Breast cancer

NICE quality standard

Draft for consultation

January 2016

Introduction

This quality standard covers the management of early (ductal carcinoma in situ and invasive), locally advanced and advanced breast cancer, recurrent breast cancer and familial breast cancer in adults. This includes breast cancer identified through screening and by assessment of symptoms from the point of referral to a specialist team. It does not cover adults with non-cancerous breast tumours.

This quality standard will replace the existing NICE quality standard for breast cancer (QS12). This topic was identified for update following the annual review of quality standards in 2014. The review identified that there had been changes in the areas for improvement for breast cancer and new guidance published on familial breast cancer.

Why this quality standard is needed

Breast cancer is the most common cancer in the UK, with over 50,000 new cases diagnosed and 11,716 deaths recorded in the UK in 2012 (Cancer Research UK Breast cancer, 2014). Of these new cases, a small proportion are diagnosed in the advanced stages, when the tumour has spread significantly within the breast or to other organs of the body. In addition, some women who have been previously treated subsequently develop either a local recurrence or metastases.

The quality standard is expected to contribute to improvements in the following outcomes:

- mortality
- 1- and 5-year survival

- stage at diagnosis
- quality of life.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- NHS Outcomes Framework 2015–16
- Public Health Outcomes Framework 2013–16.

Tables 1–2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Improvement areas*** **Reducing premature mortality from the major causes of death** 1.4 Under 75 mortality rate from cancer* i One- and ii Five-year survival from all cancers iii One- and iv Five-year survival from breast, lung and colorectal cancer *v One- and vi Five-year survival from cancers diagnosed at stage 1 & 2***
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 Public Health Outcomes Framework for England, 2013–16

Domain	Objectives and indicators

4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.5 Under 75 mortality rate from cancer*
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared	

Patient experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to breast cancer.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect patient experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for breast cancer specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole breast cancer care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people with breast cancer.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality breast cancer service are listed in Related quality standards. [Link to section in web version]

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating people with breast cancer should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source(s) on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting people with breast cancer. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1. People with suspected breast cancer referred to specialist services receive the triple diagnostic assessment in a single hospital visit **[new 2016]**.

Statement 2. People with biopsy-proven invasive breast cancer or ductal carcinoma in situ (DCIS) are not offered a preoperative MRI scan without specific clinical indication **[new 2016]**.

Statement 3 People with oestrogen receptor-positive (ER-positive), human epidermal growth factor receptor 2-negative (HER2-negative) or lymph node-negative early

breast cancer have gene expression profiling and expanded immunohistochemistry tests **[new 2016]**.

Statement 4. People with newly diagnosed invasive breast cancer and those with recurrent breast cancer (if clinically appropriate) have the oestrogen receptor (ER) and human epidermal growth factor receptor 2 (HER2) status of the tumour assessed **[2011, updated 2016]**.

Statement 5. People with breast cancer who develop metastatic disease are assessed by a multidisciplinary team **[2011, updated 2016]**.

Statement 6. People with locally advanced, metastatic or distant recurrent breast cancer are assigned a key worker **[2011, updated 2016]**.

Statement 7 (Placeholder). Exercise for people with breast cancer **[new 2016]**.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Question 3 Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Questions about the individual quality statements

Question 4 For draft quality statement 2: Is there any evidence of overuse of MRI in preoperative assessment an area for quality improvement? If so please provide details.

Question 5 For draft quality statement 3: Are there other areas of genetic testing for breast cancer that should be covered in this quality standard and if so, what is the supporting evidence for these?

Question 6 For draft quality statement 4: How should 'if clinically appropriate' be defined in terms of when the oestrogen receptor (ER) and human epidermal growth factor receptor 2 (HER2) status of a tumour should be reassessed in people with recurrent breast cancer?

Question 7 For draft quality statement 6: Is there evidence to suggest that people with advanced breast cancer are not having a key worker assigned to them?

Question 8 For draft placeholder statement 7: Do you know of any evidence-based guidance that could be used to develop this placeholder statement? If so, please provide details. If not, would new evidence-based guidance relating to exercise–improved health outcomes for people with breast cancer have the potential to improve practice? If so, please provide details.

