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“THE PERCEPTION OF HEALTHCARE PROFESSIONALS REGARDING THE RELOCATION OF THE FOLLOW-UP AND AFTERCARE OF BREAST CANCER FROM SECONDARY TO INTERMEDIATE CARE”

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Abstract

Introduction

Breast cancer patients and survivors are reporting a range of symptoms after treatment that are detrimental to their Quality of Life. At present, aftercare sub-optimally meets the psychosocial needs of breast cancer patients. Because of this, there is a growing demand for personalised aftercare. Moving the aftercare of breast cancer to a new location outside of the hospital's breast cancer clinic to deliver specialised care (intermediate care) can ensure better continuity and psychosocial aftercare. The change in location would lower the pressure on the breast cancer clinic, and shift the focus from physical examination to a focus on psychosocial wellbeing. Currently, there is insufficient primary empirical evidence to draw broad conclusions regarding best practice for breast cancer follow-up in intermediate care. This study aimed to gain insight into the perception of healthcare professionals and general practitioners on the relocation of the follow-up and/or aftercare of breast cancer from its current place in the hospital to intermediate care.

Method

The study focussed on discovering the advantages and disadvantages, perceived barriers, necessities and benefits for the patient, regarding a change in location of the follow-up and aftercare of breast cancer, as seen by the healthcare professionals and GP's. Participants were healthcare professionals in oncology departments in hospitals and radiotherapeutic institutes participating in the EMBRAZE cancer care network. A representative from the "Nederlandse Huisartsen Genootschap" (NHG) was interviewed for the perspective of the GP's. The study had an exploratory design and consisted of ten interviews and surveys. Interview data was coded in Atlas.ti. Survey data was analysed using Excel 2019.

Results

The majority of the respondents mentioned certain conditions have to be met before aftercare could be relocated. Essential factors to consider before aftercare could be relocated were; in-service training for healthcare personnel in intermediate care and a shared EPD. Respondents worried that relocating would not succeed because of the high workload of the GP's, the volume of patients needed in intermediate care to guarantee quality and the loss of financial resources for the hospital. Considered advantages were; alleviating the burden on the breast cancer clinic, a higher involvement of the patients GP, personalised and nearby aftercare, a cost reduction and less medicalisation of the patient. Respondents are more apprehensive, considering the relocation of the follow-up of breast cancer. The respondents' main worry regarding this change in location was the loss of resources for the hospital. Relocating patients and healthcare professionals to intermediate care would result in a knowledge- and financial loss. Furthermore, respondents mention that patients might be apprehensive regarding the relocating the follow-up since patients seem to prefer contact with an oncologist or surgeon.

Conclusion

Respondents think the relocation of aftercare would be desirable. However, healthcare professionals do not consider the relocation of the follow-up to be as desirable. To conclude, relocation could be a positive development with positive effects for patients and the healthcare system. Though multiple conditions have to be met before this will be possible, making relocation of breast cancer care a challenge. Further research is needed to create and organise a strong framework for this new intermediate form of breast cancer care.

Table of Contents

Introduction

Breast cancer

Breast cancer is one of the most frequently occurring types of cancer both in the developed and less developed world(1). It is the most common type of cancer in women, with a percentage of 28% of all cancer diagnoses. In the Netherlands alone, around 14.940 people got diagnosed with invasive breast cancer in 2019, as well as the 2.241 people that got diagnosed with non-invasive breast cancer(2). In the Netherlands, one in seven of all women will develop breast cancer during their life span, and from 2011 through to 2017, 88% of all invasive breast cancer patients are still alive after five years(2). Furthermore, breast cancer accounts for one-third of all cancers in women, and at diagnosis, 23% of the women are younger than 55 years of age. Moreover, the number of breast cancer patients has been increasing since the late 1980s, and early 90's due to early detection and advancement in detection and treatment(3).

In general, the treatment of breast cancer consists of local therapy (surgery, radiotherapy) and systematic therapy (-chemotherapy, hormonal therapy, monoclonal antibodies)(4). Treatment of breast cancer is highly customisable, depending on variables such as the type and location of the tumour, genetic factors and personal preferences(5). The prognosis of women with breast cancer has improved due to early detection, especially in the context of population screening, and adjuvant treatment in connection with locoregional treatment(5). Moreover, due to the increasing incidence and improved survival, a substantial increase in the prevalence of breast cancer is also expected(6).

Breast cancer patients and survivors are reporting a range of symptoms after treatment that are detrimental to their Quality of Life (QoL)(7). There are physical and psychosocial problems that can occur after treatment for breast cancer, including fear of recurrence, fatigue, trouble sleeping and social disruptions(8). The time of diagnosis, the initial stages of treatment and the months following completion of treatment are thus challenging times for patients both physically and emotionally(9). During these periods, poor adjustment to regular life and a decreased QoL in breast cancer patients can occur. Therefore, it is critical for health care professionals to recognise the impact of breast cancer treatment on their patients.

The problems mentioned above play a significant role in the patient's life from the moment of suspicion of breast cancer, while receiving treatment and during the aftercare and follow-up. These problems are, therefore, an essential part of the focus of aftercare. Having a clear picture of treatment- and follow-up related health problems following breast cancer treatment is useful in anticipating the needs of patients during the aftercare(10).

Aftercare and follow-up

The concepts of aftercare and follow up are not always clearly distinguished and are often used interchangeably(4). The definition of the Intergraal Kankercentrum Nederland(IKNL) and the Nationaal Borstkanker Overleg Nederland(NABON) aftercare and follow-up guideline regarding breast cancer is used in this study.

The term follow-up exclusively entails the monitoring for second primary tumours and locoregional recurrences, utilising mammograms and physical examination(4). The term aftercare implies care given regarding the physical and psychosocial effects of the treatment. Aftercare is meant to reduce the disease burden and improve the quality of life of the patients(4). It is also used to detect side- and late effects of breast cancer treatment and evaluate medical practices. Furthermore, aftercare entails psychological support in order to rehabilitate after breast cancer(8).

In the Netherlands, the NABON IKNL guideline regarding aftercare and follow-up of breast cancer recommends yearly check-ups for physical examination, a mammogram and registration of side- and late effects for at least five years after treatment(4). This period can be extended based on the received treatment(hormonal), age of the patient(≤50) and patient enrolment in studies with a ten-year follow-up.

Developments in aftercare and follow-up

At present, arrangements for the aftercare sub-optimally meet the psychosocial needs of patients(8). Hospitals are facing an increasing number of aftercare patients in breast cancer clinics due to rising amounts of patients because of the ageing population(11), better survival rates and early detection methods(6). This increase in pressure on breast cancer clinics leads to a lack of resources to focus on the psychosocial aspects of breast cancer survivorship(10). Furthermore, the current aftercare process, with a focus on a physical examination, leaves no room for patients to shift the focus from the disease to rehabilitation(12). Lastly, women with breast cancer often report unmet psychosocial needs after primary treatment(13).

Because of this, there is a growing demand for personalised aftercare within breast cancer aftercare guidelines(7), with a focus on individual supportive care needs(14, 15). Patients report several needs in aftercare; a permanent contact person, customisable aftercare, directions to reliable (online) resources and a safe transfer from aftercare in the hospital to the general practitioner(GP)(9). Furthermore, the focus of the aftercare should encompass the transformation from patient to person, and help the reintegration in society. Moreover, the patient should be more involved in Shared Decision Making (SDM) during aftercare, when the patient's input is both relevant and possible.

Research shows that involving patients in SDM leads them to choose less intensive aftercare(16) and further personalisation of follow-up and aftercare may lead to aftercare of greater relevance and value to individual patients(7). For healthcare professionals, customising aftercare can lead to patients classified as either low or high risk and respective groups might benefit from a less or more intensive follow-up after breast cancer and for personalised follow-up(17).

