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Section 1 - Introduction

1.1 About this resource

This information booklet is designed for Service clinicians (clinical coordinators, radiologists, surgeons, pathologists) and other members of the assessment multidisciplinary teams (nurse counsellors and radiographers). This document is also useful for those clinicians who work off site and when arranging face-to-face meetings for updates could be challenging.

Considering time demands on clinical staff, the aim when developing this booklet was to create a succinct resource to provide key information about the National Accreditation Standards (NAS) in a more accessible format than the detailed and longer, complete NAS document.

This document provides a brief summary of the new NAS resulting from the national review and summarises significant changes from a clinical perspective highlighting background knowledge that would be expected of clinical roles. It will also be suitable for new clinical staff who need to familiarise themselves with the NAS and accreditation.

A list of other documents and key references is located on page 20 for those who want to obtain more comprehensive information about the NAS and the accreditation model.
Section 2 - The National Accreditation Standards (NAS)

2.1 Overview

The National Accreditation Standards (NAS) have been used to ensure women receive consistently high quality breast screening since the BreastScreen Australia program commenced in 1990 and have since undergone three revisions.

The current NAS (October 2015) came from a major review of BreastScreen Australia’s (BSA) accreditation system in 2011–2014 which included each component of accreditation: NAS, the accreditation process and national, state and service governance arrangements.

Key drivers for this review included:

• The NAS had not been comprehensively revised for 10 years
• The NAS should be streamlined to lessen overall burden of accreditation
• A need for the NAS to better reflect new business and clinical practices
• A need to align the NAS with current international evidence and best practice
• A need to ensure the system is based on continuous quality improvement

An expert NAS working group used a comprehensive approach to review all standards, including extensive analysis of actual historical BSA data, stakeholder consultations and comparisons with equivalent international breast screening programs and standards.

As a result, previous standards were revised, deleted or left unchanged, and a small number of new standards were introduced where the need was identified.

This document does not cover all the changes or reasons for these, but gives an overview and uses some examples to highlight the approach taken and the outcomes from the review.

The graphs below (Figure 1 and Figure 2) show frequency distribution charts for actual data reported on two standards by BreastScreen Australia Services over a number of years. The distribution was used to assess whether the standards should remain the same or be adjusted in some way, and this approach was used for all standards.
Example 1

**NAS 2.8.1:** ≤0.35% women attending for first screen are found not to have invasive cancer or DCIS after a diagnostic open biopsy.

The red dotted line and arrow indicates the standards (≤0.35%) and the distribution of results shows the majority were met by falling below the target. The average result was 0.23%. Based on this it was decided that this standard does not need to be changed.

**NOTE:** The scattering of results above the target (distribution tail or outliers) reflects those Services not meeting the NAS and needing to implement improvement measures.

Service Performance for 2.8.1

(≤0.35% of women who attend for their first screen are found not to have invasive cancer or DCIS after a diagnostic open biopsy)

Figure 1

Example 2

**NAS 2.7.1:** ≥75% invasive cancers or DCIS are diagnosed without the need for diagnostic open biopsy.

The distribution of results shows that ALL were met and fell above the 75% target, with none below 80%. The average result was 91.6%, with the majority clearly above 85%.

Based on this it was decided this standard should be changed, with the blue line and arrow showing the new NAS target (≥85%). This new setting compares more favourably with other international breast screening program standards.

Service Performance for 2.7.1

(≥75% of invasive cancers or DCIS are diagnosed without the need for diagnostic open biopsy)

Figure 2

Mean = 0.23
Std. Dev. = 0.14
N = 98

Mean = 91.61
Std. Dev. = 4.252
N = 98
2.2 Key features of the NAS

Review of the BSA accreditation program resulted in changes in two areas:

- National Accreditation Standards (NAS)
- Accreditation Model (governance / management processes)

The NAS structure now includes **7 High Level Standards** that reflect a broad goal related to the screening and assessment pathway or supporting functions, as follows:

1. Access & Participation
2. Cancer Detection
3. Assessment
4. Timeliness
5. Data Management & Information Systems
6. Client Focus
7. Governance & Management

These High Level Standards are split into:

- **12 Criteria**
- **42 NAS Measures**
- **61 Protocols**

An example of this new NAS structure for Standard 2 (Cancer Detection) relating specifically to interval cancer measures is shown below.

