



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

National Quality Review of Symptomatic Breast Disease Services in Ireland

Report of the Quality Review Assessment at
Waterford Regional Hospital

22 February 2010

About the Health Information and Quality Authority

The Health Information and Quality Authority is the independent Authority which has been established to drive continuous improvement in Ireland's health and social care services. The Authority was established as part of the Government's overall Health Service Reform Programme.

The Authority's mandate extends across the quality and safety of the public, private (within our social care function) and voluntary sectors. Reporting directly to the Minister for Health and Children, the Health Information and Quality Authority has statutory responsibility for:

Setting Standards for Health and Social Services – Developing the quality and safety standards, based on evidence and best international practice, for health and social care services in Ireland (except mental health services).

Monitoring Healthcare Quality – Monitoring standards of quality and safety in our health services and investigating as necessary serious concerns about the health and welfare of service users

Health Technology Assessment – Ensuring the best outcome for the service user by evaluating the clinical and economic effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.

Health Information – Advising on the collection and sharing of information across the services, evaluating information and publishing information about the delivery and performance of Ireland's health and social care services.

Social Services Inspectorate – Registration and inspection of residential homes or children, older people and people with disabilities where applicable. Monitoring day- and pre-school facilities and children's detention centres; inspecting foster care services.

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1 Recommendations

The following represents the full list of recommendations for Waterford Regional Hospital, listed by themes, each of which can be found within the relevant section in the main content of this report.

Recommendations

Theme: Governance

G1. The role of the Lead Clinician should be formalised with specific responsibility for the symptomatic breast disease service.

G2. The service must ensure the continuing sustainability of symptomatic breast disease services to effectively and efficiently manage the needs of its patients. Locum arrangements must be finalised while the permanent appointments of a consultant radiologist and consultant breast surgeon are ongoing.

G3. The corporate governance and clinical reporting arrangements require ongoing evaluation by the Hospital and the National Cancer Control Programme to ensure that they are sustainable in order to effectively and efficiently manage the needs of its patients.

G4. The service should ensure that the patient healthcare record is available for all symptomatic breast disease clinics and off-site symptomatic breast disease care.

Theme: Multidisciplinary Approach

MDT1. The service should put arrangements in place to ensure that all clinical findings and multidisciplinary team decisions are clearly recorded.

MDT2. The centre should review practice around the documentation of patient notes so that all information pertaining to a patient's care is complete and easily accessible from a single source.

Theme: Skills, Education and Training

SET1. The service should ensure that a formal policy is developed to support and monitor continuous professional development.

Theme: Data Management

DM1. The service should ensure that the Patient Analysis and Tracking System is configured and implemented fully.

DM2. The service should ensure that all data fields required for the National Quality Assurance Standards and National Cancer Control Programme key performance indicators are configured in the Patient Analysis and Tracking System.

DM3. The service should ensure that a robust data validation process for accuracy, auditing and validation of data is finalised.

Theme: Access

A1. The service should develop and implement a consistent triage system for the SBD service.

A2. The service should put a targeted programme of action in place to ensure that all patients triaged as non-urgent are offered an appointment within 12 weeks, with this target being met in more than 95% of patients.

A3. The service should ensure that chemotherapy completion dates for patients are communicated to the third party provider of radiation oncology services.

A4. The service should ensure that turnaround times for FISH (fluorescence in situ hybridisation) specimens and pathology reporting continue to be monitored and improved.

Theme: Clinical Effectiveness

CE1. The service should incorporate specific symptomatic breast disease clinical audit activities within the clinical governance structure to systematically and critically analyse the quality of care provided.

2 Introduction

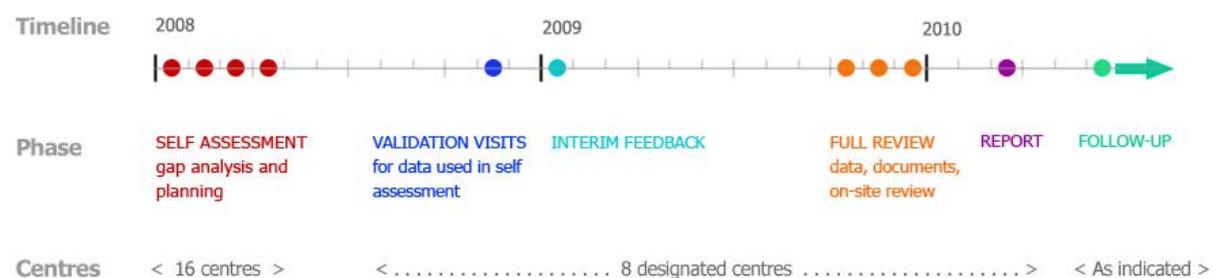
The Health Information and Quality Authority (the Authority) launched the *National Quality Assurance Standards for Symptomatic Breast Disease*⁽¹⁾ (hereafter referred to as the Standards) in May 2007 and advised all hospitals providing symptomatic breast disease (SBD) services that they should be meeting these Standards by the end of 2009.

In autumn 2007, the Authority announced the commencement of the National Quality Review Programme to establish how hospitals providing symptomatic breast disease services were meeting the requirements of the Standards. This report presents the findings from the Authority's Review of the national symptomatic breast disease service in Ireland as they relate to Waterford Regional Hospital. It provides an objective assessment of services as they were at the end of 2009.

Given the fluidity of services during the transition of breast cancer treatment services to eight designated centres, the Authority decided to adopt a dynamic approach to monitoring compliance and focus its efforts on both the quality of care and the effective management of the transition in the eight designated centres. The Authority's approach has been designed to reflect the continuous change programme that has been in train over the past two and a half years and stage of development of the designated centres at a given point in time.

This led to a Quality Review Programme that involved five phases across a two-and-a-half-year period, as services centralised to the eight designated centres and as the centres progressed towards full establishment. Figure 1 summarises the timeline for the Authority's activity over this period.

Figure 1: Summary Timeline for the National Quality Review Programme during 2008 to 2010



The Standards provide a framework for the methodology for all phases of this Quality Review Programme. The Authority's activity and approach through each phase of the Review Programme to date is described below.

Phase 1: Self assessment, January to April 2008

This involved the 16 publicly funded hospitals then providing symptomatic breast disease services, undertaking a self-assessment of their performance against the Standards. To facilitate the development of a self-assessment tool, the Authority reconvened the Symptomatic Breast Disease Services National Quality Assurance Group in an advisory capacity. The tool was a self-assessment questionnaire structured according to the sections in the Standards, plus an additional section on preparing for transition. The questionnaire allowed centres to allocate a score for each requirement of the Standards according to where they believed their level of compliance to be. This enabled each hospital to systematically assess the extent to which its symptomatic breast disease services were meeting the requirements set out in the Standards, as well as considering its arrangements for managing service change.

In addition to publicly funded hospitals, the Authority invited private hospitals providing SBD services to participate voluntarily in the self-assessment process. As a result, 11 private providers undertook the self-assessment exercise.

In assessing their own performance, the Authority advised hospitals that any activities or methods used for deciding how they scored themselves should be in place for a minimum of three months in advance of the self-assessment to merit the assignment of a score. In any other case, the Authority indicated that a score of zero should be assigned.

A summary report was provided to the centres in relation to how they had self-reported compliance for each standard compared to what other centres reported.

Phase 2: Validation assessment process, autumn 2008

Having conducted the self-assessment process against the Standards, and fed back the overall outcomes to the eight centres, it was important to test the rigour of the data and processes used by hospitals to self-assess and declare their performance against the standards. **Given that the transition towards eight centres was already underway at this time, this part of the review process was focused only on the eight designated specialist centres.**

The aim of the validation assessment was for the Authority to corroborate the self-assessment scores awarded by the centres through reviewing and challenging the information used by centres to inform completion of their self-assessment questionnaire.

The Authority spent a day on site at each of the eight designated centres. Focusing particularly on those Standards with associated performance indicators, the objective was to validate the self-assessed scores through a review of the evidence used by the centre to complete the self-assessment questionnaire in April 2008. The Authority also sought evidence of how centres were *routinely* measuring performance against these Standards and what evidence they could provide to demonstrate that they were meeting the Standards on an ongoing basis.

Phase 3: Feedback to designated specialist centres, January 2009

Following the validation process, the Authority provided each centre with an interim report in order for the centres to focus their improvement requirements on any gaps in meeting the Standards at that time.

The interim reports took the form of a commentary on the quality of evidence used by the centres to complete the validation assessment questionnaire. These included recommended steps for the future (see Appendix 1).

The Authority had further on-site meetings in June 2009 at each centre to assess the robustness of implementation plans as centres progressed towards full implementation of the Standards by the end of 2009.

Phase 4: Quality Review Visit – October to December 2009

The designated centres were expected by the Authority to be compliant with the Standards by the end of 2009. As indicated from the outset of the Quality Review, the Authority planned a definitive assessment of progress with the implementation of the Standards and progressing towards full establishment as national designated centres towards the end of 2009. This phase of the National Quality Review involved an in-depth review of the performance of the designated specialist centres' compliance with the Standards through:

- a document review
- an analysis of activity
- a review of access and clinical data
- an on-site review of each designated centre which included validation of data against patient records
- qualitative interviews
- patient discussions
- observation of clinical areas.

Interviews were also undertaken with the NCCP.

The detailed methodology for this phase is described in Appendix 2.

In designing its assessment approach for this phase of the National Quality Review, the Authority took account of a number of factors, some of which arose from lessons learned in the self-assessment phase of the process. These included:

- the National Quality Assurance Standards, as they were written, are very detailed and contain a mixture of Standards, targets, indicators and guidelines for clinicians totalling 285 separate requirements
- the Standards are not prioritised or weighted in terms of importance
- as some centres were newly established and resources were still being identified, the eight centres were likely to be at different stages of development and not all aspects of the Standards would be embedded to the same extent in all centres – especially those centres consolidating after significant service configuration changes
- given the above, certain service and performance factors are essential for the provision of safe, high quality care and would cause significant concern if they were not in place.

However, it was a fundamental requirement that the Standards provided the basis for the assessment process given that these are the requirements approved by the Board of the Authority and mandated by the Minister for Health and Children. Therefore, taking account of the above issues, the Authority analysed all 285 requirements in the Standards to identify the key issues on which the assessment needed to focus in a patient-centred way. As a result, **key representative standards** from the Standards (see Appendix 3) were identified. To help shape the review, these representative standards were then grouped into seven **generic themes**. These were:

- **Governance** (how the service is organised, how people are accountable and how decisions are made)
- **Multidisciplinary Approach** (the way different clinicians work together to ensure the best possible patient care)
- **Skills, Education and Training** (whether staff have specialist training for SBD services)
- **Person-centred Care** (how well patients are informed and involved in decisions about their care)
- **Data Management** (how well the centre collects, checks and uses information about patient care)
- **Access** (whether patients receive treatment at the right time and in the right place)
- **Clinical Effectiveness** (whether important clinical factors are delivered properly and whether the right facilities are in place).

Recognising that centres would be at different stages of development towards implementing the full range of standards, the Authority identified the most important elements in each theme that must be in place for quality and safety. These **essential elements** that each designated specialist centre must have as the foundation for safe, high quality symptomatic breast disease care are set out in **Figure 2**.

Some of these essential elements are fundamental to providing safe care for individual patients on a day-to-day basis (for example multidisciplinary teams and

"triple assessment"⁺) and others are important for the sustainable and consistent delivery of quality care to all patients over time. For example, collecting and using data to monitor performance or ensuring that sufficient numbers of patients are treated by professionals in order that professionals maintain their expertise.

The Authority would regard the absence of these essential elements as raising serious questions about the reliability of quality and safety of services provided in any given centre.

These elements provided an important focus of the Review and the Authority's findings in relation to them are set out in this report. All of the essential elements are based on the Standards, with the exception of the Governance essential element which is derived from the Authority's recommendations from previous investigations in relation to SBD services.

⁺ Triple assessment is an assessment of a patient by three main methods: clinical examination; diagnostic imaging; and clinical review of pathology samples (biopsies).

Figure 2: Essential elements for safe, high quality symptomatic breast disease care in specialist centres

Theme 1: Governance
Essential Element 1 (a) A comprehensive integrated governance structure with an organisational framework that incorporates systems and processes must be in place to allow effective general and clinical decision making, incorporating risk management, clinical service delivery and evaluation.
Essential Element 1 (b) The service will have robust clinical management, referral and patient pathways ensuring an effective integration of patient care.
Essential Element 1 (c) The governance structure will include defined responsibilities for shared service delivery as specified in the contractual agreement with another service provider.
Theme 2: Multidisciplinary Approach
Essential Element 2 (a) Core Team. The symptomatic breast disease (SBD) service must have a: <ul style="list-style-type: none">▪ lead clinician▪ consultant breast surgeon and team▪ consultant histopathologist▪ consultant radiologist and radiographer▪ clinical nurse specialist breast care▪ consultant radiation oncologist▪ consultant medical oncologist▪ consultant plastic and reconstructive surgeon.
Essential Element 2 (b) The centre should hold at least one triple assessment clinic per week. <i>Triple assessment aims to achieve a non-operative diagnosis for patients through the delivery of:</i>

- *clinical examination of the patient*
- *imaging by mammography and / or ultrasound*
- *pathology sampling.*

This approach minimises the need for open surgery in women with benign breast disease and permits definitive one-stage surgery in women with malignant disease, through the agreement of the clinical findings of the clinician, radiologist and pathologist. Clear communication between disciplines is essential in providing triple assessment to patients.

Essential Element 2 (c)

The multidisciplinary team (MDT) meeting must be held at least weekly. Patients discussed at the MDT meeting shall include all:

- new patients who have clinical or radiological / sonographic abnormalities
- patients who have had triple assessment
- patients following the first therapeutic operation
- patients for whom discussion at the meeting is deemed appropriate.

All members of the core team must attend the MDT meeting.

Decisions reached by the multidisciplinary team must be communicated to the patient and referring clinician.

Theme 3: Skills, Education and Training

Essential Element 3 (a)

Each member of the core team must have specific training and clinical expertise in breast cancer, must undertake continuing professional education and development on a regular basis with designated time for breast work.

Theme 4: Person-centred Care

Essential Element 4 (a)

The service must ensure that patients can access their care in a timely manner, have sufficient time, support and information in decision making and that their care pathway is integrated.

Integrated care encompasses shared decision making, enhanced by effective information processes, and local and regional support groups.

Essential Element 4 (b)

The centre must have a dedicated facility where the administrative, clinical and diagnostic areas are in close proximity.

The centre must be equipped with basic mammography, stereotactic mammography equipment and an ultrasound machine.

Theme 5: Data Management

Essential Element 5 (a)

Each centre shall have an information and data system that can be integrated with the other in-house systems.

Essential Element 5 (b)

Each centre must record basic data in relation to access, diagnosis, pathology, primary treatment and clinical outcomes.

Essential Element 5 (c)

There will be a data set, dictionary and standard operating procedure (SOP) for data validation.

Essential Element 5 (d)

The data must be available for audit and the SBD team must hold regular audit meetings to enable monitoring of key performance indicators with the National Quality Assurance Standards.

Theme 6: Access

Essential Element 6 (a)

The service must ensure that all patients referred for assessment are triaged and referred appropriately.

Essential Element 6 (b)

Patients requiring surgery, medical oncology and radiation oncology are seen and managed in a timely manner according to specified targets.

Theme 7: Clinical Effectiveness

Essential Element 7 (a)

The centre must have the facilities to treat more than 150 newly diagnosed

patients with primary breast cancer per year. The centre must provide care of breast disease from referral through to care of advanced disease encompassing clinical audit as the principal method to monitor clinical effectiveness.

Essential Element 7 (b)

The service should ensure that the necessary arrangements are in place to undertake effective clinical audit activities that include the systematic and critical analysis of the quality of care being provided, the procedures being used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient.

The Authority developed a Quality Review Programme methodology which provided hospitals with a framework to understand the evidence required to assess and demonstrate their performance against the Standards and to identify gaps in the quality and safety of their symptomatic breast disease services.

