



PHASE II FINAL REPORT (Jan 2019 – Dec 2021)

The University of Hong Kong
2022/10/3

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同心同步同進 RIDING HIGH TOGETHER

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2. Acknowledgement

The Project would not have been successful without the advice from our Advisory Committee on the direction of our Project, support from our education sub-committee members who provided valuable comments on our capacity building programmes. We would like to express our gratitude to all members in the Advisory Committee and all members of the education sub-committee.

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3. Executive Summary

The JCECC Phase II Project (2019 – 2021) aims at improving the quality of community end-of-life care (EoLC) for patients and families touched by end-of-life issues, enhancing the EoLC competencies of service providers, and promoting public awareness on EoLC. The Project consists of 4 components: (1) Capacity Building for Professionals, (2) Community EoLC Model Development and Direct Services, (3) Capacity Building for Volunteers, and (4) Knowledge and Skills Transfer for General Public. **Figure 1.1** summarised the outputs, outcomes and impacts of each project component.

Component	Outputs	Outcomes	Impacts
Capacity Building for Professionals	Trained 7 246 health and social care professionals: <ul style="list-style-type: none"> 7 029 health and social care professionals 31 leaders in EoLC 186 social work students 	<ul style="list-style-type: none"> 85.1% health and social care professionals reported improved understanding on EoLC (target 80%) 92.9% social work students have improved knowledge and values on EoLC (target 80%) 	<ul style="list-style-type: none"> 2.8% improvements in EoLC competency among surveyed health and social care professionals 16.4% higher EoLC competency in JCECC training programme participants as compared to non-participants
Community EoLC Model Development and Direct Services	<ul style="list-style-type: none"> Two standardised community EoLC models developed The home-based “Integrated Community End-of-Life Care Support Teams (ICESTs)” served 1 410 cases The Integrated Residential Care Home for the Elderly End-of-Life Care Support Team (IRHESTs)” served 502 cases 3 ICEST manuals were published 	<ul style="list-style-type: none"> Patients reported 33.8% improvement in quality of life (target 20%) 91.2% of patients perceived that their preferences of care were respected (target 75%) Family members reported 31.9% improvement in quality of life (target 20%) 90.2% family members perceived that the services have effectively supported them in taking care of patients at home (target 75%) 97.6% bereaved family members reported low risk for complicated grief (target 95%) 	<ul style="list-style-type: none"> The 3 ICEST NGOs (HKSR, HC, SJS) saved HK\$ 92, 261 medical cost per patient. The Social return on Investment (SROI) analysis showed that HK\$1 invested in ICEST generated HK\$ 3.58 of social values in return. The ICEST with enhanced medical and nursing support (HOHCS model) saved HK\$ 106,991 medical cost per patient The IRHESTs saved HK\$ 113,801 medical cost per patient
Capacity Building for Volunteers	Trained 418 volunteers: <ul style="list-style-type: none"> 1 193 attendances in elective courses 43 trained as volunteer leaders 236 participated in appreciation event 	<ul style="list-style-type: none"> 98.8% volunteers showed improved understanding on EoLC (target 80%) Volunteers showed 7%-14.5% improvements in EoLC competencies after core training 	<ul style="list-style-type: none"> Volunteers showed significantly improved EoLC competency ranged between 6.7% - 11.7% in various domains 6 months after core training
Knowledge and Skills Transfer	<ul style="list-style-type: none"> Public education activities reached more than 5 046 000 people Over 4 000 patients and family carers educated 	<ul style="list-style-type: none"> Mean level of satisfaction of participants of public education was 4.25/5, suggesting the public education programmes were well received 	<ul style="list-style-type: none"> 9.3% increase in the surveyed respondents from the community have heard of terms related to EoLC (target 10% increase) 2.4%* increase in the surveyed respondents from the community who are comfortable to openly discuss EoLC (target 10% increase) <p><i>*the baseline in 2018 was already 88.2%, making further 10% increase too ambitious and difficult</i></p>

Figure 1.1 Outputs, outcomes and impacts of each project component

Tables 1.1 and 1.2 further summarised the Project deliverables and outcomes in details.

Table 1.1 Output marked against pledged deliverables

Item		Project Deliverables (Total of 3 Years)		Actual (Session “[S]”; Beneficiary/Attendance “[B]”)					
				Total		Achievement Percentage			
		Session	No. of Beneficiary/ Attendance	[S]	[B]	[%]	[%]		
1.	Capacity Building								
	Competence Development Programmes								
	a)	Training for social work students	12	180	14	186	116.7%	103.3%	
	b)	Training for home care nurses	12	480	30	717	250.0%	149.4%	
	c)	Training on health and social care professionals in the community		116	2,880	149	6,312	128.4%	219.2%
		i)	Basic course on EoL psychosocial care	3	1,450	3	3,674	100.0%	253.4%
		ii)	Intermediate course on EoL psychosocial care	30	220	37	356	123.3%	161.8%
		iii)	Advanced course on EoL psychosocial care	26	60	37	97	142.3%	161.7%
		iv)	Competence domain-specific training	18	270	29	988	161.1%	365.9%
		v)	ICEST model training	8	80	10	230	125.0%	287.5%
		vi)	Setting-specific training	27	720	29	877	107.4%	121.8%
		vii)	Volunteer coordinator training	4	80	4	90	100.0%	112.5%
	d)	Leadership training programme	18	25	20	31	111.1%	124.0%	
	e)	Training on volunteers		59	900	59	1,890	100.0%	210.0%
		i)	Volunteer core training	12	360	12	418	100.0%	116.1%
		ii)	Volunteer elective training	30	300	30	1,193	100.0%	397.7%
		iii)	Volunteer leaders training	16	40	16	43	100.0%	107.5%
		iv)	Volunteer appreciation event	1	200	1	236	100.0%	118.0%
	f)	Online education for patients /caregivers	3	650	2	4,090	66.7% ^a	629.2%	
	g)	Training Manual for Nurses and Healthcare Professionals in the Community	1	500	1	500	100.0%	100.0%	
	h)	Volunteer Coordinator Manual	1	400	0	0	0.0% ^b	0.0% ^b	
	Knowledge and Skills Transfer								
	a)	Public education activities(Seminar/ Public Lecture Series at HKU and public talks at Community Centres)	12	1,800	14	35,788	116.7%	1988.2%	
	b)	International conference and local symposium	2	500	2	963	100.0%	192.6%	
	c)	Video production	12	12,000	13	12,505	108.3%	104.2%	
	d)	Newsletters/e-Newsletter	3	30,000	1	47,693	33.3% ^c	159.0%	
	e)	Radio Programme Series	9	1,000,000	10	1,000,000	111.1%	100.0%	
	f)	Newspaper Columns & Press Conferences	22	990,000	21	3,594,859	95.5%	363.1%	
	g)	Project Website and Facebook Page		150,000		354,954		236.6%	

2.	Direct Services						
	a)	Service Model Manual	1	800	3	1,603	300.0% 200.4%
3.	Systematic Evidence-development and utilisation						
	a)	Programme Evaluation	18	9,000	18	15,030	100.0% 167.0%
	b)	Community-wide Impact assessments	5	4,500	5	4,379	100.0% 97.3%

Notes.

^a The patient and caregiver online learning platform was launched only in 2020 while the number of year that the platform was in service was counted as deliverable.

^b Due to the resignation of the key staff working on the volunteer coordinator manner in mid-2020 and the challenge in hiring a new staff for only half a year, there was a delay in the production of the manual. However, all contents of the volunteer coordinator manual were reviewed by external reviewers by the end of 2021, and the manual was finally published in mid-2022 after typesetting and book design.

^c The 2nd newsletter in 2020 was originally scheduled at the end of 2020. However, due to unexpected high staff turnover in the training team in October 2020, the team prioritised the production of the online 3-tiered course. The 3rd newsletter in 2021, scheduled in the second half of 2021, was also postponed as the project team prioritised the production of the ICEST manuals and volunteer coordinator manual during the same period. The project team eventually produced 3 ICEST manuals, which out-numbered the pledged outputs, in bilingual. To better capture new development of the Project in Phase III and review the achievements in Phase II, the project team will produce a newsletter by the end of 2022.

Table 1.2 Outcome marked against pledged KPI

		Pledged	Actual	Achievement percentage
Home-based End-of-Life Care Services (organised by 5 NGO Partners)				
1)	Patients have experienced an overall 20% improvement of quality of life as reflected by reduction of physical symptoms, anxiety and depression, practical concerns and loneliness after receiving the services (<i>Condition</i>)	100% of Patients with overall 20% improvement	33.8%	169.0%
2)	75% of patients have perceived that their preferences of care are respected (<i>Satisfaction</i>)	75%	91.2%	121.6%
3)	Family members have experienced an overall 20% improvement of quality of life as reflected by reduction of caregiver strain, depressive symptoms and anxiety after receiving the services (<i>Condition</i>)	100% of Family members with overall 20% improvement	31.9%	159.5%
4)	75% of family members have perceived that the services have effectively supported them in taking care of patients at home (<i>Satisfaction</i>)	75%	90.2%	120.3%
5)	95% of bereaved family members have been assessed at lower risk for complicated grief. (<i>Condition</i>)	95%	97.6%	102.7%
Capacity Building Programmes for Health and Social Care Professionals, Students and Volunteers				
1)	80% health and social care professionals have reported improved understanding on end-of-life care (<i>Knowledge</i>)	80%	85.1%	106.4%
2)	80% social work students have improved basic knowledge and values on end-of-life care (<i>Knowledge</i>)	80%	92.9%	116.1%
3)	80% volunteers have increased understanding on the important terms and services related to end-of-life care (<i>Knowledge</i>)	80%	98.8%	123.5%
Public Education Programmes				
1)	A 10% increase in the surveyed respondents from the community have heard of various terms related to end-of-life care, palliative care and bereavement services (<i>Knowledge</i>)	10% increase	9.3%	93.0% ^a
2)	A 10% increase in the surveyed respondents from the community are willing to openly discuss end-of-life issues (<i>Attitude</i>)	10% increase	2.4%	24.0% ^b

Notes.

^a This was calculated by comparing the results of 2018 and 2021 public survey. The results suggested that the public sequentially gained more knowledge on EoLC-related terminologies, supporting the effectiveness of the public education effort in the past 3 years. Public awareness might take a longer time to change. The current degree of improvement suggested that public education effort is in the right direction despite the social unrest and pandemic in the past two years.

^b This was calculated by comparing the results of 2018 and 2021 waves of public survey. Although the improvements not yet reached the pledged target, the total percentage of respondents who expressed willingness to openly discuss EoLC issues in 2018 was 88.2%, and the percentages were maintained above 90% in 2020 and 2021 suggesting the majority of the respondents were open towards discussing EoLC. Given the high baseline in 2018, it might be difficult if not impossible to promote 10% further improvements. Moreover, more effort and longer time might be needed to motivate the minority who were uncomfortable to talk about this topic.

4. Capacity Building for Professionals

4.1. The Programme

4.1.1. Training for professionals in hospitals (CUHK)

Over the 3 years, the CUHK Jockey Club Institute of Ageing had offered over 300 activity sessions to over 30,000 participants from both the public and the healthcare sector. These included 31 and 92 training sessions for 954 doctors and 3545 nurses respectively either from NTEC hospitals or in private practice, in the formats of seminars, lectures, symposium, online training, or train-the-trainer sessions. 46 training sessions were organised for allied health professionals, with 1588 community nurses, social workers, personal care workers and programme workers from various RCHEs benefited.

4.1.2. Training for professionals: Home Care Nurses in the Community

The training of home care nurses provided by the HKU School of Nursing was divided into two parts: Entry Level and Advanced Level. Over the 3 years, 37 sessions of training have been delivered and the two-level course had trained up altogether 717 nurses. Consolidating from the training experience in the 3 years, a training manual for nurses in the community was published and benefited 500 nurses in 2021.

4.1.3. Training in Residential Care Homes for the Elderly (RCHEs) (by HKAG)

The training for RCHEs were developed and delivered by the HKAG. Over the 3 years, HKAG had delivered 382 sessions of basic EoLC training to 1 833 professional staff and support care workers in over 48 RCHEs to build their homes' capacity to provide EoLC to their residents. Further 78 sessions of advanced training were provided to 310 RCHE staff, and 22 sessions of capacity building programme were delivered to 176 Visiting medical officers.

4.1.4. Training for professionals: Health and Social Care Professionals in the Community

The trainings for health and social care professionals in the community were mainly provided by the Faculty of Social Sciences, the University of Hong Kong, and is divided into long-term, intermediate term and short-term trainings.

4.1.4.1. Long-term Course

A 10-month leadership training programme, targeting middle management and service development personnel in related healthcare and social care fields, was held between October 2020 and September 2021. It aims to upskill the participants with essential leadership capacities to develop and to sustain quality EoLC service in Hong Kong. 31 leaders were nominated by 21 NGOs to participate in the programme. International and local guru including Prof Linda Ginzel, Dr. Wang Ying Wai, Prof David Currow and Prof Terry Lum etc. were invited to deliver inspiring lectures to participants. Altogether 29 proposals on EoLC-related projects were developed by the participants and pitched in August 2021. A closing ceremony was held on September 17, 2021 with 20 guests attending (**Figure 4.1**).

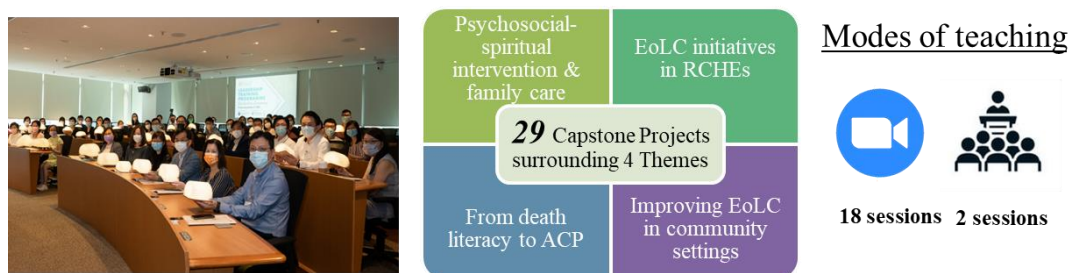


Figure 4.1 Leadership programme 2020/2021

4.1.4.2. Intermediate-term Course

A 3-tiered community psychosocial EoLC course structured based on seven core EoLC competences was launched in 2019 and continued to deliver training the professionals in the community throughout Phase II Project afterwards (**Figure 4.1**). The programme consists of a Basic Module (purely online course), the Intermediate Module and Advanced Module (designed with the “flipped classroom” pedagogy), which were launched in September 2019, May 2020, and December 2020 respectively. The entire course consists of 75 learning hours (7 hours for basic, 26 for intermediate, and 42 for advanced). 17 local experts in health and social care in the EoLC and palliative care context were invited as speakers in the learning videos. The three modules benefited 3,674, 356, and 97 participants respectively. Because of the COVID-19 pandemic, all tutorials of Intermediate and Advanced Modules were conducted via Zoom, but the interactive learning elements (e.g., role play, group discussion) were kept in the virtual learning environment.



Figure 4.2 3-tiered Community Psychosocial End-of-life care curriculum

4.1.4.3. Short-term Course

Short-term courses included courses that last between one session to eight sessions targeting on specific topics, settings, or target groups.

Domain Specific Workshops were independent workshops on topics with high training needs. Between January 2019 and December 2020, 18 workshops have been organised covering the 7 domains of EoLC competences. Among these workshops, 14 were delivered by local speakers and 4 were by international speakers. Nine of the workshops were held in classroom whereas the remaining were held via Zoom due to the COVID-19 pandemic (**Figure 4.3**).



Modes of teaching



9 workshops



9 workshops

Figure 4.3 Domain specific workshops

Setting specific trainings for special groups or settings such as professionals working with patients with dementia or intellectual disabilities, or officers in the Police force welfare office were offered in Phase II Project. Since July 2020, setting specific trainings have been delivered in series to elderly community service settings such as DECC, NEC, DE, IH, and EH. The trainings were differentiated into professional and support care worker levels with a purpose of upskilling different rank of workers to integrate EoLC values into their interaction with elderly who have EoLC needs (Figure 4.4). Training series such as the “關心速遞”, “閒話生死”, and “得心應手” have been organised in 2020 and 2021 benefiting 688 professionals and 189 support care staff. Moreover, a symposium was especially held in April 2021 for managerial staff in community elderly service units to raise their awareness on the relevance of EoLC to their service setting. Overall, a total of 29 sessions of setting specific trainings had been delivered to up to 877 professional and frontline workers. In particular, most sessions targeted exclusively on community elderly service settings were oversubscribed.

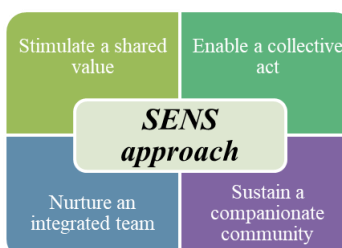
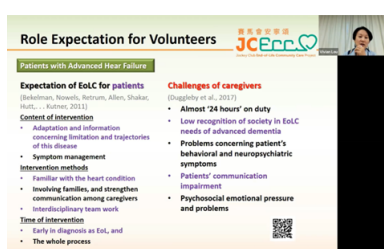


Modes of teaching



Figure 4.4 Setting specific trainings in 2021

Volunteer coordinator course were organised between 2020 and 2021. The two Zoom sessions, co-taught between HKU and 4 NGO partners, benefited 90 workers (Figure 4.5). A framework named **SENS** approach (Stimulate a shared value, Enable a collective act, Nurture an integrated team, and Sustain a companionate community) was built by the Project team based on the JCECC experience to structure the training for volunteer coordinators. A volunteer coordinator manual has been drafted and will be published in early 2022.



Mode of teaching



Figure 4.5 Volunteer coordinator training

Altogether 3 batches of **Social work student courses** were organised between 2020 and 2021 to benefit 186 social work students from The University of Hong Kong, The Chinese University of Hong Kong, The City University of Hong Kong, Hong Kong College of Technology, The Hong Kong Baptist University, The Hong Kong Polytechnic University, and Caritas Institute of Higher Education. The Project team experimented with different modes of teaching in these 3 batches of courses, with the first batch taught via 4 Zoom sessions, the second batch integrated the online basic module as part of the prerequisite followed by 3 Zoom sessions, and the last batch was delivered via a full-day face-to-face workshop (**Figure 2.6**). These workshops equipped the professional-to-be with essential knowledge and skills of EoLC.



Figure 4.6 Training for social work students

ICEST training for NGO partners had been organised between 2019 and 2020. In total, seven sessions were organised with 161 attendances. The training sessions aimed to equip partners with the skills of using the ICEST Model manual, and feedbacks on the manual was collected to further improve the manual. In 2021, one batch of ICEST training was organised for health and social care professionals and support care staff in the elderly community service settings. The workshops were oversubscribed with 44 professionals and 25 support care staff benefited from the training (**Figure 4.7**). Moreover, 3 ICEST manuals, two for professionals and one for support care workers, were published by the end of 2021. The manuals for professionals were published in both English and Chinese.



Figure 4.7 ICEST model training in 2021 and ICEST Manuals

The Certificate Course on End of Life care for Primary Care Doctors was held for primary doctors on March 17, 2019 in collaboration between Prof. Amy Chow and the project team of the Haven of Hope Christian Services.

4.2. Programme Evaluation

4.2.1. Outcomes

4.2.1.1. *Training for professionals: Home Care Nurses in the Community*

Three sets of questionnaires were delivered to the participants, including Multidimensional Orientation toward Dying and Death Inventory (MODDI-F), Self-competence in Death Work Scale (SC-DWS) and Professional Quality of Life Scale (Chinese version) at the beginning and end of the entry level course and advanced level course respectively. Preliminary data analysis on completed questionnaires revealed that nurses had significantly greater self-competence in death work, less fear, greater acceptance of dying/death, and significantly lower burnout level after attending both the entry and advanced level courses.

4.2.1.2. *Long-term Course*

Pre-Post-followup assessments have been conducted with 18 leadership programme participants. Pre-post changes showed that participants experienced statistically significant changes in all aspects of their leadership competencies after the training programme with an overall 34.4% improvements (**Figure 4.8**). These competences include personal quality as a leader, working with others, managing and improving services, setting directions, creating visions, and delivering strategy. Upon follow-up evaluation 3 months after the completion of programme, further improvements were observed in all competencies compared with the post-programme assessment although statistically insignificant (**Figure 4.8**). Participants also reported high levels of satisfaction towards the programme, with all participants (n=29) rating their level of satisfaction 7 or above out of 10 in the post-programme assessment.

In the focus groups, participants shared that they enjoyed the sharing of the international and local experts who enriched their understandings in the global and local development of EoLC and its key agendas. Besides, the good variety of course content broadened their horizons and cultivated new perspectives. The programme was able to achieve its objectives and intended outcomes despite the programme was delivered via Zoom most of the time due to the COVID-19 pandemic. For further improvements, participants in the focus groups suggested moving from service design to actually making real impacts on the field, setting up an Alumni Association to continue the momentum and arranging more sharing time among NGOs to foster professional networking. Graduates also expressed a preference for face-to-face sessions for networking purpose although they understood the limitations under the pandemic.

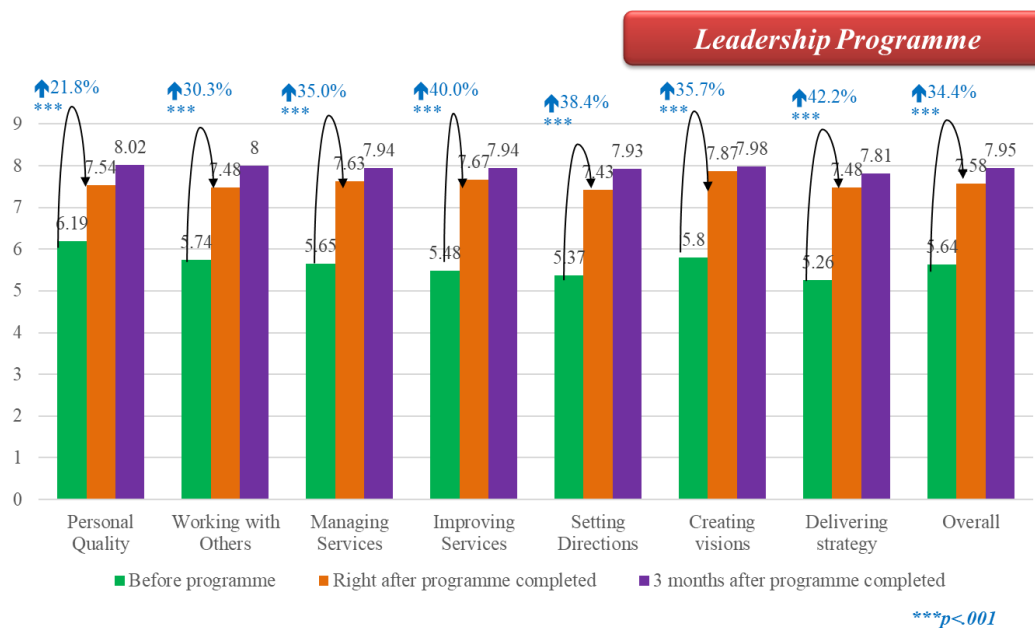


Figure 4.8 Outcomes and Impacts of 2020/2021 Leadership Programme (n=18)

4.2.1.3. Intermediate-term Course

In general, the outcomes on the **3-tiered community psychosocial EoLC course** were very promising. The pre-post course evaluation on the basic module showed that participants reported significant improvements in all competence domains with an overall improvement as great as 47.3% (**Figure 2.9**). Among participants who completed the entire 3-teired course, the improvements were even greater with an overall improvement reaching 69.9% (**Figure 2.10**). All these changes reached statistical significance ($p < .001$). Nevertheless, the number of participants who participated in the evaluation in the intermediate and advanced modules were limited. In the qualitative comments, some participants reflected that the commitment in the advanced module was too heavy.

