Does limiting long-term follow-up for breast cancer allow all referrals to be seen in 2 weeks?

S POTTER, S GOVINDARAJULU, M SHERE, F BRADDON, J TURNER, AK SAHU, SJ CAWTHORN

Breast Care Centre, Frenchay Hospital, Bristol, UK

ABSTRACT

INTRODUCTION The UK National Institute for Health and Clinical Excellence (NICE) recommends that breast cancer follow-up should be limited to 2–3 years stating this will ‘release resources’ making it ‘possible for all women with breast symptoms to be seen within 2 weeks’. In 2000, breast cancer follow-up services in North Bristol were redesigned to reflect evidence-based best practice. The aim of this paper is to assess the impact of this policy on numbers of follow-ups, clinic capacity and waiting times.

PATIENTS AND METHODS Data regarding the numbers of new and follow-up patients seen in breast clinic between January 2000 and December 2005 were collected from the hospital Patient Administration System. New patients were categorised as either ‘routine’ or ‘urgent’ according to ‘2-week wait’ rule guidelines. Median waiting times were calculated for each group and nominal appointment times assigned in an attempt to assess the effect of any changes on clinic capacity.

RESULTS The number of follow-ups decreased by 33% as a result of the new policy. Numbers of referrals over the same period, however, increased by 14%. Routine referrals declined, but there was a 27% increase in ‘2-week wait’ patients. Waiting times for routine appointments initially decreased in response to reduced follow-up, but then rose as the number of ‘2-week wait’ referrals increased.

CONCLUSIONS Reducing long-term follow-up is a simple and effective method of increasing clinic capacity but its effects are inadequate and transient in the face of increasing service demand. Additional innovative and creative strategies will be required if all breast patients are to be seen within 2 weeks.

KEYWORDS

Breast cancer – Follow up – Guidelines – Capacity

CORRESPONDENCE TO

SJ Cawthorn, Consultant Surgeon, Breast Care Centre, Frenchay Hospital, Beckspool Road, Frenchay, Bristol BS16 1JE, UK
T: +44 (0)117 970 1212; E: simon.cawthorn@nbt.nhs.uk

A recent survey of 256 surgeons and oncologists identified important reasons for breast cancer patients to be seen in clinics after completion of their treatment (Chris Holcombe, Honorary Secretary, The Association of Breast Surgeons at the British Association of Surgical Oncologists). These were to: (i) detect recurrence and psychological morbidity; (ii) identify the sequelae of treatment; (iii) provide access to aesthetic surgery; (iv) assess suitability of secondary adjuvant therapy (*i.e.* Letrozole after Tamoxifen); and (v) assess their current status (are they alive and disease free).

The duration and nature of follow-up after treatment for early breast cancer has been a matter for debate. Traditionally performed by specialists, the primary aims of follow-up are to detect local recurrence and disease in the contralateral breast.^{1,2} Most recurrences, however, occur between clinic visits and are detected by patients themselves,³ prompting them to seek help, often from their gen-

eral practitioners (GPs).⁴ Some authors have even suggested that routine follow-up gives false re-assurance and may even delay presentation with symptoms of recurrence until the next clinic visit. A further study found that GP follow-up was as effective as specialist care and led to greater degrees of patient satisfaction.^{1,5}

The UK National Institute for Health and Clinical Excellence (NICE) has published guidelines⁶ for breast cancer follow-up stating that ‘routine long-term follow-up has not been shown to be effective and should cease’. NICE recommends that follow-up should be limited to between 2–3 years with the specific intention that this will ‘release resources – notably clinic and consultant time’ making ‘it possible for all women with breast symptoms to be seen within 2 weeks’. The Association of Breast Surgeons (ABS) at the British Association of Surgical Oncologists (BASO)⁷ ‘deplores unnecessary and overly frequent follow-up visits

to see a variety of junior doctors after a prolonged wait in crowded out-patient clinics'. ABS at BASO states that follow-up should be dependent upon the individual, the cancer and the treatment received. In two recent surveys, only 8% of members of ABS at BASO and only 9% of specialists registered on the Cancer Research Clinical Trials Unit database followed NICE guidance.⁸

In 2000, in an attempt to rationalise follow-up practices and improve the outcome for our patients, the available evidence regarding the benefit of follow-up in breast cancer was evaluated as part of the Cancer Collaborative re-design of the breast clinic services. Subsequently, the following policy changes were introduced at our centre:

1. The frequency of routine clinic visits was reduced and patients were seen annually.
2. Routine follow-up was discontinued at 3 years for patients who had undergone mastectomy who were not receiving hormone therapy.
3. Routine follow-up was discontinued at 5 years for patients receiving hormone therapy and/or treated with breast conservation following a final clinic visit.

