

**NA BCOP** | National Audit of Breast Cancer in Older Patients

**ABS** ASSOCIATION OF BREAST SURGERY

**Royal College of Surgeons** ADVANCING SURGICAL CARE

**HQIP** Healthcare Quality Improvement Partnership

## Getting the most out of the NABCOP. What does your data say about your trust?

NABCOP-ABS Symposium  
UK Oncology Forum 13-Jun-2019

#OF19  
#NABCOP2019

[www.nabcop.org.uk](http://www.nabcop.org.uk)  
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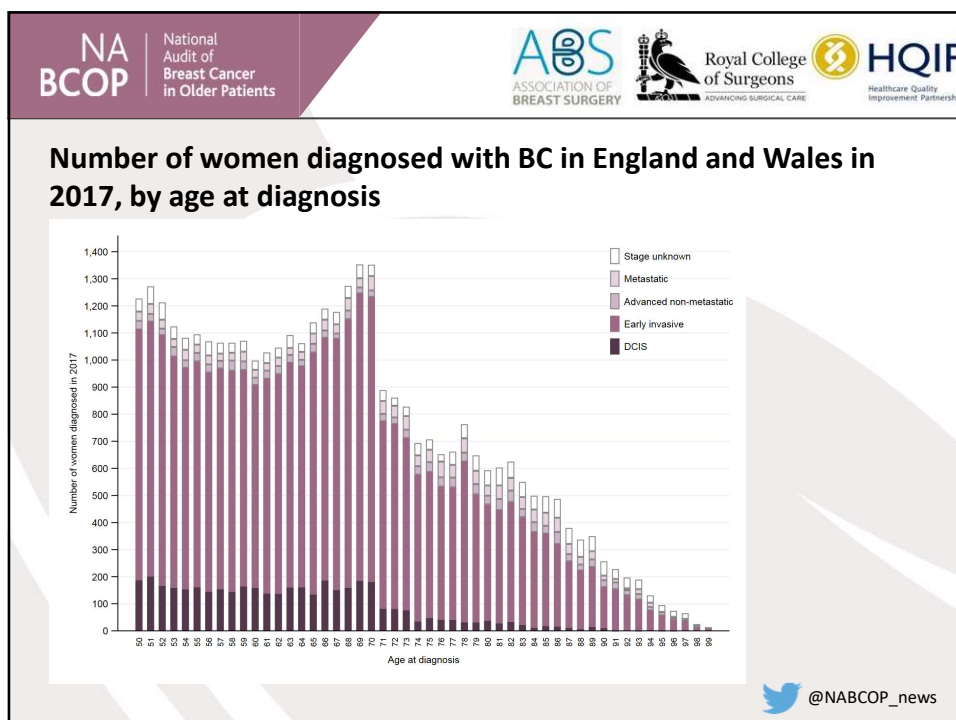
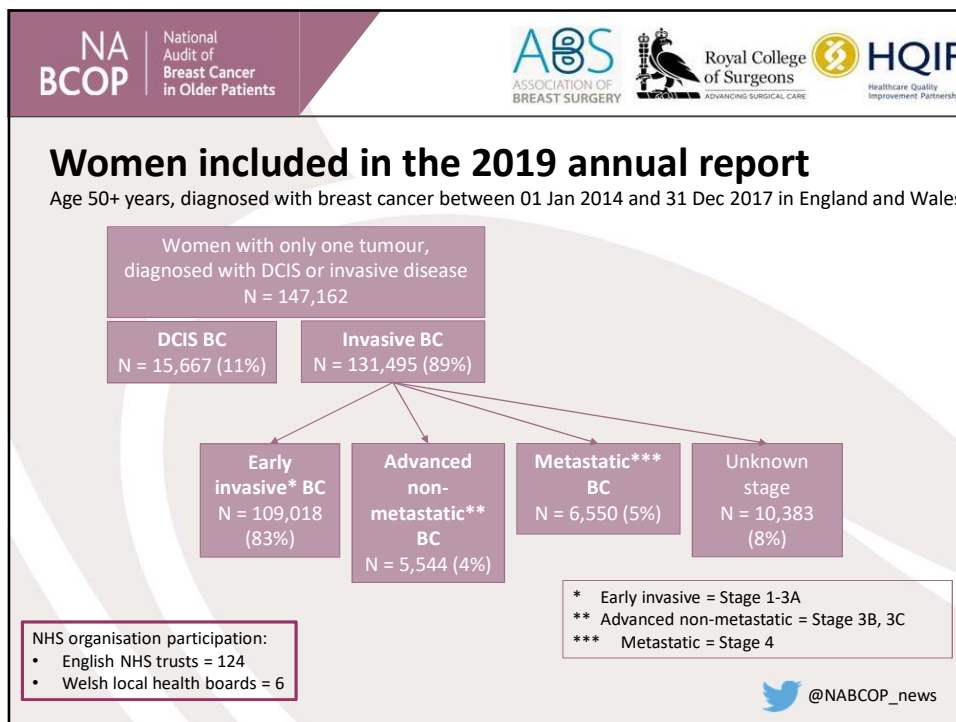
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## What is the NABCOP?

- The NABCOP is a collaboration between ABS and RCSEng
  - Commissioned by HQIP as part of the National Clinical Audit Patient Outcomes Programme (NCAPOP)
  - Started in April 2016
- Aim: To audit breast cancer care received by women aged 70+yrs in NHS organisations in England and Wales
  - Compare with care received by women aged 50–69 years
- Use existing data sources

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Data Item	Total % available	England		Wales	
		% available (all trusts)	No. trusts >80%	% available (all LHBs)	No. LHBs >80%
		<b>All tumours (invasive / non-invasive)</b>			
Laterality	100%	100%	124	100%	6
CNS contact	74%	76%	83	56%	0
WHO performance status	50%	53%	38	1%	0
<b>Invasive tumours</b>					
Grade	100%	100%	124	99%	6
Tumour stage	94%	95%	124	82%	5
Nodal stage	94%	94%	124	100%	6
Metastases stage	94%	95%	123	82%	5
Overall stage	93%	94%	123	74%	2
ER status	91%	91%	107	94%	6
HER2 status	85%	85%	92	89%	6
Whole tumour size	79%	80%	62	63%	1
PR status	58%	58%	54	57%	2

	50–69 years (n = 68, 613)	70+ years (n = 40, 405)
<b>Grade of disease</b>		
1	19%	14%
2	53%	58%
3	27%	26%
<b>Tumour size (cm)</b>		
>0.1 to 2	65%	50%
>2 to 5	31%	46%
>5	4%	4%
<b>Number of malignant lymph nodes (if examined)</b>		
0	75%	72%
1–3	21%	23%
4–9	4%	5%
10+	0%	0%




  

	50–69 years (n = 68, 613)	70+ years (n = 40, 405)
<b>ER status</b>		
Positive	87%	87%
Negative	13%	13%
<b>HER2 status</b>		
Positive	12%	10%
Borderline	7%	7%
Negative	81%	83%

**Early invasive breast cancer (n = 109, 018)**


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## Fitness decreases with age, but the majority remain fit

	Early invasive (n=109,018)		Metastatic (n=6,550)	
	50-69 years	70+ years	50-69 years	70+ years
<b>WHO Performance Status (PS)</b>				
0	89%	58%	59%	32%
1	9%	24%	23%	28%
2+	2%	18%	18%	40%
<b>Charlson comorbidity index (CCI)</b>				
0	91%	75%	81%	59%
1	7%	15%	13%	22%
2+	2%	11%	5%	19%
<b>electronic Frailty Index (eFI)</b>				
Fit	83%	58%	63%	36%
Mild-moderate	13%	19%	25%	23%
Severe	4%	23%	12%	41%

