



# After recurrence surveillance recedes: professional accounts of how non-recurrence concerns become service work in cancer survivorship aftercare

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## ARTICLE INFO

### Keywords:

Cancer survivorship  
Qualitative research  
Follow-up care  
Aftercare  
Service organisation  
Organisational placeability

## ABSTRACT

After cancer treatment, suspected recurrence often retains a clear service form through appointments, tests, specialist review and escalation. Other treatment-related concerns, including swallowing, nutrition, bowel, sexual, functional and psychosocial problems, may persist or emerge as scheduled surveillance recedes. We examined how professionals described such concerns becoming easier or harder for services to recognise and act on.

We conducted a focused interpretive qualitative analysis of 27 professional interviews with participants working in two London NHS trusts and additional supportive-care services, including third-sector provision outside London. Using the Framework Method, we analysed accounts of service timing, accepted remit, capacity and cross-boundary work. Professional accounts were treated as evidence about service organisation and reported practice, not as proxies for survivor experience.

The analysis identified five related findings that converged on three dimensions of organisational placeability: whether a concern remained visible within service attention, whether at least one service accepted it within its remit, and whether a feasible, authorised response could follow. When these dimensions did not align, concerns depended more heavily on self-initiation, local workarounds or discretionary professional brokerage.

The study does not estimate unmet need, compare follow-up models or evaluate patient-initiated follow-up. It indicates that a contact route alone is insufficient. Service redesign should also specify which service can take up a concern and what response can follow after recurrence surveillance recedes.

## 1. Introduction

After cancer treatment, follow-up often has one especially clear task: detecting possible recurrence. That task has a recognisable organisational form. Scheduled clinics, imaging, examination, specialist responsibility and escalation routines keep recurrence risk within service attention (Armstrong, 1995, 2012; Jefford et al., 2022).

Other concerns may still arise from cancer or its treatment without initially presenting as possible recurrence. Survivors of head and neck cancer may experience persistent or returning difficulties with swallowing, nutrition, speech, dental health, pain, lymphoedema, function

or psychosocial wellbeing (Goyal et al., 2022; Taylor et al., 2024; Verdonck-de Leeuw et al., 2022). Gastrointestinal survivorship can involve bowel dysfunction, nutritional problems, neuropathy, sexual concerns, fatigue and psychological morbidity (Chang et al., 2023; Lisy et al., 2025; Vaz-Luis et al., 2022). Such concerns may persist after apparent recovery or become salient only after specialist review has become less frequent. Their clinical legitimacy does not ensure that a service will take them up.

This creates an organisational asymmetry. Possible recurrence usually remains tied to a defined risk, timetable, speciality and escalation route. A late or cross-domain concern may instead sit between oncology,

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<https://doi.org/10.1016/j.ssmqr.2026.100876>

Received 6 July 2026; Received in revised form 15 August 2026; Accepted 18 September 2026

Available online 19 September 2026

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surgery, specialist nursing, allied health, psycho-oncology, primary care, community provision and third-sector support. Patient-side evidence remains essential for understanding why these arrangements matter. Studies based on survivor accounts show that survivors may undertake substantial practical, emotional and administrative work when available support does not fit longer-term need (Adam, Duncan, et al., 2023; Adam, Nair, et al., 2023; van der Smissen et al., 2025). They do not answer the narrower service question examined here: how does a specific concern acquire an organisational position after recurrence-centred routines have receded?

This study is set in England's National Health Service, a publicly funded system in which most care is free at the point of use and access is based on clinical need (Department of Health and Social Care, 2023). Survivorship aftercare is distributed rather than delivered by a single provider. Specialist teams, clinical nurse specialists, allied health services, psycho-oncology, primary and community care, navigation services and third-sector organisations may each contribute. Clinical nurse specialists may provide continuing cancer-related advice or contact, while multidisciplinary care brings several disciplines into review or management. Signposting directs a person elsewhere without itself transferring responsibility. Patient-initiated follow-up requires the patient or carer to initiate contact when a concern arises.

Follow-up redesign has altered where review occurs, who provides it and who initiates contact. Specialist-led, nurse-led, allied-health-led, shared-care, primary-care-led, stratified and patient-initiated models have all been proposed or implemented (Chan et al., 2023; Dretzke et al., 2023; Liemburg et al., 2026; Lisy et al., 2025; Lorenc et al., 2022; Paterson et al., 2025). Recent work also shows persistent variation in how survivorship models are named and in how, when and by whom their component activities are delivered (Vos et al., 2026). Current English guidance frames patient-initiated follow-up as a clinically designed pathway requiring condition-specific information, suitability assessment, safety-netting and reliable operational processes (NHS England, 2025a). The 2026 National Cancer Plan for England adds personal cancer plans, digital patient-reported outcome measures and named neighbourhood care leads (Department of Health and Social Care, 2026). These arrangements may strengthen contact or concern visibility. They do not by themselves establish which service will accept a particular concern or what feasible response can follow.

Several established literatures explain parts of this problem. Surveillance medicine shows how clinical systems organise recurring attention around future risk (Armstrong, 1995, 2012; Armstrong & Eborall, 2012). Candidacy theory treats access as a negotiated process involving recognition, navigation, presentation, professional adjudication and service operating conditions (Dixon-Woods et al., 2006; Sinnott et al., 2026). Care-trajectory and invisible-work scholarship shows how distributed care depends on coordination across professionals, organisations and records (Allen, 2019; Allen & Pilnick, 2005; Star & Strauss, 1999). Together, these perspectives explain why access and coordination remain contingent. Less explicit is the concern-level organisational configuration examined here: how concern visibility, accepted service remit and connection to a feasible, authorised response align or separate after recurrence surveillance recedes.

We use 'organisational placeability' to examine this configuration. It refers to a provisional relation between a post-treatment concern and the service system, defined by how those three dimensions align or separate. The object is the concern in relation to services, not the survivor. The concept therefore focuses on how a clinically relevant concern gains, loses or regains an organisational route after recurrence surveillance recedes.

This study aimed to explain how professionals described non-recurrence survivorship concerns becoming easier or harder for services to recognise and act on after recurrence surveillance receded. We analysed 27 professional interviews with participants working in two London NHS trusts and additional supportive-care services, including third-sector provision outside London, focusing on service timing,

accepted remit, capacity and cross-boundary work. Professional accounts were treated as evidence about service organisation and reported practice, not as proxies for survivor experience. The study does not estimate unmet need or compare the effectiveness of follow-up models. It specifies how a clinically relevant concern can become, or fail to become, routine aftercare work.