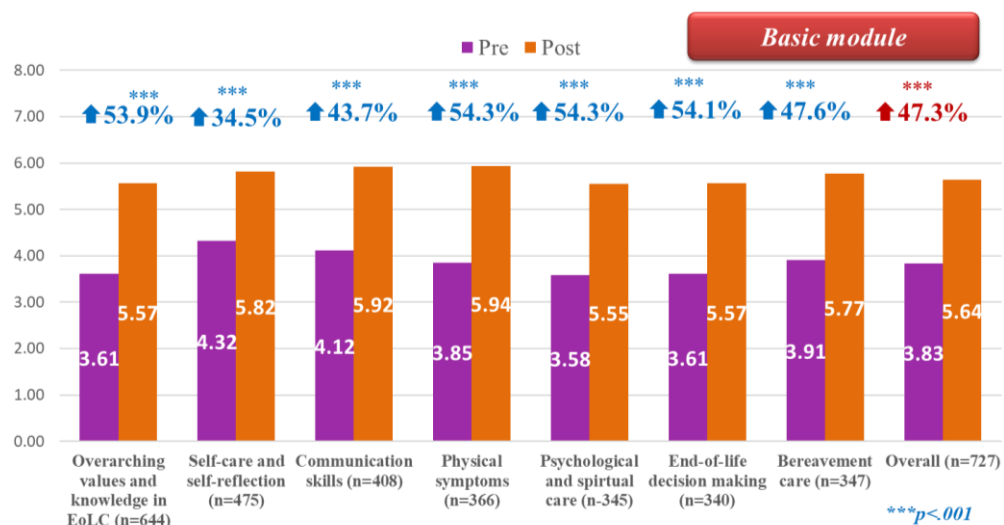


Figure 4.9 Outcomes of online basic course (paired t-tests)

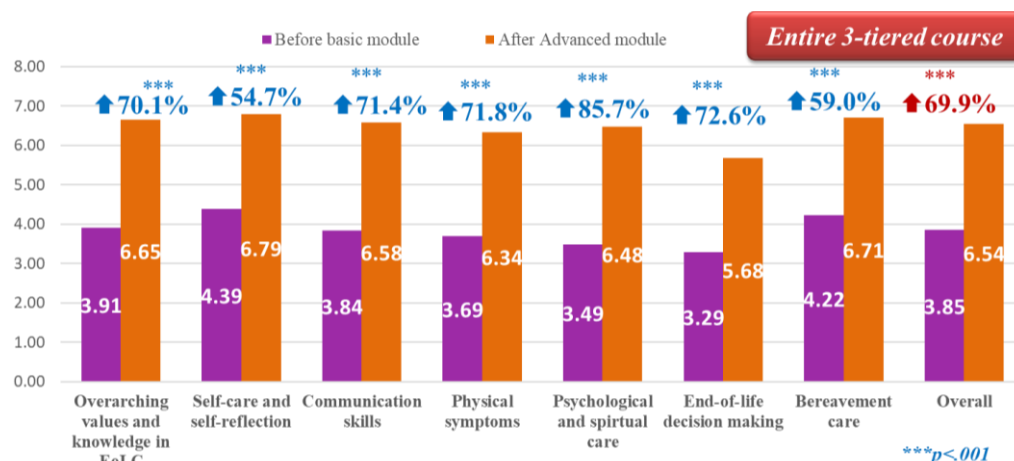


Figure 4.10 Outcomes of 3-tiered course (paired t-test, n=20)

4.2.1.4. Short-term Course

Between January 2019 and December, 2021, the aggregated outcomes from 18 **Domain-specific workshops** showed that the workshops have been effective in enhancing the EoLC competences of the participants in various domains (n=444). The pre-post workshop changes in the competences of the participants showed that participants experienced statistically significant improvements in all competence domains, with percentages of improvement ranged between 14.4% - 27.7% in various domains, and an overall improvement of 26.2% (**Figure 4.11**). Further analysis comparing the effectiveness of courses conducted with classroom format and those by Zoom revealed no differences between the two formats.

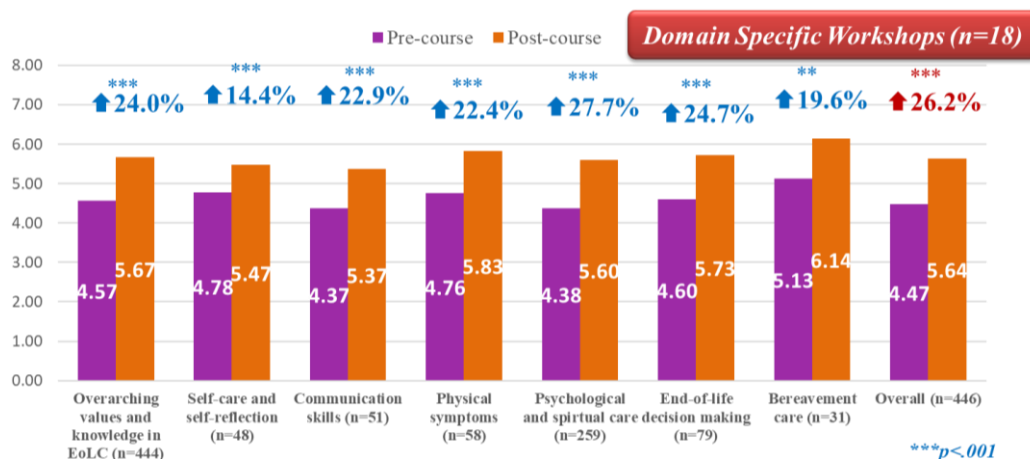


Figure 4.11 Changes in EoLC competent in domain specific courses (paired t-tests)

Pre-post course evaluation was conducted in 5 **setting specific trainings** with responses from 142 professionals. Participants showed significant improvements in all EoLC competences with an overall improvement of 33.8% (**Figure 4.12**). Similarly, in the pre-post course evaluation on training for supporting care staff in community elderly service units, assessed participants (n=39) reported an averaged 17.2% EoLC competence which was statistically significant (**Figure 4.12**). In qualitative comments, participants from elderly community service settings revealed limited training on EoLC topics available to them.

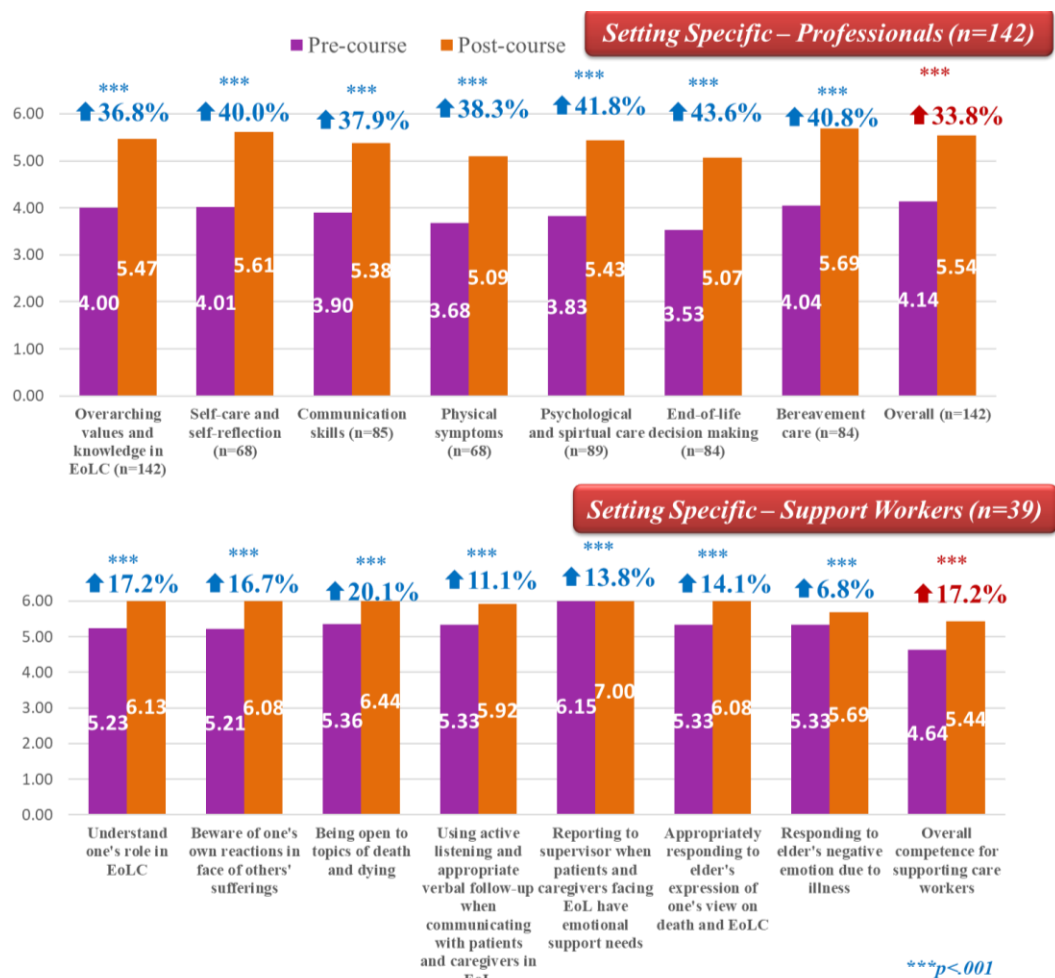


Figure 4.12 Changes in EoLC competence in setting specific courses 2021

Pre-post course evaluation was conducted in 3 **Social work student courses** with responses from 136 social work students. Participants showed significant improvements in all EoLC competence domains with an overall improvement of 68.02% (**Figure 4.13**). Further analysis showed no significant differences in the effectiveness between the three course formats (see p. 10 for the description on the three different formats).

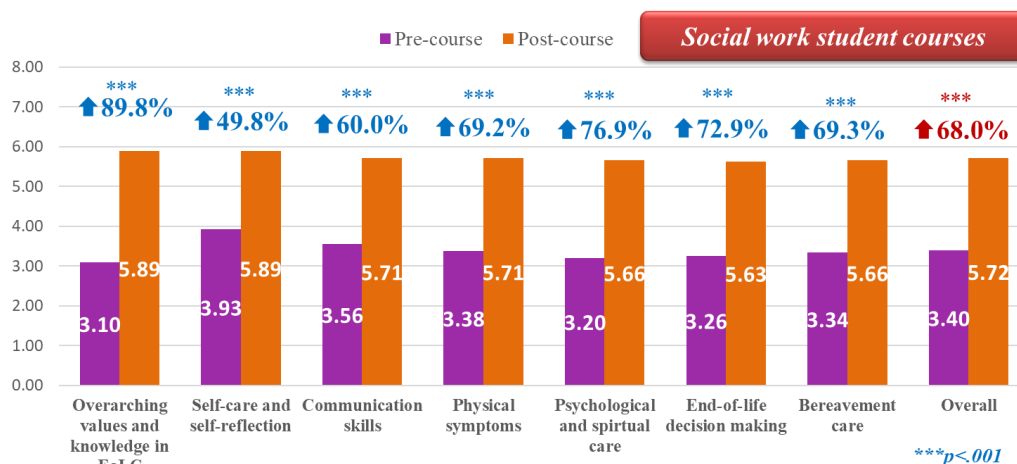


Figure 4.13 Changes in EoLC competence in social work student courses (paired t-tests, n=136)

Evaluation was conducted on the **ICEST model training** held in 2021. Assessed professionals and supporting care workers showed significant improvements in their overall ICEST competencies with improvements of 59.9% and 21.9% for professionals and support care workers respectively (**Figure 4.14**).

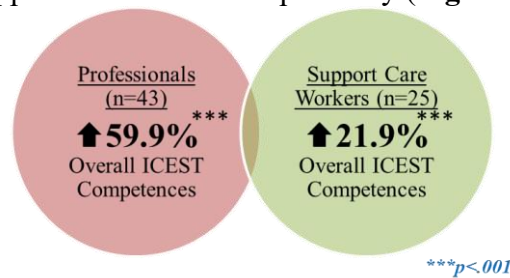


Figure 4.14 Changes in ICEST competencies among professionals and support care workers in ICEST model training

4.2.2. Impact

Three waves of annual survey for health and social care professionals have been conducted. Professional bodies and associations for doctors, nurses, and social workers were approached for invitation. Among completed survey with ineligible participants excluded, a total of 470, 328, and 357 health and social care professionals (physicians, nurses, social workers etc.) who work in medical settings or elderly service settings were recruited in 2019, 2020, and 2021 waves respectively. Detail demographics are shown in **Figure 4.15**. Subsequent analyses were controlled for the differences in EoLC experience and involvement in respondents across years.

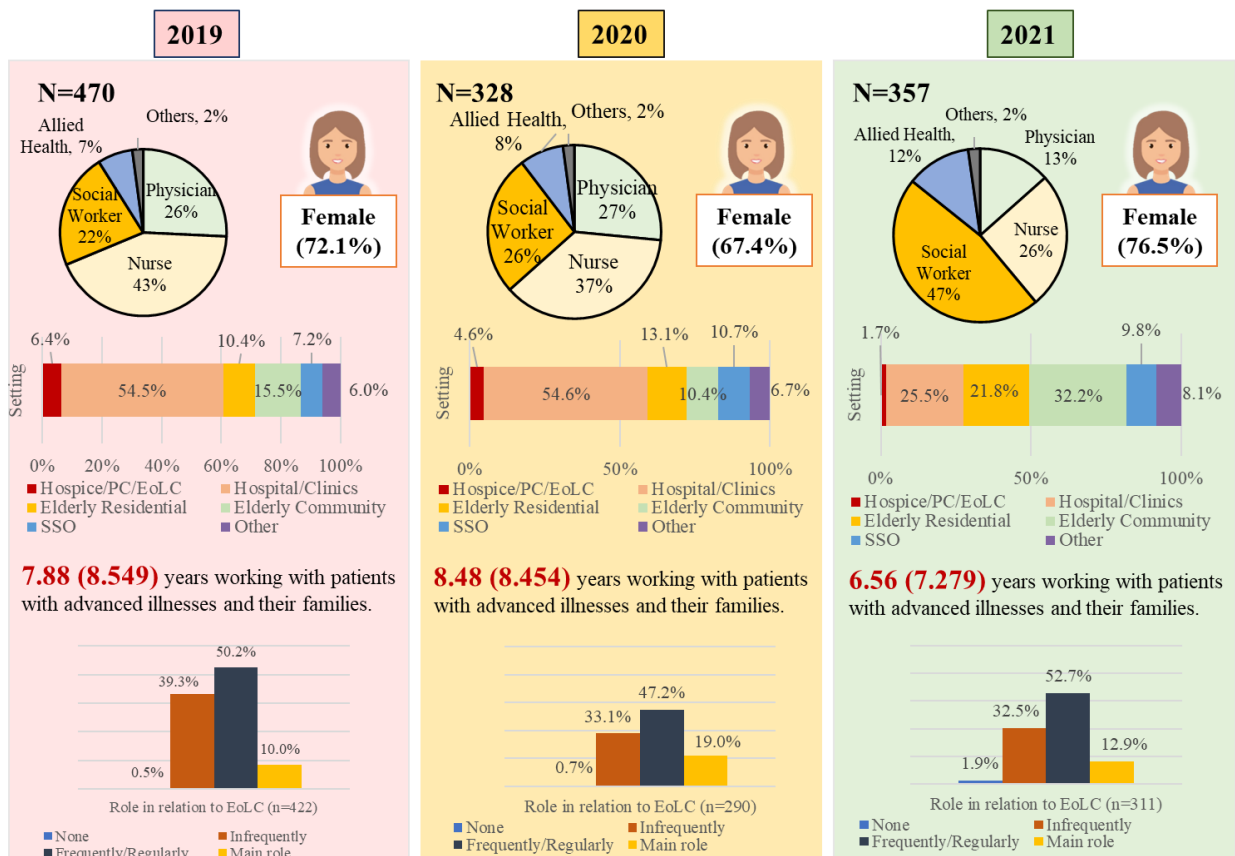


Figure 4.15 Participants' demographic characteristics across three waves.

Changes in Competence level across years

Overall, professionals showed a significant improvement in overarching values and knowledge between 2019 and 2021 (7.1%), and in psychosocial-spiritual care between 2020 and 2021 (5.5%) (Figure 4.16). There was an increase of 2.8% in overall EoLC competence although the change not yet reached statistical significance.

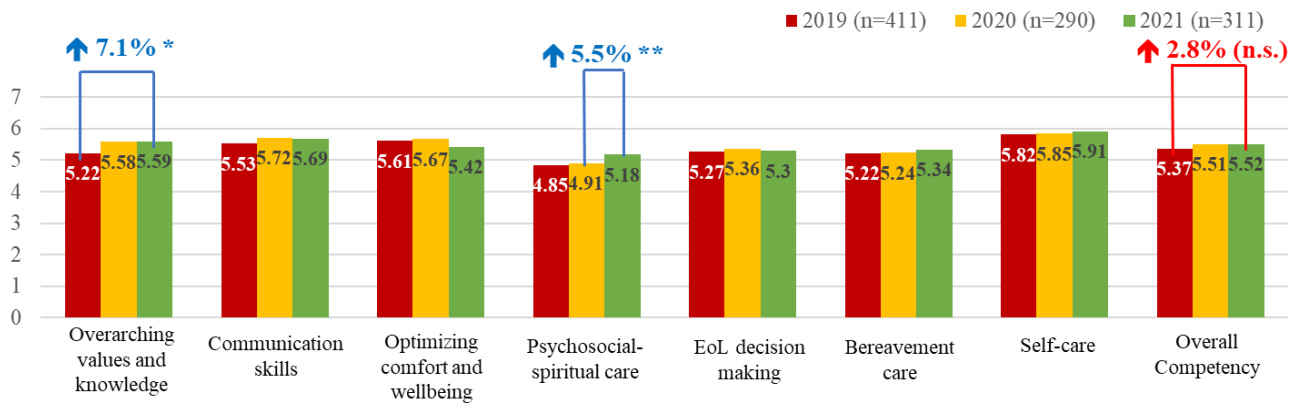


Figure 4.16 Changes in EoLC competencies across years (n=1 012)

Comparison between Project participants and non-participants on competence levels

Respondents who participated in JCECC programme reported a significantly better levels of competence in all competence domains except optimising comfort and wellbeing (Figure 4.17). The overall EoLC competence of programme participants were 16.4% ($p < .001$) greater than non-participants.

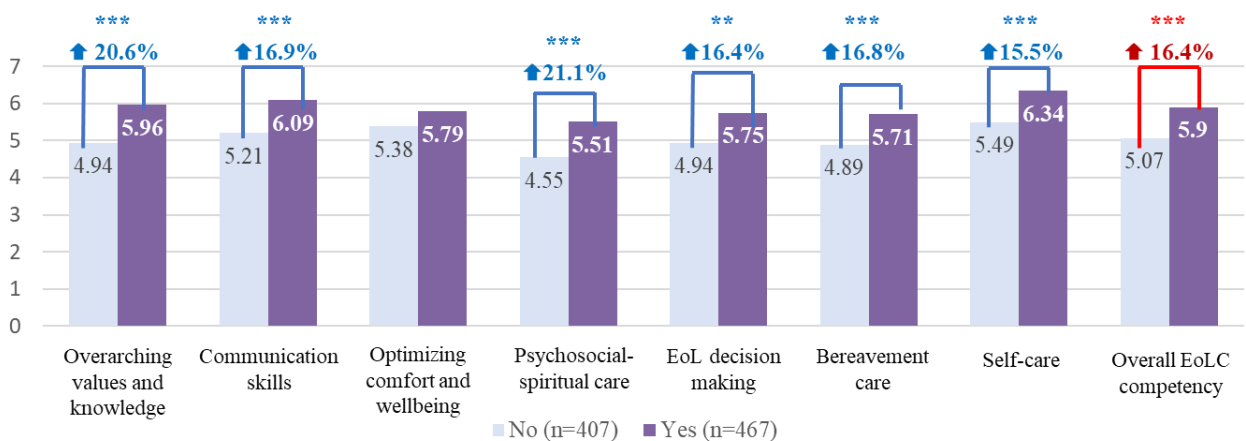


Figure 4.17 Comparison of 7 competence domains between respondents who have and who have not participated in JCECC programme (n=874)

Moreover, respondents who participated in JCECC programme experienced a significantly better physical health and quality of life, as well as a higher job satisfaction and job meaningfulness than those who have not participated in JCECC training programme (**Figure 4.18**). However, we should note that there is no implication on causal relationship in this analysis.

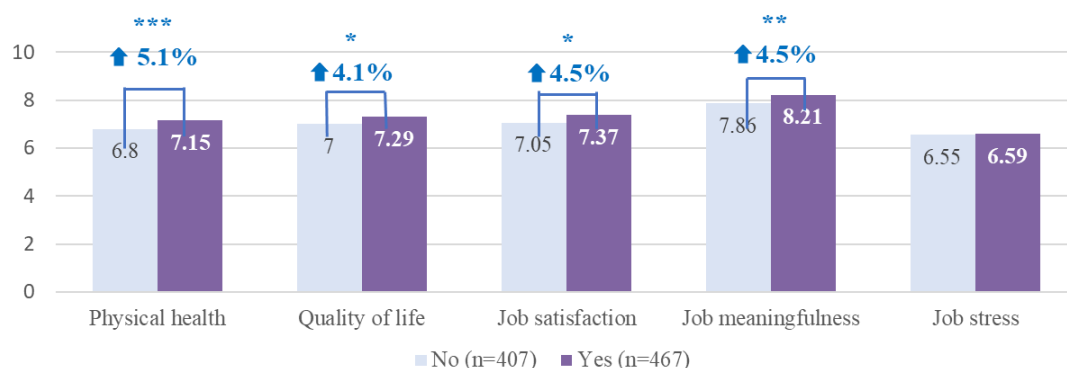


Figure 4.18 Comparison of personal and job-related well-being between respondents who have and who have not participated in JCECC programme (n=874)

Satisfaction towards Capacity Building Programme of JCECC

The percentage of participants who have heard of the project is slightly more across three waves (57.2% for 2019, 67.1% for 2020 and 86.6% for 2021). Among these participants, the levels of agreement on “The project has enhanced professional capacities in providing end-of-life care” increased significantly from 7.84/10 in 2019 to 8.26/10 in 2021 (**Figure 4.19**).

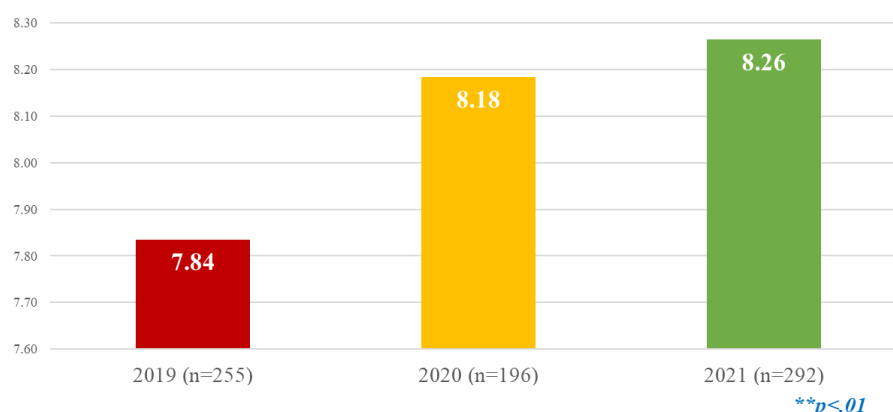


Figure 4.19 Comparison on agreement level on JCECC has enhanced professional capacities in providing EoLC between 2019, 2020, and 2021 (n=743)

4.3. Conclusions

The most prominent milestone in the capacity building for professionals in the Phase II Project is the **development of a standardised curriculum on community psychosocial EoLC delivered via online learning and flipped classroom format**. This programme alone reached over 3,500 health and social care professionals throughout the Phase II

Project. The programme is sustainable due to its online nature, which is even unaffected during the COVID-19 pandemic. Another advancement in the Phase II Project capacity building is the **development of setting or model specific training that met the training needs of professionals of various levels of involvement in EoLC**, including the elderly service setting specific training, ICEST model training, volunteer coordinator training, and social work student training. Despite most trainings were transformed to online live training during the COVID-19 pandemic, the Project team adapted the training activities to the virtual teaching environment and continued to deliver all sorts of training with promising effectiveness. Evaluation also reflected similar effectiveness regardless of training formats (Zoom verse face-to-face).

