Chapter
7

Survivorship and Palliative Care

Direction

7.1 With the ageing population and treatment advancement, the survival rates of most cancers have improved over the years with more patients living with and beyond cancer. We need to identify and prioritise cancer survivorship needs and strengthen support to this growing population seeking to improve the quality of life of the survivors and their families.

Strategies

A. Taking care of cancer patients in primary care settings

7.2 Cancer survivors whose risk of cancer recurrence has dropped to a low level may receive care in a primary care setting such as having periodic check-ups in a nurse clinic or Family Medicine clinics.

B. Initiating a refer-back mechanism for quick access to the Hospital Authority's cancer care team

7.3 A structured refer-back mechanism will be set up to allow fast tracking patients from primary care to specialist care by the Hospital Authority's ("HA's") cancer care team whenever needed, e.g. when relapse occurs or when there are complications. The success of this transitional care pathway will be underpinned by one-stop coordination and collaboration between the HA's cancer care team and family medicine physicians, either at the HA or in the community. The HA will develop and pilot such collaboration model. Enhancement of psychosocial support and allied health outreach services will also be explored in the longer term.

C. Engaging community partners to reinforce medical-social collaboration

7.4 Quality of life for cancer survivors should be observed and improved. An important goal is to support them in the community by reinforcing medical-social collaboration and empowerment. These involve engaging and collaborating with community partners, cancer support/patient groups and other relevant stakeholders to provide better support to both the patients and their families. There is also a need to enhance cancer literacy of the public so as to transform the concept of care for survivors and perceive cancer as a chronic illness.

D. Establishing a sustainable service model for cancer survivors

7.5 There is currently a lack of unified surveillance and survivorship protocols, and specific rehabilitation programmes for those with long term morbidities. To better coordinate the survivorship care, the HA will identify and prioritise their needs, and develop strategies and a holistic care model that will lead to improved quality of life.

7.6 The HA will review and align existing service provision for survivors, including revisiting the role of different disciplines and collaboration among specialties for the scope of care and follow-up in cancer survivorship. Nurses, allied health professionals and medical social workers will be engaged for the development of a comprehensive service model for cancer survivors. A structured rehabilitation and supportive programme will be developed to ensure timeliness of the support and care received, including appropriate transition to the community and palliative care services.

7.7 The HA will set up nursing coordinators to facilitate survivorship care, which includes providing support to most Multi-disciplinary Teams ("MDTs") and Family Medicine, facilitating referrals, and providing guidance, psychosocial support and education to patients. Patients will be empowered; and medical-social collaboration (e.g. non-governmental organisations ("NGOs") and patient support groups) will be reinforced.

E. Enhancing palliative support for end-of-life patients

7.8 Patients with life-limiting conditions are in need of palliative care, aiming to provide timely and holistic care to address their physical, psychosocial and spiritual needs, and to be given the opportunity to participate in the planning of their end-of-life care with a view to improving the patient's quality of life till the end of their life journey.

7.9 Patients approaching the end-of-life tend to have higher utilisation of hospital services such as Accident and Emergency attendances and acute admissions, which may not be entirely necessary. As such, emphasis should be placed on the collaboration among different specialties along the care continuum from hospital to community settings, with optimal involvement of the HA, community partners and the welfare sector. 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.

7.10 The HA will strive to step up day care, home care, support to residential care homes, and community partnership to support terminally-ill cancer patients. In particular, the support to residential care homes of the elderly residents with terminal illness through expanding the end-of-life care programmes will also be enhanced. The HA will continue to review and enhance related services by building up capacity and networking with community partners to meet patients' need.

7.11 The HA has since September 2014 commenced the Integrated Chinese-Western Medicine ("ICWM") Pilot Programme in designated hospitals to gather experience on the ICWM. Cancer palliative ICWM services is one of the four disease areas being tested out in two designated public hospitals under the Pilot Programme.[20] With the Government's commitment in developing Chinese Medicine ("CM") in Hong Kong and recognising of CM as part of Hong Kong's healthcare system, the HA will continue to review ICWM treatment services in its hospitals. The Chinese Medicine Hospital will explore the feasibility of providing a CM centric cancer palliative service.

20 Currently, HA patients will pay an additional $200 per day for receiving the ICWM services.

7.12 Apart from other clinical means to allow terminally-ill patients to have more options of their own treatment and care arrangements, the Government is planning to consult the public in 2019 on arrangement of advance directives and the relevant end-of-life care.

Expected Outcome by 2025

7.13 The HA seeks to achieve the following in terms of helping survivors stay healthy in the community –

(a) empower patients by developing a medical-social collaboration model;

(b) introduce a fast-track refer-back mechanism so that cancer survivors can have ready access to the HA's cancer care team if need be;

(c) define the role and scope of MDT support, including allied health services for survivorship;

(d) establish and pilot the collaboration model for Oncology Specialist Outpatient Clinic and Family Medicine Clinic/General Outpatient Clinic for survivorship;

(e) enhance structured rehabilitation and supportive care programme for survivors; and

(f) enhance palliative care support for patients approaching end-of-life.