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

KEY PERFORMANCE INDICATORS IN PATHOLOGY

Recommendations from the Royal College of Pathologists

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Note: Some hyperlinks in the original document no longer exist and have been deleted

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The Royal College of Pathologists (RCPath) has acknowledged the urgent need to reform pathology services in the UK to achieve more efficient use of resource and has outlined the requirements for this to be accomplished without reduction in the quality of pathology services. Given that direct measurement of the effect of the quality of a medical laboratory service on patient outcomes is rarely possible, surrogate measures or key performance indicators (KPIs) are required.

What is required of Key Performance Indicators?
A key performance indicator is a measurement of pathology service performance in selected areas and should be defensible, credible, supported by body of evidence in the literature, feasible and acceptable to all stakeholders. The requirement that the indicators are 'key' by definition means that key performance indicators will be small in number and will not be a comprehensive evaluation of all aspects of a clinical pathology service. Key performance indicators therefore should not replace the search for agreed and appropriate in depth quality standards linked to patient pathways.

Key performance indicators have been developed under the following five headings:

1. The quality of the end-to-end pathology service is intimately associated with the availability and documentation of accompanying clinical advice
2. The quality of the end-to-end pathology service is intimately associated with the quality of accompanying clinical advice
3. Timeliness in pathology ensures an appropriate level of patient care
4. Assessing user satisfaction in a standardised way ensures the quality of pathology services are assessed appropriately and can be benchmarked
5. Teaching and training ensure the future quality and resilience of clinical pathology services.

Clinical Pathology Accreditation (CPA)
The RCPath actively encourages its members to engage positively with CPA, which is now owned by the United Kingdom Accreditation Service (UKAS). However the limitations and restrictions of CPA, as currently based on the international standard (ISO 15189), have been widely discussed. Specifically, CPA accreditation concentrates on evaluating processes within the laboratory, but does not adequately cover the crucial interfaces between patients, clinicians and the laboratory. As Lord Carter's reports pointed out, quality evaluation must cover 'the end-to-end process'.

Within the UKAS there is an acknowledged need for the profession to define standards and how they should be measured so that the remit of CPA in accrediting pathology services can be widened to include the measurement of performance against these standards. This document makes suggestions to assist this process.

The Patients in Pathology
The profession has a responsibility not only to consider the needs of patients but also to seek their views actively. In terms of patient safety the importance of considering the 'end to end' process cannot be overestimated, this includes the need for 'failsafe' systems as failure to receive or act on the result of investigations is more often the cause of serious patient damage than an incorrect pathology result. This section gives a selection of brief 'patient stories', to illustrate the importance of pathology as 'the hidden science that saves lives'.

1. Quality and Performance in Pathology

The RCPath has acknowledged the urgent need to reform pathology services in the UK to achieve more efficient use of resource and has published a statement on the Reconfiguration of Pathology services outlining the requirements for this to be accomplished without reduction in the quality of pathology services. Given that direct measurement of the effect of the quality of a medical laboratory service on patient outcomes is rarely possible, surrogate measures, or key performance indicators, are required.

These key performance indicators build on work the RCPath has been undertaking in recent years. Specifically reference is made to 'Reconfiguration of NHS pathology services: a statement from the RCPath written in the context of an urgent need to reform pathology services in the UK to achieve more efficient use of resources. This executive statement, which was issued on 5 July 2010, and is available at http://www.rcpath.org/publications-media/college-responses/archived-responses

This was further developed with the help of the NHS Confederation, Academy of Medical Royal Colleges and British Medical Association in a project entitled 'Clinical Responses to the Downturn.' The full report on this collaborative work is available at http://www.nhsconfed.org/Publications/Documents/Clinical_responses_to_downturn_full_Dec2010.pdf

A meeting held at the RCPath in October 2009 entitled 'What is quality in pathology?' provided an opportunity to consider the challenges of defining and assessing quality in pathology. The published report of this meeting is available at http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/R/rcpathqualityevaluation3.pdf

2. What is required of Key Performance Indicators?

A key performance indicator should be defensible, credible, supported by body of evidence in the literature, feasible and acceptable to all stakeholders. The requirement that the indicators are 'key' by definition means that key performance indicators will be small in number and will not be a comprehensive evaluation of all aspects of a clinical pathology service. Key performance indicators therefore should not replace the search for agreed and appropriate in-depth quality standards that are linked to patient pathways.

The key performance indicators reflect existing guidance, standards, codes of conduct, tissue pathways and cancer datasets, issued by the RCPath independently or in conjunction with other professional bodies and specialist associations. As such, the key performance indicators represent a few areas which lend themselves to external scrutiny and regular active measurement selected from the abundant literature of specialist clinical activity in identifying best practice. They have been derived from consultations with members of the profession in the main pathology disciplines of Chemical Pathology, Immunology, Haematology, Medical Microbiology and Virology and Histopathology.

The key performance indicators have been designed with the quality of care for patients in mind. Not all measures will be easily achievable in all laboratories as currently configured. It is anticipated that co-ordinated local, and regional, effort and perseverance will be required to meet some of these key performance indicators and that communication between professionals and patient care will improve as a result. Other key performance indicators make explicit the professionalism of pathology delivery which has to date been implicit and almost universally in place.

