Deloitte
Access Economics

# Evaluation of the GP CanShare Program

## Central and Eastern Sydney Primary Health Network

Evaluation Report

November 2025

# Contents

Contents ........ 2
Glossary ........ 3
Executive Summary ........ 4
1 Introduction to the Evaluation ........ 7
2 Evaluation Methodology ........ 11
3 Evaluation Findings ........ 17
4 Recommendations ........ 38
Appendices ........ 41
Limitations of Our Work ........ 50

Deloitte refers to one or more of Deloitte Touche Tohmatsu Limited ("DTTL"), its global network of member firms, and their related entities (collectively, the "Deloitte organisation"). DTTL (also referred to as "Deloitte Global") and each of its member firms and related entities are legally separate and independent entities, which cannot obligate or bind each other in respect of third parties. DTTL and each DTTL member firm and related entity is liable only for its own acts and omissions, and not those of each other. DTTL does not provide services to clients. Please see www.deloitte.com/about to learn more.

Liability limited by a scheme approved under Professional Standards Legislation.

© 2025 Deloitte Touche Tohmatsu.

# Glossary

| Abbreviation | Meaning |
|---|---|
| ATSI | Aboriginal and/or Torres Strait Islander |
| CESPHN | Central and Eastern Sydney Primary Health Network |
| CNC | Clinical Nurse Consultant |
| ED | Emergency Department |
| GP | General Practitioner |
| ITS | Information Technology Support |
| KPI | Key Performance Indicator |
| MBS | Medicare Benefits Schedule |
| PHN | Primary Health Network |
| PREM | Patient-Reported Experience Measure |
| SESLHD | South Eastern Sydney Local Health District |
| SLHD | Sydney Local Health District |
| SVHS | St Vincent’s Hospital Network Sydney |

# Executive Summary

## Context

Cancer remains a leading cause of illness and death in Australia, with over 130,000 new cases expected this year and incidence rates continuing to rise. The disease places significant demands on the health system, accounting for over a million hospitalisations annually and driving substantial resource needs, particularly as the population grows and ages. Despite this demand, fragmentation across primary, community, and acute healthcare settings persist, impacting care coordination and patient support.

To address this challenge, the Central and Eastern Sydney Primary Health Network developed the GP CanShare Program, aiming to enhance the healthcare experience for people with cancer and cancer-related palliative needs, and to build GP capability in effectively managing cancer care. The Program's integrated shared care model connected major cancer centres, GPs, and community services, supported by hospital-based care coordinators and a dedicated GP support line, to provide more seamless, informed, and patient-centred care throughout the region. The model was implemented by three providers across multiple sites in the Central and Eastern Sydney Primary Health Network area (with some variations across providers in terms of the design and delivery of shared care).

To assess how effectively these objectives were being achieved, the Central and Eastern Sydney Primary Health Network engaged Deloitte Access Economics (formerly Siggins Miller Consultants) to undertake an independent evaluation of the GP CanShare Program.

## Evaluation Methodology

The evaluation's findings were drawn from both qualitative and quantitative data collection processes including consultations with key stakeholders across the sector, such as patients, Clinical Nurse Coordinators, General Practitioners, project stakeholders and Medical Specialists. The insights gathered from the surveys, data reports, and stakeholder consultations were thematically organised, reviewed and then assessed against the evaluation questions. These inputs have informed the development of this report, which consolidates key findings regarding the:

- Design
- Implementation
- Effectiveness
- Outcomes
- Value
- Sustainability and scalability of the GP CanShare Program.

It also outlines a set of feasible and implementable recommendations, which could be considered for future similar initiatives. These recommendations include establishment of structures, frameworks, and processes that help lead to more efficient and effective care delivery for patients. Limitations to the evaluation included the response rates to the surveys, and challenges with the availability of program activity data across sites. These limitations are discussed throughout the report.

## Findings

Data available to the evaluation suggests that the GP CanShare Program was likely effective, supported patients, and achieved its intended outcomes (that were measurable). However, opportunities for further improvement to the shared care model were also identified, to make certain aspects, such as communication channels, more efficient for longer term sustainable delivery of care. The key findings from the evaluation are outlined below:

1. The shared care models (as implemented across the various sites) appeared appropriate, sustainable, and effective for GPs and patients. For those that responded to the surveys, there were high levels of satisfaction, perceived usefulness of documentation, and ease of engagement highlighted that the

program design supported effective coordination, information sharing, and clinical decision-making. The Program coordinator role was highly valued by all stakeholders and appeared central to success.

2. The Program was implemented as intended, with good engagement from GPs, Specialists, and patients. Care plans and documents were delivered on time, were detailed, and supported effective shared care.
3. There was some limited data available that indicated that the model supported healthcare experiences, improved GP capability, and supported effective shared care. Patients felt informed and engaged, and GPs reported improved knowledge and coordination with Specialists.
4. Based on the responses to surveys, there was some evidence to suggest the Program improved awareness, care coordination, access to timely care, quality, and appropriateness of care. The cancer care coordinator roles and the shared care approach were critical success factors (enabled by the availability of information systems to support shared care and communication between acute and primary health settings).
5. High engagement and recommendation rates for the limited survey responses available across program stakeholder groups suggest that the Program could be sustainable and has potential for scaling, however a broader changing environment (i.e., federal funding for shared care models by a single provider) should be considered. Core elements such as the coordinator role, timely documentation provision, and shared care training and education opportunities contributed to success. Sustainability was a focus of CESPHN and providers throughout design and implementation and many elements of the Program have been embedded into usual processes post funding (i.e., developed materials, investment in secure messaging, etc.). These are summarised per site in the body of the report.

## Recommendations

Recommendations for improving future similar programs were organised against the six evaluation domains. A summary of those recommendations is outlined in Table ES1 below. The evaluation notes that these recommendations are provided in the context of this program alone (i.e., with the expectation that future funding might be available), and should the funding not be continued or available, may serve as lessons learned for future similar models in the future.

Table ES1. Summary of recommendations and lessons learned

| Domain | Recommendations and Lessons Learned to Consider for Future Similar Programs |
|---|---|
| 1. Program Design | • Streamline communication with dedicated systems and clear, consistent documentation. The availability of interoperable secure messaging systems that were known and accessible to general practice and integration with clinical workflows and EMRs was critical to the adoption of the program as well as the reduction of administrative burden on CNCs.<br>• Ensure patients, general practice and other key stakeholders are involved early in care planning to empower their decisions, as evidenced in the design of this Program.<br>• Build shared care pathways and engagement with general practice locally for sites delivering shared care services to support engagement (including identifying barriers to GP engagement and awareness) and expand this to other healthcare professionals who might be working with patients with cancer related care needs (i.e., specialists, allied health, etc.). This might include allocating for example a champion GP who supports engagement within that location and contributes to governance and continuous quality improvement processes.<br>• Where possible, ensure that the core model delivery is consistent across sites to reduce confusion for patients, GPs, and specialists, while allowing for some regional flexibility to meet local needs.<br>• Ensure that funding for positions is as secured as possible to minimise attrition over time of CNCs and program delivery staff. |
| 2. Program Implementation | • Consider opportunities to develop shared resources including GP details, across sites and discuss areas where there is likely overlap between providers so that there is clarity for all program stakeholders where possible on the program.<br>• Engage regularly with clinicians to understand enablers and barriers to implementation and service |

| Domain | Recommendations and Lessons Learned to Consider for Future Similar Programs |
|---|---|
| | delivery on the ground.<br>• Create simple feedback mechanisms so that all stakeholders can provide input into the programs and to help identify areas for continuous quality improvement.<br>• Identify opportunities where the awareness of any programs can be built for GPs, specialists, and patients in existing events, days, and training locally. |
| 3. Program Effectiveness | • Engage with patients in a structured manner to understand effectiveness and consider the possibility in future evaluations for data linkage opportunities to understand the impact of these programs on broader health system utilisation.<br>• Ensure that there are simple coordination tools to support the communication between all members of care teams, general practitioners, specialists and patients.<br>• Continue to schedule ongoing education sessions for healthcare practitioners which serve a dual purpose in terms of improving understanding of cancer related care needs as well as their understanding of the model of shared care.<br>• Continue to monitor access and equity metrics regularly over time, including regular reporting. This would include clearly defining key metrics (i.e., occasions of service, enrolment, communications, etc.) that are then used consistently across sites. |
| 4. Program Outcomes | • Maintain and clearly define the coordinator role both within sites implementing the program as well as by the commissioning body (i.e., CESPHN)<br>• Ensure documentation and communication is standardised and actionable where possible, including when appropriate ensuring consistency in how the model is implemented across sites.<br>• Collect demographic and outcome data for all patients to support monitoring and evaluation.<br>• Promote the Program early to all relevant stakeholder to support uptake and usability. |
| 5. Program Value | • Consider opportunities for data linkage to provide data on resource use and hospitalisation avoidance as well as other system uptake and cost or benefit variables. |
| 6. Program Sustainability and Scalability | • Retain the program coordinator and documentation processes to maintain quality during expansion.<br>• Engage local stakeholders before rollout to address regional needs and support adoption, including any local adaptations required for the model in those areas.<br>• Develop a step-by-step implementation guide for consistency across sites where appropriate. |

Source. Deloitte, based on a triangulation of all data.

# 1 Introduction to the Evaluation

Cancer is a leading cause of illness and death in Australia. The GP CanShare program was introduced with the aim to improve the quality of care provided to cancer patients by enhancing the communication and sharing of patient care plans between primary and acute care providers. Deloitte was engaged by Central and Eastern Sydney Primary Health Network to undertake an evaluation of the GP CanShare program to determine impact and outcomes and use these findings to inform recommendations for future improvements.

This section introduces cancer, explaining what it is and its impact in Australia, including trends in mortality. Following on from this it provides an overview of the GP CanShare program, detailing why it was introduced, alongside the purpose and key objectives of the evaluation that was undertaken by Deloitte.

## 1.1 Overview of Cancer and Challenges in Australia

In Australia, cancer remains a leading cause of illness and death and has increased over the past two decades. It is estimated that over 130,000 Australians will be diagnosed with cancer this year, which is the equivalent of one person every four minutes.[1] When age-adjusted, the 2025 rate of cancer is around 30% higher than in 2000.[2] Cancer treatment requires substantial healthcare resources. Between 2021 and 2022, there were approximately 1.4 million cancer-related hospitalisations across Australia, accounting for about one in eight of all hospital admissions. Of these, 75% were same-day hospitalisations, while 25% required an overnight stay.[3]

Addressing cancer is vital due to its significant impact on health and wellbeing. The World Health Organization estimates that at least one third of all cancer cases are preventable. Global experts further suggest that more than half of all cancers could be prevented through a combination of healthy lifestyle choices and regular screening.[4] As Australia's population continues to grow and age, the number of cancer cases is expected to rise, with around 204,000 cases predicted by 2033.[5] Continued efforts in prevention, early detection, and ensuring equitable access to quality care and support services are essential to help reduce the burden of cancer and improve outcomes for all affected individuals. However, a key challenge in the Australian cancer care system is the fragmentation and limited integration across primary, community and acute care settings. This widely acknowledged issue affects care affects care coordination and the overall patient experience, leading to gaps in communication, continuity, and support throughout the cancer journey.

## 1.2 Central and Eastern Sydney Primary Health Network

The Central and Eastern Sydney Primary Health Network (CESPHN) is a Primary Health Network (PHN) that stretches from Strathfield to Sutherland, east to the coastline, and includes Lord Howe Island. The boundaries of CESPHN align with those of South Eastern Sydney Local Health District (SESLHD) and Sydney Local Health District (SLHD). PHNs are funded by the Australian Government to drive innovation to meet specific local health needs and support local delivery of commissioned programs. CESPHN was established to strengthen primary care, work towards integration across sectors and commission health services to meet the health needs of the local community.

Adult cancer care in the CESPHN region is provided across two local health districts, SESLHD and SLHD, and one health network, St Vincent's Hospital Network Sydney (SVHS). It also encompasses three segments –

[1] Cancer Australia. Awareness. Available from: https://www.canceraustralia.gov.au/awareness (accessed 1 August 2025)
[2] Australian Institute of Health and Welfare. Cancer Data in Australia. Available from https://www.aihw.gov.au/reports/cancer/cancer-data-in-australia/contents/overview (accessed 1 August 2025)
[3] Australian Institute of Health and Welfare. Cancer. Available from https://www.aihw.gov.au/reports/australias-health/cancer (accessed 1 August 2025)
[4] Cancer Australia. Awareness. Available from: https://www.canceraustralia.gov.au/awareness (accessed 1 August 2025)
[5] Australian Institute of Health and Welfare. Cancer. Available from https://www.aihw.gov.au/reports/australias-health/cancer (accessed 1 August 2025)

general practice, community cancer services and Specialist services. A total of nine cancer centres supported by 73 multidisciplinary teams and community palliative care services operate within the region. There are also approximately 560 general practices, offering significant potential to enhance shared care for patients with cancer and help reduce the burden on hospital-based oncology teams, reduce avoidable hospital admissions, and support a cohesive patient experience in relation to their care.

## 1.3 The GP CanShare Program

In 2019 CESPHN undertook a review of the role of primary care providers in cancer management. The review found that there is a significant and increasing burden of cancer, cancer care, and cancer-related palliative care needs. It also identified that better integration between primary and acute care, enhanced capability of GPs to effectively manage patients with cancer and cancer-related palliative care, and an integrated and shared model of care for patients in this area across acute and primary settings would support better care for patients in the region.

To address these identified concerns, CESPHN implemented the GP CanShare program (the Program) in the region to deliver two longer term outcomes:

1. Improved healthcare experience for people with cancer and cancer-related palliative care in the CESPHN region.
2. Enhanced capability of GPs to effectively manage care for their patients with cancer and cancer-related palliative care.

To achieve the main outcomes, the Program has two components (see Figure 1.1 below):

1. The implementation of an integrated shared model of care linking major cancer centres with GPs and community services to support patient outcomes.
2. The establishment of a CESPHN wide GP Cancer Support Line to support the access to high quality advice and information for general practice.

Figure 1.1. Components of the Program

Source. Deloitte, based on program information. Note: the GP Support Line was discontinued partway through the delivery of the Program.

### 1.3.1 Shared Model of Care

As part of the Program, provider sites have designed and implemented a model of care within their location that meets the proposed service description by CESPHN, whereby hospital-based cancer care coordinators liaise with general practices, patients, and other specialists in a shared care model that enables integration and continuity of care. This included the transfer of:

- Written patient information,
- Familiar knowledge gained in daily professional practice, and
- Practical knowledge and skills.

