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, general practitioner (GP), nurses, 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), nurses 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.

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

<table>
<tr><th>SPECIALIST</th><th>GP</th></tr>
<tr><td colspan="2">– 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</td></tr>
<tr><td>– 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</td><td>– 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</td></tr>
<tr><td>– 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</td><td>– Agree to the Shared Care Plan</td></tr>
<tr><td colspan="2">– 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</td></tr>
<tr><td colspan="2">– 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</td></tr>
<tr><td>– Provide the GP with a detailed treatment summary (through completion of the Shared Care Plan)</td><td>– 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</td></tr>
<tr><td>– 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</td><td>– 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</td></tr>
</table>

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	

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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 cancer nurses, breast care nurses, and primary care nurses. These roles and responsibilities include:

CANCER NURSES (GENERAL)

- Encourage patients to have a regular GP
- Advocate for and promote shared follow-up and survivorship care to specialists and health service managers
- Identify and educate suitable patients about shared follow-up and survivorship care
- Set patient expectations about shared follow-up care by promoting and discussing the model of care at diagnosis and during the treatment period
- Facilitate development of the Shared Care Plan
- Help patients to navigate the health care system to support follow-up care

BREAST CARE NURSES

- Equip patients with the knowledge and skills to be proactive about their care and make appropriate healthy lifestyle choices by engaging in ongoing discussion
- Assess and progress rapid referrals back to the relevant specialist
- Strongly encourage patients to seek medical care promptly if symptoms or issues appear in between follow-up appointments
- Support primary care nurses to deliver their roles in shared follow-up care
- For patients who live in regional and rural areas and have completed treatment, breast care nurses in metropolitan areas can facilitate referrals to local specialist nurses for continuity of care

PRIMARY CARE NURSES

- Identify and educate suitable patients about shared follow-up and survivorship care
- Coordinate organisational aspects of patient care, including maintaining, monitoring and improving patient information systems, and managing patient recall and reminders as per the shared follow-up care schedule
- Complete some aspects of follow-up care, including provision of additional wellbeing and psychosocial support
- Encourage patients to make appropriate healthy lifestyle choices by engaging in ongoing discussion
- Plan and coordinate care, including routine monitoring and follow-up of patients' care plans*
- Support care coordination by assisting with updating the patient's My Health Record
- Support collaboration and partnership with other members of the multidisciplinary team as part of follow-up and survivorship care

* Note: Care plans may include but are not limited to the Shared Care Plan, Team Care Arrangements, General Practitioner Management Plans (GPMPs), Chronic Disease Management Plans and Mental Health Care Plans.

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