Table 1. Models of survivorship care plans according to the main scientific societies

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| SCIENTIFIC SOCIETY | TYPE OF CARE MODEL | CARE TEAM | DIAGNOSIS AND TREATMENT | FOLLOW-UP CARE PLAN | OTHER HIGHLIGHTS |
| American Society of Clinical Oncology | Simultaneous sharing. | Family doctor, oncologist, radiotherapy, oncologist, surgeon, oncology nurse and social worker. | Diagnosis background (cancer type, date and stage).  Type of treatment.  Symptoms and/or side effects after active treatment. | Early detection of recurrences and management of long-term side effects.  Continuous treatment, visit schedule and diagnostic tests. Information on alarm symptoms and consultation with a care plan physician.  Concerns during the transition to the survivorship stage in relation to different needs. | Survivorship support centres.  Patient associations. |
| Minnesota Cancer Alliance | Sequential sharing. | Not specified. Patients are only described as paired with a medical figure, not a nurse.  Family support. |  | Detection and management of long-term side effects.  Schedule of visits and diagnostic tests.  A medical professional should attend for each case.  Problems or concerns that may arise in relation to different aspects.  Survivor environment. |  |
| Institute of Medicine | Sequential sharing. | Specialized team.  Primary care team. | Diagnostic tests. Characteristics of the tumour. Type of treatment. Toxicities during treatment. | Probable course of recovery from treatment toxicities. Continuous treatment. Schedule of visits and diagnostic tests. Identification of a key point of contact and a continuous care coordinator. Psychosocial, nutritional and other support services provided. |  |

Table 2. Summary of results

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| AUTHOR  Country | OBJECTIVE | SAMPLE | DESIGN | SURVIVORSHIP CARE PLAN (SCP) | NURSING PARTICIPATION | KEY RESULTS | JBI QUALITY |
| Baker De Guzman et al.,  (2014)  United States | To know the care plan, perceptions and the planning needs of rural cancer survivors with low income after treatment. | N=7  Breast cancer | Longitudinal descriptive. Qualitative. | Based on the ASCO model.  Created 6 months-2 years after the end of treatment.  SCP + follow-up visit. | Design and delivery.  In-person visit. | SCPs were not identified as such in the midst of a great deal of bureaucracy.  Information related to diagnosis and treatment was recalled, along with difficulties related to follow-up during survival.  Parcelling out the information and establishing a schedule for follow-up visits were recommended. | 5 |
| Boekhout et al.,  (2015)  Canada | To evaluate the implementation of a SCP versus usual care. | N= 408  Breast cancer. | Randomized Control Triel. | Based on the IOM model.  Referral to PC for follow-up. | In-person delivery. | The SCP was not considered very useful in terms of adherence to the plan, knowledge about the person responsible for the treatment or increasing the number of hospital visits.  Greater adherence to the SCP and its increased usefulness in research is expected more than two years after the end of treatment. | 8.33 |
| Brant et al.,  (2016)  United States. | To examine the evolution of symptoms and quality of life in survivors after a SCP implemented by a continuity of care nurse. | N= 67  Lymphoma (15) and breast (52) cancers. | Descriptive. | No model specified.  Survival is planned,  starting at diagnosis.  Involves the primary caregiver. | Delivered by nurse  PC physician provides explanation and follow-up. | Fatigue was a relevant problem for the patient.  The SCP decreased the anxiety of the survivors. | 7.5 |
| Clarke et al., (2020)  United Kingdom. | To evaluate the detection of the holistic needs of the cancer survivor with the use of a SCP. | N=68  Prostate cancer. | Randomized Control Triel. | No model specified.  SCP with online monitoring and in-person appointments as required. | Delivery and monitoring. | Little use of plans despite providing training for all professionals. When plans are delivered, coordination of care is achieved. Most of the holistic needs were detected.  Perceived as useful by patients and nurses. | 7.25 |
| Coyle et al.,  (2014)  Canada. | To evaluate the profitability of a SCP versus usual care. | N= 408  Breast cancer. | Randomized Control Triel. | No model specified.  SCP + face-to-face visit.  PC follow-up guide provided. | Design, delivery and explanation. | The SCP arm did not have better results in terms of QALYs.  The SCP arm had increased care costs. | 6.25 |
| AUTHOR  Country | OBJECTIVE | SAMPLE | DESIGN | SURVIVORSHIP CARE PLAN (SCP) | NURSING PARTICIPATION | KEY RESULTS | JBI QUALITY |