The care coordinators also supported GP knowledge gaps, shared information on care planning, and ensured a coordinated approach to care between primary and acute providers. They were a primary point of contact for general practices in relation to the care needs of patients with cancer, providing regular updates on all aspects of a patient's care to their care team and assisting with timely access to information.

More specifically, the shared model of care from CESPHN included:

- Relevant care coordinators (e.g., Clinical Nurse Coordinators [CNC], social workers, etc.) working collaboratively with Specialist teams in the CESPHN region at major cancer centres.
- Providers embedding the care coordinators in relevant workstreams, and the care coordinators strengthening the integration between acute care, community-based oncology and palliative care teams, and general practice.
- The models of care supporting seamless care coordination for patients and the liaison between the patients' Specialists or palliative care team and their GP.
- The coordinators engaging with patients, their GPs and their care teams to establish ongoing, two-way communication channels for information relevant to the patients care.
- The coordinators supporting patients to access their GPs for issues that can be addressed in primary care.
- The care coordinators being involved across the continuum of the patient's care to coordinate any multidisciplinary teams (MDTs) or community services. Care coordinators having oversight for the primary and acute care aspects of the patients care and treatment plan.
- Care coordinators supporting GP knowledge, sharing information on care planning, and providing the GP with an avenue to contribute to the care plan to ensure there is an agreed approach across primary and acute providers. This included knowledge transfer to GPs about prognosis, treatment, and any physical, psychological and social problems for the patient. Care coordinators also informed GPs of any aspects of the patients care that Specialists expect them to undertake.
- If relevant, the care coordinator collaborated and liaised with community services, including community palliative care, should it be relevant for the patient to ensure continuity of care.

The shared model of care component of the Program was delivered across the following providers and locations as outlined in Table 1.1

Table 1.1. Program Sites and Locations

| Provider | Location/s |
|---|---|
| SESLHD | Prince of Wales Hospital<br>St George and Sutherland Hospital |
| SLHD | Concord Repatriation General Hospital<br>Royal Prince Alfred Hospital |
| SVHS | Kinghorn Cancer Centre |

Source. Deloitte

There was some variation in how the Program was implemented across sites, and an earlier report developed in 2022 by the evaluation summarises how the model was implemented across these sites (Attachment A: GP CanShare Program Process Report).

### 1.3.2 GP Support Line

A GP cancer support line was established to provide access to high quality advice from credible medical specialists to GPs to enhance cancer care management. The services offered by the support line included support with service navigation and cancer related enquiries, such as: survivorship care, psychological care, palliative care and advance care planning, treatment and symptom management, service navigation advice, and assistance with referral pathways and advice relating to the care of patients prior to Specialist consultation (particularly for urgent presentations). There was limited uptake of the GP cancer support line, so it was discontinued on 31 December 2022.

## 1.4 Program Evaluation's Purpose and Overview of the Final Evaluation Report

In 2020, CESPHN engaged Deloitte Access Economics (the evaluation team) to undertake an independent

evaluation of the Program. The overarching objective of this evaluation was to explore how the Program had been implemented, assess its effectiveness and impact, and identify opportunities to strengthen and expand its reach in the future. This work was carried out over several phases and in close collaboration with CESPHN, ensuring that the evaluation remained relevant, and evidence informed.

This document is the Final Evaluation Report (the Report) and brings together the insights gathered throughout the evaluation. It outlines the methodology adopted, describes how the evaluation framework was developed in partnership with CESPHN, and presents key findings drawn from qualitative and quantitative data analysis. Based on these findings, the Report offers conclusions about the Program's performance and highlights areas for potential growth and refinement. The structure of the Report is as follows:

1. Introduction to the Evaluation – Provides background and context for the Program and the rationale for the evaluation.

2. Evaluation Methodology and Approach – Describes the evaluation approach, design, and data collection methods.

3. Evaluation Findings – Presents the key insights emerging from the evaluation in response to the evaluation questions.

4. Recommendations – Offers feasible recommendations (based on the insights gathered from the findings) on how the Program and other similar programs in the future could be further enhanced.

# 2 Evaluation Methodology

A developmental approach was adopted for the evaluation, incorporating principles of participatory co-design and action learning. This approach facilitated ongoing collaboration with stakeholders, providing continuous opportunities for feedback, input, and guidance throughout the evaluation process. Overall, this approach ensured the evaluation remained responsive and relevant, providing insights to support the ongoing development of the Program.

This section provides an overview of the methodology used by the evaluation team to undertake the evaluation of the Program, outlining how the methodology was developed and the rationale behind the different components of it to allow for a comprehensive review to be undertaken.

## 2.1 Program Logic

Firstly, a program logic (see Appendix A) was developed in collaboration with CESPHN for the Program as a whole. A program logic is a tool that demonstrates the connection between a program's inputs and activities and the achievement of its outputs and outcomes. It is underpinned by a theory of change, which outlines the assumptions regarding the relationships between inputs, outputs, and outcomes. Additionally, the program logic identified external and non-program factors that would influence the Program's ability to meet its intended objectives.

The core components of the program logic included:

- Inputs – human, financial, and organisational resources available for the Program.
- Processes – activities, tools, events, technologies, and actions involved in the Program's implementation.
- Outputs – the direct products resulting from the activities and processes.
- Intermediate and long-term outcomes – specific changes within systems, organisations, and personnel that result from the Program's work and contribute towards achieving its goals.
- Non-program factors – external influences in the system that affect the achievement of outputs and outcomes but are beyond the control of the program.

Individual site program logics that capture the differences in the delivery of the overarching model were also developed (see Attachment A).

## 2.2 Data Strategy Matrix

A data strategy matrix (see Appendix B) was also developed to map different data sources against specific elements of the program logic and evaluation questions, supporting a systematic assessment of the Program.

## 2.3 Evaluation Questions

Table 2.1 below outlines the key evaluation domains, and associated questions which were developed, that guided the evaluation and its data collection. The evaluation was to be only able to answer these questions based on the extent, nature and quality of data that was available.

Table 2.2.1. Evaluation domains, questions and sub-questions

| Domain | Key Evaluation Questions |
| --- | --- |
| 1. Program Design | a) Is the service model developed for the program appropriate, sustainable, and effective for GPs and Practice Nurses?<br>b) Is the service model developed for the program appropriate, sustainable, and effective for people with cancer and cancer-related palliative needs and their family and carers? |
| 2. Program Implementation | a) Is the program being implemented as intended? If not, why? |
| 3. Program Effectiveness | a) What is the effectiveness of the program to improve the healthcare experience for people with cancer and cancer-related palliative needs and their family/carers?<br>b) What is the effectiveness of the program to enhance the capability of GPs to effectively manage care for their patients with cancer and cancer related palliative needs?<br>c) What is the acceptability & usability of the shared care model according to GPs and practice nurses?<br>d) What are the access and equity enablers, or barriers, that may impact on care coordination and GP access to services? |
| 4. Program Outcomes | a) Are the expected outcomes of the program being met (improved awareness and knowledge)?<br>b) Are the expected outcomes of the program being met (improved coordination of care)?<br>c) Are the expected outcomes of the program being met (improved access to care)?<br>d) Are the expected outcomes of the program being met (improved quality of care)?<br>e) Are the expected outcomes of the program being met (improved appropriateness of care)?<br>f) What is the efficacy and utility and timeliness of the shared care model approach to cancer management with regard to the cancer coordinator position?<br>g) What is the efficacy and utility and timeliness of the shared care model approach to cancer management with regard to the patient care coordination?<br>h) What is the efficacy and utility and timeliness of the shared care model approach to cancer management with regard to the GP integration and support for each of the three service providers?<br>i) Does the uptake of the services vary dependent on general practice demographics (for example, location of general practice)?<br>j) What are the critical success factors and barriers to achieving the programs overall objectives? |
| 5. Program Value | a) Is the program cost effective and value for money? |
| 6. Program Sustainability and Scalability | a) Is the program sustainable and scalable?<br>b) Are there any suggestions and/or recommendations on the future program's direction and scalability? |

Source. Deloitte, developed in consultation with CESPHN

## 2.4 Evaluation Data Collection

The information for this evaluation was gathered via a mixed-methods approach, involving both qualitative and quantitative data collection processes. The qualitative data provided in-depth, contextual information while the quantitative data improved generalisability of the evaluation findings. The mixed-methods approach combined these strengths to provide a well-rounded understanding of both what happened and the factors that shaped those outcomes. This included:

- A developmental methodological approach to enable progressive learning to occur so that the service could adapt and work towards the achievement of the Program's overall objectives. This approach enabled structured feedback and insights to be provided regarding the Program's effectiveness, scalability, and sustainability as it is being implemented, to ultimately allow for iterative adaptions to be made.

- Principles of both participatory co-design and action learning, allowing provision of ongoing feedback, input, and guidance from all stakeholders, ensuring consistent collaboration throughout the evaluation. The participatory co-design approach ensured that the evaluation team remained in constant contact with program leaders and stakeholders, working through key milestones to ensure they can provide feedback, input, and guidance. This was the foundation of action learning which consists of ongoing cycles of evaluation and opportunities to gather insights about the program to inform decision-making in real-time.

### 2.4.1 Desktop and Document Review

A desktop and document review and analysis were conducted of all existing available documents and data, including the following data provided by CESPHN:

- Project plans for each of the project components
- Provider information (including contracts for review)
- Final agreed model and governance arrangements
- KPI reports, progress/summary/other relevant reports, and any other relevant provider data that each site collects and provides quarterly

### 2.4.2 Stakeholder Consultations

A key requirement of a participatory co-design evaluation approach was that all stakeholders have an opportunity to be actively involved in the evaluation. For most stakeholders, the evaluation activity that most easily supports this inclusive approach is stakeholder engagement and consultation through interviews and focus groups. Semi-structured protocols were used for interviews and focus groups with key stakeholders to gain a deep understanding of the enablers and barriers that contribute to the implementation of the program, whether the program is operating as intended, what is working well in what contexts, what outcomes are being achieved, who are the strategies working for, and any possible recommendations from stakeholders. The following are examples of key stakeholder groups who were consulted as part of the evaluation:

- GPs and Practice Nurses
- Nurse Care coordinators
- Patients who are using the program
- Specialists who have patients that are accessing the program
- Executive/Senior leadership and Heads of Departments who are endorsing the project
- Members of the GPCanShare Advisory Committee
- Cancer Specialists involved in care
- CESPHN project team (involved in coordination and implementation)

### 2.4.3 Patient and GP Experience Surveys

Patient-Reported Experience Measures (PREMs) were used to gather information on patients' views of their experience while they were receiving care. While not measuring quality of care directly, it provided an indication of the quality of patient care received by a patient. To decrease the burden on patients for this evaluation, in addition to offering a face-to-face consultation, the evaluation team also collected data through a survey that measured each patient's experience in the program. The questions were designed to help answer several evaluation questions and were disseminated by CNCs/care coordinators at each site. In recognition of the time limitations commonly experienced by GPs, a GP experience survey was also developed to be disseminated by CNCs/care coordinators. This experience survey was developed to better understand participating GPs thoughts and opinions on the Program as well as gather data that would help to answer the evaluation questions.

### 2.4.4 Action Learning Reflection

Research indicates that adopting a participatory and action learning approach to evaluation is important for enhancing the relevance and use of evaluation findings among key program stakeholders.[6] The approach involved ongoing cycles of four distinct steps: evaluation, making sense, planning, and action:[7]

- The evaluation stage included gathering data, information or insights about the program and the context in which it exists.
- The making sense stage involved sensemaking of the information gathered and engaging in collective learning and reflective processes about what this means for the Program and evaluation moving forward.
- The planning stage involved making decisions about the future implementation, delivery and evaluation of the Program and planning changes based on the new knowledge and insights gathered from the sensemaking process.
- Finally, the action stage involved implementing ideas and changes based on the collective sensemaking and planning stages.

This approach was an important way of getting timely feedback on what barriers or challenges were emerging, what changes were being made, and the learning from these challenges. It was also a useful mechanism for sharing learning across providers or sites, as often similar barriers were faced amongst them.

## 2.5 Data Analysis and Reporting

Each of the evaluation questions involved a review of a range of primary and secondary data sources. Table 2.2 below provides an overview of the key data sources that were used as part of this evaluation, which were analysed in accordance with the data strategy matrix.

