Guidelines for the Implementation of the National Histopathology Quality Improvement Programme

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FACULTY OF PATHOLOGY
ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt
National Quality Improvement Team

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GLOSSARY OF TERMS

Block	Samples obtained from a patient (for example when a biopsy is taken) are preserved within a piece of paraffin wax, from which slides are then made. This is known as a block.
Case	This refers to a patient's pathological material. This may comprise a single sample or multiple samples (specimens) from the same patient.
Case ID	This refers to a unique identifier associated with each case. The case ID is a combination of multiple identifiers containing information such as the specimen type, year, unique case number, specimen identifier, block identifier and/or character.
CC	Cancer Centre
Chuck	A round or square flat metal grid on which tissue is placed in a cryostat as a solid support for cutting frozen sections.
CL	The Clinical Lead is the individual with designated overall responsibility for the programme within their local site. They are also responsible for identifying a designated person or two people locally with responsibility for the operational support of NQAIS-Histopathology and other administrative tasks on an ongoing basis (Local Operational Manager).
Cytopathology	The examination of cells to determine the cause or the nature of disease.
GC	General Centre
Histopathology	The examination of tissue to determine the cause or the nature of disease.
LIS	Laboratory Information System
KQI	Key Quality Indicator
LOM	The Local Operations Manager is responsible for reviewing and verifying the accuracy and completeness of local QI data utilising local report and analysis tools, coordination of the ongoing setup and removal of authorised local users for NQAIS-Histopathology in conjunction with the Clinical Lead.
NQAIS-Histopathology	NQAIS-Histopathology functions as a central repository for quality improvement data from participating hospital's Laboratory Information Systems (LIS).

Recommendation	This refers to recommendations that should be implemented in each histopathology laboratory to fully support quality improvement activities. Where quality targets are absent due to lack of sufficient evidence on which to base a standard, a recommendation is usually made.
Slide	When a tissue sample is obtained from a patient it is processed within a laboratory and ultimately sliced very thinly. The thin slice of tissue is placed on a glass slide. The glass slide is then stained to colour the cells and assessed using a microscope by the pathologist.
Specimen	A piece of tissue received into the pathology laboratory for analysis and diagnosis. A patient may have one or more specimens submitted at any one time.
Stain	This refers to a pigment applied to slides to highlight particular features of interest. The most widely used stain is known as H&E (Haematoxylin & Eosin).
Target	This refers to a target associated with Quality Indicators.
QI	Quality Improvement

Chapter 1 Background

This document provides guidance to pathologists on the implementation of the Quality Improvement (QI) Programme. Local protocol will determine how these guidelines are adapted and it is recommended that systems are maintained to collate the required data for each Key Quality Indicator (KQI) outlined in this document.

The National Histopathology QI (NHQI) Programme was launched by the Faculty of Pathology (RCPI) in January 2009 in collaboration with the National Cancer Control Programme (NCCP) and Directorate of Quality and Clinical Care in the Royal College of Physicians of Ireland (RCPI). Funding was initially provided by the NCCP and was taken over by the HSE National Quality Improvement Team in 2014. RCPI continues to manage the programme.

The central goals of the NHQI Programme are to give the public greater confidence in histopathology services in Ireland, to enhance patient safety and improve patient-centred care with timely, accurate and complete pathology diagnoses and reports. This is achieved in a manner that is both supportive and encouraging to the participating histopathology laboratories.

This quality improvement programme is a small component in maintaining a quality laboratory. The roles of QI Clinical Lead and Local Operational Manager should be established within each histopathology laboratory to ensure routine review of quality data and to initiate improvements where required. The department should work within their local quality, patient safety and risk structures to collect, analyse, report on and respond to quality improvement data.

This document outlines:

- The KQIs by which individual histopathology laboratories will monitor their activities
- Existing national and international targets for each key indicator
- Recommendation for best practice to fully support the implementation of quality improvement activities.

Finally, all parties accept that this QI Programme is an evolving process and that this document will require regular reviews. It is intended that the guidelines will be reviewed on a suggested three to five yearly basis by the Working Group and approved by the Steering Committee of the Specialty QI Programmes and the Faculty of Pathology.

Chapter 2 Recommended Procedure Codes

Participating laboratories are required to use the following list of Procedure (P) codes for coding QI Programme data.

The P codes are entered by the laboratory staff at various stages depending on the workflow processes in the laboratory.

The P codes are designated according to the definitions given below and were originally set up to reflect the complexity of specimens and need for different turnaround times (Table 1).

2.1 P CODES SUMMARY

TABLE 1: P Codes Summary

Master Code	Detail
P01	Small Biopsy
P02	GI Endoscopic Biopsy
P03	Cancer Resection
P04	Non Biopsy – Other (includes all external cases received)
P05	Cytology for Cerebrospinal Fluid
P06	Non Gynaecological Cytology – FNA
P07	Non Gynaecological Cytology – Exfoliative
P09	Gynaecological Cytology
P10	Post-mortem - Coroner
P11	Post-mortem - Non Coroner/Consented/House
P12	Coroner P&P Post-mortem SIDS/Metabolic
P13	Coroner P&P Post-mortem Perinatal/Neonatal/Stillborn
P14	Coroner P&P Post-mortem General Paediatric
P15	Coroner P&P Post-mortem Foetus less than 500grams
P16	Non-Coroner P&P Post-mortem SIDS/Metabolic
P17	Non-Coroner P&P Post-mortem Perinatal/Neonatal/Stillborn
P18	Non-Coroner P&P Post-mortem General Paediatric
P19	Non-Coroner P&P Post-mortem foetus less than 500grams
P20	No Autopsy Performed

2.2 PROCEDURE (P) CODES 01-04 IN DETAIL

The P01 and P02 codes are allocated irrespective of the final diagnosis, benign or malignant. The focus of these codes is the size of the specimen, which is biopsy only (Table 2).

The P03 and P04 codes differentiate between oncological/cancer resections and non-oncological /non-cancer resections, with the P04 code also accounting for pieces of tissue which are larger than biopsy fragments and for external cases received for review (Table 2).

