立法會
Legislative Council

LC Paper No. CB(2)2294/09-10

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(These minutes have been seen by the Administration)

Panel on Health Services

Minutes of meeting
held on Monday, 14 June 2010, 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 Audrey EU Yuet-mee, SC, JP Hon CHAN Hak-kan Hon CHAN Kin-por, JP Hon CHEUNG Kwok-che Hon IP Kwok-him, GBS, JP Dr Hon PAN Pey-chyou Hon Alan LEUNG Kah-kit, SC Hon Albert CHAN Wai-yip
Members absent	:	Hon Albert HO Chun-yan Hon Cyd HO Sau-lan
Public Officers attending	:	<u>Items III and IV</u> Dr York CHOW Yat-ngok, GBS, JP Secretary for Food and Health <u>Items IV, V and VI</u> Mrs Susan MAK, JP Deputy Secretary for Food and Health (Health) 1 <u>Item IV only</u> Dr Cindy LAI Kit-lim, JP Acting Deputy Director of Health

Dr Tina MOK
Principal Medical & Health Officer (1)

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

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

Item V only

Miss Gloria LO
Principal Assistant Secretary for Food and Health (Health) 2

Dr W L CHEUNG
Director (Cluster Services)
Hospital Authority

Dr K M CHOY
Chief Manager (Service Transformation)
Hospital Authority

Item VI only

Professor Lakshman P Samaranayake
Director, Prince Philip Dental Hospital

Mrs Miranda YIM
Principal Executive Officer (Health)

Mr Kenneth SHE Siu-kuen
Assistant Director/2
Electrical & Mechanical Services Department

Dr Ricky LI Chung-leung
Chief Engineer/Health Sector
Electrical & Mechanical Services Department

Clerk in attendance : Miss Mary SO
Chief Council Secretary (2) 5

Staff in attendance	:	Ms Maisie LAM Senior Council Secretary (2) 6 Ms Sandy HAU Legislative Assistant (2) 5

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I. Confirmation of minutes
(LC Paper No. CB(2)1755/09-10)

The minutes of the meeting held on 11 May 2010 were confirmed.

II. Information paper(s) issued since the last meeting
(LC Paper No. CB(2)1687/09-10)

2. Members did not raise any queries on the letter dated 25 May 2010 from Hong Kong Doctors Union to the Director of Health regarding the treatment provided by the Hospital Authority for wet aged-related macular degeneration patients.

III. Discussion items for the next meeting
(LC Paper Nos. CB(2)1758/09-10(01) to (02))

3. Members agreed to discuss the following items proposed by the Administration at the next regular meeting scheduled for 12 July 2010 at 8:30 am -

(a) Healthcare Reform Second Stage - Strategy Document on Development of Primary Care;

(b) Commencement of provisions related to proprietary Chinese medicines in the Chinese Medicine Ordinance (Cap. 549); and

(c) Issues related to health services under the Framework Agreement on Hong Kong/Guangdong Co-operation.

4. Mr CHAN Hak-kan expressed concern about the recent outbreaks of the hand, food and mouth disease ("HFMD") in Hong Kong. Mr CHAN proposed to discuss measures to prevent and combat the disease at the next regular meeting.

5. Secretary for Food and Health ("SFH") advised that HFMD was usually caused by a group of viruses called enteroviruses. Common causative agents of HFMD included Coxsackie virus A and Enterovirus 71 ("EV71"). In Hong Kong, HFMD occurred throughout the year but more frequently during summer (from May to July) in the past few years. This year, an increase in HFMD activity had been reported in the Mainland since late April 2010 and a continuous rise in HFMD activity was noted in Hong Kong in the past few weeks. As of today, there were some 380 HFMD cases in Hong Kong, among which 16 were serious cases and there was one fatal case.

