

**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 30th June 2010

Present

Dr R Wilson	Chairman
Dr J Liston	Secretary
Dr C Beattie	North West
Dr G Briggs	N.Ireland
Dr J Cooke	South East Coast
Dr A Duncan	West Midlands
Prof F Gilbert	RCR Breast Group
Dr R Given-Wilson	Training Centre
Dr K Gower Thomas	Wales
Dr A Hubbard	Equipment Sub-group
Dr M Lamont	Breast Clinician
Dr J Lavelle	North West
Dr J Litherland	Scotland
Dr M Michell	London
Dr P Nisbet	Jersey
Dr C Record	South Central
Dr J Steel	South West
Dr W Thompson	NEYH
Dr A Turnbull	East Midlands
Dr R Whitney	Eastern
Dr M Wilson	Manchester Training Unit
Prof J Patnick	NHSBSP
Ms R Bennett	CSEU
Dr R Blanks	CSEU

Apologies

Dr S Bradley	West Midlands
Dr A O’Doherty	Dublin
Dr M Wallis	NIB

In Attendance

Prof A Gale	PERFORMS
Ms Y Chen	PERFORMS

1. Minutes of last meeting held on 9th December 2010

Item 6d was amended to read “It is recommended that units move from using analogue equipment to digital equipment in a single transfer”.

The minutes were otherwise agreed as an accurate record.

2. Matters arising

2.1 Department stores

No units are currently offering screening within department stores.

2.2 MRI Screening Guidelines

As the guidelines are in draft form they are not on the main NHSBSP website. Instead they can be found on the NBSS website which has to be accessed from an NHS site via a screening unit using the screening unit's password. It was agreed that the guidelines would be easier to access if they were included on the RCR Breast Group website.

Action: Fiona Gilbert

3. National Audit 2008/09

Data was presented by Rachel Bennett and Roger Blanks for women aged 50-70. The overall recall rate in the prevalent round was 8.8%, a slight improvement on the 07/08 rate of 9.1%. However there was wide variation in recall rates between units ranging from 4.3% to 17.2%. High recall rates did not necessarily correlate with high cancer detection rates. Two units with high recall rates had low cancer detection rates. There was also wide variation in PPV for recall. 7 women were assessed for each cancer detected in the best performing units versus > 30 women assessed per cancer detected in the worst performing units. Analysing data over 3 years demonstrated that 26 units did not achieve the NHSBSP minimum standard recall rate (<10%) in women being screened for the first time. It is of concern that age extension i.e. inviting younger women may exacerbate this problem. Reasons suggested for high prevalent round recall rates included anxiety about missing cancers especially in small units if their cancer detection was low in the previous year (although the apparent low detection may just reflect statistical instability due to the small numbers screened). The relative % of experienced versus inexperienced readers or "doves" versus "hawks" in individual units will influence unit culture. Some regional cultural differences are also evident. To benchmark the scale of the problem MM enquired how the UK compares with Europe. JP agreed to investigate.

Action: Julietta Patnick

Solutions suggested include arbitration or consensus reading of all recalls including concordant recalls. However the former could lead to the 3rd reader / arbitrator disagreeing with both the 1st and 2nd reader's recall decision. If an interval cancer subsequently developed at the same site could there be medico-legal consequences for the 3rd reader/ arbitrator? In one unit this situation is avoided as films are removed from the viewer as soon as one reader recalls and then the films are read by at least two other readers. There are so many variations in the exact type of double reading used in different units that it has not been possible to compare individual unit's PPV for recall with type of reading although published studies have shown double reading with arbitration by a 3rd or more readers prior to recall results in reduced recall rates. Small units may be unable to undertake double reading at all times as their pool of readers will be relatively small but it was suggested that arrangements could be made with other units to cross cover during times of annual leave etc. Such

arrangements will be easier when the NHSBSP is fully digital. Readers with high recall rates should ideally read in pairs with readers who have low recall rates. Self audit and education is key. It was suggested that the PERFORMS film sets included a slightly different case mix e.g. cases more akin to real-life instead of including cases with exceptionally subtle features or cases that could cause readers to inappropriately recall. It may be beneficial for trainee readers to spend time in other units. As incident round recall rates are generally well within target it was suggested that units make extra effort to obtain films for comparison if women attending their prevalent screen have previously had mammograms taken in a symptomatic unit.

All except one unit achieved an SDR of >1.0 in the incident round. In the prevalent round seven units had an SDR of <1.0 including two units with an SDR of <0.85. At the QA directors meeting in May 2010 it was agreed to set revised SDR targets of minimum standard ≥ 1.0 and target ≥ 1.40 .

4. **PERFORMS**

Alastair Gale presented the SA09 round report. 569 participants completed both parts and another 100 completed one of the two halves. A small number of participants stated they were “too busy” to undertake both film sets. QA radiologists should discuss participation in PERFORMS with screen readers at QA visits.