TABLE 2: P Codes 01-04 Expanded Explanation

Code	Detail
P01	**Small biopsy:** Core, needle, punch, shave biopsies/shave excisions of skin. Small biopsies include but are not limited to liver (for tumour diagnosis only), bronchial, lung core, endometrial pipelle, skin punch, prostate cores, lymph node core and targeted core biopsy for tumour i.e lung, soft tissue, omentum and ovary.
P02	**Endoscopic GI biopsy:** Biopsies from oesophagus to anus.
P03	**Cancer resections:** wide local excisions and excisions of entire organ(s). May also include specimens with no residual primary tumour – post prior wide local excision, completion mastectomy/lobectomy, insitu/non invasive disease or post neoadjuvant treatment. Also included are local excisions/therapeutic excisions such as GI polypectomy specimens/endoscopic mucosal resection (EMR) – for excision of a polyp/cancer in the anus or oesophagus.
P04	**Non Biopsy – Other:** All other surgical specimens which are neither small biopsies nor cancer resections including but not limited to: Medical liver biopsy, transurethral resection (TUR) bladder, transurethral resection of the prostate (TURP), lymph node excision, bone marrow trephine, colectomy for diverticular disease/inflammatory bowel disease/medical renal biopsy/other benign GI indication, skin ellipse for benign disease, hysterectomy for fibroids/menorrhagia/non malignant indication, endometrial curetting, appendix, gallbladder, fallopian tubes, placenta, Large loop excision of the transformation zone (LLETZ)/prophylactic mastectomy. External material received internally for review (including cytology cases) should be coded as P04.
P05	**Neuropathology Cytology:** Cytology for cerebrospinal fluid
P06	**Non Gynaecological Cytology – FNA:** Thyroid/lung/endobronchial ultrasound (EBUS) lung
P07	**Non Gynaecological Cytology – Exfoliative:** Urine/ascitic fluid

FURTHER INFORMATION:

1. **Skin excisions** may contain a malignancy and may be coded as P01 or P04 on receipt, the code should not be changed to P03 as this is not a designated cancer resection. Subsequent wide local excisions are coded as P03 even in the absence of residual disease/malignancy as this is an oncological staging process for margins.

   Examples:

   P03 code is used for the following cases:
   - Re-excision/wide local excision of melanoma and melanoma in-situ +/- sentinel node biopsy.
   - Re-excision/wide local excision of other rare malignancies such as merkel cell carcinoma, skin adnexal carcinomas.

   P04 code is used for the following cases:
   - All initial diagnostic ellipse excisions irrespective of the diagnosis i.e. squamous cell carinomas (SCC), basal cell carcinomas (BCC), melanoma, melanoma in-situ and other rarer malignancies*.
   - Re-excision of BCC and SCC.

   *The complexity of these cases is captured subsequently by the use of P03 to code the re-excision specimen.

2. **Polypectomy specimens** may contain a malignant polyp, we suggest coding these as P03 if they have been sent as an excision specimen i.e. pinned on a board.

3. **Complex biopsies** such as bone marrow trephines, medical liver biopsies with special stains and renal biopsies are coded as P04.

4. **Margin excisions** of cancer cases are oncological operations and even in the absence of residual disease/malignancy are coded as P03.

2.3 RECOMMENDED QUALITY (Q) ACTIVITY CODES

Table 3 is a list of all the quality (Q) codes pertaining to the NHQI programme. Where possible codes have been grouped into categories. It is recommended to adopt the following list of Q codes for the classification of a primary organ/site for each case.

TABLE 3: Recommended Quality (Q) Activity Codes

National Code	National Description
Q001	Case Referred Externally for Review
Q002	Case Received Internally for Review
Q003	Case Referred Externally for Opinion
Q004	Inter Institutional Agreement
Q005	Inter Institutional Disagreement
Q064	Case Received for Expert Opinion
Q006	Case subject to Intradepartmental Consultation
Q007	Frozen Section Correlation – Concordance

Q008	Frozen Section Correlation – Deferral
Q009	Frozen Section Correlation - Major Discordance
Q061	Frozen Section Turnaround Time ≤ 20mins
Q062	Frozen Section Turnaround Time > 20mins
Q013	Case Subject to Focused Real Time Review
Q015	Focused Review – Agreement
Q016	Focused Review – Disagreement
Q017	Case Subject to MDT/M&M Review
Q018	MDT/M&M Review - Agreement
Q019	MDT/M&M Review – Disagreement
Q020	Supplementary Reports
Q021	Amended Reports
Q022	Corrected Reports
Q023	Report Communicated Directly to Clinician
Q063	Critical Diagnosis Value Reporting
Q014	Case Subject to Report Completeness Review
Q030	Report Complete
Q031	Report Incomplete
Q032	Case Subject to Random Review
Q033	Random Review – Agreement
Q034	Random Review – Disagreement
Q035	Post-mortem - Toxicology Performed
Q036	Post-mortem - Histology Performed
Q037	Post-mortem - Neuropathology Performed
Q038	Post-mortem - Neither Toxicology nor Histo nor Neuro Performed
Q039	Post-mortem - Organ Retained
Q040	Perinatal & Paediatric Post-mortem - SIDS/Metabolic
Q041	Perinatal & Paediatric Post-mortem - Non SIDS/Metabolic
Q042	Autopsy Case Review Satisfactory
Q043	Autopsy Case Review Unsatisfactory
Q044	Perinatal & Paediatric Autopsy Satisfactory ≥ Min Accepted Score
Q045	Perinatal & Paediatric Autopsy Unsatisfactory < Min Accepted Score
Q046	Excellent – Applies to Autopsy Case Review
Q047	Good – Applies to Autopsy Case Review
Q048	Satisfactory – Applies to Autopsy Case Review
Q049	Unacceptable – Applies to Autopsy Case Review

Q050	Poor – Applies to Autopsy Case Review
Q052	Pre Analytic High Risk Non Conformance
Q053	Pre Analytic Medium Risk Non Conformance
Q054	Pre Analytic Low Risk Non Conformance
Q055	Analytic High Risk Non Conformance
Q056	Analytic Medium Risk Non Conformance
Q057	Analytic Low Risk Non Conformance
Q058	Post Analytic High Risk Non Conformance
Q059	Post Analytic Medium Risk Non Conformance
Q060	Post Analytic Low Risk Non Conformance
Q065	Outsourced Data

OTHER QUALITY CODES:

Q024	Cytology Interpretation Error
Q025	Histology Interpretation Error
Q026	Cytology Sampling Error
Q027	Histology Sampling Error
Q028	Agreement
Q029	Disagreement

2.4 RECOMMENDED PRIMARY ORGAN/SITE Q CODES

Table 4 is a list of Primary Organ Site (POS) codes developed by the NHQI Programme.

TABLE 4: Recommended Primary Organ/Site Q Codes

National code (POS)	National Description
QADR	Adrenal
QANAL	Anus
QBIL	Biliary Tract (intra- and extra-hepatic) and Gallbladder
QBLAD	Bladder
QBM	Bone Marrow
QBR	Breast
QCERV	Cervix
QCNS	Central Nervous System
QCOL	Colon (includes appendix)
QCVS	Cardiovascular (pericardium, cardiac, vascular)
QDUOD	Duodenum

QFT	Fallopian Tube
QGAST	Stomach
QHEP	Liver
QHN	Upper Aerodigestive Tract, Maxilla/Mandible
QKID	Kidney
QLN	Lymph Node (primary disease)
QLUNG	Lung
QMED	Mediastinum
QMEL	Melanoma
QNCNS	Central Nervous System
QNPNS	Peripheral Nervous System
QNMUS	Neurology Neuromuscular
QOES	Oesophagus
QOTH	Other (includes placenta, eye, scrotum, urethra)
QOV	Ovary
QPANC	Pancreas
QPAT	Parathyroid
QPEN	Penis
QPER	Peritoneum/Omentum
QPL	Pleura (includes pleural fluid cytology)
QPROS	Prostate
QRECT	Rectum
QSAL	Salivary Gland
QSBO	Small Bowel (jejunum and ileum)
QSKEL	Skeletal System (bones/joints)
QSKIO	Other
QSKIT	Non-Melanoma Tumour
QSOFT	Soft Tissue
QSPL	Spleen
QTEST	Testis
QTHY	Thyroid
QURE	Ureter
QUT	Uterus
QVUL	Vulva/Vagina

Chapter 3 Data Quality

REPORTING ON DATA QUALITY

It is important that the QI data which are uploaded and subsequently analysed by the programme management are 'fit for purpose', meaning they are accurate, relevant and timely, to facilitate the necessary quality improvement activities and associated decision-making. The quality of the QI data is dependent on several factors such as the availability of clinicians to input and run quality checks on the data before it is uploaded into NQAIS-Histopathology.