Personalising aftercare can also entail a change in location; The Dutch Cancer Society(KWF) report “Aftercare in cancer: the role of primary care” recommends that patients, after completion of their primary treatment, continue aftercare in primary care(18). Because of the long term nature of cancer treatment, and the need for focus on rehabilitation, the demand on healthcare providers has changed. Personalised aftercare thus requires integrated care in a new setting closer to the patients home. Similarly, the Intergraal Kankercentum Nederland(IKNL) is now researching if the follow-up or aftercare of low-risk breast cancer patients can be moved from the hospital to a new location in intermediate care. The change in location would lower the pressure on the breast cancer clinic(5), and shift the focus from physical examination to a focus on psychosocial wellbeing(12).

The transition from secondary to intermediate care

Cost-effective and holistic survivorship care is now more critical than ever, with the increasing life expectancies and patient volume in breast cancer clinics(19). The existing method for delivering cancer care is becoming unsustainable and is not adequate to deliver high-quality aftercare to the population(20). Furthermore, change is needed to constrain healthcare costs and maintain accessible and affordable healthcare in our current financially unsustainable healthcare system(21).

Moving the aftercare of breast cancer to a new location outside of the hospital’s breast cancer clinic to deliver specialised care (intermediate care) can ensure better continuity and psychosocial aftercare(12). The relocation of aftercare is a new development initiated and supported by the Dutch government and Dutch collaborations of medical specialists (Federatie Medisch Specialisten), hospitals (Nederlandse Vereniging van Ziekenhuizen) and healthcare insurances (Zorgverzekeraars Nederland) among others(22). This statement is known as ‘de juiste Zorg op de juiste plek’ and published in 2018 in the ‘Bestuurlijk akkoord medisch-specialistische zorg 2019-2022’. The incentives for this statement are individualised healthcare close to home, prevent rising healthcare costs and use of healthcare innovations (e-health)(21). Especially for ageing breast cancer patients, this relocation can lower the disease burden when aftercare is located to home. Additionally, relocation to intermediate care can reduce the burden on hospital care and their healthcare professionals, ultimately leading to cost reduction(21).

Not only the relocation of aftercare can improve the patients' perception of care. A study revealed that cancer patients who received survivorship care from Primary Care Professionals(PCP) such as Nurse Practitioners, Physician Assistant or GP’s, reported significantly lower distress levels and higher satisfaction with care(23). Moreover, with an anticipated shortage of oncology providers, increasing reliance is being placed on PCP’s for the provision of survivorship care. Furthermore, Arving et al. determined that breast cancer patients who received psychosocial support by trained nurses made less use of the hospitals' psychosocial support network(24). However, despite the willingness of PCP’s to engage in providing survivorship care, breast cancer patients also believe that there are communication and coordination barriers between PCP’s and secondary healthcare professionals(17). Moreover, GP’s already experience a high patient load in a stressed primary care system. At the same time, the actual amount of breast cancer patient per GP’s practice remains too low to adequality perform the follow-up or aftercare of breast cancer(18).

Further research is needed to examine high-quality, sustainable, and comprehensive survivorship care, and to create a strong framework for this new intermediate form of healthcare(25). To move towards more personalised (after) care in practice, more information on cost-effectiveness and viability is necessary(26, 27). Furthermore, additional insight is needed in the organisation of aftercare and follow-up outside of the hospital(28, 29), because at the moment, despite research, it is still unclear how effective aftercare outside the hospital is(30). Further research in the organisation of aftercare in intermediate care is needed. Currently, there is insufficient primary empirical evidence to draw broad conclusions regarding best practice for breast cancer follow-up in intermediate care(28).

Objectives

Study aim

This study aimed to gain insight in the perception of healthcare professionals and general practitioners (GP's) on the relocation of the follow-up and/or aftercare of breast cancer from its current place in the hospital to intermediate care. In this study, intermediate care was defined as a location outside the hospital where specialised care can be provided that is outside the bounds of primary care. The study focussed on discovering the advantages and disadvantages, perceived barriers, immediate necessities and benefits for the patient, regarding a change in location of the follow-up and aftercare of breast cancer, as seen by the healthcare professionals and GP's.

Research questions

The research question of this study was:

"What is the perception of healthcare professionals and general practitioners on relocating the follow-up and/or aftercare of breast cancer from secondary care to intermediate care?"

To explore this research question, the following secondary research questions were selected regarding the perception on relocation according to healthcare professionals and GP's.

- Is it desirable to relocate the follow-up or aftercare of breast cancer to intermediate care?
- What are the perceived advantages or disadvantages of relocating the follow-up or aftercare of breast cancer to intermediate care?
- What are perceived necessities for the relocation of the follow-up or aftercare of breast cancer to intermediate care?
- What are the benefits and disadvantages for patients regarding the change in location of the follow-up or aftercare of breast cancer?

Methods

Study participants

The selected healthcare professionals were all employed in hospitals and radiotherapeutic institutes participating in the EMBRAZE cancer care network in Zuid-Holland, Zeeland and Brabant. The participants were healthcare professionals in oncology departments, and all were involved in the follow-up and aftercare of breast cancer. A representative from the "Nederlandse Huisartsen Genootschap" (NHG) was interviewed for the perspective of the GP's.

Sample size

The interview sessions sometimes had more than one participant per interview. There was no maximum amount of participants per interview or in total. A total of sixteen healthcare professionals from six hospitals and three other institutes participated in this study. For detailed information regarding the participants, see the section Participant Characteristics.

Recruitment procedure

The healthcare professionals in hospitals were contacted through a letter to the chairwoman of the cancer care network. This letter is included in Appendix I. The employee of the NHG was also contacted via email to participate in the study.

Study design and procedure

The study had an exploratory design. It aimed to obtain a better understanding of the perception of healthcare professionals on relocating the aftercare and or follow-up. The qualitative study consisted of interviews regarding this perception. Healthcare professionals in selected hospitals participated in this interview and answered the questions added to this report in Appendix III.

The definition of aftercare and follow-up in this study were discussed in a short introduction before the interview. The interview itself consists of 2 parts. In the first part of the interview, the participants answered open questions on whether or not the change in location from secondary to intermediate care is desirable. Participants then listed what the possible advantages or disadvantages might be, according to him/her. Participants also stated necessities and perceived patient advantages/disadvantages concerning the change in location of the follow-up or aftercare. In the second part, the 5 point Likert scale was used to get a quantifiable response on several statements regarding the attitude of the participant on the relocation of aftercare and or follow up. After the interview, a summary was written and sent to the participants so that they could make alterations afterwards.

Data management

The interviews were recorded on a mobile phone; the participants granted permission for this before the interview. The audio files will be deleted after the conclusion of the study. Participant data was anonymised. Furthermore, each interview received a number, with interview data only being linked to this number. The researcher knows which numbers correlate to which hospital. Interview answers used in the final report were anonymised. Personal information of the participants, such as the workplace, is also not published in the final report. In the final report, only the interview number and type of institute is mentioned. Direct quotes were anonymised before being used in the report.

Data analysis

Transcripts were made by taking notes during the interviews, and edited them for clarity afterwards for use in the data analysis. To further analyse the given answers, information was coded using Atlas TI 8.1 for Windows via the inductive approach(31) to form a grounded theory(32). The inductive approach was selected because it is suited for open-ended and process-oriented research questions. The inductive approach uses these observations and uses it to formulate a grounded theory based on given data(33). The interview questions were examined beforehand and, based on the knowledge of the interviews; a code list was made in Atlas with themes that would likely arise in the interviews. This list was supplemented during coding.

The first cycle of coding was about classification. The interview questions were in line with the research questions and followed the same order. Parts of the interview were given a code that matched with the interview question. These subsections were then open coded. A description of the answer was given as code for an answer to the corresponding research question. Subsequently, researchers searched for similar answers given in other interviews. These answers were given the same code, while the code was adapted to fit the multiple answers better. The recoding continued until all answers to the interview questions had been assigned a code. Some answers were more common than others; therefore, some codes appear in multiple interviews. Some of the answers only occurred once, and their codes were unique. Thus, common themes and outliers emerged from the interviews. After coding, an analysis of the five-point Likert scale was made. The answers given by the participants were added to an Excel spreadsheet, and the greatest similarities and differences were clustered.

Ethical considerations

Participation in this study was voluntary, and there were no physical, mental or social risks associated with participation in this study. Participants could withdraw consent during any part of the research, without consequences.