In order to take account of the realities of patients' experience, the Authority included a patient representative as a member of the Review team and discussions with patients as part of the process

Phase 5: Local and national reporting of findings

This involves the publication of the findings of the review in two formats. A separate local report on the findings and recommendations, represented by this report, has been issued to each designated centre and has been published on the Authority's website (www.hiqa.ie) along with a national report on the overall findings of the Review.

Where there remained aspects of services still being bedding down at the time of the Authority's Review, tailored on-site follow ups will be undertaken as indicated during 2010.

This report presents the findings from the Authority's Quality Review of symptomatic breast disease services at Waterford Regional Hospital against the Standards.

To summarise, the evidence on which these findings are based includes:

- documents provided by Waterford Regional Hospital (see Document Request template, Appendix 5)
- access* and clinical effectiveness data⁺ for patients who had been newly diagnosed with primary breast cancer and seen at the centre during the 13-

* **Access** refers to the provision and evaluation of processes to ensure the timely delivery of care and treatment to patients.

consecutive-week period from 1 April 2009 to 30 June 2009 (see Data Request template, Appendix 5)

- activity data for new patients seen for the seven-month sample period 1 January 2009 to 1 August 2009
- the findings of the Authority's on-site Quality Review on 12 and 13 November 2009 including:
 - validation of data against a number of patient records
 - qualitative interviews with relevant staff
 - discussion with patients
 - the observation of clinical areas.

If improvements or changes were made following submissions the Authority has reflected these, where appropriate, in the overall findings.

⁺ **Clinical effectiveness:** *the extent to which clinical interventions achieve desirable clinical outcomes by the provision of evidenced-based care with effective clinical audit processes.*

3 Overview

3.1 Waterford Regional Hospital

Waterford Regional Hospital (WRH) is one of the eight cancer centres of the Health Service Executive's (HSE's) National Cancer Control Programme (NCCP) and one of two centres in the HSE South Network. WRH provides cancer services to people who live in Waterford, Wexford, Kilkenny, Carlow and south Tipperary to a population size of 450,000⁽⁵⁻⁶⁾. The range of services provided encompasses diagnosis, staging and all aspects of cancer treatment except for radiation oncology services which are currently provided by third-party providers.

Radiation oncology is planned to be provided on-site in the future as an integrated satellite site managed by the Radiation Oncology Centre at Cork University Hospital as detailed in the National Plan for Radiation Oncology (NPRO)⁽⁷⁾.

In April 2008, the SBD service at WRH, using a self-assessment questionnaire (to measure its performance against the Standards) that was issued by the Authority as part of the Quality Review Programme, self-reported its percentage compliance with the Standards in a range between 29.3% and 94.9%.

In October 2008, the Authority reviewed the information that it had used to determine its self-assessment scores. The Authority observed that the SBD service at WRH:

- had completed the self-assessment questionnaire using snap-shot audits and professional judgment
- did not have appropriate information technology (IT) systems or personnel in position to facilitate continuous routine monitoring of performance against the Standards
- did not provide evidence to demonstrate that the appropriate arrangements were in place to assure itself that it was meeting the Standards.

In January 2009, following this Review, the Authority made a number of recommendations to WRH and the other hospitals (see Appendix 1).

In August 2009, for the purpose of the Review, WRH submitted activity data which provided a preliminary overview of the centre's activity for new patients seen at the SBD centre for the seven-month sample time period of between 1 January 2009 to 1 August 2009, illustrated in Table 1. **The figures below were reported by the centre in their data submission and were not validated by the Authority.**

**Table 1: New Patient referral activity at Waterford Regional Hospital
 (1 January 2009 to 1 August 2009)**

Patient referral activity at Waterford Regional Hospital (WRH) 1 January 2009 – 1 August 2009	
Total number of new patients seen at the WRH SBD service	1947
Total number of newly diagnosed primary breast cancer patients	119

Table 2: New patient referral activity by urgent triage category reported by Waterford Regional Hospital, 1 January 2009 to 1 August 2009

New patient referral activity by urgent triage category at Waterford Regional Hospital 1 January 2009 to 1 August 2009	
Total number of new patient referrals received during the sample time period that were triaged as urgent by the SBD Service	1117
Total number of new patient referrals triaged as urgent who were offered an appointment to be seen within 10 working days of the date of receipt of referral	636
Percentage of new patient referrals triaged as urgent who were offered an appointment to be seen within 10 working days of the date of receipt of referral	57%

Table 3: New patient referral activity by non urgent triage category reported by Waterford Regional Hospital I, 1 January 2009 to 1 August 2009

New patient referral activity by non urgent triage category at Waterford Regional Hospital, 1 January 2009 to 1 August 2009	
Total number of new patient referrals received during the sample time period that were triaged as non urgent by the SBD Service	830
Total number of new patient referrals triaged as non urgent who were seen within 6 weeks of the date of receipt of referral	170
Percentage of new patient referrals triaged as non urgent who were seen within 6 weeks of the date of receipt of referral	98%
Total number of new patient referrals triaged as non urgent who were seen within 12 weeks of the date of receipt of referral	429
Percentage of new patient referrals triaged as non urgent who were seen within 12 weeks of the date of receipt of referral	65%

4 Findings

Introduction

The findings of the Quality Review are described hereafter, by theme, in accordance with the identified essential elements. The findings for each theme are summarised in a conclusion section at the end of each theme section and reports if the key elements for the delivery of safe, quality care were in place at the time of Review.

4.1 Theme 1: Governance

Governance

Governance refers to the organisational framework that incorporates systems and processes for effective decision making to enable and demonstrate the provision, management and evaluation of a high quality safe service.

It defines local and national reporting structures and identifies clinical and managerial lead persons accountable for effective timely decision making, risk management and service evaluation and delivery.

It includes defined responsibility for shared service delivery where there is a contractual agreement with another service provider.

Essential Element 1 (a)

A comprehensive integrated governance structure with an organisational framework that incorporates systems and processes must be in place to allow effective general and clinical decision making, incorporating risk management, clinical service delivery and evaluation.

Findings Essential Element 1 (a)

The symptomatic breast disease (SBD) service is a constituent of the Surgical Directorate at WRH.

The transfer of regional services to the SBD service at WRH is complete. Outreach SBD review services and medical oncology is provided at South Tipperary General Hospital (STGH) in Clonmel, St Luke's Hospital in Kilkenny and Wexford General Hospital. The consultant breast surgeons and oncologists are appointed regionally with sessions in WRH, South Tipperary General Hospital (STGH) in Clonmel, St Luke's Hospital in Kilkenny and Wexford General Hospital.

In October 2009, a network clinical risk strategy was rolled out. This was confirmed by the Authority during documentation review and interviews with staff. The implementation of this strategy resulted in the governance structure of the Hospital,

and consequently the SBD service, being revised in October 2009 immediately prior to the Authority's Review. This new structure and strategy – which identified the responsibilities, reporting and monitoring arrangements – replaced a structure that had been inaugurated in September 2009. In the network clinical risk strategy structure, the Clinical Director and General Manager report to the Network Manager. The appointment of a corporate lead for clinical audit was also described. At the time of the Review, a post holder had not yet been identified.

In September 2009, the Clinical Director and General Manager identified a breast surgeon, who has full commitment to the SBD service, as the Lead Clinician. The post has operational and strategic responsibility for the delivery of SBD services. However, the role of lead clinician was at a very early stage of development and not yet fully formalised. This raised questions about the sustainability of the role which needed to be addressed in terms of role definition, objectives and time allocation. **(see G1)**

The Review identified multiple reporting lines for the Lead Clinician: clinical reporting to the Clinical Director, operational reporting to the General Manager at WRH, and regional reporting to the Network Manager.

The service advised that there was one full-time consultant radiologist in post. At the time of the Review, the permanent radiology post had been advertised and pending this appointment, at interview it was indicated that additional locum radiology arrangements to provide 2 days per week had been put in place and that negotiations were underway with the NCCP to provide full time locum radiology holiday cover. However, these arrangements at the time of review had not been finalised. **(see G2)**

In addition, the draft minutes of the Network Cancer Service Strategy and Planning Group (October 2009) indicate that the appointment of a third consultant breast surgeon was still outstanding. This was confirmed at interview by the Lead Clinician.

Prior to the aforementioned restructuring programme (October 2009), the Breast Interest Group: Cancer Services Group oversaw the delivery of SBD services at WRH. At the time of the Authority's Review, this committee had been reconstituted to form the WRH / HSE South East Cancer Services Strategy and Planning group. The terms of reference for this group include:

- ensuring that the Standards as set out by the Health Information and Quality Authority (the Authority) are adhered to
- to regularly assess the performance of cancer subgroups against national standards and to monitor performance against key performance indicators
- to promote research, audit and continuing professional development in the delivery of cancer services in the southeast.

The inaugural meeting was held in September 2009 with the Network Manager as chairperson. Membership includes the Clinical Director, General Manager, Nurse Manager and key clinical representatives. The breast cancer service is a subgroup

with the Lead Clinician formally reporting to the committee.

The Authority reviewed the minutes of the previous Breast Interest Group which confirmed that this group had historically overseen the SBD service and compliance with the Standards. In addition, the Authority reviewed the minutes of the newly restructured committee confirming the terms of reference, membership, time-tabling and reporting structures.

The Lead Clinician identified the multidisciplinary team (MDT) meeting at WRH as the current forum used to discuss quality and care issues pertaining to the SBD service. However, the Lead Clinician identified the need for the breast cancer service subgroup to formalise this function. At the time of the Review, these governance arrangements were not in place.

The Lead Clinician had constituted and was chairperson of the multidisciplinary Symptomatic Breast Care Unit – Clinical Audit committee. The terms of reference included:

- review of SBD-specific morbidity and mortality
- monitoring compliance with NCCP KPIs
- monitoring compliance with Standards
- presenting clinical trials data
- review of patient feedback
- review of delayed and missed diagnosis.

The Authority reviewed the findings of the first meeting, held in September 2009, and confirmed that each clinical specialty within the SBD service had reviewed key performance areas pertinent to their service. This committee identified the need to report to, the yet-to-be-appointed corporate lead for clinical audit.

At the time of the Authority's Review, WRH had recently restructured the clinical and corporate governance structures which had implications for the SBD. The Review also identified multiple reporting lines for the Lead Clinician which may pose a challenge for seamless management and decision-making. The Authority concluded that the corporate governance and clinical reporting arrangements would require a period of adjustment, with ongoing evaluation to ensure the sustainability, before a judgment on their effectiveness could be made and will need to be re-assessed by the Authority. **(see G3)**

Essential Element 1 (b)

The service will have robust clinical management, referral and patient pathways ensuring an effective integration of patient care.

Findings Essential Element 1 (b)

The Authority reviewed the SBD services standard operating procedure for clinical leadership. This showed that once a patient attends a breast clinic, they become the clinical responsibility of the consultant assigned to that clinic. That patient remains under the care of that consultant throughout their clinical pathway, unless or until their care is transferred to another clinical service.

The multidisciplinary team (MDT) process is central to the management of symptomatic breast disease and includes triple assessment and multidisciplinary team meetings. The Authority found that WRH had a well defined triple assessment clinic (TAC) process and multidisciplinary structure which was evidenced throughout the staff interviews, data validation exercise and patient healthcare record review. At the time of the Review, the SBD service had a draft TAC standard operating procedure (SOP).

The Review confirmed that there was a clear patient and general practitioner (GP) communication and referral process. Review SBD clinics and oncology care are provided regionally in hospitals in Tipperary, Kilkenny and Wexford. The service was managing historical challenges in transferring patient information between these sites. The Authority was informed that patient healthcare records were not always available if a patient attends an off-site SBD review service or has their care provided in another hospital within the region. However, the consultant and specialist breast care nurses can access on-line diagnostic imaging and histology reports. **(see G4)**

The Authority concluded that the service had some of the necessary clinical management and referral process in place. The Authority has made recommendations in the remaining areas that need to be addressed.

Essential Element 1 (c)

The governance structure will include defined responsibilities for shared service delivery as specified in the contractual agreement with another service provider.

Findings Essential Element 1 (c)

The SBD service at WRH had a service level agreement (SLA) in place for radiation oncology. However, there were no service level agreements in place where care was shared with other hospitals in the region. Such service level agreements should incorporate the essential components of access, quality and the provision of necessary performance information in order to assure compliance with the National Quality Assurance Standards.

Governance: Conclusion

The SBD service at WRH had recently re-aligned its governance structure. This, in tandem with the development of the role of the Lead Clinician, requires a period of

adjustment before a conclusion can be reached in relation to the effective integration and efficacy of these structures.

The SBD service must ensure the continuing sustainability of symptomatic breast disease services in order to effectively and efficiently manage the needs of its patients.

Full-time locum radiologist holiday arrangements should be finalised while the permanent appointment of a consultant radiologist and consultant breast surgeon was ongoing.

The Authority concluded that the corporate governance and clinical reporting arrangements would require a period of adjustment, with ongoing evaluation to ensure the sustainability, before a judgment on their effectiveness could be made and will need to be re-assessed by the Authority.

The Authority concluded that the integrated governance arrangements for SBD service at WRH will need to be re-assessed by the Authority.

Governance: Recommendations

G1. The role of the Lead Clinician should be formalised with specific responsibility for the symptomatic breast disease service.

G2. The service must ensure the continuing sustainability of symptomatic breast disease services to effectively and efficiently manage the needs of its patients. Locum arrangements must be finalised while the permanent appointments of a consultant radiologist and consultant breast surgeon are ongoing.

G3. The corporate governance and clinical reporting arrangements require ongoing evaluation by the Hospital and the National Cancer Control Programme to ensure that they are sustainable in order to effectively and efficiently manage the needs of its patients.

G4. The service should ensure that the patient healthcare record is available for all symptomatic breast disease clinics and off-site symptomatic breast disease care.

4.2 Theme 2: Multidisciplinary Approach

Multidisciplinary Approach

Management of breast disease is centred around the multidisciplinary approach. This approach, with input from key essential specialties, facilitates optimum patient management decisions. This maximises the opportunity for the small number of inevitable false positive or false negative findings within a single specialty to be identified and corrected. It also enables the most appropriate integrated care plan to be developed.

Therefore, it is essential to ensure that patients attending specialist symptomatic breast disease services have access to care that is based on collective expert opinion of surgeons, radiologists, pathologists and oncologists with the support of other professions such as specialist nurses.

The clinical decisions reached should be discussed with the patient and the GP and the recommended treatment carried out within a defined time period. It is recognised that clinical decisions reached at the MDT may be modified due to patient choice and circumstances.

Essential Element 2 (a)

a) Core Team.

The symptomatic breast disease (SBD) service must have a:

- lead clinician
- consultant breast surgeon and team
- consultant histopathologist
- consultant radiologist and radiographer
- clinical nurse specialist breast care
- consultant radiation oncologist
- consultant medical oncologist
- consultant plastic and reconstructive surgeon.

Findings Essential Element 2 (a)

A review of the documentation submission by WRH, and interviews, established that the service had the core staff required for a functioning multidisciplinary team which included:

- consultant breast surgeon and team
- consultant histopathologist
- consultant radiologist and radiographer
- clinical nurse specialist breast care
- consultant radiation oncologist

- consultant medical oncologist
- consultant plastic and reconstructive surgeon
- supporting clinical and administrative staff.

However, at the time of the Review, the SBD service at WRH reported that, while it had the necessary core staff, it did not have its full complement of staff. The service advised that there was one full-time consultant radiologist in post.

At the time of the Review, the permanent radiology post had been advertised and pending this appointment, the Network Manager indicated the provision of full time locum radiology holiday arrangements were to be agreed with the NCCP. However, it was not clear that there were arrangements in place to ensure the sustainability of the service in the interim.

The Authority concluded at the time of the Review that the service had the core personnel in place. However, the centre did not have robust locum radiology arrangements in place and this deficit will need to be addressed as a priority.

