



Breast cancer quality standard

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NICE quality standard 12

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Introduction and overview

This quality standard covers the management of early (ductal carcinoma in situ^[1] and invasive), locally advanced and advanced breast cancer in adults. This includes the management of both screen-detected and symptomatic breast cancers from the point of referral to a specialist team. The scope does not include adults with rare breast tumours, benign breast disease, lobular carcinoma in situ, or the care of women with an increased risk of breast cancer because of family history.

Introduction

Breast cancer is the most common cancer in women in England and Wales and also affects a very small proportion of men. Some patients are diagnosed in the advanced stages, when the tumour has spread significantly within the breast or to other organs of the body. In addition, a considerable number of people who have been previously treated with curative intent subsequently develop either a local or regional recurrence or metastases. Breast cancer is the second biggest cause of death after lung cancer. In 2008, 39,972 people were diagnosed with breast cancer in England (39,681 women and 291 men). The lifetime prevalence is 1 in 8 women. There is a trend of increasing incidence because of lifestyle factors and improved detection, and decreasing mortality because of earlier detection and improvements in the quality and availability of effective treatments. There are more than 500,000 people in the UK today who have, or have had, a diagnosis of breast cancer. It is estimated that around 40 to 50% of these may develop metastases in the future, and therefore require treatment for advanced breast cancer. Unusually, lifestyle and environmental issues mean that the prevalence of breast cancer is greater in higher socioeconomic groups. However, mortality is higher among lower socioeconomic groups, highlighting issues of later identification because of a lower uptake of screening, barriers to accessing treatment among these groups and the impact of comorbidities.

This quality standard describes markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for adults with breast cancer in the following ways:

- Preventing people from dying prematurely.
- Enhancing quality of life for people with long-term conditions.
- Helping people to recover from episodes of ill health or following injury.

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- Ensuring that people have a positive experience of care.
 - Treating and caring for people in a safe environment and protecting them from avoidable harm.

The [NHS Outcomes Framework 2011/12](#) is available from www.gov.uk.

Overview

The quality standard for breast cancer requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole breast cancer care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to people with breast cancer.

NICE quality standards are for use by the NHS in England and do not have formal status in the social care sector. However, the NHS will not be able to provide a comprehensive service for all without working with social care communities. In this quality standard care has been taken to make sure that any quality statements that refer to the social care sector are relevant and evidence based. Social care commissioners and providers may therefore wish to use them, both to improve the quality of their services and support their colleagues in the NHS.

Subject to legislation currently before Parliament, NICE will be given a brief to produce quality standards for social care. These standards will link with corresponding topics published for the NHS. They will be developed in full consultation with the social care sector and will be presented and disseminated in ways that meet the needs of the social care community. As we develop this library of social care standards, we will review and adapt any published NICE quality standards for the NHS that make reference to social care.

It is important that the quality standard is considered by commissioners, healthcare professionals and patients alongside current policy and guidance documents, including [Improving outcomes in breast cancer](#) (NICE cancer service guidance, 2002) and the [Manual for cancer services: breast measures](#) (National Cancer Peer Review Programme, 2008), listed in the [evidence sources](#) section.

^[1] The commonest form of preinvasive breast cancer, which is confined to normal breast structures and has not infiltrated the supporting breast tissue and thus cannot have spread to other sites in the body.

List of statements

Statement 1. 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.

Statement 2. 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.

Statement 3. 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.

Statement 4. People with early breast cancer who are to undergo mastectomy have the options of immediate and planned delayed breast reconstruction discussed with them.

Statement 5. People with newly diagnosed invasive breast cancer and those with recurrent disease (if clinically appropriate) have the ER and HER2 status of the tumour assessed and the results made available within 2 weeks to allow planning of systemic treatment by the multidisciplinary team.

Statement 6. People with early invasive breast cancer, irrespective of age, are offered surgery, radiotherapy and appropriate systemic therapy, unless significant comorbidity precludes it.

Statement 7. People with early invasive breast cancer do not undergo staging investigations for distant metastatic disease in the absence of symptoms.

Statement 8. 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.

Statement 9. 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.

Statement 10. 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.

Statement 11. People who develop local recurrence, regional recurrence and/or distant metastatic disease have their treatment and care discussed by the multidisciplinary team.

Statement 12. People with recurrent or advanced breast cancer have access to a 'key worker', who is a clinical nurse specialist whose role is to provide continuity of care and support, offer referral to psychological services if required and liaise with other healthcare professionals, including the GP and specialist palliative care services.

Statement 13. 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.

In addition, quality standards that should also be considered when commissioning and providing a high-quality breast cancer service are listed in [related NICE quality standards](#).

Quality statement 1: Referral

Quality statement

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.

Quality measure

Structure: Evidence of local arrangements and written clinical protocols to ensure that 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.

Process: Proportion of people presenting with symptoms that suggest breast cancer who are referred to a unit that performs diagnostic procedures in accordance with NHS Breast Screening Programme guidance.

Numerator – the number of people in the denominator referred to a unit that performs diagnostic procedures in accordance with NHS Breast Screening Programme guidance.

Denominator – the number of people presenting with symptoms that suggest breast cancer.

What the quality statement means for each audience

Service providers ensure systems are in place for people presenting with symptoms that suggest breast cancer to be referred to a unit that performs diagnostic procedures in accordance with NHS Breast Screening Programme guidance.

