



醫院管理局  
HOSPITAL  
AUTHORITY

Hospital Authority

Strategic Service Framework for  
*Palliative Care*



# *Vision* for HA Palliative Care Services

**All patients** facing life-threatening and life-limiting conditions and their **families/carers** receive **timely, coordinated and holistic palliative care** to address their physical, psychosocial and spiritual needs, and are given the opportunities to **participate** in the planning of their care, so as to **improve their quality of life** till the end of the patients' life journey.



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# Foreword by *Chairman*

Facing illness and disease can be a distressing event, and even more so for patients with life-threatening or life-limiting conditions such as cancer and end organ failure. Palliative care helps in improving their quality of life along the disease progression till the last phase of their life journey.

Over the past years, there has been a steady development of palliative care services in the Hospital Authority (HA). While the service was initially developed for cancer patients, it has been extended to non-cancer patients in recent years to better address their needs.

In the context of a rapidly ageing population and growing chronic disease burden in Hong Kong, there is a need to strengthen our healthcare services for supporting the various needs of patients along the care pathway. In alignment with the Government policy on long-term care for the elderly and the related ongoing initiatives and discussions on palliative and end-of-life care, it is an opportune time for us to formulate this Strategic Service Framework for Palliative Care, to improve the palliative care services in HA. It is also our duty to plan this service well, and empower our colleagues to deliver palliative care alongside with other acute and curative services, so that comprehensive healthcare services are provided to our population from cradle to grave.

My heartfelt gratitude goes to the wide range of clinical colleagues, patient representatives and my fellow Board members for their support and contributions in formulating this Strategic Service Framework. Successful implementation of the Framework requires collaborative effort across disciplines, specialties and hospitals in HA for integrating palliative care into the care continuum. With the commitment and dedication of all of us here in HA, I am confident that we will raise the standards of our palliative care services to benefit all patients in need.



**Prof John C Y LEONG**

Chairman  
Hospital Authority

# Foreword by *Chief Executive*

Life is a journey, with a beginning and also an end. As I mentioned in my speech at the 2016 Hospital Authority Convention, our mission of helping patients stay healthy is underpinned by a strong belief in whole-life well-being, from birth to death. As healthcare workers, our job is not only about saving lives and treating illnesses, but also about providing care that is congruent to the patients' needs and preferences, and when the time comes, to help them live with dignity and peace in the last stages of their life journeys.

Being the major provider of public healthcare services in Hong Kong, we are taking care of many patients with life-limiting and life-threatening conditions who require palliative care. Palliative care is not the 'treatment option of last resort'. It is an integral part of the continuum of holistic care for patients suffering from a serious illness, and should be provided early in the course of the illness according to the patients' needs. Patients should also have more opportunities to participate in the planning of their care, so that their choices in the final stages of life are known and respected for a better quality of life.

The Strategic Service Framework for Palliative Care is an overarching blueprint to guide our clinicians and executives in aligning the palliative care service initiatives in our operation planning. My sincere thanks go to all the staff and other stakeholders who have contributed to the Framework's development. To achieve our vision of better access to quality palliative care services for all patients with a serious illness, there needs to be a fundamental shift in our culture and in the way we understand and deliver palliative care. I look forward to working with you all in striving for change, to bring better care to patients in need and their families/carers.



**Dr P Y LEUNG**

Chief Executive  
Hospital Authority

# Preface

The Strategic Service Framework for Palliative Care is going to guide the development of the Hospital Authority (HA)'s palliative care services over the next five to ten years. It outlines our strategic directions for building up a sustainable service model and system infrastructure, so as to address the service gaps and improve the quality of our palliative care.

Under the Framework, focused efforts will be made to improve the governance and organisation of our adult palliative care services, and strengthen the collaboration between palliative care and non-palliative care teams. Emphasis is put on enhancing ambulatory and community services so that patients can be taken care of in their usual place of residence. At the same time, structured and family-centred paediatric palliative care is to be established in our paediatric services network for addressing the needs of chronically or seriously ill children and their families. Across HA, palliative care services are monitored for continuous quality improvement, and key enablers are also identified to support the strategies.



We are delighted to see the active participation from a wide range of stakeholders during the formulation of the Framework, including frontline clinical staff, Head Office and Cluster executives, and patient representatives. Their views and aspirations have been most valuable in shaping our future service development. In particular, we would like to express our gratitude to the members of the Taskforce and Working Groups for their guidance and expert advice, as well as the Subgroup members for developing the palliative care service plans for respective Clusters. We would also like to extend our appreciation to everyone who provided suggestions and feedback on the draft Framework. We look forward to your continuing support as we implement the strategies in the years to come.



**Dr Libby LEE**

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**Dr W L CHEUNG**

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# Executive Summary

## Introduction

The Strategic Service Framework for Palliative Care (the Framework) is an overarching document developed by the Hospital Authority (HA) to guide the development of adult and paediatric palliative care services in the next five to ten years. It outlines the strategies and key enablers for building up the service model and system infrastructure to address existing issues and improve the service quality.

Patients with life-limiting conditions are in need of palliative care. They could be having different diseases, in different hospitals or healthcare settings, and under the care of healthcare teams of different specialties. Along the disease trajectories, patients may experience multiple symptoms and distress requiring palliative care support at different time points. Therefore, concerted efforts are required from each and every healthcare staff in supporting these patients and their families/carers. Through this Framework, HA is moving towards the following vision:

**“ All patients facing life-threatening and life-limiting conditions and their families/carers receive timely, coordinated and holistic palliative care to address their physical, psychosocial and spiritual needs, and are given the opportunities to participate in the planning of their care, so as to improve their quality of life till the end of the patients' life journey. ”**

The Framework is targeted at patients suffering from life-threatening and life-limiting conditions, covering both adults and children with cancer or non-cancer diseases. Emphasis is placed on the collaboration among different specialties along the care continuum from hospital to community settings. While the focus is on palliative care services in HA, collaboration with community partners and the welfare sector is also highlighted for supporting the patients and their families/carers in the community.

## Planning Process

The development of the Framework commenced in early 2016. Under the policy directions and guidance of the Medical Services Development Committee (MSDC) and Directors' Meeting, a Taskforce was set up to oversee the formulation process. Working Groups were also formed to advise on the future service models and system infrastructure for adult and paediatric palliative care. Overall, a highly participative and broad engagement approach was adopted, with contribution from frontline clinical staff, Cluster management, Head Office executives and patient groups.

Literature review was conducted to understand the international development and service models of palliative care. Situation analysis was carried out to evaluate the existing service utilisation pattern in HA and identify service gaps and areas for improvement. It was supplemented by hospital visits in the Clusters to observe the service operation and provision. In addition, overseas experts shared their views and experience on palliative care in a Summit which was attended by different key stakeholders including palliative care and non-palliative care specialist doctors, nurses, allied health (AH) professionals, and executives. Themed discussions were held during the Summit to gather ideas for developing the Framework. Moreover, regular briefings and presentations were made to the relevant Coordinating Committees, Central Committees and the Patient Advisory Committee to collect feedback.

Consultation on the draft Framework was conducted between 26 May 2017 and 22 June 2017. The responses and comments received were carefully considered and deliberated by the Taskforce. Subsequently, the refined Framework was submitted to the Directors' Meeting for endorsement, followed by the MSDC for final approval.



# Framework Strategies for Adult Palliative Care

In the Framework, there are four strategic directions for improving the governance and service organisation, care coordination, place of care and performance monitoring of adult palliative care services respectively, as follows:

1. Enhance governance by developing Cluster-based services with the collaboration of medical and oncology palliative care specialists
2. Promote collaboration between palliative care and non-palliative care specialists through shared care model according to patients' needs
3. Enhance palliative care in the ambulatory and community settings to support patients and reduce unnecessary hospitalisation
4. Strengthen performance monitoring for continuous quality improvement

Under each strategic direction, strategies are formulated with reference to the identified areas or opportunities for improvement so as to address the service gaps and key issues.



# 1. Enhance Governance by Developing Cluster-based Services with the Collaboration of Medical and Oncology Palliative Care Specialists

## Opportunities for Improvement

At present, adult palliative care services are mainly department or hospital-based, and are provided by palliative care teams (PC teams) located in 16 hospitals. The teams are led by palliative care specialists who are either from the Department of Medicine (medical PC teams) or the Department of Clinical Oncology (oncology PC teams). Collaboration between different PC teams is limited, resulting in variable service accessibility, particularly for hospitals without a PC team. Overall, the palliative care coverage for non-cancer patients is lower than for cancer patients. It is because both medical and oncology PC teams serve cancer patients, while non-cancer patients are covered mainly by the medical PC teams. In addition to the Central Committee on Palliative Care which oversees the palliative care services in HA at Head Office level, Coordination Committees on Palliative Care Services have also been established in all the Clusters. There is still room to further enhance the roles of these Cluster Committees in service coordination and development.

## Strategies

Enhancing the governance of adult palliative care services is the cornerstone of the overall service development. The direction is set towards Cluster-based service organisation to improve service accessibility and the coordination of care. Strategies include:

- Strengthening collaboration between medical and oncology palliative care specialists to develop Cluster-based services. Palliative care services are delivered through a coordinated network covering both cancer and non-cancer patients in all hospitals of the Clusters. This enables the pooling of expertise and optimal use of resources and facilities for more accessible palliative care
- Reinforcing the role of the Cluster Coordination Committees on Palliative Care Services to support Cluster-based service organisation and improve the implementation, coordination and monitoring of palliative care services at the Cluster level



## 2. Promote Collaboration between Palliative Care and Non-Palliative Care Specialists through Shared Care Model according to Patients' Needs

### Opportunities for Improvement

Care coordination is indispensable in palliative care given that patients requiring the service are often under the care of different specialties. However, there is currently a heavy reliance on palliative care specialists to deliver the service, while the parent teams of non-palliative care specialists focus on providing disease management without much collaboration between the palliative care and non-palliative care teams. Due to limited awareness and knowledge of palliative care among non-palliative care specialists, referrals to PC teams are often made at the very end stage of the patients' disease trajectory, affecting the timeliness and accessibility of palliative care.

### Strategies

Enhanced collaboration between palliative care and non-palliative care specialists, and integration of adult palliative care into the care continuum are promoted. Instead of simply adding a layer of specialist palliative care for every patient with a life-threatening or life-limiting illness, a shared care model is to be adopted, supported by training and skills transfer. The aim is to ensure the provision of timely and appropriate care according to the needs of patients and their families/carers. Strategies include:

- Stratifying patients according to their palliative care needs and disease complexity. Patients whose palliative care needs are not complex are taken care of by the parent teams. For cases with complex palliative care needs but still receive disease modifying treatment, they are co-managed by both the parent teams and palliative care specialists through consultative support, case conferences, etc. Only patients with complex palliative care needs or difficult symptoms are managed by palliative care specialists in a palliative care setting
- Integrating palliative care into the care pathway for early identification of patients in need and initiation of advance care planning (ACP). With training and skills transfer, healthcare staff working in non-palliative care settings are equipped to identify the palliative needs of patients and their families/carers. ACP is conducted by the parent teams to address patients' and their families/carers' needs and preferences regarding their care
- Strengthening specialist palliative consultative service in non-palliative care settings is a key component of the shared care model, so as to support the parent teams in providing palliative care to their patients

### 3. Enhance Palliative Care in the Ambulatory and Community Settings to Support Patients and Reduce Unnecessary Hospitalisation

#### Opportunities for Improvement

Patients approaching the end of life, especially in the last year of life, tend to have high utilisation of hospital services such as Accident & Emergency attendances and acute admissions, even though most of them prefer to be cared for at their usual place of residence. Acute hospitalisation may be stressful to the patients or their families/carers if the goal of palliation is unmet, and put significant pressure on the healthcare system inappropriately. Limitations of palliative care services in the ambulatory and community settings may have accounted for the situation. For instance, the provision of therapeutic procedures is available in only some of the palliative care day settings; there are also considerable gaps and inconsistencies in palliative home care service because it is organised separately by the medical and oncology PC teams.

#### Strategies

It is important to provide ambulatory and community palliative care support to patients and their families/carers in order to facilitate care in place and reduce unnecessary hospitalisation. The emphasis is on enhancing day care, home care, support to residential care homes, and community partnership. Strategies include:

- Refining and aligning the palliative care day service model across Clusters, with the service components being refocused to provide fast track support and therapeutic procedures for symptom management
- Expanding palliative home care service with a Cluster-based arrangement and adopting a case management approach for the home care teams to support both cancer and non-cancer patients. There is also collaboration with Community Nursing Service under the principle of shared care model
- Enhancing palliative care support to residential care homes for the elderly (RCHes) through expanding the end-of-life care programme provided by the Community Geriatric Assessment Teams
- Enhancing medical-social collaboration with community partners such as non-governmental organisations (NGOs), patient groups and volunteers, so as to better mobilise community resources for supporting patients and families/carers



## 4. Strengthen Performance Monitoring for Continuous Quality Improvement

### Opportunities for Improvement

At present, there are limited data on the performance and outcome of palliative care services in HA. The services are mainly monitored on their service throughputs. With regard to quality and performance monitoring, the data are captured manually and are not standardised. Quality indicators are yet to be developed for systematic performance monitoring, benchmarking across units and for informing service planning.

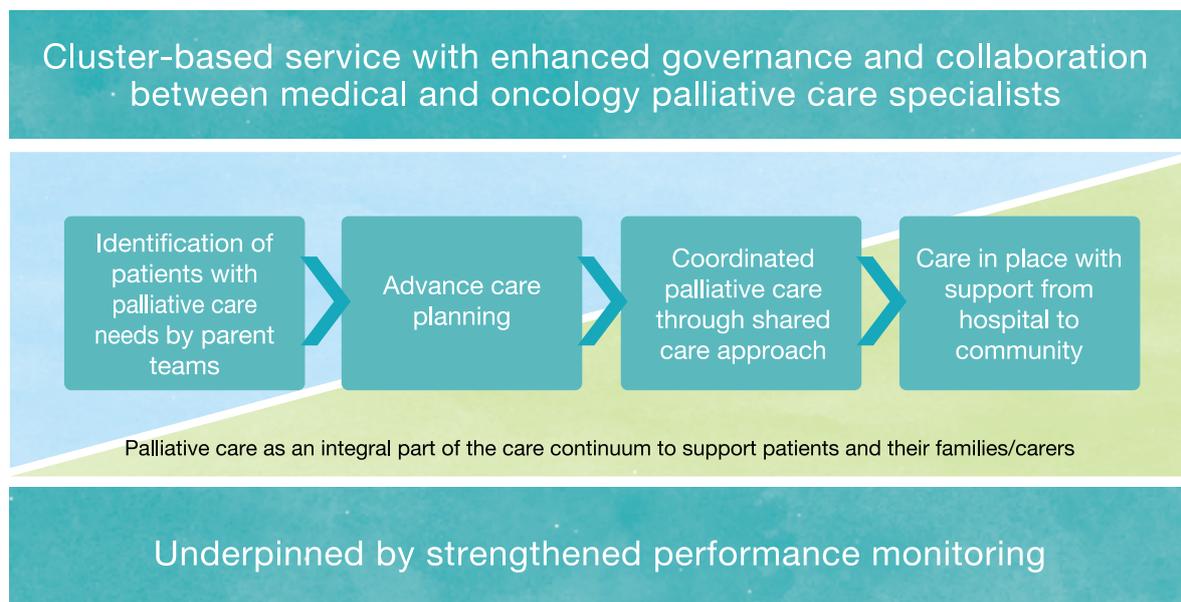
### Strategies

Systematic monitoring of palliative care service quality is instrumental to drive service improvement. Strategies include:

- Enhancing data collection with standardisation of data capture and alignment of measurement tools
- Identifying key domains and developing indicators for the evaluation and monitoring of clinical outcomes and service quality

Under the Framework, a new service model is envisioned for adult palliative care in HA, with the integration of palliative care into the care continuum as illustrated in **Figure 1** below.

Figure 1. Future Service Model of Adult Palliative Care in HA



# Framework Strategies for Paediatric Palliative Care

## Opportunities for Improvement

In contrast to adult palliative care services, specialist palliative care is currently not available in HA for paediatric patients. Children suffering from life-threatening or life-limiting illness are being looked after by the respective paediatric subspecialty teams, which mainly deliver disease management and may also look into the palliative care needs of their paediatric patients if required. Community support for these patients is also generally limited even though collaborations have been made in recent years between the paediatric departments and NGOs to help bridge the service gap. Overall, the provision and development of paediatric palliative care services is not carried out in a structured manner.

With the upcoming development of Hong Kong Children's Hospital (HKCH), paediatric services in HA will be reorganised into a coordinated service network. It is opportune to re-engineer our system to provide holistic care for paediatric patients ranging from acute curative to palliative care.



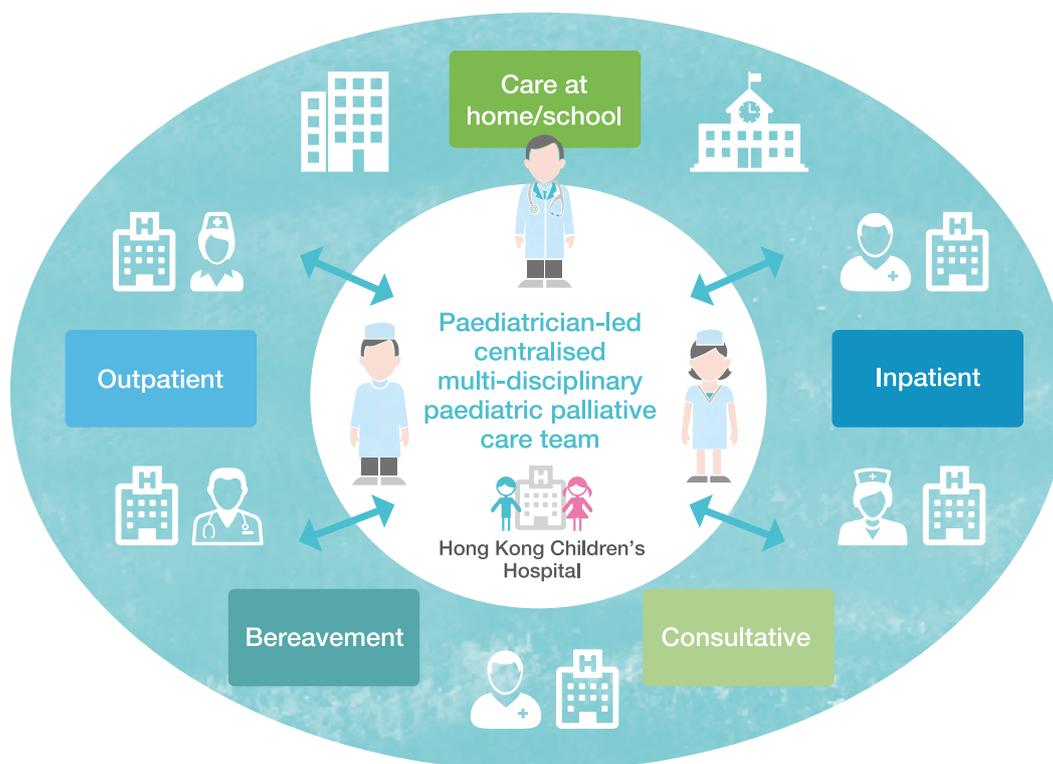
## Strategies

In the Framework, there are three strategic directions for establishing structured paediatric palliative care services in HA to address the specific needs of children and their families through a family-centred approach. The directions are as follows:

1. Establish Territory-wide Paediatric Palliative Care Services in HA
2. Promote Integrated and Shared Care with the Parent Teams
3. Enhance Community Support for Children and Families in Need of Palliative Care

Under the future service model for paediatric palliative care, territory-wide paediatric palliative care services under a single clinical governance are established. A centralised paediatric PC team will work with the designated care team of doctors and nurses at regional level to provide comprehensive palliative care services for the needs of children. The latter plays a significant role in coordinating with community partners, special schools and local paediatric sub-specialty teams; and in the provision of palliative home care service in their local community. Overall, a continuum of paediatric palliative care services is provided, covering inpatient, outpatient, home care, support to schools and bereavement care. Community services are also strengthened through enhanced partnership with NGOs and patient groups. The new service model is illustrated in **Figure 2** below.

**Figure 2. Future Service Model of Paediatric Palliative Care in HA**



A **centralised paediatric PC team** works with the designated care team of doctors and nurses at **regional level** to provide a continuum of **territory-wide** palliative care services from hospital to community under a **single clinical governance**

## Key Enablers

For effective implementation of the Framework strategies, various key enablers are required to build up the system infrastructure for adult and paediatric palliative care.

### Manpower and Training

A Cluster-based perspective of workforce planning and deployment is needed to support the service models. A systematic approach is also to be adopted for training to drive cultural change in integrating palliative care into the care continuum:

- Basic training for all healthcare staff to raise their general knowledge and awareness of palliative care
- Advanced training for non-palliative care teams working directly with patients suffering from life-threatening or life-limiting illnesses to build up their competency in implementing the shared care model
- Specialist training for doctors, nurses and designated training for AH staff in the PC teams

### Facilities

Physical designs for facilitating palliative care, including home-like, peaceful and soothing environment are incorporated into the hospital development and redevelopment projects in HA. In addition, capacity planning covering inpatient and ambulatory facilities for palliative care is to be put in place to cope with the projected service demand and take into consideration changes in the service model.



## **Logistic Support in Hospital Wards**

The logistics and operations of the hospital wards should be designed to cater for the palliative care needs of patients and their families/carers. Flexible visiting hours are introduced so that patients can spend more time with their loved ones. Arrangement can also be made for families/carers to stay overnight with the patients if hospital operation allows.

## **Information Technology (IT) Support**

There is a need to enhance the IT system to support the workflow, communication and care coordination across disciplines, specialties and care settings along the palliative care journey. This includes building up a common platform for the documentation of ACP, and setting up a palliative care database. The development of tele-care and mobile apps should also be explored to support care in place.

## **Transportation**

Transportation support for patients such as Non-emergency Ambulance Transfer Service needs to be strengthened for improving patients' access to palliative care day services as well as the transfer of patients between hospitals or to RCHEs.

## Implementation and Monitoring

Successful implementation of the Framework will require the joint effort of Clusters, hospitals and frontline clinical staff. The process of change should start now, led by clinical leaders, Cluster management and HA Head Office. The strategies will be implemented by phases according to the priority of service needs and readiness of key enablers at both the clinical and Cluster levels. Some of the strategies do not require additional resources, while others will incur resources which could be sought through the HA annual planning process.

The implementation process will be monitored at different levels, including the existing mechanism of annual plan programme monitoring, progress review of the operational plans at the Cluster and corporate levels, and the development of HA-wide quality indicators on palliative care services.

## Conclusion

Palliative care is an integral part of the care continuum. Quality palliative care makes a significant difference in helping adult and paediatric patients and their families/carers cope with the distress of serious illness and anticipating death. The Framework not only highlights the future service models that HA aspires to deliver, it also calls for a fundamental shift in our culture, so that all healthcare workers are aware that good patient care is not only about saving lives, but also about helping patients live with comfort, dignity and peace till the last phase of their life journey.