Results

Participant Disciplines

In total, the study consists of 9 interviews, with 16 respondents of different specialities including; internist oncologists, nurse specialists, surgical oncologists, radiotherapists, physician assistants and a manager and representative. The interviews were spread out over six different hospitals, two radiotherapeutic institutes and one scientific association. The interviews took place on-site, with number nine being the exception; this was an interview by phone. The table below lists the interview number, the number of respondents and the type of hospital.

Interview number	**Number of respondents**	**Type of Institute**
1	3	University Hospital
2	1	General Hospital
3	1	General Hospital
5	5	Top Clinical Hospital
6	2	General Hospital
7	1	Top Clinical Hospital
8	1	Scientific Association
9	1	Radiotherapeutic Institute
10	1	Radiotherapeutic Institute

Table 1: Respondent Data

Context of Results

As mentioned above, a total of 9 interviews, with 16 respondents were conducted. In the results below a number is given after a statement by a respondent, i.e. (8). This number indicates in how many interviews this statement was given. This number, however, does not indicate how many of the respondents gave that specific statement, because some interviews were communal; not every question was answered individually by each respondent. Moreover, the presentation of the results is in the same order as the interview questions added in Appendix III. The results regarding the perception of the healthcare professionals on the relocation of aftercare are presented first, followed by the perceived patient benefits. The second section of the results focusses on the participants' perception of the relocation of the follow-up, followed again by the perceived patient benefits. The last section of the results focusses on an analysis of the five-point Likert scale.

Aftercare in an intermediate care setting

Under which conditions is relocation desirable?

The following section of the interview describes the perception of healthcare professionals regarding the relocation of the aftercare of breast cancer to an intermediate care setting. The overall response to this question was positive. According to participants, it is desirable to relocate aftercare to an intermediate care setting(8). However, specific requirements have to be met. Several respondents mentioned that in-service training would be necessary for healthcare professionals working in intermediate care to guarantee experience and knowledge(4). According to one respondent, those working in intermediate care should be involved in the process of treatment earlier, to guarantee knowledge about a patient's needs. Subsequently, respondents mentioned that one of the requirements would be a shared electronic medical record (EMR)(2). This EMR ensures that healthcare professionals in the hospital and intermediate care would be able to share patient data. Lastly, commenting on the role of GP's in the aftercare of breast cancer, one respondent mentioned that aftercare is already partially relocated to a new setting. According to them, the GP is already involved because;

"In the first year after treatment, treated women visit the GP much more often than women without breast cancer, also for not cancer-related issues".

Respondents mentioned further conditions regarding the relocation of aftercare. According to them, all involved parties need to communicate to ensure adequate information transfer when the patient receives aftercare outside of the hospital(3). The respondents also mentioned that effective communication is necessary to obtain a trusting relationship with patients. This trust between patients and healthcare professionals is essential for successful aftercare. As one respondent said:

"In the hospital, the treatment continues seamlessly into aftercare. During treatment, a patient develops a relationship with the healthcare professionals who are treating her. Aftercare is difficult without this relationship, and it is hard to develop this relationship after the treatment."

Furthermore, respondents mentioned that it might be possible to relocate aftercare to a clinic outside the hospital, while the intermediate care staff trained in the hospital(3). In this scenario, the clinic would have the expertise of specialists and remain outside the hospital with the previously mentioned advantages. Conversely, the respondents mentioned that the hospital must remain the centre of expertise regarding the aftercare of breast cancer(2). Aftercare could be relocated to a clinic outside the hospital on the condition that the hospital would not lose this expertise.

However, a small number of respondents indicated that relocating aftercare to an intermediate care setting would not be appropriate(2). They offered several considerations for this point of view. Initially, they suggested that GP's already have a high workload, and adding the aftercare of breast cancer patients to their workload would further exacerbate this problem(2). Furthermore, there were some suggestions that it is challenging to relocate the aftercare to a local intermediate care setting because of a lack of breast cancer patients in this setting(2). Healthcare professionals need to treat a certain amount of patients to remain knowledgeable in a subject. Currently, there are no GP's that have a sufficient amount of breast cancer patients in their clinic to do so. This lack of patients creates challenges for GP's to deliver the same quality of aftercare, and to be as informed about guidelines and new developments as the breast cancer clinic. Furthermore, as a closing statement on moving aftercare to an intermediate setting, one respondent mentioned that it would be desirable to invest more in hospital staff, rather than relocating aftercare.

What are the advantages or disadvantages, according to healthcare professionals?

The majority of the respondents responded that a significant advantage of relocating aftercare to an intermediate setting would be a reduction of the burden on breast cancer clinics(6). As a result, the hospital could then solely focus their efforts on the follow-up of breast cancer. Respondents continue that aftercare could be more successful in an intermediate care setting(2). Similarly, respondents state that in this intermediate care setting, the patients need for additional aftercare can be assessed(2).

The financial aspect also played a role in the perceived advantages or disadvantages. A respondent speculated that relocating the aftercare could lead to a reduction of costs since a less specialised doctor could carry out the aftercare. As a disadvantage, other respondents mentioned that financing is essential for both the hospital and its staff, relocating aftercare to outside the hospital would lead to a reduction in financial resources(2). One respondent expressed concern regarding relocation; they worried that in the more rural regions, relocating healthcare personnel to different intermediate care centres costs more than having patients travel to a hospital in the region.

Interestingly, one respondent stated that since aftercare is mainly psychosocial, aftercare should be not offered in a disease-specific setting, but in a more integrated setting with a holistic approach. A holistic approach would have the further advantage of healthcare professionals in intermediate care having sufficient patient numbers to maintain expertise and deliver effective aftercare.

What are the patient’s benefits and disadvantages according to healthcare professionals?

A commonly recurring view amongst respondents was that there is a difference in the interaction between patients and nurse specialists, compared to those between patients and doctors(7). Some participants felt that patients would rather talk to the doctor regarding the aftercare of breast cancer(6). In contrast, others considered that patients are more open about their psychosocial needs in a consult with a nurse specialist(2). Respondents mentioned that being located closer to a patient in an intermediate care setting could be beneficial for providing aftercare(3). It additionally benefits the patient, because one of the most emphasised advantages in relocating aftercare is eliminating stress in patients(3); as one respondent stated:

“Many patients experience tension and stress when they return to the hospital. Offering aftercare outside the hospital can reduce stress for patients.”

By relocating the aftercare to another location, the patient can move towards another phase in life, one of the primary functions of aftercare. Thus, relocating aftercare would increase its effectiveness. To illustrate, one respondent stated:

“Aftercare is about re-integration in society, self-image, and your relationships. There is often too little time for this in hospitals. If you create a new setting for that, then it will probably be easier for patients to talk about this”

Furthermore, according to all but one respondent, aftercare could be made more accessible by being closer to patients homes, eliminating travel time and costs. It would also make it easier to connect a patient to additional care, i.e. a local psychologist. However, the remaining respondent argued that relocating the aftercare would diminish its continuity and accessibility. By relocating aftercare to a GP’s clinic, it could create a situation where patients have to wait a long time before a nurse specialist is available in their GP’s clinic. The respondent explained that this is currently the case with local diabetes nurses, who rotate between different GP clinics in a community, often creating situations where patients have to wait to receive care. Lastly, two respondents mentioned that patients are flexible. They mentioned that in their rural regions, patients do not mind the travel time to receive aftercare.

What are the patient’s needs according to healthcare professionals?

In the final part of the survey, respondents were asked about the patient's needs regarding the location change of aftercare from hospitals to an intermediate setting. Respondents mentioned reliability as a central theme.

Firstly, respondents mention that according to patients, the essential part of the patient-healthcare professional bond is trust(6). Trust needs to be established in any location where aftercare might be given, hospital and intermediate care setting included. Secondly, respondents mentioned that patients prefer honest communication with their healthcare professionals(4).