### 2.2.1 NAS Standard Structure - an example

**Cancer Detection Standard:**
Cancer detection is maximised in the target population and harm is minimised

**Criterion 2.3:**
The Service and/or SCU minimises the number of interval invasive breast cancers.

<table>
<thead>
<tr>
<th>NAS MEASURE 2.3.1</th>
<th>a. The Service and/or SCU monitors and reports the proportion of women aged 50–74 years who attend for screening who are diagnosed with an interval invasive breast cancer in the first calendar year following a negative screening episode.</th>
<th>b. &lt;7.5 per 10,000 women aged 50–69 years who attend for screening are diagnosed with an interval invasive breast cancer in the first calendar year following a negative screening episode.</th>
</tr>
</thead>
</table>

**Protocol 2.6**
The Service and/or SCU implements a protocol for:

a. identifying all interval invasive breast cancers and interval cases of DCIS;
b. reviewing and investigating all interval invasive breast cancers and interval cases of DCIS within the Service and/or SCU; and
c. identifying and implementing changes to improve practice where necessary.
Table 1 | Some Standards have both Measures and Protocols, while others have only Measures or only Protocols

<table>
<thead>
<tr>
<th>Standard</th>
<th>Items included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 1 - Access &amp; Participation</td>
<td>NAS Measures &amp; Protocols</td>
</tr>
<tr>
<td>Standard 2 - Cancer Detection</td>
<td>NAS Measures &amp; Protocols</td>
</tr>
<tr>
<td>Standard 3 - Assessment</td>
<td>NAS Measures &amp; Protocols</td>
</tr>
<tr>
<td>Standard 5 - Data Management</td>
<td>NAS Measures &amp; Protocols</td>
</tr>
<tr>
<td>Standard 4 - Timeliness</td>
<td>NAS Measures Only</td>
</tr>
<tr>
<td>Standard 6 - Client Focus</td>
<td>Protocols Only</td>
</tr>
<tr>
<td>Standard 7 - Governance &amp; Management</td>
<td>Protocols Only</td>
</tr>
</tbody>
</table>

2.2.2 NAS Measures and Risk Levels

Each NAS Measure is also allocated a risk rating or level to reflect the potential impact on clients if that Measure is not met as follows:

Level 1: High Risk
8 NAS Measures

Level 2: Moderate Risk
27 NAS Measures

Level 3: Low Risk
7 NAS Measures
2.2.3 NAS Commentary

In addition to the Standards, Criteria, Measures and Protocols, the full NAS document includes supplementary information related to these items in sections labelled ‘Commentary’. The Commentary provides further background material, context, rationale and guidelines relevant to a specific Measure or Protocol and should be referred to if clarification is needed.

Example of commentary section for Protocol 2.1 (Cancer Detection Standard)

Discordant Reads

The use of double blind screen reading in the Program will mean that on occasion there will be different reading outcomes from different screen readers. The Service and/or SCU will have a protocol in place for reconciling discordant reads that result in a single recommendation about whether or not the woman will be recalled for further assessment, to exclude or detect the presence of breast cancer.

One of two approaches can be used to reconcile the reads into a single recommendation; either:
1. by using a third reader to decide between the two screen reading outcomes; or
2. through a consensus read, where the two original screen readers consider the mammogram together through discussion to reach agreement on the outcome.

If the Service and/or SCU chooses to use a third reader, it must be a radiologist with a high level of expertise in screen reading. A Service and/or SCU may choose to have more than one ‘third reader’ review the images, however this is a local decision for the individual Service and/or SCU.

