CANCER PROFESSIONAL DEVELOPMENT FRAMEWORK
ABOUT THIS FRAMEWORK

This framework has been developed as a guide for cancer service providers in planning professional development activities for their cancer professionals. Underpinning the framework are key documents such as National Service Improvement Framework for Cancer Services (NSIF) and state and territory cancer plans. The framework was developed by the Office of Postgraduate Medical Education (formerly known as the Centre for Innovation in Professional Health Education) at The University of Sydney as part of the National Strengthening Cancer Care initiative funded by Cancer Australia. The Framework was developed in collaboration with the National Cancer Nurse Education project (EdCaN), also funded by Cancer Australia.

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The University of Sydney

The Office of Postgraduate Medical Education (formerly known as CIPHER)
www.opme.usyd.edu.au

National Cancer Nursing Education Project (EdCaN)
www.edcan.org

Clinical Oncological Society of Australia
www.cosa.org.au

The Royal Australian College of General Practitioners
www.raogp.org.au

National Breast & Ovarian Cancer Centre
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The Cancer Council Australia
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CANCER PROFESSIONAL DEVELOPMENT FRAMEWORK

This framework has been developed as a guide for cancer service networks and organisations in planning professional development activities for their cancer professionals. Networks refer to both clusters of cooperating facilities within health services and structured clinical networks designed to improve cancer services.

Its reference points are:

1. The stages and needs of people with cancer as they move along the “patient pathway” *
2. The “optimal service outcomes” derived from those needs and described in the National Service Improvement Framework for Cancer Services (NSIF) and state and territory cancer plans
3. The priority service areas identified by the needs analysis of cancer professionals in Phase I of the Professional Development in Cancer Care Project

* National Service Improvement Framework for Cancer (2005) Australian Health Ministers’ Conference

The result is a matrix which describes people’s needs; the optimal services to meet those needs; and the professional performance and organisational support they require.
1. REDUCE THE RISK OF CANCER

The Patient Pathway (Access consistent information to understand risk; access a safe, risk reducing environment; actively reduce risk)

People’s needs
People want to:
- understand their risk of developing cancer
- know how to reduce their risk of cancer
- have a safe environment
- be able to access risk prevention programs
- understand how their family history affects their risk of cancer
- access highly credible, nationally consistent, evidence based information about the risk of cancer and the ability to reduce cancer risk

NSIF Ch 2 Reduce the Risk of Cancer P13

Optimal services

1.1 People in the community will have:
- access to consistent and evidence-based information about opportunities for cancer risk reduction

Professional performance elements

To assist in informing individuals about risk reduction, professionals should be able to:
- help assess any increased risk of cancer due to family history or other factors
- indicate the amount of population risk reduction that might occur from adopting risk reduction behaviours
- explain the quality of the available evidence
- integrate information about risk across cancers and other chronic diseases
- indicate which information is appropriate for different community groups
- communicate the above in a clear, easy to understand manner
- explain risk using a combination of word, numerical and graphical formats to optimise understanding

Organisational Support

To support service provision, cancer networks will need to:
- distribute up-to-date information about risk reduction evidence, strategies and campaigns
- highlight where this information needs integrating across cancers

To support individual professionals, cancer services will need to:
- identify which community groups within their service area may need specific risk reduction information
- ensure that individual practitioners have access to up-to-date risk reduction information from specialist services
- ensure that practitioners have access to guidelines on communicating risk and graphical templates to assist in this process
1.2 People will be encouraged to:
- take action to reduce their risk of cancer

Optimal services

1.3 People with special needs and disadvantaged groups will:
- have access to appropriate, tailored information and programs

Professional performance elements

To assist individuals to take action to reduce their risk of cancer, professionals should be able to:
- reinforce current media information and community based programs promoting risk reduction
- help individuals to identify their own cancer risk and relevant risk reduction behaviours
- advise individuals about how to access specific risk reduction programs (e.g., smoking cessation, skin protection, weight reduction, vaccination programs)
- empower people at risk through short intervention programs

To assist special needs groups in the community, professionals should be able to:
- advise individuals about how and where to access specific risk reduction programs that meet their special needs
- use tailored information and communication strategies appropriate to the group involved

Organisational Support

To support service provision, cancer networks will need to:
- provide access to data about participation in risk reduction programs

To support individual professionals, cancer services will need to:
- provide patient information about how to access specific risk reduction programs
- provide data about local participation in risk reduction programs

