5th Annual National Data Report

1 Jan - 31 Dec 2017

FACULTY OF PATHOLOGY

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Histopathology

National Quality Improvement Programme

HSE

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

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Dr Niall Swan	Consultant Histopathologist, St Vincent's University Hospital Dublin
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Dr Ann Treacy	Consultant Histopathologist, Mater Private Hospital Dublin
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EXECUTIVE SUMMARY

The National Quality Improvement Programme in Histopathology (The HQI Programme) was initiated in January 2009. The purpose of the programme is to improve the accuracy, consistency and quality of service with the aim of improving patient safety and enhancing patient care.

This is the fifth annual report of national anonymised aggregate data contained within the reporting tool, National Quality Assurance Intelligence System (NQAIS), from 1 January to 31 December 2017. It gives an indication of the quality of histopathology practice in Ireland and enables individual laboratories to compare their performance against the national average. Thanks to the programme, we can report on national metrics in histopathology, making Ireland the first country in the world to do so. The report includes analysis on the first three rounds of targets and recommendations released by the HQI Programme.

This report will allow informed decision making on the future steps to be taken so as to support the ongoing quality improvement process of Irish histopathology services. Where statistics suggest that there may be an area of improvement, findings should be confirmed locally using local hospital data.

The HQI Programme has now reached the 'project performance, *control*' stage in the five stage project development lifecycle and is now ready to be implemented into operational mode so that it is fully embedded into the Irish Healthcare System.

The HQI Programme Working Group would like to take this opportunity to acknowledge the Clinical leads and Local Operational Managers within each hospital for leading the work of data collection, collation and quality improvement initiatives in their hospitals. We also wish to thank our approving bodies such as the Specialty QI Programme Steering Committee and the Faculty of Pathology Board for their continuous support.

Dr Sine Phelan

Chair of the HQI Programme Working Group

COMMENTS ABOUT THE HISTOPATHOLOGY QI PROGRAMME

"Pathology, like many diagnostic services, involves decision making under conditions of uncertainty and an element of error is unavoidable. But an effective quality assurance programme that tracks error rates gives us the best chance to keep them to a minimum."

Professor Conor O'Keane
Director of Quality and Clinical Care, Royal College of Physicians of Ireland

"With its annual nationwide quality evaluation system, the Irish Histopathology National Quality Improvement Programme really embodies Peter Drucker's statement 'What Gets Measured Gets Improved'. I am confident that this programme will continue to improve quality and patient safety in Ireland. Really impressive!"

Professor Omar Hameed
Regional Medical Director, Hospital Corporation of America; Adjunct Professor of Pathology, Vanderbilt University Medical Center

"It is a constructive, national, standardised response to concerns raised by events in the past which shows that we do learn from things that have gone wrong."

Dr Philip Crowley
National Director of the HSE Quality Improvement Division

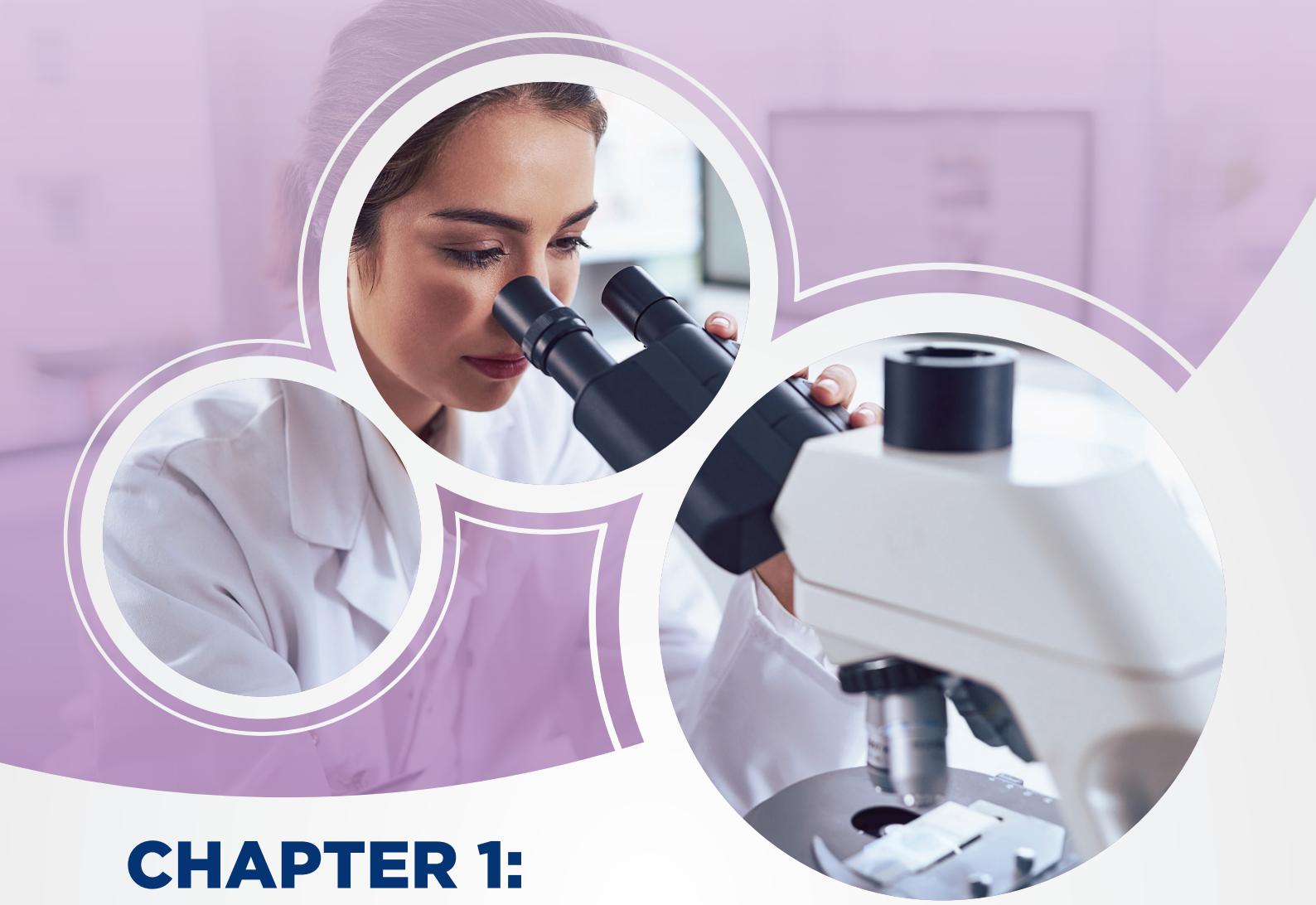
A MESSAGE FROM A PATIENT ADVOCATE

"I am an organisational psychologist who had a cancer diagnosis in 2006 and have survived because of a team of scientists and my sister who was a match for a stem-cell transplant. The Histopathology National QI programme comprises of a small group of Histopathologists who dedicate time and expertise to promoting systematic quality improvement across key areas of Histopathology.

What impresses me most is how engaged specialists are across the whole hospital network in improving the way they work together and the outcome improvements for patients that result from this work.

I am struck by the participants' engagement in and enthusiasm for QI projects. It is a direct contradiction to the reports and consequences of system and process failures coming to light in recent times. As a patient it gives me confidence in the health system's work to improve itself."