2.2.4 Expanded Target Age Group

In May 2013, the Commonwealth announced funding to expand the target age range from women aged 50–69 years to women aged 50–74 years.

The NAS now include new measures to account for this expansion. This will be done in a phased approach over four years. During this time some NAS Measures will include two parts:

Part ‘a’ requires collection and monitoring of performance for the 50-74 age range, but no target has been set

Part ‘b’ essentially reflects the previous 50-69 age range and target

Example for NAS Measure 2.1.2 (Invasive cancer detection rate for subsequent round screens)

2.1.2

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>The Service and/or SCU monitors and reports the proportion of women aged 50–74 years who attend for their second or subsequent screening episode who are diagnosed with invasive breast cancer.</td>
</tr>
<tr>
<td>b.</td>
<td>≥35 per 10,000 women aged 50–69 years who attend for their second or subsequent screening episode are diagnosed with invasive breast cancer.</td>
</tr>
</tbody>
</table>

After collecting data for both measures over four years, a new target will be set for part ‘a’ and part ‘b’ will be retired.
2.3 Overview of Relevant Standards for Clinical Roles

**Primary standards**
Information with the greatest clinical relevance is found in the following two high level NAS:

- Standard 2: Cancer Detection
- Standard 3: Assessment

Sections 3 and 4 of this document will focus primarily on these two Standards

**Other standards**
Some areas in the NAS cover broader operational aspects that clinicians should be aware of, including:

- Standard 4: Timeliness
- Standard 6: Client Focus
- Standard 7: Governance & Management

While these may not appear directly applicable, they do have important and relevant aspects and implications for clinical provision and outcomes.

An overview of standards 4, 6, and 7 is provided in Section 5.

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2.4 Brief Summary of Process and Governance Changes

- Accreditation Surveys (previously Site Visits) will be conducted every four years.
- The State Coordination Unit will also undergo a survey.
- Services and the State Coordination Unit will be assessed against and held accountable for performance against any NAS Measure for which they have sole or joint responsibility – Division of responsibility is defined in the NAS Accountability Framework.
- The National Surveyor attends and leads each survey team.
- There is increased focus on quality improvement at State and Service levels.
- The State Quality Committee (SQC) will establish a structured approach to quality improvement across BreastScreen NSW.
- The SQC is to provide recommendations on quality improvement and monitor the State Quality Plan and Service Quality Improvement Plans.

Further details on key process changes can be found in BSNSW Accreditation Fact Sheet 1 – see references.
Section 3 - STANDARD 2: CANCER DETECTION

Breast cancer detection is maximised and harm is minimised

3.1 Cancer Detection NAS Measures

BreastScreen Australia aims to achieve significant reductions in breast cancer morbidity and mortality by early detection, leading to better treatment and improved survival for screened women.

Each step in the screening and assessment pathway needs to meet quality standards for clinical and technical practice, including high quality imaging, screen reading and reporting.

Population screening differs from diagnostic services as it is offered to well women and must balance maximising cancer detection, particularly small cancers, with minimising potential harm caused by unnecessary investigations.

Using mortality rates as an indicator is difficult due to the long time delays between screening and measurable impact on death from breast cancer.

To monitor population screening, interim indicators (NAS Measures) are used to give more timely information about performance against standards that underpin achievement of reduced mortality rates, including:

- Invasive breast cancer detection rate
- Small invasive breast cancer detection rate
- Ductal carcinoma in situ (DCIS) detection rate
- Interval breast cancer rate

Balancing this are NAS measures that monitor investigations that may cause unnecessary anxiety or harm, such as:

- Total number of images needed
- Extra images for technical problems (technical repeats)
- Recall to assessment rates
- Early review rates

The NAS measures allow Services to assess the quality of screening and assessment provided and enables quality improvement strategies to be implemented when needed.

It is beyond the scope of this document to cover each NAS Measure in detail. Please refer to the NAS Commentary October 2015, Standard 2 Cancer Detection, for complete descriptions.