Essential Element 2 (b)

The centre should hold at least one triple assessment clinic per week.

Triple assessment aims to achieve a non-operative diagnosis for patients through the delivery of:

- *clinical examination of the patient*
- *imaging by mammography and / or ultrasound*
- *pathology sampling.*

This approach minimises the need for open surgery in women with benign breast disease and permits definitive one-stage surgery in women with malignant disease, through the agreement of the clinical findings of the clinician, radiologist and pathologist. Clear communication between disciplines is essential in providing triple assessment to patients.

Findings Essential Element 2 (b)

The Authority confirmed that the service had a draft operational procedure, patient pathway and documentation process thereby ensuring an integrated approach for the delivery of triple assessment.

The clinic timetable confirmed the weekly scheduling of triple assessment clinics (TAC). The Hospital had introduced a new user-friendly healthcare record layout. The review of the patient's healthcare record confirmed the clinical and radiology assessments were clearly identified and all scores recorded in the TAC pro forma. The referring consultant is responsible to ensure all appropriate patients details are referred to the MDT meeting coordinator for inclusion at the next MDT meeting.

The Authority found that the centre was holding a minimum of one weekly triple assessment clinic.

Essential Element 2 (c)

The multidisciplinary team (MDT) meeting must be held at least weekly. Patients discussed at the MDT meeting shall include all:

- new patients who have clinical or radiological / sonographic abnormalities
- patients who have had triple assessment
- patients following the first therapeutic operation
- patients for whom discussion at the meeting is deemed appropriate.

All members of the core team must attend the MDT meeting.

Decisions reached by the multidisciplinary team must be communicated to the patient and referring clinician.

Findings Essential Element 2 (c)

The Authority reviewed and confirmed that the service had a standard operating procedure (SOP) in place for the organisation and functioning of the MDT meeting. This SOP included security and patient confidentiality controls, attendee roles and responsibilities and, if required, video-conferencing arrangements. All attendees had dedicated time to attend the MDT meeting and record their attendance. An annual MDT meeting evaluation process was in place. The Lead Clinician was chairperson of the MDT meeting, and arrangements were in place to cover planned leave.

The Authority confirmed that patients discussed at the MDT meeting included all:

1. New patients who have clinical or radiological/ sonographic abnormalities.
2. Patients who have had triple assessment.
3. Patients following the first therapeutic operation.
4. Patients for whom discussion at the meeting is deemed appropriate.

The Authority observed that the MDT meeting diagnosis and outcomes were written at the end of the TAC pro forma. However, these were not clearly identified as MDT meeting notes and were not dated in all cases. At the time of the Review, the centre reported that a new MDT meeting template had been introduced. This template was reviewed by the Authority and if fully implemented should allow a more comprehensive record of the MDT meeting. **(see MDT1)**

Detailed histopathology and radiology reports were observed. However, printed reports and ultrasound guidance of core biopsies and ultrasounds of axillae were not documented in all cases but could be accessed electronically. The centre should review practice around the documentation of patient notes so that all information

pertaining to a patient's care is complete and easily accessible from a single source.
(see MDT2)

The Authority reviewed and confirmed the services communication process to ensure all patients with a definitive diagnosis of breast cancer discussed at the MDT meeting are contacted. The patient discussion group confirmed that their GPs were aware of their diagnoses and the review of patients' healthcare records confirmed that this information was being provided to GPs.

The Authority concluded that the service had the necessary multidisciplinary arrangements in place for the delivery of safe care.

Multidisciplinary Approach: Conclusion

The service was actively committed to delivering triple assessment through a multidisciplinary approach and had the necessary operational policies and evaluation processes to ensure that the multidisciplinary team is involved in all clinical decision making and treatment planning. Wherever possible, patients were central to this process and encouraged to participate in decisions about their treatment options and care.

Overall, the Authority concluded that the SBD service at WRH had the necessary multidisciplinary arrangements in place for the delivery of safe care. However, there were no clear locum arrangements in place for consultant radiologist cover. The Authority has made recommendations in relation to this that need to be addressed.

Multidisciplinary Approach: Conclusions

MDT1. The service should put arrangements in place to ensure that all clinical findings and multidisciplinary team decisions are clearly recorded.

MDT2. The centre should review practice around the documentation of patient notes so that all information pertaining to a patient's care is complete and easily accessible from a single source.

4.3 Theme 3: Skills, Education and Training

Skills, Education and Training

The theme of skills, education and training refers to the appointment of staff that have the required knowledge, credentials, skills and competencies to deliver a safe quality service. This includes the organisation's continuous professional development arrangements, in-service training and the monitoring mechanisms to ensure competency.

Essential Element 3 (a)

Each member of the core team must have specific training and clinical expertise in breast cancer, must undertake continuing professional education and development on a regular basis with designated time for breast work.

Findings Essential Element 3 (a)

The Authority found that the centre had a number of arrangements in place to ensure that the core team had the necessary training and clinical expertise.

By reviewing the documentation submitted by the Hospital, and during the on-site discussions with the team, there were several arrangements identified by the Authority whereby continuing professional development and competencies of staff are monitored. The mechanisms within the SBD team included MDT meeting, peer interaction, quality review, clinical audit and attending national and international courses, seminars and master classes.

The service reported that all consultant staff are expected and contractually bound to be academically involved by participating in teaching, training, research and ensuring evidenced-based clinical practices.

Clinical nurse specialists in breast care had relevant qualifications and clinical experience, and were registered on the national clinical nurse specialists register. During the review of facilities, the Authority confirmed as satisfactory the ward-based teaching and mentoring support provided by the specialist breast care nursing team.

The Authority reviewed and confirmed that the Hospital had:

- a corporate education, funding and study leave policy
- in-service educational programme and timetable
- training and attendance records are maintained for all staff

- triple assessment processes and multidisciplinary team meeting ensure peer review and concordance of clinical findings
- an SBD service clinical policy and guideline manual
- mandatory training in:
 - mammography
 - communication
 - PATS training
 - safe administration of chemotherapy.

The Authority found that the core team had the necessary training and clinical expertise in breast cancer, and undertook continuing professional education and development on a regular basis. However, they should ensure that a formal policy is developed to support and monitor continuous professional development in the symptomatic breast disease service. **(see SET1)**

Skills, Education and Training: Conclusion

The Authority found the centre had a number of arrangements in place to ensure the core team had the necessary training and clinical expertise, and undertake continuous professional education and development on a regular basis. All consultant staff are expected and contractually bound to be academically involved by participating in teaching, training, research and ensuring evidenced-based clinical practices

The specialist breast care nurses were registered on the national clinical nurse specialists register. In-service staff training and educational attendance records were maintained and monitored by the service.

Overall, the Authority found the SBD service had a number of arrangements in place to ensure that the core team had the necessary training and clinical expertise. However, the service should ensure that a formal policy is developed to support and monitor continuous professional development.

Skills, Education and Training: Recommendations

SET1. The service should ensure that a formal policy is developed to support and monitor continuous professional development.

4.4 Theme 4: Person-centred Care

Person-centred Care

Person-centred care refers to the practices and protocols which ensure that the patient is central to the delivery of coordinated and integrated care. This care is delivered, as far as is reasonably practicable, in a safe environment.

Systems and processes should be in place to ensure the patient is fully informed of all treatment options. This encompasses shared decision making with care being enhanced by effective information processes, local and regional support groups.

Furthermore, this includes stakeholder involvement and ongoing monitoring and evaluation of service provision from the patients' perspective.

Essential Element 4 (a)

The service must ensure that patients can access their care in a timely manner, have sufficient time, support and information in decision making and that their care pathway is integrated.

Integrated care encompasses shared decision making, enhanced by effective information processes, local and regional support groups.

Findings Essential Element 4 (a)

The Authority confirmed during the staff interviews, the review of on-site facilities and the review of patient healthcare records and documentation, that the SBD service at WRH had most of the necessary arrangements in place to ensure a person-centred approach in the delivery of symptomatic breast disease services.

In order to explore the provision of patient-centred care from a patient's perspective, the centre was asked by the Authority to select six service users with a diagnosis of breast cancer for participation in a discussion group. In order to take account of the realities of the patients' experience, the Authority included a service user representative as part of the Review team who led the patient discussion group.

The patient group reported their personal experiences. It is important to note that the experiences of other service users may be different.

Five patients participated in the discussion group at WRH, attending from Waterford city and country, and Wexford.

The majority of the patients had a history of breast symptoms, with repeated visits to their GP. Instances of missing letters, delayed or inconsistent results from both private and public services reported. Most of the difficulties reported by these patients related to the time prior to attending the specialist breast disease clinic for triple assessment.

Three specific themes were explored:

- access
- clinical care
- information and support

Person-centred care as reported by the patient discussion group at WRH was as follows:

Access

Patients in the discussion group reported that once they were in the service, the liaison between the SBD clinic and their GP was timely and comprehensive. However the group noted that more information regarding the service could be provided to local GPs.

Patients that were invited to take part in clinical trials stated that the information given to them was excellent, they reported that further information pertaining to the process of assignment to clinical treatment and the time commitment required would have been beneficial.

Clinical care

All of the patients in the group reported very high levels of satisfaction with and confidence in their care and the manner in which it had been delivered. Those who had to travel stated that they were very happy with how they were facilitated to have all the necessary tests carried out on the one day. The patient group reported that Standards in relation to the integration of their care pathway from diagnosis to treatment were all met.

The patients in the group had received their treatment in a variety of settings, and staff were described as excellent in the SBD clinic, the radiotherapy clinic and the regional day oncology clinics concerned.

Significant praise was given by the discussion group to the specialist breast care nurses (SBCNs) for the care and support they provided. Patients reported feeling comfortable in contacting the SBCNs at any time, also reporting that they were easy to talk to and provided significant emotional support.

Information and support

All of the patients in the discussion group reported satisfaction with the level and volume of information given to them. Most of the patients reported that given the volume of information they were getting, that some of the information given to them verbally could have been reinforced by reminder notes, or a journal record.

All of the patients in the group reported that they had received sufficient information on lymphoedema and none reported any difficulties in this regard. One of the patients reported that she was unaware that dietary advice was available to her through the services of a dietician based in the clinic.

Of those patients that availed of cancer support services which are available in each county within the catchment area, their reports were enthusiastic about the services and support they received there.

The Authority concluded that WRH had the essential arrangements in place to deliver person-centred care.

Essential Element 4 (b)

The centre must have a dedicated facility where the administrative, clinical and diagnostic areas are in close proximity.

The centre must be equipped with basic mammography, stereotactic mammography equipment and an ultrasound machine.

Findings Essential Element 4 (b)

The Authority's review of the facility included the:

- symptomatic breast disease facility
- diagnostic imaging department
- day ward, medical oncology
- day ward, local and general procedures
- surgical in-patient ward.

The service was incorporated into the WRH outpatient department, allocating SBD-specific clinic times. The infrastructure ensures patient privacy is maintained and the facility includes an area for patient counselling, prosthesis fitting and education rooms. The diagnostic imaging department is accessible and clearly signed – this is a new facility with the essential imaging equipment and infrastructure to support the SBD service. A specialist breast care nurse was also available to the department.

Throughout the observational review, staff confirmed the in-service educational programme and support provided by the SBD team.

The Authority concluded that WRH had the essential structures in place to deliver person-centred care.

Person-centred Care: Conclusion

WRH had the essential facilities for delivering person-centred care. The symptomatic breast disease service has written information about breast disease, cancer and local support groups.

Patients reported satisfaction with the level of information available to allow them to consider options for treatment.

The Authority concluded that the SBD service at WRH had the necessary arrangements and facilities in place to deliver person-centred care.

4.5 Theme 5: Data Management

Data management

Data management refers to the collection and provision of high quality, accurate, valid and timely data which provides, when validated and analysed, information and results that are disseminated to relevant parties and shared between similar service providers to support continuous improvement. This includes the identification and effective management of variances.

Essential Element 5 (a)

Each centre shall have an information and data system that can be integrated with the other in-house systems.

Findings Essential Element 5 (a)

The Symptomatic Breast Disease Centre used the following Information Systems:

- Patient Administration System (PAS) – patient demographics and appointment system
- Patient Analysis and Tracking System (PATS) – symptomatic breast disease clinical information system
- Laboratory Information System – laboratory results reports
- Implementation of the National Integrated Medical Imaging System (NIMIS) system was planned for June 2010.

Patient Administration System (PAS)

The PAS is used by all specialties at WRH to manage patient referrals and speciality appointments. The centre confirmed this system was interfaced with PATS for importing of patient demographic data.

Patient Analysis and Tracking System (PATS)

At the time of the Review, the SBD Centre explained that the Patient Analysis and Tracking System (PATS) was being developed in conjunction with the SBD services at Cork University Hospital and Mid-Western Regional Hospital Limerick. At the time of the Review, the system configuration was ongoing. **(see DM1)**

The service reported radiation oncology treatment was provided by a third-party provider, with medical oncology treatment being provided at WRH, St Luke's Hospital in Kilkenny, South Tipperary General Hospital in Clonmel, and Wexford General Hospital. Limited treatment records were observed where treatment was provided at another location. However, at the time of Review, the Authority noted the PATS

did not have a medical oncology data section and the radiation oncology section required further data fields to effectively capture patients' referral timelines. **(see DM2)**

The service reported the first phase of the PATS system was introduced in September 2009, had had been interfaced with PAS and that system configuration was underway. However, at the time of Review, the service was experiencing difficulties in successfully integrating the radiology and laboratory systems, and work was ongoing with this.

The Authority concluded that the service had for the most part the appropriate information management systems and should now ensure the Patient Administration and Tracking System (PATS) is configured, tested and introduced. However, it was unclear, at the time of the Review, whether the other information management systems can be fully integrated with PATS.

Essential Element 5 (b)

Each centre must record basic data in relation to access, diagnosis, pathology, primary treatment and clinical outcomes.

Findings Essential Element 5 (b)

Since September 2009, the Authority confirmed that staff were entering the triple assessment clinic (TAC), multidisciplinary team (MDT) meeting, histology, radiology and surgical data on PATS.

At the time of the Review, the Patient Administration and Tracking System was not live, therefore the Authority was unable to make a judgment as to the effectiveness of the data collected.

Essential Element 5 (c)

There will be a data set, dictionary and standard operating procedure (SOP) for data validation.

Findings Essential Element 5 (c)

The centre had a dataset and data dictionary reflecting the current level of system configuration.

There was no data validation process in place. The service identified the need for a standard operating procedure for data validation to be developed and data to be validated. **(see DM3)**

The Authority found that the service had the required data set and dictionary. However, there was no data validation process or standard operating procedure for data validation in place.

Essential Element 5 (d)

The data must be available for audit and the SBD team must hold regular audit meetings to enable monitoring of key performance indicators with the National Quality Assurance Standards.

Findings Essential Element 5 (d)

The service had the capacity to collect patient access data and has been reviewing this at the MDT meetings. Since September 2009 the centre is using PATS to collect the data pertaining to some of the key performance indicators and the National Quality Assurance Standards.

However, at the time of Review this system was not live and there was no data validation processes in place, consequently the service was unable to effectively monitor and ensure the accuracy of information pertaining to the key performance indicators and the National Quality Assurance Standards. This will require re-assessment by the Authority.

Data Management: Conclusion

At the time of the Review, the SBD service was developing the Patient Analysis and Tracking System (PATS) which facilitates data collection at all critical points in the patient pathway. This was happening in conjunction with the SBD service at Cork University Hospital and the Mid-Western Regional Hospital Limerick. The team reported the first phase of the system was introduced in September 2009 and that system configuration was underway.

The Authority concluded that the SBD service at WRH had most of the appropriate data management arrangements in place.

However, at the time of the Review the Patient Analysis and Tracking Systems were not live, data validation processes were not in place and audit processes were underdeveloped. This will require re-assessment by the Authority.

The Authority has made recommendations in the remaining areas that need to be addressed.

Data Management: Recommendations

DM1. The service should ensure that the Patient Analysis and Tracking System is configured and implemented fully.