HIQA recommend that health and social care organisations develop a data quality framework, covering the following four components 1) a data quality strategy, 2) a data quality assessment tool, 3) reporting on data quality and 4) a data quality improvement cycle[1].

The NHQI Programme Working Group are aware of local coding issues that impact the quality of the QI data collected and have made recommendations to provide clarity for users. The programme manager ensures that local users are adequately trained on the use of NQAIS-Histopathology to ensure the data uploads, including data quality reports are run appropriately.

DATA QUALITY ASSESSMENT

For the purposes of data analysis for the annual national data report, data quality is assessed under the following internationally accepted dimensions of accuracy, reliability, relevancy, completeness, consistency and timeliness[1].

Each dimension will be dealt with in more detail in the annual national data report outlining any data related challenges faced or improvements made in the preceding year.

RELEVANCE

This refers to whether the data collected meets the needs of users, both now and into the future.

The purpose of the Histopathology QI data is to aid decision making in the context of the laboratory environment. The Working Group consider and assess the KQIs and the targets on an ongoing basis in terms of relevance. A review of coding is carried out on an annual basis, using previous data extracts to investigate the levels of use certain codes have received in the previous year.

ACCURACY AND RELIABILITY

The dimension of accuracy refers to how precisely or otherwise the data collected represent or describe what they were intended to. Reliability refers to the reality and consistency of that representation over time.

The QI data collected for the HNHQI Programme consists of a range of KQIs, designed to measure quality at both a local and national level in laboratories.

Data completeness is an additional measure that must be considered as part of the assessment of accuracy and reliability of data.

TIMELINESS AND PUNCTUALITY

Timeliness deals with the agreed timeline within which the data are collected, punctuality refers to whether the data was made available to potential users when promised or expected.

Data, relating to the same suite of key quality indicators should be uploaded to NQAIS-Histopathology on a retrospectively rolling 12-month period. Laboratories are requested to have completed their data uploads to NQAIS-Histopathology by the end of March each year for inclusion in the annual national data report.

The programme upload schedule can be viewed here, which provides guidance on the timelines for compliance with monthly uploads. In addition, the Lapsed Participation Process can be located here outlining the necessary steps where a site is no longer compliant with the upload schedule.

COHERENCE AND COMPARABILITY

Data that are coherent are logically consistent and can be combined with other sources easily. Comparability of data refers to the potential to compare data usefully to other sources.

The process for input, sign-off and uploading to NQAIS-Histopathology should be as consistent as possible and is outlined in detail in the following NQAIS-Histopathology User Manual.

Laboratories are notified about any amendments to current policies and processes via email with supporting documentation. Any major changes will also be outlined in the national data report.

ACCESSIBLITY AND CLARITY

The accessibility of data refers to the ease with which data can be obtained by potential users. Clarity of data refers to the way data are presented e.g. graphs, tables etc and how easily potential users can understand and use the data.

Laboratories may access their own data in NQAIS-Histopathology. Training is provided to aid the reliability of this process.

Further training or any refreshing of specific elements can be requested from the programme manager.

Each laboratory can access their own data on NQAIS-Histopathology provided they have the appropriate permissions, here they can compare their own performance to the national aggregate

REPORTING ON DATA QUALITY

Data quality is monitored by the programme management, with reports currently made to the Working Group when issues arise.

CONTINUOUS IMPROVEMENT OF DATA QUALITY

The use of superior data analysis tools will permit a more in-depth consideration of data quality into the future, however limitations encountered in the data captured by local systems must be factored in. It is hoped that the MedLIS project will not only result in a nationally coordinated diagnostic reporting system benefiting patient care greatly, but the parallel use of synoptic reporting will ensure that data collection is more accurate and complete.

The programme invites discussion from all participants on data quality and how this might be improved.

Chapter 4 The National Quality Assurance and Improvement System (NQAIS)

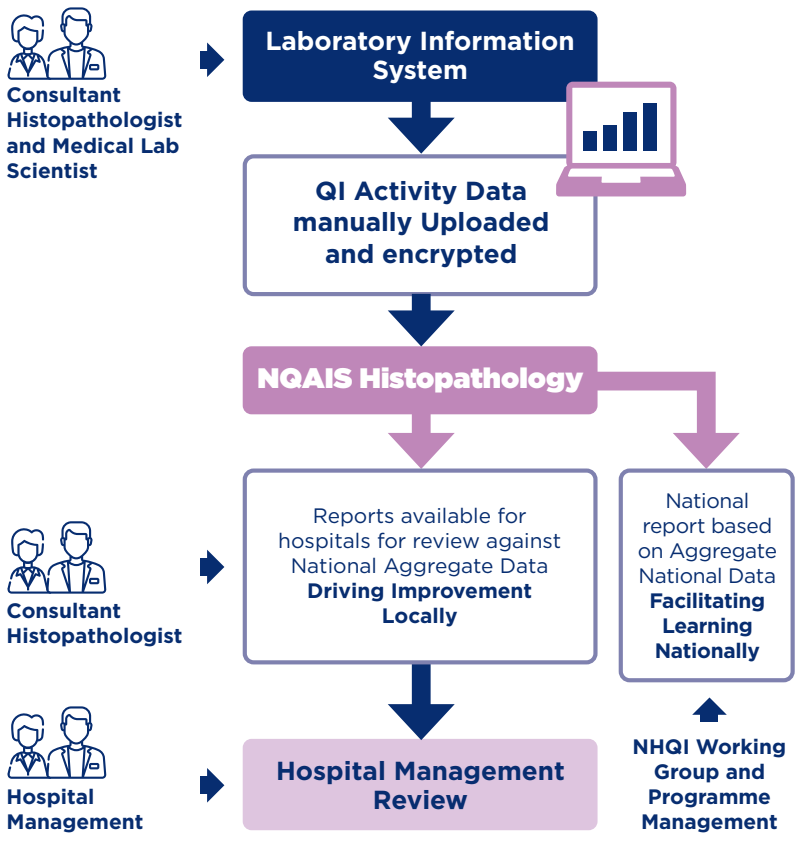
NQAIS-Histopathology functions as a central repository for quality improvement data from participating hospitals' Laboratory Information Systems (LIS). It allows the programme to generate national reports on the accuracy and timeliness of diagnostic reporting in laboratories across Ireland. The data relating to predefined KQIs are extracted from NQAIS-Histopathology and used to produce an annual report on these national metrics in histopathology. Ireland is the first country in the world to generate this lab-based report. Laboratories can use the report to identify best practice and any variations, to review, improve and sustain the quality of their work in the context of national norms and targets set by the NHQI Programme.