As the top tier of our Capacity Building Programme, leadership programme was also delivered to cultivate future leaders in community EoLC by linking them with international network. Our evaluation also suggested that there is a possibility that the leadership programme could have a long-term impact on the leadership competencies of our alumni. **Overall, the capacity building programmes for professional was very successful in reaching out to a large group of health and social care professionals, and in enhancing their EoLC competencies according to their training needs.**

Our annual community-wide professional surveys suggested an increasing trend of level of EoLC competencies across years among health and social care professionals in the community, with an overall 2.8% improvement in EoLC competency between 2019 and 2021, and significant improvements in overarching values and knowledge on EoLC and psychosocial-spiritual care in particular. Moreover, among respondents with similar experience in EoLC, participants of JCECC training programmes showed significantly higher levels of EoLC competences than non-participants. This again supports the effectiveness of our Capacity Building programmes. Lastly, the surveys also showed that respondents reported significantly greater average level of agreement on the effectiveness of JCECC capacity building programmes in enhancing professionals' competencies in EoLC across years. **Overall, results from the surveys lent support to the impacts of JCECC Capacity building programmes on the health and social care professionals in the community.**

5. Model Development and Direct Services

5.1. The Programme

Two standardised EoLC service models have been rigorously tested. The Integrated Community End-of-Life Care Support Teams (ICESTs) model is a home-based EoLC service run by 4 NGOs (HKSR, SJS, HC, HOHCS). HOHCS is considered an ICEST with enhanced medical and nursing support. On the other hand, HKAG developed a model Integrated Residential Care Home for the Elderly End-of-life Care Support Team (IRHESTs) for RCHes patients. Due to the pandemic, all service teams have been affected by social distancing policy and have suspended visitation during the pandemic. However, the service teams have creatively used technology to continue their services and build connection with the patients and families. The data collected during the Phase II Project was further used to **consolidate standardised manpower structure and service outputs for the two service models. Three manuals were developed on the ICEST.** The following part reported on the outcomes, outputs and impacts of the two service models. The outcomes will be reported by types of service models.

5.2. Evidence Generation - ICESTs

5.2.1. Service Users

Between Jan 2019 and Dec 2021, the four service teams together served 1 410 cases. The mean age of these patients was 77.86 (sd=11.963) years old, with 52.4% male. Cancer and non-cancer patient each constituted almost half of the sample. For 917 carers who provided data, the mean age was 59.11 (sd=14.237), 40.7% and 42.2% being spouse or child of patient, and they on average provided 59.71 (sd=55.549) hours of care per week (**Figure 5.1**).

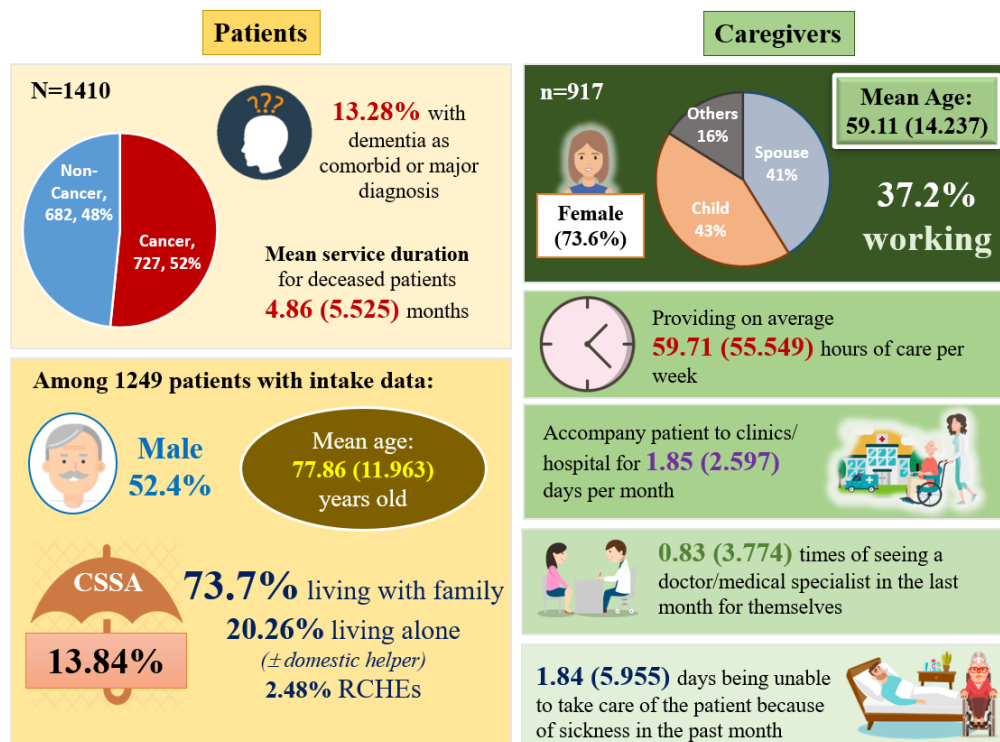


Figure 5.1 ICEST patient and carer background

5.2.2. Service Outputs

Based on the service records of 1 125 cases between January 1, 2019, and December 31, 2021 with retrievable service records, each patient on average received 8.33 hours of service per month before death. **Figure 5.2** shows the composition of professional input in the monthly service hours.

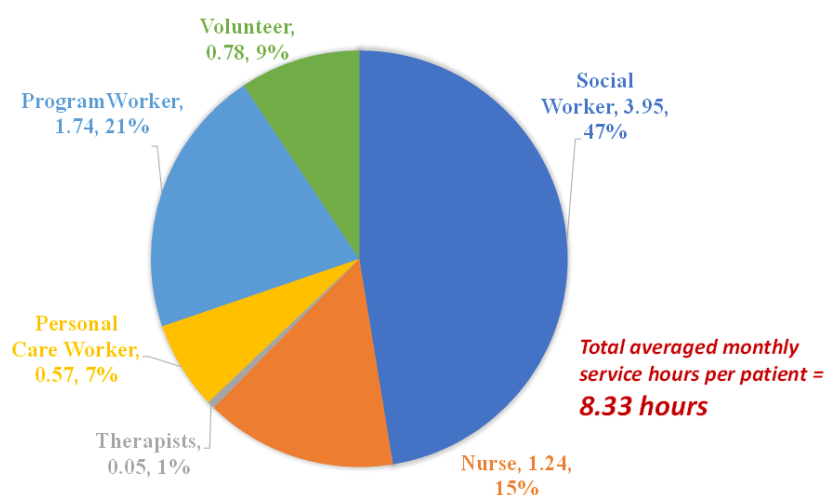


Figure 5.2 Service outputs per case in ICESTs¹

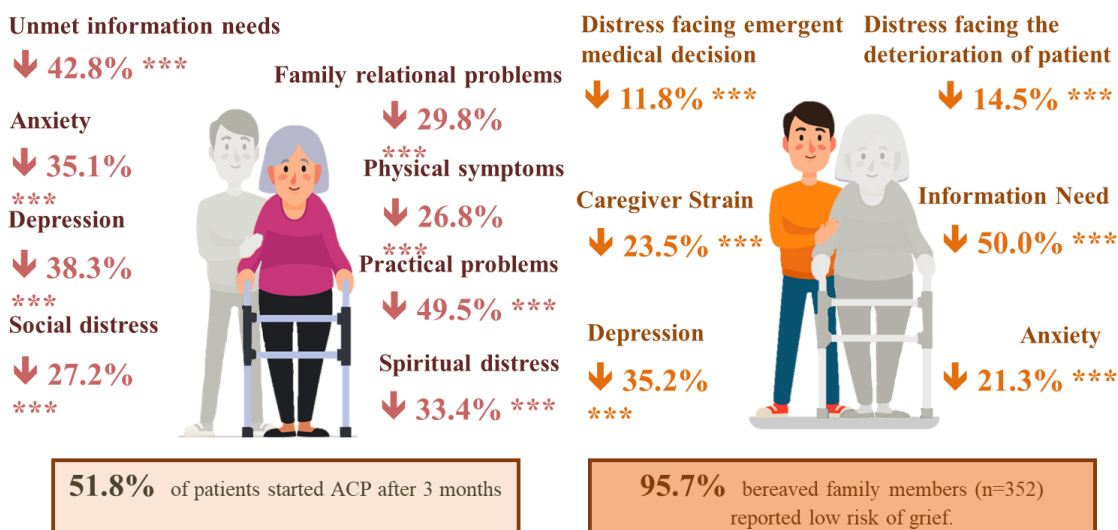
Notes.

¹ The above information includes cases that received services from St. James Settlement, the Hong Kong Society for Rehabilitation, and S.K.H Holy Carpenter Church District Elderly Community Centre.

5.2.3. Outcomes

406 patients were assessed at intake and after 3 months of services (**Figure 5.3**). They reported significant improvements in psychosocial, physical symptoms, and practical problems, including anxiety (reduced by 35.1%), depression (reduced by 38.3%), social distress (reduced by 27.2%), spiritual distress (reduced by 33.4%), family relational problems (reduced by 29.8%), physical symptoms (reduced by 26.8%), and practical problems (reduced by 49.5%). Moreover, 51.8% of the patients have started ACP by 3 months in service. Regarding carers, 343 of them completed intake and follow-up assessment at the 3rd month (Figure 4.3). They also reported significant reduction in distress facing emergent medical decision (11.8%), distress facing deterioration of patient (14.5%), caregiver strain (23.5%), information need (50.0%), depression (35.2%), and anxiety (21.3%). Two months after patient's death, 95.7% of the assessed bereaved family members reported low risk of grief.

Patients' (n= 406) changes after 3 months: Carers' changes after 3 months (n=343):

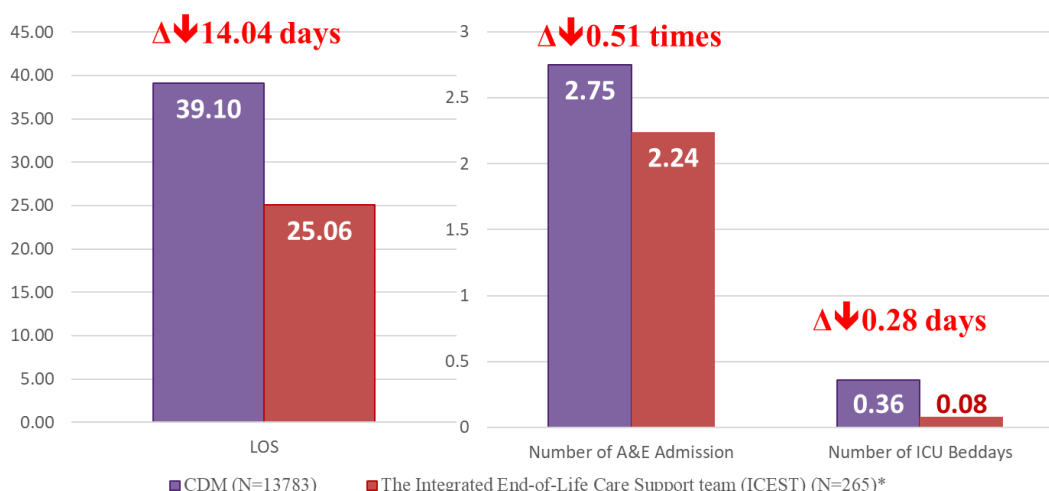


Notes: • Mean values and standard deviations in parentheses of demographics were reported.
• The % changes refer to the mean magnitude of changes among patients served by three community-based NGOs
• Level of significance was represented as *** p<.001

Figure 5.3 Outcome on ICEST patients and family carers

5.2.4. Impact

Medical service utilisation in the last 6 months of life of 265 deceased patients from 3 ICEST NGOs (HKSR, HC, SJS) was reported by their bereaved family carers or retrieved from the hospital. Compared to the end-of-life patients in general who died in HA public hospital in 2015, these deceased patients in ICESTs had 0.51 less A&E admissions, 0.28 less ICU beddays, and 14.04 reduced hospital beddays (**Figure 5.4**). The medical cost saved per patient was HKD 92,261.

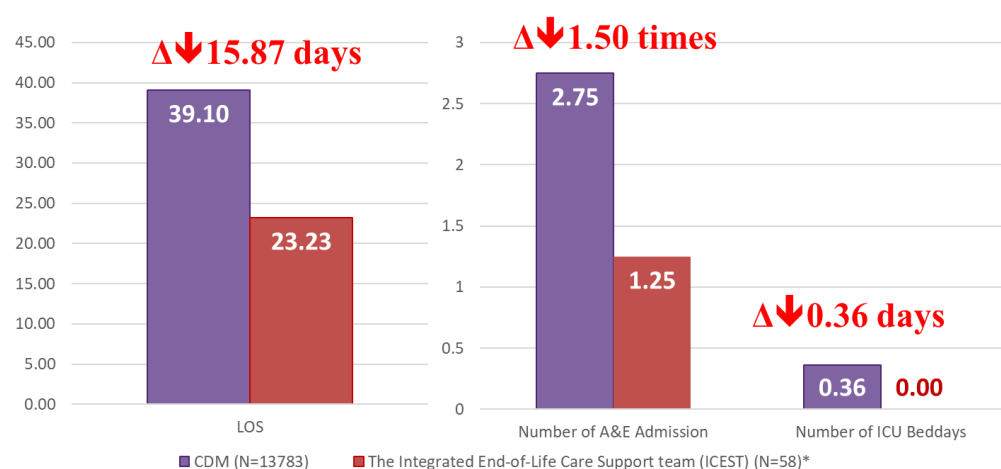


¹ Patients who received services by Integrated Community End-of-Life Care Support Team ("ICEST"), i.e. three NGOs, namely St. James Settlement, The Hong Kong Society for Rehabilitation and S.K.H. Holy Carpenter Church DECC, with similar manpower and resources were evaluated for impact assessment
² The University of Hong Kong obtained data of the medical services in the last 6 months of life among patients who died of cancer, chronic obstructive pulmonary disease, heart failure, end-stage renal disease, motor neuron disease, and Parkinson's disease from the central database of Hospital Authority. After clinical data mining, the impact of the project on patients' use of medical services was evaluated through comparing with the data of six-month before the death of patients.

Figure 5.4 Comparison between patients in ICEST and patients in general in the utilization of medical services in the last 6 months of life

Regarding HOH, medical service utilisation in the last 6 months of life of 58 deceased patients with retrievable. Compared to the end-of-life patients in general who died in

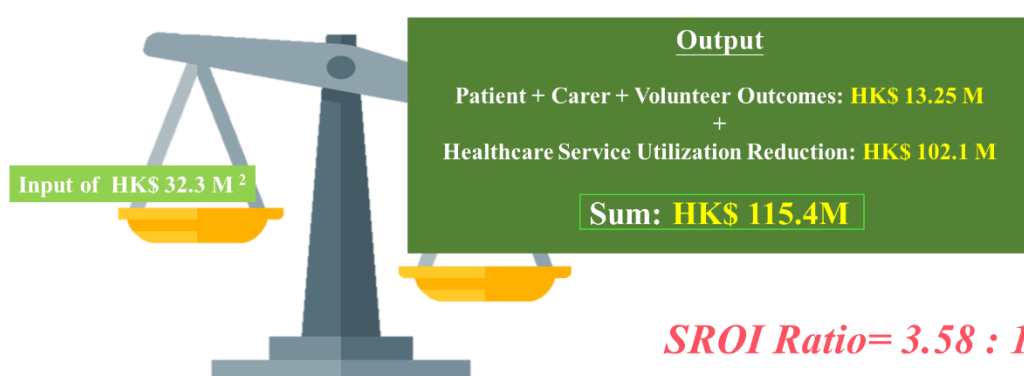
HA public hospital in 2015, these deceased patients in HOH had 1.50 less A&E admissions, 0.36 less ICU beddays, and 15.87 reduced hospital beddays (**Figure 5.5**). The medical cost saved per patient was HKD 106,991.



¹ The University of Hong Kong obtained data of the medical services in the last 6 months of life among patients who died of cancer, chronic obstructive pulmonary disease, heart failure, end-stage renal disease, motor neuron disease, and Parkinson's disease from the central database of Hospital Authority. After clinical data mining, the impact of the project on patients' use of medical services was evaluated through comparing with the data of six-month before the death of patients.

Figure 5.5 Comparison between patients in HOH and patients in general in the utilization of medical services in the last 6 months of life

Social return on Investment (SROI) analysis was further conducted on the 3 ICESTs over the 3 years. Findings suggested that \$1 HK invested in ICEST could generate \$3.58 HK of social values in return, suggested the ICEST was cost-effective (**Figure 5.6**). Further analysis suggested that the model was even more cost-effective during COVID-19 pandemic, with the highest SROI ratio recorded during the 4th wave of COVID-19, reaching 6.73:1 (**Figure 5.7**).



Notes.

¹ Involves cases from 3 ICESTs: St James' Settlement, The Hong Kong Society for Rehabilitation, and S.K.H. Holy Carpenter Church DECC

² This is the JCECC project budget for 3 ICEST NGOs between 1 Jan, 2019 and 31 Dec, 2021. Output was estimated by projecting the quantity of changes to full sample between the same period (1 Jan, 2019 and 31 Dec, 2021). This is a temporary result as data collection is still underway.

Figure 5.6 SROI analysis on ICEST

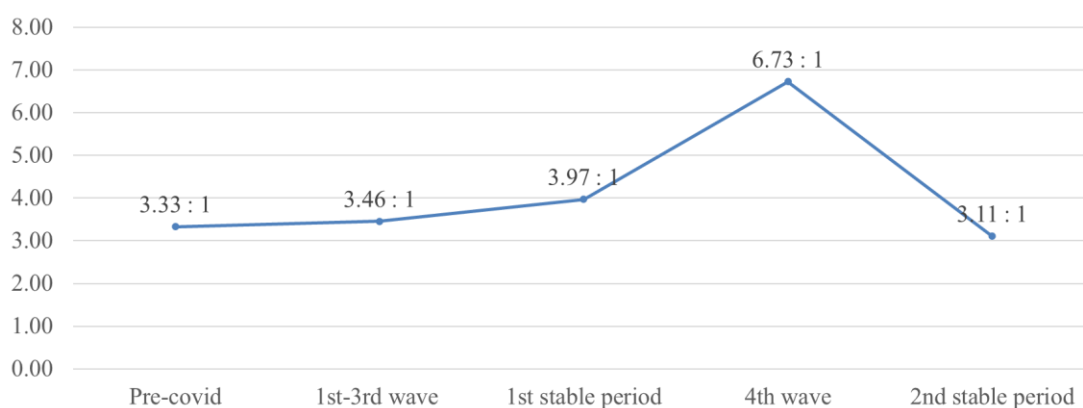


Figure 5.7 SROI ratios in different periods during the Phase II Project

5.3. Evidence generation - IRHESTs (HKAG)

5.3.1. Service Users

Up to December 31, 2021, 502 cases were reported to the HKU team by HKAG. These residents had a mean age of 89.59 (sd=7.747) years old and 25.10% were male. Sixty-nine percent were diagnosed with dementia. The major diagnoses were diversified as shown in **Figure 5.8**. By December 31, 2021, 287 passed away with a mean service duration of 5.70 (sd=6.039) months while those surviving (n=204) had a mean service duration of 14.38 (sd=9.913) months. Regarding family carers (n=502) assessed, the mean age was 59.35 (sd=10.415), 67.3% being female, and majority was adult children (72%). They on average visited the patient for 2.24 (sd=2.178) times per week.

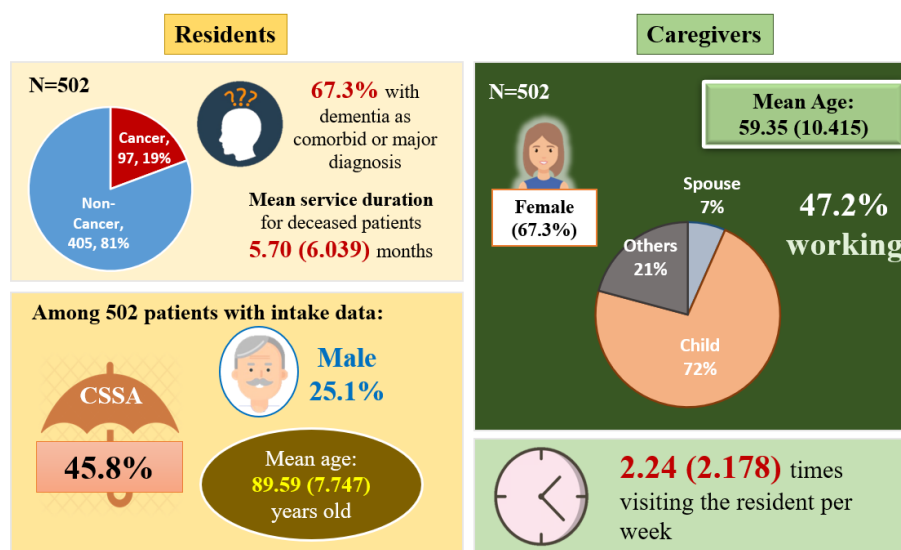


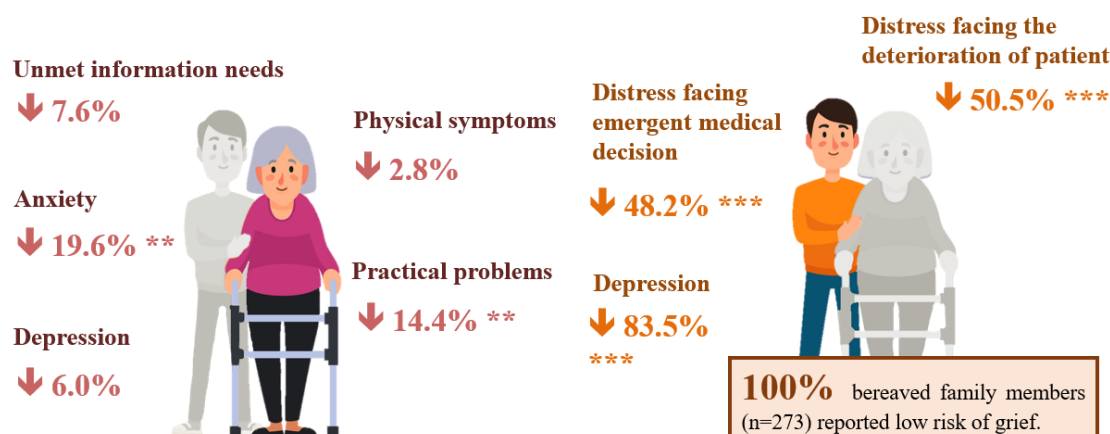
Figure 5.8 IRHEST patient and carer background

5.3.2. Outcomes

323 patients received intake and 3-month assessments (**Figure 5.9**). They reported significant reduction in practical problems (14.4%) and anxiety (19.6%). They also reported reduction in physical symptoms, unmet information needs and depression, but the changes didn't reach statistical significant level. Regarding carers (n=271), they

reported significant reduction in depression (by 83.5%), and distress in facing emergent medical decision (48.2%) and facing deterioration of patient (50.5%). All assessed bereaved family members reported low risk of complicated grief.