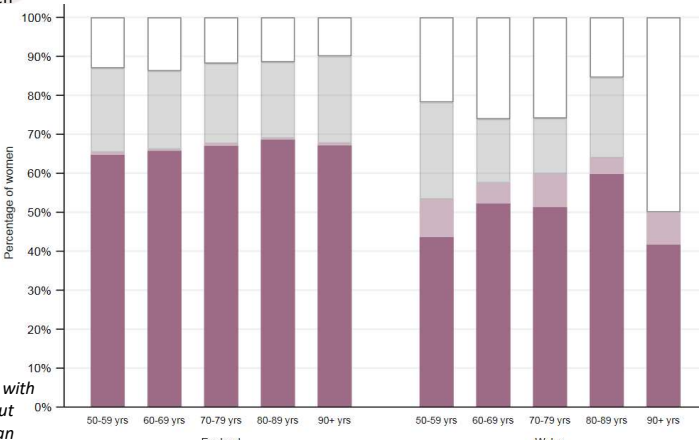
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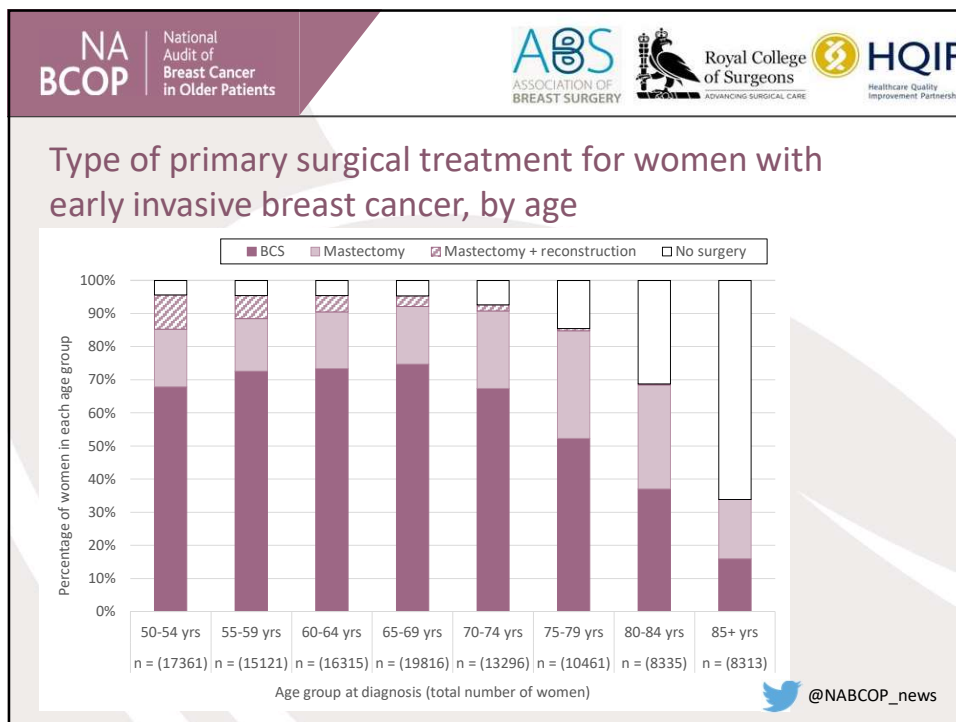
## Triple diagnostic assessment in a single visit

- In women with non-screen detected early invasive BC



\* US imaging = % of women with no mammogram reported but who were reported to have an ultrasound performed on the same date as their diagnostic biopsy

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## EVIDENCE

Surgical excision decreases breast cancer related mortality for older patients with early invasive breast cancer <sup>1</sup>


1. Ward SE et al. Omission of surgery in older women with early breast cancer has an adverse impact on breast cancer-specific survival. *BJs*. 2018;105(11):1454-63.

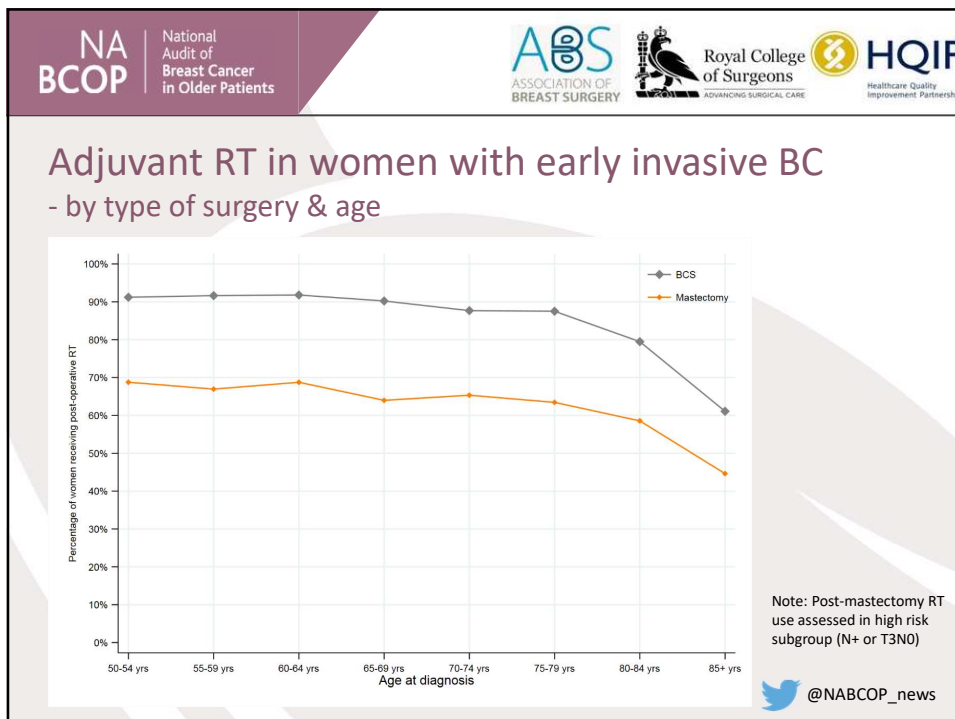
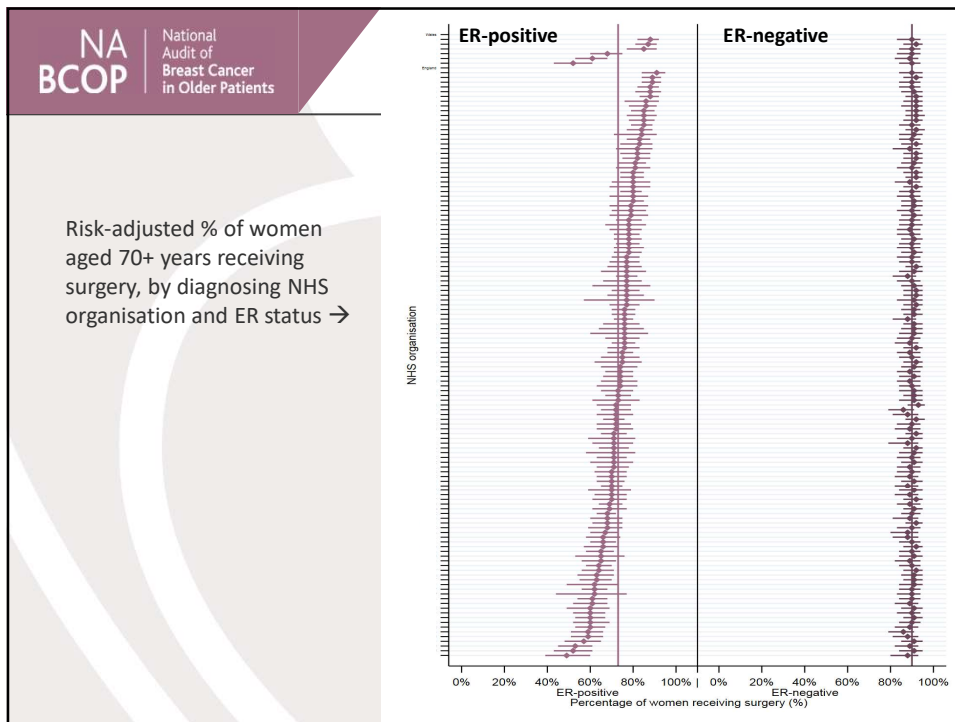
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Likelihood of receiving surgery for early invasive BC, as measured by patient fitness, age and ER status		ER-positive				ER-negative			
		50-69 years		70+ years		50-69 years		70+ years	
		No. of women	% having surgery	No. of women	% having surgery	No. of women	% having surgery	No. of women	% having surgery
Measure of fitness	All women	54087	96%	31170	73%	8155	95%	4702	90%
<b>Charlson comorbidity index (CCI)</b>									
	0	46517	97%	21681	84%	7027	96%	3367	94%
	1	3349	95%	4167	62%	508	94%	633	88%
	2+	1028	87%	2969	38%	209	95%	457	77%
	unknown	3193	82%	2353	38%	411	83%	245	69%
<b>WHO Performance Status (PS)</b>									
	0	18727	96%	6814	87%	3253	95%	1043	95%
	1	1741	94%	2794	71%	394	92%	466	94%
	2+	423	77%	2021	29%	72	94%	324	74%
	unknown	33196	96%	19541	73%	4436	90%	2869	63%
<b>electronic Frailty Index (eFI)</b>									
	Fit	42214	97%	16831	87%	6323	96%	2643	94%
	Mild-moderate	6448	96%	5594	79%	1032	96%	814	91%
	Severe	2232	90%	6392	46%	389	94%	1000	82%
	unknown	3193	82%	2353	38%	411	83%	245	69%

