

1. NATIONAL CO-ORDINATING COMMITTEE FOR QA RADIOLOGISTS (“BIG 18”)

Minutes of the meeting of the National Co-ordinating Committee for
QA Radiologists (“Big 18”) held on Wednesday 07 December 2005

Present

Dr R Wilson	Chairman
Dr J Liston	Secretary
Dr J Cooke	South East-East
Dr G Crothers	N. Ireland
Dr E Denton	RCR Breast Group
Dr K Duncan	Scotland
Dr A Evans	East Midlands
Dr R Given-Wilson	St George’s Training Centre
Dr K Gower Thomas	Wales
Dr E Kutt	South West
Dr J Lavelle	Greater Manchester/Lancs/Cumbria
Dr M Michell	London
Dr P Nisbet	Jersey
Dr A O’Docherty	Dublin
Dr N Perry	Equipment Sub-Group
Dr C Record	South East-West
Dr W Thompson	NEYH
Dr M Wallis	West Midlands
Dr F White	Mersey/Cheshire
Dr M Wilson	Manchester Training Centre
Dr R Blanks	CSEU
Ms R Bennett	CSEU
Mrs J Patnick	NHSBSP

In Attendance

Ms H Scott	AVRC, University of Loughborough
Mr F Neilson	NEYH QARC

Apologies

Dr S Barter	Eastern
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1. Minutes of last meeting held on 29 June 2005

Amendments agreed: -

Item 3 – Substitute “some” instead of “all” Scottish Programmes have high recall rates. The group expressed concern that the optimum screening method (2 views) was still not being used in Scotland.

Item 14b – The Department of Health has a target of 15% of diagnostics being undertaken in the independent sector not 50%.

The minutes were otherwise agreed as an accurate record.

2. **Matters arising**

Assistant Practitioners

Nothing further to report. Legal restrictions still apply to what assistant practitioners can do and they must be supervised at all times.

Consolidated Guidance of NHSBSP Standards

Individuals should write to Julietta Patnick highlighting any errors or inconsistencies so that corrections may be made prior to publication of the second addition.

Action: QA radiologists

3. **PERFORMS**

Hazel Scott presented an overview of the new PERFORMS film set (SA07). The recording system is reported to be easy to use. The average reader identified 89% of cancers. Correct recall and correct return to routine screen rates were similar to previous PERFORMS sets. No difference was identified in the sensitivity or specificity between radiologists and radiographer readers. All readers undertaking PERFORMS for the first time must return data protection forms before participation.

Review of past PERFORMS cases identified that cases of asymmetry and benign cases especially those including calcification were most frequently incorrectly interpreted. RW enquired whether the majority of incorrectly interpreted cases were read at the end of the session indicating reader fatigue. JP requested that an overview of PERFORMS results was sent to the National Office to be included in the BSP password protected website.

Action: Hazel Scott

QA radiologists identified the need to know the names of screen readers who had undertaken PERFORMS prior to QA visits so that non-participants may be asked what equivalent scheme had been undertaken. JP agreed to ask Professor Gale.

Action: Julietta Patnick

Hazel Scott was thanked for her excellent presentation and for producing a comprehensive booklet, which was circulated to the QA radiologists.

4. **Do Once and Share** (Summary provided by Fergus Neilson)

Fergus Neilson presented the Do Once and Share Project Breast Cancer. This is a project which will shape IT provision for symptomatic breast cancer patients within the National Programme for IT. The main points were: -

- Connecting for Health (CFH), the organisation within the NHS which is implementing the NPfIT, has not, so far, been very good at involving health professionals and patients in the definition of the systems to be implemented.

- Sir Muir Gray is leading the Do Once and Share projects (currently covering about 50 disease areas) to make sure that there is proper and full involvement.
- There are 5 commercial companies, which have been contracted as “Local Service Providers (LSPs)” to provide IT solutions in their geographic area.
- The DOAS projects aim to provide standard, national optimal pathways and datasets – rather than allowing five different models to emerge around the country.
- The Breast Cancer DOAS is based in the North East of England (Fergus Neilson is the Project Manager and Clive Griffith is the Clinical Lead). They will draft the pathways and data sets locally and then take nationally to groups and individuals for review and validation.
- FN described an environment where data is entered only once at the point of collection; data/information is shared seamlessly between clinics and health professionals to aid the patient experience; patients can have bookings made for/with them immediately for the next stage of the journey; and data for secondary purposes (such as cancer registration and audit) will, by definition, given proper permissions, be available to those organisations which need it.
- FN asked for more people to come forward as reviewers if they wished (currently Robin Wilson, Matthew Wallis, Graham Hoadley and Will Thompson have come forward). Please email Fergus.neilson@nhs.net.
- He started the debate about how the work should be coached forward, reviewed and signed off after this six-month project is completed. He is aware that the best way to make sure that a satisfactory system eventually arrives on peoples’ desks, clinics, wards and theatres etc is to make sure that it has a group of representative, responsible people to review and sign off what is produced before it is implemented. **HOW SHOULD SUCH A GROUP BE FORMED?**
- Matthew Wallis promoted the idea that the current NBSS system will largely provide for the needs of symptomatic as well as screening and so, if a product exists, CFH should be asked to use it. FN said that he was not sure how this would work contractually within CFH, however, he fully supports the principle that screening and symptomatic should be dealt with in the same way after the point of diagnosis and so the systems should be also be the same. He will raise the NBSS issue with CFH.
- The issue of sharing patient data outside the NHS (e.g. to Scottish breast clinics or private sector) was raised. Fergus said that this is the kind of issue that he wants people to raise and possibly suggest solutions to and that this would be included in the final report to CFH.