Peter Clarke
Patient Advocate
Member of the Steering Committee, National Quality Improvement Programmes



CHAPTER 1:

INTRODUCTION TO THE PROGRAMME

ABOUT THE HQI PROGRAMME

The National Quality Improvement Programme in Histopathology (HQI Programme) was launched by the Faculty of Pathology in January 2009 in collaboration with the National Cancer Control Programme (NCCP) and Directorate of Quality and Clinical Care (DQCC). While the initial funding support was provided by the NCCP, the HSE Quality Improvement Division (HSE QID) has been the Programme's funding body since 2014.

The HQI Programme aims to enhance patient safety and improve patient centred care with timely, accurate and complete pathology diagnoses and reports. This is done in a manner that is both supportive and encouraging to the participating histopathology laboratories.

The economic benefits of the programme have not been formally analysed yet but it has resulted in increased quality improvement activities at a local level, documentation of quality of service, opportunities for improved efficiency of services as well as potential reduction of unnecessary testing and reduced errors.

THE PROGRAMME GIVES PATIENTS GREATER CONFIDENCE IN PATHOLOGY DIAGNOSIS IN IRELAND

Providing a national QI framework that ensures enhanced patient care and safety with timely, accurate and complete diagnoses and reports

HOW THE PROGRAMME WORKS

The Faculty of Pathology has set evidence based targets so that histopathology laboratories can track their performance in a number of key areas, for example how quickly test results are processed and reported.

Laboratories enter their data into their Laboratory Information System (LIS). A software add-on to the LIS has been created by NQAIS Local Operations Manager to extract the relevant data. This data is uploaded to NQAIS on a monthly basis.

Laboratories can see how they are performing compared to the national average and identify if there are issues that need to be addressed or areas in which they are excelling.

Laboratories that are performing better than average are encouraged to share their best practice approach with other laboratories, resulting in improved standards overall.

HOSPITALS WE WORK WITH

Thirty two public and private hospital laboratories participate in the Histopathology National QI Programme and contributed data to the HQI Programme's 2017 dataset. On page 6 is a map and a list of all of these hospitals.

PURPOSE OF THIS REPORT

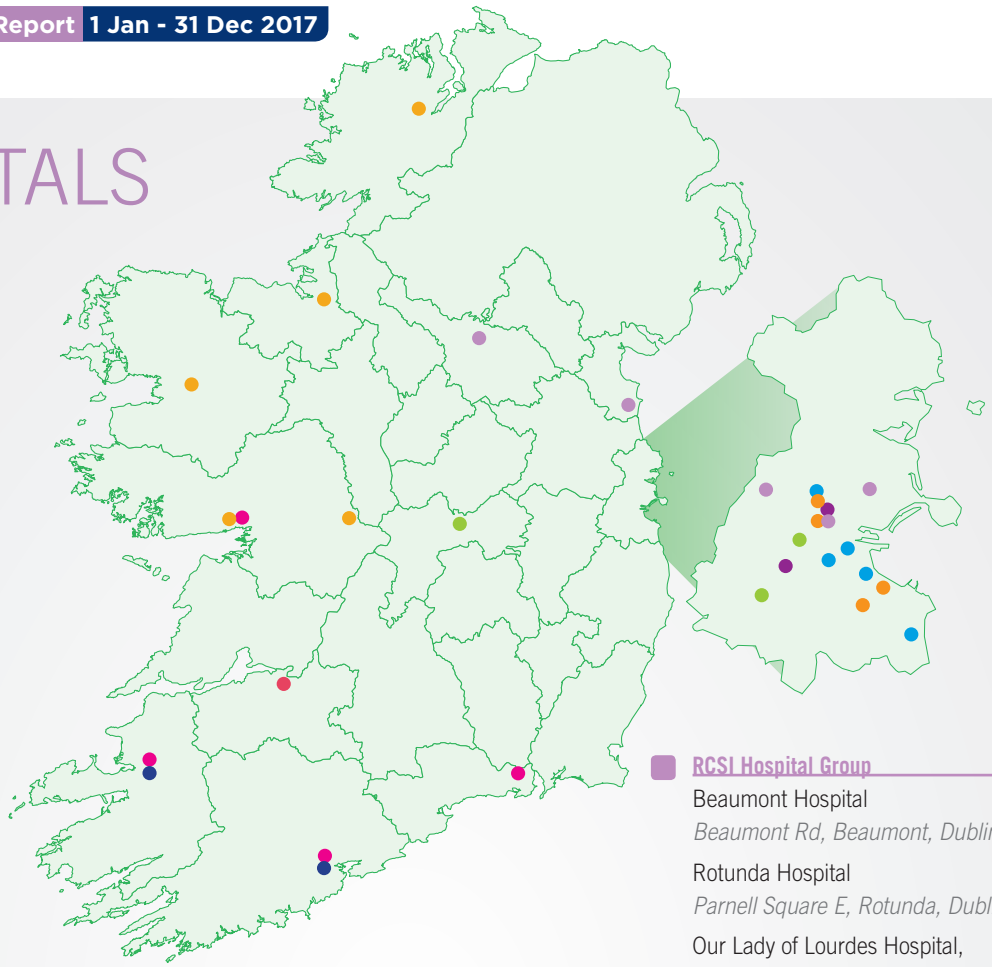
This report will allow informed decision making on the future steps to be taken so as to support the ongoing quality improvement process of Irish histopathology services. Where statistics suggest that there may be an area of improvement, findings should be confirmed locally using local hospital data.

The HQI Working Group encourages you to identify your laboratory within the report and discuss your local performance against the targets, recommendations and national averages with your laboratory staff, local hospital management team and quality and patient safety teams. Where statistics suggest that there may be an area in need of improvement, findings should be discussed locally using local hospital data.

WHAT THIS REPORT CANNOT DO

This report cannot and should not be used to produce league tables or compare hospitals. Comparison to other hospitals is not possible as no two hospitals will have the same patient profile. Different hospitals specialise in treating patients with different and sometimes much more complex care needs, making comparisons between hospitals ineffective.

HOSPITALS WE WORK WITH



Dublin Midlands Hospital Group

Midland Regional Hospital Tullamore
Arden Rd, Puttaghan, Tullamore, Co. Offaly, R35 NY51

AMNCH Tallaght Hospital
Cookstown, Tallaght, Co. Dublin

Coombe Women & Infants University Hospital
8 Cork St, Merchants Quay, Dublin, D08 XW7X

St. James's Hospital
James's Street, Ushers, Dublin 8

Ireland East Hospital Group

National Maternity Hospital
Holles St, Grand Canal Dock, Dublin, D02 YH21

Mater Misericordiae University Hospital
Eccles St, Inns Quay, Dublin 7, D07 R2WY

St. Colmcille's Hospital
Loughlinstown, Co. Dublin, D18 E365

St. Vincent's University Hospital*
196 Merrion Rd, Dublin 4, D04 Y8V0

Royal Victoria Eye and Ear Hospital
Adelaide Rd, Saint Kevin's, Dublin 2, D02 XK5