Furthermore, they mentioned that proper communication towards patients about the relocation of aftercare outside the hospital would help patients accept this as the new standard(2). Patients need to be informed about the change in location before the relocation. Patients need to trust this change, and in order to make this happen, healthcare professionals need to discuss this process beforehand with patients. Lastly, respondents feel that patients need the assurance that, when patients are referred back to the hospital, a referral can be arranged quickly(2).

Follow-up in an intermediate care setting

Under which conditions is relocation desirable?

The next section of the survey describes the perception of healthcare professionals regarding the relocation of the follow-up of breast cancer to an intermediate care setting. The opinion regarding this change was also mixed (positive 4, neutral 2, negative 3).

Several respondents expressed that it made no sense to relocate the follow-up to a location outside of the hospital because the patients still had to come to the hospital for a mammogram(3). The requirement for this change in location was a centre with medical specialists and equipment available to provide the care associated with the follow-up of breast cancer(3). The respondents mentioned that this is similar to the current follow-up in the hospital, and would not yield many advantages. More importantly, respondents mentioned that the follow-up is an integrated part of the treatment(3). One respondent stated:

"In particular, it is not desirable because patients undergo treatment in a hospital, and the follow-up is associated with treatment. Therefore it can be seen as one package that should be kept in a hospital, aimed at the medical part."

Additionally, a respondent mentioned that the follow-up differs between patients based on different treatments. Thus knowledge about the follow-up for different treatments is still a necessity in this other location. The respondent worried that relocation of the follow-up would disperse this expertise. As a result, the hospital staff would still have to manage the follow-up process, only now from a more considerable distance because of the change in location. Lastly, a respondent mentions that they need the resources to deliver additional care, such as online recourses or extra consults, to patients who need it most. They stated:

"If a patient experiences many consequences of the treatment, you want to be able to provide extra care. This [care] may not be possible if you are a nurse specialist in a GP practice."

Despite the previously mentioned reasons, some respondents were cautiously positive(4). One of them stated that relocation of the follow-up might be desirable for specific patient groups, i.e. patients in their second year after treatment and other groups associated with low risks of recurrences. Lastly, one participant with a positive opinion about relocating follow-up argued that the follow-up is not necessarily complex care, nor is it always necessary. An intermediate care setting could easily carry this out; however, the hospital remains a more conveniently location because of the centralisation of care; the convenience of the treatment, follow-up and aftercare all in one location.

To conclude, several respondents mention again points that have been covered in the relocation of aftercare or are very similar, such as;

That expertise and knowledge in the follow-up of breast cancer can only be attained by treating a high enough volume of patients(2). A respondent explains that redirecting patients towards intermediate care for the follow-up to increase expertise would not be a viable solution since it would further increase the high workload of the GP's.

Secondly, respondents worry again that if there is much uncertainty in intermediate care regarding the follow-up of a patient, the intermediate care will still refer her back to the hospital, subverting the purpose of the relocation of the follow-up(4).

Lastly, the respondents mention that, just like in the hospital, it is crucial to remain knowledgeable regarding the follow-up in intermediate care(2). In the hospital, the multidisciplinary consults (MDO), are used to ensure expertise, and the respondents wonder if an intermediate care facility could use a similar setting.

What are the advantages or disadvantages, according to healthcare professionals?

A mentioned beneficial effect of the follow-up in an intermediate care setting would be the accessibility of the GP's. According to one respondent, it would be easier to involve the GP in the follow-up process of one of their patients, if the follow-up would take place outside of the hospital. This would make it easier to keep the GP informed about their patient.

Responcents mentioned some disadvantages regarding the relocation of the follow-up of breast cancer to an immediate care setting. Several respondents are very proud of their "one-stop-shop" regarding the follow-up of breast cancer(2). Patients undergo a mammogram in the hospital and receive the diagnostic result during the same visit. This streamlined process eliminates much waiting related insecurity from patients, according to respondents. When changing the follow-up to a new location outside of the hospital, it would probably not be possible to guarantee the same level of service for the patient.

A final surprising note from one of the respondents mentioned their happiness on keeping the follow-up of patients inside of the hospital. The respondent stated:

"The annual checks are pleasant; often, these are personal conversations with people who know the healthcare professionals well. It is a kind of 'glue keeping the clinics' appointments together'; it is light-hearted compared to some other appointments. It would be unfortunate not to have this anymore and to replace it only with more severe appointments".

Furthermore, the respondents reiterated several points that have already been covered during the relocation of aftercare, such as;

The relocation of aftercare eases the burden on the breast cancer clinic in the hospital(6). The same was said about the relocation of the follow-up(5). It eases the burden on breast cancer clinics, and respondents mention that it could clear up resources for healthcare professionals to invest in other urgent patient matters(3).

To conclude, respondents worry that relocating the follow-up would cost the hospital expertise, knowledge and financial resources(4). Respondents also state that GP's currently do not have the expertise to provide the follow-up of breast cancer(6). These limitations would result in patients being sent back to the hospitals when GP's are in doubt about certain situations, such as distinguishing late effects of chemotherapy, detecting lumps or assessing psychosocial needs.

What are the patient’s benefits and disadvantages according to healthcare professionals?

The opinion on the patients' benefit regarding the relocation of the follow-up of breast cancer according to healthcare professionals is mixed (positive 1, neutral 5, negative 3). New arguments concerning a positive reaction from a patients’ perspective are mentioned below.

An argument for the relocation of aftercare to improve accessibility was made by a respondent who anticipates that a doctors’ consultation hours could be more accessible to patients if they were in their neighbourhood, or available in the evening. Following the accessibility, a respondent mentioned that there was a financial patient benefit; this incentive alone could persuade patients in accepting the relocation. The respondent mentioned that clinic consults count towards a patients deductible, and clinic consults are more expensive than a consult with a GP.

When asked about the arguments against the relocation, the majority of the respondents stated that patients would strongly prefer staying with their medical specialist in the hospital for their follow-up(6). In some cases, respondents even mentioned that patients would rather see the medical specialist for the follow-up than a nurse specialist(2). Changing the location of the follow-up, and introducing a new caregiver would be a significant adjustment for patients. One respondent stated:

“Sometimes, patients experience difficulties when they see a nurse specialist instead of a doctor. Changing the follow-up or aftercare in the hospital to intermediate care is probably even more difficult for patients.”

Several arguments similar to the advantages and disadvantages regarding the relocation of the aftercare were made such as;

Most respondents mentioned that relocating the follow-up of breast cancer could benefit patients by eliminating travel time(7). Furthermore, several respondents mentioned that like the aftercare, the follow-up could be less invasive if it was conducted outside of the hospital, thus eliminating location-based stress in patients(3). One respondent mentioned the following:

“The advantage for patients is that they do not have to go to the hospital where they have been treated. Entering a hospital is often more stressful for patients than receiving care in the neighbourhood.”

To conclude, respondents mention that patients often feel that the hospitals’ healthcare professionals have full knowledge of their experiences during treatment(3). Forcing the patient to relocate to a new setting with new healthcare professionals for their follow-up can cause feelings of anxiety and uncertainty for the patient.

What are the patient’s needs according to healthcare professionals?

In the final part of the survey about the relocation of the follow-up, respondents were asked about the needs of patients regarding the change in the location of the follow-up from the hospital to an intermediate setting.

Respondents mentioned that healthcare professionals performing the follow-up should be aware of the emotional and physical experiences of the patient during the treatment(2). Additionally, respondents mentioned again that patients need to be assured that the follow-up outside of the hospital is just as effective at detecting cancer recurrences as it is now. Furthermore, it should assure patients that their GP is up to date on the latest guidelines regarding the follow-up of breast cancer.

Respondents also mentioned the need for a uniform nationwide follow-up protocol(2). Patients nowadays spend much time on the internet, and the differences between treatments and follow-up protocols are confusing for patients. Commenting on this, one respondent stated:

*“There is already much variation in treatments, which also creates confusion. It is hard for patients if someone in *city X* is only allowed back to the hospital twice if they can return to the doctor for ten years in *city Y*.”*

To continue, several respondents made statements similar to the needs regarding the relocation of the aftercare, such as;

Difficulty regarding the relocation of follow-up again has to do with trust, according to respondents(6). A patient needs to trust that the quality of a follow-up in an intermediate setting would be comparable or better than in the hospital. The patient also needs to trust that the healthcare professionals in intermediate care are just as capable as the breast cancer clinic. Instilling this trust in patients also entails expectation management on the patients' side.