The principles underpinning the key performance indicators are that clinical advice and interpretation are important and need to be provided by appropriately qualified pathology staff, to a high quality, at all times - including out of hours and during holiday periods.

It is crucial that pathology professionals provide advice on the appropriateness of tests and are empowered to provide testing protocols, maximum test ordering systems and, in an evidence-based way, to refuse to undertake inappropriate requests.

Timeliness and documentation of clinical interpretation and advice should be appropriate to the clinical context. It is likely that these indicators will require modification in the light of events in healthcare management, new technologies and different ways of working.

Many of the pathologists who gave their time and expertise to this project have a track record of delivery of service specifications, pathology dashboards, performance indicators and clinical input to major regional reconfiguration projects. Links to these regional projects are available on request.

3. Key Performance Indicators

While a clinical service is the sum of its parts, these key performance indicators have been designed to help in the assessment of the overall quality of the pathology service and not to assess the professional performance of an individual pathologist.

A. The quality of the end-to-end pathology service is intimately associated with the availability and documentation of accompanying clinical advice

i) KPI: Clinical Advice Availability

Baseline: Biochemistry, Haematology and Medical Microbiology and Virology clinical advice to be available 24 hours a day 7 days a week 365 days a year.

Further Details: Medical staff job plans to detail clearly availability for clinical advice and laboratory oversight. This is time to be spent separately from other inpatient/outpatient/ academic/other activity. Supporting Professional Activity (SPA) maintain the quality of laboratory clinical advice is to be included in the Job Plan.

Challenge: Except for a few very large laboratory services this indicator may require cross-cover from other laboratory services in a Network (see Frequency section below).

Frequency: Network agreements and job planning to be in place by November 2012 with annual reporting each November thereafter.

In addition to the advantages to the individual and their employer of clarity of Job Planning, this will allow appropriate cover and handover to be considered. It will allow medical staff salaries - calculated as laboratory-attributable DCC (Direct Clinical Care) and SPA (excluding Clinical Excellence Awards) - to be included in assessment of cost and efficiency, such as number of tests per qualified WTE.

Provision of specialist services and/or out of hours cover may require co-operation between organisations or a Network approach. This should be clearly indicated in all user information and complaints and incident handling and in the number of tests per qualified WTE as costs and activity should reflect all users and all providers.

Guidance:

Guidelines on Job Planning. RCPath
http://www.rcpath.org/workforce/medical-workforce/job-descriptions/job-descriptions.htm

ii) KPI: Timeliness of responding to requests for clinical advice

Baseline: Percentage of days in which duty clinical biochemists/haematologists/ microbiologists/virologists respond to all responses to requests for clinical advice within 30 minutes (including out of hours).

Further Details: Clinical advice on appropriate laboratory investigations and on the interpretation of test results are of increasing importance, as medical undergraduate experience of laboratory medicine has steeply declined while simultaneously the range and complexity of laboratory investigations has expanded. It is therefore necessary that patients in hospital and community settings are cared for by clinical staff who have 24/7 access to timely clinical laboratory expertise. The clinical laboratory expertise must be aligned to the repertoire of tests offered by a laboratory (see below 5(i)). Response times longer than 30 minutes to be self-reported by pathology services. Reporting can be undertaken by medical staff and healthcare scientists. Data collection methods will vary by laboratory depending on the route by which clinical advice is sought. One delayed (>30 minutes) response is a failure to meet target clinical advice response times for that day.

Challenge: 90% by April 2012 increasing to 97% by April 2014.

Frequency: To report, as at the 30 May and 30 November, the percentage of days in which duty clinical biochemists/haematologists/microbiologists/virologists responded to requests for advice within 30 minutes (including out-of-hours).

Non-availability of clinical advice in biochemistry, haematology and microbiology (including virology) within 60 minutes is reasonable grounds for reporting of a clinical incident or near-miss.

Guidance:

Out-of-hours reporting of laboratory results requiring urgent clinical action to primary care: Advice to pathologists and those that work in laboratory medicine. The Royal College of Pathologists. Nov 2010**.** http://www.rcpath.org/publications-media/publications#general

Urgent and emergency care. DH.
http://www.dh.gov.uk/en/Healthcare/Urgentandemergencycare/index.htm

iii) KPI: Availability of clinical advice at multidisciplinary meetings (MDM)

Baseline: Percentage of multidisciplinary meetings supported by the input of a Consultant Histopathologist.

Further Details: MDM to discuss malignancies and suspected malignancies include meetings to discuss cervical screening cases. In addition locally agreed benign MDM may include transplant services, renal meetings, inflammatory skins and gastrointestinal inflammatory disease. The requirement for these meetings and the level of Consultant Histopathologist input should be governed by local and regional patient pathways. The Consultant Histopathologist attending the MDM should be a member of the team reporting the relevant cases and attendance may be defined by a team rota.

Challenge: 90% by April 2012 increasing to 95% by April 2014.

Frequency: To report, as at the 30 May and 30 November, the percentage of MDM attended by a Consultant Histopathologist.

Guidance:

Published cancer service guidance. NICE.
http://www.nice.org.uk/Guidance/CSG/Published
Datasets for reporting cancer. RCPath.
http://www.rcpath.org/publications-media/publications/datasets/datasets-TP.htm

iv) KPI: Coding of histopathology cases

Baseline: SNOMED or SNOMED-CT Topography, Morphology and Procedure codes to be used in all Histopathology cases.