The Children's Hospital Group

Children's University Hospital, Temple Street
Temple Street, Dublin

Our Ladys Children's Hospital
Our Lady's Children's Hospital, Crumlin

University of Limerick Hospital Group

University Hospital Limerick
St Nessan's Rd, Dooradoyle, Co. Limerick, V94 F858

Private Hospitals Association

Blackrock Clinic
Rock Rd, Intake, Blackrock, Co. Dublin, A94 E4X7

Bon Secours Hospital Cork
College Rd, University College, Cork

Bon Secours Hospital Dublin
9 Glasnevin Hill, Dublin, D09 YN97

Bon Secours Hospital Tralee
Strand St, Tralee, Co. Kerry, V92 P663

Galway Clinic
Doughiska, Galway

Mater Private–Dublin
Eccles Street, Dublin

Beacon Hospital
Beacon Court, Bracken Road, Sandyford Industrial Estate, Dublin 18

RCSI Hospital Group

Beaumont Hospital
Beaumont Rd, Beaumont, Dublin

Rotunda Hospital
Parnell Square E, Rotunda, Dublin 1

Our Lady of Lourdes Hospital, Drogheda
Windmill Rd, Drogheda, Co. Louth, A92 VW28

Connolly Hospital Blanchardstown
Mill Rd, Abbotstown, Dublin 15

Cavan/Monaghan General Hospital
Lisdaran, Cavan, H12 N889

Saolta Hospital Group

Sligo General Hospital
The Mall, Rathquarter, Sligo, F91 H684

Mayo General Hospital
Westport Rd, Curragh, Castlebar, Co. Mayo, F23 H529

Letterkenny General Hospital
Kilmacrennan Road, Ballyboe Glencar, Letterkenny, Co. Donegal, F92 AE81

Portiuncula Hospital
Dunlo, Ballinasloe, Co. Galway, H53 T971

Galway University Hospitals
Newcastle Rd, Galway, H91 YR71

South/South West Hospital Group

Cork University Hospital
Wilton, Cork

Kerry General Hospital
Ratass, Tralee, Co. Kerry, V92 NX94

Waterford Regional Hospital
Dunmore Road, Waterford, X91 ER8E

** St. Vincent's Private Laboratory participates in the programme and its data is included in SVUH uploads.*

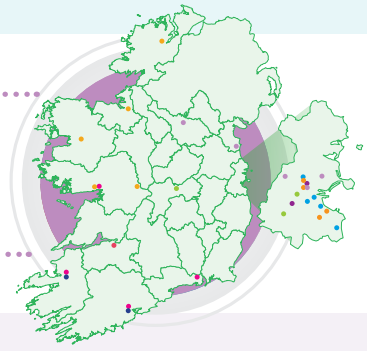
KEY RECOMMENDATIONS FOR THE FUTURE

CHAPTER 2:

REPORT HIGHLIGHTS

1st Country in the World
that reports on national metrics
in histopathology

32 Laboratories
in Ireland participate
in the programme



5th Annual National
Data Analysis Report

466,429 cases

784,034 specimens

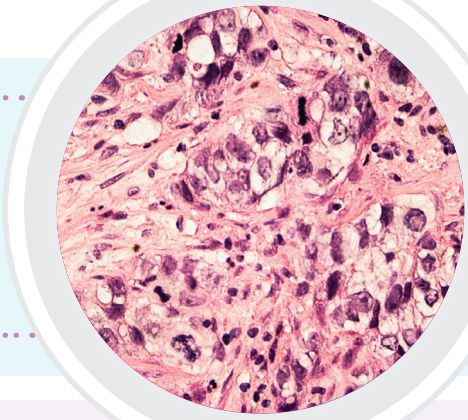
1,323,937 blocks

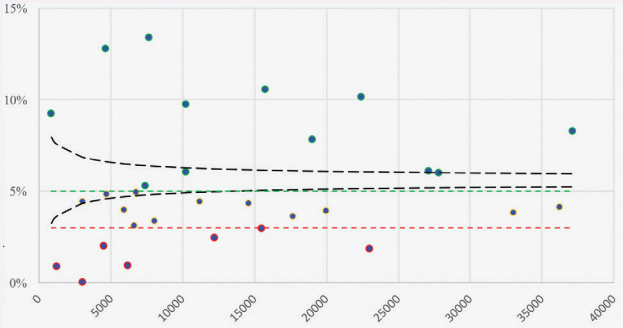
were **processed in 2017**

10.85% Increase in the number of cases examined between **2013-2017**

18% Increase in the number of blocks processed between **2013-2017**

40% Increase in the volume of cases requiring Immunohistochemical stains in the five years **(2013-2017)**





Funnel plots are being used in the report for the first time

REPORT SUMMARY POINTS

- Between 2016-2017 the national volume of cases increased by 3.2 %, blocks by 3.3% and specimens by 6.4%
- In the five years (2013-2017) the national volume of cases has increased by 11%, blocks by 18%, and specimens examined by 18%
- In the five years (2013-2017) the national volume of cases requiring Immunohistochemical stains has increased by 40% and the actual number of stains shows a 31% increase. This further reflects the increased complexity of diagnosis
- Histology and Non-Gynaecological Cytology FNA Intradepartmental Consultation as a whole was consistently above both the minimum and achievable targets
- Non-Gynaecological Cytology Exfoliative and Autopsy Intradepartmental Consultation as a whole was above the minimum target
- 31% of Cancer Centre Small Biopsy (P01) cases were reviewed at MDT meetings in 2017
- In 2017 nationally, with a yearly average of 99.6%, the target of 95% is met for all Small Biopsy (P01) cases with an MDT meeting having an agreement
- In 2017 nationally, with a yearly average of 99.4%, the target of 95% is met for all Cancer Resection (P03) cases with an MDT having an agreement (Quality Codes Q017, P019)
- Cytology MDT agreement as a whole is consistently above the target
- The recommendation of achieving less than 1% maximum for all Histology-Cytology Amended/ Corrected reports was met in all 32 sites for all months of 2017
- However, in 2017 nationally, the 80% of cases completed by Day 5 Turnaround Target was not met for Small Biopsy (P01) cases, GI Endoscopic Biopsy (P02)
- In 2017 nationally the 80% Completed by Day 7 Turnaround Time Target was not met for Non Biopsy Cancer Resection (P03) cases and Non Biopsy Other (P04) cases. This is likely to relate to challenges around resource deficits in histopathology laboratories, including recruitment and retention of Medical Laboratory Scientists and Consultant Histopathologists
- Over the past 3 years Frozen Section Correlation has increased to being sustained above the 97% Concordance Target
- In 2017, all sites combined had 77.84% Frozen Section TAT less than 20mins

CHAPTER 3:

INTRODUCTION TO ANALYSIS

An essential component of the Histopathology National Quality Improvement Programme is an online quality assurance and improvement system that was built to store, analyse and report on laboratories' performance. It was developed by the Faculty of Pathology and HSE Health Intelligence Ireland.

Known as National Quality Assurance and Improvement System (NQAIS), it functions as a central repository for quality improvement data from the hospital's own Laboratory Information System (LIS). It allows us to generate national reports on the accuracy and timeliness of diagnostic testing in hospital laboratories across Ireland.

32 laboratories (25 public and 7 private) are currently using NQAIS. Thanks to NQAIS, laboratories can spot best practice and variations from best practice, review, improve and sustain the quality of their work in the context of national norms and targets set by the Faculty of Pathology.

