



## **CANCER PROFESSIONAL DEVELOPMENT FRAMEWORK**

**(DRAFT March 08)**

<http://www.cancercpd.org.au>



## **DRAFT Cancer Professional Development Framework**

This draft framework is being developed as a guide to cancer service networks in planning professional development activities for their cancer professionals.

Its further development and refinement will continue throughout the life of the Professional Development Packages project.

Its reference points have been:

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 recent state and territory cancer plans
3. The priority service areas identified by the needs analysis of cancer professionals in Phase I of this project
4. Current evidence based guidelines for areas of professional practice

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

*Planning and Guideline References to date:*

**Patient pathway and optimal services**

National Service Improvement Framework for Cancer (2005) Australian Health Ministers' Conference <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pg-ncds-cancer>

Stage 2: "Cancer Institute of NSW Accreditation Standards, Draft Ver .01, July 2007

Queensland Cancer Control Strategic Directions 2005–2010 (2006) QLD Health <http://www.health.qld.gov.au/cancercontrol/>

A Cancer Services Framework for Victoria (2003) The Collaboration for Cancer Outcomes Research and Evaluation <http://www.health.vic.gov.au/cancer/>

WA Health Cancer Services Framework (2005) WA Health Cancer Services Taskforce <http://www.healthnetworks.health.wa.gov.au/cancer/docs/2797%20CancerFramework20800.pdf>

NSW Cancer Plan 2007-2010 (2006) NSW Cancer Institute <http://www.cancerinstitute.org.au/>

**Professional performance outcomes**

NBCC 'Making Multidisciplinary Care a reality' [http://www.nbcc.org.au/bestpractice/resources/MDR192\\_makingmultidisciplin.pdf](http://www.nbcc.org.au/bestpractice/resources/MDR192_makingmultidisciplin.pdf)

NBCC 'Multidisciplinary Care: What are the medicolegal implications?' [http://www.nbcc.org.au/bestpractice/resources/MDIR\\_multidisciplinacare.pdf](http://www.nbcc.org.au/bestpractice/resources/MDIR_multidisciplinacare.pdf)

Dept Human Services VIC "A guide for implementing multidisciplinary care" <http://www.health.vic.gov.au/cancer/docs/mdcare/multidisciplinarpolicy0702.pdf>

NHMRC Clinical Practice Guidelines for the Psychosocial Care of Adults with Cancer <http://www.nhmrc.gov.au/publications/synopses/ files/cp90.pdf>

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>

MJA Vol 186, No 12, 18 June 2007 Special Supplement – *Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers* [http://www.mja.com.au/public/issues/186\\_12\\_180607/cia11246\\_fm.html](http://www.mja.com.au/public/issues/186_12_180607/cia11246_fm.html)

**Organisational support**

The Development of an Accreditation Program for NSW Cancer Services [http://www.cancerinstitute.org.au/cancer\\_inst/profes/accreditation.html](http://www.cancerinstitute.org.au/cancer_inst/profes/accreditation.html)

# 1. REDUCE THE RISK OF CANCER

(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

NISIF Ch 2 Reduce the Risk of Cancer P13

Optimal services	Professional performance elements	Organisational Support
<p><b>1.1</b>  <i>People in the community will have access to consistent and evidence-based information about opportunities for risk reduction</i></p>	<p><i>To assist in informing individuals about risk reduction, professionals should be able to:</i></p> <ul style="list-style-type: none"> <li>- help assess any increased risk of cancer because of family history or other factors</li> <li>- indicate the amount of risk reduction that might occur from adopting risk reduction behaviours</li> <li>- explain the quality of the evidence available</li> <li>- integrate information about risk across cancers</li> <li>- indicate information which is appropriate for different community groups</li> </ul>	<p><i>To support service provision cancer networks will need to :</i></p> <ul style="list-style-type: none"> <li>- distribute up to date information about risk reduction evidence, strategies and campaigns</li> <li>- highlight where this information needs integrating across cancers</li> </ul> <p><i>To support individual professionals, cancer services will need to:</i></p> <ul style="list-style-type: none"> <li>- identify which community groups within their service area may need specific risk reduction information</li> <li>- ensure that individual practitioners have access to up to date risk reduction information from specialist services</li> </ul>
<p><b>1.2</b>  <i>People will be encouraged to take action to reduce their risk of cancer</i></p>	<p><i>To assist individuals to take action to reduce their risk of cancer, professionals should be able to:</i></p> <ul style="list-style-type: none"> <li>- reinforce media information and community based programs promoting risk reduction</li> <li>- help individuals to identify their own cancer risk and relevant risk reduction behaviours</li> <li>- advise individuals about how to access specific risk</li> </ul>	<p><i>To support service provision cancer networks will need to :</i></p> <ul style="list-style-type: none"> <li>- compile data about participation in risk reduction programs</li> </ul> <p><i>To support individual professionals, cancer services will need to:</i></p> <ul style="list-style-type: none"> <li>- provide patient information about how to access specific risk reduction programs</li> </ul>

