NICE National Institute for Health and Care Excellence

NICE quality standard

Breast cancer

Quality standard
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www.nice.org.uk/guidance/qs12

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This standard is based on CG81, CSG1 and NG101.

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

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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.

The previous version of the 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The National Audit of Breast Cancer in Older Patients reported the percentage of patients aged

50 years and over who were calculated to have received the triple diagnostic assessment in a single visit. The denominator is women with non-screen-detected early invasive breast cancer.

Outcome

a) Stage at diagnosis of breast cancer.

Data source: The National Disease Registration Service's stage at diagnosis report includes information on breast cancer staging data in England.

b) Breast cancer survival rates.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

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 ensure that they commission specialist services that provide triple diagnostic assessment in a single hospital visit for people with suspected breast cancer.

Peoplewho 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, page 33]

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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from local protocols and service specifications.

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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Patient satisfaction with preoperative treatment of people with biopsy-proven invasive breast cancer or DCIS.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient satisfaction surveys.

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 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), recommendations 1.2.2 and 1.2.3

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, recommendation 1.2.3]

Quality statement 3: Tumour profiling tests

Quality statement

People with early breast cancer are offered a tumour profiling test if it could help when making decisions about chemotherapy. **[new 2016]**

Rationale

Tumour profiling tests aim 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 making shared decisions about chemotherapy after surgery. Tumour profiling tests have been shown to be effective in predicting the course of disease in people with oestrogen receptor (ER)-positive, or progesterone receptor (PR)-positive, human epidermal growth factor receptor 2 negative (HER2-negative) and lymph node-negative early breast cancer who have been assessed as being at intermediate risk of distant recurrence. They can also be used for some people with ER-positive or PR-positive, HER2-negative early breast cancer with 1 to 3 positive lymph nodes.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to provide tumour profiling tests for people with early breast cancer if it could help when making decisions about chemotherapy.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from local protocols and service specifications.

Process

a) Proportion of people with ER-positive or PR-positive, HER2-negative and lymph node-negative early breast cancer who are at intermediate risk of distant recurrence who receive a tumour profiling test.

Numerator – the number in the denominator who receive a tumour profiling test.

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Proportion of women who have been through the menopause with ER-positive or PR-positive, HER2-negative early breast cancer with 1 to 3 positive lymph nodes who receive a tumour profiling test.

Numerator – the number in the denominator who receive a tumour profiling test.

Denominator – the number of women who have been through the menopause with ER-positive or PR-positive, HER2-negative early breast cancer with 1 to 3 positive lymph nodes.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

a) Breast cancer recurrence (distant and local).

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Mortality from breast cancer.

Data source:NHS Digital's cancer registration statistics report cancer mortality, including

counts, age-specific and directly age-standardised rates by ICD10 codes by age group, gender, deprivation and sub-integrated care board geography.

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 early breast cancer to have a tumour profiling test. Laboratories processing the tests should take part in a UK national external quality-assurance scheme.

Healthcare professionals (such as oncologists, nurses and specialists) ensure that people with early breast cancer have a tumour profiling test if it could help when making decisions about chemotherapy. The tests can be used for people with ER-positive or PR-positive, HER2-negative and lymph node-negative early breast cancer who are at intermediate risk of distant recurrence, according to their indications. They can also be used alongside consideration of clinical risk factors to guide adjuvant chemotherapy decisions for women who have been through the menopause with ER-positive or PR-positive, HER2-negative early breast cancer with 1 to 3 positive lymph nodes. An oncologist should explain what the test results mean, and the risks and benefits of treatment options based on all available risk factors.

Commissioners ensure that they commission services that undertake tumour profiling tests for people with early breast cancer if it could help when making decisions about chemotherapy.

People diagnosed with a particular type of 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 DG58 (2024), recommendations 1.1, 1.4, 1.6 and 1.7

Definitions of terms used in this quality statement

Tumour profiling test

EndoPredict, Oncotype DX and Prosigna can be used within their intended purpose to guide adjuvant chemotherapy decisions for people with ER-positive or PR-positive, HER2-negative early breast cancer. [NICE's diagnostic guidance on tumour profiling tests to guide adjuvant chemotherapy decisions in early breast cancer, recommendations 1.1, 1.4 and 1.6]

Intermediate risk of distant recurrence

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, recommendation 1.4]

Equality and diversity considerations

Healthcare professionals should consider whether tumour profiling tests are suitable to guide adjuvant chemotherapy decisions for:

- men with ER-positive or PR-positive, HER2-negative early breast cancer with 1 to 3 positive lymph nodes, and
- trans, non-binary or intersex people with ER-positive or PR-positive, HER2-negative early breast cancer with 1 to 3 positive lymph nodes, depending on their hormonal profile.

[NICE's diagnostic guidance on tumour profiling tests to guide adjuvant chemotherapy decisions in early breast cancer, recommendation 1.1]

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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from local protocols and service specifications.

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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from local protocols and service specifications.

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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The National Audit of Breast Cancer in Older Patients reported the percentage of patients aged 50 years and over with early invasive breast cancer who had ER status reported (by age group).

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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The National Audit of Breast Cancer in Older Patients reported the percentage of patients aged 50 years and over with early invasive breast cancer who had HER2 status reported (by age group).

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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Breast cancer survival rates.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

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 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).

Peoplewith 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 1.3.2 and 1.3.4

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 opinion]

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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from local protocols and service specifications.

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: Data can be collected from information recorded locally by healthcare professionals and service providers, for example from patient records.

Outcome

a) Breast cancer recurrence (distant and local).

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Incidence of adverse events from chemotherapy.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

c) Mortality from breast cancer.

Data source:NHS Digital's cancer registration statistics report cancer mortality, including counts, age-specific and directly age-standardised rates by ICD10 codes, by age group, gender, deprivation and sub-integrated care board geography.

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 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from local protocols and service specifications.

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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Patient satisfaction with information and support received throughout their care for breast cancer.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient satisfaction surveys. The National Cancer Patient Experience Survey reports responses to questions about support from a main contact person for people with cancer, including breast cancer.

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 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 and expert opinion]

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.

The previous version of the quality standard for breast cancer is available as a pdf.

Minor changes since publication

April 2025: Source guidance sections were updated to align with the updated NICE guideline on early and locally advanced breast cancer.

May 2024: Changes have been made to align this quality standard with the new NICE diagnostics guidance on tumour profiling tests to guide adjuvant chemotherapy decisions in early breast cancer. Statement 3 was amended to reflect recommendations on testing options for some people with ER-positive or PR-positive, HER2-negative early breast cancer with 1 to 3 positive lymph nodes. A structure measure has been removed from statement 1.

Data source sections have been updated throughout, and additional examples of data sources provided where relevant.

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 standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

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 guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the

quality statements are highlighted in each statement.

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.

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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 Radiology
- Royal College of General Practitioners (RCGP)