We use NQAIS to produce an annual report on national metrics in histopathology, making Ireland the first country in the world to do so.

SAMPLING

Each laboratory records histology, cytology, neuropath cytology, autopsy cases in their local LIS. Information on these cases, including data on quality activities performed, are then extracted from the LIS on a monthly basis and uploaded to the QI Programme's data collection tool, NQAIS-Histopathology, for local analysis. This dataset gave us 466,429 cases to analyse for 2017.

DATA COLLECTION

As cases are processed within the laboratory, they are assigned specific codes associated with the type of specimen and quality activities performed. These are recorded within the local LIS.

Data on all histopathology/cytology cases and the associated quality activities performed is added to NQAIS-Histopathology on a monthly basis by local laboratory staff. Each laboratory's QI Clinical Lead then reviews the data and signs it off, which triggers its addition to the national dataset. All data for January-December 2017 was added and signed off by March 2018 by all participating laboratories. No patient identifiable information is collected within NQAIS-Histopathology. Hospital identifiable data in the national dataset is anonymised by patient and hospital.

DATA ANALYSIS

The national dataset was analysed by the HQI Programme's Data Analyst between March and May 2018. Performance against the HQI Programme's Round 1, Round 2, Round 3 Targets and Recommendations were analysed in this report. These included Intradepartmental Consultations, Multidisciplinary Team Review, Addendum Reports, Frozen Section Correlation and Turnaround Times. The targets and recommendations for each quality activity are listed at the beginning of each section. Information on the national pathology workload have also been supplied.

Data was analysed to establish trends across the various quality areas for three groupings: national, cancer centres (CCs) and general centres (GCs). Each individual pathology case nationally has equal weight in all statistics in this report. The trend charts were not calculated by combining the averages of all centres within that category.

The areas of analysis are set out in the National Histopathology Quality Improvement Guidelines. In some quality areas, we also have sufficient data to analyse the performance over multiple years on a quarterly basis. Where this is possible, this multi-year data has been provided. Full guidelines are available on the website: https://www.rcpi.ie/quality-improvement-programmes/histopathology/.

The 2017 data is presented on quarterly graphs, bar charts, tables and for the first time on funnel plots. The latter have the ability to present additional layers of easy to interpret information that traditional bar charts cannot, which makes it easier to identify outliers relative to other data points.

Figures and tables giving information as to each anonymised centre's 2017 performance against the minimum and achievable targets have been supplied. Where the number is black or the chart element outline is green, it means that the laboratory exceeded the achievable target for 2017. Where the chart element is yellow, it means that the centre exceeded the minimum target for the quality area but did not exceed the achievable target. Where the chart element is red, laboratories did not meet the minimum target. 2016 data is also supplied for comparison purposes. The anonymised labels (e.g. CC1, GC1) have been kept the same from year to year. This means that it is possible to track a laboratory's change over the two years.

APPROVAL PROCESS

This report has been drafted by the Working Group of the HQI programme and then approved by the Specialty Quality Improvement Programme Steering Committee and the Board of the Faculty of Pathology, RCPI.

CHAPTER 4:

WORKLOAD

The following graphs show the workload nationally. There are no targets or recommendations set against volumes of cases completed, however, many statistics calculated in this report compare the number of quality activities completed against these figures.

Figure 4.1: *The volume of cases by procedure code completed nationally in 2017*

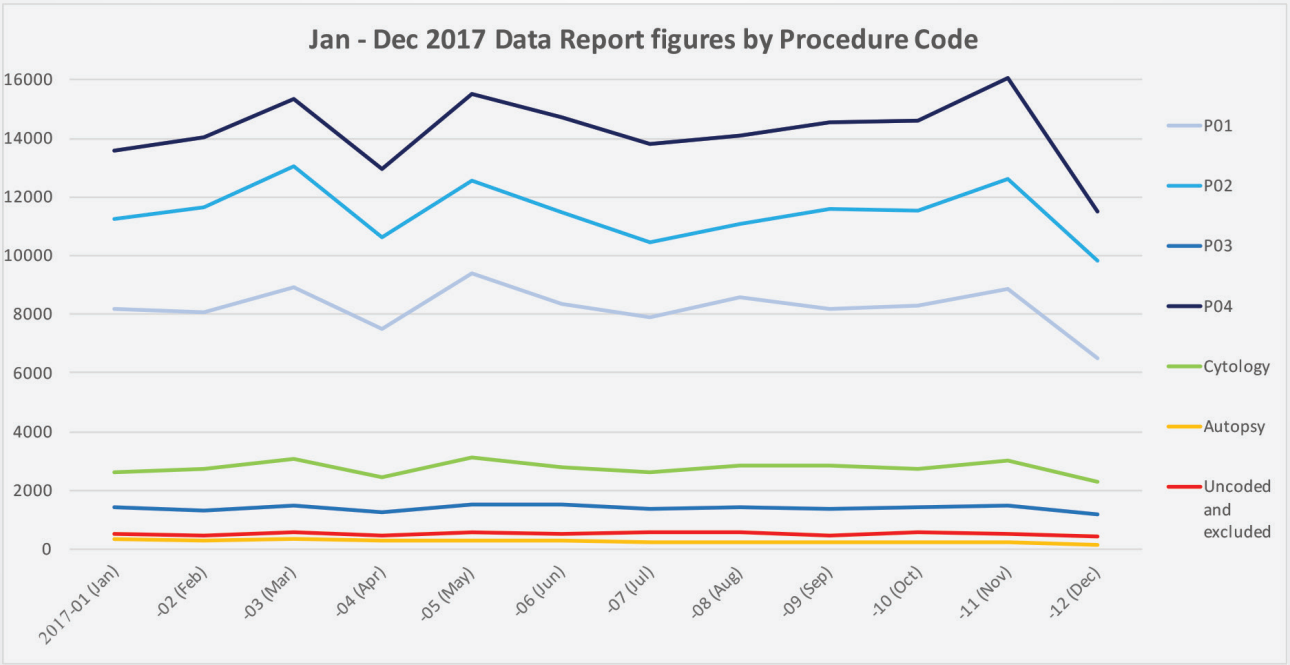
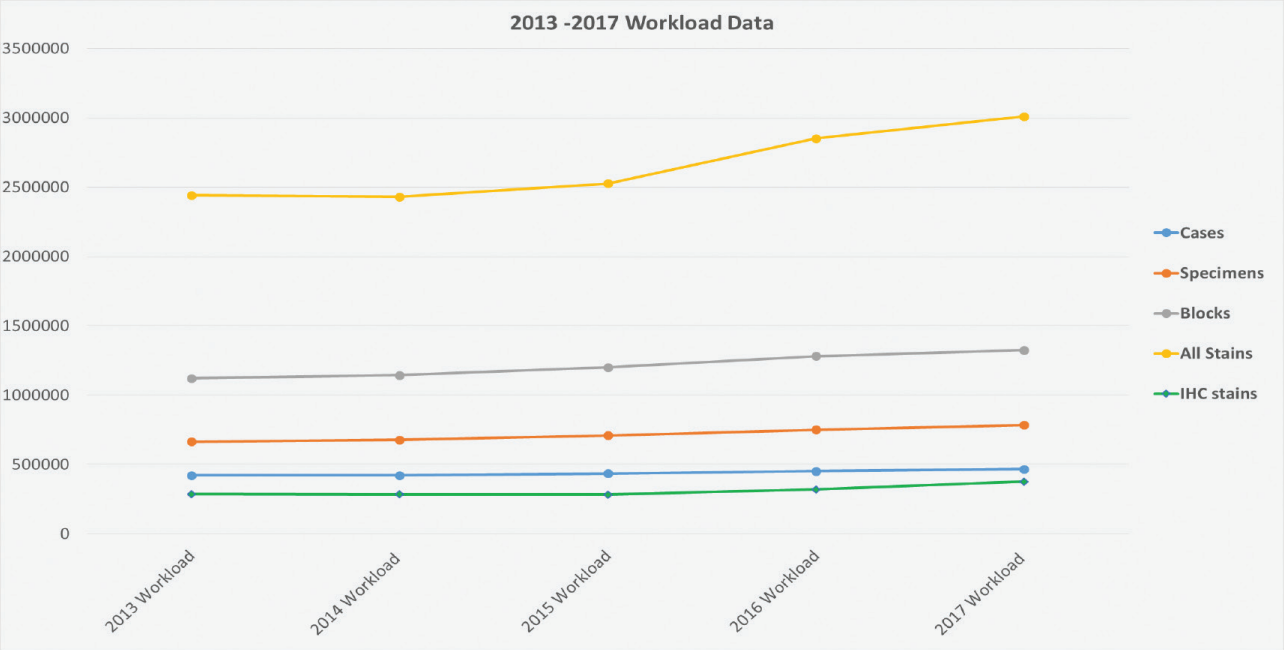