As a closing statement, one respondent mentioned again that it is mostly a matter of clear communication towards patients. Some patients might have preferences regarding the location of the follow-up, but the key is communication with patients about the subject. Lastly, all respondents stated again that expertise and trust are crucial for the quality of care.

Analysis

Context of the analysis

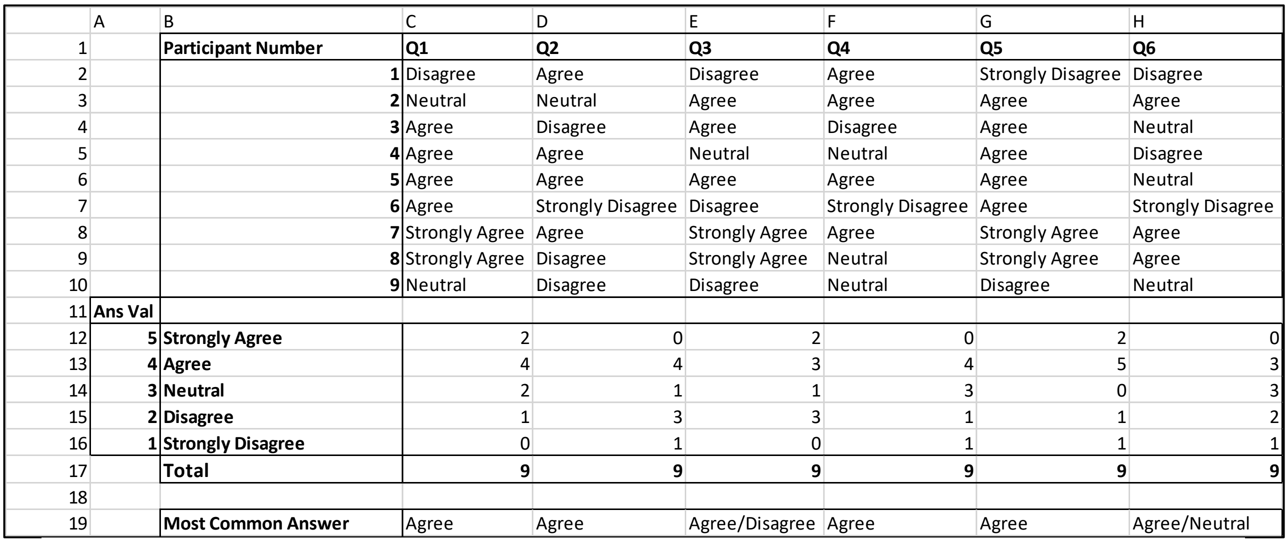
After the interview, the respondents were asked to fill in a short survey. Unfortunately, one of the interviews consisted of a short interview by phone, with no possibility of conducting a survey. The rest of the respondents were asked about their perception regarding the change in location of aftercare and follow-up in a five-point Likert scale format. Most of the surveys were filled in by individuals; however, during interview five, the group communally decided the answers.

An analysis of the answers was made using Excel 2019, and the participant numbers are in the order of the interviews. However, since some interviews consist of two meetings (thus two surveys), the participant numbers do not correlate to the interview number given in Table 1: Respondent Data. Moreover, since the focus group is small, this study focusses on providing insight into the differences and similarities in perception regarding the change in location of the follow-up and aftercare. To conclude, an overview of the entire Excel spreadsheet can be found in Appendix IV: Survey Analysis Data.

Analysis

The results of the participants consist of answers ranging from Strongly Agree to Strongly Disagree. The overview of the analysis is shown on the next page. Q1 through Q6 correlate to the statements in Appendix III, Table 2: Five-point Likert scale.

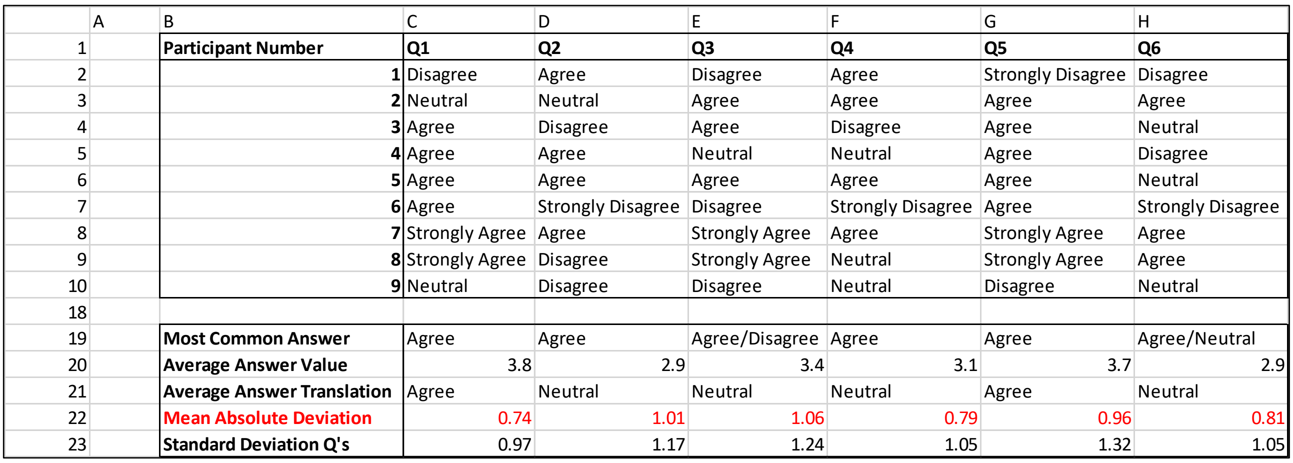
In the figure below, cell A11 assigned the answer options a value ranging from 5 to 1. In row 12 through 16, the sum of the answer options per question are given. This results in row 19, where the most common answer to each question is given. It indicates that overall, the participants answered that they mostly agree with the statements in Appendix III.



	A	B	C	D	E	F	G	H
1		**Participant Number**	**Q1**	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**
2		**1**	Disagree	Agree	Disagree	Agree	Strongly Disagree	Disagree
3		**2**	Neutral	Neutral	Agree	Agree	Agree	Agree
4		**3**	Agree	Disagree	Agree	Disagree	Agree	Neutral
5		**4**	Agree	Agree	Neutral	Neutral	Agree	Disagree
6		**5**	Agree	Agree	Agree	Agree	Agree	Neutral
7		**6**	Agree	Strongly Disagree	Disagree	Strongly Disagree	Agree	Strongly Disagree
8		**7**	Strongly Agree	Agree	Strongly Agree	Agree	Strongly Agree	Agree
9		**8**	Strongly Agree	Disagree	Strongly Agree	Neutral	Strongly Agree	Agree
10		**9**	Neutral	Disagree	Disagree	Neutral	Disagree	Neutral
11	**Ans Val**							
12	5	**Strongly Agree**	2	0	2	0	2	0
13	4	**Agree**	4	4	3	4	5	3
14	3	**Neutral**	2	1	1	3	0	3
15	2	**Disagree**	1	3	3	1	1	2
16	1	**Strongly Disagree**	0	1	0	1	1	1
17		**Total**	**9**	**9**	**9**	**9**	**9**	**9**
18								
19		**Most Common Answer**	Agree	Agree	Agree/Disagree	Agree	Agree	Agree/Neutral

Figure 1: Statement Answers

Furthermore, by assigning a value to each answer option, the Mean Answer Value (MAV), or mean, per question has been calculated in the figure below. The Average Answer Value was needed to calculate the Mean Absolute Deviation(MAD), the average distance between each data point and the MAV. This number, highlighted in red below, shows how significant the average variances between the answers per question are. For instance, it indicates that question 3 has the greatest variance, meaning that the participants have given that question the most diverse answers. It also shows that question 1 has the lowest MAD, meaning that this question has been given mainly the same answers to all the questions.

