立法會
Legislative Council

LC Paper No. CB(2)643/09-10
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Panel on Health Services

Minutes of meeting
held on Monday, 9 November 2009, at 8:30 am
in Conference Room A of the Legislative Council Building

Members present	:	Dr Hon Joseph LEE Kok-long, SBS, JP (Chairman) Dr Hon LEUNG Ka-lau (Deputy Chairman) Hon Fred LI Wah-ming, SBS, JP Hon CHEUNG Man-kwong Hon Andrew CHENG Kar-foo Hon Albert CHAN Wai-yip Hon Audrey EU Yuet-mee, SC, JP Hon Alan LEONG Kah-kit, SC Hon Cyd HO Sau-lan Hon CHAN Hak-kan Hon CHAN Kin-por, JP Hon CHEUNG Kwok-che Dr Hon PAN Pey-chyou
Members absent	:	Hon Albert HO Chun-yan Hon IP Kwok-him, GBS, JP
Public Officers attending	:	Items III & IV Dr York CHOW, GBS, JP Secretary for Food and Health Mrs Susan MAK, JP Deputy Secretary for Food and Health (Health)1 Dr P Y LAM, JP Director of Health Mr Shane SOLOMON Chief Executive Hospital Authority

Item III only

Dr Thomas TSANG, JP
Controller, Centre for Health Protection

Dr P Y LEUNG
Director (Quality & Safety)
Hospital Authority

Item IV only

Dr Gloria TAM, JP
Deputy Director of Health

Dr Monica WONG
Principal Medical & Health Officer(1)

Dr Libby LEE
Chief Manager (Patient Safety & Risk Management)
Hospital Authority

Clerk in attendance	**:**	Miss Mary SO Chief Council Secretary (2)5
Staff in attendance	**:**	Ms Maisie LAM Senior Council Secretary (2)7
		Ms Sandy HAU Legislative Assistant (2)5

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I. Information paper(s) issued since the last meeting

There was no information paper issued since the last meeting.

II. Discussion items for the next meeting
(LC Paper Nos. CB(2)182/09-10(01) and (02))

2. Members agreed to discuss the following items at the next regular meeting to be held on 14 December 2009 -

(a) Redevelopment of Yan Chai Hospital;

(b) Private hospital development; and

(c) Funding for Health and Health Services Research Fund.

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III. Implementation of the seasonal influenza and pneumococcal vaccinations
(LC Paper Nos. CB(2)182/09-10(05) to (08))

3. Secretary for Food and Health (SFH) briefed members on the details and progress of implementation of the seasonal influenza and pneumococcal vaccination schemes launched by the Government in 2009-2010, details of which were set out in the Administration's paper [LC Paper No. CB(2)182/09-10(05)]. SFH also took the opportunity to brief members on the implementation of human swine influenza (HSI) vaccination, details of which were as follows -

(a) following completion of procurement procedures by tender for the HSI vaccine, the Administration had placed an order for three million doses of HSI vaccine from French manufacturer Sanofi Pasteur S.A. at a price of $237 million. The first batch of 500 000 doses would be delivered by mid December 2009 and the remaining 2.5 million doses were expected by January 2010;

(b) vaccination would be provided free of charge to the five high-risk target groups of about two million people, i.e. healthcare workers; chronic patients and pregnant women; children aged six months to under six years; elderly aged 65 and above; and pig farmers and slaughterhouse workers, by the end of December 2009. The vaccination was voluntary. The vaccine would also be provided to the private medical sector on a cost recovery basis to cater for demand of persons outside the target group who wished to receive vaccination at their own cost. Details of the arrangements would be announced later in November 2009; and

(c) according to the World Health Organization (WHO), there had been no unusual adverse effect observed in countries which had started their own HSI vaccination programme. The HSI vaccine had the same risk comparable to that of the seasonal influenza vaccine.