Table 2.2 Main Primary and Secondary Data Sources Relevant to the Evaluation

| Data | Type | Source | Detail / Description | Collection Strategy | Number of Responses |
|---|---|---|---|---|---|
| GP CanShare Site Activity Data | Secondary Data | Individual Sites | Activity data about the patients engaged in the Program at each individual site (SVHN, SESLHD, SLHD). Data included patient demographics, current GP status, CNC contact with patient GPs, notes on treatment plan updates and ongoing communication with relevant stakeholders | Individual sites were provided with a template for required program activity data early in the evaluation, noting limitations with data collection and storage across sites. | N/A |
| Patient Reported Experience Measure (PREM) | Primary Data | Evaluation Survey | A relevant patient experience measure has been developed based on literature on appropriate domains. This was distributed by the evaluation team to site staff such as CNCs and Social Workers to then pass onto patients. | The PREM was disseminated by CNCs and social workers on the ground, at the point that was best suited to how the program was implemented in their location. PREMS were also translated into multiple languages, guided by program activity data about the most spoken languages, to try and support response rates.<br><br>Toward the end of the evaluation, CESPHN also provided incentives | 54 |

[6] Torres, R. T. & Preskill, H (2001). Evaluation and Organizational Learning: Past, Present, and Future. American Journal of Evaluation, 22(3)

[7] Action Evaluation Collaborative (2016). Participatory Action Learning. Available from https://actionevaluationcollaborative.exposure.co/participatory-action-learning (accessed 1 August 2025)

| Data | Type | Source | Detail / Description | Collection Strategy | Number of Responses |
|---|---|---|---|---|---|
| | | | | to sites to support their dissemination of the survey, and encourage response rates. | |
| GP Reported Experience Measure | | Evaluation Survey | A relevant GP experience measure was developed based on literature on appropriate domains. This was distributed by the evaluation team to site staff such as CNCs and Social Workers to then pass onto GPs through communications they have with them. Typically, GP engagement can be quite low in evaluations, so it was necessary to develop multiple methods of distribution or ways to help GPs engage as the evaluation progressed. | GP experience surveys were disseminated through a link to the survey on communications (where possible for different sites) as well as via direct contact from CNCs and social workers. | 40 |
| Specialist Reported Experience Measure | | Evaluation Survey | A relevant Specialist experience measure was developed based on literature on appropriate domains. This was distributed by the evaluation team to site staff such as CNCs and Social Workers to then pass onto Specialists who were involved in the Program. | The specialist reported experience survey was developed and disseminated in the last two years of the evaluation, due to feedback from sites about the level of specialist engagement. Dissemination was via CNCs and social workers who sent the survey link to known specialists who engaged with the program. | 24 |
| Action Learning Reflection Portal | | Evaluation Survey | Research indicates that adopting a participatory and action learning approach to evaluation is important for enhancing the relevance and use of evaluation findings among key program stakeholders. This survey was open to all stakeholders that have a role in implementing the program and as monitored regularly by the evaluation team and used for real time learning and to provide recommendations on program implementation as the evaluation progresses. This was to ensure the Program could improve over the course of the evaluation, rather than waiting until the end to provide recommendations for improved efficiency, as that would be counter intuitive to the Program's goals. | The action learning portal was shared with all CNCs, project team members (including CESPHN), and social workers who were involved in the delivery of the project. It could be accessed at any time, and some sites built the provision of feedback into their usual project governance and management meetings or tasks.<br><br>The action learning portal could also be used to capture ad hoc feedback that was provided directly to sites about the Program and its outcomes or impacts, as required. | 38 |
| Stakeholder Consultations | | Consultations | Consultations were conducted with CNCs and care coordinators, patients, GPs, evaluation advisory committee members, the Program advisory committee members, the Program management, and cancer Specialists across the evaluation to gain their insights and to help answer evaluation questions. Consultations were based on protocols that helped to fill gaps which activity and other data could not provide. | Consultations were held throughout the project including yearly meetings with sites to confirm their approach, outcomes, and any changes to the activities they were delivering. | 26 |

Source: Deloitte

#### 2.5.1 Qualitative and Qualitative Data Analysis

The qualitative data collected from consultations and open-ended response on surveys was analysed using thematic analysis. The analysis involved scanning data to identify patterns and themes, then developing a coding system for commonly appearing themes. Themes were then counted to discern whether a theme is common or infrequent. Afterwards a test sample from each stakeholder group was coded separately by different team members, then tested for inter-rater reliability. A narrative was extracted from the data that was checked against other data sources (if applicable) to address the project's key objectives. The evaluation team met regularly to discuss the data being collected, and undertake processes to enhance rigour and quality, including reflexive discussions to inform the synthesis and construction of themes. Routine descriptive methods were used to describe the data at the participants, the GPs and responses level, from the action learning portal.

#### 2.5.2 Triangulation of Data for Reporting

Regular reports, outlining the progress of the overall evaluation, any risks and risk management information, or any vital/critical findings to that date were provided to CESPHN. All quantitative and qualitative data gathered as part of the evaluation activities was triangulated to answer the evaluation questions. The process of triangulation also assisted with the formulation of overall conclusions and to cross-check the accuracy of data from any single source and to inform the contribution story relevant to each evaluation question. The triangulated data was used to determine the quality and outcomes of the service being delivered as well as the barriers and enablers that hinder or support the implementation and delivery of the program.

### 2.6 Limitations and considerations

The robust methodology of this evaluation has provided a comprehensive analysis of the Program. However, there certain limitations that must be acknowledged when interpreting the findings. One challenge faced by the evaluators was the lower-than anticipated response rates for GP and patient surveys. A detailed mitigation strategy, with a variety of options to increase survey uptake, was developed to address this issue. This included translating surveys into multiple languages to improve accessibility, providing more targeted communications to CNCs and GPs and recirculating consent forms to all sites. This encouraged some additional response rates, however the sample of responses remains small. Additionally, it must be noted that all % figures outlined in the key findings are approximations only which have been rounded down to the nearest whole number. Furthermore, qualitative feedback provided strong complementary evidence, helping to contextualise the quantitative results and strengthen the evaluation findings.

# 3 Evaluation Findings

The insights gathered from the surveys, data reports, and stakeholder consultations were thematically organised, reviewed and assessed against the evaluation questions. Based on the data available, it is likely that the Program was effective and demonstrated progress towards its key intended outcomes. Opportunities for further improvement to the shared care model were also identified, to make certain aspects more efficient, for longer term sustainable delivery of care.

This section provides an overview of the key findings gathered from the quantitative and qualitative analysis undertaken as part of the Program evaluation and presents these in a thematic manner based on the evaluation domains. While figures have been disaggregated by the relevant local health district/network, variations primarily reflected differences in response numbers across districts rather than meaningful differences in opinion. Data tables summarising the quantitative analysis are included in Appendix C.

## Program Design

Related Evaluation Questions

(1a) Is the service model developed for the program appropriate, sustainable, and effective for GPs and Practice Nurses?

(1b) Is the service model developed for the program appropriate, sustainable, and effective for people with cancer and cancer-related palliative needs and their family and carers?

In assessing the Program's design, the evaluation considered the appropriateness, sustainability and effectiveness of the service model (a shared care model) for healthcare practitioners and patients – people with cancer and cancer-related palliative needs, their families and/or their carers. The evaluation drew on evidence from a literature review and stakeholder consultations with Program users to address this question.

Overall, from both a patient and healthcare practitioner perspective, the Program was highly effective and appropriate as it benefited both groups and appropriately met their needs. The literature review supported this perspective, finding that shared care models targeted longitudinal, preventative, community based, and integrated approaches towards patient care, improving patient outcomes in a range of areas, especially in the provision of palliative care. Such models were also found to assist acute care providers, such as Specialists, with managing the increasing demand for their services[8].

The perspective of Program users, captured via surveys and semi-structured interviews is elaborated on below.

*GPs and Practice Nurses, and other healthcare practitioners*

The original design of the CESPHN program was to support primary healthcare connections with GPs and general practice staff including practice nurses. However, during early implementation and rollout, it was clear that other healthcare practitioners involved in multidisciplinary care of patients with cancer related needs also benefited or engaged with the program. The following section reflects on insights available to the evaluation about the extent to which the Program met the needs of these healthcare practitioners, noting local differences in model design and delivery that influenced patient and healthcare practitioner engagement.

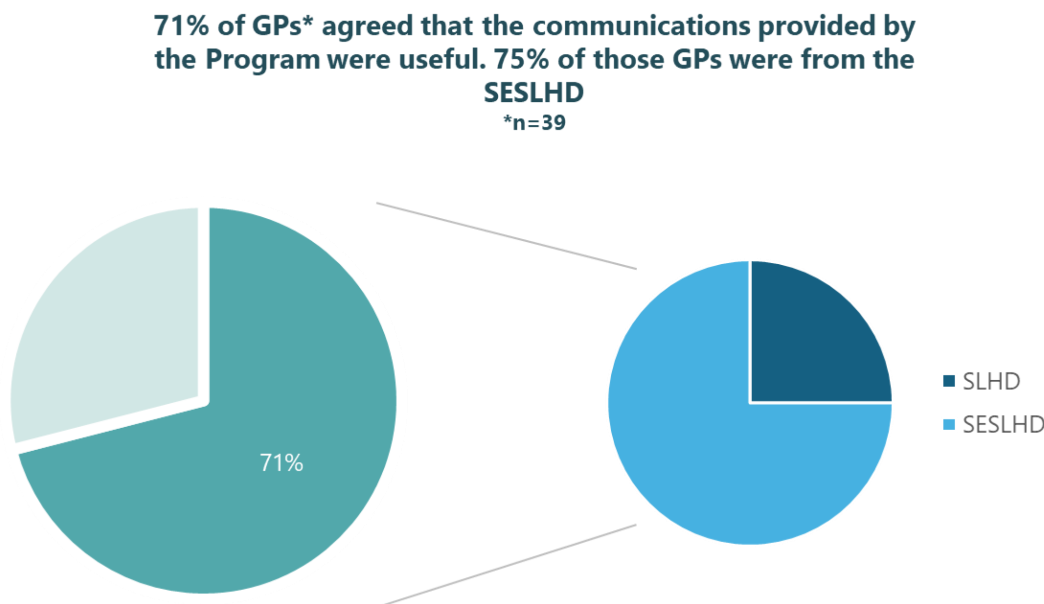
The shared care service model was designed to support GPs and practice nurses in managing patients with cancer and cancer related palliative care needs. Historically, healthcare professionals have experienced challenges when navigating the healthcare landscape for patients who are seeing different professionals for

[8] Quill, T. E., & Abernethy, A. P. (2013). Generalist plus Specialist palliative care creating a more sustainable model. New England Journal of Medicine, 368(13), 1173-1175

different reasons (e.g. a GP and a Specialist). Communication issues, particularly timeliness of information transfer and completeness of said information have often been cited as barriers to providing appropriate and effective patient care. However, feedback indicates that the Program helped alleviate this issue.

According to the GP Experience Survey, the majority of GPs agreed that the documents provided by the Program coordinator were provided in a timely manner, contained enough detail to inform patient care, were high quality and were useful overall (see Figure 3.1 below).

Figure 3.1 Overall effectiveness of communication




Source. Deloitte, General Practitioner Survey

Feedback also suggested that most GPs readily engaged with the Program, with the majority reporting that the Program was easy to access. Qualitative responses emphasised that direct email access to GPs facilitated a clearer understanding of patient care needs, strengthening collaboration. Furthermore, 82% of GPs (n=39) agreed or strongly agreed that they would recommend the service to other GPs or practice nurses. Those who responded to the Action Learning Portal Survey also provided qualitative feedback highlighting that the GP input was helpful to gather a better understanding of the patients' care situation, and the ability to receive emails directly from the GPs was seen as a positive.

However, a challenge identified within the Program were the processes in place for email monitoring, which were at times convoluted. This could be improved by setting up specific mailboxes, for specific activities to streamline how email communication is managed. Collectively these findings suggested that the service model was appropriate, effective, and sustainable for GPs and that there were opportunities for future development for communication channels. However, while there wasn't sufficient data collected to determine the extent of this effectively for practice nurses, they also provided positive feedback about the Program (see Case Study 1 below).

*'GP CanShare was helpful in all aspects of its work, allowing us to offload clinical load without concerns that patients will fall through the gap.'*

– Healthcare practitioner

### Case Study 1. GP CanShare Support with Patient Communication

A practice nurse working in cancer outreach found the Program invaluable at supporting vulnerable patients in communicating with healthcare professionals and navigating access. One legally blind patient, who was typically seen in her home, was having difficulty finding a GP. This resulted in her rationing her medication as she couldn't access a GP for a repeat prescription. The care coordinator provided support to connect the patient with a GP, enabling the patient to receive a prescription for her essential medication, and relieving the nurse of the responsibility to carry out this task in addition to their regular duties which was viewed positively.

*Patient experience*

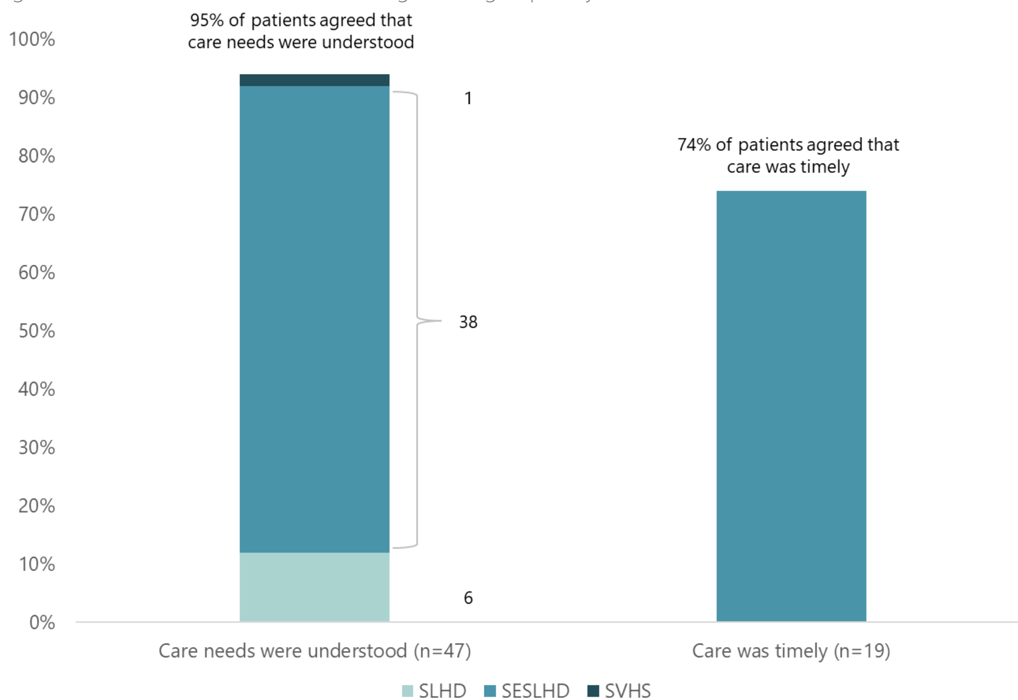
Patient data and feedback indicated that the Program was highly effective and appropriate for those that responded to the surveys. For example, 95% of patients agreed or strongly agreed that the Program coordinator understood their needs (n=47) and 94% agreed or strongly agreed that the Program coordinator was helpful (n=46). In particular, the emotional reassurance, accessible support and personalised care through the program were highly valued by patients.

*'The Program is a significant pillar of support for patients with cancer, and just as importantly, their families.'*

– Patient

Survey results indicated that patients also viewed the impact of the Program in a positive manner, with the majority of patients satisfied with their care experience while involved in the Program (see Figure 3.2). Patients particularly commented on the responsiveness of the care coordinators, finding them to be engaged and helpful. Other patients noted that the Program, via care coordinators, helped them be more involved in decisions about their care and consequently improved their relationship with, and trust in, their care team as they were more confident that their current condition was well understood. However, some challenges were noted by patients. Some patients noted that the communication between GPs and Specialists, for the area of blood tests, was limited, and could be improved to ensure both stakeholders are communicating more effectively to discuss the patient's delivery of care.

Figure 3.2. Patient satisfaction with the Program, as grouped by local health district/network.




