
Introduction

The European Commission Initiative on Breast Cancer (ECIBC) is built upon the principles of sustainability, continuity and the transparent inclusion of experts and stakeholders to develop a project that will have an impact on breast cancer care in Europe.

The ECIBC is under the coordination of the Commission’s Joint Research Centre (JRC), based on an agreement with the Commission’s Directorate-General Health and Food Safety (DG SANTE), and aims to ensure and harmonise the quality of breast cancer services across European countries. DG SANTE has the policy leadership as regards the implementation of EU health policy on cancer. The Commission expert group on Cancer Control, which is a forum for Member States and stakeholders to provide input into cancer policy development at EU level, will regularly review the development of the ECIBC in order to guarantee its compatibility and coordination within the overall EU policy on cancer.

JRC has the scientific and technical responsibility for the ECIBC and coordinates its implementation, ensuring synchronisation of all ECIBC objectives and the delivery of quality outputs in a timely way. Owing to the inter-dependence of the different working groups within the ECIBC, close coordination and collaboration is essential to ensure the success of the initiative. JRC also ensures appropriate linkages with other Commission services and EU projects in areas relevant to the project (for example, with the EU Joint Action on Cancer Control—CANCON).

This is the second time that a plenary of the ECIBC takes place. The first ECIBC plenary took place in 2013 and informed European countries and stakeholders about the future launch of the ECIBC, its aims and planned deliverables. The current plenary now aims to update on the progress of the ECIBC. This includes reporting on the current status of the two major pillars of the ECIBC:

- the development of the *European Guidelines for Screening and Diagnosis in Breast Cancer* and
- the development of the *European Quality Assurance Scheme for Breast Cancer Services*.

In addition to this, the plenary will report on further actions carried out by the JRC related to the development of the *Guidelines* and the *Quality Assurance Scheme*. This comprises among others the project to develop a platform for evidence-based guidelines on breast cancer care and several surveys carried out by the JRC on breast cancer services in Europe. Furthermore, the ECIBC plenary will also give the floor to other European projects dealing with breast cancer care to relate them to the work ECIBC is doing. Particular attention is thereby drawn to finding synergies in breast cancer care practices and the assurance of their quality across European countries, focusing particularly on patient/person-centred care.

Finally the ECIBC plenary sets out to provide a platform for the discussion and exchange of current priority issues in breast cancer service provision in general throughout Europe as well as to address related (healthcare) policies.

We expect the quality of the presentations foreseen, together with the productive input and exchange of ideas from its participants, will guarantee the plenary’s success. We are very much looking forward to a lively and fruitful discussion at the 2015 ECIBC plenary, taking place in Baveno at the Lake Maggiore.
Agenda – Day 1

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### December 10

#### Current Topics in Breast Cancer Care Research

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| 09:15-10:00 | **Key note:** The Concept of patient centred care and measuring the quality of health services  
Chris Graham, Picker Institute, UK |
| 10:00-11:00 | Practice and Challenges in Assuring the Quality of Breast Cancer Care in Europe  
Hungary: Kitti Horváth, Chief Medical Officer’s Office, Hungary  
Malta: Miriam Dalmas, Ministry for Energy and Health, Malta  
Norway: Solveig Hofvind, Cancer Registry of Norway |
| 11:00-11:30 | Coffee |
| 11:30-13:00 | Together for Improving Care for (Breast) Cancer:  
Other Projects on Cancer from EU and abroad  
CanCon: Tit Albreht, CanCon chair, EU-TOPIA: Harry de Koning, Erasmus University, Rotterdam, US-Breast Center Accreditation: Cary Kaufmann, Bell-ingham Breast Cancer Center, European Network of Cancer Registries: Nadya Dimitrova, National Cancer Registry, Bulgaria |
| 13:00-14:00 | Lunch |
| 14:00-16:00 | Current Topics from Breast Cancer Care Research: Parallel Workshops  
1. Continuity of care for breast cancer  
2. Communication in person-centred services  
3. Key outcomes for studies on breast cancer screening  
4. Volume-outcome relation in breast cancer care |
| 16:00-16:30 | Coffee  
Evaluation of Event |
| 16:30-17:30 | Guided Poster Tour |
| 20:00 | Gala Dinner |
### Agenda – Day 3

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| **10:00-10:45** | Key note: Dealing with evidence from qualitative research in guideline development  
Özge Tunçalp, Department of Reproductive Health and Research, WHO, Geneva |
| **10:45-11:00** | Coffee |
| **11:00-12:30** | Report from the parallel workshops |
| **12:30-13:00** | Last minute presentations  
• Equity of access to breast cancer screening programmes in 27 European countries, Ana Molina, FISABIO  
• International consensus on methodological standards for guidelines, Ina Kopp, Guidelines International Network, Institute for Medical Knowledge Management, Germany  
• Delivery more for less, Elizabeth Benns, Independent Cancer Patients’ Voice, UK |
| **13:00-13:30** | Closing words  
DG SANTE, JRC |
| **13:30-14:30** | Closing lunch |
Welcome note: EC policies on (breast) cancer, **Michael Hübel, DG SANTE**

The European Union has been active on cancer prevention and control since 1985. Cancer screening is a cornerstone of this approach. In the 2003 Council recommendations on cancer screening, the Council set out set principles of best practice in the early detection of cancer, and invited all Member States to take common action to implement national population-based screening programmes for breast, cervical and colorectal cancer, with appropriate quality assurance. European Guidelines for quality assurance for breast, cervical and colorectal cancer screening have been developed as benchmarks on how to go about screening. Based on this work, DG Health and Food Safety have requested the Commission’s Joint Research Centre to develop a new version of the *European Guidelines for Quality Assurance in Breast Cancer Screening and Diagnosis*, and a voluntary European Quality Assurance scheme for Breast Cancer Services underpinned by accreditation and evidence-based guidelines–the European Commission Initiative on Breast Cancer.

Patients’ expectations on EC-(breast)cancer policies, **Susan Knox, Europa Donna**

EU policy provides the framework for improving and defining standards for breast cancer services in the EU and beyond. The EC *European Guidelines for quality assurance in breast cancer screening and diagnosis* published in 2006 provided the basis for Europa Donna to advocate for the key priorities of screening and treatment in specialist breast units. Our short guide based on this document was translated into 17 languages and countries outside the EU are using it as well. ED has also worked on getting important Resolutions and Declarations on breast cancer passed by the European Parliament. For the last 10 years we have worked with the Commission on disseminating information and providing training concerning EU guidelines to Member States. This has led to the development of the ECIBC for which we have the highest expectations. Europa Donna views this as the culmination of our advocacy work for the last seven years.
The European Commission (EC) launched the European Commission Initiative on Breast Cancer (ECIBC), a project to support European countries with a harmonised and benchmarked policy for improving quality while reducing inequalities. Along the last 20 years, many guidelines were made available at national/regional/local level, and quality assurance (QA) schemes were developed and running across EU. However, an evidence-based approach was not always applied and the auditing systems are diverse. The JRC, coordinator of ECIBC upon DG SANTE mandate, with the invaluable collaboration of ECIBC National Contacts, patients’ associations and experts, has mapped out how BC services are organised in Europe, ISO standards applied for BC care, availability of BC data, and BC QA schemes. The next steps are (i) to develop evidence-based guidelines, (ii) to set-up a modular, flexible and voluntary QA scheme underpinned by that evidence and by Regulation (EC) No 765/2008 on accreditation, including training requirements and a dedicated website.