	<p>reduction programs (eg smoking cessation, skin protection, weight reduction, vaccination programs)</p> <ul style="list-style-type: none"> <li>- empower people at risk through short intervention programs</li> </ul>	<ul style="list-style-type: none"> <li>- collect data about local participation in risk reduction programs</li> </ul>
<p><b>1.3</b> <i>People with special needs and disadvantaged groups will have access to appropriate, tailored information and programs</i></p>	<p><i>To assist special needs groups in the community, professionals should be able to:</i></p> <ul style="list-style-type: none"> <li>• advise individuals about how to access specific risk reduction programs that meet their special needs</li> </ul>	<p><i>To support service provision cancer networks will need to :</i></p> <ul style="list-style-type: none"> <li>- compile data about participation in risk reduction programs</li> </ul> <p><i>To support individual professionals, cancer services will need to:</i></p> <ul style="list-style-type: none"> <li>- provide patient information about how to access specific risk reduction programs</li> <li>- collect data about local participation in risk reduction programs</li> </ul>

## 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

NISIF Ch 3: Find Cancer Early P23

Optimal services	Professional performance elements	Organisational Support
<p><b>2.1</b>  <i>People will receive advice and information about population screening programs including:</i></p> <ul style="list-style-type: none"> <li>- <i>their eligibility for participation</i></li> <li>- <i>the benefits and limitations</i></li> <li>- <i>the processes involved, including time, cost and any discomfort</i></li> <li>- <i>the likelihood that an early sign or symptom may be cancer</i></li> </ul>	<p><i>To assist in finding cancer early, professionals should be able to:</i></p> <ul style="list-style-type: none"> <li>- provide advice about population screening programs to eligible people, including those with special needs</li> <li>- discuss the significance of any early signs or symptoms of cancer, including other possible causes of the changes</li> <li>- direct people where to go for diagnosis and give them a time frame for optimum treatment</li> </ul>	<p><i>To support service provision cancer networks will need to :</i></p> <ul style="list-style-type: none"> <li>- promote the availability of population screening programs</li> <li>- compile data about participation in these programs</li> </ul> <p><i>To support individual professionals, cancer services will need to:</i></p> <ul style="list-style-type: none"> <li>- provide patient information about how to access population screening programs</li> <li>- collect data about local participation in these programs</li> </ul>
<p><b>2.2</b>  <i>People with a sign or symptom that may be cancer, regardless of where live, will:</i></p> <ul style="list-style-type: none"> <li>- <i>be advised about the likelihood that an early sign or symptom may be cancer</i></li> <li>- <i>have timely access to a full range of diagnostic and other support services according to the nature and level of their need</i></li> </ul>	<p><i>In providing these services professionals should be able to:</i></p> <ul style="list-style-type: none"> <li>- discuss the significance of any early signs or symptoms of cancer, including other possible causes of the changes</li> <li>- direct people where to go for diagnosis and give them a time frame for optimum treatment</li> <li>- describe what is involved in each diagnostic test</li> <li>- inform patients about results within an agreed timeframe</li> <li>- discuss their results and the implications in a manner consistent with communication and psychosocial guidelines</li> </ul>	<p><i>To support service provision cancer networks will need to :</i></p> <ul style="list-style-type: none"> <li>- establish agreed care timeframes for providing results and accessing services across the network</li> <li>- develop and distribute a cancer service network orientation package for all cancer professionals</li> <li>- compile an up to date directory of the full range of networked cancer and related support services</li> <li>- ensure providers are appropriately represented on cancer network committees</li> <li>- approve accredited communication programs</li> </ul>