The tables below (tables 2,3 and 4) provide an overview of NAS Measures.
Table 2 | New Cancer Detection NAS Measures

<table>
<thead>
<tr>
<th>NAS measure</th>
<th>Brief description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.4</td>
<td>Invasive cancer, small cancer and DCIS rates for women screening annually</td>
<td>Small proportion women at increased risk are screened annually. These NAS allow monitoring and analysis of the outcomes for women at increased risk.</td>
</tr>
<tr>
<td>2.2.3</td>
<td>Report the percentage of women who have up to four images per screen, including technical repeats</td>
<td>Additional images increase discomfort, radiation dose and costs. Important to minimise unnecessary images, so deviation from the standard two views (total four images) per client is documented. Monitoring this over time will assist in developing an appropriate future target.</td>
</tr>
<tr>
<td>2.5.1</td>
<td>Positive Predictive Value (PPV) for recall to assessment for invasive cancer and DCIS (by initial and subsequent screening rounds)</td>
<td>Measures accuracy of a recommendation to recall women to assessment that results in a diagnosis of breast cancer or DCIS. Indicates the proportion of women who may have been recalled to assessment for potentially unnecessary investigations. Monitoring this assists in balancing the benefits and potential harms of the screening for individual women and target population.</td>
</tr>
</tbody>
</table>

Table 3 | Key revisions to existing Cancer Detection NAS Measures

<table>
<thead>
<tr>
<th>NAS measure</th>
<th>Brief description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.1</td>
<td>Interval cancer rates at 0-12 months and at 13-24 months after last screen</td>
<td>New NAS now has a target rate for 13-24 month interval cases of 15/10,000 screens. <strong>NOTE:</strong> This was also changed from a higher Level 1 to moderate Level 2 risk status if unmet.</td>
</tr>
<tr>
<td>2.5.2</td>
<td>Technical recall rates</td>
<td>Reviewed based on data from 2007 to 2010 with an average for all Services at 1.39%. The new requirement changed from ≤3% to ≤2% of all screening images. This is consistent with the European Commission guidelines that the technical repeat rate should be &lt; 3% (acceptable) and &lt;1% (desired)</td>
</tr>
</tbody>
</table>
### Table 4 | Rationale for Measures left unchanged given previous questions about suitability

<table>
<thead>
<tr>
<th>NAS measure</th>
<th>Brief description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4.1</td>
<td>Number of reads per reader &gt;2,000 per annum</td>
<td>Significant difference in cancer detection rates reported for readers who read &lt;2,000 versus &gt;2,000 screens per year. UK Breast Screening requires at least 5,000 cases per year. In Australia the major metro Services have sufficient throughput to reach 5,000, but it may not be possible in smaller States or rural areas. Analysis of the national data found readers in most Services (88%) could feasibly read 2,000 per year. When reading for multiple Services the reads at each BreastScreen Service is aggregated to give an annual total.</td>
</tr>
<tr>
<td>2.6.3 &amp; 2.6.5</td>
<td>Initial (&lt;10%) and subsequent (&lt;5%) screening round recall to assessment rates</td>
<td>Important to achieve a balance between cancer detection and recall for assessment. Studies have shown women recalled to assessment and found not to have breast cancer experience heightened anxiety and may be reluctant to return for rescreen. The 2012 national average recall to assessment rate for women attending for their first screening round was 10.8% (range of 6.6% to 12.8%). The recall to assessment rate for women attending for their subsequent screening rounds was 3.4% (range 1.9% to 4.0%). NAS Measures maintained for first and subsequent screening episodes at &lt;10% and &lt;5% respectively. Consistent with UK Breast Screening recall to assessment rate for the first round of &lt;10% and &lt;7% for the subsequent round women. European Guidelines have recall to assessment standards of &lt;7% for the first screening round and &lt;5% for the subsequent screening rounds.</td>
</tr>
</tbody>
</table>
3.2 Cancer Detection - NAS Protocols