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## Who are we?



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## More importantly, who are you?

- What is your role?
- What are you hoping to get out of the next 60 minutes?


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## What data do the NABCOP use?


- Existing national datasets provided by NCRAS (England) and CANISC (Wales)
  - No** audit-specific database
  - No** additional data entry required by NHS organisations

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  Healthcare Quality Improvement Partnership

## Where does the data come from?

- Cancer Registry
  - Sourced from COSD
- Cancer Outcomes and Services Dataset (COSD)
  - Routinely uploaded from your trust
- Hospital Episodes Statistics (HES)
  - Admitted patient care; A&E
- SACT
  - Chemotherapy & other systemic therapy information
- RTDS
  - Radiotherapy information
- ONS
  - Mortality data

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## How does the data get there?


- MDT data entered
- Various data entry system providers
  - Somerset Cancer Registry [Screenshots in these slides]
  - Infoflex [No screenshots available for this workshop]
- Forms part of routine COSD data submissions for your trust

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Improvement Partnership


## Where can I see/check my data?

- The NABCOP NHS Organisation Data Viewer
  - What is published in the Annual Report
  - Combines all data sources
  
- CancerStats *[see handout in your packs]*
  - COSD data items only (not including pathology)
  - Real time; up to previous month




Home » NABCOP » NABCOP Level 2

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## CNS contact

**Audit standards: NICE (2018)**


All people with breast cancer should have a named CNS or other specialist key worker with equivalent skills, who will support them throughout diagnosis, treatment and follow-up.

**The NABCOP recommendations:**




NHS organisations must ensure that:

- Women are assigned a named breast CNS to provide information and support.
- Data on the assignment of a named breast CNS are submitted to the national cancer registration services.

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## Where does this data come from?

TEST\_Test (Ms)    Born 1-Jan-1957 (62y)    Gender Not Known    Hospital No 1234567    NHS No 1000001234

Diagnosis    Staging    Mets at Diagnosis    **Faster Diagnosis**    Additional Info

Patient Status  First NHS funded treatment commenced

Tumour Status at Diagnosis  Primary    Assessed By

Date of Diagnosis (Clinically Agreed)     Date Patient Informed

Informing Care Professional     Method of communication

Diagnosis Uncertainty

Referral Subtype

Primary Diagnosis (ICD)

Primary Diagnosis (SNOMED)  [Advanced Search](#)

Primary Diagnosis Subsidiary Comment

Laterality     Organisation

Basis of Diagnosis     Topography (ICDO3)

Morphology (SNOMED)

Grade of Differentiation


Diagnostic Route


Date Referred to CNS     Date First Seen by CNS

CNS Seen By Indication Code


Other Tumour Site

**Disclaimer:**  
SCR screenshot, not InfoFlex


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## Where does this data come from?

TEST\_Test (Mrs)    Born 1-Jan-1957 (67y)    Gender Not Known    Hospital No 1234567    NHS No 100001234

**Diagnosis**    Staging    Mets at Diagnosis    **Faster Diagnosis**    Additional Info

Patient Status  First NHS funded treatment commenced

Tumour Status at Diagnosis  Primary    Assessed By

Date of Diagnosis (Clinically Agreed)      Date Patient Informed

Informing Care Professional      Method of communication

Diagnosis Uncertainty

Referral Subtype

Primary Diagnosis (ICD)

Primary Diagnosis (SNOMED)      [Advanced Search](#)

Primary Diagnosis Subsidiary Comment

Laterality

Organisation

Topography (ICD03)

Basis of Diagnosis

Morphology (SNOMED)

Grade of Differentiation

Diagnostic Route

Date Referred to CNS      Date First Seen by CNS

CNS Seen By Indication Code

Other Tumour Site

**Disclaimer:**  
SCR screenshot, not InfoFlex

Y1 - Yes, including Clinical Nurse Specialist present when patient given diagnosis

Y3 - Yes, Clinical Nurse Specialist not present when patient given diagnosis but saw patient during same consultant clinic session

Y4 - Yes, Clinical Nurse Specialist not present during consultant clinic session when patient given diagnosis but seen at other time


Y5 - Clinical Nurse Specialist not present when patient given diagnosis but the patient was seen by a trained member of the CNS team

N1 - No, patient not seen at all by Clinical Nurse Specialist but Clinical Nurse Specialist informed of diagnosis


NN - No, patient not seen at all by Clinical Nurse Specialist and Clinical Nurse Specialist not informed of diagnosis

99 - Not known (Not Recorded)


Close    Power has unsaved changes No audit information available    Reset Values




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## The NABCOP NHS Organisation Data Viewer

**NABCOP 2019 Annual Report: NHS Organisation Data Viewer**


Report Chapter	Topic
DQ_Summary	Data Quality (DQ) summary, by NHS Organisation, of the table for Chapter 3.2
Chapter 3.2	Data Quality
hd_Summary	Individual summaries, by NHS Organisation, of figures from Chapter 5 onwards
hd_Summary_Compare	A summary that allows for comparison of two selected NHS Organisations
Chapter 5.1	Route to diagnosis
Chapter 5.2	Triple diagnostic assessment in a single visit
Chapter 5.3	Involvement of a breast clinical nurse specialist (CNS) or key worker
Chapter 6.1	Surgical treatment for DCIS
Chapter 7.1	Surgical treatment for early invasive breast cancer
Chapter 7.2	Radiotherapy treatment for early invasive breast cancer treated with surgery
Chapter 7.3	Adjuvant chemotherapy plus trastuzumab for HER2-positive early invasive breast cancer
Chapter 8.1	Chemotherapy for metastatic breast cancer at initial presentation

