E13. How can you tell if your local breast unit is any good?

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The field of breast cancer care is changing rapidly. More disciplines are involved in breast cancer treatment, which makes communication and organisation more demanding. Medical knowledge on new therapies and diagnostic tools grows exponentially. Promising techniques, such as genetic profiling, will allow for tailor-made therapies. Meanwhile, patients are getting older, often with multiple comorbidities, leading to difficulties in treatment decisions. As a result, treatment and organisation of care are getting more complex. One of the major challenges in the near future will be how to translate all new developments into practice, while professionals are faced with cutting costs on financial resources.

At the same time, the social demand for information on the quality of healthcare is rising and in several European countries there is growing political interest in quality assurance of healthcare. However, while there are prompt and detailed data on the quality of goods and food, data on the utilisation and outcomes of healthcare are hardly available. Several studies have shown disparities in patient outcomes after treatment for breast cancer between specialised, high volume centres and low volume centres.[1–6] However, identifying responsible factors is difficult, since comparative data on differences in practice of our breast cancer facilities are lacking. So how can you tell if your local breast unit is any good?

An effective tool for both implementation of changes in practice and measuring quality is the use of real-time, validated quality measures. This lecture will outline two critical tools for quality measurement: quality indicators and clinical auditing.

Quality indicators

A valuable tool for quality measurement is the use of quality indicators: measurable aspects of care, which reflect the quality of care. There are three types of quality indicators: structural indicators, process indicators and outcome indicators.[7,8] Examples of indicators for breast cancer treatment are: the availability of specialised nurses (structure), the percentage of patients who are discussed in a multi-disciplinary board (process), and the tumour free margin rate after breast conserving surgery (outcome).

The development of quality indicators is usually carried out in consensus meetings and is adherent to national guidelines.[9] To ensure validity there are several requirements for indicators, concerning the reliability of the data, the comparability of the results, and the statistical reliability. These should be taken into account when developing indicators.

The reliability of data requires that the data source is complete and that the gathering of data is done in a uniform way. Because of that, registrations should include all pre-defined patients and definitions of the required data should be clear. In addition, the comparability of the results requires that differences in patient populations are taken into account. Therefore, the results should be adjusted for differences in case mix. Finally, the results have to be statistically reliable. This means that when the results of hospitals are compared, statistical random variability should be taken into account.

Quality indicators are a usable tool for quality measurement and have provided more transparency on the quality of breast caner care. However, there are several restraints: quality indicators give only a proxy for quality and do not provide a complete overview. Moreover, a better performance on a single quality indicator does not necessarily relate to better quality of care.

Auditing

The clinical audit is an instrument for quality measurement, which does provide a complete overview of the quality of care. An audit is a detailed registration of clinical data from different healthcare providers, concerning all aspects of treatment: structure, process and outcomes. Moreover, it contains baseline characteristics which can be used for risk adjustment. Adjusted results are fed back to individual providers, providing real-time information of their own performance compared to the mean. This has an intrinsic effect of improving quality (‘the Hawthorne effect’). In several countries, including the US, the UK, the Nordic Countries and the Netherlands, audits have been successfully implemented and have had a proven effect on the quality of care, while reducing costs.[10–13]

In addition to performance monitoring and feedback, audits have the possibility to identify ‘best practices’. Identifying and adopting these ‘best practices’ might improve the overall quality of care. There are several strategies described to implement ‘best practices’ into

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practice: up-to-date guideline development, development of 'critical pathways' and 'outcome based referral'. [14,15] EUSOMA has recognised the importance of auditing and has implemented the recommendation of data registry for auditing in the EUSOMA position paper 'the requirements of a specialist Breast Unit'. [16] With the development of smart information technology and electronic health records, there will be opportunities for real-time gathering of performance data in the near future. Standardised reporting of operative reports and pathology reports has already been shown to improve the quality of cancer surgery. [17]

In short, initiatives for quality measurement and improvement are promising. Combining clinical auditing and quality indicators provides reliable information on the quality of health care. Moreover, it is an effective instrument for quality improvement. Thus, efforts should be made to initiate auditing of our breast units, and to measure and compare our patient outcomes. Then we can really tell whether our breast cancer care is any good.

Conflict of interest statement

None declared.

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