## 2. Methods

### 2.1. Study design

We conducted a focused interpretive qualitative analysis of the professional-interview component of a wider cancer survivorship research programme using the Framework Method (Gale et al., 2013). The analytic corpus comprised only the 27 professional interviews. Survivor interviews, bridging questionnaires and co-design workshop data were not coded or treated as independent corroborating evidence in this analysis. Issues raised elsewhere in the wider programme nevertheless informed some interview probes; responses to those probes were treated as elicited professional accounts.

The same 27 professional interviews also contributed to a related published analysis that combined professional and survivor interviews with co-design workshops to examine accountability at treatment completion and develop a post-treatment handover standard (Author(s), 2026). The present article addresses a distinct concern-level question: how non-recurrence concerns remain visible to services, fit an accepted service remit and connect to a feasible response after recurrence surveillance recedes.

### 2.2. Setting, participants, recruitment

Participants held roles in two London NHS trusts and additional supportive-care services, including third-sector provision outside London. Their accounts covered head and neck, gastrointestinal or upper gastrointestinal, and cross-cutting survivorship contexts. The service landscape included specialist medical review, clinical nurse specialist contact, allied health rehabilitation, psycho-oncology, navigation and third-sector cancer support. Accounts represented scheduled surveillance, later-review clinics, continuing specialist nursing contact, referral, navigation and supportive-care routes. These were local configurations rather than standardised pathway models.

In this analysis, a service referred to an organisationally recognised team, clinic or provider function with a recognised role in accepting or responding to a concern. Individual accounts were treated as reports from those service positions, not as evidence of trust-wide or national policy.

Eligible participants organised, delivered, referred into or supported post-treatment care for adult cancer survivors. Purposive recruitment sought variation in professional role, service setting, tumour pathway and involvement in survivorship aftercare. Participants were recruited through direct invitation, existing professional networks and limited colleague referral. These routes did not provide a complete invitation denominator, so a response rate could not be calculated.

The 27 participants spanned medical, specialist nursing, allied health, psycho-oncology, navigation and third-sector roles across head and neck, gastrointestinal or upper gastrointestinal, and cross-cutting settings; Table 1 reports the full composition. Because head and neck services were overrepresented, the corpus provides greatest depth on long-term functional effects and allied health work. It does not represent the distribution of survivorship problems by cancer type.

For this focused analysis, adequacy of the available professional corpus was considered through information power rather than a formal claim of data saturation (Malterud et al., 2016). The research question was focused, participants held roles directly relevant to service organisation, and the corpus contained variation across professional and service contexts. The 27 interviews were judged sufficiently

**Table 1**  
Professional characteristics and primary service context (n = 27).

| Characteristic                 | Category                                           | n (%)   |
|--------------------------------|----------------------------------------------------|---------|
| <b>Professional group</b>      | Medical clinicians                                 | 5 (19)  |
|                                | Clinical nurse specialists                         | 5 (19)  |
|                                | Allied health professionals                        | 10 (37) |
|                                | Psycho-oncology practitioners                      | 2 (7)   |
|                                | Third-sector, navigation or supportive-care roles  | 5 (19)  |
| <b>Primary service context</b> | Head and neck                                      | 15 (56) |
|                                | Gastrointestinal/upper gastrointestinal            | 6 (22)  |
|                                | Cross-cutting or non-site-specific supportive care | 6 (22)  |
| <b>Age range</b>               | 20–29                                              | 2 (7)   |
|                                | 30–39                                              | 7 (26)  |
|                                | 40–49                                              | 12 (44) |
|                                | 50–59                                              | 6 (22)  |
| <b>Gender</b>                  | Female                                             | 23 (85) |
|                                | Male                                               | 4 (15)  |
| <b>Ethnicity</b>               | White                                              | 23 (85) |
|                                | Minority ethnic groups                             | 4 (15)  |

**Note.** Percentages use n = 27 and may not sum to 100 because of rounding. Professional groups and primary service context reflect the principal role and setting from which participants spoke, not the full scope of practice. Gastrointestinal and upper gastrointestinal contexts, ethnicity categories and quotation labels were aggregated to protect confidentiality.

information-rich to examine service timing, accepted remit and cross-boundary work within the stated scope.

No general practice or community pharmacy professionals were interviewed. Primary care therefore appears only through participants' accounts of discharge, referral, shared care and responsibility boundaries.

### 2.3. Data collection and transcript preparation

The lead author (PK) conducted remote semi-structured interviews using Microsoft Teams or Zoom between June and September 2025. Interviews lasted approximately 30–60 min. The interviewer was an implementation scientist and qualitative health-services researcher with no clinical, supervisory or working relationship with participants.

The topic guide was tailored by professional role and explored participants' responsibilities in post-treatment care, meanings of survivorship within their service, persistent concerns after treatment, follow-up organisation, service boundaries, later contact arrangements and concerns that did not fit routine pathways. Participants also discussed which survivors they perceived as more or less able to secure review or support. The interviews elicited professional accounts of service arrangements and examples of everyday practice; they were not designed as complete dated reconstructions of concern emergence, contact and response.

Some probes drew on concerns raised elsewhere in the wider programme or proposed possible explanations about service boundaries and unequal navigability. The underlying survivor material was not analysed in this study; the professional responses were treated as prompted accounts and compared with qualifications, disagreement and divergent examples.

All participants received written study information and provided written informed consent before interview. Consent covered audio-recording, transcription, anonymised quotation and further qualitative analysis within the approved survivorship programme. Audio was extracted from Microsoft Teams and Zoom recordings and transcribed offline using Buzz Captions. Obvious transcription artefacts, formatting problems and speaker-label errors were corrected during transcript preparation. All cleaned transcripts were pseudonymised before coding.

Displayed quotations were de-identified and attributed by broad professional role group rather than exact job title, local service name or raw transcript identifier. Minor editing for readability was limited to removing verbal repetition or identifying detail without changing

substantive meaning. Candidate extracts were reviewed with the preceding question and surrounding response so that answers elicited by direct prompts were not presented as spontaneous participant claims. Final wording for all displayed quotations was confirmed against the original recordings.