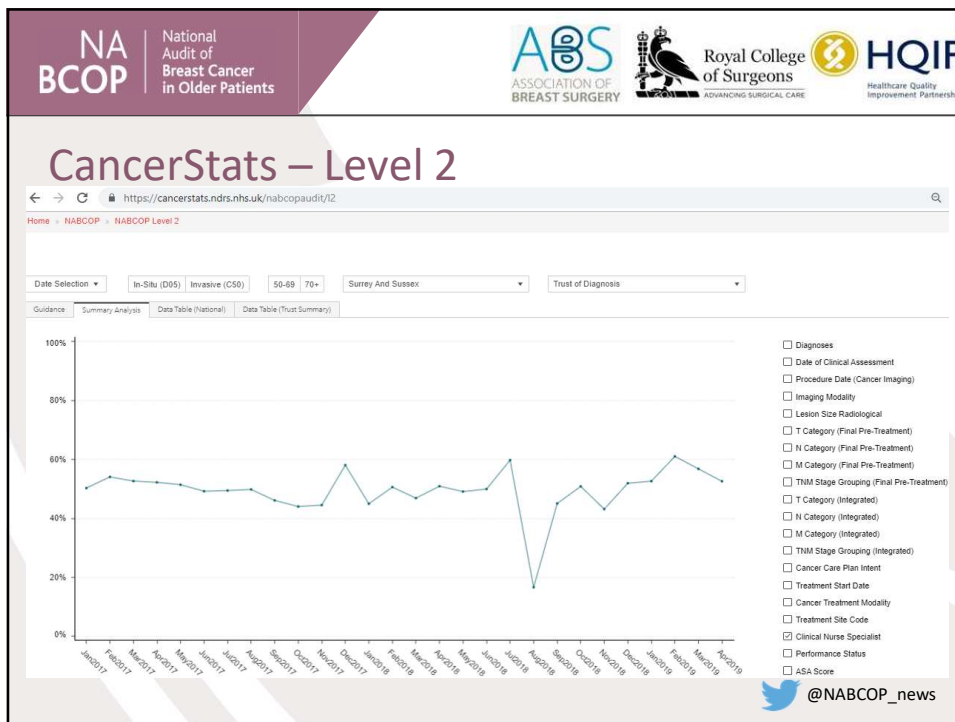
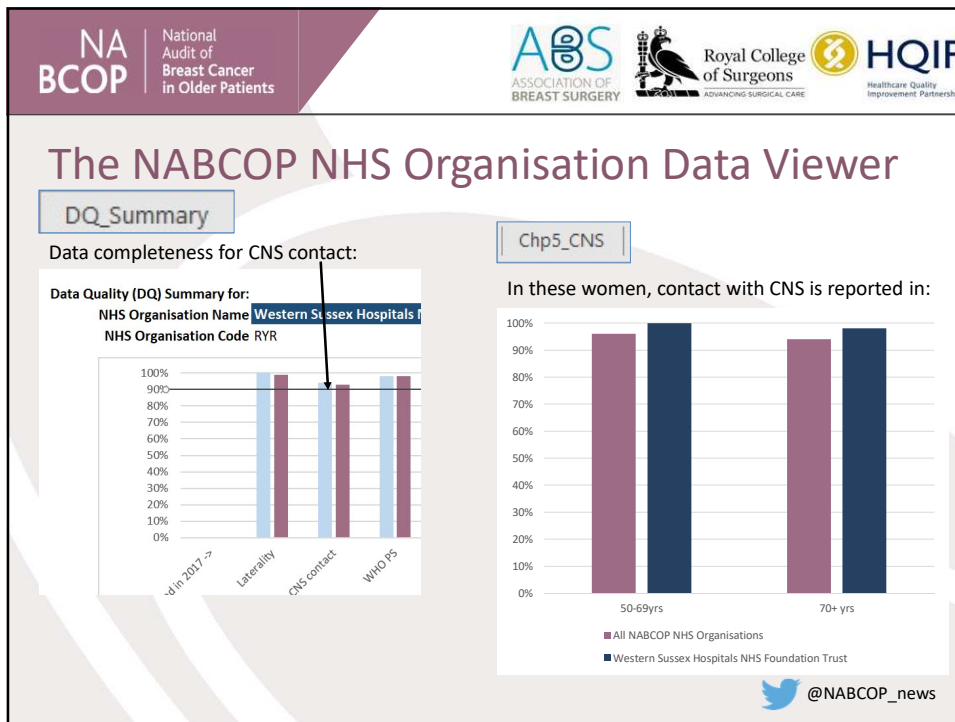
**Click in the cell below to scroll & pick the NHS organisation you want to be highlighted in the subsequent tabs:**

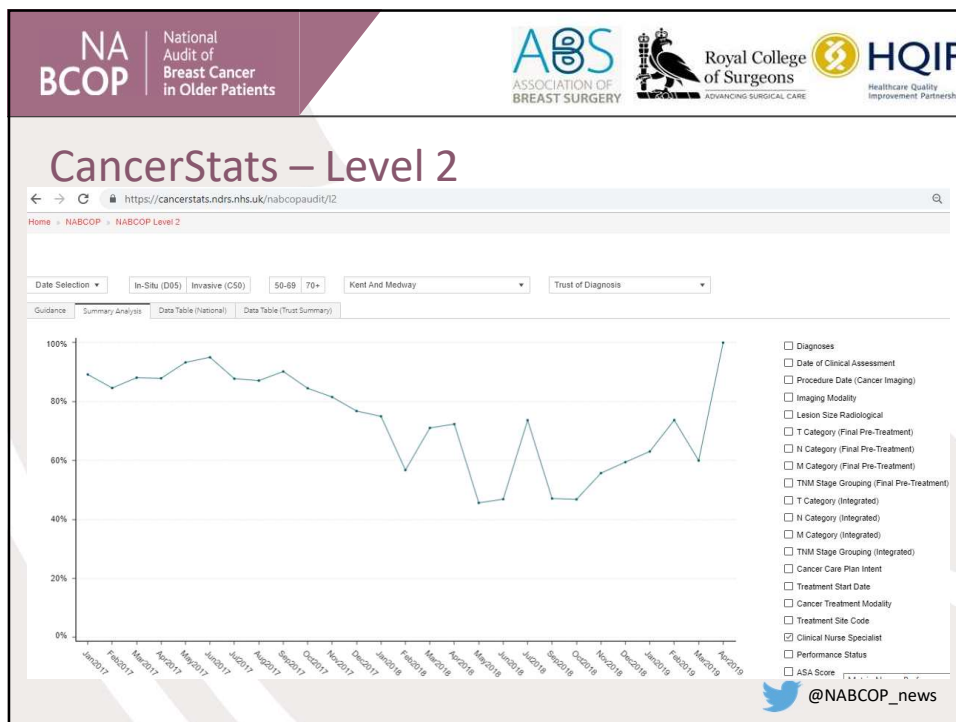
Western Sussex Hospitals NHS Foundation Trust

**Click in the cell below to scroll & pick an NHS organisation you would like to compare the above organisation with in the "Ind\_Summary\_Compare" tabs:**

\* Click here (on CONTENTS tab) to scroll & select NHS Organisation \*

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## Data completeness

**Audit standards: NICE (2018)**

Ensure that the ER, PR and HER2 statuses are available and recorded at MDT meetings when systemic treatment is discussed.