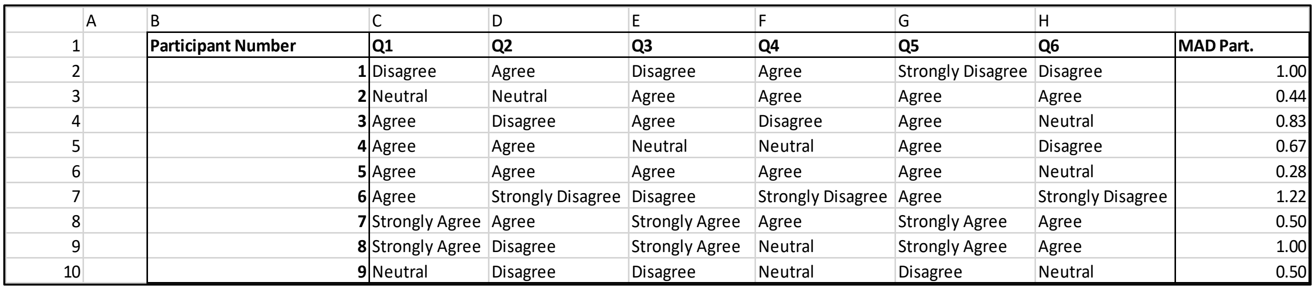


	A	B	C	D	E	F	G	H
1		**Participant Number**	**Q1**	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**
2		**1**	Disagree	Agree	Disagree	Agree	Strongly Disagree	Disagree
3		**2**	Neutral	Neutral	Agree	Agree	Agree	Agree
4		**3**	Agree	Disagree	Agree	Disagree	Agree	Neutral
5		**4**	Agree	Agree	Neutral	Neutral	Agree	Disagree
6		**5**	Agree	Agree	Agree	Agree	Agree	Neutral
7		**6**	Agree	Strongly Disagree	Disagree	Strongly Disagree	Agree	Strongly Disagree
8		**7**	Strongly Agree	Agree	Strongly Agree	Agree	Strongly Agree	Agree
9		**8**	Strongly Agree	Disagree	Strongly Agree	Neutral	Strongly Agree	Agree
10		**9**	Neutral	Disagree	Disagree	Neutral	Disagree	Neutral
18								
19		**Most Common Answer**	Agree	Agree	Agree/Disagree	Agree	Agree	Agree/Neutral
20		**Average Answer Value**	3.8	2.9	3.4	3.1	3.7	2.9
21		**Average Answer Translation**	Agree	Neutral	Neutral	Neutral	Agree	Neutral
22		**Mean Absolute Deviation**	0.74	1.01	1.06	0.79	0.96	0.81
23		**Standard Deviation Q's**	0.97	1.17	1.24	1.05	1.32	1.05

Figure 2: Mean Absolute Deviation

Moreover, the Standard Deviation (STDEV) has been calculated to express by how much the given answers per question differ from the MAV of that question. This indicates that the most significant deviation from the average answer value was in Q5. However, since the average answer value is not statistically relevant, this deviation does not bear more significance than the variance in Q3.

Lastly, the MAD was also used to calculate which of the participants has the most significant variance in the given answers. This deviation shows that participant 6 has the most significant variance in their answers to the questions, meaning that their answers have the biggest range from Strongly Disagree to Strongly Agree. It also indicates that participant 5 has the smallest range in answer variance of all the participants.



	A	B	C	D	E	F	G	H	
1		**Participant Number**	**Q1**	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**	**MAD Part.**
2		**1**	Disagree	Agree	Disagree	Agree	Strongly Disagree	Disagree	1.00
3		**2**	Neutral	Neutral	Agree	Agree	Agree	Agree	0.44
4		**3**	Agree	Disagree	Agree	Disagree	Agree	Neutral	0.83
5		**4**	Agree	Agree	Neutral	Neutral	Agree	Disagree	0.67
6		**5**	Agree	Agree	Agree	Agree	Agree	Neutral	0.28
7		**6**	Agree	Strongly Disagree	Disagree	Strongly Disagree	Agree	Strongly Disagree	1.22
8		**7**	Strongly Agree	Agree	Strongly Agree	Agree	Strongly Agree	Agree	0.50
9		**8**	Strongly Agree	Disagree	Strongly Agree	Neutral	Strongly Agree	Agree	1.00
10		**9**	Neutral	Disagree	Disagree	Neutral	Disagree	Neutral	0.50

Figure 3: Participant Mean Absolute Deviation

Discussion

The study revealed that healthcare professionals have different opinions regarding the relocation of the follow-up or aftercare of breast cancer from the hospital to intermediate care. In general, the perception of relocation was positive, though various perceived necessities have been mentioned before the relocation of the aftercare and/or follow-up of breast cancer can begin.

Firstly, relocation and further personalisation for the follow-up alleviates the tremendous burden on the breast cancer clinic(12), but at the same time, respondents worry about increasing involvement of GP's. The ever-increasing workload of the GP's already makes it difficult for them to be more involved in the aftercare and follow-up of breast cancer(17). Moreover, to guarantee the quality of care in an intermediate setting, a certain patient volume is needed. The GP's currently do not treat breast cancer patients and are at the moment unable to supply adequate breast cancer aftercare. Respondents state that increasing patient volume by making central clinics per region for aftercare or follow-up could help to alleviate this problem.

Interestingly, another workaround was suggested by a respondent. Clustering patients form different diseases with similar chronic conditions or late effects in intermediate care, will increasing patient volume. To further explain this point, one respondent stated that since aftercare is mainly psychosocial, aftercare should be not offered in a disease-specific setting, but in a more integrated setting with a holistic approach. Taking aftercare outside of the hospital to an intermediate care setting under the guidance of a PCP can thus decrease costs in a currently financially strained healthcare system(21, 26, 30).

Furthermore, guaranteeing the quality of care is one of the primary necessities for the relocation of breast cancer aftercare. Respondents question all facets necessary to retain quality, and the biggest necessity reported is a patient EMR with access for all healthcare professionals. Indeed, literature also shows that, (better) IT systems and means of communication to relay patient information between the different healthcare professionals are a necessity(10), especially with the growing treatment and follow-up options. The current EMR is not working as intended and is nevertheless an absolute necessity for communication and continuity of breast cancer care(34). Moreover, respondents mention that improved communication and information sharing between parties is one of the essential needs to convince patients of the relocation of care.

Furthermore, the patients' benefits are discussed during this study. Respondents in this study reported that the most significant advantage of relocating breast cancer aftercare to a new setting in intermediate care is to alleviate place-bound stress in patients. In literature, it is evident that relocating care to a new location outside the hospital in intermediate care makes it possible to focus more on offering personalised care(12, 35). Furthermore, providing care in a less medicalised, informal setting, can provide patients with a more comfortable experience(30), as is the case in the Alexander Monro Breast Cancer Hospital(36). In contrast, respondents mention that some patients would rather travel to receive breast cancer aftercare in the hospital where they were treated.

Moreover, even though healthcare professionals see several benefits for patients with the relocation of aftercare, the patients themselves might also be an obstacle to overcome. While a study suggests that patients report higher satisfaction with their care when being treated by a PCP(23), patients mention to respondents that they would rather be seen by an oncologist or surgeon, instead of receiving cancer aftercare from a possibly better-equipped healthcare professional(37). Respondents imply that communication and expectation management towards the patients' will circumvent this issue.

Lastly, the continuity of care for patients is also an area of interest. Several hospitals in the EMBRAZE network have a “one-stop-shop”; patients receive the diagnostic outcome the same day, or even during the same visit to the hospital. Relocating a part of the breast cancer care to a new location could jeopardise this practice. According to respondents, relocation would thus lead to further increased waiting times during follow-up. As a result of increased waiting times, the patients’ QoL can diminish by elevating stress levels(38, 39).