5. CSEU study into factors contributing to screening units' performance

The CSEU intend to collect data regarding reading practice within individual units via the NDROR questionnaire. Data to be collected will include the type of reader (radiologists, clinicians, radiographer), experience of individual readers, actual number of films read per reader, type of reading ie. consensus versus arbitration etc. It was suggested that data for the percentage sent to arbitration and reading speed should be collected as well.

A questionnaire to identify the equipment used in individual units is being developed by Ken Young. Data to be collected will include type of screening equipment (film screen, CR or DR), assessment equipment including type of stereotactic guidance, availability of a faxitron and the availability of vacuum assisted core biopsy. The questionnaire will also include the type of ultrasound equipment used and its age.

The CSEU will develop an assessment clinic questionnaire. Data to be collected will include number of assessment clinics per week, number of women per clinic, length of clinic and details of staff involved in each clinic. Enquiry should also be made as to whether all biopsies are undertaken at the first clinic visit and provision for study leave and annual leave.

Action: Rachel Bennett

6. NBSS Assessment data

MW agreed to email the provisional specification to QA radiologists. Once the system is fully developed it should be possible to print biopsy labels, pathology request forms and to track women through the system including referrals to oncology.

Action: Matthew Wallis

Julietta Patnick is concerned that women occasionally continue to receive the wrong result i.e. women who should be recalled for assessment are incorrectly sent a routine recall letter. JP believes that direct entry of screening results by the screen reader will eliminate some of these errors. JP intends to write to Trust Chief Executives advising them of this change in practice. Screening units will need to develop business cases to purchase the extra IT equipment required to institute "Direct entry of results".

Action: Julietta Patnick

7. Consent for assessment

The consensus view of the committee was that formal written consent was not regarded necessary provided the patient was given full information about the procedure and its consequences.

8. Untoward incident update and reporting

The RCR breast group critical incidents report 2005 was circulated.

9. QA Visit Guidelines

The NHSBSP QA visit guidelines are to be updated and revised by the QA Directors group.

10. Screening and the 31 day and 62 day cancer waiting time targets

The 62-day target between date of screen and date of first treatment will be used by the NHSBSP. Three units have agreed to act as Pilot sites to ascertain if this target is achievable. If a woman requiring a technical recall chooses to delay the appointment the clock will stop. If a woman attends an assessment clinic within a different Trust to the treatment Trust and the target time is breached, the penalty for the breach will be apportioned between both Trusts.

11. Contracting out of the NHS for screening

Lister InHealth has been awarded a contract commencing 1st April 2006 to screen women formally screened by Exeter Breast Screening Service. The specification states that screening must be undertaken to NHSBSP standards. The local QA team intend to undertake an early QA visit.

12. CAD update/CADET 2

CADET 2 is a prospective study to ascertain if double reading is as accurate as single reading with CAD. The final version of the protocol is still to be agreed. A study recently published in Radiology reports that CAD increases the time to read and increases the recall rate (Khoo LAL, Taylor P, Given-Wilson RM. Computer aided detection in the United Kingdom national breast screening programme: Prospective Study. Radiology 2005; 237: 444-449).

It is also proposed to undertake a study looking at the efficacy of CAD combined with full-field digital mammography.

13. Imaging women with implants

It is acknowledged that the sensitivity of mammography for the early detection of carcinoma is greatly reduced by the presence of silicone implants, but the suggestion that women should be offered breast ultrasound as an alternative screening test was rejected.

14. Screening AT Gene carriers

Advice is to be obtained from geneticists and physicists regarding the risk.

Action: Julietta Patnick

15. Audit of Interval Cancers

A draft of "Audit of interval breast cancers" was circulated. It was agreed to change the title to "Audit of breast cancers". It was agreed that interval cancers should be sub-divided into 1 – 12, 13 – 24, 25 – 36 and >36 months. Comments from QA radiologists concerning the draft should be sent to Julietta Patnick by the end of December.

Action: QA Radiologists

16. Report from other groups

a) ACBCS committee

Nothing to report as this committee has not met since the last QA radiology meeting in June 2005.

b) QA Directors

A meeting is scheduled for the 22nd December 2005. Agenda items to be discussed include: -

Resources needed by screening units with slippage to return to the 36 month screening round target.

A new tariff price for breast screening.

Withdrawal of funding from QARCs for physics testing of equipment.

c) BASO

A meeting was held on the 28th September 2005. Items discussed included: -

It is likely that future surgical trainees in breast/endocrine surgery will not need to enter a general surgical rotation and will not participate in on-call rotas.

The first medico- legal case relating to a breast ultrasound scan performed by a surgeon is pending. Any person undertaking breast ultrasound must have undergone appropriate and approved training and be deemed competent to undertake the procedure. The RCR produced a document entitled "Ultrasound training recommendations for medical and surgical specialties". The consensus view of the QA radiologists was that all surgeons undertaking breast ultrasound should adhere to these standards. RW agreed to write to Mr Bishop.

Action: Robin Wilson

d) National QA Evaluation

Topics discussed included: -

Coverage – the age bands in future KC63's will match the age bands in KC62's.

Information about round-length will be added to KC62's.

A request was made that non-operative diagnosis rates be divided into insitu and invasive.

ONS study of HRT use.

e) Digital Mammography Steering Committee

All full field digital systems will be authorised for use by the NHSBSP. One CR system (Fuji Profect) will also be authorised.

17. Any other Business

COG Guidance and NICE advise that all cases in which a needle biopsy has been undertaken as part of triple assessment must be reviewed in a multidisciplinary meeting.

Roger Blanks was thanked for his very important contributions to breast screening QA. He will continue to be employed by the CSEU but will now undertake research only for the cervical screening programme. Rachel Bennett will take the lead for the breast screening work and was welcomed to the group.

18. Date of next meeting

Wednesday 21st June 2006.