

Going Further on Cancer Waits: The Symptomatic Breast Two Week Wait Standard

A guide to support implementation



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Aim of Guide

This guide seeks to support cancer networks, trusts and breast units working to deliver the symptomatic breast 2ww standard. It sets out:

- background to why this standard was introduced;
- technical information related to implementation of the standard;
- information to support sustainable delivery of the standard including advice on how to ensure there are effective breast pathways in place and skill mix considerations;
- information from breast units that are already implementing the standard including: how they achieved it, challenges they faced and suggestions for those getting started;
- where to go for further information and support.

Executive Summary

1. The symptomatic breast 2ww standard goes live (ie. is due to be implemented across the NHS) from 1 January 2010.
2. Data on performance against the symptomatic breast 2ww standard should have been collected locally from 1 January 2009 (in accordance with the DSCN20/2008 mandate) and should have been uploaded on to the Cancer Waiting Times database (CWT-Db) from 30 April 2009.
3. A small number of units are already seeing all patients with breast symptoms on a 2ww pathway but evidence from a readiness questionnaire in October 08 plus data already submitted to the CWT-Db suggests that many units may still have some way to go if they are to achieve this standard by 1 January 2010.
4. Key to implementing the symptomatic breast 2ww standard are:
 - good data capture systems – these should ensure that all relevant data are captured and available (preferably electronically and linked to other systems such as PAS) and that progress can be tracked with minimal manual intervention;
 - effective pathways – these should ensure that good clinical care (as outlined in relevant NICE guidance) is provided through a robust system that offers quality, timely, equitable and “value for money” services;
 - good prospective patient management and navigation systems – these should ensure that you know where patients are in the system and allow you to navigate them through the pathway so that they are in the right place at the right time receiving the right care.
5. In addition, implementation of the 4 High Impact Changes identified by NHS Improvement for cancer service pathways when the original CWT standards were implemented have been shown to reduce waiting times, improve performance and have a direct impact on the quality of the patient experience. These are:
 - one route into the system;
 - straight to test approach;
 - timely decision making;
 - appropriate follow-up.
6. Achieving this standard will ensure that all patients with breast symptoms benefit from faster care pathways (2ww and 62 days). This should improve their experience of the service and could also, potentially, improve their outcome.
7. There is no one size fits all approach to how the symptomatic breast 2ww standard can be implemented. In some units, extra capacity has been created by providing training to support the development of advanced practitioner roles. In other units extra clinics have been created, and in some, separate clinics have been set up to manage different patient cohorts such as the under 35s.
8. Sharing practice and learning from different units should help other breast units with the challenge of delivering this standard by 1 January 2010.
9. Sustainability is unlikely to be guaranteed where pathways are designed to fit the maximum waiting time ie. 2 weeks. Trusts that generally achieve consistent delivery and sustained performance of cancer waits standards have pathways that deliver **within** the standard timescales.
10. Further information is available at www.improvement.nhs.uk/cancer. Cancer Network and Trust Service Improvement Leads are also a source of support.

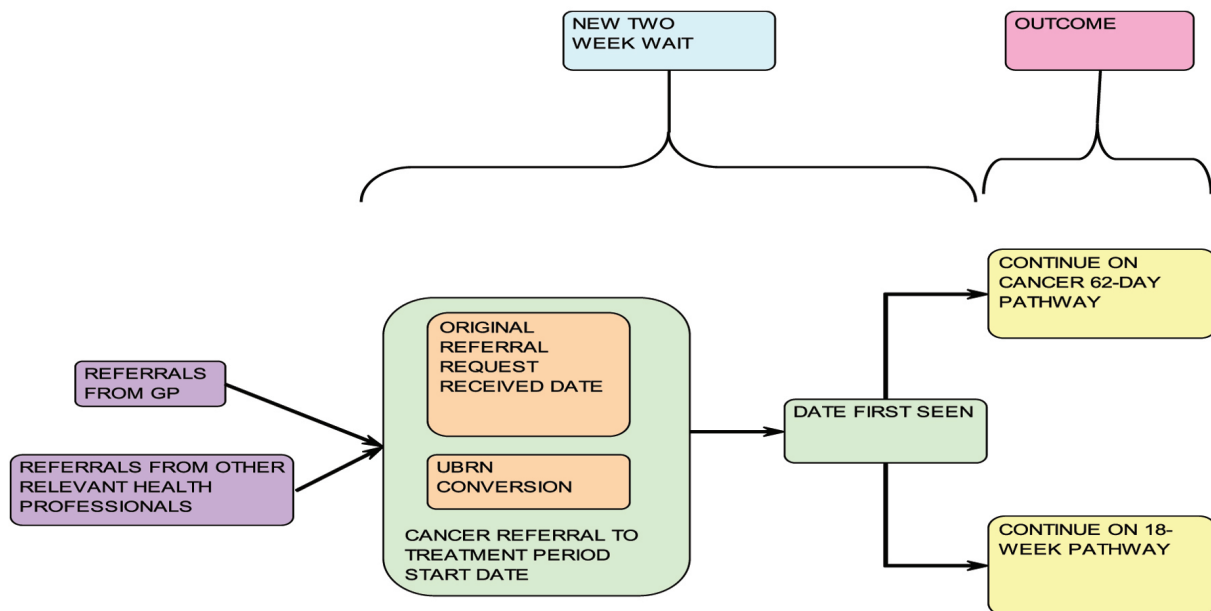
1. Background to the Symptomatic Breast 2ww Standard

- 1.1. The NHS Cancer Plan (published in September 2000) summarised a number of service standards relating to waiting times. This included a 2 week standard (2ww) from urgent GP referral for suspected cancer to first hospital assessment.
- 1.2. The Cancer Reform Strategy (published in December 2007) noted that the current cancer waits service standards did not apply to all cancer patients or treatments and they would therefore be expanded to extend the range of patients who could benefit.
- 1.3. As part of this expansion the existing 2ww standard was expanded so that any patient referred with breast symptoms would be seen within 2 weeks, whether cancer was suspected or not. This standard goes live from 1 January 2010 although Trusts should already be collecting data for this standard (in accordance with the DSCN20/2008 mandate) and uploading it onto the National Cancer Waiting Times Database (CWT-Db).
- 1.4. A key reason for introducing this standard was that only about half of diagnosed breast cancers were coming through the urgent 2ww route. For example, in Q3 (Oct-Dec) 2008/09 there were 4581 patients diagnosed with breast cancer following an urgent 2ww referral compared to 4539 patients diagnosed with breast cancer following other types of referral (including from the screening service). As a result there were a significant proportion of patients that were not benefiting from the faster pathways (2ww and 62 days) that could improve, not only their experience of the service, but also, potentially, their outcome. The new standard aims to address this.
- 1.5. In October 2008 the National Cancer Action Team (NCAT) issued a questionnaire to assess readiness in England to implement this standard. Completion was voluntary. Results from 76 of around 170 breast units were received and indicated that there was still some way to go if this standard was to be fully implemented across the country from 1 January 2010. The position over the last 9 months is likely to have moved on but the results of the questionnaire are available, for information, at **Annex A**.
- 1.6. In January 2009 a small workshop was organised by NCAT to consider the results of the questionnaire and to seek views from delegates on issues such as how to manage backlogs, how to overcome bottlenecks and how to increase capacity including the potential role of advanced practitioners. A summary of the discussions at the workshop are set out at **Annex B**.

