



# PC4

## Principles Statement: Shared Care

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# IMPLEMENTATION OF SHARED CARE FOR CANCER PATIENTS

## INTRODUCTION

The term 'shared care' is usually applied to the sharing of care between a cancer specialist and primary care provider (primarily a general practitioner but also community nurses, practice nurses and allied health practitioners) where care is delivered in two or more settings by two or more professionals. As such, the model of shared care is similar to models applied in other areas, for example in antenatal care, and in chronic diseases such as diabetes, hepatitis and HIV.

Shared care is distinct from hospital-led care and primary care-led care: it is also distinct from a setting where multiple providers deliver care to the patient without working together or sharing information. In the context of shared care both the specialist and the primary care provider maintain ongoing involvement in patient care, and in doing so share information and clinical responsibilities, agree on common processes proactively, and involve the patient in the process.

In cancer, shared care can be delivered across many aspects of the cancer journey including during treatment, follow up care, survivorship care and end-of-life care. Traditionally shared care often involves sharing of similar aspects of care, but it may also involve the allocation of particular tasks to specific professionals, allowing each to contribute their different expertise.

## POTENTIAL BENEFITS OF SHARED CARE IN CANCER

Shared care offers a number of advantages to patients, including the potential for treatment closer to home, more efficient care with less duplication, greater coordination and ultimately a more comprehensive and holistic approach to care. A number of randomised clinical trials comparing shared care and specialised care have not shown any difference in outcomes, including recurrence rate, cancer survival and quality of life.<sup>1,2</sup>

Shared care however, offers the potential for better integration of the management of other comorbidities that cancer patients suffer from, and

a more streamlined delivery of health care has potential for cost savings.

## BARRIERS TO UPTAKE OF SHARED CARE

Despite the potential benefits the uptake of shared care in cancer remains low. This may be due to a number of barriers such as lack of patients' and providers' knowledge about its benefits or how to implement it, lack of provider communication, and lack of system support including funding models, tools and resources.

## OBJECTIVES

This document outlines the fundamental principles to successfully implement the delivery of shared care between primary and specialist providers for people with cancer. This framework for the design, implementation and evaluation of shared care across different settings may assist in planning practice and further research in this area.

## SHARED CARE PRINCIPLES

- I. The **core objective** of shared care is optimising care of the patient through improvement in access, acceptability and quality of the care delivered.
- II. **Parties involved** in shared care include the individual patient for whom care is delivered (and his/her carer) and the health care providers - both primary and specialist. Planning and execution of shared care must include all parties to ensure that the scope and processes meet their needs and are:
  - a. **Acceptable** to all parties – patients and carers, primary care and specialist providers.
  - b. **Flexible** regarding scope, design and the processes involved in delivering shared care. The model must fit into existing work

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flow and there needs to be an ability to renegotiate the model as circumstances change.

c. **Clear with regards to:**

- **Expectations** – these relate to both outcomes and processes and should include the responsibilities of each party, including triggers for review and plans for rapid access into each setting: it is important to document the agreed responsibilities and processes.
- **Communication pathways** – this includes clarity and explicit agreement regarding format, frequency and triggers for communication.
- **Implementation process** – requires clarity at both individual and organisational level. There should be broad stakeholder consultation and engagement about process, costs and resources and how these will be provided. An organisational level implementation process is likely to inform individual level implementation process but it should not serve as a substitute or replace individual implementation planning.
- **Integration** – The shared care models are integrated into the existing infrastructure and work flow and align with the existing drivers and enablers of care. This may be aided by appropriate use of information technology.
- **Evaluation** – this is essential to ensure that shared care delivers what it is meant to and problem areas are identified and modified.

- III. Identify barriers to the implementation of shared care, and strategies to address them.
- IV. Develop and increase access to resources and tools.
  - a. Establish a clearing house of resources that support shared care.
  - b. Identify resources that need to be developed, and partners that can contribute to their development.
- V. Identify the evaluation elements in a shared care model that are associated with a well-functioning shared care model, and tools that assist in its evaluation.

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## REFERENCES:

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## PC4 PRIORITIES FOR SUPPORTING UPTAKE OF SHARED CARE IN CANCER

- I. Encourage and promote shared care through meeting presentations, publication, stakeholder engagement and policy development.
- II. Examine experiences of successful shared care projects and settings to build a greater understanding of what works and why.

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