

# Breast cancer

Quality standard

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[nice.org.uk/guidance/qs12](https://www.nice.org.uk/guidance/qs12)

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This standard is based on CG80, CG81, DG10, CSG1 and CG164.

This standard should be read in conjunction with QS56, QS15, QS124 and QS143.

## 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, and covers care from the point of referral to a specialist team. It does not cover adults with non-cancerous breast tumours. For more information see the [breast cancer topic overview](#).

This quality standard has been updated. It was identified for update after the annual review of quality standards in 2014. The review identified that there had been changes in the areas for improvement for breast cancer. For further information about the update, see [update information](#). Statements from the 2011 quality standard that are no longer national priorities for improvement, but are still underpinned by current accredited guidance, are included after the updated statements in the [list of quality statements](#).

### *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](#)). Of the new cases, a small proportion was diagnosed in the advanced stages, when the tumour had spread significantly within the breast or to other organs of the body. In addition to new diagnoses, people who have been previously treated for breast cancer may 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 – safety, experience and effectiveness of care – 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 and 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  | <p><i>Improvement areas</i></p> <p>Reducing premature mortality from the major causes of death</p> <p>1.4 Under 75 mortality rate from cancer*</p> <p>i One- and ii Five-year survival from all cancers</p> <p>iii One- and iv Five-year survival from breast, lung and colorectal cancer</p> <p>v One- and vi Five-year survival from cancers diagnosed at stage 1 &amp; 2**</p> |
| <p><b>Alignment with Public Health Outcomes Framework</b></p> <p>* Indicator is shared</p> <p>** Indicator is complementary</p> <p>Indicators in italics in development</p> |   |

**Table 2 [Public Health Outcomes Framework for England, 2013–16](#)**

| Domain | Objectives and indicators |
|--------|---------------------------|
|--------|---------------------------|

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

## *Safety and people's experience of care*

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 people using services. 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](#).

## **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 sources 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 are offered 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 unless there are specific clinical indications for its use. [new 2016]

Statement 3 People with oestrogen receptor-positive (ER-positive), human epidermal growth factor receptor 2-negative (HER2-negative) and lymph node-negative early breast cancer who are at intermediate risk of distant recurrence are offered gene expression profiling with Oncotype DX. [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 have their treatment and care managed 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]

|   |
|---|
| In 2016 this quality standard was updated and statements prioritised in 2011 were updated (2011, updated 2016) or replaced (new 2016). For more information, see <a href="#">update information</a> . |
|---|

Statements from the 2011 quality standard for breast cancer that may still be useful at a local level, but are no longer considered national priorities for improvement:

- People presenting with symptoms that suggest breast cancer are referred to a unit that performs diagnostic procedures in accordance with NHS Breast Screening Programme guidance.
- People with early invasive breast cancer are offered a pre-treatment ultrasound evaluation of the axilla and, if abnormal lymph nodes are identified, ultrasound-guided needle biopsy (fine needle aspiration or core). Those with no evidence of lymph node involvement on needle biopsy are offered sentinel lymph node biopsy when axillary surgery is performed.

- People with early breast cancer undergoing breast conserving surgery, which may include the use of oncoplastic techniques, have an operation that both minimises local recurrence and achieves a good aesthetic outcome.
- People with early breast cancer who are to undergo mastectomy have the options of immediate and planned delayed breast reconstruction discussed with them.
- People with early invasive breast cancer, irrespective of age, are offered surgery, radiotherapy and appropriate systemic therapy, unless significant comorbidity precludes it.
- People with early invasive breast cancer do not undergo staging investigations for distant metastatic disease in the absence of symptoms.
- People with early invasive breast cancer are involved in decisions about adjuvant therapy after surgery, which are based on an assessment of the prognostic and predictive factors, and the potential benefits and side effects.
- People having treatment for early breast cancer are offered personalised information and support, including a written follow-up care plan and details of how to contact a named healthcare professional.
- Women treated for early breast cancer have annual mammography for 5 years after treatment. After 5 years, women who are 50 or older receive breast screening according to the NHS Breast Screening Programme timescales, whereas women younger than 50 continue to have annual mammography until they enter the routine NHS Breast Screening Programme.
- People who have a single or small number of potentially resectable brain metastases, a good performance status and who have no (or minimal) other sites of metastatic disease are referred to a neuroscience brain and other rare CNS tumours multidisciplinary team.

