

Breast cancer

Quality standard

Published: 28 September 2011

www.nice.org.uk/guidance/qs12

Contents

Introduction	5
Why this quality standard is needed	5
How this quality standard supports delivery of outcome frameworks	6
Safety and people's experience of care	6
Coordinated services.....	6
List of quality statements.....	8
Quality statement 1: Timely diagnosis	10
Quality statement.....	10
Rationale	10
Quality measures	10
What the quality statement means for different audiences.....	11
Source guidance.....	11
Definitions of terms used in this quality statement	12
Quality statement 2: Preoperative MRI scan	13
Quality statement.....	13
Rationale	13
Quality measures	13
What the quality statement means for different audiences	14
Source guidance.....	14
Definitions of terms used in this quality statement	14
Quality statement 3: Gene expression profiling	16
Quality statement.....	16
Rationale	16
Quality measures	16
What the quality statement means for different audiences.....	17
Source guidance.....	18
Definitions of terms used in this quality statement	18

Quality statement 4: ER and HER2 receptor status.....	19
Quality statement.....	19
Rationale	19
Quality measures	19
What the quality statement means for different audiences.....	21
Source guidance.....	21
Definitions of terms used in this quality statement	21
Quality statement 5: Multidisciplinary team management of metastatic breast cancer.....	23
Quality statement.....	23
Rationale	23
Quality measures	23
What the quality statement means for different audiences	24
Source guidance.....	24
Quality statement 6: Key worker.....	25
Quality statement.....	25
Rationale	25
Quality measures	25
What the quality statement means for different audiences.....	26
Source guidance.....	27
Definitions of terms used in this quality statement	27
Using the quality standard.....	28
Quality measures	28
Levels of achievement	28
Using other national guidance and policy documents.....	28
Diversity, equality and language	29
Development sources.....	30
Evidence sources.....	30
Policy context	30

Definitions and data sources for the quality measures	31
Related NICE quality standards	32
Quality Standards Advisory Committee and NICE project team	33
Quality Standards Advisory Committee.....	33
NICE project team	35
Update information	37
About this quality standard.....	38

This standard is based on CG81, CSG1 and NG101.

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 to 16](#)
- [Public Health Outcomes Framework 2013 to 16](#).

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 NICE 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. [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 [update information](#).

Statements from the 2011 quality standard for breast cancer that are still supported by the evidence may still be useful at a local level:

- 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 different audiences

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.

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. NICE guideline CSG1 \(2002\), 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. [[NICE's guideline on improving outcomes in breast cancer](#)]

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 different audiences

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.

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 management. NICE guideline NG101 \(2018\), 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.

[[NICE's guideline on early and locally advanced breast cancer: diagnosis and management, 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. [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. Gene expression profiling 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 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.

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

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 different audiences

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.

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.

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

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

[Tumour profiling tests to guide adjuvant chemotherapy decisions in early breast cancer. NICE diagnostics guidance 34 \(2018\), recommendation 1.1](#)

Definitions of terms used in this quality statement

Gene expression profiling

EndoPredict, Oncotype DX Breast Recurrence Score and Prosigna are recommended by NICE as options 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. [[NICE's diagnostic guidance on tumour profiling tests to guide adjuvant chemotherapy decisions in early breast cancer](#)]

Intermediate risk

A validated tool, such as PREDICT or the Nottingham Prognostic Index, must be used to determine if a person is at intermediate risk of distant recurrence. [[NICE's diagnostic guidance on tumour profiling tests to guide adjuvant chemotherapy decisions in early breast cancer](#)]

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 a change in receptor status will lead to a change in management.

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 different audiences

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).

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. NICE guideline CG81 \(2017\)](#), recommendation 1.1.6
- [Early and locally advanced breast cancer: diagnosis and management. NICE guideline NG101 \(2018\)](#), recommendations 1.6.2 and 1.6.4

Definitions of terms used in this quality statement

Clinically appropriate

Where there is a recurrence of a breast tumour and it is suspected that the ER and HER-2 status

may be different to the original tumour and will lead to a change in management. [Expert consensus]

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 different audiences

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.

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. NICE guideline CG81 \(2009\), 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 different audiences

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.

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. NICE guideline CG81 (2009), 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. [NICE's guideline on advanced breast cancer: diagnosis and treatment 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 how to use quality standards](#) 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 for this quality standard](#) 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.

- [Early and locally advanced breast cancer: diagnosis and management. NICE guideline NG101 \(2018\)](#)
- [Tumour profiling tests to guide adjuvant chemotherapy decisions in early breast cancer. NICE diagnostics guidance 34 \(2018\)](#)
- [Advanced breast cancer: diagnosis and treatment. NICE guideline CG81 \(2009, updated 2017\)](#)
- [Improving outcomes in breast cancer. NICE guideline CSG1 \(2002\)](#)

Policy context

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

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

- [Welsh Government. Together for health – cancer delivery plan for the NHS to 2016 \(2016\)](#)
- [Department of Health. Living with and beyond cancer: taking action to improve outcomes \(2013\)](#)
- [Department of Health. National cancer patients' experience survey programme 2012/13 \(2012\)](#)
- [Royal College of General Practitioners. National audit of cancer diagnosis in primary care \(2011\)](#)

Definitions and data sources for the quality measures

[National cancer intelligence network \(NCIN\) \(2015\)](#)

Related NICE quality standards

- [Patient experience in adult NHS services. NICE quality standard 15 \(2012, updated 2019\)](#)
- [Metastatic spinal cord compression in adults. NICE quality standard 56 \(2014\)](#)

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 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

December 2018: Changes have been made to align this quality standard with the updated [NICE diagnostics guidance on tumour profiling tests to guide adjuvant chemotherapy decisions in early breast cancer](#). Statement 3 was amended to reflect the different options for tumour profiling tests now recommended in the guidance. The source guidance was also updated.

July 2018: Changes have been made to align this quality standard with the updated [NICE guideline on early and locally advanced breast cancer](#). References and source guidance sections have been updated.

August 2017: The rationale and source guidance details for statement 4 were updated and a definition added to ensure consistency with the [NICE guideline on advanced breast cancer](#), which was updated in August 2017.

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.

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, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See our [webpage on quality standard advisory committees](#) for details of standing committee 2 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

This quality standard has been included in the [NICE Pathways on early and locally advanced breast cancer](#) and [advanced breast cancer](#), which bring together everything we have said on a topic in an interactive flowchart.

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

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.

ISBN: 978-1-4731-1932-1

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 \(RCGP\)](#)