To support service provision, cancer networks will need to:
- provide access to data about participation in risk reduction programs

To support individual professionals, cancer services will need to:
- provide patient information about how to access specific risk reduction programs
- collect data about local participation in risk reduction programs
- provide tailored information appropriate to the group with special needs
- provide trained advocates for communication between people with special needs and health professionals
2. FIND CANCER EARLY

The Patient Pathway (Screening, diagnosis, timely access to cancer services, appropriate referral, supportive care)

People’s needs

People want to:
- have cancer found as early as possible, if early treatment is beneficial
- have enough information to decide whether to participate (if eligible) in population screening programs
- be able to access population screening and diagnostic services
- be confident that population screening and diagnostic services are providing high quality care
- understand their test results
- if they are diagnosed with cancer, to be told appropriately and provided with support

NSIF Ch 3: Find Cancer Early P23

Optimal services

2.1 People will receive advice and information about population screening programs including:
- their eligibility for participation
- the benefits and limitations
- the processes involved, including time, cost and any discomfort
- the likelihood that an early sign or symptom may be cancer

Professional performance elements

To assist in finding cancer early, professionals should be able to:
- provide advice about population screening programs (appropriate participation, how to access them, their limitations) to eligible people, including those with special needs
- discuss the significance of any early signs or symptoms of cancer, including other possible causes of the changes

Organisational Support

To support service provision cancer networks will need to:
- promote the availability of population screening programs
- compile data about participation in these programs

To support individual professionals, cancer services will need to:
- provide patient information about how to access population screening programs
- collect data about local participation in these programs
2.2 People with signs or symptoms that may be cancer, regardless of where they live, will:
- be advised why early signs or symptoms need to be investigated
- have timely access to a full range of diagnostic and other support services according to the nature and level of their need
- be given their results in an appropriate and timely manner
- receive information and support through the diagnosis process

Professional performance elements

In providing these services, professionals should be able to:
- discuss the significance of any early signs or symptoms of cancer, including other possible causes of the changes
- direct people where to go for investigation and give them a timeframe for diagnostic decision
- describe the pros and cons of what is involved in key diagnostic tests
- inform patients about results within an agreed timeframe
- discuss results and the implications in a manner consistent with communication and psychosocial guidelines
- orientate patients in accessing a full range of cancer support services as close as possible to their place of residence
- explain how the cancer services in both regional and metro setting can best meet their needs
- Perform diagnostic tests as per tumour specific and haematological care protocols

Organisational Support

To support service provision, cancer networks will need to:
- establish agreed care timeframes for providing results and accessing services across the network
- develop and distribute a cancer service network orientation package for all cancer professionals
- compile an up to date directory of the full range of networked cancer and related support services
- ensure providers and consumers are appropriately represented on cancer network committees
- approve accredited communication programs

To support individual professionals, cancer services will need to:
- ensure access to and promote the cancer service network orientation package and service directory to their professionals
- adopt agreed timeframes for providing results and accessing services
- support attendance at accredited communication skills programs
- provide opportunities for health professionals to meet with other clinical and support service professionals
2.3 People diagnosed with cancer will receive advice on their referral which includes:
- confirmation of diagnosis and assessment of extent of disease
- treatment options to consider, including best options
- information about their nearest multidisciplinary team
- treatment delivery and after effects management
- an explanation of the care pathway for their case
- advice about how the cancer service can support them along their patient pathway
- particular considerations for remote and rural situations

**Optimal services**

**Professional performance elements**

*In providing these services professionals should be able to:*
- communicate clearly and sensitively when “breaking bad news”
- explain the protocols for tumour specific and haematological cases
- explain the role of a health professional who is responsible for coordinating care (or how care will be coordinated if such role is not available)
- explain the role of a multidisciplinary team
- use a systematic approach to determine a full range of patient care and support requirements
- employ a common (network) set of care protocols, referral pathways and support services
- pass on patient information to professional colleagues and support services that meets agreed communication standards and uses available templates
- access and navigate a networked patient record system (where such a system exists)

**Organisational Support**

*To support service provision cancer networks will need to:*
- adopt tumour specific and haematological care protocols across the network
- involve all service providers in developing patient referral pathways which could include provision for external referral, telemedicine or drawing on other community resources where necessary
- provide a regularly updated directory of network multidisciplinary team meetings
- develop and promote the use of common communication standards and templates
- provide a regularly updated directory of network support services
- keep providers informed about new protocol developments
- involve service providers (including primary health providers) in the development of a networked patient records system
- monitor referrals and collect data and patient feedback for network analysis and review.