Healthcare professionals ensure they are aware of local referral pathways for breast cancer to ensure that people with symptoms that suggest breast cancer are referred to a unit that performs diagnostic procedures in accordance with NHS Breast Screening Programme guidance.

Commissioners ensure they commission services that make sure 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 in whom breast cancer is suspected are referred to a unit that carries out diagnosis in accordance with NHS Breast Screening Programme guidance.

Source guidance

NICE clinical guideline 27, recommendation 1.6.1

Breakthrough Breast Cancer (2011) Best practice diagnostic guidelines for patients presenting with breast symptoms.

NHS Breast Screening Programme (2010) Clinical Guidelines for Breast Cancer Screening Assessment (third edition).

Data source

Structure: Manual for cancer services: breast measures (National Cancer Peer Review Programme).

Process: Manual for cancer services: breast measures (National Cancer Peer Review Programme).

Definitions

The NHS Breast Screening Programme implements the Best Practice Diagnostic Guidelines for Patients Presenting with Breast Symptoms (2011), which are endorsed as current policy by the Department of Health. Diagnostic procedures are performed in accordance with the Clinical Guidelines for Breast Cancer Screening Assessment Third Edition (2010), which contain diagnostic algorithms for assessment of symptomatic patients

Quality statement 2: Clinical assessment

Quality statement

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.

Quality measure

Structure:

- a) Evidence of local arrangements, including written clinical protocols, to ensure that people with early invasive breast cancer are offered a pre-treatment ultrasound of the axilla and, if abnormal lymph nodes are identified, ultrasound-guided needle biopsy (fine needle aspiration [FNA] or core).
- b) Evidence of local arrangements including written clinical protocols to ensure that people with early invasive breast cancer and no evidence of lymph node involvement are offered sentinel lymph node biopsy when axillary surgery is performed.

Process:

- a) Proportion of people with early invasive breast cancer who receive a pre-treatment ultrasound evaluation of the axilla.

Numerator – the number of people in the denominator receiving a pre-treatment ultrasound evaluation of the axilla.

Denominator – the number of people with early invasive breast cancer.

- b) Proportion of people with early invasive breast cancer who receive a pre-treatment ultrasound that identifies abnormal lymph nodes who receive an ultrasound-guided needle biopsy (FNA or core).

Numerator – the number of people in the denominator receiving an ultrasound needle biopsy (FNA or core).

Denominator – the number of people with early invasive breast cancer who receive a pre-treatment ultrasound that identifies abnormal lymph nodes.

c) Proportion of people with early invasive breast cancer and no evidence of lymph node involvement on needle biopsy who receive sentinel lymph node biopsy.

Numerator – the number of people in the denominator receiving sentinel lymph node biopsy.

Denominator – the number of people with early invasive breast cancer and no evidence of lymph node involvement on needle biopsy.

Outcome: Re-operation rates for axillary surgery.

Numerator – the number of patients in the denominator receiving more than one axillary operation to remove ipsilateral axillary lymph nodes.

Denominator – the number of patients with node-positive early invasive breast cancer who receive an axillary operation.

What the quality statement means for each audience

Service providers ensure systems are in place for people with early invasive breast cancer to be offered a pre-treatment ultrasound evaluation of the axilla and, if abnormal lymph nodes are identified, ultrasound-guided needle biopsy (FNA or core). In addition, ensure systems are in place for those with no evidence of lymph node involvement to be offered sentinel lymph node biopsy when axillary surgery is performed.

Healthcare professionals ensure that 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 (FNA or core). Ensure that those with no evidence of lymph node involvement are offered sentinel lymph node biopsy when axillary surgery is performed.

Commissioners ensure they commission services that provide pre-treatment ultrasound evaluation of the axilla for people with early invasive breast cancer and, if abnormal lymph nodes are identified, ultrasound-guided needle biopsy (FNA or core). Ensure services offer sentinel lymph node biopsy to those with no evidence of lymph node involvement when axillary surgery is performed.

People with early invasive breast cancer are offered an ultrasound scan of the armpit (axilla) before cancer treatment starts, to look for possible spread of the cancer to the lymph nodes. If abnormal lymph nodes are found, people are offered an ultrasound-guided needle biopsy to take a tissue sample from a lymph node. If there is no evidence of abnormal lymph nodes, people are offered another test called sentinel lymph node biopsy, which is performed during surgery for the cancer.

Source guidance

NICE clinical guideline 80, recommendations 1.1.3 and 1.4.1 (key priorities for implementation).

Data source

Structure: a) and b) Local data collection.

Process: a), b) and c) The Association of Breast Surgery (ABS) Breast Screening Audit. and National Cancer Dataset and Cancer Outcomes and Services Dataset (in development). Also contained within NICE clinical guideline 80 audit support, criteria 1 and 2.

Outcome: Local data collection.

Quality statement 3: Breast conserving surgery

Quality statement

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.

Quality measure

Structure: Evidence of local arrangements and written clinical protocols to ensure that 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.

Process: Proportion of people with early breast cancer who undergo breast conserving surgery.

Numerator – the number of people in the denominator who have breast conserving surgery.

Denominator – the number of people with early breast cancer having surgery.