The [2011 quality standard for breast cancer](#) is available as a pdf.

## Quality statement 1: Timely diagnosis

### *Quality statement*

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

### *Rationale*

Early diagnosis of breast cancer allows for prompt treatment, which results in 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. It will also 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 carry out the triple diagnostic assessment at a single hospital visit 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.

#### Outcome

a) Stage at diagnosis of breast cancer.

**Data source:** Local data collection.

b) Breast cancer survival rates.

**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 specialist breast cancer 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, people using services and carers*

People who have been referred to a breast cancer specialist are offered a full assessment carried out at a single visit to the hospital or specialist unit. The assessment involves an examination, breast imaging and a biopsy (if needed). During the biopsy a small amount of breast tissue is removed and tested for cancer. Having the assessment in a single visit helps to ensure that people 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: Preoperative MRI scan

### *Quality statement*

People with biopsy-proven invasive breast cancer or ductal carcinoma in situ (DCIS) are not offered a preoperative MRI scan unless there are specific clinical indications for its use. [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 except in specific clinical situations. Carrying out an unnecessary preoperative MRI scan may cause additional stress without any benefit and waste 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 unless there are specific clinical indications for its use.

**Data source:** Local data collection.

#### **Process**

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

Numerator – the number in the denominator in which there is a specific clinical indication for preoperative MRI.

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

**Data source:** Local data collection.

## Outcome

Patient satisfaction with preoperative treatment 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 and specialist breast cancer 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 unless there are specific clinical indications for its use.

**Healthcare professionals** (such as doctors, nurses and specialists) 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 unless there are specific clinical indications for its use.

**Commissioners** (such as clinical commissioning groups) ensure that they commission services in which people with biopsy-proven invasive breast cancer or DCIS are not offered a preoperative MRI scan unless there are specific clinical indications for its use.

### *What the quality statement means for patients, people using services and carers*

People with invasive breast cancer that 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.

### *Source guidance*

- [Early and locally advanced breast cancer: diagnosis and treatment](#) (2009) NICE guideline CG80, recommendation 1.1.1 and 1.1.2

### *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](#) (NICE guideline CG80) recommendation 1.1.1]



## Quality statement 3: Gene expression profiling

### *Quality statement*

People with oestrogen receptor-positive (ER-positive), human epidermal growth factor receptor 2-negative (HER2-negative) and lymph node-negative early breast cancer who are at intermediate risk of distant recurrence are offered gene expression profiling with Oncotype DX. [new 2016]

### *Rationale*

Gene expression profiling aims to identify certain genes found in breast cancer tumours. Testing for the levels of expression of these genes can give an indication of how a tumour might develop, which can help in planning treatment. Oncotype DX has been shown to be effective in predicting the course of disease in people with ER-positive, HER2-negative and lymph node-negative early breast cancer who have been assessed as being at intermediate risk of distant recurrence. This information can help with decisions about prescribing chemotherapy after surgery.

### *Quality measures*

#### Structure

Evidence of local arrangements to provide gene expression profiling with Oncotype DX for people with ER-positive, HER2-negative and lymph node-negative early breast cancer who are at intermediate risk of distant recurrence.

**Data source:** Local data collection.

#### Process

Proportion of people with ER-positive, HER2-negative and lymph node-negative early breast cancer who are at intermediate risk of distant recurrence who receive gene expression profiling with Oncotype DX.

Numerator – the number in the denominator who receive gene expression profiling with Oncotype DX.

Denominator – the number of people with ER-positive, HER2-negative and lymph node-negative early breast cancer who are at intermediate risk of distant recurrence.

**Data source:** Local data collection.

## Outcome

a) Breast cancer recurrence (distant and local).

**Data source:** Local data collection.

b) Incidence of adverse events from chemotherapy.

**Data source:** Local data collection.

c) Mortality from 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 specialist breast cancer services) ensure that systems are in place for people with ER-positive, HER2-negative and lymph node-negative early breast cancer who are at intermediate risk of distant recurrence to have gene expression profiling with Oncotype DX.

