

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

Minutes of the meeting of the National Co-ordinating Committee for  
QA Radiologists held on Wednesday 01 July 2009

### Present

Dr R Wilson	Chairman
Dr J Liston	Secretary
Dr G Briggs	N.Ireland
Dr K Gower Thomas	Wales
Dr A Hubbard	Equipment Sub-group
Dr J Lavelle	Greater Manchester/Lancs/Cumbria
Dr J Litherland	Scotland
Dr P Loynes	West Midlands
Dr M Michell	London + RCR Breast Group
Dr P Nisbet	Jersey
Dr A O’Doherty	Dublin
Dr C Record	South Central
Dr J Steel	South West
Dr W Thompson	NEYH
Dr M Wallis	NIB
Dr F White	Mersey/Cheshire
Dr R Whitney	Eastern
Dr M Wilson	Manchester Training Unit
Mrs J Patnick	NHSBSP

### Apologies

Dr J Cooke	South East Coast
Dr A Evans	East Midlands
Dr R Given-Wilson	Training Centre
Mr M Sibbering	Surgical Representative
Ms S Sellars	NHSBSP

### In Attendance

Dr G Rubin	(Representing South East Coast)
Dr L Wilkinson	(Representing Training Centre)
Mr RG Blanks	CSEU
Ms RL Bennett	CSEU
Ms H Scott	PERFORMS
Ms J Reed	Midlands QA Group
Prof A Ramirez	Cancer Research UK

### 1. Minutes of last meeting held on 10 December 2008

Item 5 was amended to read “The Oxford Research Group have developed an information leaflet for the use by the PILOT sites”.

The minutes were otherwise agreed as an accurate record.

## **2. Matters arising**

### **2.1 Non-operative diagnosis of screen detected cancer**

A multidisciplinary meeting including pathologists, surgeons, radiologists (RW+MW) and JP took place on 15/01/09. It was agreed that from 01/04/2010 core biopsy should be used by all NHSBSP units as the primary diagnostic technique for the diagnosis of screen detected abnormalities. If there was continued use of cytology it should not normally be used alone. Cytological examination remained acceptable for the assessment of axillary lymph nodes.

Various audit projects were suggested including: -

- Axillary non-invasive diagnostic procedures.
- Evaluation of the management of B5a lesions.
- Benign diagnoses within the NHSBSP.
- Management and subsequent history of B3 lesions.

JP is currently liaising with the pathologists re: the draft minutes. The final minutes will be circulated soon.

**Action: Julietta Patnick**

### **2.2 Breast MRI surveillance guidelines**

This item was discussed under item 7.

### **2.3 B3 cores with atypia**

Ian Ellis issued guidelines through the Pathology Big18 advising that the presence or absence of atypia should be included in all B3 core biopsy reports.

### **2.4 Screening disabled women/IRMER**

Sarah Sellars, Margot Wheaton and Ali Guest have commenced drafting guidance for women who have incomplete/partial mammographic screening. A draft will be circulated for comment in due course.

**Action: Sarah Sellars**

IRMER guidance is also being updated to include a paragraph on "incomplete/partial mammography".

## **3. PERFORMS update**

Results of the last round SA08 and first half of SA09 were presented by Hazel Scott.

Following discussion it was agreed that: -

1. The relevant QA Radiologist should be made aware of any NHSBSP readers in their Region who have not participated fully in the PERFORMS exercise.
2. Regions should be identified on the charts. JP to write to Alastair Gale.

**Action: Julietta Patnick**

3. Outliers included several radiology registrars prompting discussion as to whether trainees should be included in the analysis of PERFORMS performance. It was agreed that only SpRs who were actually film readers i.e. whose opinion was recorded as one of the readers on NBSS should be included in the NHSBSP annual audit. However all SpRs specialising in breast radiology should continue to be allowed to sit PERFORMS.

HS requested units to send appropriate cases for inclusion in future PERFORMS film sets.

**Action: All**

#### 4. CSEU Audit

Rachel Bennett presented the 07/08 annual CSEU screening audit. The overall SDR was 1.38 (prevalent 1.45; incident 1.36). This rate has remained fairly static since 03/04. There has been a slight overall decrease in recall rates resulting in an increase in PPV but recall rates in the prevalent round have increased. Analysis of 3 years data (2005 - 08) show that the spread of performance has decreased but that some outliers remain, particularly at prevalent screens.

28 programmes achieve invasive cancer detection rate targets but are not achieving the minimum standard for recall to assessment. 2 programmes who do not achieve the minimum standard for recall achieve only the minimum standard for cancer detection. High recall rates are expensive both in terms of unit resources and women's anxiety. Small units tend to have higher recall rates. There was discussion over the relative merits of introducing a PPV target or RV target i.e. number of cancers detected per women assessed. It was concluded that the current targets for cancer detection and recall rate were sufficient but that the latter needed to be more stringently enforced. JP to discuss at QA Directors meeting.