Outcome:

- a) Mastectomy rates.
- b) Re-operation rates after first breast conserving surgery.
- c) Breast cancer local recurrence rate.

Numerator – the number of people in the denominator who have a local recurrence.

Denominator – the number of people with early breast cancer who have had breast conserving surgery.

- d) Patient satisfaction with outcome of breast surgery.

Numerator – the number of people in the denominator who report satisfaction with the aesthetic outcome of breast conserving surgery.

Denominator – the number of people early breast cancer who have had breast conserving surgery.

What the quality statement means for each audience

Service providers ensure systems are in place for people with early breast cancer who undergo breast conserving surgery, which may include oncoplastic techniques, to have an operation that both minimises local recurrence and achieves a good aesthetic outcome.

Healthcare professionals ensure people with early breast cancer who undergo breast conserving surgery, which may include oncoplastic techniques, have an operation that both minimises local recurrence and achieves a good aesthetic outcome. They should also record local recurrences.

Commissioners ensure they commission services that provide operations, including oncoplastic techniques, that both minimise local recurrence and achieve a good aesthetic outcome.

People with early breast cancer who have an operation to remove just the tumour and a small amount of breast tissue around it (breast conserving surgery), which may include techniques to improve appearance, have an operation that minimises the risk that the cancer will come back, as well as giving a good cosmetic appearance.

Source guidance

NICE clinical guideline 80, recommendation 1.5.1 (key priority for implementation).

Data source

Structure: Local data collection.

Process: National Mastectomy and Breast Reconstruction (MBR) Audit. Previous figures are available from www.ic.nhs.uk. This data collection ended in March 2011.

Outcome:

a) and c) National Mastectomy and Breast Reconstruction (MBR) Audit. Previous figures are available from www.ic.nhs.uk. This data collection ended in March 2011.

b) and d) Local data collection.

Definitions

Breast conserving surgery may include wide excision and partial reconstruction.

Quality statement 4: Mastectomy

Quality statement

People with early breast cancer who are to undergo mastectomy have the options of immediate and planned delayed breast reconstruction discussed with them.

Quality measure

Structure: Evidence of local arrangements and written clinical protocols to ensure that people with early breast cancer who are to undergo mastectomy have the options of immediate and planned delayed breast reconstruction discussed with them.

Process:

a) Proportion of people with early breast cancer having mastectomy who have an immediate or planned delayed breast reconstruction.

Numerator – the number of people in the denominator who have an immediate or planned delayed breast reconstruction.

Denominator – the number of people with early breast cancer having mastectomy.

b) Proportion of people with early breast cancer who are to undergo mastectomy who have the options of immediate or planned delayed breast reconstruction discussed with them.

Numerator – the number of people in the denominator who have the options of immediate or planned delayed breast reconstruction discussed with them.

Denominator – the number of people with early breast cancer who are to undergo mastectomy.

Outcome: Patient satisfaction with discussion about breast surgery options.

What the quality statement means for each audience

Service providers ensure systems are in place for people with early breast cancer who are to undergo mastectomy to have the options of immediate and planned delayed breast reconstruction discussed with them.

Healthcare professionals ensure they discuss the options of immediate and planned delayed breast reconstruction with people with early breast cancer who are to undergo mastectomy.

Commissioners ensure they commission services in which the options of immediate and planned delayed breast reconstruction are discussed with people with early breast cancer who are to undergo mastectomy.

People with early breast cancer who are to undergo mastectomy (an operation to remove the whole breast) have the options of immediate and planned delayed breast reconstruction discussed with them.

Source guidance

NICE clinical guideline 80, recommendation 1.5.1 (key priority for implementation).

Data source

Structure: Local data collection.

Process:

a) National Mastectomy and Breast Reconstruction (MBR) Audit. Previous figures are available from www.ic.nhs.uk. This data collection ended in March 2011.

b) Local data collection. Contained within NICE clinical guideline 80 audit support, criterion 3.

Outcome: Local data collection.

Definitions

All appropriate breast reconstruction options should be offered and discussed with people, irrespective of whether they are all available locally.

People with early breast cancer who are to undergo mastectomy should have an operation that minimises local recurrence and achieves a good aesthetic outcome.

Quality statement 5: Pathology – ER and HER2 status

Quality statement

People with newly diagnosed invasive breast cancer and those with recurrent disease (if clinically appropriate) have the ER and HER2 status of the tumour assessed and the results made available within 2 weeks to allow planning of systemic treatment by the multidisciplinary team.

Quality measure

Structure:

- a) Evidence of local arrangements and written clinical protocols to ensure that people with newly diagnosed invasive breast cancer have the oestrogen receptor (ER) and human epidermal growth receptor 2 (HER2) status of the tumour assessed.
- b) Evidence of local arrangements and written clinical protocols to ensure that people with recurrent disease have the ER and HER2 status of the tumour assessed if clinically appropriate.
- c) Evidence of local arrangements and written clinical protocols to ensure ER and HER2 status results are available within 2 weeks to allow planning of systemic treatment by the multidisciplinary team.

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.

- 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.

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.

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.

e) Proportion of people with newly diagnosed invasive breast cancer or recurrent disease who have ER status results available within 2 weeks.

Numerator – the number of people in the denominator who have ER status results available within 2 weeks.

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

f) Proportion of people with newly diagnosed invasive breast cancer or recurrent disease who have HER2 status results available within 2 weeks.