*To support individual professionals, cancer services will need to:*
- support the use of networked referral pathways, taking into account patients’ place of residence
- promulgate tumour specific and haematological care protocols
- assist in gathering patient feedback about referral experiences
- ensure workplace access to standardised communication templates
- provide an orientation to patient record systems
### Optimal services

2.4 **People diagnosed with cancer, their families and carers will:**

- have access to a full range of supportive care services, including psychologists, psychiatrists, palliative care specialists, physiotherapists and community based services if needed

### Professional performance elements

**In providing these services, professionals should be able to:**

- appreciate the range of potential psychosocial, palliative and other support issues facing people with cancer, their families and carers throughout the cancer journey
- determine likely psychosocial risks for individual patients
- use selected diagnostic and assessment tools to help identify psychosocial, palliative and other support needs
- initiate discussion with patients about a range of supportive care issues including palliative and psychosocial issues
- engage patients in identifying and discussing specific issues affecting their wellbeing and that of their family or carers
- provide patients with information about available support services
- refer clinically anxious or distressed patients and patients with treatment related pain or symptoms appropriately and consistently to a full range of supportive care services, including psychosocial support and palliative care
- recognise and respond to situations where they can contribute directly to the support of patients, their families, carers and fellow professionals
- develop strategies to monitor and deal with anxiety and stress affecting their own professional and personal lives

### Organisational Support

**To support service provision, cancer networks will need to:**

- involve service providers in the development of supportive care, psychosocial referral and palliative care protocols for their network
- provide a regularly updated directory of network support services
- provide advice on how to access professional counseling services or alternate counseling and support services
- approve and support training programs for identifying and dealing with psychosocial issues and other support issues, including self-care for professionals

**To support individual professionals, cancer services will need to:**

- develop and implement a psychosocial and palliative care services model of care
- promote training in communication techniques needed to identify and discuss psychosocial and other support issues
- promote training in the use of psychosocial, pain and other symptom assessment tools
- implement standard, evidence-based screening for patients at risk of psychosocial distress and other supportive care service needs
- provide workplace access to an up-to-date directory of the full range of available network support services
- promote and provide access to supportive care services for the professional and personal well being of their own professionals
- consider the provision of protected time, study leave, career progression and timely access to information and resources as part of their organisational support for staff
3. TREATMENT AND SUPPORT DURING ACTIVE TREATMENT

The Patient Pathway (coordinated care, care planning, multidisciplinary care, evidence-based treatments)

People’s Needs

People want to:
- understand what may happen to them during active treatment
- trust their treatment team to provide them with best care
- know who is coordinating their care and who can answer their questions and that their care will be coordinated and seamless
- have access to the best and most appropriate care regardless of where they live or their cultural or linguistic background
- be told honestly and clearly about their care treatment options so they can make the best decisions
- limit the symptoms of the disease and the side effects of treatments to maintain the best quality of life
- limit the impact of the cancer treatment on their daily lives and that of their families and carers
- be able to discuss their concerns and feelings and receive support if needed for themselves and families

NSIF Ch 4: Treatment and support during active treatment P37

Optimal services

3.1 People newly diagnosed with cancer, their families and carers will:
- experience the transition between diagnosis and treatment as seamless and coordinated care
- have the option of a designated person to coordinate or advocate for their care
- have access to a named GP
- have access to a patient held record

Professional performance elements

In providing these services professionals should be able to:
- provide clear, up-to-date information to patients regarding the next steps in their care pathway, including services within the public and private sectors
- convey all patient information confidentially and within agreed timeframes
- explain the role of an identified health professional responsible for coordinating care or advocate to their patients, support staff and professional colleagues
- ensure that the patient has a GP who is informed and involved throughout the patient’s journey
- advise patients about accessing and holding their own care record

Organisational Support

To support service provision, cancer networks will need to:
- manage the transitions between the public and private sectors
- develop a system to determine patient care coordination requirements
- develop a system and communication standards to ensure that patient information is communicated effectively to other providers at primary, secondary and tertiary levels
- encourage the introduction of an identified health professional responsible for coordinating care and/or systems which directly support the patient’s journey
- provide a regularly updated directory of network support services

