

<i>Topic</i>	<i>#</i>	<i>Question</i>	<i>Answer</i>	<i>Comments/Actions</i>
MORNING SESSION – IT SOLUTION & INFORMATION GOVERNANCE				
IT Solution – Data Extraction	1	How will extract solution deal with multiple versions of LIS software?	In most instances this will not be a problem. For Winpath users specifically the changes will be applied to version 5.28 only and labs on older versions will need to consider upgrading.	<ul style="list-style-type: none"> • Action: Consult with sites on older versions of Winpath to determine potential complications
	2	Which consultant data is extracted, reporting consultant or reviewing consultant?	Reporting consultant. Most sites don't record reviewing consultant in LIS.	<ul style="list-style-type: none"> • Both reporting and reviewing Pathologist are involved in QA process.
	3	How long after a case is first reported do we continue to extract data?	It is planned to extract data relating to a case up to 1 year after the case is reported. This will be reviewed after a period of data collection and can be amended based on real data & data volume.	
	4	Will it be possible to extract QA data from reports?	No. Extract facility will extract data entered in specific data fields only.	
Central Data Repository - NQIS	5	Will system be used exclusively for QA programme data or will there be opportunity to avail of data for research purposes?	According to the current first draft of the Information Governance document, secondary use of data for research purposes is not allowed. The reason for this is to protect data from research activities external to the Faculty while the programme is in set up phase. Tissue codes and Morphology codes are included in the extract, however, to allow for greater analysis of the data in the future.	<ul style="list-style-type: none"> • Using data for Research widely accepted • Appraisal of Dutch PALGA system suggested. • Action: Review access to data for research purposes at Steering Group level in embedding phase of programme

	6	Will there be training provided on the NQIS?	Yes. The system is user friendly so relatively little training is required to begin using. Training will be provided to one or two users from a lab who will then have to train other users within their department.	
Mapping	7	When can we expect a National list of codes to be circulated?	The group was advised that a National set of QA programme P codes and Q codes exists and will be circulated shortly. However a comprehensive list of Tissue codes remains to be compiled. The preferred option would be a SNOMED license for the National list of Tissue codes but the feasibility of this is still under review. A decision is required on this before the end of the year.	<ul style="list-style-type: none"> • Action: Define national list of tissue codes & morphology codes for use centrally to which local codes will be mapped
	8	Has there been any progress made on the acquisition of a National SNOMED license?	A separate group led by HIQA has been working on a recommendation for the procurement of a National License. This will be issued Dec/Jan. A separate project to include funding, procurement and implementation of a National License would then be required.	
Benchmarks	9	When will benchmarks be set?	A proposal for the methodology for setting benchmarks is required by June of next year but Benchmarks will not be set until data has matured and stabilised. This may take a number of years. Participants will however be able to see the National norm based on 2010 data and we may be able to allow a facility where targets can be set locally within preset reports. This would allow the use of International benchmarks locally if preferred.	

	10	How will hospitals be grouped together when Benchmarks are set?	<p>It is not yet decided how hospitals will be grouped for the setting of Benchmarks but it is currently proposed that hospitals will be grouped as follows in preset reports:</p> <ul style="list-style-type: none"> • All labs • All cancer centres • All non cancer centres <p>This grouping may also be used for the setting of benchmarks. This will be considered when the proposal for a methodology for benchmarking is in development.</p>	<ul style="list-style-type: none"> • There remains divergence in participants views on Benchmarking. • Some participants feel that International Benchmarks should be used where available & that performance to benchmarks can be used to support a case for better resource & staffing where required. • Others feel that caution should be exercised in the setting of benchmarks. They should not be set for some time and should take hospital size and resourcing into account. • Others feel that performance to benchmarks is secondary to driving improvement based on local figures over time.
Information Governance	11	Will there be local access to local data for further analysis?	Yes	
	12	Will HSE and local hospital management have access to reports?	Local protocol should define whether reports are shown to local management. It is proposed that Faculty and Steering Group, which has representation from HSE's NCCP, DQCC & ISD, will see reports with Hospital Identity anonymised.	