Source. Deloitte, Patient Experience Survey

*'This is a great Program – it offers a support system for patients to bridge the gap between their GP and the hospital care plans.'*

– Patient

## Conclusion

Based on the data available from healthcare practitioners, patients and research indicated that the Program's service model was appropriate, sustainable and effective. There were no concerns about the model raised during implementation, however small changes for continuous quality improvement were made over time. There was limited uptake or activity delivered as part of the phone line and this was discontinued on 31 December 2022.

# Program Implementation

Related Evaluation Questions

(2) Is the program being implemented as intended? If not, why?

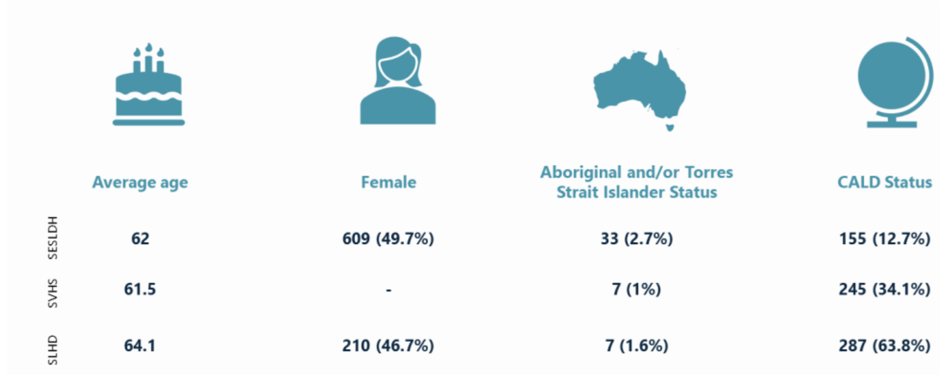
As part of the Program, the provider sites designed and implemented a shared model of care within their location that met the proposed service description by CESPHN. In assessing the Program's implementation, the evaluation considered whether the shared model of care was implemented as intended, and the underlying causes for any variation from the intended plan. A summary of the process and design of the model in each site is available in the provided Attachment A. The evaluation used research and stakeholder consultations to inform the answer to this question.

Analysis of stakeholder feedback indicated that the Program was implemented as intended – as both a shared model of care and a GP support line were delivered. Survey data suggested that the Program's purpose, including individual roles, was well understood by healthcare practitioners, and that the Program overall was well coordinated. This was especially noteworthy, as research indicates that careful management of integrated care systems is required, as poor coordination amongst health professionals has been shown to be associated with poorer patient outcomes[9]. As the design and implementation of the shared care model encouraged increased integration and communication between Specialists and general practice, the model acted as a mechanism for enhancing cancer patient experience and outcomes.

*Patient overview and service delivery*

During the Program, a total of 4,226 cancer patients were enrolled across SESLHD, SVHS and SLHD, consistent with the intended target population. Figure 3.3 below provides an overview of the key demographics divided by their local health district/network.

Figure 3.3 Patient overview




Source. Deloitte, based on program activity data provided by sites. Note: some data points are not available across all sites, and only the available data has been reported here. Demographic data for SLHD was only available for a sample of 450 of the 2,282 patients enrolled. All demographic findings for SLHD are therefore based solely on the available data.

Each site also reported regularly to CESPHN on key indicators of performance, aligned with the goals of the program, as outlined in the table below.

Table 3.1 Summary of key performance Indicators by provider.

| Performance Indicator | SESLHD | SVHS | SLHD |
|---|---|---|---|
| No. of patients enrolled in endorsed GPCanShare shared care model | 1225 | 718 | 2282 |
| No. of occasions of service (relating to patient) | 6408 | 1557 | 6912 |

[9] NSW Ministry of Health. End of Life and Palliative Care Framework 2019-2024. (2019.) NSW Ministry of Health.

| Performance Indicator | SESLHD | SVHS | SLHD |
|---|---|---|---|
| No. of GPs/Practice Nurses contacted for GPCanShare promotion | 785 | 1102 | 419 |
| No. of GPs/Practice Nurses educated on GPCanShare program with CNC practice visit or phone call | 605 | 181 | 180 |
| No. of CPD events held on cancer management | 6 [10] | 3 | 3 |
| No. of CPD events held on cancer related palliative care | 1 | 1 | 2 |
| Proportion of patients in GPCanShare referred to hospital and/or community services (acute, community care services, other palliative care services) with General Practice notified of this referral | 100% | 100% | 100% |
| Proportion of suitable palliative GPCanShare patients that are escalated or referred to clinically indicated pathways or services including palliative care*** | 100% | 100% | 100% |

Source: Program activity reporting by Providers as of July 2025.

Most of the performance indicators either met the goals set in the contracting arrangements, or were on track to deliver to set goals before the conclusion of services across each provider.

*Program implementation*

Data collected from stakeholder surveys indicated that the Program delivered the shared model of care and GP support line in accordance with the initial intent of the Program as:

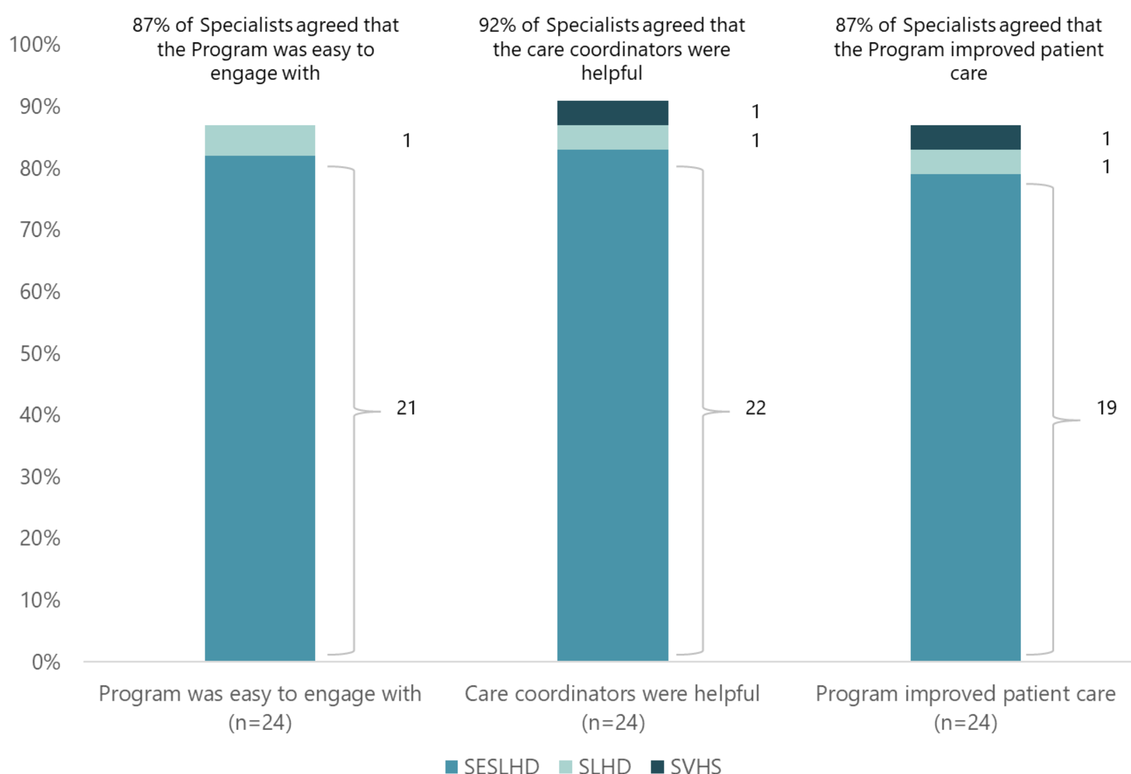
- The Program was identified as easy to engage with, and healthcare practitioners understood their role in the shared care model.
- The care plan documents were provided in a timely manner, and contained enough detail to inform patient care, were of high quality, and were useful.
- The Program overall helped healthcare practitioners provide better support to their patients, and helped increase the coordination of care between Specialists and relevant GP teams (See Case Study 2 and Figure 3.4 below, which provides additional quantitative detail).

Case Study 2. Improved Coordination through the Program

A Program nurse provided essential coordination between a patient's care team. After being seen by a Specialist, the patient's GP received a same-day update outlining the consult with the patient and the plan moving forward. This was extremely beneficial as the patient had minimal external support and relied heavily on their GP. The nurse provided updates and the discharge summary following the patient's surgery as necessary. They also arranged follow-up appointments for the patient with the Specialist, while ensuring that the GP was kept updated. The patient, GP and Specialist found the support highly invaluable.

[10] *Note: Difficulties in monitoring CPD events have arisen from the lack of handover by prior CNCs in the role*

Figure 3.4 Program implementation insights from Specialists, as grouped by local health district/network.




Source. Deloitte, Specialist Survey

Those who responded to the Specialist and Patient Experience Surveys also provided qualitative feedback highlighting they were satisfied with the Program implementation and hoped the Program would continue. However, there were aspects of the implementation which were mentioned that could be improved, such as the consistency in the way in which coordinators were used, as some Specialists noted that they felt not all GPs and patients seemed to utilise the coordinators effectively with some re-booking clinic appointments unnecessarily. Collectively, the data available to the evaluation suggested that overall, the program was implemented as intended.

### Conclusion

There was good evidence that the Program was implemented as intended, with some challenges that were identified and addressed by CESPHN and sites. Very early in the Program, there were significant impacts from COVID-19 related restrictions and workforce redistributions that impacted on initial design phases and program delivery, however these were actively managed by all stakeholders. Staff turnover was also observed in multiple sites and sometimes created challenges in terms of the handover and continued delivery of work, especially given well accepted workforce shortages and competition for relevant processions which meant roles could be challenging to fill at times.

# Program Effectiveness

Related Evaluation Questions

(3a) What is the effectiveness of the program to improve the healthcare experience for people with cancer and cancer-related palliative needs and their family/carers?

(3b) What is the effectiveness of the program to enhance the capability of GPs to effectively manage care for their patients with cancer and cancer related palliative needs?

(3c) What is the acceptability & usability of the shared care model according to GPs and practice nurses?

(3d) What are the access and equity enablers, or barriers, that may impact on care coordination and GP access to services?

The effectiveness of the Program was measured by assessing the extent to which the Program demonstrated evidence towards the achievement of the intended outcomes. Specifically, the following outcomes were considered using a mixture of both quantitative and qualitative data points:

- The extent to which the Program improved the healthcare experience for people with cancer and cancer-related palliative needs and their family and/or carers.
- The extent to which the Program enhanced the capability of GPs to effectively manage care for their patients with cancer and cancer related palliative needs.
- The acceptability & usability of the shared care model according to GPs and practice nurses.
- Access and equity enablers, or barriers, that impacted on care coordination and GP access to services.

Based on the available data there is some evidence to suggest that the Program was effective, with strong reflections from the limited number of patients who completed experience surveys on their healthcare experience, good feedback from some GP's about the support for their cancer related knowledge and capabilities and having minimal concerns raised in terms of access and equity.

*The healthcare experience*

For the small number of patients who completed surveys, they reported that the Program positively influenced their healthcare experiences. According to the Patient Experience Survey, 80% of patients agreed or strongly agreed that they felt that their GP was better informed about their care over the last three years (i.e., since the commencement of the Program) (n=5), and 89% agreed or strongly agreed that the Program care team was able to communicate effectively about their needs (n=19). Overall satisfaction was very high – 89% of patients agreed or strongly agreed that they were satisfied with the care experience in the Program, and 89% would recommend the Program to other patients (n=19).

*'This is a great Program – it really makes it easier to stay compliant'*

– Patient

Patients also provided feedback indicating that the Program was particularly helpful with communication and support during an otherwise stressful and upsetting time. The data available to the evaluation suggested that the Program was effective in improving the healthcare experience for people with cancer and cancer-related palliative needs and their family/carers. However, small sample sizes for response rates from patients (as indicated by the provided n for each question) made it difficult to draw strong conclusions about the Program as a whole, based on the data available.

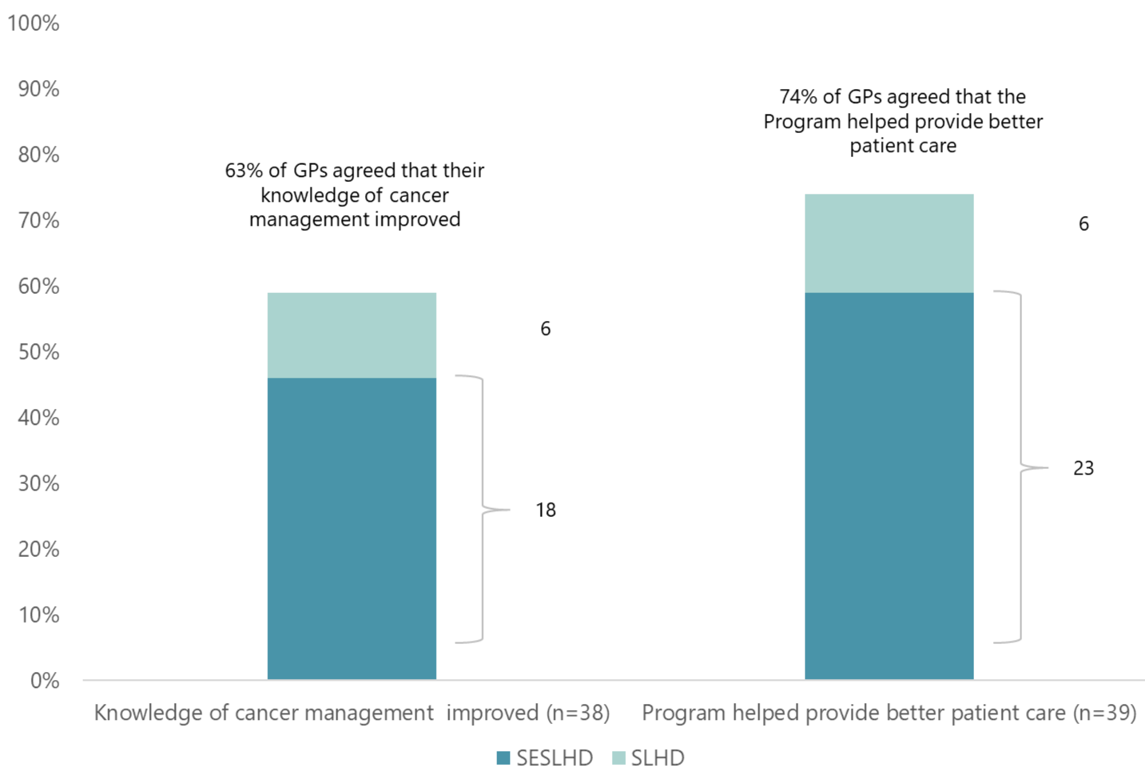
*'My coordinator was always extremely helpful and proactive in my care'*

– Patient

*Clinical capabilities*

The majority of GP's who provided feedback through surveys indicated that the Program strengthened their clinical knowledge and capabilities, by improving their knowledge of best practice cancer management. Accordingly, these GPs said that the Program aided them in providing better support to their patients (see Figure 3.5 below). Coordination between GPs and relevant multidisciplinary teams also improved, as 71% of GPs agreed or strongly agreed that the Program helped increase coordination of care for their patients (n=38). Collectively, these findings provide some evidence that the Program enhanced the ability of GPs to manage care for patients effectively.