2. The Symptomatic Breast 2ww Standard

- 2.1. The symptomatic breast 2ww standard should ensure that all patients (men and women) with breast symptoms (where cancer is not suspected) are seen by a specialist within 2 weeks of a referral being received from their GP or other relevant health professional.
- 2.2. The standard covers breast symptoms not covered by the NICE referral guidelines for suspected cancer but that a healthcare professional believes still need to be seen by a specialist.
- 2.3. There are two types of breast referral that are excluded from the symptomatic breast 2ww standard. These are referrals:
- from family history clinics (unless a patient is symptomatic);
 - for cosmetic breast surgery (such as enlargement or reduction).
- 2.4. The **starting point** for this standard (ie day 0 when the clock starts) is the receipt of the referral for an appointment in the appropriate breast clinic (recorded as the **CANCER REFERRAL TO TREATMENT PERIOD START DATE** on the CWT-Db). The referral can be received either:
- direct from the GP or other healthcare professionals who may see a patient with breast symptoms (recorded as **ORIGINAL REFERRAL REQUEST RECEIVED DATE** on the CWT-Db); or
 - via Choose & Book, in which case the **UBRN CONVERSION** (the Unique Booking Reference Number conversion date for an appointment) would mark the start of the 2ww period.
- 2.5. The **end point** for the standard would be when the patient is seen for the first time by a specialist or in a diagnostic clinic following the referral receipt. This is recorded as **DATE FIRST SEEN**.
- 2.6. If cancer is confirmed the patient continues on a 62 day pathway for treatment.
- 2.7. If cancer is excluded the patient continues on the 18 week pathway.
- See diagram 1.

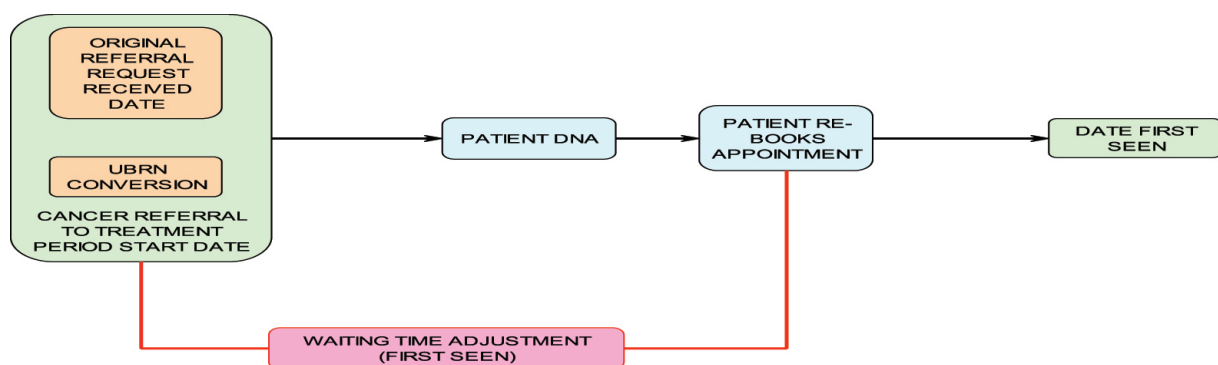
Diagram 1 - the symptomatic breast 2ww pathway:



- 2.8. There is **only one pause** (clock stop) allowed for the symptomatic breast 2ww standard. This is if a patient DNAs (Does Not Attend) their initial outpatient appointment ie. does not turn up and gives no notice. This would allow the clock to

effectively be re-set from the receipt of the referral (recorded as the [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#)) to the date upon which the patient rebooks their appointment. See diagram 2.

Diagram 2 - pausing the clock for the symptomatic breast 2ww standard



- 2.9. The difference between the two types of breast 2ww standard we now have (urgent and symptomatic) are that:
- the urgent breast 2ww standard is where the GP suspects cancer;
 - the symptomatic breast 2ww standard is where the GP (or other relevant health professional) is referring a patient for breast symptoms but does not suspect cancer.
- 2.10. Patients coming through the new symptomatic breast 2ww route need to be distinguished from the suspected cancer breast 2ww patients by the data item 'TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE' where:
- code 01 is suspected breast cancer; and,
 - code 16 is exhibited (non cancer) breast symptoms.
- 2.11. It is necessary to differentiate between the two for monitoring the separate Vital Signs requirements. The differentiation might also help to monitor appropriateness of referrals and therefore identify any education needed about signs and symptoms of breast cancer amongst relevant healthcare professionals.
- 2.12. Data on the symptomatic breast 2ww should have been collected from 1 January 2010 (in accordance with the DSCN20/2008 mandate) and should have been uploaded on to the CWT-Db from 30 April 09 when the updated database came on line. You do not need to upload 2ww and breast 2ww data separately. All data can go in the single monthly csv file, a separate upload is not required.
- 2.13. You should make sure that you know the next deadline for uploading data – a list of upload deadlines is available from http://nwww.connectingforhealth.nhs.uk/nha/cancerwaiting/prop_report
- 2.14. It is strongly advised that you do not wait until the last available day to upload data to the CWT-Db. You should leave time to validate data and some contingency to go through the CWT-Db's three distinct phases of validation. These are:
- Initial: where the format of the file is checked, and the system confirms the NHS Number is valid;
 - Cross-Field Phase 1: where the system runs the logic tests (detailed within the .csv specification) that can be discretely run within a two week wait or 31-day record. All records in a file must pass for the file to be placed in the upload queue; and
 - Cross-Field Phase 2: where the system identifies potential matched records that are already in existence within the CWT-Db and then runs validation within 62-day records. All validations passed at Phase 1 are rechecked on the matched records. Records that pass are saved individually, failures are reported to the provider and not saved.
- 2.14. Because of this phased validation process a user should not assume that any record that is accepted into the upload queue will be saved on the CWT-Db. Users should log in and check the following day, then make any necessary corrections.