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Most serious cases were associated with EV71 and the fatal case was associated with Coxsackie A16. As Hong Kong had already entered the summer peak of HFMD, it was expected that the number of infection would remain high until the end of the school term, i.e. around mid July 2010. SFH further advised that as no vaccination and specific treatment was available for HFMD, only symptomatic treatment would be given to patients to provide relief from fever, aches or pain from the ulcers and the illness would be self-limiting in most case. The Centre for Health Protection ("CHP") had issued letters to schools, kindergartens and child-care centres urging them to promote personal and environmental hygiene at the school setting to reduce the risk of infection.

6. Mr CHAN Hak-kan asked whether consideration would be given to suspending classes to control the spread of HFMD.

7. SFH responded that at present, schools, kindergartens and child-care centres were requested to inform CHP if there was a suspected outbreak of HFMD at their institutions. CHP would closely monitor the situation and where situation warranted, individual institutions would be advised to suspend classes for a period of 14 days to control the spread of the disease.

8. In response to Dr PAN Pey-chyou's enquiry as to whether the situation of HFMD infection in this year was more severe than the past few years, SFH advised that the up-to-date HFMD activity was already three-to-four-fold higher than that of 2009 and was the highest when compared with that in the past five years.

IV. Mechanism for handling medical incidents in public and private hospitals
(LC Paper Nos. CB(2)1467/09-10(09) and (10))

9. SFH, Director (Quality & Safety), Hospital Authority ("Director (Quality & Safety), HA") and Acting Deputy Director of Health ("DDH(Acting)") briefed members on the mechanism for handling medical incidents in public and private hospitals, as well as the new measures recently introduced by HA and the Department of Health ("DH") respectively to further improve the mechanism and enhance patient safety, details of which were set out in the Administration's paper (LC Paper No. CB(2)1467/09-10(09)).

10. Mr CHAN Hak-kan noted that unlike public hospitals where the HA Head Office would appoint a panel to investigate the root causes of the sentinel events or serious untoward events for risk identification and implementation of improvement measures, the private hospitals were tasked with the responsibility to conduct self-investigation into the root causes of the sentinel events and take remedial actions to reduce the probability of recurrence of such event in the future. He expressed concern about the difference in the mechanism of public hospitals and private hospitals for the management of medical incidents as well as the impartiality of the private hospitals in investigating the causes of sentinel events occurred in their hospitals.

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11. Responding to Mr CHAN's concern about the difference between the public and private hospitals' mechanism for handling medical incidents, SFH said that HA had engaged an Australian consultant to launch a pilot scheme for accreditation of five public hospitals in Hong Kong in April 2009. At the same time, three private hospitals had participated in the pilot scheme. One of the key objectives of the pilot scheme was to develop a set of common hospital accreditation standards, including standards with regard to the management of medical incidents and complaints, for measuring the performance of both public and private hospitals in various aspects in the long run. One private hospital had already been awarded the accreditation status in March 2010 and it was envisaged that the remaining participating hospitals would be accredited in 2010-2011.

12. ADDoH said that there was no cause for concern about the impartiality of the self-investigaton conducted by the private hospitals, as private hospitals were encouraged to invite independent persons and specialists with fellowship in the Hong Kong Academy of Medicine to join the investigaton committee to enhance its independence. Apart from requiring the private hospital concerned to investigate the root cause of the event and submit to DH the full investigation report within four weeks of the occurrence of the event, DH would also pay site visit to the hospital to gather more information relating to the event and conduct direct investigation if it was considered that the event constituted a high public health risk. It should also be noted that if a death was a reportable death within the meaning of the Coroners Ordinance (Cap. 504), the hospital concerned was required to report the death of the patient to the Coroner, who might inquire into the cause of and the circumstances connected with the death.

13. Mr Alan LEONG asked whether the discrepancies in the types and descriptions of sentinel events and serious untoward events to be reported by public hospitals and private hospitals to HA and DH respectively would be removed in future upon the introduction of hospital accreditation.