The reports run in NQAIS-Histopathology are called Key Quality Data (KQD) reports, and should be reviewed by the QI Clinical Lead quarterly, at a minimum, to ensure areas of concern and/or best practice are identified and acted on. To facilitate communication and highlight learning opportunities, KQD reports should be discussed with Quality and Patient Safety (QPS) Committee (or equivalent) and senior management in each hospital. The quarterly KQD reports may provide a streamlined method of delivering this information to senior management and the QPS Committee. (See Memorandum of Understanding)

DATA SOURCE

Each laboratory contributes data on histology, cytology and autopsy from their local LIS. Data are extracted from the LIS on a monthly basis and uploaded to NQAIS-Histopathology.

How is QI Data collected?



As cases are processed within the laboratory, they are assigned specific procedure codes associated with the type of specimen and quality activities performed. These are recorded within the LIS. Data on all histopathology/cytology cases and the associated quality activities performed are extracted from the LIS and uploaded to NQAIS-Histopathology on a monthly basis by the Local Operational Manager (LOM).

LOCAL OPERATION MANAGER

The Local Operations Manager is responsible for reviewing and verifying the accuracy, and completeness of local QI data utilising local report and analysis tools, coordination of the ongoing setup and removal of authorised local users for NQAIS-Histopathology in conjunction with the Clinical Lead.

QI CLINICAL LEAD

The QI Clinical Lead is the individual with designated overall responsibility for the programme within their local site. She/he is also responsible for identifying a designated person or two people locally with responsibility for the operational support of NQAIS-Histopathology and other administrative tasks on an ongoing basis (Local Operational Manager).

Chapter 5 Workload

The NHQI Programme guidelines outline a range of activities that should be performed in order to gather the necessary data. The guidelines also outline targets and recommendations associated with specific KQIs for histopathology laboratories.

5.1 QUALITY ACTIVITIES

Definition: An activity that should be performed by those participating in the programme to create the QI data necessary to generate KQD reports.

Targets

Definition: These are developed by the NHQI Working Group using international evidence, expert opinion, and analysis of data collected through the NQAIS-Histopathology tool in consultation with clinical users.

Recommendation

Definition: This refers to recommendations that should be implemented in each histopathology laboratory to fully support quality improvement activities. Where quality targets are absent, due to lack of sufficient evidence with which to base a standard upon, a recommendation will usually be made. These recommendations are wholly endorsed by the SQI Steering Committee and the Faculty of Pathology. The view is that recommendations will be made targets, when sufficient evidence is available, in consultation with clinical users.

5.2 LABORATORY HISTOLOGY WORKLOAD

Each monthly and yearly report provides specific data for each laboratory with respect to total number of cases, specimens, blocks and stains (including special stains and immunohistochemistry). The workload can be tracked month to month and year to year to assess trends and fluctuations in workload and compared against national aggregate data.

Workload is analysed under the following headings:

1) **Total Case Numbers**
2) **Specimens**
3) **Blocks**
4) **All Stains**
5) **IHC Stains**
6) **Routine H&E**
7) **Extra H&E**
8) **Special Stains (& Cases)**
9) **Frozen Section Stains**
10) **Molecular Studies** – The NHQI Programme recognise this is important and there is a plan to add detail at a later date

Chapter 6 Intradepartmental Consultation

6.1 INTRADEPARTMENTAL CONSULTATION (Q006)

Intradepartmental consultation (IDC) occurs when a consultant pathologist seeks a second opinion from another consultant pathologist within their department or within their regional hospital network on a particular case prior to authorisation of the final report. Pathologists should record the consultation in the Local Information System (Q006) and where appropriate in the final report.

Key Quality Data:

The number of IDC's that take place.

Key Quality Indicator:

The total annual number of cases with IDC's divided by the Total Cases (in the Non-Autopsy Cohort) expressed as a percentage and broken down by All Sites, General Centres and Cancer Centres.

Key Quality Targets % IDC:

Case Type	Minimum target	Achievable Target
Histology Cases (P01, P02, P03, P04)	3%	5%
Non-Gynaecological Cytology FNA (P06) Cases	7%	9%
Non-Gynaecological Cytology Exfoliative (P07) Cases	3%	5%
Autopsy Cases	1%	1%

IDC is a highly effective form of solicited peer review that is best categorised as a quality improvement process measure that reduces pathology error[2].

The above minimum and achievable targets are to be applied to departmental activity. However, it is recommended that a minimum target of 10% be suggested for locum or newly appointed consultant histopathologists for a period of time determined by individual departments.

6.2 % IDC – HISTOLOGY (P01, P02, P03 AND P04)

Currently it is the only metric that is submitted monthly by participating histopathology departments to the HSE for inclusion in Hospital Patient Safety Indicator Report (HPSIR).

The four histology specimen categories are intentionally combined to generate a mean histology IDC rate which also allows for the significant variation in IDC rate present between specimen types (P02 specimens typically have a lower IDC rate due to low complexity of majority of cases) following review of national data.

6.3 % IDC – CYTOLOGY CASES, NON-GYNAECOLOGICAL CYTOLOGY FNA (P06)

Non-Gynaecological Cytology FNA specimens have higher targets than other specimen types due to the greater likelihood of direct impact on patient care resulting from these cases.

6.4 % IDC – CYTOLOGY CASES, NON-GYNAECOLOGICAL CYTOLOGY EXFOLIATIVE (P07)

Non-Gynaecological Cytology exfoliative specimens have the same minimum and achievable targets as the combined histology specimens.

6.5 % IDC – AUTOPSY CASES

Autopsy IDC can include seeking an opinion on any component of a case (e.g. cardiac or renal) and does not require a complete review of the entire autopsy.

Chapter 7 Multidisciplinary Team Review

7.1 MULTIDISCIPLINARY TEAM REVIEW

Multidisciplinary Team (MDT) meetings form an essential part of the clinical care of patients with cancers, suspected cancer or other clinical conditions. Histopathologists are in a key position to participate fully in such meetings and play an important role in patient management. Organisation of MDT meetings and determining cases for review is the responsibility of the MDT coordinator or clinical teams within the hospital. The reviewing pathologist should prepare the cases assigned for review at MDT, reconcile any discrepancies noted prior to MDT and attend the MDT meetings to present and discuss cases.

If a case is discussed at MDT, the Q017 code can be added irrespective of whether slide review has taken place, given that peer review in the form of clinical and/or radiological correlation will have occurred. However, it is anticipated that slide review will have been undertaken in a significant proportion of cases, which are discussed at MDT. This process involves the review of selected slides at the discretion of the reviewing pathologist. If slide review of a case listed for MDT takes place, but the case ultimately is not discussed at MDT, the Q017 code should not be used.