Coverage of the HSI vaccination programme

4. Noting that around 67% of the confirmed HSI cases in Hong Kong were under 19 years and HSI proved to be readily transmissible in school settings, Mr CHEUNG Man-kwong urged the Administration to include primary and secondary students in the HSI vaccination programme. Mr CHEUNG pointed out that the Administration's decision to suspend the classes of primary schools, special schools, kindergartens and child care centres in June 2009 until the commencement of the new school year had caused great disruption to school teaching. With the commencement of the new school year 2009-2010, the Department of Health (DH) had advised 47 schools to suspend classes due to outbreak of influenza-like illness, albeit that Hong Kong had yet entered the winter influenza peak season. Hence, including primary and secondary students in the vaccination programme would on the one hand reduce the

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risk of these students and their family members contracting HSI, and on the other hand minimise disruption of school teaching caused by suspension of classes.

5. SFH and Director of Health (DoH) responded as follows -

(a) the supply of HSI vaccines were relatively limited as the vaccine manufacturers worldwide could only produce the HSI vaccines to meet the demand of some 5% of the world population. Hence, the HSI vaccination programme was aimed at protecting people which were more vulnerable and had a higher risk of medical complications, hospitalisation and death arising from HSI;

(b) based on the current scientific information, the Scientific Committees of the Centre for Health Protection (CHP) were of the opinion that HSI vaccines should be provided to the five target groups mentioned in paragraph 3(b) above. It should be noted that primary and secondary students were less likely to develop complications when comparing with children under six years. Moreover, being vaccinated against HSI was not the only way to protect a person from the virus. Notwithstanding the aforesaid, primary and secondary students could still receive vaccination from the private medical sector at their own cost if they so wished;

(c) if there was a HSI outbreak in a school, CHP would make suggestions to the affected school on whether class suspension was necessary with regard to individual circumstances. In the new school year, some 1 000 influenza-like-illness outbreaks in schools and pre-school institutions were reported to CHP. So far, CHP had advised some 50 schools/pre-school institutions to suspend classes to prevent the spread of influenza.

6. Mr CHEUNG Man-kwong remained of the view that primary and secondary students should be included as target groups for HSI vaccination, as doing so would reduce the risk of the students and their family members contracting the disease and avoid causing public panic at times of outbreaks in schools. He suggested that vaccination priority should first be given to primary students, and then to junior secondary students and lastly to senior secondary students. Mr CHEUNG further pointed out that people aged six to 24 years were amongst the priority groups for receiving HSI vaccine in the United States.

7. Mr Andrew CHENG considered that primary students aged six years to under twelve years were particularly vulnerable to HSI, as they had close contacts for extended period of time at schools. Pointing out that HSI remained mild so far and many of the three million doses of HSI vaccines might not be used, Mr CHENG called on the Administration to consider including primary students in the programme without their having to receive vaccination from the private medical sector at their own cost.

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8. SFH stressed that the Administration had to be prudent in deciding the target groups for vaccination. The Scientific Committees considered that the balance between benefits of vaccination and potential risk of adverse vaccine effects was less clear for other groups of the population at this point in time. Depending on the progress of the vaccination programme and any changes noted in the HSI epidemic, the Administration would seek the advice of the Scientific Committees on whether, and if so, which other groups of the population should be included in the HSI vaccination programme.

9. DoH supplemented that the Administration was proceeding with planning for vaccination of the specified target groups at this stage. It should also be noted that family members of students who had higher risk of complications arising from HSI had already been covered under the vaccination programme.

10. Mr CHEUNG Man-kwong requested the Administration to provide a specific timetable for working out whether the Administration would include the primary and secondary students in the HSI vaccination programme.

11. SFH responded that further scientific evidence was needed to make a case for mass vaccination in other groups of the population. This included local data on the proportion of primary and secondary students infected with complications, requiring hospitalisation and case fatality; overseas experience; and recommendations of WHO.