DM2. The service should ensure that all data fields required for the National Quality Assurance Standards and National Cancer Control Programme key performance indicators are configured in the Patient Analysis and Tracking System.

DM3. The service should ensure that a robust data validation process for accuracy, auditing and validation of data is finalised.

4.6 Themes 6 and 7: Access and Clinical Effectiveness

WRH submitted access and clinical effectiveness data for patients newly diagnosed with primary breast cancer and seen at the service during the 13-week sample period from 1 April 2009 to 30 June 2009.

Based on the data submitted by WRH, it was identified that a total of 42 patients newly diagnosed with primary breast cancer were seen at the SBD service. There were no patients diagnosed with ductal carcinoma in situ.

The Authority carried out an on-site validation of 25% of the patient healthcare records to assure the accuracy and reliability of the data submitted by the centre in relation to the access and clinical effectiveness data: To ensure confidence in the data submitted, the validation process included a review of the:

- clinical classification coding⁺
- diagnostic imaging and histopathology reports
- patient consent form
- MDT pro forma
- patient information records
- documented clinical decisions
- patient access and treatment timelines
- correspondence to the referring doctor
- referrals to other clinical specialties.

Based on this validation, the Authority concluded it could place reliance on the data submitted for the sample data set.

The section of the report that follows sets out what the Standards and some related NCCP key performance indicators (KPIs) (see Appendix 6) demonstrated for this sample group of patients for the 13-week sample period according to the themes of Access and Clinical Effectiveness. A description and reference code for the selected Standards and NCCP KPIs is provided with the Hospital findings below.

⁺ **Clinical classification coding:** relates to triple assessment scores for clinical examination, radiological result and histopathology result.

4.6.1 Theme 6: Access

Access

Access refers to the provision and evaluation of processes to ensure the timely delivery of care and treatment to patients.

The service is designed so that patients' experience is determined by clinical need rather than other factors such as cultural differences or geographic location.

Essential Element 6 (a)

The service must ensure that all patients referred for assessment are triaged and referred appropriately.

Findings Essential Element 6 (a)

Patient triage processes

Triage is the process for directing patients with different levels of clinical urgency in a timely manner to the most appropriate part of the service. The SBD operational policy, the on-site review and the review of patients' healthcare records confirmed the GP-patient referral triage process in place at the centre. At the time of the Review, there were varying triage practices in the SBD service. One consultant surgeon reviewed and triaged all patient referrals, the second involved the SBCN initially reviewing and triaging patient referrals with final sign-off given by the consultant surgeon. The latter arrangement was not supported by a standard operating procedure. **(see A1)**

The Lead Clinician confirmed that he planned to review these practices and develop a consistent triage system.

The Authority concluded that the service did not have a consistent triage process in place. This will need to be re-assessed.

Essential Element 6 (b)

Patients requiring surgery, medical oncology and radiation oncology are seen and managed in a timely manner according to specified targets.

Findings Essential Element 6 (b)

Waterford Regional Hospital submitted access and clinical effectiveness data for patients newly diagnosed with primary breast cancer and seen at the service during the 13-week

sample period from 1 April 2009 to 30 June 2009.

The findings below set out what this data sample demonstrated according to the theme of Access. The Authority validated this data on-site and concluded that it could place reliance on the data sample submitted.

A reference code for the selected Standards is provided with the Hospital findings below.

Readers should note the corresponding explanatory notes (where applicable) which are based on further information provided by the service.

The following data reported relates to patients newly diagnosed with primary breast cancer and seen at the service during the 13-week sample period from 1 April 2009 to 30 June 2009.

PERFORMANCE MEASURE:	TARGET	WRH COMPLIANCE for 13 week sample
Access for urgent patients	TARGET	WRH COMPLIANCE for 13 week sample
Patients triaged as urgent; and subsequently newly diagnosed with primary breast cancer , are offered an appointment to be seen within 10 working days of the date of receipt of referral (Standard 2.8).	>95%	90% *See Standard 2.8 below
Access for non-urgent patients	TARGET	WRH COMPLIANCE for 13 week sample
Patients triaged as non-urgent; and subsequently newly diagnosed with primary breast cancer , are seen within 12 weeks of receipt of referral (KPI 1b)	>95%	* See KPI 1b below

Imaging	TARGET	WRH COMPLIANCE for 13 week sample
Patients triaged as urgent; and subsequently newly diagnosed with primary breast cancer , receive imaging on the first visit (Standard 6.14).	>90%	94%
Definitive diagnosis ⁺	TARGET	WRH COMPLIANCE for 13 week sample
Patients triaged as urgent; and subsequently newly diagnosed with primary breast cancer , have a definitive diagnosis achieved within 10 working days of being seen at the centre (Standard 4.9).	>90%	100%
Surgical intervention	TARGET	WRH COMPLIANCE for 13 week sample
Patients with primary operable breast cancer, have surgery (providing surgery is the first line of treatment) within 20 working days of definitive diagnosis (KPI 5a).	>90%	94%

What the data showed

*** Access for urgent patients (Standard 2.8)**

In early 2009, the SBD service at WRH was challenged to meet the access timelines for urgent and non-urgent patients referred to the service. WRH indicated that this pertained to the large number of patients being referred, the inadequate number of available consultant breast surgeons, radiology sessions and non-consultant hospital doctors (NCHDs) available to the SBD service.

Since July 2009, the SBD service has been assigned a full-time register and senior house officer (SHO) and the consultant radiologist post has been advertised. In tandem, the SBD service has facilitated additional clinics and revised its triage process to include urgent, early and routine.

Waterford Regional Hospital's Access and Clinical Effectiveness data submission to the

⁺ For the purpose of this review, the date of the definitive diagnosis is taken as the date of diagnosis at the MDT meeting.

Authority indicated that 90% of urgent patients were offered an appointment to attend the specialist breast service within two weeks of receipt of referral. At the time of the Review the service was fully compliant for the two months preceding the Review.

*** Access for non-urgent patients (KPI 1b)**

WRH's Access and Clinical Effectiveness data submission to the Authority indicated that three patients were triaged as non-urgent patients during the sample period of 1 April 2009 to 30 June 2009.

Of these patients, two were offered an appointment to attend the specialist breast service within 12 weeks of receipt of referral. At the time of the Review, additional documentation provided demonstrated that the service was compliant with the Standards for early referrals (to be seen within six weeks) for the two months preceding the Review.

At the time of the Review the SBD service was 86% compliant in relation to the access timelines for routine referrals (i.e. to be seen within 12 weeks). **(see A2)**

Medical oncology and Radiation oncology

The entire sample patient group would not have reached the medical and radiation oncology phase of treatment. Therefore, the data validation exercise did not include compliance with the Access Standards for medical and radiation oncology.

However, the Authority noted the work of the WRH in proactively reviewing access KPIs for medical and radiation oncology. Documentation showed that, while there were difficulties for patients receiving treatment within the target timelines, access timelines were being actively monitored and corresponding actions set to improve access timelines going forward.

Minutes from the Symptomatic Breast Care Service Clinical Audit Committee noted that there was no formal communication of chemotherapy completion date from WRH to the radiation oncology service provider. **(see A3)** In addition, the minutes noted delays in fluorescence in situ hybridisation (FISH) specimens from a third-party provider and pathology reporting. **(see A4)**

At the time of the Review, these were being actively reviewed and monitored by the service.

Access: Conclusion

In early 2009, the SBD service at WRH was challenged to meet the access timelines for

urgent and non-urgent patients referred to the service and were actively looking to address the historic waiting list.

WRH indicated that this waiting list pertained to the large number of patients being referred, the inadequate number of available consultant breast surgeons and radiology sessions and non-consultant hospital doctors (NCHDs) available to the SBD service. Since July 2009, the SBD service had been assigned a full-time registrar and senior house officer (SHO) and the consultant radiologist post has been advertised.

In tandem, the SBD service had facilitated additional clinics and revised its triage process. At the time of the Review, the service was compliant with all access timelines for urgent and early appointments. However, there remained an access delay for patients referred as routine and who needed to be seen within 12 weeks of referral.

Overall, the Authority concluded that the SBD service at WRH had most of the necessary arrangements in place to ensure timely access to care for urgent and early referrals. However, it was not able to ensure timely access to care for patients requiring to be seen within 12 weeks. This will need to be re-assessed by the Authority.

Access: Recommendations

A1. The service should develop and implement a consistent triage system for the SBD service.

A2. The service should put a targeted programme of action in place to ensure that all patients triaged as non-urgent are offered an appointment within 12 weeks, with this target being met in more than 95% of patients.

A3. The service should ensure that chemotherapy completion dates for patients are communicated to the third party provider of radiation oncology services.

A4. The service should ensure that turnaround times for FISH (fluorescence in situ hybridisation) specimens and pathology reporting continue to be monitored and improved.

4.6.2 Theme 7: Clinical Effectiveness

Clinical effectiveness: refers to the extent to which clinical interventions achieve desirable clinical outcomes by the provision of evidenced-based care with effective clinical audit processes.

Clinical audit: the systematic, critical analysis of the quality of care, including procedures used for diagnosis and treatment, use of resources and resulting outcome and quality of life for the patient.

Essential Element 7 (a)

The centre must have the facilities to treat more than 150 newly diagnosed patients with primary care breast cancer per year. The centre must provide care of breast disease from referral through to care of advanced disease encompassing clinical audit as the principal method to monitor clinical effectiveness.

Findings Essential Element 7 (a)

Waterford Regional Hospital submitted access and clinical effectiveness data for patients newly diagnosed with primary breast cancer and seen at the service during the 13-week sample period from 1 April 2009 to 30 June 2009.

The findings below set out what this data sample demonstrated according to the theme of Clinical Effectiveness. The Authority validated this data on-site and concluded that it could place reliance on the data sample submitted.

A reference code for the selected Standards is provided with the Hospital findings below.

Readers should note the corresponding explanatory notes (where applicable) which are based on further information provided by the service.

The following data reported relates to patients newly diagnosed with primary breast cancer and seen at the service during the 13-week sample period from 1 April 2009 to 30 June 2009.

PERFORMANCE MEASURE:	TARGET	WRH COMPLIANCE for 13 week sample	
Non-operative diagnosis	TARGET	WRH COMPLIANCE for 13 week sample	
A non-operative diagnosis is achieved in malignant disease (Standard 6.16).	>90%	100%	
Ultrasound of the axilla	TARGET	WRH COMPLIANCE for 13 week sample	
Patients with a diagnosis of invasive breast cancer shall have an ultrasound assessment of their axilla. Ultrasound of the axilla plays a central role in determining patients' suitability for sentinel node biopsy (Standard 6.21).	>95%	100%	
Imaging prerequisites	TARGET	WRH COMPLIANCE for 13 week sample	
Pre-operative mammography with ultrasound examination is carried out on patients with primary operable breast cancer (Standard 6.1).	>95%	100%	
Histopathology data	TARGET	WRH COMPLIANCE for 13 week sample	
To provide important and relevant data on patients with invasive breast carcinoma (Standard 7.13A):	>95%	100%	
<ul style="list-style-type: none"> ▪ Histological tumour type is recorded. 	>95%	100%	
<ul style="list-style-type: none"> ▪ Histological tumour grade is recorded. 	>95%	100%	
<ul style="list-style-type: none"> ▪ invasive tumour size is recorded 	>95%	100%	
<ul style="list-style-type: none"> ▪ The presence or absence of vascular invasion 	>95%	100%	
<ul style="list-style-type: none"> ▪ Radial margin status in wide local excision specimens is recorded 	>95%	100%	

<ul style="list-style-type: none"> Posterior (deep) margin status is recorded. 	>95%	100%
Hormone receptor status	TARGET	WRH COMPLIANCE for 13 week sample
Oestrogen receptor status is recorded (Standard 7.13 B).	>95%	100%
HER2 status	TARGET	WRH COMPLIANCE for 13 week sample
HER2 status shall be assessed using immunohistochemistry. Borderline positive cases shall be assessed using fluorescent in situ hybridisation (FISH) (Standard 7.13 C).	>95%	100%
Ductal carcinoma in situ	TARGET	WRH COMPLIANCE for 13 week sample
To provided appropriate data in patients with ductal carcinoma in situ (DCIS): DCIS grade is recorded.	>95%	*See Standard 7.14 below
<ul style="list-style-type: none"> Radial margin status in wide local excision specimens is recorded (Standard 7.14). 	>95%	*See Standard 7.14 below
Pre-operative localisation	TARGET	WRH COMPLIANCE for 13 week sample
Patients with clinically occult lesions, or where there are doubts about the location of the tumour, shall have pre-operative localisation guided by ultrasound or by stereotactic mammography equipment / X-ray (Standard 5.10).	>90%	*See Standard 5.10 below

What the data showed

***Ductal carcinoma in situ (Standard 7.14)**

The service reported that no patients were diagnosed with ductal carcinoma in situ (DCIS) during this sample period.

***Pre-operative localisation (Standard 5.10)**

WRH reported data in relation to patients being assessed as having a clinically occult lesion (classification S2) and having had pre-operative image-guided localisation. Based on this data, the Standards target is achieved.

Essential Element 7 (b)

The service should ensure that the necessary arrangements are in place to undertake effective clinical audit activities that include the systematic and critical analysis of the quality of care being provided, the procedures being used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient.

Findings Essential Element 7 (b)

A key component of clinical audit is that performance is reviewed (or audited) with a supporting framework to enable improvements to be made if required. At WRH, clinical audit of the mortality and morbidity of patients was undertaken as part of the general surgical services.

Since the Lead Clinician's appointment in September 2009, a specific SBD clinical audit process was established which the Authority reviewed. This clinical audit process involved all clinical specialists working within the SBD service and to date has reviewed key areas specific to surgery, histopathology and diagnostic imaging.

The Clinical Director and SBD Lead Clinician confirmed their plan to report the SBD clinical audit activities through the yet to be appointed Clinical Lead for clinical audit. In the interim, which the Authority confirmed, the Lead Clinician reports the clinical audit findings to the Clinical Director.

The Authority found that the service had some SBD-specific clinical audit systems in place. However, these were in an early stage of development and require further development and integration within the corporate governance structures. **(see CE1)**

Clinical Effectiveness: Conclusion

The Authority found that, for the 13-week sample period from 1 April 2009 to 30 June 2009, a total of 42 patients newly diagnosed with primary breast cancer were seen at the SBD service at WRH.

Clinical Audit specific to SBD services was in an early stage of development.

The Authority concluded that for the 13-week sample period from 1 April 2009 to 30 June 2009, the SBD service at WRH had most of the necessary arrangements in place to

demonstrate clinical effectiveness. The Authority has made recommendations in the remaining areas that need to be addressed.

Clinical Effectiveness: Recommendations

CE1. The service should incorporate specific symptomatic breast disease clinical audit activities within the clinical governance structure to systematically and critically analyse the quality of care provided.

5 Conclusion

5.1 Overview

The purpose of this Review was to assess whether the eight designated centres were meeting the National Quality Assurance Standards. This journey began in autumn 2007 when the Authority announced the commencement of the National Quality Review Programme to assure members of the public by the end of 2009 as to whether hospitals providing symptomatic breast disease services were meeting the Standards and thereby have the systems, processes and controls to deliver and maintain the added value and standards expected in a national designated centre.

There is evidence that the overall Quality Review Programme – together with the Standards – has been a focus for change and improvement in the quality and safety of symptomatic breast disease services. The Quality Review Programme provided guidance to the centres in their journey towards endeavouring to meet the Standards at a time of significant service change as the NCCP implemented the plan to move to eight designated centres, requiring a phased process to reflect the evolving nature of the service.

The early phases of the Quality Review Programme provided the eight centres with a focus for planning and prioritising actions needed as they continued to strengthen their arrangements for the SBD service and as they progressed towards meeting these Standards by the end of 2009.

In April 2008, WRH undertook a self-assessment exercise against the Standards and had a resulting score for all elements in a range between 29.3% and 94.9% compliance. WRH had completed the self-assessment questionnaire using snap-shot audits and professional judgment.