Figure 3.5 Program impact on GP clinical capabilities, as grouped by local health network/district.




Source. Deloitte, GP Survey

*'GPs feel comfortable contacting the Program team to help navigate the service and to ask for advice regarding the cancer care of their patient'*

– Healthcare practitioner

*The shared care model*

The shared care model appeared to be widely accepted and considered usable. According to the GP Experience Survey, most GPs agreed that the Program was overall useful (n=39). Healthcare practitioners agreed that care coordinators were especially useful for facilitating communication and collaboration across different disciplines by acting as a central point of organisation so that the delivery of care was cohesive.

*'The Program was particularly helpful when patients had different specialties and had a variety of different follow up instructions from different doctors.'*

– Healthcare practitioner

Stakeholders who responded to the Specialist Experience Survey also provided qualitative feedback that the input from the GPs was helpful to better understand the patients' care situation.

Taken together, the data available to the evaluation suggested that the Program was acceptable and usable by the GPs (there was not sufficient data collected to determine the extent of this for practice nurses), however there was an opportunity to improve the data collection approach that was used to gather patient information to provide a more holistic view of the patients' care situation.

*Access and equity*

Access and coordination were generally reported as positive for those that provided feedback. According to the Patient Experience Survey, 84% of patients agreed or strongly agreed that it was easy for them to access their GP (n=19). In addition, the majority of GPs agreed or strongly agreed that the Program helped increase coordination of care for their patients between them and relevant multidisciplinary teams. However, some healthcare professionals noted that across the wider CESPHN, a key barrier was the disconnect between different healthcare sites. While care coordinators assisted with facilitating communication, healthcare professionals noted that some ambiguity over roles and responsibilities remained.

Differences across sites in the availability of the Program and how it was operationalised and delivered made it challenging for GPs and other healthcare practitioners to understand exactly what was being provided, and what the roles of the care coordinators were. Collectively, the data suggested that although the Program's coordination was positive, there were opportunities for further enhancement, particularly in relation to the frameworks in place to make communications more streamlined and efficient for all stakeholders involved.

It was also identified during the implementation of the Program that there were some patients who might access acute services within the CESPHN region, but have a GP who was outside of the region. Discussion with CNCs and sites led to a change in the programs design which allowed for these programs to access the Program as part of supporting the equity of access for these patients, especially when considering that they likely would travel further and face more costs to access acute care (and therefore would likely benefit most from this sort of Program).

### Conclusion

The program demonstrated good progress towards achievement of intended outcomes (based on the evidence available) by:

- Improving the healthcare experience for people with cancer and cancer-related palliative needs and their family/carers.
- Enhancing the capability of GPs to effectively manage care for their patients with cancer and cancer related palliative needs.
- Having an acceptable and usable shared care models.
- Having accessible services.

Again, these conclusions are based on the experience and outcome data available, which is limited by the low response rates to all survey tools. The generalisability of findings to all patients, GPs, and specialists who participated in the Program is difficult to appropriately assess. When combined with the good evidence internationally about shared care models (see Attachment A) it is likely that the Program provided value to GPs, patients, specialists and the health system. Reflections on program outcomes (including other anticipated and unanticipated outcomes reported by Providers) is also covered in the following chapter.

# Program Outcomes

**Related Evaluation Questions**

(4a) Are the expected outcomes of the program being met (improved awareness and knowledge)?

(4b) Are the expected outcomes of the program being met (improved coordination of care)?

(4c) Are the expected outcomes of the program being met (improved access to care)?

(4d) Are the expected outcomes of the program being met (improved quality of care)?

(4e) Are the expected outcomes of the program being met (improved appropriateness of care)?

(4f) What is the efficacy and utility and timeliness of the shared care model approach to cancer management with regard to the cancer coordinator position?

(4g) What is the efficacy and utility and timeliness of the shared care model approach to cancer management with regard to the patient care coordination?

(4h) What is the efficacy and utility and timeliness of the shared care model approach to cancer management with regard to the GP integration and support for each of the three service providers?

(4i) Does the uptake of the services vary dependent on general practice demographics (for example, location of general practice)?

(4j) What are the critical success factors and barriers to achieving the programs overall objectives?

In assessing the Program's outcomes, the evaluation considered whether the expected outcomes (improved awareness and knowledge, coordination of care and the access, quality and appropriateness of care) were being met. It also considered the efficacy, utility and timeliness of the shared care model approach to cancer management. Finally, the evaluation considered whether the uptake of services varied depending on general practice demographics (e.g., location), and any critical success factors and barriers to achieving the Programs overall objectives. To determine this, the Program was monitored on a regular basis to measure whether it was achieving its intended outcomes.

Overall, data available suggests that the Program improved integration and coordination between cancer and palliative care Specialists, GPs, and community services, leading to better knowledge, awareness, and quality of care for cancer patients. GPs and Specialists both reported enhanced collaboration and communication, with patients experiencing easier access, timely care, and high satisfaction. The coordinator role was particularly valued for its impact on responsiveness and patient support. However, some challenges included language barriers, timely promotion, patient and GP understanding of the program, and communication frameworks. To maximise outcomes, future efforts could focus on streamlining communications, improving patient and GP awareness earlier, and addressing access barriers for diverse communities. These points are explored in further detail below.

*Integration and collaboration*

The overarching objective of the Program was to strengthen the integration between cancer and palliative care Specialists, community services, and general practices, while enhancing the capabilities of general practices to manage and care for their cancer patients more effectively. As discussed previously, coordination of care outcomes was largely achieved based on available survey data: 71% of GPs agreed or strongly agreed that the Program helped increase coordination of care for their patients between them and relevant Specialist teams (n=38). Similarly, 83% of Specialists agreed or strongly agreed that the Program service helped increase coordination of care for their patients between them and relevant GP teams (n=24). Specialist Experience Survey respondents shared qualitative feedback that collaboration was easy and that the team was engaging, especially the Day Centre, where being able to refer patients for simple injection

services to their GPs had a significant impact. The Action Learning Reflection Portal Survey further highlighted the success of direct communication with GPs via email, and the helpfulness of GP input for gathering patient context.

However, barriers such as the need to streamline communication channels (e.g. distinguishing between general and specific mailboxes) and limited promotional activities were noted, with earlier promotion identified as beneficial for patient awareness. The differences in how the model was implemented across sites also meant that there was variation in terms of the degree to which patients, GPs, and specialists were aware that they were involved in the Program, and some stakeholders reflected that patients might expect that this sort of coordination is already part of the health system. CNCs in consultations said that often patients expected that this sort of coordination was already part of the health system and might not have understood how this differed from usual care, which also likely contributed to the very low survey response rates.

The availability of interoperable secure messaging systems was also seen as a critical enabler of informational continuity of care and the timely and safe provision of relevant records, documentation and clinical notes between healthcare providers.[11] One of the unanticipated positive outcomes of this Program was the uplift of some sites information systems and processes that were required to deliver the work and investment in health pathways relevant to this stream.

*Awareness and knowledge*

Awareness of the Program among both patients and general practice played a crucial role in its overall effectiveness. While 63% of GPs reported improved knowledge of cancer management best practices, indicating positive professional awareness among those engaged, qualitative feedback also revealed that some GPs were not aware of the Program at all, limiting its potential reach and impact (n=39). While the Program improved awareness among those involved, the evaluation found it was not possible to determine whether uptake varied depending on general practice demographics such as location, due to insufficient data.

CNCs across sites consistently raised with the evaluation and CESPHN the challenges in engaging with general practices, especially given the demand on the primary healthcare sector in this region. Significant efforts were made by CNCs to support the engagement with local general practices including site visits, meetings, and the dissemination of promotional material. It is difficult to understand whether the challenges with uptake were due to demand (i.e., those GPs did not have patients with cancer related needs), availability (i.e., the time that GPs have available to engage with the Program), or lack of awareness.

Patient awareness of the Program was complex and impacted by the differences in local site implementation of the model. Some patients might not have been aware that they were involved in the program, as the activities instead supported back-end processes that streamlined the dissemination of communications to GPs, or focused instead on GP engagement and education. A few respondents highlighted that limited and delayed promotional activities meant some patients and clinicians missed out on early engagement with the Program. One healthcare practitioner also noted that since they had patients across multiple sites, the lack of consistency in the model of care delivered made it difficult for them to understand what was being delivered, and what support were available to them and patients across different providers.

The data available to the evaluation suggests that although the Program helped improve access to care for patients, the extent to which it did, could have been further enhanced by reducing differences in delivery across sites, and continued engagement with GPs over time. The engagement of GPs is complex, and could be further investigated to understand what the barriers are that limited engagement in the program for them.

---

[11] The Royal Australian College of General Practitioners. (2025, April). *Using email in general practice.* https://www.racgp.org.au/running-a-practice/technology/business-technology/using-email-in-general-practice

*Quality and appropriateness of care via the shared care model*

The shared care model was found to have delivered a meaningful improvement in both quality and appropriateness of care as indicated by survey data and participant feedback. As discussed previously, both Patients and GPs reported support and satisfaction, evidenced by 73% of GPs who stated the Program helped them support their patients (n=39) and 89% of patients who expressed satisfaction with their care experience (n=19). These positive quantitative findings were given further weight by qualitative feedback from both groups, which pointed to the ease of communication between GPs and the Program team as a crucial enabler of timely and effective care. However, while these communication channels were seen as strengths, some participants noted that limited time for promotional activities restricted the Program's reach, indicating that not all patients who could benefit were aware of the support available.

Central to the Program's success was the cancer coordinator role, which bridged gaps between patients, GPs, and Specialist services. Both GPs and patients agreed that the coordinator was helpful, citing their assistance and responsiveness, which contributed to care that felt timely and tailored to individual needs. This integration was particularly valued in facilitating smooth patient transitions and addressing issues quickly, making the coordinator a core component in the shared care model. The connection between primary and Specialist care was another area of strength, as Specialists themselves reported benefits from the Program, including better coordination with GPs, and improved support to patients.

At the same time, feedback revealed areas for improvement that, if addressed, could further strengthen the care model. Direct communication between GPs and other stakeholders, such as via email, valued for its efficiency, but there was a consensus that communication frameworks could be streamlined, particularly by clarifying the approaches to information sharing, and using interoperable and acceptable secure messaging software that is fit for purpose where possible. In addition, several respondents highlighted the need to initiate promotional activities earlier, believing this would ensure more patients are aware of, and able to benefit from, the Program at critical points in their care journey.

*Other outcomes*

In the final June 2025 reports by providers, they were also able to indicate additional outcomes achieved related to the implementation of the Program in their location. These are summarised per site in the tables below.

Table 3.2 Summary of additional program outcomes - SLHD

| Program Outcomes | Achievements |
| --- | --- |
| No. GPs involved with GPCanShare[12] | 1483 GPs |
| HealthLink used to deliver correspondence to GPs | Over 3877 Health Link transmissions between staff and GPs (not including fax, virtual fax, mail and email) |
| The team undertook a number of presentations to both internal and external services and teams to promote the service and network. | Presentation (oral and poster) Opportunities at Conferences, and Symposiums:<br>• 2023 Healthcare Redesign Symposium at University of Tasmania: Oral Presentation on GPCanShare: An Integrated Model of Care for Colorectal Patients in Sydney Local Health District.<br>• 2023 Oceanic Palliative Care Conference: Keynote speaker on 'Keeping on speaking terms: building autonomy of allied health communication with primary care'<br>• 2023 Cancer Institute NSW Cancer Innovation Conference: Poster presentation on 'Integrated Model of Care for Prostate Cancer Patients in Sydney Local Health District.<br>• SLHD Clinical Council Presentation: GPCanShare Integrated care service<br>• 2021 CINSW Primary Cancer Health Advisory Committee Presentation |

[12] Note: the GP involvement from the Social Worker in this site are not included in these numbers. The Social Worker role was only filled for part of the project delivery.

| Program Outcomes | Achievements |
|---|---|
| | • 2023 The GPCanShare Social Worker in their PanKind presentation explored coping strategies in context of Pancreatic Cancer diagnosis. |

Source: Program activity reporting by Providers as of July 2025.

Table 3.3 Summary of additional program outcomes - SESLHD

| Program Outcomes | Achievements |
|---|---|
| No. of patients assisted with patients finding new GPs | 63 |
| No. of patient enrolled for the delivery of injectables by general practitioner | 131 |
| Total number of patients declining GPCanShare program [13] | 51 |
| Total number of outgoing referrals from CNCs (including calls/emails from GPs not related to cancer, external referrals to other patient support services)[14] | 283 |
| No. Referral back to relevant MDT (SESLHD southern Sector)[15] | 71 |

Source: Program activity reporting by Providers as of July 2025.

Table 3.4 Summary of additional program outcomes - SVHS

| Program Outcomes | Achievements |
|---|---|
| Number of individual GPs with patients enrolled to GPCanShare shared care model | 426 |
| Number of general practices with patients enrolled to GPCanShare shared care model | 206 |
| Communication from GPs and practice nurses to GPCanShare (email and phone) | 145 |

Source: Program activity reporting by Providers as of July 2025.

These provider specific additional outcomes of the Program demonstrate the differences in how the models were implemented across the sites, as well as describe the other impacts of the programs to GPs, patients, and the health system. The flexibility of the Program allowed for regional focuses on activities related to identified areas of need in those locations (i.e., delivery of injectables by general practitioners for patients with cancer related care) so that sites could make sure the delivery of the model suited their locations.