12. Mr Andrew CHENG asked whether in the meantime, HSI vaccination could be provided to students of those primary and secondary schools located in districts where there was suspension of classes due to outbreak of influenza-like illness, so as to protect these students against HSI infection. SFH replied in the negative, and pointed out that people in different districts were exposed to the same level of risk of infection of a communicable disease such as HSI in a densely populated city like Hong Kong.

13. The Chairman asked the Administration whether consideration could be given to procuring additional HSI vaccines at this point in time to cover the primary and secondary students as and when necessary, as it might be difficult to secure supply at a later time.

14. SFH said that if the development of the pandemic had made it necessary to recommend additional population group(s) to receive vaccination, the Administration could secure additional supply of vaccines or flexibly make adjustments using the 500 000 doses of vaccines originally intended to release to the private medical sector to cater for demand of persons outside the target group who wished to receive vaccination voluntarily.

15. Ms Audrey EU asked whether SARS patients were eligible for the HSI vaccination programme. Ms EU further asked about the estimation of private doctors' take-up rate of the vaccine, as she was given to understand that many private doctors were resistant to get vaccinated for the reason that Tamiflu

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remained an effective chemoprophylaxis and treatment option against HSI so far.

16. SFH replied in the negative to Ms EU's first question, and stressed that persons who recovered from SARS were not at increased risk of complications arising from HSI. He pointed out, however, that SARS patients with chronic diseases would be covered under the HSI vaccination programme. As regards Ms EU's second question, SFH said that HSI vaccination was recommended for healthcare workers both for the maintenance of essential workforce to deliver healthcare services and for reducing the risk of transmitting the virus to patients with low immunity and were vulnerable to infectious diseases. Whilst the HSI vaccination programme had not yet started, it should be noted that a considerable number of healthcare workers had received seasonal influenza vaccination each year.

Implementation of the vaccination programme

17. In reply to Ms Audrey EU's enquiry about whether people being administered the HSI vaccine could at the same visit receive the pneumococcal and seasonal influenza vaccines, SFH advised that different vaccines would better be administered at different sites so that it would be clear which vaccine the reactions or side effects, if any, were associated with.

18. Mr Albert CHAN requested the Administration to disseminate clear information to each population group involved on the vaccines, including those covered by the Childhood Immunisation Programme (CIP), they should receive and the vaccination timetable.

19. SFH responded that the arrangement to roll out the seasonal influenza and pneumococcal vaccinations and the HSI vaccination programme separately in late October 2009 and December 2009/January 2010 could avoid possible confusion to the public. Efforts had been and would continuously be made to step up publicity closer to the time of the commencement of each vaccination programme. DoH supplemented that there was no cause for concern that parents would miss the CIP vaccinations, as 80% of the newborns and children in Hong Kong received their vaccinations under CIP at the Maternal and Child Health Centres of DH and appointments would be made after each vaccination for the next scheduled date of immunisation. As regards elderly, residents of Residential Care Homes for the Elderly would be administered seasonal influenza and pneumococcal vaccinations by the visiting health teams coordinated by DH. HA would also provide the vaccinations for long-stay inpatients with chronic diseases, including the elderly, in public hospitals.

20. In reply to Mr Albert CHAN's enquiry about the expenditure incurred so far for the HSI vaccination programme, SFH said that the three million doses of vaccine were at a price of $237 million and the injection cost was estimated to be $50 per dose for the some two million people in the target group. Amongst these three million doses of vaccine, about 500 000 doses would be released to the

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private medical sector on a cost recovery basis for persons outside the target group. It was estimated that the total cost of the vaccination programme would stay within the budget commitment of $700 million.

21. Dr PAN Pey-chyou asked about the measures to prevent recurrence of the dispensing incident occurred in September 2009, in which some children receiving catch-up vaccination of Pneumococal Conjugate Vaccine were given syrup panadol with incorrect dosage labelling with respect to their age.

22. DoH advised that to prevent recurrence of similar incidents, DH had been working with the Auxiliary Medical Service to implement rectifying measures, including putting in place double checking measure and having designated staff dispensing syrup panadol.