Further details: To facilitate MDM review, electronic communication with cancer registries and audit of histopathology clinical opinions SNOMED or SNOMED-CT Topography, Morphology and Procedure codes are to be used in all Histopathology cases. While they may not be in use in every histopathology service, most LIMS systems include the capacity to record P 7 (procedure) codes. Some pathology services may need to upgrade their IT support to meet this Indicator.

Challenge: 95% SNOMED or SNOMED-CT T, M and P codes by April 2012
100% SNOMED OR SNOMED-CT T, M and P codes by April 2014

Frequency: To report, as at the 30 May and 30 November, the percentage of Histopathology cases that were coded using SNOMED or SNOMED-CT.

Guidance:

National Cancer Intelligence Network
http://www.ncin.org.uk/collecting_and_using_data/default.aspx
SNOMED CT. A standard clinical terminology is essential for the interoperability of electronic health records across care settings.
http://www.connectingforhealth.nhs.uk/systemsandservices/data/uktc/snomed

v) KPI: Documentation of histopathology second opinions

Baseline: Documentation in original histology report of MDM or other histopathological review and discussion and of any alterations to the report arising from this quality assurance process

Further Details: Histopathology reports may be amended, refined, or remain unchanged, as a result of pre-MDM or other histopathological review. In addition the MDM discussion may provide additional clinical or radiological information which may influence the report. The principle underpinning this indicator is the need for a feedback loop from internal or external histopathological review (second opinions) and for all amended or refined reports to be documented in the patient records on all sites (e.g. cancer unit and cancer centre). This is to provide assurance about the quality of initial reporting, pathology review reporting,

professional communication and documentation of the reasons underlying patient management decisions. As a minimum, where the report and slides have been reviewed, the original reporting pathologist must receive promptly a copy of the reviewing pathologist's opinion/report and return of the slides. The original reporting pathologist should indicate agreement with any report alteration by the reviewing pathologist by adding a Supplementary Report to that end to the original report. This becomes an agreed consensus Supplementary Report. In the event of a persisting difference of opinion a third opinion should be sought to ensure clarity and patient safety. In the majority of cases there will be no change to the original report following pre-MDM or other histopathological review and discussion. The addition of a synoptic Supplementary Report or the addition of a computer code should be used to document this quality assurance process and its outcome.
Challenge: 90% by April 2012 increasing to 95% by April 2014.
Frequency: Cases discussed at MDM (identified by the pathology service or cancer co-ordinators) will form the denominator for this KPI. To report, as at the 30 May and 30 November, the percentage of histopathology cases discussed at MDM which have documentation of the MDM taking place and consensus on any refined or altered diagnosis on review.

Guidance:
Independent Inquiry into Histopathology Services
http://www.uhbristol.nhs.uk/files/nhs-ubht/Histopathology%20report%20December%202010.pdf

B. The quality of the end-to-end pathology service is intimately associated with the quality of accompanying clinical advice

i) KPI: Consultant appraisal

Baseline: Percentage of Consultants providing laboratory oversight and clinical advice who have completed appraisal (all disciplines)
Further Details: It is the professional responsibility of each consultant providing UK pathology services to maintain their appraisal portfolio and complete an appraisal covering their clinical practice annually. This will be a requirement for revalidation of medical staff.
Challenge: 100% by April 2012.
Frequency: To report, as at the 30 May, the percentage of consultant pathologists who have a completed appraisal for the preceding calendar year or have documented approval from their Responsible Officer or clinical line manager to defer.

Guidance:
NHS Revalidation Support Team (RST)
http://www.revalidationsupport.nhs.uk/
http://www.gmc-uk.org/doctors/revalidation.asp
http://www.rcpath.org/revalidation

ii) KPI: Clinical Scientific staff appraisal

Baseline: Percentage of staff who perform clinical work with completed clinical appraisal.
Further details: It is the professional responsibility of each healthcare scientist providing clinical interpretation and advice as part of a UK pathology service to maintain their appraisal portfolio and complete an appraisal covering their clinical practice annually. Clinical Scientists, Clinical Cytologists, cut up practitioners and others will take responsibility within a laboratory setting for outputs on which patient care will directly depend. It is considered that these staff should undergo an appraisal which is performed by a clinician who understands this work and can provide an appropriate clinically supportive and challenging appraisal. This may be the service clinical lead or if the scientist is single-handed a triangular appraisal arrangement with peers within a network may be appropriate.
Challenge: 100% by April 2012.
Frequency: To report, as at the 30 May, the percentage of clinical pathology staff in all disciplines who have a completed clinical appraisal for the preceding calendar year or have documented approval to defer from the service clinical lead or clinical line manager.

Guidance:
Consultant Clinical Scientists generic job description. RCPath.
http://www.rcpath.org/workforce/medical-workforce/job-descriptions/job-descriptions.htm

iii) KPI: Continuing Professional Development (CPD)

Baseline: Percentage of consultants registered with RCPath or Royal College of Physicians (RCP), or equivalent, for CPD.
Further Details: It is the professional responsibility of each medical Consultant providing UK pathology services to maintain and update their clinical skills in areas they routinely and occasionally practice. Pathologists who are not Fellows of the RCPath (e.g. trained overseas) are welcome and encouraged to register with the RCPath through its Affiliate membership.
Challenge: 100% by April 2012.
Frequency: To report, as at the 30 May, the percentage of consultant pathologists registered for CPD with the RCPath or RCP.