Action: All QA Radiologists

In part one, 19 outliers including one severe + three who had been outliers in previous PERFORMS sets have been contacted and remedial action taken where necessary. 28 outliers have been identified in the second part including 10 readers new to PERFORMS. AG was asked if there was a difference in the % of radiologists versus AP outliers.

Action : Alastair Gale

PERFORMS are short of suitable cases to include in the next set. QA radiologists should encourage all units to submit suitable cases especially those that will educate and facilitate a reduction in recall rates. Cases which have been recalled following 3rd reader arbitration i.e. one reader has missed or misinterpreted the mammographic signs are generally useful cases.

Action: All QA Radiologists

Currently PERFORMS are using original FFD mammograms and distributing the sets as laser printed films with a reporting tablet. The films could be circulated on CDs, DVDs or USBs but image quality might then vary. In the future it is hoped to send both the PERFORMS images and software directly via PACS but there are hurdles to overcome including interfacing with different PACS systems.

At the moment there may be up to 6 months delay before an outlier is notified. AG would like to introduce immediate feedback to potential outliers via a “traffic light” warning system. He would like to work with and help outliers improve their performance. No persistent severe outlier has ever been identified by PERFORMS.

The question was asked if we still need PERFORMS as detailed real-life screening data regarding individuals reading performance can now routinely be obtained from NBBS. It was agreed that PERFORMS remained a useful educational exercise and had the benefit that the sensitivity and specificity of all NHSBSP readers was compared with peers using the same cases.

5. Guidelines revision updates (Assessment + Radiology)

NHSBSP Assessment guidelines are at the printers.

A draft version of QA guidelines for Breast Cancer Screening Radiology was circulated by RW prior to the meeting. The section on standards for working practice required extensive revision to reflect the changes introduced by the adoption of skill mix and the requirement to focus on standards for tasks and responsibilities rather than job titles. It was agreed however that radiologists would be expected to be involved with film reading, assessment and MDT meetings. European guidelines included in the training appendix will be replaced by RCR training guidelines. Breast radiologists who have not trained in a unit undertaking NHSBSP screening should spend some time at one of the NHSBSP Training Centres. It was agreed to revise the standard to minimise core biopsy miss rates (B1 or B2 from cancer) allowing assessment of individual’s targeting accuracy. Following detailed discussion RW agreed to redraft the Radiology guidelines and send them to QA radiologists for wider circulation. All comments to be sent back to RW with track changes.

Action: Robin Wilson + QA Radiologists

In addition RB agreed to revise cancer detection rate standards etc. in line with new SDR standards.

Action: Roger Blanks

Following this the “Consolidated Guidance on Standards for the NHS Breast Screening Programme” will need to be updated.

6. False Negative Assessment

Recent provisional data from the CSEU suggests that in some units 4% - 15% of women presenting with an interval cancers have previously attended an assessment clinic although it is not known if this was for assessment of the same site or a different area. It was suggested it would be useful to audit screen detected cancers and ascertain the % that had previously been assessed for the same abnormality. A means of formally assessing individual radiologist’s adherence to NHSBSP Assessment guidelines is needed possibly through the development of a new NBSS

crystal report. There will be a need to ascertain not only that a procedure has been done but also to measure individual's sensitivity when performing ultrasound, biopsies etc. It is proposed that when a previously assessed interval cancer is identified by a screening unit, a proforma (still to be developed) is completed and returned to QARCs.

JP will convene a false negative assessment working party to include radiologists, an advanced radiographer practitioner, surgeon and NBSS expert.

Action: Julietta Patnick

7. QA Visit Guidelines

The radiology section for inclusion in revised "NHSBSP Guidelines for QA Visits" was tabled and agreed at the Big 18 meeting in December 2006. For various reasons the guidelines have not yet been published. Following discussion it was agreed to include a) Individuals assessment practice + b) false negative assessments within the list of data to be reviewed. It is mandatory to review the films and records of all women seen at an assessment clinic for each assessment radiology lead.

It was agreed that the radiology section of the QA visit guidelines should be used by QA teams immediately.

Action: All QA Radiologists

8. Cancer Reform Strategy update

a) Higher Risk screening

Lars Holmberg is speaking at Symposium Mammographicum. All factors that increase a woman's risk may be assessed and the same screening strategies applied to all women with the same risk. Screening including call/recall and setting /monitoring standards and outcomes will be the responsibility of the NHSBSP but assessment of an individual woman's risk will not. Women with very high risk BRACA etc will only be accepted for MRI screening after assessment by geneticists. The threshold for including women within the moderate risk group may be higher than the current threshold but screening of this group every 18 months may be recommended until 70 years old.

NBSS Software is being evaluated at the pilot sites.

b) Screening Extension

No change in screening extension (47-73) is anticipated in the forthcoming government NHS White Paper. JP continues to lobby ministers to provide funding for digital equipment.