In autumn 2008, the Authority found that WRH did not have appropriate IT systems or personnel in position to facilitate continuous routine monitoring of performance against the standards and did not provide evidence to demonstrate that the appropriate arrangements were in place to assure itself that it was meeting the Standards.

In January 2009, during Phase 3 of the Quality Review Programme, the Authority issued a number of broad recommendations in relation to the implementation of effective governance arrangements to oversee the safe transition to a designated centre. These included the nomination of a lead clinician, developing and monitoring a prioritised implementation plan, and formalising a reporting mechanism to the National Cancer Control Programme.

At this stage of the National Quality Review Programme, the SBD service at Waterford Regional Hospital should be meeting the Standards. The Quality Review, focused on

seven identified themes derived from the Standards and work previously conducted by the Authority around symptomatic breast disease and patient experiences. In doing so, it was essential that the Quality Review assessed and reflected patients' perception and actual experiences of the services provided and utilised pertinent information and data to assess the service.

This report and resulting conclusion details the performance of the symptomatic breast disease service at WRH. These key conclusions are as follows:

5.2 Findings

5.2.1 Governance

The SBD service at WRH had recently re-aligned its governance structure. This, in tandem with the development of the role of the Lead Clinician, requires a period of adjustment before a conclusion can be reached in relation to the effective integration and efficacy of these structures.

The SBD service must ensure the continuing sustainability of symptomatic breast disease services in order to effectively and efficiently manage the needs of its patients.

Full-time locum radiologist holiday arrangements should be finalised while the permanent appointment of a consultant radiologist and consultant breast surgeon was ongoing.

The Authority concluded that the corporate governance and clinical reporting arrangements would require a period of adjustment, with ongoing evaluation to ensure the sustainability, before a judgment on their effectiveness could be made and will need to be re-assessed by the Authority.

The Authority concluded that the integrated governance arrangements for SBD service at WRH will need to be re-assessed by the Authority.

5.2.2 Multidisciplinary Approach

The service was actively committed to delivering triple assessment through a multidisciplinary approach and had the necessary operational policies and evaluation processes to ensure that the multidisciplinary team is involved in all clinical decision making and treatment planning. Wherever possible, patients were central to this process and encouraged to participate in decisions about their treatment options and care.

Overall, the Authority concluded that the SBD service at WRH had the necessary multidisciplinary arrangements in place for the delivery of safe care. However, there

were no clear locum arrangements in place for consultant radiologist cover. The Authority has made recommendations in relation to this that need to be addressed.

5.2.3 Skills, Education and Training

The Authority found the centre had a number of arrangements in place to ensure the core team had the necessary training and clinical expertise, and undertake continuous professional education and development on a regular basis. All consultant staff are expected and contractually bound to be academically involved by participating in teaching, training, research and ensuring evidenced-based clinical practices

The specialist breast care nurses were registered on the national clinical nurse specialists register. In-service staff training and educational attendance records were maintained and monitored by the service.

Overall, the Authority found the SBD service had a number of arrangements in place to ensure that the core team had the necessary training and clinical expertise. However, the service should ensure that a formal policy is developed to support and monitor continuous professional development.

5.2.4 Person-centred Care

WRH had the essential facilities for delivering person-centred care. The symptomatic breast disease service has written information about breast disease, cancer and local support groups.

Patients reported satisfaction with the level of information available to allow them to consider options for treatment.

The Authority concluded that the SBD service at WRH had the necessary arrangements and facilities in place to deliver person-centred care.

5.2.5 Data Management

At the time of the Review, the SBD service was developing the Patient Analysis and Tracking System (PATS) which facilitates data collection at all critical points in the patient pathway. This was happening in conjunction with the SBD service at Cork University Hospital and the Mid-Western Regional Hospital Limerick. The team reported the first phase of the system was introduced in September 2009 and that system configuration was underway.

The Authority concluded that the SBD service at WRH had most of the appropriate data management arrangements in place.

However, at the time of the Review the Patient Analysis and Tracking Systems were not live, data validation processes were not in place and audit processes were underdeveloped. This will require re-assessment by the Authority.

The Authority has made recommendations in the remaining areas that need to be addressed.

5.2.6 Access

In early 2009, the SBD service at WRH was challenged to meet the access timelines for urgent and non-urgent patients referred to the service and were actively looking to address the historic waiting list.

WRH indicated that this waiting list pertained to the large number of patients being referred, the inadequate number of available consultant breast surgeons and radiology sessions and non-consultant hospital doctors (NCHDs) available to the SBD service. Since July 2009, the SBD service had been assigned a full-time register and senior house officer (SHO) and the consultant radiologist post has been advertised.

In tandem, the SBD service had facilitated additional clinics and revised its triage process. At the time of the Review, the service was compliant with all access timelines for urgent and early appointments. However, there remained an access delay for patients referred as routine and who needed to be seen within 12 weeks of referral.

Overall, the Authority concluded that the SBD service at WRH had most of the necessary arrangements in place to ensure timely access to care for urgent and early referrals. However, it was not able to ensure timely access to care for patients requiring to be seen within 12 weeks. This will need to be re-assessed by the Authority.

5.2.7 Clinical effectiveness

The Authority found that, for the 13-week sample period from 1 April 2009 to 30 June 2009, a total of 42 patients newly diagnosed with primary breast cancer were seen at the SBD service at WRH.

Clinical Audit specific to SBD services was in an early stage of development.

The Authority concluded that for the 13-week sample period from 1 April 2009 to 30 June 2009, the SBD service at WRH had most of the necessary arrangements in place to demonstrate clinical effectiveness. The Authority has made recommendations in the remaining areas that need to be addressed.

Overall Conclusion

Based on the evidence of this Quality Review, the Authority concluded that Waterford Regional Hospital had in place some of the core requirements for quality and safety as set out in the Standards; including lead clinician, triple assessment, MDT approach, audit of key aspects of the patient journey and patient information. However, some of the essential requirements relating to governance, data management and patient access were in an early phase of development. There remained opportunities for improvement and where the Authority indicated has made recommendations.

The recently restructured clinical and corporate governance arrangements require a period of adjustment, with ongoing evaluation and support to ensure sustainability, before a judgment on their effectiveness can be made, and this will need to be re-assessed by the Authority.

Waterford Regional Hospital should develop, publish and implement an action plan against the recommendations.

The Authority would like to acknowledge the cooperation of managers and clinicians in the designated centres and the National Cancer Control Programme in the conduct of this Quality Review. The SBD service at Waterford Regional Hospital deserves recognition for the changes implemented and the improvements made to date. The Authority would also like to thank the service-user representative from Europa Donna Ireland and the many patients who gave up their time to share their stories and experiences with us for the benefit of current and future patients.

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7 Glossary of useful terms and abbreviations

AMNCH: Adelaide and Meath Hospital, Incorporating the National Children's Hospital, Dublin

Axillary: pertaining to the armpit area, including the lymphnodes that are located there

BreastCheck: BreastCheck is a government-funded programme providing breast screening, and invites women aged 50 to 64 for a free mammogram on an area-by-area basis every two years (see NBSPP)

Carcinoma: cancer of the cells covering the internal or external surfaces of the body

Chemotherapy: the treatment of disease, usually cancer, using chemical substances (drugs), the aim of which is to destroy cancer cells

Clinical audit: the systematic, critical analysis of the quality of care, including procedures used for diagnosis and treatment, use of resources and resulting outcome and quality of life for the patient

Clinical directorates: discrete service units in which all the service, workforce planning, budgeting and overall management arrangements are held by one team under the direction of the clinical director

Clinical examination coding: relates to triple assessment scores for clinical examination, radiological result and histopathology result

Clinical practice guidelines: clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances

Clinically occult lesion: A lesion or area of abnormal tissue which cannot be located under clinical examination.

CNS: clinical nurse specialist. The nurse specialist as a nurse who is prepared beyond the level of a nurse generalist and authorised to practice as a specialist in a branch of the nursing field

Computerised tomography (CT): the practice of taking images of the body in a number of selected planes using radiography, and thereby building a three-dimensional image of an area

Consultant: a consultant is a registered medical practitioner in hospital practice who, by reason of his / her training, skill and experience in a designated specialty, is consulted by other registered medical practitioners and undertakes full clinical responsibility for patients in his / her care, or that aspect of care on which he / she has been consulted, without supervision in professional matters by any other person. Consultants include surgeons, physicians, anaesthetists, pathologists, radiologists, oncologists and others

CPD: continuing professional development

CT: computerised tomography

DCIS: ductal carcinoma in situ

Ductal carcinoma in situ (DCIS): a non-invasive condition in which abnormal cells are found in the lining of a breast duct. The abnormal cells have not spread outside the duct to other tissues in the breast

False negative case: a case that turns out (within a period of two years) to be carcinoma despite a negative cytology or core result (this will by necessity include some patients in whom an area different from the lesion was sampled but who present with an interval cancer)

False positive case: a case that was given the clinical examination cytology or biopsy code of C5 or B5 and which turns out at open surgery to be a benign lesion

Fine needle aspiration (FNA): use of a needle attached to a syringe to withdraw cells from a tumour

FISH: fluorescent in situ hybridisation

Fluorescent in situ hybridisation (FISH): fluorescence in situ hybridisation (FISH) is a test that “maps” the genetic material in a person’s cells. This test can be used to visualize specific genes or portions of genes. FISH testing is done on breast cancer tissue removed during biopsy to determine whether the cells have extra copies of the HER2 gene. The more copies of the HER2 gene that are present, the more HER2 receptors the cells have. These HER2 receptors receive signals that stimulate the growth of breast cancer cells

Governance structure: The governance arrangements that clearly describe responsibilities, delegated levels of authority, reporting relationships and **accountability within an organisation**

GP: general practitioner

HER2: human epidermal growth factor receptor 2 is a protein involved in normal cell growth. It is found on some types of cancer cells, including breast and ovarian. Cancer cells removed from the body may be tested for the presence of human epidermal growth factor receptor 2 to help decide the best type of treatment

Histopathology: the study of diseased cells and tissues using a microscope

Hormone receptor status: the level of certain proteins, called hormone receptors, in cancer tissue. Hormones can attach to these proteins. A high level of hormone receptors may mean that hormones help the cancer grow

HSE: Health Service Executive

Invasive breast cancer: cancer that has spread from where it started in the breast into surrounding, healthy tissue. Most invasive breast cancers start in the ducts (tubes

that carry milk from the lobules to the nipple). Invasive breast cancer can spread to other parts of the body through the blood and lymph systems

IT: information technology

KPI: key performance indicator

Lymph nodes: lymph nodes are found throughout the body, and act as filters or traps for foreign particles and are important in the proper functioning of the immune system. They become inflamed or enlarged in various conditions, which may range from trivial, such as a throat infection, to life-threatening such as cancers

Lymphoedema: a condition in which extra lymph fluid builds up in tissues and causes swelling. It may occur in the arm if lymph vessels are blocked, damaged, or removed by surgery

Magnetic resonance imaging (MRI): a technology that uses radio waves and a powerful magnet linked to a computer to create detailed images of areas inside the body. These images can show the difference between normal and diseased tissue

Mammography: the use of film or a computer to create an X-ray image of the breast

Medical oncology: The specialty of medical oncology is dedicated exclusively to the study of cancer and how it is best treated, particularly with systemic therapy

Morbidity: a diseased condition or state. The incidence of a particular disease or group of diseases in a given population during a specified time period.

MRI: magnetic resonance imaging

Multidisciplinary team (MDT): a term used to describe a treatment planning approach or team that includes a number of doctors and other health care professionals who are experts in different specialties (disciplines)

Multidisciplinary team meetings: meetings where the multidisciplinary team discuss the results / care / treatment plan of the patient

NBSP: National Breast Screening Programme (see Breastcheck)

NCCP: National Cancer Control Programme

Network Manager: within the HSE structure, the network managers are responsible for a group of hospitals within a network

Non-urgent: the non-urgent triage category includes patients that have presented to the referring GP with signs and symptoms of breast disease and these patients should be seen at the centre within 12 weeks

NQAS: National Quality Assurance Standards for Symptomatic Breast Disease Services

Oestrogen receptor status: the presence or absence of oestrogen receptors (proteins to which oestrogen will bind) in cancer cells. If the cells have oestrogen receptors, they may need oestrogen to grow, and this may affect how the cancer is treated

PACS: Picture Archive and Communication System

PAS: Patient Administration System

PATS: Patient Analysis and Tracking System

Prosthesis: a breast prosthesis is a breast form worn either inside a bra or attached to the body

Protocol: a detailed plan of a medical treatment or procedure

Radial margin status: the margin status is described as negative or clean when the pathologist finds no cancer cells at the edge of the tissue having been removed in cancer surgery, suggesting that all of the cancer has been removed. The margin status is described as positive or involved when the pathologist finds cancer cells at the edge of the tissue having been removed in cancer surgery, suggesting that all of the cancer has not been removed

Radiation oncology (or radiotherapy): Cancer treatment that uses high-energy electromagnetic radiation such as X-rays to kill cancer cells. During radiotherapy, a significant amount of healthy normal tissue is sometimes irradiated. To reduce the side effects caused by this, the radiation dose is often split into a number of treatments, enabling the normal healthy tissue to recover before the next treatment is given

Radiological abnormality: an abnormality detected by radiation (such as X-rays) or other imaging technologies (such as ultrasound, mammography and magnetic resonance imaging) used to diagnose or treat disease

SBCN: specialist breast care nurse

SBD: symptomatic breast disease

Sentinel node biopsy: removal and examination of one or a few lymph nodes to which cancer cells are likely to spread from a primary tumour. Used to predict nodal stage of disease

SLA: service level agreement

Sonographic abnormality: an abnormality detected by ultrasound

SOP: standard operating procedure

Specialist centre: where disease specific care is delivered by specialist consultants and other specialist healthcare professionals

Stereotactic biopsy: a biopsy procedure that uses a computer and a 3-dimensional scanning device to find a tumour site and guide the removal of tissue for examination under a microscope

Symptomatic: individuals who have one or more symptoms (e.g. breast lump) that may be due to a disease (e.g. breast cancer)

TNM: tumour nodes metastasis

Triage category: category to which medical treatment is prioritised based on urgency (i.e. urgent, non-urgent)

Triage process: the process of assigning priorities of medical treatment based on urgency

Triple assessment clinic (TAC): a clinic at which clinical examination, imaging and pathology tests are carried out in the diagnosis of breast disease

Ultrasound: a procedure in which high-energy sound waves are bounced off internal tissues or organs and make echoes. The echo patterns are shown on the screen of an ultrasound machine, forming a picture of body tissues called a sonogram

Urgent: the urgent triage category includes patients that have presented to the referring general practitioner (GP) with signs and symptoms of breast disease and these patients should be seen at the centre within two weeks

Appendices

Appendix 1

Recommendations made by the Authority to centres in January 2009, following validation review.

In order to continue to support the transition from designated specialist centres to national specialist centres, the Authority therefore strongly recommends that each designated centre should:

1. Establish clear governance structures for overseeing the transition from a designated centre to a specialist centre. This should include the nomination of a senior manager / clinician to lead, be supported by, and accountable to the board / senior management team of the hospital in relation to progress towards this goal and the implementation plan as specified in recommendation 2 below. The structures should also take into account establishing formal linkages with all neighbouring hospitals that will be transferring the care for patients with symptomatic breast disease to designated centres, where applicable, and also a reporting mechanism into the National Cancer Control Programme.
2. Review the interim report^{*} and develop a prioritised implementation plan to address the gaps in the outstanding requirements – this plan should be signed off by the National Cancer Control Programme.
3. Work with other designated centres, under the coordination of the National Cancer Control Programme, to agree and address areas in need of standardisation. For example, referral mechanisms, diagnostic reporting conventions and core patient pathways to ensure consistency in approach across the country.
4. Ensure that the main risks associated with the transition to becoming a specialist centre are identified and measures put in place to manage and mitigate against them (Section 13 of the self-assessment tool provided the important questions that centres should be addressing).