Patients' (n= 323) changes after 3 months: Carers' changes after 3 months (n=271):



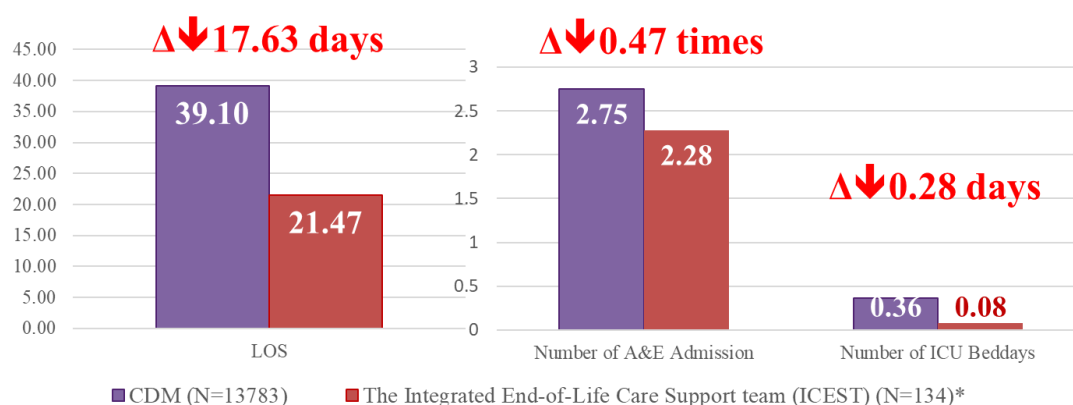
Notes

- Mean values and standard deviations in parentheses of demographics were reported.
- The % changes refer to the mean magnitude of changes among patients served by three community-based NGOs
- Level of significance was represented as * $p < .05$, ** $p < .01$ *** $p < .001$

Figure 5.9 outcomes of IRHEST patients and carers

5.3.3. Impacts

Among 287 deceased patients from IRHESTs, data on medical service utilisation in the last 6 months of life of 134 deceased patients was retrievable. Compared to the end-of-life patients in general who died in HA public hospital in 2015, these deceased patients in ICESTs had 0.47 less A&E admissions, 0.28 less ICU beddays, and 17.63 reduced hospital beddays (**Figure 5.10**). The medical cost saved per patient was HKD 113,801.



¹ The University of Hong Kong obtained data of the medical services in the last 6 months of life among patients who died of cancer; chronic obstructive pulmonary disease, heart failure, end-stage renal disease, motor neuron disease, and Parkinson's disease from the central database of Hospital Authority. After clinical data mining, the impact of the project on patients' use of medical services was evaluated through comparing with the data of six-month before the death of patients.

Figure 5.10 Comparison between patients in IRHESTs and patients in general in the utilization of medical services in the last 6 months of life

5.4. Conclusions

Both the ICEST and IRHEST models showed promising effectiveness and medical cost savings. The two models not only successfully reduced the psychosocial distresses and practical concerns of both patients and family carers, it helped bereaved family carers to overcome the grieving process with low risk of complicated grief, and it helped patients to remain at home for a longer time while released hospital beds for other patients who need them. Especially, the SROI ratio of 3.85:1 of ICEST further suggested it is a sustainable model. Given the development of manualised intervention and care pathway, it is time to upscale the two models to serve more beneficiaries, and particularly beneficiaries of more diverse backgrounds to test the performance of the models. In future, evaluation should also be further advanced to extend SROI analysis to IRHEST and examine the mechanism of changes of the models.

6. Capacity Building for Volunteers

6.1. The Programme

Four types of volunteer training have been launched by JCECC volunteer team of the University of Hong Kong, namely, volunteer core training, volunteer elective training, and volunteer leaders training courses (**Table 6.1**). During the 3-year period between 2019 and 2021, a total of 12 sessions of core training, 30 sessions of elective training, 16 sessions of leaders training, and 4 sessions of coordinator training were conducted. In 2019, the core training and elective training were delivered in face-to-face classroom format, while all courses were continued with Zoom in 2020 and 2021. Over the 3 years, the volunteer core course trained up 418 volunteers, whereas the elective training and leader training benefited 1 193 and 43 volunteers respectively. It should be noted that trainings in Phase II Project have also be provided to volunteers in other community service units apart from our NGO partners. In addition, a volunteer appreciation event was held in 2021 with 236 volunteers participated and celebrated their journey together. Except for the elective courses, all the core course and leader course were co-taught by HKU Project team and 4 NGO partners.

Table 6.1 Structure of tiered volunteer training in Phase II




Training programme	Programme goal	Target participants	Trained volunteers	Mode of teaching
Core course	Provides comprehensive basic training in EoLC volunteer skills and knowledge	Adults who passed the screening process	418	 Face-to-face in 2019  Zoom in 2020 and 2021 Co-taught 
Elective courses	Introduce specific topics related to EoLC volunteer service	Volunteers who have completed the core training	1 193 (attendance)	
Leader course	Provides leaders training to EoLC volunteers with leadership potential, and to strength peer support among EoLC volunteers	Experienced volunteers with leadership potential, nominated by the EoLC volunteer team coordinators of their partner NGOs	43	



Figure 6.1 Volunteer trainings

Moreover, apart from the 8-domain competency framework built for core course in phase I Project, a framework was further developed in collaboration between HKU Project team and 4 NGO partners to guide the training on volunteer leaders. The framework consists of

4 core competences that are crucial for volunteer leaders, including (1) activity planning, (2) self-care, (3) team building, and (4) bridging functions.

6.2. Programme Evaluation

6.2.1. Quantitative Studies

Core Course. Feedbacks for the volunteer training are encouraging. Assessed volunteers (n=138) who participated in the core course showed improvements in all aspects of EoL competence from T0 (pre-training test) to T1 (post-training test) (**Figure 6.2**). The effects maintained after 6 months of training (T2) with significant improvements ranged between 6.7% and 11.7% in various competency domains compared with baseline. Further analysis showed no significant difference in the improvements in volunteer competencies between the course delivered through face-to-face and via Zoom. Suggesting both teaching modes were equally effective.

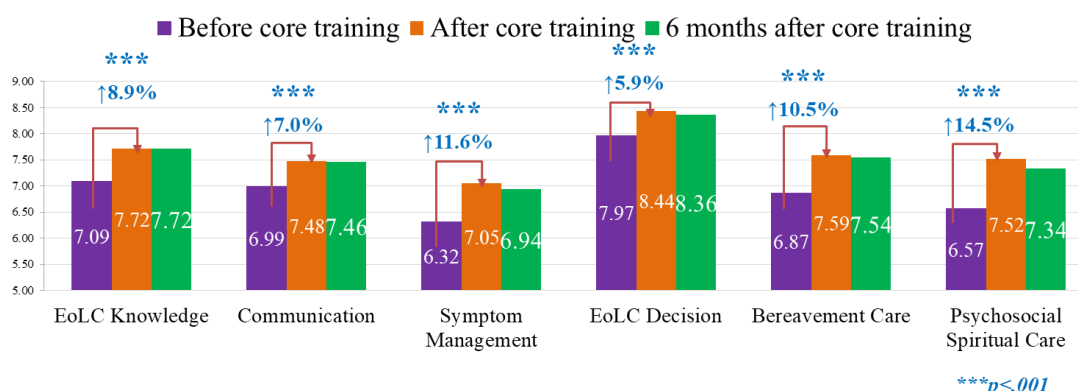


Figure 6.2 Outcomes of volunteer core training between Jan 2019 and Dec 2021 (Repeated measures; n=138)

Elective Courses. Volunteers who further participated in elective courses reported high levels of satisfaction, with all courses obtaining satisfaction scores above 4 (out of 5) regardless of course format (**Table 6.2**). Similarly, most courses obtained similar level of satisfaction regardless of mode of delivery (Face-to-face or Zoom).

Table 6.2 Satisfaction level towards volunteer elective courses between 2019 and 2021

Elective courses	N	Satisfaction (1-5)		
		Face-to-face	Zoom	Overall
Communication				
Practical skills in comfort call	49	--	4.59 (.61)	4.59 (.61)
Physical care				
Home safety	52	--	4.30 (.70)	4.31 (.70)
Communication through massage	37	4.86 (.35)	--	4.86 (.35)
Psychosocial-spiritual care				
Religious view on death	86	4.11 (.93)	4.35 (.80)	4.26 (.86)
Cheer-up activities	46	--	4.39 (.61)	4.39 (.61)
Life review	84	4.19 (.79)	4.45 (.61)	4.36 (.69)
Family activities in EoLC	26	--	4.54 (.65)	4.54 (.65)
EoL decision making				
Legal issues in death and dying	92	4.81 (.46)	4.67 (.55)	4.73 (.52)
Self-care and self-reflection				

Mindfulness workshop	30	--	4.53 (.57)	4.53 (.57)
Self-care with Zentangle	49	--	4.67 (.47)	4.67 (.47)
Self-care one-day camp	21	4.33 (.66)	--	4.33 (.66)
Bereavement care				
Bereavement care	75	4.62 (.49)	4.56 (.58)	4.59 (.58)
Funeral knowledge**	51	4.18 (.61)	4.70 (.47)	4.41 (.61)
Overall	698	4.47 (.70)	4.51 (.62)	4.50 (.65)

Notes. ** $p < .01$

Leader training. Volunteers who participated in the volunteer leader training were assessed on their competencies in activity planning, self-care, team building, and taking up a bridging role. Volunteer leaders reported significant improvements in all competencies except self-care, which had a relatively high baseline, after completing the course (Figure 6.3).

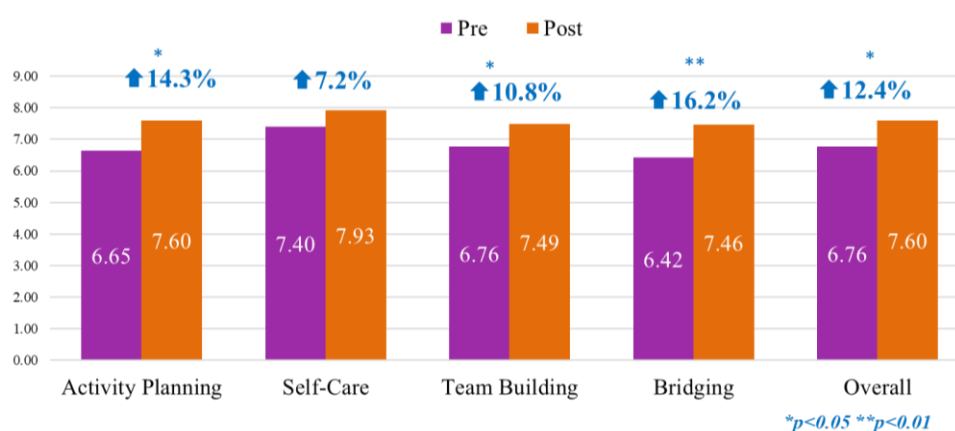


Figure 6.3 Outcomes of volunteer leader training (2020 and 2021 batches)
(Paired t-tests; $n=24$)

Service statistics. Service statistics of volunteers were retrievable from HKSR, HC, and SJS between October 2019 and December 2021. The record showed that 4 295 hours of volunteer services were provided by volunteers in 27 months.

6.2.2. Qualitative Studies

Focus groups were conducted to understand volunteers' experiences in our training programmes. The interviewed volunteers all remarked that the training programmes offered by JCECC were very valuable in providing them with the basic knowledge and skills for serving end of life patients and their families in the community. The programme is especially valuable to them because training for volunteers in the end-of-life care area is quite rare in Hong Kong. Many of them also mentioned specifically the elective training programme offered by JCECC, saying that they are very useful and relevant to their learning needs and personal interests.

The interviewed volunteers also highlighted that the opportunity to serve those in need as end-of-life care volunteers are both personally rewarding and meaningful to society. Many of the volunteers have personally experienced the loss of loved ones to long term illness, and in their service of others find meaning in their own life journey as well. They consider it a privilege to be able to walk with patients and their families in their

end-of-life, to share the joy, pride, and legacy of the patient, and to be a good listener and be with them in their time of need. When asked to describe the magnitude of importance the volunteer training and service experience were to them, many of them said that it is priceless and impossible to compare to anything else. The closest metaphors they offered were going on an important life journey. Volunteers were also very proud of their ability to use their own individual skills and experiences in their service, some examples being volunteers lending their talents in hairdressing, music, design, photography, crafts etc. to help cheer up service users and fulfil their wishes. Their enjoyment and gain from the training closely related to the supports received from organisations and other volunteers. A good spirit of teamwork encouraged them to continue the service.

With regards to the areas of improvement, most of the comments revolve around the difficulty in participating in volunteer training and service under the everchanging pandemic situation. For quite a long period of time, volunteer service was severely reduced to ensure proper social distancing, which meant that many volunteers could not visit patients at home in person. Virtual visits became more common but were quite awkward for some volunteers as they were not used to the new mode of communication without being in the same room as the person they are talking to. Some of them remarked that the JCECC phone visit training elective course offered in response to the pandemic was useful in helping them learn new skills to cope with the pandemic. Communication is also a skill that needs to be enhanced in future.

6.2.3. Observations

Apart from the evaluation results, the Project team has also found growing training needs on EoLC among volunteers in other service agencies, for examples, volunteers from religious groups, hospitals, and elderly service units. The Project team was approached by these agencies for training and thus considerable quotas in the JCECC volunteer training were assigned to these agencies. In addition, the Project team received increasing number of enquires of general public who were interested in learning about EoLC but not ready to join as agency volunteers.

6.3. Conclusions

In the Phase II Project, the volunteer capacity building programme was advanced from a single-layer foundation course to a tiered training programme that provided continuous support to volunteers and built sustainable volunteer teams in EoLC. Moreover, the Project team also consolidated the volunteer training and management experience and developed a volunteer coordinator training targeting health and social care professionals (described in the chapter 2). Despite the COVID-19 pandemic has posted challenges to volunteer services, it was also an opportunity to develop new volunteer services. During the pandemic, the Project team and NGO partners were able to retain volunteers by engaging them in remote support/virtual visits and offering continuous online training. The online training was also found to be as effective as the classroom face-to-face training. Overall, the number of engaged volunteers continued to grow throughout the Phase II Project, with increasing level of sophistication of volunteer training and support and extended to volunteers of service units other than JCECC NGO partners.

7. Knowledge and Skill Transfer for General Public

7.1. The Programme

The knowledge and skill transfer (public education) component targets on the general public with an aim to raise the public awareness and knowledge on end-of-life care by means of different tools and channels. There are three main themes of the knowledge and skill transfer component throughout the three years of the Project in 2019 – 2021, namely “End-of-Life Decision Making (抉擇有時)” in 2019, “Communication (溝通有法)” and “Good Living/Good Dying (晚晴有你)” in 2020 and 2021. Some major events included:

7.1.1. Inauguration Ceremony and Press Conference

The inauguration ceremony of the Projects’ Phase II was held on May 7, 2022 at the Rayson Huang Theatre of the University of Hong Kong. There were approximately 250 participants attended the inauguration ceremony. The ceremony was accompanied by a symposium entitled “Symposium on Improving End-of-Life Care Outcomes for Older Adults at A System Level: Opportunities and Challenges”. Professor David Currow from Australia, Dr. Mok Chun Keung and Dr. Rebecca Yeung from the Hospital Authority were the speakers (**Figure 7.1**).



Figure 7.1 Inauguration Ceremony

The event also came along with a press conference, featured the dissemination of Phase I achievements, research findings and cases sharing from NGO partners. A number of media attended the press conference. A press conference report is attached in **Appendix I**.

7.1.2. Public Seminar Series in collaboration with Food and Health Bureau

In the period of October to December 2019, The HKU team collaborated with the Food and Health Bureau of the HKSAR Government, and the Hospital Authority to organise a public seminar series called “賽馬會安寧頌安寧照顧社區講座系列：晚期照顧抉擇您有 Say” (**Figure 5.2**). The seminar series was held across different region in Hong Kong, aiming at disseminating EoLC knowledge and gather public information for the Bureau on proposal for regulation of advance directives and dying in place. There were over 550 participants attended the seminar series. JCECC’s support to the consultation process was acknowledged in the consultation report released in July 2020.



Figure 7.2 Public Seminar Series

7.1.3. Public Education Campaign, Newspaper Columns, and Mass Media Coverage

In 2020, we incorporated the theme of communication and good living/good dying in our public education activities to promote EoLC.

A public education campaign on EoLC, called the “Food and Life Campaign (晚晴心語)” was coordinated. The campaign involved a series of public education activities, included a production of two public education booklets, namely “晚晴心語 – 饒饌日常” and “晚晴心語 – 智蘊樂活”. The former is a recipe *cum* true story book which contained public submission of family recipes and true stories related to EoLC. The latter contained useful tips related to EoLC from six different professionals. Riding on the recipe book, a recipe submission campaign was organised from June to October 2020 to collect public recipes in the community. The two booklets were published in May 2021.

The Project also promoted the Food and Life Campaign in the “Healthpedia (精靈一點)” of Radio Television Hong Kong (“RTHK”) a session of radio programme in RTHK “新紫荊廣場”. Another session in the TVB “Big City Shop (流行都市)” was also arranged to promote the Campaign. Collaborated with Ming Pao, the project also produced 16 issues of regular newspaper column as of December 2020. To align with the campaign, the issues in August to December 2020 were related to food and communication in EoLC. There was also one magazine article published on “Sportsroad” on promoting the campaign on July 30, 2020 (**Figure 7.3**).



Figure 5.3 Publicity of Public Education Campaign

Based on the published booklets, the project also organised a virtual cooking class and sharing session, featured two KOL chefs and Mr. Cheng Chi Man as MC in the activity. The virtual cooking class and sharing session was broadcasted on the Project's Facebook page and attracted 34,000 online view rates (**Figure 7.4**).



Figure 7.4 Virtual Cooking Class and Sharing Session

7.1.4. Public Seminars Series under the Food and Life Campaign

To echo with the theme “Food and Life Campaign”, a series of public seminars “「食得是福」系列” was organised in August 2020. The series consisted of three seminars, including: “餐桌上的情書” which talked about touching stories on EoLC related to food; “重拾進食樂趣” which talked about the swallowing issues in EoLC; and “醫食同源” which was about different ways of EoLC in terms of Chinese and Western medicine. Due to the COVID-19 pandemic, the seminars were conducted via Zoom and Facebook live. There were over 600 viewers for the seminar series on Facebook. (**Figure 7.5**).



**Including physical (before COVID-19 pandemic) and virtual sessions*

Figure 5.5 Public Seminar Series on Food and Life (「食得是福」系列)

7.1.5. Online Learning for Patients and Carers

In light of the successful experience with the online learning platform for professionals, the project extended the online learning components to family carers and patients. An online learning platform for patients and carers was developed in 2020, with four chapters namely “故事分享篇”, “自我照顧篇”, “溝通篇” and “社區資源篇” (<http://foss.hku.hk/jcecc/en/online-learning-patients-and-carers/>). As by the end of Phase II, the platform attracted over 2,600 viewers.

7.1.6. Resource Guidebook

In response to the lockdown of the community support services during COVID-19, the Project team produced the electronic COVID-19 community resources guidebook for end-of-life patients and their family caregivers (“**新型冠狀病毒病下的社區晚期病人照顧資源冊**”) in a timely manner in June 2020, benefiting around 10,000 general public via our list of correspondence.

7.1.7. Video Production

Altogether 11 videos were developed targeting general public. In line with the “Food and Life Campaign”, two promotional videos were produced to encourage more participants from the public to participate in the recipe submission (**Figure 7.6**).



Figure 7.6 Food and Life Campaign Promotional Videos

Besides, the project team also produced 9 public education videos related to EoLC and ACP (**Figure 5.7**). Some of the videos were also used in the patients and carers self-learning platform.



Figure 7.7 EoLC Public Education Videos

7.1.8. Project Website and Facebook

During Phase II Project, the project website which was developed in Phase I was continuously used. The project team regularly updated the website contents which included new events and trainings, publications and papers and newly-developed videos. Besides, the Project also hosted a Facebook page to increase engagement with the general public. Initially, the Facebook page was managed by the HKU Project team. To strategically engage the public, a PR vendor “Fimmicks” was hired to provide professional advices and services for the growth of the page. As of the end of Phase II Project, the page had over 7,000 followers. The accumulated number of views of both the Project Website and the Facebook Fanpage by the end of Phase II Project was over 354, 000 views.

7.1.9. A regional symposium and an International Conference were held in Phase II Project. International Conference and local symposium

A regional symposium and an International Conference were held in Phase II Project. In October 2019, the Project held a face-to-face symposium titled “Concerted Efforts in ACP – Regional and Local Experiences” in collaboration with HA with the objectives to understand the current landscapes, challenges and developments of ACP in Asia (**Figure 5.8**). Moderated by Professor EK Yeoh and Professor Helen Chan, presentations were delivered by Professor Deng Renli from mainland China, Ms Chee Wai Yee, Mr Andy Sim from Singapore, Miss Amy Yuen, JP from FHB, Dr Sin Ngai Chuen and Dr C K Wong from HA and Professor Amy Chow from HKU. Speakers shared insightful and fruitful experience and directions on developing effective measures on ACP and AD. The symposium was attended by 260 professionals, with 93% of participants rated highly on their satisfaction (4 or above out of 5).



Figure 7.8 Symposium on ACP in 2019

In 2021, a virtual international conference titled “Community End-of-Life Care: Sustainable Development and New Frontier” was held between June 16-19, with 703 professionals participated (**Figure 7.9**). Renown speakers in palliative and EoLC field including Professor Xavier Gomez-Batiste from Spain, Professor Kathy Eagar from Australia, and Professor Heather Richardson from UK were invited as keynote speakers in the conference. 33 other speakers and 9 panelists from 11 countries/regions were also invited in various sessions. Pre-conference seminars delivered by Dr. Ednin Hamzah and Professor Eric Andrew Finkelstein were also arranged. 47 oral presentations and 21 poster presentations were conducted in the conference. Altogether 68 abstracts were finally published in the Journal of Palliative Medicine. This is the first conference that the Project held via a conference platform called Airmeeet. Participants in general found

the conference meaningful with 77% thought they gained more competence in providing care for patients and families facing EoL issues after attending the conference.

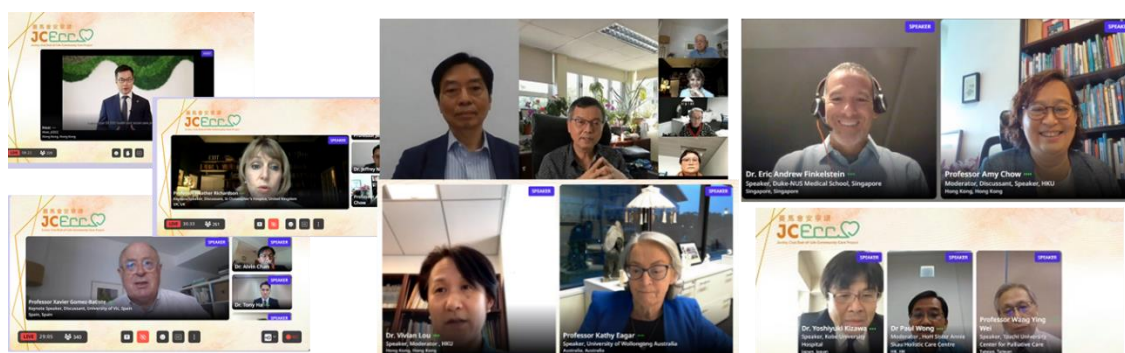


Figure 7.9 JCECC International Conference in 2021

7.2. Programme Evaluation

7.2.1. Outcomes

Satisfaction levels were collected from 9 public talks held during Phase II Project. High levels of satisfaction were reported with an average score of 4.25 out of 5, suggesting that the public talks were well accepted by the participants.

7.2.2. Impacts

Two waves of community-wide public survey were held in Phase II Project, one between June and September, 2020, and another held between June and September, 2021. A total of 1 511 and 1 505 respondents aged 18 or above were successfully surveyed in 2020 and 2021 respectively. The response rates were 89.2% and 83.0% respectively. The public knowledge, attitude and behavior related to EoLC in 2020 and 2021 were compared with 2018 to gauge the changes over time.

7.2.2.1. Participants

In the 3 years, around two-thirds were female (**Figure 7.10**). Except gender, the samples in the three years shown significant differences in other demographics and experience with EoLC. Regarding age, in all years, the middle-aged (aged 41-60) was the biggest group constituting to around half of the sample, followed by approximately one-third being older adults (aged 61 or above) and one-fifth or less being younger adults (aged 18-40). Nevertheless, the sample in 2020 was relatively younger with a higher proportion of those aged between 18-40 but lower proportion of older adults when compared to 2021. As for education, although those with primary school education or above contributed to over 95% of the sample in each year, the respondents in 2020 were more likely to have tertiary education or above, reaching 43.8% as compared to 35.3% and 38.1% in 2018 and 2021. There was around one-fourth to one-third of our samples who reported suffering from chronic illness/life-threatening disease, around one-third also reported having family member(s) suffering from chronic illness/life-threatening disease(s). However, the respondents in 2020 were also less likely to report having chronic illness/life-threatening disease (25% in 2020 Vs. 35% in 2018 and 2021), less likely to have family member(s) who have chronic illness(es)/life-threatening disease(s) (33% in

2020 Vs. 36% in 2018 Vs. 39% in 2021), and less likely to be taking care of family member(s) with chronic illness(es)/life-threatening disease(s) (13% in 2020 Vs. 16% in 2021 Vs. 18% in 2018) when compared to the respondents in 2018 and 2021.

