Copy — NJG
GG
SH. ✓

ESSENDON BREAST X-RAY PROGRAM JOB DESCRIPTION

Position: Research Medical Record Administrator

Employee: (name)

Qualifications: Eligibility for membership of the Medical Records Administrators Association.

Classification: (According to AMEH schedules)

Responsible to: Manager, Breast X-Ray Program

Training: Director, Cancer Epidemiology Centre, ACCV

Hours of Employment: 0.5 EFT

Duties:

1. To ensure the accuracy of data on the appropriate record forms.
2. To collect required data on all women referred from the Program for further investigation and treatment.
3. To ensure availability of required data when women return for clinical assessment.
4. To correct inaccurate data entered on computer in accordance with the agreed protocol.
5. To liaise with Anti-Cancer Council of Victoria staff and ensure that regular progress reports, including error and missing data reports, are provided to the Program Manager.

14/8/89

Copy to Mr Ian Russell.

18-4.20

To Dr Campbell. DMS, RMH.
This is agreed to at ACCV.
It would be appreciated if Dr Graham Giles could be involved in selecting the Research MRA.
[signature]
14/8

THE AMALGAMATED MELBOURNE & ESSENDON HOSPITALS

BREAST X-RAY PROGRAM

To: Ms. Susan Hurley
Cancer Centre Epidemiology

From: Delia Flint-Richter
Program Manager

Date : 12th September, 1989

Re: Failure of Computer to Generate the following i.d.'s on letter lists.

It is important for me inform you that on September 1st, we identified that the computer failed to generate 97 letters; - 54 letters for women and 43 letters for Doctors, on various letter lists.

Attached is a list of unique i.d.'s and types of letter that were missing.

I contacted Ross immediately and Heather attended to the error.

Now all these letters have been generated and forwarded to the respective women and Doctors.

This information must be considered when interpreting the statistical report at the next Executive Meeting.

Delia Flint-Richter
Program Manager

copies: Dr. D.Campbell, Director of Medical Services

Professor B. Tress, Acting Program Director ,

LIST OF MISSING LETTERS

Unique i.d.	Letter Required	Drs. Letter
39752	R/T	No
25701	R/T	No
2815	R/T	Yes
45298	R/T(Italian)	Yes
15318	R/T	No
38943	R/T	Yes
25390	R/T	Yes
16785	R/T	Yes
10938	R/T	Yes
12710	CL(Language-Italian)	No
30801	CL(Italian)	No
34883	CL(Greek)	Yes
45282	CL(English)	Yes
20591	CL(Italian)	Yes
31303	CL(Greek)	No
25914	CL(Italian)	Yes
45285	CL(Italian)	Yes
7533	RS	Yes
23139	RS	Yes
37201	RS	No
7853	RS	Yes
1355	RS	Yes
13005	RS	Yes
38771	RS	Yes
20749	RS	Yes
4541	RS	No
2471	CL	No
30953	CL	No
40818	CL(After Recall)	Yes
40759	CL(After Recall)	No
2781	CL(Language Italian)	Yes
40881	CL(Language Italian)	Yes
6252 - notified =0.	CL	Yes
7230	CL(Language Greek)	No
4453	CL(Language Yugoslav)	Yes
12530	CL (After Recall)	Yes
35149	CL(After Recall)	Yes
15628	CL(After Recall)	Yes
6862	CL(After Recall)	No
15341	CL(After Recall)	Yes
9989	CL(After Recall)	Yes
40748	CL(After Recall)(Lang)	No
1292	CL(After C/A)	No
32276	CL(After C/A)	No
2441	CL(After C/A)	Yes
34276	CL(After C/A)	Yes
32011	CL(After C/A)	Yes
8476	CL(After C/A)	Yes
4938	CL(After C/A)	No
18931	CL(After C/A)	Yes
4111	CL(After C/A)(Lang)	Yes
38162	CL(After C/A)(Lang)	Yes
18050	CL(After C/A)(Lang)	No
27365	CL(After Recall)(Lang)	Yes
8112		Yes
10816		Yes
29374		Yes
29683		Yes
29685		Yes
31538		Yes

- Modem
- ~ 2 weeks.

JOHN P. COLLINS

SUITE 16
PRIVATE CONSULTING ROOMS
ROYAL MELBOURNE HOSPITAL
PARKVILLE 3052
TELEPHONE: 347 0122

25th August, 1989

Mrs. D. Reading,
Education Unit,
Anti Cancer Council of Victoria,
1 Rathdowne Street,
CARLTON 3053

Dear Mrs. Reading,

In the last 2 days I have been contacted by 1 patient of mine and 1 general practitioner regarding the method of recruitment of patients to the breast screening project. Some concern has been expressed that the patients have been contacted directly by phone requesting that they attend the clinic. Both patients had previously had mammograms performed by different routes, but were encouraged during this phone conversation to come to Essendon rather than their pre-arranged mammographic review.

Both patients were encouraged to come to Essendon because it was free and because if the number of people attending the project could be increased then this would be in the best interests of this patient in that the government would provide a continued free service for years to come.

As I am sure you are aware I am committed to and actively involved in the Essendon project. I was extremely alarmed when I heard that this method of recruitment was being utilised and I would have to say that I think it is outside what I would consider reasonable.

I have on a number of occassions over the last 6-9 months dealt with enquiries from anxious practitioners in the Essendon area, particularly as the recruitment drive has intensified. I am sure you are aware that there is amongst the medical community, considerable disquiet regarding individually addressed letters being received by the patients, although I must say that up until this time I had felt that the patient had the option to discard these and that therefore I felt they were reasonable.

...2/

JOHN P. COLLINS

SUITE 16
PRIVATE CONSULTING ROOMS
ROYAL MELBOURNE HOSPITAL
PARKVILLE 3052
TELEPHONE: 347 0122

Obviously as we enter a new phase of intensive recruitment, other strategies need to be looked at, however, I would consider this to be a quantum leap and personally I just cannot accept it.

I expressed my concern regarding this to the project director and he recommended I write to you personally.

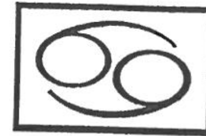
I would like to repeat that I wholeheartedly support the project up to this point, however, I think this has gone a little too far and I think that discussions at the AMBH and ACCV should now take place to look at these more aggresive strategies before they are implemented.

Yours sincerely,

JOHN P. COLLINS

cc Mr. I. S. Russell, PCR 15, Royal Melbourne Hospital
Dr. N. Gray ACCV 1 Rathdowne Street, Carlton

Cancer Epidemiology Centre
Victorian Cancer Registry
1 Rathdowne St., Carlton South, Victoria 3053 Australia.
Telephone (613) 662 3300 Fax (613) 663 3412



MEMORANDUM

TO: Delia Flint-Richter
Manager, Breast X-Ray Program

FROM: Trish Livingston
Cancer Epidemiology Centre

DATE: 8 August, 1989

SUBJECT: The Counsellor's Retrospective Contact Numbers

Thankyou for forwarding Pam's retrospective account of contact numbers for May and June, 1989.

As previously mentioned, the data collected from Pam will be assigned to specific cost centres. It will follow a similar strategy to the Activity Survey.

In order to apportion the data into one of the Service cost centres, I need the following information:

.details of contact numbers for the month (or part there of) of April;

.a breakdown of FORM, PHASE and OTHER for the month of May;

.an explanation of the difference between phases 4 and 5;

.client contacts for June amounts to 138, however, the categorisation totals 65; an explanation of how the remaining 73 are to be categorized.

Could you provide a breakdown by month of the number of women counselled under the following headings:

prescreening (phase 1)	screening (phase 2)	recall CAC (phase 3)	post CAC (phase 4 /& ?5)

retrospectively for July and monthly thereafter.

With thanks

Trish.

cc Pam Whitehead
   Susan Hurley
   Ian Russell
memo7.doc

THE AMALGAMATED MELBOURNE & ESSENDON HOSPITALS

BREAST X-RAY PROGRAM

To: Susan Hurley
Centre of Epidemiology

From: Delia Flint-Richter
Program Manager

Date : 29th June, 1989

Re: Generation of Letters

At present I am reviewing the Program's Procedures and Staff duties.

Glenys has discussed with me ways by which her tasks can be more time effective then it is at present.

There are two areas with respect to the generation of clear letters which we would like you to see if the present Computer Program could be modified.

(1) Generation of clear letters for women and doctors (Cl.List; Cld. Lis)

Presently the women's list is generated in numerical unique I.D. order, would this be possible for the Women's Dr's clear letters too?

(2) Language Letters

Women who specify their results to be sent in a language other than the 5, for which we have translations, have to have a letter done manually in English.

Would it be possible for the Computer Program to generate English letters to women who specify a language other than Polish, Italian, Maltese, Greek and Spanish please.

Glenys and I are happy to discuss this with you.

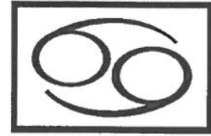
As you know, I shall on leave next week, returning on 10th July, 1989.

Many thanks,

Delia Flint-Richter
Program Manager

copies: Mr. I. Russell, Program Manager
Dr. D. Campbell, Director of Medical Services
Glenys Steeper

Cancer Epidemiology Centre
Victorian Cancer Registry
1 Rathdowne St., Carlton South, Victoria 3053 Australia.
Telephone (613) 662 3300 Fax (613) 663 3412



June 22, 1989

Mr. I. Russell,
Program Director, Breast X-Ray Program
Private Consulting Rooms,
c/o RMH Post Office, Parkville 3050

Dear Ian,

Thank you for your letter of 5th June, which I received on the 20th June, regarding women who had apparently not been recalled for clinical assessment. I am pleased that the management of these women has at last been resolved. I was, however, amazed by your expression of concern that considerable time had elapsed before these violations had come to attention. This is simply not the case. I became aware of these protocol deviations in December 1988, during preparation of a statistical report, and I informed Delia and yourself immediately (by telephone). A list of these women's unique_ids was forwarded by Georgina Chambers to Delia at the time, and I understood that these women were to be recalled. The statistical report prepared for the Management Committee on February 27th, 1989 also included these women, under "Cases missing form D".

As we discussed on May 29th at our meeting with Dorothy Reading, David Hill, and Graham Giles, I think that the best way to ensure that the data are accurate is to institute quality assurance procedures at the time of form completion and data entry, and I understood you were establishing such procedures as a matter of urgency. Audit, or quality control, procedures, which you suggest, should be regarded as a second-line approach to ensuring data quality. In fact, we have been conducting audits. We brought the protocol deviations outlined above to your attention, and documented other protocol deviations (including ultrasound recording), and problems with incomplete data entry in Statistical Report No. 6 (to the Program Executive Committe). Further, on May 18th I brought to your attention the marked backlog in entry of clinical assessment forms and major inconsistencies in the data entered. A memorandum was sent to Delia, at your request, that same day detailing these problems.