Development of a voluntary European Quality Assurance Scheme for Breast Cancer Services, Francesco Sardanelli, QASDG chair

Development of European guidelines for breast cancer screening and diagnosis, Chris de Wolf, GDG chair

Guidelines platform and web hub, Liisa Pylkkänen, JRC, Luciana Neamtiu, JRC

ECIBC will develop and implement a voluntary European QA Scheme for breast cancer (BC) supported by evidence-based guidelines. The EC Guidelines Development Group will develop guidelines for BC screening and diagnosis. However, recommendations on the remaining BC services will be based on guidelines developed by other entities. High-quality evidence-based guidelines will be collected in the Guidelines Platform (GP) with the goal of providing healthcare providers and citizens clear and objective guidance on all BC services and promoting informed decisions. The process to search, evaluate, update, and host guidelines in the ECIBC web hub will be discussed. The web hub is a necessary interface for the ECIBC with the public. Due to the complexity of the initiative and the intrinsic multifaceted nature of the information related to its main outcomes, the web hub needs to be carefully conceived and developed. The concept agreed within the EC and how the stakeholders of the initiative will be involved in all the steps of the web hub development and publication will be discussed.
Surveys and research activities: breast cancer screening and care in Europe, implemented breast cancer quality assurance schemes, and standards used in breast cancer care, Silvia Deandrea, JRC, Aslı Ulutürk, JRC

Developing a single European quality assurance scheme and breast cancer screening guidelines applicable in all Member States, as foreseen by the ECIBC, is highly complex. In order to encompass different healthcare systems’ settings and the related quality systems within each country, a series of research activities was launched. A first report was based on a survey conducted on 25 Member States in 2012-2013; a second one concerns ISO accreditation, certification and conformity assessment of breast cancer services under National Accreditation Bodies’ governance; a third report focuses on peer reviewing and healthcare accreditation of breast cancer services. A paper co-authored with the Fundación para el Fomento de la Investigación Sanitaria y Biomédica de la Comunitat Valenciana (FISABIO) providing some general indicators on breast cancer screening programmes in Europe and on equity of access to those programmes for 27 European countries is now submitted for publication. Finally, two new surveys are under development, one on the implementation of the European Parliament Resolution on breast units and one on the European integrative oncology centers. The combination of these research activities provides a much clearer map of Breast Cancer Services in Europe.

The Concept of patient centred care and measuring the quality of health services, Chris Graham, Picker Institute, UK

Over the last two decades, the concept of person (or patient) centred care has become increasingly prominent in health services across the world. The aim of person centred care is to provide health services in a way that respects and responds to the knowledge, preferences, needs, and values of individual service users. At the core of the approach is the principle that users of health services should have a role in assessing the quality of care, by being given the opportunity to provide feedback about their own experiences. Measures of ‘patient experience’, including but not limited to patient surveys, are now widely used to assess the extent to which care is person-centred. This talk will trace the development of person-centred care and, alongside it, the increasing importance of measuring and using patient experience. This will address the role of patient feedback in measuring and understanding service quality, with examples from cancer care and chronic disease settings.
Abstracts [4]

Day 2 Practice and Challenges in Assuring the Quality of Breast Cancer Care in Europe

Hungary, Kitti Horváth, Chief Medical Officer’s Office, Hungary

Hungary is a middle-income Central-Eastern European country, joined the EU in 2004. She currently has 9.87 million inhabitants. The cancer burden the country has to carry is rather heavy. Overall cancer mortality rate in 2013 was the highest among the EU28. As to the breast cancer incidence, 34.7/100.00 new cases and 25.0/100.000 fatal cases were reported. The Chief Medical Officers’ Office, on behalf of the National Public Health and Medical Officers Services (ÁNTSZ), carries the task for organization, coordination, monitoring and evaluation of breast cancer screening. For overall cancer care the National Cancer Institute bears the professional responsibility. Population-based organized breast screening facilities in Hungary are available since 2002; 42 Breast Screening Centres have been contracted by tender. Each centre has been connected with other elements of breast cancer care, forming a Breast Unit, as defined by the European Guidelines, 4th edition (2006). The National Screening Registry regularly receives feedback from the mammography units about all indicators. By the appropriate interpretation of these data quality assurance for breast cancer screening can be guaranteed.

Malta, Miriam Dalmas, Malta associate partner in the Joint Action on Comprehensive Cancer Control (JA CANCON) and on the Board of Member States on the European Reference Networks

Comprehensive breast cancer care services are offered in Malta. To date, these services are not governed by any specific legal or regulatory requirements. Furthermore, these services have not as yet been awarded or included in a national or international accreditation or certification system. At different levels (including both national and individual organisational levels), there is works in progress to introduce applicable accreditation and certification systems.

Norway, Solveig Hofvind, Cancer Registry of Norway
CanCon, Tit ALBREHT, CanCon chair

Joint Action CANCON (Cancer Control) is focusing on the quality improvement in four important areas of cancer control – development of comprehensive cancer care networks, community cancer care, survivorship issues and guidance on several existing or potential screening programmes. In the latter, several challenges and new knowledge have shed new light on how screening programmes should be organised. A workpackage on screening is exploring guidance on cervical, breast, colorectal, prostate, lung and stomach cancer. This should provide an up-to-date knowledge and advice to policymakers on how to act in the face of the challenges arising from these screening programmes. The listed core topics will each prepare a comprehensive chapter for the publication entitled European Guide for Quality Improvement in Cancer Control, which will be published at the end of the project and presented at the final conference, which will be one of the events of the Maltese Presidency to the Council of the European Union.