To support individual professionals, cancer services will need to:
- keep a register of the care coordinators supporting their patients
- have a system which ensures the involvement of GPs in care planning from the time of admission
- support professional development about the patient pathway, care protocols and timeframes for each tumour stream
- ensure guidance about and access to systems which provide patient held records
3.2 People with cancer will be confident that they:
- are being treated in a safe manner according to the best available evidence
- are included, with their family and/or carer, in the development of their care plan
- understand their care plan
- can access the information about guidelines and/or protocols used by their service providers to develop their plan
- will be invited to participate in clinical trials where appropriate (but may decline to do so)
- have access to supportive care services
- have equity of access to treatment regardless of age, where they live or their cultural and linguistic background
- have care tailored according to any specific needs relating to age or their cultural and linguistic background

In providing these services, professionals should be able to:
- ensure all patients are managed in a facility that is appropriate to administer the treatment being given
- audit their own cancer care practice within a framework of evidence-based guidelines (or best available evidence in the absence of guidelines)
- assess and manage risk within their own practice
- search for and independently assess evidence-based information about latest treatments and clinical trials
- explain to patients, their families and carers the evidence supporting treatments as well as the associated risks
- be aware of complementary therapies, consumer information sources and their relationship to evidence-based practice
- develop a care plan with the patient & their family and/or carer which reflects the above and meets agreed care protocols and information standards
- communicate the care plan to their patients, their families and carers as well as to other cancer and support professionals
- include supportive care eg pain and symptom management, psychosocial care and social support

Organisational Support
To support service provision, cancer networks will need to:
- ensure service providers can provide workplace access to current sources of evidence-based information and latest treatments
- ensure these sources are also accessible to patients
- develop guidelines and templates for consistent care planning
- conduct reviews and audits of patient outcomes based on care planning
- ensure equity of access to treatment for all patients within their jurisdiction
- ensure adequate resources and support services are available to manage treatment
- manage scope of practice and treatment across facilities, haematological and tumour streams

To support individual professionals, cancer services will need to:
- ensure workplace access to current sources of evidence-based information about latest treatments, guidelines and clinical trials
- ensure guidelines and templates are used for care planning
- develop local systems and protocols for palliative care of side effects of treatment and therapies
- provide support for participation in clinical trials
- support protected time for accessing evidence-based information as essential professional development
- collect and contribute patient outcomes data to the review and audit of care planning
- manage appropriate scope of practice within their facilities
3.3 People newly diagnosed with cancer will:
- have their case discussed in at least one multidisciplinary team meeting

**Professional performance elements**

**In providing these services, professionals should be able to:**
- **Explain to patients**
  - the principles of MDC, including the current evidence for patient outcomes
  - how their particular MDT works and who its members are
  - how to provide input to their MDC care plan
  - the MDT recommendations for their care, including any treatment and palliative care options available to them
  - how patient information is shared within the team
  - how medico-legal responsibility for their care plan is shared between MDT members
  - the cost to them of MDC as part of their cancer care
  - decisions made in the MDT regarding their treatment
  - obtain "informed consent" from patients for their case to be discussed by the MDT and for information gathered to be shared
  - comply with the attendance and case selection criteria for membership of their MDT
  - attend and contribute to MDT meetings either in person or via tele or video conference (or by providing input before the meeting)
  - take the role of "treating clinician" and give an accurate and comprehensive presentation of a patient's medical history and diagnostic tests at the MDT meeting
  - coordinate or chair an MDT meeting as the lead clinician
  - contribute to a detailed MDT care plan
  - claim relevant MBS items for their MDC involvement
  - contribute to the audit or review of MDC processes and outcomes
  - communicate the outcomes of any case discussed at a MDT meeting in a timely way to clinicians relevant to the care of a person including the person's GP.

