

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 13 December 2006

Present

Dr R Wilson	Chairman
Dr J Liston	Secretary
Dr J Cooke	South East-East
Dr G Crothers	N. Ireland
Dr K Duncan	Scotland
Dr A Evans	East Midlands
Dr R Given-Wilson	St George’s Training Centre
Dr K Gower Thomas	Wales
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 W Thompson	NEYH
Dr M Wallis	West Midlands
Dr F White	Mersey/Cheshire
Dr R Whitney	Eastern (Deputy)
Dr M Wilson	Manchester Training Centre
Dr S Willson	South West (Deputy)
Mr R Winder	NHSBSP

Apologies

Dr S Barter	Eastern
Dr E Denton	RCR Breast Group
Dr E Kutt	South West
Dr C Record	South East-West
Ms R Bennett	CSEU
Mrs J Patnick	NHSBSP

In attendance

Ms H Scott	Loughborough university
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1. Minutes of last meeting held on 21 June 2006

The minutes were agreed as an accurate record.

2. Matters arising

PERFORMS

It was confirmed by Richard Winder that Alistair Gales’s team had been requested to regularly provide QA radiologists with a list of the names of readers in their region who participated in the PERFORMS films set.

BASO Audit

Richard Winder confirmed that the National Office would write to Hugh Bishop requesting that BASO data was identified using the same codes as used by the CSEU.

Action: R Winder

3. Review of PERFORMS

A PERFORMS update was given by Hazel Scott. Booklets were circulated reviewing the results of PERFORMS SA07(2). 87% of readers recorded a correct return to screen result and 83% a correct recall result. The average cancer detection rate was 85% compared to a cancer detection rate of 88% in the previous film set. It was noted that several readers had detected <70% of the cancers but Hazel reported that there was only one severe outlier for d' values. She also confirmed that no single reader had been an outlier more than once in consecutive film sets. Interesting data was also presented entitled "PERFORMS and fatigue on the task". Reporting accuracy tends to decrease twice. Initially mid way through and then again on the last set of cases. It was suggested that reading PERFORMS with a break after 30 minutes on task might reduce the loss of vigilance mid task. Fatigue effects with decreased performance at the end suggests that continuous time on the task for longer than 1 hour 10 minutes should be avoided. This finding could have relevance to real life screening practice.

Andy Evans suggested a study might be undertaken correlating "real life" performance with PERFORMS and agreed to contact Alistair Gale to discuss. If other units would like to participate they should contact AE.

Action: A Evans

Hazel informed the group that Loughborough was extremely short of cases for the next round of PERFORMS and asked QA radiologists to encourage units to send suitable films for inclusion in PERFORMS.

Action: QA radiologists

The QA radiologists were of the opinion that the repeated use of "normal" cases in consecutive test film sets would be satisfactory. HS to discuss with Alistair Gale.

Action: H Scott

A request was made for PERFORMS to collect teaching sets of particular radiological abnormalities e.g. stromal deformities, asymmetries etc.

Action: H Scott

4. Assessment Clinic Workload Questionnaire

This has not been progressed as the National Office is of the opinion that numerous other questionnaires have already been sent to units.

5. Factors Contributing to Optimal Performance of Individual Screening Units

Rachel Bennett was unable to attend the meeting but reported that since data for the study was coming from a number of sources the report was delayed. 25% of the questionnaires regarding film reading protocols sent out earlier this year as part of the radiographer only double reading project were awaited

6. Benign Biopsy Audit Results

Mike Michell tabled a summary of the results of a national audit of benign surgical biopsies during the periods 95/96, 00/01 and 04/05. 75% of programmes had contributed data. The study was set up as the benign surgical biopsy rates have remained stable despite increased use of image guided needle biopsy and improvements in pre-operative cancer diagnosis. Preliminary results identify that approximately 63% of benign biopsies in 2004/05 had a prior B3 core biopsy versus 32% and 9% in 00/01 and 95/96 respectively. It was agreed that dialogue is needed with the pathologist to ascertain if B3 core biopsies can be sub-divided into those requiring surgery and those that do not require a surgical diagnostic biopsy. RW agreed to write to Sarah Pinder requesting that this item is discussed at the next pathology QA meeting.

Action: R Wilson

7. National QA Radiology Audit

18 potential audit topics had been circulated to QA radiologists in October to discuss with colleagues in their regions. From the responses received the order of preference was:-

1. Staging of axilla – use of ultrasound ± FNAC or core biopsy.
2. Additional information obtained through use of pre-operative MRI in cases of lobular carcinoma diagnosed on core biopsy.
- 3.) Interval cancers in previously assessed women.
- 3.) Mammographic features of interval cancers correctly identified at screening by the first reader but incorrectly returned to routine recall through arbitration/consensus.

MM reported that London was currently undertaking an audit of the ultrasound preoperative assessment of the axilla in 500 – 600 screen detected cancer cases. All equivocal nodes with a cortical thickness >2mm were being subjected to FNAC for further assessment. There appears to be variable practice around the UK i.e. many units do not undertake routine axillary ultrasound. Nottingham use core biopsy versus FNAC for further assessment. WT agreed to design a questionnaire and send it to all units to ascertain current practice.

Action: W Thompson

MM agreed to circulate the criteria used in London to define equivocal or abnormal nodes. Units were encouraged to collect and send prospective data to MM.