In view of the problems which staff appeared to be having with recall of symptomatic women for clinical assessment, I arranged for some changes to be made to the computer program, including a facility for the computer to move automatically to the appointment screen for entry of a clinical assessment appointment when a Form A for a woman with symptoms is entered. I sent you a copy of a memorandum to Delia, detailing these changes (April 19th). Has this change helped?

Yours sincerely,

Susan Hurley,
Epidemiologist

copies to: Dr D. Campbell, Professor Lovell, Dr N. Gray, Dr G. Giles

DR. JOHN R. SULLIVAN
M.D., M.R.C.P. (UK), F.R.A.C.P.
HAEMATOLOGIST/ ONCOLOGIST

SUITE 6
12 ST ANDREW'S PLACE
EAST MELBOURNE 3002
TELEPHONE: 650 3562
PROVIDER NO. 247505Y

RL

COPY

JRS:rw

20th June 1989

-> SH.
Can we find out how she came to be invited?
Should letters of invitation contain a clause to cover this sort of situation?

Dr. Nigel Grey,
Anti-Cancer Council of Victoria,
1 Rathdowne Street,
CARLTON, 3053

22 JUN 1989

Dear Nigel,

Re: Mrs. Ilga MENTLIKOWSKI

I am writing in regard to the abovenamed patient whom I am treating for metastatic carcinoma of the breast and who was referred to me by Mr. David Thomas.

The patient was rather disturbed to receive notification from the Anti-Cancer Council, which she has supported diligently by donations, requesting that she should attend the Essendon & District Hospital for a mammogram. She felt that this direction was inappropriate, particularly as she felt satisfied with her present medical care. It would appear that the present study, as it is constituted at least for this patient, has resulted in some interference with the doctor/patient relationship between myself and the patient. I am writing to request that further attempts at social engineering Swedish style should be ceased and the acceptable Australian method of volunteering for studies be resumed.

Yours sincerely,

JOHN R. SULLIVAN

36582

10 Vincent
Oak Park 3046

Director Graham G. Giles Ph.D
Cancer Epidemiology Centre
Victorian Cancer Registry

MEMORANDUM

TO: Delia Flint-Richter

DATE: 1st June, 1989

FROM: Susan Hurley

==

I attach a list of unique ids and dates of attendance for women who reported either a "breast lump" or "bleeding from the nipple" but apparently have not had a clinical assessment form (D) entered onto the computer. You will note that five of these women attended during the "trial" period of the program, and the other twelve attended during November 1988.

Would you please discuss these cases with Mr Russell and advise me what action is planned for these women, and how they should be regarded for statistical purposes.

Susan

cc. Mr. Ian Russell
Dr. David Campbell
Prof. Lovell
Dr. Graham Giles

ANTI-CANCER COUNCIL OF VICTORIA, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053
☎ (03) 662 3300 Facsimile (03) 663 3412 Telex ACCV AA 34158

UNIQUE ID	DATE OF ATTENDANCE
39816	11 October 1988
39830	18 October 1988
39867	24 October 1988
39880	26 October 1988
16889	31 October 1988
20919	2 November 1988
24871	2 November 1988
30938	2 November 1988
39894	3 November 1988
21122	10 November 1988
22470	10 November 1988
22564	10 November 1988
39911	10 November 1988
12788	11 November 1988
13213	11 November 1988
39914	11 November 1988
22282	16 November 1988

10th May, 1989

Mr. Ian Russell,
Project Director,
Breast X-Ray Program,
Essendon & District Memorial Hospital,
Chester Street,
MOONEE PONDS 3039

Dear Ian,

Susan Hurley mentioned to me that you have asked her about our ability to provide the data tabulations requested by SECU.

As I indicated in my letter to you of 15th March, I do not believe that any data should be sent to SECU until the issues related to SECU's publication and provision of data policy are resolved.

It is not possible at present to prepare any data for SECU because of the resignation of the Mammography Project Officer, Ms. Georgina Chambers, and the time which will be required to train her successor. We obviously are concerned to collaborate with SECU but given resources at the moment it will be impossible to comply with their requests for at least 2 - 3 months. Currently, the local evaluation has a higher priority than preparation of data for SECU. Also, I mentioned in my letter of 15th March I believe the scope, quantity and timing of the data requested by SECU is unreasonable and requires negotiation.

If you would like to discuss these matters further please give me a call.

With best wishes,

Yours sincerely,

Graham G. Giles, Ph.D.,
Director,
Cancer Epidemiology Centre.

THE AMALGAMATED MELBOURNE & ESSENDON HOSPITALS

BREAST X-RAY PROGRAM

To: Management Committee Members

From: Delia M.Flint-Richter
Program Manager

Date: 5th May, 1989

Subject: Australian Institute of Health-
Publication and Provision of Data Policy

In my memo of 14th April, 1989, re the A.I.H.-Publication and Provision of Data Policy which was discussed at the last Management Committee (02/03/89) I neglected to include a copy of a letter on this subject from Dr. Graham Giles.

Enclosed is a copy together with another copy of the correspondence received from Dr. Michael Fett, Head S.E.C.U.

I would appreciate if you would forward your comments on this important issue to me by 15th May, 1989.

Delia Flint-Richter
Program Manager

Distribution:

Dr. D. Campbell
Professor G.J.A. Clunie
Professor B. Tress
Ms. M. Hayes
Ms. S. Hurley
Ms. M. Bickley
Dr. S. Duckett
Mr. I. Russell
Professor R. Lovell
Ms. K. Gallagher
Dr. D. Hill

Director Graham G Giles PhD

Cancer Epidemiology Centre

Victorian Cancer Registry

15th March, 1989

Mr. Ian Russell,
Program Director,
Breast X-Ray Program,
Royal Melbourne Hosptial,
POST OFFICE 3050

Dear Mr. Russell,

RE: Screening Evaluation Co-ordination Unit Publication and Provision of Data Policy

I understand that at the last meeting of the Breast X-Ray Program Management Committee this issue was raised by Professor Lovell. I am told that the the meeting resolved to circulate the publication and provision of data policy to members and it was suggested that I convey my comments to you in writing for circulation with the policy.

My comments are as follows:

I do not believe that the policy as set out in Dr. Michael Fett's letter of 2nd February to pilot project Directors is representative of discussion held between Anti-Cancer Council's staff, yourself, Dr. Fett and Dr. McCann on 7th June 1988, and ACCV staff and yourself the day before. The critical issues agreed on during these meetings and not documented in the policy circulated by Dr. Fett, are the rights of program and Anti-Cancer Council staff to publish papers relating to the program before any publications, refereed or non refereed, produced by the Australian Institute of Health. Secondly, the right of the Program Management Committee to review, and veto if necessary, any proposed publication by the Australian Institute of Health, refereed or non refereed, before it is submitted for publication.

I therefore suggest that the Essendon Breast X-Ray Program policy regarding provision of data to SECU read as follows:

1. Staff of the Australian Institute of Health, and former Institute staff who have worked on the national evaluation, may not publish any data from the Essendon Breast X-Ray Program or present any such data at meetings, conferences, etc unless such data have been published previously by program or ACCV staff, or the Program Management Committee has agreed that the AIH may do so.

.../2

ANTI-CANCER COUNCIL OF VICTORIA, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053
☎ (03) 662 3300 Facsimile: (03) 663 3412 Telex: ACCV AA 34158

2. Institute staff or former institute staff may not publish any data from the Essendon Breast X-ray Program in either non refereed or refereed publications without prior approval of the Program Management Committee of the Breast X-Ray Program. (This will give local staff the opportunity to veto any publications proposed by the AIH which might prejudice their chances of having their own work published first. It will also give the Program Management Committee the right and the opportunity to comment on any interpretation of program data by the AIH.)

3. The Australian Institute of Health staff or former staff preparing non refereed or refereed publications must check with the Program Management Committee as to whether any relevant local staff wish to be co-authors of the proposed publications.

I believe that it is essential that these issues be resolved before any data are sent to the AIH. I was surprised to receive the publication and provision of data policy in its present form as I had thought these issues were resolved at our meetings of 6th and 7th June 1988. I have discussed these issues with David Hill and Dorothy Reading who have agreed with my comments. We also believe it would be wise to obtain written agreement from Dr. Michael Fett to these conditions, before any data are sent, in view of the Institute's production of an unauthorised version of the Program's protocol last year.

Regarding Dr. Fetts request for 50 pages of data tabulations to be produced regularly according to his timetable, I suggest that once the publication and provision of data policy has been agreed on to the Management Committee's satisfaction, we discuss a more reasonable data set and timetable with Dr. Fett. We did agree to do so with the National Evaluation and I can reaffirm our intentions to cooperate but I believe this particular request and timetable is unreasonable.

If you would like to discuss any of these matters further please give me a call.

With best wishes,

Yours sincerely,

Graham G. Giles,
Director,
Cancer Epidemiology Centre.

AUSTRALIAN INSTITUTE OF HEALTH

M.Fett
(062) 435068
88/103
Maples 001015

Pilot Project Directors
Breast Cancer Screening Evaluation
Cervical Cancer Screening Evaluation

Publication and Provision of Data Policy

Enclosed is a document outlining a policy to apply to the use of data collected by pilot projects and provided to the Australian Institute of Health for the national evaluation of breast and cervical screening. The policy addresses the use of data from pilot projects for publication in journals and other non-official documents.

It has now been endorsed by the Breast Cancer Screening Evaluation Steering Committee and the Cervical Cancer Screening Evaluation Steering Committee of the Australian Health Ministers' Advisory Council.

If you have any comments on the policy, please feel free to contact me.

Yours sincerely

Michael J Fett (Dr)
Head
Screening Evaluation Co-ordination Unit

2 February 1989

AUSTRALIAN HEALTH MINISTERS' ADVISORY COUNCIL

BREAST CANCER SCREENING EVALUATION STEERING COMMITTEE
CERVICAL CANCER SCREENING EVALUATION STEERING COMMITTEE

Publication and Provision of Data Policy

This paper describes the policy which will apply to the use of data collected by pilot projects and provided to the Australian Institute of Health for the national evaluation of breast and cervical screening. It relates to:

- the use of such data for publication purposes by current staff of the Institute and by former Institute staff who have worked on the national evaluation;
- the provision of such data to persons other than those who have worked on the national evaluation; and
- data of an aggregate nature related to breast and cervical cancer screening.

Non-Refereed Publications

There is no restriction on the use of data for the preparation of official reports and for providing advice to governments.

Refereed Publications

1. Publications will be co-authored with relevant pilot project staff, if they desire.

2. Before 30 June 1991, data may be submitted for publication only with the written consent of relevant pilot project staff and, if by prior agreement, of relevant State governments.