In view of the differences in the background of respondent in these three years and some of these variables showed significant correlations with multiple knowledge and attitude items, therefore, comparison across years were adjusted for demographic information of respondents including gender, age, education, whether the respondent has chronic illness/terminal illness, whether the respondent has family member(s) with chronic illness/terminal illness, and whether the respondent is currently taking care of family member(s) with chronic illness/terminal illness.

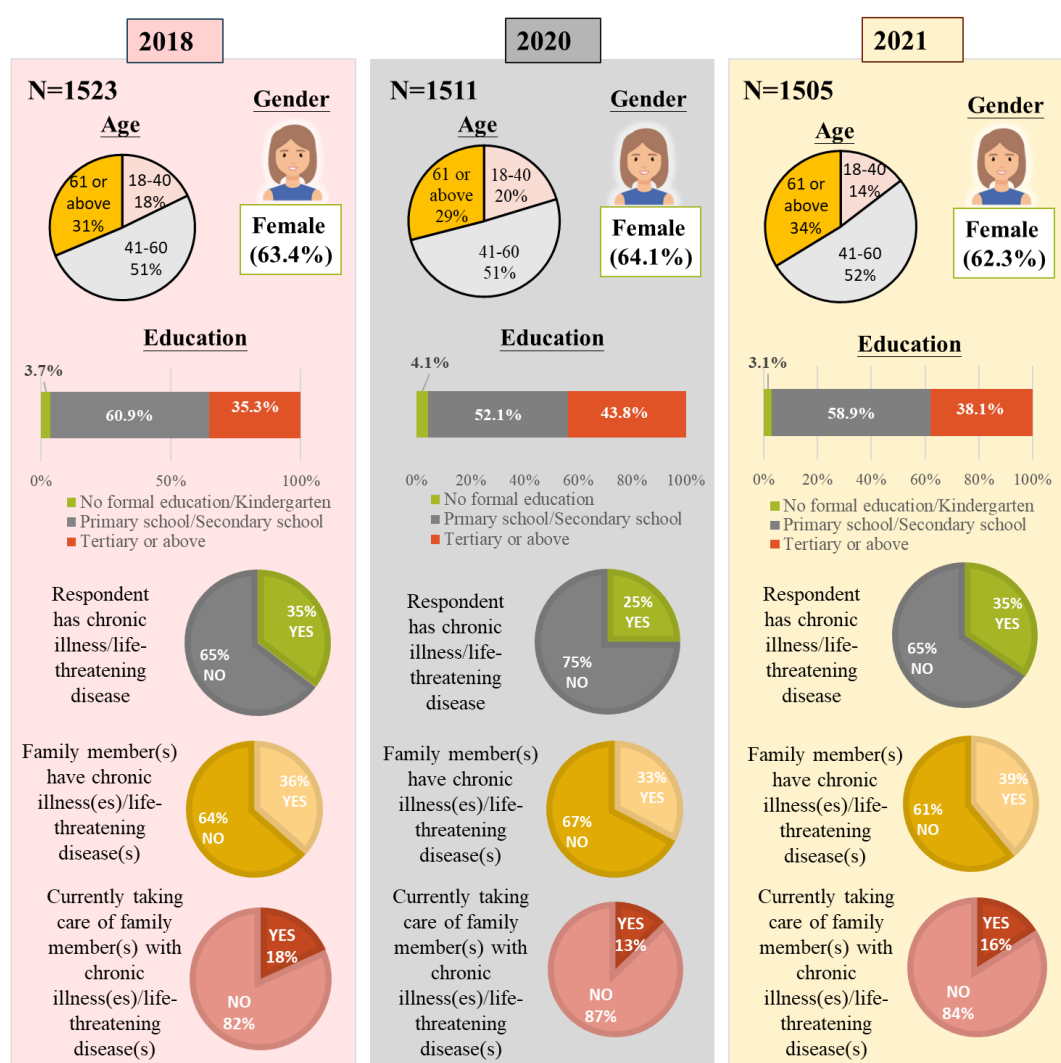
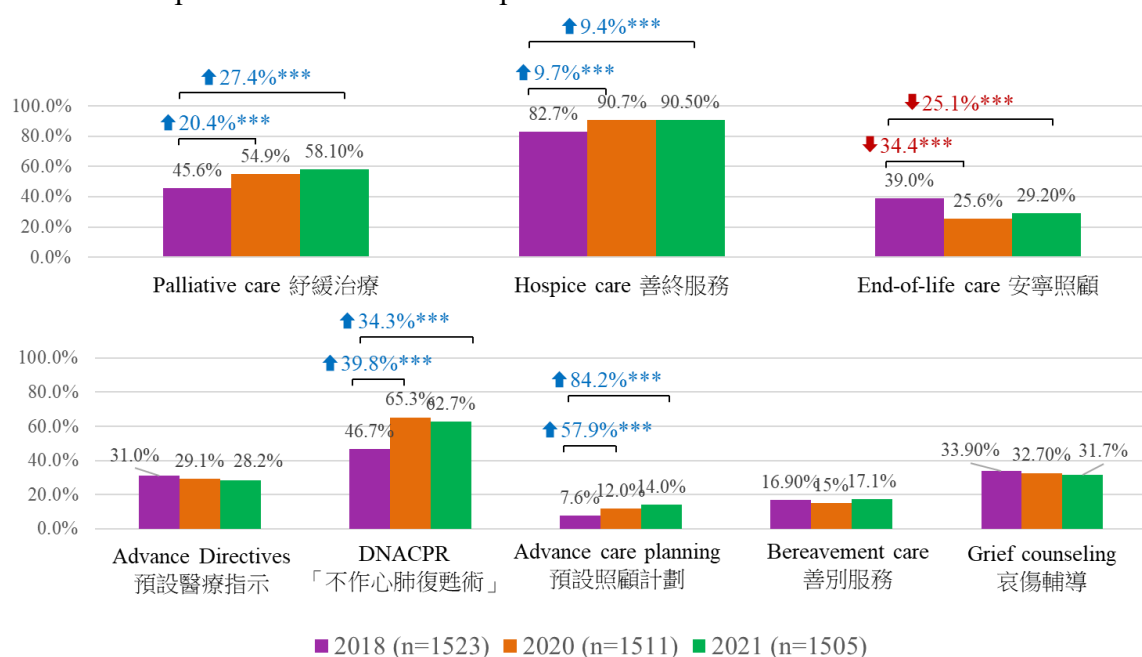


Figure 7.10 Participants' demographic characteristics across three waves.

7.2.2.2. Knowledge

Respondents were asked if they have heard of eight EoLC-related terms, including palliative care, hospice care, end-of-life care (EoLC), advance directives (AD), DNACPR, advance care planning (ACP), bereavement care, and grief counseling (**Figure 7.11**). Comparing the overall change in percentage of respondents who

have heard of these terms across years, it was found that significantly higher proportion of respondents have heard of the terminologies. There was an increase of 7.3% between 2018 and 2020, and 9.3% between 2018 and 2021. Analysing the change on each term revealed that significantly more respondents have heard of palliative care, hospice care, DNACPR, and ACP across years. Comparing between 2018 and 2021, the percentages of increase for ACP, DNACPR, Palliative care, and hospice care were as high as 84.2%, 34.3%, 27.4%, and 9.4% respectively. Nevertheless, respondents who have heard of EoLC significantly dropped by 25.1% between 2018 and 2021 (from 39% in 2018 to 29.2% in 2021). One of the possibilities is that the term “EoLC” might not be explicitly mentioned in the public education while the other two terms were more commonly used. There was no significant change in the remaining terminologies. Despite so, the result suggested the public showed overall improved awareness on EoLC-related terms.

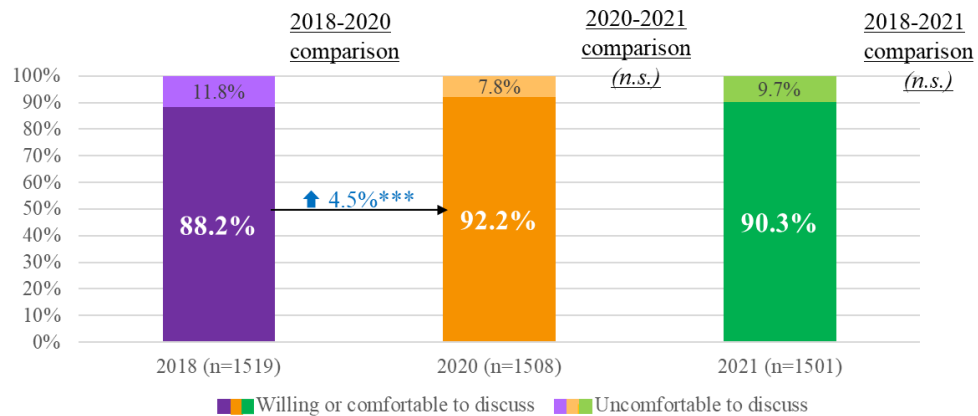


Notes. Differences in demographics (gender, age, education, whether one has chronic illness, whether one's family member(s) have chronic illness/terminal illness, whether one is currently taking care of family member(s) with chronic illness/terminal illness) across years were controlled for in the calculation of significance tests. Bonferroni correction was applied.
*** $p < .001$.

Figure 7.11 Comparison between 2018, 2020 and 2021 on hearing EoLC-related terms

7.2.2.3. Attitude

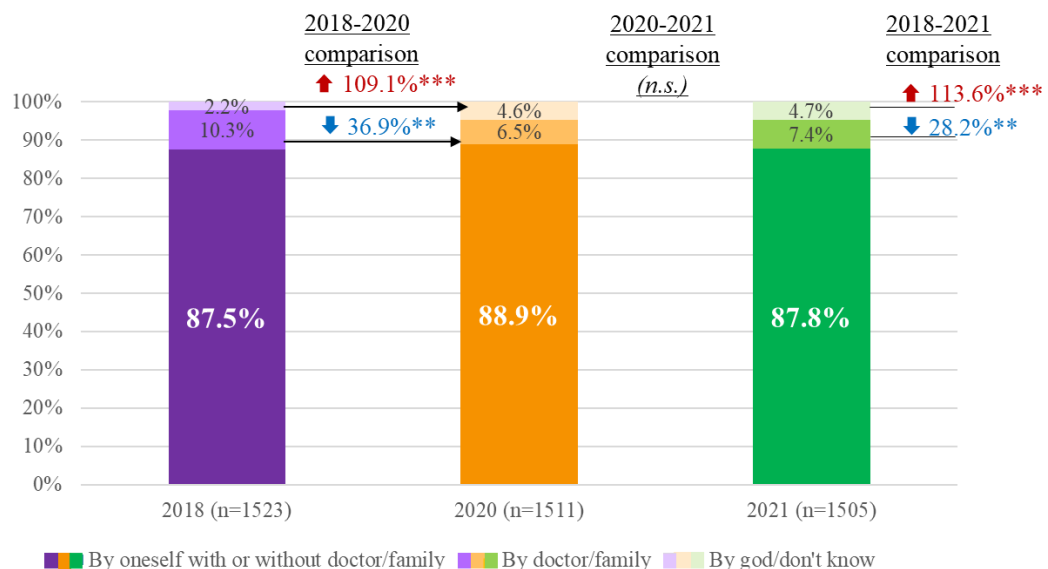
Openness towards the topic. Respondents were asked their feelings towards talking about EoLC and death and dying. Indeed, over the years, majority of the respondents reported being comfortable to discuss this topic, ranging from 88.2% in 2018, 90.3% in 2021, to 92.2% in 2020 (**Figure 5.12**). Respondents who felt comfortable discussing this topic increased significantly for 4.5% from 2018 to 2020 but dropped a little bit in 2021, resulting in a 2.4% increase from 2018 to 2021.



Notes. Differences in demographics (gender, age, education, whether one has chronic illness, whether one's family member(s) have chronic illness/terminal illness, whether one is currently taking care of family member(s) with chronic illness/terminal illness) across years were controlled for in the calculation of significance tests. Bonferroni correction was applied. *** $p < .001$; n.s.=not significant for all comparison.

Figure 7.12. Openness towards talking about EoLC and death and dying

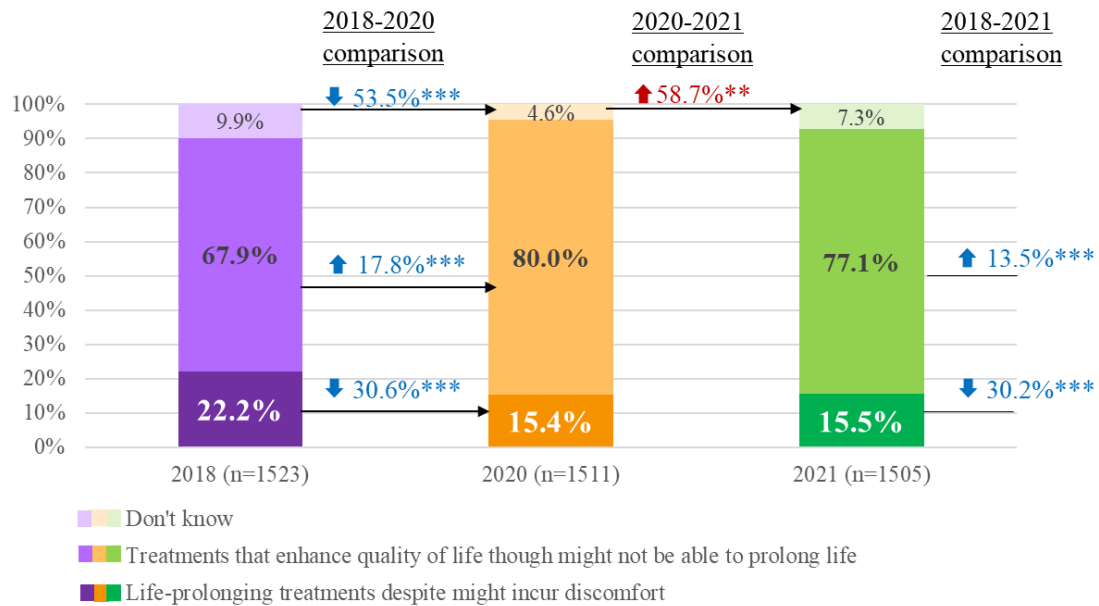
Preferred person to be involved in making medical decision. Respondents were asked who should be making the final medical decision for them if they were under a hypothetical situation of last 6 months of life (Figure 7.13). In all years, almost 9 in 10 persons thought that they should be involved in making the decision (87.5% in 2018, 88.9% in 2020, and 87.8% in 2021). While the proportion of those who thought themselves should be involved did not change across years, those who thought the decision should be made by either doctor or family members dropped significantly in 2020 and 2021 by 36.9% and 28.2% when compared to 2018, while those who answered “to be determined by God/don’t know” significantly increased by 109.1% and 113.6% simultaneously.



Notes. Differences in demographics (gender, age, education, whether one has chronic illness, whether one's family member(s) have chronic illness/terminal illness, whether one is currently taking care of family member(s) with chronic illness/terminal illness) across years were controlled for in the calculation of significance tests. Bonferroni correction was applied. *** $p < .001$; ** $p < .01$; n.s.=not significant for all comparisons.

Figure 7.13. Final medical decision

Preferred type of treatment. Under a hypothetical situation of last 6 months of life, respondents were asked whether they would choose treatments that may not prolong life but enhance quality of life OR treatments that are life-prolonging but might incur discomfort (**Figure 7.14**). Results suggested that increasingly more respondents preferred treatments that emphasized quality of life instead of life-prolonging from 2018 to 2021, with this trend peaking in 2020. In 2021, almost 8 in 10 people chose treatments promoting quality of life representing a 13.5% increase when compared to 2018. At the same time, those who chose life-prolonging treatments reduced significantly by 30.2%.

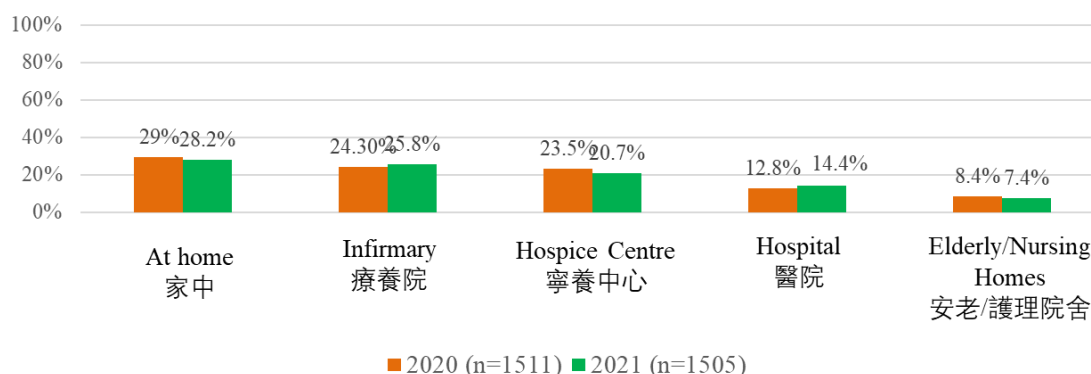


Notes. Differences in demographics (gender, age, education, whether one has chronic illness, whether one's family member(s) have chronic illness/terminal illness, whether one is currently taking care of family member(s) with chronic illness/terminal illness) across years were controlled for in the calculation of significance tests. Bonferroni correction was applied.

*** $p < .001$; ** $p < .01$; * $p < .05$.

Figure 7.14. Preferred type of treatment

Preferred place of EoLC. Regarding preferred place of EoLC, respondents were given five options and asked to choose the most preferred one. Comparison can only be made between 2020 and 2021 (**Figure 7.15**). There were no significant changes across years. Moreover, the order of options remained consistent, with domestic home being the most frequently opted place (29% in 2020 and 28.2% in 2021), followed by infirmary (24.3% in 2020 and 25.8% in 2021), hospice centre (23.5% in 2020 and 20.7% in 2021), hospital (12.8% in 2020 and 14.4% in 2021), and finally elderly/nursing homes (8.4% in 2020 and 7.4% in 2021).



Notes. Differences in demographics (gender, age, education, whether one has chronic illness, whether one's family member(s) have chronic illness/terminal illness, whether one is currently taking care of family member(s) with chronic illness/terminal illness) across years were controlled for in the calculation of significance tests. Bonferroni correction was applied.

Figure 7.15 Most preferred place for EoLC across years

Preferred place of Death. Respondents were asked an open-ended question to name a preferred place of death if they were under a hypothetical situation of last 6 months of life. In all years, hospital was the most frequently chosen place for death (**Figure 7.16**). However, number of respondents choosing hospital reduced while those choosing domestic home or infirmary/hospice centre increased across years. Respondents who chose hospital reduced from 61.2% in 2018 to 47.4% in 2021, equivalent to a 22.5% reduction, while the percentages for domestic home and infirmary/hospice centre increased from 25.7% and 5.5% in 2018 to 35.6% and 11.1% in 2021, representing 38.5% (domestic home) and 101.8% (infirmary/hospice centre) increases between 2018 and 2021. At the same time, there was a significant reduction in proportion choosing elderly homes between 2018 and 2020 (70% reduction in proportion).

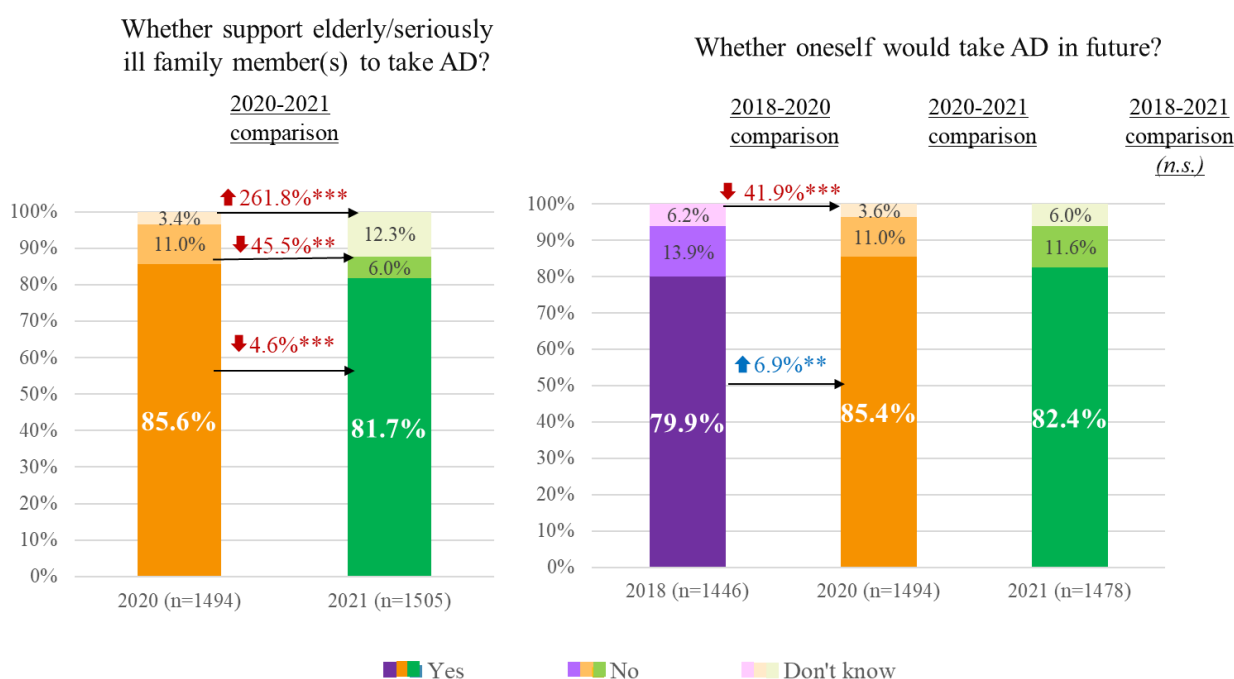


Notes. Differences in demographics (gender, age, education, whether one has chronic illness, whether one's family member(s) have chronic illness/terminal illness, whether one is currently taking care of family member(s) with chronic illness/terminal illness) across years were controlled for in the calculation of significance tests. Bonferroni correction was applied.

*** $p < .001$; ** $p < .01$.

Figure 7.16. Most preferred place of death across year

Attitude towards conducting AD. Respondents were asked whether they support their senior family member(s) or family member(s) with serious illness to conduct AD, and whether they would conduct AD in future (**Figure 7.17**). Comparison on the support towards conducting AD with family member(s) can only be made between 2020 and 2021. Interestingly, the proportions of both respondents who supported the idea and those who disagreed with the idea dropped significantly while those who answered “don’t know” increased significantly by 261.8%. On the other hand, the support towards conducting AD in future for oneself increased by 6.9% in 2021 when compared to 2018. This may suggest there were increased difficulties perceived by respondents in making this decision for others, but not for oneself. Nevertheless, more than 8 in 10 respondents in 2020 and 2021 supported the idea of conducting AD for senior or ill family members or oneself, suggesting a possibility that the general public was supportive to AD in general.



Notes. Differences in demographics (gender, age, education, whether one has chronic illness, whether one’s family member(s) have chronic illness/terminal illness, whether one is currently taking care of family member(s) with chronic illness/terminal illness) across years were controlled for in the calculation of significance tests. Bonferroni correction was applied.