Protocols underpin and support the achievement of NAS Measures. Nine Protocols (2.1-2.9) for the Cancer Detection Standard cover key processes in the following areas:

- Screen reading, QA and reporting processes
- Image identification and safety measures
- Assessment of image quality
- Review of interval cancer cases
- Screen reader qualifications, training and experience
- Screen reader audit, review and feedback
- Managing women with symptoms or implants

It is important to be aware that the NAS provides supplementary notes (or commentary) on each Protocol that gives additional context and content.

Key points from NAS commentary for Protocol 2.6

- Interval cancers are identified by matching screening outcomes with the NSW Cancer Registry.
- The Service implements a procedure to assess each interval cancer or DCIS diagnosed following a previous negative screening result.
- Interval cancers are reviewed by Service Designated Radiologist.
- Individual readers provide feedback on interval cancers, especially those for which they are the screen-reader.
- Review involves examining screening images, with diagnostic images if available, to determine if the interval was a true interval or a failure of the screening process.
- True interval may be an aggressive breast cancer that grows between scheduled screening episodes, or a breast cancer, that due to its characteristics, was not visible on the screening images and not able to be detected.
- A breast cancer or DCIS detected retrospectively on the previous screening image represents a failure of the screening process.
- For BreastScreen Australia >80% of interval invasive breast cancers are found to be true intervals (AIHW Monitoring Report 2009-2010).
- Review is used to determine whether there is a need to change clinical protocols and/or improve reader skills.
Section 4 - STANDARD 3: Assessment

4.1 Assessment and diagnosis of breast cancer is appropriate, safe and effective

Multidisciplinary care is best practice in the assessment, diagnosis and care of women who have an abnormality detected through screening.

This requires the relevant specialist staff working as a team to ensure all women recalled for assessment of a screen detected abnormality receive an outcome, based on the combined skills and knowledge of the multidisciplinary team (MDT).

It is important that women have all the necessary clinical, imaging and pathology investigations when attending for assessment and that they receive a timely outcome to minimise anxiety.

A MDT approach is also an effective use of specialised clinical resources. Attendance of the specialist staff at assessment leads to efficient and effective communication and reduces the time demands on busy clinicians.

This approach enables women to be reassured that they do not have breast cancer or to confirm a diagnosis of breast cancer or suspected breast cancer. It provides care and counselling to support the woman’s referral for treatment, diagnostic open biopsy, or further diagnostic investigations.

4.1.1 Assessment NAS Measures

To evaluate if assessment and diagnosis of breast cancer is appropriate, safe and effective the following NAS Measures are used:

- Needle biopsies (inadequate specimens, false negative or false positive outcomes)
- Diagnostic sensitivity of needle biopsies
- Benign outcomes following diagnostic open biopsy
- Correct identification of lesions at first excision
- Specimen imaging of excised lesions
- Majority cancers / DCIS diagnosed without need for surgical excision

The Services use these NAS Measures to evaluate the quality of assessment provided and implement quality improvement strategies when needed.

The tables below (5,6 and 7) provide an overview of assessment NAS Measures.

4.1.2 New Assessment NAS Measures

A key change was made to pathology standards. Previously FNA cytology and core biopsy outcomes had different targets, but core biopsy is now almost predominantly used for breast lesions other than cysts. A review of BreastScreen Australia data showed it was appropriate for a combined percutaneous needle biopsy category to be used.