After the MDT meeting, minutes should be recorded in line with local hospital policy and practice of the cases discussed, appropriate Q codes recorded for each case reviewed and any Amended/Corrected or Supplementary Reports issued as required.

Cases which are discordant at MDT Review should be reviewed as part of the departmental discrepancy case conference.

If a case is reviewed more than once at MDT, each individual review should be coded however, it should be noted NQAIS-Histopathology currently will only record one code (Q017) per case.

MDT Disagreement

Only disagreement at MDT due to pathological interpretation should be classified as ‘disagreement at MDT’. Disagreement which arises due to the provision of additional clinical information does not come under this category. Disagreement is defined as when it is deemed necessary to issue an Amended Report. A Corrected report such as related to a transcripted error does not warrant a disagreement code.

Cases Recieved from an External Institution

Cases received from an external institution for MDT review should be coded as Q002, following review and reporting an agreement (Q004) or disagreement (Q005) code assigned. These cases do not get Q017/Q018/Q019 MDT codes unless a pathologist from the institution which generated the case participates in the MDT in person or remotely i.e. via video link. A report should be sent back to referring institution so that agreement/disagreement codes be assigned there.

Key Quality Data:
The number of cases reviewed by the MDT with agreement.

Key Quality Indicator:
The number of cases reviewed by the MDT with agreement, divided by the number of cases reviewed by the MDT expressed as a percentage and broken down by All Sites, Cancer Centres and General Centres.

Key Quality Targets Multidisciplinary Team Review:	
Case Type	Target
% MDT Review Agreement (P01, P02, P03, P04, P06, P07)	Greater than or equal to 95%

Recommendation: % Cases Discussed at MDT Meeting:

1. Minimum 10% of all cases (Cancer Centres)
2. Minimum 5% of all cases (General Centres)
3. Achievable Target 95% or more of all cancer resection specimens (General and Cancer Centres)

* A high proportion of cancer resection cases (P03) should be discussed at MDT

7.2 EXPLANATION OF MDT CODING

Case Type	Correct Q Codes
MDT Case Review	Q017
MDT Case Agreement	Automatic Default Code Q017
MDT Case Disagreement	Q019

Chapter 8 Addendum Reports

8.1 ADDENDUM REPORTS

An Addendum Report refers to any pathology report issued subsequent to the original report and should be classified as corrected, supplementary or amended. Definitions of the three categores of Addendum Reports are outlined below. The NHQI programme has engaged in considerable debate with regards to the use of these categories and the consolidation of Amended and Corrected Reports. Different codes continue to be used with targets and recommendations developed which will be monitored and revised as required.

8.2 COMBINED AMENDED/CORRECTED REPORTS

The rationale for combining Amended and Corrected Reports was as a result of a multi-institutional audit of Amended and Corrected Reports at three participating laboratories which revealed significant misclassification of these two categories. We have therefore, combined the two for data analysis purposes.[3] The original target agreed for Corrected Reports for both histology and cytology cases was 2%. The target of 1% for combined Amended/Corrected Reports was agreed by the NHQI Working Group, this was based on analysis of data gathered in previous years which reveals that the percentages of Corrected Reports do not exceed 1% for General Centres, Cancer Centres or a combined national average for both.

8.3 CORRECTED REPORT (Q022)

This is a report issued when transcription, patient identification, specimen site, or other report related errors occur. Corrected Reports do not change the original interpretive diagnosis.

8.4 AMENDED REPORT (Q021)

An Amended Report is issued when the final report diagnosis changes due to an interpretive error or other important pathologic information becomes available that results in a major change in diagnosis and/or treatment.

The reasons for the revision should be explained in the report and the clinician notified directly, as an Amended Report may significantly affect patient care.

It is recommended that all Amended Reports/cases be reviewed at a QI discrepancy case conference.

Amended Reports may be reported as high-risk non-conformances and evaluated through the hospital quality management system to assess impact on patient care.

Key Quality Data:
The number of reports, issued subsequent to the original report, classified as Combined Amended/Corrected Reports.

Key Quality Indicator:
The number of reports (from Non-Autopsy Cohort), issued subsequent to the original report, classified as Combined Amended/Corrected reports expressed as a percentage of all reports issued.

Key Quality Targets Combined Amended/Corrected Reports:	
Case Type	Target
Histology Cases (P01, P02, P03, P04)	1% or less
Cytology Cases (P06, P07)	1% or less

8.5 SUPPLEMENTARY REPORTS (Q020)

A Supplementary Report is issued when new information becomes available after the final report has been submitted, these include:

- Newly obtained clinical information.
- Findings on additional histological sections or review of archival material.
- The results of special studies such as immunohistochemistry or molecular diagnostics, and the results of a consultations may be included in a Supplementary Report.

When issued following a provisional report, the Supplementary Report acts as the final report.

Some centres may have rates higher than the target due to high volumes of cases requiring supplementary molecular or immunohistochemical analysis.

Review of Supplementary Reports as an audit activity may locate incorrectly coded Amended and Corrected Reports and would also be valuable in tracking the percentage of Supplementary Reports containing the final diagnosis.

Key Quality Data:
The number of reports, issued subsequent to the original report, classified as Supplementary Reports.

Key Quality Indicator:
The number of reports, issued subsequent to the original report, classified as supplementary reports expressed as a percentage of all reports issued.

Key Quality Targets Supplementary Reports:	
Case Type	Target
Histology Cases (P01, P02, P03, P04)	10% or less
Cytology Cases (P05, P06, P07)	10% or less

Chapter 9 Turnaround Time

9.1 TURNAROUND TIME (TAT)

Turnaround Time (TAT) is a key monitor of the overall function of the laboratory service and is considered a critical element of quality due to impact on the clinical management of patients. Turnaround time is measured from the time the lab receives the specimen to the time the final report is authorised. To ensure a meaningful representation of all the different types of specimens encountered in the hospital, there are different TAT categories for different specimen types.

There are four categories for histology specimens (Small Biopsy, GI Endoscopic Biopsy, Cancer Resection and Non-Biopsy Other) and three categories in cytology (Non-Gynaecological Cytology FNA and Non-Gynaecological Cytology Exfoliative).

For TAT calculations the day of receipt of a specimen is considered day zero. The percentage of cases completed by day one includes samples completed on day zero and day one. Days are calculated in working days and do not include weekends or bank holidays.

Key Quality Data:

The number of reports authorised (completed or turned around) and the time taken to authorise a case.

Key Quality Indicator:

The number of reports authorised by the relevant day as per P code category, expressed as a percentage of the total reports within the same P code category broken down by All Sites, General Centres and Cancer Centres and measured against the relevant target.

E.g. the number of small biopsy cases (P01), expressed as a percentage of total number of small biopsy cases, completed by day 5 measured against a target of 80%.