**Healthcare professionals** (such as doctors, nurses and specialists) ensure that people with ER-positive, HER2-negative and lymph node-negative early breast cancer who are at intermediate risk of distant recurrence have gene expression profiling with Oncotype DX.

**Commissioners** (such as clinical commissioning groups) ensure that they commission services that undertake gene expression profiling with Oncotype DX for people with ER-positive, HER2-negative and lymph node-negative early breast cancer who are at intermediate risk of distant recurrence.

## *What the quality statement means for patients, people using services and carers*

People diagnosed with a particular type of early breast cancer (called oestrogen receptor-positive, human epidermal growth factor receptor 2-negative and lymph node-negative early breast cancer), who have been assessed as being at particular risk of the cancer spreading, are offered a test that

can help to predict how the cancer might develop. This information can be used to 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 10, recommendation 1.1

## *Definitions of terms used in this quality statement*

### **Gene expression profiling with Oncotype DX**

At the time of publication (June 2016), Oncotype DX was the only test (of four available to the NHS) recommended by NICE as an option for guiding adjuvant chemotherapy decisions for people with ER-positive, HER2-negative and lymph node-negative early breast cancer who are assessed as being at intermediate risk of distant recurrence.

[[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 10)]

### **Intermediate risk**

Intermediate risk of distant recurrence is defined as a Nottingham Prognostic Index (NPI) score above 3.4. It is anticipated that an NPI score can be simply calculated from information that is routinely collected about people with breast cancer. The NICE diagnostics guidance also highlights other decision-making tools or protocols are also currently used in the NHS and these may also be used to identify people at intermediate risk.

[[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 10)]

## 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 classify the primary tumour and decide how best to treat and manage the cancer. If breast cancer recurs, the ER and HER2 status of the tumour may be different from that of the original primary tumour. Therefore recurrent tumours (either at the site of the primary tumour or metastatic tumours) should be assessed for their ER and HER2 status, if clinically appropriate.

### *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.

## Outcome

Breast cancer survival rates.

**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 breast cancer (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, people using services 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 the person has the treatment and care that will work best for them.

### *Source guidance*

- [Advanced breast cancer: diagnosis and treatment](#) (2009) NICE guideline CG81, recommendation 1.1.8. (In 2015, NICE decided that the recommendations in this guideline on the assessment of ER and HER2 should be updated. The update is expected to publish in June 2017. If the recommendations change, this quality statement will be reviewed.)
- [Early and locally advanced breast cancer: diagnosis and treatment](#) (2009) NICE guideline CG80, recommendations 1.6.1 and 1.6.3

## Quality statement 5: Multidisciplinary team management of metastatic breast cancer

### *Quality statement*

People with breast cancer who develop metastatic disease have their treatment and care managed by a multidisciplinary team. [2011, updated 2016]

### *Rationale*

When a multidisciplinary team manages the treatment and care of people with advanced breast cancer who develop metastatic disease, health outcomes are improved. In particular, the role of the multidisciplinary team involves assessing the patient, discussing potential treatments for the cancer and symptom relief, and reviewing the impact of treatment across the whole care pathway.

### *Quality measures*

#### Structure

Evidence of local arrangements to ensure that a multidisciplinary team manages the treatment and care of 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 have their treatment and care managed by a multidisciplinary team.

Numerator – the number in the denominator who have their treatment and care managed by a multidisciplinary team.

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

*Data source:* Local data collection.

#### Outcome

a) Breast cancer recurrence (distant and local).

**Data source:** Local data collection.

b) Incidence of adverse events from chemotherapy.

**Data source:** Local data collection.

c) Mortality from 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 services) ensure that systems are in place for people with breast cancer who develop metastatic disease to have their treatment and care managed 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 have their treatment and care managed by a multidisciplinary team.

**Commissioners** (such as clinical commissioning groups) ensure that they commission services that have a multidisciplinary team who manage the treatment and care of people with breast cancer who develop metastatic disease.

### *What the quality statement means for patients, people using services and carers*

**People with breast cancer that has spread to other parts of the body** (known as metastatic disease) have their treatment and care managed by a team of healthcare professionals who specialise in different areas of care. The team carry out an assessment and discuss all possible treatment options to help make sure the person has the treatment and care that will work best for them.