14. SFH agreed that it would be necessary to align the different descriptions of reportable sentinel events and serious untoward events of public and private hospitals. It was hoped that a territory-wide hospital accreditation scheme could be implemented in around four years' time following the completion of the pilot accreditation scheme. A set of common standards for measuring the performance of both public and private hospitals in the management of medical incidents, among others, could then be put in place.

15. Mr CHAN Hak-kan noted from Annex E to the Administration's paper that the number of maternal death/serious maternal injury cases reported by private hospitals had increased from two in 2007 to 12 in 2009. He sumrised that the main reason why there was a surge in this type of sentinel event was because of the rapid expansion of obstetric service in private hospitals in recent years. Noting from the media reports that serious maternal injury cases had repeatedly occurred in a private hospital, Mr CHAN asked the Administration whether consideration would be given to imposing penalty on private hospitals which had been involved in sentinel events that were repetitive in nature.

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16. SFH pointed out that 11 out of the 12 maternal death/serious maternal injury cases in 2009 were cases of non-fatal postpartum hemorrhage. It should also be noted that the total number of births in Hong Kong in 2009 outnumbered that in 2007 by some 20 000 to 30 000 and many of the births were given by non-local women. The fact that quite a significant proporation of the non-local women who gave birth in Hong Kong had little antenatal care might increase the risks of postpartum hemorrhage for the mothers.

17. As regards Mr CHAN's second question, ADDoH said that upon identifying the root causes of the sentinel events in private hospitals after investigation, DH would follow up cases which were caused by system factors, such as shortage of manpower and facilities or non-compliance with procedures, and recommend how the related services should be improved. ADDoH further said that to enhance patient safety, private hospitals providing obstetric services were required to have a resident medical practitioner in the specialty of obstetrics and gynecology available on immediate call within the establishment at all times to deal with emergencies in case the admitting doctors could not arrive at the hospital within 30 minutes.

18. Mr CHAN Kin-por was concerned that the increased turnover rate of senior doctors of some specialties, say Surgery and Obstetrics and Gynaecology, in public hospitals would increase the likelihood of medical incidents.

19. Director (Quality & Safety), HA responded that reports of the root cause analysis of medical incidents so far revealed that these incidents were mainly caused by system factors. In the light of this, the turnover of senior doctors would have no direct negative impact on the occurrence rate of medical incidents, albeit that the turnover might affect the training provided to interns.

20. Mr CHAN Kin-por sought the number of cases of non-compliance with the requirements set out in the Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes ("the Code") with a breakdown by category in the past five years.

Admin ADDoH agreed to provide the information after the meeting. In response to Mr CHAN's further enquiry as to whether DH had cancelled the registration of any private hospital for failing to comply with the requirements under the Code, ADDoH replied in the negative. She explained that if a private hospital was found in breach of the requirements set out in the Code, DH would issue advice or warning letter to the private hospital concerned based on the severity of the case, and request it to implement improvement measures within a specified period of time. DH would also monitor the performance of private hospitals by conducting routine and surprise inspections.

21. Dr LEUNG Ka-lau considered that the descriptions of some of the events that were required to be reported under HA's sentinel and serious untoward event policy as set out in Annex A to the Administration's paper were too vague and could be subject to different interpretation. For instance, it was not clear as to whether prescription and dispensing errors resulting in major permanent loss of function or death were both regarded as medication error. Some frontline staff also found it difficult to determine

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whether an adverse event resulting in permanent loss of function or death was not a complication and was required to be reported under the policy.

22. Director (Quality & Safety), HA advised that HA's list of reportable sentinel and serious untoward events was drafted with reference to similar lists adopted in other countries, such as Australia and the United States. Following some two years' implementation of the Sentinel Event Policy since October 2007, frontline staff were now much more familiar with the reporting criteria. Referring to the examples quoted by Dr LEUNG in paragraph 21 above, Director (Quality & Safety), HA advised that both prescription and dispensing errors resulting in major permanent loss of function or death would be regarded as reportable medication error. Given that it was sometimes arguable as to whether an adverse event resulting in permanent loss of function or death was a complication or not, guidance in classification would be provided to frontline staff where necessary.