**Organisational Support**

**To support service provision, cancer networks will need to:**
- develop protocols and communication frameworks for MDTs in their network
- encourage MDT participation by their professionals
- establish data collection and management protocols for the timely audit and review of their MDTs
- provide accredited training in communication and teamwork skills for cancer professionals in their network

**To support individual professionals, cancer services will need to:**
- ensure their MDTs have terms of reference including case selection criteria, and documentation of team recommendations according to protocols
- ensure GPs are invited to be members of multidisciplinary teams and informed of outcomes
- support the network data collection, audit and review of their MDTs
- wherever possible provide facilities and resources to support MDT meetings
4. MANAGEMENT AND SUPPORT AFTER AND BETWEEN TREATMENT

The Patient Pathway (care, discharge and survivorship planning and multidisciplinary follow-up)

People’s Needs

People want to:
- know what may happen to them at and following the completion of treatment
- have information about and help dealing with uncertainty and fear of recurrence
- have information about and help in preventing and dealing with ongoing side effects of treatments and disease
- understand how they can tell if the cancer has come back or is progressing
- know who is coordinating their care, or who they can use as a reference point or system navigator
- know how to take care of themselves and how to maintain optimal health
- have help to maintain a maximum level of independence and physical, psychological and social functioning

NISIF Ch 5 Management and support after and between active treatment P55

Optimal services

4.1 People who are receiving treatment for cancer will:
- experience care, discharge and survivorship planning which considers the full range of their ongoing needs as well as those of their families and carers

Professional performance elements

In providing these services, professionals should be able to:
- recognise that a care or discharge plan is necessary and may be needed at any level of care (not just at the tertiary level)
- appreciate the full range of a patient’s needs during and after discharge, including those needs involving their families and carers
- respond appropriately to the patient’s needs specific to their cancer type, treatment approach and palliative care regime
- monitor and review a patient’s care plan to take account of changes to their needs during their care
- provide information to all patients and their carers regarding available support services to meet new needs, including psychosocial support and palliative care
- liaise with a care coordinator about changes to treatment and any newly identified needs
- give particular consideration to the patient’s survivorship needs prior to discharge
- ensure that the patient’s GP is kept informed and involved during discharge

Organisational support

To support service provision, cancer networks will need to:
- develop common protocols and communication standards around care and discharge planning
- promote the need for care planning at all levels of care
- involve providers in developing communication protocols for care and discharge planning
- encourage the direct involvement of care coordinators in care, discharge and survivorship planning

To support individual professionals, cancer services will need to:
- flag when a care, discharge or survivorship plan is appropriate
- support patient expectations that the full range of their needs should be considered during care and at discharge
- provide access to an up-to-date local support service directory
- provide a notification system to ensure the involvement of care coordinators and GPs in care, discharge and survivorship planning
- ensure management of ongoing case load and defined exit and entry points for care coordinators
4.2 People who have been receiving treatment for cancer will:
- be accompanied by consistent care and discharge documentation
- be supported in an effective transition between their care at the treatment centre and their care in the community
- know who to contact if there is a recurrence of their disease

In providing these services, professionals should be able to:
- follow recommended care and discharge planning protocols
- discuss with a patient what will happen following completion of care and help deal with any uncertainty and fear of recurrence
- make sure a patient knows who is coordinating their ongoing care
- access a patient’s record to ensure that discharge information is coherent and avoids duplication
- meet agreed communication standards for patient transfer
- explain the format and use of discharge documentation to patients for inclusion as part of a patient held record
- follow-up with care coordinators and GPs to keep them up-to-date with current treatments and their possible affects on patients

4.3 People who have been receiving treatment for cancer will:
- be followed-up by a multidisciplinary team with appropriate membership for their needs

In providing these services, professionals should be able to:
- be prepared to take on the role of coordinating an MDT
- liaise with a patient’s care coordinator and GP about any newly identified discharge or survivorship needs
- liaise closely with the patient’s GP about the MDT membership required to match their needs
- actively engage the patient’s GP as an ongoing member of the discharge and survivorship MDT

To support service provision, cancer networks will need to:
- engage service providers in the continued audit and review of discharge planning and outcomes
- liaise with GP Divisions to keep them up to date with developments and current data around discharge planning and outcomes

To support individual professionals, cancer services will need to:
- ensure their ready access to discharge protocols and communication templates
- monitor the quality and timeliness of care and discharge planning information sent to care coordinators and GPs
- provide education on patient’s expectations around the use of discharge planning as part of patient held records
- promote participation in approved communication programs

To support service provision, cancer networks will need to:
- keep records of the membership, role and function of MDTs operating in the network
- liaise with GP Divisions to keep them up to date with the involvement of GPs in network MDTs

To support individual professionals, cancer services will need to:
- have a system to support liaison between cancer specialists, palliative care specialists, care coordinators and GPs
- wherever possible provide facilities and resources to support MDT meetings
5. CARE AND SUPPORT AT THE END OF LIFE

