages. This communication strategy outline has served us well in the past winter season.

15. At the same time, DH and HA have been forging closer

partnership with the media through closer regular contacts so that the latter will be better placed to convey accurate public health information to the public.

16. The CHP will enrich this communication strategy after its establishment. To play their roles well, DH and HA are developing communication strategies relevant to their roles and functions. The CHP will also ensure that the respective communication strategies developed by the DH and HA complement and supplement each other as well as dovetail with the overall, government-wide communication strategy.

17. DH and HA have been organizing training programmes for their staff to improve their communication skills. Some examples of these training programmes include a workshop on risk assessment and communication conducted by the School of Public Health of the University of Hong Kong organized by DH in December 2003, a Crisis Communication and Management seminar organized by HA in October 2003 and a training package on risk communication delivered by the Director of Risk Communication Centre, New York in March 2004 which was attended by DH, HA, HWFB staff as well as representatives from private hospitals.

18. HA has also made substantive progress in improving internal communication with its staff. Designated internal communication coordinators have been appointed in all clusters and Staff Communication Ambassadors have been appointed in all hospitals. The internal communication infrastructure has also been reformed. Preparation for activating 24-hour staff help desks during times of crisis has been put in place. Staff to man these help desks are receiving training in March and April 2004. HA is also reviewing the effectiveness of the existing consultation channels.

19. For communications between patients and their families during isolation, hospital clusters have adopted different options including videophones, public-switch-telephone-network videophones and video conferencing equipment in isolation facilities. The equipment will be

activated and put into use in times of a major outbreak.

Surveillance, Information and Data Management

20. To improve the current data management system to better support the control of communicable diseases, we are planning the development of a Communicable Disease Information System (CDIS) that enables both the public and private sector to perform the critical functions of disease surveillance including case notification, timely alert and early detection of emerging infectious diseases. The CDIS will capture data from the following sources:

- notification of patient information in the case of notifiable diseases by medical practitioners working in both the public and the private sectors;
- clinical and epidemiological data within the health care environment of DH and HA;
- laboratory information from DH and HA laboratories; and
- at a second stage, syndromic surveillance data obtained from the existing General Out-Patient Clinics sentinel network as well as public and private hospitals, schools, elderly homes and private primary care clinics.

Based on current estimate, the project will cost about \$234 million and will largely be completed in three years' time.

Cooperation with the Pearl River Delta

21. Since the SARS outbreak last year, a great deal of efforts have been made by the Guangdong Province, Macao and Hong Kong to ensure prompt and timely exchange of important information about infectious disease outbreaks and incidents. A SARS notification mechanism among Guangdong, Hong Kong and Macao for regular exchange of latest

information has been established. The three places agreed to exchange information about statutory notifiable diseases of the three places on a monthly basis and infectious diseases of concern as and when necessary; report promptly among the three places sudden upsurge of any infectious diseases of unknown nature or of public health significance; and establish a point-to-point information exchange mechanism. The three places also agreed to explore the development of an information system on notification of infectious diseases; start collaboration on scientific research and strengthen exchange and collaboration on surveillance; discuss and exchange planning and development of admission and treatment facilities for infectious diseases; and enhance training and visit of professionals in public health and infectious diseases.

22. The recent SARS cases in Guangdong have demonstrated the collaborative efforts in the prevention and control of the disease in the Pearl River Delta. On further cooperation, experts of the three places met in February 2004 to exchange views on the prevention of avian influenza and share professional experience on the management of the disease. DH and HA will continue to liaise with the authorities of Guangdong and Macao to strengthen communication on notification of infectious diseases and promote further exchanges among professionals of the three places.

Research and Training

23. After the SARS epidemic, the Government established a \$500 million research fund to encourage, facilitate and support research on the prevention, treatment and control of infectious disease, in particular emerging infectious diseases such as SARS. Of this amount, \$50 million is provided to support research projects on infectious diseases in the Mainland through the Chinese Ministry of Science and Technology. The remaining \$450 million is used to support research on infectious diseases in Hong Kong. By the end of March 2004, the Research Fund for the Control of Infectious Diseases has provided funding support to a wide portfolio of research projects, as follows:

- \$22 million earmarked for the University of Hong Kong to undertake a portfolio of basic laboratory, epidemiological and public health research in emerging infectious diseases, and \$8 million for the University to strengthen its Bio Safety Level III laboratory facilities;
- \$25 million earmarked for the Chinese University of Hong Kong to undertake a portfolio of clinical trial and public health research in emerging infectious diseases;
- funding consideration is being made to support a portfolio of research studies on nosocomial infection and long term follow-up of SARS patients to be undertaken by a consortium comprising the Hong Kong University of Science and Technology, the Hong Kong Polytechnic University and HA; and
- funding consideration of \$18 million is being made to support 24 investigator-initiated projects on infectious diseases covering basic research, etiology, epidemiology and public health as well as clinical and health services research.