23. Pointing out that vaccines required storage temperatures between 2°C and 8°C to remain potent and effective, the Chairman asked about the measures to ensure that vaccines were transported and stored, in particular at private clinics, within the aforesaid temperature range.

24. Controller, CHP said that both HSI and seasonal influenza vaccines had to be kept in the temperature range of 2°C and 8°C. Measures were put in place to ensure the proper storage of vaccines. For instance, units/refrigerators for transporting and storing vaccines would have thermometers to monitor if temperature went outside the recommended temperature range. Private medical practitioners would also exercise their professionalism to ensure that vaccines stored remained safe and effective.

Other issues

25. Ms Audrey EU asked about the arrangements for class suspension if the HSI virus became more virulent or severe in the coming influenza peak.

26. SFH responded that whether a territory-wide class suspension was necessary would depend on the actual epidemic situation. Traditionally, the winter influenza season in Hong Kong tended to arrive between February to March. Although it was uncertain at this point in time whether the HSI virus would become more severe and when would the winter influenza peak arrive, it should be noted that the Northern hemisphere had entered the influenza peak season at an earlier time this year. In the event that a territory-wide class suspension was necessary, consideration was being made to extending the Lunar New Year or Easter school holidays and shortening the summer break. DH would monitor the situation and work closely with the Education Bureau in this regard. It was hoped that the suspension would cause minimal disruption to internal and public examinations as well as admission arrangements.

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Conclusion

Admin 27. In closing, the Chairman requested the Administration to provide a response in writing on the suggestion of including primary and secondary students in the HSI vaccination programme after consulting the Scientific Committees, and to take into account members' views about the dissemination of information on the various vaccination programmes to the public.

IV. Mechanism for handling medical incidents in public and private hospitals

(LC Paper Nos. CB(2)182/09-10(03) and (04))

28. SFH, Chief Executive, HA (CE, HA) and Deputy Director of Health briefed members on the mechanism for handling medical incidents in public and private hospitals, details of which were set out in the Administration's paper [LC Paper No. CB(2)182/09-10(03)].

Occurrence rate of medical incidents

29. Mr CHAN Kin-por asked whether the Administration had compared the occurrence rate of medical incidents between hospitals as well as with those in other countries, so as to identify the level of performance of hospitals.

30. SFH responded that it was difficult to compare different private hospitals given the variations in their policies and mechanisms to identify, report and manage sentinel events. Nevertheless, private hospitals should comply with the requirements on the management of medical incidents set out in the Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes (the Code) issued by DH. It was expected that the introduction of hospital accreditation in the future would enhance transparency and accountability of private hospitals, including their standards with regard to the management of medical incidents. As regards public hospitals, it should be noted that the complexity of, and hence the risk associated with, operations taken at different public hospitals were different. CE, HA supplemented that no single hospital presently stood out as having a much higher rate of sentinel events.

31. SFH further said that it was difficult to compare the local medical incidents statistics with those in other countries because of the differences in the mechanisms for reporting medical incidents. Notwithstanding this, given that HA had engaged an Australian consultant to develop a set of hospital accreditation standards, the performance of the participating public and private hospitals might be compared with that of Australia and those countries which employed a similar set of accreditation standards. CE, HA supplemented that whilst there were rooms for improvement, public hospitals in Hong Kong had a much lower rate of sentinel events than that of other countries. According to a report published by WHO some three years ago,

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the percentage of adverse events in hospital admissions was about 10% in western countries.

32. Dr PAN Pey-chyou sought information from HA on the types of sentinel events which recorded a major drop since the implementation of the Sentinel Event Policy.