Question 9 Is there any evidence to suggest that there is variation in offering chemoprevention to women who have an increased risk of breast cancer, and in the use of drugs such as tamoxifen in premenopausal women? If so, should a statement on these areas be included in this quality standard?

Quality statement 1: Timely diagnosis

Quality statement

People with suspected breast cancer referred to specialist services receive the triple diagnostic assessment in a single hospital visit **[new 2016]**.

Rationale

Early diagnosis of breast cancer allows for prompt treatment, which has been shown to be effective in achieving better health outcomes for people with breast cancer. Giving people with suspected breast cancer the triple diagnostic assessment at a single hospital visit will help to ensure rapid diagnosis. In addition, it will help to reduce the anxiety and stress associated with multiple visits for different parts of the triple diagnostic assessment.

Quality measures

Structure

Evidence of local arrangements to ensure that specialist services use single hospital visits to undertake triple diagnostic assessment in people referred with suspected breast cancer.

Data source: Local data collection

Process

Proportion of people with suspected breast cancer referred to specialist services who receive the triple diagnostic assessment in a single visit.

Numerator – The number in the denominator who receive the triple diagnostic assessment in a single visit.

Denominator – The number of people with suspected breast cancer referred to specialist services.

Data source: Local cancer data.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as secondary care services) ensure that systems are in place to provide triple diagnostic assessment in a single hospital visit for people referred to specialist services with suspected breast cancer.

Healthcare professionals (such as doctors, nurses and specialists) ensure that people with suspected breast cancer referred to specialist services have the triple diagnostic assessment in a single hospital visit.

Commissioners (such as clinical commissioning groups) ensure that they commission specialist services that provide triple diagnostic assessment in a single hospital visit for people with suspected breast cancer.

What the quality statement means for patients, service users and carers

People who have been referred to a breast cancer specialist should have a full assessment carried out during a single visit to the hospital or specialist unit. The assessment should involve an examination, an X-ray (mammogram) or ultrasound scan, and a biopsy, in which a small amount of breast tissue is removed and tested for cancer. This will help to ensure that they receive a quick diagnosis and do not need to make several hospital visits.

Source guidance

- Improving outcomes in breast cancer (2002) NICE guideline CSG1, page 33

Definitions of terms used in this quality statement

Triple diagnostic assessment

This consists of clinical assessment, mammography and/or ultrasound imaging, and fine needle aspiration or core biopsy [Improving outcomes in breast cancer (NICE guideline CSG1)]

Quality statement 2: MRI

Quality statement

People with biopsy-proven invasive breast cancer or ductal carcinoma in situ (DCIS) are not offered a preoperative MRI scan without specific clinical indication **[new 2016]**.

Rationale

An MRI scan is not needed to assess a tumour before surgery for people with biopsy-proven invasive breast cancer or DCIS apart from in specific clinical situations. Carrying out an MRI scan in these people may cause additional stress without any benefit and is an unnecessary use of healthcare resources.

Quality measures

Structure

Evidence of local arrangements to ensure that people with biopsy-proven invasive breast cancer or DCIS do not have an MRI scan for preoperative assessment without specific clinical indication.

Data source: Local data collection

Process

Proportion of MRI scans for preoperative assessment of people with biopsy-proven invasive breast cancer or DCIS where there is a specific clinical indication.

Numerator – the number in the denominator where there is a specific clinical indication.

Denominator – the number of MRI scans for preoperative assessment of people with biopsy-proven invasive breast cancer or DCIS.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (such as secondary care services) ensure that systems are in place so that people with biopsy-proven invasive breast cancer or DCIS are not offered a preoperative MRI scan without specific clinical indication.

Healthcare professionals (such as doctors, nurses and specialists) ensure that they are aware of local referral pathways for breast cancer to ensure that people with biopsy-proven invasive breast cancer or DCIS are not offered a preoperative MRI scan without specific clinical indication.

Commissioners (such as clinical commissioning groups) ensure that they commission services that make sure people with biopsy-proven invasive breast cancer or DCIS are not offered a preoperative MRI scan without specific clinical indication.

What the quality statement means for patients, service users and carers

People with invasive breast cancer, which has been confirmed by a biopsy of their tumour, and people with a type of cancer called ductal carcinoma in situ (or DCIS) are not usually offered an MRI scan before surgery unless there is a specific reason.