Guidance:
The guide to the CPD scheme. RCPath.
http://www.rcpath.org/cpd
http://www.rcplondon.ac.uk/cpd
Continuing professional development: guidance for all doctors. GMC.
http://www.gmc-uk.org/education/continuing_professional_development.asp

iv) KPI Histopathology reporting of cancer resections

Baseline: Percentage of cancer resections that were reported using template or proforma including College cancer dataset information.
Further details: SNOMED or SNOMED-CT Topography, Morphology and Procedure codes to be used to identify cancer resections (see KPI A iv above). To facilitate harmonised reporting practices, user interpretation, MDM review, electronic communication with cancer registries and audit, all Cancer resections should be reported using an electronic dataset system or a locally agreed template or proforma including College cancer datasets. Some pathology services may need to upgrade their IT support to meet this indicator.
Challenge: 80% by April 2012 increasing to 90% by April 2014.
Frequency: To report, as at the 30 May and 30 November, the percentage of cancer resection cases that were reported using template or proforma including College cancer dataset information.

Guidance:
National Cancer Intelligence Network
http://www.ncin.org.uk/collecting_and_using_data/data_collection/default.aspx
Published cancer service guidance. NICE.
http://www.nice.org.uk/Guidance/CSG/Published

C. Timeliness in pathology ensures an appropriate level of patient care

i) KPI: A&E blood sciences turn-around-times

Baseline: Percentage of core investigations, i.e. renal function, liver function tests and full blood counts from A&E completed within 1 hour of receipt, including out of hours.
Challenge: 85% by April 2012 increasing to 90% by April 2014. The standard will move to 1 hour from sample collection by April 2015.
Frequency: To report, as at the 30 May and 30 November, the percentage of renal function, liver function tests and full blood counts requested by A&E completed and available to the requestor within 1 hour of receipt including out-of-hours. Exception reports to be completed and reported for all A&E blood sciences requests which are not reported within 1 hour of receipt.

Guidance:
Urgent and emergency care. www.gov.uk/dh (document is currently under review)

ii) KPI: Critical results communication

Baseline: Percentage of biochemistry, haematology, medical microbiology and virology critical requests phoned/actively communicated by laboratory within 2 hours of result being available to the laboratory (includes out of hours)
Further detail: The active communication of critical results is part of the overall responsibility for patient care of a clinical pathology service. Requestors have a responsibility to ensure contact details are clear. Local agreements must be in place to cover patient pathways defining critical results and providing clear lines of communication and failsafe systems.
Challenge: 90% by April 2012 increasing to 97% by April 2014.
Frequency: To report, as at the 30 May and 30 November, the percentage of critical results phoned/actively communicated by the laboratory within 2 hours of the result being available to the laboratory (includes out-of-hours).

Guidance:
Out-of-hours reporting of laboratory results requiring urgent clinical action to primary care: Advice to pathologists and those that work in laboratory medicine, The Royal College of Pathologists, 2010.
http://www.rcpath.org/publications-media/publications/publications.htm#general
or the RCGP website http://www.rcgp.org.uk/

iii) KPI: Histopathology diagnostic biopsy turnaround times

Baseline: Percentage of diagnostic biopsies reported, confirmed and authorised within 7 days of biopsy
Further Details: SNOMED or SNOMED-CT Procedure codes to be used to identify diagnostic biopsy cases (see KPI 2.1, iv). Percentage of all biopsy cases (excluding those requiring decalcification) reported, confirmed, electronically authorised and electronically available to the requestor within 7 calendar days of biopsy being taken. Diagnostic biopsies are not designed to treat the condition but to diagnose it. Excision biopsies are excluded from this indicator. Examples of diagnostic biopsies are needle core biopsies, endometrial biopsies/curettings, endoscopic biopsies, colposcopic biopsies and punch biopsies. In most histopathology departments, these are transferred from formalin fixation container to cassette by biomedical scientists and do not require dissection or prolonged fixation prior to processing. This indicator is not restricted to cancer pathway cases.
Challenge: 80% by April 2012 increasing to 90% by April 2014.

Frequency: To report, as at the 30 May and 30 November, the percentage of histopathology diagnostic biopsy cases reported, confirmed, authorised and electronically available to the requestor within 7 calendar days of biopsy being taken.