EU-TOPIA, Harry de Koning, Erasmus University, Rotterdam

Breast, colorectal and cervical cancer cause 250,000 deaths each year, representing 20% of EU-cancer mortality. Although important progress has been made in both detection and treatment, there is persisting inequity in progress to reduce its burden. The objective of EU-TOPIA is to systematically evaluate and quantify the harms and benefits of the running programmes for breast, cervical, and colorectal cancer in all European countries, and identify ways to improve health outcomes and equity for citizens. We will first identify significant inequities in screening outcomes by assessing the key set of quality indicators for benefits and harms in each country. Using these indicators, outcomes and cost-effectiveness of existing cancer screening programmes in 2015 will be estimated. For this, state-of-the-art models of the natural history of the cancers will be constructed, using country-specific data. Barriers hindering implementation of optimal screening programs will be assessed, leading to road maps for improved screening. These road maps contain feasible changes, e.g., to extend or reduce the program, to change the screen test used or change key quality indicators, to perform activities that reduce screening related harm or incorporate new developments in screening, and provide policymakers with evidence for increased, decreased or optimized use of screening. The project will lead to reduced inequity, reduced number of cancer deaths and over-diagnosed cases, and increase in life years gained and better cost-effectiveness by 2025.
Breast Care provided by the multidisciplinary team makes it difficult to correlate results with interventions, whether good or bad results. In addition, there are relatively few evidence based quality metrics available to apply to centers wishing certification. Appropriate quality measures are those which are a) recognized by providers as being important, b) have variation in performance across centers, c) are feasible to extract performance data, and d) have a positive cost-benefit ratio. Another confounding problem is that quality measures must apply to the many varieties of breast centers, large and small, academic and community, urban and rural. In the US, two programs developed independently, each providing half of the quality equation. One program (NAPBC) focused on defining the structural components of care. They had to define structural requirements that were rigid enough to maintain high quality care but flexible enough to recognize the realities of the local community. The second quality program (NQMBC) focused on process measurements, or how well does the multidisciplinary team perform in each area of breast care. Although they measured specific performance levels, they had difficulty identifying benchmarks. Providing a single benchmark may be too high for many centers, while appearing too low and not providing improvement incentive for the better quality centers. The ideal breast center certification combines both multidisciplinary structural requirements along with process of care assessment (including benchmarks) that recognize both the realities of local environment and the needs of individual patients.
European Network of Cancer Registries, **Harry Comber, National Cancer Registry, Ireland**

There are over 20 national and 82 regional cancer registries in Europe, covering 72% of the population of the EU. All of these registries have contributed, or have the potential to contribute, to the quality of breast cancer care in some way. Because definitions are standardised across Europe, registries can provide long-term descriptions of trends in breast cancer incidence, stage, treatment, survival and mortality by country, region or hospital. Registries linked to screening programme data can also identify and compare in detail (including molecular makers) symptomatic, screened and interval cancers, and allow international comparisons. Improving data collection through the establishment of links to clinical cancer registries and the wider availability of electronic data means registries have an increasing scope and timeliness of data which can be linked to measures of quality of care and screening history. They can also help estimate the cost-effectiveness of new technologies, and of interventions such as rapid referral clinics or specialist breast centres. The potential of cancer registries to contribute to breast cancer quality assessment is limited by a number of factors. Cancer registration in Europe remains heterogeneous for historical, economic and legal reasons, so the scope of data captured by registries is very variable. Some countries have complete population coverage, others have regional coverage, and a few have no effective population-based cancer registration. Some registries do not have access to death certificates, which makes survival calculation inaccurate. Many capture stage and treatment at diagnosis, but not all. Some can provide more detail—for instance on type of surgery, completeness of excision, molecular markers, comorbidity and follow-up data—and a few collect data on quality of life, for selected cohorts. Linkage of screening data to cancer registries is not being done in some countries for cost, legal or administrative reasons. The ENCR, with JRC, is working on improving the standardisation and coverage of cancer registration in Europe. There is considerable potential for quality assurance and research through more widespread sharing of the more extensive data now collected by registries, clinical programmes and screening programmes, and the more detailed analysis of the data already collected.
1. **Continuity of care for breast cancer: what is it about and how can it be measured?**

**Aim of the session**

To successfully treat breast cancer patients it does not only need a multi-disciplinary approach but also a network of various services. Thereby assuring continuity of care becomes a crucial issue for the quality of care. Continuity of care implies continuity in terms of the management of the disease, continuity in terms how information is passed on from one service (provider) to the next and continuity in the relation of patient to service providers. This parallel session will:

1. explore which are the sensitive issues in assuring continuity in breast cancer care,
2. and how quality of care can be assessed in respect to its continuity.

The parallel session aims at developing examples, options and ideas for assessing continuity of care in a reliable and valid way that allows for comparing services.

**Structure of the session**

The parallel session will be opened by two presentations; both reporting examples of how to measure continuity of care as a dimension of the quality of care:

- **Jenny King**, from the Picker Institute, will report on the tools that the Institute has developed for assessing quality of care and experiences with their implementation.
- **Simone Wesselmann**, from the German Cancer Society, will report of how continuity of care is assessed within the certification of breast cancer centres by the Cancer Society.

**Charles Shaw** as the chair of this parallel session and **Anke Bramesfeld** from the JRC will explore and discuss with the participants to what extend these examples could be transferred to other health systems, or health care system requirements and how assessment of continuity of care would possibly need to look like, if applied on a European level.

The results of the parallel session will be reported by a rapporteur, who will be chosen spontaneously in the morning of December 11th.
1. Continuity of care for breast cancer: what is it about and how can it be measured? (cont.)

Integrated Care – what is important and how do we measure it?, Jenny King, Picker Institute, UK

This presentation first looks at what is important from a user perspective in person-centred coordinated care including the things users believe should always happen for care to be coordinated. It will then look at a project aimed to produce a robust user-reported measure that can capture the experience of older people with chronic conditions receiving health and/or social care services from different providers. The tool, under development by the International Foundation for Integrated Care, National Voices, the Nuffield Trust, the Picker Institute, and The King’s Fund in England, looks to assess coherence, coordination and quality of care.

Continuity of care, Simone Wesselmann, German Cancer Society, Germany

Continuity of care from the patients’ perspective is a core element of good care. Continuity of care comprises three major points: (1) one care provider for the patient with breast cancer who is a stable contact person through the complete care pathway, (2) communication between care providers, and (3) cooperation between care providers. The European QA scheme follows a patient-centered approach and therefore requirements must be defined which reflect the three aspects and focus on multidisciplinary, interprofessional communication and cooperation of care providers in a certified network along the treatment pathway of breast cancer patients. Additionally the requirements must be uniquely defined and (if applicable) measurable in order to be used by care providers for quality assurance and improvement.

2. Communication in person-centred services

Aim of the session
All information concerning breast cancer should be delivered to both patients and healthy women (e.g. in screening) in an honest, clear and easily understandable way, and if applicable, visual information and decision-aids may be used. All patients should be given choices and enough time to decide on treatment options, participation in trials and tissue donation. Communication training is an essential tool for healthcare professionals to be able to correctly interact with patients. Furthermore, the continuity of communication needs to be ensured throughout the entire patient journey – keeping the person in the centre.

This parallel session aims to explore:

1. which are the sensitive issues in the continuity of person-centered communication in breast cancer care (e.g. problems),
2. how the continuity of communication can be improved (e.g. tools),
3. and, how the continuity and person-centredness of communication can be measured (e.g. indicators).

This parallel session aims to discuss examples and possibilities for assessing person-centred communication in breast cancer services in order to facilitate development of recommendations and enable comparison of the quality of breast cancer services.

Structure of the session
The session will consist of three presentations, from different perspectives, providing examples of how the continuity of communication and patient centredness can be achieved:

- **Luzia Travado**, from the Champalimaud Clinical Centre, Lisboa, Portugal, will focus on psychosocial support and communication needs in breast cancer patients.
- **Yvonne Wengström**, from Karolinska Institute and University Hospital, Stockholm, Sweden, will discuss how continuity of communication can be ensured throughout the patient journey.
- **Kathi Apostolidis**, from European Cancer Patient Coalition, Brussels, Belgium will present the patient perspectives and experiences on the need to move from disease-centred to patient-centred communication.