23. Dr LEUNG Ka-lau asked whether information disclosed by frontline staff to the investigation panel was subject to legal professional privilege under HA's sentinel and serious untoward event policy.

24. Director (Quality & Safety), HA responded that appropriate level of confidentiality would be applied to the root cause analysis report to protect the identity of patients and staff concerned. In the event that the Coroner decided to investigate the cause of a death, HA would first seek legal opinion before providing any confidential information so requested.

25. Mr Andrew CHENG urged the Administration to establish an independent statutory Office of the Health Service Ombudsman to handle medical incidents occurred in public hospitals so as to ensure impartiality of the investigation and better protect the interest of patients. Mr Alan LEONG expressed similar views, and said that a motion on "Establishing an independent statutory Office of the Health Service Ombudsman" was passed by the Legislative Council ("LegCo") on 14 January 2009.

26. SFH responded 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, upon occurrence of a medical incident, the HA staff of the hospital concerned would immediately explain the incident and give an account of its handling of the incident to the patients, check and understand their need and demand, and provide them with suitable assistance. Patients not satisfied with the explaination could lodge a complaint with the respective hospitals. At present, all complaints would be handled and responded to directly by the respective hospitals in the first instance. Complainants who wished to put forward further views or were not satisfied with the handling/outcome of his complaint could file an appeal with HA's Public Complaints Committee, which comprised medical experts and lay members from different sectors of the community, for a review. It should be noted that there were also other well-established complaint redress avenues in Hong Kong, such as the Medical Council of Hong Kong. SFH further said that the objective of HA's mechanism for handling medical incidents was to promote a patient centered and learning culture among staff and encourage staff to report medical

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incident in a timely and open manner and share their experience in handling medical incidents with a view to avoiding recurrence of similar incidents in future. HA also made public the causes and details of medical incidents in a transparent and open manner and ensured that the cases of affected patients were handled fairly and impartially. He did not see the need to change the existing mechanism as it could effectively and properly handle medical incidents and complaints on medical services of public hospitals.

27. In response to Mr Andrew CHENG's enquiry about the factors that DH would consider when determining whether details of a sentinel event occurred in a private hospital should be disclosed to the public, ADDoH said that DH would consider the merits of each case and disclose details of a event to the public if it constituted a persustent public health risk or involved a large number of patients.

28. Dr PAN Pey-chyou cast doubt on whether the existing mechanism of HA for handling medical incidents could prevent recurrence of similar incidents in future. According to Annex B to the Administration's paper, the number of the first two types of reportable sentinel events in HA, i.e. "Surgery/interventional procedure involving the wrong patient or body part" and "Retained instruments or other material after suregery/interventional procedure requiring re-operation or further surgical procedure", was five and 10 respectively for the period from 1 October 2007 to 30 September 2008. However, the number of these events had increased to 10 and 13 respectively for the period from 1 October 2008 to 30 September 2009.

29. Director (Quality & Safety), HA advised that the number of surgical incidents had also been on the rise in different countries in recent years. In the light of this, the World Health Organization ("WHO") had made safe surgery the second Global Patient Safety Challenge, with a view to improving the safety of surgical care around the world by ensuring adherence to proven standards of care in all countries. The focus of the Challenge was the WHO Safe Surgery Checklist which required the surgery team to complete the listed tasks before it proceeded with the operation. In HA, the "Time-out" process had been fully and partially implemented in the Department of Surgery and the Department of Medicine respectively to ensure verification of key information and process.

30. Mr Albert CHAN asked about the reason why unanticipated death or serious injury of infant after birth was not a reportable sentinel event in HA. Mr Alan LEONG raised a similar question, and pointed out that this type of event was however included in the list of sentinel events to be reported by private hospitals.