3. After 30 June 1991, data less than 12 months old may be submitted for publication only with the written consent of relevant pilot project staff and, if by prior agreement, of relevant State governments.

4. After 30 June 1991, data more than 12 months old may be submitted for publication without the written consent of relevant pilot project staff but, if by prior agreement, only with the written consent of relevant State governments.

Third Parties

Data will be provided to persons other than those who have worked on the national evaluation only with the written consent of relevant pilot project staff and, if by prior agreement, of relevant State governments.

MAPLES 000431

BREAST CANCER SCREENING EVALUATION

CERVICAL CANCER SCREENING EVALUATION

Publication and Provision of Data Policy

Letter of 2 February 1989

This documentation has been sent to the following people.

Dr Margaret Davy
Dr Margaret Dorsch
Ms Delia Flint-Richter
Ms Diane Moore
Ms Jenny Muller
Dr Frank Pacey
Dr Mary Rickard
Ms Onella Stagoll

Copies have been sent to the following people.

Ms Carla Cranny
Dr Stephen Duckett
Dr Cathy Dugdale
Prof John Forbes
Dr Graham Giles
Ms Marilyn Hatton
Dr David Hill
Dr Les Irwig
Dr Heather Mitchell
Dr David Roder
Mr Ian Russell
Prof Rob Sanson-Fisher

Victoria's first hospital
EST. 1848

THE ROYAL MELBOURNE HOSPITAL

EST. 1964

ESSENDON AND DISTRICT MEMORIAL HOSPITAL

The Amalgamated Melbourne & Essendon Hospitals

89-45-MB/kr
23rd May, 1989

Ms. S. Hurley,
Epidemiologist,
Cancer Epidemiology Centre,
Anti Cancer Council of Victoria,
1 Rathdowne Street,
CARLTON VIC. 3053

Dear Ms. Hurley,

Thank you for your letter requesting access to further clinical information about women referred from the Mammography Screening Program.

I have authorised Miss Nancye Durham, Manager, Medical Records to provide the information you require. Miss Durham suggests you liaise directly with Ms. S. Cannon in Medical Records to facilitate this access.

Yours sincerely,

D.G. Campbell,
DIRECTOR OF MEDICAL SERVICES

c.c. Miss N. Durham

Postal address: c/o Post Office, The Royal Melbourne Hospital, Victoria 3050, Australia
Telephone: (03) 347 7111. Telex: RMHOSP AA37704. Facsimile: (03) 347 4558

Memorandum

To: Delia Flint-Richter

From: Susan Hurley

Date: April 19, 1989

Subject: Data, Letters, Backup

Copies to: Ian Russell, Graham Giles

---

1. Clinical assessment appointments

You have mentioned to me and Georgina that you have had difficulty entering clinical assessment appointments in the appointment system. Georgina checked this on Friday and it appears to be working. Because the data base has been designed to follow the protocol, it is of course not possible to enter appointments for women who have not been referred for clinical assessment. The forms that indicate a women is to be referred for clinical assessment must be entered before entering an appointment.
Would you please check this aspect of the appointment system as soon as possible so that if there are any remaining problems I can ask the programmer to fix them.

3. Signature stamps

As previously agreed, could you please arrange for two signature stamps (yours and Ian Russell' signatures) to be made and sent to me as soon as possible.

4. Letter Logging (non-standard letters)

As discussed at the Executive, would you please ask the staff to make an entry in the letter logging facility when sending a non-standard results letter to a woman or her doctor. The appropriate codes are "O" and "OD" respectively. We have discussed this before, but no such entries have been made.

5. Backup

(i)Recording of backup in book
As previously discussed would you please ask whoever does the daily and weekly backups to enter details in the log book provided. On the weekend I was concerned to find that the last entry was for 10/2/89.

(ii) Failure of weekly backup
As you know the backup utility failed on Saturday. Would you please arrange for Explicit to fix it. I have asked Herman Reedas from Sequel to install a simpler backup system, but the Unix backup utility should be fixed and used in the interim.

6. Referral of women with symptoms to clinical assessment, deviation from protocol (Item 2 on Statistical report No. 6).

(i) The list of project numbers for women who reported symptoms (bleeding or breast lump) on forma, but were seen in the recall mammography clinic is

attached. The protocol states that women with symptoms should be referred to clinical assessment, irrespective of findings on screening mammography. This means that even if the radiologists record clear or recall mammography (RS or RT) on formb the woman should go directly to clinical assessment.

(ii) To help avoid this occurring in the future I have asked Herman Reedas to include some extra validation on the computer system. However, I must stress that the computer system should not be relied upon to run the project according to the protocol - appropriate administrative procedures to avoid deviations from the protocol are required (and this is clearly your responsibility).

The extra validation is detailed below. If you have any problems with this please let me know today - I will not be available tomorrow. I would apprecaite it if you would direct any further requests for changes to the computer program to me, rather than the Sequel consultants.

Validation

-Disallow entry of form C if a woman has symptoms (bleeding or breast lump) on form A

-Ensure that a clinical assessment appointment, but not a recall mammography appointment, can be entered if a woman has symptoms on Form A.

When a woman ticks symptoms on Form A, your staff should tell the woman that the program's policy is for her to attend the clinical assessment clinic, then enter the Form A immediately and the appointment screen will appear so that the appointment can be made **at that time. It is vital that this is done, because these women will not receive any standard letter regarding their screening results.**
The Form Bs should be completed as normal. Before the clinical assessment clinic a member of staff should check the histories to see if any woman also needs further mammography. This could be done quite easily using the participant summary report, which was intended to be generated for each woman attending the clinic. If further mammography was required (Form B) this could be done before the clinical assessment clinic,**and the results entered on Form D.** This is why space was included for mammography on Form D.

Susan

ANTI-CANCER COUNCIL OF VICTORIA

1 Rathdowne Street, Carlton South, Vic. 3053
Telephone - (03) 662-3300

Facsimile Transfer Information

☐ Routine ☑ Urgent ☐ Confidential
☐ Please advise addressee on telephone: ____________

Date: 20 April 1989
To: Delia Flint-Richter

Pages (inc. this one): 3
From: Susan Hurley

Fax No: 375.4905

Fax No: (03) 663-3412

Subject:

UNIQUE_IDS FOR WOMEN WHO REPORTED SYMPTOMS BUT WERE SEEN IN RECALL MAMMOGRAPHY CLINIC

unique_id
12788
17015
20619
20919
24871
28719
30852
34982
35513
37382
39880
39914
40053
40092
40161

MEMORANDUM

TO: Delia Flint-Richter

DATE: 18th May, 1989

FROM: Susan Hurley

==

RE: Women diagnosed as having malignant disease

As discussed ths morning, I attach a list of women with either malignant or benign disease entered as the result on Form D (39 total, 5 with malignant diseae).

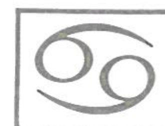
The problems appear to be:

- there should be more women with a diagnosis of malignant disease
- surgical biopsies may not be being recorded on form D. (Even if the diagnosis of malignant disease is made on the basis of FNA, subsequent results of surgical biopsy should be entered later).
- one woman (40078) has a diagnosis of malignant disease, but apparently no entry for FNA, surgical Bx paraffin or surgical Bx frozen.
- one woman (12345) apparently has a diagnosis of malignant disease but a benign result for surgical Bx paraffin, and no result for either FNA or surgical biopsy frozen.

cc G. Giles.
Prof. Lovell.

Susan

Director: Graham G. Giles Ph.D



Cancer Epidemiology Centre

Victorian Cancer Registry

MEMORANDUM

copies sent to GC DR JC G3 IR

TO: Delia Flint-Richter, Program Manager
Breast X-Ray Program
(copy to Ian Russell, Program Director)

DATE: 17th January, 1989

FROM: Susan Hurley, Cancer Epidemiology Centre,
Anti-Cancer Council of Victoria

==

RE: Evaluation & Data management at the Breast X-ray Program

Georgina and I have been reviewing progress at the breast X-ray program and I have summarised below the current matters which I think require your attention. We have discussed some of these items before. If you would like to discuss any matters further, please give me a call.

1. Monitoring attendance

We need to monitor the percentage of available appointments that are filled. This will enable us to plan recruitment activities and determine whether any problems related to achieving target screening volumes are due to service delivery rates or declining recruitment. Could you please advise me and Dorothy of the number of daily appointments available each week, two weeks in advance.

2. Letters

We plan to start monitoring efficency measures, such as time from screening to notification of women, as part of the program evaluation.

(i) "All-clear" letters to women

I understand that currently these letters are sent out on Monday, Wednesday and Friday. Now that the computer system can accommodate two users I would like to suggest that these letters be sent out daily, and that the Program should aim to send "all-clear" letters two days after women have been screened. To achieve this, both radiologists will need to read the mammograms within 24 hours, and presumably, will need to be informed that two days is the target turnaround time.

(ii) "Recall" letters

I understand that women are sent these letters on the Wednesday before recall clinic. This would often involve some delay between screening and notification. I would like to discuss this further with you and Dorothy Reading.

ANTI-CANCER COUNCIL OF VICTORIA, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053
☎ (03) 662 3300 Facsimile (03) 663 3412 Telex: ACCV AA 34158

3. Quality of data

We have been concerned about some inconsistencies and omissions in data collection.

For example:

- next of kin recorded as contact person in Form A. (the name of a neighbour or friend should be recorded)
- a range of procedures and recording practices related to women who have had a mammogram in previous six months
- Clients misinterpreting the questions relating to breast symptoms. It is very important that we know who has had a breast lump or bleeding from the nipple in the last 12 months - women sometimes reply to these questions as if they referred to their lifetime.

Form "D" not being completed during clinical assessment clinics.

In the light of this experience could Georgina have a session with you to clarify these problems. I think updating the workflow and data collection procedures, and documentation, and identifying which staff members are responsible for particular data collection and checking tasks would be helpful. I would like to stress that is neither feasible nor appropriate for Georgina to monitor data collection on a daily basis. Would it be worthwhile devoting some time at one of your staff meetings to a discussion of the rationale for collecting particular data? Georgina and I would be happy to participate in such a meeting if you think this is appropriate.

At this stage do you think it would be worth training most of the staff to use the computer system, as this would help to achieve rapid data entry when screening at full capacity?

4. Independent reading of mammograms by radiologists

I am still concerned that we cannot be assured that radiologists are reading the mammograms independently. The way I see it, the current procedures are not in line with the independent reading specified in the protocol.

5. Economic evaluation

We need to discuss collection and categorisation of Breast X-ray program expenditure data with you and the hospital accountant. Could you arrange for Georgina to meet with the hospital accountant as soon as possible to discuss plans.