Key Quality Targets Turnaround Time:

Case Type	Target
Small Biopsy (P01)	80% cases turned around in 5 days or less
GI Endoscopic Biopsy (P02)	80% cases turned around in 7 days or less 100% cases turned around by day 10
Cancer Resection (P03)	80% cases turned around in 7 days or less
Non-Biopsy Other (P04)	80% cases turned around in 7 days or less
Neuropathology Cytology (P05)	80% cases turned around in 5 days or less
Non-Gynaecological Cytology FNA (P06)	80% cases turned around in 5 days or less
Non-Gynaecological Cytology Exfoliative (P07)	80% cases turned around in 5 days or less

It is recommended that TATs are to be reviewed at monthly departmental QA meetings. Targets that were not achieved should be discussed and if possible, investigated as to the reason. It is also recommended that regular review of coding practices within laboratories including appropriate introduction to coding for new staff be undertaken.

Chapter 10 Frozen Section

10.1 FROZEN SECTION

Frozen Section (FS) is a specimen of tissue that has been quick-frozen, cut by microtome and stained immediately for rapid diagnosis.

10.2 CORRELATION OF FROZEN SECTION DIAGNOSIS WITH FINAL DIAGNOSIS

Monitoring the correlation of FS diagnosis and permanent section diagnosis is an integral component of the NHQI programme. It is recommended that permanent section slides should be analysed with the accompanying FS slides to establish if any discrepancy exists. It is recognised that certain FS activities have higher discordance rates, e.g. diagnosis of a primary lesion on FS may be more challenging than FS evaluation of margin status. Errors may arise due to sampling or interpretative issues. FS discordances should be reconciled in the final pathology report and reviewed and discussed at the departmental discrepancy conference.

10.3 FROZEN SECTION CONCORDANCE RATE (Q007)

This represents cases where FS and permanent section diagnosis are in agreement.

Key Quality Data:
The rate of correlation of FS diagnosis with permanent section diagnosis.

Key Quality Indicator:
The number of FS cases with concordance, expressed as a percentage of the total number of frozen section cases, measured against the target and broken down by All Sites, General Centres and Cancer Centres.

Key Quality Targets Frozen Section Concordance Rate:	
Case Type	Target
FS Concordance Rate	Greater than or equal to 97%

10.4 FROZEN SECTION CORRELATION – DEFERRAL RATE (Q008)

Key Quality Data:
The number of cases where a FS diagnosis was deferred until final diagnosis was reached on permanent section review.

Key Quality Indicator:
The number of cases where a FS diagnosis was deferred until final diagnosis was reached on permanent section review, expressed as a percentage of the total number of FS cases and measured against the target, broken down by All Sites, General Centres and Cancer Sites.

Key Quality Targets Frozen Section Correlation - Deferral Rate:	
Case Type	Target
FS Deferral rate	Less than or equal to 5% and greater than 1%.

10.5 FROZEN SECTION CORRELATION – DISCORDANCE (Q009)

This represents discordance between the original FS diagnosis and the one rendered upon final diagnosis. Errors can be categorised into interpretative or sampling errors.

Please see coding tables in Chapter 2

10.6 FROZEN SECTION TURNAROUND TIME

Turnaround Times:	
Less than or equal to 20 minutes - Q06	Greater than 20 minutes - Q062

The turnaround time for a FS is an important parameter due to the intraoperative nature of the consultation, with real-time clinical decisions being made on FS results. The College of American Pathologists (CAP) benchmarks for frozen section turnaround times are included in the references for information purposes.

Key Quality Data:
The number of FS cases and time taken to authorise a case.

Key Quality Indicator:
The time taken to authorise a FS case expressed as a % of the total number of FS cases, broken down by All Sites, General Centres and Cancer Centres and measured against the relevant target.

Key Quality Targets Frozen Section Turnaround Time:	
Case Type	Target
FS Turnaround Time	Greater than or equal to 85% complete within 20 minutes

While frequent review of FS activity is recommended, it is also advised to present cumulative QI data and that a longer time period be used given the relatively low number of cases which would result in too low a denominator when calculating targets.

10.7 FROZEN SECTION CONCORDANCE RATE (Q007)

Long-term monitoring of FS permanent section correlation data has been shown to be associated with sustained improvement in performance by laboratories.

10.8 FROZEN SECTION CORRELATION – DEFERRAL RATE (Q008)

Note that deferral rate is greater than 1%. FS are not equivalent to evaluation of permanent sections for diagnoses and in certain instances, e.g. an artefacted specimen or a difficult to classify lesion, deferral to permanent section may be prudent. The rate of deferral of diagnosis to permanent section is less than or equal to 5%.

10.9 FROZEN SECTION TURNAROUND TIME

Turnaround time is measured from the time that the laboratory receives the FS specimen to the time that the pathologist reports the FS diagnosis to the clinician. When a FS case comes to the laboratory, the turnaround target per chuck is less than or equal to 20 minutes.

Chapter 11 Cytopathology Quality

In previous versions of the NHQI Guidelines, cytology was viewed as a standalone diagnostic specialty. However, the use of cytology/histology codes (Q011 & Q012) has been discontinued since August 2015.

All cytological QI activities are monitored independent of histology cases using existing Q codes with suggested monitoring of intradepartmental consultation (Q006) Multidisciplinary Team Review (Q017), Amended and Corrected Reports (Q021/Q022) and cases communicated directly to a clinician (Q023).

Target:	Please see Chapter 6, Chapter 9, Chapter 11 and Chapter 14 for related targets.

Recommendations

Review and monitoring of cytology cases using existing QI codes – intradepartmental review, MDT review, MDT discrepancies, Amended Reports, Corrected Reports, Reports Communicated directly to a clinician.

Chapter 12 Recommended Review and Audit Activity

RETROSPECTIVE/ FOCUSED REAL TIME REVIEW

It is recommended that Focused Real Time Review of previous negative cases, and specific clinically relevant areas of practice identified locally, is conducted post-authorisation. Examples of suggested areas suitable for the application of Focused Real Time Review include positive or negative prostate needle biopsies, cervical biopsies, and melanocytic lesions. Local protocols and practices should determine which case type to review, the frequency and number of cases to be considered. Cases with disagreements should be reviewed and discussed at departmental QI discrepancy conferences.

Target:	Agreement - Greater than 95% with Retrospective/Focused Real Time Review.

Recommendation
Review of 10% locum/new consultant cases for one month.

It is recommended that a minimum of one review is performed yearly and in real time, such that if a significant discrepancy that would affect patient care is found, the physician is notified as soon as possible.

Retrospective/Focused Real Time Review codes:
Case subject to focused real time review – Q013
Focused review agreement – Q015
Focused review disagreement – Q016

REPORT COMPLETENESS

Measuring the completeness of pathology reporting is an important component of NHQI Programme. Report completeness is reported on in the national data report under the heading of data quality (see chapter 3) however, this section refers to international standards in relation to the completion of pathology reports.

The Canadian Association of Pathology (CAP) reports that many studies have shown that standardised reporting forms, including synoptic reports or checklists, are highly effective in improving report adequacy, particularly for cancer reporting. The Association of Directors of Anatomic and Surgical Pathology, RCPath (UK), CAP and International Collaboration on Cancer Reporting (ICCR) Standards and Datasets for Histopathology on Cancers and Tissue Pathways have been written to help pathologists work towards a consistent approach for the reporting of the most cancers.

