The Royal College of Pathologists
Pathology: the science behind the cure

RCPath KAIs and discussion points

This document accompanies an article published in the *Bulletin* in January 2019 entitled Updating the College's KPIs to create key assurance indicators (KAIs).

A few points justify highlighting

In reviewing the original KPI relating to staffing, we found that most of the content related to senior staff, since other aspects were (and still are) encompassed within the second group that includes training. We have therefore been more explicit in the revision that the first section relates to senior staff and considered how this needs to apply to locum and associate specialists and to staff who, while still in training, are responsible for providing clinical advice to service users. We have added emphasis on handover between staff to maintain stewardship of samples and the clinical decision-making those samples permit.

We have also considered what qualifications provide 'equivalence' with FRCPath as advanced practitioner and other blended roles for biomedical and clinical scientists expand. We have not sought, in this revision, to specify what an appropriate workload for any individual practitioner might be, although we consider this to be an extremely important topic. Any such measures would differ greatly between specialties and in different organisations. We strongly recommend that appropriate workload is discussed, agreed and reviewed regularly in your service.

The training and education section contains a specific KAI through which laboratories should demonstrate they innovate using continuous quality improvement and/or more formal research approaches. This is in line with the NHS Constitution that requires us to be 'at the forefront of medical knowledge' and is intended also to promote the wider application of continuous quality improvement in daily laboratory practice.

The section covering test repertoire has been updated to recognise the increasing use of point-of-care testing (POCT) and the diverse governance arrangements in place to ensure POCT is safe and of high quality. The emphasis is now on assuring governance for tests rather than maintaining awareness of the repertoire. While not all POCT is directly governed by laboratories, we believe that pathology staff are ideally placed to support Trust boards and general practices in establishing good governance for POCT.

Unsurprisingly, at all stages of consultation about these revisions, seeking patients' opinions about pathology services has been one of the most controversial topics. We remain firmly committed to requiring laboratories to seek ways to gain information from patients, as well as clinical service users, to sustain and improve services. We appreciate the burden that running regular surveys can create and we have therefore suggested conducting surveys at less frequent intervals than envisaged in the original KPI publications.

Access to a standard survey for clinical users can be requested by contacting usersurvey@rcpath.org and the College is considering how it might improve this in future. Currently, we do not have, or have any plans to develop, a standard survey for patient opinions. We recognise the genuine difficulty in accessing meaningful opinions from patients who have only minimal, if any, direct contact with the laboratory. Hence our suggestion that laboratories should

discuss with colleagues, maybe in the context of multidisciplinary teams (MDTs), groups of patients to survey who may have more awareness of pathology in their particular care pathways. A local survey could then be created by the MDTs, tailored to the experience of those patients and capturing valuable pathology information in the context of a wider pathway of care. The latter is a principle we also wish to promote. We also anticipate that, within a fairly short timeframe, increasing direct communication between pathology staff and patients will make the current challenges of surveying patients' opinions considerably more straightforward.

In undertaking our revision, we have consciously stepped back from stating explicit turnaround times for specimens, which risk being measures of what is conveniently measurable rather than measuring what matters. We have crafted the new KAIs for specimen turnaround to espouse the fundamental principle that, to have best value, a test result should be available at the point in time when a clinical decision needs to be made. We believe that professional staff in laboratories, in conjunction with their clinical users, are best placed to agree what turnaround times are needed to meet this requirement.

We also expect that, for any individual specimen where a professional's knowledge tells them that the result should be communicated more rapidly than anticipated by the local protocol, they will ensure this is done; capturing information about such value-adding professional activity is a vital source of information about the quality of pathology as a clinical service and we encourage all pathology staff to find ways to do this. As an additional note on this point, we do not anticipate that the suite of specialty-specific KAIs that the Specialty Advisory Committees are currently developing will recreate a new set of defined turnaround time targets.

Some of the original KPIs relating to technical quality, including external quality assurance (EQA), have been omitted from the updated document. This is not because we do not consider these aspects of laboratory practice to be unimportant. The exact opposite is true; high quality and reliable test results are absolutely crucial for laboratory services. However, the governance of technical quality is the bread and butter of accreditation against ISO15189:2012 and it is not the intention of RCPath to duplicate such standards.

The Specialty Advisory Committees will be asked to consider EQA among the specialty-specific indicators they will be developing. Furthermore, we recognise there is an ongoing debate around the validity of interpretive EQA as a measure of diagnostic competency and/or quality. A KAI may be added to address expectations of participation in interpretive EQA at a future date, when there is greater professional consensus about this topic.

In conclusion, the Clinical Effectiveness team has attempted to take note of a vast array of sometimes contradictory opinion from a wide range of stakeholders, including membership-wide consultation, in framing the newly published portfolio of generic KAIs. We are continuing to work on a small number of additional specialty-specific indicators for consultation and publication next year. Through those, it may be possible to provide guidance on appropriate workload in different specialties and to develop further the concept of KAIs that demonstrate the value of pathology in wider patient pathways.