**The NABCOP recommendations:**

NHS organisations must ensure that the following information is uploaded to the national cancer registration services:

- Tumour size consistent with the entered T stage
- N stage, M stage
- ER status and HER2 status
- WHO performance status.

NHS organisations should identify a clinician responsible for reviewing and checking their units' data returns.

**Data completeness target = 90%**

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## How does this data get from your MDT to NCRAS?

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TEST\_Test (Mrs) Born 1-Jan-1957 (62y) Gender Not Known Hospital No 1234567 NHS No 1000001241

**Diagnosis** **Staging** **Mets at Diagnosis** **Faster Diagnosis** **Additional Info**

Radiological TNM Staging  
No Radiological TNM Staging Records

Pathological TNM Staging  
No Pathological TNM Staging Records

Final Pre-Treatment (Clinical) Staging ?

Date    T  N  M  TNM: ?

TNM Stage Grouping (Final Pre Treatment)  Organisation

Certainty Factors ? T  N  M  Overall

Final (Integrated) Staging ?

Date    T  N  M  TNM: ?

TNM Stage Grouping (Final Integrated)  Organisation

Site Specific Staging

**Breast** **Misc**

Nottingham Prognosis Index ?




Nottingham Prognosis Index

Tumour Size (mm)	<input type="text"/>	Tumour Grade	<input type="text"/>
Lymph Node Score	<input type="text"/>		
NPI	<input type="text"/>	Prognosis	<input type="text"/>

**Disclaimer:**  
SCR screenshot, not InfoFlex






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## The NABCOP NHS Organisation Data Viewer

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**NABCOP 2019 Annual Report: NHS Organisation Data Viewer**

**Report Chapter Topic**

**DQ\_Summary** Data Quality (DQ) summary, by NHS Organisation, of the table for Chapter 3.2

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*Click in the cell below to scroll & pick the NHS organisation you want to be highlighted in the subsequent tabs:*




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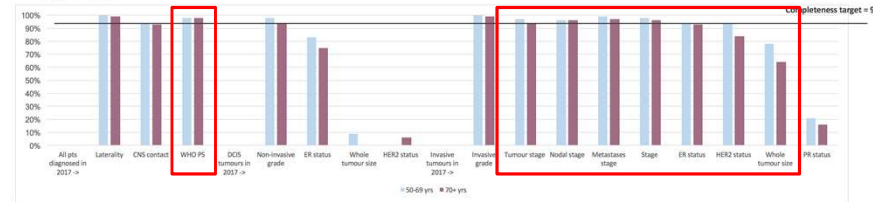




## The NABCOP NHS Organisation Data Viewer

**DQ\_Summary**

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**Data Quality (DQ) Summary for:**  
**NHS Organisation Name:** Western Sussex Hospitals NHS Foundation Trust  
**NHS Organisation Code:** W78

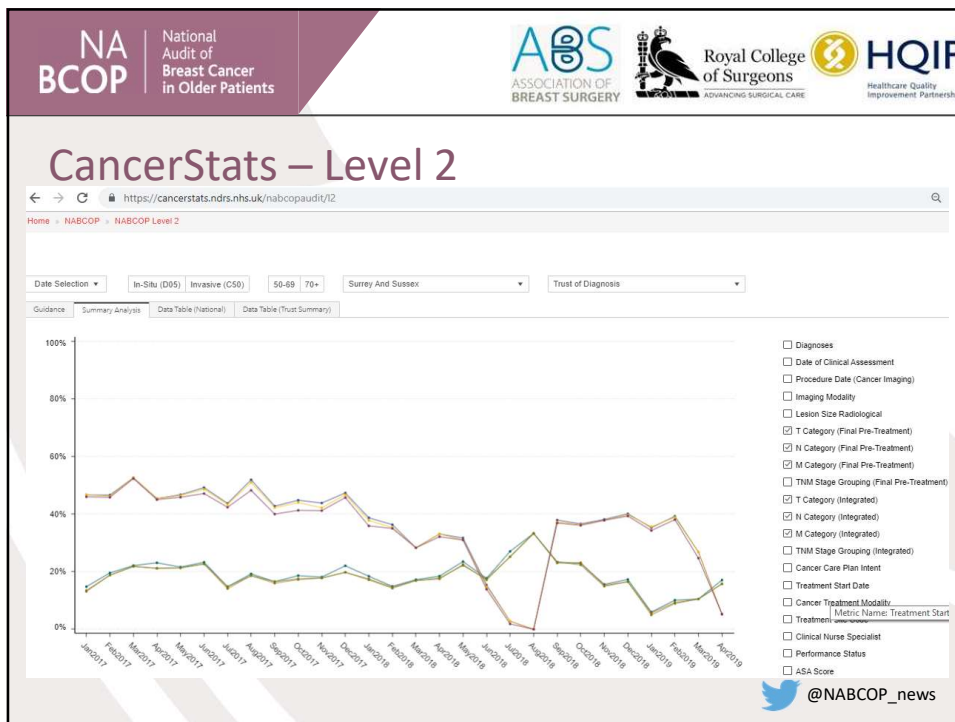
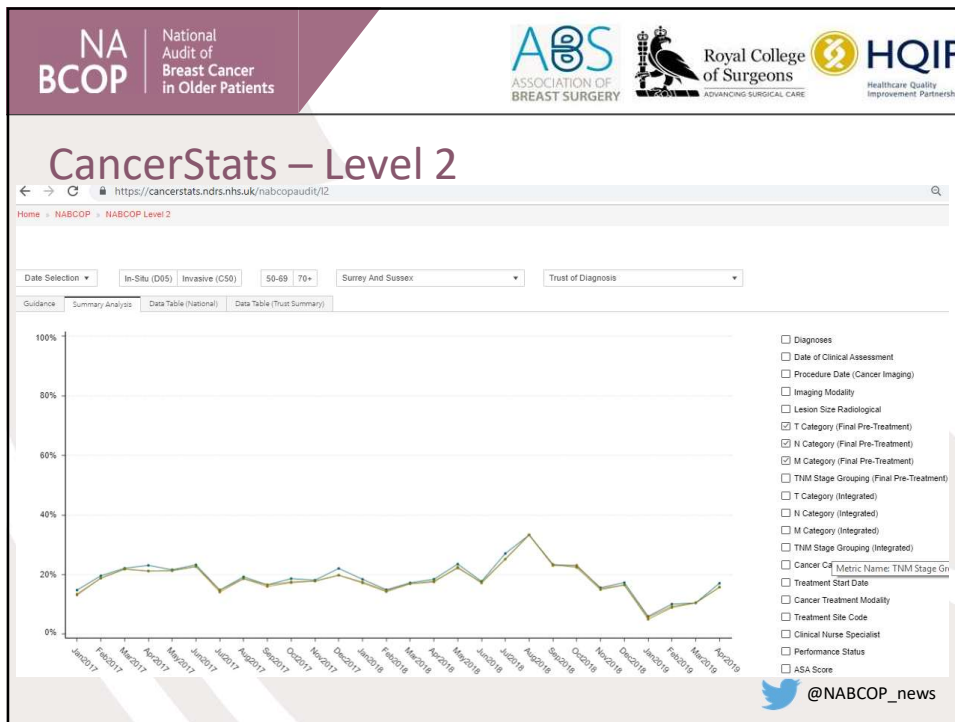