**Action: Julietta Patnick**

Units with persistently high recall rates should consider arbitrating all potential recall cases i.e. arbitrating concordant first/second read cases as well discordant cases. Training units should review teaching cases including examples of "what not to recall".

#### 5. Real time performance

Jacque Reed presented the findings of a Midlands QA Group audit. 37 readers participated. The NBSS individual film reader reports were analysed in conjunction with BASO data. Generally if an individuals overall cancer detection rate was good their small cancer detection rate was also good. Cancer detection rates of advanced practitioners and radiologists were similar but the radiologists specificity was better with lower recall rates (R = 4.9%. AP = 6.1%) and lower inappropriate recalls to assessment (R = 12.67%. AP = 18.87%). The latter were defined as cases returned to routine recall following arbitration. It was noted that most of the APs had less years experience compared to the radiologists. Specificity increased with the volume of cases read. There was no relation between volume read and cancer detection except in readers reading >25,000 cases over 3 years where a slight fall in cancer detection was observed.

## 6. Access preference of women for breast screening

Amanda Ramirez presented the findings of a survey “ Women’s preferences for the delivery of the NHS Breast Screening Programme in 2009”( *Attached* ).

Permanent units in hospital settings with parking facilities and convenient access to public transport are the general recommendations. There is greater need for mobile units in community settings among women without access to a car in rural areas, but these only account for about 2% of the population of women invited for screening.

A paper is currently being prepared for journal submission.

Following discussion it was agreed that the National Screening Office would approach Department stores asking if they would be willing to provide accommodation for the placement of static screening units as this has proved to be successful in London.

**Action: Julietta Patnick**

## 7. Cancer reform strategy update

JP reported that 28 units had acquired some digital equipment and 4 units had entirely converted to digital screening. Expressions of interests from units to be involved in the first wave of the breast screening age expansion were invited.

Lars Holmberg has joined the Screening Advisory committee. He has set up a working group to provide guidance for the NHSBSP screening women with a positive family history. A limited number of screening protocols will be developed into which women with varying risk levels may be entered (Bins). Meanwhile individual units need to work up their own local protocols for: -

1. Developing a local “road map” for women with a possible increased risk ie. consultation with their general practitioner to assessing their risk to registration with their local screening provider.
2. Links with genetics departments to identify women with increased breast cancer risk.
3. Provision for women already under going family history screening within symptomatic breast services.

JP will send a letter to all NHSBSP units.

**Action: Julietta Patnick**

The Advisory Committee would like to set up 3 demonstration sites to pilot the new NBSS module and report on the logistics of screening women at very high risk who require both MRI and mammography. The breast MRI surveillance guidelines are expected to be published shortly.

## **8. Storage of previous mammograms**

Options were presented by Louise Wilkinson. Digitising films was thought to be unnecessary and too expensive. The NHSBSP require films to be kept for a minimum of 8 years, so off site storage may be the best option for some units. Films could be recalled for comparison when required.

## **9. NBSS**

A limited amount of background information will be inputted for women undergoing family history screening e.g. moderate risk or high risk + if the latter gene positive/gene negative/unknown.

A draft MRI screening and assessment screen was circulated by MW for comment.

**Action: All**

As women who have already been treated for breast cancer are at increased risk it would be logical to screen them within the NHSBSP. This is currently under discussion. It would be essential that these women were flagged as separate from "well women" routinely invited for screening.

MW also circulated an extract from the latest NBSS support bulletin regarding NBSS/PACs interfaces.

## **10. Survey of screening reading practice + Survey of breast radiologists' Practice (item 11).**

A film reading and workforce questionnaire has been developed by Ros Given-Wilson and Matthew Wallis. It may be combined with a revised survey of breast radiologists' practice developed by MM. The questionnaire will then be circulated via QARCs for completion by Screening Programme Directors.

**Action: R G-W / MW /MM**

## **12. QA Guidelines re: individuals screen reading performance**

The Director of Screening is responsible for ensuring that the screen reading quality in their unit meets acceptable standards. If the screen reading quality of the Director of Screening is thought to be unacceptable then the Regional QA Radiologist should advise.

**13. Joint review of National (UK) radiology standards for screening + Radiology (59-2005) and Assessment guidelines (49-2005) -Item 14**

MM advised that breast symptomatic diagnostic guidelines are being developed by a multidisciplinary group within the Cancer Reform Strategy and are due to be published in the autumn. The NHSBSP Assessment guidelines and the Radiology guidelines need to be revised. The latter need to include a section on professional standards. Volunteers willing to join small working groups are asked to contact RW or JL

**Action: All**

**15. ABS at BASO non-operative diagnosis audit**

The non-operative diagnosis rate for “all cancers” has improved dramatically over the last 10 years but there is still a wide variation in performance with respect to pre-op under staging of invasive cancers and to a lesser extent non-operative diagnosis of in-situ disease. Use of VACB does not seem to be the answer in the UK.