All presentations will focus on how the continuity and patient-centredness in communication can be improved and measured. After the presentations the working group will discuss to what extent these examples and viewpoints could be applied in the development of patient-centred communication in breast cancer care at the European level. **Luzia Travado** will chair this parallel session and serve as a rapporteur of the session in the morning of December 11th. **Liisa Pylkkänen** from the JRC will support the working group in their tasks.
2. Communication in person-centred services  (cont.)

Psychosocial support and communication needs in breast cancer patients, Luzia Travado, Champalimaud Clinical Centre, Lisboa, Portugal

Good communication with patients and their families is closely linked to better treatment compliance and better clinical outcomes. Effective communication has the potential to reduce patients’ anxiety and uncertainty, identify their unique concerns and needs, and lead to appropriate referrals for necessary care, thereby promoting patient-centered care. Good or effective communication is considered a key component of good medical practice, and a core competence that can be trained. As such it has been proposed that promoting effective communication between patients, caregivers and healthcare professionals can be achieved through: including communication skills training (CST) in undergraduate and postgraduate curricula for physicians, nurses, and other allied health care professionals in cancer care; continued professional development programmes in psychosocial oncology in all cancer settings. However much remains to be done as to make it a mandatory requirement for clinical practice and for accreditation of medical units including SBU.

How continuity of communication can be ensured throughout the patient journey, Yvonne Wengström, Karolinska Institute and University Hospital, Stockholm, Sweden

Patient perspectives and experiences on the need to move from disease-centred to patient-centred communication, Kathi Apostolidis, European Cancer Patient Coalition, Brussels, Belgium
3. Key outcomes for studies on breast cancer screening

**Aim of the session**
The parallel session aims at discussing on a core set of desirable and undesirable outcomes to be assessed in breast cancer screening studies in order to facilitate an informed decision making.

**Structure of the session**
*Mireille Broeders* (Radboud University Medical Center, the Netherlands) and *Bettina Borisch* (University of Geneva, Switzerland) will open the session with two presentations.

*Roberto D’Amico* (University of Modena and Reggio Emilia, Italy), as chair of this parallel session, will steer the discussion after the presentations. The results of the parallel session will be reported by a rapporteur, *Holger Schünemann* (McMaster University, Canada), in the morning of 11th December.
Key outcomes for studies on breast cancer screening, **Mireille Broeders**, Radboud University Medical Center, the Netherlands

Continuous monitoring and evaluation of a screening programme is necessary to ensure that it is as effective as expected. Screening outcomes, both desirable and undesirable, become available throughout the screening process and afterwards. In general, a distinction can be made between evaluating the performance of the screening programme and its impact on health indicators such as mortality. Performance indicators reflect the provision and quality of the activities constituting the screening process without directly reflecting the reduction in mortality. Evaluating the long-term benefits and harms of screening for breast cancer takes many years and requires the application of complex epidemiological and statistical methodologies. Ascertainment of impact of the programme further demands that follow up of screened and non-screened cohorts continues over extended periods of time and that adequate links exist between programme data and other relevant data sources. A frequently used but challenging alternative is to identify and monitor early surrogate measures, such as the rate of advanced cancers, that can possibly predict outcome.

Key outcomes for studies on breast cancer screening, **Bettina Borisch**, University of Geneva, Switzerland

The study and evaluation of outcomes for breast cancer screening (programs) is important for the individual as well as for the public health institutions that run screening programs. EU Member States and their respective health care systems may value outcomes differently and the single citizen has again another demand as to the quality and outcomes of screening. The citizen as well as the ’national’ questions that may need further outcome studies will be presented.
4. Volume-outcome relation in breast cancer care

Aim of the session
In spite of the consistent results shown for several other diseases (i.e. AIDS, abdominal aortic aneurysm coronary angioplasty, myocardial infarction, knee arthroplasty, coronary artery bypass, etc.), the extent of the association between the volume of activity and the outcomes for breast cancer care is not always straightforward, because the results depend, among other factors, on the definition of caseload (whole hospital, centre, surgeon, etc.), the outcome chosen (mortality, proxies, etc.), and the set threshold. Selection bias and a different case-mix also deserve careful statistical adjustment. The objectives of this session are:

1. explore the existing evidence on the association between caseload and outcome for breast cancer,
2. discuss the most appropriate and feasible outcomes to be measured for this purpose.

Contributions from experts from different countries may stimulate a discussion on how healthcare policies introducing (or not) thresholds in the number of cases treated affected the organisation of cancer care and the access to the services.

Structure of the session
The parallel session will be opened by two presentations, both reporting examples of the assessment of the impact on volumes on outcomes in (breast) cancer care:

- Marina Davoli, from the Outcome Evaluation Programme–National Agency for Health Services (Italy), will report on the monitoring of Italian hospital data.
- Günter Heller, from the Federal Institute for Quality Assurance and Transparency in Healthcare (IQTIG) (Germany), will report on a retrospective analysis on case numbers and process quality in breast surgery in Germany.

The chair (tbc) of this parallel session and Silvia Deandrea from the JRC will explore and discuss with the participants the methodology and clinical issues arising from the presentations and if a European quality assurance scheme on breast cancer may take into account the volume of activity of the centres seeking certification.

The results of the parallel session will be reported by a rapporteur, who will be chosen spontaneously in the morning of December 11th.
4. Volume-outcome relation in breast cancer care  (cont.)

Monitoring of Italian hospital data, **Marina Davoli**, *Outcome Evaluation Programme – National Agency for Health Services, Italy*

Hospital or physician volume represents a measurable variable with a relevant impact on effectiveness of health care. Since 2009, the National Outcomes Programme (PNE) evaluates outcomes of care of the Italian hospitals; nowadays it represents an official tool to assess the National Health System (NHS). There is clear evidence from the scientific literature of an association between volume of breast cancer surgery, 30 days intra hospital mortality, five years survival and rate of conservative surgery. Although the systematic review of the literature does not permit to identify predefined volume thresholds, the EUSOMA guidelines identify a minimum threshold of 150 for a breast unit and 50 for single surgeon. In Italy in 2014 there are 467 hospitals performing more than 10 breast cancer surgeries, among these only 123 (26%) perform more than 150 surgeries corresponding to 70% of operated women. The biggest hospitals often have more than one ward in which surgery is subdivided; the proportion of women having surgery in high volume wards (more than 135) is 62% in 2014, as compared with 54% in 2010; we also observed a great geographical variability. In June 2014 the Ministry has approved a national guideline for the organization of the breast units and some regions are reorganizing the breast cancer network of hospitals to comply with different standards including the volume of care. However, the available data from PNE show that it is still very high the proportion of women having breast cancer surgery in proper sites.
4. Volume-outcome relation in breast cancer care  

Retrospective analysis on case numbers and process quality in breast surgery in Germany,  
Günter Heller, Federal Institute for Quality Assurance and Transparency in Healthcare (IQTIG), Germany  

Background: Numerous studies from around the world have shown a positive association between case numbers and the quality of medical care. The evidence to date suggests that conformity to guidelines for the treatment of patients with breast cancer is better in German hospitals that have higher case numbers.  