### 2.4. Analysis and reflexivity

The professional interviews were the empirical cases. Organisational placeability referred to reported relations between particular post-treatment concerns and the service system. Coding captured post-treatment concerns, surveillance and review position, discharge, service timing, accepted service remit, caseload rules, capacity, liaison, discretionary brokerage, supportive-care involvement and professional perceptions of unequal navigability.

Following the Framework Method, analysis proceeded through familiarisation, open coding, framework development, indexing, matrix charting and cross-case comparison (Gale et al., 2013). Matrix rows represented individual participants, with broad service context recorded as a case attribute; columns represented developing categories. Charted entries retained links to the source transcript and candidate quotation. Transcripts were managed and coded in NVivo 15 (Lumivero). The framework was refined iteratively as comparisons across roles and settings distinguished service description from analytic interpretation.

Organisational placeability was developed from the professional accounts rather than imposed as an a priori code. The analysis distinguished three linked dimensions: visibility within service attention, acceptance within at least one service remit, and connection to a feasible, authorised response. Timing was interpreted as service position, such as scheduled review, post-discharge or outside an active caseload, rather than elapsed time from treatment. Contact, referral initiation, receiving-service acceptance and clinical resolution were kept analytically distinct. A feasible, authorised response was defined as an action that a professional or service was permitted and practically able to provide or arrange within its recognised role; referral initiation alone did not establish receiving-service acceptance.

The lead analyst (PK) coded the full professional corpus. A second analyst (BS) independently double-coded nine of the 27 transcripts (33.3%), purposively selected to span professional roles and service contexts. The analysts compared their coding, discussed divergent or ambiguous applications, and returned to full transcript context to refine code definitions, category boundaries and the working analytic framework. Agreed revisions were recorded in the codebook and analytic memos and incorporated into review of the full corpus. Double coding supported analytic consistency, transparency and reflexive dialogue; it was not used to calculate a formal intercoder-reliability coefficient (Gale et al., 2013; O'Connor & Joffe, 2020).

The final three-dimensional frame was applied across all 27 interviews to identify supporting, contradictory and boundary configurations. The interviews were not analysed as complete concern trajectories; absence of a dimension from a transcript was therefore not treated as evidence that the corresponding service process did not occur.

Conceptual literature informed interpretation rather than functioning as a fixed coding template. Surveillance medicine informed attention to the institutional visibility of recurrence risk (Armstrong, 1995, 2012). Candidacy informed interpretation of recognition, navigation, service permeability and professional adjudication (Dixon-Woods et al., 2006; Sinnott et al., 2026). Care-trajectory and invisible-work scholarship informed analysis of liaison, translation and brokerage across service boundaries (Allen, 2014, 2019; Allen & Pilnick, 2005; Star & Strauss, 1999). These literatures served as interpretive comparators, not substitutes for survivor data or subgroup analysis.

Quotations were selected for analytic fit, contextual integrity and variation across roles and settings, including divergent or boundary cases. Potential overlap with related programme outputs was checked separately. Survivor and workshop quotations were not used.

Reflexive discussion examined whether specialist boundaries and local workarounds were being normalised, whether contactability was being mistaken for funded longitudinal provision, and whether professional accounts of self-navigation were being extended into claims about survivor experience. Accounts of later-review clinics, continuing nursing contact, direct re-entry and well-functioning local routes were retained to test and bound the developing explanation.

Prompt provenance was also considered because some questions introduced prior-programme concerns or candidate explanations. Participants' qualifications, resistance and divergent examples were retained alongside agreement.

One professional participant subsequently joined the author group and contributed substantive service-contextual interpretation of the findings and critical revision of the manuscript. This author did not code or adjudicate their own interview. The initial analysis was conducted without that interview. As a sensitivity check, the lead analyst subsequently coded and incorporated it; inclusion did not materially alter the five findings, the three dimensions or the principal interpretation.

### 2.5. Ethics and reporting

The wider study received ethical approval from the East Midlands Leicester South Research Ethics Committee (REC reference 25/EM/0132), with Health Research Authority and Health and Care Research Wales approval. Audio files, transcripts and participant records were stored on secure institutional systems with restricted access. Reporting was checked against the Consolidated Criteria for Reporting Qualitative Research (O'Brien et al., 2014; Tong et al., 2007).

## 3. Results

Across the 27 interviews, professionals described uneven conditions under which a non-recurrence concern could become service work. Concerns were easier to take up when they remained visible within service attention, fitted an accepted remit and could be connected to a feasible response. They were harder to take up when review had receded, concerns crossed clinical or supportive-care boundaries, or further attention depended on survivor recognition, activation and persistence.

The analysis comprised five related findings. They are presented

separately for clarity and should not be read as a fixed chronological sequence. First, scheduled recurrence review kept some concerns visible. Second, late and cross-domain concerns lost fit with review timing and caseload rules. Third, accepted service remit shaped who could take up a concern. Fourth, professionals connected concerns to action through liaison and local workarounds. Fifth, self-initiated contact shifted some of the work of becoming visible towards survivors. Fig. 1 depicts organisational placeability and its three dimensions. Table 2 maps each finding to concern visibility, accepted service remit and connection to a feasible, authorised response, and states the boundary of each claim.

### 3.1. Scheduled recurrence review kept some concerns visible

Professionals described recurrence surveillance as having a clearer institutional form than many other survivorship concerns. It involved scheduled appointments, tests, specialist review and a familiar logic of escalation. Routine head and neck follow-up was described as alternating review appointments after treatment, with imaging, examination and symptom questions organised around possible recurrence:

"We treat patients, then we follow them up with alternating outpatient appointments once they've completed their treatments. We do a post-treatment scan, usually at about four months in squamous cell carcinoma. ... Every time we see the patient, we examine them ... ask them the questions about possible signs of recurrence." (Medical clinician 01, head and neck pathway)

This surveillance structure also created opportunities for some non-recurrence concerns to become visible. Asked what worked well in current follow-up, one allied health professional described joint clinic review as both enabling and inconsistent:

"When a patient comes in, even if it's three years, four years, five years down the line, there's an issue. We're told on the day and asked, 'Can you please come in and join this review?' ... We can get a plan in place ... they get that full, all-round care because that's why we attend that clinic. We're all there. ... When those clinics work well, it can be an amazing encounter for a patient ... But I do think that doesn't always happen." (Allied health professional 01, head and neck pathway)