# 摘要

## 引言

《紓緩治療服務策略》是醫院管理局 ( 醫管局 ) 訂立的一份策略性文件，為醫管局未來五至十年的成人和兒童紓緩治療服務發展提供指引。當中闡述了紓緩治療服務的發展策略以及相關的配套工作，以應對現有的服務缺口和提升服務質素。

紓緩治療是為照顧患有危疾重症的病人。他們的病症和情況各異，並在不同醫院或醫療設施、由不同專科的醫護團隊治理。由於病人會出現多種症狀和不適，往往需要在治理過程中不同的階段接受紓緩治療，因此需要每一位醫護人員共同協力照顧這些病人及其家屬。透過本服務策略，醫管局將邁向實現以下的願景。

“ 所有面對危疾重症的病人及其家屬均獲得適時、協調和全面的紓緩治療服務，以照顧他們身、心、社、靈的需要，並有機會參與規劃本身的護理，從而提升他們的生活質素，直至病人走完人生的最後階段。 ”

本服務策略主要針對患有危疾重症的病人，包括成人和兒童、癌症和非癌症病人。當中強調由醫院以至社區，不同專科醫護團隊之間的合作。雖然焦點是放在醫管局提供的紓緩治療服務，亦有包含與社區夥伴和社福界的合作，以支援病人在社區接受護理。

## 規劃過程

制訂本服務策略的工作始於 2016 年年初。根據醫療服務發展委員會和總監會議的政策方向及指引，我們成立了專責小組，負責監督服務策略的制訂過程。專責小組轄下設有工作小組，負責就成人和兒童紓緩治療的未來服務模式及所需的系統基建提供意見。為了集思廣益，我們邀請了前線臨床醫護人員、聯網管理層、總辦事處行政人員和病人組織廣泛參與服務策略的制訂過程。

期間，我們進行了文獻綜述，以了解紓緩治療的國際發展趨勢和服務模式；亦進行了情況分析，評估醫管局現時的紓緩治療服務使用情況並識別可改善的範疇。同時，我們舉辦了研討會，邀請海外專家分享紓緩治療的心得和經驗。出席研討會的持分者包括紓緩治療專科和非紓緩治療專科的醫生、護士、專職醫療人員，以及行政人員。會上討論了多項專題，藉此蒐集意見，作為制訂服務策略的依據。此外，我們到訪了各個聯網的醫院，考察紓緩治療服務的實際運作。我們亦定期向相關的臨床統籌委員會、中央委員會和病人諮詢委員會作出簡介並收集意見。

我們於 2017 年 5 月 26 日至 6 月 22 日期間就本服務策略的初稿進行了諮詢。專責小組在詳細分析和討論所得的意見後，優化了服務策略的內容，並提交總監會議審視以及醫療服務發展委員會通過。



# 成人紓緩治療策略

本服務策略訂立了四個策略方向，分別就成人紓緩治療的管治、服務統籌、護理地點，以及服務監察作出改善：

1. 加強管治，主要是透過促進內科和腫瘤科的紓緩治療專科團隊之合作，發展以聯網為本的紓緩治療服務
2. 推動共同護理模式，促進紓緩治療專科團隊和其他專科團隊的合作，以提供切合病人需要的紓緩治療服務
3. 強化日間和社區紓緩治療服務，以支援病人在社區生活及減少不必要的住院
4. 加強服務監察，務求持續提升紓緩治療服務的質素

就著可以改善的範疇及以上各策略方向，我們制訂了相應的策略，處理紓緩治療服務的缺口和主要問題。

## 1. 加強管治，主要是透過促進內科和腫瘤科的紓緩治療專科團隊之合作，發展以聯網為本的紓緩治療服務

### 可改善的範疇

現時，醫管局的成人紓緩治療服務主要由 16 間醫院提供，分別由屬於內科或臨床腫瘤科部門的紓緩醫學專科醫生領導（內科 / 腫瘤科紓緩治療專科團隊）。紓緩治療服務以部門或醫院為本，團隊之間的合作甚為有限，導致服務的便捷度存在差異，尤其在沒有紓緩治療專科團隊的醫院內，有關的服務更為有限。整體來說，內科和腫瘤科紓緩治療專科團隊均為癌症病人提供服務，而非癌症病人則主要由內科紓緩治療專科團隊照顧。因此，紓緩治療服務對於非癌症病人的覆蓋率較癌症病人為低。醫管局除了設有紓緩治療中央委員會，在總辦事處層面監督有關的服務，各個聯網亦成立了紓緩治療服務統籌委員會。然而，聯網委員會在統籌和發展紓緩治療服務方面的角色仍有改善的空間。

## 策略

強化管治是推動成人紓緩治療服務發展的基礎。整體方向是透過以聯網為本的服務安排，改善服務的便捷度和協調性。有關策略包括：

- 加強內科和腫瘤科紓緩治療專科團隊的合作，建立以聯網為本的服務網絡，為聯網內各個醫院的癌症及非癌症病人提供紓緩治療服務。這有助匯聚專才、善用設施和資源，並提升服務的便捷度
- 強化聯網紓緩治療服務統籌委員會的角色，以便透過聯網為本的服務安排，在各聯網加強推行、協調及監察紓緩治療服務

## 2. 推動共同護理模式，促進紓緩治療專科團隊和其他專科團隊的合作，以提供切合病人需要的紓緩治療服務

### 可改善的範疇

需要紓緩治療服務的病人多由不同專科的醫護團隊主診，因此服務的協調性尤其重要。目前，紓緩治療服務主要依賴紓緩治療專科團隊提供，而非紓緩治療專科的主診團隊則著重提供治癒性的治療，雙方的合作不多。由於非紓緩治療專科團隊一般對紓緩治療的認知並不足夠，病人往往在病情的晚期才被轉介至紓緩治療專科團隊，因此未必能夠適時獲得紓緩治療服務。

## 策略

促進紓緩治療專科團隊與其他專科團隊之間的合作，並將紓緩治療融入醫護過程中。透過紓緩治療專科團隊與其他專科團隊的共同護理模式並輔以培訓和技術轉移，令患有危疾重症的病人及其家屬能夠獲得適時和適切的紓緩治療服務。有關策略包括：

- 按病人的紓緩治療需要和疾病的複雜程度，將病人分流：主診團隊照顧病人較簡單的紓緩治療需要；如病人有較複雜的紓緩治療需要但仍需主診團隊的治理，紓緩治療專科團隊會透過會診服務、個案會議等形式，與主診團隊共同護理病人；至於有嚴重症狀和高複雜性紓緩治療需要的病人，則轉至紓緩治療的醫療設施，由紓緩治療專科團隊負責照顧



- 將紓緩治療融入病人的治理過程，務求及早識別需要紓緩治療的病人，並制訂預設照顧計劃。為非紓緩治療專科的醫護人員提供培訓，讓他們掌握基本技巧，識別病人及家屬在紓緩治療方面的需要。主診團隊亦會進行預設照顧計劃，以了解病人及家屬在醫療護理方面的需要和意願
- 擴展紓緩治療專科團隊的會診服務，以便透過共同護理模式，協助主診團隊照顧病人的紓緩治療需要

### 3. 強化日間和社區紓緩治療服務，以支援病人在社區生活及減少不必要的住院

#### 可改善的範疇

大部分病人都希望在熟悉的居住環境接受護理；然而，病人臨終前的醫院服務使用量（例如急症室求診及急症入院的次數）一般都相對高。這不只對病人及家屬造成壓力，亦增加整個醫療系統的負擔。出現這種情況可能是由於現時的日間和社區紓緩治療服務相當有限，例如只有個別的日間紓緩治療服務有提供治療性的醫療程序；家居護理服務亦因為是由內科和腫瘤科紓緩治療團隊各自安排而有相當大的差距。

#### 策略

醫管局將加強日間和社區紓緩治療服務，讓病人可以留在社區接受護理，減少不必要的住院。日間紓緩治療服務、家居護理服務、安老院舍的支援服務和社區夥伴的協作都是發展重點。有關策略包括：

- 優化和統一各聯網的日間紓緩治療服務模式，著重為治理病人的症狀而提供快速支援和治療性的醫療程序
- 透過聯網為本的服務安排和個案管理模式，拓展家居紓緩治療服務，以支援癌症和非癌症病人；同時以共同護理模式為原則，加強與社康護理服務的合作
- 擴展老人科外展醫療服務團隊在安老院舍提供的晚期護理計劃，為安老院舍提供最佳的紓緩治療支援
- 加強醫社合作，視非政府機構、病人組織和義工為合作夥伴，以更有效地運用社區資源，支援需要紓緩治療服務的病人及家屬

## 4. 加強服務監察，務求持續提升紓緩治療服務的質素

### 可改善的範疇

現時，有關醫管局紓緩治療服務表現和成效的數據有限，服務的監察主要限於服務使用量。有關服務質素和表現的數據主要由員工以人手記錄，數據收集準則亦不統一。由於缺乏質素指標，因而未能進行系統化的服務監察、跨部門的基準比較或為紓緩治療服務的規劃提供依據。

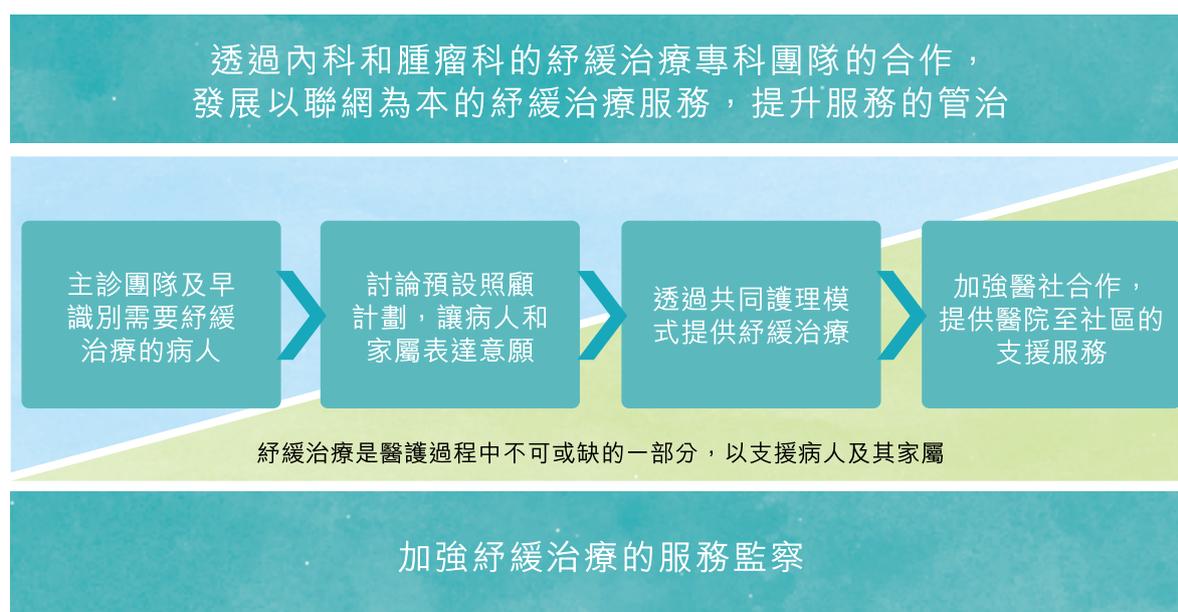
### 策略

醫管局會建立系統化的服務監察，以持續改善紓緩治療服務的質素。有關策略包括：

- 統一紓緩治療服務數據的收集標準和評估工具，以改善數據搜集工作
- 訂立服務指標，以評估和監察臨床成效和服務質素

整體而言，醫管局將會採納新的成人紓緩治療服務模式，把紓緩治療融入醫護過程當中 (圖 1)。

圖 1. 醫管局未來的成人紓緩治療服務模式



# 兒童紓緩治療策略

## 可改善的範疇

有別於成人紓緩治療服務，醫管局現時並沒有提供兒童紓緩治療的專科服務。患有危疾重症的兒童一般由兒科部門相關的附屬專科團隊護理。這些團隊主要提供治癒性的治療，亦會因應病人的需要提供紓緩治療。近年，雖然各個兒科部門透過與非政府機構合作，為這些病童提供社區支援，但這類服務仍然有限。整體而言，兒童紓緩治療服務缺乏系統性的發展和供給。

為配合香港兒童醫院的成立，醫管局的兒科服務將會進行重整，並發展成為一個協調的兒科服務網絡。這是一個改善服務模式的契機，由急症和治癒性的治療以至紓緩治療，為病童提供全面的醫療服務。

## 策略

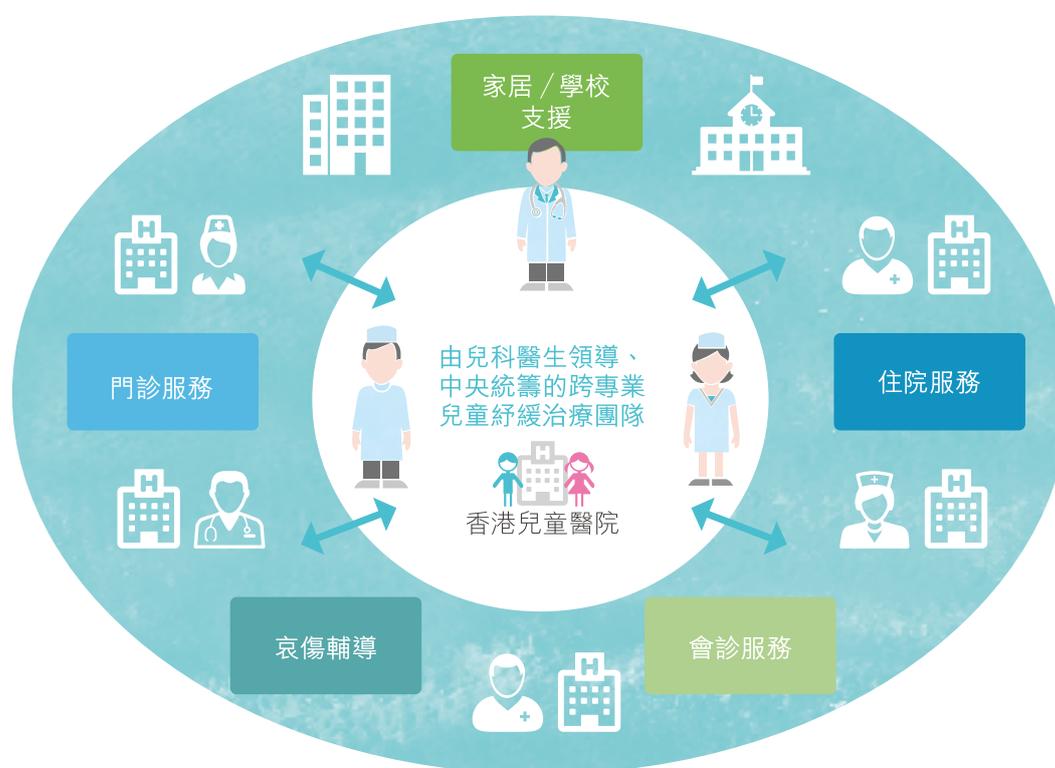
本服務策略訂立了三個策略方向，建立有系統的兒童紓緩治療服務，並以家庭為中心，照顧病童及家屬的需要。策略方向包括：

1. 設立全港性的醫管局兒童紓緩治療服務
2. 促進兒童紓緩治療團隊和主診團隊合作，並建立共同護理模式，為病童提供綜合的醫療服務
3. 加強社區支援服務，照顧有紓緩治療需要的兒童及家屬



在未來的兒童紓緩治療服務模式下 (圖 2)，醫管局將會設立全港性的兒童紓緩治療服務。由中央統籌及管治的兒童紓緩治療團隊將與地區的相關醫生和護士合作，而後者在統籌社區服務方面扮演重要的角色。他們會協調社區夥伴、特殊學校和個別兒科部門的附屬專科團隊的工作，並於社區中提供家居護理服務。總括而言，有需要的兒童將能接受全面的紓緩治療服務，當中包括住院和門診服務、家居護理服務、學校支援服務及哀傷輔導。此外，我們會加強與非政府機構和病人組織協作，強化社區支援服務。

圖 2. 醫管局未來的兒童紓緩治療服務模式



由中央統籌及管治的兒童紓緩治療團隊將與地區的相關醫生和護士合作，提供全港性的紓緩治療服務，以涵蓋醫院至社區的護理

## 系統基建和配套

為有效地落實上述各項策略，我們將會為成人和兒童紓緩治療服務發展相關的系統基建和配套。

### 人力資源及培訓

為配合新的紓緩治療服務模式，人手規劃和調配應以聯網為本。同時，須進行系統化的培訓，以推動醫管局內醫療文化的改變，將紓緩治療融入醫護過程當中：

- 為所有醫護人員提供基本的培訓，提升他們對紓緩治療的基本認識和技巧
- 為須照顧危疾重症病人的非紓緩治療專科醫護人員提供進階的培訓，讓他們能夠有效地落實共同護理模式
- 繼續為紓緩治療專科團隊的醫生、護士和專職醫療人員分別提供專科和特定的培訓

### 設施

醫院發展和重建項目會加入相關的設計元素，以便有效地推行紓緩治療服務。當中包括仿家居的設計元素，及以安寧、平和為主調的護理環境。此外，我們會為住院和日間紓緩治療服務的設施容量進行長遠的規劃，以應付未來的服務需求及配合服務模式的轉變。

### 醫院病房後勤支援

醫院病房的運作應顧及病人及家屬的紓緩治療需要。彈性的病房探訪時間可以讓病人和親友有更多時間相聚。在醫院運作許可下，亦可作出安排，讓家屬在病房通宵陪伴病人。

### 資訊科技支援

有需要加強資訊科技系統，支援在紓緩治療流程中不同專業、專科和護理設施的溝通及服務統籌工作。我們會建立共用的平台記錄病人的預設照顧計劃資料，亦會設立紓緩治療病人資料庫。另外會考慮透過發展視像護理及流動應用程式，支援病人在社區接受護理。

## 交通

我們需要加強支援病人的交通安排，例如非緊急救護車運送服務，方便病人接受日間紓緩治療服務、轉院或返回安老院舍。

## 推行及監察

要成功推行本服務策略，需要各持分者的通力合作，包括前線臨床醫護人員、以及醫院和聯網的行政人員。應由臨床領袖、聯網管理層和醫管局總辦事處帶領，現在就展開革新的過程。我們會因應服務需求的優先次序，以及臨床和聯網配套是否準備就緒，分階段落實所述的策略。部分策略並不需要額外資源，而需要額外資源推行的策略，則可透過醫管局周年工作計劃的機制，申撥所需資源。

我們會在不同的層面監察服務策略的推行，包括透過醫管局現有的周年工作計劃監察機制、跟進各聯網和總辦事處層面的實施進度，以及制訂紓緩治療服務質素指標。

## 總結

紓緩治療服務是醫護過程中不可缺少的一環。優質的紓緩治療能夠幫助患有嚴重疾病的成人和兒童及其家屬面對疾病的困擾和生命的終結。本服務策略闡釋了醫管局期望為病人提供的紓緩治療服務模式，更為醫管局的醫療文化帶來嶄新的改變，讓所有醫護人員都明白，優質的醫療服務並不單單在於拯救生命，亦應協助病人舒適、安寧和有尊嚴地走完人生的最後階段。





Part One  
*Setting The Scene*

# Introduction

## *Setting the Scene for Development of the Strategic Service Framework for Palliative Care*

According to the World Health Organisation (WHO), palliative care is an approach that improves the quality of life of patients (adults and children) facing life-threatening or life-limiting illness and their families/carers. It prevents and relieves suffering of the patients through early identification, assessment and treatment of pain and other physical, psychosocial or spiritual problems<sup>1</sup>. A team approach is used in palliative care to support the patients to live as actively as possible until the last moment, and support their families/carers during the process as well as bereavement.

Palliative care is required by patients who suffer from life-limiting conditions, commonly from cancer and other serious chronic diseases such as kidney failure, chronic respiratory diseases, cardiovascular diseases and neurological diseases. There is often a misconception that palliative care means end-of-life (EOL) care and equals to “giving up”<sup>2</sup>, and it is only for patients at the last stage of their illness. On the contrary, palliative care should be provided along with the curative treatment to support the patient at any stage in a serious illness. It aims at relieving the symptoms of both the disease and the treatment, such as pain, fatigue, shortness of breath, nausea, depression, etc. In fact, palliative care is most effective when considered early in the course of the illness, which not only improves quality of life for the patients but also reduces unnecessary hospitalisation<sup>3</sup>.

1 World Health Organisation (WHO). *WHO Definition of Palliative Care*. Available at: [www.who.int/cancer/palliative/definition/en](http://www.who.int/cancer/palliative/definition/en)

2 Chung, R. et al. (2017). Knowledge, attitudes, and preferences of advance decisions, end-of-life care, and place of care and death in Hong Kong. A population-based telephone survey of 1067 adults. *Journal of the American Medical Directors Association*; 18(4):367.e19-367.e27.

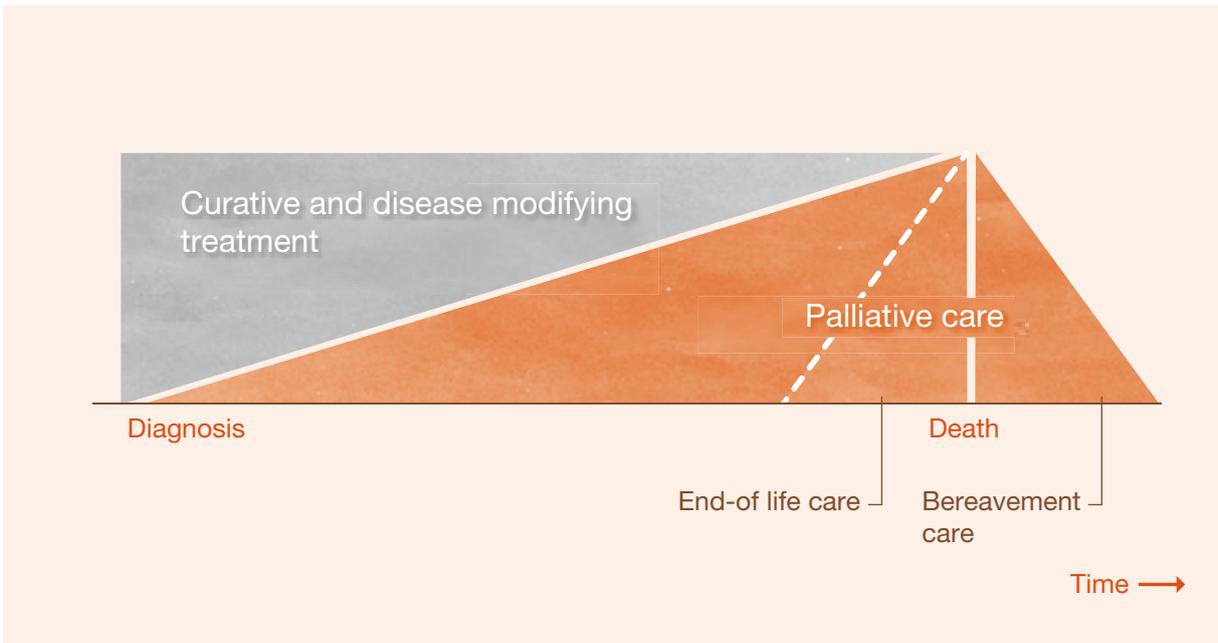
3 World Health Organisation. *Fact Sheet No. 402: Palliative Care*. Available at: [www.who.int/mediacentre/factsheets/fs402/en](http://www.who.int/mediacentre/factsheets/fs402/en)

In the perspective of quality healthcare, palliative care should be regarded as an integral part of the care continuum. It is clearly distinct from the historical development of hospice care which focuses on the very end of life period or after curative care has been exhausted (Figure 1). The concept of palliative care advocates an integrated approach, with palliative care provided alongside the curative and disease-modifying treatment to support the various needs of patients and their families/carers (Figure 2).

Figure 1. Concept of Hospice Care



Figure 2. Concept of Integrated Palliative Care



Providing palliative care is considered an ethical duty for healthcare professionals according to WHO. The provision of care should not be confined to the palliative care specialists. A quality and accessible palliative care system needs to be integrated into primary, community and home-based care<sup>4</sup>. Specialist palliative care is but one component of palliative care service delivery, where the palliative care specialists work together with healthcare professionals in other specialties to support patients suffering from life-limiting conditions.

Currently, HA is providing a spectrum of palliative care services ranging from inpatient, ambulatory to community care and bereavement services. The overall service development is overseen by the Central Committee on Palliative Care (CC(Palliative Care)) at the Head Office level. Palliative care teams (PC teams) in 16 hospitals are providing palliative care services to adult patients with over 360 palliative care beds. There are recent initiatives to enhance the palliative care services by extending the support from cancer patients to non-cancer patients, strengthening the delivery of psychosocial care as one of the core elements in palliative care, and moving from hospital-based care to reaching out into the community for better support of patients at home and in care homes.

Overall, healthcare service development is skewed towards technology advancement and service provision in acute and curative care. Hong Kong is of no exception. In the face of an ageing population and increase in chronic diseases, the Government is promoting primary and community care, and also fostering collaboration between the medical and welfare sectors to better meet patients' needs. That includes the development of a long-term care policy to improve the quality of life of the frail elderly, with ongoing initiatives and discussions on palliative and EOL care, amongst others. In alignment, HA strives to address responsively and adequately the various needs of patients and their families/carers along the care pathway, and thus sees the need to develop and enhance palliative care. A Strategic Service Framework for Palliative Care is therefore developed to shape the future palliative care services in HA.



4 World Health Organisation. *Fact Sheet No. 402: Palliative Care*. Available at: [www.who.int/mediacentre/factsheets/fs402/en](http://www.who.int/mediacentre/factsheets/fs402/en)

# Scope and Vision

## *What We Aspire and What the Framework is about*

Patients with life-limiting conditions are in need of palliative care. They could be having different diseases, in different hospitals or healthcare settings, and under the care of healthcare teams of different specialties. Along the disease trajectories, patients may experience multiple symptoms and distress requiring palliative care support at different time points. Therefore, palliative care services should not be limited by any professional boundaries, and concerted efforts are required from each and every healthcare staff in supporting the needs of patients facing serious illness and their families/carers. With this principle in mind, the following paragraphs describe our aspirations for palliative care services in HA and what the Framework is about.

## **Vision of HA Palliative Care Services**

All patients facing life-threatening and life-limiting conditions and their families/carers receive timely, coordinated and holistic palliative care to address their physical, psychosocial and spiritual needs, and are given the opportunities to participate in the planning of their care, so as to improve their quality of life till the end of the patients' life journey.

## **Scope of the Strategic Service Framework for Palliative Care**

The Framework sets out the strategic directions that HA will pursue to realise our vision for better quality palliative care services. It aims to guide the development of HA palliative care services in the coming five to ten years. It is an overarching document outlining the strategies and key enablers for building up the service model and system infrastructure, so as to address existing issues and to improve the quality of our palliative care services.

The Framework is targeted at patients suffering from life-threatening and life-limiting conditions, covering both adults and children with cancer or non-cancer diseases. In particular, the Framework puts emphasis on the collaboration among different specialties along the care continuum from hospital to community settings. While focus is given to the provision of palliative care services in HA, the importance of collaboration with community partners and the welfare sector is also highlighted for supporting patients and their families/carers in the community.

Meanwhile, in line with the long-term care policy for the elderly in Hong Kong, there are related ongoing initiatives and discussion at the Government level on palliative and EOL care. In the formulation of the Framework strategies, alignment has been made with the overall Government policy direction as well as the established HA guidelines<sup>5,6,7</sup> where appropriate. While advance care planning (ACP) is included in the Framework in terms of its service model, the legal aspects and Government policy issues on dying in place, advance directives (AD) and Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR) are beyond the scope of this Framework.

5 Hospital Authority (HA), Hong Kong Special Administrative Region. (2015). *HA Guidelines on Life-Sustaining Treatment in the Terminally Ill*.

6 Hospital Authority (HA), Hong Kong Special Administrative Region. (2016). *HA Guidelines on Do-Not-Attempt Cardiopulmonary Resuscitation*.

7 Hospital Authority (HA), Hong Kong Special Administrative Region. (2016). *Guidance for HA Clinicians on Advance Directives in Adults*.



## Advance Care Planning (ACP)<sup>a</sup>

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ACP is a process of communication among a patient with advanced progressive diseases, the healthcare providers, and the patient's families/carers regarding the kind of care that will be considered appropriate when the patient cannot make those decisions. It is an overarching and preceding process for expressing preference and values for medical and personal care, which in turn will shape the care for the patients thereafter and at the end of life. Through the ACP process, a mentally competent and properly informed patient may express preferences for future medical or personal care, or make an advance directive (AD) refusing futile life-sustaining treatment. In HA, the term of ACP extends beyond communication with mentally competent adult patients to include that with family members of mentally incompetent and minor patients, by consensus building according to the best interest of the patient.

## Advance Directives (AD)<sup>b</sup>

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A mentally competent and properly informed adult patient can make an AD, explicitly expressing his/her wish to refuse specified life-sustaining treatment (e.g. cardiopulmonary resuscitation (CPR), artificial ventilation, artificial nutrition and hydration etc.) in pre-specified conditions when he/she is in an end-stage condition and mentally incapable of making healthcare decisions. A valid and applicable AD is legally binding under common law. In HA, standardised AD forms are designed for use by HA patients to document the decision.

## Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR)<sup>c</sup>

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DNACPR is an elective decision not to perform CPR, made in advance, when cardiopulmonary arrest is anticipated and CPR is against the wish of the patient or otherwise not in the best interest of the patient. The decision encompasses respecting the view of the patient and the family, the principle of futility of treatment and the best interests of the patient. Standardised DNACPR forms are in place in HA for documenting the decision. DNACPR only means that CPR is not to be initiated in the event of cardiopulmonary arrest. It does not automatically imply forgoing other life-sustaining treatments, which should be individually considered.