<ul style="list-style-type: none"> <li>- <i>be given their results in an appropriate and timely manner</i></li> <li>- <i>receive information and support through the process of diagnosis</i></li> </ul>	<ul style="list-style-type: none"> <li>- orientate patients to accessing a full range of cancer support services as close as possible to their place of residence</li> <li>- explain how the cancer services network can best meet their needs</li> </ul>	<p><i>To support individual professionals, cancer services will need to:</i></p> <ul style="list-style-type: none"> <li>- ensure access to and promote the cancer service network orientation package to their professionals</li> <li>- adopt agreed timeframes for providing results and accessing services</li> <li>- support attendance at accredited communication skills programs</li> <li>- provide opportunities to meet with other clinical and support service professionals</li> </ul>
<p><b>2.3</b> <i>People diagnosed with cancer will receive advice about their referral, including:</i></p> <ul style="list-style-type: none"> <li>- <i>an explanation of the care pathway for their case</i></li> <li>- <i>any options for referral</i></li> <li>- <i>advice about how the cancer service can support them along their patient pathway</i></li> <li>- <i>particular considerations for remote and rural situations</i></li> </ul>	<p><i>In providing these services professionals should be able to:</i></p> <ul style="list-style-type: none"> <li>- explain the protocols for tumour specific cases</li> <li>- explain the role of a cancer care coordinator</li> <li>- use a systematic approach to determine a full range of patient care and support requirements</li> <li>- employ a common (network) set of care protocols, referral pathways and support services</li> <li>- pass on patient information to professional colleagues and support services that meets agreed communication standards and uses available templates</li> <li>- access and navigate a networked patient record system, (where such a system exists)</li> </ul>	<p><i>To support service provision cancer networks will need to :</i></p> <ul style="list-style-type: none"> <li>- adopt tumour specific care protocols across the network</li> <li>- involve all service providers in developing patient referral pathways which could include provision for external referral, telemedicine or drawing on alternate community resources where necessary</li> <li>- develop and promote the use of common communication standards and templates</li> <li>- provide a regularly updated directory of network support services</li> <li>- keep providers informed about new protocol developments</li> <li>- involve service providers (including primary health providers) in the development of a networked patient records system</li> <li>- monitor referrals and collect data and patient feedback for network analysis and review.</li> </ul> <p><i>To support individual professionals, cancer services will need to:</i></p> <ul style="list-style-type: none"> <li>- support the use of networked referral pathways, taking into account patients' place of residence</li> <li>- assist in gathering patient feedback about referral experiences</li> <li>- ensure workplace access to standardised communication templates</li> <li>- provide an orientation to patient record systems</li> </ul>

<p><b>2.4</b>  <i>People diagnosed with cancer, their families and carers will have access to a full range of supportive care services, including psychologists, psychiatrists, physiotherapists and community based services if needed</i></p>	<p><i>In providing these services professionals should be able to:</i></p> <ul style="list-style-type: none"> <li>- appreciate the range of potential psychosocial and other support issues facing people with cancer, their families and carers throughout the cancer journey</li> <li>- determine likely psychosocial risks for individual patients</li> <li>- use selected diagnostic tools to help identify psychosocial and other support needs</li> <li>- initiate discussion with patients about a range of supportive care issues including psychosocial issues</li> <li>- engage patients in identifying and discussing specific issues affecting their well being and that of their family or carers</li> <li>- provide patients with information about available support services</li> <li>- refer clinically anxious or distressed patients appropriately and consistently to a full range of supportive care services including psychosocial support</li> <li>- recognize and respond to situations where they can contribute directly to the support of patients, their families, carers and fellow professionals</li> <li>- develop strategies to monitor and deal with anxiety and stress affecting their own professional and personal lives.</li> </ul>	<p><i>To support service provision cancer networks will need to :</i></p> <ul style="list-style-type: none"> <li>- involve service providers in development of supportive care and psychosocial referral protocols for their network.</li> <li>- provide a regularly updated directory of network support services</li> <li>- provide advice on how to access professional counseling services or alternate counseling and support services</li> <li>- approve and support training programs for identifying and dealing with psychosocial issues and other support issues</li> </ul> <p><i>To support individual professionals, cancer services will need to:</i></p> <ul style="list-style-type: none"> <li>- promote training in the communication techniques needed to identify and discuss psychosocial and other support issues</li> <li>- promote training in the use of psychosocial assessment tools</li> <li>- assist in screening patients for the risk of psychosocial distress and other supportive care services needs</li> <li>- provide workplace access to an up to date directory of the full range of available network support services</li> <li>- promote and provide access to supportive care services for the professional and personal well being of their own professionals</li> <li>- 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</li> </ul>
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### 3. TREATMENT AND SUPPORT DURING ACTIVE TREATMENT