Scheduled review therefore created an opportunity for non-

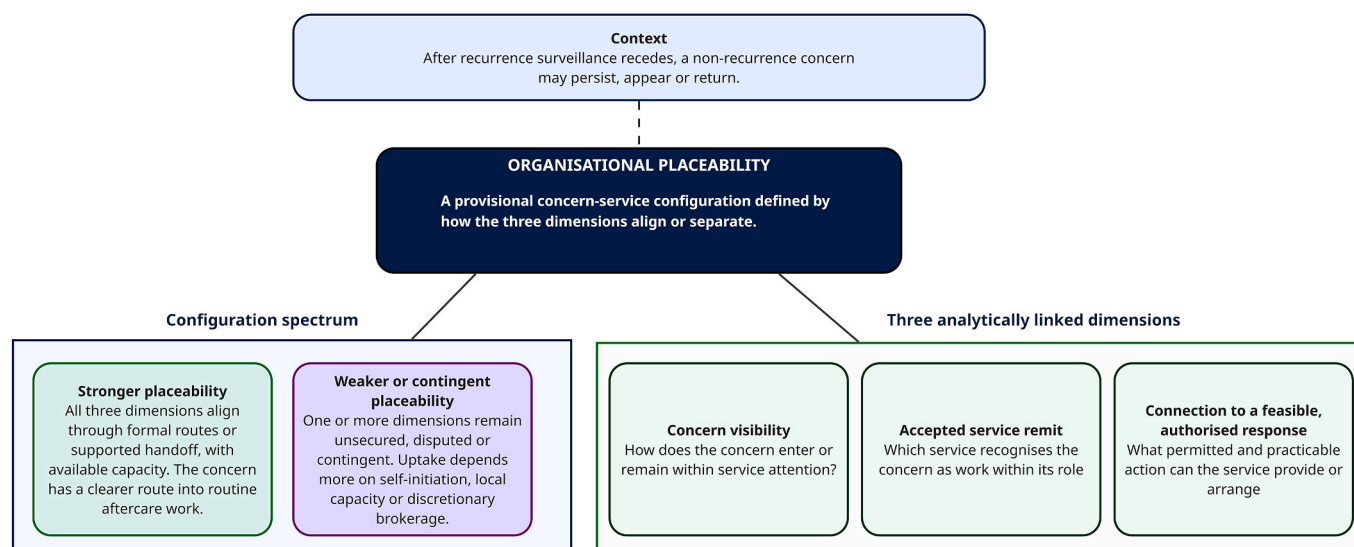


**Fig. 1.** Organisational placeability after recurrence surveillance recedes. The figure relates organisational placeability to its three analytically linked dimensions and to stronger or weaker configurations. The dashed connector situates the construct within the post-surveillance context; solid connectors show its analytic relations to the dimensions and configuration spectrum. The connectors do not indicate temporal order, causal direction or probability.

**Table 2**

How non-recurrence concerns became easier or harder for services to take up after surveillance receded.

| Finding                                                                            | Concern visibility                                                                                                           | Accepted service remit                                                                                              | Connection to a feasible, authorised response                                                                   | Claim boundary                                                                                                                                  |
|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 Scheduled recurrence review kept some concerns visible                           | A scheduled clinic, record and professional contact allowed a non-recurrence concern to enter service attention when raised. | Oncology, surgery, specialist nursing or allied health could take it up when relevant professionals were available. | Examination, documentation, joint review or further assessment could follow.                                    | Surveillance created an opportunity for recognition, not comprehensive provision or assured action.                                             |
| 2 Later and cross-domain concerns lost fit with timing and caseload rules          | Visibility weakened after discharge, outside an active caseload or when the survivor returned through an indirect route.     | Responsibility could become unclear across specialist, allied health, community and supportive-care services.       | Direct re-referral, later-review clinics or renewed contact could restore a route.                              | This does not mean all care ended after discharge or that later-review provision was uniform.                                                   |
| 3 Accepted remit shaped who could take up a concern                                | A concern could reach services but remain weakly visible when no service recognised it as its work.                          | Uptake was more workable where remit, relevant expertise and practical capacity aligned.                            | Referral, general-practice-mediated access or specialist advice could follow.                                   | Primary-care claims derive only from other professionals' accounts and do not establish national provision.                                     |
| 4 Professionals connected concerns to action through liaison and local workarounds | Brokerage kept a concern visible across service boundaries.                                                                  | Professionals used authority and working relationships to negotiate another service's involvement.                  | Direct contact, triage, re-referral, appointment acceleration and ad hoc review connected concerns to action.   | Brokerage did not establish formal responsibility, reliable receiving-service uptake or a stable pathway.                                       |
| 5 Self-initiated contact shifted visibility work towards survivors                 | Recognition, route knowledge and activation became prerequisites for professional attention.                                 | A receiving service still had to recognise the concern as falling within its remit.                                 | Advice, triage, navigation or onward referral followed only after the concern surfaced through a useable route. | These are professional perceptions of service-design vulnerability, not measurements of survivor experience, prevalence or subgroup inequality. |

Note: The table maps the five empirical findings to the three dimensions of organisational placeability. It does not compare follow-up models, quantify unmet need or report survivor experience.

recurrence concerns to surface when they were raised, relevant staff were present and the clinic could absorb additional work. A further medical account questioned fixed review intervals, reinforcing that surveillance provided an organising platform rather than comprehensive survivorship provision.

### 3.2. Late and cross-domain concerns lost fit with review timing and caseload rules

Concerns were harder to place when they arose after discharge, outside an active caseload or after formal review had reduced. Professionals described this as a mismatch between recurrent survivorship need and time-limited service arrangements.

In head and neck allied health, active therapy goals created a caseload boundary. Discharge was not presented as abandonment because survivors were told that they could return. The difficulty was that the longer the interval, the less clear the professional and service home became:

"Once we've got to a point where that patient doesn't have any active speech therapy needs or goals ... we'll discharge them, and we always caveat it with, 'You can come back to us.' When the gap is sort of months to a year, it's less complicated because ... they've still got an active head and neck consultant reviewing them for the next five or so years. But those patients who we're thinking much longer term in terms of survivorship, it definitely gets muddy." (Allied health professional 02, head and neck pathway)

The same account described back-and-forth between hospital teams over who should see the patient, which could delay face-to-face review. Timing and service remit were therefore distinct problems, but they could compound one another.

