

Shared Care Models for Cancer Survivorship: A Narrative Review of What Works, for Whom, and Why

Review began 09/22/2026

Review ended 10/11/2026

Published 10/17/2026

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DOI: 10.7759/cureus.118077

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Abstract

The number of people living after a cancer diagnosis is growing, increasing demand on specialist-led follow-up, which has traditionally centred on recurrence surveillance and may not address broader needs such as late effects and coexisting chronic conditions. Shared care models, which distribute post-treatment follow-up across oncology, general practice, nursing, and pharmacy, have been proposed as one response. Three decades of randomised trials of general practitioner (GP)-led, nurse-led, structured shared care, and patient-initiated follow-up have generally reported patient-reported outcomes similar to those of specialist-led follow-up in selected, mostly lower-risk survivor populations, and several reported higher satisfaction or lower costs. Evidence on survival and recurrence detection remains uncertain, and quality-of-life findings are mixed.

In this narrative review of randomised trials identified through a structured PubMed/MEDLINE and trial-registry search, we examine how shared-care interventions are organised and which components warrant further evaluation, while recognising remaining uncertainty about clinical outcomes and generalisability. Rather than organising evidence by model, we map the randomised trials onto six recurring components: GP education and protocols, survivorship care plans, structured intersectoral communication, nurse coordination, pharmacist teleconsultation, and patient activation tools. As most trials tested packages of care rather than individual components, this mapping is descriptive and hypothesis-generating. In the available trials, protocols and nurse coordination were common features of interventions with similar safety-related outcomes, while care plans and activation tools were more often associated with satisfaction and process outcomes than with quality of life. Exploratory findings suggest that culturally and linguistically tailored interventions may improve communication, but the influence of health literacy and cultural context requires further study. We recommend factorial and dismantling trials to assess the contributions of individual components and identify combinations that meet prespecified clinical and patient-reported outcome targets within local resource constraints, alongside embedded implementation research.

Categories: Family/General Practice, Oncology

Keywords: cancer survivorship, follow-up care, primary care, shared care, survivorship care plans

Introduction And Background

The global burden of cancer survivorship has reached a scale that strains even well-resourced health systems. Approximately 19.3 million new cancer cases were diagnosed worldwide in 2020, and this figure is projected to rise to 28.4 million by 2040 [1]. Improving survival rates across many cancer types have produced a rapidly expanding population of survivors whose care needs extend well beyond the acute phase of treatment [2]. Definitions of “cancer survivor” vary; in its broadest use, the term includes anyone living after a cancer diagnosis, from the time of diagnosis onward [2,3]. This review focuses on the post-treatment phase, after completion of primary treatment, when routine follow-up begins. In many health systems, however, post-treatment follow-up remains predominantly specialist-led, based on recurring outpatient appointments with oncologists whose caseloads are growing and whose review is oriented primarily toward recurrence surveillance [3,4].

The philosophy underpinning cancer follow-up has, however, begun to shift. For decades, post-treatment care was organised almost exclusively around recurrence detection, a narrowly oncological objective that left broad domains of survivorship need unaddressed [4]. The sequelae of cancer treatment (including fatigue, psychological distress, sexual dysfunction, and cardiovascular and metabolic late effects) and the accumulated burden of comorbid disease are not incidental to survivorship; they are central to it [5]. This has driven a reconceptualisation of follow-up as holistic survivorship care: an ongoing, multidimensional endeavour concerned with health promotion, comorbidity management, psychological wellbeing, and quality of life, as much as with disease monitoring [4,6].

How to cite this article

Burashed K K, Alsindi H E (October 17, 2026) Shared Care Models for Cancer Survivorship: A Narrative Review of What Works, for Whom, and Why. Cureus 18(10): e118077. DOI 10.7759/cureus.118077

Specialist-led follow-up was not designed primarily for this broader mandate. Oncology appointments are episodic, often brief, and conducted outside the primary care relationships in which coexisting conditions are managed, and preventive care is delivered [3,4]. For many survivors with stable disease and a low risk of recurrence, whose needs increasingly relate to late effects and other chronic conditions, the added value of routine specialist visits over well-supported alternatives is uncertain, because trials comparing the two have generally found similar patient-reported outcomes [7]. This has motivated interest in moving part of follow-up into primary care and community settings. Such a shift requires infrastructure: clear role definitions, reliable communication between providers, and practitioners equipped to manage needs that sit at the intersection of oncology and general medicine. Uncertainty about role boundaries and lack of training are among the most frequently reported barriers to general practitioner (GP) involvement in survivorship care [8,9].

Shared care models have been proposed as one response to this challenge. Broadly, they encompass any arrangement in which responsibility for post-treatment follow-up is distributed across two or more provider types, most commonly oncology and general practice, with nursing, pharmacy, and allied health increasingly involved [3]. Shared care differs from GP-led or nurse-led follow-up in that responsibility is not transferred from one provider to another but is explicitly divided between them. In a typical arrangement, for example, the oncology team provides a treatment summary and survivorship care plan, sets the surveillance schedule, and remains available for rapid re-referral, while the GP conducts scheduled reviews, arranges agreed surveillance tests, manages coexisting conditions, and contacts the oncology team if recurrence is suspected [10]. A systematic review of eight randomised controlled trials (RCTs) and three descriptive studies reported that shared care produced outcomes broadly similar to usual specialist-led care across quality of life, mental health, unmet needs, and clinical domains, with higher patient satisfaction and lower costs in some studies [10]. More recently, an overview of 12 systematic reviews capturing 53 primary studies reported no meaningful differences in physical or psychosocial outcomes across survivorship care models, and suggested that nurse-led and primary care-led models may generate cost savings for survivors and health systems [11].

Similar average outcomes, however, leave important questions unanswered. They do not tell clinicians which components of shared care contribute to outcomes, which patients benefit most, or which implementation conditions are required for adoption in routine care. The literature has been shaped by trials designed to compare whole models of care rather than to isolate the components within them [11]. Existing syntheses have addressed a different question. Systematic reviews and overviews have compared whole models of care (shared, GP-led, nurse-led, or patient-initiated follow-up) with specialist-led care [7,10-12], or have evaluated a single intervention type, such as survivorship care plans [13], or the barriers to shared care [14]. To our knowledge, none has mapped the randomised evidence across models onto the components from which the interventions are built. This review addresses that gap.

The objectives of this narrative review are to: (1) summarise the randomised evidence on GP-led, nurse-led, structured shared care, and patient-initiated follow-up, with attention to the certainty of evidence for each outcome; (2) identify the intervention components that recur across these models and map the reported outcomes of the packages that contained them; (3) describe patient, disease, and system factors that may modify effects; (4) summarise barriers and enablers to implementation; and (5) propose research priorities, including component-level trial designs. Because nearly all trials tested multicomponent packages, the component mapping is intended to generate hypotheses rather than to estimate the effects of individual components.

Review

Methods of this narrative review

Design

This is a narrative review informed by a structured literature search. It was not designed or conducted as a systematic review; it was not prospectively registered, and duplicate screening, formal risk-of-bias assessment of individual studies, and certainty-of-evidence grading were not undertaken. PRISMA 2020 reporting therefore does not apply, and a study-selection flow diagram is not provided because the number of records at each stage of selection was not logged. The methods are described below so that the scope and selection process are transparent.