Numerator – the number of people in the denominator who have HER2 status results available within 2 weeks.

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

What the quality statement means for each audience

Service providers ensure systems are in place for people with newly diagnosed invasive breast cancer and those with recurrent disease (if clinically appropriate) to have the ER and HER2 status of the tumour assessed and for results to be available within 2 weeks.

Healthcare professionals ensure people with newly diagnosed invasive breast cancer and those with recurrent disease (if clinically appropriate) have the ER and HER2 status of the tumour assessed and results are available within 2 weeks.

Commissioners ensure they commission services that assess ER and HER2 status of the tumour for people with newly diagnosed invasive breast cancer and those with recurrent disease (if clinically appropriate) and ensure results are available within 2 weeks.

People with newly diagnosed invasive breast cancer and, if appropriate, those with breast cancer that has come back or spread have tissue from their tumour tested to find out its 'oestrogen receptor' (ER) and 'human epidermal growth receptor 2' (HER2) status. The test results are available within 2 weeks to help plan further treatment.

Source guidance

[NICE clinical guideline 81](#), recommendation 1.1.8 (key priority for implementation) and [NICE clinical guideline 80](#), recommendations 1.6.1, 1.6.3 and 1.6.4.

Data source

Structure: a), b) and c) Local data collection.

Process: a), b), c), d), e) and f) Local data collection.

Definitions

ER and HER2 status should be assessed on recurrent disease if not assessed at the time of initial diagnosis (ER will usually have been assessed at the time of initial diagnosis, unless the original diagnosis was made several years ago before testing for ER or HER2 was routine) or if it is felt the biology of the tumour may have changed.

Quality statement 6: Management

Quality statement

People with early invasive breast cancer, irrespective of age, are offered surgery, radiotherapy and appropriate systemic therapy, unless significant comorbidity precludes it.

Quality measure

Structure: Evidence of local arrangements and written clinical protocols to ensure that people with early invasive breast cancer, irrespective of age, are offered surgery, radiotherapy and appropriate systemic therapy, unless significant comorbidity precludes it.

Process:

a) Proportion of people older than 70 with early invasive breast cancer who receive breast conserving surgery.

Numerator – the number of people in the denominator who receive breast conserving surgery.

Denominator – the number of people older than 70 with early invasive breast cancer.

b) Proportion of people aged 70 and under with early invasive breast cancer who receive breast conserving surgery.

Numerator – the number of people in the denominator who receive breast conserving surgery.

Denominator – the number of people aged 70 and under with early invasive breast cancer.

c) Proportion of people older than 70 with early invasive breast cancer who receive radiotherapy after breast conserving surgery.

Numerator – the number of people in the denominator who receive radiotherapy after breast conserving surgery.

Denominator – the number of people older than 70 with early invasive breast cancer who have breast conserving surgery.

d) Proportion of people aged 70 and under with early invasive breast cancer who receive radiotherapy after breast conserving surgery.

Numerator – the number of people in the denominator who receive radiotherapy after breast conserving surgery.

Denominator – the number of people aged 70 and under with early invasive breast cancer who have breast conserving surgery.

e) Proportion of people older than 70 with early invasive breast cancer that is oestrogen-receptor (ER) positive who receive endocrine therapy.

Numerator – the number of people in the denominator who receive endocrine therapy.

Denominator – the number of people older than 70 with early invasive breast cancer that is ER-positive.

f) Proportion of people aged 70 and under with early invasive breast cancer that is ER-positive who receive endocrine therapy.

Numerator – the number of people in the denominator who receive endocrine therapy.

Denominator – the number of people aged 70 and under with early invasive breast cancer that is ER-positive.

g) Proportion of people older than 70 with early invasive breast cancer that is hormone receptor-negative who receive chemotherapy.

Numerator – the number of people in the denominator who receive chemotherapy.

Denominator – the number of people older than 70 with early invasive breast cancer that is hormone receptor-negative.

h) Proportion of people aged 70 and under with early invasive breast cancer that is hormone receptor-negative who receive chemotherapy.

Numerator – the number of people in the denominator who receive chemotherapy.

Denominator – the number of people aged 70 and under with early invasive breast cancer that is hormone receptor-negative.

What the quality statement means for each audience

Service providers ensure systems and written clinical protocols are in place so that people with early invasive breast cancer, irrespective of age, are offered surgery, radiotherapy and appropriate systemic therapy, unless significant comorbidity precludes it.

Healthcare professionals ensure that people with early invasive breast cancer, irrespective of age, are offered surgery, radiotherapy and appropriate systemic therapy, unless significant comorbidity precludes it.

Commissioners ensure they commission services that offer people with early invasive breast cancer, irrespective of age, surgery, radiotherapy and appropriate systemic therapy, unless significant comorbidity precludes it.

People with early invasive breast cancer, whatever their age, are offered surgery, radiotherapy and other appropriate treatments, unless other illnesses or conditions mean it is unsuitable.

Source guidance

[NICE clinical guideline 80](#), recommendation 1.12.1 (key priority for implementation).

Data sources

Structure: Local data collection.

Process:

a), b) West Midlands Cancer Intelligence Unit (2007) [Breast Cancer Clinical Outcome Measures \(BCCOM\) Project](#). Outcome measure 5: number and proportion of breast cancers treated surgically.

c), d), e), f), g) and h) Local data collection.