3. Supporting Sustainable Delivery of Symptomatic Breast 2ww Standard

3.1. When considering how best to implement the symptomatic breast 2ww standard locally there should be two over-riding principles:

- patients' needs should be at the centre of improvement work;
- the focus should be on delivering effective pathways, rather than delivering performance standards.

3.2. There are three questions that you need to be able to respond to positively if you are to ensure that you can deliver the symptomatic breast 2ww (and the other cancer waits standards) in a sustainable way:

- **do you have a good data capture system in place** ie. to ensure that all relevant data are captured and available (preferably electronically with links to other systems such as PAS) and that progress can be tracked with minimal manual intervention;
- **are effective breast care pathways in place** ie. to ensure that good clinical care is provided through a robust system that offers quality, timely, equitable and "value for money" services;
- **does the team have good prospective patient management and navigation systems in place** ie. to ensure that you know where patients are in the system and allow you to navigate them through the pathway so that they are in the right place at the right time receiving the right care.

Your Cancer Network or Trust Service Improvement Leads should be able to offer you advice about how to take this work forward. In terms of ensuring effective pathways are in place the following might help:

Effective pathways

3.3. The key action to take (if it has not already happened) is to map and investigate the relevant patient pathways for symptomatic breast patients (see diagram 1). As patients that go on to be diagnosed with breast cancer will continue on a 62 day pathway it is important to consider the **whole** patient pathway rather than just up to **DATE FIRST SEEN** which ends the 2ww period.

3.4. Mapping the pathway(s) in your local area will ensure that you can:

- define and understand the current patient process;
- identify delays, bottlenecks (ie. the stage in the patient journey which causes patients to wait), duplication and where to begin measuring capacity and demand;
- identify what/where are the specific constraints (eg. lack of a specific skill or piece of equipment);
- identify opportunities for improvement and key issues in service delivery;
- avoid reliance on one perspective ie. not just focus on one part of the patient journey;
- understand, capture and incorporate the patients' and carers' viewpoints.

- 3.5. If you put an effective pathway in place you will ensure that:
- quality and timely care is delivered to patients throughout their breast care journey;
 - services are equitable and offer value for money;
 - cancer waiting times standards are delivered in a **sustainable** way;
 - minimum intervention and support is needed in terms of tracking and navigation as the pathways should 'automatically' pull patients through their journeys.
- 3.6. A Pathway Mapping Event with clear objectives and scope, supported by key stakeholders, and attended by the relevant clinical, managerial and service leaders plus staff involved in the relevant stages of patient care can be a useful first step. At such an event it is suggested that each step is mapped using "post it" notes ie: who (person), does what (action), where (place), when, to whom and with what (ie. equipment). Then each step is worked through focusing on what happens 80% of the time.
- 3.7. For each step it is suggested that you ask:
- can it be eliminated?
 - can it be done in another way eg. separate clinics for follow up patients, family history patients etc?
 - can it be done in a different order?
 - clinics in the community?
 - can it be done by someone else eg. by a specially trained nurse instead of a doctor?
 - can it be done in parallel eg. one-stop clinics for ultrasound, fine needle aspiration and clinical examination;
 - can any "bottlenecks" be removed?
 - does it add value for the patient?
 - would patients find it an acceptable option?
- 3.8. If you identify any potential changes it is suggested that they are tackled using the Improvement Model Approach ie. Plan - Do - Study - Act (PDSA) cycles. Your Cancer Network or Trust Service Improvement Leads should be able to advise on this.
- 3.9. Useful markers for whether you have an effective pathway are that it:
- is agreed and understood by all providers/stakeholders across the pathway and supported by protocols and guidelines;
 - has clear timings for each step with identified escalation points and allocation of responsibility;
 - is achievable well within the standard time;
 - includes the Cancer High Impact Changes ie:
 - one route into system;
 - straight to test approach eg. one stop triple assessment clinics;
 - timely decision making;
 - appropriate follow up.
 - has strong teamwork and a well functioning MDT with clarity of role in pathway coordination;
 - it is the sort of pathway we would want for ourselves and our families.
- Skill Mix**
- 3.10. It is likely to be necessary to create additional capacity to implement the symptomatic breast 2www standard. Use of skill mix to enable different models of care such as nurse led assessment are options worthy of local consideration.
- 3.11. At the workshop held in January 2009 to consider implementation of this standard there was general agreement that there was a need to focus on skills not people and that units should consider if it was appropriate locally for certain health professionals (such as nurses, radiographers

and radiologists) to extend their roles into areas such as:

- clinical breast examination;
- breast ultrasound;
- fine needle aspiration (FNA);
- punch biopsies;
- seroma care;
- supporting patients discharged with drains.

- 3.12. It was suggested that the introduction of an advanced breast practitioner role would enable different models of care to be considered locally to expand capacity such as: nurse practitioner led clinics for follow up patient and radiographers carrying out image guided biopsies.
- 3.13. There was general agreement that a national training programme is not needed. There are a range of existing courses around the country suitable for training advanced practitioners. Localities need to consider if this is a route they wish

to pursue and, if so, consider who to train and in what. For example, a breast centre could choose to train all their nursing staff to a certain level of breast care or certain individuals to take on certain tasks.

- 3.14. It was suggested at the workshop that national criteria should be developed to support locally developed training and that a directory of training programmes applying the national criteria should then be established. NCAT, the DH and NHS Improvement are taking this work forward. Further details of the workshop discussions are at Annex B.

Conclusion

- 3.15. Whatever the outcome of pathway planning, skill mix considerations etc, it is recommended that units/trusts/networks develop a delivery plan with clear milestones and responsibilities for implementation of the symptomatic breast 2www standard.

4. Information from units already delivering the Symptomatic Breast 2ww Standard for all referrals

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| <p>4.1. This section includes examples from breast units that advise that they are delivering a two-week wait for all breast referrals (urgent & symptomatic).</p> <p>4.2. The approaches taken by the units are different and the examples demonstrate that there isn't a one-size fits all approach to how the symptomatic breast 2ww standard can be implemented.</p> <p>4.3. In some units, extra capacity has been created by providing training to support the development of clinical nurse specialist roles, in others, extra clinics have been created and, in some cases, this has</p> | <p>involved separating out clinics for new patients from follow-up clinics or developing clinics for specific patient cohorts such as the under 35s.</p> <p>4.4. It is hoped that by sharing practice from different units and the learning from those sites all breast units will be able to meet the new national minimum standard by 1 January 2010.</p> <p>4.5. Practice from 7 breast units that report that they see all breast referrals within two weeks is set out in this section along with key messages that can be drawn from the information provided.</p> |
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Key messages from units seeing all referrals in two-weeks:

- Strong leadership within the unit
- Culture in the unit is open to change and service improvement
- Buy-in and support from frontline staff in the unit
- Desire to implement a two-week wait for all breast referrals
- A 'Can do' attitude
- Communication between staff in the unit and other departments
- Developing skills within team to increase capacity
- Process monitoring and having a clear idea of demand and capacity

Barriers identified by units achieving the 2ww standard:

- Clearing any backlog and maintaining the standard
- Staff willing to support running extra clinics
- Managing increasing numbers of referrals and blips month to month
- Utilising Choose and Book efficiently for breast referrals
- New cancer waiting time rules and a lack of ability to make adjustments
- Don't have enough clinics but have enough capacity

Best practice in achieving the 2ww standard:

- Secure extra capacity, without impacting on other services
- Review the entire patient pathway to ensure efficiency, starting with referrals made by the GP
- Ensure access to clean and reliable data on demand and capacity in order to ensure process monitoring
- Involve patients and staff in decisions about changes to pathways and processes

Patient involvement

- 4.6. While meeting the symptomatic breast 2ww standard is unlikely to require significant service re-alignment, breast units, like Frenchay Hospital, have benefited from consulting with patients on their experience to support achieving the standard, including developing primary care services. Results of past patients surveys, peer review or feedback gained from participating in Breakthrough Breast Cancer's Service Pledge can be used to ensure changes to services to achieve the standard align with patient views.

Sharing best practice

- 4.7. The examples that follow highlight seven units that report that they are delivering a two-week wait for all breast referrals. We are aware that there are other units also delivering such a service and would encourage them to share their experience either with the National Cancer Action Team or with Breakthrough Breast Cancer so that we can promote best practice/ different service models already underway.

Countess of Chester Hospital NHS Foundation Trust

Ursula Keyes Breast Care Unit

How is the breast unit achieving a two-week wait for all breast referrals?

The unit increased capacity by starting clinics a quarter of an hour earlier, split new and review clinics and used evening clinics to clear existing backlog. The unit has trained a clinical nurse specialist to see patients and created an extra clinic each week for patients under 35.

Were additional resources needed?

Training the clinical nurse specialist required some extra resource, but an existing session with the consultant was used for the under 35s clinic.

What were some of the challenges in meeting the standard?

Putting on clinics in the evening and finding staff to work the extra clinics has been a challenge. It is widely acknowledged within the unit that consultants are already being stretched as is the extra capacity from the evening clinics. However, overall, clinicians are happy to be involved and the process has gone very smoothly.

Suggestions for those just getting started?

The advice from the unit is that you need to clear the backlog. You need to make sure everyone in the unit is engaged in the process and get support to add additional capacity where needed, ie an extra clinic each week. Finally, ensure a consistent administrative support is responsible for the unit's appointments system.

Who has been the driving force behind achieving a two-week wait for all breast referrals?

The lead consultant surgeon in the unit has been the driving force.

For further information, please contact Fiona Curtis, Cancer Manager at fiona.curtis@coch.nhs.uk

King's College Hospital NHS Foundation Trust

How is the breast unit achieving a two-week wait for all breast referrals?

The unit has been meeting a two-week wait for all breast referrals since 1999, based on their work showing half of cancers were in the non-urgent group. All patients are seen by a consultant and while there are a set number of new patient clinics each week, additional clinics are added as needed on alternate days in order to achieve a two-week wait for all referrals and thus match capacity to demand.

Were additional resources needed?

No additional resources have been needed. What has been needed is flexibility in clinic scheduling and investment into the clinical and information systems within the organisation.

What were some of the challenges in meeting the standard?

Keeping the process monitoring going and constantly looking for new ways to do things better in the unit.

Suggestions for those just getting started?

Start by making small changes (PDSA's, learning by small successes and small failures) and build on each them. Once you start achieving the wait, make sure you keep it up. Make sure you have your process monitoring in place to identify upcoming issues.

Key principles at the unit are:

- Pull work in not push work away, so work hard to bring down waits, shorten the administrative time and distance from referral to seeing a patient.

- Work hard at getting information back to patients eg. fax bookings within 10 minutes to GPs or to patients at work so they can get time off from their supervisor more quickly.
- Plan holidays, public holidays, conferences and planned downtime well ahead of time. Small planned adjustments (extra clinics) work better than virtuoso efforts and don't have clinics overrun.
- No named consultant booking or consultant upgrades.
- Flat service model, there is one kind of appointment, behind that is the complexity.
- Emphasise providing service focussed on patients not targets.
- Clearly identifying process through protocol driven information systems, which use workflow documents and not requests.
- Add value for every attendance a patient makes on coming to the unit.
- Allow all levels to provide their own solutions.
- Map out work to be done against who is best able to provide it, rather than demarcating work to one professional group.
- Every episode of patient contact is important and people handling each one need access to the information and resource to meet patients' needs.
- Aim for 10 days rather than 2 weeks - your working life will be that much better.
- Shorten cycle time between seeing, diagnosing and treating patients.
- Aim to see more new patients than follow-up patients, aim to do all but reconstructive surgery in day surgery.
- Strive for co-location for symptomatic clinics,

King's College Hospital NHS Foundation Trust...continued

breast imaging, oncology services, plastics services and gynae-endocrine support.

Remember:

"Do today's work today" – Mark Murray IHI

"What are we doing next Tuesday?"

And finally make sure you feedback to everyone in the unit on your progress. The number of patients seen and current waiting times appear on all the computers in the unit to ensure all staff are aware of their progress – the benefits of hard work are visible to all.

Who has been the driving force behind achieving a two-week wait for all breast referrals?

Achieving the wait has been a team effort but has been led by one of the consultant surgeons.

For further information, please contact Jonathan Roberts, Consultant Surgeon
jonathan.roberts1@nhs.uk

North Bristol NHS Trust

Frenchay Hospital

How is the breast unit achieving a two-week wait for all breast referrals?

An additional number of routine referral slots were agreed and added to all clinics (clinics are not every day). One of the clinical nurse specialists has undertaken training in ultrasound and breast palpation and is now responsible for the hormonal therapy clinic. This has resulted in an additional clinic for routine referrals by releasing the consultant from the aforementioned clinic. The unit is currently piloting the use of a nurse practitioner based in the community to enable additional routine referrals to be seen. Approaches to achieving a two-week wait and progress are consulted on and monitored with patients.

Were additional resources needed?

The unit has achieved the wait without any additional investment. The appointment timetable was re-organised in order to fit in the extra clinics and funding for training nurses was organised through a joint pilot project with the University of the West of England and NHS Improvement.

What were some of the challenges in meeting the standard?

The unit would like to have facilities to offer all patients, regardless of referral route, a full one stop clinic/diagnostic service. Currently only three clinics per week are dedicated one stop clinics. Pathology and radiology provide services for the whole trust but can offer an informal one stop diagnostic service outside of the designated clinics.