Search

PubMed/MEDLINE was searched from 1 January 1996 to 20 July 2026. The search was supplemented by backward and forward citation tracking of the included trials and prior systematic reviews, searches of trial registries (ClinicalTrials.gov, International Standard Randomised Controlled Trial Number (ISRCTN), Australian New Zealand Clinical Trials Registry (ANZCTR)), and hand-searching of major oncology conference proceedings for trials without full-text publications. Three concept blocks were combined: cancer and survivorship, alternative follow-up model, and follow-up with an RCT filter; a parallel search combined the cancer and model blocks with implementation and qualitative terms. The full PubMed strategy

is reported in the Appendices. Searches were limited to English-language publications.

Eligibility

The core evidence base comprised RCTs and pre-planned qualitative substudies of RCTs that enrolled adult survivors or adult survivors of childhood cancer, evaluated a GP-led, nurse-led, structured shared care, or patient-initiated follow-up (PIFU) model against specialist-led or usual care, and reported at least one patient-reported, clinical, process, or economic outcome. No cancer-type restriction was applied. Additional sources were used for context and are identified as such where cited: systematic reviews and overviews; one non-randomised pilot study of shared care for adult survivors of childhood cancer [15]; one RCT conducted in newly referred patients rather than in post-treatment follow-up, retained because its intervention centred on oncologist-to-GP communication [16]; trial protocols, used only to describe intervention content; registry entries for ongoing trials without published results; implementation frameworks and implementation studies; and epidemiological sources.

Study Selection and Data Extraction

For each included trial, we recorded country and health system, cancer type, population and timing of enrolment, design and sample size, intervention elements, comparator, outcomes, and the direction of reported effects, using the primary results publication and, where available, the protocol.

Appraisal of Included Trials

No formal risk-of-bias tool, such as the Cochrane RoB 2 tool, was applied to individual trials. Instead, for each included RCT, we tabulated design features relevant to the risk of bias and to the interpretation of its results: design and sample size, whether the trial was a pilot or was designed to test non-inferiority, blinding (not feasible in any trial, so patient-reported outcomes were assessed in an open-label setting), attrition where reported, and whether the trial was powered for recurrence or survival. For model-level outcomes, we relied on the risk-of-bias and Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) assessments of the Cochrane review [7] and, for PIFU, on the RoB 2 assessments of a 2023 systematic review [12].

Component Classification

Six recurring intervention components were defined from intervention descriptions in the included trials and prior reviews [10,11]: GP education and protocol provision, survivorship care plans (SCPs), structured intersectoral communication, pharmacist input, nurse care coordination, and patient activation tools. Each trial's intervention was coded for the presence of each component. Because almost every trial tested a multicomponent package, this coding records which components were present in packages, not their independent effects.

Synthesis and Handling of Heterogeneity

Outcomes were compared across studies by outcome domain (recurrence and survival; health-related quality of life (HRQoL) and psychological outcomes; satisfaction and preference; process outcomes such as surveillance adherence and physician implementation of recommended care; and costs) rather than by pooling. For each trial and domain, we recorded the direction of effect and, where reported, the effect estimate with its 95% confidence interval (CI) or p-value, as published. We did not use vote counting based on statistical significance. Findings were synthesised narratively; no meta-analysis or meta-regression was performed because interventions, comparators, populations, and outcome measures were heterogeneous, and a Cochrane review has already pooled model-level outcomes [7]. Because the trials differed substantially in interventions, comparators, populations, timing of follow-up, and outcome instruments, a pooled estimate would not have had a meaningful interpretation. Heterogeneity was therefore not assessed statistically; instead, it was addressed by grouping trials by model and by component, tabulating the population, setting, design, and outcome measures of each trial, and interpreting differences in findings in light of these features rather than attributing them to components alone. Reporting of the synthesis was informed by the Synthesis Without Meta-analysis (SWiM) guideline [17]. Effect estimates are reported as published by the original trials. We distinguish trials designed to test non-inferiority or equivalence from trials reporting a non-significant difference in a superiority comparison because the latter does not establish equivalence. Where we refer to the certainty of evidence, we draw on the GRADE assessments of the Cochrane review [7]; we did not perform our own certainty assessment. All journal references were checked against PubMed records; ongoing trials without results publications are cited by registry entry.

Defining the landscape: Models, terminology, and the problem of heterogeneity

The literature on post-treatment cancer follow-up is organised around a small number of recurring service-delivery archetypes, summarised in Table 1 [15,16,18-32]. These labels are analytically convenient, but their

boundaries are porous, and that porousness has shaped how the evidence base has been read.

Model	Defining feature	Exemplar studies	Findings reported
GP-led	Surveillance transferred to family physician with guidelines	Grunfeld 1996, breast[24]; Grunfeld 2006, breast[18]; Wattchow 2006, colon [19]; Murchie 2010, melanoma [25]	No detected differences in recurrence-related or patient-reported outcomes; lower costs in some trials
Nurse-led	Specialist/clinical nurse assumes surveillance and support	Moore 2002, lung [21]; Kimman 2011, breast[26]; Saltbæk (MyHealth) 2024, breast [27] (systematic review: Lewis 2009 [20])	Similar clinical outcomes in available trials; higher satisfaction; fewer physician visits; improved quality of life in MyHealth
Structured shared care	Formal oncology–primary care role division with information exchange	Nielsen 2003, mixed, newly referred patients[16]; Blaauwbroek 2008, adult survivors of childhood cancer (non-randomised pilot) [15]; Emery (ProCare) 2017, prostate [28]; Jefford (SCORE) 2023, colorectal[29]; Chan (EMINENT) 2025, breast [30]; Ke (BASIC) 2025, breast[31]	Feasible and acceptable; similar patient-reported outcomes; lower costs in some trials
Patient-initiated	Fixed visits replaced by patient-triggered access	Brown 2002, breast [32]	No quality-of-life advantage

TABLE 1: Taxonomy of principal follow-up models.

GP: general practitioner.

GP-led (primary care-led) follow-up transfers routine surveillance wholly or substantially to the family physician, typically supported by follow-up guidelines and open re-referral pathways [18,19]. Nurse-led follow-up substitutes a specialist or clinical nurse for the physician in the surveillance and supportive role [20,21]. Structured shared care describes a formal, explicit division of responsibility between oncology and primary care, characterised not merely by joint involvement but by deliberate information exchange and defined roles [10,15]. PIFU replaces fixed-schedule visits with patient-triggered access, usually paired with symptom-recognition guidance; its integration with primary care varies substantially [22]. A 2023 systematic review of 10 RCTs (n = 1,754; six in breast cancer) found that, in breast cancer, PIFU did not appear to affect recurrence detection or patient-reported outcomes and may reduce clinic visits, although all included trials had risk-of-bias concerns [12].

The interchangeable use of these labels has contributed substantially to heterogeneity within the survivorship literature. Reviews frequently group GP-led care, nurse-led clinics, multidisciplinary survivorship programmes, and structured shared care under a single umbrella despite important differences in organisation, intervention intensity, and provider responsibilities, so studies evaluating fundamentally different interventions are often synthesised together [22,23]. “Shared care” in particular spans a wide spectrum, from loose GP notification at discharge to formalised protocols with defined roles, care coordination, and structured cross-sectoral communication [10]. Overviews of the field have acknowledged that grouping such diverse interventions under single labels limits the ability to identify which elements of a follow-up programme are responsible for observed effects; poor reporting of intervention characteristics compounds this, leaving telemedicine use, visit frequency, and follow-up content largely unexaminable [11].