Guidance:
Audit of turnaround times for histopathology specimens before and after the institution of a pathology voice-recognition system. RCPath.
http://www.rcpath.org/clinical-effectiveness/clinical-audit/examples-of-high-quality-audit/histopathology/histopathology.htm
Learning how to achieve a seven day turnaround time in histopathology. NHS Improvement.
http://system.improvement.nhs.uk/ImprovementSystem/ViewDocument.aspx?path=Cardiac%2fNational%2fDiagnostics%20Web%20Uploads%2fHistology%20Guide%202.pdf

iv) KPI: Overall Histopathology reporting turnaround times

Baseline: Percentage of all histopathology and diagnostic cytology final reports available within 10 calendar days of procedure.
Further Details: Percentage of all histopathology (excluding those requiring decalcification) and diagnostic cytology cases reported, confirmed, electronically authorised and electronically available to the requestor within 10 calendar days of resection or procedure. This indicator includes all cases which do not require decalcification and are not covered by C iii) above. This will include major cancer resections, integrated reporting of haematological malignancies, benign therapeutic resections and the final reports on diagnostic biopsies which required reflex tests (such as further levels, special stains and immunohistochemistry) and will enable confident planning of post-operative multidisciplinary discussions. Reflex molecular tests are excluded from this indicator but should have documented and agreed pathways with specified and monitored turnaround times.
Challenge: 80% by April 2012 increasing to 90% by April 2014.
Frequency: To report, as at the 30 May and 30 November, the percentage of histopathology and diagnostic cytology cases reported, confirmed, authorised and electronically available to the requestor within 10 calendar days of procedure.

Guidance:
Audit of turnaround times for histopathology specimens before and after the institution of a pathology voice-recognition system. RCPath.
http://www.rcpath.org/clinical-effectiveness/clinical-audit/examples-of-high-quality-audit/histopathology/histopathology.htm
Learning how to achieve a seven day turnaround time in histopathology. NHS Improvement.
http://system.improvement.nhs.uk/ImprovementSystem/ViewDocument.aspx?path=Cardiac%2fNational%2fDiagnostics%20Web%20Uploads%2fHistology%20Guide%202.pdf

v) KPI: Cross-matching of deceased donor transplantation

Baseline: All deceased donor solid organ transplant HLA antibody testing samples to be reported, confirmed, authorised and actively communicated within 12 hours
Further Details: Prolonged ischaemic times reduce the viability and likelihood of successful deceased donor transplantation
Challenge: 99% within 12 hours by April 2012 and 99% within 8 hours by April 2014.
Frequency: To report, as at the 30 May and 30 November, the percentage of deceased donor solid organ transplant HLA antibody test results communicated within 12 hours and 8 hours of the sample being taken. Exception reports to be completed and reported for all deceased donor transplantation cross-matching requests which are not reported within 12 hours of the sample being taken.

Guidance:
User Guide for Histocompatibility and Immunogenetics Services. NHS Blood and Transplant.
http://hospital.blood.co.uk/library/pdf/inf136_1_4.pdf

vi) KPI: Routine antenatal screening tests for Hepatitis B, HIV, Syphilis, and Rubella susceptibility

Baseline: Percentage of routine antenatal screening tests for Hepatitis B, HIV, Syphilis, and Rubella susceptibility reported, confirmed, authorised and electronically available to requestor within 6 calendar days from sample being taken.
Further Details: Percentage of antenatal screening tests (excluding presentation in labour or late presentation) reported, confirmed, authorised and electronically available to requestor within 6 calendar days calculated from sample being taken.
Challenge: 90% by April 2012 increasing to 97% by April 2014.
Frequency: To report, as at the 30 May and 30 November, the percentage of routine antenatal screening tests for Hepatitis B, HIV, Syphilis, and Rubella susceptibility electronically available to requestor within 6 calendar days from sample being taken.

Guidance:
Care pathways. Infectious diseases in pregnancy pathway. NHS infectious diseases in pregnancy screening programme
http://infectiousdiseases.screening.nhs.uk/carepathways#fileid10660
http://infectiousdiseases.screening.nhs.uk/standards

vii) KPI: Late presentation antenatal screening tests

Baseline: Percentage of antenatal screening tests performed on women presenting late or in labour reported, confirmed and actively communicated to requestor within 24 hours from sample being taken.
Further Details: Percentage of antenatal screening tests performed on women presenting late or in labour reported, confirmed and actively communicated to requestor within 24 hours from sample being taken.
Challenge: 97% by April 2012 increasing to 99% by April 2014.
Frequency: To report, as at the 30 May and 30 November, the percentage of late presentation antenatal screening tests actively communicated to requestor within 24 hours from sample being taken.

Guidelines:
Care pathways. Infectious diseases in pregnancy pathway. NHS infectious diseases in pregnancy screening programme
http://infectiousdiseases.screening.nhs.uk/carepathways#fileid10660
http://infectiousdiseases.screening.nhs.uk/standards

D. Assessing user satisfaction in a standardised way ensures the quality of pathology services are assessed appropriately and can be benchmarked

i) KPI: Standardised User Satisfaction Survey

Baseline: All requestors to be asked to participate in a standardised user satisfaction survey on an annual basis commencing in 2012.

Further detail: The RCPath User Satisfaction Survey is designed primarily to obtain a broad measure of the level of satisfaction of users with the laboratory services available to them. It generates numeric scores and potentially allows benchmarking against the levels of user satisfaction produced by other laboratories. More information is available at http://www.rcpath.org/rcpath-user-satisfaction-survey and the survey can be accessed via usersurvey@rcpath.org. It is anticipated that the results will be of interest to those who commission laboratory services, especially if they are contemplating a change of laboratory service provider, or if a change has recently been implemented. However, there are also optional, free-text, specialty-specific questions that will allow respondents to indicate in more detail how they think the service could be improved. The results of these questions should be of particular value to laboratory managers.

Challenge: Results of the second round of user survey to be reported in 2013 and annual reporting each year thereafter.

Frequency: Documented participation in a standardised user survey with publication of results reported annually on 30 May.