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

#### 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

NISIF Ch 4: Treatment and support during active treatment P37

Optimal services	Professional performance elements	Organisational Support
<p><b>3.1</b>  <i>People newly diagnosed with cancer, their families and carers will:</i></p> <ul style="list-style-type: none"> <li>- <i>experience the transition between diagnosis and treatment as seamless and coordinated care</i></li> <li>- <i>have a designated care coordinator</i></li> <li>- <i>have access to a named GP</i></li> <li>- <i>have a patient held record</i></li> </ul>	<p><i>In providing these services professionals should be able to:</i></p> <ul style="list-style-type: none"> <li>- provide clear, up to date information to patients regarding the next steps in their care pathway</li> <li>- convey all patient information within agreed timeframes and with confidentiality</li> <li>- explain the role of the cancer care coordinator to their patients, support staff and professional colleagues</li> <li>- ensure that the patient has a GP who is informed and involved throughout the patient's journey</li> <li>- advise patients about accessing and holding their own care record</li> </ul>	<p><i>To support service provision cancer networks will need to :</i></p> <ul style="list-style-type: none"> <li>- develop a system to determine patient care coordination requirements</li> <li>- develop a system and communication standards to ensure that patient information is communicated effectively to other providers at primary, secondary and tertiary levels</li> <li>- encourage the introduction of care coordination roles which directly support the patient's journey</li> <li>- provide a regularly updated directory of network support services</li> </ul> <p><i>To support individual professionals, cancer services will need to:</i></p> <ul style="list-style-type: none"> <li>- keep a register of the care coordinators supporting their patients</li> <li>- have a system which ensures the involvement of GPs in care planning from the time of admission</li> <li>- support professional development about the patient pathway, care protocols and timeframes for each tumour stream</li> <li>- provide patients with a patient held record</li> </ul>

<p><b>3.2</b>  <i>People newly diagnosed with cancer will have their case discussed in at least one multidisciplinary team meeting.</i></p>	<p><i>In providing these services professionals should be able to:</i>          Explain to patients</p> <ul style="list-style-type: none"> <li>○ the principles of MDC, including the current evidence for patient outcomes</li> <li>○ how their particular MDT works and who its members are</li> <li>○ how to provide input to their MDC care plan</li> <li>○ their MDT recommendations for their care, including any treatment options they may have</li> <li>○ how medico-legal responsibility for their care plan is shared between MDT members</li> <li>○ the cost to them of MDC as part of their cancer care</li> </ul> <ul style="list-style-type: none"> <li>- obtain “informed consent” from patients for their case to be discussed by the MDT</li> <li>- comply with the attendance and case selection criteria for membership of their MDT</li> <li>- attend and contribute to MDT meetings either in person or via tele or video conference (or by providing input before the meeting)</li> <li>- take the role of “treating clinician” and give an accurate and comprehensive presentation of a patient’s medical history and diagnostic tests as at the MDT meeting</li> <li>- coordinate or chair an MDT meeting as the lead clinician</li> <li>- contribute to a detailed MDT care plan</li> <li>- claim relevant MBS items for their MDC involvement</li> <li>- contribute to the audit or review of MDC processes and outcomes</li> </ul>	<p><i>To support service provision cancer networks will need to :</i></p> <ul style="list-style-type: none"> <li>- develop protocols and communication frameworks for MDTs in their network</li> <li>- encourage MDT participation by their professionals</li> <li>- establish data collection and management protocols for the timely audit and review of their MDTs</li> <li>- provide accredited training in communication and teamwork skills for cancer professionals in their network</li> <li>-</li> </ul> <p><i>To support individual professionals, cancer services will need to:</i></p> <ul style="list-style-type: none"> <li>- ensure GPs are members of multidisciplinary teams</li> <li>- support the network data collection, audit and review of their MDTs</li> <li>- wherever possible providing facilities and resources to support MDT meetings</li> </ul>
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<p><b>3.3</b>  <i>People with cancer will be confident that they:</i></p> <ul style="list-style-type: none"> <li>- <i>are being treated according to the best available evidence</i></li> <li>- <i>understand their care plan</i></li> <li>- <i>can access the information about guidelines and/or protocols used by their service providers to develop their plan</i></li> <li>- <i>will be invited to participate in clinical trials where appropriate (but may decline to do so)</i></li> </ul>	<p><i>In providing these services cancer professionals should be able to:</i></p> <ul style="list-style-type: none"> <li>- search for and compile evidence based information about latest treatments and clinical trials</li> <li>- explain to patients, their families and carers the evidence supporting treatments as well as the associated risks</li> <li>- be aware of complementary treatments, consumer information sources and their relationship to evidence based practice</li> <li>- develop a care plan which reflects the above and meets agreed care protocols and information standards</li> <li>- communicate the care plan to their patients, their families and carers as well as to other cancer and support professionals</li> <li>- audit their own cancer care practice within a framework of evidence based guidelines (or best available evidence in the absence of guidelines)</li> </ul>	<p><i>To support service provision cancer networks will need to :</i></p> <ul style="list-style-type: none"> <li>- ensure service providers can provide workplace access to current sources of evidence based information and latest treatments</li> <li>- ensure these sources are also accessible to patients</li> <li>- develop guidelines and templates for consistent care planning</li> <li>- conduct reviews and audits of patient outcomes based on care planning</li> </ul> <p><i>To support individual professionals, cancer services will need to:</i></p> <ul style="list-style-type: none"> <li>- ensure workplace access to current sources of evidence based information about latest treatments, guidelines and clinical trials</li> <li>- support protected time for accessing these sources as essential professional development</li> <li>- collect and contribute patient outcomes data to the review and audit of care planning</li> </ul>
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#### 4. MANAGEMENT AND SUPPORT AFTER AND BETWEEN TREATMENT