Definitions

People should receive an age-independent assessment of comorbidity that includes performance status to determine the presence of significant comorbidity.

Comprehensive geriatric assessment, where a key feature is the ability to function independently without additional support, can be very valuable in deciding whether the patient can cope with adjuvant treatments.

Equality and diversity considerations

Breast cancer treatment should be based on clinical need and fitness for treatment rather than age. Treatment and care of all patients with early invasive breast cancer should take into account patients' needs and preferences.

Quality statement 7: Staging

Quality statement

People with early invasive breast cancer do not undergo staging investigations for distant metastatic disease in the absence of symptoms.

Quality measure

Structure: Evidence of local arrangements and written clinical protocols to ensure that people with early invasive breast cancer do not undergo staging investigations for distant metastatic disease in the absence of symptoms.

Process: Proportion of people with early invasive breast cancer who do not undergo staging investigations for distant metastatic disease in the absence of symptoms.

Numerator – the number of people in the denominator who do not undergo staging investigations for distant metastatic disease.

Denominator – the number of people with early invasive breast cancer who have no symptoms suggestive of distant metastatic disease.

What the quality statement means for each audience

Service providers ensure systems are in place so that people with early invasive breast cancer do not undergo staging investigations for distant metastatic disease in the absence of symptoms.

Healthcare professionals ensure that people with early invasive breast cancer do not undergo staging investigations for distant metastatic disease in the absence of symptoms.

Commissioners ensure they commission services in which 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 do not undergo investigations for cancer elsewhere in the body if they have no symptoms that the cancer has spread.

Source guidance

Scottish Intercollegiate Guideline Network (SIGN) guideline 84, recommendation 2.3.2.

Data source

Structure: Local data collection.

Process: Local data collection.

Definitions

Staging is indicated for inflammatory, locally advanced or recurrent breast cancer.

Quality statement 8: Adjuvant therapy planning

Quality statement

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.

Quality measure

Structure: Evidence of local arrangements to ensure systems are in place for people with early invasive breast cancer to be 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.

Process: Proportion of people with early invasive breast cancer who 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.

Numerator – the number of people in the denominator who 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.

Denominator – the number of people with early invasive breast cancer who have had surgery.

Outcome: Patient satisfaction with the decision-making process.

What the quality statement means for each audience

Service providers ensure systems are in place to involve people with early invasive breast cancer 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.

Healthcare professionals ensure that 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.

Commissioners ensure they commission services that involve people with early invasive breast cancer 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 with early invasive breast cancer are involved in decisions about additional treatments after surgery. The decisions are made by reviewing the different factors that might affect the results of additional treatments, and the possible benefits and side effects.

Source guidance

NICE clinical guideline 80, recommendations 1.6.6 and 1.6.7.

Data source

Structure: Local data collection.

Process: Local data collection.

Outcome: National Cancer Patient Experience Survey Programme 2010.

Definitions

Discussions about adjuvant therapy after surgery may be supported by the use of appropriate models to support estimates of prognosis and the benefit of adjuvant treatment. These models include, but are not limited to:

- Adjuvant! Online
- Nottingham Prognostic Index
- CancerMath
- Predict.

Quality statement 9: Clinical follow-up

Quality statement

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.

Quality measure

Structure:

a) Evidence of local arrangements and written clinical protocols to ensure that people having treatment for early breast cancer are offered personalised information and support, including a written follow-up care plan.

b) Evidence of local arrangements to ensure that people having treatment for early breast cancer are provided with details of how to contact a named healthcare professional.

Process: Proportion of people having treatment for early breast cancer who receive personalised information and support, including a written follow-up care plan and details of how to contact a named healthcare professional.

Numerator – the number of people in the denominator receiving personalised information and support, including a written follow-up care plan and details of how to contact a named healthcare professional.

Denominator – the number of people having treatment for early breast cancer.

What the quality statement means for each audience

Service providers ensure systems are in place to offer people having treatment for early breast cancer personalised information and support, including a written follow-up care plan and details of how to contact a named healthcare professional.

Healthcare professionals ensure 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.

Commissioners ensure they commission services that offer people having treatment for early breast cancer personalised information and support, including a written follow-up care plan and details of how to contact a named healthcare professional.

People having treatment for early breast cancer are offered personalised information and support, including a written plan for their care after treatment and details of how to contact a named healthcare professional.

Source guidance

NICE clinical guideline 80, recommendation 1.14.6 (key priority for implementation).

Data source

Structure: a) and b) Local data collection.

Process: Local data collection. Contained within NICE clinical guideline 80 audit support, criterion 8.

Definitions

This statement focuses on people with early breast cancer. People with recurrent and advanced disease are addressed in statements 11 and 12.

Personalised information and support should include:

- details of named healthcare professionals and how to contact them
- dates of any follow-up appointments and review of ongoing adjuvant therapy (including assessment of bone density)
- details of surveillance mammography (frequency and duration)

-
- explanations of types of recurrence (ongoing risk), signs and symptoms and how to report them
 - support in coping with the fear and anxiety of recurrence
 - explanations of the incidence and of interventions for possible effects of treatment, including menopausal symptoms, fatigue, lymphoedema, pain, sleep disruption, future pregnancy and bone health
 - information about the possible psychosocial impact of breast cancer, including anxiety, depression, altered body image, sexuality and relationships
 - practical information about diet, reducing body mass index (BMI) and exercise (lifestyle changes that may help to reduce the risk of recurrence and enhance recovery), finances and work, breast prostheses and travel insurance
 - signposting to further sources of information and support.