| de Rooij et al.,  (2017)  Holland. | To evaluate the long-term impact of an automatically generated SCP on patients with ovarian cancer. | N= 174  Ovarian cancer. | Randomized Control Triel. | Based on the IOM model.  SCP created at a face-to-face visit at the end of treatment. | Collaboration in design, delivery and monitoring. | Compared with the usual care arm, the SCP arm was less likely to believe that treatment would help cure the disease and had fewer visits to a specialist at 6 months. | 8.33 |
| de Rooij et al.,  (2019)  Holland. | To evaluate the impact of the SCP compared to an information-based coping style. | N= 131  Ovarian and endometrial cancer. | Randomized Control Triel. | Based on the IOM model  SCP created at a face-to-face visit at the end of treatment | Collaboration in design, delivery and monitoring. | There were no significant differences according to the type of cancer and the coping style. The SCP was the most effective strategy for improved coping. | 8.33 |
| Ezendam et al.,  (2014)  Holland. | To evaluate the effect that sending the SCP to the PC physician has on communication with the rest of the team and the patient. To determine the opinion of the PC physician regarding the SCP. | N=266  Endometrial cancer. | Randomized Control Triel. | Based on the IOM model.  SCP created after surgery at a face-to-face visit.  Copy sent to PC physician. | Collaboration in design, delivery and monitoring. | SCP arm: Provided benefits for communication with the patient (1/4) but should be more concise.  82% wanted to receive SCPs in the future; 84% preferred electronic SCPs.  40% would like to participate more in the care of the survivor. | 8.33 |
| Glaser et al., (2019)  United States. | To describe a comprehensive person-centred survivor care programme. | N=908  Various cancers. | Descriptive. | No base model specified.  Self-created. | Design, delivery and monitoring. | Comprehensive SCPs were developed using the SCP tool. SCPs considered survival, support services and the principles of integrative medicine. Both professionals and patients agreed with comprehensive care and the SCP; the goal of smooth transition could be achieved with easy access and ease of information transfer and would require institutional support, leadership and funding. | 5 |
| Hawkins-Taylor et al.,  (2019)  United States. | To examine the use of SCPs. | N=189  Various cancers. | Multicentre descriptive. | No model specified.  Includes a treatment summary, possible late and long-term effects, signs of cancer recurrence and instructions for follow-up care. | Design, delivery and monitoring. | Among the most frequent uses of the SCP by the patient were sharing it with his/her spouse and requesting information from doctors and nurses about symptoms. The least common was sharing it with the PC physician. Patients with some types of cancer (gynaecological) showed greater use of the SCP. | 7.33 |
| AUTHOR  Country | OBJECTIVE | SAMPLE | DESIGN | SURVIVORSHIP CARE PLAN (SCP) | NURSING PARTICIPATION | KEY RESULTS | JBI QUALITY |
| Jefford et al.,  (2013)  Australia. | To evaluate the impact of a SCP implemented by nurses versus usual care. | N=180  Colon cancer. | Randomized Control Triel. | No model specified.  SCP + educational materials. | Delivery and telephone follow-up. | There were no differences between the two arms with respect to psychological disorders. | 8.33 |
| Jeppesen et al.,  (2018)  Holland. | To evaluate the impact of the SCP on the use of health care after endometrial cancer treatment. | N= 221  Endometrial cancer. | Randomized Control Triel. | Based on the IOM model.  SCP created at a face-to-face visit at the end of treatment. | Collaboration in design, delivery and monitoring. | Compared with the usual care arm, the SCP arm had more PC visits at 6 months (p = 0.04) and 12 months (p < 0.01).  Visits decreased after 24 months. | 8.33 |
| Maly et al.,  (2017)  United States. | To examine the effects of a SCP plus a nursing consultation versus usual care. | N=212  Breast cancer. | Randomized Control Triel. | Based on the Minnesota Cancer Alliance model. | Delivery and monitoring. | Increased concern about being overweight. Greater adherence among patients in the SCP arm.  Married participants were less adherent to the plan; therefore, involvement of both members of the couple was recommended. | 7.5 |
| Mayer et al.,  (2014)  United States | To evaluate the viability and ease of use of a SCP and to define the optimal time of delivery during the first 12 months after diagnosis. | N=28  Colon cancer. | Descriptive. | Based on the Minnesota Cancer Alliance model  Printed copy to the PC physician. | APN design  Nurse delivery and agreement with the patient. | SCP completion time: If the patient only underwent surgery, 50 min; if the patient also underwent chemotherapy, 90 min.  Delivery to patient: For surgery-only patients, 16 min; for surgery and chemotherapy patients, 26 min.  Participants felt the SCPs were easy to understand and that enough time and active participation are dedicated to them.  Professionals perceived the SCPs as useful but very long. | 7.5 |