** Following the validation process, the Authority provided each centre with a tailored interim report. As this was feedback reported at an interim stage of an ongoing Quality Review Programme, the Authority did not publish the reports. The interim reports took the form of a commentary on the quality of evidence used by the centres to complete the validation assessment questionnaire. This included recommended steps for the future.*

Appendix 2

Methodology - National Quality Review Programme – Phase 4

1.1 Phase 4. Quality review visit, October / November 2009

Phase 4 of the Quality Review involved an in-depth review of the performance of the designated centres in order to assess their performance against the Standards. For the purposes of assessment, all 285 Standards were categorised into a format that facilitated the Quality Review.

The development of the assessment methodology for Phase 4 of the Quality Review Programme, covered in this report, involved two main stages:

- *categorisation of the Standards*
- *assessment process.*

1.1.1 Categorisation of the Standards

The National Quality Assurance Standards (the Standards), which were mandated in 2007, are structured according to the patient pathway from referral, through diagnosis, treatment and aftercare. This lends them to be easily used in the day-to-day management of the service. However, due to the multidisciplinary nature of the service, there is some crossover and repetition of Standards between the specialties of care that does not facilitate a straightforward assessment against the Standards. Consequently, for the purposes of assessment for Phase 4 of the Quality Review, all 285 Standards were categorised into a format that facilitated the Quality Review with a particular focus on the patient journey.

A number of key representative Standards were identified during the categorisation phase (see Appendix 3).

These included:

- those Standards that relate to key events of the patient experience from referral to treatment and beyond
- the fundamental patient quality and safety requirements
- clinical practice guidelines
- the essential requirements of the service.

These key representative Standards were subsequently categorised into a format that facilitated the Quality Review using seven generic themes as follows:

- Governance
- Multidisciplinary Approach
- Skills, Education and Training
- Person-centred Care
- Data Management
- Access
- Clinical Effectiveness.

Recognising that centres may be at different stages of development towards implementing the full range of Standards, the Authority identified the really important factors in each theme that must be in place for quality and safety. These ***essential elements*** that each designated centre must have in place as the foundation for safe, high quality symptomatic breast disease care are set out in **Figure 2** in the main report.

All the essential elements are based on the Standards with the exception of the *Governance* essential element, which is derived from the Authority's recommendations from previous investigations in relation to SBD services.

It is important to note that the Standards, as they were adopted by the Board of the Authority and mandated by the Minister for Health and Children, will remain in place and will continue to be used for monitoring the performance of designated centres until such a time that the Standards are revised.

The Authority used multiple sources of evidence to inform its assessment of the symptomatic breast disease (SBD) service at each designated centre. In drawing conclusions about the governance arrangements at the centre, the assessment was also guided by the recommendations from work previously conducted by the Authority in relation to symptomatic breast disease care.

1.1.2 Assessment Process

The themes of Governance; Multidisciplinary Approach; Skills, Education and Training; Person-centred Care; Data Management; Access and Clinical Effectiveness provided the foundation upon which the assessment process for Phase 4 of the Quality Review was designed and developed. A number of instruments and processes were identified to generate pertinent, consistent and reliable information. The assessment process can be broken down into three main stages.

1.1.3 Stage 1, Pre-visit

(i) Pre-visit documentation request (17 August 2009)

The Authority requested documentation (see Appendix 4) from the designated centre in advance of the on-site assessment visit in order to assess the documentary evidence of

the local arrangements. This documentation was submitted to the Authority within three weeks of the Authority's request.

(ii) Pre-visit data request (31 August 2009)

The Standards set out the elements for the provision of safe, high quality symptomatic breast disease care and define how the quality of service provided in such centres can be measured. The Standards include clinical practice guidelines, standards and quality objectives with outcome measures that are required by centres to assure themselves and the public that they are providing safe high quality care. In July 2009, the NCCP identified, from the Authority's Standards, a number of key performance indicators (KPIs). The NCCP requires each designated centre to report on their performance against these KPIs to the NCCP on a monthly basis.

The Authority requested the designated centres to submit data specific to the Standards selected by the Authority and some of the related NCCP KPIs in advance of the on-site assessment (see Appendix 5).

The data request related to two separate data samples: activity data, and access and clinical effectiveness data.

Activity data: seven-month sample period

- The first part of the data request related to activity data for new patients seen at the SBD service for the seven-month sample time period of 1 January 2009 to 1 August 2009. (Due to a refurbishment programme, the Mater Misericordiae University Hospital provided data for the period 1 June 2009 to 1 November 2009.)

This data informed the preliminary overview of the activity of the service.

Access and clinical effectiveness data: 13-week sample period

The second part of the data request related to access and clinical effectiveness data for a selected sample group of patients who had been newly diagnosed with primary breast cancer and seen at the service during the 13-consecutive-week sample period from 1 April 2009 to 30 June 2009. (Due to a refurbishment programme, the Mater Misericordiae University Hospital provided data for the period 1 June 2009 to 30 August 2009.) This sample time period was selected in order to review up-to-date performance data which was as close as possible to the time of the on-site assessment visit. The data requested related to specific access and clinical effectiveness Standards in the patient treatment pathway from first referral through to the first therapeutic operation.

The centres were also requested to submit documentation relating to their data management process, which included the centres' data set, data dictionary or data definition document and their standard operating procedure for validating data.

(iii) Review of pre-visit documentation received (September 2009)

In order to assess evidence of compliance, the Authority reviewed the documentation submitted by each centre against the Standards under the themes of Governance; Multidisciplinary Approach; Skills, Education and Training; Person-centred Care; Data Management; Access and Clinical Effectiveness.

(iv) Review of pre-visit data received (September/October 2009)

In order to assess evidence of compliance with the Standards, the submitted data was reviewed by the Authority. The Authority also reviewed the submitted documentation relating to the centres' data management processes in order to assess the services' capacity to collect required data for reporting against the Standards. The findings of this part of the process are described in Chapter 4 of the main report, Findings.

The Authority notified the centres of the date of the on-site assessment visit at least one month in advance of the visit. The centre also received a description of the format of the assessment process along with a programme for the on-site visit.

1.1.4 Stage 2, the on-site visit

The Authority met and engaged with key staff members of the symptomatic breast disease team and a number of service users at each designated centre. The on-site visit took place over the course of two days during October and November 2009. The main elements of the on-site visit were as follows.

(i) On-site documentation review

Where further documentation was required in addition to documentation received before the on-site assessment, it was reviewed by the Authority on site in order to assess evidence of compliance with the Standards.

(ii) On-site validation of data

The Authority carried out a data validation process on site. As part of this validation:

- the Authority cross-checked this data against the patient healthcare record for 25% of the sample group
- patient healthcare records were selected proportionately by diagnosis (invasive breast cancer / ductal carcinoma in situ) and by surgical (wide local excision / mastectomy) and non-surgical treatment to ensure a cross section of patients referrals were validated
- patient healthcare records were randomly selected within these categories
- a coded number was assigned to each patient healthcare record reviewed to ensure patient confidentiality.

The purpose of the validation of 25% of the patient healthcare records was to assure the accuracy and reliability of the data submitted by the centre in relation to the access and clinical effectiveness data for the selected sample group of patients newly diagnosed with primary breast cancer and seen at the centre during the 13-consecutive-week period.

(iii) Data system demonstration

As part of the on-site data validation, in order to demonstrate the centre's capacity to collect pertinent data pertaining to the patients care pathway, each centre demonstrated its data management information system to the Authority.

(iv) Observation in clinical areas

In order to obtain information about the centre's environment and physical facilities, the Authority visited a number of the centre's facilities. This included structural and equipment observation of both inpatient and outpatient diagnostic and therapeutic facilities.

(v) Interviews

The Authority interviewed relevant staff using a standardised set of questions based on the themes identified in the Standards. This afforded the opportunity for the centres to provide further information and the Authority to gain clarification on any issues that would inform the Authority's findings.

Interviewees at each centre included:

- chief executive officer / general manager
- lead clinician
- data manager
- specialist breast care nurse
- multidisciplinary team
- NCCP cancer network manager

- hospital network manager where relevant.

At each centre, an interview was carried out with the local representative of the NCCP in order to explore the relationship between the centre and the NCCP. This interview contributed to part of the national report.

(vi) Discussion group with patients

In order to explore the provision of patient-centred care from a patient's perspective, each designated centre was asked by the Authority to select six service users with a diagnosis of breast cancer for participation in an Authority-led discussion group. To take account of the realities of the patient experience, the Authority included, as part of the Quality Review team, a service-user representative who led discussion groups with a selection of patients.

1.1.5 Stage 3, following the on-site visit

The Authority's findings for phase 4 of the Quality Review have been published in two separate formats:

- an individual public report for each centre
- a national report outlining the key findings for the eight designated centres.

A draft report of each centres' assessment findings was issued to that centre for factual accuracy. The centres were invited to respond in writing to the Authority within five working days to make any comments on the draft report. Every comment received was carefully considered by the Authority prior to finalising the report.

1.2 Quality assurance

To maximise the consistency and reliability of the assessment process for Phase 4 of the Quality Review, the Authority put a series of quality assurance processes in place. These included:

- a single communication approach with all eight designated centres
- internal peer review at various stages during the development of the assessment methodology
- consistency in the design and development of the assessment methodology
- consistency in having a single team of assessors attending all eight designated centres as part of the Quality Review
- a standardised interview format
- the standardised collection and recording of information using an electronic assessment tool

- ensuring that there are clear links between judgments reached and the evidence on which they are based
- each assessment report being quality reviewed by Authority personnel, external to the Quality Review assessment team
- each centre being invited to review each individual draft report for the purpose of factual accuracy
- acceptance and sign off of the local and national reports by the Chief Executive and Board of the Authority

Appendix 3

Key Representative Standards

NQAS

reference NQAS

Theme: Governance (Total 7)

- 1.1 Specialist breast centres shall provide care / services to a population size of approximately 300,000–350,000. They shall have facilities to provide care / service to more than 150 newly diagnosed patients with primary breast cancer per year. All specialist breast centres shall be separate entities, rather than part of a general surgical clinic, and shall have facilities for at least one triple-assessment clinic per week.
- 1.13 All personnel involved in specialist breast centres shall have allocated, dedicated time for satisfactory conduct of work.
- 4.4 The patient shall relate to a specific clinician at each stage of treatment, e.g. the consultant surgeon in the early stages of the disease, the consultant medical oncologist during the phase of adjuvant treatment, the consultant radiation oncologist and, where appropriate, the palliative care physician. These arrangements shall be explicit and understood by the patient.
- 13.1 The *Report on the Development of Services for Symptomatic Breast Disease* (2000) and, more recently, the National Cancer Forum (2006) have recommended that a certain number of specialist breast centres be developed in Ireland and supported by staffing and physical structure to allow each centre to operate to a high standard of care delivered with skill, compassion and efficiency to all patients with breast complaints.
- 13.2 The requirements for each centre have been set out and justified in previous documents and supported by publications from the international scientific and medical literature. Justification for specialised centres derives from the convincing evidence of improved outcomes, both in survival and quality of life, for patients treated by specialists in the context of a multidisciplinary team approach to care.

- 13.3** The nomination and designation of centres should be announced without further delay and resources allocated immediately to support each centre. Public support for and confidence in these centres can come only when they are active and measure up to the standards defined in this document.
- 13.6** It should be expected that detailed documentation of activity be recorded in each centre so that administrative and clinical audit can be undertaken. An identical and comprehensive data set of information should be in place in each centre so that the activity centres can be compared with each other regularly, probably once a year.

Theme: Multidisciplinary Approach (Total 14)

- 1.2** The specialist breast centres shall hold at least one triple assessment clinic per week for newly referred patients with suspected breast disease.
- 1.3** A functioning multidisciplinary team must be available at the breast centre. The core personnel required for this team are:
- consultant breast surgeon and team
 - consultant histopathologist
 - consultant radiologist and radiographer
 - clinical nurse specialist breast care
 - consultant radiation oncologists
 - consultant medical oncologists
 - consultant plastic and reconstructive surgeons
 - clinic staff
 - administrative staff.
- 3.20** Following triple assessment, and when the diagnosis is of breast cancer, the patient shall be given an appointment for a return visit within two weeks so that the definitive diagnosis can be given.
- 3.27** Diagnostic procedures for breast disease requires triple assessment:
1. Clinical examination.
 2. Imaging by mammography and / or ultrasound.
 3. Pathology sampling.

- 4.1** A multidisciplinary breast team meeting shall be held at least weekly to discuss every patient who has had a core biopsy or FNA and to plan subsequent treatment for the patient.
- 4.2** A session must be allowed for attendance by representatives from all specialties at weekly team case management and audit meetings.
- 4.3** Information necessary for effective team functioning and clinical decision-making shall be available at each meeting, including a list of patients to be discussed, imaging and pathology and copies of relevant clinical and diagnostic information and reports.
- 4.6** Team members shall be prepared for the multidisciplinary team meeting. Preparation for and attendance at meetings shall be recognised as clinical commitments and time shall be allocated accordingly.
- 4.7** Patients discussed at the multidisciplinary team meeting shall include: (1) all new patients who have clinical or radiological / sonographic abnormalities, (2) all patients who have had triple assessment, (3) all patients following the first therapeutic operation, and (4) those for whom, at any time, discussion at the meeting is deemed appropriate.
- 4.8** Every patient undergoing core biopsy, surgical biopsy or fine needle aspiration (FNA) shall be discussed at the multidisciplinary meeting to ensure concordance of data.
- 4.9** A definitive diagnosis (cancer or a benign condition) shall be achieved within two weeks of an urgently referred patient's attendance at the specialist breast centre.
- 4.14** Local protocols shall be in place to ensure patient confidentiality during multidisciplinary meetings.
- 6.20** The consultant radiologist together with the consultant surgeon shall be centrally involved in the organisation of the diagnostic breast service. An immediate report shall be available to the consultant surgeon at the time of triple assessment.

14.2 Audit and other issues of relevance to data monitoring and management shall be discussed at the multidisciplinary team meetings.

Theme: Skills, Education and Training (Total 10)

3.11 All clinical members of the breast care multidisciplinary team shall be trained in communication and counselling skills and shall maintain such training on a continual basis.

5.1 Individual consultant surgeons shall treat a minimum of 50 and a maximum of 150 new patients with breast cancer per year and must attend at least one diagnostic clinic per week.

5.34 Sentinel node biopsy shall be carried out only by surgeons who have had formal training in the technique and who have audited their accuracy in at least 30 cases.

6.9 Radiographers shall attend regular update courses.

6.12 In order to maintain expertise, a radiographer involved in mammography shall perform a minimum of 20 mammographic studies a week.

7.2 Consultant histopathologists involved in the delivery of the symptomatic breast pathology service shall participate in a quality assurance programme.

9.7 All healthcare professionals administering chemotherapy shall attend a training course at least once every two years.

10.2 The special breast care nurse (SBCN) shall have undergone specific training and have officially recognised qualifications in oncology and breast care. The training in Ireland currently involves the acquisition of an officially approved higher diploma in oncology and breast care.

12.1 All specialists involved in the care of patients with breast disease shall have undergone specific training in a specialist breast centre.

12.2 All members of the team shall undertake regular continuing professional education.

Theme: Person-centred care (Total 14)

- 1.14** Each specialist breast centre shall have dedicated purpose-built physical facilities suitable for the care of patients with breast complaints.
- 1.15** The administrative and clinical examination areas and the diagnostic areas shall all be in close proximity, preferably in a single dedicated area.
- 1.18** Specific mandatory requirements include inpatient beds and dedicated operating time.
- 1.19** Each specialist breast centre shall be equipped with basic mammography and stereotactic mammography equipment, together with the required processing equipment and ultrasound machine.
- 2.7** At key points in the patient's clinical pathway, there shall be coordination and integration of services with the general practitioner (GP) and the specialist breast centre.
- key information shall be provided to GPs in relation to the services provided by the breast centre
 - information and communication pertinent to the patient shall be provided to the GP in a timely manner.
- 3.1** The patient shall be offered clear, objective, full and prompt information in verbal, written and other appropriate formats. Special and minority needs shall be catered for.
- 3.2** Information provided in leaflets and other formats, both oral and written, shall be in clear and comprehensible language. Patient groups should be involved in their compilation and design.
- 3.5** Patients' preferences regarding who should accompany them at the time when their diagnosis and treatment are being discussed should be taken into account.
- 3.9** The patients' records shall include a checklist to show what information has been provided.