In addition to these changes, a nurse-led follow-up service was introduced to provide continuity of care and to ensure that the patient's emotional needs might be identified and met, together with side effects of treatment when present. All patients were also offered three 6-monthly nurse-led assessments in the first 18 months following their surgery to monitor arm volume changes and to advise in the prevention of symptomatic lymphoedema by preclinical detection. At 3 or 5 years, having reviewed their treatment, patients were informed that the risk of recurrence was very low. An information sheet was given detailing worrying signs and symptoms that might indicate a recurrence and contact details enabling them to access the clinic in case of any concern. Patients were informed that they were not being 'discharged' from the clinic completely, but rather 'released from active follow-up'. All patients continued to be monitored with 2-yearly follow-up mammography and were informed that they had a long-standing 'open appointment' and could contact the clinic at any time to make an appointment to be seen if they had any concerns.

This strategy represents a dramatic departure from 'standard' clinical practice. The aim of this paper is to assess the impact of this strategy on numbers of follow-ups, clinic capacity and waiting times in our centre.

Patients and Methods

The Frenchay Breast Care Centre serves a population of 500,000 in Bristol and North East Somerset. In excess of 4000 new patients are seen annually and close to 400 new

cancers diagnosed each year. The Centre is staffed by two consultant surgeons, one associate specialist breast physician, one staff grade breast surgeon, one specialist registrar, two breast care nurses and one part-time follow-up clinic nurse.

Data regarding the numbers of new and follow-up patients seen at the clinic from 1 January 2000 to 31 December 2005 were collected prospectively and collated using the hospital Patient Administration System. New patients were classified as being 'routine' referrals and 'urgent', according to the '2-week wait' guidelines. Median waiting times for both groups of patients were calculated. Nominal times for appointments were assigned as 5 min for a follow-up, 10 min for a routine new patient and 20 min for a '2-week wait' one-stop referral in an attempt to assess the impact of the changes on clinic capacity. Any trends in the data were noted.

Results

As a result of the new follow-up policy, the number of such patients seen in clinic decreased by 33% ($n = 3241$) from 9688 in 2000 to 6447 in 2005. This decrease was only seen for the first 2 years after the policy change, however; by 2002, the annual numbers of follow-up patients seen had reached a steady state (Fig. 1). We calculated that this decrease in the number of follow-up patients seen would release an additional 270 h of clinic capacity a year (approximately 5 h or 1.5 clinics per week) which would then be available for new patient referrals.

The numbers of new referrals seen over the same period, however, rose by 14% from 3523 in 2000 to 4036 in 2005.

The pattern of referrals received by the Breast Care Centre also changed during this time. As Figure 2 illustrates, whilst the number of 'routine' or 'non-urgent' referrals has decreased by 9% (130) from 1461 in 2000 to 1331 in

Figure 2 Trends in the numbers of '2-week wait' and 'routine' referrals to breast clinic 2000–2005.

2005, the number of urgent '2-week wait' referrals increased by 27% (529) from 1961 in 2000 to 2490 in 2005.

These changes in the referral patterns and the reduction in the number of routine follow-up patients seen have impacted waiting times for appointments. As expected, the clinic capacity freed by reducing follow-up initially led to a decrease in the waiting time for routine appointments, resulting in a median wait of just 14 days in 2002. As the numbers of new '2-week wait' referrals continued to increase and divert clinic capacity, however, waiting times for routine appointments from 2003 onwards again began to rise. The median waiting time for a routine appointment in 2005 was 21 days. The 2-week waiting times have always been maintained (Fig. 3).

This can also be considered by looking at total patient days waited for routine and urgent appointments (Fig. 4) and the distribution of the allocation of clinic time to the urgent, non-urgent and follow-up patients (Fig. 5).

Figure 3 Waiting times for 'routine' and '2-week wait' appointments 2000–2005.

Figure 4 Patient days waited for 'routine' and '2-week wait' appointments 2000–2005.