Guidance:

Seeing the person in the patient. The Point of Care review paper. The King's Fund. 2008.
http://www.healthissuescentre.org.au/documents/items/2010/05/319001-upload-00001.pdf

Feeling better? Improving patient experience in hospital. NHS Confederation
http://www.nhsconfed.org/publications/reports/pages/feeling-better-improving-patient-experience-in-hospital.aspx

Scottish Inpatient Patient Experience Survey 2010: Volume 2: Technical Report
http://www.scotland.gov.uk/Publications/2010/09/30111425/14

E. Teaching and training ensure the future quality and resilience of clinical pathology services

i) KPI: Teaching, training, supervision and succession planning

Baseline: Proportion of the aggregate of staff in training, in Biomedical Science (BMS), clinical scientist and medical staff groups, to be between 15 and 30% of the aggregate of fully-qualified BMS, clinical scientist and medical staff.
Further detail: Considering together the WTE of all scientific and clinical staff (e.g. BMS, Clinical Scientist and medical staff) in training and comparing this with the total WTE of fully-qualified staff in the same staff groups. If teaching and training has been centralised in a hub/spoke arrangement in a network the network proportion of staff in training (as above) should be submitted. It may be that a smaller pathology department does not train medical staff but has an increased training profile for healthcare scientists.
Challenge: The proportion of scientific and medical staff in training (see above) to fully-qualified must be no less than 15% and not exceed 30%.
Frequency: Proportion of scientific and medical staff in training over the previous 36 months to be calculated and reported annually on 30 May.

Guidance:
GMC. Education and Training section
http://www.gmc-uk.org/education/index.asp
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/Chiefprofessionalofficers/Chiefscientificofficer/DH_086661
Standards of education and training guidance. Health Professions Council.
http://www.hpc-uk.org/assets/documents/1000295FStandardsofeducationandtrainingguidance-fromSeptember2009.pdf
Standards of education and training guidance. Health Professional Council.
http://www.hpc-uk.org/assets/documents/1000295FStandardsofeducationandtrainingguidance-fromSeptember2009.pdf
IBMS. Qualifications
http://www.ibms.org/go/qualifications

4. Clinical Pathology Accreditation (CPA)

The RCPath actively encourages its members to engage positively with CPA. Now owned by the UKAS, the limitations and restrictions of CPA, as currently based on the international standard (ISO 15189), have been widely discussed. Within the UKAS there is an acknowledged need for the profession to define standards and how they should be measured so that the remit of CPA in accrediting pathology services can be widened to include the measurement of performance against these standards.

In the consideration of key performance indicators some enhancements to the current CPA standards were agreed which would provide UKAS with improved confidence in the quality of the services provided by accredited laboratory services.

Some of the CPA standards below make explicit standards of professionalism of pathology delivery which have to date been implicit and almost universally in place. However it is reasonable for the public to expect the accreditation of a pathology service to take into account these standards.

Testing at a distance (e.g. send-aways and hub and spoke configuration) is frequent in current pathology provision. However, loss of service quality is not an unavoidable consequence of testing at a distance and deterioration in patient care should not be regarded as acceptable. CPA standards, particularly those involving locally agreed patient pathways, pertain to the laboratories receiving outsourced (sent away) tests in the same way as they apply to the local service. Equally, pathology services should not be maintained locally on a point of principle if this is at the expense of service quality. The CPA accreditation processes should address the issues involved in pathology service quality to inform strategic decision-making and commissioning.

5. Suggested CPA standards beyond ISO 15189

i) Test repertoire

Suggestion: A detailed pathology service test and profile repertoire to be available, updated annually and included in user information. This repertoire to make explicit the proportion and types of tests which are outsourced (sent away) to other providers and to specify and document the CPA status of these provider laboratories to allow the CPA visitors to make comments on the CPA status and/or any concerns they may have regarding these other provider laboratories. The repertoire should by regularly reviewed and up-dated in light of the appropriateness of tests, clinical testing protocols for specific conditions and maximum test ordering systems.
Timeframe: Detailed repertoire to be in place and included in user information for piloting in 2012 CPA visits.

ii) Turnaround times

Suggestion: Agreed local patient pathways to include turnaround times for all tests included in pathology service repertoire. This may involve the grouping of tests and profiles into appropriate turnaround time categories taking into account local circumstances and clinical priorities. Timeliness does not equate with speed. Some tests may require different turnaround times for different users. Turnaround times need to be defined from the time of collection to completion and confirmation of the test result so that it is available to the requestor and should specify the turnaround times of any interim reports pending reflex tests or second opinions. Pathways should be formulated with regard to appropriate and optimal patient outcomes.
Timeframe: All standard operating procedures to be in place for piloting in 2012 CPA visits.

iii) Critical results communication

Suggestion: Critical results are those requiring urgent clinical or public health action. In line with local patient pathways, appropriate thresholds for critical results and methods of active laboratory communication to requestors to be determined and documented in user information. Communication of out of hours critical results to be in keeping with RCPath and Royal College of General Practitioners (RCGP) guidance.
Timeframe: All standard operating procedures to be in place for piloting in 2012 CPA visits.

iv) Point of care testing (POCT)