	13	Could the media have access to reports under FOI?	No. We have been assured by the department of health legislation that the upcoming Health Information Bill includes an exemption for clinical audit activities from FOI enquiries	
	14	If Data Controller (Faculty & Steering Group) has a responsibility to report serious incidents & poor patterns of practice to Data Originator (Laboratory) how can anonymity be preserved?	This requires further consideration. It is a normal requirement of Policy documents of this nature but in reality the Clinical Lead will be aware of and action consistent poor performance as soon as it is observed through the NQIS and before it is observed by Data Controller.	<ul style="list-style-type: none"> • Further consideration and consultation is required on Information Governance Policy by the standing Histopathology Working Group • Serious incidents not the correct term as serious incidents will always be captured before they are reported as part of QA programme • Action: remove reference to serious incidents in Policy • Look to NEQAs scheme in the UK for relevant policies • Serious incidents recorded on STARSWEB system by hospital risk managers
	15	Should hospital management be included in data sign off step?	It was envisaged that Clinical director would be involved. Hospital management had not originally been included in this step. This will be considered further in Information Governance consultation period.	<ul style="list-style-type: none"> • Action: Consider this at Histopathology Working Group. • Action: Engage with Hospital Management and potentially Hospital IT managers on Information Governance Policy
General	16	What is the status of the Unique Health Identifier for patients?	This is dependent on many variables and may take some time yet. It falls outside of the scope of the QA programme.	

	17	Are the dates and times of supplementary reports recorded for the QA programme?	No. We currently extract date and time of first authorised report only. TAT of supplementary reports is not a requirement of the current guidelines.	
	18	There appears to be an overlap with INAB accreditation process and QA programme, has there been much interaction with them?	The Faculty has been working with INAB separately about the design of their accreditation process but has not yet engaged with them on the detail of the QA programme	<ul style="list-style-type: none"> • The Faculty never intended to become an accreditation body. This QA programme was designed to compliment/enhance INAB & CPA processes • Action: Engage with INAB on detail of QA programme
AFTERNOON SESSION – GUIDELINES & QUERIES				
Autopsy	19	How do you capture the authorisation date of an Autopsy report on the LIS?	As it is recommended that Autopsy is entered in LIS and given a specimen number, the case can be authorised in the same fashion as a histology case.	<ul style="list-style-type: none"> • Final report date, including toxicology results, and not provisional report date is used to calculate TAT.
	20	When are Autopsy cases selected for review?	Following a consultation period it has been decided to conduct reviews immediately before authorisation of report.	
	21	What % of cases should be reviewed?	5%	

Hospital Workload	22	What level of detail do we need in the recording Workload and in particular stains? Should we be recording the number stains broken down by stain type or is it sufficient to record the number of cases with Special Stains and the Number of cases with Immunohistochemical stains?	<p>This was thrown open to the floor for discussion and while there is difference of opinion, the consensus appears to be to go with summary level detail.</p> <p>Also given that detailed workload figures are being generated in most laboratories in a separate work flow for accreditation purposes, the workload requirements as they stand may be duplication and add an unnecessary level of complexity.</p>	<ul style="list-style-type: none"> • Numbers of slides are huge • The way stains/slides are recorded locally varies hugely from lab to lab • Collecting Workload for National comparison is a difficult task and requires further consideration • In the Future how workload is collected may have to become more standardised as we all move to INAB accreditation • Action: Consider simplifying how workload is requested for this QA programme bearing in mind work which has been commissioned with LIS Vendors
	23	Why is it necessary to link everything back to case?	<p>This is the raw data approach which has been chosen over the initially proposed summary data approach. The extract is being set up this way to capture raw case level data in order to reduce local level workload in the long term, ensure data is more uniform and allow for analysis of the data in the future</p>	