- 3.10** Patients shall be asked to provide feedback on their experience of the treatment, including all side effects, facilities and services. This feedback will be recorded.
- 3.19** Before attending, the patient shall receive information regarding procedures that may be undertaken at the specialist breast centre and the length of time they are likely to take.
- 3.21** A patient who is receiving a diagnosis of cancer shall have a clinical nurse specialist present at the time of consultation about the diagnosis.

The specialist breast care nurse shall:

- be present to discuss the implications of treatment and provide advice and emotional support throughout the assessment process, and
 - continue to provide information and support for the patient during the cancer continuum from diagnosis through to follow up.
- 11.2** Every patient shall have access to a Reach to Recovery or similar volunteer following breast cancer surgery.
 - 11.5** Patients shall have access to a named person in the specialist breast centre with whom they can communicate at any time, usually the specialist breast care nurse.

Theme: Data Management (Total 3)

- 14.3** There shall be agreed standardised data forms and definitions used to collect data in each unit. An IT system shall be in place to facilitate data collection.
- 14.6** A dataset definitions document will be required to outline clearly how each data field should be completed. This will ensure that no data field is open to interpretation and will speed up the data collection at each centre.
- 14.9** A minimum of 10% of the data should be validated and all data fields should be assigned a critical or a non-critical status. Guidelines listing the corrective actions to be taken will be required in cases where errors are found.

Theme: Access (Total 8)

- 2.8** An urgent triaged patient referred by the GP is offered an appointment to attend the specialist breast centre within two weeks of receipt of the referral.
- 2.1.3** Routine Referrals – to be seen within 12 weeks.
- Routine referral relates to a patient whom the referring doctor considers to require an opinion or investigation at the specialist breast centre but where there is no clinical concern about breast cancer. These patients shall be seen within 12 weeks.
- 2.9** There shall be monitoring of breast centre capacity and demand to ensure an appropriate balance between urgent and non-urgent referrals. Following triage, the GP shall be informed of the waiting time.
- 6.14** An urgently referred patient has all imaging done in the first visit.
- 4.9** Definitive diagnosis of cancer is achieved within two weeks of an urgently referred patient's attendance at the specialist breast centre
- 4.11** A patient shall be offered admission for the first therapeutic operation within three weeks of definitive diagnosis.
- 11.8** Patient follow-up after primary therapy for early breast cancer shall be coordinated by one medical consultant skilled in the surveillance of cancer patients and breast examination. Rapid access to another member of the multidisciplinary team shall be facilitated as specific issues arise. A surgical oncologist is the most appropriate coordinating doctor for those patients who have been treated with surgery alone. For those patients who have received adjuvant chemotherapy, the coordinating physician should be a medical oncologist.
- 11.16** There shall be an open access policy to enable GPs or other healthcare professionals to refer patients back to the breast care team without delay if they suspect recurrent cancer or problems related to treatment for breast cancer.
- 14.1** Data regarding the patient's waiting times between referral and first appointment, between first appointment and receipt of diagnosis, and between diagnosis and surgery, shall be collected.

Theme: Clinical Effectiveness (Total 11)

- 6.16** A non-operative diagnosis is achieved in benign and malignant disease.
- 5.32** For patients with sonographically normal lymph nodes and where the FNA or core biopsy does not demonstrate metastases, sentinel lymph node biopsy is recommended.
- 5.10** Patients with clinically occult lesions, or where there are doubts about the location of the tumour, shall have pre-operative localisation guided by ultrasound or by stereotactic mammography equipment / X-ray.
- 6.21** Patients with a diagnosis of invasive breast cancer shall have an ultrasound assessment of their axilla. Ultrasound of the axilla plays a central role in determining patients' suitability for sentinel node biopsy.
- 6.1** Pre-operative mammography with ultrasound examination is carried out on patients with primary operable breast cancer.
- 7.13 A** To provide important and relevant data on patients with invasive breast carcinoma:
- Histological tumour type is recorded
 - Histological tumour grade is recorded
 - Invasive tumour size is recorded
 - The presence or absence of vascular invasion is recorded
 - Posterior (deep) margin status is recorded
 - Lymph node status is recorded
- 7.13 B** Oestrogen receptor status is available.
- 7.13 C** *HER2* status shall be assessed using immunohistochemistry. Borderline positive cases shall be assessed using fluorescent in situ hybridisation (FISH).
- 7.14** To provide appropriate data in patients with ductal carcinoma in situ (DCIS)
- DCIS grade is recorded
 - Radial margin status in wide local excision specimens is recorded

- 8.4** The consultant radiation oncologist shall coordinate patient follow-up with surgery and medical oncology units.
- 9.11** Details of chemotherapy treatment shall be recorded by administering staff.

Appendix 4

Symptomatic Breast Disease Service Quality Review 2009

Documentation request prior to onsite quality review

Instructions for submitting documentation:

The Authority requests that:

1. All documentation is submitted in hard copy (copies of original documentation only)
2. Please indicate on each page as requested what documents you are submitting and the reasons why documents are not submitted.
3. All documents submitted should be referenced to the appropriate reference number on each page of this document.
4. All documentation, **including the completed documentation request checklist**, must be submitted **no later than 5pm on Wednesday 9th September 2009** to:

The Health Information and Quality Authority,
Healthcare Quality and Safety Directorate,
Head Office,
Mahon City Gate,
Mahon,
Cork

5. Any queries in relation to documentation to be submitted should be emailed to _____@hiqa.ie

Under Section 12 of the Health Act 2007, the Authority request that you submit the following information:		
1. Governance		
No.	Documentation Required	Please tick if document is attached or state reason if not attached
1.1	<u>Governance Structure</u> (Indicate operation linkages and reporting structures between both)	
	1.1.1 Organogram for the Governance structure of the hospital	
	1.1.2 Organogram for the Organisation structure of the Symptomatic Breast Disease Service	
1.2	Monitoring compliance with the National Quality Assurance Standards	
	1.2.1 Terms of reference for the committee responsible	
	1.2.2 Membership of the committee	
	1.2.3 Scheduling of meetings for this committee from 1st January 2009 to week commencing 17th August 2009	
	1.2.4 Minutes of all meetings from 1st January 2009 to week commencing 17th August 2009	
1.3	Clinical Leadership	
	1.3.1 Standard operating procedure / Policy for clinical leadership, indicating the most responsible person for the patient as they transfer through the pathway of care.	
1.4	Clinical Risk Management:	
	1.4.1 Risk Management policy	
	1.4.2 Clinical Incident Reporting policy	
	1.4.3 Number of clinical incidents / adverse events pertaining to SBD services reported between 1st January 2009 and week commencing 17th August 2009	
	1.4.4 Quality improvement initiatives implemented as an action following investigation of identified incidents	

1.5 Service Level Agreements		
	1.5.1 Service Level Agreements or equivalent document for services being provided by a third party at any stage of the patients care pathway (i.e. pathology or radiology or other service)	
1.6 Core Personnel		
	1.6.1 Complete the attached form (Appendix 1) detailing the full complement of core personnel to the symptomatic breast disease service	
1.7 Confidentiality		
	1.7.1 Standard operating procedure / policy for patient confidentiality	
2. Person Centred Care		
No.	Documentation Required	Please tick if document is attached or state reason if not attached
2.1 Patient Information		
	2.1.1 Standard operating procedure / policy for developing and providing patient information	
	2.1.2 List names / titles of all patient information leaflets provided by the Centre, indicating on the list whether the leaflet was produced by the Centre or sourced externally	
	2.1.3 Checklist template used to document information provided to the patient	
	2.1.4 Consent policy for patients	
2.2 Patient Satisfaction with the symptomatic breast disease service		
	2.2.1 Patient Satisfaction data specific to symptomatic breast disease services from 1st January 2009 to week commencing 17th August 2009	
	2.2.2 Complaints policy	

	2.2.3 Number of complaints received and subsequent action plans for the symptomatic breast disease service from 1st January 2009 to week commencing 17th August 2009	
2.3	General Practice	
	2.3.1 Information pack for General Practitioners (GP) (to include any information pertaining to communication with GP's, including schedule of any GP information sessions)	
3. Multidisciplinary Approach		
No.	Documentation Required	Please tick if document is attached or state reason if not attached
3.1	Multidisciplinary Meeting	
	3.1.1 Standard operating procedure / policy for Multidisciplinary Meetings	
	3.1.2 Scheduling of meetings from 1st January 2009 to week commencing 17th August 2009	
	3.1.3 List of multidisciplinary membership	
	3.1.4 Agenda for all meetings from 1st January 2009 to week commencing 17th August 2009	
	3.1.5 Template used for recording information following multidisciplinary discussion	
3.2	Triple Assessment Clinic	
	3.2.1 Standard operating procedure / policy for Triple Assessment Clinics	
	3.2.2 Scheduling for Triple Assessment Clinics from 1st January 2009 to week commencing 17th August 2009	
	3.2.3 Standing Operating Procedure / policy to demonstrate how patients are referred to the triple assessment clinic	

4. Skills, Education and Training		
No.	Documentation Required	Please tick if document is attached or state reason if not attached
4.1	Training and Competency	
	4.1.1 Policy for continuous professional development for the multidisciplinary team	
	4.1.2 Policy to monitor and maintain competencies as per the National Quality Assurance Standards for the multidisciplinary team	
5. Clinical Effectiveness		
No.	Documentation Required	Please tick if document is attached or state reason if not attached
5.1	Clinical Guidelines	
	5.1.1 Standard operating procedure / policy for developing clinical guidelines for the symptomatic breast disease service	
	5.1.2 List of clinical guidelines in use in the symptomatic breast disease service	
5.2	Clinical Audit	
	5.2.1 Standard operating procedure / terms of reference for the clinical audit committee for symptomatic breast disease	
	5.2.2 Scheduling of meetings for this committee from 1st January 2009 to week commencing 17th August 2009	
	5.2.3 Agendas from 1st January 2009 to week commencing 17th August 2009	
	5.2.4 Minutes and action sheets from 1st January 2009 to week commencing 17th August 2009	

Appendix 5

Data request prior to onsite quality review

Symptomatic Breast Disease Service Quality Review 2009

Data request prior to on-site quality review

Hospital Name: _____

Instructions for completing this data request form:

The Authority requests that the following data request form is completed and submitted in hardcopy.

5. For the purposes of this data request exercise only, please note descriptions of the following terms will be used in this document:
 - a. **Definitive diagnosis** – this is achieved following discussion and clinical decision being reached at the Multidisciplinary Team (MDT) meeting.
 - b. **Patient with newly diagnosed primary breast cancer** – this refers to patients with a primary cancer in either the left or right breast or both and excludes patients with re-occurrences.
 - c. **Patient with primary operable breast cancer** – patients that have been assessed as being suitable for surgery.
 - d. **Non-urgent referrals** – refers to patients triaged as early or routine by the Symptomatic Breast Disease (SBD) centre
6. This data request form must be submitted **no later Monday, 28 September 2009** to:

The Health Information and Quality Authority,
Healthcare Quality and Safety Directorate,
Head Office,
Mahon City Gate,
Mahon,
Cork

Under Section 12 of the Health Act 2007, the Authority requests that you submit the following information:

Section A				
ALL questions in Section A refer to data for				
a) the sample time period of <u>1 January 2009 – 1 August 2009</u>				
b) the Patient Sample group – new patients seen at the Symptomatic Breast Disease (SBD) Centre				
Question Reference	Question	Information Type	Please state numeric figure/percentage figure as requested	Please tick if providing supporting narrative and add narrative to DaR Appendix x
DaR.1	What is the total number of new patients seen at the SBD centre for this sample time period?	Numeric figure		
DaR.2	Of the total number of new patients seen at the SBD centre (see DaR.1), what is the total number of referrals received during the sample time period that were triaged as urgent by the SBD centre?	Numeric figure		
DaR.3	Of the total number of referrals received during the sample time period that were triaged as urgent by the SBD centre (see DaR.2), what is the total number and percentage of patients offered an appointment to be seen within 10 working days of the date of receipt of referral?	Numeric figure		
		Percentage figure to be submitted		
DaR.4	Of the total number of new patients seen at the SBD centre (see DaR.1), what is the total number of referrals received during the sample time period that were triaged as non-urgent by the SBD centre?	Numeric figure		

Section A – continued				
ALL questions in Section A refer to data for				
a) the sample time period of <u>1 January 2009 – 1 August 2009</u>				
b) the Patient Sample group – new patients seen at the Symptomatic Breast Disease (SBD) Centre				
Question Reference	Question	Information Type	Please state numeric figure/percentage figure as requested	Please tick if providing supporting narrative and add narrative to DaR Appendix x
DaR.5	Of the total number of referrals received during the sample time period that were triaged as non-urgent by the SBD centre (see DaR.4), what is the total number and percentage of patients seen within 6 weeks of the date of receipt of referral?	Numeric figure		
		Percentage figure to be submitted		
DaR.6	Of the total number of referrals received during the sample time period that were triaged as non-urgent by the SBD centre (see DaR.4), what is the total number and percentage of patients seen within 12 weeks of the date of receipt of referral?	Numeric figure		
		Percentage figure to be submitted		
DaR.7	Of the total number of new patients seen at the SBD centre for the sample time period (see DaR.1), what is the total number of newly diagnosed primary breast cancer patients?	Numeric figure		

Section B				
ALL questions in Section B refer to data for				
a) the sample time period of the 13 consecutive weeks from <u>1 April 2009 – 30 June 2009</u>				
b) the Patient Sample group – seen and newly diagnosed with primary breast cancer				
Question Reference	Question	Information Type	Please state numeric figure/percentage figure as requested	Please tick if providing supporting narrative and add narrative to DaR Appendix x
DaR.8	What is the total number of newly diagnosed primary breast cancer patients seen at the SBD centre during the sample time period of 1 April 2009 – 30 June 2009?	Numeric figure		
DaR.9	Of the total number of newly diagnosed primary breast cancer patients (see DaR.8), what is the total number and percentage of patients that were triaged as urgent by the SBD centre?	Numeric figure		
		Percentage figure to be submitted		
DaR.10	Of the total number of patients that were triaged as urgent (see DaR.9), what is the total number and percentage of patients offered an appointment to be seen within 10 working days of the date of receipt of referral?	Numeric figure		
		Percentage figure to be submitted		
DaR.11	Of the total number of patients that were triaged as urgent (see DaR.9) and clinically assessed as having S4 or S5 classification, what is the total number and percentage of patients that received imaging on the first visit?	Numeric figure		
		Percentage figure to be submitted		
DaR.12	Of the total number of patients that were triaged as urgent (see DaR.9), what is the total number and percentage of patients that had a definitive diagnosis achieved within 10 working days of being seen at the centre?	Numeric figure		
		Percentage figure to be submitted		