In order to allocate staff expenditures to appropriate cost centres we need to monitor staff time to determine, for example, how much time is spent on screening related activities and how much time is spent on recall. Naturally we want to minimise any disruption to normal work caused by this monitoring and we would like to pilot test an activity survey form, preferably on a couple of relatively quite days in January.

6. Other matters

Some "B" forms are being filled out in pencil. I think it would be worth insisting that they be completed in biro.

Appointment sheets - these need to be kept for evaluation purposes. I am a little concerned that they are unbound.

MEMORANDUM

TO: Delia Flint-Richter

DATE: 19th May, 1989

FROM: Susan Hurley

==

RE: Backup of Computer System

I talked to Herman Reedas from SEQUEL late yesterday who said that he asked you to do a full backup on Tuesday afternoon and then leave the tape in the tape backup each night for the automatic daily backup. It seems from our conversation yesterday that you did not do the full backup until Thursday. Herman was unusre what implication this would have and has asked that you fax the backup log to Hugh Grady at SEQUEL each day.

Hugh will let you know when there is no need to continue to do this.

FAX NO. 3754905

THE AMALGAMATED MELBOURNE AND ESSENDON HOSPITALS

BREAST X-RAY PROGRAM

TO: Ms. S. Hurley
Centre of Epidemiology

FROM: Delia M. Flint-Richter
Program Manager

DATE: 28th April, 1989.

RE: PROGRAM COST EVALUATION

As requested, enclosed are documents from Noel Thane on the cost analysis for the months from August, 1988 to March, 1989.

Noel did mention that the information on Sick Leave, Special Leave etc. will need to be obtained from the Personnel Department.

I would like to discuss this with you and Noel is happy to meet with us if you wish to have any of the information clarified.

As mentioned to Patricia this morning, the additional set of stamps arrived this morning so there is not need to return the set you took to the ACCV yesterday.

The system to ensure independent reading as discussed at the Executive Committee Meeting of 18th April, was implemented on 19th April, 1989. So far all is well, but could you please inform me when it is intended to have the B Forms carbon sensitised. Is this for me to investigate or the ACCV?

DELIA M. FLINT-RICHTER

Director Graham G. Giles Ph.D

Cancer Epidemiology Centre

Victorian Cancer Registry

16th May, 1989

Dr. David Campbell,
Medical Director,
Amalgamated Melbourne & Essendon Hospitals,
Royal Melbourne Hospital,
POST OFFICE,
PARKVILLE 3050

Dear Dr Campbell,

RE: Access to medical records at RMH for Breast X-Ray Program Evaluation

As mentioned in the Breast X-Ray Program Protocol, we need to collect information about investigations and treatment received by women referred from the Breast X-Ray Program to the Royal Melbourne Hospital. I have discussed the logistics of this with Nancy Durham, Chief Medical Records Administrator. She requested a memorandum from you authorising us to access the medical records, and advising who would be abstracting the data. I would appreciate it if you would send Miss Durham such a memorandum. The histories will be abstracted by Miss Trish Livingston, an employee of the Victorian Cancer Registry and Cancer Epidemiology Centre, who is therefore required by the Cancer Act to maintain the confidentiality of any patient identifying information which she sees.

Thank you very much for your help.

Yours sincerely,

Susan Hurley,
Epidemiologist,
Cancer Epidemiology Centre.

ANTI-CANCER COUNCIL OF VICTORIA, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053
☎ (03) 662 3300 Facsimile (03) 663 3412 Telex ACCV AA 34158

Director: Graham G. Giles Ph.D

Cancer Epidemiology Centre

Victorian Cancer Registry

March 16, 1989

Dr D Campbell
Medical Director
Amalgamated Melbourne and Essendon Hospitals
Royal Melbourne Hospital Post Office
Victoria 3050

Dear Dr Campbell

Re. Breast X-Ray Program

I have become increasingly concerned at the amount of time Georgina Chambers and Susan Hurley have been spending on the mammography project and the types of tasks that they have been undertaking. Naturally, we have been pleased to be able to assist in the development phase of the project but now that everything is up and running I consider that it is now time to re-divert our resources to our primary brief i.e. evaluation.

Georgina is employed solely to work on the mammography project. Her responsibilities are for the development and support of the computer program, extraction of routine statistics for the Executive and Management committees and evaluation and research. Susan is responsible for overseeing these activities on a day to day basis and she is conducting another major research project at the ACCV, quite separate from the mammography project.

I am aware that the Breast X-Ray program has been experiencing teething problems and that Georgina and Susan have been assisting the Program Manager with protocol interpretation, development of procedures and work flow, selection of staff and day to day operational aspects of the Program. It is neither possible nor appropriate for them to continue to do so and I have asked them to restrict their activities to support for the computer program, extraction of statistics, evaluation and research. These responsibilities were set out in the protocol and documentation tabled at the Executive meeting in June 1988.

Regarding the computer program, development of the application has now finished. Some minor modifications to the appointment/recruitment screens, requested by the Program Manager will be made over the next few weeks and some small bugs will be fixed. We will then transfer a copy of the computer program to the ACCV as set out in the protocol. We will repeat this exercise on a weekly or fortnightly basis and this should minimise any interruption to day to day work flow caused by Georgina's presence at the Program to extract statistics.

I trust that you will understand our need to undertake only those responsibilities set out in the protocol and associated documentation. If I can clarify any of these points please give me a call.

Yours sincerely,

Graham G Giles

ANTI-CANCER COUNCIL OF VICTORIA, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053
☎ (03) 662 3300 Facsimile: (03) 663 3412 Telex: ACCV AA 34158

MEMORANDUM

TO: Delia Flint-Richter
Breast X-Ray Program

DATE: 29th March, 1989

FROM: Susan Hurley

==

RE: Matters arising from the executive meeting of 21st March, 1989

1. I am available to meet with you and Ian Russell on Tuesday 11th April at 3.30 pm at Essendon to discuss the outstanding reply to SECU.

2. I enclose your draft report to the Victorian Health Promotion Foundation with my comments. Please give me a call if any of these comments are not clear.

3. I was pleased that the Executive resolved to change the procedures by which radiologists record their reading of screening mammograms on Form B, to ensure that readings are truely independent. As was mentioned at the meeting, I met briefly with Jenny Cawson who showed me the current method of recording readings. I don't believe that it is necessary for me to attend any meeting to organise the new procedure, but I do have a suggestion for changing the flow of paper work to ensure that readings are independent. My suggestion is, that the first radiologist removes their Form B from the woman's history after recording their reading and places this in a pile. This pile of Form Bs would then be removed by program staff before the second radiologist records their reading.

Susan

cc: Mr. I. Russell
Dr. G. Giles

THE BREAST X-RAY PROGRAM

MAMMOGRAPHIC SCREENING PROGRAM

REPORT TO THE

HEALTH PROMOTION

FOUNDATION OF VICTORIA

21st March, 1989.

Breast X-ray Program

Mammographic Screening Program at
Essendon and District Memorial Hospital
Chester Street
Moonee Ponds 3039
Telephone (03) 375 1900

21/3/89.

Ms. Rhonda Galbally
Executive Director
Health Promotion Foundation of Victoria
333 Drummond Street
CARLTON. VIC.

Dear Ms. Galbally,

I am pleased to submit a progress report of the activities of the Essendon Breast X-Ray Program.

Ms. Delia Flint-Richter was appointed Manager of the Program on 18th July, 1989. Preparatory to the Program commencing a three week period of trial screening commenced on 10th October, 1989. This trial period enabled the process of data collection and the mechanics of mammography and client handling to be tested before the clients in the target area were invited to participate.

Screening of the target population commenced on October 31st, and on the 11th of November the Program was officially opened by the former Minister of Health - The Hon. David White.

A full staff complement has now been recruited. All staff had an initial period of inservice training to instruct them how to handle the clients and how to assist them with problems relating to or having a bearing on the Breast X-Ray Program. Inservice training continues and is being supervised by the Health Education Unit of the Anti Cancer Council of Victoria.

It is noteworthy that there was some anxiety about the recruitment of radiographers. This is a major problem. Although we have recruited excellent radiographers for the Program and have a small list of additional radiographers who could be called for relieving duties, it is probable that if mammography programs extend there will not be sufficient trained radiographers to meet demands.

The necessary radiology equipment has been purchased. There was some delay in obtaining the appropriate viewing equipment but the required equpment is now in service and functioning satisfactorily.

Some initial difficulty was experienced with the data collection and processing hardware and software which has been resolved by purchasing additional hardware and software and reconfiguration of the computer system. Data analysis is being handled by the Epidemiological Center of the A.C.C.V.

At first the Program relied upon word of mouth and articles in the local newspapers to recruit clients. It is the policy of the Program that a woman should not have to wait more than a day or so for an appointment and it was feared that if the advertising campaign was too intense at the beginning there might be a flood of requests for appointments.

The recruitment strategy has been designed to attract increasing numbers of women as the Program gears up. The current capacity is 250 women per week and the recruitment program is correspondingly intensifying. (Attachment A)

Before the Program got underway, the Director met with the relevant committee of the Australian Medical Association and an invitation was extended to all General Practitioners in the area to visit the Program and discuss any problems they foresaw. It is pleasing to report the wholehearted cooperation given by General Practitioners in the area.

One General Practitioner clinic has indicated interest in collaborating closely with the Program and a General Practitioner recommendation study protocol has been developed. (Attachment B)

Monthly statistical analyses are produced (Attachment C). It is pleasing to note that the Program has not resulted in a high recall rate (10.6%). This is comprised of recall because the patients completing the initial questionaire reported the presence of a lump, distortion of the breast or nipple discharge (1.7%); because of technical problems (1.2%); or, because of radiological abnormalities detected on the initial films

♀ recalled for further mammography are not necessarily examined by a surgeon

bleeding from the nipple.

Patients recalled because of reported lumps or breast symptoms or who need further mammography or who are considered to have a suspicious radiological lesion are examined by a consultant surgeon in a special review clinic. The surgeon is accompanied by a nurse counsellor who hears first hand the advice given to the patient. The counsellor is then able to give continuing support to the woman who is invited to phone or call on the counsellor subsequently if she has further problems.

Until 10th February, 1989, 1457 women had been screened, 16 had a surgical biopsy, 11 of them had a cancer (7 invasive and 4 in situ). The biopsies and radiological localisation of impalpable lesions are conducted at Essendon Hospital.

The Cancer Epidemiology Centre are responsible for the data management and computing aspects of the Breast X-Ray Program and a report of their activities is in Attachment D.

In summary: There have been inevitable teething problems associated with the development of a new breast screening program. These have been satisfactorily overcome as a result of the close cooperation between the Essendon Breast X-Ray Program staff, the Management and medical staff A.M.E.H. and the Directorate and staff of the A.C.C.V.

