Roles and responsibilities of the shared follow-up and survivorship care team

This resource is for all members of the shared follow-up and survivorship care team. It outlines the roles and responsibilities of the specialist and general practitioner (GP), and their respective teams, in delivering shared follow-up and survivorship care for patients with early breast cancer and ductal carcinoma in situ (DCIS).

To ensure that safe and effective follow-up and survivorship care is delivered according to best practice recommendations, it is essential that the roles and responsibilities of each member of the shared follow-up and survivorship care team are discussed and agreed prior to commencing shared follow-up and survivorship care.

Who is involved in the shared care team?

The shared care team may include:

- ✓ specialist, registrar, breast care nurse or cancer care coordinator (where available) in the specialist setting, and
- ✓ GP and practice nurse in the general practice setting.

Where more than one specialist is involved in a patient's follow up care, it is important that a lead specialist is identified. The lead specialist providing follow-up and survivorship care will often be the breast surgeon; however, depending on a patient's treatment regimen, it may be the medical oncologist or radiation oncologist.

Supporting the patient

It is important for the shared care team to support patients to have a clear understanding of the roles and responsibilities of all those involved in their shared follow-up and survivorship care. This includes the role of their GP, their specialist(s), and the patient themselves. The patient must also understand their role in adhering to the follow-up schedule and actively managing their health.

Good health literacy in patients enables them to understand and navigate the shared follow-up care process. The degree of patient engagement with their follow-up schedule is critical to adherence to the follow-up schedule.

Roles and responsibilities of the shared care team: Initiating shared care

Specialist	GP
✓ Initiate discussion about, and promote, shared follow-up and survivorship care with patients who are likely to be suitable, at diagnosis or during active treatment. This may be supported by Cancer Australia's resources for shared follow-up and survivorship care: **canceraustralia.gov.au/clinical-best-practice/shared-follow-care/early-breast-cancer**	
✓ Assess the patient's suitability for shared follow-up and survivorship care, including consideration of the individual patient's risk of recurrence, needs, preferences, circumstances, and health literacy	✓ Support the specialist's assessment of the individual patient's risk of recurrence, needs, preferences, circumstances, and health literacy, and agree that the patient is suitable for shared follow-up and survivorship care
✓ Develop the Shared Care Plan ✓ Ensure that agreement to the Shared Care Plan has been obtained from the patient and their GP, and agreement is documented	✓ Agree to the Shared Care Plan
✓ Support the patient to understand and consent to their follow-up care being shared between their GP and specialist(s) by providing clear information to the patient about the importance of follow-up care, the schedule of follow-up appointments	
✓ Build an environment of support in the specialist setting/ general practice and ensure systems and processes are in place to support the shared follow-up and survivorship care approach	
✓ Provide the GP with a detailed treatment summary (through completion of the Shared Care Plan)	✓ Ensure that a detailed treatment summary has been received (as part of the Shared Care Plan) from the specialist when the patient commences shared follow-up and survivorship care
✓ Be available to provide specialist consultation or advice as required by the GP, according to the urgency of the GP's request either through formal referral (Rapid Access Request) back to the specialist setting or through available secure messaging platforms	✓ Be aware of local level processes for accessing specialist advice and enacting Rapid Access Requests and use these processes appropriately within the local health setting

Roles and responsibilities of the shared care team: During shared care

Specialist	GP
✓ Deliver best practice follow-up and survivorship care in line with Cancer Australia's recommendations for follow-up care for early breast cancer as well as the patient's individual risk of recurrence, needs, preferences, circumstances, and health literacy.	
✓ Communicate clinical findings and test results during the follow-up period in a timely manner to the patient and other members of the shared follow-up and survivorship care team. Communication and sharing of information between the specialist and the GP can be supported through the use of electronic health records (such as My Health Record), digital health platforms, secure messaging, and telehealth.	
✓ Provide rapid access to patients and GPs when needed by applying and enacting agreed rapid access processes	✓ Directly communicate with the specialist to seek advice as required, using agreed methods ✓ Refer the patient via Rapid Access Request to the specialist if there are any symptoms, signs, or imaging results suggestive of a breast cancer recurrence or for urgent advice about any aspect of patient care as required, including reporting adverse events
✓ Alert GP to new treatments, potentially relevant to a particular patient, which may require a specialist consultation	
	✓ Participate in relevant accredited education about early breast cancer follow-up and survivorship care, and, if required, breast cancer in general
✓ Develop and maintain relationships with relevant GPs and general practices	✓ Develop and maintain relationships with relevant specialist cancer providers and services
✓ Support patients to actively manage their health, including prevention and living well	

Roles and responsibilities of the shared care team: Nurses

Some of the key roles and responsibilities in supporting the commencement and delivery of shared follow-up and survivorship care align with the scope of practice of nurses, including breast care nurses and general practice nurses. These may include:

- ✓ Helping to identify and educate suitable patients about shared follow-up and survivorship care
- ✓ Supporting development of the Shared Care Plan
- ✓ Assisting patients to understand and navigate the shared care approach
- ✓ Scheduling and monitoring appointments and providing appointment reminders
- ✓ Delivering follow-up and survivorship care in line with evidence-based guidance
- ✓ Establishing and maintaining relationships with and between the patient, GP and specialist
- ✓ Facilitating communication and information sharing between specialist and primary care settings.