Methods: We used data obtained by an external program for quality assurance in inpatient care (externe stationäre Qualitätssicherung, esQS) for the years 2013 and 2014 to investigate seven process indicators in the area of breast surgery, including histologic confirmation of the diagnosis before definitive treatment, axillary dissection as recommended by the guidelines, and an appropriate temporal interval between diagnosis and operation. Case numbers were categorized with the aid of various threshold values. Moreover, subgroup analyses were carried out for patients under age 65, patients in good general health, patients without lymph-node involvement, and patients with a tumor size pT0 or pT1 or an overall tumor size less than 5 cm.  

Results: Data on 153,475 patients from 939 hospitals were analyzed. Six of seven indicators had values that were better overall, to a statistically significant extent, in hospitals with higher case numbers. Although this relationship was not consistently seen, the worst results were generally found in the category with the lowest case numbers. Similar though less striking results were obtained in the subgroup analyses. An exception to the general finding was that, in hospitals with higher case numbers, the interval between diagnosis and operation was more often longer than three weeks.  

Conclusion: Guideline adherence is higher in hospitals that treat more cases. The present study does not address the question whether this, in turn, affects morbidity or mortality. To improve process quality in peripheral hospitals, the quality assurance program should be continued.
Dealing with evidence from qualitative research in guideline development, Özge Tunçalp, Department of Reproductive Health and Research, WHO, Geneva

There is growing recognition that guideline questions sometimes fail to reflect the priorities of key stakeholders and that issues related to the acceptability and feasibility of the recommended interventions are not necessarily addressed through effectiveness reviews. Qualitative syntheses are increasingly conducted, but methods to assess how much confidence to place in synthesis findings, which is an essential consideration for guideline development, are poorly developed. The Confidence in the Evidence from Reviews of Qualitative research (CERQual) approach provides a transparent approach to assess how much confidence to place in findings from a qualitative evidence synthesis. Like the GRADE approach (Grading of Recommendations Assessment, Development and Evaluation), currently used for effectiveness evidence, this approach facilitates the use of qualitative evidence to inform decisions and shape policies. Department of Reproductive Health and Research of the World Health Organization, as part of the GRADE-CERQual Project Group, has been developing guidelines conducting and incorporating evidence from qualitative syntheses.

Equity of access to breast cancer screening programmes in 27 European countries, Ana Molina, FISABIO

Aim: To assess equity of access in European breast cancer screening programmes. Methods: Two surveys were launched in 2012 and 2013, in the context of the European Commission Initiative on Breast Cancer (ECIBC), and the European Partnership for Action Against Cancer (EPAAC), respectively. A joint follow-up of the surveys was undertaken in 2014. Results: Twenty-seven countries contributed to these surveys. Sixteen recognised not reaching some social groups, such as women without health insurance, without residence permits and in prison. Twenty-two reported that participation was periodically monitored by socioeconomic variables, and 13 identified social groups that participate to a lesser extent with the deprived population and ethnic minority groups being the most commonly. Finally, 17 countries have performed interventions to tackle inequalities mostly with a general approach. Conclusions: It would be advisable to improve interventions to tackle inequalities in access to breast cancer screening programmes in Europe with both general and targeted approach.
Participants

Dr. Tit Albreht, M.D. (1961), Slovenian, Ph.D. in Health Services Research at the University of Amsterdam, Head of the Centre for Health Care, National Institute of Public Health of Slovenia, Senior Researcher in the field of health services research, health policy and health systems, member of the Scientific Committee of EUPHA, member of the Slovenian Preventive Medicine Society, member of the Health Council of the Ministry of Health of Slovenia. He is an Associate Professor of Public Health at the Department of Public Health of the Medical Faculty in Ljubljana. He acts as a reviewer of several scientific journals and of projects submitted for financing to the European Commission. He is currently coordinator of the Joint Action Cancer Control (CanCon), dedicated to the development of health policy support and advice to cancer control policies at the level of the EU and of the Member States.

Kathi Apostolidis. Kathi is the Vice President of ECPC-European Cancer Patient Coalition and a Public Affairs Consultant with extensive experience in regulatory affairs, marketing and communications. She represents ECPC at the EMA’s Patients and Consumers Working Group, she is member of the European Commission Expert Group on Cancer Control and of the Expert Group EIBC/QASDG on the Commission Initiative on Breast Cancer, participates as ECPC representative in Work Packages of the EU Joint Action on Cancer Control. She is a member of the Cancer Patients Working Group of ESMO, of the Steering Committee of HTAi’s Patients and Citizens Involvement Group. At the national level, she is the Chair of the Intergroup Committee for Cancer Patient Rights Advocacy/Greece (DEDIDIKA), she serves as a Deputy Board Member at KEFI-Association of Cancer Patients, Volunteers and Physicians/Greece, and is also member of other Greek and international cancer patient associations. As a twice breast cancer survivor, she was involved in breast cancer and cancer patient rights advocacy since 1995. She has a broad interest in cancer care policy and many aspects of front line cancer care, survivorship, cancer research and economics, health technology assessment, digital technology in cancer care. Graduate of the University of Athens, Philosophy Dept. and Political & Economic Sciences and of McGill University, Canada in Business Administration. She is a member of the editorial board of the Journal of Compassionate Health Care.

Prof. Bettina Borisch, Professor of Public Health, Institute of Global Health, University of Geneva. Director of the World Federation of Public Health Associations, headquartered in Geneva. Dr Borisch is an MD and a Histopathologist, MPH and Fellow of the Royal College of Pathology (UK). Her scientific research work delves into neoplastic lesions of the immune system and breast cancer. Her interests also include community-based oncology, health communication and global health. She studied medicine and history at the Universities of Kiel (Germany) and Lausanne (Switzerland). She is appointed professor and head of the Institute of Clinical Pathology, University of Geneva in 1995. She becomes the president of the Swiss Cancer League’s program against breast cancer. She completes an MPH in 2005 and orientates her activities to Public Health and Global Health. She joins the Institute of Social and Preventive Medicine in 2005 (from 2015 on: Institute of Global Health). She is Editor in Chief of Pathobiology and the Co-Editor of Journal of Public Health Policy. In addition to her academic work she acts as the Director and Head of the World Federation of Public Health Associations and holds positions at several Committees of Public Health oriented institutions. She was president of Europa Donna–The European Breast Cancer Forum and Founding President of the Swiss Forum of Europa Donna. She teaches at the University of Geneva, the Swiss School of Public Health and she also teaches patient support groups. She is (co)author of over 120 scientific papers.
Participants

Dr. Mireille Broeders is a cancer screening epidemiologist with an academic degree in biomedical health sciences. She is an Associate Professor at the Dept. for Health Evidence, Radboud University Medical Center, in Nijmegen, the Netherlands. Her research focuses on establishing the impact of cancer screening programmes, in particular screening for breast cancer, and the potential value of moving to risk-based screening regimes. She has a special interest in observational research designs that can be used in this field of research. As a long-standing member of the National Evaluation Team for Breast Cancer Screening, she is also involved with the evaluation of the long-term benefits and harms of the Dutch nation-wide breast screening programme. She further works as scientific supervisor at the Dutch Reference Centre for Screening in Nijmegen. This has broadened her research interests to include, e.g., the implementation and evaluation of technological developments in the breast screening programme, pain experience during breast compression and test sets for radiologists. All research projects at the Centre aim at the safeguard and constant improvement of the quality of the breast cancer screening programme. At a European level, she contributed, as editor and author, to the European Guidelines for Quality Assurance for Breast Screening and Diagnosis. She has been co-leading the EUROSCREEN working group, a European research effort to summarise breast cancer screening service screening outcomes, published as supplement to the Journal of Medical Screening (2012). She has co-authored over 100 papers in peer-reviewed journals.