There are issues around year on year increases in referral rates and how to keep up with demand.

Another challenge has been using Choose and Book and getting the appointments filled. When a patient rings the national central appointments office they might have been offered an appointment a month later when there were free slots available prior to the date given. The unit has only just recently learnt that they can block the national office from having access to appointments beyond two weeks to encourage the administration team to look within all clinics for availability. This is working. If all clinics are full, the Breast Care Centre is contacted and can overbook certain clinics to ensure all referrals are seen in two weeks.

Suggestions for those just getting started?

Units need to have an up-to-date knowledge of their referral numbers and a better understanding of how to work with central appointments to achieve a two-week wait for all referrals. Clinics and appointment slots need to be co-ordinated so the unit isn't constantly fighting fire.

Who has been the driving force behind achieving a two-week wait for all breast referrals?

It's been a team effort, but one of the consultant surgeons and a breast care nurse have encouraged the unit to continuously provide a better service.

For further information, please contact Jane Barker, Breast Care Nurse at jane.barker@nbt.nhs.uk

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Jasmine Centre, Doncaster Royal Infirmary

How is the breast unit achieving a two-week wait for all breast referrals?

The unit has always tried to maintain a two-week wait for all breast referrals since 1997. They are currently striving for a 7 day wait. The unit increased capacity by adding one extra clinic and through employing a nurse practitioner.

Were additional resources needed?

The extra clinic was self-funding as a result of payment by results.

What were some of the challenges in meeting the standard?

Coordinating referrals between the two breast units in the trust has been a challenge, as well as changes to cancer waiting times and no longer

being able to make adjustments when one unit receives a larger number of referrals than the other.

Suggestions for those just getting started?

Speak with the local primary care trust and work towards a solution which includes the local health needs, ie exploring the role of nurse practitioners in the community. It is also important to be aware of what type of service patients want.

Who has been the driving force behind achieving a two-week wait for all breast referrals?

It's been a team effort.

For further information, please contact Jackie Simpkin, Cancer Manager at

Jackie.Simpkin@dbh.nhs.uk

Cambridge University Hospitals

NHS Foundation Trust

Addenbrooke's

How is the breast unit achieving a two-week wait for all breast referrals?

The unit struggles at times to maintain a two-week wait for all referrals. Additional clinics and using a varying number of slots throughout the week to keep up with referrals, along with the use of nurse practitioners, has helped the unit continue to see all referrals within two weeks.

Were additional resources needed?

Resources have been needed for training the nurse practitioners and the team are at times carrying out extra clinics in their free time, due to limited resources. Another consideration is that any extra clinic requires additional support and resources from pathology and radiology and admin staff. There are knock on effects and costs which are often forgotten and therefore not planned or budgeted for.

What were some of the challenges in meeting the standard?

Keeping capacity aligned to referrals can be difficult, particularly if there is a blip in referrals. It can be difficult to plan when month to month averages vary by more than 100 patients. The unit also has difficulty with Choose and Book ending up with vacant slots which if they were allowed to close earlier, they would be able to fill with patients.

Suggestions for those just getting started?

Ensure you have the agreement for extra resources in place before you start organising extra clinics, otherwise it will be difficult to gain the additional resources.

Who has been the driving force behind achieving a two-week wait for all breast referrals?

Achieving the standard has been led by the lead consultant surgeon at the unit, but the Nurse Consultant has played an equally important role in training and developing a nationally accredited programme for nurse practitioners.

For further information, please contact Dawn Chapman, Nurse Consultant at dawn.chapman@addenbrookes.nhs.uk

Princess Royal Hospital NHS Trust

How is the breast unit achieving a two-week wait for all breast referrals?

The unit has been achieving the standard for many years. The key is not to have fixed clinic capacity but to be able to expand capacity by the provision of an overflow clinic. Also, the use of cytology within clinic reporting, alongside core biopsy, allows for fewer second clinic visits.

Were additional resources needed?

No additional resources have been needed but a lack of staffing has, at times, had a significant impact on the unit's ability to achieve the wait. At one stage, the unit needed to insist that they were no longer able to achieve the standard as a result of breast care nurse and data manager posts not being replaced following retirement. Management are aware of the problem and these posts have now been recruited.

What were some of the challenges in meeting the standard?

Maintaining the standard with varying levels of staffing has been the biggest challenge. There have also been ongoing problems with Choose and Book, as a result of patients being able to choose to wait longer than two-weeks. Finally, incorporating over-flow clinics has been a challenge. The Wednesday clinic is scheduled to run until 18.00 but it sometimes runs over till 20.30 (the unit chose this model rather than a separately scheduled overflow clinic).

Suggestions for those just getting started?

Review and challenge poor models of working. Mammogram capacity is an issue so we have developed an approach where only women who have symptoms suggestive of breast cancer, or are at increased risk, are offered a mammogram. An overflow clinic is essential to cope with peaks in demand.

Who has been the driving force behind achieving a two-week wait for all breast referrals?

Achieving the standard has been clinically led. For further information, please contact Christopher Hinton, Breast Consultant at christopherhinton@tiscali.co.uk

Guy's and St Thomas' NHS Foundation Trust

How is the breast unit achieving a two-week wait for all breast referrals?

In 2005, the unit developed a Model of Care which included an aspiration to see all breast referrals within 2 weeks and a further aim to reduce this to 48 hours from referral, regardless of being urgent or routine. The 48 hour wait to be seen at the breast clinic was developed because the unit recognised that two thirds of 'routine' referrals resulted in a breast cancer diagnosis.

Who has been the driving force behind achieving a two-week wait for all breast referrals?

Achieving the standard has been led by the MDT lead and Director for the Integrated Cancer Centre. This has been with the complete support of members of the breast unit.

For further information, please contact Mairead Griffin, Lead Cancer Nurse at mairead.griffin@gstt.nhs.uk

Were additional resources needed?

Implementing the wait has required advanced nurse practitioners to support diagnostics clinics, along with two additional staff in radiology to support the provision of one-stop-clinics for patients.

What were some of the challenges in meeting the standard?

Securing clinical and nursing support, funding, organisation, culture and sustainability.

Suggestions for those just getting started?

Ensure you have engaged and gained the support of all the key stakeholders, especially surgery, radiology and pathology right from the beginning. Having them on board and sharing the vision will make achieving the standard and providing one-stop-clinics possible.