*Enablers and barriers*

Providers and Program delivery staff throughout the evaluation have raised several enablers and barriers that either supported or got in the way of the delivery of the Programs in different locations. These are outlined in Table 3.5 and Table 3.6 below based on consultations, as well as information reported by providers in Final Reports.

---

[13] There were challenges for this provider in tracking all patients who have formally declined the GPCanShare program throughout clinical notes

[14] There were difficulties for this provider in monitoring all patients especially changes with tracking data

[15] There were difficulties in tracking all patients referred to relevant MDTs

Table 3.5 Program enablers

| Enabler | Description |
|---|---|
| Dedicated staff | • A strong commitment by staff to support the design and implementation of the model. Within providers, there appeared to be good working relationships, collaboration and collegiality to support the program.<br>• SVHS CNCs were contactable via phone and email from the outset of the project. SVHS established a dedicated, shared inbox which promoted transparency within the team, supported teamwork, and provided a one-stop shop for other healthcare practitioners to contact the service. Several GPs supplied feedback directly to CNCs in this site about their responsiveness throughout the program. |
| Systems | • The presence of secure messaging systems and processes within sites, or that was implemented as part of the Program as well as continued work to support the utilisation of digital health.<br>• Embedding care plan templates within electronic medical systems (eMR) enabled real time care plan generation for GPs in the SESLHD northern sector. |
| Advocacy and support for the program | • The presence of champions within local areas who could support the implementation and delivery of the program at both at a strategic or operational levels within sites, CESPHN, and in local general practices.<br>• Strong engagement with consultants and specialists was noted by some sites as a key part of the program, which highlighted that this was also a referral mechanism for patients into the program (and prompted the addition of the Specialist Survey by the evaluation as this important connection emerged).<br>• Advocacy and support for the program from key stakeholders including from the HealthPathways team, the Primary Health Care Advisory Group, steering committees, working groups, and through the participation in Canterbury GP evenings, was reported by SLHD. Advocacy and support from all of the working groups, sites, providers and CESPHN was also consistently raised as an enabler of the Program across locations.<br>• Trust and credibility of CNCs that was built over time through consistent effort and engagement with primary health care and within sites.<br>• Administrative and IT support for SESLHD (especially in one site), including MOSAIQ integration with the eMR. |
| Partnerships and collaboration | • SESLHD developed partnerships with services such as Cancer Outreach, Medical Specialists, Nurse Practitioners, Nurse Specialists, and the Haematology and Oncology Outpatient Service.<br>• Early collaboration with key stakeholders by SESLHD to promote and expand the program, to promote adoption and support the development of site-specific models of care.<br>• Positive working relationships with CESPHN, Aged Care GPs, Nurse Specialists, and Specialists, supported by education sessions and ongoing GP engagement.<br>• Collaboration with SLHD Translation Services translate care plans into patients' preferred languages.<br>• Cooperative approaches between SLHD and SESLHD to assist GPs in navigating the public health system, improving information sharing across two NSW health districts.<br>• Collaboration with SESLHD and the University of New South Wales on related research projects helped explore clinical service improvement and better patient outcomes.<br>• Establishing relationships with general practices (including practice managers, nurses, and GPs) in the CESPHN region from the outset, with continued engagement over time. Practice visits and engagement activities supported the uptake of the Program as well as the implementation of HealthLink in some specific sites. |
| Change management | • One provider noted that investment in formal change processes and support from the Agency for Clinical Innovation (ACI) from their clinical redesign team helped staff to assess and manage barriers and implementation challenges as they arose. For example, electronic correspondence (i.e., HealthLink, Health Pathways, virtual fax) and ongoing promotion of these to internal SLHD stakeholders was identified in the ACI Clinical Redesign program. |
| Governance and leadership | • Strong internal governance and leadership support by providers supported effective rollout.<br>• The GPCanShare Clinical Governance Committee helped to steer the program through strong leadership and guidance throughout the Programs design and implementation.<br>• SLHD ceased a governance framework through the working group and steering committee. Other providers also developed local working groups and/or steering committees that supported the programs implementation and local uptake. This also supported the embedment of some processes and changes funded by the Program into local sites that were maintained post the completion of the funding. |

| Enabler | Description |
|---|---|
| Receptiveness to feedback | • CESPHN was receptive to feedback about the program design and there are some key examples of changes to the program based on feedback. This included updating referral criteria to accommodate all patients receiving care from general practice sites outside of the CESPHN area, providing extra support for patients from rural and remote areas, and supporting the translation of evaluation tools into multiple languages.<br>• Additionally, CESPHN continuously discussed the number of patient enrolments with sites, and measured occasions of service (versus just number of patients enrolled) recognising feedback about what was required to deliver integrated services across acute and primary health settings. |
| Model flexibility | • A flexible, CNC led coordination model at SESLHD supported tailoring of the model across sites including the delivery of services that were distinct and aligned with established support systems. Other sites adopted different approaches, based on what best suited their local areas and complemented existing models in their locations. |
| Evidence-informed approaches | • Evidence based research and early consultation processes within the CESPHN area helped to develop the program in line with the vision and strategic goals of the Program.<br>• Some sites undertook additional evidence-informed processes (i.e., ACI Clinical Redesign) to design elements of the Program implemented in their local areas that informed strong design elements which was positively regarded by CNCs and senior stakeholders in those areas. |

Table 3.5 Program barriers

| Barrier | Description |
|---|---|
| System and communication challenges | • Across sites, issues with having access to the right IT systems (including secure messaging software/platforms) that were well integrated into existing systems and local health records was an ongoing issue for the program. Over the program's delivery, it was becoming more challenging to effectively share information given restrictions from NSW Health about how patient information can be sent and shared. The interoperability of eMR systems across sites as well as local general practices and the functionality of systems also varied.<br>• Secure messaging and IT systems were a facility/LHD wide issue and in most locations, it was beyond the scope of the GP CanShare teams to get these sorts of systems rapidly or at all which required additional time and commitment from sites.<br>• Many local practice administration staff were unaware of HealthLink or unclear on how to use secure messaging platforms and receipt of communications by GPs (i.e., whether they were received, and whether they were used) was seen to be a barrier to their usefulness. Understanding GP use and receipt of communications and documentation was difficult, especially given limited response to surveys.<br>• Considerable time and effort to coordinate and prepare patient information, depending on the model implemented by different sites. |
| Initial lack of clarity | • In early implementation, among most sites there was a lack of clarity about how the model of care was going to be shaped in practice. There seemed to often be a sense of uncertainty about which group (e.g., CESPHN, provider, evaluation team etc.) had ownership and authority of what the model looked like. This limited understanding about the scope of control, decision-making power and approval processes required for what work, when, and by whom. Because of this, the design and delivery of the model for each provider took time and engagement with CESPHN and other sites early on. |
| Internal stakeholder engagement | • Some stakeholders reported that the level of internal engagement required across different sites/services, levels and departments to support program delivery (i.e., across ITS [Information Technology Support] groups, leadership groups, ethics groups, etc.) was more burdensome than expected. Within providers, there were often complex organisational complexities which required extensive collaboration.<br>• Difficulties in engaging the required scope of stakeholders was further complicated by the fact that most stakeholders were often time poor (i.e., GPs, practice managers, practice nurses, specialists and other site-based stakeholders), and it was not a requirement of their role to engage in the program.<br>• Some noted that cancer care can be siloed both across facilities as well as across tumour streams which meant implementation required additional effort for rollouts in each facility, site, tumour stream, and location.<br>• For some sites there were complex (or in a few instances limited or no) communication channels across |

| Barrier | Description |
|---|---|
| | facilities and streams for the program to support dissemination of information and to promote program buy-in. |
| Engagement with GPs and practices | • Challenges with engaging local GPs made it hard to ensure the design of the model by each provider was aligned to their needs and perspectives, and to measure Program impact. There was uncertainty at times about how to best engage GPs to promote the Program. This was influenced by instances of limited existing relationships with practices to leverage for Program implementation.<br>• Some patients reported to CNCs that they did not have the confidence to follow-up with GPs and could be at times hesitant to engage in the program due to having a more established relationship with their specialist as opposed to their GP. Some patients also did not have a regular GP and a few sites invested time into building those connections for patient where relevant.<br>• GP contact details were often outdated, and it took a considerable amount of time for local sites to ensure there were correct details prior to forwarding correspondence to GPs. Local changes in general practices and turnover meant that this required continued effort throughout the delivery of the Program.<br>• Some GPs declined to participate in the program due to the complexity of cancer patients and existing high workloads (which was further exacerbated early on due to the COVID-19 pandemic). |
| Buy-in | • In some cases, buy-in from other groups was observed, as for example, surgeons who might be involved in cancer care may not see how GPs could be involved with patient care.<br>• Local GP engagement was a critical factor, and was reported consistently as a challenge by CNCs, despite significant efforts to engage with GPs. Some of the reasons for these challenges included the existing pressures on general practice and lack of times for GPs to engage with the program. |
| Existing cancer care | • Many tumour streams already have established workflows and processes across facilities that might not always be known by staff involved in the program. This influenced the extent that the model could be implemented in existing workflows, to support buy-in for the program, and understanding of when to introduce the program to patients. |
| Promotion | • From both CESPHN and in internal provider teams, there was limited understanding about what information was required to be shared, including the channels to do so. This was perpetuated by confusion about accountability for promotion activities, and limited collaboration across implementation teams influenced by 'red tape' within local areas due to working across multiple providers, sites and practices which all have their own requirements and rules. |
| Model design | • The model design at times made it difficult to engage rural and remote patients who accessed sites through outreach services (especially when there were specific specialised services in some locations). The requirements for the service by CESPHN (e.g., location based inclusion/exclusion criteria) was raised, discussed and adapted to support these patients.<br>• Engagement with practice nurses, who often play a critical role in chronic disease management, was seen as a missed opportunity by some sites, noting that other sites incorporated this into their models.<br>• Variations in how the program was implemented across providers and sites, and variations in KPIs across sites made it challenging to evaluate impact and replicate successful strategies including supporting whole-of-service collaboration across teams.<br>• The early termination of the GPCS Support Line was reported to create confusion and uncertainty locally and across the SVHS network, which may have led to some GPs and other healthcare providers disengaging with the Program. Reportedly some GPs and healthcare providers gave feedback that the discontinuation meant they assumed other aspects of the program had (or would be) discontinued. |
| Conflicting cultures | • Differences across providers, sites and primary care/hospital settings including different priorities, terminology, approval processes, and ways of working. This made it challenging for collaboration and decision-making including co-branding of promotional materials. |
| Staffing limitations | • Recruitment and retention of staff was noted as a challenge (particularly during COVID-19). Small teams with staffing gaps had high workloads and periods of reduced capacity.<br>• The presence of only one allied health role at SLHD sites limited opportunities for handover, multidisciplinary collaboration and comparative evaluation. This was also challenging in periods of extended leave. |
| KPIs and volume pressures | • The patient enrolment targets were reported by some providers to be high, and one indicated that this might risk the prioritisation of volume over personalised care. This was reported to have resulted in |

| Barrier | Description |
|---|---|
| | single-touch interventions, which limited opportunities for integrated care and follow-up. Additionally, the mismatch between enrolment numbers and actual occasions of service potentially contributed to challenging caseloads. |
| Evaluation challenges and changes to program intent | • The original goals of the program shifted over time, particularly due to healthcare delivery challenges following the COVID-19 pandemic. One site reported that the needs for the program may have shifted post COVID-19 restraints were removed.<br>• It was challenging to evaluate the impact of the program on patient outcomes due to a lack of linked outcome data, access to patient information, and evaluation tool uptake. |
| Medical specialist reluctance | • Medical specialists raised some concerns within one provider location about the comprehensiveness of GPs assessments, specifically in identifying cancer recurrence and providing specialised education and practice in oncology. These concerns were compounded by high recurrence rates for specific cancer types, which impacted program rollout and meant some cancer streams were not suitable for the Program. |
| Out-of-pocket costs | • Most GP practices in SESLHD charged out of pocket fees, creating a financial barrier for some patients to engage in the Program. |
| Discontinuation of funding | • Given the funding window for the program, this influenced the ability to recruit and engage primary care staff and practice nurses who reported having negative experiences in the delivery of other programs within limited funding windows (i.e., when programs were not maintained). |

These enablers and barriers provide examples of the extent of consideration by local sites and providers, as well as the commitment from all stakeholders to continuous quality improvement over time. The above tables also provide examples of how changes to program design and delivery were made over time to address identified barriers by CESPHN, providers, and sites. They also provide good lessons learned for any future similar programs or initiatives.

### Conclusion

Based on available survey responses and provider Final Reports, the Program supported better integration between primary and acute care settings, GP knowledge about cancer related topics, and positive experiences of care by patients with broadly high satisfaction reported. The extent to which this was the experience of others who did not respond to surveys is difficult to assess, however in qualitative interviews with program stakeholders they shared similar sentiments about the Program.

There were a range of enablers and barriers (both program and non-program) that impacted on service delivery. There was a strong commitment to the Program and its continuous improvement by CESPHN, providers, and local sites including actions taken to address identified barriers over time.

# Program Value, Sustainability and Scalability

Related Evaluation Questions

(5) Is the program cost effective and value for money?

(6a) Is the program sustainable and scalable?

(6b) Are there any suggestions and/or recommendations on the future program's direction and scalability?

When assessing the Program's sustainability and scalability, the evaluation considered whether the model adopted as part of the Program was sustainable, replicable for other regions, given that the Program focused on the CESPHN region only, or scalable to other conditions in the CESPHN region. There was also some consideration of the extent to which the program provides value for money and qualitative reflections on cost effectiveness, possible and able to be concluded based on the data and information available. The initial design of the evaluation included some consumer estimated value questions in the Patient Experience Survey, however the very low response rates to this survey means that it was not possible to consider value in this way. Instead, reflections on value and cost effectiveness based on qualitative data is summarised in this section.

*Sustainability and Scalability*

Sustainability and scalability of the program were limited by the discrete time period for funding availability for the delivery of the Program, however it was built in from the beginning that there should be attention paid to the development of elements of the Program into enduring workflows, including a focus on investing in system level development within sites to support the endurance of impacts of funding over time.

In final reporting, providers summarised the elements of program delivery that have been embedded in usual workflows and therefore can be maintained within existing funding agreements post this program. These are summarised by site below.