MW circulated a draft questionnaire for comment which he intends sending to the 10 best performing units and the 10 least well performing units to try and identify areas where changes in practice might improve performance. It was suggested that visiting some of the units would also be required by a radiologist and pathologist. JP agreed to provide funding. In some units some of the issues may be pathological e.g. If DCIS is found in a core biopsy further levels may not be taken to look for invasion, variation in protocols used for examining surgical specimens, rate of diagnosis of LCIS etc. MW to ask Clive Wells to discuss at the pathology Big 18.

**Action: Robin Wilson**

**16. Report from other groups**

**16a. QA Directors**

The QA Director meet next week.

**16b. ACBCS Committee** *(summary provided by Ros Given-Wilson)*

The following points were discussed:

1. Age extension. Five pilots are currently beginning age extension, four with randomisation. If this is successful there will be an application to extend randomisation throughout the programme brought forward later this year.
2. Cancer reform strategy implementation: All PCT's have been asked to produce plans for the roll out of age extension by the end of this year.
3. Uptake – There is a gradual drift downwards in uptake and the need to improve GP engagement with the screening programme was discussed.

4. Progress on the roll-out of digital mammography – This is disappointing and the slow process was thought to be related to the complexity of linking with PACS and NBSS.
5. Payment by results – The Department of Health is beginning work to set up a tariff for screening. It was thought that the tariff should apply to women screened and possibly there should be a lower payment for women invited who did not accept. The screening tariff would cover full cost of screening up to the referral onwards with a diagnosis of breast cancer.
6. High risk surveillance – Lars Holmberg has set up a small group to produce guidance on high risk screening. This would detail the screening strategy including types of screening; intervals and start and stop dates for given levels of risk. There was also discussion about the complexity of taking family history screening into the NHSBSP. It was thought that guidance should be produced by the end of 2009 detailing the route map for women to get into the NHSBSP, how women with complex familial syndromes and multi-organ risk are managed and what happens to women already under surveillance outside the NHSBSP. It was also thought that the roll-out of MRI screening should be expedited while waiting for the recommendations on other screening strategies which are unlikely to be ready until next year.
7. Results to date from the radiographer only reading project were reviewed. More data is needed.
8. The leaflet for screened women “the facts” is due to be updated by the end of the year.

**16c. ABS at BASO** (*summary provided by Will Thompson*)

Future of the association.

Breast Surgeons are the majority of the BASO membership even though the Association of Breast Surgeons at BASO is a sub-group. The membership was surveyed and it has been agreed to take the proposal to the BASO-ACS committee that two separate associations are formed BASO-ACS and BASO ABS.

It was felt that this proposal gave the ABS the opportunity to develop as a multidisciplinary association for breast disease, but also allowed BASO ~ ACS to develop an independent voice and expand its contacts with other surgical oncology disciplines.

Guidelines sub-committee

It is planned to review guideline annually and include representation from radiology and pathology.

**16d. National Imaging Board**

NBSS /PACS interfacing remains challenging.

**16e. National Co-ordinating Group for equipment** *(summary provided by Anne Hubbard)*

The new draft standard for ultrasound were discussed and accepted in principle, but these need to be re-written with a reduction in the current length (79 pages). Doubts were expressed whether Radiologists would fill in the required forms and log book. The guidelines are to be trialled at volunteer units.

A CEP review of elastography shows there is insufficient evidence to include this at the present time.

A review of the equipment in the standard in the NHSBSP has shown 3 sets over 10 years still in use in the programme. Dr H to write to the Regional QA Radiologist in these areas.

Progress with testing and approving new Digital equipment proceeding as fast as possible. Ken Young has posted a table on the NBSS website to show progress with testing in advance of publication. Units are advised to check that equipment has completed physics and clinical evaluations before purchase.

Guidelines on image display for theatre, path labs, U/S rooms etc are to follow.

An economic evaluation of CAD has been requested.

The trailer purchase framework is now on the PASA website 5 manufacturers tenders have been accepted.

A collective bulk equipment purchase is being organised in the NE in Oct 09/March 10/Oct 10, continuing into 2011, hoping to achieve a substantial price reduction.

Digital fault reports are now being collected separately by Jemy Odoko and published in the NHSBSP annual fault reports- those with digital please submit reports regularly to assist those units yet to choose equipment to purchase.

Many units are reporting a decline in the quality assurance of processing chemicals with the frequent supply of defective batches. There is concern our continued engineering support and supply of spare parts for older processors.

**17. Breast Physicians**

A paper summarising the current position of breast physicians written by Liz Edwards was circulated. Although they are highly valued as individuals within their own multidisciplinary teams they have so far been unable to get CCT accreditation and are unrepresented on executive committees e.g. BASO, Big 18. It was agreed to invite a Breast Physician representative to join the Radiology Big 18 group.

**Action: Julietta Patnick**

**18. Any Other Business**

JP anticipates another paper written by the Nordic Cochrane Centre will be published in the BMJ shortly criticising the NHSBSP for over diagnosing “harmless” breast cancer.

Jim Steele reported that despite good performance, validated by a recent QA visit, the screening service in Plymouth had been put out to tender by the local PCT’s.

**19. Date of Next Meeting**

**Wednesday 09 December 2009**