Three new standards measure the quality of pathology in assessment. Performance will reflect clinical and imaging aspects of assessment, as well as the skill of the collector, nature of the lesion, the localisation technique used, and interpretative skills and experience of the pathologist.
<table>
<thead>
<tr>
<th>NAS measure</th>
<th>Brief description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.1.1</strong></td>
<td>&lt;5% malignant percutaneous needle biopsy lesions classified benign or inadequate /insufficient.</td>
<td>Percutaneous needle biopsy samples require sufficient material for pathology assessment. For core biopsies for micro calcifications this includes samples without calcium. A false negative or insufficient sample requires further investigation or excision regardless of the needle biopsy modality.</td>
</tr>
<tr>
<td><strong>3.1.2</strong></td>
<td>0% benign lesions assessed by percutaneous needle biopsy classified as false positive</td>
<td>False positives occasionally occur. The threshold is zero for client safety, transparency and accountability, and such events need to be reported and reviewed. Should a false positive result occur, the Measure is unmet and the Service conducts a root cause analysis. The NAS commentary includes guidelines for investigation of possible false positive needle biopsy diagnoses of breast malignancy in BreastScreen Australia and when a needle biopsy result is classified as a false positive. For example, a false positive FNA followed by a true negative core biopsy, prior to recommendation for surgery or treatment, is not considered to be a false positive for the purpose of this standard.</td>
</tr>
<tr>
<td><strong>3.1.3</strong></td>
<td>Absolute sensitivity percutaneous needle biopsy &gt;90%</td>
<td>Absolute sensitivity is a measure of the number of cases diagnosed accurately that are categorised as malignant. It is related to the inadequate rates, as high rates of inadequacy decrease the sensitivity. The requirement for this Measure was set to reflect results of core biopsies collated from BreastScreen Australia data where the average across all Services was &gt;92%.</td>
</tr>
</tbody>
</table>
All women with impalpable lesions undergoing excision have specimen imaging recorded

Small impalpable lesions require excision by image guidance for diagnosis or treatment using specialist skills in radiology, surgery and histopathology. Specimen imaging gives a degree of certainty that the lesion detected by mammography and/or sonography has been satisfactorily removed.

The surgical specimen will be imaged according to standard protocols to allow the surgeon and pathologist to assess the adequacy of the excision. While a verbal report by a radiologist can be received, it is desirable the specimen image be available for the surgeon to review for intraoperative decisions. The orientation and copy of the specimen image will also allow the pathologist to assess the location of the lesion within the specimen and margins of resection. It is a requirement that specimen imaging be undertaken and recorded for; a screen detected abnormality that is impalpable pre-operatively; any localised procedure; and if a lump becomes palpable during an operation.

NOTE: This was also changed from a moderate Level 2 to the lower Level 3 risk status if unmet.

≥ 85% of invasive breast cancers or DCIS are diagnosed without the need for excision

Accurate diagnosis for most women without diagnostic open biopsy reduces the number requiring more invasive and unnecessary investigations. Breast surgeons should be able to proceed to definitive surgery based on a preoperative histopathological diagnosis of cancer. This is defined as a malignant result on a percutaneous needle biopsy (DCIS and invasive cancer) which is consistent with suspicious or malignant imaging findings.

The aim is to provide a preoperative diagnosis for the majority of women whilst ensuring a balanced consideration of the diagnostic options for each individual woman assessed. Based on analysis of the BreastScreen Australia data this target was increased from ≥75% to ≥85% which better aligns with UK Breast Screening Programme that has a minimum standard of 90% (invasive) and 85% (non-invasive) rates for preoperative diagnosis of breast cancer.

NOTE: This was also changed from a moderate Level 2 to the higher Level 1 risk status if unmet.
3.1.4 and 3.1.5 <0.35% first screening round women and ≤0.16% subsequent screening round women are found not to have invasive breast cancer or DCIS after diagnostic open biopsy

Benign diagnostic open biopsy is defined as an open biopsy recommended by the Service for diagnostic purposes, where the histopathology finding was not invasive cancer or DCIS. A diagnostic open biopsy with a benign finding includes atypical ductal hyperplasia; radial scar and lobular carcinoma in situ (LCIS).

