**Quality Improvement- Performance targets**

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**Quality Improvement- Performance targets**

1. Purpose of procedure
	* 1. It is a requirement of UKAS ISO15189:2012 standards and a stated component of the Departmental Quality Policy, that the service provided by the department should relate to the needs and requirements of its users. The establishment of quality objectives assists in the delivery of a quality service to our users.
		2. In addition, the Department aspires to operate in line with the Trust’s corporate aim of ‘Zero waits and Zero complaints’.
2. Principle of Procedure
	* 1. The Department of Cellular Pathology has adopted the Royal College of Pathologists targets for reporting histopathological and non-gynaecological cytology samples. These are 80% in 7 calendar days and 90% in 10 calendar days.
		2. Exception reports are generated monthly, for all cases remaining unreported after 20 days.
		3. The department completes the Pathology Quality Assurance Dashboard, established by NHS England in 2017.
		4. The department aims to meet with users in order to define specific turnaround times to assist in the delivery of their service. They will, for the most part, be concerned with the timeliness of the delivery of the service but may encompass other aspects such as the quality of information or compliance with legislation.
		5. The fulfilment of objectives can be assessed during the process of the Annual Management Review. Objectives may be revised in accordance with the demands of users and / or the resources of the department.
3. Personnel
	* 1. The statistics for Turnaround times, and appropriate graphs and the 20 day exception report are generated by the IT team. The results are discussed monthly at the monthly Histology performance meeting
		2. The Pathology Quality Assurance Dashboard is completed monthly by the Quality manager and presented at the Integrated laboratory medicine executive meeting.
4. Health & Safety
	* 1. Not applicable
5. Summary of significant changes
	* 1. Transferred into new format and Cytology performance targets added.
6. Sample / Equipment / Reagents / QC
	* 1. Not applicable
7. Procedure
	* 1. This document is stored on Q-pulse and is published on the Integrated Laboratory Medicine website at www.newcastlelaboratories.com
	1. Daily sectional objectives
		1. Specimen reception
* All day process specimens received before 11.00, trimmed and on processor by 11.30
* All same day do-able specimens received before 16.00, trimmed and on processor by 18.00.
* All medium and large BMS designated specimens trimmed and on processor 18.00.
* All medical staff, or Advanced Practiioner, designated specimens trimmed and on processor by 18.00.All received fresh specimens are opened by relevant medical or BMS staff by 18.00.
	+ 1. Slide production
* All embedded blocks from overnight process to be cut and issued.
* All urgents issued by 11:00am.
* Cases from day process commencing up to 11:00am are to be issued same day.
* All PM cases received fixed and before 11:00a.m. are to be issued the day following receipt of samples.
	+ 1. Immunocytochemistry
* To issue all ICC requests within one working day of receipt.
	+ 1. Neuropathology
* All embedded blocks to be cut and issued.
* All ICC and special requests to be issued.
* All intra-operative diagnoses (smear/frozen section) to be available within 15 minutes from receipt of specimen (monitor by audit)
* Forensic Medicine Unit CNS autopsy material to be processed, embedded cut and have H&Es issued within 10 working days of receipt of tissue (monitor by audit)
* All CNS autopsy material to be dissected within 3 months of receipt (monitor by audit)
* Coroners CNS autopsy cases to have histology issued within 25 working days of brain dissection (monitor by audit)
	+ 1. Frozen sections
* Slides are to be issued within 10 minutes of receipt of specimen.
	+ 1. General Office
* All urgent biopsy reports to be typed and issued on the day of receipt.
* All micro reports from today are available for authorisation at the end of next working day.
	+ 1. Cytology - specimen reception
* NG data entry to be completed before next slide issue
* Gynae to have number allocated in time for next for next LBC run and by end of day
* Unacceptable samples to be returned on the same day
* All consumable orders to be issued on day of receipt.
	+ 1. Cytology - preparation and staining
* All non gynae specimens prepared previous day to be issued by 10.00am
* LBC and special stains to be issued by 12.00 noon
* Diff Quik specimens received in the morning to be issued by 13.30
* LBC and special stains prepared before 14.00 to be issued by 15.30
	+ 1. Mortuaries
* Autopsy histology forwarded to laboratory same day as taken at PM.
* All planned autopsies completed.
	1. Cellular Pathology reporting: Agreed Turnaround times
		1. Gastrointestinal (GI) team
* All CWT biopsies to be reported within 4 days. Provision can be made to report clinically urgent specimens within 24hours but only if the clinician contacts the pathologist directly.
* Biopsies from clinically benign cases will be reported within 20 days from receipt.
* 100% of the cancer resections will be reported within 20 days.
* Specimens from the Bowel Cancer screening service – 100% reported within 7 days (acceptable = 90%, achievable 95% - as per PHE screening standards.
	+ 1. Dermatology