****p<.001; **p<.01. n.s.=not significant for all comparisons.*

Figure 7.17 Attitude towards conducting AD

For respondents in 2020 and 2021 who expressed no intention to conduct AD for themselves, they were further asked the major reason(s) behind their decision in an open-ended manner. There is no significant difference across years on the frequencies of reasons being mentioned, thus the results from both years were analysed together (n=235) (**Figure 7.18**). Findings showed that “Let it be” (49.3%) was the reason offered by almost half of the respondents. This answer was usually expressed in Chinese like “聽天命”, “順其自然”. Other frequently mentioned reasons included deeming AD unnecessary because of current good health (11.6%) and youth (8.10%). Some respondents thought that AD is not helpful as “decision

can be changed easily” (6.6%), it “makes troubles for others” (6.0%), it “means forgiving treatments or prolonging life” (5.7%), and it is “not legally-bind” (2.7%). Some people thought that AD is unnecessary since family members or doctors will make the decision for them (3.9% and 2.4% respectively). A minority refused AD lest it would make family member (1.2%) or themselves (0.6%) upset or stressed. Indeed only 2.7% did not choose to conduct AD since they thought they didn’t have sufficient knowledge on it. However, multiple reasons raised such as “AD means forgiving treatments”, “not legally-bind”, “others will make the decision for me” reflected needs for further education on definitions, scope and benefits of AD for respondents.

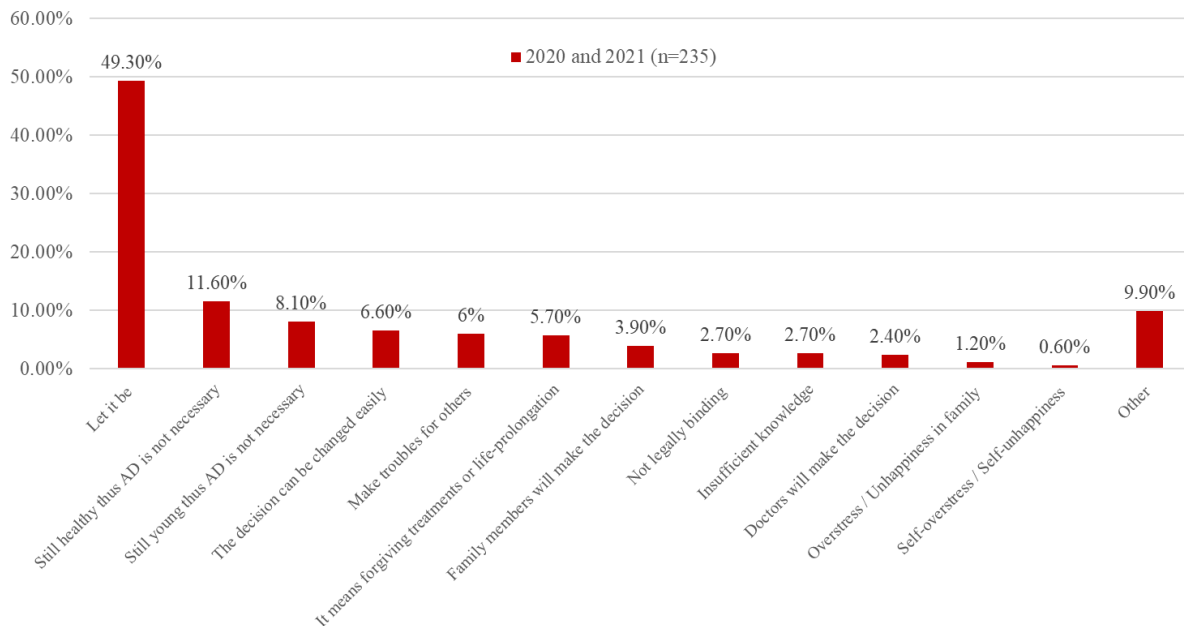
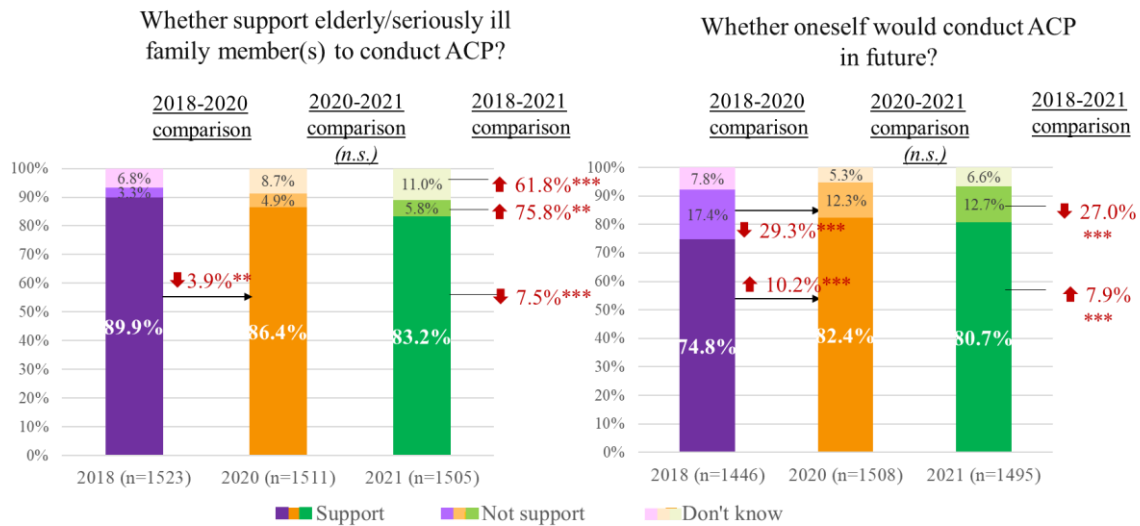


Figure 7.18 Reasons for not taking AD for oneself

Attitude towards conducting ACP. Respondents were also asked whether they support their senior or seriously-ill family member(s) to conduct ACP, and whether they would conduct ACP for themselves in future (**Figure 7.19**). The findings mirrored the attitude on AD such that there was a decreasing trend of support for conducting ACP for others but increasing trend of support on doing so for oneself. The proportion of support in case of family members reduced by 7.5% from 2018 to 2021, while those who supported the idea in case of oneself increased significantly by 7.9% at the same time. This might further suggest more considerations in deciding for others than for oneself. Nevertheless, similar to the support for AD, over eight in ten people would support conducting ACP for family members or for oneself in 2020 and 2021 reflecting the general public might support ACP at large.



Notes. Differences in demographics (gender, age, education, whether one has chronic illness, whether one's family member(s) have chronic illness/terminal illness, whether one is currently taking care of family member(s) with chronic illness/terminal illness) across years were controlled for in the calculation of significance tests. Bonferroni correction was applied.
 *** $p < .001$; ** $p < .01$. n.s.=not significant for all comparisons.

Figure 7.19 Attitude towards conducting ACP

Respondents in 2020 and 2021 were also asked the reasons for not conducting ACP for themselves in future (Figure 7.20). The findings also mirrored those on AD. “Let it be” (32.3%), “good health” (14.4%), “making troubles for others” (11.0%), “future difficult to predict” (10.9%), “too young for ACP” (9.1%), “family members/doctors will make the decision” (5.9% and 1.3%), “insufficient knowledge” (5.9%), “not legally-bind” (4.3%) were again most commonly mentioned. While negative emotions towards such discussion was not mentioned as a common reason, the process and benefits of ACP can be further educated to the public to raise their confidence on ACP.

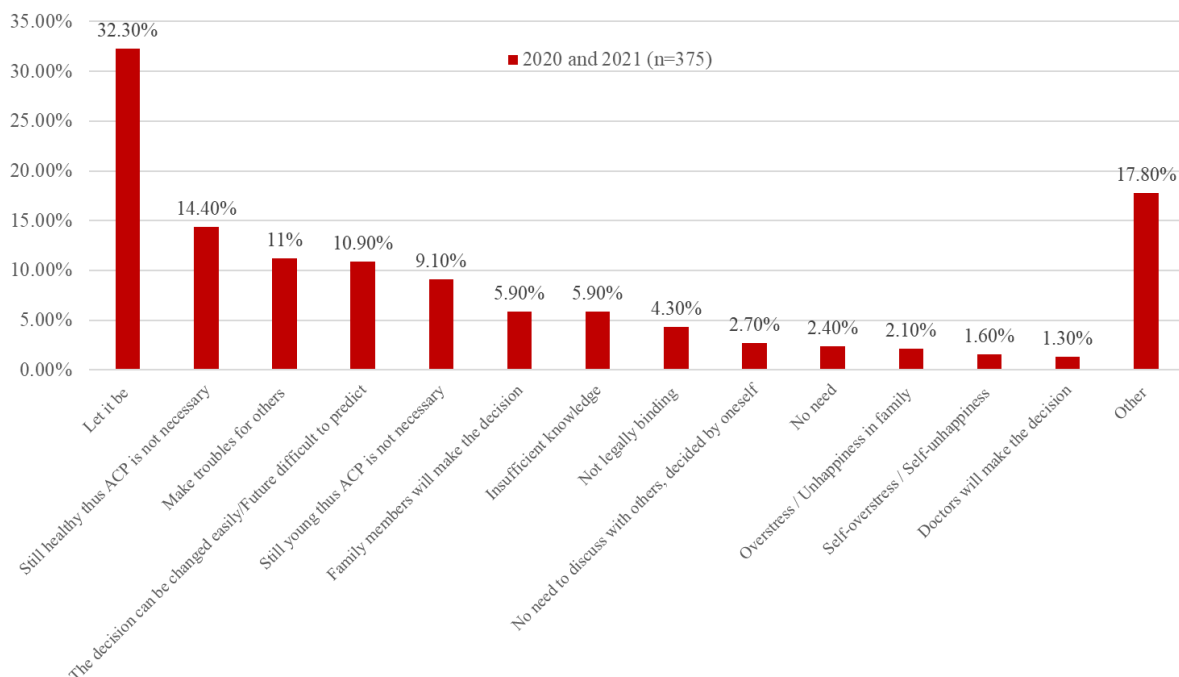
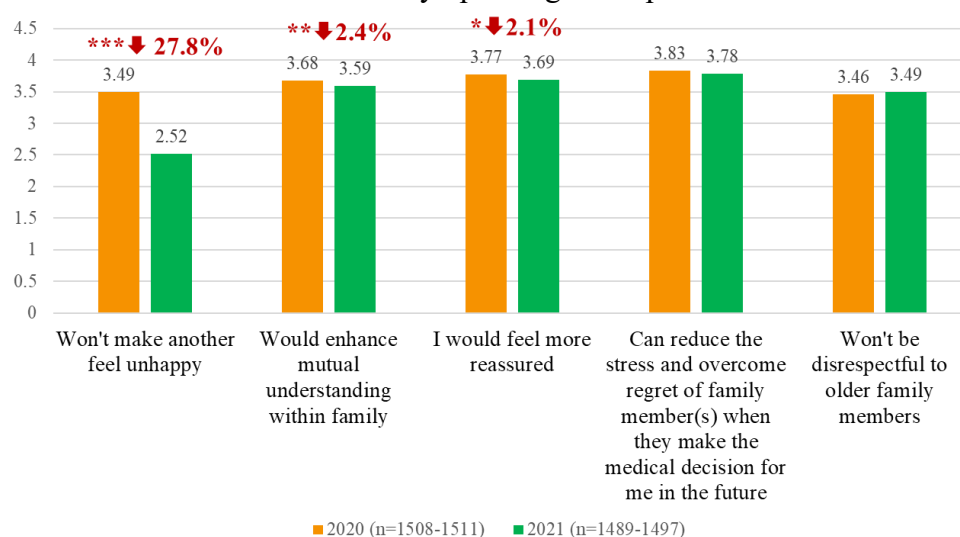


Figure 7.20 Reasons for not taking ACP for oneself

Attitude towards discussing EoLC and death and dying with family member(s). Respondents in 2020 and 2021 were asked to rate their levels of agreement towards five statements on their attitude towards discussing EoLC and death and dying topic with family member(s). All items were rated on a 5-point scale from 1=totally disagree to 5=strongly agree. **Figure 7.21** shows the mean score on each item in each year. In general, the ratings on most items in both years passed the mid-point score of the scale (i.e. 2.5 out of 5) suggesting the respondents inclined to have favorable attitude towards discussion, and believed that it would bring some benefits for both oneself and family members, and won't make others unhappy or being deemed disrespectful. Nevertheless, there was a reducing trend on three of the attitudes from 2020 to 2021, including discussing this topic with family "won't make another feel unhappy" (reduced by 27.8%), "would enhance mutual understanding" (reduced by 2.4%), and "would help me feel more reassured" (reduced by 2.1%). Notably, the mean score on "won't make another feel unhappy" dropped to 2.52 (SD=.183) in 2021, which was below the mid-point. One possibility is that the social distancing and increasing deaths among older adults during COVID pandemic has led to increasingly depressing atmosphere in the society especially around older adults. Respondents might concern that talking about death and dying issues would make the already upsetting atmosphere even worse.

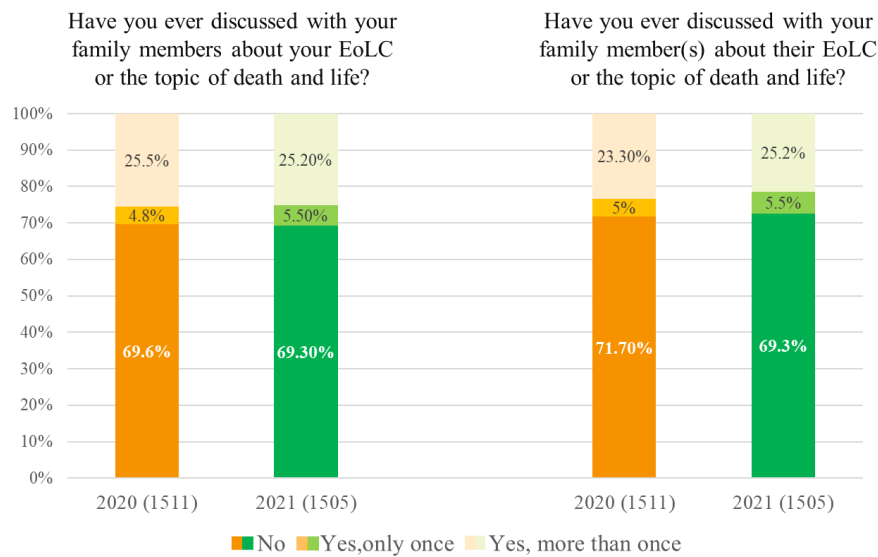


Notes. Differences in demographics (gender, age, education, whether one has chronic illness, whether one's family member(s) have chronic illness/terminal illness, whether one is currently taking care of family member(s) with chronic illness/terminal illness) across years were controlled for in the calculation of significance tests.
 *** $p < .001$; ** $p < .01$; * $p < .05$.

Figure 7.21 Attitude towards discussing EoLC and death and dying issues with family members in 2020 and 2021 (1=strongly disagree to 5=strongly agree)

7.2.2.4. Behavior

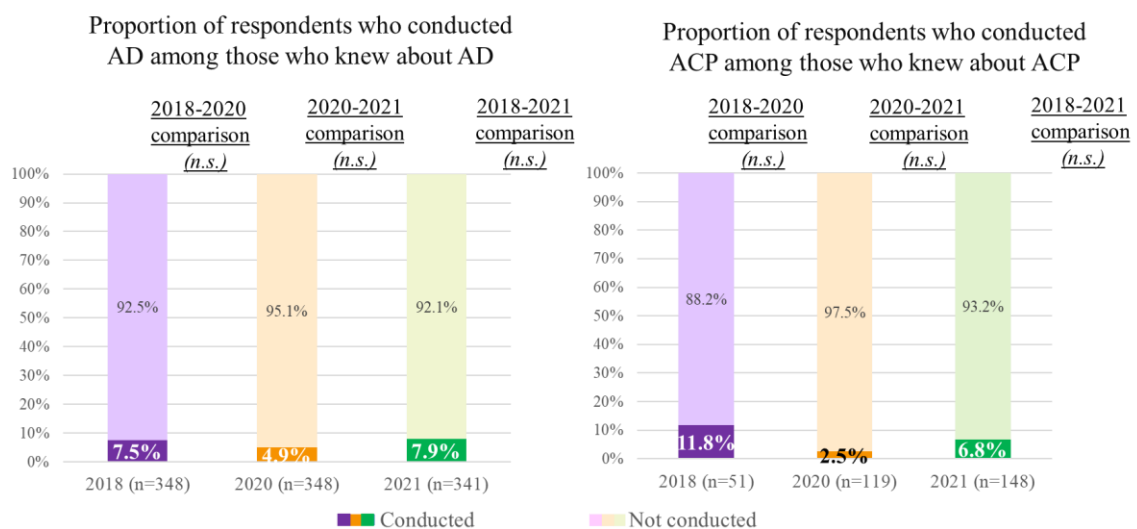
Discussion with family members about EoLC or death and dying. Respondents in 2020 and 2021 were asked if they have ever discussed with family members about their own EoLC or death, or about their family members' EoLC or death. Findings showed that only around 3 in 10 respondents in both years have discussed this topic with family member(s) (**Figure 7.22**). No significant differences were found between the two years.



Notes. Differences in demographics (gender, age, education, whether one has chronic illness, whether one's family member(s) have chronic illness/terminal illness, whether one is currently taking care of family member(s) with chronic illness/terminal illness) across years were controlled for in the calculation of significance tests.

Figure 7.22 Experience in discussing EoLC or death and dying with family member(s)

Conducting AD and ACP. Respondents who knew about (understood the meaning of) AD or ACP were further asked if they have conducted AD or ACP for themselves. Findings suggested that only minority have first-person experience with AD or ACP. The proportions of those who have conducted AD ranged between 4.9% in 2020 to 7.9% in 2021, whereas the percentages of those who have conducted ACP ranged between 2.5% in 2020 to 11.8% in 2018 (**Figure 7.23**). Given that AD and ACP were recommended to only patients with more advanced illness as defined by the Hospital Authority, we repeated the analysis after selecting respondents with chronic illness/terminal illness. Yet, the findings still showed that relatively low proportion of patients have AD (10.9% in 2018, 6.2% in 2020, and 11.2% in 2021) and ACP (21.1% in 2018, 4.3% in 2020, and 11.3% in 2021).



Notes. Differences in demographics (gender, age, education, whether one has chronic illness, whether one's family member(s) have chronic illness/terminal illness, whether one is currently taking care of family member(s) with chronic illness/terminal illness) across years were controlled for in the calculation of significance tests. Bonferroni correction was applied. n.s.=not significant for all comparisons.

Figure 7.23 Experience in conducting AD and ACP

7.3. Conclusions

Despite the COVID-19 pandemic between 2020 and 2021, the Project team had continued to offer public education via social media to promote EoLC among general public. The community-wide public survey reflected that the surveyed respondents became more likely to have heard of 4 out of 9 EoLC-related terminologies including palliative care, hospice care, DNACPR, and ACP. Despite the reduced proportion of respondents who were aware of the term EoLC in later years, the overall proportion of respondents who have heard of various EoLC-related terminologies increased by 9.3% **supporting the improvement of awareness on EoLC-related terminologies as a whole.**

The surveys also suggested that majority of the respondents were open to discuss EoLC and death and dying issues and showed attitude favoring community EoLC. Around 9 in 10 of the surveyed respondents were comfortable with EoLC and death and dying topics in all years, and an increasing trend from 2018 to 2020 was also noticed. Moreover, slightly less than one-third of our respondents expressed that they have discussed EoLC or death and dying issues with family members at least once. Besides, there were increasingly more respondents who opted for treatments emphasising quality of life, more respondents opted for dying at home while the number of respondents who chose to die at hospital reduced when compared between 2018 and 2021. Moreover, in all waves of surveys, home was the most frequently chosen place for EoLC. In addition, almost 9 in 10 respondents would like to be involved in making EoLC medical decision for themselves. This preference for self-determination provides an incentive for ACP that allows active participation in one's own medical decision before one lose mental capacity to do so. **These attitudes shown that the respondents are supportive towards community EoLC and are also ready for the discussion of topics related to EoLC and death and dying.**

Findings on attitude towards AD, ACP, and discussion of EoLC and death and dying issues with family members reflected that **majority (around 8 in 10) of the respondents supported conducting AD and ACP for oneself as well as for older or seriously-ill family members, and they tended to agree with the benefits of discussing EoLC and death and dying issues with family members.** Across years, there was a reducing trend in the support on conducting AD and ACP for family members but an increasing trend in the support on conducting these for oneself. One possibility for the reducing trend in the support for family members to conduct AD and ACP might be due to the growing worries of making another upset by talking about death and dying. Indeed, between 2020 and 2021, the respondents showed significantly higher levels of agreement that “discussing EoLC and death and dying issues with family member would make another upset”. This might partly be attributable to the already depressing atmosphere during the pandemic when considerable number of older adults were negatively affected psychologically or physically due to the social distancing policy, visitation restrictions in the hospital, and disrupted healthcare routine. **It is suggested that tools and advice should be offered to the general public in future to support them in the discussion of this topic with family members, and to try to delink such discussion with the feeling of sadness and distress while connection with love and meaningfulness should be fostered.**

Nevertheless, apparently this emotional factor was not the key barrier among those who opted not to taking AD and ACP for oneself. On the other hand, among those with chronic illness/terminal illness who knew about AD/ACP, only small proportion of them actually conducted AD/ACP. From the reasons for not taking AD and ACP for oneself given by

respondents, we suggested **more education on the benefits of AD/ACP on family members, the importance of earlier and continuous discussion to ensure patients' wish could be respected, and that AD and ACP do not mean giving up on life are necessary in future.**

8. Network Building

Representatives from Labour and Welfare Bureau (LWB), Food and Health Bureau (FHB), as well as Social Welfare Department (SWD) have been engaged as advisory committee members in JCECC to provide valuable advice on the directions of the Project, especially in the development of the ICESTs and IRHESTs. Seven meetings have been held with the advisory committee and a few additional meetings were held with the committee members to seek advices on the future directions of Phase III Project in 2021. In 2020, the Project Team prepared a proposal on ICEST model and presented to the late Deputy Director of Social Welfare (Services), Mr. Lam Ka-tai, and Mr. Tan Tick-Yee, Assistant director (Elderly). The proposal received positive comments, but the progress was delayed due to COVID pandemic. On the other hand, to support Government's development of caregiver policy, the Project team also submitted a report to Prof. Alice CHONG, the senior researcher in Labour and Welfare Bureau (LWB), who has been leading policy research for developing caregiver policy.

On service level, JCECC has networked with HA Hong Kong East Cluster and individual hospitals in the New Territories West Cluster, Hong Kong West Cluster, and Kowloon Central Cluster in the collaboration on ICESTs. Similarly, JCECC has close collaboration with the 7 Community Geriatric Assessment Teams (CGATs) and parent teams in public hospitals in the Kowloon West, Kowloon Central and Kowloon East clusters in the IRHEST. The Project has foster co-share mechanism with hospital partners to provide seamless care to patients and families in the models.

In terms of capacity building, the Project has formed an education sub-committee for ensuring high quality of the capacity building programmes developed by the Project team. Prestigious local experts in palliative and EoLC were invited to the sub-committee as reviewers of our training materials. The Project has also fostered collaboration with professional bodies and community organisations such as the Hong Kong Society of Palliative Medicine, the Hong Kong College of Family Physicians, the Hong Kong Social Workers Association, the Association of Nursing Staff, the Society for Life and Death Education through professional survey, and the formation of the organising committee for the international conference, and collaboration in training activities etc.

Collaboration was not only formed locally but internationally. Since the start of Phase II Project, the Project has initiated a collaboration with the King's College London to validate the Chinese version Integrated Palliative Care Outcome Scale (IPOS). This study was also in a collaborative project with the Queen Mary Hospital. Moreover, the Project has fostered strong networks with renown speakers from various international or regional professional bodies in palliative and end-of-life care, such as the Worldwide Hospice Palliative Care Alliance (WHPCA), Asia Pacific Hospice Palliative Care Network (APHN), Lien Centre for Palliative Care in Singapore, St Christopher's Hospice in UK, and Australian Palliative Care Outcomes Collaborative (PCOC) etc. Speakers from these organisations have been invited to be speakers/trainers in various training programmes under the JCECC.