Issued by HA Clinical Ethics Committee:

a HA Guidelines on Life-Sustaining Treatment in the Terminally Ill (2015)

b Guidance for HA Clinicians on Advance Directives in Adults (2016)

c HA Guidelines on Do-Not-Attempt Cardiopulmonary Resuscitation (2016)

# Planning Context

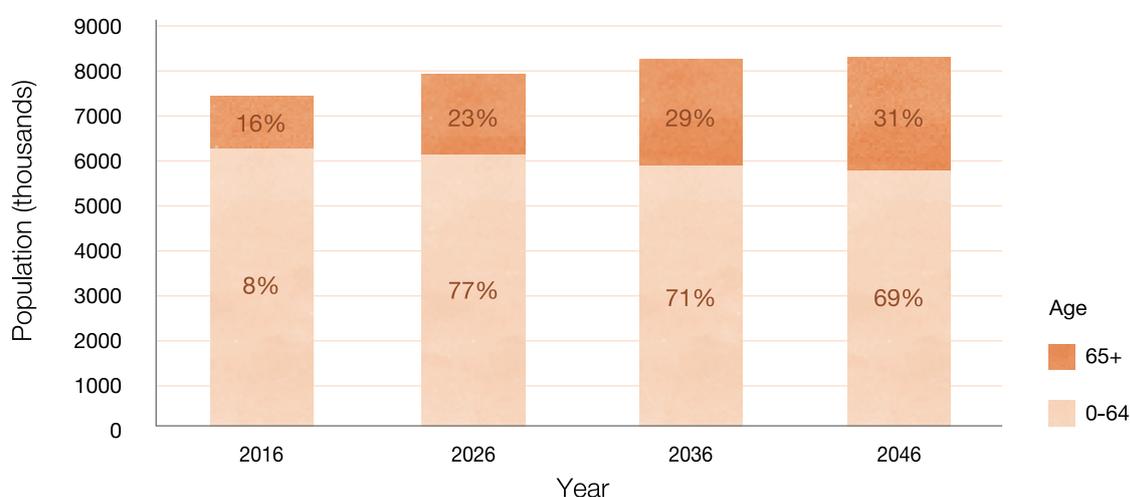
## *Contextual Factors for Driving the System Change*

There are some contextual factors that have provided the impetus for the development of the Strategic Service Framework for Palliative Care in HA, such as the growing evidence of palliative care, and the increasing need for palliative care as a result of an ageing population and the rising burden of chronic diseases. These factors are the main drivers for change in the system and are outlined in this chapter.

## Escalating Demand for Palliative Care Due to Population Ageing and Chronic Disease Burden

Hong Kong is challenged with an escalating demand for palliative care services due to an ageing population and a rising prevalence of chronic diseases. According to the latest population estimates and projections by the Census and Statistics Department, the proportion of elderly people aged 65 and above will grow from 16% in 2016 to 31% in 2046. The overall Hong Kong population will increase from 7.3 million to 8.2 million during the same period (Figure 3)<sup>8</sup>.

Figure 3. Hong Kong Population (2016 – 2046)

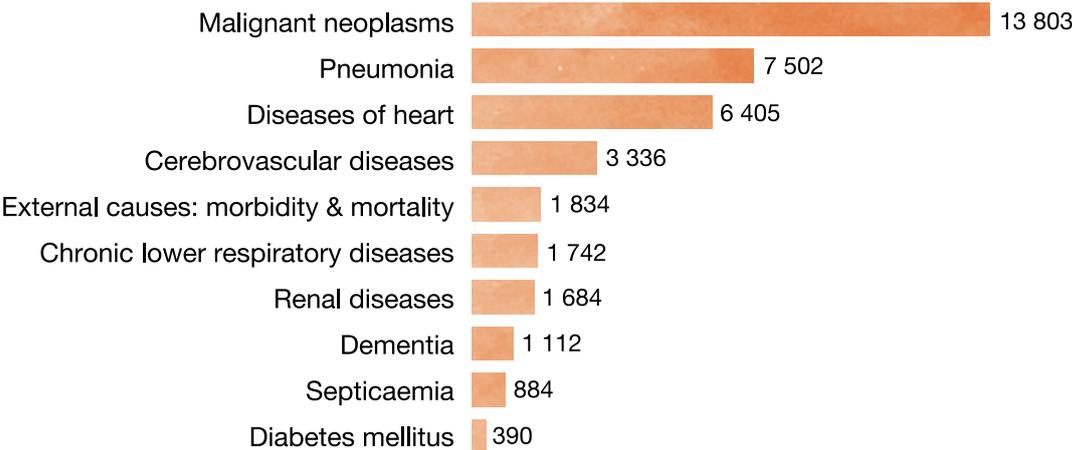


<sup>8</sup> Census and Statistics Department, Hong Kong Special Administrative Region. 2016 Population By-census and Hong Kong Population Projections 2015-2064.

Elderly people contribute to the majority of the mortality in Hong Kong. In 2014 there were approximately 46 000 deaths in Hong Kong<sup>9</sup>, among which nearly 80% were elderly people aged 65 or above, and of whom around 40% were residents of residential care homes for the elderly (RCHEs). While more elderly people live longer, the prevalence of chronic diseases is also on a rising trend. According to the Census and Statistics Department, 75% of elderly people suffered from one or more chronic conditions in 2014<sup>10</sup>. Cancer and other chronic diseases of the heart, respiratory, neurological and renal systems as well as diabetes mellitus accounted for about 60% of the deaths in Hong Kong (Figure 4)<sup>11</sup>.

Elderly people require more healthcare services, particularly the public services which are highly subsidised. For instance, elderly population aged 65 years or above accounted for around half of all the patient days in HA. The chance of an elderly person being hospitalised is about four times that of a non-elderly person, and the bed requirement in terms of general bed utilisation rate for elderly people is about nine times that of non-elderly people. Therefore, with the ageing population and chronic disease burden in Hong Kong, there will be a significant impact on the service demand of HA ranging from acute and curative care to palliative care services in supporting the various needs of patients along the care pathway. Concerted efforts on enhancing the palliative care services in HA are needed to cope with the rising demand and to ensure sustainability of the services.

Figure 4. Top Ten Causes of Deaths in Hong Kong (2014)



9 Immigration Department and Hospital Authority, Hong Kong Special Administrative Region.  
 10 Census and Statistics Department, Hong Kong Special Administrative Region. (2015). *Thematic Household Survey Report No. 58*.  
 11 Department of Health, Hong Kong Special Administrative Region. (2015). *Tables on Health Status and Health Services 2014*.

## HA's Unique Position in the Delivery of Palliative Care

As the major public healthcare provider in Hong Kong, HA is managing about 90% of the inpatient services (in terms of the number of bed days) in Hong Kong. The majority of patients suffering from a life-threatening or life-limiting illness are under the care of HA, which is reflected by the fact that about 90% of the approximately 46 000 deaths in Hong Kong in 2014 presented to or occurred in HA. While palliative care is not restricted to dying patients, many patients require palliative care support during the last phase of their life journey. Hence, the high number of dying patients passing through the HA system has put HA in a unique position of responsibility and opportunity to provide palliative care services to patients in need. Moreover, tasked with the responsibility of training healthcare professionals, HA has an important role in upholding the professional standard and building up a competent workforce for the delivery of quality palliative care, in addition to serving as the major provider of palliative care services.

## High Hospital Service Utilisation in Last Phase of Life

It is observed in local and international data that hospital service utilisation escalates in the last year of life<sup>12,13,14</sup>. On analysis of HA data in 2014, substantial utilisation by patients in their last year of life is noted in terms of Accident & Emergency (A&E) attendances, hospital admissions and patient days. The rise started in the last 6 months with the surge being seen in the final two months of life (**Figure 5**). This applied both to patients dying with cancers and those with end-organ failure. In particular, the average number of A&E attendances and patient days of elderly patients in their last year of life were five and ten times of other elderly patients respectively.

However, higher utilisation of healthcare services is not necessarily associated with higher quality of care<sup>15</sup>. Literature review shows that a significant number of seriously ill patients who would prefer palliative care found their medical care was at odds with their preference<sup>16</sup>. With the existing dominant focus on acute curative care in the system, it is crucial to reconsider whether the current service delivery models can effectively and adequately address the various needs of the patients and their families/carers along the care pathway of a serious illness.

12 Fassbender, K. et al. (2009). Cost trajectories at the end of life: the Canadian experience. *Journal of Pain and Symptom Management*; 38(1):75-80.

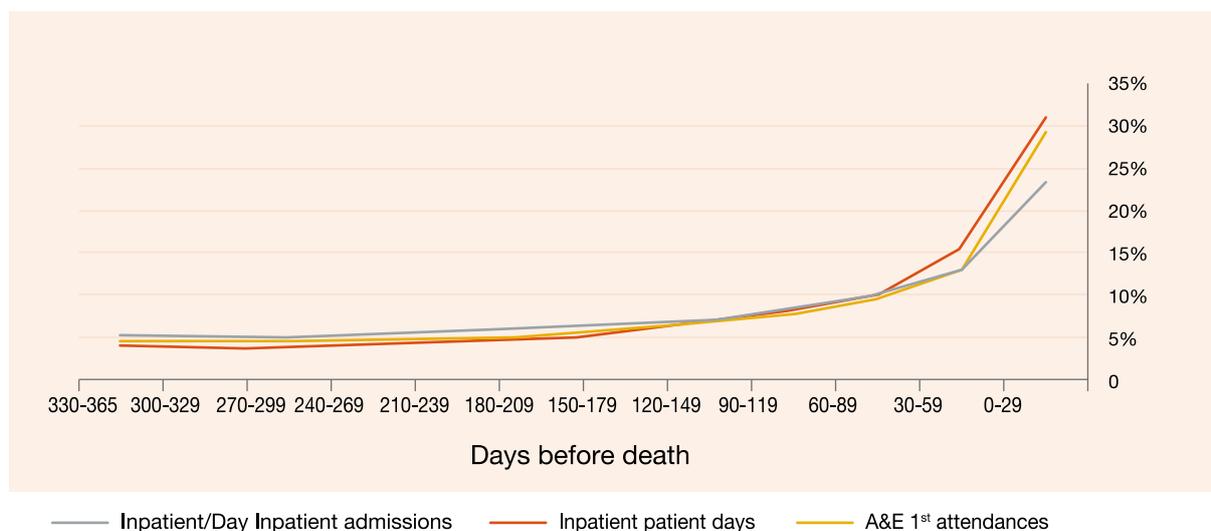
13 Menec, V. et al. (2004). *Patterns of Health Care Use and Cost at End of Life*. Winnipeg: Manitoba Centre for Health Policy.

14 Goldsbury, D.E. et al. (2015). Acute hospital-based services used by adults during the last year of life in New South Wales, Australia: a population-based retrospective cohort study. *BMC Health Services Research*; 15:537.

15 Fisher, E. et al. (2009). *Health Care Spending, Quality, and Outcomes: More Isn't Always Better*. The Dartmouth Institute for Health Policy & Clinical Practice.

16 Teno, J.M. et al. (2002). Medical care inconsistent with patients' treatment goals: association with 1-year Medicare resource use and survival. *Journal of the American Geriatrics Society*; 50(3):496-500.

Figure 5. Distribution of HA Hospital Service Utilisation in the Last Year of Life for Patients who Died in 2014



## Growing Evidence Supporting the Development of Palliative Care

With the introduction and adoption of an integrated approach in palliative care, more and more evidence is available supporting the development of palliative care services. Both overseas and local studies show that palliative care can improve pain and symptom control<sup>17,18,19</sup>, as well as the overall quality of life<sup>18,20</sup> during the patient's last stage of life. Greater patients' participation is enabled as there is a greater respect for patients' preference on treatment options<sup>19,20</sup>. At the same time, it can reduce sufferings while forgoing invasive yet futile interventions<sup>20,21</sup> and the unnecessary use of acute care services, such as visits to emergency departments, admission to acute care wards, and admission to intensive care units<sup>20,21</sup>. Furthermore, early palliative care services are beneficial to the families/carers in reducing their stress burden<sup>22</sup>.

Palliative care is therefore not simply a concept, and there is clear evidence demonstrating its role at both the patient and system level. Development of palliative care services has been regarded as one of the top priorities in the healthcare policy agenda worldwide<sup>23,24</sup>, as well as locally in HA.

17 Smith, T.J. & Cassel, J.B. (2009). Cost and non-clinical outcomes of palliative care. *Journal of Pain and Symptom Management*; 38(1):32-44.

18 Mueller, P.S. (2014). Community based specialist palliative care teams lead to less use of acute care at the end-of-life. *Journal Watch General Medicine*; 34(14):109-10.

19 Higginson, I.J. et al. (2003). Is there evidence that palliative care teams alter end-of-life experiences of patients and their caregivers? *Journal of Pain and Symptom Management*; 25(2):150-68.

20 Temel, J.S. et al. (2010). Early palliative care for patients with metastatic non-small-cell lung cancer. *New England Journal of Medicine*; 363(8):733-42.

21 Tse, D.M.W. et al. (2007). The impact of palliative care on cancer deaths in Hong Kong: a retrospective study of 494 cancer deaths. *Palliative Medicine*; 21(5):425-33.

22 Dionne-Odom, J.N. et al. (2015). Benefits of early versus delayed palliative care to informal family caregivers of patients with advanced cancer: outcomes from the enable III randomised controlled trial. *Journal of Clinical Oncology*; 33(13):1446-52.

23 National Palliative and End of Life Care Partnership, England. (2015). *Ambitions for Palliative and End of Life Care: A National Framework for Local Action 2015-2020*.

24 Department of Health and Ageing, Australia. (2010). *Supporting Australians to Live Well at the End of Life: National Palliative Care Strategy 2010*.

## Recognition of Palliative Care Needs in Paediatrics

Death and dying is not limited to elderly people or adults. There were around 260 deaths of age less than 18 in 2014 in Hong Kong. 83% of them occurred in HA. Though it only accounted for less than 1% among all the deaths, such infrequency does not suppress the need for developing palliative care to support paediatric patients and their families. Caring for a chronically ill or dying child is an enormous and complex task<sup>25</sup>. When a child dies, it is one of the most traumatic events a family can experience, with lasting physical and emotional effects<sup>26</sup>. Difference in disease spectrum and importance in addressing the developmental needs are recognised as the unique considerations in caring for sick children. However, the existing palliative care services in HA focuses on supporting adult patients, with no structured development of paediatric palliative care. Designated planning and development of service model for paediatric palliative care is therefore warranted.

In this context, there is a pressing need to have coordinated planning at the system level so as to better equip healthcare staff to address the challenges and improve the quality of palliative care services in HA. The overall background also helps in guiding the focus and informing the scope for formulation of the Strategic Service Framework for Palliative Care with an aim to drive system and cultural change.

25 Davies, B. et al. (1998). Development of paediatric palliative care. In: Doyle, D. et al. (editors) *Oxford Textbook of Palliative Medicine*. Second edition. Oxford: Oxford University Press, pp. 1011-117.

26 McSherry, M. et al. (2007). Psychosocial and spiritual needs of children living with a life-limiting illness. *Paediatric Clinics of North America*; 54:609-29.

# Planning Process

## *How We Developed the Strategic Service Framework for Palliative Care*

### Project Governance

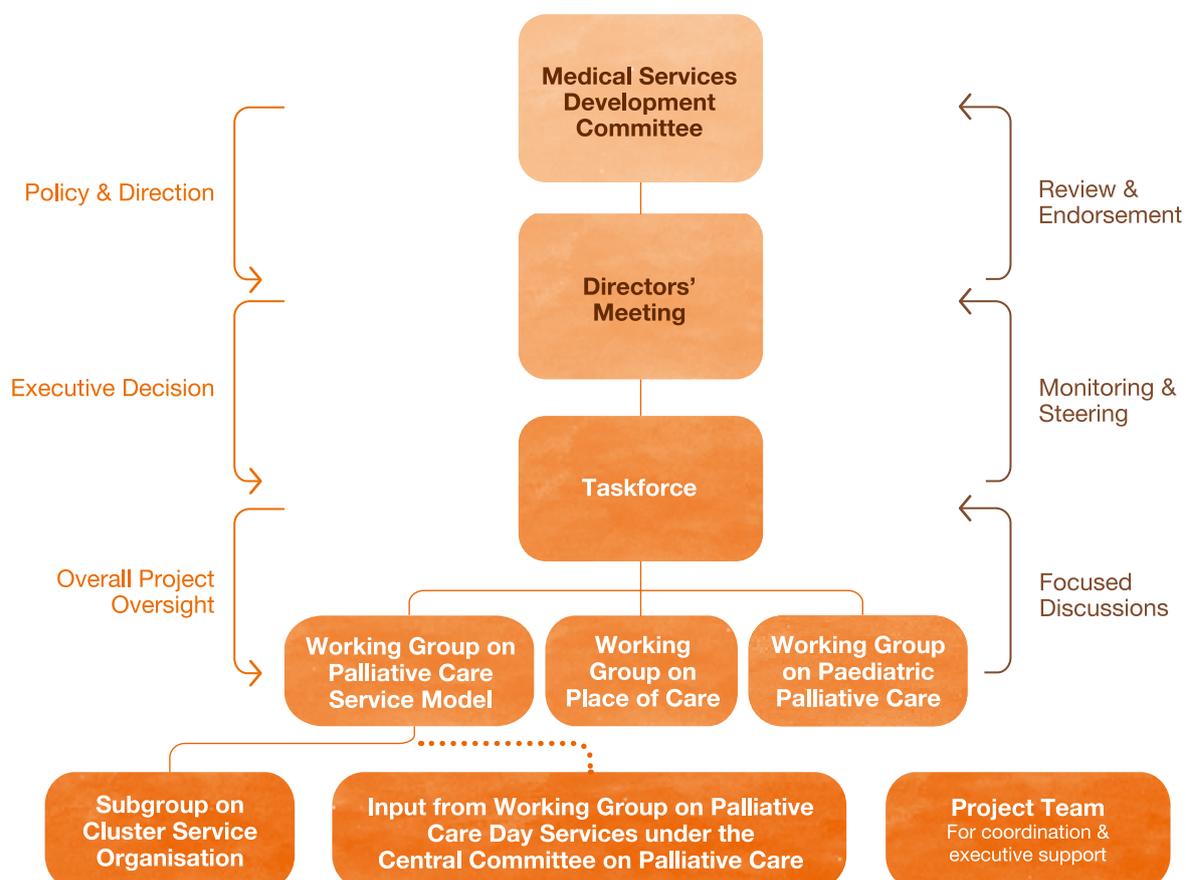
Under the policy directions and guidance of the Medical Services Development Committee (MSDC) and Directors' Meeting, a designated Taskforce was set up to oversee the development of the Framework. The Taskforce was co-chaired by the Director of Strategy and Planning Division and the Director of Cluster Services Division of HA. The terms of reference and membership of the Taskforce are set out in **Appendix 1**.

Under the Taskforce, Working Groups (**Appendix 2 to 4**) were formed to advise on the future service models and required system infrastructure for adult and paediatric palliative care. Discussions from the Working Group on Palliative Care Day Service of CC(Palliative Care) were also brought back to the Taskforce to inform the development of the Framework. Moreover, to enhance the organisation of palliative care services at Cluster level, a Subgroup (**Appendix 5**) was set up with representatives nominated from each of the seven Clusters to identify their service gaps and formulate Cluster-specific plans for enhancing the palliative care services in their respective Clusters.



A project team from the Strategy and Planning Division provided the overall executive support for developing the Framework. The governance structure of the project is illustrated in **Figure 6**.

Figure 6. Project Governance Structure



## Formulation Process

The development of the Framework commenced in early 2016. The process consisted of review on existing palliative care services, engagement of stakeholders, formulation and prioritisation of strategies, consultation and approval. A highly participative and broad engagement approach was adopted with the involvement of frontline clinical staff, Cluster management and Head Office executives, as well as patient groups.

During the formulation process, literature review was conducted so as to understand the development and service models of palliative care internationally. The project team also worked closely with clinical colleagues on statistical analysis to evaluate the existing utilisation pattern of palliative care services in HA and identify potential service gaps.

A Summit was conducted in which overseas experts from United Kingdom and Australia shared their views and experience on palliative care. The Summit was attended by around 40 key stakeholders involved in the planning and delivery of palliative care services in HA, including palliative care and non-palliative care specialist doctors, nurses and allied health (AH) professionals, as well as executives from Cluster and Head Office. Themed discussions were

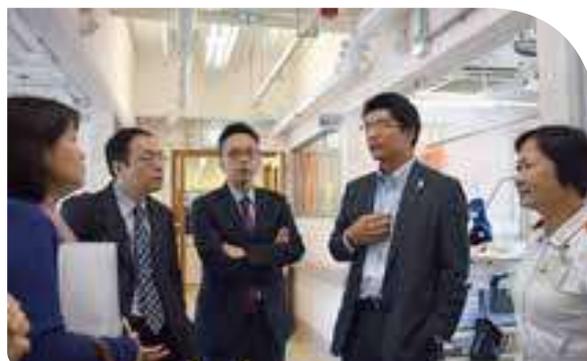


held during the Summit to gather ideas for informing the Framework's development. A trip to Taiwan was also arranged to gain exposure to the care model and practice of their palliative care services. In addition, a series of Working Group and Subgroup meetings were held for detailed discussion on the service models of adult and paediatric palliative care. Detailed plans were also formulated by the Clusters for enhancing their respective palliative care services with a focus on service organisation at the Cluster level.

In parallel, hospitals visits were carried out in all Clusters, which included palliative care facilities covering inpatient, ambulatory and community care. Prior to the visits, a survey was conducted to systematically collect information on the current service arrangement and facilitate in-depth discussions during the visits. Furthermore, briefings were made to relevant Coordinating Committees (COCs), Central Committees (CCs) and the Patient Advisory Committee (PAC), to update members on the progress of the Framework formulation and seek their views and input.

All the findings and recommendations were put forward to the Taskforce for formulating the Framework. Reports were also made to the Directors' Meeting and MSDC on a regular basis, with direction and advice sought from members.

Consultation on the draft Framework was conducted between 26 May 2017 and 22 June 2017, to solicit feedback and suggestions from key stakeholders. These included senior management, frontline clinical staff, relevant COCs, CCs, their sub-committees and working groups, other relevant committees, the PAC and related patient groups. The responses and comments received were carefully considered and deliberated by the Taskforce. Subsequently, the refined Framework was submitted to the Directors' Meeting for endorsement, followed by the MSDC for final approval.



Part Two

*Adult Palliative  
Care Services*



# Overview of Adult Palliative Care Services in HA

## *What We Are Doing Now*

Adult palliative care services in Hong Kong was first started by Our Lady of Maryknoll Hospital in 1982. Between 1986 and 1988, another four hospitals, namely the Ruttonjee Sanatorium, Haven of Hope Hospital, United Christian Hospital and Nam Long Hospital, also set up their adult palliative care services. After the establishment of HA in 1991, there was a steady growth of adult palliative care services in various public hospitals. Professional development also advanced with the establishment of professional societies, including the Hong Kong Society of Palliative Medicine and the Hong Kong Hospice Nurses Association in 1997, as well as the accreditation of the subspecialty of Palliative Medicine under the Hong Kong College of Physicians (HKCP) in 1998 and the Hong Kong College of Radiologists (HKCR) in 2002<sup>27</sup>.

Currently, adult palliative care services in HA are mainly provided by PC teams in 16 hospitals. The teams are led by palliative care specialists who are either working in the Department of Medicine (medical PC teams) or the Department of Clinical Oncology (oncology PC teams). Traditionally, oncology PC teams serve cancer patients only. Medical PC teams also used to serve cancer patients, but they have been extending their services to non-cancer patients in recent years due to patients' needs. The list of PC teams in the different Clusters is shown in the table below **(Table 1)**.

27 Chan, K.S. (2002). Two decades of palliative care. *Hong Kong Medical Journal*; 8(6):465-466.

Table 1. PC Teams in HA

	Oncology PC Team	Medical PC Team
Hong Kong East Cluster (HKEC)	Pamela Youde Nethersole Eastern Hospital (PYNEH)	Ruttonjee & Tang Shiu Kin Hospitals (RTSKH)
Hong Kong West Cluster (HKWC)	Queen Mary Hospital (QMH)	Grantham Hospital (GH)
Kowloon Central Cluster (KCC)	Queen Elizabeth Hospital (QEH)	Hong Kong Buddhist Hospital (HKBH) Our Lady of Maryknoll Hospital (OLMH)* Tung Wah Group of Hospitals Wong Tai Sin Hospital (WTSH)*
Kowloon East Cluster (KEC)	-	United Christian Hospital (UCH) Haven of Hope Hospital (HHH)
Kowloon West Cluster (KWC)	Princess Margaret Hospital (PMH)	Caritas Medical Centre (CMC)
New Territories East Cluster (NTEC)	Prince of Wales Hospital (PWH)	Bradbury Hospice (BBH) Shatin Hospital (SH)
New Territories West Cluster (NTWC)	Tuen Mun Hospital (TMH)	

\* Re-delineated from KWC to KCC with effect from 1 December 2016

Both medical and oncology PC teams are available in all Clusters except KEC, in which oncology service is yet to be fully provided. The oncology PC team of KCC is providing cross-Cluster palliative care support to KEC patients. NTWC is the only Cluster where both the medical and oncology PC teams are located in the same hospital. With the re-delineation of Cluster boundary between KWC and KCC effective from 1 December 2016, the medical PC teams in OLMH and WTSH have been regrouped from KWC to KCC.

## Governance Structure

At the Head Office level, CC(Palliative Care) oversees the palliative care services in HA and provides advice on service development. It comprises palliative care specialists, AH representatives, nursing representatives and Head Office executives. Its membership and terms of reference are set out in [Appendix 6](#).

At the Cluster level, Cluster Coordination Committees on Palliative Care Services have been established in all Clusters since 2013 to coordinate their respective palliative care services according to the policy overlay set by CC(Palliative Care). Each Cluster Committee is led either by the respective Cluster Chief Executive (CCE), Hospital Chief Executive or a Cluster Palliative Care Service Coordinator nominated by the CCE. Medical representatives from palliative care specialists (i.e. specially trained physicians and oncologists), nurses as well as AH professionals are key members of the Committees. In some Clusters, representatives of non-palliative care background, such as senior doctors from Medicine, Surgery and Anaesthesiology specialties, are also involved in the Committees.