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

###### 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 service standard	Professional performance requirements	Organisational support needed
<p><b>4.1</b></p> <p><i>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</i></p>	<p><i>In providing these services professionals should be able to:</i></p> <ul style="list-style-type: none"> <li>- recognize that a care or discharge plan may be needed at any level of care (not just at the tertiary level)</li> <li>- appreciate the full range of a patient's needs during and after discharge, including those needs involving their families and carers</li> <li>- monitor and review a patient's care plan to take account of changes to their needs during their care</li> <li>- make recommendations about support services to meet new needs, including psychosocial support</li> <li>- liaise with a care coordinator about changes to treatment and any newly identified needs</li> <li>- give particular consideration to the patient's survivorship needs prior to discharge</li> <li>- ensure that the patient's GP is kept informed and involved during discharge</li> </ul>	<p><i>Cancer networks should support their service providers by :</i></p> <ul style="list-style-type: none"> <li>- developing common protocols and communication standards around care and discharge planning</li> <li>- promoting the need for care planning at all levels of care</li> <li>- involving providers in developing or trialling communication formats for care and discharge planning</li> <li>- encourage the direct involvement of care coordinators in care, discharge and survivorship planning</li> </ul> <p><i>Service providers should support their cancer professionals by:</i></p> <ul style="list-style-type: none"> <li>- flagging when a care, discharge or survivorship plan is appropriate</li> <li>- supporting patient expectations that the full range of their needs should be considered during care and at discharge</li> <li>- providing local access to an up to date support service directory</li> <li>- providing a notification system to ensure the involvement of care coordinators and GPs in care, discharge and survivorship planning</li> </ul>