Other allied health accounts described the same timing problem from the clinic side. Concerns were easier to identify while survivors remained within head and neck review. When they returned later through other routes, the issue could be less visible to the relevant allied health team, particularly when it appeared in a clinic not designed for joint survivorship review or was not flagged early enough for the professional to respond.

The five-year surveillance boundary created another version of this timing problem. After formal discharge, survivors could need to return

through general practice to re-enter the specialist pathway:

"They would only need to go to the GP if they've been discharged after five years, so they'd need to go back onto the pathway." (Clinical nurse specialist 01, head and neck pathway)

Before that point, the same account described specialist nursing contact through Macmillan navigators, with clinical nurse specialists acting as a point of contact. Discharge therefore changed the organisational route through which a concern could regain specialist attention; it did not make the concern less clinically relevant.

A different local arrangement preserved a direct route back into allied health care:

"We thankfully do have a re-referral system where patients can contact us if they want to get back in touch. They don't have to go via their GP. But I think we are in quite a fortunate position ... I don't think that's the case routinely." (Allied health professional 03, head and neck pathway)

The same service had recently introduced a living-well-after-treatment clinic approximately 12 months after early therapy discharge. Direct re-referral and scheduled later review performed different functions: one preserved a survivor-activated route, while the other created an expected opportunity for concerns to surface. Neither arrangement was described as routine across pathways.

### 3.3. Accepted service remit shaped who could take up a concern

Professionals did not describe a simple access problem in which any service could respond once contacted. They described uncertainty about which service had the authority, expertise or capacity to take up a non-recurrence concern.

Head and neck allied health accounts showed that remit depended on more than clinical relevance. A concern was easier to take up when the survivor remained under a named consultant, clinic timing matched allied health availability and the issue was flagged early enough for the relevant professional to act. When those conditions did not align, a concern could remain clinically legitimate but still lack a workable service home.

The same problem appeared outside head and neck services. In one gastrointestinal or upper gastrointestinal account, an allied health

professional described a local gap between specialist oncology dietetics and community provision. The issue was not only referral delay, but whether an accepted community role existed for oncology late-effects expertise:

"I don't know of our local community dietitians ... having anything with regards to an oncology or late-effects clinic, or any kind of cancer specialism within the community. I actually don't think that job role in title even exists. ... So there's one gap already. The community dietitians and generalists are not equipped to deal with the level of complexity of these oncology patients." (Allied health professional 04, gastrointestinal/upper gastrointestinal pathway)

The same participant described local variation in community case-load capacity and specialist input, with some nutritional-support requests routed through general practice. This is a local, positional account. It does not establish the national availability or quality of community dietetic provision.

A cross-cutting psycho-oncology account showed a different service boundary. Here, fit depended on how far the distress remained cancer-related, the time since treatment and available resource:

"We don't have a hard cutoff, but it's a rough cutoff. ... If somebody's distress is really significantly related to their cancer, then it might make sense that we keep seeing them. ... If their distress is broader, then we refer them to talking therapies in the community. ... And that's a resourcing issue. If we had more resource, we'd provide more, but this is how we manage the resource that we have." (Psycho-oncology practitioner 01, cross-cutting service)

This account separates accepted remit from practical capacity. A team could recognise a concern as relevant to its expertise while limiting provision because of timing, scope and available resource.

Primary care appeared in these accounts as part of the aftercare boundary, not as an empirical voice. No general practice or community pharmacy professionals were interviewed. The analysis can therefore show how primary care appeared in descriptions of discharge, referral and community provision, but not how primary-care professionals understood or enacted those responsibilities.

### 3.4. Professionals connected concerns to action through liaison and local workarounds

Where formal arrangements were weak, professionals described practical work that made concerns more placeable. This included identifying problems, translating a concern into another service's terms, contacting colleagues, bringing appointments forward, arranging ad hoc review, checking whether planned care had occurred and keeping contact open where local arrangements allowed.

In these accounts, coordinating care meant identifying a concern, deciding that another service needed to act and creating a connection through which action could follow. Asked whether the participant was acting as a case manager, one medical clinician rejected that label but described identifying problems and coordinating or delivering care where no clear service structure existed:

"We just don't have a structure for managing them at all. So quite often I'm identifying and detecting the problem and then coordinating the care or delivering the care." (Medical clinician 02, gastrointestinal pathway)

Allied health accounts described the same work in more practical terms. Professionals contacted hospital clinicians directly when a survivor had raised a problem through general practice but needed specialist review. They asked for appointments to be brought forward and checked whether scans, procedures or consultations had been arranged. Coordination therefore involved converting a concern into a service action that another professional could take up.

A clinical nurse specialist described a different arrangement. The

team had no dedicated late-effects clinic but maintained open-list contact, allowing staff to triage concerns once survivors made contact:

"We don't have a specific clinic for them. At the moment, there's no capacity ... it really relies on the patient to self-declare. They have our contact numbers. We never discharge them off our list ... and then we can triage what their issues are. We tend to be the liaison between the MDT ... but it's kind of squeezing them into various different clinics or various sessions that we make ad hoc." (Clinical nurse specialist 02, head and neck/supportive-care context)

Open-list contact preserved a route into professional attention but remained contingent on survivor initiation and staff capacity; it was neither active surveillance nor a dedicated late-effects service.

Some professionals described more formal arrangements that could reduce reliance on individual availability. Asked what would make local workarounds more formal, one allied health professional described a designated multidisciplinary review space:

"There being an actual space, an actual ... identified outpatient slot ... an opportunity for someone to come in and see all professionals and know that that's what's going to happen, and actually formalising that, as opposed to it being slightly ad hoc and dependent on whether there's someone around in clinic or whether they're already with another patient." (Allied health professional 05, head and neck pathway)

This was a boundary case, not a service standard proposed by the study. It shows that scheduled space and professional availability could strengthen placeability while also revealing why discretionary brokerage remained fragile.

Third-sector and supportive-care participants described another part of this work. They could provide orientation, psychosocial support and navigation after hospital review had reduced, but they did not necessarily own clinical assessment. Their contribution kept some concerns visible and helped survivors identify what to do next, while remaining dependent on specialist or community services for clinical action.