Figure 4.2: *2013-2017 Workload Data*



Appendix 1 at the end of the report contains information on volumes of cases completed per procedure type (P-code) per laboratory in 2017.

Table 4.0: *2013-2017 Workload Data*

Type	No. (Cases) 2013	No. (Cases) 2014	No. (Cases) 2015	No. (Cases) 2016	No. (Cases) 2017
	2013 Workload	2014 Workload	2015 Workload	2016 Workload	2017 Workload
Cases	420,790	422,220	435,276	452,036	466,429
Specimens	664,799	677,462	709,969	750,718	784,034
Blocks	1,121,696	1,142,906	1,200,053	1,281,374	1,323,937
All Stains	2,440,966	2,430,030	2,526,534	2,850,511	3,008,483
IHC stains	285,660 (43,865 cases)	285,039 (45,057 cases)	281,551 (49,200 cases)	320,439 (55,688 cases)	376,639 (61,804 cases)
Routine H&E	1,726,901 (384,524 cases)	1,731,050 (373,116 cases)	1,819,076 (381,144 cases)	2,086,091 (418164 cases)	2,170,295 (431903 cases)
Extra H&E	286,757 (58,178 cases)	275,874 (58,633 cases)	295,515 (61,701 cases)	304,475 (63,261 cases)	317,584 (63,621 cases)
Special stains (& cases)	139,102 (56,176 cases)	135,222 (53,822 cases)	127,845 (52,691 cases)	136,411 (58,275 cases)	141,320 (57,555 cases)
Frozen Section stains	33,991 (1,669 cases)	31,827 (1,573 cases)	28,593 (1,485 cases)	28,834 (1,398 cases)	29,680 (1,358 cases)
No. of units	33	32 (excludes unit that closed in 2013)	32	32	32

Between 2016 and 2017, the volume of cases nationally increased by 14,393 cases (3.2 %), 42,562 blocks (3.35%) and 47,709 specimens (6.4%).

In the five years from 2013 to 2017 the national volume of cases has increased by 45,639 (10.85%), blocks have increased by 202,241 (18%), and the number of specimens received by 119,235 (18%).

Comment on complexity: This means individual patients are having more specimens submitted to Histopathology and these specimens are more complex, requiring more analysis as there are more blocks of tissue submitted for examination.

In the same five years from 2013 to 2017, the national volume of cases requiring Immunohistochemical stains (IHC stains) has increased by 40%, and the actual number of stains shows a 31% increase. This further reflects the increased complexity of diagnosis and the additional information that pathology can provide from tissue samples to guide patient care.

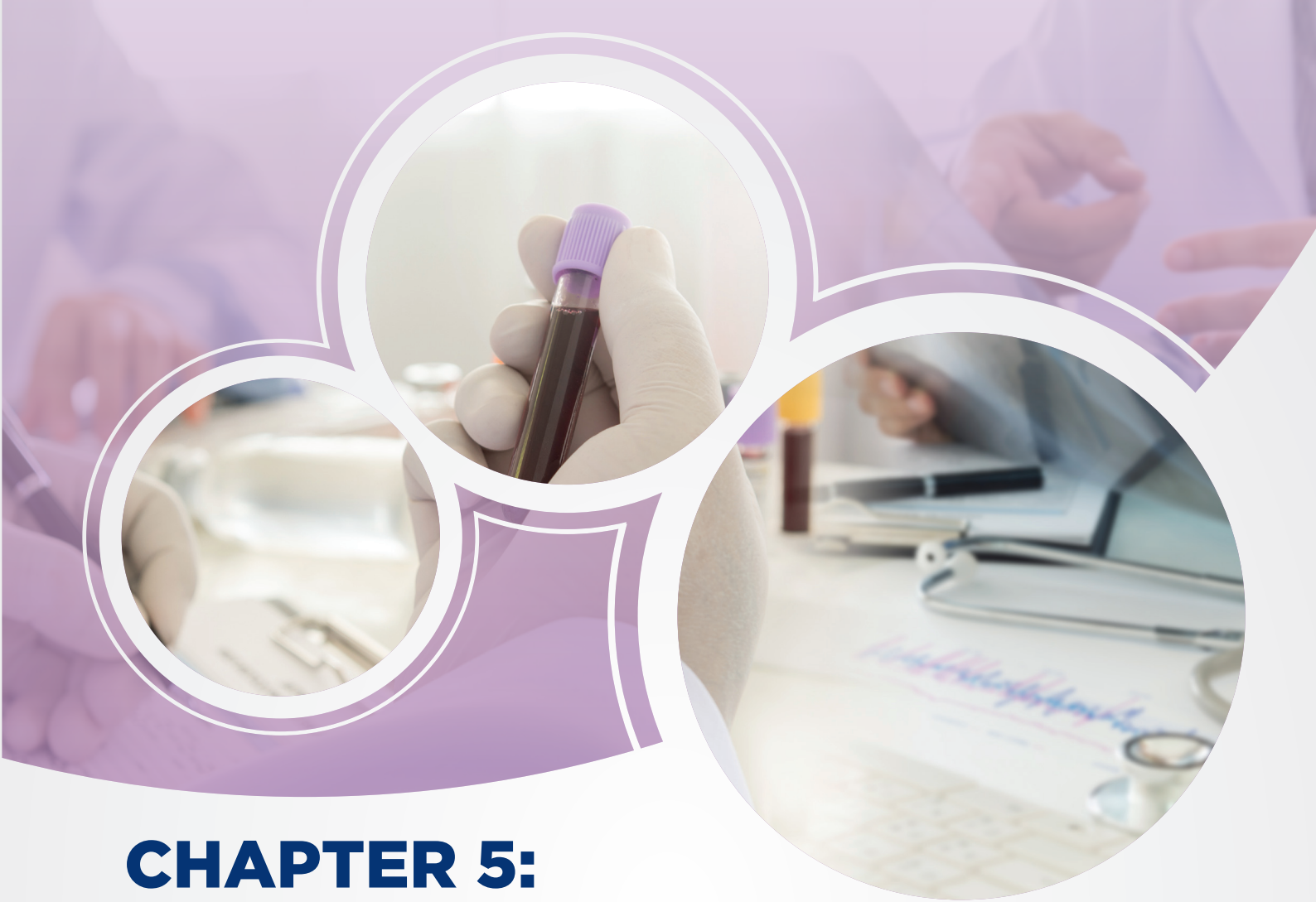
Below are targets and recommendations set by the Histopathology QI Working Group.