Table 3.4 Summary of elements being maintained post the completion of this Program by Provider and Site

| Provider | Site | Elements being sustained post-funding |
|---|---|---|
| SESLHD | Prince of Wales Nelune Comprehensive Cancer Centre / Royal Hospital for Women | • Continued use of care plan templates within the cancer electronic records system (MOSAIQ).<br>• GP communication embedded in workflows for selected medical tumour streams.<br>• Nurse Practitioner–led transitions in palliative care supported by CNC communication. |
| | St George Hospital Cancer Care Centre & Sutherland Hospital Bangawarra Cancer Care Service | • Continuation of the shared care model between selected medical specialists and tumour streams across the SESLHD Southern Sector.<br>• Ongoing support for transitioning injectable therapies back to primary care.<br>• Guidance for nursing staff in assisting patients to transition to new GPs.<br>• Support for patients moving back to GP care upon completion of specialised cancer care. |
| SVHS | | • Ongoing collaboration with GPS including education about referral pathways and Health Link, discussions with GPs about opportunities for continued collaboration, and the development of agreed referral pathways with administrative teams and practice managers.<br>• Ongoing support for patients already enrolled in the Program through handover of at-risk and priority population patients to existing cancer care coordinator roles within local sites.<br>• Development of automatic sharing processes for cancer clinic updates with primary care providers via Health Link. |

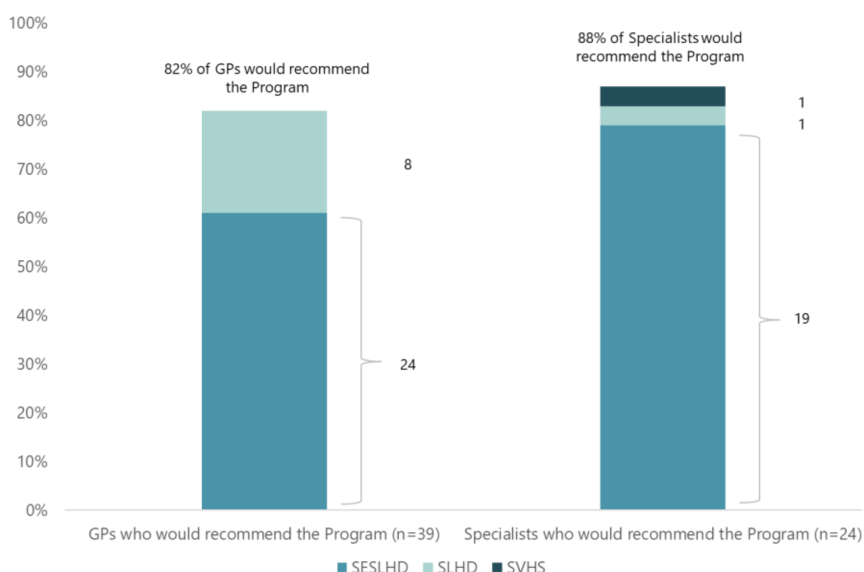
| Provider | Site | Elements being sustained post-funding |
|---|---|---|
| | | • Transition of Health Link to business as usual and transition of ownership of Health Link is underway to another site.<br>• The adaptation of update documents designed for this Program by other Centres in this area. |
| SLHD | | • Promotion of Health Link to SLHD based services that are now reviewing further investment in the system noting the value in streamlining correspondents with GPs and other healthcare providers.<br>• Use of Health Pathways to provide service navigation to primary care the engagement by cancer specialist services to update cancer specific information and service referral points.<br>• Uptake of Health Link by MDTs in the SLHD region to support the engagement between primary care and other care providers.<br>• Embedment of an early ambulatory clinical social work and palliative care multidisciplinary clinic in the SLHD palliative care services and to be extended to one site (taking lessons learned from this Program).<br>• Planned adaptation of tools and resources developed for this Program in future cancer coordinator programs or roles to support similar initiatives. |

Source: Program activity reporting by Providers as of July 2025.

The fact that elements of the Program can be sustained post funding demonstrates the commitment of CESPHN and providers to sustainability through design and implementation over the evaluation period. These sustained elements leverage activities completed during the programs delivery including: the development of key relationships between stakeholders, the development of referral and care pathways, investment in secure messaging and other interoperable systems, engagement and knowledge building within the local acute and primary care settings about shared care, the development of collateral, training and other documentation (i.e., communication templates) that can be adapted to existing care and roles in sites, and so on.

Most providers reflected that at the conclusion of the Program there were functions, processes, and elements of the Program that have been integrated into existing systems and that there was some increased interest and desire to invest in shared cancer care in their local sites. In terms of the views of key stakeholders about the continued interest in the program, the majority of both GPs and Specialists would also recommend the service to other GPs, Practice Nurses or Specialists (see Figure 3.6 below).

Figure 3.6. Recommendation rates of the Program. as grouped by local health network/district.




Source. Deloitte

*'While the current process has room to grow, the Program is much needed and valued by the GPs.'*

– Healthcare practitioner

*Program Value*

The lack of available data linkage (i.e., to follow patient outcomes over time) and the very small response rates to patient surveys meant it was not possible to assess quantitatively the value of the program. However, based on qualitative feedback and the survey results available from a range of stakeholders there was strong satisfaction and limited examples of achieved efficiencies in care coordination and reductions in hospital admissions in some instances.

Patients had very high satisfaction with the Program and indicated that it was valued by them. The GPs and other healthcare specialists also indicated positive feedback related to the Program and how it supported them in care continuity. For healthcare practitioners, the creation of written plans and reminders to patients and practitioners about appointments and scans in particular was reported to help reduce the number of missed visits and appointments for their patients.

*'The Program would be a very interesting model to explore regionally, where care centres can be a great distance away for some patients.'*

– Healthcare practitioner

It was also highlighted that the Program was practical and efficient in enhancing patient care post cancer treatment. However, a small few stakeholders who provided feedback found that the communication channels were not always effective, some experienced a lack of engagement with patient care teams.

Conclusion

While the Program has now concluded, there was a strong focus on sustainability and embedment of activities by CESPHN, providers and sites throughout. This is demonstrated by the elements that sites and providers indicated have been maintained post funding.

While value for money was not possible to assess quantitatively, there was some evidence of efficiencies, patient and GP perceived value, and high satisfaction across groups that suggest that the Program did provide value to stakeholders, and most importantly to patients.

The scalability of the Program is difficult to comment on due to the limited evidence available, and given the conclusion of the Program, however there was some evidence in the rollout for patients accessing outreach services in rural and remote areas that similar programs might be useful to those outside of urban and outer urban areas. As noted in the previous chapter, the scalability of the Program to different sites, general practices, and cancer streams appears highly reliant on a range of factors including buy-in, interoperability of systems, existing processes or shared care models, local processes and practices, and ways of working. This should be considered in any future considerations of the rollout or scaling of similar Programs.

# 4 Recommendations

Using the information available to the evaluation, recommendations were developed, which could be considered for future similar initiatives.

The following section provides recommendations based on the key insights gathered from the Program's evaluation findings. The recommendations have been developed so that they might be useful for CESPHN to consider and implement in any future similar programs or initiatives.

| Domain | Recommendations to Consider for Future Similar Programs |
|---|---|
| 1. Program Design | • Streamline communication with dedicated systems and clear, consistent documentation. The availability of interoperable secure messaging systems that were known and accessible to general practice and integration with clinical workflows and EMRs was critical to the adoption of the program as well as the reduction of administrative burden on CNCs.<br>• Ensure patients, general practice and other key stakeholders are involved early in care planning to empower their decisions, as evidenced in the design of this Program.<br>• Build shared care pathways and engagement with general practice locally for sites delivering shared care services to support engagement (including identifying barriers to GP engagement and awareness) and expand this to other healthcare professionals who might be working with patients with cancer related care needs (i.e., specialists, allied health, etc.). This might include allocating for example a champion GP who supports engagement within that location and contributes to governance and continuous quality improvement processes.<br>• Where possible, ensure that the core model delivery is consistent across sites to reduce confusion for patients, GPs, and specialists, while allowing for some regional flexibility to meet local needs.<br>• Ensure that funding for positions is as secured as possible to minimise attrition over time of CNCs and program delivery staff. |
| 2. Program Implementation | • Consider opportunities to develop shared resources including GP details, across sites and discuss areas where there is likely overlap between providers so that there is clarity for all program stakeholders where possible on the program.<br>• Engage regularly with clinicians to understand enablers and barriers to implementation and service delivery on the ground.<br>• Create simple feedback mechanisms so that all stakeholders can provide input into the programs and to help identify areas for continuous quality improvement.<br>• Identify opportunities where the awareness of any programs can be built for GPs, specialists, and patients in existing events, days, and training locally. |
| 3. Program Effectiveness | • Engage with patients in a structured manner to understand effectiveness and consider the possibility in future evaluations for data linkage opportunities to understand the impact of these programs on broader health system utilisation.<br>• Ensure that there are simple coordination tools to support the communication between all members of care teams, general practitioners, specialists and patients.<br>• Continue to schedule ongoing education sessions for healthcare practitioners which serve a dual purpose in terms of improving understanding of cancer related care needs as well as their understanding of the model of shared care.<br>• Continue to monitor access and equity metrics regularly over time, including regular reporting. This would include clearly defining key metrics (i.e., occasions of service, enrolment, communications, etc.) that are then used consistently across sites. |

| Domain | Recommendations to Consider for Future Similar Programs |
|---|---|
| 4. Program Outcomes | • Maintain and clearly define the coordinator role both within sites implementing the program as well as by the commissioning body (i.e., CESPHN)<br>• Ensure documentation and communication is standardised and actionable where possible, including when appropriate ensuring consistency in how the model is implemented across sites.<br>• Collect demographic and outcome data for all patients to support monitoring and evaluation.<br>• Promote the Program early to all relevant stakeholder to support uptake and usability. |
| 5. Program Value | • Consider opportunities for data linkage to provide data on resource use and hospitalisation avoidance as well as other system uptake and cost or benefit variables. |
| 6. Program Sustainability and Scalability | • Retain the program coordinator and documentation processes to maintain quality during expansion.<br>• Engage local stakeholders before rollout to address regional needs and support adoption, including any local adaptations required for the model in those areas.<br>• Develop a step-by-step implementation guide for consistency across sites where appropriate. |

# Appendices

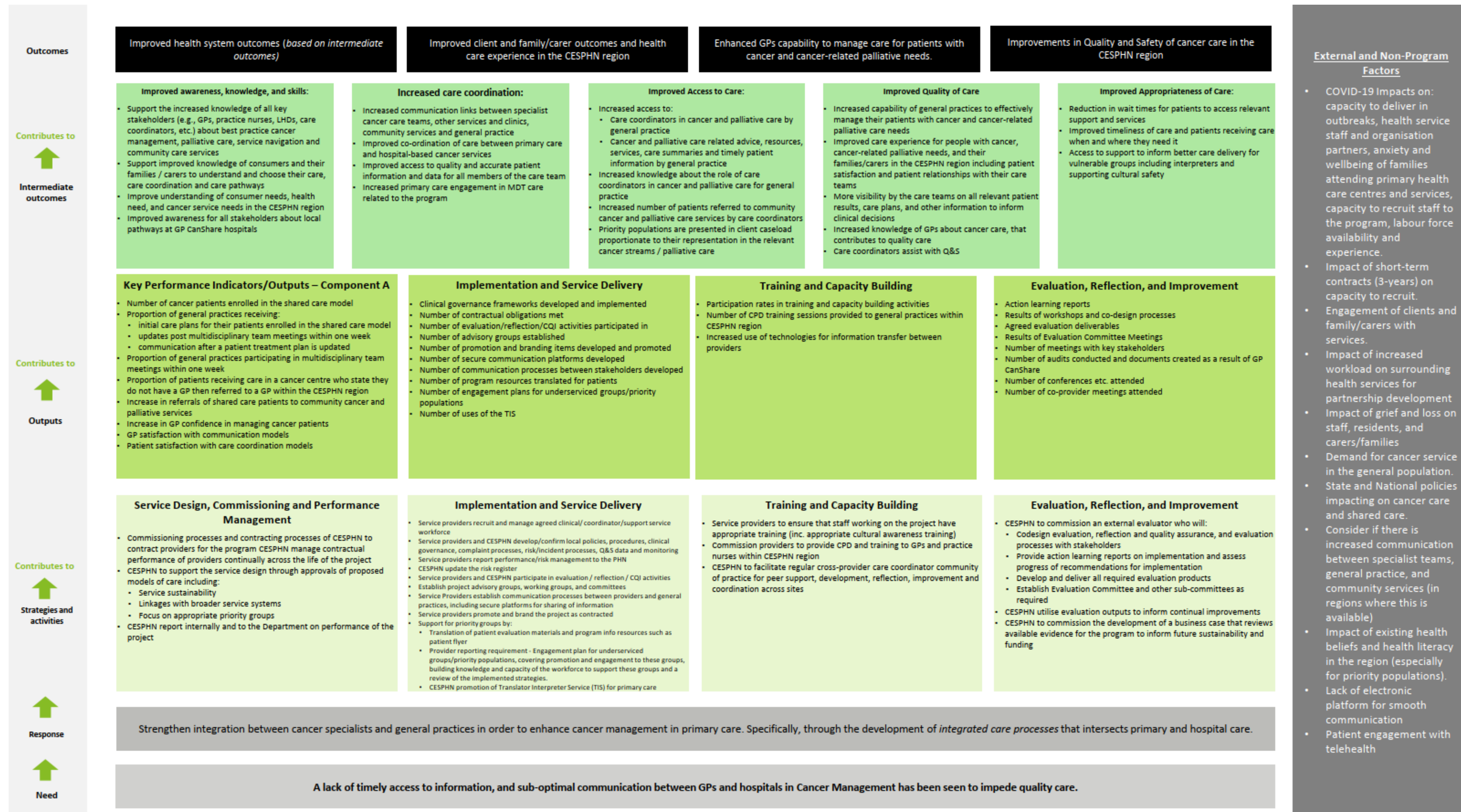
Appendix A – Program Logic

Appendix B – Data Strategy Matrix

Appendix C – Survey Data Tables

Appendix D – Program Activity Data

# Appendix A – Program Logic




Source: Deloitte based on Program documentation

# Appendix B – Data Strategy Matrix

| Intermediate Outcome | Method | Data Source |
|---|---|---|
| Improved awareness, knowledge and skills | • Stakeholder consultations<br>• Stakeholder surveys | • Interviews with GPs and practice nurses, CNCs or other care coordinators<br>• Outcome measure survey with CNCs/care coordinators<br>• Outcome measure survey with GPs<br>• Action Learning Portal responses |
| Increased care coordination | • Stakeholder consultations<br>• Stakeholder surveys<br>• Activity data | • Activity data about the number of GPs engaged in the program and number of communication instances per patient<br>• Interviews with GPs and CNCs/ care coordinators<br>• Experience surveys with GPs and CNC/care coordinators |
| Improved access to care | • Stakeholder consultations<br>• Stakeholder surveys<br>• Activity data | • Activity data about priority population access and number of patients in total<br>• Interviews with GPs and CNCs/care coordinators<br>• Experience and outcome surveys with GPs and CNC/care coordinators<br>• Action Learning Portal responses |
| Improved quality of care | • Stakeholder consultations<br>• Stakeholder surveys<br>• Activity data | • PREM survey with patients, CNCs/care coordinators and GPs<br>• Data on avoidable hospital admissions and wait times<br>• Interviews with GPs and CNCs/care coordinators<br>• Action Learning Portal responses |
| Improved appropriateness of care | • Stakeholder consultations<br>• Stakeholder surveys | • Action Learning Portal responses<br>• Interviews with GPs and CNCs/care coordinators<br>• Experience survey with GPs |