### 3.5. Self-initiated contact shifted visibility work towards survivors

Professionals described limits to relying on survivors to initiate or sustain contact. Further attention was easier for people who recognised that a change warranted review, knew whom to contact, could use the available route and felt able to ask for help. These are professional accounts of service design and navigability, not direct measurements of survivor experience or inequality.

Responding to a direct question about patient-initiated follow-up, one medical clinician who had not implemented PIFU in upper gastrointestinal care used an example from routine follow-up, rather than an observed PIFU case, to describe the recognition and education the model would require:

"The problem with PIFU is that you need to be quite careful because you need patients who are engaged in the process and are aware of what should cause them to initiate follow-up. I've had routine patients come back to see me in clinic who've had extraordinarily florid symptoms that are very worrying, and they've kind of sat on them for six months because they were just waiting for the next follow-up. ... You need to really work with the patients to know what should prompt them to request a follow-up, because otherwise they just don't know." (Medical clinician 03, gastrointestinal/upper gastrointestinal pathway)

The clinician nevertheless said, "I think it works. We've never tried it in upper GI," before identifying a service-side requirement. Where the administrative contact route was unreliable, requests could return through general practice and be booked into the wrong clinic. Self-initiation therefore depended on both recognition and a dependable receiving route.

Positive and conditional accounts set an empirical boundary. One allied health participant described using a selective open-door arrangement for 12 years, explaining the model, providing direct contact details and considering a written summary; the account also linked wider use to caseload pressure. Other participants treated self-initiation as workable when education, rapid access and safety-netting were explicit. These accounts do not establish effectiveness, but they show that vulnerability arose from unsupported implementation rather than from self-initiation alone.

Recognition was only one part of the route. Responding to a direct question about unequal access, a third-sector participant described how systems could remain easier to navigate for people who were already more activated:

“The ones that can navigate these systems are the ones that usually shout the loudest and the ones that are seeking support, whereas the ones that sort of go under the radar. ... I had a gentleman in not long ago who hadn't downloaded the app. ... He didn't know when his next appointment was, and he would never have asked for help. ... But I think hospital systems are hard for certain groups to navigate.” (Third-sector/supportive-care participant 01, cross-cutting service)

Together, these examples identify a service-design vulnerability rather than its prevalence. Self-initiated routes required survivors to recognise a concern, identify a useable contact route and reach a professional able to respond. When those supports were weak, later or cross-domain concerns depended more heavily on confidence, route knowledge, communication access, persistence and local capacity.

Across the five findings, organisational placeability varied through three dimensions: concern visibility within service attention, acceptance within at least one service remit, and connection to a feasible, authorised response. Later-review clinics, open-list nursing contact, direct professional liaison and third-sector support could strengthen these dimensions, but their availability remained contingent on local capacity, relationships and survivor self-initiation.

## 4. Discussion

### 4.1. Organisational placeability as a concern-level service problem

Clinical legitimacy was not enough. A non-recurrence concern became easier for services to take up only when it remained visible, fitted at least one accepted remit, and connected to a feasible, authorised response. We call this provisional concern-service configuration organisational placeability. The construct describes the concern in relation to services, not the survivor.

The three dimensions perform different analytic jobs. Visibility is more than remaining on a clinic list: the concern must be elicited, recorded or reach a professional able to interpret it. Accepted remit concerns whether an organisationally recognised team, clinic or provider function regards the concern as its work. Connection to a feasible, authorised response remains analytically distinct because a service may accept a concern within its remit yet lack the authority, staff, appointments or useable referral route needed to act. Such a response is one that a professional or service is permitted and practically able to provide or arrange within its recognised role. Referral initiation alone does not establish receiving-service acceptance, and organisational uptake does not establish clinical resolution.

Fragmentation describes the surface pattern. Organisational placeability specifies the concern-level configuration beneath it: visibility, accepted remit, and connection to a feasible, authorised response may align or separate. A concern can be visible yet fall outside any accepted remit; it can be accepted in principle yet lack staff, authority, or a workable route to action; it can also be referred without being accepted by the receiving service. Candidacy provides a broader account of negotiated access (Dixon-Woods et al., 2006; Sinnott et al., 2026),

access-interface frameworks connect population abilities with service accessibility (Levesque et al., 2013), and professional-boundary scholarship examines divisions of work (Nancarrow & Borthwick, 2005). Organisational placeability adds a narrower question: how does a particular concern become, or fail to become, accepted service work across follow-up models?

Recent cancer research provides a close comparator. Dew et al. (2026) describe practitioners, from long-term survivors' accounts, as gatekeepers, brokers and boundary enforcers across cancer journeys. The present analysis addresses a different object: the configuration governing the fate of a particular non-recurrence concern after surveillance recedes. Brokerage is one mechanism through which placeability may be restored; it is not the whole construct.

Placeability is also distinct from downstream handover accountability examined in related programme work. The present study asks whether a concern acquires any accepted organisational destination and feasible response. The related analysis asks how responsibility, action, timelines and closure are made explicit at treatment completion (Author (s), 2026). The distinction is analytically useful but empirically recursive: acceptance may be provisional, referrals may be declined and a concern may return to renewed navigation.

### 4.2. The cancer-specific asymmetry created by recurrence surveillance

Referral boundaries, scarce capacity and unequal ease of navigation are not unique to cancer. The cancer-specific contribution lies in how survivorship organises them. Suspected recurrence remains a strongly institutionalised service object, supported by review schedules, imaging, examination, specialist responsibility and urgency. A swallowing, nutritional, bowel, sexual, psychological or functional concern may remain attributable to cancer or treatment without activating the same routines.

Surveillance medicine helps explain this asymmetry because it directs organised attention towards a future disease event and structures when, where and by whom that risk becomes visible (Armstrong, 1995, 2012; Armstrong & Eborall, 2012). Once scheduled surveillance recedes, a survivor may remain medically known while a particular concern loses concern-level visibility. The service problem is therefore not only reduced contact. It is the withdrawal of an organisational platform that previously made recognition and escalation more likely.

The accounts identified routes through which concern visibility or connection to action could be maintained or restored, rather than implying a one-way decline. Later-review clinics, direct re-referral, continuing nursing contact and supportive-care routes were described as possible routes back into attention or action. Organisational placeability is therefore provisional; it should not be read as a fixed patient attribute, an observed chronological pathway or a universal causal law.

