Roles and Responsibilities for the delivery of care

This resource is for all members of the shared care team*. It outlines the roles and responsibilities for the specialist and primary care practitioner/s, and their respective teams in the commencement and delivery of shared follow-up care for low-risk endometrial cancer.

Shared follow-up and survivorship care for low-risk endometrial cancer is designed for women who have completed active treatment for low-risk endometrial cancer. Shared care involves the joint participation of primary and specialist teams in the planned delivery of patient care. Shared care can provide women with the benefits of care by a specialist team combined with continuity of care and ongoing management from primary care practitioner/s.

Establishing agreed shared care arrangements, roles and responsibilities

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

A Shared Care Plan has been developed to document shared care arrangements for individual patients and support a joint approach between the specialist team and primary care practitioner/s for the delivery of shared follow-up care.

Who is involved in the shared care team?

The shared care team may include:

Specialist team

- The specialist team may include gynaecological oncologists, medical oncologists, radiation oncologists, gynaecologists, nurses, cancer care coordinator (where available) and/or allied health professionals in the specialist setting.
- The specialist team will determine suitability for shared follow-up care and initiate discussion about shared follow-up care with the woman.
- Alternatively, the specialist team may continue discussions about shared follow-up care, which have been initiated by either the primary care practitioner/s or the woman.

Where more than one specialist is involved in a woman'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 gynaecological oncologist; however depending on a woman's treatment regimen, it may be the medical oncologist or radiation oncologist.

Primary care practitioner/s

- The primary care practitioner/s (GP and primary health care nurse) play an important role in the provision of follow-up care following the initial discussion between the specialist team and the woman about shared follow-up care in the primary care setting.
- Alternatively, the woman or primary care practitioner/s may have initiated discussions about shared care; the specialist team, prior to the commencement of shared care, will then continue these discussions.

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 gynaecological cancer nurses and primary health care nurses. Specialist and primary health care nurses play an important coordinating role in the shared care team.

* Shared care team refers to members of the specialist multidisciplinary gynaecological cancer team (specialist team; including but not limited to gynaecological oncologists, medical oncologists, radiation oncologists, gynaecologists, nurses and/or allied health professionals) and the primary care practitioner/s (including General Practitioner (GP) and primary health care nurse).

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Delivering shared follow-up and survivorship care

It is important that the shared care team take an active and shared role in delivering shared follow-up and survivorship care. Care of the woman requires coordination through timely and effective communication. It is essential to establish clear communication pathways, ongoing information sharing and referral practices at commencement of shared follow-up care.

Supporting the woman

It is important for the shared care team to support women 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 woman herself.

The woman is encouraged to take an active role in shared follow-up care, including discussing her specific care needs; contributing to the development of the Shared Care Plan; bringing the Shared Care Plan to follow-up appointments; and monitoring her own health, including for symptoms of cancer recurrence.

Additionally, good health literacy in women 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.

Overview of roles and responsibilities by stage of care

<table>
<tr><th colspan="3">INITIATING SHARED FOLLOW-UP AND SURVIVORSHIP CARE</th></tr>
<tr><th>Specialist team</th><th>Primary care practitioner/s</th><th>Nurse</th></tr>
<tr><td colspan="3">– initiate discussion about, and promote, shared follow-up and survivorship care with women who are likely to be suitable</td></tr>
<tr><td>– assess the woman's suitability for shared follow-up and survivorship care, including consideration of the individual woman's risk of recurrence, needs, preferences, circumstances and health literacy</td><td colspan="2">– support the specialist team's assessment of the individual woman's risk of recurrence, needs, preferences, circumstances and health literacy, and agree that the woman is suitable for shared follow-up and survivorship care</td></tr>
<tr><td colspan="3">– develop the Shared Care Plan collaboratively with the woman, and ensure all parties have agreed to and are provided a copy of the Shared Care Plan</td></tr>
<tr><td colspan="3">– support the woman to understand and consent to her follow-up care being shared between her primary care practitioner/s and specialist team by providing clear information to the woman about the importance of follow-up care and the schedule of follow-up appointments</td></tr>
<tr><td colspan="3">– build an environment of support in the specialist setting/primary care setting 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 colspan="2">– ensure that a detailed treatment summary has been received (as part of the Shared Care Plan) from the specialist when the woman 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 colspan="2">– 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>
<tr><td colspan="3">– shared follow-up and survivorship care may be supported by Cancer Australia's resources for shared follow-up and survivorship care: https://canceraustralia.gov.au/clinical-best-practice/shared-follow-care/low-risk-endometrial-cancer</td></tr>
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<table>
<tr><th colspan="3">DELIVERY OF SHARED FOLLOW-UP AND SURVIVORSHIP CARE</th></tr>
<tr><th>Specialist team</th><th>Primary care practitioner/s</th><th>Nurse</th></tr>
<tr><td colspan="3">– deliver best practice follow-up and survivorship care in line with Cancer Australia's Shared follow-up care model for women with low-risk endometrial cancer: Guidance Toolkit as well as the woman's individual risk of recurrence, needs, preferences, circumstances and health literacy</td></tr>
<tr><td colspan="3">– communicate clinical findings and test results during the follow-up period in a timely manner to the woman and other members of the shared care team</td></tr>
<tr><td>– agree to be available to provide specialist consultation or advice as required by the primary care practitioner/s, according to the urgency of the primary care practitioner/s request; the Rapid access request has been developed to support this process</td><td>– directly communicate with the specialist team to seek advice as required, using agreed methods
– refer the woman via Rapid access request to the specialist team if there are any symptoms, signs or imaging results suggestive of a recurrence, or for urgent advice about any aspect of care as required, including reporting adverse events</td><td>– facilitate communication and information sharing between the specialist team and primary care practitioner/s</td></tr>
<tr><td>– send updated results to the primary care practitioner/s, noting any significant change in the woman's health status</td><td colspan="2">– record on the Shared Care Plan any follow-up care and results provided by the primary care practitioner/s
– send updated results to the specialist team, noting any significant change in the woman's medical status</td></tr>
<tr><td>– alert primary care practitioner/s to new treatments, potentially relevant to a particular woman, which may require a specialist consultation</td><td colspan="2">– monitor and manage treatment-related side effects, co-morbidities and secondary prevention (in addition to routine primary care visits)
– assess the woman for psychosocial distress, anxiety or depression and provide appropriate support and referrals</td></tr>
<tr><td>– develop and maintain relationships with relevant GPs and primary care practitioner/s</td><td>– develop and maintain relationships with relevant specialist cancer providers and services</td><td>– establish and maintain relationships with and between the woman, primary care practitioner/s and specialist team</td></tr>
<tr><td colspan="3">– support women to actively manage their health, including living well</td></tr>
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Further information and resources

Shared Care Plan

Provides a template for the specialist team, the primary care practitioner/s and women to input into an agreed follow-care up plan.

Rapid access request

Provides a template for documenting communication and referral systems between primary care practitioner/s and the specialist team when rapid access to specialist consultation is required.

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