24. For the purpose of infection control training, \$150 million from the Training and Welfare Fund was available for HA to set up programmes of infectious disease control training, epidemiology, crisis evaluation, quality management and risk assessment. From September 2003 to March 2004, more than 30,000 health care workers across different disciplines in HA (including contractors' staff) have been given basic and/or refresher training on infection control. In addition, approximately 550 of the targeted professional staff have received more in-depth training on contact tracing, outbreak management, avian flu management, training on nasopharyngeal aspirates, clinical epidemiology and surveillance and psychological preparation for crisis.

25. In addition, DH has developed partnership programmes with the Hong Kong College of Community Medicine, local universities, and overseas institutions including the Faculty of Public Health of the United

Kingdom to provide public health training to its staff on a systematic basis. Secondment opportunities to the World Health Organisation, CDC Atlanta, and the Health Protection Agency of the United Kingdom are also made available to staff to enhance competence and capacity. Between November 2003 and January 2004, a total of 1,176 medical/nursing/paramedical staff have received training through the infection control seminar series "Be Prepared for the Return of SARS".

Coordination within Hong Kong

26. Effective communication and coordination are vital at every level when dealing with a major outbreak. Since late 2003, HWFB has assumed a more proactive role in coordinating inter-departmental efforts to combat communicable diseases of public health significance to our community. The underlying tenet is that a population-based, cross-sectoral approach is vital for effective prevention and control of infectious diseases, and hence departments/agencies other than DH/HA and various sectors of the community must be engaged to contain outbreaks or minimize risks thereof. A case in point is the high-level inter-departmental meeting chaired by SHWF in January 2004 to review precautionary measures to prevent the return of SARS in Hong Kong. Inter-departmental meetings are triggered on a need basis, an important objective of which is to engage the participation of the private sector through efforts of departments/agencies with well-established connections to the trades concerned.

27. On interface with private hospitals, DH maintains an effective disease surveillance system with the private sector where each private hospital is required to submit to DH weekly return on pneumonia cases, and daily return on SARS and acute respiratory illness outbreak. With effect from January 2004, private hospitals and medical practitioners are also required to report pneumonia cases with history of travel to Guangdong within 10 days before onset of symptoms. DH also provides free laboratory consultation services on SARS for private hospitals. Regular and ad hoc inspections to private hospitals are carried out to ensure they are implementing proper infection control practices. A

dedicated website is established to enhance communication with private hospitals. Sentinel private doctors also participate in various sentinel surveillance systems: influenza-like illness, hand-foot-mouth disease, acute conjunctivitis, acute diarrhoeal disease, and antimicrobial resistance, etc.

28. On interface between DH and HA, DH collaborates with HA in the collection of data in sentinel surveillance of infectious diseases among the elderly in residential care homes for the elderly. There is also regular and ad hoc exchange on information on outbreak reporting, inpatient discharges and deaths statistics on specified infectious diseases. HA representative is a member of Interdepartmental Coordinating Committee on Dengue Fever while DH representative is a member of HA Central Committee on Infectious Disease. On interface between HA and the private sector, HA has established referral channels for private hospitals and drawn up referral guidelines.

29. Actions have been taken to improve the working relationships among DH, HA and private sector, universities and primary care sector. The CHP to be established will put together staff from HA, DH and academic institutions. There will also be rotation of staff between DH and HA in the CHP. Upon the establishment of the CHP, the Infection Control Branch will support surveillance and epidemiological investigation of unusual infections and nosocomial infections in hospitals. It has been agreed that about 40 professional staff of HA will be seconded to different branches of the CHP to provide support and exchange experience in various public health specialties in mid-2004. It has also been agreed with universities that experts in the relevant fields be invited as honorary advisers to provide input to the public health programmes. The CHP will set up a number of scientific committees comprising professionals of the CHP, HA, academia and other organizations to provide strategic directions to manage hazards of public health importance. A network of laboratories among DH, HA and the universities have also been set up.