### 4.3. Professional brokerage as compensatory organisational work

Professional liaison was the study's clearest mechanism for repairing weak routes. Participants translated concerns into another service's terms, contacted colleagues, brought appointments forward, re-referred, triaged and fitted survivors into available clinics. Care-trajectory and invisible-work scholarship helps interpret these activities as articulation work: the practical labour that aligns people, information, timing and organisational boundaries so that care can proceed (Allen, 2014, 2019; Allen & Pilnick, 2005; Star & Strauss, 1999).

These accounts show brokerage functioning as compensatory organisational work. Accounts of workarounds illustrated professional skill while also indicating that formal routes could not reliably carry the concern. They raise, but do not establish, the possibility that dependence on informal ties redistributes access, conceals demand and normalises work without protected capacity.

Dew et al. (2026) distinction among gatekeeping, brokerage and boundary enforcement sharpens this duality. The same professional who

opens a route may also decide that a concern falls outside a service boundary. Brokerage should therefore be analysed neither as generic goodwill nor as an uncomplicated solution; its possible distributive effects and organisational costs require further study.

The positive cases remain important. Direct re-entry, later review, continuing nursing contact and third-sector support show that reduced surveillance does not entail an absence of care. Yet contactability is not equivalent to dedicated provision. Where action still depends on self-declaration, staff availability or personal relationships, a route exists but remains contingent.

#### 4.4. Follow-up models, PIFU and self-initiation

Care-model labels do not settle this problem. Contemporary reviews continue to find substantial heterogeneity in how survivorship models are named and assembled, and recommend specifying which components are delivered, when and by whom (Vos et al., 2026). Placeability adds a concern-level question to that programme of research. Two survivors enrolled in the same nominal model may encounter different organisational responses because their concerns arise at different times, fit different remits or require different expertise.

Patient-initiated follow-up should not be treated as intrinsically burdensome or inequitable. Current NHS guidance already presents PIFU as a clinically supported process that requires patient understanding, reliable systems and active management rather than a purely administrative removal of appointments (NHS England, 2025a). The PETNECK2 acceptability study likewise shows that self-initiation can be supported through professional education, symptom guidance and an app or booklet, with increased knowledge and confidence reported by many participants (Matheson et al., 2026). Comparative evidence remains limited across cancer pathways, particularly for effectiveness, safety, equity, workload and capacity; current evidence supports attention to implementation conditions more strongly than equivalence claims (Dretzke et al., 2023; Lobont et al., 2026).

Implementation conditions shape what PIFU delivers. A rapid evaluation across five English NHS trusts found that PIFU altered clinical and administrative work, patient selection, safety-netting, and workload, with effects varying by pathway and local configuration (Lobont et al., 2026). Self-initiation alone does not determine placeability. Education must help people recognise a trigger; contact routes must be useable; and the receiving service must have the remit and capacity to respond.

The equity claim remains bounded. These professional interviews do not show which survivor groups experienced poorer access or how often a concern remained unseen. They identify a service-design vulnerability: when recognition, route knowledge, communication access and persistence become preconditions for attention, the work of producing visibility shifts towards survivors. Candidacy and digital candidacy help interpret that transfer without converting professional perceptions into measured inequality (Dakin et al., 2024; Dixon-Woods et al., 2006; Mackenzie et al., 2025).

#### 4.5. PROMs and survivorship care plans: visibility without uptake

Patient-reported outcome measures and survivorship care plans could strengthen two parts of the configuration. PROMs may make a swallowing, functional or psychosocial concern legible. A care plan may clarify expected effects, contact routes and the intended division of responsibility. Neither instrument creates organisational uptake by itself.

PROM implementation depends on whether clinicians value the information, electronic records and workflows can receive it, staff know how to interpret it, and services have time and capacity to respond. A recent umbrella review also identifies patient burden and e-health literacy as material implementation conditions (Rammant et al., 2026). Survivorship care-plan reviews report possible gains in information and professional knowledge, but no consistent improvement in survivor-reported outcomes (Brennan et al., 2014; Hill et al., 2020). The

relevant question is therefore not whether a form was completed. It is whether the information reaches an authorised recipient and produces a useable response.

A cluster-randomised trial of an ePRO-informed decision-support tool in head-and-neck survivorship increased the number of burdensome concerns discussed from 3.3 to 4.1 and the proportion discussed from 44% to 57% (Salz et al., 2025). This supports the visibility function when measurement is coupled to point-of-care recommendations, but the trial did not establish receiving-service ownership, completed action or post-surveillance re-entry.

The findings support a testable proposition: measurement without ownership can document an unplaced concern, while a care plan without responsive routes can externalise navigation rather than reduce it. Services using PROMs or care plans should specify who reviews the information, how response thresholds are interpreted, what happens when a concern crosses remits and which route remains available after non-response or redirection. These functions require empirical evaluation; the present study did not assess either intervention.

The National Cancer Plan for England makes this distinction immediately relevant. Its commitments to personal cancer plans, real-time PROMs, named neighbourhood care leads and end-of-treatment summaries create settings in which placeability can be tested, not evidence that it has already been secured (Department of Health and Social Care, 2026).

#### 4.6. Implications for service redesign and multidisciplinary pathways

Placeability translates into service functions rather than a preferred follow-up model. Pathways need a route through which later concerns can become visible, an organisationally recognised recipient able to assess the concern, and sufficient authority and capacity to provide or arrange a response. Multidisciplinary clinics, later-review points, open-access nursing contact, shared-care agreements, navigation and community services may each deliver some of these functions. Their labels do not establish that they do.

Current policy makes this question immediate: NHS England asks ICBs and providers to expand digitally enabled, patient-led follow-up, including PIFU, remote consultation and digital monitoring, while reducing avoidable routine follow-up (NHS England, 2025b).

These findings justify evaluating a bounded first-contact function, not assuming its effectiveness. Services possess knowledge of their own boundaries, referral criteria, and internal routes that survivors cannot reasonably be expected to reconstruct. Where protected capacity and downstream agreements exist, the contacted service would acknowledge the concern, assess urgency, identify an appropriate recipient, arrange a supported handoff, and explain what follows if the proposed recipient declines uptake. The function should neither become an unfunded inbox nor require every contacted service to retain clinical responsibility.

Placeability does not require specialist uptake or additional intervention for every concern. A legitimate and useable disposition may be advice, supported self-management, community care or a reasoned decision that no further service action is needed at that point. What matters is that the concern receives an understandable organisational response rather than being returned as an unresolved routing problem to the survivor.