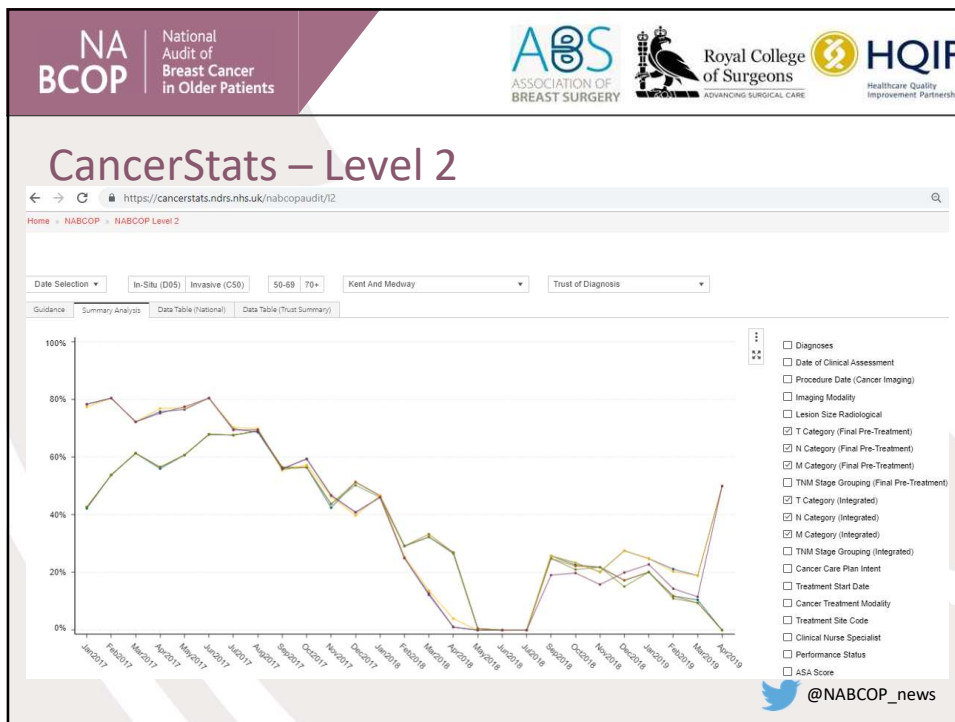
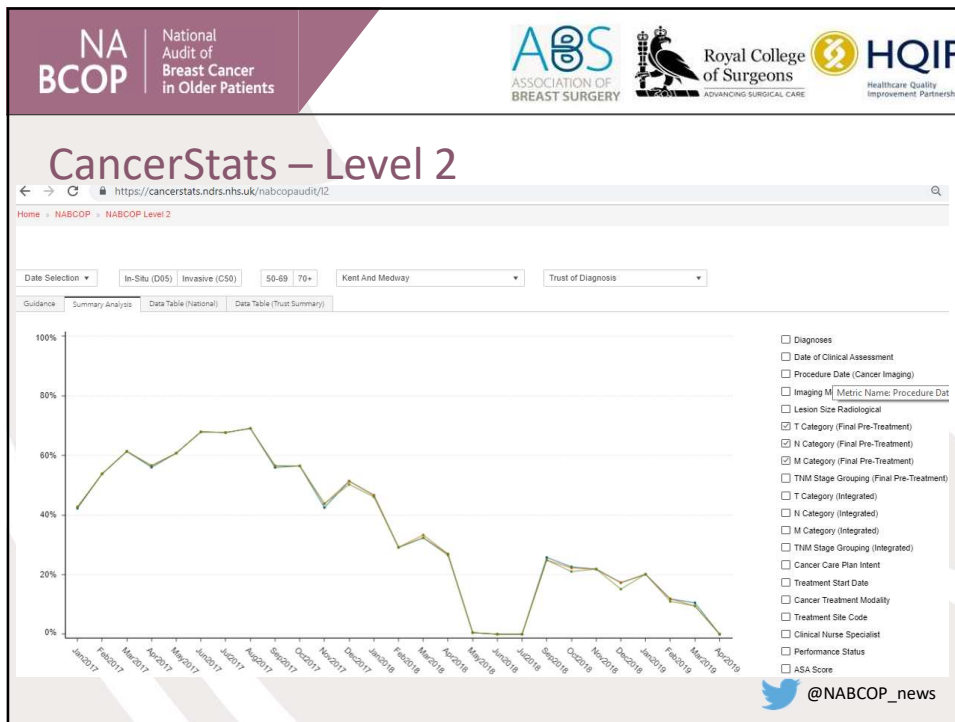
	All pts diagnosed in 2017 ->	Laterality	CNS contact	WHD PS	DCIS tumours in 2017 ->	Non-invasive grade	ER status	Whole tumour size	HER2 status	Invasive tumours in 2017 ->	Invasive grade	Tumour stage	Nodal stage	Metastases stage	Stage	ER status	HER2 status	Whole tumour size	PR status
50-69 yrs	222	100%	94%	98%	47	98%	83%	9%	0%	275	100%	97%	95%	99%	98%	94%	94%	78%	21%
70+ yrs	196	99%	93%	98%	16	94%	75%	0%	6%	180	99%	94%	95%	97%	96%	93%	84%	64%	16%

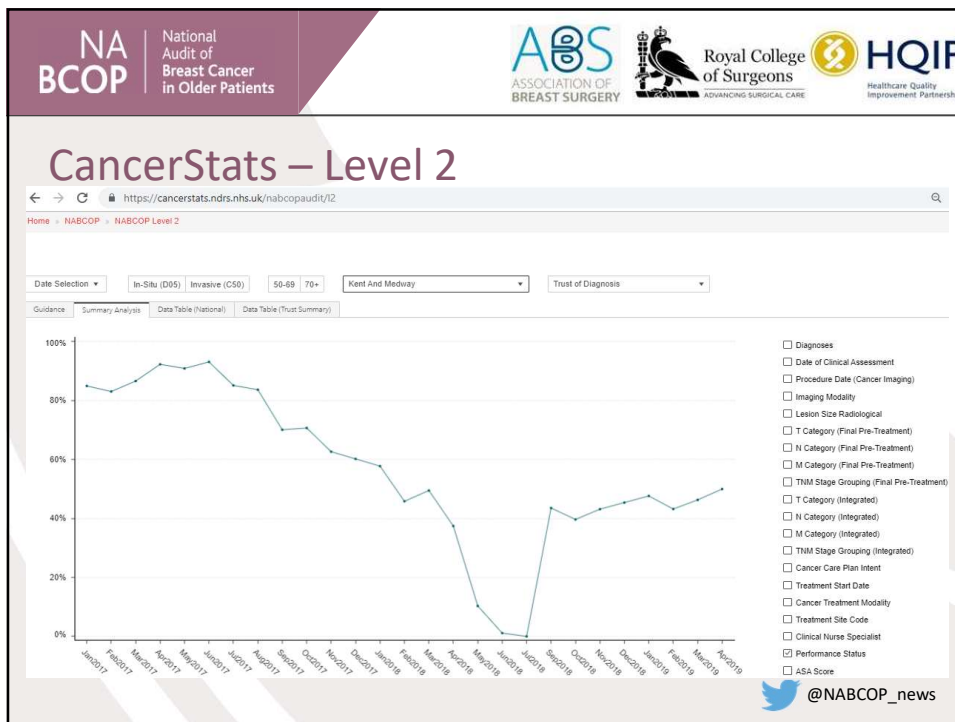
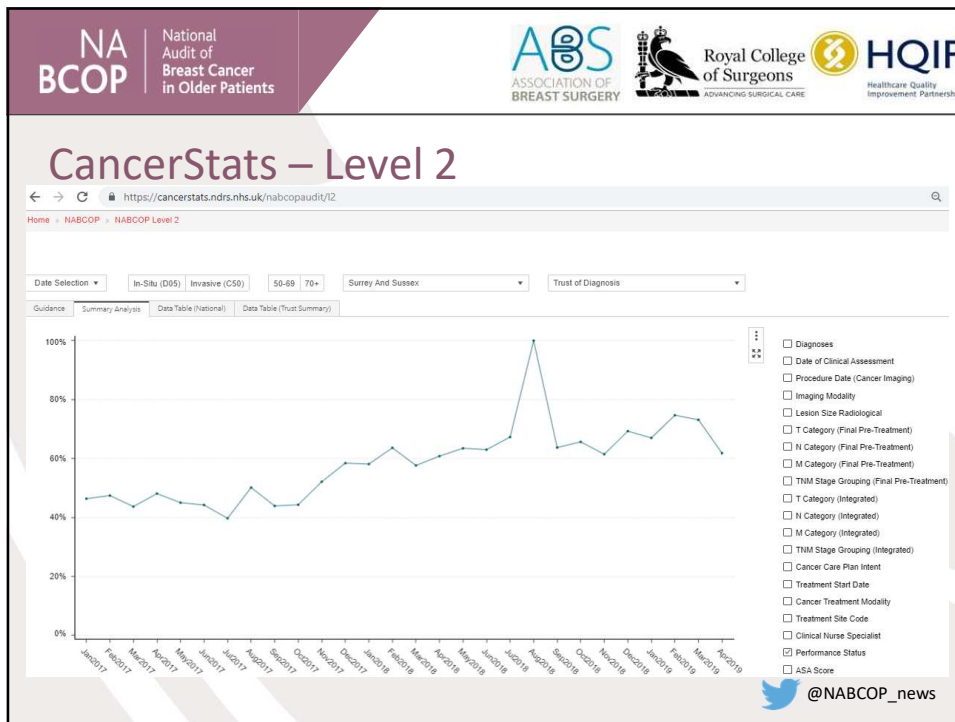
**NABCOP 2019 recommendation on completeness of data items:**