33. CE, HA responded that the Sentinel Event Policy was implemented since October 2007. During the first and second six-month periods of implementation, a total of 23 and 21 sentinel events were reported respectively and "Death of an inpatient from suicide (including suicide committed during home leave)" was the top category of all reported events (12 and 13 cases). Suicide remained the top reported events for the period from 1 October 2008 to 31 March 2009 (11 out of 25 cases). To minimise the risk of re-occurrence of the event, measures including the introduction of a standardised suicidal risk assessment tool and redesigning the bathrooms to mitigate potential setting for committing suicide by patients were put in place. It should be noted that for the period from 1 April to 30 September 2009, only four inpatient suicide cases were reported. At the request of Dr PAN, CE, HA undertook to provide the number of sentinel events reported from 1 October 2007 to 30 September 2009, with a breakdown by category to show the trend of reporting.

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Types of sentinel events to be reported

34. Mr CHAN Hak-kan noted with concern the discrepancies in the types and descriptions of sentinel events to be reported by public hospitals and private hospitals to HA and DH respectively as set out in Appendices B and C to the Administration's paper. He enquired whether it was due to the difference on the commencement date of the reporting requirement and whether the Administration would consider amending the two lists for consistency. Ms Audrey EU raised a similar question.

35. Dr LEUNG Ka-lau noted that starting from 1 January 2010, in addition to the existing medical incidents classified as sentinel events, HA would require clusters/hospitals to report all serious untoward events relating to medication error and patient misidentification. He was concerned about the unclear descriptions of some sentinel events under the refined Sentinel Event Policy. Taking item 2 in Appendix B as an example, Dr LEUNG said that deleting the phrase "requiring re-operation or further surgical procedure" after "retained instruments or other material after surgery/interventional procedure" had made the descriptions ambiguous as to whether this included objects that were intentionally left in place or implanted as a part of a planned intervention.

36. DoH responded that all private hospitals were required to report sentinel events within 24 hours upon occurrence of the event to DH with effect from 1 February 2007. The types of sentinel events to be reported by public and private hospitals respectively shared similar wording as both were drafted with reference to the authoritative lists of adverse medical incidents which were classified as sentinel

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events. It was expected that the types of sentinel events to be reported by public and private hospitals would be standardised in the future with the introduction of hospital accreditation.

37. The Chairman asked whether consideration could be given to making the amendments before the introduction of hospital accreditation for consistency. DoH agreed to discuss with HA in this regard.

Disclosure of sentinel events in private hospitals

38. Mr CHAN Hak-kan noted that HA would consider disclosing a sentinel event in public hospital to the public if it had immediate major impact to the public or involved patient's death, and DH would consider disclosing details of an event in private hospital to the public if it had major impact on the public health care system, or if it constituted a persistent public health risk or involved a large number of patients. Mr CHAN asked whether the criteria for disclosure could be standardised.

39. SFH and DoH responded as follows -

(a) private and public hospitals were presently required to report all sentinel events to DH and HA respectively. A sentinel event could be caused by human and/or system factors. For single cases in private hospitals which involved only the medical practitioner and the patient or his/her family, due consideration would be given to the issue of confidentiality and whether the event had major impact on the public health care system in deciding whether it should be made public;

(b) upon receipt of the notification of a sentinel event from a private hospital, DH would gather preliminary information from the hospital and ensure that it would conduct investigations into the event. DH might also pay site visit to the hospital to gather more information relating to the event and conduct its own investigation if it was considered that the event constituted a high public health risk; and

(c) one of the key objectives of the pilot scheme launched by HA in April 2009 for accreditation of public hospitals in Hong Kong was to develop a set of common hospital accreditation standards for measuring the performance of both public and private hospitals. The set of common standards would include standards with regard to the management of medical incidents.

40. Mr CHEUNG Man-kwong noted that under the reporting system of DH, private hospitals could develop their own policies and mechanisms to manage sentinel events, including whether to disclose the events to the public. He urged the Administration to devise a uniform mechanism to require all private hospitals to make public all sentinel events which were caused by system factor, irrespective of whether they were a single incident not involving a large number of patients,

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without compromising the privacy of patients.

41. SFH reiterated that upon receipt of the notification, DH would consider disclosing details of an event to the public if it had major impact on the public health care system, or if it constituted a persistent public health risk or involved a large number of patients. The private hospital concerned would also make formal responses to the media if patients had disclosed the events.