9. Non -op diagnosis audits

Papers written by Matthew Wallis and Shan Cheng were circulated prior to the meeting. Non-operative diagnosis rates have generally been improving over the last 5 years but achieving high non-operative diagnosis rates for non-invasive versus invasive disease remains much more difficult. In 2008/09 only 29 units achieved the 90% target and 44 units failed to meet the 85% minimum standard. 21% of B5a cancers were found to be invasive at surgery. Review of malignant open biopsies show that cases with prior B1, B2 and B4 core biopsies have fallen but that cases with a prior B3 core had risen suggesting that targeting is not the problem. Some units require multiple visits and repeat biopsies to achieve a non-operative diagnosis. It was suggested that QA radiologists review the practice at units where more than two attempts at needle biopsy are required frequently to establish the non-operative diagnosis.

Action: QA Radiologists

MW was unable to attend but will be invited to discuss the papers in greater depth at the next Big 18 meeting in December.

Action: Joyce Liston

10. Workforce + Activity surveys

Summaries written by Matthew Wallis were circulated prior to the meeting. Responses to the workforce survey were patchy but currently it is estimated that 367 breast imaging sessions are vacant and a further 678 sessions will become vacant over the next 5 years due to retirements. The RCR has opted not to remain on the DH shortage specialist register.

11. Benign Bx targets / Surgical QA guidelines

QA Guidelines for Surgeons in Breast Cancer Screening published in March 2009 include revised lower minimum standards (<15 per 10,000 in prevalent screen and <10 per 10,000 in incident screen) + targets (<10 per 10,000 in prevalent screen and <7.5 per 10,000 in incident screen). In the CSEU prevalent screen data 08/09, approximately 80% of units would fail to meet this new minimum standard.

There was unanimous agreement that this benign biopsy target cannot be achieved if pathologists continue to advise the surgical excision of most B3 lesions. The anomaly of lobular neoplasia being classified as B3 (if found in a core biopsy or VACB) but the same tissue being classified as benign (if found in a surgical excision specimen) was again discussed. There has been significant change in radiological practice with increased use of VACB. Pathological guidance is needed as to which B3 abnormalities found on VACB may be left in situ and which require surgical excision. RW will discuss with Martin Lee, Mark Sibbering and Ian Ellis.

Action: Robin Wilson

12. Short term recall

Women attending a short-term recall appointment > 1 year since their original assessment should have bilateral mammography.

13. Membership of Big 18

Each Region may be represented by a single radiologist. Regions with more than one QA radiologist should consider attending alternate meetings.

14. Reports from other groups: -

a) QA Directors

Topics discussed included revised SDR target and false negative assessment.

b) ACBCS committee

Topics discussed included the new screening information leaflet "Breast Screening :The Facts". Double reading of screening mammograms will become mandatory once a unit is completely digital.

c) ABS at BASO

The meeting are to be restructured with a screening meeting in the morning.

d) National Imaging Board

Due to other commitments and after many years of dedicated work Matthew Wallis has tendered his resignation and will no longer represent radiology on the National Imaging Board. Jim Steele volunteered to represent radiology and his offer was accepted.

e) National co-ordinating group for equipment *(Report provided by AH)*

Workstations.

Services to be reminded that it is not necessary to purchase manufacturer specific workstations, and that volume procurement via Supply Chain can be used in principle as currently practiced for mammography.

The exception to this is sets used for tomography, which are currently vendor specific. A new DICOM standard for Tomography is to be introduced.

Managed Service Arrangements.

Supply Chain does not handle Managed Service arrangements, so these will need to go to European tender. NHSSC may provide these in future.

MHRA update

There are concerns about MACROLANE safety, as breast cosmetic enlargement is not a licenced use of this product, and there is a theoretical risk of toxicity from degradation products. As women do not regard this as "surgery" it may not be mentioned to radiographers at screening. Women appear not to have been informed of the risks of interference with screening mammography.

K Care

Equipment evaluation functions taken over by NICE Manchester group.
CAD economic report and Specimen Cabinet report will be the last from the dissolved CEP.

Digital Progress

20% of mammography equipment in England and Wales is now digital. About 40 % of screening units have at least one digital set. A relatively high level of faults recorded for all digital sets.

Some private services using CR are bidding for screening work. As the resolution achieved tends to be lower, and dose is generally higher than for DR, this should be discouraged and a statement has been put on the screening website to this effect.

All equipment used in screening should have been through both a technical and clinical evaluation.

Small field Digital problems.

Supply of new needle guides for Siemens Opdima, and disposable bushes for the GE Senographe stereo now a problem-as have been discontinued-
E-mail from Chesterfield

In April we ordered bushes (small plastic needle guides) from GE for our Senographe stereo mammo machine. GE have sold the company that makes these to a French concern, who are apparently not supplying the UK. There are now none in the GE warehouse.

15. Any other business

a) Consent

The consensus opinion was that obtaining formal written consent prior to undertaking needle biopsies was not necessary or possible in one-stop breast clinics or assessment clinics. A tick box may be used to record that verbal consent was given.

b) Bilateral assessment

It was reported that occasionally women recalled for assessment of both breasts had only one breast assessed. This was thought to be a local issue but suggestions to avoid this mistake included marking the appropriate sites on the mammogram films at the time of reporting.

Date of next meeting

Wednesday 8th December 2010