Beneath these model labels lies a recurring set of discrete intervention components that appear across interventions largely irrespective of which professional nominally leads care: SCPs, GP education and protocol packages, structured intersectoral communication, pharmacist input, nurse care coordination, and patient activation tools. These are the actual building blocks from which each “model” is assembled, yet they have rarely been examined as such. Figure 1 shows a component-based framework that highlights the active components of each model of care and how they can all be integrated into a single, shared model.

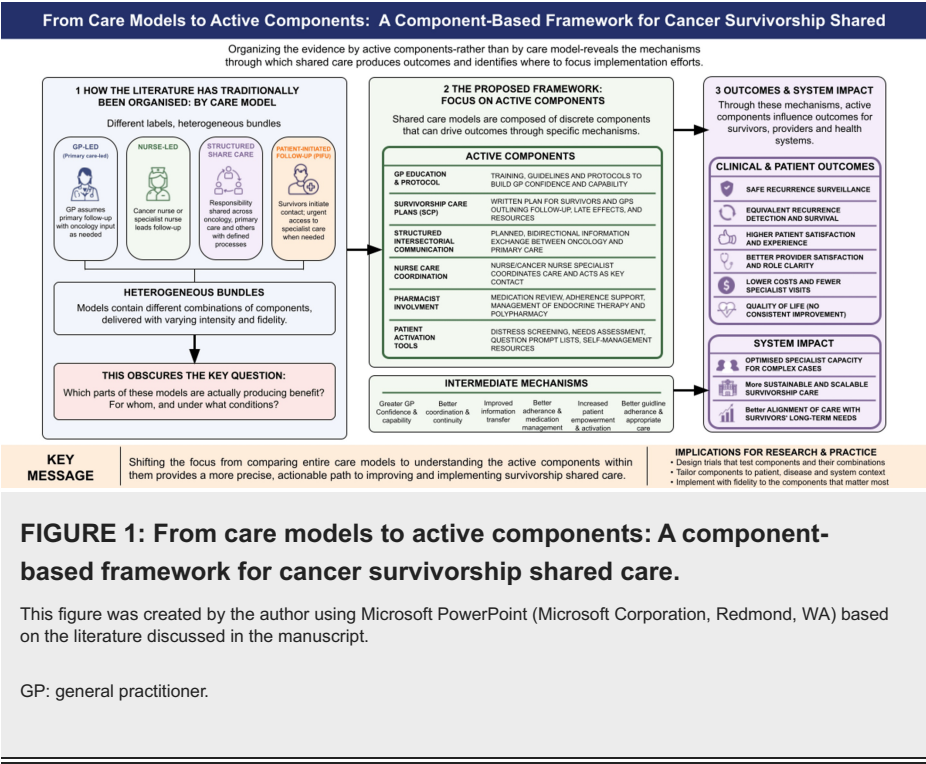


FIGURE 1: From care models to active components: A component-based framework for cancer survivorship shared care.

This figure was created by the author using Microsoft PowerPoint (Microsoft Corporation, Redmond, WA) based on the literature discussed in the manuscript.

GP: general practitioner.

The reason is methodological. Most RCTs were designed and powered to compare whole models (for example, whether GP-led or nurse-led follow-up is non-inferior to specialist care) rather than to isolate components [11]. The resulting literature generally reports similar patient-reported outcomes, with some studies showing greater satisfaction or lower costs; however, clinical safety evidence is less certain, and quality-of-life findings vary [7]. The MyHealth trial, for example, evaluated individualised nurse-led follow-up and reported improvements in quality of life, supporting further investigation of tailored supportive-care approaches [27]. SCPs illustrate the component problem most sharply: several RCTs found no effect on patient-reported outcomes when the plan was evaluated as a stand-alone document [11].

This review therefore departs from the conventional model-by-model organisation and reorganises the evidence around its constituent components, asking, for each component, which trials included it, in what combination, and with what reported effect. Before turning to the findings, we summarise the characteristics and limitations of the trial evidence on which this synthesis rests.

Characteristics and quality of the trial evidence

Design and Risk of Bias

Several features of the trial evidence should temper interpretation of everything that follows. Many early trials were relatively small, single-country studies with limited statistical power for uncommon outcomes such as recurrence and cancer-specific mortality. Blinding of participants and care providers was generally impossible because of the nature of the interventions, introducing potential performance and detection bias, particularly for patient-reported outcomes such as satisfaction and quality of life. Interventions ranged from simple GP-led follow-up to complex multicomponent programmes incorporating SCPs, nurse coordination, pharmacist input, and structured communication, making direct comparisons difficult. Follow-up durations varied and were often too short to evaluate long-term survivorship outcomes. More recent studies, including SCORE, MyHealth, EMINENT, and BASIC, used more fully protocolised interventions and reported implementation in more detail, but EMINENT and BASIC were pilot or feasibility studies, and none of the recent trials was powered to detect differences in survival or recurrence [27,29-31]. Table 2 summarises the design, population, main results (with effect estimates and 95% CIs or p-values where reported), and design features relevant to the risk of bias for each trial.

Trial (country)	Design; n	Population	Comparison	Main results as reported (estimate, 95% CI or p)	Features relevant to risk of bias
Grunfeld 1996 [24]	RCT; 296	Stage I–III breast cancer in remission, ≥3 months after	GP vs. hospital clinic	Median time to confirmation of recurrence 22 vs. 21 days; small SF-36 differences (e.g., social functioning −1.8, 95% CI −7.2 to 3.5);	Open label; 18-month follow-up; not powered for