Suggestion: Local community and hospital POCT repertoire to be in place according to agreed patient pathways. As these are often contentious, the POCT repertoire and pathways to make explicit the areas of pathology service quality management input which have been agreed. These pathways to be signed off by appropriate clinical and scientific managers in all involved organisations.
Timeframe: Documented and signed POCT repertoire and pathways to be in place for piloting in 2012 CPA visits.

v) Laboratory professional direction

Suggestion: The Laboratory Director to be registered with the Health Professions Council as a Clinical Scientist or be on the Specialist Register of the General Medical Council. In exceptional circumstances the Laboratory Director of a spoke service may be registered with the Health Professions Council as a Biomedical Scientist with documented clinical support and advice from the Laboratory Director of an appropriate hub as part of a service-level agreement or contract. It is also possible that some pathology services may have long-standing laboratory direction from someone who has not achieved RCPath by examination, perhaps due to published works or who has been 'grandfathered' prior to the introduction of the College examinations in the field. However all employers should satisfy themselves that all alternatives to this situation have been explored, including closer working with other pathology services and succession planning should be in place. All new appointees to service posts and all those who have begun to provide a clinical service in the last 10 years would be expected to have RCPath by examination or equivalent for the employer to be able to satisfy him/herself that clinical governance arrangements are robust and patients are safe.
Timeframe: Documented Health Professions Council or General Medical Council Specialist Registration to be in place for piloting in 2012 CPA visits.

vi) Professional qualifications

Suggestion: All medically-qualified consultants and consultant-level Healthcare Scientists providing clinical advice, diagnostic and / or interpretive services to have FRCPath by examination in the relevant specialty, or equivalent. In most instances achievement of specialist registration by CESR / Article 14 is the route of equivalence demonstration. European legislation ensures recognition of EEA doctors' qualifications. However this legislation also stresses that the employer is responsible for patient safety by ensuring the competence of employees to perform their duties appropriately. It is usual for an employer to make use of Royal College of Pathologists advice regarding job descriptions, shortlisting and Advisory Appointments Committee interviews to ensure this. CPA standards are for clinical laboratory services and so Honorary Fellowship and FRCPath by published works are not equivalent to FRCPath by examination (see 5 above).
Timeframe: Documented FRCPath by examination or documented equivalence to be in place for piloting in 2012 CPA visits.

vii) Cover and handover

Suggestion: Documented and named cover for planned leave for clinical advice and laboratory oversight with accompanying handover protocols. There should be no reduction in the quality of clinical advice given or turnaround times when cover is provided. Any requirement for changes to patient pathways during cover or handover must be made clear in the user information.

Timeframe: Named responsibility for cover and evidence of co-ordination of leave planning to be in place for piloting in 2012 CPA visits.

viii) Primary identifier

Suggestion: The NHS number or in Scotland the Community Health Index (CHI) to be used as the primary identifier.

Timeframe: Standard operating procedures for NHS number as primary identifier to be in place for 2014 CPA visits.

ix) Prospective monitoring of outstanding histopathology cases

Suggestion: Since 80% of histopathology cases (which do not require decalcification) should be reported within 10 calendar days (see KPI C iv above) monitoring of outstanding (late) histopathology cases must be undertaken. Each histopathology service is to have a documented system to identify cases remaining unreported longer than is anticipated, and to have a documented system to manage and report these cases. Exception reporting should be undertaken of all cases (including decalcified cases) remaining unreported after 20 calendar days.

Timeframe: Documentation of monitoring and reporting to be available for piloting in 2012 CPA visits.

x) Laboratory EQA (External Quality Assessment) analytical scheme membership

Suggestion: Pathology services will participate in accredited EQA schemes covering all analytical areas of the service repertoire (see 1 above) if available. In the absence of an accredited EQA scheme covering the area, the pathology service should participate in an alternative EQA scheme covering this aspect of the service repertoire. The pathology service should make alternative arrangements for quality assurance if no EQA scheme exists. The NEQAS registration and laboratory performance records for all analytical schemes relating to tests and profiles in the repertoire to be available for CPA visits.

Timeframe: Performance records for all analytical EQA schemes related to the service repertoire to be available for piloting in 2012 CPA visits.

xi) Histopathology EQA interpretive scheme membership

Suggestion: Interpretive EQA scheme membership will be undertaken as a minimum by the lead / MDM lead in each area covered by the service repertoire.

Timeframe: Participation records for all leads / MDM leads in relevant analytical EQA schemes related to the service repertoire to be available for piloting in 2012 CPA visits.

xii) User and patient satisfaction surveys

Suggestion: Documented results and actions arising from the implementation of standardised user satisfaction survey and any patient satisfaction survey undertaken. A standardised user satisfaction survey is available, administered by the RCPath usersurvey@rcpath.org.

Timeframe: Documented completion of standardised user survey to be in place for piloting in 2012 CPA visits with results and actions arising from results in place for piloting in 2013 CPA visits.

xiii) EQA scheme professional direction

Suggestion: EQA Scheme Director to be registered with the Health Professions Council as a Clinical Scientist or Biomedical Scientist or be on the Specialist Register of the General Medical Council.

Timeframe: Documented Health Professions Council or General Medical Council Specialist Registration to be in place for piloting in 2012 CPA visits.