9. Publications

Overall, there were 7 publications produced during the Phase II Project, targeting the general public or health and social care professionals. Besides, 6 academic paper arise from the Phase II Project and published in international peer-reviewed journals.

9.1. Project publication

- 綜合社區安寧照顧支援隊(ICEST) - 專業同工工作指引上冊
- 綜合社區安寧照顧支援隊(ICEST) - 專業同工工作指引下冊
- 綜合社區安寧照顧支援隊(ICEST) - 支援同工工作指引
- 「晚晴心語：饒饌日常」食譜及心情故事分享
- 「晚晴心語：智蘊樂活」晚期病人生活與照顧小貼士
- 新型冠狀病毒病下的社區晚期病人照顧資源冊 (ebook)
- 安寧義工服務發展與統籌手冊 (published in 2022)

9.2. Academic manuscripts

- Takemura, N., Fong, D. Y. T., & Lin C. C. (2022). Evaluating end-of-life care capacity building training for home care nurses. *Nurse Education Today*, 117, 105478. <https://doi.org/10.1016/j.nedt.2022.105478>
- Jiao, K., Chow, A. Y., Wang, J., & Chan, I. I. (2021). Factors facilitating positive outcomes in community-based end-of-life care: A cross-sectional qualitative study of patients and family caregivers. *Palliative medicine*, 35(6), 1181–1190. <https://doi.org/10.1177/02692163211007376>
- Wong, K. T. C., Chow, A. Y. M., & Chan, I. K. N. (2021). Effectiveness of Educational Programs on Palliative and End-of-life Care in Promoting Perceived Competence Among Health and Social Care Professionals. *American Journal of Hospice and Palliative Medicine®*. <https://doi.org/10.1177/10499091211038501>
- Law, M., Lau, B., Kwok, A., Lee, J., Lui, R., Liu, K., . . . Chan, C. (2020). Empowering families facing end-stage nonmalignant chronic diseases with a holistic, transdisciplinary, community-based intervention: 3 months outcome of the Life Rainbow Program. *Palliative and Supportive Care*, 1-10. doi:10.1017/S1478951520001224
- Wang, Q., Chan, I. K. W., & Lou, V. W. Q. (2020). Effectiveness of a Holistic Capacity-Building Program for Volunteers in Community-Based End-of-Life Care. *Research on Social Work Practice*, 30(4), 408–421. <https://doi.org/10.1177/1049731519898530>
- Xiu, D., Chow, A., & Chan, I. (2020). Development and psychometric validation of a comprehensive end-of-life care competence scale: A study based on three-year surveys of health and social care professionals in Hong Kong. *Palliative and Supportive Care*, 1-10. doi:10.1017/S1478951520000723

10. Conclusions, Learnings and Future Directions

10.1. Conclusions

Building on the success of Phase I Project, the Phase II Project amplified its outcomes and impacts through standardisation of both community EoLC service models as well as capacity building programmes. The ICESTs and IRHESTs were developed in partnership with Hospital Authority and were rigorously tested with promising cost-effectiveness. The models receive positive feedback from relevant Government units. On the other hand, standardised community psychosocial EoLC curriculum was developed targeting health and social care professionals, while a tiered training curriculum was offered to EoLC volunteers. Our programme evaluation suggested that all 4 project components were successful in generating desirable outcomes and impacts despite the challenges brought to us by the COVID-19 pandemic in the past two years. With the continued efforts of the JCECC Project in the past 6 years, and the concerted efforts of the Government, the ranking of Hong Kong in the Quality of Death Index, drastically leaped from the 22nd among 80 places around the world in 2015 to the 9th among 81 in 2021^{1,2}. Overall, the Project has made a big difference on the quality of Community EoLC in Hong Kong. The COVID-19 pandemic served as a catalyst for the raising interest and needs for community EoLC, and there is an urgent needs for further upscaling the community EoLC services and engaging both health and social care professionals and the general public for advocacy.

In terms of outcomes:

1. the Capacity Building Programmes successfully enhanced health and social care professionals and volunteers' EoLC competencies;
2. the EoLC community models were able to promote quality of life of both patients and their family carers; and
3. the participants of the public education programmes were satisfied with the programmes.

The project components also generated positive impacts:

1. a desirable direction of changes in EoLC competencies among health and social care professionals in the community was observed with JCECC training programme participants reporting significantly higher self-perceived competencies in EoLC;
2. the community EoLC service models saved considerable medical costs and lengthen the time that patients could stay in their preferred place of care, and the ICEST was able to generate HK\$ 3.58 social value with HK\$ 1 investment; and
3. the surveyed general public showed improvements in awareness on various EoLC-related terminologies and increasing percentage of surveyed general public showed willingness to discuss EoLC and death and dying topics.

10.2. Learnings and Future Directions

We identified areas that more work can be done to make the Project's impacts more sustainable.

¹ Finkelstein, E. A., Bhadelia, A., Goh, C., Baid, D., Singh, R., Bhatnagar, S. & Connor, S. R. (2022). Cross Country Comparison of Expert Assessments of the Quality of Death and Dying. *Journal of Pain and Symptom Management*, 63(4), e419-e429. doi: <https://doi.org/10.1016/j.jpainsymman.2021.12.015>

² Duke-NUS Medical School (n.d.). Cross country Comparison of Expert Assessments of the Quality of Death and Dying 2021. Retrieved from: <https://www.duke-nus.edu.sg/lcpc/quality-of-death>

Capacity Building Programmes for health and social care professionals

Cultivating future leaders to be impetus in promoting community EoLC promote sustainable development in community EoLC. While our leadership programme had successfully empowered future leaders with necessary competency in designing evidence-based EoLC programme, future programme should take one step forward to offer support to these trained professionals to turn their ideas into actual actions. In particular, such programme should involve building a mutual support platform among professionals and creating synergy with international bodies that offered EoLC leadership training should also be considered.

Upskilling frontline health and social care professionals with EoLC competency needed in their service settings is also crucial in fostering sustainability. The use of online learning in the 3-tiered community psychosocial EoLC course was proved to be able to benefit a vast number of professionals and be sustainable. However, while the basic module benefited over 3 500 professionals and received overwhelmingly positive feedback, the advanced module only benefited 95 professionals. It was probably because the advanced module was only launched by December 2020, and it required a relatively high commitment (42 hours). Moreover, the participants who took part in the evaluation of the intermediate and advanced modules were limited such that it was challenging to fully evaluate the outcomes of independent modules. The Project team should continue to offer this curriculum to more professionals in coming years. Especially, modifications should be made by condensing the tutorials and beefing up the online learning materials in the advance module to make it more affordable for participants, and more incentives should be offered to attract participants to take part in evaluation. Besides, both our setting specific training targeting community elderly service units and the ICEST model training were oversubscribed and reflected high training needs in these areas. Similar training should be continued in future to prepare trained work force to offer ICEST services and EoLC approach in the elderly service sector.

Continuous training is required and thus competent trainers in EoLC are necessary. It was thus similarly important to nurture experienced EoLC practitioners to become trainers to continue to offer training to the professional community. Train-the-trainer approach in cultivating future trainers should be considered.

Lastly, it was observed that professionals have become adapted to online learning (e.g. Zoom). Evaluation also showed that training provided in physical classroom and via Zoom yielded similar effectiveness. Indeed, we found some professionals favor online training over classroom training as the trainings were more accessible and it helped them save time and travelling costs. It was thus suggested to organise more trainings in hybrid mode to maximise the accessibility of professionals to training. More online training delivered by overseas speakers can also be arranged in future.

Community EoLC Models Development and Direct Services

The promising outcomes and cost-effectiveness of the two models over the past 6 years, the ICEST and IRHEST, offer a solid ground to further scale up to benefit more patients and family carers in future. Outcome and impacts of the service prototype models when replicated in districts with service clients of different demographic characteristics will offer implications for further improving the prototypes. To further advance the rigor of

evaluation, future analysis should be extended to assess the cost-benefits of IRHEST using the social return on investment (SROI) framework, to understand mechanism of changes in the models, and to evaluate the process of medical-social collaboration in the models.

Capacity Building Programmes for Volunteers

Learned from the success of the 3-tiered community psychosocial EoLC, the volunteer curriculum developed in the Phase II Project should also be turned into blended learning to make the learning materials accessible to a bigger population and more sustainable. The online self-learning part can also be offered to the general public who are interested in learning about EoLC but not yet ready to join as NGO volunteers. Regarding the training contents, the COVID-19 pandemic has given rise to new roles and training needs among volunteers and these should be incorporated into the training contents in future. Moreover, the experience on EoLC volunteers coordination, especially the use of volunteer leaders should be further consolidated and taught to professionals in the community given that volunteers are indispensable stakeholders in community EoLC.

Public education

Despite our community-wide public survey suggested improved awareness on EoLC knowledge and increased openness towards this topic among the general public, more work has to be done to turn these knowledge and attitudes into actual actions among the public. Besides, the survey showed that majority of the surveyed respondents hold positive attitude towards community EoLC (e.g. EoLC at home, die at home) and conducting ACP and AD for oneself and for family member(s) with chronic/terminal illness. Nevertheless, the shared barriers in taking action revealed potential misconceptions on ACP and AD, and a lack of skills in initiating the discussion. Therefore, it is paramount for the project to widely disseminate accurate information on EoLC-related services, AD, and ACP, offer practical tips on how to constructively discuss these topics, and create opportunities to motivate the public to actually discuss these with families or loved ones. To do so, public campaign that involves a series of well-planned public education and engaging activities (e.g. talks, exhibitions, competitions etc.) conveying the same message is needed. The noise would not be loud enough if we only rely on the network of the Project team. The Project team should engage various stakeholders (e.g. NGOs, media, professionals) in promoting and/or implementing the public campaign and engage celebrities/KOLs to attract the public's attention.

Figure 10.1 summarises the future directions for the four project components.

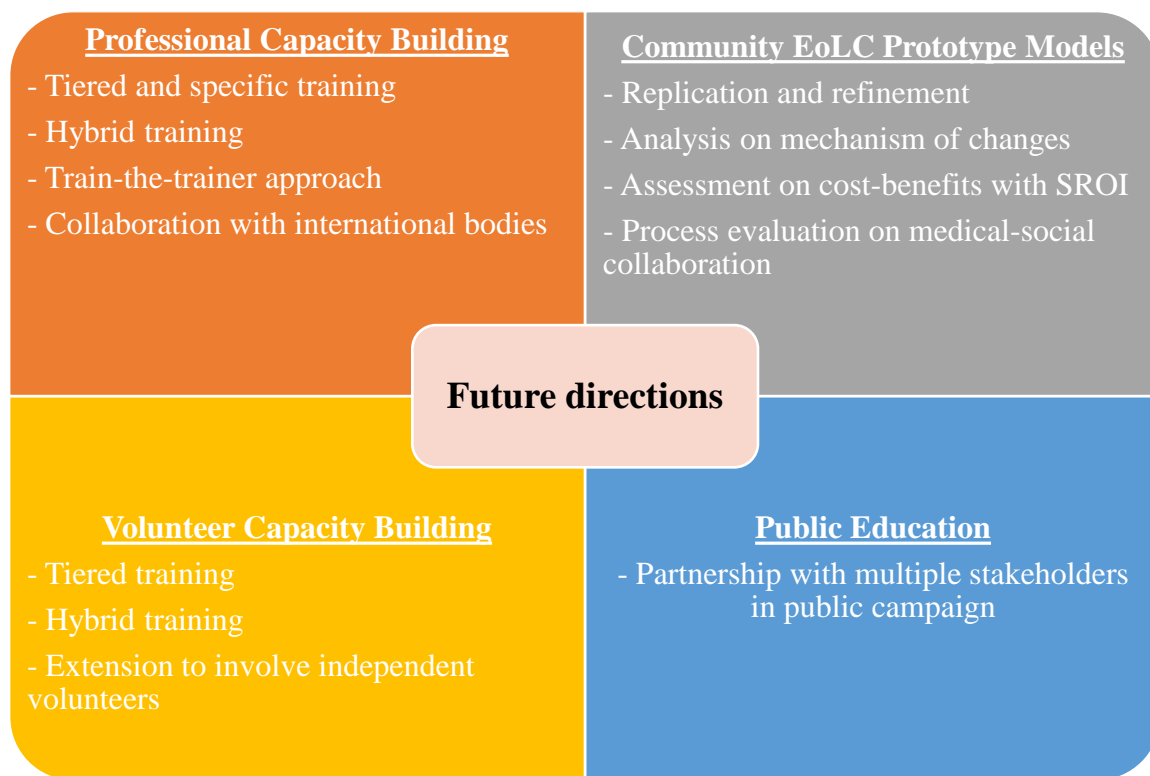


Figure 10.1 Future directions on project components

Appendix I Press Report

「賽馬會安寧頌」計劃成果發佈記者招待會

Press Conference for “Jockey Club End-of-Life Community Care Project”

日期: 二零一九年五月七日（星期二）

時間: 上午十時三十分至上午十一時十五分

地點: 香港大學邵仁枚樓 2 樓 204 室

Date: Tuesday May 7, 2019

Time: 10:30 am – 11:15 am

Venue: Room 204, Runme Shaw Building, The University of Hong Kong

「賽馬會安寧頌」計劃成果發佈記者招待會

Press Conference for “Jockey Club End-of-Life Community Care Project”

Press Attendance List	
<u>Newspaper</u>	報章
Sky Post	晴報
<u>Channel</u>	電台
Cable TV	有線電視
Metro Finance	新城財經台
RTHK	香港電台
TVB	無線電視
<u>Online Media</u>	網上媒體
HK01	香港 01

Summary of Media Coverage

I. Newspaper Clipping

<u>Newspaper</u>	<u>報章</u>
Headline Daily News	頭條日報
Hong Kong Economic Times	經濟日報
Sing Tao Daily	星島日報
Sky Post	晴報
The Standard	英文虎報

II. Website Coverage

<u>Website</u>	<u>網站</u>
Bastillepost	巴士的報
Headline Daily News	頭條日報
HK01	香港 01
Hong Kong Economic Times	經濟日報
Sing Tao Daily	星島日報
Sky Post	晴報
The Standard	英文虎報
Topick (by Hong Kong Economic Times)	Topick

III. Media Broadcast

<u>Channel</u>	<u>電視台</u>
TVB	無線電視

日期: 2019-05-08

報章: 頭條日報

版位/ 發行數目: 44/814,741

標題: 安寧服務助晚期病患減焦慮

安寧服務助晚期病患減焦慮

香港人口老化問題日益嚴重，社會對安寧照顧服務的需求亦日漸增加。「賽馬會安寧頌」計劃，為患有慢性及晚期病患的長者提供安寧照顧服務，培訓專業人員及舉辦公眾教育活動等。計劃獲香港賽馬會慈善信託基金再度撥款，開展第二階段。

「安寧頌計劃」昨日公佈首三年計劃的成效(圖)，包括病者身體狀況同焦慮減少；參與計劃的病人死前六個月的住院日數平均減少五日，減輕醫療系統負擔，並已培訓超過一萬名社區及公立醫

院醫護人員，提供安寧服務；另外，超過三十五萬名市民透過計劃的多媒體資訊，獲得更多有關安寧服務的知識。

香港賽馬會慈善信託基金再度撥款逾一億二千四百萬港元，開展第二階段，兩階段合共撥款逾二億五千五百萬港元。計劃旨在強化現有社區及醫療系統的聯繫，為本港安寧服務提供多一項選擇。其中一名參與計劃的黃婆婆臨終前在家寧養，在社工幫忙下完成心願參觀慈山寺及農場，又有義工上門教做陶瓷，婆婆最後將製成品送給女兒留

念。另一個案李婆婆，最後日子在院舍內的安寧房間，環境乾淨企理，家屬可二十四小時探訪，平靜地陪伴李婆婆走最後一程。



日期: 2019-05-08
報章: 經濟日報

版位/ 發行數目: A11/100,000
標題: 馬會安寧頌 紓晚期病患情緒

馬會安寧頌 紓晚期病患情緒

為改善晚期病患者生活及為其家屬提供支援，香港賽馬會慈善信託基金於2016年推行首階段為期3年的「賽馬會安寧頌」計劃。

至今逾5000人受惠

受惠者至今逾5,000人，與2015年在公立醫院死亡的同類病人對比，參與計劃的病人死亡前6個月的住院日數平均少近5日。

現年62歲的蘭英前年9月攜患有柏金遜症及晚期肝硬化的母親參與計劃，母親的身體狀況每況愈下，走路不穩兼「周身痛」，從護士定期家訪中，學會抱扶母親的技巧，計劃又安排陶瓷藝術家上門教母親製作陶瓷煲，分散其注意力，從而減輕痛症，其母於同年12月底離世，蘭英坦言沒遺憾。

港大社會科學學院社會工作及

社會行政學系副教授周燕雯指，首階段計劃有36間安老院舍、2,610名安老院長者及家庭成員參與，另有2,392名在家寧養的晚期病患者及其家屬接受服務。

周燕雯指，晚期患者會覺得自己「無用」而出現抑鬱徵狀，如自我形象低落，計劃會派出社工與患者傾訴，喚起他們從前也為家庭付出貢獻，作情緒疏導。



港大社會科學學院社會工作及社會行政學系副教授周燕雯（右三）指，計劃會派出社工與晚期患者傾訴作情緒疏導。

（冼偉倫攝）

日期: 2019-05-08

報章: 星島日報

版位/ 發行數目: A12/100,000

標題: 安寧頌計劃成效佳

馬會撥 1.2 億展次階段

安寧頌計畫成效佳 馬會撥1.2億展次階段

港人人均歲數愈來愈長，人口老化問題日益嚴重，賽馬會慈善信託基金早於二〇一六年推出為期三年的「賽馬會安寧頌」計畫，為患有慢性及晚期病患的長者提供安寧照顧服務、培訓專業人員及舉辦公眾教育活動；馬會昨日宣布再度撥款一億二千四百萬元，開展第二階段計畫，同樣為期三年。

計畫項目總監周燕雯表示，團隊於計畫開始的三個月後，對參與計畫的在家寧養病人及其家屬進行調查，發現病人接受服務後，身體不適徵狀指數由九點七下降至七點九，減低一成八。

跟二〇一五年相關數據比較，參與計畫的病人死亡前六個月的住院日數平均減少約五日，下降超過一成二。計畫過去三年共服務七百七十七名病人，按此推算，共為公立醫院騰空三千七百八十四日牀位，大大減輕深切治療病牀及急症室的使用量。

日期: 2019-05-08
報章: 晴報

版位/ 發行數目: 16/450,088
標題: 晚期病者用安寧服務 抑鬱徵狀減近半

面對危疾，病人及親屬身心均需承受壓力。有調查指，晚期患者使用安寧服務後，抑鬱及身體不適徵狀分別減少47%及18%，亦能減低照顧者壓力達19%；與2015年在公立醫院死亡的同類病人對比，參與計劃的病人死亡前半年的住院及使用急症室比率平均少12.5%及11.6%。專家認為計劃能減輕急症室的使用量。

記者：李蕭蕭 編輯：梁偉澄 美術：魏偉然 攝影：洗偉倫

晚期病者用安寧服務 抑鬱徵狀減近半

現年62歲的蘭英前年9月帶患有帕金森症及晚期肝癌化的母親參與計劃，她說母親走路不穩兼「周身痛」，計劃安排陶瓷藝術家上門教其母製作陶瓷煲，分散注意力減輕痛症，其母於同年12月底離世，蘭英坦言即使母親臨終前說不出話，但感覺她走得安心。

社工上門聽心事 護士教照顧

香港賽馬會慈善信託基金於2016年推行首階段為期3年的「賽馬會安寧頌」計劃，改善晚期病人生活及為其家屬提供護理服務支援。港大社會科學學院社會工作及社會行政系副教授周燕雯稱，首階段有36間安老院舍、2,610名安老院長者及家屬參與，另有2,392名在家寧養

的晚期病人及其家屬接受服務。勞福局局長羅致光昨於啟動禮稱，自首階段起不少晚期病人獲多方面臨終支援，第2階段延續至2021年，冀更多人受惠。

團隊於計劃開始3個月後，對參與在家寧養的晚期病人及其家屬進行調查。結果顯示，患者使用服務後的抑鬱及身體不適徵狀減47%及18%；患者家人的焦慮徵狀及照顧壓力分別減27%及19%；與2015年在公院死亡的同類病人對比，參與計劃的病人死亡前半年的住院日數及比率平均少近5日及12.5%，使用急症室次數及比率平均少0.32次及11.6%。

聽過計劃者略增

團隊於2016至2018年間進行3階段調查訪問4,638名市民，每階段平均約1,500人。結果顯示，有聽過安寧照顧的人數比例由2016年30%增至去年39%。

周燕雯稱晚期患者會自覺「無用」，計劃派出社工與患者傾訴疏導其情緒，不少人面對親人患病或不懂如何照顧，計劃亦會派護士上門教家屬抱扶技巧。

安寧服務計劃會派出社工與晚期患者傾訴，疏導其情緒。
(iStock)



周燕雯指計劃第2階段已於今年1月展開，服務由36間安老院舍擴至48間。

Countdown to passing eased

Jane Cheung

Elderly people suffering from terminal illnesses have been found to feel physically and mentally better after joining an end-of-life community program.

For not only does the Jockey Club End-of-Life Community Care Project treat their illnesses but also offers psychological support.

Many patients who considered themselves useless show themselves to be less depressed and anxious after talking to volunteers.

The Hong Kong Jockey Club Charities Trust provided HK\$225 million and partnered with the University of Hong Kong to initiate the end-of-life care project in 2016.

The six-year project can improve the quality of end-of-life care, enhance the capacity of service providers and raise awareness of the service.

Project director Amy Chow Yin-man, an HKU associate professor of social work and administration, said a survey showed elderly people in the program saw symptoms reduced by 18 percent.



Amy Chow

"Practical and psycho-social support were also able to relieve the anxiety of end-of-life patients and family members," she said.

The service has also eased pressure on hospitals.

The program has trained over 10,000 health-care professionals and helped about 5,000 elderly citizens with terminal illnesses to stay at home with family members. It has also covered 36 homes for the elderly.

And very importantly public education activities have led to more openness in society, such as breaking the taboo about not talking about death.

In a survey of 4,638 citizens between 2016 and 2018, the proportion of respondents who were found to understand end-of-life care concepts rose from 30 to 39 percent over the two years.