Equality and diversity considerations

All information about treatment and care should be personalised and tailored to the individual needs of the patient (refer to [Diversity, equality and language](#)).

Quality statement 10: Follow-up imaging

Quality statement

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.

Quality measure

Structure:

- a) Evidence of local arrangements and written clinical protocols to ensure that women treated for early breast cancer have annual mammography for 5 years after treatment and then, if they are 50 or older, receive breast screening according to the NHS Breast Screening Programme timescales.
- b) Evidence of local arrangements and written clinical protocols to ensure that women treated for early breast cancer have annual mammography until they are 50, when they enter the routine NHS Breast Screening Programme.

Process:

- a) Proportion of women treated for early breast cancer and 45 or older at the time the post-treatment surveillance started, who have had 5 years of annual mammography before entering the NHS Breast Screening Programme.

Numerator – the number of women in the denominator who have had annual mammography for 5 years before entering the NHS Breast Screening Programme.

Denominator – the number of women treated for early breast cancer who were 45 or older when post-treatment surveillance started.

b) Proportion of women treated for early breast cancer and younger than 45 when post-treatment surveillance started, who have had annual mammography until they entered the NHS Breast Screening Programme at the age of 50.

Numerator – the number of women in the denominator who have had annual mammography until they entered the NHS Breast Screening Programme at the age of 50.

Denominator – the number of women treated for early breast cancer who were under 45 when post-treatment surveillance started.

c) Proportion of women treated for early breast cancer who are within 5 years of finishing their treatment who have had a mammography within the previous year.

Numerator – the number of women in the denominator who have had a mammography within the previous year.

Denominator – the number of women treated for early breast cancer who are within 5 years of finishing their treatment.

What the quality statement means for each audience

Service providers ensure systems and processes are in place so that women treated for early breast cancer have annual mammography for 5 years after treatment; and that after 5 years women who are 50 or older receive breast screening according to the NHS Breast Screening Programme timescales, while women younger than 50 continue to have annual mammography until they enter the routine NHS Breast Screening Programme.

Healthcare professionals ensure that women treated for early breast cancer have annual mammography for 5 years after treatment; and that after 5 years women who are 50 or older receive breast screening according to the NHS Breast Screening Programme timescales, while women younger than 50 continue to have annual mammography until they enter the routine NHS Breast Screening Programme.

Commissioners ensure they commission services that ensure that women treated for early breast cancer have annual mammography for 5 years after treatment; and that after 5 years women who are 50 or older receive breast screening according to the NHS Breast Screening

Programme timescales, while women younger than 50 continue to have annual mammography until they enter the routine NHS Breast Screening Programme.

Women treated for early breast cancer have an annual breast screen for 5 years after treatment. After 5 years women who are 50 or older have breast screening according to NHS Breast Screening Programme timings, whereas those under 50 continue with annual breast screening until they reach 50 and start screening through the NHS Breast Screening Programme.

Source guidance

NICE clinical guideline 80, recommendations 1.14.1 and 1.14.2.

Data source

Structure: a) and b) Local data collection.

Process: a), b) and c) National Cancer Dataset and Cancer Outcomes and Services Dataset (in development).

Equality and diversity considerations

This statement applies only to women because men are not screened for breast cancer, either routinely or following treatment for breast cancer.

Men are not screened for breast cancer because it is so rare, and those men who do have breast cancer will receive a mastectomy, which will leave no breast tissue to screen. The only circumstances in which a man with breast cancer would not receive a mastectomy are if he is not fit enough for the operation or the tumour is inoperable. In both these circumstances screening is inappropriate.

Quality statement 11: Multidisciplinary team

Quality statement

People who develop local recurrence, regional recurrence and/or distant metastatic disease have their treatment and care discussed by the multidisciplinary team.

Quality measure

Structure: Evidence of local arrangements and written clinical protocols to ensure that systems are in place for the multidisciplinary team to discuss the treatment and care of all people who develop local recurrence, regional recurrence and/or distant metastatic disease.

Process: Proportion of people who develop local recurrence, regional recurrence and/or distant metastatic disease who are discussed by the multidisciplinary team.

Numerator – the number of people in the denominator whose treatment and care is discussed by the multidisciplinary team.

Denominator – the number of people who develop local recurrence, regional and/or distant metastatic disease.

What the quality statement means for each audience

Service providers ensure systems are in place for the multidisciplinary team to discuss the treatment and care of all people who develop local recurrence, regional recurrence and/or distant metastatic disease.

Healthcare professionals ensure that they discuss within the multidisciplinary team the treatment and care of all people who develop local recurrence, regional recurrence and/or distant metastatic disease.

Commissioners ensure they commission services that have systems in place for the multidisciplinary team to discuss the treatment and care of all people who develop local recurrence, regional recurrence and/or distant metastatic disease.

People with breast cancer that has spread or come back have their treatment and care discussed by a specialist breast cancer healthcare team (a multidisciplinary team).

Source guidance

NICE clinical guideline 81, recommendation 1.5.9.