When reviewing a report for completeness, it is recommended that the report be evaluated for the presence of core items defined by guidelines from the bodies listed. If any one of these core items is omitted, the report is considered incomplete. If all core items are present, the report is considered complete. With the introduction of the new national Laboratory Information System (LIS) in the coming years, standardised reporting of cancer cases will be integrated as part of the software and review of report completeness will become part of regular QI activities.

Target:	Not possible to set currently.

Recommendation

- Review of the report as part of the MDT review.
- Audit opportunity.

Chapter 13 Inter-institutional Consultation

13.1 CASE REFERRED EXTERNALLY FOR REVIEW (Q001)

Inter-institutional case review provides an additional mechanism for evaluating diagnostic accuracy at the original institution. It occurs when a patient's treatment is transferred to another institution triggering a review of the original diagnosis. It can also occur when a clinician requests a review of the original diagnosis by an external institution.

13.2 CASE RECEIVED INTERNALLY FOR REVIEW (Q002)

Case received internally for review refers to when a patient's treatment is transferred internally triggering a review of patient diagnosis or where a clinician has requested a review of the original diagnosis performed externally. All cases received internally for review should be coded as P04.

13.3 CASE REFERRED EXTERNALLY FOR OPINION (Q003)

Inter-institutional opinions, which relate to cases referred externally for opinion refer to when a pathologist seeks the opinion of a colleague or clinician with perceived expertise opinion at a separate institution due to diagnostic difficulty or lack of consensus opinion from intradepartmental consultation. In the QI report in NQAIS-Histopathology, it is located in the Quality Area 'inter-institutional consultation'.

13.4 CASES RECEIVED INTERNALLY FOR EXPERT OPINION (Q064)

This refers to cases that are received in from other institutions/hospitals for expert opinion. In the QI Report, it is located in the Quality Area 'inter-institutional consultation'.

13.5 INTER-INSTITUTIONAL AGREEMENT/DISAGREEMENT (Q004 & Q005)

Cases subject to Inter-institutional consultation are given an agreement (Q004) or disagreement (Q005) code on return of the case. This is also recorded on the external report and does not apply to cases sent or received for an expert opinion. Where a report is received back after inter institutional consultation with a diagnosis that is discordant from the primary diagnosis made, it is recommended that the case be brought to an intradepartmental discrepancy case conference and an amended or corrected report be issued.

Target Set:	Not possible to measure/set.

Recommendations:

- Inter-institutional consultations present learning opportunities.
- Review of discordant cases at departmental discrepancy conference and issue of an Amended/Corrected Report as appropriate.
- Ensure reports from external sites are returned.

Chapter 14 Laboratory Based Non-Conformances

A Laboratory Based Non-Conformance is any event that has the potential to cause harm and should be classified according to the HSE Risk Assessment Matrix.

Reporting of Laboratory Based Non-Conformances is a requirement for laboratory accreditation. Each histopathology laboratory should have existing policies, processes and procedures in place for reporting Non-Conformances and determining corrective and preventative action.

Since this is already embedded in the quality management systems of laboratories undergoing INAB/ISO 15189 accreditation, it was decided recording of Non-Conformances in NQAIS-Histopathology QI data would duplicate work and coding of Non-Conformances for NQAIS-Histopathology is not currently recommended by the programme. Non-Conformances should be reviewed within the laboratory.

Target:	Target is not applicable.

Recommendation

Laboratory Based Non-Conformances should be reported as per existing laboratory policy and discussed at laboratory quality meetings.

Chapter 15 Laboratory Based External Quality Assessment

National Laboratory Based External Quality Assessment Schemes (NEQAS) in histopathology form a key part of laboratory quality management.

It is highly recommended that all histopathology laboratories participate in external quality assessment schemes that assess and score the quality of slide preparation and staining.

Participation in EQA schemes is recorded under laboratory accreditation schemes. Since this is already in place, recording of EQA scheme participation in QI data would duplicate work.

Target:	Not set

Recommendation

The programme recommends that EQA scheme participation is recorded in existing laboratory accreditation policy.

Chapter 16 Reports Communicated Directly to Clinician by Pathologist (Q023) and Critical Diagnosis Reporting (Q063)

Communication between pathologists and other clinicians is an important component of professional practice. Local policies and professional judgment of the pathologist often determine when to communicate directly with other clinicians. Reasons for communication include urgent cases, unsuspected malignancies, medical emergencies and also in an effort to discover further clinical information.

In many cases the communication relates to 'critical diagnoses' (Q063). A list of critical diagnoses should be developed locally within each department/hospital with development of a local Standard Operating Procedure (SOP) to determine the use of the code. A record of the communication is advised either in the report or within the reporting system (specimen notepad).

Suggested examples include unsuspected malignancy, mycobacterial infection, life-threatening infection, fat in endometrial curetting, and Amended Reports (both codes should be used i.e. Q062 and Q021).

Q023 should not be used for cases communicated to clinicians that are not defined as critical diagnoses.

These codes to not apply to Frozen Section cases and on-site cytology evaluation.

Target:	Not set

Recommendation

Communication with clinicians is encouraged.
Development of list of critical diagnoses within each department with SOP etc.

Chapter 17 Adult Autopsy Guidelines

Autopsy in the NHQI Programme should include review of both Coroner and Non-Coroner case types.

17.1 INTRADEPARTMENTAL CONSULTATION (Q006)

Intradepartmental Consultation (IDC) occurs when a consultant pathologist seeks a second opinion from another consultant pathologist within their department or within their regional hospital network on a particular case. Generally, a pathologist should seek a second opinion if there is any doubt about the correct diagnosis, in particular information that might appear on the death certificate. Pathologists should record the consultation in the NQAIS system and where appropriate in the final report.

Any review of an autopsy case that occurs prior to authorisation of the final report should be recorded as an IDC.

Target:	1% cases

17.2 AUTOPSY CASE REVIEW (Q032)

Autopsy case review involves auditing of the final report of randomly selected or focused cases. This review should take place every six months and within six months of the report being finalised. Obtaining an IDC on an element of an autopsy (e.g. histological sections of myocardium, wording of cause of death statement) does not qualify as a review of a case.

Autopsy Codes:
Autopsy case review satisfactory Q042.
Autopsy case review unsatisfactory Q043.

Target:	90% satisfactory

Recommendation
Minimum number of cases reviewed is to be decided locally. ICU deaths and sudden cardiac deaths suggested types of cases.

17.3 AUTOPSY TURNAROUND TIME

The NHQI Programme recognises the potential benefit of provisional autopsy reporting to clinicians, pathologists and the coroner and recommends that provisional reporting be adopted as a/the standard practice.

For the purposes of the QI Programme, the TAT of the autopsy final report will be monitored.

Key Quality Target Autopsy Turnaround Time
Final report turnaround time is measured from the date of autopsy to the date the final report is authorised.

17.4 AUTOPSY MORBIDITY AND MORTALITY MEETINGS (Q017)

Morbidity and Mortality Meetings, ICU meetings or surgical grand rounds are carried out at most hospitals. Discussion of autopsy findings is encouraged at these meetings and represents a form of MDT review and discussion. Cases should be coded using the MDT codes for Agreement (Q017) and Disagreement (Q019).

