

**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 29 June 2005

Present

Dr R Wilson	Chairman
Dr J Liston	NEYH/Secretary
Dr S Barter	Eastern
Dr J Cooke	South East-East
Dr G Crothers	N. Ireland
Dr K Duncan	Scotland
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 C Record	South-East West
Dr W Thompson	NEYH
Dr M Wallis	West Midlands
Dr R Blanks	CSEU
Ms R Bennett	CSEU
Mrs J Patnick	NHSBSP

In attendance

Dr U Beetles representing Dr M Wilson, Manchester Training Centre
Dr C Beattie representing Dr F White, Mersey /Cheshire
Dr R Whitney , Deputy Eastern

Apologies

Dr P Britton	RCR Breast Group
Dr A Evans	East Midlands
Dr P Nisbet	Jersey
Dr A O’Doherty	Dublin
Dr N Perry	Equipment Group
Dr F White	Mersey /Cheshire
Dr M Wilson	Manchester Training Centre

1. Minutes of last meeting held on 15 December 2004

The minutes were agreed as an accurate record.

2. Matters arising

2.1. PERFORMS

Alistair Gale’s unit has relocated from Derby to Loughborough University. A new set of PERFORMS films will be read at Coventry BSS prior to wider circulation. Recirculation is scheduled to start in August 2005.

2.2. Radiographer Only Reading Study

Arbitration of discordant cases must be undertaken by a reader who reads > 5000 cases/year.

2.3. Forrest 3 Report

This is likely to be published in December 2005 once radiation risk calculations have been finalised.

2.4 Family History Screening Guidelines

NICE will take into account results of the MARIBS trial when the guidelines are revised.

2.5 RCR Critical Incident Reporting

Few reports have been received by SB.

2.6 Patient Choice

RW reported that women must be advised of the clinicians preferred management option in order to help the patient make an informed choice. This discussion should be documented in each patient's notes.

3. CSEU National QA Audit Figures 03/04

Prevalent screens → little change compared to previous years.

Incident screens → steady increase in cancer detection rates since 98/99.

03/04 prevalent + incident SDR = 1.38 which is significantly higher than the Swedish 2 Counties study SDR of 1.00.

PPV referral diagram shows good overall improvement over 3 years.

The introduction of 2 views for all screens is estimated to result in an increase in cancer detection of 20% and a decrease in recall rate of 11% (Ref: Clin Rad 2005: 60; 674-680).

Individual programme statistics identify only 3 programmes with SDRs <1.00. Two other units with lowish SDRs also have low recall rates and might benefit from increasing their recall rates a little. One programme has an SDR of 1.96 but this is artificially raised due to significant (>12 months) slippage.

JP reported that only one programme screened 100% of eligible women within 36 months but 24 programmes reached the screening round length target of inviting 90% within 36 months. JP agreed to share slippage data with the CSEU.

Action: JP

It was emphasized that care is needed in the using screening data as anomalies may arise due to various factors including small size of programme, slippage, poor data collection, merging of units resulting for example in only 1 years data being shown in the 3 year table.

RW requested 3 year SDR data for tumours <15mm in size.

The CSEU intend monitoring how slippage and use of HRT affects PPVs.

Recall rates were discussed in detail. One English and some Scottish programmes have high recall rates which do not appear to result in a proportionate rise in cancer detection. QA radiologists visiting units with low PPV's should assess why so many women who prove not to have cancer are being recalled. Conversely, units with both low SDR's and low recall rates might benefit from increasing their recall rates in order to improve their SDR's.

JP requested that the CSEU undertake a study to ascertain the factors that contribute to the performance of the 10 best performing units compared to units with lower PPVs. RB suggested that a qualitative questionnaire including factors such as exact type of double reading, age/experience of film readers etc. might best provide comparative information. RB will speak to S Moss re: protocols, timescales, cost etc. JP agreed to fund a project.

Action: RB/JP

4. NBSS Assessment Data

MW tabled revised forms. In the future it is hoped that pathology request forms will automatically be generated. The inclusion of a drop down box to document the reasons why women were placed on early recall was requested. The new data set will include a comments box but the "search" facility will not be able to access information included in this section so it is recommended that most information requiring auditing is included in the main data set.

5. RQA Report

MW tabled a revised simplified version.

6. Disclosure of Audit

The Department of Health requires that all DoH documents are sent to 'Gateway' for approval prior to publication. Gateway advised that the NHSBSP can only advise best practice not dictate how a procedure is done i.e. cannot instruct that women must be told that their films will be audited. The National Screening Office therefore plans to publish the first section (Protocol for Review and Classification of Previous Mammograms) as an internal NHSBSP document. The other two sections (Psychological and Medico legal) will be published as "Advice on Best Practice in Disclosure of Cancer Screening Audit" and will include the relevant sections from the cervical and bowel screening documents. This document will be sent to Chief Executives of NHS Trusts and copied to Chief Executives of Foundation Trusts for information. Individual Trusts may develop information leaflets for women (advising of the audit and the availability of the results) if they wish but it is no longer the intention to produce national information leaflets.

7. Categorisation of Interval Cancers

Categorisation 1, 2 and 3 should be applied prior to review of the symptomatic films. The purpose of the latter is to confirm that the site of the mammographic abnormality designated as category 2 or 3 is at the site where the interval cancer developed.

8. Short Term Recall

A paper was circulated by JP for discussion. It was agreed that all screening episodes should be closed within 3 months i.e. allowing enough time for repeat biopsies etc. if required. Most early clinic recalls will occur after 12 months when bilateral mammograms should be obtained. Exceptionally e.g. if biopsy not possible/consent not given an early review may be required at <12 months. The reason should be documented as well as the optimum management advised by the clinician.

