

1. 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 16 June 2004

Present

Dr R Wilson	Chairman
Dr J Liston	Yorkshire/Secretary
Dr S Barter	Eastern
Dr P Britton	RCR Breast Group
Dr J Cooke	South East-East
Dr G Crothers	N. Ireland
Dr K Duncan	Scotland
Dr A Evans	Trent
Dr R Given-Wilson	St George’s Training Centre
Dr K Gower Thomas	Wales
Dr G Hunnam	Eastern
Dr J Lavelle	Greater Manchester/Lancs/Cumbria
Dr M Michell	London
Dr A O’Doherty	Dublin
Dr N Perry	Equipment Group
Dr W Thompson	Northern
Dr M Wallis	West Midlands
Dr M Wilson	Manchester Training Centre
Dr F White	Merseyside/Cheshire
Dr R Blanks	CSEU
Mrs J Patnick	NHSBSP

Apologies

Dr E Kutt	South West
Dr P Nisbet	Jersey
Dr G O’Sullivan	South East-West

1. Minutes of last meeting held on 10 December 2003

Dr S Barter represents Eastern region not Essex. The minutes were otherwise agreed as an accurate record.

2. Matters arising

2.1. Measuring Individual Performance in Real Life

The paper prepared by the CSEU discussing the evidence on reading performance in relation to number of films read is to be submitted for publications after further discussions between Roger Blanks and Sue Moss at the CSEU.

Action: Roger Blanks

2.2. RCR Breast Group Survey

The survey has now been distributed to Wales, Scotland and Ireland .

2.3. Programme Extension

Julietta Patnick stated that the maximum health gain for the population will be obtained by screening more women age 65 to 70. Programmes should therefore prioritise programme extension 50-70 ahead of slippage but programmes should plan to return to the three year interval at the earliest possible opportunity. JP reported that 40% of units have already extended and another 40% intend to extend by December 31st 2004.

3. KC62 Results 02/03

The CSEU will mail corrected comparative charts plus PPV referral diagrams as soon as possible. Roger Blanks requested that the data is then verified by QA radiologist for the units in their region. The CSEU was requested to use screening unit names instead of codes. Prevalent round SDRs continue to increase. This may be secondary to wide spread use of HRT and 2 views as well as improved NHSBSP performance. Two programmes have lowish SDRs plus low recall rates – the QA radiologists representing these units were advised to discuss the results with the clinical directors of these units.

Roger Blanks requested the following additional data is routinely included on KC62 returns:-

- a)What % of women have their first offered appointment within 36 months?
- b)What % of women have their first offered appointment within 38 months?
- c)The number of months when 90% of eligible women are offered their first appointment.

Julietta Patnick agreed to co-ordinate the sending of this data from QARCs to the CSEU.

Action: Julietta Patnick

4. Effectiveness of Two Views Incident Screening

The CSEU have conducted a study to assess the effect of changing to two views at incident screen on both cancer detection rates and recall rates. Previous detailed investigations using test-sets and observational studies have suggested that the effect will be the same as that for prevalent screens with the proviso that the increasing use of double reading with arbitration will marginally reduce the observed effect. The study was conducted by comparing 2002/3 data with 2001/2 data for programmes that changed to two views sometime during those two screening years. A correction factor was added to allow for the fact that the full impact of two views, by comparing data from these two years, would only be seen in those programmes changing at midnight on 31st March 2002. The expected effects were observed and the study has provisionally concluded that the effect of two views is as predicted causing a substantial increase in cancer detection rates at the same time as a fall in recall rates. There was no evidence that the increase in detection rate was due to slippage and two important observations were noted. Firstly that slippage was a bigger concern for programmes that had not switched to two views. Secondly from an analysis of a subset of programmes, a substantial number of programmes in the study group showed evidence of slippage correction i.e. they

were able to both change to two views at the same time as partly or completely correcting their slippage problem. This was an unexpected finding as the CSEU had been alerted to the probability of slippage. The evidence suggested that the effects of slippage from some programmes were being cancelled out by slippage correction from a similar number of programmes. The study results will be submitted to an appropriate journal as soon as possible. (*Summary provided by R Blanks*).

Action: Roger Blanks

5. Digital Stereotaxis Study

This study is still ongoing but it is understood that the retrospective data collection process has been completed. Julietta Patnick suggested Karen Bennison should be invited to the next Big 18 meeting to give an update.

Action: Joyce Liston

6. Digital Mammography Business Plan

Julietta Patnick's office is developing a "case study" instead of a "business plan" for use by NHSBSP units as there is minimal data available to include in the latter. Ken Young will be asked to become involved in choosing suitable equipment. There is concern that no manufacturers equipment has been tested within a high throughput environment such as the NHSBSP. Some units are using full field digital equipment for assessment but none for initial screening. Robin Wilson suggested units consider leasing digital equipment as the technology is evolving rapidly.