31. Director (Quality & Safety), HA advised that since March 2006, HA staff were required to immediately report all medical incidents, including incidents related to infants and mothers after birth, via the Advance Incident Reporting System to hospital/cluster management and HA Head Office. The Department of Obstetrics and Gynaecology of HA would also compile an annual statistics report on neonatal death and maternal death. For instance, among the 41 040 infants born in public hospitals in 2008, 193 infants died within seven days after birth. The statistics would be subject to review of the Central Coordinating Committee of Obstetrics and Gynaecology and

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internal audit of HA. He further pointed out that the introduction of the Sentinel Event Policy in 2007 was aimed at further strengthening the reporting, management and monitoring of adverse medical incidents classified as sentinel events in HA and facilitating international comparison on statistics of sentinel events. Hence, the list of reportable sentinel and serious untoward events was not meant to be exhaustive. Notwithstanding this, he took note of members' concern.

32. In response to Mr Albert CHAN's enquiry as to whether HA would consider inviting independent persons to sit on the investigation panels and making public the investigation reports. Director (Quality & Safety), HA advised that HA had been doing so for incidents of wide public concern. To enhance accountability to the public, HA would also compile, every six months, a report on sentinel event for release to the public.

33. Mr Albert CHAN was of the view that the investigation panels of HA should also be empowered to adjudicate the amount of compensation for victims of medical incidents in order to avert the need for the victims to go through the very cumbersome legal proceedings.

34. Director (Quality & Safety), HA responded that HA would consider the issue as necessary having regard to the development of legal system in Hong Kong. At present, claims for compensation would be followed-up through loss adjuster or HA's legal adviser, or be subject to the decision by the court and there were established procedures in HA to handle the claims.

35. In closing, the Chairman requested the Administration to take into account the concerns of members on the discrepancies in the types and descriptions of sentinel events and serious untoward events to be reported by public hospitals and private hospitals. To facilitate the Panel's future discussions on the matter, Mr Albert CHAN requested the Research and Library Services Division of the LegCo Secretariat to conduct a research on the mechanism for investigating medical incidents in public and private hospitals in selected overseas places. Members did not raise any queries.

V. Cataract Surgeries Programme

(LC Paper Nos. CB(2)1758/09-10(03) and (04))

36. Deputy Secretary for Food and Health (Health) 1 ("DSFH(H)") and Director (Cluster Services), HA briefed members on the outcome and evaluation of the Cataract Surgeries Programme ("the Programme") launched by HA in 2008, and the extension of the Programme in 2010-2011, details of which were set out in the Administration's paper (LC Paper No. CB(2)1758/09-10(03)). Director (Cluster Services), HA further advised that new cataract centres were planned to be set up in the Grantham Hospital and the Tseung Kwan O Hospital in 2010 and 2011 respectively to increase HA's througput of cataract surgeries.

37. Mr Fred LI asked -

(a) whether the waiting time for cataract surgeries in HA, which had been shortened from around 35.5 months in December 2007 to around 31

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months in December 2009, could be further reduced, in particular for the Kowloon East ("KE") Cluster where relatively more elders resided; and

(b) what was the average cost of HA for conducting a cataract surgery in public hospitals.

38. Director (Cluster Services), HA responded as follows -

(a) HA was planning to set up a new cataract centre in the Tseung Kwan O Hospital in the KE Cluster to increase the annual throughput of cataract surgeries from 2 000 to 4 500. It was expected that the waiting time for cataract surgeries in the KE Cluster could be shortened to less than 24 months within two years upon the commencement of operation of the new cataract centre in April 2011; and

(b) the average cost per cataract surgery in HA was in the range of $10,000 to $15,000, which covered both same-day treatment as well as more complex cases requiring multi-day in-patient services.

39. In response to Mr Albert CHAN's enquiry about the longest waiting time for cataract surgeries in the KE Cluster, Director (Cluster Services), HA advised that the longest waiting time would be around three to four years. At the request of the Chairman, Director (Cluster Services), HA undertook to provide after the meeting a breakdown of the notional waiting time for cataract surgeries in HA by cluster.