9. Assistant Practitioners

Assistant Practitioners are not state registered and therefore not allowed to independently use ionising radiation without supervision by a state registered practitioner i.e. radiographer. This is a potential barrier to maximising the use of APs in the NHSBSP as currently two APs cannot work on a mobile without supervision. The National Screening Office is aware of the issues and hopes to find a solution.

10. Serious Service Failure in Eastern Region

A report circulated by SB was discussed. Despite the unit achieving most NHSBSP targets there was a failure of clinical governance at several levels including inadequate training validation and supervision of advanced practitioners. The unit had a QA visit in Feb 2003, which identified a unit under pressure due to staff shortages but there was not thought to be any serious compromise in standards.

11. Format of QA Visits

Following interview, examination of statistics and peer review of films the QA radiologist currently decides if there are further issues to investigate. It was suggested that the QA process could be made more rigorous by: -

Asking open questions e.g. How do you do a stereotactic core biopsy?
How do you record the right results?

Attending units real MDM.

Previous and post visit meeting of QA team to discuss the main multidisciplinary issues.

Review the last 20-30 classified interval cancers (irrespective of classification) to ensure all cases are classified appropriately. Currently the QA guidelines

advise review only of false negative cases.

Use of standard radiology pro-forma questionnaire.

Use of a written post-visit QA action plan with amalgamation of multidisciplinary issues and timescales for implementation.

Responsibility for implementation of QA recommendations rests with Trust/PCTs/SHA. It was noted that SHAs can instruct NHS Trusts but can only advise Foundation Trusts.

JP agreed to revise the QA visit guidelines with Ellie Scrivens. A draft would be taken to the QA Directors meeting.

Action: JP

12. ABS at BASO Non-operative Diagnosis

Information was circulated by MW. Overall 82% of units achieved the NHSBSP non-operative diagnosis target of >90%. Only one unit failed to meet the minimum standard. The average non-op diagnosis rate for invasive cancers was 96% versus a non-op rate of 81% for in-situ disease. In some units a high percentage of B5a core biopsies proved to be invasive at surgery so a true non-operative diagnosis is not achieved. In 03-04 overall 26% of cases with B5a cores proved to have invasive disease at surgery. MW suggested measuring this routinely in the future via KC62 modifications. Currently the BASO audit should be used to identify these cases.

13. Consolidated Guidance of NHSBSP Standards

This publication had been very difficult to produce and it was acknowledged by the National office that it contained duplications and inconsistencies. JP requested that each professional group highlights inconsistencies and informs the national screening office.

Action: QA group

14. Reports from other Groups

a) QA Directors

Topics discussed included: -
NPfIT

QA Reports- once a QA visit report is issued it belongs to the Trust and is in effect a public document as individuals may request access to the report via the Chief Executive. If there are issues to raise concerning a named individual it is suggested that the QA Director should send a covering letter to the Trust's Chief Executive and avoid naming individuals in relation to specific concerns.

b) ACBCS Committee

Topics discussed included: -

“Screening for breast cancer: past and future” will be ready for publication once the section on radiation risk ratios at different ages has been completed.

Round length – SHA’s will be instructed to submit a five-year action plan to the National Screening Office.

NICE Family History Guidelines.

Issues around how non- NHSBSP units demonstrate that they are screening to NHSBSP Quality Standards.

Disclosure of Audit.

The Department of Health has a target of 50% (? 15% - *to be confirmed at next meeting*) of diagnostics being undertaken in the independent sector. It is not clear if this will apply to screening.

c) BASO MEETING: 2nd March 2005

(Summary provided by Will Thompson)

Symptomatic committee

From 2007 the “Motorcycle museum meeting” will be a 2-day event, to include a scientific meeting and a conference dinner.

Future training of breast surgeons. With the anticipated demise of the “general surgeon”, trainees will choose between the following paths:

Visceral i.e. upper or lower GI
Hepato-biliary
Vascular
Endocrine
Breast

There was some discussion of the concept of the “office-based” breast surgeon who would also carry out his/her own diagnostics, including imaging. I explained that the growing number of advanced practitioner and consultant radiographers, already being trained to meet the shortfall in radiologists, might obviate the need for such training. In informal discussion some committee members expressed doubts that a surgeon would have sufficient time to perform their own scans etc.

Screening committee

The group intends to publish data from the annual BASO audit (presented at the Motorcycle Museum).

There are now ~1000 patients registered into the Sloane project; Pfizer has agreed to continue to support the project.

Sentinel node biopsy. An important governance issue was highlighted concerning the responsibility of the ARSAC certificate holder who must provide proof, when applying for a certificate to cover this procedure, that any surgeons performing the technique have undergone appropriate theoretical and supervised practical training. In this regard it was noted that the certificate received by the surgeon at the completion of training does NOT demonstrate competence in the procedure. However, despite this emphatic statement a certificate is only awarded if the surgeon meets the minimum standard.

There was mention of the following trials:

Age trial. An interim report is on the online version of the B.J.Cancer (bjcancer.com). It shows a 10% mortality reduction in the age group 40-50, thought to be of borderline significance.

DCIS trial. Annual v. 3 yearly mammography – no significant difference in outcome.

d) National OA Evaluation Group

The ONS have conducted a survey of life styles including HRT use. It is estimated that the background incidence of breast carcinoma may have risen by 20% due to HRT use. The results of this survey will be tabled for discussion at the next Big 18 meeting

15. Appointment of Secretary

JL completes her term of office as QA radiologist representing the NEYH Region in August but will remain secretary of the Big 18.

16. Date of next meeting

Wednesday 07 December at Royal College of Radiologists