- NHS organisations must ensure that the following information is uploaded to the national cancer registration services:
  - Tumour size consistent with the entered T stage
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  - ER status and HER2 status for invasive breast cancer
  - WHD performance status.
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## What are the actions for your trust?

- Are all your patients seeing a CNS?
- Where does data completeness need improving?

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## Why is the NABCOP data important?

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## Why is the NABCOP data important?

- Understand the characteristics of the breast cancer
- Understand reasons behind treatment decisions
- Allow comparison between NHS organisations
- Transparency and continuous evaluation of local practice

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## Treatment for women with early invasive breast cancer (EIBC) - stage 1-3A

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## How do you treat your patients?

MDT discussion to determine treatment pathway.


Based on:

- Patient health + fitness
- Cancer staging
- Molecular marker test results

} COSD (Cancer Registry)

Treatment information:

- Surgery } HES
- Radiotherapy } RTDS
- Chemotherapy } SACT

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## Early invasive breast cancer - Surgery

**Audit standards: NICE (2018)**

Treat patients, irrespective of age, with surgery and appropriate systemic therapy, rather than endocrine therapy alone, unless significant comorbidity precludes surgery

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## Surgery

The NABCOP found:

- Overall rate of surgery decreased with age
  - 95% in 50–69 years, 74% in 70+ years
- Women aged 70+ years more likely to receive surgery for ER-negative compared to ER-positive breast cancer, irrespective of measurement of fitness

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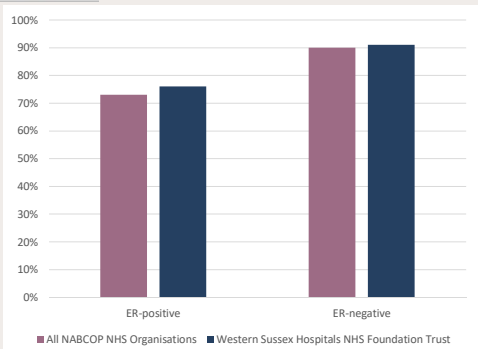
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## The NABCOP NHS Organisation Data Viewer

Click in the cell below to scroll & pick the NHS organisation you want to be highlighted in the subsequent tabs:

Chp7\_EIBC\_Surgery



ER Status	All NABCOP NHS Organisations	Western Sussex Hospitals NHS Foundation Trust
ER-positive	~74%	~77%
ER-negative	~90%	~91%

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Treat patients, irrespective of age, with surgery and appropriate systemic therapy, rather than endocrine therapy alone, unless significant comorbidity precludes surgery

**The NABCOP recommendations:**

Improving the data completion on the WHO performance status will enable better understanding of the reasons behind the variation in the patterns of primary surgery.

**NHS organisations must ensure that:**

- medical optimisation of women with ER-positive EIBC is instituted to maximise potential for their suitability for surgery.

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## What are the actions for your trust?

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## Radiotherapy

**Audit standards: NICE (2018), RCR (2017)**

- Consider RT for all patients undergoing BCS for EIBC
- Omission of RT may be appropriate for women who are low-risk
- RT following mastectomy for women with moderate or high-risk of recurrence (N+ or T3-4 N0)

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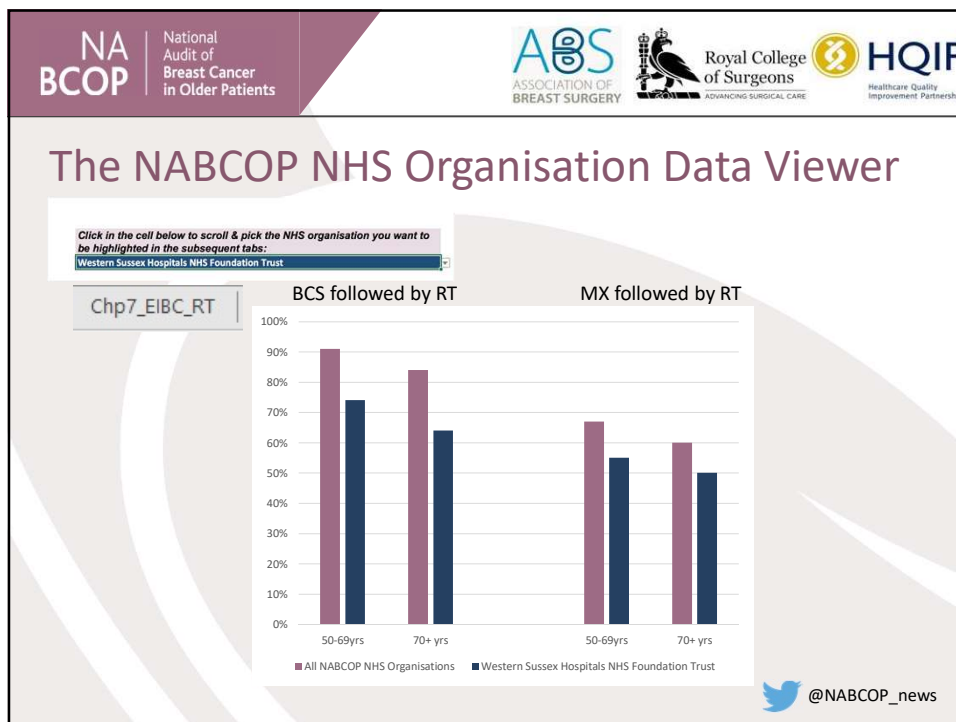
## Radiotherapy

The NABCOP found:

- Overall, 89% of women received RT post-BCS:
  - 91% in 50-69 years, 84% in 70+ years
- Overall, 64% of women received RT post-mastectomy (Mx) for high-risk\* EIBC:
  - 67% in 50-69 years, 60% in 70+ years

\* high-risk: women with node-positive EIBC or node-negative T3

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## Radiotherapy

**Audit standards: NICE (2018), RCR (2017)**

- Consider RT for all patients undergoing BCS for EIBC
- Omission of RT may be appropriate for women who are low-risk
- RT following mastectomy for women with moderate or high-risk of recurrence (N+ or T3-4 N0)

**The NABCOP recommendations:**

**NHS organisations must ensure that:**

- Women with high-risk EIBC are counselled on the benefit and risk of adjuvant radiotherapy based on tumour characteristics and objective assessment of patient fitness, rather than chronological age alone.