42. DoH supplemented that upon identifying the root causes of the sentinel event after investigation, DH would follow up cases which were caused by system factor, such as shortage of manpower, or were repetitive in nature. If the private hospital concerned had implemented improvement measures in order to prevent similar incidents from happening in the future, DH would consider not disclosing the event to the public. Disclosure would however be made if no remedial action had been taken or the event had major impact on the public health care system. In more serious cases, DH might suspend the service in question or cancel the registration of the private hospital.

43. In response to the Chairman's enquiry as to whether DH would report to the Medical Council of Hong Kong any sentinel events in private hospitals which involved professional misconduct of the private medical practitioners, DoH advised that this would depend on the willingness of the patient concerned to lodge a complaint against the medical practitioner.

44. Ms Audrey EU cited a news article on the ratio of midwives to births in private hospitals. She then asked about the requirements on the number of midwives in private hospitals.

45. DoH responded that about 60% to 70% of women giving birth at private hospitals would choose to perform caesarean section. The current requirement was to ensure a ratio of one midwife to one woman in the labour environment, and one midwife to three women for antenatal care before delivery.

Penalty imposed on private hospitals

46. Ms Audrey EU sought information about the penalty for failing to report sentinel events to DH within 24 hours upon occurrence of the event. Ms Cyd HO asked whether private hospitals would be penalised for non-compliance with the requirements set out in the Code.

47. DoH responded that no penalty was imposed on private hospitals failing to comply with the requirements set out in the Code, including reporting of incidents. DoH however pointed out that compliance with the requirements under the Code was a condition for the registration of private hospitals. Under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165), DH might at any time cancel the registration of a private hospital in the event of a contravention of the specified conditions relating to the accommodation, staffing or

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equipment but no revocation had been made so far. Ms Audrey EU considered that private hospitals should be penalised for non-compliance with the requirements on the management of medical incidents.

48. Ms Cyd HO noted that under section 8 of Cap. 165, if any person was guilty of an offence against this Ordinance (other than an offence in respect of which some other penalty was specifically provided by this Ordinance) he shall in respect of each offence be liable on summary conviction to a fine of $1,000, and, in the case of a continuing offence, to a further fine of $50 in respect of each day on which the offence continues after conviction. Ms HO was of the view that the penalty levels failed to give a deterrent effect on non-compliant private hospitals, and asked when Cap. 165 was last reviewed.

49. DoH advised that it had been some time since the last amendment of Cap. 165, but the Code had been updated from time to time as appropriate. DoH said that putting in place comprehensive legislation might not be able to flexibly cater for the advancement of medical technology and rising community aspiration for quality services due to the considerable time required to amend the legislation. It was against this background that the Code was developed and implemented in 2003 to set out the standards of good practice for healthcare institutions to adopt in order to provide quality care to patients.

50. Mr Fred LI was of the view that DH should step up its efforts to closely monitor the compliance of private hospitals with the requirements set out in the Code, in particular the handling of medical incidents. In addition, penalty for non-compliance should be imposed for cases not as serious as requiring the cancellation of registration.

51. DoH said that through the reporting system, DH monitored the operation of private hospitals and ensured that they took prompt actions in accordance with established mechanisms so as to minimise the harm caused to the patients. When sentinel events occurred, DH would follow up on the implementation of improvement measures to prevent the recurrence of similar events in the future. At the request of Mr LI, the Administration undertook to provide more details in writing on the sentinel events occurred in private hospitals since 1 February 2007 which were caused by system factor and recommendations from DH on how the related services should be improved.

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Investigation of medical incidents

52. Mr Albert CHAN sought information about the support, in particular advice by medical experts from relevant fields, provided to patients involved in adverse medical incidents in public hospitals.