The unit is now able to cope with the requisite number of women to complete the survey and to evaluate the issues of recruitment, acceptability and development of standard for which it was designed.

A detailed analysis of Revenue and Expenditure is in the Financial Statement (Attachment E).

Yours sincerely,

IAN S. RUSSELL
Program Director

BREAST X-RAY PROGRAM PROMOTIONAL RESOURCES

A promotional poster and matching brochure have been designed to motivate women to contact the Program for an appointment or more information. These resources will be displayed widely throughout the community, in pharmacies, doctors' surgeries, community health centres, hairdressers, and any other locations frequented by our target population.

The distribution of the second brochure *What happens at the Breast X-ray Program* will be restricted. The purpose of this brochure is to answer some of the questions women may have about the Program and to enable women to give an informed consent to having screening mammography. Each woman making an appointment will have this brochure sent to her; doctors and community health staff will give this brochure to women upon request or in response to enquiries; the education officer will give it to women who wish to make an appointment at a community group meeting.

Work on the translation of printed resources into some of the languages relevant to our target population has commenced.

The following resources have also been developed and will be used in presentations to community groups.

* An 8 minute VHS video *Rose takes care of Rose*. The video is a simple dramatic presentation. Some of the issues explored are networking, barriers to attending the program and taking action for your own health. Viewers are taken through the Breast X-ray Program and see a mammogram being performed.
* A photographic display has been produced, a set of 8 colour photographs are used to demonstrate the service and the mammography procedure.
* Several sets of colour slides demonstrating the service are available for use by people involved in the program.

BSRMG05R
2nd March, 1989

Summary of recruitment strategies employed to the 1st February, 1989:

1. <u>GENERAL PRACTITIONERS</u>:

Personal visits to doctors by the Education Officer, requesting they encourage women to attend the program. Promotional brochures and posters have been supplied to GPs. Nearly all practices in the immediate target area have been seen - approx. 20 practices - with the majority of doctors expressing their enthusiasm and support. Many have already sent women along to the Program.

<u>Evaluation:</u>

Practitioners from the Margaret Street Clinic, a large medical practice in Moonee Ponds, have agreed to participate in an evaluation of the effectiveness of GP recommendation. Attached is the protocol for your information.

2. <u>STREET DISPLAYS</u>: A total of 35 hours have been spent actively recruiting women from the Moonee Ponds Market, Highpoint West Shopping Centre and Puckle Street. The Education Officer and sessional workers have been staffing the displays.

<u>Evaluation</u>:

Approximately 1000 women have been approached and provided with information about the program. 250 appointments have been generated on the spot and approximately 30 have been made later as a result of the displays. 9 of these appointments were cancelled and 7 women did not turn up for their appointment.

This strategy is extremely labour intensive and time consuming though an effective means of filling immediate vacancies.

3. <u>LOCAL BUSINESS HOUSES</u>: Proprietors of local shops frequented by women in the target age group have been approached and are happy to display our promotional materials.

4. BROCHURE MAIL-OUTS: Two residents' associations have been approached and have posted about 150 brochures out with their regular newsletter. Appointments generated as a result of this strategy have not been assessed.

5. WOMEN'S COMMUNITY GROUPS: Contact has been made with several organisations and appointments to speak to women's groups are being pursued.

6. PHARMACISTS: Pharmacies in the immediate target area have been visited - most pharmacists have expressed their support and are happy to display our promotional resources.

7. HAIRDRESSERS: I am currently visiting hairdressing salons and encouraging hairdressers to discuss the Program with their clients and give out promotional brochures. Some appointments have already been generated as a result of this intervention.

8. OCCUPATIONAL HEALTH NURSES (OHN): Contact has been made with 30 OHNs in the Essendon area - through this means we anticipate reaching some of the women in the workforce.

9. BOWLING CLUBS: Several bowling clubs have been approached and speaking engagements arranged over the next 3-4 weeks.

10. ESSENDON HOSPITAL: Distribution of brochures with pay slips and talks with Environmental and Food Services employees served to generate some appointments.

11. MEDIA PUBLICITY: Advertisements have been placed in the local newspapers to provide essential media coverage. The more economical and effective strategy of editorial coverage is still being sought.

COMMENTS:

At present, available appointments are being filled close to capacity, one to two days in advance. Controlled media publicity, post offices, church groups, bowling clubs, hairdressers, networking through volunteers and GP practices will be the focus of recruitment interventions over the next month or two. A target of 50 women a day has been adopted for the recruitment program.

A recruitment letter is currently being compiled. Pre-testing and piloting of the recruitment letter will be completed by April when a strategy involving its implementation will be instituted.

GENERAL EVALUATION

Questionnaire for evaluation of cues to attendance is attached.

Meredith Giffin
Education Officer

Dorothy Reading
Director of Education
A.C.C.V.

14th February, 1989
BSRMG03R

ATTACHMENT B

SCREENING MAMMOGRAPHY

GP RECOMMENDATION STUDY

PROTOCOL

This document needs some indication regarding its source → i.e CBRC, ACCV

INTRODUCTION

Although a GP referral is not necessary for attendance at the Breast X-ray Program at the Essendon and District Memorial Hospital, we have considerable reason to believe that a GP recommendation would be a very important influence on a woman's decision to attend. First, the GP is an appropriate person to give such a recommendation, as many people see their GP as an important source of preventive health information(1). Secondly, there is some evidence that people are receptive to preventive health messages given in general practice. Individuals who present to a doctor may feel physically vulnerable because of their illness and therefore more likely to be responsive to suggestions for screening(2).

We would like to find out more about the influence of a GP recommendation on a woman's decision about screening. Therefore, the aim of this study is to estimate the proportion of women who subsequently attend for screening mammography at the Essendon Breast X-ray Program after GP recommendation

Target group

All women age 50 to 69, who live in the catchment area of the Breast X-ray Program visiting the Margaret St Clinic during the selected period. The study is to commence Monday 6th February and to continue for 10 working days if possible.

Procedure

1. The Breast X-ray Program display stand is to be placed in a prominent position in the waiting room during the study period.

2. The receptionist is to check to see whether each woman who presents in the study period is between the ages of 50 and 69, and lives in one of the suburbs listed in the brochure. All of Essendon and Moonee Ponds is in the area. If the woman is eligible, the receptionist is to fill out her name next to an identifying ID number on the master log and complete the first three questions of the consultation form, ie, patient ID, doctor ID and woman's age. The consultation form should be paper clipped along with a Breast X-ray Program brochure to the woman's record card.

3.After dealing with the woman's presenting problem(s), the GP should give the pamphlet to all eligible women. The GP should also give a brief explanation to the woman about the general purpose of screening mammography and the Program at Essendon Hospital. A statement should be made that the practice is recommending all women in the appropriate age group attend for screening. The GP should ask if the woman has any questions and answer them as necessary. A suggested spiel is attached.

4. At the conclusion of each consultation the GP should fill in all relevant details on the consultation form. THE CONSULTATION FORM SHOULD BE COMPLETED EVEN IF THE BROCHURE WAS NOT GIVEN, AND THE REASON FOR THIS NOTED IN THE APPROPRIATE PLACE.

Receptionist responsibility

1. Check the eligibility of women, ie, are they between 50 and 69 and live in the suburbs on the brochure

2. List women's names consecutively on the master log next to a unique ID number

3. Complete first three questions of the consultation form of eligible women, ie, Pt ID (from master log), Dr ID and patient age

3 Paper clip consultation form and brochure to the record cards of all eligible women

4 Collect all consultation forms at the end of each clinic session

5. At the conclusion of the consultation session it will also be useful to double check the appointment book against the master log sheet to make sure that no women in the 50-69 year age group were missed.

GP responsibility

1. Initiate discussion and recommend screening mammography to all eligible women

2. Complete consultation forms.

GP RECOMMENDATION MAMMOGRAPHY PROJECT.

Consultation Form

1. DR ID........................
2. PT ID........................
3. PT AGE......................

4. REASON(s) FOR VISIT...
....

5 Did the woman initiate discussion about screening mammography?

☐ 1 Yes
☐ 2 No

6. Was the Breast X-ray Program brochure given?

☐ 1 Yes
☐ 2 No

IF NOT GIVEN, why not?...
....
....

7. Was the verbal recommendation for screening mammography given by the doctor?

☐ 1 Yes
☐ 2 No

IF NOT GIVEN why not ?..
....
....

8 Were there any difficulties in advising the woman about mammography?
....
....
....

9 Are there any other comments about this consultation?...................
....
....
....

ATTACHMENT C

Table 1. Breast X-ray Program statistics,
31 October 1988 - 10 February 1989

Outcomes from:	Screening mammography	Recall mammography	Clinical assessment
clear	1298 (89%)		
recall mammography- (suspicion of a lesion)	113 (7.7%)	67 referred 11 clear	24 clear 10 benign 2 malignant
recall mammography (technical)	18 (1.2%)	14 clear 1 referred	1 clear
clinical assessment symptoms	25 (1.7%)		11 clear 1 benign
mammography	0		
TOTAL SCREENED	**1457**		

Screening mammograms requiring a consensus recommendation: 158 (10.8%)

Note: Statistics extracted from computer data base.
A policy of automatic referral of women from recall mammography to clinical assessment was in effect until 14 February, 1989

Data missing from computer - 22 February 1989

Screening mammograms requiring a consensus recommendation: 3
C Forms (recall mammography due to a suspicion of a lesion): 35
C Form (recall mammography due to a technical fault): 3
D Form (due to a suspicion of a lesion): 31
D Form (due to symptoms): 13

— As suggested at Exec meeting — please stamp "confidential" & include some statement forbidding release to other organisations

Table 2. Breast X-ray Program statistics,
16 January 1988 - 10 February 1989

Outcomes from:	Screening mammography	Recall mammography	Clinical assessment
clear	454 (90.7%)		
recall mammography- (suspicion of lesion)	37 (7.5%)	8 clear 2 referred	
recall mammography (technical)	2 (0.4%)		
clinical assessment symptoms	5 (1.0%)		3 clear
mammography	0		
TOTAL SCREENED 495			

Screening mammograms requiring a consensus recommendation: 47 (9.5%)

Note: Statistics extracted from computer data base
A policy of automatic referral of women from recall mammography to clinical assessment was in effect until 14 February, 1989.

<u>Data missing from computer - 22 February 1989</u>

Screening mammograms requiring a consensus recommendation: 2
C Forms (recall mammography due to a suspicion of a lesion): 27
C Forms (recall mammography due to a technical fault): 2
D Forms (due to suspicion of a lesion): 2
D Forms (due to symptoms): 2

Table 5. Appointments and attendances for screening mammography, 16th January 1989 - 10th February 1898

Week	Nominated number of available appointments	Actual number of available appointments	Number of women screened	Percentage of actual appts filled
16/01 - 20/01	-	186	139	74.7
23/01 - 27/01	-	197	118	59.9
30/01 - 03/02	168	142	84	59.1
6/02 - 10/02	214	196	154	78.6

The nominated numbers of available appointments were specified by the Program Manager. The actual numbers of available appointments were estimated retrospectively from the appointment book.