(UK)		primary treatment		depression slightly higher mid-trial with GP care (0.6, 95% CI 0.1 to 1.2); no anxiety difference	survival
Grunfeld 2006 [18] (Canada)	RCT; 968	Early-stage breast cancer after active treatment	Family physician vs. cancer centre	Recurrence-related serious clinical events 16/483 (3.3%) vs. 18/485 (3.7%) [▲ add 95% CI from full text]; no HRQoL difference	Open label; few events; median follow-up 3.5 years
Wattchow 2006 [19] (Australia)	RCT; 203	Colon cancer after potentially curative treatment	GP vs. surgeon	No differences in SF-12, HADS, or satisfaction (satisfaction P = 0.06 at 24 months); recurrence 7.1 vs. 8.0 per 1,000 months (P = 0.92)	Open label; 157/203 assessed at 24 months; not powered for recurrence or death
Vos (I CARE) 2021 [33] (Netherlands)	2×2 factorial RCT; 303 (1-year interim)	Colon cancer after curative surgery	GP-led vs. surgeon-led (± eHealth app)	QLQ-C30 summary score change +1.6 vs. +3.9 (MD: −2.3, P = 0.094); role functioning and global health favoured surgeon-led care	Open label; interim analysis; participants younger and more often male than decliners
Murchie 2010 [25] (UK)	Cluster RCT (35 practices); 142	Treated cutaneous melanoma, recurrence-free	GP-led vs. hospital	Greater satisfaction with GP-led care (summary score: 26.4, 95% CI: 24.9–27.9 vs. 33.5, 95% CI: 32.5–34.4; lower = more satisfied; P < 0.001); no SF-36 or HADS difference	Open label; unequal arms (53 vs. 89)
Moore 2002 [21] (UK)	RCT; 203	Lung cancer after initial treatment, expected survival ≥3 months; not restricted to early stage	Nurse-led vs. conventional medical	Median survival: 9.2 (95% CI: 6.2–12.1) vs. 10.4 (7.6–13.2) months, P = 0.99; less dyspnoea at 3 months (P = 0.03); better emotional functioning at 12 months (P = 0.03)	Open label; multiple patient-reported comparisons
Saltbæk (MyHealth) 2024 [27] (Denmark)	RCT; 503	Stage I–II breast cancer	Individualised nurse-led vs. physician-led visits	FACT-B TOI at 2 years, MD: 5.05 (95% CI: 3.30–6.79), P < 0.001; lower fear of recurrence, anxiety, and depression; physician visits 370 vs. 1,326	Open label with patient-reported primary outcome; single centre
Brown 2002 [32] (UK)	RCT; 61	Breast cancer after treatment	Patient-initiated vs. clinic follow-up	No major differences in QoL or psychological morbidity	Small; open label
Nielsen 2003 [16] (Denmark)	RCT; 248	Newly referred patients, mixed cancers, at start of care (not post-treatment)	Shared-care programme vs. usual care	Better patient evaluation of cooperation (especially men and patients aged 18–49); more GP contacts; no QoL or performance status difference	Open label; not a follow-up population; package intervention
Emery (ProCare) 2017 [28] (Australia)	Phase II RCT; 88	Low- to moderate-risk prostate cancer, within 8 weeks of completing treatment	Structured shared care vs. usual care	No clinically important differences in distress, QoL, or satisfaction; preference for shared care 63% vs. 24% (P < 0.001); cost AUS\$1,411 vs. AUS\$1,728 (difference AUS\$323, plausible range 91–554)	Phase II; small; not powered for clinical outcomes
Jefford (SCORE) 2023 [29] (Australia)	Non-inferiority RCT (margin −10 points); 150	Colorectal cancer after curative treatment	Structured shared care vs. usual oncologist care	GHS/QoL, MD: −4.0 (95% CI: −9.0 to 0.9), non-inferior; higher CEA test completion; similar recurrences; USD 314 lower health costs per patient	Open-label; patient-reported primary outcome
Chan (EMINENT) 2025 [30] (Australia)	Pilot RCT; 61	Stage 0–III breast cancer after treatment	Nurse-enabled shared care vs. specialist-led	No HRQoL difference (P > 0.05); 100% completion of intervention elements; fewer radiation oncology appointments (0.69 vs. 1.27 per patient, P = 0.013)	Pilot; single centre; not powered for clinical outcomes
Ke (BASIC)		Breast cancer ≥3	Interprofessional		Pilot; not

2025 [31] (Singapore)	Pilot RCT	years after treatment, low risk	shared care vs. usual care	Feasible and acceptable [▲ add primary outcome estimates from full text]	powered for effectiveness
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TABLE 2: Pivotal randomised controlled trials of alternative cancer follow-up models.

RCT: randomised controlled trials; SF-36: 36-Item Short Form Survey; GP: general practitioner; HRQoL: health-related quality of life; SF-12: 12-Item Short Form Survey; HADS: Hospital Anxiety and Depression Scale; QLQ-C30: Quality of Life Questionnaire-Core 30; MD: mean difference; FACT-B TOI: Functional Assessment of Cancer Therapy–Breast Trial Outcome Index; QoL: quality of life; CEA: carcinoembryonic antigen; GHS/QoL: global health status/quality of life (the summary scale of the European Organisation for Research and Treatment of Cancer QLQ-C30).

Certainty of Evidence by Outcome

The Cochrane review of follow-up strategies, which applied GRADE, illustrates how certainty differs by outcome: it concluded that non-specialist-led follow-up makes little or no difference to HRQoL (low-certainty evidence), anxiety (moderate certainty), and depression (high certainty), whereas its effects on overall survival, time to detection of recurrence, and cost were uncertain (very low-certainty evidence) [7]. MyHealth was published after that review [27]. For PIFU, a 2023 systematic review rated all 10 included RCTs as having risk-of-bias concerns, mainly related to missing data [12].

Populations Studied

Populations also differed across studies (Table 2). Most post-treatment follow-up trials enrolled survivors who had completed curative-intent treatment for early-stage or locoregional disease, for example early-stage breast cancer [18,27,30], colon or colorectal cancer after curative treatment [19,29,33], and, in BASIC, survivors at least three years after treatment who had been designated low risk by their oncologist [31]. There were important exceptions. Moore’s lung cancer trial enrolled patients who had completed initial treatment and were expected to survive at least three months, a population not restricted to early-stage disease [21]; Blaauwbroek’s non-randomised pilot included adult survivors of childhood cancer, a group with lifelong risk of late effects [15]; and Nielsen’s trial enrolled newly referred patients at the start of their cancer care rather than after treatment [16]. Conclusions drawn from the trial evidence therefore apply mainly to lower-risk survivors in the surveillance phase.

Model-level evidence: Three decades of randomised trials

Across three decades, randomised trials of alternative follow-up have mostly reported outcomes similar to those of specialist-led care in the populations studied, although the trials differ in population, intervention, outcome, and statistical design, and the certainty of the evidence varies by outcome [7]. Table 2 summarises the trials.

GP-Led Follow-Up

Grunfeld and colleagues’ 1996 UK trial randomised women with breast cancer in remission to routine follow-up in primary care or the hospital clinic and found no difference in time to detection of recurrence, HRQoL, or anxiety [24]. A companion analysis found that patients were at least as satisfied with primary care follow-up [34]. A larger Canadian trial (n = 968) of family physician versus specialist follow-up in early-stage breast cancer found no significant difference in recurrence-related serious clinical events or HRQoL, while shifting activity to a lower-cost setting [18]. Similar findings have been reported beyond breast cancer: Wattchow and colleagues found no difference between general-practice and surgeon-led follow-up for colon cancer in quality of life or recurrence detection [19], and Murchie and colleagues, in a cluster RCT, reported high patient satisfaction with GP-led melanoma follow-up [25]. In the Dutch I CARE trial, the summary quality-of-life score at one year did not differ significantly between GP-led and surgeon-led colon cancer survivorship care (mean difference: –2.3 points, P = 0.094), although role functioning and global health scores favoured surgeon-led care [33]. None of these trials was powered to detect differences in survival.

Nurse-Led Follow-Up

In Moore and colleagues’ lung cancer RCT, nurse-led follow-up was acceptable to patients, produced better emotional functioning scores and less severe dyspnoea, generated fewer investigations, and showed no survival disadvantage relative to conventional medical follow-up [21]. The largest recent trial, MyHealth, randomised 503 women with stage I-II breast cancer to individualised nurse-led follow-up (three to five self-management sessions, regular symptom reporting, and navigation to health services) or regular physician-led visits [27]. Breast cancer-specific quality of life at two years was higher with nurse-led follow-up (Functional Assessment of Cancer Therapy–Breast (FACT-B) Trial Outcome Index, mean difference: 5.05 points, 95% CI: 3.30-6.79), with lower fear of recurrence, anxiety, and depression, and far fewer physician visits [27]. MyHealth is therefore an important exception to the otherwise largely null quality-of-life literature.

