

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 21st June 2006

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 N Perry	Equipment Sub-Group
Dr C Record	South East-West
Dr M Shaw	Eastern (Deputy)
Dr W Thompson	NEYH
Dr M Wallis	West Midlands
Dr F White	Mersey/Cheshire
Dr M Wilson	Manchester Training Centre
Ms R Bennett	CSEU
Mrs J Patnick	NHSBSP

Apologies

Dr S Barter	Eastern
Dr A O’Docherty	Dublin

1. Minutes of last meeting held on 7th December 2005

The minutes were agreed as an accurate record.

2. Matters arising

Screening AT gene carriers

Screening advisory committee consulted.

PERFORMS

JP agreed to ask Alistair Gale’s team to regularly provide QA radiologists with a list of the names of readers in their Region who participated in the PERFORMS film sets. QA radiologists should let the PERFORMS team know if readers retire or cease to screen read for any other reason.

Action: JP /QA radiologists

3. CSEU National QA Audit Results 04/05

The results were circulated by RB. One unit with a very low recall rate was also noted to have a low SDR. The relevant QA radiologist was advised to contact the Director of this unit and arrange to review cases. Another unit had a very high recall rate. MW reported that this temporary problem had now been resolved.

QA radiologists were reminded to share and review this data at their Regional QA radiology meetings.

PPV diagrams for individual units will be ready for circulation at the end of July. RB agreed to subdivide results into prevalent and incident screens as well 1 year and cumulative 3 year results.

Action: RB

4. NBSS Update

a) **Clinical module including assessment, pathology data, MDM and surgical data.**

To be piloted in Spring 2007. Should interface with symptomatic databases and be compliant with CfH.

For women who have undergone neoadjuvant chemotherapy it is acknowledged that surgical pathological data will underestimate the original tumour size. The imaging measurements, ideally ultrasound, should be recorded instead. Recording of size will be reviewed by the screening evaluation group.

b) **Direct entry of screening results**

JP indicated that this change in practice should be cost neutral, as fewer clerical staff will be required. It was acknowledged that converting revenue funding to capital is not always straightforward. JP advised units to discuss the matter with their host Trust's Risk Management department. If a screening unit has not implemented direct entry by 2007 and has a "wrong results" incident it would be difficult to justify why a Trust had wilfully been operating outside the national standard.

b) **CfH interface** (*MW summary*)

There is an ongoing programme to evaluate "legacy systems" and their ability to interface with CfH and the spine. NBSS will need to be spine compliant to enable it to act as a RIS to drive PACS. This work is ongoing. The PACS rules are "radiology" based and are tightly controlled by SLAs/contracts. Breast Screening is outwith the current contracts and the rules are not compatible with breast screening. If screening data was to be transferred in the same way as radiology data the network would collapse and other solutions need to be found.

5. **Assessment Clinic Workload**

No workload figure was included in the QA guidelines as the number of woman that can be seen in an assessment clinic is influenced by numerous variables including:-

Number of available mammography and ultrasound machines.

Staffing - ? One or more radiologist. ? Number of radiographers.

Skill mix - ? Number of advanced practitioners/what tasks are they undertaking.

Is surgeon/breast clinician or radiologist undertaking breast examination and discussing results with women.

Teaching - SpRs may slow or enhance clinic throughput depending on experience/competence.

PPV for recall/ % women requiring a needle biopsy at first assessment visit etc.

Simon Daniels has symptomatic workload information.

ED advised that if a unit wished to critically examine their assessment clinic workflow their Trust could engage, for a fee, the services of the “Diagnostic Imaging Service Redesign Team”.

JP agreed to liase with RG-W to develop a short questionnaire that could be sent to units by their local QARC.

Action: JP

6. **NDROR questionnaire**

The purpose of this proposed questionnaire was to determine factors contributing to optimal performance of individual screening units. A new assessment clinic questionnaire was not developed by the CSEU following the last Big 18 meeting. Instead RB is reviewing data already collected via the NHSBSP Service questionnaire. The deadline for submission of this questionnaire was Jan 15th 2006 and it included a section on Diagnostic Assessment Clinics. A return rate of only 50% was reported.

Action: RB

7. **Ultrasound Equipment specification**

An updated specification is needed for ultrasound equipment intended to be used for the diagnosis of breast disease. Tony Evans, a physicist in Leeds is currently evaluating ultrasound equipment for antenatal screening but the group felt that as requirements are so different it would be better to undertake a dedicated breast ultrasound evaluation. It was suggested that RW writes to the Physics Big 18 group asking them to write a specification.