5. Conclusion

- 5.1. The symptomatic breast 2ww standard goes live from 1 January 2010 and all Trusts are expected to be implementing the standard from this date.
- 5.2. All Trusts should already be uploading data on to the CWT-Db for this system (as per DSCN20/2008 mandate) so should be able to see how they are progressing towards this standard and any shortfall they need to make up in the next few months
- 5.3. Key to implementing the symptomatic breast 2ww standard (alongside the other cancer waits standards) are:
 - good data capture systems;
 - effective pathways;
 - good prospective patient management and navigation;
 - implementation of the 4 High Impact Changes:
 - one route into the system;
 - straight to test approach;
 - timely decision making; and
 - appropriate follow-up.
- 5.4. There is no one size fits all approach to how the symptomatic breast 2ww standard can be implemented but examples set out in this document show that sustainable implementation is achievable.
- 5.5. Service Improvement Leads should be contacted for advice if needed.

6. Further Information & Support

Information

- 6.1. Further information to support implementation of cancer waiting times standards can be found at: www.improvement.nhs.uk/cancer. This includes:
- A Guide to Delivering & Sustaining the Going Further on Cancer Waits Standards Through Effective Pathway Management, 2009;
 - 'The Challenge of Implementing Sustainable Improvement in Cancer Waiting Times' June 06;
 - 'How to Guide –Achieving Cancer Waiting Times', 2005;
 - The Cancer High Impact Changes.
- 6.2. In addition:
- the Connecting for Health website at: <http://nwww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation> includes some useful documentation such as the GFOCW Guide v6.5.
 - the NICE website at: <http://www.nice.org.uk/guidance/index.jsp> includes referral and treatment guidelines relevant to breast cancer
 - Choose and Book have produced guidance notes (December 2008) on Urgent Referrals for Suspected Cancer Two-Week Waits: Implementation within Choose and Book. This is available at: http://www.chooseandbook.nhs.uk/staff/implement/guides/2ww_guide

Local Support

- 6.3. Cancer network service improvement teams should be able to provide service improvement advice and support to enable you to deliver the symptomatic breast 2ww standard.

Acknowledgements

- 6.4. Thank you to the NHS organisations that provided case studies and to all those who have had an input into this document.

Annex A

Readiness to Implement 2ww for all Symptomatic Breast Referrals:

In autumn 08 a questionnaire was circulated (via cancer networks and via BASO - the British Association of Surgical Oncology) to breast units to establish their 'readiness' to implement symptomatic breast 2ww standards. This section summarises the results of the questionnaire.

Summary Of Questionnaire Results (position in October 2008)

76 of approximately 170 breast units responded to all or part of the questionnaire either directly or via their cancer network. As cancer networks responded in some cases it has not been possible to provide a definitive list of the 76 units. However, those that it was possible to identify from the responses are listed at Appendix 1.

A summary of the survey results follow. However it should be noted that this sets out the position in October 2008 ie. 9 months ago.

Number of breast units currently seeing all breast referrals within two weeks of receipt of referral.

- 12% of the units that responded (9 out of 76) confirmed that they were already seeing all breast referrals within 2 weeks;
- 88% of the units that responded (67 out of 76) were not yet seeing all breast referrals within 2 weeks (although a small number confirmed that this was achieved on occasion but not consistently).

Estimated performance of those units not yet meeting 2ww for all patients.

Of 32 units that responded to this question:

% of all symptomatic referrals (non urgent) currently seen within 2 weeks	No of units achieving this level of performance
80-90%	10
51-79%	3
26-50%	6
0-25%	13

The gap to address therefore ranges from 10 – 100% ie. 10-100% of symptomatic referrals not yet seen within two weeks in some breast units in October 08.

Assessment of how capacity could be/is going to be expanded to meet 2ww.

Of 38 units that responded to this question:

- 37 were already undertaking or had undertaken an assessment of how capacity could be expanded;
- 1 planned to do so early in 2009.

Actions being taken (or considered) to support implementation of all breast referrals in 2 weeks

- increasing capacity by not having breast unit staff on-call;
- extended roles for breast care nurses;
- one stop clinics 4-5 days a week;
- book referrals directly into a clinic rather than being triaged first;
- under 35 clinics;
- nurse led clinics;
- advanced practitioners doing screening sessions so radiologists can focus on symptomatic services;
- staff completing ultrasound courses to enable them to do u/s guided biopsies without having to involve radiologists;
- monitoring performance weekly and arranging additional clinics on an adhoc basis as needed.

How many of the units used the breast assessment competencies developed by Skills for Health to develop their workforce?

Of 65 units that responded to this question:

- 65% (42 of 65 units) did not use the competencies;
- 35% (23 of 65 units) did use the competencies.

How many units have plans to develop breast assessment practitioners as a workforce solution to expand capacity?

Of 41 units that responded to this question:

- 54% (22 of 41 units) had plans to develop practitioners.

Of those units that had plans:

- the following staff groups/areas were likely to be developed to fulfil this role:
 - breast care nurses (13 units)
 - radiographers (6 units)
 - sonographers to do breast ultrasound work (2 units)
 - breast physician (1 unit)
- tasks being considered for the expanded roles included:
 - ultrasound (2 unit)
 - clinical assessment (2 units)
 - mammogram reading (2 units)
 - managing follow up clinics

Concerns about expanding practitioner role.

The following concerns were expressed:

- patients seeing an "assessment practitioner" would be more expensive in the long run as patients would often need to return to see a consultant anyway – better for consultant breast surgeon to assess patients on their first visit;
- medico legal aspect of a breast care nurse carrying out this role, despite them being fully trained;
- using trained non medical staff in new patient assessment or cancer follow up to free up medical staff is not the way to go;

- If non-medical staff are to be used more widely then a national training scheme with a recognised qualification available in all regions is necessary – otherwise local support unlikely.

Have any units accessed either of the training courses available at Addenbrookes Hospital or the University of the West of England (Bristol) in developing breast assessment techniques?

- 3 Units mentioned that staff (incl doctors and associate specialists) had attended ultrasound courses at Bristol
- 2 Units mentioned that staff had completed or applied for advanced practice for breast care nurse courses at Addenbrookes.

Are you aware of any other courses to develop breast assessment practitioners – either locally or elsewhere in the country?

The following were identified:

- Royal College of Surgeons intermediate and advanced courses for breast disease
- Masters level education for nurses eg. advanced assessment skills course at KCL and RMH.
- Diploma in breast evaluation, Kingston
- Course in clinical breast examination - Jarvis breast screening centre, Guildford.
- NHSBSP training courses
- Courses for GPs on the management of breast disease which includes breast examination and assessment of patients prior to referral – run by Greater Manchester and Cheshire Network
- Medical Ultrasound: extending your roles and clinical examination & diagnostics course - John Moores University, Liverpool

Any units planning on developing a local course to increase the number of breast assessment practitioners or planning to send staff on existing courses?