Structured Shared Care

More recent RCTs have tested formalised shared care, in which care is explicitly divided between specialist and primary care using defined roles, protocols, and coordinating tools. The ProCare trial, a phase II RCT of 88 men (prostate), replaced two hospital visits with three primary care visits supported by an SCP, recall systems, and distress screening; it found similar disease-specific quality of life and psychological distress, lower costs, and a patient preference for shared care [28]. SCORE (colorectal; n = 150) demonstrated non-inferiority on global quality of life (mean difference: -4.0 points, 95% CI: -9.0 to 0.9; non-inferiority margin: -10), with similar unmet needs, satisfaction, and recurrence outcomes, better adherence to recommended carcinoembryonic antigen (CEA) surveillance, and lower costs [29]. EMINENT, a 61-participant pilot RCT in breast cancer, combined a specialist-nurse SCP consultation, a pharmacist consultation, and a GP case conference [35]; the intervention was feasible, HRQoL did not differ between groups, and the authors concluded that it appeared as safe as specialist-led care, although the pilot was not powered to assess uncommon clinical outcomes and larger studies are needed [30]. The Singapore BASIC pilot combined distress-thermometer screening, family physician review, three-monthly community-pharmacist teleconsultations, and an SCP, and established feasibility and acceptability in an Asian health system [31]. Because these trials describe their structural elements in detail, they allow the component mapping that follows. The earlier Danish RCT of Nielsen and colleagues, conducted in newly referred patients rather than in post-treatment follow-up, tested a programme centred on oncologist-to-GP communication [16].

Summary Across Models

Several trials reported no detected differences in recurrence-related outcomes [18,19,21,24,29], but the overall evidence remains insufficient to establish survival and recurrence-detection equivalence across models [7]. Patient satisfaction was generally similar or higher with the alternative model [21,25,28,29,34]. Several trials reported lower costs [18,28,29], although cost evidence overall is of very low certainty [7], and lower costs alone do not establish cost-effectiveness. Quality-of-life findings are mixed: many trials report no difference [7,18,24,29], some domains favoured surgeon-led care in I CARE [33] whereas the MyHealth trial found clinically relevant improvements with individualised nurse-led follow-up [27].

Interpreting Similar Outcomes

Similar outcomes may support adoption in appropriately selected patients when surveillance protocols, communication pathways, and timely specialist access are maintained [7,29]. Similar average outcomes do not, however, establish that models are interchangeable, nor do they explain why some interventions were associated with better satisfaction, adherence, process, or quality-of-life outcomes while others were not. The trials that reported such differences (SCORE's surveillance adherence, ProCare's patient preference, and MyHealth's quality-of-life improvement) differ in their constituent components as much as in their model labels [27-29]. This is the central limitation of a model-by-model reading of the evidence and the starting point for the component-level mapping that follows.

Mapping the components: What might drive the benefit?

Every model tested is a package of separable components: an SCP here, a GP protocol there, a nurse coordinator, a pharmacist consultation, a patient-completed distress screen. Because these components recur across models that are otherwise heterogeneous in structure and setting, the randomised evidence can be re-read across the model taxonomy to ask where each component was present and what the packages containing it achieved. Because almost all trials tested complete packages, this mapping cannot establish the independent effect of any single component; its purpose is to identify patterns and generate hypotheses for component-level trials.

GP Education and Protocol Provision

In every GP-led trial reviewed here, the GP was supported by structured guidance. In Grunfeld's Canadian breast cancer RCT, family physicians followed a defined guideline framework with educational materials and a rapid re-referral pathway [18]. Wattchow's colon cancer trial similarly provided GPs with explicit follow-up guidance, including scheduled clinical review and surveillance testing [19]. Blaauwbroek's non-randomised pilot of shared care for adult survivors of childhood cancer was likewise supported by an SCP and structured guidelines for the family doctor, and was reported to be feasible [15]. Structured guidelines and re-referral pathways were therefore common features of the evaluated GP-led interventions, but their independent contribution to safety has not been established, because no trial compared otherwise identical models with and without protocols. Uncertainty about surveillance schedules and re-referral thresholds is a frequently reported reason for GP reluctance to assume follow-up [8,9,14], which makes protocol provision a plausible candidate component for formal testing.

Survivorship Care Plans

No component has been tested more often than the SCP, and its reported effects depend on the outcome

examined. Grunfeld's RCT of an SCP for breast cancer survivors transferring to primary care found no improvement in cancer-specific distress, HRQoL, patient satisfaction, or continuity of care compared with usual care [36]. This is one influential negative trial rather than a definitive verdict on all care-plan formats, populations, and outcomes.

Other trials embedded SCPs within broader packages, with different results. In SurvivorCare, an SCP combined with a needs assessment, educational materials, an end-of-treatment session, and three nurse telephone calls did not reduce distress or unmet needs or improve quality of life among colorectal cancer survivors, but significantly increased satisfaction with care [37]. In Maly's trial among 212 low-income, predominantly Latina breast cancer survivors, a tailored SCP accompanied by a one-hour session with a bilingual nurse increased the extent to which physicians implemented recommended survivorship care (mean implementation score: 60.8 versus 48.6), without a difference in quality of life [38]. In a clinic-based survivorship intervention trial in breast cancer, SCPs showed limited effect on adherence to lifestyle recommendations [39,40].

A systematic review of 13 randomised and 11 non-randomised studies reached a similar overall conclusion: randomised studies were mostly negative for physical, functional, and psychological well-being, whereas findings were more positive for proximal outcomes such as information received, satisfaction with care, and physician implementation of recommended care, particularly when SCPs were delivered with counselling [13]. Taken together, these data suggest that any value of the SCP may lie less in the document itself than in how it is delivered and acted upon, a hypothesis that trials comparing delivery formats could test.

Structured Intersectoral Communication

Almost every model assumes oncologist-to-GP information transfer, but no RCT has isolated communication as a single component. The closest test is Nielsen's Danish trial in 248 newly referred cancer patients, in which the intervention combined a knowledge package transferred from oncologist to GP, improved communication channels between the two, and active patient involvement, including encouragement of patient contact with the GP [16]. The programme improved patients' evaluation of cooperation between primary and secondary care, particularly among men and younger patients (18-49 years), and increased GP contacts, without differences in quality of life or performance status [16]. Because the intervention was itself a package, delivered at the start of cancer care rather than during post-treatment follow-up, its effects cannot be attributed to communication alone. Communication failure between settings is nonetheless among the most frequently reported barriers to shared care [11,14], and structured communication remains under-tested as a discrete component, a genuine gap given that every other component depends on it.