Source guidance

- Early and locally advanced breast cancer: diagnosis and treatment (2009) NICE guideline CG80, recommendation 1.1.1

Definitions of terms used in this quality statement

Specific clinical indication for preoperative MRI scan

Offer MRI of the breast to patients with invasive breast cancer:

- if there is discrepancy regarding the extent of disease from clinical examination, mammography and ultrasound assessment for planning treatment
- if breast density precludes accurate mammographic assessment

- to assess the tumour size if breast conserving surgery is being considered for invasive lobular cancer.

[Early and locally advanced breast cancer: diagnosis and treatment (2009) NICE guideline CG80]

Question for consultation

Is there any evidence of overuse of MRI in preoperative assessment an area for quality improvement? If so please provide details of this.

Quality statement 3: Gene expression profiling and expanded immunohistochemistry tests

Quality statement

People with oestrogen receptor-positive (ER-positive), human epidermal growth factor receptor 2-negative (HER2-negative) or lymph node-negative early breast cancer have gene expression profiling and expanded immunohistochemistry tests **[new 2016]**.

Rationale

Gene expression profiling and expanded immunohistochemistry tests aim to identify certain genes or proteins found in breast cancer tumours. Testing for the levels of these genes or proteins can give an indication of how a tumour might develop, and therefore help in planning treatment. Gene expression profiling and expanded immunohistochemistry tests have been shown to be effective in guiding adjuvant chemotherapy in people with ER-positive, HER2-negative or lymph node-negative early breast cancer.

Quality measures

Structure

Evidence of local arrangements to provide gene expression profiling and expanded immunohistochemistry tests for people with ER-positive, HER2-negative or lymph node-negative early breast cancer.

Data source: Local data collection.

Process

Proportion of people with ER-positive, HER2-negative or lymph node-negative early breast cancer who receive gene expression profiling and expanded immunohistochemistry tests.

Numerator – the number in the denominator who receive gene expression profiling and expanded immunohistochemistry tests.

Denominator – the number of people with ER-positive, HER2-negative or lymph node-negative early breast cancer.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (such as secondary care services/specialist breast cancer services) ensure that systems are in place for people with ER-positive, HER2-negative or lymph node-negative early breast cancer to have gene expression profiling and expanded immunohistochemistry tests.

Healthcare professionals (such as doctors, nurses and specialists) ensure that people with ER-positive, HER2-negative or lymph node-negative early breast cancer to have gene expression profiling and expanded immunohistochemistry tests.

Commissioners (such as clinical commissioning groups) ensure that they commission services that undertake gene expression profiling and expanded immunohistochemistry tests for people with ER-positive, HER2-negative or lymph node-negative early breast cancer.

What the quality statement means for patients, service users and carers

People diagnosed with a particular type of early breast cancer (called oestrogen receptor-positive, lymph node-negative or human epidermal growth factor receptor 2-negative early breast cancer) have gene expression profiling and expanded immunohistochemistry tests. The results of these tests will help with decisions about chemotherapy after surgery to remove the cancer.

Source guidance

- Gene expression profiling and expanded immunohistochemistry tests for guiding adjuvant chemotherapy decisions in early breast cancer management: MammaPrint, Oncotype DX, IHC4 and Mammostrat (2013) NICE diagnostics guidance DG10, recommendation 1.1

Definitions of terms used in this quality statement

Gene expression profiling and expanded immunohistochemistry tests

This refers to gene expression profiling with MammaPrint, Oncotype DX, IHC4 and Mammostrat used to identify certain genes or proteins found in breast cancer tumours. [Gene expression profiling and expanded immunohistochemistry tests for guiding adjuvant chemotherapy decisions in early breast cancer management: MammaPrint, Oncotype DX, IHC4 and Mammostrat (NICE diagnostics guidance DG10)]

Question for consultation

Are there other areas of genetic testing for breast cancer that should be covered in this quality standard and if so, what is the supporting evidence for these?

Quality statement 4: ER and HER2 receptor status

Quality statement

People with newly diagnosed invasive breast cancer and those with recurrent breast cancer (if clinically appropriate) have the oestrogen receptor (ER) and human epidermal growth factor receptor 2 (HER2) status of the tumour assessed **[2011, updated 2016]**.