Harry Comber graduated with a BSc in Chemistry from UCC in 1971 and was awarded a PhD in molecular biology for study on the control of tumour cell proliferation from the Institute of Cancer Research, London, in 1974. He then studied medicine at University College Cork, graduating in 1978, and entered the Cork General Practice Training Programme the following year. He worked as a general practitioner, researcher and Director of the Cork General Practice Training Programme until 1992, when he became the founding Director of the National Cancer Registry. He has been the Irish representative, and Chair, of the Scientific Council of the International Agency for Research on Cancer, and is currently a member of the Advisory Committee on the National Cancer Strategy and is Deputy Chair of the Steering Committee of the European Network of Cancer Registries. Research and Clinical Interests: as Director of the National Cancer Registry, Harry has a commitment to population-based research in cancer. This has encompassed areas as diverse as cancer causes and health economics, but with a focus on variation within, and between, populations in cancer risk and outcomes. This work has been widely disseminated, in over 80 peer-reviewed publications and more than 30 registry-published reports and has had a significant impact on national cancer strategies and on the establishment of the National Cancer Control Programme. One of his consistent interests has been in inequalities and inequities in access, treatment and outcomes.

Dr. Miriam Dalmas. I am a medical professional specialising in Public Health Medicine. Since 2009, I have been engaged as a medical consultant in Public Health Medicine. My main role is in the coordination of policy development and in providing general support to the Chief Medical Officer (CMO). I occupied the post of Director for Policy Development, EU and International Affairs for the Ministry for Health from 2007-2011. For the past six years my work has focussed on the national cancer policy and I was the main author of the National Cancer Plan 2011-2015. I have also led the creation of the National Health Systems Strategy 2014-2020 that was launched in 2014. Presently, I am representing Malta as an associate partner in the Joint Action on Comprehensive Cancer Control (JACANCON) and on the Board of Member States on the European Reference Networks. Recently, I have been tasked with the coordination of a new National Cancer Plan 2016-2020. In 2005, I graduated as a Master in Business Administration from the University of Malta. Since 2010, I am a doctoral candidate with the Faculty of Economics, Management and Accounting at the University of Malta in the field of Management and specifically on the subject of Organisational Learning.
Participants

Marina Davoli. Scientific Director, Italian National Outcome Program Department of Epidemiology Lazio Region, Roma, Italy. Medical Degree in 1985 at the University of Rome ‘La Sapienza’. Master of Science (MSc) in Epidemiology – London School of Hygiene and Tropical Medicine in 1991. Head of the Department of Epidemiology, Regional Health Service, Lazio Region, Operational Centre of the National Outcome Program. Member of the Regional Drug Formulary of the Lazio Region. Member of the Scientific Committee of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon. Coordinating Editor of the Cochrane Drugs and Alcohol Group. Member of the GRADE (Grading of Recommendations Assessment, Development and Evaluation) Working Group. Main activities: systematic reviews of the scientific literature on the effectiveness of health care interventions; epidemiological studies on the health status of the population; comparative effectiveness research on drugs and other health care interventions; comparative analysis of health care outcomes across hospitals and geographical areas for the National Outcome Evaluation Programme and the Lazio Regional Outcome evaluation programme; coordination of the work package of the EU Project DECIDE on strategies for the dissemination of evidence to policy makers. Author of more than 100 scientific publications on peer reviewed journals, H index 21.

Henricus J de Koning. Born in the Netherlands, Professor Henricus (Harry) J de Koning worked as a Researcher and an Assistant Professor in the Department of Public Health of the Erasmus University in Rotterdam from 1987 to 1999. He became an Associate professor in 1999 and in 2008 he was appointed Professor of Public Health & Screening Evaluation in the same department in Rotterdam. He was also Senior Associate Department of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health from 2011 to 2012. Since 2011 he has been a Member of the Medical Advisory Board of the Royal Netherlands Academy of Arts and Sciences (KNAW). His major scientific contributions are in the areas of: designing, running and evaluating large-scale multidisciplinary population-based randomized controlled screening trials to establish the efficacy of screening; evaluating active international screening programs and tests to establish effectiveness; guiding public health policies using predictions of favorable and unfavorable effects and the cost of screening, based on micro-simulation modelling of the natural history of disease, and cost-effectiveness and cost-utility analyses.

Dr. Chris de Wolf. I am a medical expert specialised in breast cancer screening. I studied medicine in the Netherlands (VU Amsterdam) and afterwards I was engaged by the policy development department of the Dutch Ministry of Health (1989-1990). On request of the European Commission, I worked on European cancer screening strategies within the Europe against Cancer program for 8 years, where I was charged with the development of the European Guidelines for Quality Assurance in Breast Cancer Screening and Diagnosis. In 1999 I took a position as Head Screening and Early Detection at the International Union against Cancer (UICC, Geneva). Between 2004-2014, I had many positions all related to breast cancer screening in Switzerland. Currently, I am quality assurance specialist for Swiss cancer screening, medical director of the breast screening program in canton Wallis and consultant to the breast screening programs in Thurgau and Basel. All these activities I execute through my company ADSAN Sarl (Agence pour le développement et évaluation des politiques de santé).
Participants

Silvia Deandrea obtained her degree of Medical Doctor and specialisation in Public Health and Preventive Medicine at University of Pavia, and obtained her Biostatistics PhD at University of Milano in 2011. Before joining the Joint Research Centre in 2012, she worked in healthcare quality consultancy for the Joint Commission International, in cancer epidemiology research at Mario Negri Institute of Pharmacological Research (Milano, Italy) and in population-based cancer screening programmes organisation and evaluation at Cancer Prevention Unit of Milano Local Health Authority. For the breast and colorectal cancer programmes she covered the role of quality manager and she coordinated local activities in the context of multicentre research projects. Her current research interests include quality assessment and standardisation in breast and colorectal cancer screening, cancer pain epidemiology and Bayesian methods for evidence synthesis. She is author of more than 20 articles published in peer-reviewed international journals.