Pharmacist Teleconsultation

Pharmacist input is the newest and least-evidenced component, appearing only in the most recent generation of trials, and the two trials that include it do so differently. In EMINENT, the pharmacist contribution is a single telehealth consultation for medication reconciliation and education, delivered by a hospital cancer pharmacist and embedded within the nurse-coordinated package [30,35]. BASIC is the only trial to test recurring pharmacist teleconsultation as a standing component: three-monthly teleconsultations with community pharmacists, coordinated through the SCP [31]. The rationale is plausible: endocrine therapy adherence and toxicity monitoring, polypharmacy reconciliation, and comorbidity management are tasks that often fall between oncologist and GP and are well matched to pharmacist expertise. Both trials establish feasibility and acceptability; neither is powered for effectiveness. Pharmacist teleconsultation is therefore best characterised as a proof-of-concept component with a mechanistic rationale and no efficacy evidence yet.

Nurse Care Coordination

The EMINENT model positions the specialist nurse as the connective element of the intervention: the nurse co-develops the SCP, sequences the pharmacist consultation, convenes the GP case conference, and sets the shared follow-up schedule [35]. In the pilot, this arrangement was feasible, with no between-group difference in HRQoL [30]. In SurvivorCare, a nurse-delivered package increased satisfaction but not quality of life [37]. In MyHealth, the nurse role combined navigation to health services with structured self-management support and symptom reporting, and quality of life improved [27]; because coordination and self-management support were delivered together, the benefit cannot be attributed to coordination alone. Coordination may also involve rehabilitation services when cancer-related symptoms impair function [41]. Implementation studies point to coordination failure, unclear role boundaries, and communication breakdown between settings as commonly reported barriers to shared care [14,42]. A dedicated coordinator is a plausible response to these barriers, but its independent effect on patient-reported outcomes has not been isolated.

Patient Activation Tools

Distress thermometers, question-prompt lists, needs assessments, and self-management support recur across trials as add-on components. BASIC embedded a distress thermometer and problem list completed before the family physician consultation [31]; SurvivorCare incorporated a structured needs assessment [37]; Maly's nurse counselling session functioned as patient activation layered onto the SCP [38]; and MyHealth's self-management sessions and symptom reporting are activation-oriented components within a nurse-led model [27]. Evidence on who benefits from these tools is limited and exploratory. In the Maly trial, differences between Latina and non-Latina participants were reported for the intervention arm and should be regarded as exploratory [38], and BASIC and EMINENT were pilots not powered for subgroup analyses [30,31]. Outside shared care, a secondary moderator analysis of the Oncokompas eHealth self-management RCT found larger HRQoL benefit among survivors with lower self-efficacy, higher personal control, and higher health literacy, and larger symptom benefit among those with a higher baseline symptom burden [43]. Whether activation tools benefit particular subgroups of shared-care recipients has not been tested in adequately powered trials with prespecified interaction tests.

Synthesis: Patterns Across Components

Table 3 maps each component to the trials that included it and the direction of the observed effects. Two tentative patterns emerge, both of which require confirmation in component-level trials. First, in the available trials, components appear to align with outcome types: GP protocols and nurse coordination were common features of packages with similar safety-related outcomes, whereas SCPs and activation tools were more often associated with satisfaction and process outcomes, such as physician implementation of recommended care, than with quality of life. Quality of life improved in one large trial, MyHealth, whose nurse-led model combined individualised self-management support, symptom reporting, and navigation [27]. One hypothesis is that quality of life is more likely to change when follow-up actively addresses symptoms and supportive-care needs than when it changes only who delivers surveillance; however, differences in populations, timing, outcome instruments, and trial design could also explain the variation, and this review cannot attribute negative findings to component content alone. Second, the components that might plausibly be most active, structured intersectoral communication and self-management or activation support, are among those least often tested in isolation. The field has mostly tested whole packages; dismantling designs are needed to identify the contribution of each part.

Component	Key trials	What was tested	Principal finding
GP education and protocol provision	Grunfeld 2006 [18]; Wattchow 2006 [19]; Blaauwbroek 2008 (non-randomised pilot) [15]	GP-led follow-up under structured guidelines, education, and re-referral pathways	Present in all GP-led packages with no detected differences in recurrence-related outcomes; independent contribution not established
Survivorship care plans	Grunfeld 2011 [36]; SurvivorCare [37]; Hershman 2013 [39]; Maly 2017 [38]; EMINENT [30]; BASIC [31]; systematic review [13]	SCP alone or as the core of a package, vs. usual care	No reliable QoL or distress benefit; gains in satisfaction and physician implementation of recommended care in some trials, mainly when delivered with counselling
Structured intersectoral communication	Nielsen 2003 [16]	Package of oncologist-to-GP knowledge transfer, communication channels, and patient involvement, in newly referred patients	Better patient evaluation of cooperation, especially men and patients aged 18–49; no QoL difference; not isolated as a single component
Pharmacist teleconsultation	BASIC [31] (recurring, community pharmacist); EMINENT [30] (single, cancer pharmacist)	Teleconsultation for endocrine therapy monitoring, polypharmacy, and comorbidity	Feasible and acceptable; not powered for effectiveness
Nurse care coordination	EMINENT [30]; SurvivorCare [37]; MyHealth [27]	Nurse as coordinator across GP, pharmacist, and oncologist; nurse-led individualised follow-up with navigation	Feasible; satisfaction improved in SurvivorCare; QoL unchanged in EMINENT and SurvivorCare but improved in MyHealth, where coordination was combined with self-management support
Patient activation tools	Maly 2017 [38]; BASIC [31]; SurvivorCare [37]; MyHealth [27]	Distress thermometers, question-prompt lists, needs assessments, self-management sessions as add-ons	Exploratory subgroup signals only; no adequately powered, prespecified interaction tests

TABLE 3: Intervention components: Which trials included each component, and with what reported result.

GP: general practitioner; QoL: quality of life; SCP: survivorship care plan.

For whom does shared care work best? Moderators of effect

The model-level and component-level findings above describe average effects. Averages conceal a more clinically actionable question: For whom, and under what conditions, does shared care deliver benefit rather than merely match specialist-led care? Because almost every trial in this literature was powered for its main comparison rather than for interaction testing, moderator evidence derives largely from underpowered subgroups and cross-trial comparison and should be read as hypothesis-generating. Four domains recur, and one cross-cutting signal (cultural and literacy tailoring) is conceptually important but little studied.

Cancer Type

The evidence base is heavily weighted toward breast and colorectal cancer. Breast cancer is anchored by the Grunfeld family physician trials [18,24], MyHealth [27], and, more recently, the nurse-enabled EMINENT [30] and pharmacist-inclusive BASIC [31] models. Colorectal cancer is supported by the Wattchow GP-versus-surgeon trial [19], the GP-led I CARE trial [33], and SCORE [29]. Prostate cancer is an emerging third stream, with ProCare providing the principal randomised signal [28]. Gynaecological and head and neck cancers remain markedly under-represented, and lung cancer evidence rests largely on a single nurse-led trial [21], so the conclusions of the model-level evidence apply chiefly to breast and colorectal cancer and should be extrapolated to other cancers only with caution.

Patient Factors

Age, comorbidity burden, health literacy, care preference, and geographic remoteness may all moderate effects. Self-selection is visible in the trials themselves: in I CARE, participants were on average younger and more often male than decliners, constraining generalisability [33]. A higher comorbidity burden may strengthen rather than weaken the case for GP involvement, since continuity and whole-person management are primary care strengths, although this has not been tested directly. Health literacy is a potential patient-level moderator that may influence whether information-transfer components such as

SCPs translate into empowerment or merely into paperwork [43]. Preference may also matter: survivors who value continuity may be better served by GP-led models, whereas those who derive reassurance from specialist contact may experience shared care as a loss.