## Key Members in Service Delivery

The provision of palliative care services in HA adopts a multi-disciplinary team approach to address the multi-faceted needs of patients and their families/carers. Doctors, nurses, medical social workers, clinical psychologists, physiotherapists, occupational therapists, dietitians, other AH professionals, spiritual workers and volunteers work as a team to provide holistic care. As at May 2016, there were over 40 doctors, 300 nurses and 60 AH full-time equivalent staff providing specialist palliative care services in HA. This includes seven Nurse Consultants (NCs) who are responsible for ensuring the nursing standards and protocols in palliative care in the respective Clusters.



## Service Scope

The scope of HA palliative care services covers the continuum of care from hospital to community settings. There are four main service components, including inpatient and consultative, ambulatory, community and bereavement care.

### Inpatient and Consultative Palliative Care Service

As at 31 December 2016, there were over 360 palliative care beds in HA. Palliative care inpatient services mainly provide services to patients with complex symptoms and psychosocial problems that require day-to-day medical intervention. It also provides services for the imminently dying patients.



advanced progressive diseases, who have significant symptoms or complex psychological problems that require palliative care but still under the care of the parent team.



Since many terminally ill patients in need of palliative care are admitted to other specialties (e.g. Medicine, Surgery) for treatment, palliative care specialists also provide palliative consultative service in the wards of other departments for these patients and their families/carers. Palliative consultative services cover patients hospitalised in other departments with

## Ambulatory Palliative Care Service

Ambulatory palliative care service includes specialist outpatient clinics (SOPCs) and day care services. It plays an important role in facilitating early discharge of patients and reducing unnecessary or avoidable readmissions.

Specialist outpatient care is one of the important pillars of palliative care. The outpatient clinics provide support to terminally ill patients living in the community with the presence of symptoms that require specialist care for symptom palliation and complicated psychosocial problems relating to their disease.

Moreover, HA has set up a number of palliative day care centres to strengthen the different modalities of physical and psychosocial support for terminally ill patients and their families/carers, including interventional therapeutic procedures and consultation, pain management programme and psychosocial support programme. Working in partnership with non-governmental organisations (NGOs), volunteers and the Patient Resource Centres (PRCs), the palliative day care centres also organise a wide array of activities and provide volunteering services to suit different needs of patients and their families/carers and improve their overall well-being.



## Community Palliative Care Service

Patients facing terminal illness and living in the community often have difficulties commuting to the hospital/clinic to receive ambulatory treatment. They may also prefer to spend their last stage of life in their familiar environment. In this context, palliative home care service has been playing a vital role to support patients in the community and reduce unnecessary hospitalisation. Palliative home care team is



an integral part of the HA palliative care services, providing outreach symptom management and monitoring, psychosocial and spiritual care, ACP, care coordination, counselling and bereavement support to patients in the community setting.

In addition to the support for patients living at home, in recent years HA has also strengthened palliative care for elderly patients living in RCHEs through the Community Geriatric Assessment Team (CGAT) service. Starting from 2015-16, an EOL care programme has been piloted by CGATs to provide better support for terminally ill residents living in RCHEs. CGATs work in partnership with the hospital PC teams, and collaborate with RCHEs and NGOs to enhance the medical and nursing care of elderly residents facing terminal illness and to provide training to RCHE staff. The programme started with four CGATs (RTSKH, FYKH, SH, TMH) in 2015-16, and was extended to the CGATs of QEH/KH as well as CMC in 2016-17.



The EOL care programme is a tripartite collaboration among healthcare professionals, patients and their families/carers, and RCHE staff. Suitable RCHE residents are identified by CGAT or RCHE staff for CGATs' assessment on the readiness of patients and/or their families/carers for ACP discussion. The goals and preferences of care options for the patients' final stages of life are discussed with the patients and their families/carers during the ACP process. They are documented in the RCHEs' as well as the patients' clinical records by the CGATs, with regular reviews especially when there is a change in the patients' condition. This facilitates communication with stakeholders in different settings to provide care according to patients' wish as far as practicable. There is also coordination among HA departments (e.g. A&E and inpatient services) and RCHEs so as to enable support at appropriate settings.



Evaluation of the programme has shown positive outcomes, with high adherence to the patients' preference on care options according to ACP, including 95% adherence for DNACPR and 100% adherence for refusal of tube feeding and ventilator support. Coordinated admission was also arranged for around 60% of the patients from RCHEs where needed.

## Psychosocial Care and Bereavement Service

HA has improved palliative care psychosocial services for terminally ill patients as well as bereavement services for their families/carers by introducing a stepped-care service model in 2012-13, and strengthening services provided by medical social workers and clinical psychologists. This involves early identification of patients and families/carers at higher risk of suffering from severe psychosocial distress, and the provision of professional psychosocial and emotional intervention (e.g. crisis intervention, psychotherapy, in-depth counselling, adjustment and coping empowerment).

Patients and families/carers' needs are addressed and assessed using standardised assessment measures throughout the patient journey, with attention given to those points known to be particularly challenging, such as from curative to non-curative phase, at EOL/dying phase, and after death (for families/carers). Practical and emotional support is offered according to their needs. Those assessed to be of high risk will be referred to clinical psychologists for specialist psychological intervention (e.g. psychotherapy, cognitive behavioural therapy). Families/carers who require assistance with their bereavement will receive psychosocial support to facilitate a normal grieving process and to prevent the occurrence of complicated grief or other detrimental consequences of bereavement.



## Other Supportive Services

Indispensable partners of the PC teams are volunteers, who generously offer their time, talents and endless energy to support our patients. With appropriate training, they offer friendship and practical help that improves the quality of life of adults and children living with a life-limiting illness, and their families/carers. The social and emotional support they provide carries a significant impact to the patients and their families/carers. Activities include experience sharing, support groups, social functions (e.g. festival events, birthday party), visits to ward or home, etc. HA regularly organises training programmes for volunteers so as to improve their knowledge and skills in supporting terminally ill patients.

There are also various NGOs and patient groups actively supporting the provision of palliative care. Examples of their services include recreational activities (e.g. game activities, family photo taking, outing), promoting life and death education, complementary therapy (e.g. art therapy, music therapy), organising various training workshops, as well as providing community support for terminally ill patients and bereavement care for their families/carers.



# Key Areas Identified for Improvement in the Current Practice

## *What We Need to Improve on*

A comprehensive review has been conducted on the adult palliative care services in HA to identify areas for improvement, so that strategies could be formulated in the Framework to address the issues. The process involved structured analysis of hospital survey return, a series of hospital visits and Cluster-based discussion, as well as Working Groups and Subgroup meetings. Four key areas for improvement have been identified: (i) governance and organisation of service; (ii) care coordination; (iii) place of care; and (iv) performance monitoring.

## Governance and Organisation of Service

### Organisation of Palliative Care Services

At present, adult palliative care services are mainly department or hospital-based and are divided into medical and oncology PC teams, which are usually located in different hospitals. Cross-support between departments and hospitals is suboptimal under this service organisation, which has led to variable access to palliative care services among hospitals as well as among different types of patients. For hospitals that do not have their own PC team, patients' access to palliative care services is relatively limited.

Even for hospitals with a PC team, the coverage is limited by whether the team is led by the medical or oncology department. For example, in a hospital with only an oncology PC team, patients suffering from non-cancer diseases (i.e. non-cancer patients) and thus are not under the care of the oncology department are less likely to receive palliative care services. Overall, the palliative care coverage for non-cancer patients is lower than for cancer patients. According to service data in 2012-13, around 68% of cancer patients had received palliative care, compared to around 44% of patients suffering from end-stage renal failure (ESRF) who had received the relevant service. This is because both medical and oncology PC teams serve cancer patients, but non-cancer patients are covered mainly by the medical PC teams.

Moreover, the setup among different PC teams varies in terms of manpower establishment and facilities. Cross-support and collaboration between PC teams are not common, which limits the service development. For example, both the medical and oncology PC teams organise their own home care teams as well as manage their own day care facilities. As such, patients under the care of a medical PC team without day facilities cannot receive services provided in the day centre operated by an oncology PC team in the same hospital/Cluster. Nursing manpower also varies among the home care teams, leading to different levels of care provision to patients with the same needs.

## **Role of Cluster Coordination Committee on Palliative Care Services**

Although Cluster Coordination Committees on Palliative Care Services are established in all the Clusters, there is room to further enhance their roles in service coordination and development. Some Cluster Committees are more active than the others, and demonstrate better linkage between the Cluster Committees and CC(Palliative Care) at the corporate level. The service development is usually better aligned with the policy direction in these Clusters.

Composition of the Committees varies among different Clusters. For instance, in some Clusters the Committees have not involved the NC(Palliative Care) and AH professionals, who are important players in the palliative care service. The Cluster management team or representation from different hospitals within a Cluster is sometimes not involved in the Committees. It is believed that the composition of the Cluster Coordination Committees has contributed to the observed differences in palliative care services across different hospitals of the Clusters.



## Care Coordination

Not all patients with life-limiting and life-threatening conditions who require palliative care are under the care of palliative care specialists. In fact, the patients are mostly taken care of by healthcare teams in other specialties, for example the surgical team in the management of colorectal cancer patients; renal physicians in the management of chronic renal failure patients, etc. These non-palliative care specialists are commonly referred to as the “parent team” of the patients. Hence, care coordination is indispensable in the delivery of palliative care to meet the patients’ needs, particularly between the palliative care and non-palliative care specialists.

### Collaboration between Palliative Care and Non-Palliative Care Specialists

Adult palliative care services in HA currently relies heavily on palliative care specialists, while the majority of the non-palliative care specialists focus on providing curative care in managing the disease conditions of their patients. Awareness and knowledge of palliative care are limited among the non-palliative care specialists and they often hold on to the traditional hospice concept, thinking that palliative care is a last resort to be provided at the last phase of life when possible curative means are exhausted. This affects the timeliness and accessibility of palliative care for patients requiring the service, including the initiation of discussion on ACP to address patients’ needs and preference along the disease progression. Instead of integrating palliative care in their practice, referrals are often made by the parent teams to the palliative care specialists at the very end stage when curative or disease-modifying treatment is no longer effective for a patient, and are mostly aimed at handing the patient over to the PC team for EOL care. Meanwhile, due to limited service capacity, the PC teams have to prioritise their services to cater for patients with more complex or imminent needs.

Collaboration between palliative care and non-palliative care specialists is only at the starting phase in HA. Successful examples of recent initiatives include collaboration with renal physicians on palliative care service for patients with ESRF, and the EOL care programme in RCHes through collaboration with the CGATs led by geriatricians. Other collaboration formats include PC teams working with the surgical specialties to support cancer patients, and conducting joint pain clinic with pain specialists or anaesthetists. Overall, there are still considerable gaps in the service coverage and accessibility of palliative care, particularly for patients with non-cancer conditions other than ESRF, such as cardiac, pulmonary and neurodegenerative diseases, and dementia. The situation urges the development of a structured service model and key enablers for better coordinated care.

## Place of Care

Most of the patients prefer to be cared for at their usual place of residence where they can take comfort in a familiar environment and being surrounded by their loved ones<sup>28</sup>. However, service data shows that there are repeated A&E attendances and acute hospital admissions for patients in their last year of life, especially during the last six months of life. Acute hospitalisation may be stressful to the patients or their families/carers if the goal of palliation is unmet, and put significant pressure on the healthcare system inappropriately. Limitations of palliative care services in the ambulatory and community settings may have accounted for the high hospital utilisation.

## Day Care Setting

Although palliative day care services are available in all the Clusters, the target groups of patients and service components are not aligned among them, resulting in variation in service provision. While they all provide multi-disciplinary support for patients and their families/carers covering their physical and psychosocial needs, some of the palliative day care centres put more focus on the social and recreational aspects, such as educational activities and birthday or festival celebrations. Meanwhile, the provision of therapeutic procedures such as abdominal tapping and blood transfusion is available in only some of the palliative care day settings, because only some of the hospitals have designated day beds for palliative care. Patients requiring these procedures in the other hospitals will have to be admitted to the inpatient wards. There is a need to delineate the roles of palliative day care service in the care pathway in order to allow patients to continue staying in the community with their loved ones and reduce unnecessary hospitalisation.

## Community Setting

Both the medical and oncology PC teams organise their own home care teams, which limits any possible synergistic effect, such as sharing of expertise and pooling of manpower. This arrangement also affects the level of support and service coverage for patients with cancer or non-cancer conditions residing in different parts of the Clusters.

28 Chung, R. et al. (2017). Knowledge, attitudes, and preferences of advance decisions, end-of-life care, and place of care and death in Hong Kong. A population-based telephone survey of 1067 adults. *Journal of the American Medical Directors Association*; 18(4):367.e19-367.e27.

Meanwhile, there are some duplication between the existing palliative home care service and the Community Nursing Service (CNS), which provides support to the discharged patients requiring nursing care and treatment. The same patient may receive home visits made by both the palliative home care nurse and CNS nurse. Therefore, there is a need to develop a clear role delineation and collaborative model for patient-centred, coordinated and sustainable service delivery.

The EOL care programme provided by CGATs in the RCHEs has shown positive outcomes according to an evaluation, but barriers have also been identified, particularly the acceptance and readiness of hospital staff, RCHE staff, patients and their families/carers with regard to palliative care. Enhancement, such as education to raise awareness and knowledge of palliative care, is required for expanding the programme.

Apart from the EOL care programme in RCHEs, there is generally a lack of structured partnership with the social sector to provide palliative care support for patients in the community. Although there are some collaboration with community partners, such as NGOs, patients groups and volunteer services, the degree of linkage varies among PC teams, resulting in variable level of support available to patients and families/carers. For instance, some PC teams provide the information for patients and families/carers to access the community resources on their own, while others link up patients with community resources through palliative care nurses or medical social workers. More structured collaboration is required to better mobilise the community resources and support patients in the community.

## Performance Monitoring

Another key area for improvement relates to the systematic monitoring of palliative care services in terms of quality and performance. Currently, the available data in our system are generally quite inadequate for identifying service gaps and for benchmarking across units. The palliative care services are mostly monitored on their service throughputs on a regular basis. With regard to quality and performance monitoring, the PC teams use their local database on service utilisation and outcome measurement of patients under their care, which are not aligned or standardised across HA, and the data are captured manually. Moreover, different measurement tools are adopted by different teams on symptom severity and functional performance. Although CC(Palliative Care) has coordinated clinical audits and programme evaluation for the service, standardised quality indicators have yet to be developed for systematic performance monitoring and for informing service planning.

# Strategic Service Framework for Adult Palliative Care Services

## *What We Are Going to Do*

Based on the key areas identified for improvement, and with reference to international practice and local experience, a comprehensive strategic service framework is formulated for adult palliative care. It is aimed at achieving the vision that all patients facing life-threatening and life-limiting conditions and their families/carers will receive timely, coordinated and holistic palliative care to address their physical, psychosocial and spiritual needs, and are given the opportunities to participate in the planning of their care, so as to improve their quality of life till the end of the patients' life journey.

## Strategic Framework

There are four strategic directions in the Framework. Under each direction, strategies are formulated to address the existing issues and improve adult palliative care services in HA. Key enablers are also identified to facilitate effective implementation of the Framework. The table below summarises the Framework, while details of the strategic directions and strategies are outlined subsequently in this chapter.



<b>Areas for Improvement</b> <i>(What we can do better)</i>	<b>Strategic Directions</b> <i>(Where we are going)</i>	<b>Strategies</b> <i>(How we will get there)</i>
<b>Governance and Service Organisation</b>	Enhance governance by developing Cluster-based services with the collaboration of medical and oncology palliative care specialists	<ul style="list-style-type: none"> <li>• Strengthen collaboration between medical and oncology palliative care specialists to develop Cluster-based services</li> <li>• Reinforce the role of Cluster Coordination Committee on Palliative Care Services to support Cluster-based service organisation</li> </ul>
<b>Care Coordination</b>	Promote collaboration between palliative care and non-palliative care specialists through shared care model according to patients' needs	<ul style="list-style-type: none"> <li>• Stratify patients' palliative care needs for shared care</li> <li>• Integrate palliative care into the care pathway for early identification of patients in need and initiation of ACP</li> <li>• Strengthen specialist palliative consultative service in non-palliative care settings</li> </ul>
<b>Place of Care</b>	Enhance palliative care in the ambulatory and community settings to support patients and reduce unnecessary hospitalisation	<ul style="list-style-type: none"> <li>• Refine and align palliative care day service</li> <li>• Expand palliative home care service</li> <li>• Enhance palliative care support to elderly patients in care homes</li> <li>• Enhance medical-social collaboration to support palliative care in the community</li> </ul>
<b>Performance Monitoring</b>	Strengthen performance monitoring for continuous quality improvement	<ul style="list-style-type: none"> <li>• Enhance data collection with standardisation of data capture and alignment of measurement tools</li> <li>• Identify key domains and develop indicators for evaluation and monitoring of clinical outcomes and service quality</li> </ul>

## **Strategic Direction 1: Enhance Governance by Developing Cluster-based Services with the Collaboration of Medical and Oncology Palliative Care Specialists**

Enhancing the governance of adult palliative care services is the cornerstone of the overall service development. The direction is set towards Cluster-based service organisation with collaboration between medical and oncology palliative care specialists. This is in accordance with the corporate direction outlined in HA Strategic Plan 2017-2022, which promotes the development of Cluster/network-based services to improve collaboration between specialties for more streamlined care, as well as to support the concentration of expertise and optimal use of facilities. Key strategies are outlined below.

### **Strengthen Collaboration between Medical and Oncology Palliative Care Specialists to Develop Cluster-based Services**

In contrast with the existing department-based service arrangement, which is bounded by specialty and hospital, a Cluster-based service organisation is envisioned for palliative care in HA under the Framework. It is underpinned by collaboration between medical and oncology PC teams, with clinical leadership from the palliative care specialists to support both cancer and non-cancer patients in all hospitals of the Clusters. This enables the pooling and sharing of expertise as well as optimal use of facilities and resources between the medical and oncology PC teams for more accessible palliative care at the Cluster level.

In each Cluster, a coordinated service network covering inpatient, ambulatory and community palliative care services is put in place to support all patients and families/carers in need. It is to be facilitated through common clinical management protocols and multi-disciplinary guidelines, regular sharing sessions between teams in terms of case conferences or joint ward rounds, and joint training activities on palliative care for healthcare staff from different specialties and hospitals in the Clusters.

## **Reinforce the Role of Cluster Coordination Committee on Palliative Care Services to Support Cluster-based Service Organisation**

While CC(Palliative Care) continues its role in overseeing the overall palliative care services at the corporate level, its membership has to be reviewed to adopt Cluster-based representation instead of the existing hospital-based composition. Structured linkage should also be established between CC(Palliative Care), the Coordination Committees on Palliative Care Services in the Clusters, as well as COCs/CCs of other relevant specialties and services to coordinate the overall palliative care services in HA.

The existing Cluster Coordination Committees on Palliative Care Services have to be empowered, with roles and accountability strengthened for the development of Cluster-based services. The enhanced governance structure is aimed at improving the access to palliative care for both cancer and non-cancer patients under the care of different specialties and hospitals in the Clusters. The Committees are responsible for coordinating the service planning, resources bidding, implementation and monitoring of palliative care services of their respective Clusters.

The membership of the Committees should therefore be reviewed and enhanced with the inclusion of all relevant key stakeholders from the various disciplines and specialties, including palliative care specialists, NC(Palliative Care) and AH professionals. In particular, the involvement of Cluster management in the Committees is essential to facilitate the execution of Cluster-based services in terms of governance, resources management and administrative support. Representatives from hospitals with no PC teams, as well as other non-palliative care specialties such as medical and surgical stream specialties, A&E and pain specialists should also be considered. Meetings should be held regularly so that the roles and functions of the Committees can be executed effectively.



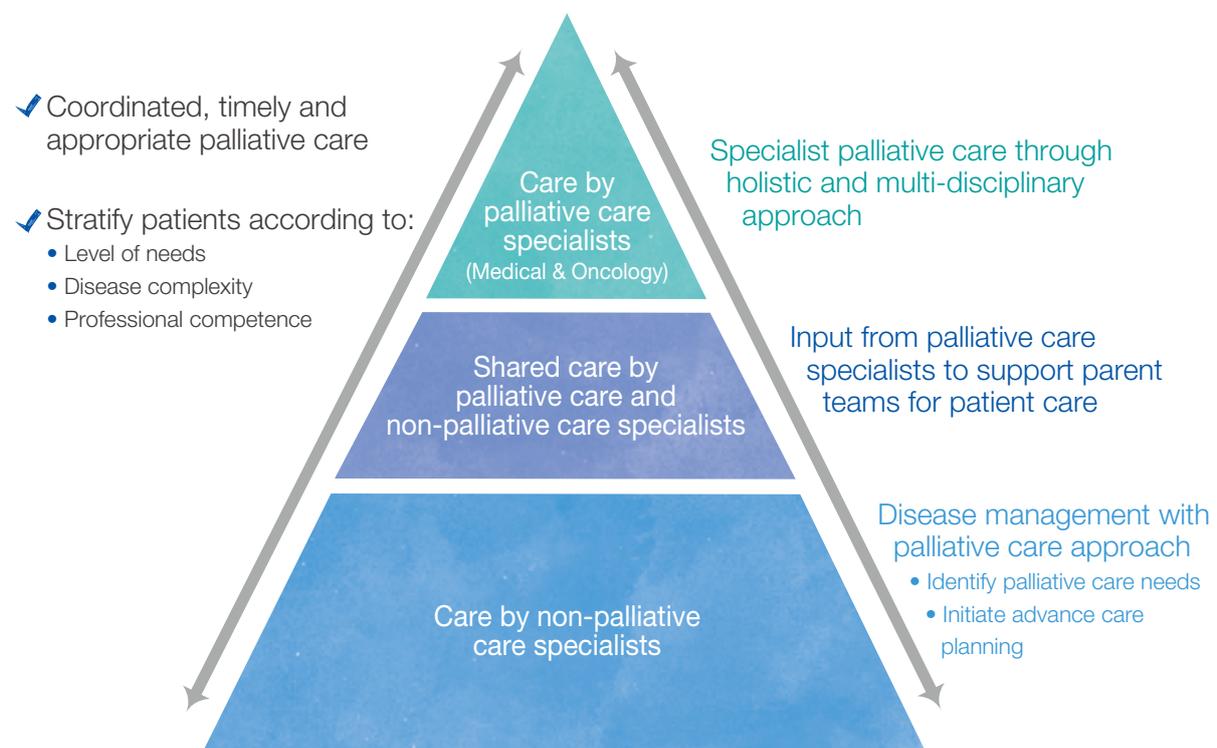
## Strategic Direction 2: Promote Collaboration between Palliative Care and Non-Palliative Care Specialists through Shared Care Model According to Patients' Needs

There is growing evidence worldwide supporting the partnership between palliative care and non-palliative care specialists for the delivery of sustainable, timely and accessible palliative care<sup>29</sup>. Moreover, capacity building is required through their collaboration using a shared care model in order to cope with the escalating service demand. Instead of simply adding a layer of specialist palliative care for every patient with a life-threatening or life-limiting illness, a needs-based approach is advocated by matching the appropriate level of service response to the needs of patients and with the participation of non-palliative care specialists<sup>30</sup>. Key strategies relating to the shared care model are outlined below.

### Stratify Patients' Palliative Care Needs for Shared Care

Patients are stratified for shared care between palliative care and non-palliative care specialists according to their level of needs, their disease complexity and the professional competency of their care teams in palliative care, as illustrated in **Figure 7**.

Figure 7. Shared Care Model between Palliative Care and Non-Palliative Care Specialists



29 Quill, T.E. et al. (2013). Generalist plus specialist palliative care – creating a more sustainable model. *New England Journal of Medicine*; 368:13.

30 Palliative Care Australia. (2005). *A Guide to Palliative Care Service Development: A Population Based Approach*.

Under the shared care model, majority of the patients whose palliative care needs are not complex are continued to be taken care of by the parent teams for the basic management of pain, other physical symptoms and psychosocial problems. For cases with complex palliative care needs but still requiring active input from the parent teams on managing the disease conditions



and hence have to remain under the care of non-palliative care specialists, they are co-managed by both the parent teams and palliative care specialists for holistic care through consultative support, case conferences, and joint clinics or ward rounds. Only patients with highly complex palliative care needs or difficult symptoms are taken care of by the palliative care specialists in a palliative care setting. This way, timely and appropriate level of service is provided to all patients requiring palliative care at any stage in a serious illness, ranging from symptom control, psychosocial support, care at the end of life, to bereavement support for families/carers.

Dynamic changes occur in the patients' condition as well as their level of needs. The model acknowledges these changes and stresses the importance of stratification to the appropriate care team according to the patients' changing needs. This is enabled by structured referral mechanism and detailed referral criteria. Link nurses are identified in the non-palliative care settings as a contact point to facilitate care coordination and the integration of palliative care into the practice of different specialties.

## **Integrate Palliative Care into the Care Pathway for Early Identification of Patients in Need and Initiation of ACP**

For the shared care model to work, palliative care has to be integrated into the care pathway of patients suffering from a life-threatening or life-limiting illness regardless of the specialties of their care team. According to WHO, it is an ethical duty for healthcare professionals to provide palliative care for patients in need<sup>31</sup>. With training and skills transfer, all healthcare professionals working in non-palliative care settings, especially the parent teams who are managing the patients' disease conditions should be able to identify the palliative care needs of patients and their families/carers. Clinical triggers such as the surprise question (i.e. "would you be surprised

31 World Health Organisation. *Fact Sheet No. 402: Palliative Care*. Available at: [www.who.int/mediacentre/factsheets/fs402/en](http://www.who.int/mediacentre/factsheets/fs402/en)

if this patient were to die in the next six to 12 months?”), general indicators of decline in terms of deteriorating physical conditions and functional performance, as well as disease-specific indicators for cancer and end-organ failure conditions are important tools to help proactive identification and triggering of palliative care support<sup>32</sup>.

It is also the responsibility of the parent team to initiate ACP discussion with patients and their families/carers. The ACP facilitates communication on the anticipated progression and prognosis of the disease, discussion on available treatment options, and expression of wishes and preferences by the patients and families/carers for future medical or personal care, such as place of care, treatment and feeding options as well as AD on refusal of life-sustaining treatment. Positive outcomes of ACP include improved patient satisfaction, reduced unnecessary sufferings, and enhanced concordance with patient and family wishes<sup>33</sup>. Documentation with regular reviews and ongoing discussion is required along the care journey.