Chris Graham. Chris is the Director of Research and Policy at the Picker Institute, a charity with a vision of the highest quality health and social care for all, always. Chris has over a decade of experience in working on and promoting person centred care and the measurement and use of patient experience information. He is currently involved in a number of research projects investigating the measurement and improvement of patient experience. These include a major study investigating the value of ‘near real-time’ feedback for improving compassion in care, as well as collaborating with other charities and academic institutions to develop new approaches to measuring integrated care and user experiences along pathways. Chris is the chief investigator for the NHS Patient and Staff Survey Co-ordination Centres, run on behalf of Care Quality Commission (CQC) and NHS England respectively, which are sent to over 500,000 people each year. He is an NIHR fellow and an associate member of the Health Services Research Unit at University of Oxford. Prior to joining the Picker Institute, Chris worked at the CQC and Healthcare Commission, where he was responsible for managing national research programmes.

Guenther Heller, MD PhD. 1996-2002: Institute for Medical Sociology and Social Medicine, University of Marburg. 2002-2010: Research Institute of the Local Sickness Funds (Wissenschaftliches Institut der AOK: WIdO). 2010-2015: AQUA – Institute for Applied Quality Improvement and Research in Health Care GmbH. Since October 2015: Federal Institute for Quality Assurance and Transparency in Healthcare (IQTIG). My primary research interests lie in the fields of epidemiology and healthcare research. I have performed several analyses using large population-based datasets addressing volume outcome or volume quality relations, e.g. in the fields of perinatology, neonatology and breast surgery.
Participants

*Solveig Hofvind* (1961). Head of the Norwegian Breast Cancer Screening Program, professor in radiography at Oslo and Akershus University College of Applied Sciences. Hofvind is radiographer by training and did her master at the Norwegian school of sport sciences (Physical activity and risk of breast cancer). After 13 years work at Akershus University hospital, where she was the pioneer in establishing a breast clinic and the Norwegian Breast Cancer Screening Program, she started to work at the Cancer Registry of Norway. The Cancer Registry is responsible for the administration and quality assurance of the screening program. Hofvind started working as an information advisor for the breast and cervical cancer screening programs in 1998. Four years later she started working on her PhD, which she finished in 2005 (The Norwegian Breast Cancer Screening Program: Selected process indicators and their utilization in epidemiological research). Hofvind was guest professor at the University of Vermont, 2006-07, and 2010-11 and a substantial network internationally. She has about 90 peer-review publications, mainly related to epidemiological aspects of breast cancer and mammographic screening.

*Kitti Horváth*, MD. I was born in Budapest, Hungary in 1986. I firstly graduated from high school in the United States of America (2004) and then in Hungary (2006). I started my higher education in 2006 at the Faculty of Medicine, University of Szeged, where I had the chance to organize almost all my internships abroad experiencing the flow of different health care systems. On the field of research I worked at the Institute of Surgical Research of the university (new possibilities in sepsis treatment) and also at the centre of Siemens Healthcare in Germany (radiological innovations in minimal invasive surgical interventions). My interest towards health promotion began directly in the first year of university, so I joined the Hungarian Medical Students’ International Relations Committee (HuMSIRC) to participate in their prevention activities. Following my accession I soon became the national public health officer of the committee and after a couple years of national and international experience I was elected to be the Director of the Standing Committee on Public Health of the International Federation of Medical Students’ Associations (IFMSA) in 2012. This position allowed me to work worldwide with medical students as well as with different non-governmental organizations for a better future concerning health promotion and care. After graduating from medical university I became a resident doctor at the Internal Medicine Department of the Hungarian Defence Forces’ Medical Centre. Beyond my clinical work I joined the Chief Medical Officers’ Office of Hungary in 2015 and started specialising mainly on breast cancer and breast screening.

Participants

**Cary S. Kaufman**, MD. Cary Kaufman is an Associate Clinical Professor of Surgery at the University of Washington, Fellow of the American College of Surgeons and the Medical Director of the Bellingham Regional Breast Center in Washington State. Dr. Kaufman was trained at UCLA and the University of Washington and for the last 30 years has practiced as a breast surgeon. His professional life has focused on three areas: individual patient care, functional research, and physician education. He has lectured on the diagnosis and treatment of breast cancer both nationally and internationally. His interest in quality assessment of breast care has led him to have served as the Chairman of the National Accreditation Program for Breast Centers, the President of the National Consortium of Breast Centers, a Board Member of the American Society of Breast Surgeons, a Trustee of the National Consortium of Breast Centers and Chair Emeritus of the National Quality Measures for Breast Centers. He is a current member of many societies including the Society of Surgical Oncology and the American Society of Breast Surgeons. He is or has been a journal reviewer for the *Annals of Surgical Oncology*, the *American Journal of Clinical Oncology*, *The Breast Journal*, *JAMA*, and the *Journal of Surgical Oncology*. He has published over 50 articles on multiple aspects of breast care, diagnosis and treatment, including pioneering work on cryoablation for breast tumors, assessing the quality of breast care, intraoperative use of breast ultrasound, defining the value of preoperative needle biopsy, digital specimen mammography and specimen tomodraphy as well as other subjects.

**Jenny King**. As Associate Director of Research at the Picker Institute, an international charity working across health and social care, Jenny is responsible for the organisation’s research work stream. This includes managing large scale academic related grant-funded projects and commissioned evaluations designed to create new knowledge and influence policy and practice in health and social care. Jenny has eight years of experience carrying out qualitative and quantitative research exploring patient centred care, integrated care and staff experience. A current project, commissioned by The National Institute for Health Research (NIHR), and in collaboration with the University of Oxford, aims to strengthen relational care provided in hospitals and to evaluate a real-time feedback approach for informing care delivery. The study addresses an urgent need for research that evaluates the introduction and impact of real-time feedback approaches in the NHS. Jenny joined the Picker Institute in 2008 after completing an MSc in Forensic Psychology.

**Susan Knox** is a two time breast cancer survivor and has been Executive Director of Europa Donna since 1999. She is responsible for all on-going European advocacy initiatives in the areas of information, education and lobbying, including Pan-European advocacy conferences, meetings and information sessions at the European Parliament and European Commission, European Breast Cancer Advocacy Training Courses, publications and websites. In 2008 she launched ED’s first prevention initiative – BREAST HEALTH DAY, which takes place annually on 15 October (see website www.breasthealthday.org). In addition, Susan represents ED on numerous other projects: BIG Scientific Committee, MIN-DACT and AURORA Committees, European Commission Expert Group on Cancer Control, the ECIBC project, and European Breast Cancer Conferences(EBCC). She is a speaker on patient advocacy at various international conferences and courses and has written widely on the subject. In 2009 she was also named advocacy editor of the scientific journal *The Breast*. Prior to joining Europa Donna, Susan held various managerial positions in both the corporate and non profit sectors, working for Citibank and a non-profit long-term care facility for the aged. Susan holds a B.A. degree from Smith College and an M.A. degree from Columbia University.
Participants

Donata Lerda. Born in 1962, graduated in Chemistry in 1987. Worked in the Public Administration in Italy for more than 20 years and started working in the EC in 2007. She is expert in quality assurance, accreditation, auditing and management of networks; she also has a deep knowledge of the European Commission working rules. She coordinates the European Commission initiative on Breast Cancer.