30. Discussions have been held with private hospitals and medical associations on enhancing collaboration between the private sector in the event of an outbreak, and with voluntary sector and non-governmental

organizations in providing care for those who are affected by the outbreak. All private hospitals have prepared and submitted their SARS contingency plans to DH. Some private hospitals have indicated that they are willing to take in non-SARS patients to relieve the burden to public hospitals so that public hospitals may reserve more beds to serve SARS patients. As many non-government organizations (NGOs) are providing integrated care to frail elders in the community, DH is working closely with the Hong Kong Council of Social Services (HKCSS) and other NGOs to develop a specific training programme on infection control for carers providing community support services. Guideline on prevention of communicable diseases and supplementary guideline for the prevention of respiratory infections and SARS have been issued to residential care homes for the elderly and persons with disabilities.

31. Sentinel surveillance for some 50 private doctors are already in place. Actions are being taken to expand this surveillance network to include Chinese medicine practitioners. A web-based notification system of notifiable diseases by private practitioners will be launched. Laboratory information is being shared among Government, HA and universities for clinical, epidemiological and research purpose. A Task Force led by HA comprising members from the six laboratories performing SARS tests and the Government Virus Unit under DH has also been established to consider the necessary protocol arrangements, facilitate contingency planning on operating procedures, and conduct cross-audit of safety and security measures and drills amongst laboratories performing SARS tests.

Epidemic Management Capability

32. Much effort has been made to enhance the management capability in times of an epidemic. About 1,400 isolation beds are available in the 14 acute hospitals in the 7 clusters to receive SARS patients in stages. Two infectious disease centres in two hospitals have been planned. Finance Committee's approval for the one in Prince Margaret Hospital will be sought in May 2004. A number of facilities including holiday camps and public housing blocks for isolating non-

symptomatic close contacts of SARS patients have also been earmarked. Sufficient supplies of drugs, vaccines and personal protection equipment have been arranged.

33. On cooperation with voluntary sectors, back-up service at times of outbreak from voluntary sectors such the Auxiliary Medical Service and Civil Aid Service has been arranged. Contingency plan on home/on-site confinement has been put in place, and operational guidelines for moving residents to designated quarantine centres have been drawn up.

Clinical Practice and Occupational Health

34. On clinical practice for SARS, HA has established treatment protocols for SARS and the latest guidelines will be posted to the HA website for reference. On occupational health, an alert system for reporting multiple staff taking sick leave with the same symptom has been put in place. An occupational safety and health (OSH) communication network between HA Head Office and clusters and within clusters will be developed, and an overall review of the OSH service will be conducted.

Post-SARS Environment and its Impacts

35. HA has set up 12 post-SARS clinics. All the recovered SARS patients have been invited for magnetic resonance imaging (MRI), psychosocial and other functional screenings. About 13% of them have been diagnosed with bone disease avascular necrosis, and management protocols for these patients have been established.

36. The Social Welfare Department (SWD) has taken proactive follow-up actions to provide the families with deceased SARS patients and/or recovered SARS patients with various support as and when necessary. Such support includes counselling, clinical psychological services, financial assistance, support groups, volunteer services, voluntary legal advisory services, housing assistance, and community support services.

Next Step

37. Solid progress has been made in the implementation of the recommendations of the EC Report. While some of the recommendations such as the organization review will need time to take forward having regard to the establishment of the CHP and the expansion of its functions in the longer term, other recommendations are being implemented on an on-going basis. The internal Task Force chaired by SHWF will continue to coordinate the implementation of the recommendations and report to the MC and to the Legislative Council on a regular basis.

Health, Welfare and Food Bureau
April 2004

For information

Legislative Council Panel on Health Services

Report on Hong Kong's Anti-SARS Measures

Purpose

The Health, Welfare and Food Bureau, jointly with the Department of Health, Hospital Authority, and other key Government bureaux and departments, has recently presented a report on the measures taken to combat and prevent the Severe Acute Respiratory Syndrome (SARS) over the past year. This paper informs Members of its details.

Details

2. The World Health Organization removed Hong Kong from the list of areas affected by SARS on 23 June 2003. To take advantage of the Inaugural Ceremony of the Scientific Advisory Structure of the Centre for Health Protection (CHP) on 23 June 2004, key Government bureaux/departments and agencies, led by the Health, Welfare and Food Bureau, reported their strategies and measures taken to strengthen our healthcare systems and preparedness to prevent the disease over the last 12 months on 23 June 2004 on that occasion.