Data source

Structure: Local data collection.

Process: Local data collection.

Definitions

This statement addresses people with recurrent and metastatic disease. All people with early disease have their treatment and care discussed by the multidisciplinary team as shown in other statements.

Multidisciplinary team discussions may include, but are not limited to:

- oestrogen receptor (ER) and human epidermal growth receptor 2 (HER2) status
- performance status of the patient
- site and rate of progression of recurrent disease.

Quality statement 12: Key worker

Quality statement

People with recurrent or advanced breast cancer have access to a 'key worker', who is a clinical nurse specialist whose role is to provide continuity of care and support, offer referral to psychological services if required and liaise with other healthcare professionals, including the GP and specialist palliative care services.

Quality measure

Structure: Evidence of local arrangements and written clinical protocols to ensure that people with recurrent and advanced breast cancer have access to a key worker, who is a clinical nurse specialist whose role is to provide continuity of care and support, offer referral to psychological services if required and liaise with other healthcare professionals, including the GP and specialist palliative care services.

Process: Proportion of people with recurrent or advanced breast cancer who have a key worker who is a clinical nurse specialist.

Numerator – the number of people in the denominator who have a key worker who is a clinical nurse specialist.

Denominator – the number of people with recurrent or advanced breast cancer.

Outcome:

- a) Patient satisfaction with access to a key worker.
- b) Patient satisfaction with the information, support and signposting provided by the key worker.

What the quality statement means for each audience

Service providers ensure people with recurrent or advanced breast cancer have access to a key worker, who is a clinical nurse specialist whose role is to provide continuity of care and

support, offer referral to psychological services if required and liaise with other healthcare professionals, including the GP and specialist palliative care services.

Healthcare professionals ensure people with recurrent or advanced breast cancer have access to a key worker, who is a clinical nurse specialist whose role is to provide continuity of care and support, offer referral to psychological services if required and liaise with other healthcare professionals, including the GP and specialist palliative care services.

Commissioners ensure they commission services that provide people with recurrent or advanced breast cancer with access to a key worker, who is a clinical nurse specialist whose role is to provide continuity of care and support, offer referral to psychological services if required and liaise with other healthcare professionals, including the GP and specialist palliative care services.

People with recurrent or advanced breast cancer have access to a 'key worker' (a specialist nurse) who provides and coordinates care and support throughout their care, can refer them for psychological help if needed and is in contact with other healthcare professionals, including the GP and specialist palliative care services.

Source guidance

NICE clinical guideline 81, recommendation 1.4.1.

Data source

Structure: Local data collection.

Process: A Cancer Survivorship Survey was piloted in 2011 by the National Cancer Survivorship Initiative and contained a question about having a named nurse who patients could contact if they had a worry about their cancer care.

Outcome: a) and b) National Cancer Patient Experience Survey Programme 2010.

Definitions

Adapted from Improving supportive and palliative care for adults with cancer (NICE cancer service guidance, 2004):

A key worker is a clinical nurse specialist who, with the patient's consent and agreement, takes a key role in coordinating the patient's care and promoting continuity.

Quality statement 13: Brain metastases

Quality statement

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.

Quality measure

Structure: Evidence of local arrangements to ensure that 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 central nervous system (CNS) tumours multidisciplinary team.

Process: Proportion of 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 who are referred to a neuroscience brain and other rare CNS tumours multidisciplinary team.

Numerator – the number of people in the denominator referred to a neuroscience brain and other rare CNS tumours multidisciplinary team.

Denominator – the number of 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.

What the quality statement means for each audience

Service providers ensure systems are in place for 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 to be referred to a neuroscience brain and other rare CNS tumours multidisciplinary team.

Healthcare professionals ensure they refer 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 to a neuroscience brain and other rare CNS tumours multidisciplinary team.

Commissioners ensure they commission services that refer 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 to a neuroscience brain and other rare CNS tumours multidisciplinary team.

People with breast cancer that has spread to the brain but nowhere else (or if spread to other areas of the body is minimal), are referred to a healthcare team specialising in brain cancer (a neuroscience multidisciplinary team).

Source guidance

NICE clinical guideline 81, recommendation 1.5.16 (key priority for implementation).

Data source

Structure: Local data collection.

Process: Local data collection.

Definitions

Neuroscience brain and other rare CNS tumours multidisciplinary teams are described in the National Cancer Peer Review Programme Manual for cancer services: Brain and CNS measures (2011).

Using the quality standard

It is important that the quality standard is considered by commissioners, healthcare professionals and patients alongside current policy and guidance documents, including [Improving outcomes in breast cancer](#) (NICE cancer service guidance, 2002) and the [Manual for cancer services: breast measures](#) (National Cancer Peer Review Programme, 2008), listed in the [development sources](#) section.

Commissioning support and information for patients

NICE has produced a [support document](#) to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard. [Information for patients](#) using the quality standard is also available on the NICE website.

Quality measures and national indicators

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of healthcare. They are not a new set of targets or mandatory indicators for performance management.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so aspirational achievement levels are likely to be 100% (or 0% if the quality statement states that something should not be done). However, it is recognised that this may not always be appropriate in practice taking account of patient safety, patient choice and clinical judgement and therefore desired levels of achievement should be defined locally.