Section B – continued				
ALL questions in Section B refer to data for				
a) the sample time period of the 13 consecutive weeks from <u>1 April 2009 – 30 June 2009</u>				
b) the Patient Sample group – seen and newly diagnosed with primary breast cancer				
Question Reference	Question	Information Type	Please state numeric figure/percentage figure as requested	Please tick if providing supporting narrative and add narrative to DaR Appendix x
DaR.13	Of the total number of newly diagnosed primary breast cancer patients (see DaR.8), what is the total number and percentage of patients that were triaged as non- urgent by the SBD centre?	Numeric figure		
		Percentage figure to be submitted		
DaR.14	Of the total number of patients triaged as non-urgent (see DaR.13) what is the total number and percentage of patients seen within 6 weeks of the date of receipt of referral?	Numeric figure		
		Percentage figure to be submitted		
DaR.15	Of the total number of patients triaged as non-urgent (see DaR.13) what is the total number and percentage of patients seen within 12 weeks of the date of receipt of referral?	Numeric figure		
		Percentage figure to be submitted		
DaR.16	Of the total number of newly diagnosed primary breast cancer patients (see Dar.8), what is the total number of patients who had an imaging abnormality which was classified as R3, R4, or R5 identified and had a core biopsy performed?	Numeric figure		
DaR.17	Of the total number of patients who had a core biopsy performed (see DaR.16), what is the total number and percentage of biopsies that were image guided?	Numeric figure		
		Percentage figure to be submitted		

DaR.18	Of the total number of newly diagnosed primary breast cancer patients (see DaR.8), what is the total number of patients whose definitive diagnosis was made at the MDT meeting?	Numeric figure		
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Section B – continued				
ALL questions in Section B refer to data for				
a) the sample time period of the 13 consecutive weeks from <u>1 April 2009 – 30 June 2009</u>				
b) the Patient Sample group - seen and newly diagnosed with primary breast cancer				
Question Reference	Question	Information Type	Please state numeric figure/percent age figure as requested	Please tick if providing supporting narrative and add narrative to DaR Appendix x
DaR.19	Of the total number of newly diagnosed primary breast cancer patients (see DaR.8), what is the total number and percentage of patients that were diagnosed with invasive breast cancer?	Numeric figure		
		Percentage figure to be submitted		
DaR.20	Of the total number of patients that were diagnosed with invasive breast cancer (see DaR.19), what is the total number of patients that had primary operable invasive breast cancer?	Numeric figure		
DaR.21	Of the total number of patients that had primary operable invasive breast cancer (see DaR.20), what is the total number and percentage of patients that had ultrasound of the axillary nodes?	Numeric figure		
		Percentage figure to be submitted		

Section B – Continued note sub-sample group 1				
a) the sample time period of the 13 consecutive weeks from 1 April 2009 – 30 June 2009				
b) the Patient Sample group - seen and newly diagnosed with primary breast cancer				
c) sub-sample group 1: Diagnosed with invasive breast cancer				
Question Reference	Question	Information Type	Please state numeric figure/percentage figure as requested	Please tick if providing supporting narrative and add narrative to DaR Appendix x
DaR.22	Of the total number of patients that were diagnosed with invasive breast cancer (see DaR.19), what is the total number and percentage of patients that were diagnosed without an operative procedure?	Numeric figure		
		Percentage figure to be submitted		
DaR.23	Of the total number of patients that were diagnosed with invasive breast cancer (see DaR.19) what is the total number of patients that were assessed as having a clinically occult lesion (classification S2)?	Numeric figure		
DaR.24	Of the total number of patients that were assessed as having a clinically occult lesion (classification S2) (see DaR.23), what is the total number and percentage of patients that had pre-operative image-guided localisation before surgery?	Numeric figure		
		Percentage figure to be submitted		

Section B – Continued note sub-sample group 2				
a) the sample time period of the 13 consecutive weeks from 1 April 2009 – 30 June 2009				
b) the Patient Sample group - seen and newly diagnosed with primary breast cancer				
c) sub-sample group 2: Diagnosed with invasive breast cancer AND HAD SURGERY				
Question Reference	Question	Information Type	Please state numeric figure/percentage figure as requested	Please tick if providing supporting narrative and add narrative to DaR Appendix x
DaR.25	Of the total number of patients that were diagnosed with invasive breast cancer (see DaR.19), what is the total number of patients that had surgery ?	Numeric figure		
DaR.26	Of the total number of patients that had surgery (see DaR.25), what is the total number and percentage of cases that had the histological tumour type recorded?	Numeric figure		
		Percentage figure to be submitted		
DaR.27	Of the total number of patients that had surgery (see DaR.25), what is the total number and percentage of cases that had the histological tumour grade recorded?	Numeric figure		
		Percentage figure to be submitted		
DaR.28	Of the total number of patients that had surgery (see DaR.25), what is the total number and percentage of cases that had the histological tumour size recorded?	Numeric figure		
		Percentage figure to be submitted		
DaR.29	Of the total number of patients that had surgery (see DaR.25), what is the total number and percentage of cases that had the presence or absence of vascular invasion recorded?	Numeric figure		
		Percentage figure to be submitted		

Section B - Continued				
a) the sample time period of the 13 consecutive weeks from 1 April 2009 – 30 June 2009				
b) the Patient Sample group - seen and newly diagnosed with primary breast cancer				
c) sub-sample group 2: Diagnosed with invasive breast cancer AND HAD SURGERY continued				
Question Reference	Question	Information Type	Please state numeric figure/percentage figure as requested	Please tick if providing supporting narrative and add narrative to DaR Appendix x
DaR.30	Of the total number of patients that had surgery (see DaR.25), what is the total number and percentage of cases that had the posterior deep margin status recorded?	Numeric figure		
		Percentage figure to be submitted		
DaR.31	Of the total number of patients that were diagnosed with invasive breast cancer (see DaR.19), what is the total number of cases that had a Wide Local Excision?	Numeric figure		
DaR.32	Of the total number of cases that had a Wide Local Excision, (see DaR.31) what is the total number and percentage of cases that the radial margin status is recorded?	Numeric figure		
		Percentage figure to be submitted		
DaR.33	Of the total number of patients that had surgery (see DaR.25), what is the total number and percentage of cases that had HER-2 status recorded?	Numeric figure		
		Percentage figure to be submitted		
DaR.34	Of the total number of patients that had surgery (See DaR.25), what is the total number and percentage of cases that had oestrogen receptor status recorded?	Numeric figure		
		Percentage figure to be submitted		

Section B – Continued note sub-sample group 3				
a) the sample time period of the 13 consecutive weeks from 1 April 2009 – 30 June 2009				
b) the Patient Sample group - seen and newly diagnosed with primary breast cancer				
c) sub-sample group 3: Patients with primary operable cancer				
Question Reference	Question	Information Type	Please state numeric figure/percentage figure as requested	Please tick if providing supporting narrative and add narrative to DaR Appendix x
DaR.35	Of the total number of newly diagnosed primary breast cancer patients (see DaR.8), what is the total number and percentage of patients that had primary operable breast cancer?	Numeric figure		
		Percentage figure to be submitted		
DaR.36	Of the total number of patients that had primary operable breast cancer (see DaR.35), what is the total number and percentage of patients that had surgery (providing surgery is the first line of treatment) within 20 working days of definitive diagnosis at the MDT meeting?	Numeric figure		
		Percentage figure to be submitted		
DaR.37	Of the total number of patients that had primary operable breast cancer (see DaR.35), what is the total number and percentage of patients that had pre-operative mammography with ultrasound carried out?	Numeric figure		
		Percentage figure to be submitted		

Section C – note new patient Sample group				
ALL questions in Section C refer to data for				
a) the sample time period of the 13 consecutive weeks from 1 April 2009 – 30 June 2009				
b) the Patient Sample group –diagnosed with Ductal Carcinoma In Situ at MDT				
Question Reference	Question	Information Type	Please state numeric figure/percent age figure as requested	Please tick if providing supporting narrative and add narrative to DaR Appendix x
DaR.38	What is the total number of patients newly diagnosed with Ductal Carcinoma In Situ and seen at the SBD centre during the sample time period of 1 April 2009 – 30 June 2009?	Numeric figure		
DaR.39	Of the total number of patients newly diagnosed with Ductal Carcinoma In Situ and seen at the SBD centre during the sample time period (see DaR.38) what is the total number of cases of Ductal Carcinoma In Situ.	Numeric figure		
DaR.40	Of the total number of cases of Ductal Carcinoma In Situ (see DaR.39) what is the total number and percentage of cases that had a wide local excision?	Numeric figure		
		Percentage figure to be submitted		
DaR.41	Of the total number of cases of Ductal Carcinoma In Situ (see DaR.39) what is the total number and percentage of cases that had radial margin status recorded	Numeric figure		
		Percentage figure to be submitted		
DaR.42	Of the total number of cases of Ductal Carcinoma In Situ (see DaR.39) what is the total number and percentage of cases that had the histological tumour grade recorded?	Numeric figure		
		Percentage figure to be submitted		

Section D			
Data Management			
Question Reference	Please provide a copy of the following documents/information	Tick if document is attached	If unable to provide document, please state reason in narrative – DaR Appendix x
DaR.43	Copy of the SBD Centres Data Set		
DaR.44	Copy of the SBD Centres Data Dictionary or Data definition document		
DaR.45	Copy of the hospital/SBD Centres SOP/Policy for validating data		

DaR.46 List the names of the Clinical Information Systems used in your SBD Centre: DaR Appendix x

Narrative accompanying data request (reason if unable to provide data / any other relevant information)	
DaR.1	
DaR.2	
DaR.3	
DaR.4	
DaR.5	
DaR.6	

Appendix 6

National Cancer Control Programme revised key performance indicators (July 2009)

To address the need for standardised, routine monitoring of performance against the Standards, the NCCP convened an **Expert Advisory Group on Breast Service Performance** from clinicians within the designated centres to agree an initial set of Key Performance Indicators. These are set out in the table below*. Some of these KPIs vary to some extent from the corresponding Standard on the advice of the Expert Advisory Group.

STANDARD 1: ACCESS		
Ref.	Key Performance Indicator	Target
1a	Referrals triaged as urgent by the cancer centre shall be offered an appointment within 10 working days of the date of receipt of a letter of referral in the cancer office.	>95%
1b	Referrals triaged as non urgent (i.e. early and routine) by the cancer centre, shall be offered an appointment within 12 weeks (less than or equal to 84 days) of the date of receipt of a letter of referral in the cancer office.	>95%
1c	A new patient deemed urgent following specialist assessment in the clinic (that is classified as S4, S5) shall have imaging (mammography or ultrasound) done in the first visit.	>90%
1d	Breast imaging requests (that is, mammography or ultrasound) shall be carried out within 12 weeks of clinical assessment.	>90%
STANDARD 2: IMAGING		
Ref.	Key Performance Indicator	Target
2a	Patients with primary operable breast cancer shall have pre-op mammography and ultrasound examination.	>95%
2b	A patient over the age of 35 years with a clinically palpable focal abnormality (that is classified as S3, S4 or S5) shall have mammography and targeted ultrasound examination.	>95%
2c	Core biopsies of breast shall be image-guided where an imaging abnormality which is classified as R3, R4 or R5 is identified.	>90%
Additional parameter	Consultant radiologists shall report on at least 1,000 mammograms annually.	1,000

STANDARD 3: DIAGNOSIS		
Ref.	Key Performance Indicator	Target
3a	Patients with invasive breast cancer shall be diagnosed without an operative procedure [open biopsy].	>90%
3b	For patients urgently triaged by the cancer centre and subsequently diagnosed with a primary breast cancer, the interval between attendance at the first clinic and the discussion at the multidisciplinary meeting where a B5 or C5 is first identified shall not exceed 10 working days.	>90%
Additional parameter	The number of benign open surgical biopsies shall be recorded.	volume
STANDARD 4: MULTIDISCIPLINARY WORKING		
Ref.	Key Performance Indicator	Target
4a	Breast investigations that generate a histopathology report shall be discussed at MDM.	>95%
4b	Patients with a diagnosis of breast cancer from the symptomatic service shall be discussed at MDM.	>95%
STANDARD 5: TIME TO TREATMENT		
Ref.	Key Performance Indicator	Target
5a	Surgical intervention shall be carried out within four weeks (20 working days) of the date of the multidisciplinary meeting when a B5 or C5 is first identified, provided surgery is the first treatment.	>90%
5b	For post-surgery patients, where adjuvant chemotherapy is not deemed necessary but require radiation therapy, patients shall commence radiation therapy within 12 weeks of the final surgical procedure.	>90%
5c	For post-surgery patients, requiring adjuvant chemotherapy and radiation therapy, patients shall commence radiation therapy within four weeks of the last chemotherapy administration.	>90%
5d	For post-surgery patients, where adjuvant chemotherapy is required, administration shall commence within eight weeks of the final surgical procedure.	>90%
STANDARD 6: SURGERY – ACCURATE LOCALISATION		
Ref.	Key Performance Indicator	Target
6a	Patients with a clinically occult lesion, that is classified as an S", shall have wire-guided localisation pre-operatively.	>95%

6b	Patients with a clinically occult lesion who have a wire-guided wide local excision shall have specimen mammography.	>95%
STANDARD 7: SURGERY – AXILLARY STAGING		
7	Patients with a diagnosis of primary operable breast invasive cancer shall have an ultrasound of the axillary nodes.	>95%
Additional parameters	The number of patients with sonographically normal lymph nodes and where the FNA or core biopsy does not demonstrate metastases and who have sentinel lymph node biopsies shall be documented.	Volume
STANDARD 8: SURGERY – SPECIALISATION		
8	Individual consultant surgeons shall assess and operate on a minimum of 50 new patients with breast cancer per year.	Volume
STANDARD 9: SURGERY – ACCURACY OF SURGICAL INTERVENTIONS		
9	For patients having breast conserving surgery, the number of therapeutic interventions shall be recorded.	Volume
STANDARD 10: PATHOLOGY		
10a	For primary invasive tumours: (a) Histological tumour type shall be recorded. (b) Histological tumour grade shall be recorded. (c) Invasive tumour size shall be recorded. (d) The presence or absence of vascular invasion shall be recorded. (e) Radial margin status shall be documented for all patients who have wide local excision. (f) Posterior (deep) margin status shall be recorded (g) Lymph node status shall be recorded where sampled.	>95%
10b	For primary invasive tumours, <i>HER2</i> receptor status shall be recorded.	>95%
10c	For primary invasive tumours, <i>HER2</i> receptor status shall be recorded.	>90%
10d	The histopathology report containing the prognostic data as outlined in 10a will be available within 10 working days.	>95%

* Source: NCCP 2009

Appendix 7

Useful contacts

The following websites can provide information and support about all aspects of cancer, in particular breast cancer. General practitioners (GPs) and your healthcare team can also provide you with information about local support groups.

Action Breast Cancer (Irish Cancer Society): www.cancer.ie/action

ARC Cancer Support Centre: www.arccancersupport.ie

Biobank Ireland Trust: www.biobankireland.com

Breakthrough Breast Cancer: www.breakthrough.org.uk

breastcancer.org: www.breastcancer.org

Breast Cancer Care: www.breastcancercare.org.uk

Breast Cancer Network Australia (BCNA): www.bcna.org.au

BreastCheck: the National Breast Cancer Screening Programme: www.nbsp.ie

BreastCheck: <http://www.breastcheck.ie>

Canadian Breast Cancer Foundation: www.cbcbf.org

Cancer Back up: <http://www.cancerbackup.org.uk>

Department of Health and Children: www.dohc.ie

Europa Donna: <http://www.europadonnaireland.ie>

EUROPA DONNA - The European Breast Cancer Coalition: www.europadonna.org

European Health Portal site: http://ec.europa.eu/health-eu/index_en.htm

Fertile Hope www.fertilehope.org

Health Services Executive (HSE): www.hse.ie

Irish Cancer Society: www.cancer.ie

ICORG (Irish Clinical Oncology Research Group): www.icorg.ie

Marie Keating Foundation: www.mariekeating.com

National Breast Cancer Coalition: www.natlbcc.org

National Cancer Control Programme (NCCP): www.cancercontrol.hse.ie

National Cancer Institute (United States): www.cancer.gov

National Cancer Registry Ireland: www.ncri.ie

Rethink Breast Cancer: www.rethinkbreastcancer.com

Living Beyond Breast Cancer: www.lbbc.org

The European Cancer Observatory: <http://eu-cancer.iarc.fr>

Y-Me National Breast Cancer Organisation: www.y-me.org

Young Survival Coalition: www.youngsurvival.org/