Action: RW

8. **Update on benign biopsy audit**

MM reported that the data collection is now complete and thanked BSS staff and QARCs for their assistance. The results will be tabled at the next Big 18 meeting in December.

9. Update on ABS at BASO audit

In 04/05 all units achieved a non-operative rate of >80% and all except 16 units achieved >90%. Obtaining a non-operative diagnosis for non-invasive cancer remains more difficult with a wider range reported between units.

46 cases with a B5b needle Bx → DCIS without invasive disease at surgery
42 cases with B5a or B5b needle Bx → No malignancy found at surgery

QARCS will audit these cases in detail ? Mammotome removed
? Needle Bx site identified in surgical specimen
? Wire localisation problem

A chart tabled the number of visits to make a diagnosis but it was unclear if Results Clinic visits had been inadvertently included by some services.

It was noted that not all QARCs regarded assisting with ABS at BASO data collection as a core function. JP to review QA specification.

JP agreed to discuss at QA Directors meeting if the radiology Big 18 could get coded named unit data ie. each BSS unit identified by same code as used by CSEU.

Action: JP

10. National QA radiology audits

Several suggestions were made for future audits including a) an observational study in the use of mammotome for the excision of radial scars and papillomas and b) non-operative diagnosis rates for non-invasive disease using VACB versus conventional core Bx.

It was agreed that radiologists should send suggestions to JL by end August. These would then be circulated to all to rank in priority order. The 2-3 audits with the highest score would be discussed in more detail at the next Big 18 meeting.

Action: All

11. Single reading with CAD

A brief summary of a paper written by RB et al comparing the accuracy of single reading with CAD to double reading was tabled. It concluded that evidence was limited as to the accuracy, in terms of sensitivity and specificity, of single reading with CAD in comparison to the most common practice in the UK of double reading using a protocol of consensus or arbitration.

12. Interval Cancers

It was agreed by all that further standardisation in the way interval cancers were radiologically reviewed and classified was not possible as review involved individual readers opinion. The method to use is documented in the NHSBSP publication "Audit of Breast Cancers in Women Aged 50 to 74".

The contents of information leaflets including NHSBSP “Breast Screening The Facts” and a leaflet produced by BACUP were discussed. In particular, the section in the former concerning interval cancer review “When a review shows that you should have been cared for differently, we will contact you” was queried as some women may choose not to know the result of review. JP agreed to review the wording.

Action: JP

13. Breast Screening The Facts leaflet

Discussed in item 12.

14. Radiological aspects of QA visits

It was agreed that the radiology section of QA Visit Guidelines needs revision. 2-3 radiologists are asked to volunteer to assist RW and JL.

Action: All

15. 62 day waiting time (JP summary)

The extension of the 62 day target waiting time for cancer patients to women with screen detected breast cancer is under discussion although it is unlikely to be introduced until 2008. There was a clear need for careful definition of the start time for the target as well as rules for “stopping the clock”.

16. Mammotome Users Group draft report

Draft paper written by Peter Britton tabled for comment.

Action: All

17. Report from other groups

a) ACBCS committee

Results of trial screening women aged 40-47 are awaited.

b) QA Directors

Discussion included review of interval cancers.

c) BASO

1. SLOANE - 2000 cases registered.

Radiological estimate of size correlates well with high grade DCIS but not low/intermediate grade.

2. QA visitors should produce documentary evidence that they are trained to undertake QA visits. Peer review training is acceptable.

3. Ultrasound training for surgeons – no further discussion.

- d) **National QA Evaluation**
Discussion included ascertainment of underlying incidence of breast cancer.
- e) **Digital Mammography Steering Committee**
There is a review paper of digital equipment written by Ken Young on the NHSBSP website. It is recommended that any new equipment purchased by NHSBSP units should be digital.

18. Any other Business

- a) **Critical Incident Reporting**
There was little enthusiasm for the continued collection of data by the RCR Breast Group as the NPSA now produce timely feedback. This will be discussed at the Breast Group AGM.
- b) **Health Care Commission Associates**
Volunteers are needed to undertake breast service reviews. JL to circulate information .

Action: JL

- c) **Appraisal**
It was agreed that appraisal of consultant radiographers should be undertaken jointly by a radiologist and senior radiographer.
- d) **Injection of free silicone**
Women who have had free silicone injected into their breasts should not be excluded from the Screening Programme. Instead they should be advised that the exclusion value of the examination will be greatly reduced.

19. Date of next meeting

Wednesday 13th December 2006.