Rationale

Information on the ER and HER2 status of breast cancer tumours is used to decide how best to treat and manage the cancer.

Quality measures

Structure

a) Evidence of local arrangements and written clinical protocols to ensure that people with newly diagnosed invasive breast cancer have the ER and HER2 status of the tumour assessed.

Data source: Local data collection.

b) Evidence of local arrangements and written clinical protocols to ensure that people with recurrent breast cancer have the ER and HER2 status of the tumour assessed if clinically appropriate.

Data source: Local data collection.

Process

a) Proportion of people with newly diagnosed invasive breast cancer who have the ER status of the tumour assessed.

Numerator – the number of people in the denominator who have the ER status of the tumour assessed.

Denominator – the number of people with newly diagnosed invasive breast cancer.

Data source: Local data collection.

b) Proportion of people with newly diagnosed invasive breast cancer who have the HER2 status of the tumour assessed.

Numerator – the number of people in the denominator who have the HER2 status of the tumour assessed.

Denominator – the number of people with newly diagnosed invasive breast cancer.

Data source: Local data collection.

c) Proportion of people with histologically confirmed recurrent breast cancer who have the ER status of the tumour assessed, if clinically appropriate.

Numerator – the number of people in the denominator who have the ER status of the tumour assessed, if clinically appropriate.

Denominator – the number of people with histologically confirmed recurrent breast cancer.

Data source: Local data collection

d) Proportion of people with histologically confirmed recurrent breast cancer who have the HER2 status of the tumour assessed, if clinically appropriate.

Numerator – the number of people in the denominator who have the HER2 status of the tumour assessed, if clinically appropriate.

Denominator – the number of people with histologically confirmed recurrent breast cancer.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals, and commissioners

Service providers (such as secondary care services and tertiary care specialist centres) ensure that systems are in place for the ER and HER2 status of the tumour to be assessed in people with newly diagnosed invasive breast cancer and those with recurrent breast cancer (if clinically appropriate).

Healthcare professionals (such as doctors, nurses and specialists) ensure the ER and HER2 status of the tumour are assessed in people with newly diagnosed invasive breast cancer and those with recurrent disease (if clinically appropriate).

Commissioners (such as clinical commissioning groups) ensure they commission services that assess the ER and HER2 status of the tumour for people with newly diagnosed invasive breast cancer and those with recurrent breast cancer (if clinically appropriate).

What the quality statement means for patients, service users and carers

People with newly diagnosed invasive breast cancer or with breast cancer that has come back or spread, have tissue from their tumour tested to find out more about the type of cancer (whether it is a type called oestrogen receptor-positive or human epidermal growth receptor 2-positive). This helps to make sure that people get the most effective treatment and care.

Source guidance

- Advanced breast cancer: diagnosis and treatment (2009) NICE guideline CG81, recommendation 1.1.8 (In 2015, a surveillance decision was made to update CG81 in relation to recommendations on the assessment of ER and HER2. If these recommendations change, the quality standard will be amended)
- Early and locally advanced breast cancer: diagnosis and treatment (2009) NICE guideline CG80, recommendations 1.6.1 and 1.6.3

Question for consultation

How should ‘if clinically appropriate’ be defined in terms of when the ER and HER2 status of a tumour should be reassessed in people with recurrent breast cancer?

Quality statement 5: Multidisciplinary team assessment of people with metastatic breast cancer

Quality statement

People with breast cancer who develop metastatic disease are assessed by a multidisciplinary team **[2011, updated 2016]**.

Rationale

Assessment by a multidisciplinary team has been shown to lead to improved health outcomes for people with advanced breast cancer who develop metastatic disease. It involves discussing potential treatments and their impact across the whole care pathway.

Quality measures

Structure

Evidence of local arrangements to ensure that a multidisciplinary team assesses all people with breast cancer who develop metastatic disease.

Data source: Local data collection.

Process

Proportion of people with breast cancer who develop metastatic disease who are assessed by a multidisciplinary team.

Numerator – the number in the denominator who are assessed by a multidisciplinary team.

Denominator – the number of people with breast cancer who develop metastatic disease.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as secondary care services and tertiary care specialist services) ensure that systems are in place for people with breast cancer who develop metastatic disease to be assessed by a multidisciplinary team.