Study Strength and Limitations

Admittedly, the study itself was also subject to some limitations. The study consisted of interviews in rural and urban areas. Due to the anonymous nature of the study, results are more or less generic, and cannot be traced back to individual hospitals. Therefore, the results in this study are possibly not applicable to all of the Netherlands. The respondent group also imposed some limitations. Some interviews were conducted in groups, with the possibility of respondents giving group-desired answers. Indeed, during the interviews with several respondents, individuals usually picked the same answer options during the survey. If this was not the case, the researcher used the mean of the answers given as input data for the survey analysis. Moreover, due to privacy restrictions, no patients were interviewed, thus eliminating an actual patient perspective. Lastly, the study only examined the GP's perspective through a representative of the NHG. This might not be representative of all the general practitioners.

The studies most significant strength was initiating a new thought process among the respondents. During the interview, the respondents seemed to genuinely ponder the questions asked by the researchers and consider the implications of the relocation of breast cancer care. This indicates that the study used an appropriate methodology.

Conclusion

This research aimed to gauge the perception of oncology healthcare professionals and GP’s on relocating either the follow-up or aftercare of breast cancer from secondary care to intermediate care. Based on a qualitative analysis of 10 interviews and surveys, the respondents think the relocation of aftercare would be desirable to lower patient- and breast cancer clinic stress. However, healthcare professionals do not consider the relocation of the follow-up to be as desirable, due to patient preference and possible loss of resources. To conclude, relocation could be a desirable development with positive effects for patients and the healthcare system, though multiple conditions have to be met before this will be possible, making relocation of breast cancer care a challenge. Further research is needed to create and organise a strong framework for this new intermediate form of breast cancer care.

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Appendix I: Information Letter "Tumortaskforce EMBRAZE"

Informatie onderzoek: "Percepties van zorgprofessionals over de verplaatsing van nazorg voor borstkanker patiënten"

Rotterdam 17 sep. 2019

Beste mw. Heijns,

Ik ben Inge Karbaat, student Health Sciences van de Universiteit Twente. Voor mijn bachelor thesis wil ik gaan onderzoeken wat de percepties zijn van verschillende zorgprofessionals bij het verplaatsen van de nazorg en nacontrole voor borstkanker patiënten naar een locatie buiten het ziekenhuis.

Om dit te onderzoeken haak ik aan bij de inventarisatie naar nazorg voor borstkanker patiënten van IKNL, BVN en V&VN. Ik sluit aan bij deze interviews, om zo mijn eigen survey uit te kunnen zetten zonder zorgprofessionals te belasten met een extra contactmoment. Deze survey zal na het interview ongeveer 10-15 minuten in beslag nemen en wordt mondeling begeleid door mij.

In de survey komt aan de orde wat de zorgprofessionals als mogelijke voordelen en nadelen zien van het verplaatsen van de nazorg en nacontrole van borstkanker. Ook wordt er besproken wat er in de ogen van de respondenten nodig is om deze zorg buiten het ziekenhuis goed te laten verlopen.

Naast de survey met zorgprofessionals die nauw betrokken zijn bij de nazorg en nacontrole van borstkanker binnen de EMBRAZE regio, zal ik in het kader van mijn onderzoeksvraag ook de NHG benaderen om het perspectief van huisartsen op deze verplaatsing van zorg op te nemen in mijn onderzoek.

Voor vragen en opmerkingen ben ik bereikbaar op het volgende email adres:
i.m.karbaat@student.utwente.nl

Met vriendelijke groet,

Inge Karbaat

Student Health Sciences
University of Twente

Appendix II: Participant Information Letter

Onderzoek naar de perceptie van zorgprofessionals bij de verplaatsing van de nazorg en/of nacontrole van borstkanker.

Rotterdam, dd/mm/yyyy

Beste respondent,

Graag wil ik u vragen om deel te nemen aan mijn afstudeeronderzoek. Ik ben Inge Karbaat, student Health Sciences aan de Universiteit Twente. Mijn thesis gaat over uw perceptie als zorgprofessional over het verplaatsen van de nazorg en/of nacontrole van borstkanker naar de anderhalvelijnszorg. Middels deze korte inleiding wil ik het interview toelichten.

Doel van het onderzoek:

Dit onderzoek is exploratief en richt zich op de percepties van u als zorgprofessional over de verplaatsing van nazorg en/of nacontrole van borstkanker van uit het ziekenhuis naar de anderhalvelijnszorg. Door middel van een interview wil ik onderzoeken wat u als voordelen- dan wel nadelen ziet van het verplaatsen van de nazorg en/of nacontrole. Ook wordt er gevraagd wat er in uw ogen nodig is om de verplaatsing van de nazorg en/of nacontrole goed te laten verlopen.

In dit onderzoek hebben we om verwarring te voorkomen, de begrippen nazorg en nacontrole op de volgende manier gedefinieerd:

- Nazorg: De begeleiding van borstkankerpatiënten bij gevolgen van ziekte en behandeling.
- Nacontrole: De periodieke controles waarin lichamelijk onderzoek en beeldvorming plaatsvindt t.b.v. het detecteren van nieuwe manifestaties van het behandelde mammacarcinoom of nieuwe daarmee geassocieerde maligniteiten.

Informatie over deelname:

U bent gevraagd om deel te nemen aan dit onderzoek doordat u dicht betrokken bent bij de nazorg en/of nacontrole van borstkanker binnen een ziekenhuizen aangesloten bij de EMBRAZE tumorwerkgroep. Dit interview zal ongeveer 15 minuten in beslag nemen. Al uw gegevens blijven vertrouwelijk, en antwoorden zullen geanonimiseerd opgenomen worden in mijn thesis. Na afloop zal er samenvatting opgesteld worden van het interview, deze zal naar u opgestuurd worden. Op- of aanmerkingen zijn hierop welkom.

Contact:

Mocht u na afloop van het interview nog vragen hebben, kunt u altijd contact opnemen met mij. Ik ben bereikbaar per email: i.m.karbaat@student.utwente.nl of telefonisch op: 0640652863. Dit onderzoek wordt uitgevoerd onder begeleiding van prof. Dr. S. Siesling (IKNL/UT), drs. J. van Hoeve (IKNL/UT), drs. J. Ankersmid (Santeon) en drs. S. Claassen (Alettazorgt).

Ik bedank u alvast hartelijk voor uw medewerking!

Met vriendelijke groet,

Inge Karbaat
Student Health Sciences – University of Twente

Appendix III: Interview Questions

De verplaatsing van nazorg en/of nacontrole van het ziekenhuis naar anderhalvelijnszorg.

Zoals genoemd in de begeleidende brief is dit interview onderdeel van mijn afstudeeronderzoek. Dit onderzoek gaat over uw perceptie op de verplaatsing van nazorg en of/nacontrole van het ziekenhuis naar anderhalvelijnszorg. In dit onderzoek zijn de begrippen nazorg en nacontrole als het volgt gedefinieerd:

- Nazorg: De begeleiding van borstkankerpatiënten bij gevolgen van ziekte en behandeling.
- Nacontrole: De periodieke controles waarin lichamelijk onderzoek en beeldvorming (mammografie, MRI, etc.) plaatsvindt t.b.v. het detecteren van nieuwe manifestaties van het behandelde mammacarcinoom of nieuwe daarmee geassocieerde maligniteiten.

Vragen

	Helemaal eens	**Eens**	**Neutraal**	**Oneens**	**Helemaal oneens**
1. Ik sta open voor enige vorm van nazorg in de anderhalve lijn, ongeacht de vorm of organisatie.					
2. Ik sta open voor enige vorm van nacontrole in de anderhalve lijn, ongeacht de vorm of organisatie.					
3. Het is wat mij betreft wenselijk dat de nazorg in de anderhalve lijn wordt aangeboden.					
4. Het is wat mij betreft wenselijk dat de nacontrole in de anderhalve lijn wordt aangeboden.					
5. Ik denk dat de patiënt een vorm van nazorg in de anderhalve lijn wenselijk vindt.					
6. Ik denk dat de patiënt een vorm van nacontrole in de anderhalve lijn wenselijk vindt.					

Table 2: Statements Five-point Likert scale

Het is wat mij betreft wenselijk dat de nazorg in de anderhalve lijn wordt aangeboden.