Of 52 units that responded to this question:

- 71% (37 of 52 units) have no plans to develop local courses
- 21% (11 of 52 units) are developing local courses
- 8% (4 of 52 units) are considering developing a local course

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Appendix 1 - Responses to the October 2008 Symptomatic Breast 2ww Readiness Questionnaire

Units responding direct:

- Doncaster
- Sheffield
- Barnsley
- Hereford
- Cheltenham
- Gloucester
- Worcester
- Royal Berkshire Hospital
- Countess of Chester Hospital
- Kings
- Guy's and St Thomas' Hospital
- University Hospital Lewisham
- QMH
- Torbay
- Bromley North Cumbria Uni Hospitals
- Frenchay
- Taunton
- Wigan
- University Hospital of Coventry and Warwickshire
- Tunbridge Wells
- Doncaster and Bassetlaw
- Rotherham
- East Sussex Hospital Trust

Units responding via networks:

- Mount Vernon (incl responses from 4 unnamed units)
- South West London (incl responses from 4 units - Mayday NHS Trust, Royal Marsden, St George's, Kingston Hospital)
- Sussex (incl responses from 3 unnamed units)
- Manchester and Cheshire (incl responses from 11 unnamed units)
- Surrey, West Sussex and Hampshire (incl responses from 7 unnamed units)
- Anglia (incl responses from 9 unnamed units)
- South Central (incl responses from 6 unnamed units)
- Merseyside and Cheshire (incl responses from 8 unnamed units)
- 3 counties (incl responses from 4 unnamed units)

Annex B

Notes from Workshop on Implementing Symptomatic Breast 2ww Standard (20 January 2009)

This annex summarises views and ideas expressed at a small workshop held in January 2009 to discuss implementation of the breast 2ww standard.

The views set out in this annex are not necessarily those of the National Cancer Action Team, NHS Improvement or Breakthrough Breast Cancer.

General issues raised during the morning discussion included:

- if a woman has breast symptoms they would usually want to be seen as quickly as possible ie. speed would usually be their priority over choice
- with only 9% of the units that responded to the survey indicating that they are already delivering the breast 2ww standard, there is a challenge ie. how do we clear the backlog and fill this gap.
- if average waits are 3-4 weeks (possibly more) how can we reduce this to 2 weeks – is there a solution that can be applied across the whole country?
- is it possible to deliver the breast 2ww standard in a cost neutral environment - what is the incentive for units to try and meet the standard without requesting more resources ie. where is the incentive not to spend? General view that implementation is not cost neutral, therefore

funding needs to be a local consideration.

- quality matters ie. what patients actually want – general consensus is that patients want to have all their tests (and preferably the results too) on the same day ie. one stop clinics for tests should be the gold standard and are deliverable. However, if core biopsies are used for diagnosis, same day results may not yet be feasible – results range from 2-3 days in some areas and a week in others although work from NHS Improvement indicates that core biopsy results could be back within 2-4 hours.
- it is important to consider the quality of the service for the 90%+ of women who will not have cancer. For example, they will need information on breast pain, cysts, nodularity etc and if this is provided well it can reduce anxiety and depression.
- patients diagnosed with benign disease may not need to come back to the main clinic to discuss their diagnosis. Other models may be possible eg. satellite clinics in the community to reduce the number of patients coming into hospital clinics.
- it would be useful to be able to stratify risk for certain patient groups eg. the risk of not biopsying a fibroadenoma in the under 25s, risk of cancer in under 35s etc as a means to managing patients more effectively.
- three key areas for action are commissioning, training and raising quality.

Managing Backlogs

Suggestions on how to reduce backlogs included:

- see if consultants have any spare capacity ie. to put on extra clinics
- don't cancel clinics for bank holidays – if you usually have a Monday clinic, plan ahead ie. reschedule to Tues/Wed etc well in advance – get colleagues on board to do this (perhaps write it in to job plans ie. an extra 2-3 days per annum)
- reduce follow-up or change where follow-up takes place eg. possibly discharge patients to a local service (would be useful if we could stratify risk rather than do a blanket 'ban' on follow-up after 5 years ie. base the decision on a person's risk – develop a risk stratification tool)
- keep 'follow up' and 'new' patients in separate clinics so that services can be better directed. If separate clinics not feasible then split a clinic ie first half new patients (receiving results etc) and second half follow-up patients
- possibly do Saturday clinics – would need to persuade staff of benefit in terms of a successful breast service etc
- 1 stop clinics for tests (and if have good cytology for results too)

It was also noted that:

- managing a backlog was not just about the number of patients and clinics but also about the time needed and the level of service that needed to be provided;
- if a backlog is reduced without an increase in future capacity then a queue will just come back at some point in the future.

How to overcome bottlenecks & increase capacity

Potential bottlenecks/issues raised included:

- Waiting list initiatives linked to delivering 18 weeks ie. some consultants are pulled to different disciplines to clear lists eg. dedicated knee lists etc which can cause problems elsewhere in system – cancer patients are a sub group of the 18 week group and managers need to be educated of the impact of wider 18 week initiatives on cancer patients
- Surgeons – it was noted that surgeons often work on multiple sites and have to fit in private practice so they may not have much time flexibility to provide additional capacity and, with the pivotal role they currently play, this could result in a bottleneck. As a result some suggestions were made:
 - if you do need to rely on surgeons to increase capacity then consideration needed to be given to incentivising them to change their practise ie. how can existing job plans drive flexibility in the system. For example it was estimated that about 80% of breast surgeons are no longer on call which makes a difference to available capacity. An incentive for the remainder could be to drop on-call duties if 2ww is met for all breast patients;
 - some surgeons don't see enough patients and contracts need to be clear re. number of patients they are expected to see and/or clinics they are expected to run – the onus could then be put on the surgeon to identify how they could deliver that including innovative management techniques. There is

precedent in orthopaedics where the surgeons were given a 'target' and it was left to them how they delivered it eg. they could take additional leave if standard delivered etc;