Disease Factors

As summarised above and in Table 2, most post-treatment trials enrolled survivors after curative-intent treatment for early-stage or locoregional disease, with exceptions in lung cancer [21], adult survivors of childhood cancer [15], and newly referred patients [16]. The evidence therefore speaks mainly to lower-risk survivors in the surveillance phase and does not, on its own, support transfer of high-risk or treatment-complex patients to shared care.

System Factors

Trials span publicly funded systems in the UK (Grunfeld, 1996) [24] and Canada (Grunfeld, 2006) [18], a mixed public-private system (BASIC, Singapore) [31], and universal-coverage systems with strong primary care (I CARE, Netherlands; MyHealth, Denmark; SCORE and EMINENT, Australia) [27,29,30,33]. Implementation studies suggest that two system-level conditions may be particularly important: GP familiarity with oncology follow-up and specialist willingness to relinquish surveillance [9,14,42]. Where either is absent, the components described above may not be deliverable as designed.

Cultural Adaptation and Health Literacy

An instructive, though exploratory, signal comes from populations in which shared-care components were deliberately adapted. In the Maly trial, a culturally and linguistically tailored SCP plus nurse counselling was delivered to low-income, predominantly Latina survivors; within the intervention arm, about 97% of Latina survivors versus 74% of non-Latina survivors reported that the plan improved communication with their physicians [38]. These are exploratory comparisons and do not establish ethnicity, language, or health literacy as treatment-effect moderators. The finding should also be distinguished from the Hershman/Greenlee analyses, in which SCPs showed only limited effect on lifestyle adherence [39,40]: the Maly signal concerns communication and empowerment, not behaviour change. BASIC extends the question to an Asian primary care setting, demonstrating the feasibility of a shared-care model designed for that health system [31]. Exploratory findings therefore suggest that culturally and linguistically tailored interventions may improve communication, but the influence of health literacy and cultural context requires further study in adequately powered trials.

Implementation: From trial to practice

Shared and GP-led follow-up have accumulated nearly three decades of generally favourable evidence (similar patient-reported outcomes, better guideline-concordant surveillance in SCORE, high patient satisfaction and preference, and lower costs in several trials), yet specialist-led hospital follow-up remains the dominant model internationally [11,28,29]. Implementation barriers are one important reason for this gap, alongside remaining uncertainty about clinical outcomes, applicability to higher-risk patients, and transferability across health systems.

Barriers and Enablers

The most systematic provider-side accounts of why translation stalls come from the qualitative substudies embedded within these trials. The ProCare-linked focus-group study of health professionals and the SCORE interview studies of participating oncologists and GPs converge on a consistent set of obstacles [9,14,42]. A systematic review of facilitators and barriers reinforces that these operate at clinician, patient, and system levels simultaneously [14]. The same studies identify actionable enablers, summarised in Table 4.

Barrier	Corresponding enabler
GP uncertainty about oncological surveillance	Structured, cancer-specific follow-up protocols and GP management guidelines
Communication failures between settings	Agreed bilateral communication channels; shared survivorship care plans (SCPs)
Unclear role boundaries	Explicit delineation of provider responsibilities within the SCP
Fragmented information across settings	IT infrastructure enabling cross-setting record sharing and recall systems
Coordination burden falling on unfunded staff	Nurse-led care coordination; dedicated remuneration frameworks
Provider unfamiliarity with the model	Targeted GP education and structured onboarding

TABLE 4: Barriers to shared/GP-led survivorship care and corresponding enablers.

Barriers to shared/GP-led survivorship care and corresponding enablers are synthesised from provider-side evidence [8,37,38].

The recurrence of structured protocols, SCPs, GP education, nurse coordination, and IT infrastructure across independent studies suggests that these may be important enabling conditions for the model to function [9,14,42].

GP: general practitioner; SCP: survivorship care plan.

Implementation Frameworks

Implementation science offers a formal vocabulary for this translation gap. The RE-AIM framework directs attention beyond efficacy to Reach, Adoption, Implementation, and Maintenance [44]; these dimensions have been reported less often than efficacy outcomes in shared-care trials, and this reporting gap may contribute to the slow diffusion of positive findings [11]. The Consolidated Framework for Implementation Research (CFIR) situates uptake within intervention characteristics, inner and outer setting, individuals, and process, and has been applied directly to survivorship-model design [45,46]. A CFIR-guided formative evaluation at Kaiser Permanente, for example, surfaced acceptability and feasibility concerns among clinical and operational stakeholders before trial launch, the kind of pre-implementation diagnostic that earlier efficacy trials omitted [46].

Implementation-Focused Trials

These frameworks are now shaping a generation of explicitly implementation-focused studies. The MOSES trial, a national implementation study of a shared-care model for prostate cancer survivors spanning acute centres and general practices across several Australian states, builds on the ProCare pilot [28,47]. In the United States, the Engaging Primary Care in Cancer Survivorship (EPICS) study at Kaiser Permanente Southern California evaluates models that engage primary care in survivorship follow-up within an integrated system [48], building on the CFIR-informed formative work above [46]. Together they mark a shift from asking whether shared care can work to asking how it can be reliably adopted, scaled, and sustained in routine care.

Gaps, future directions, and a proposed research agenda

The Component Isolation Problem

Shared-care models are complex interventions: they bundle SCPs, GP consultations, nurse or pharmacist input, patient education, and coordination mechanisms. As a conventional two-arm RCT evaluates the intervention only as a whole, it cannot isolate the effects of individual components [49]. We recommend factorial and dismantling trials, for example under the Multiphase Optimization Strategy (MOST), to assess the contributions of individual components and identify combinations that meet prespecified clinical and patient-reported outcome targets within local resource constraints, such as cost, staffing, and patient burden [49]. As the optimal combination is likely to differ across settings, the aim is to identify context-appropriate combinations rather than a single universal bundle. Aligning these optimisation trials with the updated Medical Research Council (MRC) framework for complex interventions would strengthen their theoretical grounding and implementation relevance [50].

Under-Studied Cancer Types

The evidence base is dominated by breast and colorectal cancer. Lung cancer evidence rests largely on Moore's nurse-led trial [21], with lung cancer survivors otherwise included mainly in mixed-tumour self-management trials [51]; head and neck cancer survivors appear chiefly in eHealth evaluations [43,52]; and

gynaecological cancer survivors are effectively absent from shared-care RCTs. These high-symptom-burden populations are a priority for dedicated trials.

Under-Studied Populations

Almost all trial data originate in high-income settings. In low- and middle-income countries (LMICs), disparities in healthcare access, infrastructure, and support systems hinder comparable progress; specialised survivorship centres are rare, and robust data remain scarce [53]; guidelines developed in high-income countries are frequently unsuitable where the oncology workforce is limited and primary care training is deficient [54]. Ethnic-minority survivors and older survivors with a high comorbidity burden are similarly under-represented and warrant purpose-designed studies.

The Pharmacist Gap

The BASIC pilot demonstrated that community pharmacists can be embedded in an interprofessional shared-care model through structured teleconsultations, establishing feasibility and acceptability [31]. It was, however, a single-site pilot; adequately powered effectiveness trials are needed.