The study does not establish which configuration is most effective. Future evaluations could examine whether later concerns are acknowledged and reviewed through accessible routes, whether they are accepted or redirected to an identified recipient, whether an authorised response is provided or arranged, and whether the first-contact function creates duplicate assessment, inappropriate escalation, unresourced workload or displaced waiting time. Equity-sensitive comparison should examine variation by communication need, disability, language, deprivation and contact mode. These are questions for testing, not validated indicators.

#### 4.7. Transferability beyond the English NHS

Transferability rests on function, not institutional resemblance. The findings are most relevant where recurrence surveillance is time-limited, survivorship responsibility is distributed across organisations or professions, and later access depends on referral or self-initiation. The actors, financing arrangements and thresholds will differ. Longitudinal integrated teams may preserve visibility and remit; insurance-based systems may add coverage and affordability barriers before a concern reaches any service.

Published standards and recommendations also differ. United States national survivorship standards already call for explicit multidisciplinary roles, referral workflows, transition arrangements and safeguards against loss to follow-up (Mollica et al., 2024). Childhood and adolescent cancer survivorship offers another contrast: evidence-based transition recommendations treat movement into adult and long-term survivorship care as an explicit organisational task (Wams et al., 2025). These examples do not establish equivalence with adult NHS services. They show that visibility, accepted remit and response capacity can be institutionalised through different forms.

Organisational placeability should therefore be treated as an analytic proposition for cross-system comparison. Research should ask which arrangements perform the three functions, where additional barriers intervene and whether the concept explains concern uptake better than care-model labels alone.

#### 4.8. Strengths and limitations

The study's main strength is its multi-professional view of service organisation. Interviews across medical, specialist nursing, allied health, psycho-oncology, navigation and third-sector positions allowed the analysis to compare how the same organisational problem appeared from different service locations. The analysis retained positive, contradictory and boundary configurations rather than treating the most difficult accounts as the whole system.

The professional-only design also limits the evidence to concerns that reached professional attention. Concerns that never reached professional attention may therefore be absent, while problems recognised by engaged staff or partly repaired through brokerage may be over-represented. Recruitment through professional networks may have favoured participants already involved in survivorship coordination, potentially overstating the availability of brokerage and understating settings with little survivorship infrastructure. Professional accounts describe service organisation and reported practice; they do not establish trust-wide policy, observed enactment or survivor experience.

Some interview questions introduced concerns raised elsewhere in the wider programme or proposed explanations about fragmentation, inequality and service design. Such probes may have encouraged agreement or socially desirable responses. We therefore treat directly prompted answers as elicited accounts rather than spontaneous convergence; participants' qualifications and disagreements bound the interpretation.

Head and neck services contributed most empirical depth, especially on long-term functional effects and allied health work. Gastrointestinal or upper gastrointestinal and cross-cutting accounts provided important contrasts around nutrition, psychological support, community provision and self-initiation, but they were fewer. The analysis therefore supports a mechanism across service positions, not an equivalent distribution of concerns across tumour groups, organisations or settings.

Primary-care professionals were not interviewed. Claims about primary care remain limited to how it appeared in other participants' accounts of discharge, referral and shared responsibility. Interviews were not observations or dated concern trajectories, and the study cannot estimate unmet need, measure subgroup inequality, compare follow-up effectiveness or determine whether organisational uptake led to clinical resolution.

Because organisational placeability was developed and examined within the same professional corpus, its analytic distinctiveness has not yet been tested independently. Comparative research should examine whether the three dimensions explain concern uptake beyond established candidacy, access-interface and professional-boundary accounts, and whether their relationships recur across independently sampled services and healthcare systems.

Concern characteristics may also alter placeability. Urgency, possible recurrence, causal attribution, complexity, chronicity, specialist competence and the existence of a recognised late-effects route may each change which service can respond. Future research should combine survivor and professional accounts with records and observation, then compare concern trajectories across services and systems while keeping experience, organisational uptake and clinical outcomes analytically distinct.

#### 5. Conclusion

After recurrence surveillance recedes, the central service problem is not simply how often follow-up occurs. It is whether a clinically legitimate non-recurrence concern can move from recognition into accepted organisational work.

Organisational placeability describes that provisional concern-service configuration. Visibility, accepted remit, and connection to a feasible, authorised response may align through scheduled review, later contact, formal pathways or supported handoff; they may also separate. The study does not identify the best follow-up model, estimate unmet need, or report survivor experience. It shows why a contact channel alone is insufficient. Service redesign should make the route from concern to an understandable organisational disposition explicit, without assuming that every concern requires specialist uptake or further intervention.

#### CRedit authorship contribution statement

**Patrick Kierkegaard:** Writing – review & editing, Writing – original draft, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Bowen Su:** Writing – review & editing, Formal analysis. **Gavriella Simson:** Writing – review & editing. **Alison McGregor:** Writing – review & editing. **Justin Gray:** Writing – review & editing.

#### Ethics declaration

Written informed consent to take part in the study and to publish the article has been obtained from all participants or their legal representatives. The privacy rights of participants have been observed.

This study was performed in compliance with relevant laws, regulatory frameworks and guidelines where the research took place. This study was approved by the East Midlands - Leicester South Research Ethics Committee. (Approval No. 25/EM/0132)

#### Data statement

The professional interview dataset analysed in this article, and the wider qualitative programme materials to which it belongs, contain potentially identifiable information and were collected under REC/HRA approval (25/EM/0132). In line with these approvals, full transcripts are not publicly available to protect participant privacy. Anonymised excerpts and analytic materials may be available from the corresponding author on reasonable request, subject to a data-sharing agreement and relevant governance approvals.

#### Declaration of competing interest

The authors declare that they have no known competing financial

interests or personal relationships that could have appeared to influence the work reported in this paper.

## Acknowledgements

This work was supported by the Cancer Research UK Convergence Science Centre (Imperial College London and The Institute of Cancer Research). P.K. is supported by the CRUK Convergence Science Centre at The Institute of Cancer Research, London, and Imperial College London (CTRQOR-2021\100009). Additional financial support for this study was provided by discretionary research funds allocated to P.K. by the Department of Surgery and Cancer, Imperial College London. The funders had no role in the design of the study; the collection, analysis, or interpretation of data; the writing of the manuscript; or the decision to submit the manuscript for publication.

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