Action: M Michell

Following discussion there appears to be variable practice regarding the use of MRI in cases where core biopsy has shown lobular cancer. WT agreed to include data collection of unit practice within the questionnaire circulated ascertaining axillary ultrasound practice.

Action: W Thompson

K G-T agreed to audit interval cancers in previously assessed women in Wales post introduction of core biopsy.

Action: K Gower-Thomas

8. Breast Screening The Facts / BACUP Leaflet

R G-W identified that there was a need for alignment of information contained in the BACUP leaflet and “Breast Screening the Facts” leaflet with NHSBSP disclosure of audit guidance. The BACUP leaflet contains the phrase “Women diagnosed with an interval cancer will always have the results of this review discussed with them” – it was agreed by all that this sentence should be omitted. Breast Screening the Facts leaflet includes “If a review of mammograms shows that you should have been cared for differently you will be contacted and offered more information about the review of your case if you wish to have it”. It was agreed that this sentence should be replaced with “We will offer more information if you wish”. Richard Winder agreed to action.

Action: R Winder

9. QA Visit Guidelines / Radiology Section Revision

Most comments received following circulation of the draft document were favourable. Further amendments were agreed. JL agreed to circulate the final draft and send it to the national screening office.

Action: J Liston

10. EU Doctors Interested in Working in the NHSBSP

It was agreed that EU doctors need to go through the official GMC mechanisms. The general view was that there is nothing useful that either the RCRBG or this committee can do in this area as all applicants need to fulfil the statutory requirements.

11. Response to European Health Directive of Free Movement of Patient within the EU

The EU is consulting on a new directive regarding legislative framework for patient movement and teleradiology. If breast screening films taken in the UK are reported outside the UK, they should be reported to the same standard as if they had been reported by a UK registered doctor and vica-versa. It is anticipated that Erica Denton, National Clinical Lead for Diagnostic Imaging will be involved in the DoH response. RCR, BIR and EUSOBI are also responding.

12. NBSS

The new clinical specification is written and approved. The software is currently being written. It will be piloted in January/February 2007 and expected to be released in 2007. Work is needed in 2007/08 on NBSS/ PACS interfaces. DoH contract with Connecting for Health PACS is probably not suitable for breast screening. It is likely a national contract framework specifically for breast screening will be needed. Requirements will include 3½ years of local storage and backup to a cluster store.

13. Family History Screening. Role of NHSBSP Central Audit

Discussions are starting on the role of NBSS in screening high risk women.

14. Reports from other Groups

a) QA Directors

The National screening office is now hosted by Yorkshire and Humber SHA. All hosted organisations are under scrutiny

b) ACBCS Committee

The following topics were discussed: -

Harmonisation of the quality of breast imaging provided for symptomatic and screened women.

Age Trial (Results to be circulated)

Final report on digital imaging for breast screening. Business case has been sent to the Department of Health.

Screening Round Length

Independent procurement of Breast Screening

c) BASO (Summary supplied by WT)

Mr Martin Lee is to take over as chairman from Hugh Bishop.

The plans for changes to the future training of breast surgeons reported at previous meetings continue but have not yet received full support in the surgical world. Included in the proposals is a diploma for non-medical staff (chiefly specialist nurses and breast clinicians, but also radiographers) to be deemed competent in aspects of breast disease. The RCR is aware of this and involved in the discussion.

The 2007 BASO yearbook is in production and will include as short section on radiological topics of interest to surgeons.

The Sloane project has now registered >3000 cases. Discrepancies in ER status reporting between units is becoming evident. It is reported that LCS has the same recurrence rate as DCIS but this was challenged by many members of the meeting.

d) National QA Evaluation

Discussion revolved around transfer of data and in particular security of data transfer.

15. AOB

a) Funding for breast screening training centres.

Recurrent monies for breast screening training have been removed from the central budget allocation of the NHSBSP. The money will be given to SHAs instead, but will not be ring-fenced for breast screening training. After discussion it was agreed that a joint letter should be written from the Big 18 Chair and RCR Breast Group Chair to the Department of Health emphasizing that training and quality assurance underpins a high quality screening service. Training also ensures that standard in symptomatic breast imaging are equivalent to screening standards.

Action: R Wilson

b) Incomplete screening examinations

Richard Winder enquired what units do if a woman withdraws consent half way through the screening examination. It was reported that most units close the episode as attended/not screened but in all cases the films that were obtained are reviewed and a letter written to the woman and her general practitioner.

c) Frequency of QA visits.

South East-West region and some breast screening sub-specialties in Scotland undertake QA visits at 2 yearly intervals. It was confirmed that the minimum requirement is to undertake QA visits at least every 3 years.

d) Use of NBSS for women for having surveillance mammograms post cancer treatment.

If the NBSS system is adapted to include women with a family history being screened it is anticipated that the view of the national screening office may allow inclusion of follow-up women. However, it is imperative to implement software changes so that the KC62 data is not contaminated.

e) Role of PET scanning of the axilla

PET assessment of the axilla is a research tool undergoing evaluation.

f) 62 Day Target

It is anticipated that when this is implemented for screened women the clock will start not on the date of screening or the date of assessment but on the date that the films were reported by the final reader (second reader or in the case of consensus / arbitration the third reader).

16. Date of Next Meeting

Monday 21st May 2007