3. The Administration learnt important lessons after the SARS epidemic last year. We attach great importance to the full and timely implementation of the recommendations of the SARS Expert Committee. With the concerted efforts of all parties, a tremendous amount of work has been done to improve and strengthen our healthcare systems and preparedness to prevent the resurgence of SARS over the past year. Highlights of the measures taken by the Administration are set out at **Annex**.

4. In giving his comments on the measures taken by the Administration and community in combating SARS on 23 June, Dr Hitoshi Oshitani, Regional Adviser in Communicable Disease Surveillance and Response, WHO West Pacific Regional Office, said he was very much

impressed by the strong commitment the HKSAR Government and leaders had made, the level of coordination and cooperation the various agencies had displayed, and the community involvement in the whole exercise.

5. To enhance transparency of the actions taken by the Administration, the Report on Hong Kong's Anti-SARS Measures presented at the occasion on 23 June was distributed to the press. The Report has also been uploaded to the website of the Health, Welfare and Food Bureau at www.hwfb.gov.hk for public access.

6. Members are requested to note the content of this paper.

Health, Welfare and Food Bureau
26 June 2004

Annex

Highlights of Anti-SARS Measures Taken

- A new organization, the Centre for Health Protection (CHP), to spearhead the community effort for the prevention and control of infectious disease was established on 1 June.
- A Board of Scientific Advisers and seven Scientific Committees under the CHP were formed on 23 June to harness and consolidate professional knowledge and expertise in combating infectious diseases.
- The epidemic intelligence exchange and experience sharing with other health authorities (e.g. WHO, Mainland and US CDC) have been institutionalized. We have strengthened the infectious disease notification mechanism with Mainland and Guangdong. The CHP has recently signed a strategic alliance with the UK Health Protection Agency. The CHP will explore cooperation with Singapore, Finland, the Netherlands, and Sweden.
- We plan to develop a Communicable Disease Information System to allow for a more systematic sharing of information on disease surveillance between the CHP, the Hospital Authority, other healthcare providers and non-healthcare institutions.
- We have established an overall contingency mechanism, underpinned by detailed contingency plans, to set out clear command structure for making and implementing decisions.
- Over 50 drills in the hospital and community settings to assess the workability of the contingency plans have been conducted. We will organize another multi-party drill in October, which will involve observers from overseas health protection agencies.
- About 1,400 isolation beds are now available in 14 acute hospitals throughout the territory for receiving and treating SARS patients. We have also sought funds to construct a new infectious disease centre in Princess Margaret Hospital.

- Since last September, more than 30,000 healthcare workers have received training on infection control.
- We have designated infection control officers and strengthened isolation facilities in the homes for the elderly and disabled. Vaccination to needy elders has also been provided.
- A Handbook on Prevention of SARS in Schools with detailed guidelines and information has been compiled. A series of precautionary measures such as temperature monitoring of students have been implemented in schools.
- A host of environmental improvement measures have been implemented in rental estates, e.g. drainage ambassador scheme, upgrading works for refuse collection and handling facilities, installation of biochemical systems to remove hazardous and odorous pollutants, and improved domestic refuse disposal arrangement. Public awareness of environmental hygiene in housing estates has been elevated through quarterly large-scale floor cleaning operation.
- Over 30,000 buildings have been inspected and over 6,000 defective pipes have been identified. So far, defective pipes in over 3,300 buildings have been rectified. Over 1,850 unauthorized building works have been removed, and over 770 defective drains have been rectified.
- We have enhanced efforts on environmental hygiene, e.g. rodent control, washing and cleaning of target areas, stringent enforcement action against littering, etc. We have also enhanced control on food premises and markets, e.g. monthly market cleansing day, incentive scheme to improve hygiene conditions of food premises, stringent enforcement actions, and regular inspection by Health Inspectors, etc.
- Wild animals surveillance for test of SARS virus has been conducted. All the results are negative.
- We have enhanced coordination with relevant Government departments and communication with the tourist trade and the Mainland authorities for dissemination of health information to incoming tourists. Specific

guidelines on precautionary and preventive measures have been drawn up in consultation with tourism and related trade.

- We have enhanced communication between Government and the public on environmental hygiene through a series of activities and public education. Major activities include eradication of blackspots, organization of month end cleansing, and district hygiene squads.