## **Strengthen Specialist Palliative Consultative Service in Non-Palliative Care Settings**

Palliative consultative service by specialist PC teams has to be strengthened as a key component of the shared care model. It is instrumental to provide proper support to the parent teams when they encounter difficulty in managing patients with palliative care needs. It has been shown to be effective in improving patient experience, reducing readmission and facilitating hospital discharge<sup>34,35</sup>.

The PC consultative team consists of palliative care specialist, palliative care nurse and AH professional, in particular medical social worker. They serve as a mobile team for the co-management of patients with the parent teams in non-palliative care settings. The scope of consultative services includes symptom management, joint ACP, discharge planning with coordination of post-discharge care, anticipatory prescribing at end of life and carer support for relatively complex cases.

It is a priority to provide palliative consultative service to those hospitals with no PC teams and for those patients with non-cancer conditions such as end-stage organ failure in order to address the existing service gaps.

32 Thomas, K. et al. (2011). *Prognostic Indicator Guidance*. Shrewsbury: The Gold Standards Framework Centre in End of Life Care Community Interest Company.

33 Henry, C. et al. (2007). *Advance Care Planning: A Guide for Health and Social Care Staff*. London: Department of Health.

34 Gade, G. et al. (2008). Impact of an inpatient palliative care team: a randomised controlled trial. *Journal of Palliative Medicine*.

35 Hospital Authority Convention. (2015). *Nurse Consultant Consultative Services to Yan Chai Hospital*.

### **Strategic Direction 3: Enhance Palliative Care in the Ambulatory and Community Settings to Support Patients and Reduce Unnecessary Hospitalisation**

It is important to provide palliative care support to patients and their families/carers in the community in order to facilitate care in place and reduce unnecessary hospitalisation, which helps to relieve the stress of both patients/carers and the healthcare system. The emphasis is on enhancing day care, home care, support to residential care homes, and community partnership, with strategies as outlined below.

#### **Refine and Align Palliative Care Day Service**

Palliative care day service provides one-stop integrated and multi-disciplinary care. Its service model is aligned within and across Clusters in order to better support both cancer and non-cancer patients living in the community. Its service components are also refocused to provide interventional therapeutic procedures and programme-based services. Examples of the therapeutic procedures include administration of intravenous fluid and medication, blood transfusion, as well as chest and abdominal tapping. Protocol-based programmes that are developed with defined selection criteria and discharge mechanism include those for symptom control such as pain, dyspnea and fatigue management; and for rehabilitation purpose such as metastatic spinal cord compression. By providing timely and fast track support to patients with symptoms and needs that can be handled in day settings, palliative care day service enables patients to stay in the community, avoiding unnecessary hospitalisation.



## Expand Palliative Home Care Service

Palliative home care service should be expanded to cope with the growing service demand in the continuity of care for discharged patients who have relatively complex palliative care needs and are not fit to attend ambulatory care programmes. A case management approach is adopted with palliative home care nurses as the care coordinators. Patients are triaged using standard assessment before appropriate



services are arranged, with the level of care defined in terms of the frequency and duration of home visits. Services such as on-site assessment and intervention, carer support, phone consultation and coordinated admission are provided according to patient needs.

The home care teams are organised as Cluster-based teams to support both cancer and non-cancer patients residing in different districts of the Clusters. The teams are supported by palliative care specialists and AH professionals for the delivery of trans-disciplinary care. There is also collaboration between palliative home care nurses and CNS nurses, with role delineation, bi-directional skills transfer and close cooperation under the principle of shared care model as set out previously. Referral mechanism and structured communication platforms are needed to facilitate cross-support between the palliative home care nurses and CNS nurses for the provision of coordinated and appropriate care to discharged patients.

## Enhance Palliative Care Support to Elderly Patients in Care Homes

The plan is to further expand the CGAT EOL care programme to more RCHEs, so that it is extended to cover more patients in all the Clusters. To address the barriers identified during the pilot, collaboration between CGAT and PC teams as well as coordination within the hospitals needs to be strengthened. This includes skills transfer from the PC teams to CGAT and RCHEs staff through structured training, clinical attachment and on-site coaching. Referral mechanism should also be established for the management of complex cases through regular case conference and joint visits.

## Enhance Medical-social Collaboration to Support Palliative Care in the Community

Community resources should be better mobilised to complement the palliative care services in HA. This is carried out through enhanced collaboration with community partners such as NGOs, patient groups and volunteers to support patients and families/carers in the community, especially with regard to personal and social care, patient and carer empowerment, and public education. Examples of support services provided by community partners include escort service, equipment loan, respite care, haircut, bathing, meal preparation, celebration activities (e.g. birthday and festival celebrations), practical help in funeral proceedings, peer support groups and other psycho-spiritual support.



In addition to linkage through palliative care nurses and medical social workers, the role of PRCs in HA hospitals should also be strengthened to act as a bridge between the clinical teams and community partners in helping patients and families/carers to access the community resources. Building on the experience from the EOL care programme in RCHEs, more structured

collaboration with NGOs and Social Welfare Department is to be developed to promote coordination between the medical and social sectors at the system level.

## **Strategic Direction 4: Strengthen Performance Monitoring for Continuous Quality Improvement**

Systematic monitoring of the quality and outcomes of palliative care services is instrumental to drive service improvement. Strategies include enhancing data collection and developing quality indicators for continuous performance monitoring.

### **Enhance Data Collection with Standardisation of Data Capture and Alignment of Measurement Tools**

Along the palliative care pathway, there are various data concerning the structure, process, output and outcome of the service. Apart from throughputs data, other useful parameters for performance monitoring should also be deliberated and agreed upon for systematic data capture. Standardisation of data definition and collection mechanism is crucial to ensure high quality of source data for further analysis. Instead of relying on local manual return, automated system should be put in place to facilitate systematic data collection. For those parameters requiring measurement tools, such as symptoms severity and performance status, alignment of measurement tools is required so as to allow benchmarking across HA.

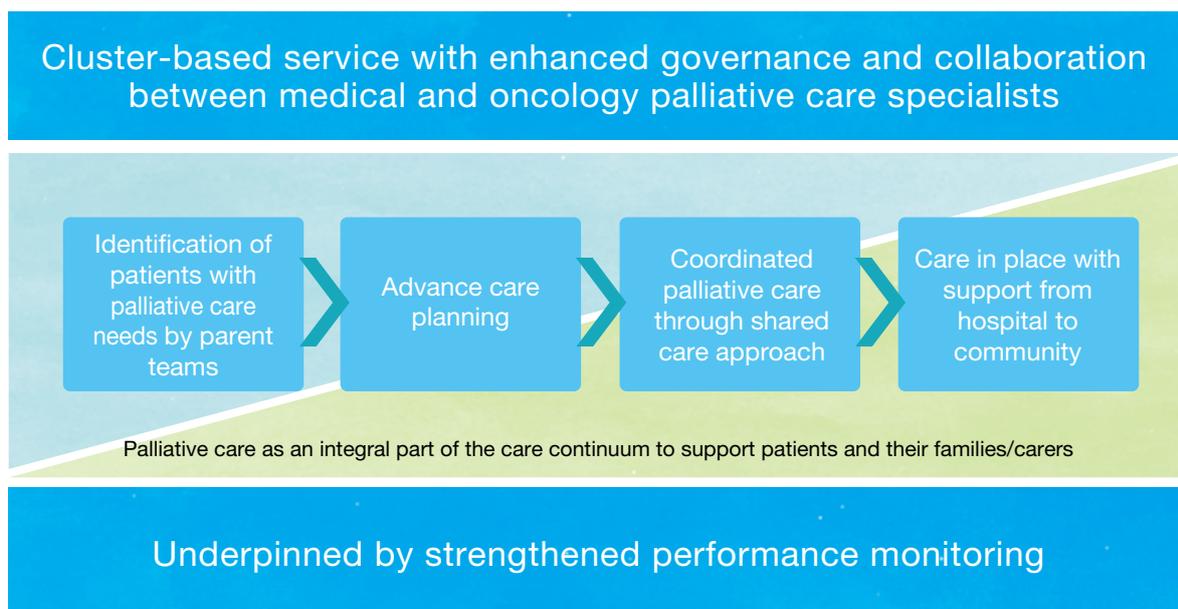
### **Identify Key Domains and Develop Indicators for Evaluation and Monitoring of Clinical Outcomes and Service Quality**

Key domains should be identified for the evaluation and monitoring of clinical outcomes and service quality, taking reference to local and international guidelines on outcome monitoring of palliative care services. Examples include patient and carer satisfaction, symptoms control and functional performance, service utilisation as well as coverage of and compliance to ACP. Benchmarking of these parameters helps to avoid inconsistency in service provision among Clusters. When the measuring parameters and tools are mature and widely adopted, they could be developed as quality indicators for outcome monitoring at both the Cluster and corporate level.

## The Future Service Model for Adult Palliative Care

Under this Framework, HA is moving towards the vision of providing timely, coordinated and holistic palliative care to patients and families/carers in need. Specialist adult palliative care services will be organised in a Cluster-based arrangement, with strengthened governance through closer collaboration between medical and oncology PC teams. Timely and coordinated palliative care is achieved through shared care between palliative care and non-palliative care specialists. And palliative care is integrated into the care pathway of patients suffering from a life-threatening or life-limiting illness regardless of the specialties of their care team. Moreover, ambulatory and community palliative care services are enhanced to support care in place and reduce unnecessary hospitalisation. Overall, performance monitoring is strengthened to facilitate service improvement. The new service model of adult palliative care in HA is illustrated in **Figure 8** below.

Figure 8. Future Service Model of Adult Palliative Care in HA



### Key Enablers

Various key enablers are identified to facilitate the development of the above service model and support effective implementation of the Framework strategies. These include manpower and training, facilities, logistic support in hospital wards, information technology (IT) support, and transport.

## Manpower and Training

Training is fundamental to drive system and cultural change in integrating palliative care into the care continuum. It has to be conducted through a system approach and by targeting healthcare staff from both palliative care and non-palliative care settings, with the collaboration among HA, academic and professional organisations.

Firstly, basic training for all healthcare staff across disciplines and specialties is needed to raise their general knowledge and awareness of palliative care. It covers the basic principles and ethical concepts of palliative care and ACP, as well as communication skills and practical care for supporting patients along the disease trajectories. It can be in the form of seminars, tutorials and workshops for introducing and explaining the concept to both professional and supporting staff.



Secondly, there is advanced training for non-palliative care teams working directly with patients who are suffering from life-threatening or life-limiting illnesses. It is aimed at skills transfer to build up competency of the teams in implementing the shared care model. It focuses on skill-sets for ACP discussion, symptom management and bereavement care through clinical attachment, rotation, direct coaching and case conference.

Thirdly, specialist training programmes will be continued to consolidate the provision of specialist palliative care services in the system. They are provided by the HKCP and the HKCR for medical and oncology palliative care subspecialty training respectively. For nurses, the Institute of Advanced Nursing Studies in HA organises Post-registration Certificate Course in Palliative Care Nursing. As regards AH professionals, designated training programmes are developed and coordinated by HA's Institute of Advanced Allied Health Studies for staff working in palliative care settings.

At the same time, detailed workforce planning for doctors, nurses and AH professionals is vital to meet the escalating service demand. A Cluster-based perspective of workforce planning and deployment is required to support the Cluster-based model. Manpower reference for inpatient, ambulatory and community palliative care has to be developed to inform service planning and resources allocation. Apart from manpower strength, the reporting line and career path for professional development are also important areas to be worked out.

### Facilities

Physical design for facilitating the delivery of palliative care is incorporated into the hospital development and redevelopment projects in HA. Home-like, peaceful and soothing environment are the general design principles for palliative care facilities to relieve stress and improve perception of care. This can be achieved by paying attention to the quality of lights, use of colour, selection of furniture, and the needs of different religions and beliefs. Provisions of facilities for families/carers, sensory gardens and social space are also some of the important physical elements, which allow various social activities and events to be held for patients and their families/carers during patients' hospitalisation.

Single rooms offering choice for patients approaching end of life with more privacy, as well as interview rooms where patients and families/carers can engage in more intimate discussion should be made available in both palliative care and non-palliative care settings of all hospitals. The design of mortuaries is another area to be improved on, which will affect the experience and memories of patients' families/carers. In particular, the design for the circulation areas, viewing



rooms and ceremony rooms in the mortuaries should convey a sense of reverence and respect for life. Modernisation of the overall design of mortuaries is also required to better suit the operational workflow and the needs of families/carers.

In addition to the design, capacity planning covering inpatient and ambulatory facilities for palliative care is to be put in place to cope with the projected service demand and take into consideration changes in the service model. In view of the existing variation across hospitals in HA, it is advisable to categorise palliative care beds as “convalescent/rehabilitation” bed type in the system when opening new palliative care beds. CC(Palliative Care) will work with the Cluster management for the alignment in future planning.

## **Logistic Support in Hospital Wards**

The logistics and operations of the hospital wards should be designed to cater for the needs of patients and their families/carers. Consideration should be given to individual patients' conditions, including their psychosocial and emotional needs, especially during their last phase of life. Flexible visiting hours are introduced so that patients can spend more time with their loved ones. Arrangement can also be made for families/carers to stay overnight with the patients if hospital operation allows.

## **IT Support**

IT support is required to enable implementation of the Framework. There is a need to enhance the IT system to support the workflow, communication and care coordination across disciplines, specialties and care settings along the palliative care journey, especially between palliative care and non-palliative specialists, as well as between home care teams and CGAT. Building up a common platform for the documentation of ACP is also important for clinical communication and ongoing reviews. A database of palliative care patients has to be set up to facilitate the identification of patients, care management as well as performance monitoring at both clinical and system level. Furthermore, the development of tele-care, mobile apps and website support should be explored to support care in place and empowerment of patients and families/carers.

## **Transport**

Along with the development of ambulatory care, transportation support for patients such as Non-emergency Ambulance Transfer Service is required to be strengthened. This way, patients can attend the day care programme in a more accessible manner, and the day service is more optimally utilised. Moreover, transportation support is also important to facilitate hospital discharge and the transfer of patients between hospitals or to RCHEs.



## Cluster Plans

*To address the challenges and improve the quality of adult palliative care services, each Cluster has formulated a service plan in accordance with the overall strategic directions of this Framework. The plans set out the Clusters' local priorities to facilitate implementation of the strategic directions, with a focus on enhancing service delivery through Cluster-based organisation.*

### Sequence of the Plans

- Hong Kong East Cluster
- Hong Kong West Cluster
- Kowloon Central Cluster
- Kowloon East Cluster
- Kowloon West Cluster
- New Territories East Cluster
- New Territories West Cluster

# Hong Kong East Cluster

## Current Palliative Care Services Arrangement



1. Pamela Youde Nethersole Eastern Hospital +
2. Ruttonjee Hospital +
3. Tang Shiu Kin Hospital

4. Tung Wah Eastern Hospital
5. St. John Hospital +
6. Cheshire Home, Chung Hom Kok

7. Wong Chuk Hang Hospital

Hospitals with A&E service are marked with the symbol +

Palliative care services in the Hong Kong East Cluster (HKEC) are provided by the oncology PC team of Pamela Youde Nethersole Eastern Hospital (PYNEH) and the medical PC team of Ruttonjee & Tang Shiu Kin Hospitals (RTSKH). The scope of services is shown in the table below:

### Service Scope of PC Teams in HKEC

Service Type	PYNEH	RTSKH
	Oncology PC Team	Medical PC Team
Inpatient	✓	✓
Consultative	✓	✓
Outpatient	✓	✓
Day	✓	✓
Home	✓	✓

There are no PC teams in the other hospitals of HKEC, namely Tung Wah Eastern Hospital (TWEH), St. John Hospital (SJH), Cheshire Home, Chung Hom Kok (CCH) and Wong Chuk Hang Hospital (WCHH). Patients of these hospitals can access palliative care services through the parent teams' referral to the PC teams in PYNEH and RTSKH.



 Palliative Care Day Centre in PYNEH



 Palliative Care Ward in RTSKH

## **Key Challenges in Palliative Care Services Arrangement**

Currently, the provision of palliative care services in HKEC mainly focuses on cancer patients. Palliative care support for patients with non-cancer conditions is generally limited. Structured palliative care service programme is only available for renal patients in PYNEH and RTSKH, while a pilot service for pulmonary disease patients in RTSKH has been initiated recently. Palliative care day services are provided to both cancer and non-cancer patients in RTSKH, but the access is limited for non-cancer patients in PYNEH as the relevant services are serving cancer patients only. The coverage of palliative care services for other hospitals in HKEC is very limited due to the lack of outreaching services under the current service arrangement.

## Strategies

### **Governance: Cluster-based Service Organisation with Collaboration between Medical and Oncology Palliative Care Specialists**

Governance under the HKEC Coordination Committee on Palliative Care Services will be enhanced with the membership widened to include representatives from PYNEH medical nursing staff, the A&E departments of PYNEH and RTSKH, and from TWEH. Regular performance monitoring will also be carried out by the Committee.

The collaboration between the two PC teams will be strengthened. Joint guidelines and protocols will be developed and shared at the website of the Cluster Coordination Committee on Palliative Care Services. Joint case conference will be conducted to facilitate communication and learning. Staff rotation and joint training arrangement, for example in nurse training, will be strengthened.

### **Care Coordination: Collaboration between Palliative Care and Non-Palliative Care Teams**

The two PC teams will strengthen palliative care consultative service by establishing a Cluster-based palliative care consultative team. In collaboration with the Departments of Medicine of PYNEH and TWEH, link nurses will be identified in these departments to act as contact point with the PC teams to support the implementation of shared care model. Staff training will be enhanced to support this arrangement, for example, through clinical attachment of nurses in the medical wards of Cluster hospitals to the RTSKH PC team.

Collaboration of PC teams with the A&E departments of PYNEH and RTSKH will be enhanced for streamlining admission and facilitating the process of death certification of patients under palliative care. Staff training for pain and symptom control at A&E will be conducted. There will also be collaboration with SJH to better support the palliative care needs of patients who are living in Cheung Chau or Islands. Follow-up care with medication support and procedures could be arranged at SJH, with support provided by the PC teams so as to minimise travelling of patients and families/carers especially at the end stage of life.

## Place of Care: Enhanced Ambulatory and Community Palliative Care

Cluster-based home care team covering cancer and non-cancer patients will be established. There will be enhancement in collaboration via joint home care protocols and case conference. Telephone support will be strengthened. Partnership with CNS and CGAT will be established with structured communication channel, as well as guideline on logistics and shared care.

Access to palliative care day service will be improved, especially for non-cancer patients in PYNEH. PRCs will be utilised as a platform for linking up the community resources and empowerment of patients and families/carers, including education on ACP for patients with organ failure, in collaboration with the Department of Medicine in PYNEH.

## Prioritisation of Strategies

Priority	Strategies
Short-term	<ul style="list-style-type: none"> <li>Enhance governance by reviewing the membership of the HKEC Coordination Committee on Palliative Care Services</li> <li>Develop and implement palliative care guidelines and protocols jointly by the PC teams of PYNEH and RTSKH</li> <li>Conduct joint case conference, and staff training and rotation between the PC teams of PYNEH and RTSKH</li> </ul>
Medium-term	<ul style="list-style-type: none"> <li>Provide basic palliative care training to the medical staff in PYNEH and TWEH</li> <li>Identify link nurses in the medical wards of PYNEH and TWEH as contact point with the PC team to support shared care model</li> <li>Establish Cluster-based palliative care consultative team and home care team in HKEC</li> <li>Conduct patient education on ACP using PRCs as a platform</li> <li>Strengthen PC teams' collaboration with A&amp;E in PYNEH and RTSKH</li> <li>Enhance palliative care support for SJH</li> </ul>
Long-term	<ul style="list-style-type: none"> <li>Improve access to palliative care day service for non-cancer patients in PYNEH</li> </ul>

## Case Illustration

### Patient Background & Current Scene



- Mr Wong, age 62 with end-stage heart failure, is under the care of PYNEH Department of Medicine and in need of palliative care
- The PC team in PYNEH is under Department of Clinical Oncology, serving mainly cancer patients

### Future Service Enhancements

**Education sessions** on the disease and ACP will be provided to Mr Wong and his family at the PRC



During Mr Wong's admission to PYNEH medical ward due to exacerbation, the **link nurse**, with support from the Cluster's palliative care nurse consultant, will **identify his palliative care needs, initiate ACP** and if needed, trigger referral to the PC team



Depends on Mr Wong's needs, **coordinated Cluster-based palliative care services** will be provided, including consultative service, parallel clinic, home care and hotline service



### Expected Outcomes

- ✓ Improved care to Mr Wong, with **basic palliative care** integrated to the care provided by the medical team and coordinated support from the specialist PC teams
- ✓ **Better understanding and acceptance of ACP** by Mr Wong and his family through early patient and family engagement and education

# Hong Kong West Cluster

## Current Palliative Care Services Arrangement



- 1. Queen Mary Hospital +
- 2. Tung Wah Hospital
- 3. Grantham Hospital

- 4. Tung Wah Group of Hospitals  
Fung Yiu King Hospital
- 5. MacLehose Medical Rehabilitation  
Centre

Hospitals with A&E service are marked with the symbol +

Palliative care services in the Hong Kong West Cluster (HKWC) are provided by the oncology PC team of Queen Mary Hospital (QMH) and the medical PC team of Grantham Hospital (GH). The scope of services is shown in the table below:

### Service Scope of PC Teams in HKWC

Service Type	QMH	GH
	Oncology PC Team	Medical PC Team
Inpatient	✓	✓
Consultative	✓	✓
Outpatient	✓	✓
Day	✓	✓
Home	✓	✓

There are no PC teams in the other hospitals of HKWC, namely Tung Wah Hospital (TWH), Tung Wah Group of Hospitals Fung Yiu King Hospital (FYKH), and MacLehose Medical Rehabilitation Centre (MMRC). Patients of these hospitals can access palliative care services through the parent teams' referral to the PC teams in QMH and GH.



Multi-disciplinary PC Team in QMH



Multi-disciplinary PC Team in GH

## Key Challenges in Palliative Care Services Arrangement

The provision of palliative care services in HKWC is mainly focused in QMH and GH. There is a need to strengthen the service coverage for other hospitals without a PC team. The palliative care support to non-cancer patients in the Cluster is also limited, especially for renal, chronic obstructive pulmonary disease (COPD) and chronic heart failure patients.

The palliative care day centre in QMH is currently utilised by cancer patients only. Enhancement of day service provision in the Cluster is required to address patients' needs. For palliative home care, the service is currently provided by separate teams under the PC teams of QMH and GH. Better arrangement is required to improve palliative home care support to patients in the community.

## Strategies

### **Governance: Cluster-based Service Organisation with Collaboration between Medical and Oncology Palliative Care Specialists**

The HKWC Coordination Committee on Palliative Care Services comprises palliative care and non-palliative care specialists, nursing and AH staff. To strengthen the governance and enhance the executive and administrative support for service development, senior Cluster management will also be included in the membership of the Committee.

To strengthen collaboration between the medical and oncology PC teams, clear role delineation will be established on service coordination. The QMH oncology PC team will coordinate the palliative care services for cancer patients as well as the palliative care day services. Palliative care services for non-cancer patients and the home care services will be coordinated by the GH medical PC team.

Service alignment among the PC teams will be further enhanced by joint protocols and multi-disciplinary guidelines such as nursing guidelines on the care of terminally ill patients. Regular case conferences will be conducted for discussion, and complicated cases will be managed by joint ward round and consultative visits in both medical and oncology palliative care wards. The PC teams will also have regular collaboration in training and patient empowerment. To better meet the needs of non-cancer patients in the Cluster, palliative care outpatient services in QMH will be expanded to support non-cancer patients.

In view of the redevelopment of GH which will include the establishment of a new cancer centre, there will be joint planning and delivery of palliative care services by the QMH and GH teams, to optimise the opportunity of these capital projects for meeting the service needs of the Cluster.

## Care Coordination: Collaboration between Palliative Care and Non-Palliative Care Teams

A Cluster-based palliative care consultative team will be set up in HKWC to extend the service coverage to TWH, MMRC and FYKH. Regular Cluster case conference will also be conducted for collaboration between palliative care and non-palliative care specialists, with involvement of representatives from all hospitals in the Cluster.

To improve the care provision for patients in non-palliative care settings, link nurses will be identified as the contact point for service coordination. Skills transfer and training will be provided to non-palliative care teams and will be extended to the non-cancer specialties. The training will also facilitate parent teams to make referrals to specialist palliative care according to patients' needs.

Currently, palliative care nurses in the consultative team are playing an important role in the ACP programme. The programme will be enhanced to cover all hospitals in HKWC especially for support to non-cancer patients including those with end organ failure. The team will also provide consultative and specialist palliative care support to the link nurses, and conduct training for non-palliative care staff.



## Place of Care: Enhanced Ambulatory and Community Palliative Care

Palliative home care services in HKWC will be provided by a Cluster-based team under the coordination of the GH medical PC team. The home care service acts as a link between hospital and community care, supporting both cancer and non-cancer patients in the Cluster. The service provision will be arranged on a district basis, with collaboration with CNS and CGAT to enhance the care coordination for patients according to their needs.

To better support patients staying in the community, telephone hotline support will be extended beyond office hours. The PC team will provide information and authorise the arrangement of admission to the ward of the parent team as required. Alignment and communication among the home care team will be enhanced through regular case conferences, joint protocols and training. There will also be discussion on pairing up logistics of home care nurses for on-leave support. Regarding the provision of palliative care day services, Cluster-based service arrangement will be adopted to ensure that it is accessible by both cancer and non-cancer patients in all hospitals of the Cluster.