The Patient Pathway (palliative care and end-of-life planning)

**People's Needs**

**People with a progressive life limiting cancer want to:**
- have the best possible quality of life
- be free of pain and have their symptoms under control
- be able to prepare for death and feel a sense of completion
- find a sense of meaning in their life and illness
- be involved in decision making about their care as much as they wish
- know that their family and carers are being supported
- not feel like a burden
- feel able to cope with the disease in a way that feels right to them
- have their practical needs met
- be treated by a team (which might be virtual) that is built around their needs and has good communication
- understand what is happening to them and what may happen in the future as their disease progresses
- be cared for in an environment of their choice, be it at home, hospital or hospice

**Families and carers want to:**
- be supported during their family member’s illness
- be able to maintain their own quality of life while caring for their family member
- be confident their family member is receiving the best care
- be able to access information specific to their needs (which may differ from those of their family member)
- receive help when needed in caring for their family member, physically and psychologically
- be supported through the bereavement period

NSI/F Ch 6: Care and support at end of life P61

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**5.1 People with cancer, their families and carers will be:**

- supported in discussing prognostic, palliative and end of life issues

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**Professional performance elements**

*In providing these services, professionals should be able to:*
- communicate appropriately to elicit the preferences and goals of patients, their families and carers about prognosis and ongoing palliative treatment
- effectively communicate with patients, their families and carers in the context of their individual responses to loss and grief, existential challenges and uncertainty
- discuss with patients, their families and carers the range of available options for ongoing palliative care

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**Organisational support**

*To support service provision, cancer networks will need to:*
- ensure referral pathways for the network include palliative care
- provide accredited communication, symptom, pain and distress management training around palliative care issues

*To support individual professionals, cancer services will need to:*
- provide practitioners time to attend structured training in all aspects of palliative care
5.2 People with cancer who are entering the final phase of their illness will be able to:
- maintain their dignity
- initiate an agreed end-of-life plan which will reduce their need for crisis management
- choose the place in which they wish to be cared for
- choose the place in which they wish to die
- be confident that their carers and family members will have access to bereavement care

Professional performance elements
In providing these services, professionals should be able to:
- recognise the transitional stages in terminal illness
- refer patients to specialist palliative care services in a timely manner and according to their needs and preferences
- develop appropriate end-of-life care plans in collaboration with patients, their families and carers
- ensure patients entering the terminal phase of their illness continue to have access to specialist palliative care
- participate as a member of a multidisciplinary team discussing any changes to the palliative care needs of individuals with advanced cancer
- provide palliative interventions and support in collaboration with a palliative care specialist
- advise patients regarding the range of medical and support services relevant to meeting end-of-life care needs
- contribute to the bereavement care provided to carers and family members

Organisational support
To support service provision, cancer networks will need to:
- engage experts in palliative care as part of relevant network committees
- ensure access to up-to-date referral protocols and pathways, including those relating to palliative care
- involve people with cancer, their families and carers together with practitioners in developing protocols and treatment guidelines for the end-of-life stage
- promote palliative care as an ongoing part of multidisciplinary care
- supporting training in end of life planning and bereavement care for all cancer professionals

To support individual professionals, cancer services will need to:
- allow practitioners the time needed to:
  - develop end-of-life planning and bereavement care skills
  - develop tailored end-of-life care plans
  - participate as members of multidisciplinary palliative care teams
- acknowledge and deal with professional stress or conflict which may arise as a result of a patient's needs
- ensure access to current palliative care pathways and protocols and standards
REFERENCES

Patient pathway and optimal services

- Stage 2: Cancer Institute of NSW Accreditation Standards, Draft Ver .01, July 2007
- WA Health Cancer Services Framework (2005) WA Health Cancer Services Taskforce
- Standards for Providing Quality Palliative Care for all Australians (2005) Palliative Care Australia

Professional performance outcomes

- NHS referral guidelines for suspected cancer http://guidance.nice.org.uk/CG27/?c=91496#summary
- Irish College of General Practitioners - Referral Guidelines for Cancer http://www.icgp.ie/index.cfm/loc/1/articleId/AB67F232-D5AB-5C10-71B7BE59FBDF1899.htm
- Australian Government Department of Health & Ageing ‘Palliative Care Curriculum for Undergraduates’ (PCC4U)

Organisational support