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40. Mr CHEUNG Man-kwong was of the view that the coverage of the Programme should be extended to patients who had been on HA's waiting list for cataract surgery for less than two years so as to further shorten the waiting time for cataract surgeries in HA. Mr CHEUNG Kwok-che expressed similar views.

41. Director (Cluster Services), HA responded that to do so might attract to the Programme patients who were currently not on the waiting list of HA and had no genuine need for subsidy to meet towards the fees for receiving cataract surgeries provided by the private sector. He however pointed out that HA was now in discussion with the private ophthalmologists to explore possible ways to enhance the Programme in the future.

42. Mr CHEUNG Kwok-che noted that out of the $55 million additional funding from the Government, $38 million would be utilised to provide an additional 5 000 surgeries in public hospitals in 2010-2011 and the remaining $17 million would be utilised to extend the Programme in 2010-2011 with the target of providing 3 000 additional cataract surgeries through the Public-Private-Partnership (PPP) model. Given that the above arrangement could only benefit 8 000 patients, he considered it more cost effective to have all the $55 million funding be utilised to provide provision of a $5,000 subsidy to patients to undertake cataract surgeries in the private sector so that about 10 000 patients would benefit from the Programme.

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43. Mr Albert CHAN held the contrary view that all the funding should be utilised to provide additional cataract surgeries in public hospitals to clear the backlog of cases on HA's waiting list.

44. Director (Cluster Services), HA responded that the current arrangement was aimed at providing additional choices of private services for patients who could afford the amount of co-payment on the one hand, and enhancing the capability of HA in providing the heavily-subsidised cataract service for needy patients, which included the setting up of two new cataract centres at the Grantham Hospital and the Tseung Kwan O Hospital, on the other hand. The need to adopt a two-pronged approach could be demonstrated by the fact that out of the 30 282 eligible patients invited, 21 501 had chosen to stay in HA's waiting list to receive cataract surgeries in public hospitals. The feedback to the introduction of a PPP model with patient co-payment was also positive, with 98% of the participating patients surveyed considered that the Programme had helped them receiving surgery earlier. Director (Cluster Services), HA further said that HA would take into account the statistics and findings under the Programme, as well as views of private ophthalmologists in mapping out the way forward.

45. Dr PAN Pey-chyou remarked that more resources should be allocated to increase both the HA throughput and the quota for patients to receive surgeries provided by the private sector in order to further shorten the waiting time for cataract surgeries.

46. Mr Andrew CHENG sought clarification from HA on the number of additional cataract surgeries to be provided by HA with the additional funding. According to the Administration's reply to a question regarding cataract surgeries raised by Hon Fred LI during the examination of the 2010-2011 Estimates of Expenditure, HA would provide an additional of 5 480 cataract surgeries in 2010-2011, instead of 5 000 surgeries as set out in paragraph 10 of the Administration's paper. Director (Cluster Services), HA confirmed that the number of additional cataract surgeries to be provided by HA in 2010-2011 would be 5 480.

47. Mr CHEUNG Man-kwong asked whether consideration could be given to increasing the amount of the fixed subsidy of $5,000 for elderly patients not on Comprehensive Social Security Assistance (CSSA) as some of them might not be able to co-pay for the cataract surgeries provided by the private sector.

48. Director (Cluster Services), HA pointed out that since the prevalence of cataract increased with age, most patients on HA's waiting list for cataract surgery were elders. It should be noted that some of the private ophthalmologists participating in the Programme had conducted surgeries for patients with limited economic means, such as recipients of CSSA and patients granted with medical fee waiver, on a charitable basis at the subsidised rate without requiring their co-payment. In response to Mr CHEUNG's further enquiry about the average amount of co-payment paid by participating patients for receiving cataract surgeries in the private sector, Director (Cluster Services), HA advised that the average amount of co-payment was in the range of $7,000 to $8,000.

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49. Mr Albert CHAN asked HA how it would monitor the fee-charging by the private ophthalmologists participating in the Programme.