53. SFH said that maintaining a relationship of mutual trust between the medical practitioners and the patients was conducive to the effective handling of medical incidents. Under the existing mechanism, the HA staff concerned, and if necessary,

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senior management of the respective hospital would provide explanation and give an account of its handling of the event to the patients in an open and honest manner. If patients decided to lodge a complaint, the complaint would be handled by the respective hospitals in the first instance. Complainants who were not satisfied with the outcome of their complaints could appeal to the Public Complaints Committee, which comprised members from different sectors of the community, for a review of their cases. Patients might also resort to legal proceedings if they so wished. In cases where professional misconduct was involved, patients could lodge complaints to the relevant healthcare professional regulatory bodies, such as the Medical Council of Hong Kong and the Nursing Council of Hong Kong. SFH further said that there were medical experts who were willing to provide advice to facilitate investigation, albeit they might not be easy to identify. Patients who were unable to afford the costs of inviting medical experts to provide advice in legal proceedings could apply for legal aid.

54. Mr Andrew CHENG said that a motion on "Establishing an independent statutory office of the health service ombudsman" was carried at the meeting of the Legislative Council on 14 January 2009. He asked the Administration whether it would study the need for establishing the office. Ms Cyd HO raised a similar question.

55. SFH responded that the proposal might affect the relationship of mutual trust between the medical practitioners and the patients and would require careful consideration. Overseas experience revealed that the setting up of an office of the health service ombudsman would not effectively reduce the number of medical incidents and might even prolong the process of investigation. While the Administration would keep an open mind on the proposal, there was no urgency in deciding the way forward and efforts would be devoted to improve the existing mechanism for handling medical incidents in public and private hospitals first.

56. Mr Andrew CHENG queried how the new Staff Discipline Committee referred to in paragraph 7 of the Administration's paper could ensure fair disciplinary proceedings across the board.

57. SFH responded that the purpose of setting up a central Staff Discipline Committee to advise the Cluster Chief Executive on the most appropriate form of disciplinary actions for the serious clinical incidents was to ensure consistency and alignment of disciplinary actions across different clusters/hospitals under HA's just culture. Mr Andrew CHENG requested HA to provide a summary of the disciplinary actions taken against the staff involved in the reported events since the implementation of the Sentinel Event Policy. CE, HA agreed.

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58. Dr LEUNG Ka-lau asked whether information disclosed by the frontline staff to the investigation panel was subject to legal privilege under the Sentinel Event Policy so as to protect the staff involved in the event from being sued by the patient concerned.

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59. CE, HA advised that appropriate level of confidentiality would be applied to the root cause analysis report to protect the identity of patients and staff concerned. In line with the existing practice for the investigation of all adverse medical incidents, HA would first seek legal opinion before providing any confidential information so requested.

60. Mr Fred LI asked whether the patients concerned would be kept informed of the actions taken by the respective hospital, and if necessary, the HA Head Office in the handling of sentinel events.

61. CE, HA advised that HA would disclose the event to the patients and their families and obtain their consents before disclosing the events to the public. After investigation, meetings would be arranged with the patients to explain the contents of the investigation report before released to the public. A patient relation officer would assist the patients throughout the process and measures would be taken to ensure that the identity of the patients would be protected.

Support to HA staff

62. Dr PAN Pey-chyou expressed concern about the immense pressure exerted on HA frontline staff due to the implementation of the Sentinel Event Policy, which might lead to an increase in the number of staff taking sick leave, seeking counseling or committing suicide. He asked whether HA was aware of the situation.

63. CE, HA admitted that the implementation of the Sentinel Event Policy might generate psychological pressure on staff on the one hand, and on the other hand result in the introduction of new policies, such as the "time-out" (surgical pause) process, with a view to reducing the risk of recurrence of similar events. However, he was not aware that there were cases where staff committed suicide because of the Policy. CE, HA further assured members that HA would support the staff involved with the events.

Conclusion

64. In closing, the Chairman requested the Administration to take into account members' views to further strengthen the monitoring of the operation of private hospitals.

V. Any other business

65. There being no other business, the meeting ended at 10:40 am.

Council Business Division 2
Legislative Council Secretariat
30 December 2009