Table 4.1: *Targets set by HQI Working Group*

Key Quality Area	Targets & Key Quality Indicators	Notes
Turnaround Time (TAT) **ROUND 1/2**	Small biopsy – 80% by day 5 GI biopsy – 80% by day 5 Cancer resection – 80% by day 7 Non-biopsy other – 80% by day 7 Cytology FNA – 80% by day 5 Cytology exfoliative – 80% by day 5	Calculation is for working days* * 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**	Histology – 3% minimum, 5% achievable Cytology FNA – 7% minimum, 9% achievable Cytology exfoliative – 3% minimum, 5% achievable Autopsy – 1%	
Frozen Section (FS) Diagnosis **ROUND 1/2**	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**	% 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**	% MDT Agreement: 95% or more	Disagreement is defined as when it is deemed necessary to issue an amended report.
Autopsy Retrospective Review **ROUND 3**	% satisfactory: more than 90%	No. of cases reviewed to be decided locally.
Autopsy Morbidity & Mortality (M&M) Conference **ROUND 3**	1% of cases presented per year at hospital M&M conference	M&M conferences are typically presented at hospital Medical & Surgical Grand Rounds.

Table 4.2: *Recommendations set by the Working Group*

Key Quality Area (Continued)	Recommendations & Key Indicator	Notes
Multidisciplinary Team (MDT) Meetings **ROUND 3**	% 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**	% Amended Reports*: • Histology cases 1% or less • Cytology cases 1% or less % Corrected Reports* • Histology cases 2% or less • Cytology cases 2% or less % Supplementary Reports* • Histology cases 10% or less • Cytology cases 10% or less	1%/2% 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. *Terms explained in chapter 7



CHAPTER 5:

INTRADEPARTMENTAL CONSULTATION

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.

Table 5.1: *Target set for Intradepartmental Consultation*

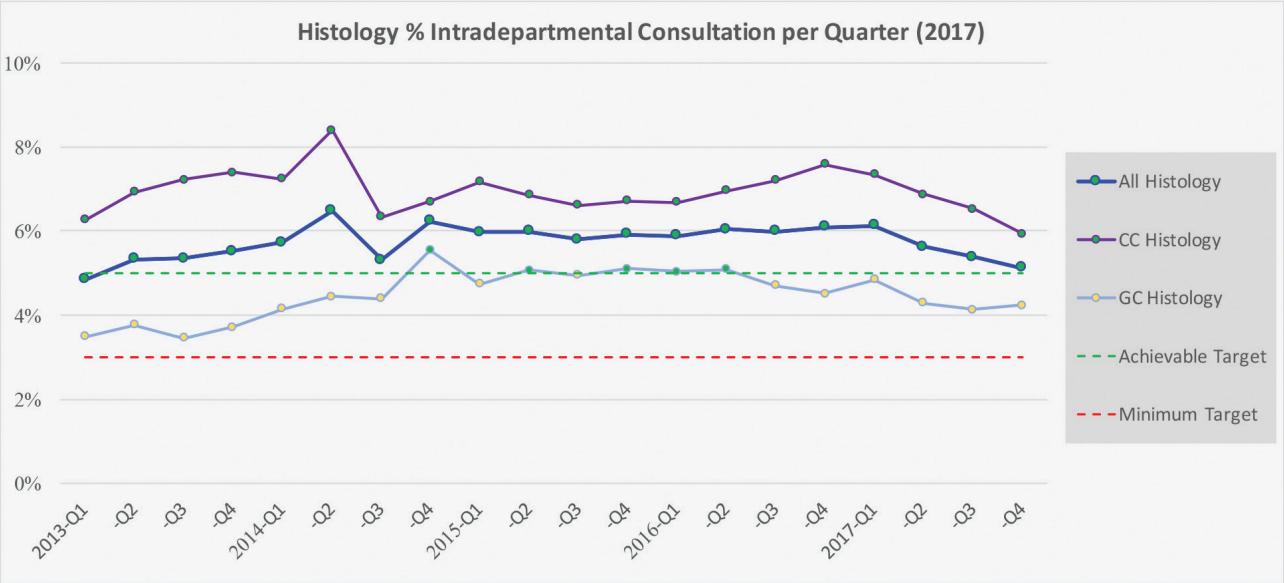
Case Type	Minimum Target	Achievable Target
Histology Cases	3%	5%
Non Gynaecological Cytology FNA cases	7%	9%
Non Gynaecological Cytology Exfoliative Cases	3%	5%
Autopsy cases	1%	1%

INTRADEPARTMENTAL CONSULTATION COMMENTARY–HISTOLOGY (P01-P04)

Histology Intradepartmental Consultation as a whole was consistently above both the minimum and achievable targets when Cancer Centres and General Centres data is combined.

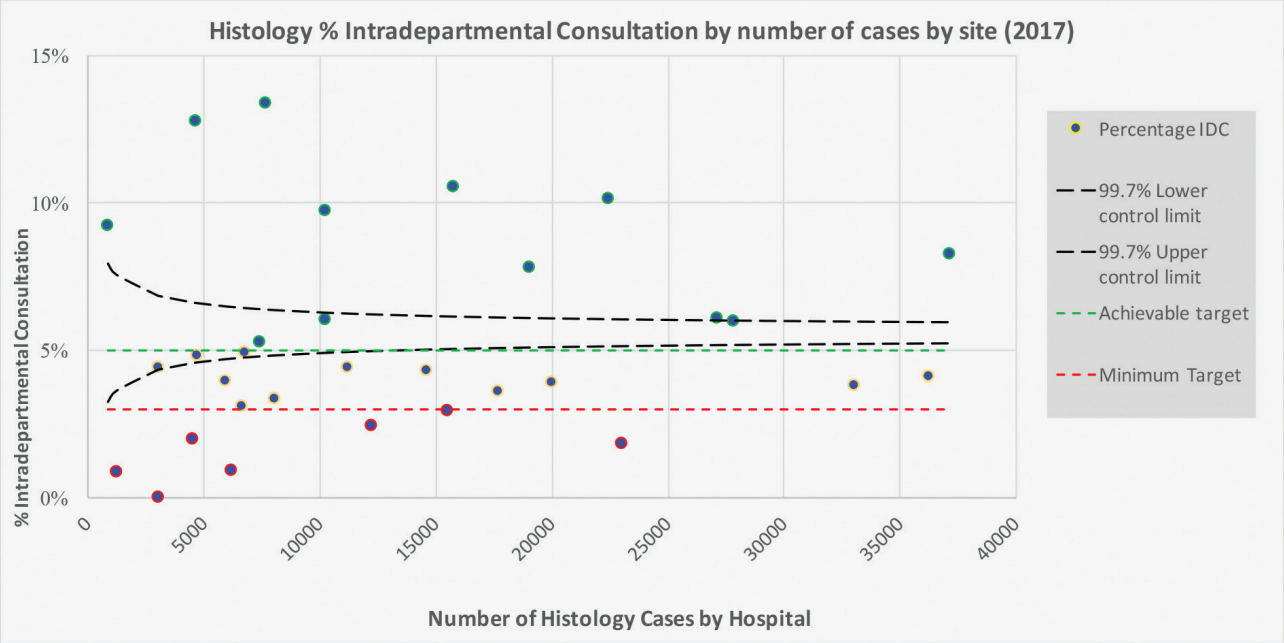
The average rate of Intradepartmental Consultation for all centres was 5.6% in 2017 and achievable target was met for 11 months of the year. Cancer centres achieved a yearly average of 6.7% while general centres averaged 4.4% in 2017.