- **Indien Helemaal eens/eens :**
    - Waarom is het volgens u **wenselijk** om de nazorg te verplaatsen naar de anderhalvelijnszorg? > Voordelen
    - Wat is er volgens u nodig voordat de nazorg verplaatst kan worden naar de anderhalvelijnszorg?
    - Wat is er volgens u nodig om de kwaliteit van de nazorg in de anderhalve lijn te garanderen?

- **Indien neutraal:**
    - Wat zijn uw overwegingen bij het verplaatsen van de nazorg naar de anderhalve lijn?
    - Wat zijn volgens u de mogelijke **voor of nadelen** van het verplaatsen van de nazorg naar de anderhalvelijnszorg?
    - Wat is er voor u nodig voordat de nazorg naar de anderhalvelijn naar de anderhalve lijn verplaatst kan worden?
    - Wat is er volgens u nodig om de kwaliteit van de nazorg in de anderhalve lijn te garanderen?

- **Indien Helemaal oneens/oneens:**
    - Waarom is het volgens u **niet wenselijk** om de nazorg te verplaatsen naar de anderhalvelijnszorg? > Nadelen
    - Wat zou u nodig hebben om de verplaatsing van de nazorg naar de anderhalve lijn wel wenselijk te maken?
    - Wat is er volgens u nodig om de kwaliteit van de nazorg in de anderhalve lijn te garanderen?

Het is wat mij betreft wenselijk dat de nacontrole in de anderhalve ljin wordt aangeboden.

- **Indien Helemaal eens/eens:**
    - Waarom is het volgens u **wenselijk** om de nacontrole te verplaatsen naar de anderhalvelijnszorg? > Voordelen
    - Wat is er volgens u nodig voordat de nacontrole verplaatst kan worden naar de anderhalvelijnszorg?
    - Wat is er volgens u nodig om de kwaliteit van de nacontrole in de anderhalve lijn te garanderen?
    -
- **Indien neutraal:**
    - Wat zijn uw overwegingen bij het verplaatsen van de nacontrole naar de anderhalve lijn?
    - Wat zijn volgens u de mogelijke **voor of nadelen** van het verplaatsen van de nacontrole naar de anderhalvelijnszorg?
    - Wat is er volgens u nodig voordat de nacontrole naar de anderhalvelijn verplaatst kan worden?
    - Wat is er nodig om de kwaliteit van de nacontrole in de anderhalve lijn te garanderen?

- **Indien Helemaal oneens/oneens**
    - Waarom is het volgens u **niet wenselijk** om de nacontrole te verplaatsen naar de anderhalvelijnszorg? > Nadelen
    - Wat zou u nodig hebben om de verplaatsing van de nacontrole naar de anderhalve lijn wel wenselijk te maken?
    - Wat is er volgens u nodig om de kwaliteit van de nacontrole in de anderhalve lijn te garanderen?

Ik denk dat de patiënt een vorm van nazorg in de anderhalve lijn wenselijk vindt.

- **Indien Helemaal eens/eens :**
    - Waarom denkt u dat de patiënt een vorm van nazorg in de anderhalve lijn wenselijk vindt?
    - Wat ziet als u de mogelijke voordelen van het verplaatsen van de nazorg naar de anderhalvelijn **volgens de patiënt**?
    - Wat is er volgens u verder nog nodig zodat de patiënt een vorm van nazorg in de anderhalve lijn wenselijk vindt?

- **Indien neutraal:**
    - Wat zijn uw overwegingen voor patiënten bij het verplaatsen van de nazorg naar de anderhalvelijn?
    - Wat ziet als u de mogelijke voordelen van het verplaatsen van de nazorg naar de anderhalvelijn **volgens de patiënt**?
    - Wat ziet als u de mogelijke nadelen van het verplaatsen van de nazorg naar de anderhalvelijn **volgens de patiënt**?
    - Wat is er volgens u nodig zodat de patiënt een vorm van nazorg in de anderhalve lijn wenselijk vindt?

- **Indien Helemaal oneens/oneens:**
    - Waarom denkt u dat de patiënt een vorm van nazorg in de anderhalve lijn niet wenselijk vindt?
    - Wat ziet als u de mogelijke nadelen van het verplaatsen van de nazorg naar de anderhalvelijn **volgens de patiënt**?
    - Wat is er volgens u nodig zodat de patiënt een vorm van nazorg in de anderhalve lijn wenselijk vindt?

Ik denk dat de patiënt een vorm van nacontrole in de anderhalve lijn wenselijk vindt.

- **Indien Helemaal eens/eens :**
    - Waarom denkt u dat de patiënt een vorm van nacontrole in de anderhalve lijn wenselijk vindt?
    - Wat ziet als u de mogelijke voordelen van het verplaatsen van de nacontrole naar de anderhalvelijn **volgens de patiënt**?
    - Wat is er volgens u verder nog nodig zodat de patiënt een vorm van nacontrole in de anderhalve lijn wenselijk vindt?

- **Indien neutraal:**
    - Wat zijn uw overwegingen voor patiënten bij het verplaatsen van de nacontrole naar de anderhalvelijn?
    - Wat ziet als u de mogelijke voordelen van het verplaatsen van de nacontrole naar de anderhalvelijn **volgens de patiënt**?
    - Wat ziet als u de mogelijke nadelen van het verplaatsen van de nacontrole naar de anderhalvelijn **volgens de patiënt**?
    - Wat is er volgens u nodig zodat de patiënt een vorm van nacontrole in de anderhalve lijn wenselijk vindt?

- **Indien Helemaal oneens/oneens:**
    - Waarom denkt u dat de patiënt een vorm van nacontrole in de anderhalve lijn niet wenselijk vindt?
    - Wat ziet als u de mogelijke nadelen van het verplaatsen van de nacontrole naar de anderhalvelijn **volgens de patiënt**?
    - Wat is er volgens u nodig zodat de patiënt een vorm van nacontrole in de anderhalve lijn wenselijk vindt?

Appendix IV: Survey Analysis Data

	A	B	C	D	E	F	G	H		I
1		**Participant Number**	**Q1**	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**	**MAD Part.**	**STDEV Part.**
2		**1**	Disagree	Agree	Disagree	Agree	Strongly Disagree	Disagree	1.00	1.22
3		**2**	Neutral	Neutral	Agree	Agree	Agree	Agree	0.44	0.52
4		**3**	Agree	Disagree	Agree	Disagree	Agree	Neutral	0.83	0.98
5		**4**	Agree	Agree	Neutral	Neutral	Agree	Disagree	0.67	0.82
6		**5**	Agree	Agree	Agree	Agree	Agree	Neutral	0.28	0.41
7		**6**	Agree	Strongly Disagree	Disagree	Strongly Disagree	Agree	Strongly Disagree	1.22	1.47
8		**7**	Strongly Agree	Agree	Strongly Agree	Agree	Strongly Agree	Agree	0.50	0.55
9		**8**	Strongly Agree	Disagree	Strongly Agree	Neutral	Strongly Agree	Agree	1.00	1.26
10		**9**	Neutral	Disagree	Disagree	Neutral	Disagree	Neutral	0.50	0.55
11	**Ans Val**									
12	**5**	**Strongly Agree**	2	0	2	0	2	0		
13	**4**	**Agree**	4	4	3	4	5	3		
14	**3**	**Neutral**	2	1	1	3	0	3		
15	**2**	**Disagree**	1	3	3	1	1	2		
16	**1**	**Strongly Disagree**	0	1	0	1	1	1		
17		**Total**	**9**	**9**	**9**	**9**	**9**	**9**		
18										
19		**Most Common Answer**	Agree	Agree	Agree/Disagree	Agree	Agree	Agree/Neutral		
20		**Average Answer Value**	3.8	2.9	3.4	3.1	3.7	2.9		
21		**Average Answer Translation**	Agree	Neutral	Neutral	Neutral	Agree	Neutral		
22		**Mean Absolute Deviation**	0.74	1.01	1.06	0.79	0.96	0.81		
23		**Standard Deviation Q's**	0.97	1.17	1.24	1.05	1.32	1.05		

Figure 4: Survey Analysis Data