Figure 5 Clinic time spent with patients 2000–2005.

Discussion

The introduction of the '2-week wait' rule in 1999 stipulated that all patients with suspected breast cancer should be seen within 2 weeks of referral. Several studies,^{9–11} however, have reported that this target has been met at the expense of prolonging waiting times for 'routine' or 'non-urgent' referrals. This is of considerable concern as a significant proportion of breast cancers are still being referred via this route. One study¹² of 15 breast units in the UK reported that a total of 36% of all breast cancers diagnosed were referred as 'non-urgent' cases. The magnitude of the problem was confirmed at our own centre, where in 2005, 27% of cancers were referred in this way.¹⁵ If over a third of cancer patients are referred as 'routine', the system is failing as the wait for routine appointments may be in excess of 3 months.¹⁴ The psychological morbidity for routine patients as they wait for several weeks to be seen is also high. As a result of the creation of the 'slow track effects', the UK Government promised 'to go further' with cancer waits for breast patients in its last election manifesto. The ultimate aim of any breast service, therefore, must be to see all new patients within 2 weeks regardless of route of referral to prevent any potential cancer patient from being disadvantaged. Such a goal would require a significant increase in clinic capacity and strategies such as reducing routine follow-up, as NICE suggests, may be a simple and practical way of achieving this.

Initially, as anticipated by NICE guidelines, limiting routine follow-up, in our case to 3–5 years, led to an increase in clinic capacity which decreased the median waiting times for routine referrals. Decreased follow-up appointments allowed routine waiting times to be reduced from a median of 20 days in 2000 to just 14 days in 2002. Due to the increase in urgent referrals, however, the median waiting time for non-routine referrals again increased, reaching 21 days in 2005. Clinic capacity was increased, but not sufficiently to cope with increasing demands on the service. Another important factor which has affected our clinic capacity has been the European Working Time Directive and its impact on the availability of the specialist registrar and staff grade surgeon in the clinic.

In addition to limiting routine follow-up to a maximum of 5 years, additional innovative strategies have been introduced in an attempt to increase clinic capacity further. First, a nurse-led follow-up clinic has been established. This service provides patients with continuity of care, allowing their emotional needs to be met and patient education to take place in addition to standard care. Our innovative breast care nurse-led postoperative histology clinics are also an invaluable resource. In the past, doctors have always informed patients of their postoperative histology results

and of the multidisciplinary team's decisions regarding further adjuvant treatment. This process, however, resulted in delays in clinic and problems with patients not seeing a breast care nurse or having sufficient time to ask questions. Whilst patients with complex problems or those facing further surgery are still given the opportunity to discuss the options with their surgeon, the breast care nurse-led clinic gives the majority of patients more time to discuss their results and future treatment in a supportive environment, benefiting patients whilst also freeing a considerable amount of time for surgeons to assess new referrals.

The publication of the NICE guidance on women with a family history of breast cancer has also resulted in reduced numbers of women being seen, and their mammographic screening has been transferred to our local breast screening unit, again in line with NICE guidance.

Limiting follow-up has undoubtedly had a beneficial effect by allowing clinic capacity to increase for a short time, but its effect in our centre was transient. Increasing service demands mean that this small change is not enough. The only way to increase capacity to meet demand in the long term is either to increase the number of appropriately trained staff available in the clinic or the number of clinic sessions available. One clinic session run by a consultant plus a trained specialist could accommodate 30–35 new routine patient slots, thus increasing capacity by over 1000 patients a year. The 'specialist' in question, however, need not necessarily be a doctor or a surgeon. The training of an 'extended role nurse specialist' who could perform triple assessment is currently being evaluated in our centre. This project is a collaboration with the University of West England, the Cancer Services Improvement Programme and the Department of Health 'Skills for Health' team who have agreed the competencies required to perform this clinical task. Nurse practitioners are also being trained to perform diagnostic ultrasound breast imaging and ultrasound-guided biopsies in accordance with the Royal College of Radiology guidelines.

Conclusions

Demand for breast clinic services looks set to increase as women become more 'breast aware' and primary care physicians become less confident to re-assure the worried-well.¹⁵ All patients deserve to be seen promptly whether 'urgent' or 'routine'. Limiting follow-up is one practical and simple solution to this problem, but other innovative and creative ways of creating capacity will be required if the '2-week wait' for all is to be achieved. The challenge for the future will be to train the specialists from whatever discipline, medical or nursing, in whatever setting, primary or secondary care to meet this demand.