## Prioritisation of Strategies

Priority	Strategies
Short-term	<ul style="list-style-type: none"> <li>Enhance Cluster-based governance with the involvement of Cluster management and collaboration between the medical and oncology palliative care specialists in GH and QMH</li> <li>Develop joint protocol and multi-disciplinary guidelines</li> <li>Conduct regular Cluster home care case conference</li> </ul>
Medium-term	<ul style="list-style-type: none"> <li>Develop Cluster-based home care team in HKWC, with collaboration with CNS and CGAT</li> <li>Set up a Cluster-based consultative team and enhance coverage for TWH, MMRC and FYKH, with palliative care nurse consultation and palliative care link nurse to support service and training</li> <li>Arrange palliative care day services in a Cluster-based manner, accessible by both cancer and non-cancer patients</li> <li>Strengthen service provision to non-cancer patients in the Cluster by expanding palliative care outpatient services in QMH</li> </ul>
Long-term	<ul style="list-style-type: none"> <li>Conduct joint service planning and delivery between the medical and oncology PC teams of GH and QMH, taking into account of the GH redevelopment and establishment of a new cancer centre</li> </ul>

## Case Illustration

### Patient Background & Current Scene



- Mrs Li, age 75, living with her daughter in Aberdeen
- Suffering from terminal colorectal cancer with follow-up by QMH Department of Oncology
- Presented to QMH A&E due to symptoms deterioration and admitted to QMH Department of Surgery
- Identified to have palliative care needs and transferred to GH palliative care ward. Required home care to support discharge
- Although both QMH oncology and GH medical PC teams support oncology patients, there is room for improvement in the collaboration between the teams

### Future Service Enhancements

QMH surgical team will provide **basic palliative care** to Mrs Li



QMH oncology PC team will provide **consultative service** to Mrs Li in the surgical ward, according to the role delineation between QMH and GH PC teams

QMH PC team will liaise with GH PC team for **transfer to GH palliative inpatient care** if Mrs Li develops complex palliative care needs



Upon discharge, palliative home care will be provided by the **Cluster palliative home care team**. There will be regular communication between QMH and GH PC teams through joint case conferences for enhanced care



### Expected Outcomes

- ✓ **Early and coordinated palliative care** service for Mrs Li in QMH, supported by palliative care specialists
- ✓ **Facilitated discharge** by Cluster-based home care services as a link between hospital and community care

# Kowloon Central Cluster

## Current Palliative Care Services Arrangement



1. Queen Elizabeth Hospital +
2. Kowloon Hospital
3. Hong Kong Buddhist Hospital

4. Kwong Wah Hospital +
5. Our Lady of Maryknoll Hospital
6. Tung Wah Group of Hospitals Wong Tai Sin Hospital

Hospitals with A&E service are marked with the symbol +

Palliative care services in the Kowloon Central Cluster (KCC) are provided by the oncology PC team of Queen Elizabeth Hospital (QEH) and the medical PC teams of Hong Kong Buddhist Hospital (HKBH), Our Lady of Maryknoll Hospital (OLMH) and Tung Wah Group of Hospitals Wong Tai Sin Hospital (WTSH). The PC teams of OLMH and WTSH were regrouped from Kowloon West Cluster to KCC in December 2016 due to re-delineation of the Cluster boundaries.

The Department of Medicine of QEH also provides palliative care services (including inpatient, consultative, outpatient and day care services) which are supported by non-palliative care specialists. The scope of services provided by the KCC PC teams is shown in the table below:

## Service Scope of PC Teams in KCC

Service Type	QEH	HKBH	OLMH	WTSH
	Oncology PC Team	Medical PC Team	Medical PC Team	Medical PC Team
Inpatient	✓	✓	✓	✓
Consultative	✓	✓	✓	✓
Outpatient	✓	✓	✓	
Day	✓		✓	✓
Home		✓	✓	



Life Celebration Party for Patients in QEH



Multi-disciplinary PC Team Case Conference in HKBH



Quiet Room in OLMH



Occupational Therapy Session in WTSH

There are no PC teams in the other hospitals of KCC, namely Kowloon Hospital (KH) and Kwong Wah Hospital (KWH). Patients of these hospitals can access palliative care services through the parent teams' referral to the PC teams in QEH, HKBH, OLMH and WTSH.

## Key Challenges in Palliative Care Services Arrangement

Currently, there is limited palliative care consultative service in KCC, with no service provision to KWH and KH. In QEH, the palliative care consultative service for patients in the medical wards is supported by renal and respiratory specialists. There is also a need to enhance the palliative care SOPC services in the Cluster, especially for non-cancer patients. Palliative care nurse clinics are currently available in QEH and OLMH only.

Under the current service arrangement, there are multiple medical PC teams in KCC including HKBH, OLMH and WTSH. However, they all have limited number of palliative care specialists, and only OLMH has been accredited as a Palliative Medicine training centre under the HKCP at the moment. Their service organisation needs to be improved in order to enhance collaboration and facilitate the service and professional development of medical palliative care.

## Strategies

### **Governance: Cluster-based Service Organisation with Collaboration between Medical and Oncology Palliative Care Specialists**

The KCC Coordination Committee on Palliative Care Services comprises Cluster management, palliative care and non-palliative care specialists, nursing and AH staff. Representatives from OLMH, WTSH and KWH have been included in the membership recently to facilitate palliative care service planning and development of the whole Cluster.

Over the years, KCC has adopted an integrated model for inpatient palliative care service which is provided at HKBH by the medical and oncology palliative care specialists. Clinical guidelines on palliative care are also shared among different PC teams. This integrated service model will

be further developed in the Cluster to promote close collaboration between the medical and oncology palliative care specialists. Besides continuation of the integrated inpatient palliative care service at HKBH, integrated grand round and case conferences will also be established by PC teams in the Cluster. The medical and oncology palliative care specialists will jointly run the Cluster-based SOPC services at KWH and WTSH. The PC teams will also provide Cluster-based palliative care consultative services to the Cluster hospitals and set up palliative care nurse clinics to improve the service coverage.

Medical palliative care services in KCC will be provided in a Cluster-based manner through the pooling of teams in HKBH, WTSH and OLMH. The arrangement will also help in facilitating the accreditation of training centre under HKCP to support professional development and sustain the service development in the Cluster.

### **Care Coordination: Collaboration between Palliative Care and Non-Palliative Care Teams**

Collaboration between palliative care and non-palliative care teams in the Cluster will be enhanced by adopting a shared care model between the palliative care consultative team and the parent teams. The consultative service will be provided under the concept of joint ownership of patients to ensure appropriate care according to patients' needs. It will be extended to QEH medical wards, KWH and KH in a stepwise approach. Furthermore, parallel clinics will be set up with the KWH medical SOPC to enhance collaboration in the provision of care.



## Place of Care: Enhanced Ambulatory and Community Palliative Care

A Cluster-based palliative home care team will be set up in KCC with two sub-units located in HKBH and OLMH. The home care team will serve both cancer and non-cancer patients in the Cluster, supported by medical and oncology palliative care specialists. The sub-units in HKBH and OLMH will be under the same reporting line. Common protocols will be shared and joint training will also be organised to facilitate service collaboration and alignment. The telephone hotline support provided by home care nurses will be strengthened, and direct clinical admission by the home care team will be coordinated. Collaboration with CNS and CGAT will also be enhanced to improve care coordination and avoid service duplication. For highly selected cases after discussion at case conference, home visits could be provided by AH professionals and doctors.

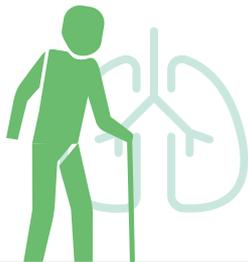
Regarding the provision of palliative day care services in KCC, improvements will be made in the alignment of the services in QEH, WTSH and OLMH. The feasibility of an additional palliative care day centre in HKBH will also be explored to cater for the service needs.

## Prioritisation of Strategies

Priority	Strategies
<b>Short-term</b>	<ul style="list-style-type: none"> <li>• Enhance inpatient palliative care consultative service at QEH through Cluster-based consultative team</li> <li>• Provide inpatient palliative care consultative service to KWH and KH through Cluster-based team</li> <li>• Set up palliative care SOPC sessions at KWH and WTSH</li> <li>• Establish palliative care nurse clinic at HKBH and WTSH</li> <li>• Apply for accreditation of palliative medicine training centre under HKCP</li> </ul>
<b>Medium-term</b>	<ul style="list-style-type: none"> <li>• Enhance palliative day care service in KCC</li> <li>• Further extend palliative care outpatient service</li> <li>• Extend Cluster-based palliative care consultative services to all hospitals in the Cluster</li> </ul>
<b>Long-term</b>	<ul style="list-style-type: none"> <li>• Review the implementation of the short and medium-term strategies and bridge remaining gaps by full implementation of the Cluster-based palliative care service structure</li> </ul>

## Case Illustration

### Patient Background & Current Scene



- Mr Wong, age 70, living with his family in Yau Ma Tei
- Chronic smoker with history of COPD for ten years, under the care of KWH Department of Medicine
- Repeated admissions to KWH, and subsequent transfer to KH
- Gradual deterioration of lung function and identified to have palliative care needs
- No palliative care services in KWH and KH, and limited palliative care services for non-cancer patients in KCC

### Future Service Enhancements

KWH medical team will provide **basic palliative care** to Mr Wong



Cluster-based palliative care consultative team will provide **consultative service** to Mr Wong during his admissions in KWH and KH

Upon discharge, Mr Wong will be followed up at **parallel palliative care outpatient clinic** with KWH medical team



As Mr Wong's condition deteriorates, the **Cluster-based home care team** will arrange home visits according to his needs



### Expected Outcomes

- ✓ **Timely palliative care service** for Mr Wong in KWH and KH, supported by palliative care specialists under a “**co-care model**” between the palliative care consultative team and medical team
- ✓ **Appropriate level of care** provided along Mr Wong's disease trajectory to support his stay in the community
- ✓ **Knowledge and skills transfer** provided to the parent team resulting in improved care to Mr Wong

# Kowloon East Cluster

## Current Palliative Care Services Arrangement



- 1. United Christian Hospital +
  - 2. Tseung Kwan O Hospital +
  - 3. Haven of Hope Hospital
- Hospitals with A&E service are marked with the symbol +

Palliative care services in the Kowloon East Cluster (KEC) are provided by the medical PC teams of United Christian Hospital (UCH) and Haven of Hope Hospital (HHH). The scope of services is shown in the table below:

### Service Scope of PC Teams in KEC

Service Type	UCH	HHH
	Medical PC Team	Medical PC Team
Inpatient	✓	✓
Consultative	✓	✓
Outpatient	✓	✓
Day	✓	
Home	✓	✓

There is no PC team in Tseung Kwan O Hospital (TKOH). The palliative care consultative and outpatient services for TKOH are provided by an associate consultant of HHH and the home care service is provided by the Cluster home care team.



Multi-disciplinary PC Team Case Conference in UCH



Garden of Palliative Care Ward in HHH



## Key Challenges in Palliative Care Services Arrangement

There is a substantial demand for palliative care services in TKOH. However, the service provision in inpatient and outpatient settings is limited due to the absence of a PC team in TKOH. A significant proportion of deaths in KEC occur in non-palliative care settings, hence there is a need to enhance the knowledge and skills of parent teams in providing general palliative care to patients, with support from the specialist palliative care consultative service for managing complex problems.

Furthermore, the coverage of non-cancer palliative care service is low for patients in KEC other than those with ESRF. Support to other non-cancer patients such as those with advanced pulmonary, cardiac, liver and neurological diseases needs to be strengthened.

## Strategies

### **Governance: Cluster-based Service Organisation with Collaboration between Medical and Oncology Palliative Care Specialists**

The KEC Coordination Committee on Palliative Care Services comprises Cluster management, palliative care and non-palliative care specialists and nursing staff. To enhance the coordination of palliative care services among different healthcare disciplines, the Committee membership will be reviewed for involving appropriate representative from the AH disciplines.

With the development of cancer service in KEC, a mechanism for collaboration between medical and oncology palliative care specialists will be established to provide palliative care services for cancer patients and to govern the service development. A Cluster-based palliative care consultative team will be set up to extend the coverage of palliative care inpatient consultative and outpatient services in all hospitals for supporting both cancer and non-cancer patients. Also, through the UCH and HHH redevelopment projects in the coming years, further enhancement in the capacity of inpatient palliative care services will be explored.

## Care Coordination: Collaboration between Palliative Care and Non-Palliative Care Teams

Collaboration between the palliative care and non-palliative care teams in KEC will be strengthened to enhance the service provision in non-palliative care settings. Strategies include collaboration with medical and surgical teams to enhance the workflow of hospital admission, linkage and triage for palliative care service; collaboration with the Cluster pain team in pain control; and collaboration with TKOH A&E Department for streamlined admission and facilitating the process of death certification for patients under palliative care. Education, training and skills transfer for healthcare workers in non-palliative care settings will also be continued and further enhanced.

## Place of Care: Enhanced Ambulatory and Community Palliative Care

The existing home care team in KEC is Cluster-based. Further collaboration among the home care nurses will be achieved through the establishment of Cluster-based home care service guidelines and case conferences. Support to palliative care patients staying in the community will be enhanced through extending the duration of telephone hotline support, improving the logistics for clinical admission and enhancing the use of existing ambulatory centre to reduce unnecessary hospital admissions. Collaboration with CNS, CGAT and Integrated Care Model (ICM) services will be further strengthened to address the needs of patients with different complexity levels of needs. The palliative care day centre in UCH will also be better utilised to support patients in TKOH and HHH, while the establishment of another palliative care day centre in HHH is being explored according to the service demand.



# Prioritisation of Strategies

Priority	Strategies
<p><b>Short-term</b></p>	<ul style="list-style-type: none"> <li>• Strengthen collaboration between palliative care and non-palliative care teams to enhance service provision in non-palliative care settings</li> <li>• Establish Cluster-based palliative care consultative team</li> <li>• Utilise UCH palliative care day centre to support TKOH and HHH patients in need</li> <li>• Develop Cluster-based guidelines and conduct case conferences for home care nurses</li> <li>• Strengthen collaboration with CNS, CGAT and ICM</li> <li>• Collaborate with TKOH A&amp;E to support patients under palliative care</li> <li>• Improve arrangement for clinical admission of palliative care patients in the community</li> </ul>
<p><b>Medium-term</b></p>	<ul style="list-style-type: none"> <li>• Establish mechanism for further collaboration between medical and oncology palliative care specialists along with the development of cancer service in KEC</li> <li>• Enhance collaboration with the Cluster pain team in TKOH</li> <li>• Extend duration of telephone hotline support for palliative care patients</li> </ul>
<p><b>Long-term</b></p>	<ul style="list-style-type: none"> <li>• Enhance capacity of inpatient palliative care service in the Cluster through UCH and HHH redevelopment projects</li> <li>• Explore the feasibility of establishing a palliative care day centre in HHH</li> </ul>



## Case Illustration

### Patient Background & Current Scene



- Mrs Chan, age 70, with advanced cancer of pancreas and under the care of TKOH Department of Surgery
- Living with her family in Tseung Kwan O District. Both patient and family were identified to have palliative care needs
- No PC team in TKOH, and in the process of developing oncology/cancer service in KEC

### Future Service Enhancements

General palliative care will be provided by TKOH surgical team, while the management of complex symptoms and palliative care needs will require support from **Cluster-based consultative team**



Mrs Chan will also receive **palliative radiation therapy** provided by the Cluster oncology team for pain control, and other **pain intervention** from the Cluster pain team

After discharge, Mrs Chan will be followed up at a satellite **palliative care SOPC** at TKOH and receive blood transfusion in the **ambulatory centre** in TKOH/HHH

When Mrs Chan's situation further deteriorates, she will receive home care provided by the **Cluster-based palliative home care team and the CNS** in a collaborative manner, to address her and her family's palliative care needs



### Expected Outcomes

- ✓ **Timely palliative care** to Mrs Chan in TKOH, supported by Cluster-based consultative team for specialist palliative care
- ✓ Mrs Chan will be supported to stay at home through **coordinated community care** including home, day and outpatient care, with reduced A&E attendance and hospital stay

# Kowloon West Cluster

## Current Palliative Care Services Arrangement



- 1. Princess Margaret Hospital +
- 2. Caritas Medical Centre +
- 3. Yan Chai Hospital +
- 4. Kwai Chung Hospital
- 5. North Lantau Hospital +

Hospitals with A&E service are marked with the symbol +

Palliative care services in the Kowloon West Cluster (KWC) are provided by the oncology PC team of Princess Margaret Hospital (PMH) and the medical PC team of Caritas Medical Centre (CMC). The scope of services is shown in the table below:

### Service Scope of PC Teams in KWC

Service Type	PMH	CMC
	Oncology PC Team	Medical PC Team
Inpatient	✔	✔
Consultative		✔
Outpatient	✔	✔
Day	✔	✔
Home		✔

There are no PC teams in the other hospitals of KWC, namely Yan Chai Hospital (YCH), Kwai Chung Hospital (KCH) and North Lantau Hospital (NLTH). Patients of these hospitals can access palliative care services through the parent teams' referral to the PC teams in PMH and CMC.



 Palliative Care Day Centre in PMH



 Multi-disciplinary PC Team in CMC

## Key Challenges in Palliative Care Services Arrangement

With the re-delineation of Cluster boundaries since 1 December 2016, the PC teams of OLMH and WTSH have been moved from KWC to KCC. The inpatient palliative care beds of OLMH and WTSH have been relocated to KCC. The inpatient service in KWC is therefore skewed geographically, with palliative care beds only available in CMC. It presents a challenge to the capacity of palliative care services in KWC, particularly on the accessibility of patients living in Tsuen Wan, Kwai Tsing and Tung Chung. Moreover, palliative care beds in KWC focus primarily on support to cancer patients, with limited support to non-cancer patients.

There is a low coverage of both cancer and non-cancer palliative care in the Cluster's acute hospitals, especially in YCH which does not have a PC team. Inter-hospital consultative services are limited without a Cluster-based team for service provision. In PMH, intra-hospital consultative service for cancer patients not under the Department of Oncology is currently unavailable. There is also a need to enhance the palliative care services for non-cancer patients in the Cluster, to better support patients with ESRF and extend the service to patients with other organ failures.

Regarding palliative home care service, there are variable coverage and intensity of home visits for patients of different hospitals in the Cluster. Enhancement of the home care service is required to better support patients in the community.

## Strategies

### **Governance: Cluster-based Service Organisation with Collaboration between Medical and Oncology Palliative Care Specialists**

The KWC Coordination Committee on Palliative Care Services comprises Cluster management, palliative care and non-palliative care specialists, nursing and AH staff. To enhance the coordination of palliative care services among different AH disciplines, the Cluster AH Coordinator will also be included in the Committee membership. The membership will also be reviewed for involving the respective organ specialists when the palliative care services are extended to cover advanced respiratory diseases and cardiac failure.

Following the re-delineation of Cluster boundaries, palliative care services in KWC are mainly centralised in CMC and provided with Cluster-based arrangement. Inpatient services are concentrated in CMC, which will be reviewed to cope with the service demand and be incorporated into the planning of Phase II hospital redevelopment project of CMC. There will be provision of palliative care outpatient services in PMH and YCH serving both cancer and non-cancer patients through collaboration between CMC medical PC team and PMH oncology PC team.

## Care Coordination: Collaboration between Palliative Care and Non-Palliative Care Teams

A Cluster-based multi-disciplinary consultative team will be established to enhance the service provision and collaboration between palliative care and non-palliative care teams. The consultative team will be based at CMC and serve all non-cancer patients in the Cluster as well as cancer patients in CMC and YCH. Link nurses will be identified in the parent teams as contact points for care coordination with the consultative team. In PMH, intra-hospital consultative service will be established by the oncology PC team to support cancer patients.

Collaboration between palliative care and non-palliative care teams will also be strengthened by setting up joint or parallel palliative care outpatient clinics in PMH and YCH as mentioned above. The clinic service is provided through collaboration among palliative care specialists, oncologists, organ specialists and pain specialists. The Cluster-based consultative team and joint or parallel clinic services are platforms for palliative care specialists to provide skills transfer to non-palliative care teams.

Besides, skills transfer and empowerment of staff in non-palliative care settings will also be enhanced through Cluster-based rotation and training programmes. Trained nurses in the parent teams of acute hospitals will act as link persons for better coordination with the PC team.



## Place of Care: Enhanced Ambulatory and Community Palliative Care

Palliative home care services in KWC will be optimised through Cluster-based home care team based at CMC, covering both cancer and non-cancer patients. Collaboration with community service providers including CGAT and CNS will be strengthened to improve care coordination according to the stratification of patients’ palliative care needs. The collaboration with CGAT team to enhance palliative care support for RCHes shall be extended to YCH, following the implementation in CMC and PMH. Referral criteria to palliative home care service, mechanism of feedback collection and liaison with the referring teams will be standardised for better alignment in care provision.

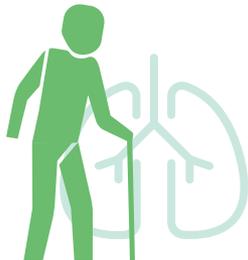
Utilisation of palliative care day centres in KWC will be optimised to better meet the service demand in the Cluster. The palliative day care centre in CMC will mainly provide interventional procedures for both cancer and non-cancer patients, while the day centre in PMH will mainly provide Cluster-wide day programmes for palliative care.

## Prioritisation of Strategies

Priority	Strategies
Short-term	<ul style="list-style-type: none"> <li>Enhance governance by reviewing the membership of the KWC Coordination Committee on Palliative Care Services</li> <li>Set up Cluster-based multi-disciplinary palliative care consultative team in KWC</li> <li>Set up joint or parallel palliative care clinics in YCH and PMH</li> </ul>
Medium-term	<ul style="list-style-type: none"> <li>Increase palliative care beds in CMC for both cancer and non-cancer palliative care patients in KWC</li> <li>Enhance the capacity of palliative home care services and collaboration with CNS and CGAT</li> <li>Provide training and skills transfer of basic palliative care knowledge to doctors and nurses in acute hospitals</li> </ul>
Long-term	<ul style="list-style-type: none"> <li>Refine and enhance the scope of palliative care day service in PMH and CMC</li> </ul>

## Case Illustration

### Patient Background & Current Scene



- Mr Lam, age 68, smoker
- With end-stage COPD, under the care of PMH Department of Medicine
- Condition deteriorated and required palliative care interventions
- PC team in PMH is under Department of Oncology for serving cancer patients

### Future Service Enhancements

PMH medical team will provide **basic palliative care** to Mr Lam, with training and support from CMC PC team



With progression of Mr Lam's condition, CMC **palliative care consultative team** will provide specialist palliative care service to Mr Lam in collaboration with PMH link nurse



As Mr Lam is assessed to require complex palliative care intervention, he will be transferred to CMC for **inpatient palliative care**



CMC palliative care consultative team will **facilitate early discharge** and arrange **palliative care parallel clinic** in PMH, and **palliative care day service** in PMH or CMC according to Mr Lam's needs



### Expected Outcomes

- ✓ Improved care for Mr Lam with **basic palliative care** provided by PMH medical team, supported by specialist palliative care consultative service
- ✓ **Timely inpatient palliative care management** to Mr Lam in CMC with early discharge, supported by **palliative care community service** as well as day care and outpatient clinic

# New Territories East Cluster

## Current Palliative Care Services Arrangement



- |  |                     |   |
|--|---------------------|---|
| 1. Prince of Wales Hospital +              | 4. Tai Po Hospital  | 7. Cheshire Home, Shatin                                |
| 2. North District Hospital +               | 5. Shatin Hospital  | Hospitals with A&E service are marked with the symbol + |
| 3. Alice Ho Miu Ling Nethersole Hospital + | 6. Bradbury Hospice |   |

Palliative care services in the New Territories East Cluster (NTEC) are provided by the oncology PC team of Prince of Wales Hospital (PWH) and the medical PC teams of Shatin Hospital (SH) and Bradbury Hospice (BBH). The scope of services is shown in the table below:

## Service Scope of PC Teams in NTEC

Service Type	PWH	SH	BBH
	Oncology PC Team	Medical PC Team	Medical PC Team
Inpatient		✓	✓
Consultative	✓	✓	✓ (serving the whole Cluster)
Outpatient	✓	✓	✓
Day	✓	✓	✓
Home		✓	✓ (serving the whole Cluster)

There are no PC teams in the other hospitals of NTEC, namely North District Hospital (NDH), Alice Ho Miu Ling Nethersole Hospital (AHNH), Tai Po Hospital (TPH) and Cheshire Home, Shatin (SCH). However, palliative care services (including consultative, outpatient, day and home care services) are available in NDH, which are provided by a satellite medical PC team of SH and BBH. Patients of AHNH, TPH and SCH, on the other hand, can access palliative care services through the parent teams' referral to the PC teams in PWH, SH and BBH.



🌿 Palliative Care Day Centre in PWH



🌿 Palliative Care Ward in SH



🌿 Multi-disciplinary PC Team in BBH

## Key Challenges in Palliative Care Services Arrangement

NTEC has a large geographical coverage of catchment districts. Currently, the palliative care support in the North and Tai Po districts of NTEC is limited. There is a need to enhance palliative home care services in the northern region of the Cluster, as well as the consultative, day and outpatient palliative services in NDH, AHNH and TPH.

Furthermore, there is a lack of out-of-hours support for palliative home care patients residing in the community. Services such as hotline telephone support and direct admission arrangement are needed, which can reduce unnecessary A&E attendances and admissions.

## Strategies

### **Governance: Cluster-based Service Organisation with Collaboration between Medical and Oncology Palliative Care Specialists**

To strengthen the governance of palliative care services in NTEC, there will be a revamp of the NTEC Coordination Committee on Palliative Care Services. Clinical lead in medical and oncology palliative care will be identified to lead the service development and collaboration between the teams in the Cluster. The membership will be reviewed to enhance the involvement of palliative care and oncology clinicians, nurses and AH staff. Palliative Care Committee will also be set up in each acute hospital to facilitate implementation of the palliative care services with participation by non-palliative care specialists.

Joint protocol and multi-disciplinary guidelines will be promulgated on topics such as pain and symptom control. Regular consultative visits in both medical and oncology wards and case conferences will be conducted. Collaboration in training will be enhanced with rotation of trainees between palliative medicine and oncology, joint palliative care training for oncology and palliative medicine trainees and nurses, as well as joint training for non-palliative care specialists, nurses and AH staff.

## Care Coordination: Collaboration between Palliative Care and Non-Palliative Care Teams

Cluster-based consultative services will be outreached to various specialties and departments using clinical triggers. The existing renal palliative care programme will be strengthened with increased coverage in Tai Po and Northern District. Shared care model will also be developed for non-cancer palliative care conditions in various hospitals of the Cluster, such as neuro-degenerative disease programme in PWH, advanced COPD programme in PWH and NDH as well as surgical palliative care in SH. Moreover, joint programme with the A&E departments in acute hospitals will be in place to better support coordinated palliative care admissions.

To support implementation of these strategies, training of palliative care link nurse will be extended to the whole Cluster. There will be continued rotation of palliative medicine trainees to the Departments of Medicine and Geriatrics for exposure and skills transfer.

## Place of Care: Enhanced Ambulatory and Community Palliative Care

Palliative home care service in NTEC will be enhanced through Cluster-based team arrangement. The existing home care teams will be pooled under single governance and reporting line. The Cluster-based home care team will be supported by both medical and oncology palliative care specialists, and will serve cancer and non-cancer patients with enhanced support to the North and Tai Po districts. Telephone support will also be strengthened through the palliative care day centre, home care team and ward telephone hotline, but adequate trained and experienced workforce is required to extend the hours of telephone support. Back up services such as direct admission to palliative care wards, designated beds in acute and extended hospitals or fast track service in A&E departments will be implemented in steps to ensure appropriate place of care for palliative care patients.