Times to notification of screening results

Table 6. Number of days from screening to generation of "all clear" letters to women.

	Week			
	16/1-20/1	**23/1-27/1**	**30/1-03/2**	**06/2-10/2**
Mean	7.4	9.4	8.3	8.7
SD	2.5	2.4	3.0	2.9
Median	7	10	9	10
Min - Max	5 - 21	6 - 16	5 - 12	2 - 13

Table 7. Number of days from screening to generation of "recall mammography due to a technical fault" letter to women

	Week			
	16/1-20/1	**23/1-27/1**	**30/1-03/2**	**06/2-10/2**
Mean	-	16	-	11
SD	-	0	-	0
Median	-	-	-	-
Min - Max	-	16	-	11

Table 8. Number of days from screening to generation of "recall mammography due to suspicion of a lesion" letter to women

	Week			
	16/1-20/1	**23/1-27/1**	**30/1-03/2**	**06/2-10/2**
Mean1	19	10.3	8.5	9.6
SD	6.9	2.6	2.9	3.3
Median	19	10	9	11
Min - Max	13 - 25	6 - 14	5 - 12	2 - 13

Note: Not all results were available when these statistics were extracted

Biopsy outcomes

Statistics obtained manually, therefore the numbers do not correspond to Tables 1 and 2.

Table 3. Biopsy outcomes, 31 October 1988 - 10 February 1989

Number of biopsies	Number of malignant disease	Number of benign disease	Biopsy ratio (biopsy:malignant)
16	10	6	1.6:1

Note: Four further biopsies awaiting results

Table 4. Biopsy outcomes, 16 January 1988 - 10 February 1989

Number of biopsies	Number of malignant disease	Number of benign disease	Biopsy ratio (biopsy:malignant)
4	4	0	1:1

Note: Three further biopsies awaiting results

Report to the Victorian Health Promotion Foundation

regarding

The Breast X-ray Program

The second page of this is missing

from the Cancer Epidemiology Centre
Anti-Cancer Council of Victoria

to

March 15, 1989

ıly
;,
f
:he

ıe Cancer Epidemiology Centre (CEC) is responsible for the data ɜnagement and computing aspects of the Breast X-ray Program and nduct of the evaluation and epidemiological research. These responsibilities ɜ detailed in the protocol. The CEC is also represented on the Program ɜnagement Committee and its Executive. Our input to the mammography ɔject over the last 12 months is summarised below.

Preparation of protocol

ɜn
ost

collaboration with Amalgamated Melbourne and Essendon Hospital (AMEH) ıff, we developed a working protocol, using the initial submission for funding a starting point.

Definition of data set

ɜ convened a working party, consisting of AMEH and ACCV ɔresentatives, to decide on the data to be collected. Information on data lection plans was also sought from other pilot mammographic screening ɔgrams. The final data set was agreed on after considerable discussion.

Workflow

ɜ drew up preliminary plans for the Breast X-ray program's daily workflow, collaboration with AMEH staff, so that the computer program for data .nagement could be commissioned. Standard letters for informing women d their doctors of screening results were composed. These have been nslated into Greek, Italian, Polish, Maltese and Spanish. The Program .nager is now responsible for further development and implementation of rkflow and procedures.

Computer Program

ɜilable data-base software were reviewed and recommendations on table hardware and software were made to the Management Committee. A ational data-base package, Ingres, was recommended and chosen. nsultants were commissioned to write an Ingres application with facilities data entry, report generation, recording recruitments and making ɔointments. The computer program also allows monitoring of attendance ɜs by comparison with the electoral register.

ally the computer program was implemented as a single-user system. It s upgraded to multi-user after screening started, because of memory tations and the need for two staff members to access the computer currently.

ATTACHMENT E

FINANCIAL STATEMENT - MAMMOGRAPHY SCREENING PROGRAMME

AS AT 31ST JANUARY 1989

			$
11/5/88	RECEIVED FROM VICTORIAN HEALTH PROMOTION FOUNDATION	477,470.00	
22/6/88	PAYMENT TO ANTI CANCER COUNCIL	(160,866.00)	316,604.00
	BALANCE 30/6/88		
14/7/88	RECEIVED FROM VICTORIAN HEALTH PROMOTION FOUNDATION	189,457.00	
31/8/88	PAYMENT TO ANTI CANCER COUNCIL	(49,256.00)	
31/1/89	RECEIVED FROM VICTORIAN HEALTH PROMOTION FOUNDATION	237,456.00	
31/1/89	PAYMENT TO ANTI CANCER COUNCIL	(49,257.00)	328,400.00
	NET GRANT INCOME		645,004.00
	less RECURRENT EXPENDITURE		
	SALARIES - PAYROLL SYSTEM	91,956.26	
	SALARIES - OUTSIDE RELIEF	739.70	
	WORK CARE LEVY	2,457.91	
	FOOD SUPPLIES	139.14	
	MEDICAL AND SURGICAL SUPPLIES	913.87	
	X-RAY FILM	9,161.11	
	DRUG SUPPLIES	22.51	
	REPAIRS & MAINTENANCE	179.80	
	CLEANING SUPPLIES	44.12	
	COMPUTER CHARGES	764.09	
	PRINTING & STATIONERY	6,641.82	
	POSTAGE	29.21	
	TELEPHONE	499.85	
	FREIGHT	32.55	
	STAFF TRAINING	222.24	
	OTHER EXPENSES	1,035.42	114,839.60
			530,164.40
	less EQUIPMENT PURCHASES	323,646.41	
	AND ORDERED BUILDING ALTERATIONS	37,625.00	361,271.41
	BALANCE OF FUND		168,892.99

THE AMALGAMATED MELBOURNE AND ESSENDON HOSPITAL

THE BREAST X-RAY PROGRAM

TO: Susan Hurley, Cancer Epidemiology Centre, Anti-Cancer Council of Victoria

FROM: Delia Flint-Richter, Program Manager Breast X-Ray Program

COPY: Mr. I. Russell Program Director

DATE: 18th January, 1989.

RE: EVALUATION AND DATA MANAGEMENT AT THE BREAST X-RAY PROGRAM

Thank you for your memo on the current issues, which you and Georgina have discussed, which require attention.

Most of these issues Georgina discussed with me on Monday, and I attended to them immediately. I believe though it is important that I do document what actions I have taken and answer your questions.

1. Monitoring attendance.

One of my staff has recorded the percentage of appointments which were filled since October 31st, 1988. This was requested by Georgina on 16/01/89 and she received the information the same day. Certainly I shall advise you and Dorothy of the number of daily appointments available each week.

As from 17th January for the week of January 23rd, 1989, and January 30th, 80 percent and 100 percent of daily appointments are available respectively. However, this will change, as Meredith is recruiting at Highpoint West today and at the Moonee Ponds Market on Saturday.

I monitor the attendance daily and am aware of Meredith's activities.

2. Letters

(1) "All Clear" letters to women.

I agree that we aim to send out letters daily. It is not always possible for both radiologists to read the mammograms within 24 hours. Jenny Cawson is not in on a Thursday, so Wednesday's mammograms cannot be read by her till Friday afternoon, and thence the data entry for these mammograms will not occur till the following Monday.

(2) "Recall" letters.

I would be happy to discuss this further with you and Dorothy. From experience women are quite stressed when they receive the recall letters, and do not like to wait too long for their appointment. At a meeting yesterday with Jill, Sheila and Pam (Counsellor) and myself, we agreed to draft an additional sentence to be included in the recall letter, informing women that Pam is available to answer any questions if they wish to phone her. The proposed change will be submitted to the next Executive Meeting for discussion and approval.

The Recall Clinic for next week already includes women who were screened earlier this week.

3. Quality of data

Georgina has already discussed with me the issues you have raised here. With respect to the examples you have given, these have been addressed and on Form A, these questions are highlighted. Staff are aware to ask telephone appointments if the woman has had a mammogram during the past 6 and 12 months, and what action to take. I believe Form A needs to have a few changes and would like to discuss these further with you.

With respect to Form "D" I now am checking each one immediately after the recall clinic.

I agree entirely that it is not feasible for Georgina to monitor the data collection. The staff have indicated to me that they are capable of doing this. Do come to one of our Staff Meetings, Georgina was to attend last Monday's meeting, but due to Stephen Smith being here, at the last minute Georgina was unable to attend.

Staff Meetings are scheduled from 1.00 pm. to 2.00 pm. on the second and fourth Wednesday of each month. The next one is on February 8th, 1989 so do let me know if you are able to attend this one.

Rapid data entry is being achieved. The two data entry people are confident they are able to enter 50-60 women's data entry daily, as long as they have no interruptions to the system. On many occasions, due to bugs in the program being attended to, they are not able to have access to the data base. Of course this will not be a problem in the near future. It is not necessary or feasible to train most of the other staff in data entry; they do not have enough time now to perform all their tasks. Receptionist staff will be trained in the appointment system and already they do the labels.

4. <u>Independent reading of mammograms by radiologists.</u>

As you know I have raised this issue several times with you and the Executive. I understand that it was agreed to have a meeting between yourself and the radiologists to discuss this issue. I shall be happy to arrange this if you give me some suitable times.

5. <u>Economic Evaluation.</u>

I have already spoken to Jim Brown re Economic evaluation, in fact last September, re this meeting. Last week Georgina asked me to arrange a time and any time is convenient to Jim Brown except Monday morning which Georgina knows. I shall arrange a meeting once I have heard from Georgina.

I am use to using activity survey forms and I am happy to implement forms for testing. We have already done this with the radiographers to identify the need for a technician. Before they are implemented even for testing, staff will need an information session on them so that they do not find the forms threatening.

6. <u>Other matters.</u>

Pencil is no longer being used, the radiographers told me it was only on a few forms.

The appointment sheets are being kept for evaluation purposes. When we increased the appointments to 50 per day it was not possible to use the book. Reception staff and myself did spend some time reviewing what was available to use, and this is what was devised. It is only a temporary measure until we can use the appointment system on the computer.

In conclusion, I believe that staff here have done a tremendous job and still are, at times, under a great deal of difficulty and stress. I appreciate the full support of you and Georgina.

I am happy to discuss these issues further with you and others as the need arises.

What do you think of having a regular meeting with me every two months?

Dm Flint-Richter.