We anticipate that the portfolio of KAIs and KPIs will continue to evolve over time, with regular updating to take account of changes in the requirements of service users, pathology staff and the environment (physical and cultural) within which laboratory medicine services are delivered.

The following pages contain a table detailing the College's new KAIs.

Table 1: The College's new KAIs

Senior staff	
KAI 1: Provision of senior staff	All medically qualified consultants and consultant-level scientists providing clinical advice, diagnostic and/or interpretative services shall have FRCPath (or have relevant equivalent qualifications) and be registered with the General Medical Council (GMC), General Dental Council (GDC) or Health and Care Professions Council (HCPC), as appropriate.
KAI 2: Senior staff cover	There shall be documented and named cover of the service by staff delivering clinical advice and laboratory oversight, including cover for planned leave. The laboratory should agree with users the requirement (or not) for clinical cover outside the normal working day and the level of cover required. Clinical advice, where acute medical advice is required, shall be available 24 hours a day, 7 days a week, 365 days a year. Where first contact for clinical advice is provided through staff still in training, clear accountability and supervisory arrangements by senior staff must be in place.
KAI 3: Senior staff handover	There shall be an evidenced policy for handover between senior staff (overseeing the laboratory or giving clinical advice) undertaking standard daytime and out-of-hours working.
KAI 4: Senior staff appraisal	All senior staff providing laboratory oversight and clinical advice at consultant or consultant-equivalent level (i.e. independent practice, clinical and scientific staff) shall have completed an annual appraisal or shall have documented approval from their Responsible Officer or clinical line manager to defer. The annual appraisal will include discussion of ongoing competency.
KAI 5: Senior staff professional development	All senior medical and scientific staff providing laboratory oversight and clinical advice at consultant or consultant-equivalent level shall be compliant with regulatory requirements for continuing professional development (CPD).
Training, education and innovation	
KAI 6: Staff numbers for the training of future laboratory staff	The proportion of staff in training shall be sufficient to sustain and develop the service, but not so high that the quality of training provided or service delivered is compromised.
KAI 7: Quality of training for laboratory staff	The quality of training provided for trainees in each professional group shall meet the requirements of the relevant professional regulatory bodies (GMC, HCPC, GDC) and include relevant inter-professional learning opportunities.
KAI 8: Commitment to innovation and continuous quality improvement (CQI)	Laboratories shall demonstrate commitment to sustained innovation of their services through CQI, which may include the conduct of formal academic research and the evaluation of novel approaches aimed at improving the health of patients and wellbeing of the wider population.

Repertoire of tests and reporting of errors	
KAI 9: Point-of-care testing (POCT)	Local community and hospital POCT equipment and repertoire, for which the laboratory has oversight, shall be documented, with itemisation and description, and published.
KAI 10: Demand optimisation	The laboratory shall actively engage in demand optimisation, designed both to reduce the number of unnecessary tests and to help ensure that appropriate tests are used.
KAI 11: Incident and error reporting	Laboratories shall ensure that errors, from specimen collection through laboratory processes to receipt of report including errors of interpretation and clinical advice, are logged and reviewed systematically, with evidence of effective learning. They shall demonstrate evidence of measures introduced to reduce the likelihood of similar future errors, and that these measures are evaluated for effectiveness.
Engagement with patients and users	
KAI 12: Communication of results to patients	The laboratory shall state whether it offers results directly to patients or, for young children and others deemed to lack capacity, to parents or appropriate carers. Those laboratories offering results directly to patients shall publish a description of their policy on this; the policy shall explain how results are safely and appropriately communicated to patients.
KAI 13: Patient experience	The laboratory shall conduct a survey on at least a two-yearly basis, to assess the opinions of a sample of patients on the quality of the pathology service as they experience it. There shall be evidence that the responses to the survey are analysed, distributed and used to improve the quality of the service.
KAI 14: Clinical user satisfaction survey	All current clinical users of the laboratory service shall be invited to participate in a user satisfaction survey, of a type that generates quantitative and qualitative results, on a two-yearly basis. There shall be evidence that the survey responses are analysed, distributed and used appropriately to inform processes to optimise service delivery.
Interpretative clinical advice and engagement with multidisciplinary teams	
KAI 15: Availability of clinical advice at multidisciplinary team (MDT) meetings	The clinical review and decision-making processes of the MDT shall be supported, where appropriate, by advice and interpretation of diagnostic reports provided by pathologists and other appropriately qualified life science professionals who attend the meetings.
Timeliness of reports and clinical advice	
KAI 16: Critical and unexpected results communications	The laboratory shall have a regularly audited process to define what results shall be called 'critical' and ensure that these are communicated urgently to a responsible clinician.
KAI 17: Response to requests for clinical advice	All enquiries to the laboratory shall be answered in a professional and timely manner, with referral to a member of the laboratory scientific or clinical team when appropriate.
KAI 18: Turnaround times linked to patient pathways	Local patient pathways, agreed with requesters, shall include anticipated turnaround times for all relevant laboratory investigations.

This document was compiled by Dr Bridget S Wilkins, Consultant Haematopathologist, on behalf of the College's Clinical Effectiveness team.