50. Director (Cluster Services), HA advised that under the Programme, patients who chose to undertake cataract surgeries in the private sector would be provided with a subsidy of $5,000, subject to co-payment of not more than $8,000 in case the private provider charged more than the amount of subsidy. Hence, the maximum fees that the participating private ophthalmologists might charge for each cataract surgery was $13,000. The present arrangement that participating patients could choose to obtain quotations from not more than two participating private ophthalmologists would also promote market competition for the benefits of patients. HA would conduct survey on selected patients to check that the private ophthalmologists were charging patients within $13,000.

51. Dr LEUNG Ka-lau urged HA to remove the $8,000 cap on co-payment as this would undesirably limit the choice of participating patients to less experienced private ophthalmologists, who were more willing to charge each cataract surgery at a level not exceeding $13,000.

52. Director (Cluster Services), HA responded that HA was discussing with the private ophthalmologists on how the Programme could be improved in the long run and there were views that the $8,000 cap on co-payment should be removed. In this circumstance, participating private ophthalmologists could publicise upfront the fees that they expected to charge on top of the subsidy amount to enhance transparency and facilitate the choice of participating patients. HA would propose to the Government measures to improve the Programme once the details were finalised.

53. Mr CHEUNG Man-kwong noted from paragraph 7 of the Administration's paper that the number of cataract surgeries reported with complications accounted for 1.5% of all surgeries completed under the Programme. He asked whether these patients were followed up by HA.

54. Director (Cluster Services), HA advised that the private ophthalmologists would continue to provide care to the patients concerned without additional charges. Patients could also go back to HA for follow-up treatment where necessary.

55. Pointing out that some other patients, such as cancer patients, also had to wait for a long time before they could receive treatment in public hospitals, Mr Albert CHAN asked whether consideration would be given to introducing PPP programme of a similar nature for other diseases. Mr Andrew CHENG raised a similar question.

56. Director (Cluster Services), HA responded that HA had rolled out various PPP programmes in the past two years. At the request of the Chairman, Director (Cluster Services), HA agreed to provide the relevant information in writing after the meeting.

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VI. Replacement of central air-conditioning system for the Prince Philip Dental Hospital
(LC Paper No. CB(2)1758/09-10(05))

57. DSFH(H) briefed Members on the proposed replacement of the central air-conditioning (AC) system for the Prince Philip Dental Hospital, details of which were set out in the Administration's paper (LC Paper No. CB(2)1758/09-10(05)).

58. Dr LEUNG Ka-lau asked the Electrical & Mechanical Services Department ("EMSD") whether there was any precedent where the sea water cooled chillers of existing central AC system were replaced by fresh water cooled chillers. Chief Engineer/Health Sector, EMSD replied in the negative. He however pointed out that it was not uncommon for Government and private buildings to use fresh water cooled central AC systems for the supply of AC.

59. Mr Andrew CHENG asked about the nuisances to be caused to the nearby residents when the replacement works were carried out. He further asked whether the works would affect the normal operation of the Prince Philip Dental Hospital.

60. Responding to Mr CHENG's first question, Assistant Director/2, EMSD said that the nuisances to be caused by the replacement works to the nearby residents would be minimal as all installation works would be carried out within the premises of the Hospital and no road excavation work needed to be carried out in the vicinity.

61. As regards Mr CHENG's second question, Assistant Director/2, EMSD advised that there were three chillers in the Prince Philip Dental Hospital. During summer time, all chillers must be in operation to provide the required cooling load but in winter time, only one chiller would suffice. As some of the chillers had to be turned off when the replacement works were carried out, the installation, testing and commissioning of the chillers would be undertaken in phases in winter, i.e. February to May 2011 and November to December 2011, when the required cooling load was lower so as to minimise the impact on the daily operation of the Hospital.

VII. Any other business

62. There being no other business, the meeting ended at 10:35 am.

Council Business Division 2
Legislative Council Secretariat
24 September 2010