Digital Integration

eHealth tools may strengthen any model. In a randomised trial across head and neck, colorectal, and breast cancer and lymphoma survivors, Oncokompas improved HRQoL and reduced some tumour-specific symptoms, although effect sizes were small and patient activation was unchanged [52]; a secondary moderator analysis suggested greater benefit for some subgroups, including head and neck and colorectal cancer survivors with a higher symptom burden [43]. Embedding patient-reported outcome platforms within shared care is a logical next step.

The Quality-of-Life Measurement Problem

Generic instruments may not capture what shared care is intended to change, such as continuity, holistic care, and reduced logistical burden, and so may miss real differences between models. Continuity, unmet-need, and experience measures should be considered as co-primary outcomes. Table 5 summarises a proposed research agenda.

Priority	Design	Population	Primary outcome(s)
1. Component-isolation trial	Factorial/MOST optimisation RCT [49, 50]	Mixed-tumour survivors	Contribution of each component; combinations meeting prespecified HRQoL and clinical targets within resource constraints
2. Neglected-tumour trial	Pragmatic multisite RCT	Lung, gynaecological, or head and neck cancer survivors [21,51,52]	HRQoL, unmet needs, continuity
3. LMIC scalability trial	Cluster RCT of pharmacist/community health worker-enabled model [31,53,54]	LMIC survivors	Feasibility, HRQoL, cost

TABLE 5: Proposed research agenda.

HRQoL: health-related quality of life; LMIC: low- and middle-income country; MOST: Multiphase Optimization Strategy; RCT: randomised controlled trial.

Limitations of This Review

This review has several limitations of its own. First, it is a narrative review: although informed by a structured search, it was not prospectively registered, and study selection and data extraction were not performed in duplicate, so relevant studies may have been missed, and selection may have been influenced by the authors’ framing. Second, the main search was conducted in a single database (PubMed/MEDLINE), was limited to English-language publications, and ended on 20/07/2026; trials published after that date are not included. Third, no formal risk-of-bias assessment of individual studies or certainty-of-evidence grading was undertaken, and no PRISMA flow diagram is provided; design features relevant to bias are tabulated instead (Table 2); statements about certainty rely on the GRADE assessments of the Cochrane review [7]. Fourth, the component coding depends on the detail with which interventions were reported, which was

often limited, and on the authors’ judgement. Fifth, because almost all trials tested multicomponent packages, the component-level patterns described here are associations derived from cross-trial comparison, which is vulnerable to confounding by population, setting, and design; they should be treated as hypotheses rather than findings. Finally, a small number of non-randomised or contextual sources were used, and these are identified where cited.

Conclusions

Three decades of randomised trials show that, in selected and mostly lower-risk survivor populations, GP-led, nurse-led, and structured shared-care follow-up generally produce patient-reported outcomes similar to those of specialist-led follow-up, and several trials reported higher satisfaction, better adherence to recommended surveillance, or lower costs. Evidence on survival and recurrence detection remains uncertain, quality-of-life findings are mixed, and economic and acceptability findings differ across studies and settings. These models are therefore reasonable options for appropriately selected patients when surveillance protocols, communication pathways, and timely specialist access are maintained.

Mapping the trials onto their components generates hypotheses rather than conclusions. GP protocols, SCPs, intersectoral communication, nurse coordination, pharmacist input, and self-management or activation support recur across interventions, but their independent and interactive contributions remain unknown. Future research should use factorial and dismantling designs to test these contributions against prespecified clinical and patient-reported outcome targets within local resource constraints, include under-represented cancer types, populations, and settings, and embed implementation research from the outset.

Appendices

Literature search strategy

This appendix reports the information sources, the PubMed/MEDLINE search strings, and the eligibility criteria used to identify the randomised controlled trials and implementation sub-studies synthesised in this narrative review.

Source	Coverage and purpose
PubMed/MEDLINE	Primary bibliographic database; January 1996 to December 2025; English-language publications.
Trial registries (ClinicalTrials.gov, ISRCTN registry, ANZCTR)	Identification of registered trials, including ongoing implementation trials without indexed results papers.
Citation tracking	Backwards and forward citation tracking of the foundational trials and of prior systematic reviews of survivorship care models.
Conference proceedings	Hand-searching of major oncology conference proceedings for studies without full-text indexed publications.

TABLE 6: Information sources.

ISRCTN: International Standard Randomised Controlled Trial Number; ANZCTR: Australian New Zealand Clinical Trials Registry.

#	Concept block	Search string
1	Cancer and survivorship	"Neoplasms"[Mesh] OR "Cancer Survivors"[Mesh] OR cancer*[tiab] OR oncolog*[tiab] OR survivorship[tiab]
2	Alternative follow-up model	"shared care"[tiab] OR "general practitioner"[tiab] OR "GP-led"[tiab] OR "nurse-led"[tiab] OR "nurse coordinat*" [tiab] OR "patient-initiated follow-up"[tiab] OR PIFU[tiab] OR "survivorship care plan*" [tiab] OR "model* of care" [tiab]
3	Follow-up and continuity of care	"Aftercare"[Mesh] OR "Continuity of Patient Care"[Mesh] OR "follow-up"[tiab] OR "follow up"[tiab] OR aftercare[tiab]
4	Study design (randomised controlled trial filter)	randomized controlled trial[pt] OR randomized[tiab] OR randomised[tiab] OR randomly[tiab]
5	Main search (trials)	#1 AND #2 AND #3 AND #4
6	Implementation and qualitative terms	implementation[tiab] OR barrier*[tiab] OR facilitator*[tiab] OR "RE-AIM"[tiab] OR CFIR[tiab] OR qualitative[tiab]
7	Parallel search (implementation substudies)	#1 AND #2 AND #6
8	Limits applied to #5 and #7	English[lang] AND ("1996/01/01"[dp] : "2025/12/31"[dp])

TABLE 7: PubMed/MEDLINE search strategy.

Mesh: Medical Subject Headings; tiab: title/abstract field; pt: publication type; lang: language; dp: date of publication; GP: general practitioner; PIFU: patient-initiated follow-up; RE-AIM: Reach, Effectiveness, Adoption, Implementation, Maintenance; CFIR: Consolidated Framework for Implementation Research.

The asterisk (*) denotes truncation.

Criteria	Inclusion
Population	Adult cancer survivors, or long-term survivors of childhood cancer, in the post-treatment phase; any cancer type.
Intervention	General practitioner-led, nurse-led, structured shared care, or patient-initiated follow-up model.
Comparator	Specialist-led or usual care follow-up.
Study design	Randomised controlled trials, or their pre-planned qualitative substudies.
Outcomes	At least one relevant outcome (clinical, patient-reported, process, cost, or implementation).
Language and period	English-language publications, January 1996 to December 2025.

TABLE 8: Eligibility criteria.

Included trials were decomposed into their constituent intervention components so that evidence could be synthesised at the component level. All cited references were confirmed to be PubMed-indexed with a verified PubMed identifier (PMID).

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

Concept and design: Khulood K. Burashed, Hind E. Alsindi

Acquisition, analysis, or interpretation of data: Khulood K. Burashed

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Disclosures

Conflicts of interest: In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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