Benign diagnostic open biopsy rate provides an indication of the effectiveness of the program in minimising unnecessary diagnostic open biopsies. Increasing use of percutaneous needle biopsies should result in a smaller proportion of women requiring diagnostic open biopsy to provide a diagnosis. While the total number of women referred for diagnostic open biopsy is decreasing, there will always be some lesions where the radiology or pathology findings require an open diagnostic biopsy for further evaluation.

3.1.7 ≥95% of all lesions are correctly identified at first excision

≥95% of all lesions should to be correctly identified at first excision to ensure anxiety and physical consequences for women are minimised. This is a critical measure of patient safety and therefore has a Level 1 risk rating. It applies to all lesions identified at assessment, not just those impalpable lesions that undergo preoperative localisation.

4.1.3 Assessment NAS Protocols

Protocols underpin and support the achievement of NAS Measures. Seven Protocols (3.1 -3.7) for the Assessment Standard cover key processes in the following areas:

- Multidisciplinary assessment team
- MDT meetings and reviews
- Correlation of clinical, radiological and pathology results
- Post-surgical case follow up
- Use of evidence based clinical assessment protocols

Table 7 | Rationale for keeping Assessment NAS Measures unchanged

<table>
<thead>
<tr>
<th>NAS measure</th>
<th>Brief description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.4 3.1.5</td>
<td>&lt;0.35% first screening round women and ≤0.16% subsequent screening round women are found not to have invasive breast cancer or DCIS after diagnostic open biopsy</td>
<td>Benign diagnostic open biopsy is defined as an open biopsy recommended by the Service for diagnostic purposes, where the histopathology finding was not invasive cancer or DCIS. A diagnostic open biopsy with a benign finding includes atypical ductal hyperplasia; radial scar and lobular carcinoma in situ (LCIS). Increasing use of percutaneous needle biopsies should result in a smaller proportion of women requiring diagnostic open biopsy to provide a diagnosis. While the total number of women referred for diagnostic open biopsy is decreasing, there will always be some lesions where the radiology or pathology findings require an open diagnostic biopsy for further evaluation.</td>
</tr>
<tr>
<td>3.1.7</td>
<td>≥95% of all lesions are correctly identified at first excision</td>
<td>≥95% of all lesions should to be correctly identified at first excision to ensure anxiety and physical consequences for women are minimised. This is a critical measure of patient safety and therefore has a Level 1 risk rating. It applies to all lesions identified at assessment, not just those impalpable lesions that undergo preoperative localisation.</td>
</tr>
</tbody>
</table>
4.1.4 NAS Protocols - An example

Protocol 3.4
The Service implements a protocol for reviewing and correlating the clinical, radiological and pathological findings for all lesions detected as a result of screening for which surgery was performed.

Protocol 3.5
Where there is discordance between assessment and post-surgical results the Service implements a protocol for the follow-up of these women which may include:
   a. notification of the surgeon;
   b. notification of the general practitioner;
   c. notification of the woman for review and assessment at the Service; or
   d. any combination of these.

It is important to be aware that the NAS provides supplementary notes (or commentary) on each Protocol which gives additional context and content.

Key points from NAS commentary for Protocols 3.4 & 3.5

- The Service implements a protocol for review of histopathology reports of all women who have surgery for a lesion detected as a result of screening
- All members of the MDT will be encouraged to participate in meetings
- The Designated Surgeon should be available to provide input into the review of surgical cases where necessary
- All relevant clinical notes; imaging and pathology reports, will be available to facilitate correlation of results and case discussion
- Where results of surgery are not found to be in accord with the assessment findings, a protocol will be implemented for the follow-up of these women
- The Service will ensure that there is a protocol in place to enable contact with these women in order that appropriate follow up takes place
- Review meetings for assessment cases, follow up of post-surgical cases, and other educational multidisciplinary meetings help foster an MDT approach and sharing of knowledge and expertise between different disciplines. These also function as a strategy for improving assessment clinic protocols and providing continuing professional education for the MDT.
Section 5 - Other Relevant Standards

5.1 Other Relevant Standards

Although these standards are not directly focussed on clinical practice, they do deal with areas that have some relevance and implication for clinical provision or outcomes. To ensure clinicians’ awareness of these, a summary is provided.