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## Early invasive breast cancer - Chemotherapy




**Audit standards: NICE (2018), ESMO (2015)**

- Adjuvant CT decisions should be based on an understanding of the balance between the risks and benefits particularly in people with comorbidities.
- CT and trastuzumab is recommended for women with HER2-positive BC, regardless of ER status.

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## Chemotherapy




The NABCOP found:

- In women with ER-negative, HER2-negative, N+ EIBC 53% had adjuvant CT
  - 73% in 50-69 years, 30% in 70+ years
- In women with HER2-positive EIBC who received surgery, 59% had CT and trastuzumab:
  - 69% in 50-69 years, 36% in 70+ years

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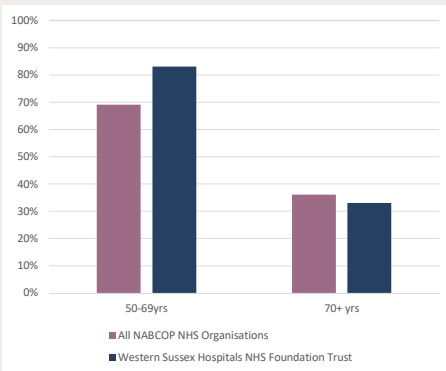




## The NABCOP NHS Organisation Data Viewer


Click in the cell below to scroll & pick the NHS organisation you want to be highlighted in the subsequent tabs:

Western Sussex Hospitals NHS Foundation Trust

Chp7\_EIBC\_CT



Age Group	All NABCOP NHS Organisations	Western Sussex Hospitals NHS Foundation Trust
50-69yrs	~69%	~83%
70+ yrs	~36%	~33%

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**Audit standards: NICE (2018), ESMO (2015)**

- Adjuvant CT decisions should be based on an understanding of the balance between the risks and benefits particularly in people with comorbidities.
- CT and trastuzumab is recommended for women with HER2-positive BC, regardless of ER status.

**The NABCOP recommendations:**

**NHS organisations must ensure that:**

- All women, irrespective of age, with:
  - (1) ER-negative, HER2-negative EIBC with malignant lymph nodes, or
  - (2) HER2-positive EIBC;
 have an objective assessment of likelihood of benefit and risk of chemotherapy based on tumour factors and patient fitness.
- They evaluate their services for medical optimisation of older women, who would benefit from receiving chemotherapy.

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# If no treatment is planned...

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TEST\_Test (Mrs) Born 1-Jan-1957 (62y) Gender Not Known Hospital No 1234567 NHS No 1000001241

**Plan MDT**

Care Plan Agreed Date: [ ] Organisation: [ ]

Recurrence Indicator: [ ]

Cancer Care Plan Intent: [ ]

- Curative
- No active treatment
- Non curative
- Not Known


Planned Treatment Type

First Treatment: [ ] Second Treatment: [ ]

To be actioned by: [ ]

Performance Status (WHO): [ ] Co-morbidity Evaluation - 27 Score: [ ]

Disclaimer:  
SCR screenshot, not InfoFlex

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TEST\_Test (Mrs)    Born 1-Jan-1957 (62y)    Gender Not Known    Hospital No 1234567    NHS No 1000001241

Plan
MDT

Care Plan Agreed Date:  Organisation:

Recurrence Indicator:

Cancer Care Plan Intent:

No Treatment Reason

- Died before treatment
- Monitoring only
- No active treatment available
- Not Known
- Other
- Patient/Parent declined treatment
- Unfit: advanced stage cancer
- Unfit: poor performance status
- Unfit: significant co-morbidity
- Unknown primary site

Performance Status (WHO):

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### Clinical Frailty Scale\*

**1 Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

**2 Well** – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

**3 Managing Well** – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

**4 Vulnerable** – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.

**5 Mildly Frail** – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

**6 Moderately Frail** – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

**7 Severely Frail** – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

**8 Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

**9 Terminally Ill** - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia  
The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.  
In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.  
In severe dementia, they cannot do personal care without help.

\* 1. Canadian Study on Health & Aging, Revised 2008.  
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495.

## Fitness assessment form for breast clinic

The purpose of this fitness assessment:

1. To create a system to trigger the identification of a pre- or frail patient
2. To identify the ‘well’ who are not having surgery

### Abbreviated Mental Test Score

<ol style="list-style-type: none"> <li>1. What is your age?</li> <li>2. What is the time to the nearest hour?</li> <li>3. Give the patient an address, ask him/her to repeat it at the end of the test e.g. 42, West Street</li> <li>4. What is the year?</li> <li>5. What is the name of the hospital/ number of residence where the patient is situated?</li> </ol>	<ol style="list-style-type: none"> <li>6. Can the patient recognise two persons (e.g. the doctor, nurse etc.)?</li> <li>7. What is your date of birth? (day and month sufficient)</li> <li>8. In what year did World War 1 begin?</li> <li>9. Name the present monarch/prime minister/president</li> <li>10. Count backwards from 20 to 1</li> </ol>
---	--

- Do you have any **severe\*** cardiorespiratory disease?      Yes / No
- \* severe = less than ordinary physical activity or rest causes tiredness, palpitations or shortness of breath
- Do you have any **other significant malignancy**?      Yes / No





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## Quality Improvement Resources

1. Annual Report Supplementary Materials
2. Quality Improvement Resources

[www.nabcop.org.uk](http://www.nabcop.org.uk)

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### Introduction to Quality Improvement

We: Tools for Quality Improvement

So: A number of organisations provide tools for QI.

Source	Title
NHS Improvement	<a href="#">Quality service improvement and redesign (QSIR) tools by stage of the patient pathway</a>
NHS Improvement	<a href="#">Quality service improvement and redesign (QSIR) tools by type of task</a>
Institute for Healthcare Improvement	<a href="#">Quality Improvement Essentials Toolkit</a>
HQIP	<a href="#">A guide to quality improvement methods</a>
East London NHS Foundation Trust	<a href="#">Quality Improvement Resources</a>

### Quality Improvement Case Studies

Below is a list of QI case studies.

Source	Title
NHS Scotland	<a href="#">QI Case Studies</a>

Do you have your own example of QI case studies in breast cancer care? Please [contact us](#) and we can add them to this list.



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## Did we meet your expectations?

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## What's coming up for the NABCOP?

- Fitness assessment collection in COSD v9
  - Live from April-2020
- Organisational survey
  - Do we have the best contact for your trust?


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e: [nabcop@rcseng.ac.uk](mailto:nabcop@rcseng.ac.uk)  
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