Collaboration between the palliative home care team, CNS and CGAT will also be strengthened with early identification of cases and enhanced communication. A collaboration model will be developed to provide care according to patients' needs. To increase palliative care support to RCHEs, an integrated PC Team comprising the medical and oncology teams will continue to collaborate with geriatricians through the CGAT EOL care programme.

To better address the Cluster’s needs for palliative day care services, the day centres of NDH, SH and BBH will be further utilised to serve the other hospitals. Subject to the future service demand, service model development and facility planning in the Cluster, including an additional day centre at AHNH or TPH would be explored to enhance service accessibility.

### Prioritisation of Strategies

Priority	Strategies
<b>Short-term</b>	<ul style="list-style-type: none"> <li>• Enhance Cluster governance by revamping the NTEC Coordination Committee on Palliative Care Services and identifying clinical lead in medical and oncology palliative care</li> <li>• Implement joint protocol and multi-disciplinary guidelines</li> <li>• Conduct regular case conferences and consultative visits in oncology and palliative care wards</li> <li>• Enhance collaboration in training</li> <li>• Enhance home care provision through Cluster-based team</li> <li>• Establish Integrated PC Team with medical and oncology palliative care and collaborate with other specialties</li> <li>• Extend palliative care link nurse training to the whole Cluster, and continue rotation of palliative medicine trainees to Medicine &amp; Geriatrics Departments</li> </ul>
<b>Medium-term</b>	<ul style="list-style-type: none"> <li>• Extend Cluster-based consultative services in collaboration with parent teams utilising clinical triggers</li> <li>• Develop shared care model for non-cancer palliative care patients, for example, neurodegenerative diseases, advanced COPD and surgical palliative cases</li> <li>• Expand renal palliative care programme with increased coverage in Tai Po and Northern District</li> <li>• Implement joint programme with A&amp;E departments of PWH and NDH to better support palliative care patients</li> </ul>
<b>Long-term</b>	<ul style="list-style-type: none"> <li>• Strengthen telephone support and further facilitate coordinated admission</li> <li>• Strengthen collaboration with CNS and CGAT</li> <li>• Utilise existing palliative care day centres to support patients in AHNH, TPH and SCH, and consider to develop a new centre at AHNH or TPH</li> <li>• Consider providing inpatient palliative care services in the acute hospitals of NTEC</li> </ul>

## Case Illustration

### Patient Background & Current Scene



- Ms Tse, age 70, living alone in Tai Po
- With ESRF, being followed up in AHNH Department of Medicine
- Opted not to undergo dialysis; required palliative care management including home care
- No PC team in AHNH, and existing provision of palliative home care focuses more on cancer patients

### Future Service Enhancements

**General palliative care** will be provided by AHNH Department of Medicine, and ACP will be initiated



Will be seen by **palliative care consultative team** in AHNH during admission to address increased palliative care needs



Follow-up sessions will be arranged at the **parallel renal clinic** in AHNH, and there will be access to the **Cluster palliative day care services** for symptom control and day procedures



Subsequently, as Ms Tse's condition further deteriorates, home visits will be provided by palliative care nurses under a **Cluster-based home care team**. More frequent visits will be provided as her needs increase



### Expected Outcomes

- ✓ **Timely palliative care service** in AHNH for Ms Tse
- ✓ Better palliative care support for Ms Tse at home through **enhanced home visit coverage** for non-cancer patients in Tai Po region

# New Territories West Cluster

## Current Palliative Care Services Arrangement



- 1. Tuen Mun Hospital +
- 2. Pok Oi Hospital +
- 3. Tin Shui Wai Hospital +

- 4. Castle Peak Hospital
- 5. Siu Lam Hospital

Hospitals with A&E service are marked with the symbol +

Palliative care services in the New Territories West Cluster (NTWC) are provided by the medical and oncology PC teams of Tuen Mun Hospital (TMH). The scope of services is shown in the table below:

### Service Scope of PC Teams in NTWC

Service Type	TMH	
	Medical PC Team	Oncology PC Team
Inpatient	✓	✓
Consultative	✓	✓
Outpatient	✓	✓
Day		✓
Home	✓	✓



 Palliative Care Day Centre in TMH



 Multi-disciplinary Medical PC Team in TMH

At the moment, there are no PC teams in the other hospitals of NTWC, namely Tin Shui Wai Hospital (TSWH), Pok Oi Hospital (POH), Castle Peak Hospital (CPH) and Siu Lam Hospital (SLH). TSWH is a new hospital that has commenced service in phases since January 2017, and the provision of palliative care services is being planned to address the needs of patients in the Tin Shui Wai district. Meanwhile, patients of POH, CPH and SLH can access palliative care services through the parent teams' referral to the PC teams in TMH.

## Key Challenges in Palliative Care Services Arrangement

Currently, palliative care services in the Cluster are mainly focused in TMH, with inadequate coverage for the other hospitals. In particular, there is a need to strengthen the service provision in POH which has a higher level of palliative care service needs compared to CPH and SLH.

There is also a limited number of palliative care specialists providing service to non-cancer patients in the Cluster, resulting in low service provision of palliative care inpatient, consultative and outpatient services for these patients.



## Strategies

### **Governance: Cluster-based Service Organisation with Collaboration between Medical and Oncology Palliative Care Specialists**

The NTWC Coordination Committee on Palliative Care Services comprises Cluster management, palliative care and non-palliative care specialists, nursing and mortuary staff. To enhance the coordination of palliative care services among different disciplines, medical social worker will be included in the Committee membership.

Collaboration between the medical and oncology PC teams will be strengthened, with the NC(Palliative Care) playing a key role in supporting both teams. Meanwhile, common clinical protocols are being developed to align the service provision in the Cluster and affirm the concept of Cluster-based service. Furthermore, the medical and oncology PC teams will organise joint training and education sessions to facilitate information and skills sharing.

The opening of TSWH presents an opportunity for strengthening the palliative care services, especially beyond Tuen Mun district. A palliative care SOPC will be set up in TSWH to serve all palliative care patients under the joint care of medical and oncology PC teams.



## Care Coordination: Collaboration between Palliative Care and Non-Palliative Care Teams

In view of the limited palliative care support to POH, CPH and SLH, Cluster-based palliative care consultative team will be set up to serve both cancer and non-cancer patients in all hospitals of the Cluster.

At the same time, integration of palliative care into different specialties is essential for providing timely and quality patient-centred care. Based on stratification of patients' needs, shared care between palliative care and non-palliative care teams will be provided through different collaborative models. For patients with a general level of palliative care needs, the care will be led by non-palliative care specialists with consultative and bereavement support from palliative care specialists. Patients with more complex needs will be taken care of through joint clinic and joint grand round between palliative care and non-palliative care teams. Moreover, the PC teams will provide continuous education and skills transfer to build up the expertise and skill-sets of the non-palliative care teams.

## Place of Care: Enhanced Ambulatory and Community Palliative Care

Currently, the palliative home care service of NTWC is provided by separate teams under medical and oncology departments. A single Cluster-based home care team will be set up to enhance service coverage through better coordination and manpower arrangement. The home care team will be under the leadership of the NC(Palliative Care), with support from both oncology and medical palliative care specialists for providing services to cancer and non-cancer patients.

Moreover, telephone consultation and coordinated admission will be strengthened for better patient support. Collaboration between the palliative home care team, CNS and CGAT will be enhanced to provide appropriate care according to patients' needs. To meet the increasing palliative care needs of Tin Shui Wai district, a palliative care day centre will be set up in TSWH to provide day services for cancer and non-cancer patients.

## Prioritisation of Strategies

Priority	Strategies
<b>Short-term</b>	<ul style="list-style-type: none"> <li>Strengthen governance through the NTWC Coordination Committee on Palliative Care Services and establish Cluster-based service organisation with collaboration between medical and oncology palliative care specialists in TMH</li> <li>Improve coverage of palliative home care service through formulation of a Cluster-based home care team in NTWC</li> </ul>
<b>Medium-term</b>	<ul style="list-style-type: none"> <li>Set up Cluster-based consultative team covering cancer and non-cancer patients in POH, TSWH, CPH and SLH</li> </ul>
<b>Long-term</b>	<ul style="list-style-type: none"> <li>Strengthen palliative care outpatient services through setting up SOPC service in POH and TSWH</li> <li>Develop inpatient palliative care services and set up a palliative care day centre in TSWH for serving cancer and non-cancer patients in NTWC</li> </ul>



## Case Illustration

### Patient Background & Current Scene



- Mr Cheung, age 59, living with wife in Yuen Long
- Refractory acute myeloid leukaemia with repeated admissions for anaemic symptoms and sepsis
- Under the care of POH Department of Medicine and Geriatrics and identified to have palliative care needs
- No palliative care services in POH

### Future Service Enhancements

**General palliative care** will be provided by POH Department of Medicine and Geriatrics, with **ACP discussion initiated**



Cluster-based palliative care consultative team will be consulted upon admission to POH, with **skills transfer to parent team** to better support the increased palliative care needs of Mr Cheung and his family. Follow-up at **palliative care SOPC** of POH will be arranged upon discharge



Blood transfusion will be arranged in palliative care **day service setting**, while **clinical admission** to palliative care ward for management of septic complications will be streamlined



Home visits will be provided by a **Cluster-based home care team** according to Mr Cheung's needs, and **social care support** will also be arranged through referral to NGOs providing services in Yuen Long district

Upon Mr Cheung's passing away, his family's **bereavement** needs will be assessed and support will be provided



### Expected Outcomes

- ✓ **Timely palliative care service** in POH for Mr Cheung, and better **support in the community** minimising unnecessary A&E attendances and acute ward admissions
- ✓ Mr Cheung's wife will be **supported to cope with the loss** of her husband

Part Three

*Paediatric Palliative  
Care Services*



# Current Situation of Paediatric Palliative Care Services in HA

## *What We Are Doing Now*

In contrast to adult palliative care services, specialist palliative care is currently not available in HA for paediatric patients. The specialist PC teams in the 16 HA hospitals mentioned earlier are providing palliative care to adult patients only. Children suffering from life-threatening or life-limiting illness are under the care of different paediatric departments, and are being looked after by the respective paediatric subspecialty teams which mainly deliver disease management. The paediatric teams may also look into the palliative care needs of their paediatric patients if required, but the service provision and development is not carried out in a structured manner.

Support for the chronically or seriously ill paediatric patients in the community is also very limited because the existing paediatric services in HA focus on hospital care. Although paediatric nurses from a few hospitals provide home visits, they mainly deliver technical support to patients on ventilator and tube-feeding. Since many of the children with serious chronic illness are living in residential special schools, a Children with Medical Complexity Community Support Programme (CCSP) has recently been developed to support them, with paediatric nurses taking up the role as care coordinators. However, the nurses are not well equipped with the knowledge and skill-sets for addressing the palliative care needs of these patients.



With limited support in the community, repeated admissions and prolonged hospitalisation are not uncommon for these children. To alleviate the problem, paediatric departments are collaborating with NGOs to support patients and families in need of palliative care, to help relieve the service gap. The services provided by the NGOs include home visits, telephone support, psychosocial activities, respite care, and family bereavement care.

Overall, structured paediatric palliative care services are yet to be developed in HA, and some of the service needs are partly met by our community partners. A number of factors have led to the relatively slow development of paediatric palliative care. This includes the uniqueness of caring for sick children, the relatively low demand for paediatric palliative care compared to adults, and the lack of specialised expertise and training.

## Uniqueness of Caring for Sick Children

The cause and trajectory of paediatric illnesses as well as the needs of children are very different from those of adult patients, making it very difficult (if at all feasible) to transfer the experience of adult palliative care to the paediatric context.

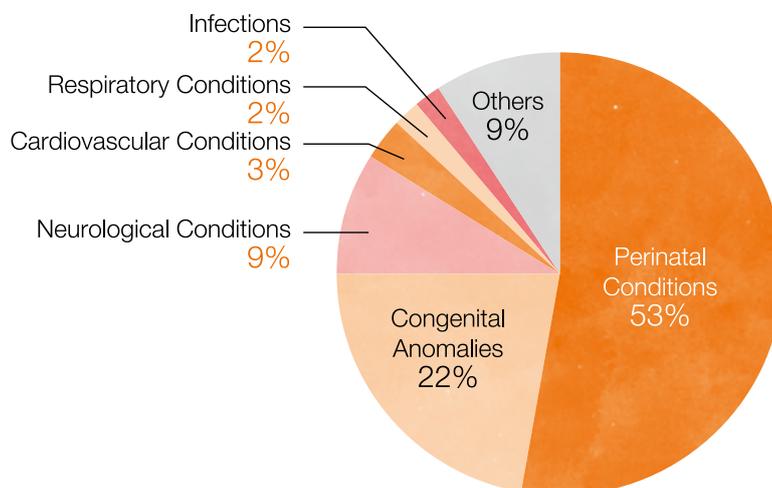
First of all, the disease spectrum of children is substantially different from adults, and many of the serious conditions, such as prematurity and genetic disorders, are unique to children. In the case of inheritable diseases, there may be more than one affected child in a family. Even illnesses that are seen in adults, like cancers and neurological disorders, can act differently in children due to differences in anatomy and physiology between children and adults. Hence, special expertise of paediatricians is required in providing age-appropriate medical care to children.

The spectrum of serious paediatric illnesses can be reflected in the data on deaths below age 18. For instance, as shown in **Figure 11**, in 2014 around half of the deaths below age 18 in HA were of infants less than one year of age, 75% of which were related to perinatal conditions and congenital anomalies. As regards young children and adolescents of age one to 17, 37% of the deaths were related to cancer, and 27% to cardiovascular, neurological, respiratory and genitourinary conditions, which might be of various congenital, genetic, metabolic or acquired diseases origins.

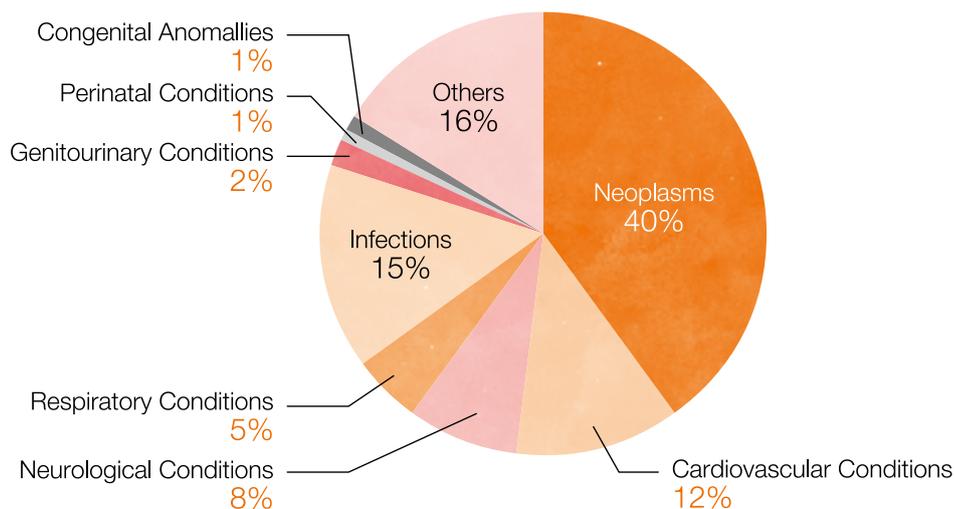


Figure 11. Principle Diagnosis of Inpatient/Day Inpatient Deaths Below Age 18 in HA (2014)

## Deaths at Age &lt;1



## Deaths at Age 1-17



In addition, as they go through illness, paediatric patients are also growing and developing physically, cognitively, socially and emotionally. As such, their medical conditions and multifaceted needs as well as their understanding of the disease evolve and change quite rapidly along the care journey<sup>36</sup>. Moreover, the duration of paediatric care journey often has a longer span compared to adults, usually lasting many years<sup>37</sup>. Some of the patients may grow into adulthood, especially with the advancement in life-prolonging options, and require transition arrangement to adult healthcare services. All these special features increase the complexity in developing paediatric palliative care services.

36 Williams-Reade, J. et al. (2015). Paediatric palliative care: a review of needs, obstacles and the future. *Journal of Nursing Management*; 23:4-14.

37 Association for Children's Palliative Care, England. (2003). *A Guide to the Development of Children's Palliative Care Services*.

## Relatively Low Demand for Paediatric Palliative Care

The service demand for paediatric palliative care in HA is much lower than that of adults. It is because serious illnesses are not common among children in a developed economy like Hong Kong. This can be partly reflected by the data showing that less than 1% (around 260 cases) of the deaths in Hong Kong in 2014 were of children/adolescents under 18 years old.

The relatively low demand limits the development progress of both service and expertise in paediatric palliative care<sup>38</sup>. However, the rare occurrence of serious illness among children makes such an encounter even more unanticipated and difficult to cope with, which may generate palliative care needs that are more complex and intense than those of adult patients. It is especially difficult for parents, siblings and other family members, as well as the healthcare teams to face the imminent death of a child<sup>39</sup>, because children in our modern society are expected to grow up and outlive their parents. Therefore, it is not unusual to pursue curative and life-prolonging options aggressively for a seriously ill child<sup>40</sup>. This may be one of the reasons that more than 50% of the deaths below age 18 in HA occurred in the intensive care settings, which is a much higher rate than for adult patients.

Such an intensive focus on cure may have downplayed the importance of palliative care for paediatric patients, causing the patients and families to endure unnecessary suffering and emotional distress<sup>40</sup>. As healthcare decisions for children are usually made by their parents, ethical dilemma will need to be resolved when there is a disagreement between a parent and the healthcare team in deciding the course of action that is in the best interest of the sick child<sup>39</sup>.

38 Meier, D.E. et al. (2007). Paediatric palliative care offers opportunities for collaboration. *Journal of Palliative Medicine*; 10(2):284-89.

39 Williams-Reade, J. et al. (2015). Paediatric palliative care: a review of needs, obstacles and the future. *Journal of Nursing Management*; 23:4-14.

40 Rushton, C.H. (2005). A framework for integrated paediatric palliative care: being with dying. *Journal of Paediatric Nursing*; 20(5):311-25.

## Lack of Specialised Expertise and Training

Studies have shown that family members reported less emotional distress and increased care satisfaction when a PC team was involved in the care of a seriously ill paediatric patient<sup>41</sup>. However, there is no dedicated team formally set up in HA for this service. In general, there is a lack of training to equip healthcare staff with the specialised knowledge and skill-sets for providing palliative care to children and families, such as effective pain and symptoms control, sensitive communication, conflict resolution, and management of ethical dilemma.

Unlike the establishment of adult palliative medicine as a recognised subspecialty, such a status for paediatric palliative care is not yet developed in Hong Kong, impeding the cultivation of clinical leadership in this service area. Contrary to the situation in the United Kingdom, Australia and the United States, where palliative medicine for children has been introduced as a paediatric subspecialty, training programme for this subspecialty has yet to be developed under the Hong Kong College of Paediatricians. Nevertheless, paediatric oncologists generally gather more experience in providing palliative care, since cancer is the leading cause of death in children above one year of age.



There is also no coordinated training for nurses and AH professionals in paediatric palliative care. Although there are initiatives in some Clusters or hospitals for supporting a small number of staff to undergo overseas training in paediatric palliative care, concerted strategies and designated resources for building up a specialised workforce for this service are generally lacking in HA.

With the upcoming development of Hong Kong Children's Hospital (HKCH), paediatric services in HA will be reorganised into a coordinated service network. It is a valuable opportunity to re-engineer our system to provide comprehensive and holistic care for paediatric patients, ranging from acute curative to palliative care, so as to better support sick children and their families along the care journey.

41 Williams-Reade, J. et al. (2015). Paediatric palliative care: a review of needs, obstacles and the future. *Journal of Nursing Management*; 23:4-14.

# Strategic Service Framework for Paediatric Palliative Care Services

## *What We Are Going to Do*

After taking into consideration the service gaps and the factors contributing to the slow development of paediatric palliative care, and with reference to overseas experience, a dedicated framework has been formulated for establishing structured paediatric palliative care services in HA. A key component of the framework is the development of a specialised PC team under the paediatric specialty to address the palliative care needs of seriously ill children and their families, which are substantially different from those of adult patients. The framework is aimed at improving the accessibility and quality of palliative care for chronically or seriously ill paediatric patients and their families, such that their quality of life could be enhanced.

In the context of paediatric palliative care, families include parents, siblings, carers and significant others who matter to the patients<sup>42,43</sup>. As with adult patients, palliative care for paediatric patients can take place at any stage of a serious illness, including from the point of diagnosis as an integrated approach alongside active treatments that aim at cure or prolonging life, and continue till the bereavement phase. It can also be provided in different settings, ranging from tertiary care facilities to the patients' home. An important emphasis is on compassionate, sensitive and open communication to help patients and families understand the situation they are facing, possible options available to them and the respective treatment goals. This empowers them to have greater participation in the decision-making process<sup>44,45</sup>.

42 Association for Children's Palliative Care, England. (2003). *A Guide to the Development of Children's Palliative Care Services*.

43 Australian Commission on Safety and Quality in Health Care, Sydney. (2016). *National Consensus Statement: Essential Elements for Safe and High-quality Paediatric End-of-Life Care*.

44 Rushton, C.H. (2005). A framework for integrated paediatric palliative care: being with dying. *Journal of Paediatric Nursing*; 20(5):311-25.

45 Craig, F. et al. (2007). IMPaCCT: standards for paediatric palliative care in Europe. *European Journal of Palliative Care*; 14(3):109-14.

## Strategic Framework

There are three strategic directions for paediatric palliative care in the Framework. Under each direction, strategies are formulated for the development of structured paediatric palliative care services in HA. Key enablers are also identified to facilitate effective implementation of the Framework. The table below summarises the Framework, while details of the strategic directions and strategies are outlined subsequently.

Strategic Directions (Where we are going)	Strategies (How we will get there)
Establish territory-wide paediatric palliative care services in HA	<ul style="list-style-type: none"> <li>• Set up a centralised paediatric PC team for coordinating the territory-wide service development</li> </ul>
Promote integrated and shared care with the parent teams	<ul style="list-style-type: none"> <li>• Integrate palliative care into paediatric services with a shared care approach to meet different levels of patient needs</li> <li>• Support local care to accommodate the preference of patients and families</li> </ul>
Enhance community support for children and families in need of palliative care	<ul style="list-style-type: none"> <li>• Develop paediatric palliative home care service</li> <li>• Enhance palliative care support for special schools and residential schools</li> <li>• Strengthen community partnership on paediatric palliative care</li> </ul>



## **Strategic Direction 1: Establish Territory-wide Paediatric Palliative Care Services in HA**

The direction is set towards establishing territory-wide paediatric palliative care services, under a single clinical governance. A centralised paediatric PC team will work with the designated care team of doctors and nurses at regional level to provide comprehensive palliative care services for the needs of children. The latter plays a significant role in coordinating with community partners, special schools, and local paediatric sub-specialty teams; and in the provision of palliative home care service in their local community.

### **Set up a Centralised Paediatric PC Team for Coordinating the Territory-wide Service Development**

The centralised paediatric PC team is led by paediatricians to coordinate the development of an age-appropriate and family-centred care to cater for the special needs of paediatric patients facing life-limiting and life-threatening conditions, in the best interests of the children. These include conditions for which curative treatment may be feasible but can fail (e.g. cancers), conditions where intensive treatment may prolong life but premature death is inevitable (e.g. severe muscular dystrophy on long term ventilator), conditions without curative options where treatment is exclusively palliative (e.g. progressive metabolic disorder), and irreversible but non-progressive conditions causing severe disability leading to susceptibility to complications and premature death (e.g. severe cerebral palsy and spinal cord injury)<sup>46</sup>.



46 Australian Commission on Safety and Quality in Health Care, Sydney, (2016). *National Consensus Statement: Essential Elements for Safe and High-quality Paediatric End-of-Life Care.*

A multi-disciplinary approach is adopted, involving paediatricians with special interest and expertise in palliative care, nurses and AH professionals such as social workers, clinical psychologists, physiotherapists, occupational therapists and dietitians. A continuum of services that includes inpatient, outpatient, home care, support to schools and bereavement care is provided to address the physical, psychosocial and spiritual needs of patients and families. Apart from symptom control and psychosocial support, the services also cover ACP especially in complex cases, and offer bereavement care to families with complicated grief. For patients who survive beyond the age of 18, collaboration with the relevant adult specialties is coordinated by the PC team to facilitate the transition to adult healthcare services.

The centralised PC team is to be based in the HKCH upon its service commencement. With the commissioning of HKCH, paediatric services in HA will be reorganised into a service network, with HKCH as the tertiary referral centre for managing complex and rare conditions, while the paediatric departments of other HA hospitals provide secondary and step-down care in the respective local communities. Therefore, territory-wide paediatric palliative care services have to be established under a single governance for coordinated care in the paediatric service network.



## **Strategic Direction 2: Promote Integrated and Shared Care with the Parent Teams**

The paediatric PC team works closely as partners with paediatricians and other members in the parent teams who are managing the patients' condition. An integrated and shared care approach is adopted to promote continuity of care. Leveraging on the established bonding between the parent teams and the patients and families, the approach facilitates early introduction of palliative care in a seamless and coordinated manner and through joint formulation of a care plan.

### **Integrate Palliative Care into Paediatric Services with a Shared Care Approach to Meet Different Levels of Patient Needs**

Palliative care should be embedded into the overall paediatric care to improve service accessibility. While the paediatric PC team is equipped to take care of patients and families with more complex palliative care needs, clinicians and other members of the parent teams should also acquire basic knowledge and skills of paediatric palliative care in order to identify and support patients in need, as well as address less complex needs. System has to be put in place for accessing the paediatric PC team. Consultative services and joint outpatient clinics are examples of shared care platform between the paediatric PC team and the parent team.

### **Support Local Care to Accommodate the Preference of Patients and Families**

Under the territory-wide service model, local care is supported to fulfil the wish of many patients and families to receive services at home or in the proximity of their homes. The paediatric PC team will work with the designated care team of doctors and nurses at regional level to ensure the continuity of palliative care in the paediatric service network. The designated care team is formed by paediatricians and nurses with interest and training in palliative care. They work closely with the centralised paediatric PC team and community partners to provide coordinated care. For patients under the care of HKCH, there will be an option of receiving palliative care in other HA hospitals closer to their home, especially towards the end of life.