Figure 5.1: *Quarterly graph–Histology % Intradepartmental Consultation per Quarter (2017)*



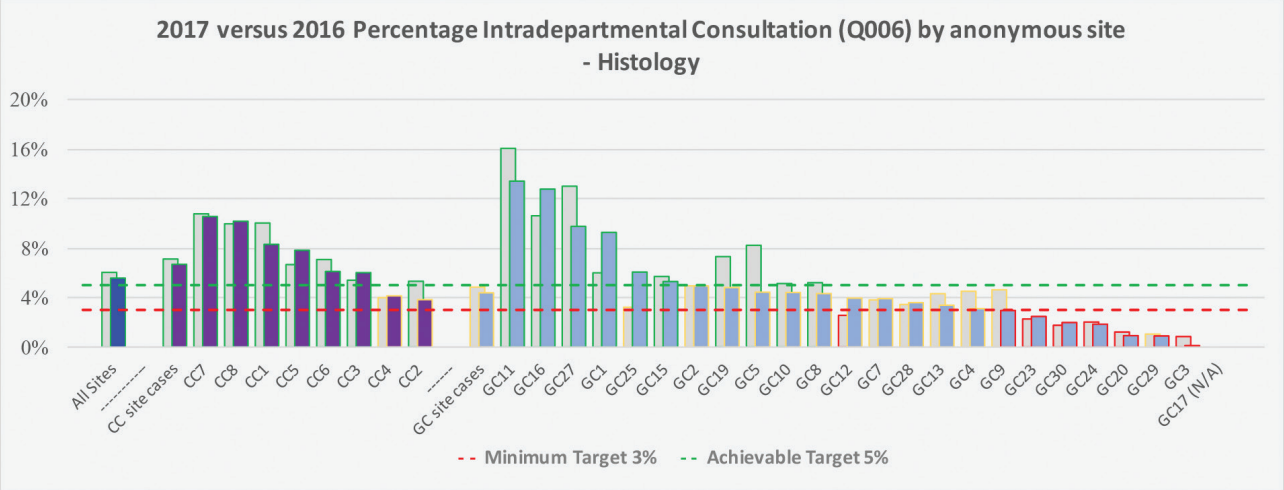
Histology Intradepartmental Consultation as a whole was consistently above both the minimum and achievable targets when Cancer Centres and General Centres data is combined

Figure 5.2: *Funnel Plot–Histology % Intradepartmental Consultation 2017*



There is a wide variation in Intradepartmental consultation rates which may relate to different workload and profile of pathology cases in different hospitals.

Figure 5.3: *Bar Chart–Histology 2016/2017 % Intradepartmental Consultation by site*



All the eight Cancer Centre sites and sixteen of the twenty three General Centre sites were above the minimum target for Intradepartmental Consultation in 2017. Seven General Centre sites did not meet the minimum target of 3% Intradepartmental Consultation. Moreover, six General Centre sites were below the minimum target for two consecutive years. Three General Centre sites had an intradepartmental consultation rate of less than 1% of cases having an IDC.

We would like to encourage laboratories to engage in relevant QI activities or associated coding, with particular focus on Histology IDC. The recommended approach is to employ QI methodologies locally such as the PDSA cycle in conjunction with the 5 WHYs or value stream mapping to investigate the root cause of the problem before implementing a structured approach to the change required.

Table 5.2: *2016/2017 Full data Intradepartmental Consultation – Histology*

Q006	2016 IDC-Histology			2017 IDC-Histology		
	No. of Cases	No. Q006	% Q006	No. of Cases	No. Q006	% Q006
Cancer Centres	**210117**	**14932**	**7.11%**	**218539**	**14599**	**6.68%**
CC1	35399	3546	10.02%	37108	3078	8.29%
CC2	30526	1610	5.27%	33001	1263	3.83%
CC3	27463	1482	5.40%	27808	1671	6.01%
CC4	34801	1388	3.99%	36251	1499	4.14%
CC5	18049	1202	6.66%	19045	1488	7.81%
CC6	26986	1908	7.07%	27087	1654	6.11%
CC7	15352	1652	10.76%	15783	1664	10.54%
CC8	21541	2144	9.95%	22456	2282	10.16%

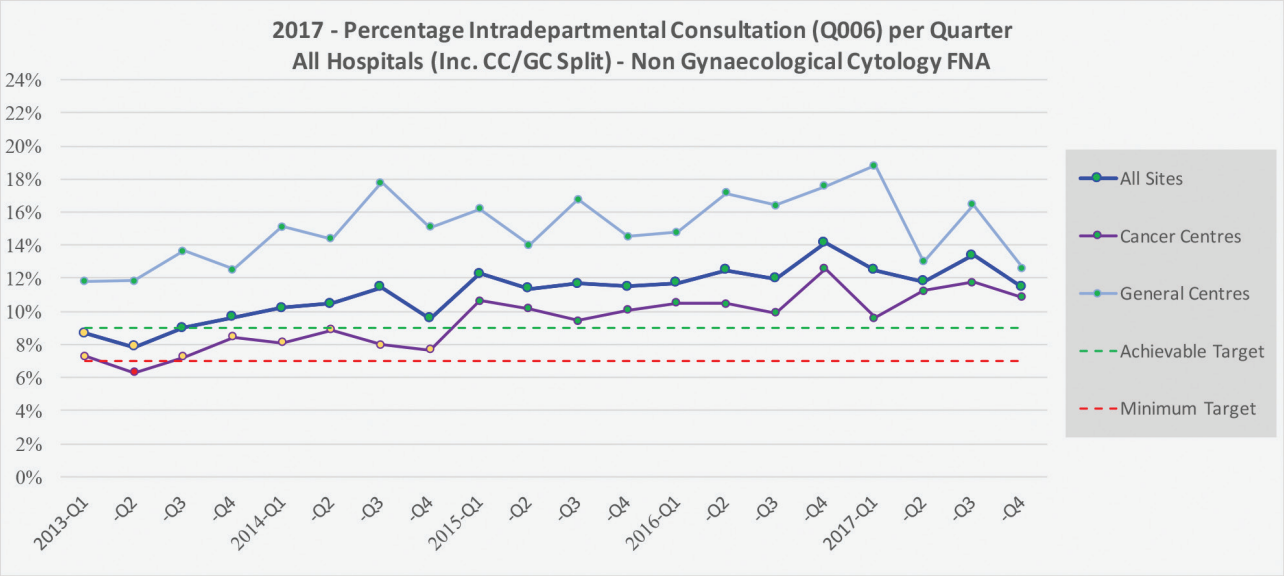
Q006 (Continued)	2016 IDC-Histology			2017 IDC-Histology		
	No. of Cases	No. Q006	% Q006	No. of Cases	No. Q006	% Q006
General Centres	**199580**	**9666**	**4.84%**	**205307**	**8998**	**4.38%**
GC1	851	51	5.99%	864	80	9.26%
GC2	7021	347	4.94%	6783	335	4.94%
GC3	3074	26	0.85%	3026	1	0.03%
GC4	6099	275	4.51%	6668	207	3.10%
GC5	2690	221	8.22%	3046	135	4.43%
GC7	19851	756	3.81%	19969	781	3.91%
GC8	14162	736	5.20%	14578	630	4.32%
GC9	14444	668	4.62%	15477	457	2.95%
GC10	12026	617	5.13%	11208	494	4.41%
GC11	7683	1233	16.05%	7686	1030	13.40%
GC12	6255	160	2.56%	5901	233	3.95%
GC13	8281	357	4.31%	8054	272	3.38%
GC15	7088	404	5.70%	7387	391	5.29%
GC16	4196	445	10.61%	4617	589	12.76%
GC17	–	–	–	–	–	–
GC19	4764	348	7.30%	4682	225	4.81%
GC20	6092	74	1.21%	6172	57	0.92%
GC23	10378	235	2.26%	12218	302	2.47%
GC24	23488	475	2.02%	23038	425	1.84%
GC25	9455	304	3.22%	10255	621	6.06%
GC27	9976	1296	12.99%	10230	997	9.75%
GC28	15823	544	3.44%	17688	635	3.59%
GC29	1339	14	1.05%	1224	11	0.90
GC30	4544	80	1.76%	4536	90	1.98%
All Sites	**409697**	**24598**	**6.00%**	**423846**	**23597**	**5.57%**