- surgeons need referrals or they have no work – could referrals be controlled with a fee per service like GPs have;
- re-look at teams so don't have to rely on surgeons ie go back to commissioners and change care pathways to introduce, for example, advanced practitioner roles.
- pathology – appointing posts is difficult due to national shortage – this can impact on turnaround of core biopsies (eg. can be 4 days) and also HER2 results. It would be hard to expand others' roles into pathology.
- shortages of radiologists/imaging capacity – could ameliorate this by expanding roles of other staff to take on some of these duties.
- impact on traditional nursing roles ie. if nurses take on expanded roles who then fulfils their important psychosocial role. If it is to remain as part of the advanced practitioners role then more practitioners will be needed as they will only be able to deal with a smaller number of patients. If they are no longer to have this psychosocial role then back fill is needed to undertake the former roles plus others such as chaperoning, passing the biopsy gun etc.
- possible inundation with inappropriate low risk referrals such as men with bilateral gynaecomastia who are anabolic steroid users or overweight, known marijuana smokers or women with cyclical breast pain etc. It was suggested that such patients should be excluded from the standard. However, it was also noted that the more exclusions that are introduced the more likely it was that a 2 tier system would be introduced and cancer missed which this standard was aiming to remove.
- education of primary care eg. to manage the survivorship and/or follow up agenda. It was also suggested that nurses in primary care could be trained to do breast examination and reassurance to reduce unnecessary referrals. It was noted that such nurses would need to sit on MDTs in secondary care and go to one stop clinics at regular intervals to maintain skills etc. However, there was also concern expressed that practice nurses would not see enough patients for this model to work in practice and that outreach clinics from secondary care into the community ie. part of the Darzi polyclinic model would be better ie. rather than train a practice nurse it might be possible to have a breast care nurse go out to a community breast clinic. In addition, advanced practitioners could manage patients with metastatic breast cancer once back in the community or patient discharged/released from follow up could go to them if they had concerns/ wanted to discuss anything.
- members of breast units need to meet to discuss bottlenecks/barriers to implementing breast 2ww and cancer networks/SHAs need to mandate production of local action plans to address bottlenecks/barriers including maximising use of staff.

The role of commissioning

It was noted that:

- commissioners are generally only interested in when providers will deliver not about the quality of what is delivered – they need to be educated about what a good quality service is and how much it will cost eg. arrange a visit to show them before they sign SLAs for services.
- the acute sector is not the only place to deliver breast services – PCTs and the private sector can be providers too, this could drive increases in quality.
- work with cancer networks to educate and drive commissioning.
- commissioners are the key but they only understand money so need to show how a high quality service can save money in the longer term.

Workforce solutions

What staff groups could have extended roles?

- There was general agreement that there was a need to focus on skills not people although the baseline requirement was that the member of staff should be a healthcare professional. It was generally agreed that any health professional could extend their role but it was thought that nurses, radiographers and radiologists might be the key target groups. There was a suggestion that nurses might be best suited to the clinical examination and face to face communication skills side and other staff such as radiographers perhaps better suited to ultrasonography. It was suggested that 1 nurse practitioner could potentially do 5 follow up clinics and 3 new patient clinics a week.

What roles could advanced practitioners undertake?

It was agreed that there were potentially lots of roles that could be undertaken by different health professionals. Examples included:

- Breast examination
- Breast ultrasound
- Fine needle aspiration (FNA)
- Punch biopsies
- Seroma care
- Wound checks
- Aspirating cysts
- Supporting patients discharged with drains
- Advanced communication skills
- Psychosocial support (but need to handover to others for more supportive role too if they have extra roles)

Training Advanced Practitioners

- A range of existing courses exist such as:
 - University of the West of England which offers a 'Specialist Practice Course in Breast Ultrasound for Experienced Breast Care Nurses' plus options for self-directed study for those wishing to learn additional clinical skills such as Breast Examination, Fine Needle Aspiration and/or seroma drainage.
 - Addenbrookes – which trains nurses to do breast examination and follow up. It is a 4 day residential course and staff then go back and shadow etc and are locally assessed until competent and feel they can taken on role independently.
 - Guildford - observation before start 5 day residential course, case studies and

assignment, portfolio of evidence (min of 50 cases – variety cysts, adenomas, carcinomas etc) and Objective Structured Clinical Examination (OSCE).

- There was general agreement that a national training course was not needed ie. it is for localities to determine who to train and in what eg. a breast centre could choose to train all their nursing staff to a certain level of breast care or certain individuals to take on certain tasks. However, it was agreed that it would be useful to have some national criteria that 'training centres' should meet and national criteria to support what happens when staff return to take on the advanced role locally before taking on the role independently eg. criteria for pre and post qualifying as an advanced practitioner. Suggestions for what was needed included:

- standards and competencies
- 'accreditation' – no. of cases to observe, supervision of practice, OSCE etc – potential role for RCN?;
- mentors and designated educational supervisors ie. about an hour per week per junior trainee
- audit
- annual review/appraisal
- on-going cpd etc
- a register of advanced breast clinicians (in the long term)

Potential barriers to advanced breast practitioner roles

Potential barriers were identified as:

- how to assess competency in breast examination
- costs of training
- cost of backfill
- how to ensure nurses (or other health professionals) feel confident to put new skills into practice
- how to ensure advanced practitioners have the confidence of doctors
- would RCN need to endorse approved courses
- organisational leadership needs to support backfill and equipment etc for when staff return from training
- cost of supervising once staff return from initial training ie. in short term it could slow down doctors so see fewer patients but would bring benefits in the longer term

Other issues raised about advanced practitioners

Other issues raised included:

- accountability of advanced practitioners – trust indemnity needs to be considered;
- there is no standard way to teach breast examination in medical schools in the UK;
- does tariff adequately cover breast one stop clinics;
- a disincentive for nurses expanding roles is the glass ceiling on their pay ie. sometimes they are not paid if they are over the threshold;
- if surgeons and nurses each do a session and do the same tasks should they be paid the same for that session? If not, are nurses just a way to do things on the cheap (ie. same thing to same standard). If standard/quality is not the same why do it;
- money, pay, recognition and title that goes with it are important ie. a nurse 'consultant' has more strategic clout than being a nurse practitioner;

- BASO offers breast cancer nurse membership at reduced offers;
- there are still some units that have generalists rather than breast specialists – this needs to change;
- consider incorporating standards in peer review;
- consider setting up an Association of Advanced Breast Practitioners.

The views set out in this annex are not necessarily those of the National Cancer Action Team, NHS Improvement or Breakthrough Breast Cancer.

National Cancer Action Team
February 2009

This guide was produced in partnership by the National Cancer Action Team, Breakthrough Breast Cancer and NHS Improvement.

- **National Cancer Action Team** supports cancer networks and the NHS to deliver the commitments in the Cancer Reform Strategy and the wider cancer programme.
- **Breakthrough Breast Cancer** is a pioneering charity dedicated to the prevention, treatment and ultimate eradication of breast cancer. It fights on three fronts: research, campaigning and education. Its aim is to bring together the best minds and rally the support of all those whose lives have been, or may one day be, affected by the disease. The result will save lives and change futures – by removing the fear of breast cancer for good.
- **NHS Improvement** works with clinical networks and NHS organisations across England to help transform, deliver and build sustainable improvements across the entire pathway of care in cancer, diagnostics, heart and stroke services.

Going Further on Cancer Waits: The Symptomatic Breast Two Week Wait Standard

A guide to support implementation

July 2009