Healthcare professionals (such as doctors, nurses and specialists) are aware of care pathways in place to ensure that people with breast cancer who develop metastatic disease are assessed by a multidisciplinary team.

Commissioners (such as clinical commissioning groups) ensure that they commission services that have a multidisciplinary team who asses people with breast cancer who develop metastatic disease.

What the quality statement means for patients, service users and carers

People with breast cancer that has spread to other parts of the body (known as metastatic disease) are assessed by a team of specialists. This allows all possible treatments to be discussed to help make sure the person has the most suitable and effective care.

Source guidance

- Advanced breast cancer: diagnosis and treatment (2009) NICE guideline CG81, recommendation 1.5.11

Quality statement 6: Key worker

Quality statement

People with locally advanced, metastatic or distant recurrent breast cancer are assigned a key worker **[2011, updated 2016]**.

Rationale

Assigning key workers to people with locally advanced, metastatic or distant recurrent breast cancer has been shown to lead to better health outcomes. Key workers provide information and support for the person with breast cancer throughout the entire care pathway. This can help to improve patient experience because people feel assured they have someone to discuss their care with and it helps to ensure that the care given takes into account the person's needs.

Quality measures

Structure

Evidence of local arrangements to ensure that people with locally advanced, metastatic or distant recurrent breast cancer are assigned a key worker.

Data source: Local data collection.

Process

a) Proportion of people with locally advanced breast cancer with an assigned key worker.

Numerator – the number in the denominator with a key worker.

Denominator – the number of people with locally advanced breast cancer.

Data source: Local data collection.

b) Proportion of people with metastatic breast cancer with a key worker.

Numerator – the number in the denominator with a key worker.

Denominator – the number of people with metastatic breast cancer.

Data source: Local data collection.

c) Proportion of people with distant recurrent breast cancer with an assigned key worker.

Numerator – the number in the denominator with a key worker.

Denominator – the number of people with distant recurrent breast cancer.

Data source: Local data collection.

Outcome

Patient satisfaction.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as secondary care services and tertiary care specialist centres) ensure that systems are in place for people with locally advanced, metastatic or distant recurrent breast cancer to have a key worker assigned to them.

Healthcare professionals (such as GPs and practice nurses) ensure they are aware of referral pathways in place so people with locally advanced, metastatic or distant recurrent breast cancer have a key worker assigned to them.

Commissioners (such as clinical commissioning groups) ensure that they commission services that assign a key worker to people with locally advanced, metastatic or distant recurrent breast cancer.

What the quality statement means for patients, service users and carers

People with locally advanced, metastatic or distant recurrent breast cancer are assigned a healthcare professional (often a nurse who specialises in breast cancer) as their ‘key worker’. This ensures that they receive all the information and support they need throughout their care.

Source guidance

- Advanced breast cancer: diagnosis and treatment (2009) NICE guideline CG81, recommendation 1.4.1

Definitions of terms used in this quality statement

Key worker

This refers to a named healthcare professional (such as a clinical nurse specialist) who can give information and support throughout the patient pathway to the person with breast cancer and/or their carers. [Advanced breast cancer (NICE guideline CG81) and QSAC consensus]

Question for consultation

Is there evidence to suggest that people with advanced breast cancer do not have a key worker assigned to them?

Quality statement 7 (placeholder): Exercise for people with breast cancer (new 2016).

What is a placeholder statement?

A placeholder statement is an area of care that has been prioritised by the Quality Standards Advisory Committee but for which no source guidance is currently available. A placeholder statement indicates the need for evidence-based guidance to be developed in this area (new 2016).

Rationale

There is some suggestion that exercise helps to improve outcomes, including quality of life, for people with breast cancer. People with breast cancer may therefore benefit from being encouraged to exercise, if appropriate and the evidence for this should be reviewed.

Question for consultation

Do you know of any relevant evidence-based guidance that could be used to develop this placeholder statement? If so, please provide details. If not, would new evidence-based guidance relating to exercise and improved health outcomes for people with breast cancer have the potential to improve practice? If so, please provide details.