<u>DELIA M. FLINT-RICHTER</u>
Program Manager

57-lr-05/6 January 26, 1989

Memorandum to: Delia Flint-Richter
Program Manager, Breast X-Ray Program

From: Georgina Chambers
Mammography Progect Officer

Re: **Summary of meeting regarding data management 19.1.89**
(Present: DFR, GC)

==

1. At this meeting we updated the original planned workflow (produced June 2, 1988). I enclose the revised version.

2. Matters requiring action were identified, including:

   - ensuring that women who present with symptoms are recalled for clinical assessment. The letter B report hs been modified so that it is only generated for women whose final recommendation from screening mammography is clear and who have not reported on form A that they had had 'bleeding from the nipple' or a 'brest lump' in the last 12 months.

   - implementation of the change to the protocol, which specifies that all women recalled for further mammography due to a suspicion of a lesion will attend clinical assessment clinic on the same afternoon. C forms should be completed by radiologists to indicate a woman's course through the program - ie they should read 'recall for clinical assessment', as this is program policy. Existing form Cs to be changed to above (change approved by IR). I have done this.

   - implementation of procedures for mailing appointments for women who are to be rescreened earlier than 2 years, including women reviewed before this meeting (appointment slips, modification to F2 letters, reminder letters).

   - protocol required for individual letters sent to women after clinical assessment.

   - retrieval of pathology reports and completion of form Ds to be monitored and streamlined. Copies of pathology reports to be sent to the Program and interpretation arranged.

   - follow-up of women referred from clinical assessment for further tests. The possibility of obtaining histories from RMH for abstraction was discussed.

3. I produced a list of participant histories requiring action and they were reviewed. Action to be taken was documented for each. These included:

- recall for clinical assessment due to symptoms
- completion of D form
- data entry for D form (forms iwth missing or incorrect dat to be returned to Delia for review)
- refiling

4. Implementation of the above tasks and further development and expansion of the workflow is required. This is not my responsibility, if I can help you with this let me know.

cc Mr I Russell
Dr G Giles
Dr S Hurley

BREAST X-RAY SERVICE

ESSENDON & DISTRICT MEMORIAL HOSPITAL

REVISED WORKFLOW

(Updated following discussions between D Flint-Richter & G Chambers, January 19, 1989)

A. REGISTRATION

1. Women will either:

   (i) make an appointment
   (ii) have an appointment made on their behalf (by letter or telephone)

   Appointments will be made using a computerised appointment system. The date of first contact with the woman will be noted.

   When women make an appointment they will be asked if they have had a mammogram previously. If they have had a mammogram in the previous 6 months, films will be retrieved (if possible) and assessed by the program radiologist.

   If the films are of an adequate technical standard and show no pathological abnormalities the woman will be contacted, and unless she has noticed breast symptoms since having the mammogram, will be asked not to attend. Information regarding recommendations for further screening practices will be forwarded to her.

   If the films cannot be retrieved or are of inferior technical quality, the woman will be contacted and an appointment for screening made. A registration form (Form A) will be completed by telephone for women who have had a mammogram in the previous 6 months. Thus, women who have recently had a satisfactory mammogram will be recorded.

2. The names, addresses and ages of the majority of potential participants will be obtained from a computer listing of the electoral register, accessible by the program staff.

3. On arrival:

   (i) The woman's name, address and DOB will be verified against the data base when the appointment for screening mammography is made.
   (ii) A sequential program no. will be allocated.
   (iii) Adhesive program labels, with the woman's name, address, DOB and project no., will be generated before the women attends for screening. Her history will be made up, with an A Form and B Form prior to her attending.

4. The woman will be asked to complete Form A. Assistance will be available to women who have difficulty and it is envisaged that Form A will be available in various languages. All women will be sent an information sheet describing the program when they make an appointment.

5. The woman will be asked to return to the reception desk when she has completed Form A, where the details of the form will be checked.

6. If a woman indicates on Form A that she has had a previous breast operation further details will be sought by the receptionist and recorded.

   If a woman indicates on Form A that in the last 12 months she has had bleeding from the nipple or a breast lump, an appointment for clinical assessment must be made for her. A colour coded sticker will be attached to her history to indicate that she has symptoms. (If her screening mammograms are found to be clear, the 'all clear letter' (letter B) must not be sent to her until she has been found to be clear after clinical assessment.

B SCREENING MAMMOGRAPHY

7. The woman will be called to the reception area, her identification checked.

Mammography Procedure

8. The woman will be taken to the mammography area by a member of staff, who will hand the woman's history to the radiographer with a set of spare labels to attach to the mammography films. The woman will then be introduced to the radiographer who will briefly explain the procedure.

9. The radiographer will check the woman's identification against the label on Form B, and the labels supplied for identification of the films.

10. The radiographer will complete the initial details on Form B including the radiographers code, number of views taken and observations relevant to the interpretation of the mammographic films.

    NOTE: Form B will be pressure sensitive (ie comprise 2 copies) so that each radiologist will receive a copy of the radiographer's observations.

11. Any breast lumps or skin lesions will be identified with a skin marker before mammography.

12. The mammography films will be labelled with the woman's program label. Each set of films and the accompanying Mammographic Screening Report Form (Form B) will be placed in a file for interpretation by the radiologists.

13. The woman will be told when her results will be posted to her, and thanked for her attendance.

Mammography Interpretation

14. Mammograms will be read independently by two radiologists, usually within 24 hours of the screening session. Each radiologist's interpretation will be recorded in a coded format on a copy of Form B.

    The results which may be entered are 'clear', 'Recall mammography due to a suspicion of a lesion', 'Recall mammography due to a technical fault', and 'clinical assessment'.

15. Each Mammographic Screening Report will be entered into the data base.

16. The 'Missing Final Recommendation' Report will be generated daily to identify reports where radiologists disagree about (i) Recommended action; (ii) Reason for recall mammography.

17. In cases of disagreement the mammography films and the two copies of Form B will be retrieved and, after consultation between the radiologists, a consensus reached and recorded. The Final Recommendation Form is provided for this prupose.

18. If the mammogram is regarded as normal by both radiologists the woman will be discharged from the screening program, and advised about recommended further screening practices.

19. Women who present with breast symptoms will be referred for clinical assessment, irrespective of mammographic findings. Women who have a history of breast cancer will be given the opportunity to be referred back to their surgeon, if screening mammography suggests abnormalities.

20. The radiologists will specify whether to recall a woman for further mammography, which may include magnification views, or directly for clinical assessment.

21. The results of screening will be advised by mail, and if the woman wishes, her GP will be sent a copy of the mammography report. Women requiring a rescreen mammogram, or a clinical assessment will be sent an appointment. Women who fail to attend such an appointment will be contacted and urged to do so. (possibly by telephone)

The letters sent to women after screening mammography are:

Letter B - All clear letter to women. The result from screening mammography was 'clear'. (ie both radiologists recorded the films as 'clear', or the final recommendation was 'clear'). Note, if a woman has indicated that she has had bleeding from the nipple or a breast lump in the last 12 months, this letter can not be sent to her until she has been found to be clear after clinical assessment.

Letter B1 - All clear letter to doctor. Note, the above conditions apply.

Letter C1 - Recall Mammography due to a technical fault - letter to women.
The result from screening mammography was 'Recall mammography - due to a Technical Fault'.

Letter C2 - Recall Mammography due to a suspicion of a lesion - letter to women.
The result from screening mammography was 'Recall mammography - due to a suspicion of a lesion'.

Letter D - Recall to Clinical Assessment Clinic due to a suspicion of a lesion.
The result from screening mammography was 'Clinical Assessment'.

C **RECALL MAMMOGRAPHY**

22. All women who are referred for Recall Mammography due to a suspicion of a lesion will be reviewed in the Clinical Assessment Clinic on the same day. Thus, a C Form and D Form will be completed on these women. The C Form will be completed by the radiologist independently of the clinical assessment. The result recorded on the C Form for such women wil be 'clinical assessemnt', because at present all women are referred for clinical assessment.

Mammography procedure

23. The radiographer will ascertain what images are required for rescreen mammography from Form B.

24. Details of the rescreen mammogram will be documented on the Recall Mammography Report (Form C).

    If the woman has been recalled due to a suspicion of a lesion, the rsult on the C Form must be 'clinical assessment', because all such women are being referred to the Clinical Assessment Clinic on the same day.

25. The recall mammography films and Form C will be labelled as previously mentioned, and stored in the patient files for interpretation by the radiologist.

Mammography Interpretation

26. All available images will be read by a radiologist while the woman waits and recommendations reported.

27. Women recalled due to a suspicion of a lesion will be referred to Clinical Assessment Clinic. Women recalled due to a technical fault will either be discharged from the program or referred for clinical assessment. Women will be advised of results during the session. Clear results will be confirmed by mail.

B Form Result	C Form Result	
RS	CA	Referred for Clinical Assessment
RT	CA	
	CL (E letter)	

The letters sent out after recall mammography are

<u>Letter E</u> - All clear letter are recall mammography - letter to women. The result from recall mammography, recorded on the C Form, is 'clear'. Note, with the present protocol, only women referred due to a technical fault can subsequently receive this letter.

<u>Letter E1</u> - All clear letter after recall mammography - Letter to doctors. Note, the above conditons apply.

D CLINICAL ASSESSMENT

Four categories of women will be seen at clinical assessment clinics.

(i) Women who indicate that in the last 12 months they have had 'bleeding fro the nipple' or a 'breast lump', regardless of their screening mammogram results

(ii) Women who referred directly to clinical assessment from screening mammography (ie their B Form result is 'clinical assessment')

(iii) Women who are referred to recall mammography due to a suspicion of a lesion (ie their B Form result is 'recall mammography due to a suspicion of a lesion'). These women will have further news taken and then reviewed at the clinical assessment clinic on the say day.

(iv) Women who are referred to recall mammography due to a technical fault (ie their B Form result is 'recall mammography due to a technical fault') and who are subsequently referred for clinical assessment (ie their C Form result is 'clinical assessment').

28. A clinical assessment clinic will be conducted once or twice a week at the Essendon & District Memorial Hospital.

29 A screening program history for recording clinical findings will be generated.

30 Any specimens (eg fine needle aspirates) will be identified by means of the woman's program label. A sticker alerting the histopathology staff that the woman is a participant in the screening program, will be adhered to pathology request slips.

31. The woman will be accompanied to the Assessment Clinic by a staff member who will introduce her to the clinician.

32. A computer summary of the initial screening mammogram and any recall mammogram reports will be generated for each woman attending the Clinical Assessment Clinic. This will be made available to the Clinical Assessment team along with the woman's screening program history and her original file containing mammography films, mammography reports (Form B +/- C), and the Personal Details Form (Form A).

NOTE: It will be the responsibility of the project staff to ensure that all relevant items are available to the clinicians.