References

1. Grunfeld E, Fitzpatrick R, Mant D, Yudkin P, Adewuyi-Dalton R, Stewart J *et al.* Comparison of breast cancer patient satisfaction with follow up in primary care versus specialist care: results from a randomised controlled trial. *Br J Gen Pract* 1999; **49**: 705–10.
2. Dewar J. Follow up in breast cancer. A suitable case for reappraisal. *BMJ* 1995; **310**: 685–6.
3. Dewar JA, Kerr GR. Value of routine follow up of women treated for early carcinoma of the breast. *BMJ* 1985; **291**: 1464–7.
4. Grunfeld E, Yudkin P, Adewuyi-Dalton R, Vessey, Mant D. Follow up in breast cancer. *BMJ* 1995; **311**: 54.
5. Grunfeld E, Levine MN, Julian JA, Coyle D, Szechtman B, Mirsky D *et al.* Randomised trial of long term follow up for early stage breast cancer: a comparison of family physician versus specialist care. *J Clin Oncol* 2006; **24**: 848–55.
6. National Institute for Health and Clinical Excellence. *Guidance on cancer services. Improving Outcomes in Breast Cancer: Manual Update*. London: NICE, 2002.
7. The Association of Breast Surgery at BASO. Guidelines on the management of symptomatic breast disease. *Eur J Surg Oncol* 2005; **31**: S1–21.
8. Donnelly P, Hiller L, Bathers S, Bowden S, Coleman R. Questioning specialists' attitudes to breast cancer follow up in primary care. *Ann Oncol* 2007; doi 10.1093/annonc/mdm193.
9. Jones R, Rubin G, Hungin P. Is the 2 week wait rule for cancer referrals working? *BMJ* 2001; **322**: 1555–6.
10. Hanna SJ, Muneer A, Khalil KH. The 2-week wait for suspected cancer: time for a rethink? *Int J Clin Pract* 2005; **59**: 1334–9.
11. Khawaja AR, Allan SM. Has the breast cancer '2 week wait' guarantee for assessment made any difference? *Eur J Surg Oncol* 2000; **26**: 536–9.
12. Sauven P. Impact of the '2 week wait' on referrals to breast units in the UK. *Breast* 2002; **11**: 262–4.
13. Potter S, Govindarajulu S, Shere M, Braddon F, Curran G, Greenwood R *et al.* Referral patterns, cancer diagnoses and waiting times following the introduction of the 2 week wait rule for breast cancer: a prospective cohort study. *BMJ* 2007; doi 10.1136/bmj.39258.688553.55.
14. Sauven P. Specialists, not GPs, may be best qualified to assess urgency [Letter]. *BMJ* 2001; **323**: 864–5.
15. Dodds W, Morgan M, Wolfe C, Raju KS. Implementing the 2 week rule for cancer referral in the UK: general practitioners' views and practices. *Eur J Cancer Care* 2004; **13**: 82–7.

New FastTrack articles – online ahead of print

If you type the following URL into the address bar of your web browser <<http://dx.doi.org/>> and then enter the DOI in the dialogue box presented on this web page, you will be taken directly to the abstract of the article.

Original articles

Telephone follow-up following office anorectal surgery
REBECCA C FALLAIZE, CHRISTINE TINLINE-PURVIS, ANTHONY R DIXON,
ANNE-MARIE PULLYBLANK	doi 10.1308/003588408X300975
Oswestry Disability Index scoring made easy
A MEHRA, D BAKER, S DISNEY, PB PYNSENT	doi 10.1308/003588408X300984
The use of warfarin as thromboprophylaxis for lower limb arthroplasty
MARK R DUNBAR, PIYUSH K UPADHYAY, SHANMUGAM KARTHIKEYAN	doi 10.1308/003588408X300957
The clinical scaphoid fracture: early computed tomography as a practical approach
Q NGUYEN, S CHAUDHRY, R SLOAN, I BHOORA, C WILLARD	doi 10.1308/003588408X300948
The value of interhospital transfer and emergency MRI for suspected cauda equina syndrome: a 2-year retrospective study
M CROCKER, G FRASER, E BOYD, J WILSON, BP CHITNAVIS, NW THOMAS	doi 10.1308/003588408X301154