Target:	1% of autopsy cases per year reviewed at MMMs

17.5 PAEDIATRIC AND PERINATAL (P&P) AUTOPSY GUIDELINES

Paediatric autopsy refers to autopsies carried out on children aged up to the age of 16.
Perinatal autopsy refers to autopsy carried out on children stillborns and infants dying within the first week of life. Only perinatal autopsies > 500g should be included.

P12 Coroner P&P Post-mortem Sudden Infant Death Syndrome/Metabolic

This code refers to a coroner's post-mortem on a child where the clinical circumstances warrant a post-mortem with additional test modalities. Obvious examples include sudden unexpected deaths where non accidental injury or inborn errors of metabolism are considerations and require investigations (e.g. skeletal survey, metabolic work-up) not routinely utilised in post-mortem practice.

P13 Coroner P&P Post-mortem Perinatal/Neonatal/Stillborn

A coroner's post-mortem on a child stillborn or dying in the first 28 days of life. This corresponds to the categorisation of infant deaths routinely used in maternity services and reflects PM's in which obstetrical history and placental examination are key considerations.

P14 Coroner P&P Post-mortem General Paediatric

This code should be used for all other coroner's post-mortems on children not covered by P12, P13 or P15.

P15 Coroner P&P Post-mortem foetus less than 500gm

This code should be used for a coroner post-mortem on a foetus under 500gm.

P16 Non-Coroner P&P Post-mortem SIDS/Metabolic

This refers to a non-coroner's post-mortem on a child where the clinical circumstances warrant a post-mortem with additional test modalities. Obvious examples include deaths where inborn errors of metabolism are considerations and require investigations (e.g metabolic work-up) not routinely utilised in post-mortem practice.

P17 Non-Coroner P&P Post-mortem Perinatal/Neonatal Stillborn

This code refers to a non-coroner's post-mortem on a child stillborn or dying in the first 28 days of life. This corresponds to the categorisation of infant deaths routinely used in maternity services and reflects post-mortems in which obstetrical history and placental examination are key considerations.

P18 Non-Coroner P&P Post-mortem General Paediatric

This code should be used for all other non-coroner post-mortems on children not covered by P16, P17 or P19.

P19 Non-Coroner P&P Post-mortem foetus less than 500gm

This is a non-coroner post-mortem on a foetus weighing under 500gm.

P20 No autopsy performed P&P only

This is a category requested by some of the maternity units to assist in data collection.

Q044 P&P autopsy satisfactory

A post-mortem where the modified Rushton Score is above the designated minimum for the appropriate category of the post-mortem.

Q045 Paediatric and Perinatal autopsy not satisfactory

This code is used when a post-mortem where the modified Rushton Score is below the designated minimum for the appropriate category of the post-mortem.

Neonatal autopsy refers to autopsy carried out on infants dying within the first 28 completed days of life.

The Paediatric and Perinatal Subspecialty Group will develop specific guidelines once sufficient data has been collected.

17.6 PAEDIATRIC AUTOPSY EXTRA-DEPARTMENTAL CONSULTATION

Paediatric Autopsy Extra Departmental Consultation occurs when cases are presented for review at multi-disciplinary Morbidity and Mortality (M&M) Meetings.

17.7 RETROSPECTIVE REVIEW

Retrospective Review is auditing of randomly selected or focused case types post reporting of final diagnosis.

For autopsy retrospective review it is recommended that all metabolic/cot deaths, all SIDS/SUDI and a minimum of 20 other paediatric autopsy (including children stillborn and neonatal deaths) cases are reviewed per year.

It is recommended that retrospective review be carried out within 1 month of PM completion and no later than 3 months.

17.8 TURNAROUND TIME

Final report turnaround time (TAT) is measured from the date of autopsy to the date the final report is authorised.

Chapter 18 Targets and Recommendations

Below are targets and recommendations set by the Histopathology QI Working Group.

TABLE 5: Targets set by Histopathology QI Working Group

Key Quality Area	Targets & Key Quality Indicators	Notes
Turnaround Time (TAT) ROUND 1 & 2 Est 2013	Small Biopsy – 80% by day 5 GI Endoscopic Biopsy – 80% by day 7 **Updated** GI Endoscopic Biopsy - 100% by day 10 **Updated** Cancer Resection – 80% by day 7 Non-Biopsy Other – 80% by day 7 Neuropathology Cytology – 80% By day 5 Cytology FNA – 80% by day 5 Cytology Exfoliative – 80% by day 5	Turnaround time is calculated based on working days and does not include weekends or bank holidays. For turnaround time calculations the day of receipt of a specimen is considered day 0.
Intradepartmental Consultation (IDC) ROUND 1 & 2 Est 2013	Histology – 3% minimum, 5% achievable Cytology FNA – 7% minimum, 9% achievable Cytology exfoliative – 3% minimum, 5% achievable Autopsy – 1%	
Frozen Section (FS) Diagnosis ROUND 2 Est 2014	FS Concordance rate – 97% or more FS Deferral rate – 5% or less FS Turnaround time – 85% within 20 minutes	Deferral rate should be more than 1%.
Retrospective Real Time Review ROUND 3 Est 2016	% Agreement (Histology) – 95% or more % Agreement (Cytology) – 95% or more	Disagreement is defined as when it is deemed necessary to issue an amended report. Programme guidance recommends locum/ new consultants have a minimum 10% rate of review for one month, but this is a local decision.
Multidisciplinary Team (MDT) Meetings ROUND 3 Est 2016	% MDT Agreement – 95% or more	Disagreement is defined as when it is deemed necessary to issue an amended report.
Autopsy Retrospective Review ROUND 3 Est 2016	% Satisfactory – more than 90%	Number of cases reviewed to be decided locally.
Autopsy Morbidity & Mortality (M&M) Conference ROUND 3 Est 2016	1% of cases presented per year at hospital M&M conference	M&M conferences are typically presented at a hospital Medical & Surgical Grand Rounds.

TABLE 6: Recommendations set by the Working Group

Key Quality Area	Recommendations & Key Indicator	Notes
Multidisciplinary Team (MDT) Meetings ROUND 3 Est 2016	% cases discussed at MDT Meeting: • Minimum 10% of all cases (cancer centre labs) • Minimum 5% of all cases (general centre labs) • Minimum 50%, achievable 90% of cancer resection specimens (all labs)	Cases listed for MDT are outside of pathologist direct control. For general labs with low MDT meeting activity a combined peer review rate (with IDC) of more than 10% is recommended.
Addendum Reports ROUND 3 Est 2016	% Combined Amended/ Corrected Reports 1. Histology cases 1% or less 2. Cytology cases 1% or less % Supplementary Reports 3. Histology cases 10% or less 4. Cytology cases 10% or less	Classification of amended/ corrected reports is to be further reviewed. Case mix can impact supplementary report rate and should be noted on NQAIS reports as applicable.

Chapter 19 References

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