| Evaluation Question | Method | Data Source |
|---|---|---|
| What is the effectiveness of the program to improve:<br>a. the healthcare experience for people with cancer and cancer-related palliative needs and their family/carers?<br>b. Enhancing the capability of GPs to effectively manage care for their patients with cancer and cancer related palliative needs? | • Stakeholder consultations<br>• Stakeholder surveys<br>• Document Review<br>• Triangulation of data from all sources | • Interviews with GPs and practice nurses, Specialists and patients, families and/or carers<br>• Experience and outcome surveys with GPs, CNCs/care coordinators and patients<br>• Documents such as activity progress reports provided by CESPHN |
| Is the program being implemented as intended? If not, why? | • Stakeholder consultations<br>• Stakeholder surveys<br>• Document Review<br>• Activity data<br>• Triangulation of data from all sources | • Interviews with GPs and practice nurses, Specialists and patients, families and/or carers<br>• Experience and outcome surveys with GPs, CNCs/care coordinators and patients<br>• Documents such as activity progress reports provided by CESPHN<br>• Activity data on KPI's |
| Is the service model developed for the program appropriate, sustainable, and effective for:<br>a. GPs and Practice Nurses<br>People with cancer and cancer-related palliative needs and their family and carers | • Stakeholder consultations<br>• Stakeholder surveys<br>• Document Review<br>• Activity data<br>• Triangulation of data from all sources | • Documents provided by CESPHN and service providers including activity progress reports, KPI reports, activity work plans etc.<br>• Interviews with GPs and practice nurses, Specialists and patients, families and/or carers<br>• Experience surveys with GPs, CNCs/care coordinators and patients |
| What are the access and equity enablers, or barriers, that may impact on care coordination and GP access to services? | • Stakeholder consultations<br>• Stakeholder surveys | • Action Learning Portal responses<br>• Interviews with GPs and practice nurses, Specialists and patients, families and/or carers |
| Is the program cost effective and value for money? | • Decision tree simulation<br>• Cost effectiveness analysis | • Cost (intervention costs, e.g. telephone support line, staff, etc., and standard care costs, e.g. relevant MBS item numbers for GP management of cancer)<br>• Outcomes (patient health outcomes)<br>• Likelihoods (e.g. rate of ED presentation) |
| What are the critical success factors and barriers to achieving the programs overall objectives? | • Stakeholder consultations<br>• Document review<br>• Activity data | • Interviews with GPs and practice nurses, Specialists, Service Providers, and/or patients<br>• Data from CESPHN and Service Provider documents (e.g. activity reports, KPI Reports, activity work plans etc.) |

| Evaluation Question | Method | Data Source |
|---|---|---|
| Is the program sustainable and scalable? Are there any suggestions and/or recommendations on the future program's direction and scalability? | • Stakeholder consultations | • Interviews with GPs and practice nurses, Specialists, Service Providers, and/or patients |
| Are the expected outcomes of the program being met?<br>a. Improved awareness and knowledge<br>b. Improved coordination of care<br>c. Improved access to care<br>d. Improved quality of care<br>e. Improved appropriateness of care<br>f. Component A Process/Impacts evaluations | Triangulation of data from all sources | |
| What is the acceptability & usability of the shared care model according to GPs and practice nurses? | • Stakeholder consultations<br>• Stakeholder surveys | • Action Learning Portal responses<br>• Interviews with GPs and CNCs/care coordinators<br>• Experience surveys with GPs and CNCs/care coordinators |
| What is the efficacy and utility and timeliness of the shared care model approach to cancer management with regard to:<br>a. the cancer coordinator position,<br>b. patient care coordination<br>c. GP integration and support for each of the three service providers | • Stakeholder consultations<br>• Stakeholder surveys | • Interviews with GPs and CNCs/care coordinators, Specialists, and other staff implementing the program<br>• Data from CESPHN and Service Provider documents (e.g. activity reports, KPI Reports, activity work plans etc.) |
| Does the uptake of the services vary dependent on general practice demographics (for example, location of general practice)? | • Cluster Analysis or other exploratory analysis to identify common factors for services with high uptake and low uptake | • Number of patients enrolled in shared care model<br>• Location data<br>• Demographic data<br>• Administrative by product data<br>• Case studies for areas with high uptake and low uptake |

Source. Deloitte

# Appendix C – Survey Data Tables

The tables below provide a breakdown of the survey data discussed in the Key Findings section.

## Program Design

Table A1. GP views on documents provided by the Program coordinator

| n=39 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| The Documents provided by the GP CanShare coordinator were overall useful | % | 43.6% | 28.2% | 7.7% | 2.6% | 7.7% | 10.3% |
| | No. | 17 | 11 | 3 | 1 | 3 | 4 |

Table A2. GP recommendations of the Program

| n=39 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| I would recommend this service to other GP's/GP Practice Nurses | % | 41% | 41% | 5.1% | 2.6% | 10.3% | - |
| | No. | 16 | 16 | 2 | 1 | 4 | - |

Table A3. Patient views on the Program coordinator understanding needs

| n=47 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| The GP CanShare coordinator understood my needs | % | 38.3% | 57.4% | 4.3% | - | - | - |
| | No. | 18 | 27 | 2 | - | - | - |

Table A4. Patient views on the Program coordinator's helpfulness

| n=46 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| The GP CanShare coordinator was helpful | % | 32.6% | 60.9% | 6.5% | - | - | - |
| | No. | 15 | 28 | 3 | - | - | - |

Table A5. Patient views on the timeliness of care

| n=19 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| The care I received as part of the GP CanShare program was timely | % | 31.6% | 42.1% | 21.1% | - | 5.3% | - |
| | No. | 6 | 8 | 4 | - | 1 | - |

## Program Implementation

Table A6. Specialist views on the ease of engagement with the Program

| n=24 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| I found it easy to engage with the GP CanShare Program | % | 79.2% | 8.3% | 4.2% | 4.2% | 4.2% | - |
| | No. | 19 | 2 | 1 | 1 | 1 | - |

Table A7. Specialist views on the helpfulness of the Program coordinators

| n=24 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| The GP CanShare coordinators were helpful | % | 79.2% | 12.5% | - | - | 8.3% | - |
| | No. | 19 | 3 | - | - | 2 | - |

Table A8. Specialist views on the improvement in patient care

| n=24 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| The GP CanShare service helped me to provide better support to my patients | % | 70.8% | 16.7% | 4.2% | - | 8.3% | - |
| | No. | 17 | 4 | 1 | - | 2 | - |

## Program Effectiveness

- Refer to Table A1 for GP views on usefulness.

Table A9. Patient views on how informed GPs are in their care

| n=5 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| To what extent do you think your GP has been better informed about your care, over the last 3 years? | % | 60% | 20% | 20% | - | - | - |
| | No. | 3 | 1 | 1 | - | - | - |

Table A10. Patient views on how effectively the care team communicated about their needs

| n=19 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| My GP CanShare team was able to communicate effectively about my needs | % | 47.4% | 42.1% | 10.5% | - | - | - |
| | No. | 9 | 8 | 2 | - | - | - |

Table A11. Overall patient satisfaction with their care experience

| n=19 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| Overall, I am satisfied with my care experience in the GP CanShare program | % | 47.4% | 42.1% | 5.3% | - | 5.3% | - |
| | No. | 9 | 8 | 1 | - | 1 | - |

Table A12. Patient recommendation of the Program

| n=19 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| I would recommend the GP CanShare program to other patients | % | 47.4% | 42.1% | 5.3% | - | 5.3% | - |
| | No. | 9 | 8 | 1 | - | 1 | - |

Table A13. GP views on Program coordination of care

| n=38 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| The GP CanShare service helped increase the coordination of care for my patient between myself and relevant specialist teams | % | 42.1% | 28.9% | 10.5% | 13.2% | 2.6% | 2.6% |
| | No. | 16 | 11 | 4 | 5 | 1 | 1 |

Table A14. GP views on Program knowledge improvement

| n=38 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| I found that my knowledge of best practice cancer management has improved due to the GP CanShare program | % | 21.1% | 42.1% | 7.9% | 13.2% | 5.3% | 10.5% |
| | No. | 8 | 16 | 3 | 5 | 2 | 4 |

Table A15. GP views on improvements in patient care

| n=39 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| The GP CanShare service helped me to provide better support to my patients | % | 43.6% | 30.8% | 7.7% | 10.3% | 2.6% | 5.1% |
| | No. | 17 | 12 | 3 | 4 | 1 | 2 |

Table A16. Patient views on ease of GP access

| n=19 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| It is easy for me to access my GP | % | 57.9% | 26.3% | 10.5% | 5.3% | - | - |
| | No. | 11 | 5 | 2 | 1 | - | - |

## Program Outcomes

- Refer to Table A11 for overall patient satisfaction
- Refer to Table A13 for GP coordination of care
- Refer to Table A14 for GP's improvement in cancer management knowledge
- Refer to Table A15 for GP views on improvements in patient care.

Table A17. Specialist views on coordination of care

| n=24 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| The GP CanShare service helped increase the coordination of care for my patients between myself and relevant GP teams | % | 70.8% | 12.5% | 8.3% | - | 8.3% | - |
| | No. | 17 | 3 | 2 | - | 2 | - |

## Program Value, Sustainability and Scalability

- Refer to Table A2 for GP recommendations of the Program.

Table A17. Specialist recommendations of the Program.

| n=24 | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | NA/Unsure |
|---|---|---|---|---|---|---|---|
| I would recommend engaging with the program to other specialists (if relevant) | % | 62.5% | 25% | 4.2% | 4.2% | 4.2% | - |
| | No. | 15 | 6 | 1 | 1 | 1 | - |

All tables are sourced from Deloitte surveys disseminated for this evaluation.

# Appendix D – Program Activity Data

The table below provides a summary of the activities conducted by the Program, based on available data.

Table A18. Program Activity Data

| | SESLHD | SVHN | SLHD |
|---|---|---|---|
| Number of Patients | 1225 | 719 (*) | 2282 |
| Occasions of Service | 6408 | 1564 (*) | 6912 |
| Enrolment Dates | 2021-2025 | 2021-2025 | 2022-2025 |
| Highest Year | 2024 - 434 (35.5%) | 2022 - 239 (33.2%) | - |
| **Demographics** | | | |
| Average Age (Range) | 62 (18-101) | 61.5 (27-99) | 64.1 (15-97) (***) |
| Female (%) | 609 (49.7%) | - | 210 (46.7%) (***) |
| Aboriginal and/or Torres Strait Islander Status (%) | 33 (2.7%) | 7 (1%) | 7 (1.6%) (***) |
| CALD Status (%) (**) | 155 (12.7%) | 245 (34.1%) | 287 (63.8%) (***) |
| Interpreter Required | 71 (5.8%) | 20 (2.8%) | 58 (12.9%) (***) |
| **Care Coordination** | | | |
| Usual GP Determined | - | 714 (99.3%) | - |
| Initial Document Type | - | Discharge Summary 303 (42.1%) | - |
| Treatment Plan Updates | - | 869-871 | - |

Source. Deloitte, based on program activity data either provided in unit level datasets shared by providers, or in July 2025 Final Reports. (*) these numbers were updated post the submission of the June 2025 report for this provider, reflecting the continued delivery of some services over time. (**) CALD status for SVHN and SLHD collates data across two data fields, including individuals who reported speaking a language other than English and/or individuals who reported they were born in a country outside of Australia. CALD status for SESLHD collates data across one data field, including individuals who report they are CALD. (***) Demographic data was only available for a sample of 450 of the 2,282 patients enrolled with SLHD as there was no consistent identification number used to combine across datasets, and some datasets did not include this data. All demographic findings for SLHD are therefore based solely on the available data.

# Limitations of Our Work

## General Use Restrictions

This report is prepared solely for use of CESPHN. This report is not intended to and should not be used or relied upon by anyone else and Deloitte accepts no duty of care to any other person or entity. The report has been prepared for the purpose of providing details of the evaluation undertaken by Deloitte in relation to the GP CanShare Program. You should not refer to or use Deloitte’s name or the advice for any other purpose.

Deloitte refers to one or more of Deloitte Touche Tohmatsu Limited, a UK private company limited by guarantee, and its network of member firms, each of which is a legally separate and independent entity. Please see www.deloitte.com/au/about for a detailed description of the legal structure of Deloitte Touche Tohmatsu Limited and its member firms.

About Deloitte

Deloitte provides audit, tax, consulting, and financial advisory services to public and private clients spanning multiple industries. With a globally connected network of member firms in more than 150 countries, Deloitte brings world-class capabilities and high-quality service to clients, delivering the insights they need to address their most complex business challenges. Deloitte's approximately 200,000 professionals are committed to becoming the standard of excellence.

About Deloitte Australia

In Australia, the member firm is the Australian partnership of Deloitte Touche Tohmatsu. As one of Australia's leading professional services firms. DeloitteTouche Tohmatsu and its affiliates provide audit, tax, consulting, and financial advisory services through approximately 6000 people across the country. Focused on the creation of value and growth, and known as an employer of choice for innovative human resources programs, we are dedicated to helping our clients and our people excel. For more information, please visit our web site at www.deloitte.com.au.

Liability limited by a scheme approved under Professional Standards

Legislation. Member of Deloitte Touche Tohmatsu Limited

© 2025 Deloitte Touche Tohmatsu