We have indicated where national indicators currently exist and measure the quality statement. National indicators include those developed by the NHS Information Centre through their [Indicators for Quality Improvement Programme](#). For statements where national quality indicators do not exist, the quality measures should form the basis for audit criteria developed and used locally to improve the quality of healthcare.

For further information, including guidance on using quality measures, please see [What makes up a NICE quality standard](#).

Diversity, equality and language

During the development of this quality standard, equality issues were considered.

Good communication between health and social care professionals and patients with breast cancer is essential. Treatment and care, and the information given about it, should be culturally appropriate. It should also be accessible to patients with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Patients with breast cancer should have access to an interpreter or advocate if needed.

Development sources

Evidence sources

The documents below contain clinical guideline recommendations or other recommendations that were used by the TEG to develop the quality standard statements and measures.

Advanced breast cancer: diagnosis and treatment. NICE clinical guideline 81 (2009; NHS Evidence accredited).

Early and locally advanced breast cancer: diagnosis and treatment. NICE clinical guideline 80 (2009; NHS Evidence accredited).

Referral for suspected cancer. NICE clinical guideline 27 (2005).

Management of breast cancer in women. Scottish Intercollegiate Guidelines Network (SIGN) guideline No. 84, 2005 (update of SIGN guideline No, 29).

Policy context

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

Breakthrough Breast Cancer (2011) Best practice diagnostic guidelines for patients presenting with breast symptoms.

Department of Health (2011) Improving outcomes: a strategy for cancer.

Department of Health (2010) The NHS outcomes framework 2011/12.

Department of Health, Macmillan Cancer Support and NHS Improvement (2010) National cancer survivorship vision.

NHS Breast Screening Programme (2010) Clinical Guidelines for Breast Cancer Screening Assessment (third edition).

Department of Health (2008) [Manual for cancer services 2008: breast measures.](#)

Department of Health (2007) [Cancer reform strategy.](#)

Department of Health (2004) [The NHS cancer plan and the new NHS: Providing a patient-centred service.](#)

Department of Health (2001) [Manual of cancer services standards.](#)

Department of Health (2001) [The NHS cancer plan: making progress.](#)

Commission for Health Improvement and Audit Commission (2001) [National service framework assessments No. 1: NHS cancer care in England and Wales.](#)

Department of Health (2000) The [NHS cancer plan: a plan for investment, a plan for reform.](#)

Department of Health (2000) [Referral guidelines for suspected cancer.](#)

Department of Health (2000) [Cancer information strategy.](#)

Definitions and data sources

References included in the definitions and data sources sections can be found below:

[Breast Cancer Clinical Outcome Measures \(BCCOM\) Project \(2007\).](#)

[Improving outcomes in breast cancer.](#) NICE cancer service guidance (2002).

National Cancer Peer Review Programme (2010) [2009–10 peer review reports.](#)

[National mastectomy and breast reconstruction audit \(2010\)](#)

[Quality and Outcomes Framework indicators.](#)

Related NICE quality standards

Patient experience in adult NHS services. NICE quality standard 15 (2012).

End of life care in adults. NICE quality standard 13 (2011).

The Topic Expert Group and NICE project team

Topic Expert Group

Ruth Bridgeman

Acting National Coordinator, National Cancer Peer Review, National Cancer Action Team

Tracy Dowling

Director of Strategic Commissioning, NHS Suffolk

Andrew Evans

Professor of Breast Imaging, Dundee University

Karen Francis

Systematic Reviewer, National Collaborating Centre for Cancer

Fiona Gilbert

Professor of Radiology, University of Aberdeen

John Graham

Consultant Oncologist and Cancer Lead, Taunton and Somerset NHS Foundation Trust

Adrian Harnett (TEG Chair)

Consultant Clinical Oncologist, Norfolk and Norwich University

Martin J Lee

Chair, NCIN Breast Clinical Reference Group

Douglas MacMillan

Consultant Oncoplastic Breast Surgeon, Nottingham Breast Institute

Ian Manifold

Clinical Lead, National Cancer Action Team

David Miles

Consultant Medical Oncologist, West Hertfordshire Hospitals NHS Trust

Elizabeth Needham

General Practitioner, Albion Medical Practice

Emma Pennery

Patient advocate member

Sarah Pinder

Professor of Breast Pathology, King's College London / Guy's and St Thomas' Hospital Hospitals

Nicola West

Consultant Nurse, Cardiff and Vale University Health Board

Ursula Van Mann

Lay member

Robin Wilson

Consultant Radiologist, The Royal Marsden NHS Foundation Trust

John Winstanley

Consultant Surgeon, Royal Bolton Hospital

NICE project team

Fergus Macbeth

Director

Lorraine Taylor

Associate Director

Mark Baker

Consultant Clinical Adviser

Anna Brett

Lead Analyst

About this quality standard

NICE quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

The methods and processes for developing NICE quality standards are described in the [healthcare quality standards process guide](#).

This quality standard has been incorporated into the NICE pathways for [advanced breast cancer](#), [early and locally advanced breast cancer](#) and [familial breast cancer](#).

We have produced a [summary for patients and carers](#).

Changes after publication

August 2013: minor maintenance.

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Contact NICE

National Institute for Health and Clinical Excellence
Level 1A, City Tower, Piccadilly Plaza, Manchester M1 4BT
www.nice.org.uk
nice@nice.org.uk
0845 003 7780