**Standard 4: Timeliness - Screening and assessment services are provided to women in a timely and efficient manner**

<table>
<thead>
<tr>
<th>NAS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.2</td>
<td>Screen read results time (≥90% screening results within 14 days)</td>
</tr>
<tr>
<td>4.2.1</td>
<td>Assessment attendance time (≥90% attend assessment within 28 days)</td>
</tr>
<tr>
<td>4.2.3</td>
<td>Number assessment visits (&gt;95% no more than 2 assessment visits)</td>
</tr>
<tr>
<td>4.2.5</td>
<td>Time to complete assessment (&gt;95% complete all assessment 15 days)</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Assessment results (&gt;95% at first assessment if not requiring biopsy)</td>
</tr>
<tr>
<td>4.2.4</td>
<td>Assessment results (≥85% given verbal results within 7 days of biopsy)</td>
</tr>
<tr>
<td>4.2.6</td>
<td>Assessment results (Written results in 14 days once assessment complete)</td>
</tr>
</tbody>
</table>

**Standard 6: Client Focus - Services are of high quality and client focused**

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>High quality information provided on screening and assessment</td>
</tr>
<tr>
<td>6.3</td>
<td>Assessment results given by clinician with counselling available</td>
</tr>
<tr>
<td>6.7, 6.8, 6.9</td>
<td>Informed consent for screening and assessment procedures</td>
</tr>
<tr>
<td>6.10, 6.11, 6.12</td>
<td>Management, support and referral for women diagnosed with breast cancer</td>
</tr>
</tbody>
</table>

**Standard 7: Governance & Management - Effective structures and processes are in place to ensure high quality governance and management**

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1, 7.2 + Appendix C</td>
<td>Staff qualifications and experience (including service clinicians)</td>
</tr>
<tr>
<td>Appendix C</td>
<td>Designated lead clinical roles (radiologist, pathologist, surgeon)</td>
</tr>
<tr>
<td>7.3, 7.4</td>
<td>Staff training</td>
</tr>
<tr>
<td>7.12</td>
<td>Infection control</td>
</tr>
<tr>
<td>7.13</td>
<td>Adverse incident reporting and management</td>
</tr>
<tr>
<td>7.14, 7.15, 7.16</td>
<td>Standard Policies &amp; Procedures (including clinical)</td>
</tr>
<tr>
<td>7.17 - 7.21</td>
<td>Provision, management and maintenance of suitable equipment and facilities</td>
</tr>
</tbody>
</table>
## References

<table>
<thead>
<tr>
<th>Item</th>
<th>Short description</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mapping Tool - NAS Measures</td>
<td>Detailed table comparing all the previous data NAS to the new NAS Measures</td>
<td>Contact CINSW</td>
</tr>
<tr>
<td>Mapping Tool - Protocols</td>
<td>Detailed table comparing all the previous non data NAS to the new Protocols</td>
<td>Contact CINSW</td>
</tr>
<tr>
<td>A3 NAS / Protocol List</td>
<td>One A3 page lists all NAS Measures and Protocols for each of the 7 Standards</td>
<td>Contact CINSW</td>
</tr>
<tr>
<td>NAS relevant to roles</td>
<td>Outlines the specific NAS Measures and Protocols relevant to various BreastScreen staff roles and disciplines</td>
<td>Contact CINSW</td>
</tr>
<tr>
<td>BSNSW Factsheet 1</td>
<td>One page summary of key changes to NAS, processes and governance model</td>
<td>Contact CINSW</td>
</tr>
<tr>
<td>BSNSW FAQ - SAS Staff</td>
<td>Covers activities, expectations and requirements of the accreditation process</td>
<td>Contact CINSW</td>
</tr>
</tbody>
</table>

For access to resources, please contact:

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