### **Strategic Direction 3: Enhance Community Support for Children and Families in Need of Palliative Care**

Children often prefer to be cared for at home when they are sick and most families also opt to care for their children at home if feasible<sup>47,48,49,50</sup>. School is another familiar environment to the children, providing a sense of reassuring rhythm to normal life with education and social life<sup>48,49</sup>. As such, community-based services are an integral part of paediatric palliative care. Support and empowerment should be given to patients, their families, and their carers in schools to allow patients to live as fully as possible in their communities.

#### **Develop Paediatric Palliative Home Care Service**

The paediatric PC team works with the designated care team of doctors and nurses at regional level to provide palliative home care services. Through visiting patients and families in their homes, their needs are assessed for the provision of appropriate support on the spot. Moreover, families can access telephone support for consultation and advice when required.

47 Association for Children's Palliative Care, England. (2003). *A Guide to the Development of Children's Palliative Care Services*.

48 Department of Health, Western Australia. (2009). *Paediatric and Adolescent Palliative Model of Care*.

49 Hynson, J.L. et al. (2003). The dying child: how is care different? *Medical Journal of Australia*; 179:S20-S22.

50 Vickers, J.L. et al. (2000). Choices and control: parental experiences in paediatric terminal home care. *Journal of Paediatric Oncology Nursing*; 17:12-21.

## **Enhance Palliative Care Support for Special Schools and Residential Schools**

Support is provided to special schools and residential schools, leveraging on the existing CCSP. There are also training and skills transfer for nurses serving as the care coordinators and for the staff in special schools. Basic knowledge and skill-sets on paediatric palliative care have to be built up in the school setting to address as far as possible the needs of chronically or seriously ill children who are attending school, with backup from the paediatric PC team.

## **Strengthen Community Partnership on Paediatric Palliative Care**

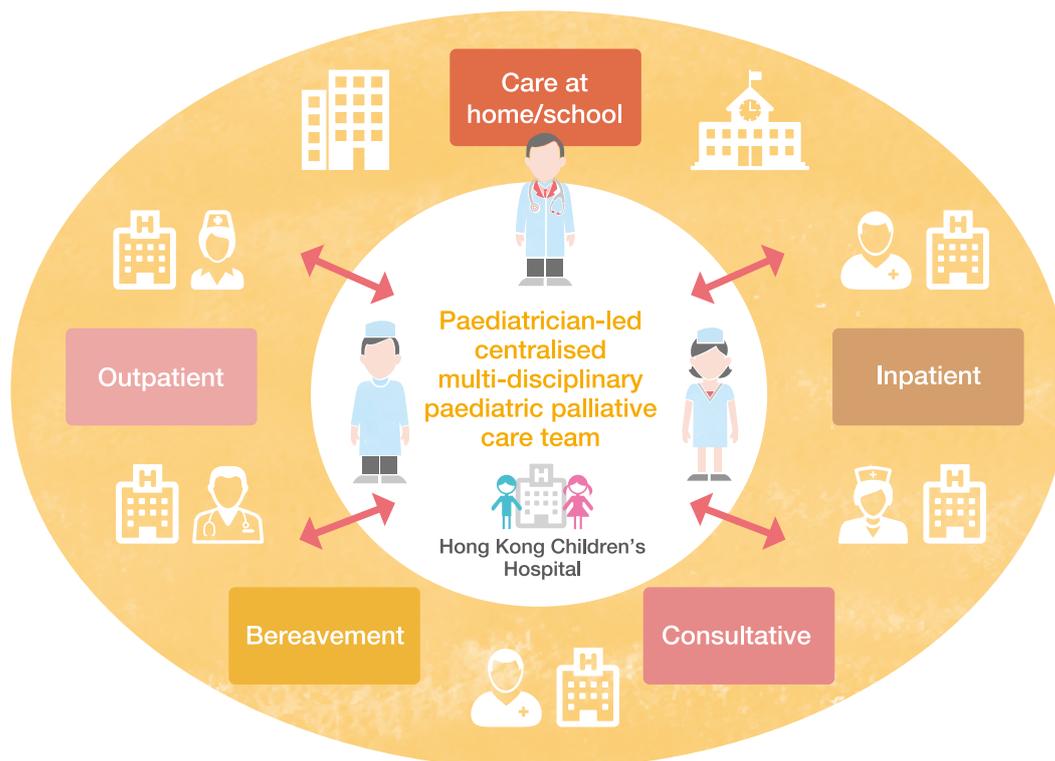
Relevant NGOs and patient groups are engaged to provide complementary support to the patients and families. With their experience and resources in the community, they are instrumental to the provision of personal care, social care and respite care to address different social and practical needs.

## **The Future Service Model for Paediatric Palliative Care**

Under this Framework, HA is moving towards the vision of providing timely, coordinated and holistic palliative care to paediatric patients and families in need. A centralised multi-disciplinary paediatric PC team is to be set up to coordinate the development of territory-wide palliative care services through the HA paediatric service network under a single clinical governance. The paediatric PC team works with the designated care team of doctors and nurses at regional level to provide a continuum of comprehensive palliative care services from hospital to community for the needs of children. The new service model of paediatric palliative care in HA is illustrated in **Figure 12** below.



Figure 12. Future Service Model of Paediatric Palliative Care in HA



A **centralised paediatric PC team** works with the designated care team of doctors and nurses at **regional level** to provide a continuum of **territory-wide** palliative care services from hospital to community under a **single clinical governance**

## Key Enablers

To facilitate the implementation of the above service model and Framework strategies, various key enablers are required for supporting the establishment of territory-wide paediatric palliative care services in HA.

Structured referral guidelines, clinical protocols and clinical standards have to be developed by the centralised paediatric PC team for the territory-wide service. Detailed workforce planning covering multi-disciplinary staff is also crucial in supporting the service implementation by phases. To ensure the quality and sustainability of the service model, appropriately trained and skilled multi-disciplinary staff is required in all the paediatric departments so that palliative care can be integrated into paediatric services. The training plans in this regard are to be coordinated by the paediatric PC team. Similar to adult palliative care services, IT support, facilities and transport are also important enablers for the effective implementation of paediatric palliative care.

Part Four

*Implementation and  
Monitoring*



# Implementation and Monitoring

## *Realising the Plan - Our Short, Medium and Long-term Goals*

The Framework set out in this document for the development of adult and paediatric palliative care services is the blueprint that will steer HA towards achieving the vision of accessible and high quality palliative care for our patients over the next five to ten years. Successful implementation of the Framework will require the joint effort of Clusters, hospitals and frontline clinical staff to develop operational plans according to the strategies. The process of change should start now. And it should be led by clinical leaders, Cluster management and HA Head Office.

In this chapter, the strategies outlined in the Framework are prioritised for phased implementation across HA. Overall consideration is given to the service needs and the readiness for implementation at both the clinical and Cluster management levels. Changes could begin in clinical areas and Clusters that have greater service needs and are more ready for implementation. Local priorities of the respective Clusters are already delineated in the Cluster plans under Part Two of this document. Some of the strategies do not require additional resources, while others will incur resources. The HA annual planning process is the mechanism through which resources could be sought to support the implementation of the relevant strategies.

# Prioritisation of Strategies

## Short Term

### Strengthen Governance Structure

A robust governance of palliative care services is essential in successfully leading the implementation of the Framework across HA. As a key initial step, the governance will be enhanced at both the corporate and Cluster levels. At the corporate level, the membership of CC(Palliative Care) will be reviewed to adopt Cluster-based representation instead of the existing hospital-based composition. Linkage with other relevant COC/CCs will also be strengthened, such as by setting up joint working groups, to enhance collaboration in the development of palliative care service models and training for different specialities. Meanwhile, governance at the Cluster level will be enhanced by reviewing the membership of the Cluster Coordination Committees on Palliative Care Services to include representatives from the Cluster management and other important stakeholders. The Cluster Committees will also be empowered for overseeing the service development and execution of the Clusters' operational plans according to the strategies set out in this Framework.

### Develop Cluster-based Service Model with Collaboration between Medical and Oncology Palliative Care Specialists

Collaboration between medical and oncology PC teams in the respective Clusters should be enhanced in the short term, so that their adult palliative care services can be organised in a Cluster-based manner. Apart from the development of common protocols and guidelines, Cluster-based home care teams and consultative service teams will also be set up to support all the hospitals in the Clusters, covering both cancer and non-cancer adult patients. There will also be collaborative activities between the teams, e.g. case conference, joint training and staff rotation.

## Promote Shared Care Model through Strengthening Palliative Care Consultative Services and Skills Transfer for Non-Palliative Care Specialists

Many adult patients who need palliative care are admitted to and under the care of other specialities. To cope with the rising service demand and provide appropriate care, it is imminent to build up a culture of shared care between palliative care and non-palliative care teams and to integrate palliative care into the management of all patients in need. Enhancement of palliative care consultative services is a starting point for fostering collaboration and skills transfer. Through providing mobile palliative care services to other specialities, the PC teams support the parent teams to address patients' palliative care needs and provide skills-transfer in the process. In the short term, consultative services will be strengthened with priority given to hospitals with no PC teams and support for patients with non-cancer conditions.

## Expand Palliative Home Care Service and Enhance Support to RCHEs

Palliative home care is pivotal in facilitating care in place by helping patients to stay in the community and reduce unnecessary hospital admissions. The home care service will expand in phases to improve service quality and support more patients in need. Collaboration with CNS will also be established with structured communication platform and cross-support to ensure coordinated and appropriate care is provided according to the patients' stratified needs.

The palliative care needs of old age home residents are also acknowledged with plans to increase support through the CGAT EOL care programme. In the coming years, the programme will be further expanded to cover more patients in RCHEs according to the service needs and readiness of different CGATs and PC teams.



## **Establish Structured Paediatric Palliative Care Services for Territory-wide Support**

In parallel, structured development of paediatric palliative care should be carried out in the short term. Given the commissioning of HKCH and reorganisation of paediatric services, it is opportune to start the systematic development of paediatric palliative care services. It is of high priority to build up the service model for meeting the palliative care needs of paediatric patients. As the first step, a centralised paediatric PC team will be set up in HKCH to provide territory-wide services in the HA paediatric service network, including inpatient, outpatient, home care, support to schools and family bereavement care.

## **Strengthen Training for Staff in Non-Palliative Care Settings**

The sustainability of palliative care services depends on our staff's competency and awareness. To drive the culture change and build up the service capacity, there is a need to strengthen the training of staff working beyond palliative care settings. Priority will be given to nurses in view of their key role in providing daily patient care and communication with families/carers. Particularly for those working in clinical areas of high service needs such as Medicine, Geriatrics and CNS, structured training through clinical attachment and skills transfer will be conducted. Nurses who have undergone the relevant training could act as link persons to liaise with PC teams for implementing the shared care model. In general, basic training programmes will be arranged for both professional and supporting staff to raise their awareness and knowledge on palliative care. Collaboration with community partners and relevant stakeholders will also be explored to support the training needs.



## Medium Term

### Refine and Align Palliative Care Day Service

In the medium term, adult palliative day care services will be enhanced through refining the service model and standards. With a refocus on therapeutic procedures and programme-based services, palliative day care can provide better symptom management for patients living in the community, and reduce unnecessary hospital stay by providing fast-track support.

### Strengthen Community Partnership

HA treasures the collaboration with community partners to support our palliative care patients and families in the community. Medical-social collaboration will help complement our services and provide comprehensive palliative care especially on the aspects of personal and social care, psycho-spiritual support and empowerment of patients and families/carers. In the coming years, we will continue to work with NGOs, patient groups and volunteers on these areas. The role of PRCs will also be strengthened for linking up the clinical teams and community resources in meeting our patients' needs. Structured collaboration with the welfare sector will also be explored to promote coordination between the medical and social sectors at the system level.

### Enhance Data Collection and Develop Quality Indicators for Performance Monitoring

To enhance performance monitoring, there will be continued review of service statistics on palliative care across HA, so as to achieve standardisation in the data definition, data collection and reporting mechanism. Subsequently, suitable quality indicators will be identified and developed for continuous monitoring and improvement of our palliative care services.

### Increase Transportation Support

Transportation support is an essential enabler to support patients' access to ambulatory palliative care services and to facilitate transfer between hospitals for inpatient care. Through reviewing HA's transport service arrangement and enhancing the capacity, we will be in a better position to meet the service needs in the medium term.

## Enhance IT Support

IT has an indispensable role to play in the successful implementation of many of the strategies outlined in the Framework. For example, IT systems can support ACP documentation for information sharing and care planning, data capture for performance monitoring as well as other innovative IT solutions for care support and empowerment of patients and families/carers. Enhancement of IT support should be initiated immediately and carried out by phases as one of the medium-term goals, with consideration of the readiness of system technologies in meeting the user requirements.

Moreover, a one-stop web-based information platform on palliative care will be developed to provide easily accessible information to healthcare staff, patients, families/carers and the general public.

## Long Term

### Enhance Physical Capacity and Design for Palliative Care in Hospital Capital Projects

In the long run, physical design and facilities for supporting the delivery of palliative care will be incorporated into hospitals that are undergoing redevelopment as well as future new hospitals in HA. For example, single rooms, interview rooms and family areas will be included, with design features to foster a caring environment and meet the needs of patients at the end of life and their families/carers. The design of mortuaries will also be improved taking into account the operational workflow and perception of the patients' families/carers.



## Monitoring

The implementation of this Framework is a continuous process of developing and improving our palliative care services. Monitoring the process is the key to ensuring proper implementation of the strategies and effective use of resources. The success of the strategies in achieving the goals of service improvement will be evaluated. The monitoring will be carried out at several levels, as follows:

- Service deliverables tied in with resources bidding through the HA annual planning process will be monitored through the existing mechanism.
- Progress on the key implementation milestones mapped out in the operational plans of the Framework will be regularly reviewed over the next five to ten years at both the Cluster and corporate level.
- Quality indicators will be developed for benchmarking, accountability reporting and continuous quality improvement of the overall palliative care services in HA.



## Part Five

# Conclusion

Palliative care is an integral part of the care continuum. Quality palliative care makes a significant difference in helping patients and their families/carers cope with the distress of serious illness and anticipating death.

We envisioned that all patients facing life-threatening or life-limiting conditions and their families/carers can receive timely, coordinated and holistic palliative care to address their needs. They can have greater participation in planning their care, are aware of the choices they can make, and have the best possible quality of life till the end of the patients' life journey.

This Framework sets out the strategies to achieve this vision. Improvements are to be made in the governance and organisation of our adult palliative care services. Collaboration between palliative care and non-palliative care teams is highlighted to improve service quality and build up the capacity for meeting the growing needs. Emphasis is put on the place of care by enhancing ambulatory and community services. At the same time, structured and family-centred paediatric palliative care is to be established in our paediatric services network for addressing the specific needs of chronically or seriously ill children and their families. Across HA, palliative care services are monitored for continuous quality improvement, and key enablers are developed to support implementation of the strategies.

The quality of palliative care in HA relies on more than changing our practice of delivering the service. This calls for a fundamental shift in our culture, so that all healthcare workers are aware that good patient care is not only about saving lives, but also about helping patients live with comfort, dignity and peace in the last phase of their life journey. The provision of palliative care should be integrated into the management of every patient suffering from life-threatening or life-limiting illness, spanning from hospital to community care. Although the process of building this culture takes time, many changes have already begun and will continue with the momentum generated from developing this Framework, and through the concerted efforts of all of us here in HA.

## Part Six

# Abbreviations and Appendices

## Abbreviations

<b>A&amp;E</b>	Accident & Emergency
<b>ACP</b>	Advance Care Planning
<b>AD</b>	Advance Directives
<b>AH</b>	Allied Health
<b>CC</b>	Central Committee
<b>CC(Palliative Care)</b>	Central Committee on Palliative Care
<b>CCE</b>	Cluster Chief Executive
<b>CCSP</b>	Children with Medical Complexity Community Support Programme
<b>CGAT</b>	Community Geriatric Assessment Team
<b>CNS</b>	Community Nursing Service
<b>COC</b>	Coordinating Committee
<b>COPD</b>	Chronic Obstructive Pulmonary Disease
<b>CPR</b>	Cardiopulmonary Resuscitation
<b>DNACPR</b>	Do-Not-Attempt Cardiopulmonary Resuscitation
<b>EOL</b>	End-of-life
<b>ESRF</b>	End-stage Renal Failure
<b>HA</b>	Hospital Authority
<b>HKCP</b>	Hong Kong College of Physicians
<b>HKCR</b>	Hong Kong College of Radiologists
<b>ICM</b>	Integrated Care Model
<b>IT</b>	Information Technology
<b>MSDC</b>	Medical Services Development Committee
<b>NC</b>	Nurse Consultant
<b>NGO</b>	Non-governmental Organisation
<b>PAC</b>	Patient Advisory Committee
<b>PC Team</b>	Palliative Care Team
<b>PRC</b>	Patient Resource Centre
<b>RCHE</b>	Residential Care Home for the Elderly
<b>SOPC</b>	Specialist Outpatient Clinic
<b>WHO</b>	World Health Organisation

# Appendix 1: Taskforce on the HA Strategic Service Framework for Palliative Care

## Terms of Reference

- To review the current and future service needs for palliative care in HA
- To advise on the future service model(s) and system infrastructure for addressing the existing and anticipated gaps in HA palliative care services over the next five to ten years
- To identify priority areas and develop strategies to enhance the quality and outcome of HA palliative care services
- To formulate a strategic service framework for HA palliative care services for consideration by the members of the Directors' Meeting and MSDC

## Membership (as at May 2017)

Co-chairs	
<b>Dr S V LO</b>	Director (Strategy & Planning), HA Head Office (up to 31 October 2016)
<b>Dr Libby LEE</b>	Director (Strategy & Planning), HA Head Office (from 1 November 2016)
<b>Dr W L CHEUNG</b>	Director (Cluster Services), HA Head Office
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<b>Dr Christina MAW</b>	Chief Manager (Primary & Community Services), HA Head Office
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<b>Dr Sharon WONG</b>	Senior Manager (Strategy & Service Planning), HA Head Office – <i>Secretary</i>

# Appendix 2: Working Group on Palliative Care Service Model

## Terms of Reference

- To identify strength and weakness of current HA palliative care services along the care pathway
- To advise on future service model and related system infrastructure for HA palliative care services, particularly the service collaboration between PC teams, with non-palliative care specialists as well as among hospitals in Clusters
- To report the recommendations to the Taskforce on the HA Strategic Service Framework for Palliative Care for consideration and formulation of strategies for addressing the existing and anticipated gaps in HA palliative care services over the next five to ten years

## Membership (as at May 2017)

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<b>Dr Sharon WONG</b>	Senior Manager (Strategy & Service Planning), HA Head Office
<b>Dr Tony HA</b>	Senior Manager (Elderly & Palliative Care), HA Head Office

# Appendix 3: Working Group on Place of Care

## Terms of Reference

- To identify strength and weakness of current HA palliative care services at home/care home
- To advise on support to patients and their families/carers on palliative care and EOL care beyond hospital, with particular focus on the care provision at patients' home and care home, as well as on community partnership
- To report the recommendations to the Taskforce on the HA Strategic Service Framework for Palliative Care for consideration and formulation of strategies for addressing the existing and anticipated gaps in HA palliative care services over the next five to ten years

## Membership (as at May 2017)

Co-chairs	
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<b>Dr Leo WAT</b>	Chief Manager (Strategy, Service Planning & Knowledge Management), HA Head Office (from 19 April 2017)
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<b>Dr Tony HA</b>	Senior Manager (Elderly & Palliative Care), HA Head Office

# Appendix 4: Working Group on Paediatric Palliative Care

## Terms of Reference

- To identify strength and weakness of current HA paediatric palliative care services along the care pathway
- To advise on future service model and related system infrastructure for HA paediatric palliative care services
- To report the recommendations to the Taskforce on the HA Strategic Service Framework for Palliative Care for consideration and formulation of strategies for addressing the existing and anticipated gaps in HA paediatric palliative care services over the next five to ten years

## Membership (as at May 2017)

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<b>Dr S P WU</b>	Consultant (Paediatrics), Queen Elizabeth Hospital
<b>Dr H B CHAN</b>	Chief of Service (Paediatric & Adolescent Medicine) & Service Director (Information Technology & Telecommunications), United Christian Hospital

### *Representatives of COC (Paediatrics)*

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### *Representatives of Nursing Grade*

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### *Representatives of Allied Health Grade*

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<b>Dr Susan FUNG</b>	Clinical Psychologist in-charge (Clinical Psychology) & Clinical Psychologist (Paediatrics), Queen Elizabeth Hospital

### *Head Office Executives*

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<b>Dr Sharon WONG</b>	Senior Manager (Strategy & Service Planning), HA Head Office
<b>Dr Tony HA</b>	Senior Manager (Elderly & Palliative Care), HA Head Office

# Appendix 5: Subgroup on Cluster Service Organisation

## Terms of Reference

- To advise the Working Group on Palliative Care Service Model on the Cluster-based palliative care service arrangement
- To suggest future service model(s) and system infrastructure, and to propose priority areas and strategies for addressing the existing and anticipated gaps in HA palliative care services over the next five to ten years

## Membership (as at May 2017)

Co-chairs	
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<b>Ms Eva LIU</b>	Cluster General Manager (Nursing), Kowloon Central Cluster / General Manager (Nursing), Queen Elizabeth Hospital – <i>Representative of Kowloon Central Cluster</i>

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<b>Ms Ivis CHUNG</b>	Chief Manager (Allied Health), HA Head Office
<b>Ms Susanna LEE</b>	Manager (Nursing) / Chief Nursing Officer, HA Head Office
<b>Dr Sharon WONG</b>	Senior Manager (Strategy & Service Planning), HA Head Office
<b>Dr Tony HA</b>	Senior Manager (Elderly & Palliative Care), HA Head Office

# Appendix 6: HA Central Committee on Palliative Care

## Terms of Reference

- To coordinate the efforts of various hospitals providing palliative care
- To advise on the future development of palliative care services and identify service targets and priorities
- To advise on the resources requirement in developing palliative care services
- To identify training needs and determine priorities in training programmes
- To advise on the development and implementation of professional guidelines, clinical targets and quality assurance system in the palliative care services
- To advise on the monitoring and evaluation of the palliative care services

## Membership (as at May 2017)

Chairman	
<b>Dr K S LAU</b>	Chief of Service (Integrated Medical Services) & Consultant (Respiratory Medicine & Palliative Care), Ruttonjee & Tang Shiu Kin Hospitals
Service Manager	
<b>Dr Christina MAW</b>	Chief Manager (Primary & Community Services), HA Head Office
Members	
<i>Representatives of PC Teams</i>	
<b>Dr Rebecca YEUNG</b>	Chief of Service (Clinical Oncology), Pamela Youde Nethersole Eastern Hospital
<b>Dr K Y CHAN</b>	Consultant in-charge (Palliative Medicine), Grantham Hospital
<b>Dr K K YUEN</b>	Consultant (Clinical Oncology), Queen Mary Hospital
<b>Dr Stanley TAM</b>	Consultant (Medical), Hong Kong Buddhist Hospital
<b>Dr K H WONG</b>	Consultant (Clinical Oncology), Queen Elizabeth Hospital
<b>Dr K S CHAN</b>	Deputy Hospital Chief Executive & Chief of Service (Medicine), Haven of Hope Hospital
<b>Dr W M LAM</b>	Deputy Chief of Service (Medicine), Haven of Hope Hospital
<b>Dr P T LAM</b>	Consultant (Medicine & Geriatrics), United Christian Hospital

<b>Members</b>	
<i>Representatives of PC Teams</i>	
<b>Dr Doris TSE</b>	Deputising Cluster Chief Executive & Clinical Stream Coordinator (Medical), Kowloon West Cluster / Hospital Chief Executive, Caritas Medical Centre
<b>Dr Annie KWOK</b>	Consultant (Medicine & Geriatrics), Caritas Medical Centre
<b>Dr K Y WONG</b>	Consultant (Oncology), Princess Margaret Hospital
<b>Dr Macy TONG</b>	Consultant (Clinical Oncology), Prince of Wales Hospital
<b>Dr Yvonne YAU</b>	Consultant (Clinical Oncology), Prince of Wales Hospital
<b>Dr Raymond LO</b>	Cluster Coordinator (Hospice & Palliative Care), New Territories East Cluster / Consultant (Geriatrics & Palliative Medicine), Shatin Hospital & Bradbury Hospice / Chief of Service (Hospice & Palliative Care), Bradbury Hospice
<b>Dr S H LO</b>	Consultant (Clinical Oncology), Tuen Mun Hospital
<i>Other Specialists</i>	
<b>Prof Godfrey CHAN</b>	Chief of Service (Paediatrics & Adolescent Medicine), Queen Mary Hospital / Commissioning Service Coordinator (Paediatric Oncology), Hong Kong Children's Hospital
<b>Dr P W YAU</b>	Associate Consultant (Paediatrics), Queen Elizabeth Hospital
<i>Representatives of Nursing Grade</i>	
<b>Ms Ellen YEUNG</b>	Nurse Consultant (Palliative Care), Hong Kong East Cluster
<b>Ms L N CHAN</b>	Executive Partner (Nursing), HA Head Office / Department Operations Manager (Pulmonary & Palliative Care Services), Haven of Hope Hospital
<b>Ms C H CHAN</b>	Nurse Consultant (Palliative Care), New Territories West Cluster
<i>Representatives of Allied Health Grade</i>	
<b>Dr Damaris HUNG</b>	Clinical Psychologist in-charge (Clinical Psychology), Grantham Hospital / Clinical Psychologist & Communication Ambassador, Queen Mary Hospital
<b>Ms Eva MA</b>	Senior Occupational Therapist, Queen Elizabeth Hospital
<b>Ms Ellie TANG</b>	Department Manager (Physiotherapy), Tung Wah Group of Hospitals Wong Tai Sin Hospital
<b>Ms Lorraine CHAN</b>	Medical Social Worker in-charge, Haven of Hope Hospital
<b>Ms Margaret SUEN</b>	Cluster Coordinator (Medical Social Work), Kowloon West Cluster / Department Manager (Medical Social Work / Health Resource Centre & Volunteer Service Coordinator), Caritas Medical Centre
<b>Dr Kitty WU</b>	Project Manager (Allied Health), HA Head Office / Cluster Coordinator (Clinical Psychology), Kowloon West Cluster / Senior Clinical Psychologist Head (Clinical Psychology) / Division II, Kwai Chung Hospital



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