Additionally, more than 75 percent of respondents said they considered quality of life to be more important than the extension of life.

jane.cheung@singtaonews.com

日期: 2019-05-08
網站: 巴士的報

版位: 新聞
標題: 安寧服務助晚期患者減抑鬱徵狀
病人留院少近 5 日

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賽馬會推安寧照顧服務 為晚期病患者及家屬提供支援

2019年05月07日 (06:08 下午)



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計劃為患有慢性及晚期病患的長者提供安寧照顧服務。

香港人口老化問題日益嚴重，患有慢性及晚期病患的長者人數不斷攀升，社會對安寧照顧服務的需求亦日漸增加。香港賽馬會慈善信託基金於2016年起，推行為期3年的「賽馬會安寧頌」計劃，為患有慢性及晚期病患的長者提供安寧照顧服務、培訓專業人員及並舉辦公眾教育活動。

計劃今天公佈首3年的服務成果，並宣佈獲香港賽馬會慈善信託基金再度撥款逾1.24億元，開展第二階段，兩階段合共撥款逾2.55億元。

近日賽馬會慈善信託基金再次撥款，推行第二階段「賽馬會安寧頌」計劃，預計兩個階段合共撥款逾2.55億元。第二階段已於2019年1月正式展開，服務亦由36間安老院舍擴展至48間，培訓更多安老院舍員工。

勞工及福利局局長羅致光今日（7日）於啟動禮指，由第一階段計劃以來，不少年長人士、晚期病人獲得多方面的臨終支援，而第二階段延續至2021年，期望資助能讓服務單位優化服務模式，從而讓更多有需要人士受惠。

香港賽馬會董事李家祥表示，過去3年，「賽馬會安寧頌」已惠及超過500名晚期病患長者及其家人，讓他們可以在充份知情下作出合適的臨終護理選擇，同時獲得心理及精神上的支援。

「賽馬會安寧頌」計劃2016年展開，為患有慢性及晚期病患的長者提供安寧照顧服務、培訓專業人員及舉辦公眾教育活動等。



有受惠者指計劃為晚期病者及其家屬提供支援。

日期：2019-05-08

網站：頭條日報

版位：港聞

標題：賽馬會推安寧照顧服務
助晚期病患者減身體不適焦慮等徵狀

賽馬會推安寧照顧服務 助晚期病患者減身體不適焦慮等徵狀



2019-05-07 16:38 列印 A 文字大小



香港賽馬會慈善信託基金於2016年起，推行為期3年的「賽馬會安寧頌」計劃。

香港人口老化問題日益嚴重，患有慢性及晚期病患的長者人數不斷攀升，社會對安寧照顧服務的需亦日漸增加。香港賽馬會慈善信託基金於2016年起，推行為期3年的「賽馬會安寧頌」計劃，為患有慢性及晚期病患的長者提供安寧照顧服務、培訓專業人員及並舉辦公眾教育活動。

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「賽馬會安寧頌」計劃項目總監、香港大學社會科學學院社會工作及社會行政系周燕雯表示，計劃自2016年1月啟動後，已培訓逾1萬名社區及公立醫院醫護人員，服務社區及36間安老院舍，共5000多在家寧養的晚期病患長者及其家屬，以及培訓586名義工支援社區安寧服務；另外，超過35萬名市民透過計劃的多媒體資訊，獲得更多有關安寧服務的知識。

調查顯示，參與在家寧養的受惠病人當中，身體不適的情況減少18%；受惠病人及其家屬，接受計劃的實務及心理支援後，焦慮情況得到顯著紓緩；家庭實務問題則減輕55%。

此外，該計劃亦證實有效減輕醫療系統的負擔，據2015年相關數據比較，參與計劃的病人死亡前6個月的住院日數平均減少約5日，下降超過12.5%。計劃過去3年共服務777名病人，按此推算，總共為公立醫院騰空3784日床位，亦大大減輕深切治療病床及急症室的使用量。

安老院舍方面，參加計劃的37位院友當中，死亡前3個月的住院日數平均減少約13日，急症室使用次數亦平均下降近20%。另外，計劃亦培訓超過2200名安老院舍職員，不論是員工在提供安寧照顧服務的意願、能力及抗逆力，均有所提升。

計劃合作夥伴香港老年學會「安寧在院舍」計劃護士鄭惠芳及個案家屬趙女士表示，計劃提升了安老院舍對晚期病者及其家屬的支援，讓他們在最後日子得到妥善照顧。另一合作夥伴香港復康會推行的「安晴·生命彩虹」社區安寧照顧計劃，項目經理羅敏姿及個案家屬蘭英指出，計劃提升家屬的照顧技巧及信心，讓服務使用者臨終前可在家中接受具質素的安寧照顧。

近日賽馬會慈善信託基金再次撥款，推行第二階段「賽馬會安寧頌」計劃，預計兩個階段合共撥款逾2.55億元。

老院舍員工。

勞工及福利局局長羅致光今日（7日）於啟動禮指，由第一階段計劃以來，不少年長人士、晚期病人獲得多方面的臨終支援，而第二階段延續至2021年，期望資助能讓服務單位優化服務模式，從而讓更多有需要人士受惠。

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「賽馬會安寧頌」計劃2016年展開，為患有慢性及晚期病患的長者提供安寧照顧服務、培訓專業人員及舉辦公眾教育活動等。



第二階段「賽馬會安寧頌」計劃今日舉辦啟動禮。



有受惠者指計劃為晚期病者及其家屬提供支援。

日期：2019-05-08
網站：香港 01

版位：港聞
標題：機構過去三年推安寧照顧服務
減輕晚期病患不適、抑鬱徵狀

機構過去三年推安寧照顧服務 減輕晚期病患不適、抑鬱徵狀



社會新聞

讚好 0

撰文：黃詠楠 2019-05-07 12:46 最後更新日期：2019-05-07 13:44

人口老化問題日益嚴重，香港賽馬會慈善信託基金於2016年起，推行為期三年的「賽馬會安寧頌」計劃，為患有慢性及晚期病患的長者提供安寧照顧服務、培訓專業人員及並舉辦公眾教育活動。

「賽馬會安寧頌」計劃項目總監、香港大學社會科學學院社會工作及社會行政系周燕雯博士指，調查顯示晚期病患接受服務後，身體不適徵狀指數由9.7下降至7.9，減低18%，而抑鬱徵狀指數亦有減低。



「賽馬會安寧頌」計劃項目總監、香港大學社會科學學院社會工作及社會行政系周燕雯指，調查顯示病人接受服務後，身體不適徵狀指數由9.7下降至7.9，減低18%。（黃詠楠攝）

香港賽馬會慈善信託基金於2016年主導，推行為期三年的「賽馬會安寧頌」計劃，為患有慢性及晚期病患的長者提供安寧照顧服務、培訓專業人員及並舉辦公眾教育活動。

「賽馬會安寧頌」計劃項目總監、香港大學社會科學學院社會工作及社會行政系周燕雯博士指，計劃自2016年1月啟動，至今已培訓超過1萬名社區及公立醫院醫護人員，服務社區及36間安老院舍、共5,000多名在家寧養的晚期病患長者及其家屬。



黃金寶李麗珊勉勵青少年勇敢面對失敗：要唔怕輸、肯承擔

【企圖跳橋】情困男圖跳汀九橋尋死 消防及時勸服救一命

馬會連續五屆支持全港運動會 推廣體育文化

周燕雯指，團隊於計劃開始三個月後，對參與計劃在家寧養的受惠病人及其家人進行調查，了解他們於生理及心理上的轉變。周指，調查顯示病人接受服務後，身體不適徵狀指數由9.7下降至7.9，減低18%。

在家庭實務問題方面，病人的擔心指數亦由1.1下降至0.5，下跌55%。周續解釋，家庭實務包括多方面，如病人想出外走動、照顧者需24小時貼身照顧患者、甚至是購買醫療器材煩惱等。而計劃正好安排了護士、社工上門探訪，除了教導照顧者紓緩技巧，亦分擔了照顧者的壓力。

另一方面，病人的抑鬱及焦慮徵狀亦分別減低47%及31%。而家人的焦慮徵狀及照顧壓力亦分別減低27%及19%。周燕雯強調，服務不是著重提供治療，而是提供心靈上的紓緩、實務支援、教導放鬆技巧。周續指，不少晚期病人覺得自己很「無用」、沒有貢獻，但多與義工傾談、參加活動後，始意識到「原來自己仲有好多叻嘅嘢。」



第二階段「賽馬會安寧頌」計劃今（7日）舉辦啟動禮。（黃詠楠攝）

另外，團隊亦於2016年至2018年間，委託了香港大學社會科學研究中心進行了三階段全港性電話調查，隨機訪問4,638名市民，發現公眾對安寧照顧認識增加。結果顯示，有聽過「安寧照顧」的比例，2016年為30%，2018年則上升至39%，上升9個百分點。

近日賽馬會慈善信託基金再次撥款，推行第二階段「賽馬會安寧頌」計劃，預計兩個階段合共撥款逾2.55億元。第二階段已於2019年1月正式展開，服務亦由36間安老院舍擴展至48間，培訓更多安老院舍員工。

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日期: 2019-05-08

版位: 港聞

網站: 香港 01

標題: 84%受訪者冀自決臨終安排

安寧照顧計劃助亡母精彩走完最後一段人生路 女兒：以前唔識求助



社會新聞

讚好 0

撰文：黃詠楠 2019-05-07 16:54 最後更新日期：2019-05-07 16:54



今年62歲的蘭英（左）過去先後經歷三個至親的離世，讓以前不懂求助。（黃詠楠攝）

曾安排父親到老人院 卻不肯吃飯、吃藥

「丈夫患癌、父親曾中風、患柏金遜病、腦退化症，而母親則有柏金遜病和肝病。」今年62歲的蘭英，過去先後經歷三個至親的離世，在丈夫逝世後，作為家中獨女，一個人扛起照顧兩老的重擔。

她憶述，曾有一刻感到十分崩潰，因為父親、母親同時入院：「但唔係一齊出院。」先出院的父親患有腦退化症，欠自理能力，蘭英無法讓其獨自留在家，便安排他到老人院待一、兩日，「已經事前同佢講好咗，佢最初咩都話好，但佢去到老人院，發覺唔係屋企，又唔肯食飯、食藥。」

義工帶母親到慈山寺、製陶瓷 「思想不集中於痛」

只有一名照顧者，不時遇到分身乏術的困境，亦只能「硬食」。蘭英苦笑道，「真係唔識搵人求助，只係自己撐。」父親於2015年逝世，她其後主力照顧母親，然而母親身體亦於一、兩年內轉差，經社工轉介後，她讓母親參與社區安寧照顧計劃，至其2017年12月離世，終年91歲。

母親愛去旅行，惟當時受病痛所困，出入亦有困難，遑論是四處遊玩。幸而參與計劃後，在社工及義工安排下，成功參觀慈山寺及農場。除此之外，更安排陶瓷藝術家上門，教其母親製作陶瓷，「等佢思想唔使集中於痛。」

她續指，在其母臨終前數日，義工更帶同製成品，將母親最愛的事物乳鴿圖片貼於煲內，「我同朋友輪流照顧媽咪咁耐，都有見過佢笑。佢見到真係好開心，雖然係相，但對佢嚟講，有人記得呢件事係開心。」蘭英坦言，一直以來已盡力照顧母親，沒留下遺憾。



計劃亦邀請了插畫及文字工作者，紀錄低母女二人去旅行的回憶。（黃詠愉攝）

有長者只求舒服離世

而趙女士亦為母親參加了計劃，她指，母親一向表明不想「長命」，只求臨終時可以舒服離世。其母在晚年時患有嚴重認知障礙、乳癌及病竇症候群，家屬亦已同意為其提供紓緩治療，並不使用入侵性呼吸裝置等。在年初，母親的情況轉差，被轉移至院舍內的「安寧房間」，「佢感覺精神多咗，我哋亦可以24小時陪住佢」，平靜走過人生最後一段路，終年94歲。



趙女士（中）指，母親一早表明想舒服離世。

第二階段「賽馬會安寧頌」今年1月初展開

由賽馬會慈善信託基金主導的「賽馬會安寧頌」，第一階段於2016年開始，為患有慢性及晚期病患的長者提供安寧照顧服務，如提供社工、護士上門支援、教授紓緩治療的技巧、個人及家庭輔導等。

近日賽馬會慈善信託基金再次撥款，推行第二階段「賽馬會安寧頌」計劃，兩個階段合共撥款逾2.55億元。第二階段已於2019年1月正式展開，服務亦由36間安老院舍擴展至48間，培訓更多安老院舍員工。

日期： 2019-05-08

網站： 經濟日報

標題： 馬會安寧頌 紓晚期病患情緒

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報章
香港經濟日報

21°C 香港時間：2019年5月08日 (三) 14:31

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中美貿易戰
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道指
MSCI
大灣區
華為

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馬會安寧頌 紓晚期病患情緒

要聞版 2019/05/08 讚好 0

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關注文章
儲存文章
贈閱友好

分享：

為改善晚期病患者生活及為其家屬提供支援，香港賽馬會慈善信託基金於2016年推行首階段為期3年的「賽馬會安寧頌」計劃。

至今逾5000人受惠

受惠者至今逾5,000人，與2015年在公立醫院死亡的同類病人對

...

撰文： 杜正之

文章標籤

香港
生活
馬會
院舍

欲覽全文，立即登記訂閱收費內容；
現有訂戶請按登入瀏覽。

立即訂閱
登入

日期： 2019-05-08

網站： 星島日報

版位： 港聞

標題： 賽馬會推安寧照顧服務

助晚期病患者減身體不適焦慮等徵狀



香港

賽馬會推安寧照顧服務 助晚期病患者減身體不適焦慮等徵狀

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香港賽馬會慈善信託基金於2016年起，推行為期3年的「賽馬會安寧頌」計劃。

香港人口老化問題日益嚴重，患有慢性及晚期病患的長者人數不斷攀升，社會對安寧照顧服務的需求亦日漸增加。香港賽馬會慈善信託基金於2016年起，推行為期3年的「賽馬會安寧頌」計劃，為患有慢性及晚期病患的長者提供安寧照顧服務、培訓專業人員及並舉辦公眾教育活動。

計劃今天公佈首3年的服務成果，並宣佈獲香港賽馬會慈善信託基金再度撥款逾1.24億元，開展第二階段，兩階段合共撥款逾2.55億元。

「賽馬會安寧頌」計劃項目總監、香港大學社會科學學院社會工作及社會行政系周燕雲表示，計劃自2016年1月啟動後，已培訓逾1萬名社區及公立醫院醫護人員，服務社區及36間安老院舍、共5000多在家奉養的晚期病患長者及其家屬，以及培訓586名義工支援社區安寧服務；另外，超過35萬名市民透過計劃的多媒體資訊，獲得更多有關安寧服務的知識。

調查顯示，參與在家奉養的受重病入當中，身體不適的情況減少18%；受重病入及其家屬，接受計劃的實務及心理支援後，焦慮情況得到顯著舒緩；家庭實務問題則減輕55%。

此外，該計劃亦證實有效減輕醫療系統的負擔，據2015年相關數據比較，參與計劃的病人死亡前6個月的住院日數平均減少約5日，下降超過12.5%。計劃過去3年共服務777名病人，按此推算，總共為公立醫院騰空3784日床位，亦大大減輕深切治療病床及急症室的使用量。

安老院舍方面，參加計劃的37位院友當中，死亡前3個月的住院日數平均減少約13日，急症室使用次數亦平均下降近20%。另外，計劃亦培訓超過2200名安老院舍職員，不論是員工在提供安寧照顧服務的意願、能力及抗逆力，均有所提升。

計劃合作夥伴香港老年學會「安寧在院舍」計劃護士鄭惠芳及個案家屬趙女士表示，計劃提升了安老院舍對晚期病者及其家屬的支援，讓他們在最後日子得到妥善照顧。另一合作夥伴香港復康會推行的「安晴·生命彩虹」社區安寧照顧計劃，項目經理羅敏姿及個案家屬蘭英指出，計劃提升家屬的照顧技巧及信心，讓服務使用者臨終前可在家中接受具質素的安寧照顧。

近日賽馬會慈善信託基金再次撥款，推行第二階段「賽馬會安寧頌」計劃，預計兩個階段合共撥款逾2.55億元。第二階段已於2019年1月正式展開，服務亦由36間安老院舍擴展至48間，培訓更多安老院舍員工。

勞工及福利局局長羅致光今日（7日）於啟動禮指，由第一階段計劃以來，不少年長人士、晚期病人獲得多方面的臨終支援，而第二階段延續至2021年，期望資助能讓服務單位優化服務模式，從而讓更多有需要人士受惠。

香港賽馬會董事李家祥表示，過去3年，「賽馬會安寧頌」已惠及超過500名晚期病患長者及其家人，讓他們可以在充份知情下作出合適的臨終護理選擇，同時獲得心理及精神上的支援。

「賽馬會安寧頌」計劃2016年展開，為患有慢性及晚期病患的長者提供安寧照顧服務、培訓專業人員及舉辦公眾教育活動等。



第二階段「賽馬會安寧頌」計劃今日舉辦啟動禮。



有受惠者指計劃為晚期病者及其家屬提供支援。

日期：2019-05-08

網站：晴報

版位：港聞

標題：晚期病者用安寧服務 抑鬱徵狀減近半

晚期病者用安寧服務 抑鬱徵狀減近半

港聞

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發佈時間: 2019/05/08

面對危疾，病人及親屬身心均需承受壓力。有調查指，晚期患者使用安寧服務後，抑鬱及身體不適徵狀分別減少47%及18%，亦能減低照顧者壓力達19%；與2015年在公立醫院死亡的同類病人對比，參與計劃的病人死亡前半年的住院及使用急症室比率平均少12.5%及11.6%。專家認為計劃能減輕急症室的使用量。

現年62歲的蘭英前年9月帶患有柏金遜症及晚期肝硬化的母親參與計劃，她說母親走路不穩兼「周身痛」，計劃安排陶瓷藝術家上門教其母製作陶瓷煲，分散注意力減輕痛症，其母於同年12月底離世，蘭英坦言即使母親臨終前說不出話，但感覺她走得安心。

社工上門聽心事 護士教照顧

香港賽馬會慈善信託基金於2016年推行首階段為期3年的「賽馬會安寧頌」計劃，改善晚期病人生活及為其家屬提供護理服務支援。港大社會科學學院社會工作及社會行政系副教授周燕雯稱，首階段有36間安老院舍、2,610名安老院長者及家屬參與，另有2,392名在家寧養的晚期病人及其家屬接受服務。勞福局局長羅致光昨於啟動禮稱，自首階段起不少晚期病人獲多方面臨終支援，第2階段延續至2021年，冀更多人受惠。

團隊於計劃開始3個月後，對參與在家寧養的晚期病人及其家屬進行調查。結果顯示，患者使用服務後的抑鬱及身體不適徵狀減47%及18%；患者家人的焦慮徵狀及照顧壓力分別減27%及19%；與2015年在公院死亡的同類病人對比，參與計劃的病人死亡前半年的住院日數及比率平均少近5日及12.5%，使用急症室次數及比率平均少0.32次及11.6%。

周燕雯稱晚期患者會自覺「無用」，計劃派出社工與患者傾訴疏導其情緒，不少人面對親人患病或不懂如何照顧，計劃亦會派護士上門教家屬抱扶技巧。

攝影：冼偉倫

記者：李嘉嘉

編輯：梁偉澄

美術：熊偉然



▲周燕雯指計劃第2階段已於今年1月展開，服務由36間安老院舍擴至48間。

聽過計劃者略增

團隊於2016至2018年間進行3階段調查訪問4,638名市民，每階段平均約1,500人。結果顯示，有聽過安寧照顧的人數比例由2016年30%增至去年39%。

日期： 2019-05-08

網站： 英文虎報

版位： Local

標題： Countdown to passing eased

Countdown to passing eased

Local | Jane Cheung 8 May 2019



Elderly people suffering from terminal illnesses have been found to feel physically and mentally better after joining an end-of-life community program.

For not only does the Jockey Club End-of-Life Community Care Project treat their illnesses but also offers psychological support.

Many patients who considered themselves useless show themselves to be less depressed and anxious after talking to volunteers.

The Hong Kong Jockey Club Charities Trust provided HK\$225 million and partnered with the University of Hong Kong to initiate the end-of-life care project in 2016.

The six-year project can improve the quality of end-of-life care, enhance the capacity of service providers and raise awareness of the service.

Project director Amy Chow Yin-man, an HKU associate professor of social work and administration, said a survey showed elderly people in the program saw symptoms reduced by 18 percent.

"Practical and psycho-social support were also able to relieve the anxiety of end-of-life patients and family members," she said.

The service has also eased pressure on hospitals.

The program has trained over 10,000 health-care professionals and helped about 5,000 elderly citizens with terminal illnesses to stay at home with family members. It has also covered 36 homes for the elderly.

And very importantly public education activities have led to more openness in society, such as breaking the taboo about not talking about death.

In a survey of 4,638 citizens between 2016 and 2018, the proportion of respondents who were found to understand end-of-life care concepts rose from 30 to 39 percent over the two years.

Additionally, more than 75 percent of respondents said they considered quality of life to be more important than the extension of life.

jane.cheung@singtaonewscorp.com

日期: 2019-05-08

網站: Topick (香港經濟日報)

版位: 港聞

標題: 安寧服務助晚期患者減抑鬱徵狀 病人留院少近 5 日

安寧服務助晚期患者減抑鬱徵狀 病人留院少近5日

社會 14:34 2019/05/07

關注文章 儲存文章

分享： f d e

熱門 鐵探 重案實錄 復仇者聯盟 許志安黃心穎出軌 生仔要考牌 抗癌新方向 消費會 兒童健康 關心速遞 港媽移民



▲ 周燕受(右三)指，計劃的第二階段已於今年1月展開，服務由36間安老院會擴至48間。(李嘉嘉攝)

面對危疾，病人及親屬身心均需承受壓力。有調查指，晚期患者使用安寧服務後，抑鬱及身體不適徵狀分別減少47%及18%，亦能減低照顧者壓力達19%；與2015年在公立醫院死亡的同類病人對比，參與計劃的病人死亡前半年的住院及使用急症室比率平均少12.5%及11.6%。專家認為計劃能減輕急症室的使用量。

為改善晚期病患者生活及為其家屬提供支援，香港賽馬會慈善信託基金於2016年1月推行首階段為期3年的「賽馬會安寧頌」計劃，受惠者至今逾5千人。

現年62歲的蘭英前年9月罹患有柏金遜症及晚期肝硬化的母親參與計劃，她坦言母親的身體狀況每況愈下，走路不穩兼「周身痛」，從護士定期家訪中，學會抱扶母親的技巧，計劃又安排陶瓷藝術家上門教母親製作陶瓷煲，分散其注意力，從而減輕痛症，其母於同年12月底離世，蘭英坦言沒遺憾：



▲ 蘭英前年罹患有帕金森症及晚期肝硬化的母親參與「賽馬會安寧頤」計劃，即使母親在同年12月離世，她仍表示沒有遺憾。（香港賽馬會提供圖片）

港大社會科學學院社會工作及社會行政學系副教授周燕靈指，首階段計劃有36間安老院舍、2,610名安老院長者及家庭成員參與，另有2,392名在家寧養的晚期病患者及其家屬接受服務。

團隊於計劃開始3個月後，對參與在家寧養的晚期病患者及其家屬進行調查，了解其心理及生理的轉變。調查顯示，患者使用服務3個月後抑鬱徵狀減少47%，身體不適徵狀亦減少18%；患者家人的焦慮徵狀及照顧壓力分別減少27%及19%。

周燕靈指，晚期患者會覺得自己「冇用」而出現抑鬱症狀，如自我形象低落，計劃會派出社工與患者傾訴，喚起他們從前也為家庭付出貢獻，作情緒疏導。她又指不少人面對親人患病或會不懂如何照顧，計劃會派出護士教導家屬抱扶病人的技巧。

日期： 2019-05-08
網站： TVB

版位： 港聞
標題： 有機構為病患長者提供非住院照顧成效佳 將擴展計劃

2019-05-07

有機構為病患長者提供非住院照顧成效佳 將擴展計劃

有機構為病患長者提供非住院照顧成效佳 將擴展計劃

2019-05-07 20:15

SD HD 粵普



有大學及社福機構合作，為晚期病患長者提供非住院的照顧服務。病人的身體不適、情緒問題都獲得改善，住院時間亦有減少。

蘭英的媽媽兩年前離世，她生前患柏金遜症和肝病，參加了賽馬會安寧護理計劃，獲醫生上門診治、義工探訪，並教授家人照顧技巧，讓病人能在家人陪伴下，走完人生最後一程。

家屬蘭英表示：「姑娘和社工姑娘上我家探我媽媽，又教我當媽媽痛時，怎樣舒緩痛楚。上門教我媽媽造陶器，令我媽媽思想不集中在痛楚，分散她注意力，她又開心些。」

計劃由港大、中大、復康會及靈實協會等合辦，由2016年開始，為期三年，有七百多名病患長者選擇在家寧養，並有36間安老院舍參加。

團隊去年底至今年初完成問卷調查，訪問約五百名在家寧養病人及其家屬。約兩成病人表示身體不適情況減少，四成七人表示抑鬱情緒獲改善。

項目總監周燕雯說：「我們的服務不是醫治服務，我們主要是心靈、輔導和義工的關注服務，和簡單教育他(照顧者)舒緩的方法、鬆弛技巧的方法。」

與公立醫院的同類病人比較，參加計劃的在家寧養及院舍病人，在過世前的三個月至半年內，住院日數均減少。

項目團隊指反映服務有成效，年初決定擴展計劃。第二階段服務，在家寧養病人人數會增加八成，及會擴展服務至48間安老院舍，亦會為不同個案提供不同程度的身體、心靈和生活上的支援。