<p><b>4.2</b>  <i>People who have been receiving treatment for cancer will be:</i></p> <ul style="list-style-type: none"> <li>- <i>accompanied by consistent care and discharge documentation</i></li> <li>- <i>supported in an effective transition between their care at the treatment centre and their care in the community</i></li> <li>- <i>know who to contact if there is a recurrence of their disease</i></li> </ul>	<p><i>In providing these services professionals should be able to:</i></p> <ul style="list-style-type: none"> <li>- follow recommended care and discharge planning protocols</li> <li>- discuss with a patient what will happen following completion of care and help deal with any uncertainty and fear of recurrence</li> <li>- make sure they know who is coordinating their ongoing care</li> <li>- access their record to ensure that discharge information is coherent and avoids duplication</li> <li>- meet agreed communication standards for patient transfer</li> <li>- explain the format and use of discharge documentation to patients for inclusion as part of a patient held record</li> <li>- follow-up with care coordinators and GPs to keep them up-to-date with current treatments and their possible affects on patients</li> </ul>	<p><i>Cancer networks should support their service providers by :</i></p> <ul style="list-style-type: none"> <li>- engaging service providers in the continued audit and review of discharge planning and outcomes</li> <li>- liaising with GP Divisions to keep them up to date with developments and current data around discharge planning and outcomes</li> </ul> <p><i>Service providers should support their cancer professionals by:</i></p> <ul style="list-style-type: none"> <li>- ensuring their ready access to discharge protocols and communication templates</li> <li>- monitoring the quality and timeliness of care and discharge planning information sent to care coordinators and GPs</li> <li>- educating patients' expectations around the use of discharge planning as part of patient held records</li> <li>- promote participation in approved communication programs</li> </ul>
<p><b>4.3</b>  <i>People who have been receiving treatment for cancer will be followed-up by a multidisciplinary team with appropriate membership for their needs.</i></p>	<p><i>In providing these services professionals should be able to:</i></p> <ul style="list-style-type: none"> <li>- be prepared to take on the role of coordinating an MDT</li> <li>- liaise with a care coordinator and GP about any newly identified discharge or survivorship needs</li> <li>- liaise closely with the patient's GP about the MDT membership required to match their needs</li> <li>- actively engage the patient's GP as an ongoing member of the discharge and survivorship MDT</li> </ul>	<p><i>Cancer networks should support their service providers by :</i></p> <ul style="list-style-type: none"> <li>- keeping records of the membership, role and function of MDTs operating in the network</li> <li>- liaising with GP Divisions to keep them up to date with the involvement of GPs in network MDTs</li> </ul> <p><i>Service providers should support their cancer professionals by:</i></p> <ul style="list-style-type: none"> <li>- having a system to support liaison between cancer specialists, care coordinators and GPs</li> <li>- wherever possible providing facilities and resources to support MDT meetings</li> </ul>

## 5. CARE AND SUPPORT AT THE END OF LIFE

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

Needs

*People 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 is 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 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

NISIF Ch 6: Care and support at end of life P61

Optimal service standards	Professional performance elements	Organisational Support
<p><b>5.1</b> <i>People with cancer, their families and carers will be supported in discussing prognostic, palliative and end of life issues</i></p>	<p><i>In providing these services professionals should be able to:</i></p> <ul style="list-style-type: none"> <li>- communicate appropriately with patients, their families and carers about prognosis, palliative treatment and support issues</li> <li>- explain to patients, their families and carers the range of available palliative care options</li> </ul>	<p><i>Cancer networks should support their service providers by :</i></p> <ul style="list-style-type: none"> <li>- ensuring referral pathways for the network include palliative care</li> <li>- providing accredited communication training around palliative care issues</li> </ul>

		<p><i>Service providers should support their cancer professionals by:</i></p> <ul style="list-style-type: none"> <li>- provides practitioners time to attend structured training in communication skills around palliative care</li> </ul>
<p><b>5.2</b>  <i>People with cancer who are entering the final phase of their illness will be able to:</i></p> <ul style="list-style-type: none"> <li>- <i>initiate an agreed end of life plan which will reduce their need for crisis management</i></li> <li>- <i>choose the place in which they wish to be cared for</i></li> <li>- <i>choose the place in which they wish to die</i></li> </ul>	<p><i>In providing these services professionals should be able to:</i></p> <ul style="list-style-type: none"> <li>- develop appropriate end-of-life care plans with the informed consent of patients, their families and carers</li> <li>- refer patients entering the terminal phase of their illness for specialist palliative care</li> <li>- participate as a member of a multidisciplinary team discussing the needs of individuals with advanced cancer and palliative care needs</li> <li>- carry out treatment in collaboration with a palliative care specialist</li> <li>- advise patients regarding MBS items relevant to palliative care services</li> </ul>	<p><i>Cancer networks should support their service providers by :</i></p> <ul style="list-style-type: none"> <li>- engaging experts in palliative care as part of relevant Network committees</li> <li>- coordinating access to up to date referral protocols and pathways, including those relating to palliative care</li> <li>- involving people with cancer, their families and carers together with practitioners in developing protocols and treatment guidelines for the end-of-life stage.</li> <li>- promoting palliative care as part of multidisciplinary care.</li> </ul> <p><i>Service providers should support their cancer professionals by:</i></p> <ul style="list-style-type: none"> <li>- allowing practitioners the time needed to: <ul style="list-style-type: none"> <li>o develop tailored end-of-life care plans</li> <li>o participate as members of multidisciplinary palliative care teams</li> </ul> </li> <li>- ensuring access to current palliative care pathways and protocols</li> </ul>