6. The Patients in Pathology

The profession has a responsibility not only to consider the needs of patients but also to seek their views actively. The key performance indicators described here have been considered by the RCPath Lay Advisory Committee. The profession is particularly grateful to this group of dedicated patients and lay people for their input. A template patient survey has been developed with the input of the Lay Advisory Committee which can be adapted for local use and is available from mailto:info@rcpath.org

In terms of patient safety the importance of considering the 'end to end' process cannot be overestimated, this includes the need for 'failsafe' systems as failure to receive or act on the result of investigations is more often the cause of serious patient damage than an incorrect pathology result. Prompted by a recent serious incident the National Patient Safety Agency has searched the National Reporting and Learning System identifying several incidents highlighting failures in many aspects of relating to the communication of test results to the right person at the right time. Communication of critical results including out of hours has been considered by the RCPath and RCGP. The resulting guidance is available on the RCGP website at http://www.rcgp.org.uk/ or at http://www.rcpath.org/publications-media/publications/publications.htm#general and is of crucial importance in providing safe healthcare twenty-four hours a day and seven days a week.

Case histories

http://www.kidneypatientguide.org.uk/site/whatTheySay.php

'I was so excited when I received the call - and so despondent when my kidney did not start working immediately (although I had been warned it might not) - and so jubilant when it did! I've enjoyed nearly five years of holidaying, cycling, going to the gym, eating, drinking and socializing and having a career.' - G.P.

'I found it very hard, at first, to accept the fact that I had kidney failure and to adjust from having an extremely busy job that I loved, to doing so much less. However, I soon realised that I could never "go back" and decided to look ahead. Balancing the medication, hospital visits and blood tests has become a way of life. I am nearing dialysis and feel, for me, it's the next step to a normal life. Think positive - it's the only way.' - J.S.

SARCOMAS
Patricia
'I have Leiomyosarcoma and I am writing to let you know my journey so far with this. I was diagnosed after the original tumour was found in a fibroid after I had had a routine hysterectomy in 2005. Then of course I had a MRI to see if it had spread and unfortunately it had already spread to my lymph glands in my abdominal area.'

http://downsyndromehope.com/?gclid=COPw9-yN3qcCFRRC4QodhDaX9Q
When the doctor told me that the newborn I held in my arms has Trisomy 21 or Down's Syndrome, a lifetime condition with a spectrum of retardation, I was stunned and angry that he could be so sure of his diagnosis. I was fearful of the future and was paralyzed with thoughts.'

HAEMATOLOGICAL CANCERS

Sian's Story
'My phone calls have often resulted in requests for medical information about myself, namely my Histology report. I now have in my possession, on hard and electronic copy, the following: Operation notes, CT scan reports, Histology reports from two hospitals, Digital images of my tumour, and my chemotherapy chart.

I have found the Histology report is the most important document to get hold of. I managed to get a copy of this by phoning my hospital and asking to go through to the Histology department. I then asked if they could provide me with a copy of the report. Don't worry if they are a bit taken aback by the patient phoning them, I don't think they are used to it.'

Ian, Chronic eosinophilic leukaemia
'In 2005 I was internally referred by Endocrinology to Haematology at my local hospital. In fact I got an appointment at 10.20 at the Haematology clinic by post, so I went along not knowing what to expect. I was eventually called in after the waiting room had cleared at about 12.45. The doctor started talking about stuff, and I just looked at him blankly. He stopped and said 'You don't know why you are here, do you?' I admitted this was true.
It turned out a routine blood test had shown an unusually high level of eosinophils in my blood.'

Breakthrough Campaigns & Advocacy Network

It was good to know that several doctors and nurses were considering all the information and making a thorough diagnosis.'

'It's vitally important that every woman has triple assessment because the doctors just can't make an accurate diagnosis without it.'

Louise
When Louise coughed up more blood the following week she became worried, and went to A&E that evening. Whilst there she received a chest x-ray, which she was told showed some 'abnormal findings'. Louise was immediately admitted to hospital, and put into isolation the very next day with suspected TB. She remained there for two weeks, though she did not truly believe that she could be infected. However the three sputum samples she provided came back positive.
http://www.thetruthabouttb.org/stories/louises-story

http://www.patient.co.uk/DisplayConcepts.asp?WordId=Chlamydia

-1 Posted by : xoxoxoxox Guest
Post date: Wed Sep 03, 2008 11:33 pm
Post subject: im scared

i am only 19 and just today went to the hospital 4 a clear of mind check and after a test the doctor told me I had p.i.d. i am verry scared and am ashamed to talk about it to anyone. i am on the antibiotics how eva am so afraid of goin in hospital and having surgery. most of all my biggest fear is not being able to have children. if anyone can give me some advice on how they got through there time it would be great. and if there anyone else who has had wot problems did u get along the way please share with me as i am terrified thank you

http://heartuk.org.uk/index.php?/healthy_living/true_stories_angie_childs

Angie

Angie has lost two of the most important people in her life to inherited high cholesterol (IHC) and she knows only too well that it is a silent, deadly condition which shortens lives and diminishes young families.

"My mother died tragically, and suddenly, at the age of 32 when I was just seven years old, making five kids under 10 motherless and I believe that four of my mother's eight siblings died of heart attacks under the age of 40 too. These deaths were sudden and undiagnosed. Then, two years ago, my twin brother Joey had a fatal heart attack, aged just 38."