Status of this quality standard

This is the draft quality standard released for consultation from 21 January 2016 to 17 February 2016. It is not NICE's final quality standard on breast cancer. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 17 February 2016. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from June 2016.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of

100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

NICE's quality standard service improvement template helps providers to make an initial assessment of their service compared with a selection of quality statements. It includes assessing current practice, recording an action plan and monitoring quality improvement.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in Development sources [Link to section in web version]

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments [add correct link] are available.

Good communication between healthcare professionals and people with breast cancer and their families and carers (if appropriate), is essential. Treatment, care and support, and the information given about it, should be both age-appropriate and culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with breast cancer and their families or carers (if appropriate) should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards Process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Gene expression profiling and expanded immunohistochemistry tests for guiding adjuvant chemotherapy decisions in early breast cancer management: MammaPrint, Oncotype DX, IHC4 and Mammostrat (2013) NICE diagnostics guidance DG10
- Familial breast cancer (2013) NICE guideline CG164
- Advanced breast cancer (2009) NICE guideline CG81
- Early and locally advanced breast cancer (2009) NICE guideline CG80
- Improving outcomes in breast cancer (2002) NICE guideline CSG1

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Cancer Research UK (2015) Achieving world-class cancer outcomes: a strategy for England 2015-2020
- Department of Health (2015) 2010 to 2015 government policy: cancer research and treatment
- NHS England (2015) Clinical commissioning policy statement: radiotherapy after primary surgery for breast cancer
- NHS England (2015) Clinical commissioning policy statement: Intra-operative radiotherapy for the treatment of early breast cancer
- Department of Health, NHS England and Public Health England (2014) The national cancer strategy: 4th annual report
- Welsh Government (2014) Together for Health - Cancer delivery plan: annual report 2014

- Department of Health (2013) Living with and beyond cancer: taking action to improve outcomes
- NHS England (2013) Are older people receiving cancer drugs? An analysis of patterns in cancer drug delivery according to the age of patient
- Department of Health (2012) National cancer patients' experience survey programme 2012/13
- Royal College of General Practitioners (2011) National audit of cancer diagnosis in primary care

Definitions and data sources for the quality measures

- National cancer intelligence network (NCIN) 2015

Related NICE quality standards

Published

- Metastatic spinal cord compression (2014) NICE quality standard 56
- Patient experience in adult NHS services (2012) NICE quality standard 15
- Breast cancer (2011) NICE quality standard 12

In development

- Referral for suspected cancer. Publication expected May 2016

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 2. Membership of this committee is as follows:

Mr Ben Anderson

Consultant in Public Health, Public Health England

Mr Barry Attwood

Lay member

Professor Gillian Baird

Consultant Developmental Paediatrician, Guy's and St Thomas' NHS Foundation Trust, London

Dr Ashok Bohra

Consultant Surgeon, Royal Derby Hospital

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Mrs Julie Clatworthy

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Dr Ulrike Harrower
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Mr Gavin Lavery
Clinical Director, Public Health Agency

Dr Tessa Lewis
GP and Medical Adviser in Therapeutics, Aneurin Bevan University Health Board

Ms Robyn Noonan
Area Service Manager Learning Disability, Oxfordshire County Council

Dr Michael Rudolf (Chair)
Hon. Consultant Physician, London North West Healthcare NHS Trust

Dr Anita Sharma
GP and Clinical Director of Vascular and Medicine Optimisation, Oldham Clinical Commissioning Group

Dr Amanda Smith
Director of Therapies, Health Service and Governance, Powys Teaching Health Board

Ms Ruth Studley
Director of Strategy and Development, Healthcare Inspectorate Wales

The following specialist members joined the committee to develop this quality standard:

John Graham
Consultant in Clinical Oncology, Taunton and Somerset NHS Foundation

Anne Armstrong
Consultant Medical Oncologist, The Christie Hospital, Manchester

Kieran Horgan
Consultant Breast Surgeon, Leeds Teaching Hospitals Trust

William Teh

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Nicola West

Breast Cancer Nurse Specialist, Cardiff and Vale University Health Board

Ursula Van Mann

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NICE project team

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Gavin Flatt

Technical Analyst

Esther Clifford

Programme Manager

Jenny Mills

Project Manager

Nicola Cunliffe

Project Manager

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

This quality standard has been incorporated into the NICE pathways on early and locally advanced breast cancer, advanced breast cancer and familial breast cancer.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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