Action : Julietta Patnick

7. Disclosure of Audit

Julietta Patnick reported that there had been delay in rewriting the cervical screening section in the same format as the breast screening section for inclusion in the disclosure of audit document. Sections need to be submitted to the DOH together. Meanwhile, units were advised to use the 1, 2, 3 classification method for interval cancer review as outlined in the 3rd draft of Disclosure of Audit guidelines. Development of information leaflets for women has not commenced. Lesley Fallowfield and Amanda Ramirez have agreed to run pilot training in September using actors and role-play.

Action : Julietta Patnick

8. NICE Family History Guidance

The guidance will be published on 23 June 04. Mammographic surveillance of these women is expected to be undertaken to NHS Breast Screening Programme standards. Robin Wilson agreed to co-ordinate the production of a short document entitled "NHSBSP standards – Key points" for use by PCTs commissioning mammographic surveillance services. All the QA radiologists agreed that robust data collection was required but no consensus was reached as to how this would be achieved.

Action: Robin Wilson

9. Radiographers Double Reading

Julietta Patnick has sent draft guidance to the Radiographer QA group for comment. A clear definition of what is meant by consensus is needed – does discussion by the 1st and 2nd reader constitute consensus or is review by the breast screening team required? The opinion of the committee was that with consensus and arbitration for the pilot study a third reader (radiologist) should always be used.

Action : Julietta Patnick

10. SpR training in breast imaging

Matthew Wallis reported no progress to date.

Action : Matthew Wallis

11. Breast Practitioner

Peter Britton has written to Hugh Bishop requesting RCR Breast Group involvement in the development phase of this proposed new professional.

Action : Peter Britton

12. Breast Ultrasound Training for Surgeons

A group of breast radiologists have developed guidance for medical trained but non-radiologists. This guidance has now been submitted to the RCR with a view to publication as an RCR document.

13. Revision of QA Guidelines

13.1 Radiology QA Guidelines

Short term recall / re-screen needs to be clarified.

Non-operative diagnosis should be used consistently in the guidelines instead of pre-operative diagnosis.

The European training guidelines should be retained.

13.2 Assessment Guidelines

It was agreed that only consultant practitioners would be able to practice autonomously. Advanced practitioners need consultant radiological supervision.

Section 2.7 should include “if additional funding and resources are available”.

Two separate lists outlining the management of calcification needs harmonising.

The section on the management of architectural distortion has been re-written following correspondence from screening radiologists. There are now 2 flow charts for the management of architectural distortion for units with or without access to mammotome vacuum assisted biopsy.

It was agreed to change the requirement that the diagnosis and management of all women who had undergone needle biopsy must be discussed at a prospective multidisciplinary meeting to “must be discussed at a multidisciplinary meeting preferably prospective”.

Action: Robin Wilson

14. Requirement to Copy Clinician Letters to Patients

This is a DOH initiative. Julietta Patnick advised that the new NBS system would shortly be able to generate new routine recall letters for women who had attend assessment i.e. assessed as normal/benign. These RR letters include a sentence advising that the woman can request copies of their clinical letters if they wish. Local trust policy should be followed re copying of clinician letters when women are referred for diagnostic or therapeutic surgery.

15. Crystal Reports

Joyce Liston requested that Crystal reports were developed centrally and distributed to individual units for use. This would ensure accuracy and comparability of data collection. Matthew Wallis advised that this had been discussed in the computer users group. QARCs had been requested to send in their requirements but few had been received.

16. BASO Audit Data

Matthew Wallis reported BASO data showed that units using predominantly cytology versus core biopsy have the lowest non-operative diagnosis rates especially for in-situ disease. 25% of cases with a core biopsy showing in-situ disease prove to have invasive disease at surgery. There was variability in the collection of “number of visits to assessment” data. Survival data for women with screen detected carcinomas looked good.

17. Reports from other Groups

17.1 QA Directors

Robin Wilson reported that the QA Directors wish to undertake review of interval cancers to retrospectively assess screening quality. There were difficulties agreeing the definition of an interval cancer.

17.2 ACBCS Committee

Mike Michell reported that the following items were discussed:-

- 2 views/coverage
- Digital mammography
- Double reading
- HRT
- Screening over 70 years
- NICE Family History screening guidance

The Forrest report is being updated by Valerie Beral to include new epidemiological evidence.

17.3 BASO

No radiologist attended the meeting on 3/3/04.

Date of Next Meeting

Wednesday 15 December 2004, 10.30 a.m. for 11.00 a.m. start at the RCR.