33. Clinical examination of the breasts will be carried out to determine whether a palpable lesion is present.

34. After reviewing the clinical and radiological findings, the clinician will decide what further investigations (either fine needle aspiration or ultrasound) are to be recommended. If possible, the recommended investigations will be offered to the woman on the same day.

Surgical Biopsy during a day surgery session at Essendon & District Memorial Hospital will be offered to women when indicated.

35 The woman will make an appointment for investigations or follow-up assessment.

36. When a woman returns to the Clinic she will be advised of the outcome of the investigations and the diagnosis (if available).

If a woman needs to be reviewed at an earlier interval than 2 years an appointment slip will be completed by the clinician, detailing the time period to the next appointment and whether it is for screening mammography, recall mammography or clinical assessment. The women will take this to the reception area and an appropriate slip will be given to the woman to take home. (Note, when appointments for clinical assessments or recall mammography are made for the following week, any existing appointments will be checked. If they were made more than a month ago, a reminder will be sent to the woman).

Clear results with recommendations for rescreening in 2 years or alternatively at an earlier interval will be advised by mail. Individualised letters to GPs with outcome of clinical assessment will be generated when required.

The letters that can be routinely generated after clinical assessment are:

Letter F1 - All clear after clinical assessment - to be rescreened in 2 years time - Letter to woman. (The result from clinical assessment For D is 'clear-rescreen 2 year'.

Letter F2 - All clear after clinical assessment - to be rescreened at an earlier interval - Letter to woman. (The result from clinical assessment, Form D is 'clear - rescreen at an earlier interval')

Other Letters - Individualised letters need to be sent to GPs after a woman has been to clinical assessment clinic, regardless of the outcome.

Also there are no routine letters to be sent to women who are diagnosed as having Benign or Malignant Disease after clinical assessment.

37. Note, the woman may need to attend a number of Assessment Clinics before a diagnosis or clear result is obtained. Alternatively, a woman may attend one Assessment Clinic and be discharged with a recommendation for surgical biopsy.

38. If breast cancer is diagnosed, a referral to the Amalgamated Melbourne & Essendon Hospitals Breast Clinic, or a surgeon of the woman's choice, will be offered.

39. **Completing Form D**

Form D - The investigations performed to establish a diagnosis will be documented on the Clinical Assessment Form (Form D). This form will be completed after all investigations have been reported. It is envisaged that this will be the responsibility of the clinician assessing the patient.

Each D Form completed during a clinical assessment will be checked by the Program Manager. If the forms are incorrectly complted they will be returned to the clinician. If the forms are awaiting investigative results, the envelope will be colour coded with a sticker, and the

envelope stored separately. When the investigative results return to the Breast X-ray program, the results and the D Form will be given to a clinician to compelte. When all results have been received and the D form fully completed it will be entered into the computer. (Note, all results must be known, and a 'final assessment' completed to enter the D Form).

40. An Assessment of Malignant Disease Form (Form E) and an Assessment of Benign Disease Form (Form F) will be completed for all women found to have breast disease. This form will be completed after definitive surgery.

Form E will contain details of definitive surgery, work-up investigations, clinical and pathological staging and planned management. Form F will contain details of surgery and pathology.

Completing Form E & Form F

Women whose D form 'final assessment result is 'malignant disease' or 'benign disease' must have an E or F Form completed. Histories that fall into this category will be colour coded with a sticker and stored separately until the E or F Form are completed.

One of the staff members will require access to the woman's medical record at the Royal Melbourne Hospital or other hospital/clinic to complete these forms.

When the forms are fully completed they will be entered into the computer.

THE AMALGAMATED MELBOURNE AND ESSENDON HOSPITAL

BREAST X-RAY PROGRAM

TO: Susan Hurley ✓
Epidemiological Centre

FROM: Delia Flint-Richter
Program Manager

COPY: Ms. Dorothy Reading
Director Health Education Unit

DATE: 2nd February, 1989,

RE: THE NUMBER OF DAILY APPOINTMENTS

At present the number of possible appointments on a daily basis, with the present staffing levels are as follows:

Monday	46	*
Tuesday	26	***
Wednesday	46	*
Thursday	50	
Friday	46	*

NB. 2nd and 3rd Mondays - screening from 2.00pm - 8pm - 34 appointments plus 14 appointments for morning radiographer.

* One radiographer finishes at 3.00 pm.
** 45 minute tutorial for each radiographer.
*** No screening in afternoon due to Recall Clinic.

The number of appointments very much depends on radiographer staffing.

Localizations are also being scheduled of a Wednesday, usually one, which can take from 1 hour to 1 1/2 hours.

Appointments do take first priority with respect to Localizations, I believe, but I believe this issue needs to be discussed at Executive Committee Meeting.

By mid-February, I am aiming to produce the staff costing to achieve the target number of 32,000 women within the 2 year period.

One radiographer is also available to do screening Monday mornings when we are screening of an evening and this is being implemented.

As one radiographer only works 30 hours per week, the budget allows for this.

I am having this letter typed as soon as possible, but am faxing this now, so you have the imformation immediately.

Thank you for your support,

DELIA FLINT-RICHTER
Program Manager

Director: Graham G. Giles Ph.D

Cancer Epidemiology Centre

17 February 1989

Delia Flint-Richter
Essendon and District Memorial Hospital
Chester Street
MOONEE PONDS VIC 3039

Dear Delia

RE: Your fax of 16 February 1989

Dorothy and I are agreeable to the changes.

Yours sincerely

Susan Hurley
Epidemiologist
Cancer Epidemiology Centre

ANTI-CANCER COUNCIL OF VICTORIA, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053
(03) 662 3300 Facsimile: (03) 663 3412 Telex: VCCG AA 34158

Appendix 2.

MEMORANDUM

TO: Delia Flint-Richter, Program Manager, Breast X-ray Program

FROM: Susan Hurley, Cancer Epidemiology Centre, ACCV

RE: Ingres software (supplied by Relational Technology Incorporated (RTI)

Further to our telephone discussion this morning, the current situation regarding Ingres software can be summarised as follows. The software is running satisfactorily, but there are two outstanding problems: the scrolling effect on the 386 console and the issue of a permanent licence for Ingres by RTI.

Scrolling effect

1. Damien Jolley and Georgina Chambers have configured the 2 computers so that the scrolling effect has no impact on workflow, as wordprocessing, entry of appointment details and report generation can now be done on the 386 console.

2. RTI required information about scan codes generated by keys on the 386 machine before addressing this problem. Explicit were unable to provide this information, so Georgina Chambers generated it using the Kermit program.

3. Mr Chris Wallace at RTI was then able to determine that the problem is due to a bug in the AT386 termcap. RTI have undertaken to fix the bug, despite the fact that Sapphire hardware is not officially supported by RTI. They have referred the problem to their office in the United States.

4. In the interim, RTI have offered the loan of a terminal. To take up this offer it would be necessary to upgrade the UNIX licence from two-users to allow three users. If you would like to accept their offer of a terminal, the Anti-Cancer Council could fund the upgrade of the UNIX licence. In the future we would probably site one of our modems at the program and use the extra user capacity for modem access. However, given the current set-up with the scrolling effect having no impact on workflow, it may not be worth accepting their offer.

Licence for RTI

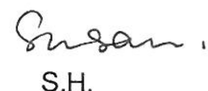
1. The temporary licence for Ingres expired on the 22nd December, making it impossible to use the application. RTI advise that this occurred because AMEH had not paid for the PC Ingres supplied initially, and had not given RTI an official order for UNIX Ingres.

2. RTI gave you an authorisation number over the telephone on the 22nd December, which extended the temporary licence and enabled you to use the application.

3. I have tried to determine when the renewed licence expires, but without knowing the authorisation number or who you dealt with at RTI, I have been unable to do this.

Suggestion

I suggest that you request RTI (in writing) to provide you with another authorisation number with a known expiry date. If they require some payment before doing so, I think it would be appropriate to arrange this, as the software is working well and RTI have undertaken to fix the scrolling problem. The balance of the account could then be paid when the scrolling problem is fixed.



S.H.

cc Ian Russell, Leanne Clavarino, Dr. Graham Giles

To: Delia Flint-Richter, Program Manager Breast X-Ray Program

From: Georgina Chambers, Susan Hurley

Date: December 2, 1988

==

In view of discussions held at the Executive meeting, December 1, 1988, we think it is important to document the back log of results for women referred to recall clinics. These were identified during the preparation of statistics for the forthcoming Program Management meeting.

Thirty one women who were screened between 31th October and 18th November, were identified during screening as requiring recall mammography due to a suspicion of a lesion or technical fault. Outcomes for only 15 of the 31 women have been entered in to the computer to date. Of the remaining 16 women:

- 9 have future bookings for recall clinic;
- 2 have no appointment for recall clinic;
- 4 have not had their recall form, (form C), completed; and
- 1 has refused to attend recall clinic (extra views are required due to a technical fault).

This back log is not due to a delay in data entry of screening or recall forms. It appears that the back log may be due to a combination of:

- a delay in return of screening forms to the data entry clerks in time for rapid identification of women requiring recall (There seems to be a delay of up to 4 days between screening and return of the form B and form C (if needed);
- a delay in appointments being generated for recall clinics (this does not appear to be a major contributing factor);
- insufficient recall appointment slots; and
- a delay in recall forms (form C) being returned to the data entry clerks.

As an important aspect of the program evaluation will be the turnaround time from screening to assessment and final results, we thought it was worth bringing this to your attention.

To: Delia Flint-Richter, Program Manager Breast X-Ray Program

From: Georgina Chambers, Susan Hurley

Date: December 2, 1988

==

In view of discussions held at the Executive meeting, December 1, 1988, we think it is important to document the back log of results for women referred to recall clinics. These were identified during the preparation of statistics for the forthcoming Program Management meeting.

Thirty one women who were screened between 31th October and 18th November, were identified during screening as requiring recall mammography due to a suspicion of a lesion or technical fault. Outcomes for only 15 of the 31 women have been entered in to the computer to date. Of the remaining 16 women:

- 9 have future bookings for recall clinic;
- 2 have no appointment for recall clinic;
- 4 have not had their recall form, (form C), completed; and
- 1 has refused to attend recall clinic (extra views are required due to a technical fault).

This back log is not due to a delay in data entry of screening or recall forms. It appears that the back log may be due to a combination of:

- a delay in return of screening forms to the data entry clerks in time for rapid identification of women requiring recall (There seems to be a delay of up to 4 days between screening and return of the form B and form C (if needed);
- a delay in appointments being generated for recall clinics (this does not appear to be a major contributing factor);
- insufficient recall appointment slots; and
- a delay in recall forms (form C) being returned to the data entry clerks.

As an important aspect of the program evaluation will be the turnaround time from screening to assessment and final results, we thought it was worth bringing this to your attention.