Luciana Neamtiu. Graduated in Mathematics and Physics in 1996, she obtained a PhD in Mathematics (Numerical analysis, optimisation and computer science applied to medicine) and a Master Degree in Project Management. She worked for more than ten years in the area of cancer registries and screening databases, and collaborated in setting-up the regional population-based cervical cancer screening programme and cancer registry in Romania. She is currently working for the European Commission’s Initiative on Breast Cancer.

Liisa Pylkkänen, MD, PhD graduated in Medicine in 1986 and obtained her PhD in 1992. She is a Specialist in Clinical Oncology (since 1995), Health Administration (since 2001) and Palliative Medicine (since 2010). She also holds Adjunct Professor position at the University of Turku, Finland (since 2001). She has worked for more than 25 years in clinical oncology and in different management positions both in academia and pharmaceutical industry. Since 2012 she served as Chief Medical Officer at the Cancer Society of Finland and currently working as Scientific Project Officer in the Healthcare Quality Team at the JRC (since 8/2015). Her scientific interest has focused on breast and prostate cancer, bone active compounds and patient support.
Participants


Charles Shaw trained as a doctor (London), manager (Canadian Hospital Association), and hospital inspector (Accreditation Canada). He received a PhD from the University of Wales on healthcare standards. He worked as a manager in the UK NHS, as an academic at University of Bristol, and as a policy adviser at the King’s Fund and Department of Health in London. Retired from the UK NHS since 2001, he is now visiting professor at Macquarie University in Australia, and freelance consultant to ministries of health. As former president of the International Society for Quality in Healthcare (ISQua), he led a global review of ‘quality and accreditation in health care services’ commissioned by WHO Geneva in 2000. He has published five European and international surveys of healthcare accreditation programmes, and guidance for new schemes for WHO (HQ, EURO and EMRO), for World Bank and for several Ministries of Health. The most recent of 150 publications in peer reviewed journals proposes a European initiative to standardise healthcare standards between accreditation, certification and regulation. Charles Shaw was leader of the EC research project on ‘external peer review techniques’ and a partner in designing hospital assessment tools for the EC MARQuIS and DUQuE projects, seeking to demonstrate an association between accreditation, certification and quality and safety in healthcare.

Luzia Travado, PhD, MSc, ClinPsych, is clinical health psychologist and psychotherapist by the University of Lisbon, specialized in psycho-oncology and palliative care, and has doctorate degree in Psychology/Health Psychology by the University of Coimbra. She is presently head of Psycho-Oncology at the Clinical Center of the Champalimaud Foundation (www.champalimaud.org), in Lisbon, Portugal (2012-). Previously was chief of Clinical Psychology at Central Lisbon Hospital Centre-Hospital S. José, where she began her career and has pioneered psychosocial programs for chronic disease patients, namely breast cancer (1985-2012). She served as adviser for the National Coordinator for Oncological Diseases in Portugal (2007-2011). She represented Portugal at the European Partnership on Action Against Cancer (2009-2014), and led the Psychosocial Oncology Action under this partnership; she presently collaborates with the European Cancer Control Joint Action (CANCON). She has been involved in European cancer policy being a speaker at various EU meetings, summits and conferences concerning cancer control and care in Europe, and also international ones related to psycho-oncology. She currently serves as President of the International Psycho-Oncology Society (www.ipos-society.org), and was Chair of the IPOS World Congress of Psycho-oncology in Lisbon in 2014. She serves as Specialty-editor for The Breast and is founder and former president of the Viva Mulher Viva Association on breast cancer. She has several scientific papers published in Int’l peer-review journals, and book-chapters. She was cover story at Cancer World in the Nov-Dec 2011 issue.
Participants

Özge Tunçalp, MD, PhD, is a physician and epidemiologist currently based in Geneva as a scientist in the Department of Reproductive Health and Research at the World Health Organization. In collaboration with country, regional and international partners, she uses quantitative and qualitative methodologies as well as innovative approaches to research quality of care for maternal and newborn health, including maternal morbidity and safe abortion in low- and middle-income countries. She is a member of the GRADE-CERQual Project Group, which develops a methodology to assess confidence in the evidence from reviews of qualitative research and leads the work on WHO guidelines on antenatal care, upcoming in 2016. Özge completed her PhD at Johns Hopkins Bloomberg School of Public Health and a postdoctoral fellowship at the Department of Obstetrics and Gynecology at Yale School of Medicine.

Yvonne Wengström is an oncology nurse and has worked at the Department of Oncology with breast cancer practice since 1989, and holds a PhD in oncology and is Professor in Nursing. She is a senior researcher at the Karolinska Institutet in Stockholm, Sweden, and leads a research team at the Department of Nursing. Dr Wengström has developed her research career with focus on breast cancer and is now recognised as a nurse leader in projects around screening, innovative interventions using e-health in cancer care, experience based co-design and is an advocate of transferring research outcomes into practice. She is also a member of several international committees and has been the President of the European Oncology Nursing Society, has participated as invited speaker at many international conferences, and is widely published. She currently serves as specialty editor for The Breast journal and is one of the founding members of the global network for collaboration the International Learning Committee (ILC).

Aslı Ulutürk was born in Izmir, Turkey in 1976. She graduated from Ankara University Faculty of Medicine in 2000 and received her specialist degree in Radiology in Gazi University in 2007. She worked in the Ultrasound Department of Women’s Health Hospital in Bartın and held the consultant radiologist position of the city in Cancer Early Diagnosis and Screening Program coordinated by the Ministry of Health for three years. Then she moved to Istanbul and worked in Chest Diseases and Tuberculosis Research Hospital focusing on follow-up of tuberculosis and lung cancer. Her main professional interests are breast imaging, abdominal and obstetrics ultrasound. She joined the Joint Research Centre in April, 2013. As a member of the Unit for Public Health Policy Support, she works with the Healthcare Quality Team.
Simone Wesselmann. As a trained gynecologist I have been the founding member of two certified breast cancer centers in Germany (2003 and 2004). The impact of certification on the overall care of patients was strikingly convincing. Its success encouraged me to continue my career in the area of quality assurance. Subsequently I graduated with a Master’s Degree in health care management, and in 2008 I started as head of the certification department of the German Cancer Society. Within our certification system we have 278 breast cancer centers certified by the German Cancer Society and the German Society for Senology in four European Member States. These centers are part of a comprehensive oncological certification system with in total over 1,100 certified centers for different tumor entities. By now the German centers treat 90% of all incident breast cancer cases in Germany. I am also a member of the Guideline Group which developed the German evidence based Guideline for Breast Cancer. The guideline is the basis for recommendations which must be met during the certification procedure. Every year my department publishes the results of over 50,000 breast cancer patients that have been treated in certified centers. In sum, my expertise has got breadth and depth, based on many years of experience in the field of quality assurance. It is part of my daily work to develop with other experts guideline based recommendations, quality indicators, nationwide working documentation and to implement a successful certification system with added value for patients and care givers.
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