### *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 leads to better health outcomes. Key workers provide information and support for the person with breast cancer throughout their care. This can help to improve patient experience because people know they have someone who they can discuss their care with. It also helps to ensure that any care takes the person's needs into account.

### *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 an assigned 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 an assigned key worker.

Numerator – the number in the denominator with an assigned 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 an assigned key worker.

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

**Data source:** Local data collection.

## Outcome

Patient satisfaction with information and support received throughout their care for 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 people with locally advanced, metastatic or distant recurrent breast cancer to have a key worker.

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

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

### *What the quality statement means for patients, people using services and carers*

People with locally advanced, metastatic or distant recurrent breast cancer have a healthcare professional (often a nurse who specialises in breast cancer) assigned to them as their 'key worker'. The key worker gives information and support throughout the person's 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: diagnosis and treatment](#) (NICE guideline CG81) and expert consensus]

## 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. 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. This tool is updated monthly to include new quality standards.

### *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](#).

## Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](#) 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 10
- [Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer](#) (2013) NICE guideline CG164
- [Advanced breast cancer: diagnosis and treatment](#) (2009) NICE guideline CG81
- [Early and locally advanced breast cancer: diagnosis and treatment](#) (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 (2016) [Together for health – cancer delivery plan for the NHS to 2016](#)
- Department of Health (2013) [Living with and beyond cancer: taking action to improve outcomes](#)
- 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

- [Metastatic spinal cord compression in adults](#) (2014) NICE quality standard 56
- [Patient experience in adult NHS services](#) (2012) NICE quality standard 15

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

**Dr Guy Bradley-Smith**

Freelance GP and Clinical Commissioning Lead for Learning Disability, North, East and West (NEW)  
Devon Clinical Commissioning Group

**Mrs Julie Clatworthy**

Governing Body Nurse, Gloucester Clinical Commissioning Group

**Mr Michael Fairbairn**

Quality Manager, NHS Trust Development Authority

**Mr Derek Cruickshank**

Consultant Gynaecological Oncologist/Chief of Service, South Tees NHS Foundation Trust

**Mrs Jean Gaffin**

Lay member

**Dr Anjan Ghosh**

Consultant in Public Health, Public Health Merton, London

**Mr Jim Greer**

Principal Lecturer, Teesside University

**Mr Malcolm Griffiths**

Consultant Obstetrician and Gynaecologist, Luton and Dunstable University Hospital NHS Foundation Trust

**Dr Ulrike Harrower**

Consultant in Public Health Medicine, NHS Somerset

**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 and Health Science, 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**

Consultant Radiologist, London North West Hospitals NHS Trust

**Nicola West**

Breast Cancer Nurse Specialist, Cardiff and Vale University Health Board

**Ursula Van Mann**

Lay member

***NICE project team***

**Nick Baillie**

Associate Director

**Karen Slade**

Consultant Clinical Adviser

**Craig Grime**

Technical Adviser

**Gavin Flatt**

Technical Analyst

**Esther Clifford**

Programme Manager

**Jenny Mills**

Project Manager

**Nicola Cunliffe**

Project Manager

## Update information

**June 2016:** This quality standard was updated and statements prioritised in 2011 were replaced.

Statements are marked as [new 2016] or [2011, updated 2016]:

- [new 2016] if the statement covers a new area for quality improvement
- [2011, updated 2016] if the statement covers an area for quality improvement included in the 2011 quality standard and has been updated.

Statements numbered 5, 11, and 12 in the 2011 version have been updated and are included in the updated quality standard, marked as [2011, updated 2016].

Statements from the 2011 version (numbered 1–4, 6–10 and 13) that are no longer considered national priorities for improvement, but may still be useful at a local level, are included after the updated statements in the [list of quality statements](#) section.

The [2011 quality standard for breast cancer](#) is available as a pdf.

### Minor changes since publication

**June 2017:** Statements from the 2011 version that are no longer national priorities but may be useful locally have been moved to the [list of quality statements](#) section.

## 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](#) and [advanced 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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## Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

## Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Association of Breast Surgery](#)

- [British Society of Breast Radiologists](#)
- [Royal College of General Practitioners](#)