95% of cases will be reported within the defined targets below:

* Defined 'Urgent' specimens - pigmented lesion clinic : < 5 days from receipt of specimen.
* Non – urgent dermatologist/opthalmologist biopsies - punches, shaves and ellipses: 7 – 14 days following receipt of specimen.
* Surgical specimens from either Dermatology Surgeon or Plastic Surgeon - excisions and re-excisions: <5 days from receipt of specimen for inclusion in MDM.
* GP skins: 5 days following receipt of specimen.
* Sentinel Lymph node biopsies (melanoma) will be reported within 10 days
	+ 1. Cardiothoracic
* Transplant biopsies - 24 hour turnaround for the verbal report;
* Other small biopsies take 3-10 days depending on degree of difficulty and additional staining.
* Cancer related surgical specimens reported in 10-15 days.
	+ 1. Breast specimens
* Breast core biopsies: 3 days from receipt.
* Breast surgical specimens (cancer related): 5 – 10 days to discuss at earliest MDM.
* Specimens originating from plastic surgery department: 10 days.
	+ 1. Urological specimens
* CWT prostate cores: <6 days from receipt
* Urology referrals: 80% of non-testis MDT samples to be authorised before 12:00 noon on day of MDT meeting (currently Thursday).
* Second opinions and testis to be reported within two weeks of receipt.
	+ 1. Neuropathology
* Surgical biopsy reports 7 days\*

\*This target to exclude cases referred for opinion and non-diagnostic cases (eg carotid endarterectomy specimens)

* Coroners’ autopsy cases histology reports 3 months
* Referred autopsy cases histology reports 3 months
* Hospital autopsy cases histology reports 3 months
* Study cases autopsy histology reports 6 months
	+ 1. Endocrinology
* Thyroid lobectomy following an AC3/4 cytology result -reported < 5 days
* Certain other cases may be clinically urgent but can be identified *on an individual basis* (eg core/open biopsies of thyroid, occasional adrenal cases)
	+ 1. Gynaecological cases
* Cervical loop & punch biopsies: <10 days from receipt. <7 days for CWT.
	+ 1. Renal biopsies
* Transplant biopsies<24 hours
	+ 1. Osteoarticular specimens
* Soft tissue biopsies for suspected malignancy 7 days
* Soft tissue resections 14 days.
	+ 1. Muscle and nerve biopsies
* Muscle biopsies 21 days
* Nerve biopsies 5 days
	+ 1. Lymphoma cases
* 14 days from receipt
	+ 1. Head and Neck specimens
* When malignancy is suspected - 7 days
* Resection specimens without bone 14 days
	+ 1. Cytopathology specimens

Cervical screening programme samples:

* Date of sample taken to receipt in laboratory – 100% of cases received in 3 days
* Cases reported within 7 days from receipt of sample – 70%
* Cases authorised within 10 days from receipt of sample – 100%

Non-gynae cytology specimens

|  |  |
| --- | --- |
| Fine Needle AspiratesCerebrospinal FluidsUrines, Bladder washing and renal washingsBronchial Alveolar Lavages (BAL) and BrushingsOther brushings (biliary, bile duct, gastric and pancreatic).Cyst fluids | Within 7 days from receipt.Those cases where there is a specified clinical urgency (for MDM discussion, clinic appointments) will be prioritised as required. |
| Joint fluids | 3 days |
| Cytology specimens requiring lung cancer mutation testing | Final report must be available within 10 working days from receipt at the test lab |