Case Type Classification	24	Can we have more than one P code per case?	No.	<ul style="list-style-type: none"> This will be discussed further at Working Group level. Need to consider how best to manage multiple codes historically entered into LIS system
	25	How to choose which P code to record if multiple procedures have taken place?	Exercise professional judgement	
	26	What is the main purpose of the P codes for the QA Programme?	To provide a reasonably simple and sensible way of categorising complexity of procedures for the purposes of calculating TAT	<ul style="list-style-type: none"> Within broader P categories, the system will allow for subdivision by organ through specific T codes
	27	Can more guidance on P code grouping be included in the coding document in the form of examples?	Yes	
MDT	28	If a case is sent out to another institute for MDT, how should it be coded?	Code as Q001 case referred externally for review	
	29	How to record no of cases per conference type?	This is too difficult to record on LIS so we will only look at no of cases reviewed at MDT. We can cross-reference by Tissue type if required. This will be changed in next revision of guidelines.	<ul style="list-style-type: none"> Action: Remove cases reviewed at MDT per conference type in next revision of guidelines.
Cyto/Histo Correlation	30	Should code be attached to Histology Case of Cytology Case?	System can process it both ways. This can be left to local protocol. It is important, however to ensure that activity is not coded twice.	

	31	Should detail of discordance e.g. sampling error or interpretation error be recorded?	For now, to get people accustomed to the activity it was agreed to record discordance only. Local sites can still record classification of discordance into sampling and interpretation error.	<ul style="list-style-type: none"> • Suggestion: Involve trainees in process through seminars provided by Working Group
Lab based Non Conformances	32	How best to classify non conformances for Histopathology? What's the feedback on the HSE risk assessment Matrix? Should a Histopathology specific matrix maybe using the RCPATH guidelines be developed?	<p>This question was thrown open to the floor.</p> <p>Some people finding HSE Matrix difficult to implement as not relevant in parts e.g. commercial considerations. Others feel it is good to use a standard national document like the HSE risk assessment matrix where possible.</p>	<ul style="list-style-type: none"> • Further consideration required • Action: Set up sub group to consider further & potentially modify Language to make it more pathology focused
	33	Once a system is agreed would it be possible for labs to record high risk and maybe also medium risk items as codes on LIS systems in the same way as previously done for surgical guidelines?	It was agreed that volumes would be low enough for this to be a manageable task	<ul style="list-style-type: none"> • Action: propose codes for recording of high & medium non conformances
	34	Is it possible to link in with Q pulse systems?	This was considered but it was considered not worthwhile	
	35	If only one person scoring and recording non conformances how to decide if scoring was done correctly?	Suggestion to review all non conformances at regular quality meetings and score or verify scoring together as a group.	

Lab based EQA	36	How will EQA schemes be recorded?	As this data is not included in the extract, it is envisaged that information will added directly into system using an online facility.	<ul style="list-style-type: none"> It was suggested that participation in an inter-laboratory comparison group (as recommended by INAB) be recorded under the section for lab-based EQA
Guidelines - TAT	37	Guidance on days to be included for TAT calculations?	TAT days include working days only. No weekends or bank holidays	<ul style="list-style-type: none"> TAT will be calculated automatically by NQIS
	38	Guidance on receipt date of sample?	TAT begins with receipt of sample in the lab. Date of receipt of sample= Day 0. Samples completed on day 0 and day 1 are counted as completed by Day 1.	
	39	On Apex there is a work around required as system automatically records date of receipt as day 1. Can this be allowed for in IT solution?	Yes	
General	40	Will HIQA adopt the standards set out in the guidelines?	HIQA are observers on our steering group and we have been advised that they are working on National Standards which will be released within the next few months. It is expected that these standards will reference standards in programmes such as ours at a high level but will not go into as much detail.	
	41	When will first reports with real data be available from NQIS?	First reports are scheduled for circulation June 2011. Access to reports locally may be available before then	
	42	Will Vendors keep to schedule?	It is certainly a risk but we are optimistic and intend to manage their development work closely	