| Mayer et al.,  (2016)  United States. | To compare the delivery of the care plan alone versus the delivery of the plan plus a follow-up visit with the primary care (PC) physician. | N=34.  Various cancers. | Randomized Control Triel Pilot. | Based on the IOM model.  SCP + PC physician visit. | Design and delivery. | Improved confidence was reported in both groups. Motivation and empowerment of the survivor can improve confidence and adherence to the plan.  Increased concern = unintended consequences that decreased with SCP + visit. | 9.1 |
| AUTHOR  Country | OBJECTIVE | SAMPLE | DESIGN | SURVIVORSHIP CARE PLAN (SCP) | NURSING PARTICIPATION | KEY RESULTS | JBI QUALITY |
| Miller et al.,  (2008) United States | Describe the development, implementation, and evaluation of a survivor care plan as a guide for other clinical areas | N=5  Breast cancer | Descriptive | Based on the IOM model | Collaboration in design, delivery and monitoring. | There was positive reaction to the SCP from all the survivors. The information on relapse prevention was very useful for survivors to understand the meaning of cancer recurrence Active participation of survivors was achieved. The therapeutic relationship with nurses was improved, increasing survivors’ trust in nurses | 7,5 |
| Nicolaije et al.,  (2013)  Holland. | To evaluate the expectations and real experiences of gynaecologists, oncologists and oncology nurses with the use of an automatically generated SCP. | N=43  Endometrial cancer. | Randomized Control Triel. | Based on IOM model.  SCP created at a face-to-face visit at the end of treatment.  Distress thermometer. | 21% nurses  Collaboration in design and delivery. | Similar expectations and motivations in both groups. SCP arm: There was no increase in the consultation time or information provided, nor was an excessive amount of information provided, although there was little time for sharing.  75% recommended delivery by nurse. | 8.33 |
| Nicolaije et al.,  (2015)  Holland. | To evaluate the impact of an automatically generated SCP on patients. | N=147  Endometrial cancer. | Randomized Control Triel. | Based on the IOM model.  SCP generated automatically. | Collaboration in design, delivery and monitoring. | 74% indicated receiving an SCP; 39% who received usual care also indicated receiving an SCP. At 12 months, compared to the usual care arm, the SCP arm indicated having received more information on support services, rated the interpersonal skills of the nurses higher, experienced more symptoms and concern about illness and had more contact with the PC physician related to illness. | 8.33 |
| Nolte et al.,  (2016)  United States. | To examine the impact of SCPs on patients and professionals and determine facilitators and barriers to implementation. | N=50  Various cancers. | Mixed methods. | Based on the IOM model. | Design, delivery, sending and monitoring. | The SCP was considered a good tool. Disparity regarding delivery times and increased commitment of PC physicians to survival care were noted.  Patients reported having a harder time discussing the SCP with their PC doctor than with their own family, but the family was not involved. | 5 |
| Singh-Carlson et al.,  (2016)  Canada. | To evaluate the implementation of a SCP. | N=16  Breast cancer. | Descriptive. | No model specified.  Delivered in person by nurse within 1 hour. | Delivery.  Multidisciplinary design. | Nurses were not identified as responsible for care. Mistrust in the management of psychosocial symptoms and variable complexity according to the context of implementation were reported. | 5 |
| AUTHOR  Country | OBJECTIVE | SAMPLE | DESIGN | SURVIVORSHIP CARE PLAN (SCP) | NURSING PARTICIPATION | KEY RESULTS | JBI QUALITY |
| Sprague et al.,  (2013)  United States. | To evaluate patient satisfaction with SCPs. | N=58  Colon (10) and breast (48) cancers. | Descriptive. | Based on the Minnesota Cancer Alliance model.  Modified by patient contributions during the consensus process. | Advanced practitioner nurse Collaboration in design.  In-person delivery. | The SCP was useful and is recommended. A few participants reported needing help to use it.  Breast cancer: Useful for monitoring and health promotion; less useful for tests. Colon cancer: Useful for everything. | 6.25 |
| Reb et al.,  (2017)  United States | To evaluate the viability and acceptability of a SCP combined with a self-care intervention. | N= 30  Colon (15) and lung (15) cancers. | Mixed methods. | SM-SCP based on the self-management model for chronic care.  Multicomponent. | Design, delivery and monitoring. | High scores for information and support. Moderately good information regarding diet (though more information was recommended) and exercise. High degree of comprehensiveness of care. More information on support resources was recommended. | 7.5 |