* + 1. Coroner cases
* Post-mortem reports must be issued within 21 days of autopsy
	+ 1. Perinatal Post-mortem reports
* 8 weeks (from date of PM to available report)
	+ 1. Referred cases
* TAT of 90% in 14 days from receipt for referred in cases provided the referral is to a team (as opposed to an individual)
	1. Measurement of turnaround times
		1. Turnaround time of total workloads and selected specimen types is routinely measured and reported monthly including:

## Histology

* Non Gynae.Cytology
* Gynae. Cytology
* Neuropathology
* Muscle and Nerve
* CWT Histology
* CWT Cytology
* Breast cores
* GP skins
* Frozen section turnaround times
	+ 1. Monthly graphs are produced showing the 7 and 10 day TAT for each individual team and a collated Histology graph. This includes non-gynae cytology samples.
		2. For the cervical screening samples the following data is captured monthly and submitted to NEYHQARC (Public Health England):
* Backlog
* Number (and %) of cases received within 3 days of sample being taken.
* Number (and %) of cases reported within 7 days of receipt
* Number (and %) of cases reported within 10 days of receipt
* Number (and %) of cases reported within 21 days of receipt
	1. Pathology Quality Assurance dashboard
		1. The dashboard is completed monthly and discussed in the Integrated Laboratory Medicine Executive monthly meeting. The data is presented to the Trust executive board quarterly.

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| --- | --- |
|  Indicator | Benchmark |
| Timeliness |
| The proportion of clinically relevant tests agreed between the requestor and provider as “urgent” reported within locally agreed turn-around times (from receipt of sample to arrival of result at requestor | >95% |
| The proportion of diagnostic histopathology cases requested for the investigation of cancer that are reported within 10 calendar days of the procedure taking place | >90% |
| The proportion of diagnostic gynae-cytology cases requested for the investigation of cancer that are reported within 7 calendar days of the procedure taking place | >90% |
| The number of result/reports not available within 42 calendar days of request | 0 |
| People |
| The proportion of pathology staff whose annual appraisal has been completed on time. | >90% |
| The proportion of consultant medical and scientific direct clinical care programmed activity not undertaken by the Trust. | <10% |
| The proportion of staff who interpret results whose annual appraisal included a discussion about their performance in an interpretative EQA scheme where one was available. | 100% |
| Users |
| The proportion of patients that respond to a survey expressing satisfaction with the service provided using a single item measure. | >90% |
| The proportion of requesting clinicians that respond to a survey expressing satisfaction with the service provided using a single item measure. | >90% |
| Analytical performance |
| The number of incidences (not the number of results issued) of incorrect reports being issued that had a potentially significant, or actual, negative impact on patient safety. | 0 |
| The number of referrals to the National Quality Assessment Advisory panels for persistent poor performance since the last review. | 0 |
| System |
| The number of tests referred to third party Pathology providers that are not accredited to the ISO15189:2012 standard, or equivalent, excluding locally agreed and documented exceptions. | 0 |
| The number of tests, methods and analytes offered in the repertoire, that are not subject to External Quality Assurance (EQA) schemes or suitable Interlaboratory comparisons. | 0 |
| The number of NICE guidelines that have been commissioned and funded locally that require action by pathology that has not been completed. | 0 |
| The number of applicable field safety notices not yet implemented where the notice was received more than 21 days ago. | 0 |

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| Data to be submitted quarterly | Data to be submitted bi-annually | Data to be submitted monthly |

1. Criteria relating to Procedure
	* 1. Not applicable
2. References
	* 1. Royal College of Pathologists - Key Performance Indicators: proposals for implementation July 2013
		2. NHS England - Pathology Quality Assurance dashboard
	1. UKAS ISO 15189
		1. ISO15189:2012 Clause 4.14.7
	2. Departmental and Trust policies

* + 1. Not applicable
	1. Forms
		1. Pathology Quality Assurance dashboard - held on the directorate shared drive
	2. Related Documents
		1. Not applicable