INTRADEPARTMENTAL CONSULTATION COMMENTARY–NON GYNAECOLOGICAL CYTOLOGY FNA (P06)

Non Gynaecological Cytology FNA Intradepartmental Consultation as a whole was consistently above both the minimum (7%) and achievable targets (9%).

Cancer Centres (CCs) averaged 10.9% Intradepartmental Consultations in 2017. General Centres (GCs) averaged at 15.3% which was above the achievable target but slightly less than last year's rate of 16.5%.

Figure 5.4: *Quarterly graph–Intradepartmental Consultation Non Gynaecological Cytology FNA*



5 year quarterly data showed all centres above the minimum and achievable targets since Q1 2015

Non Gynaecological Cytology FNA Intradepartmental Consultation as a whole was consistently above both the minimum and achievable targets

Figure 5.5: *Funnel plot–Non Gynaecological Cytology FNA % Interdepartmental Consultation*

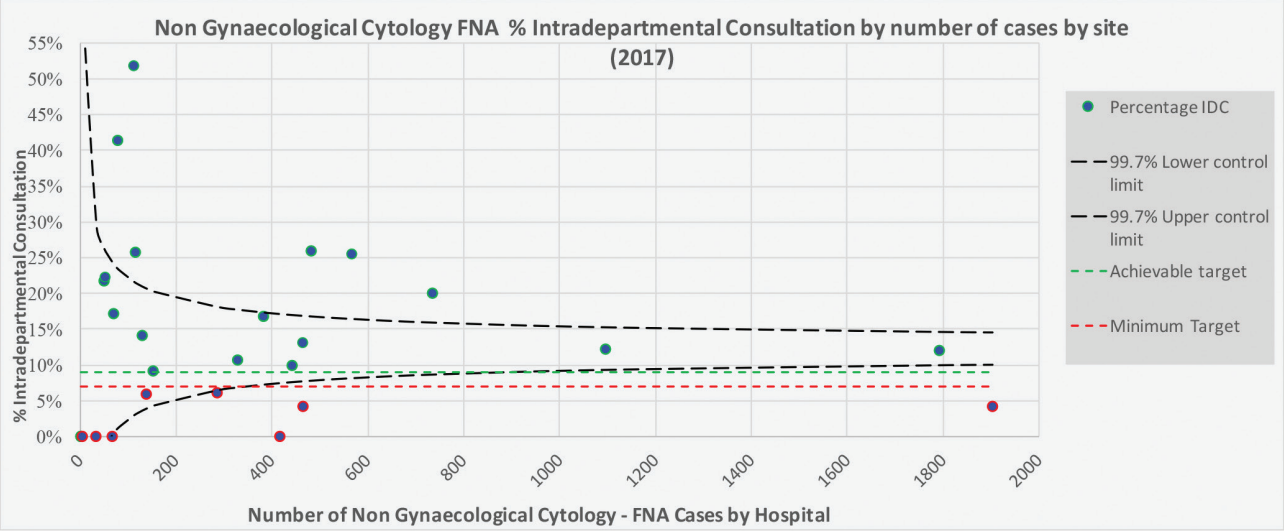
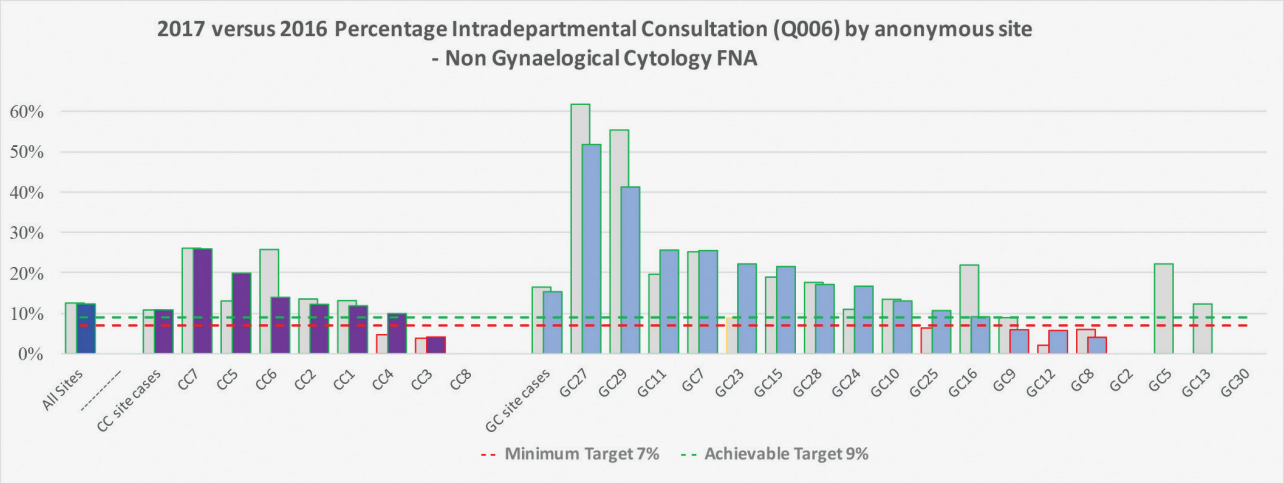


Figure 5.6: *Bar chart–% of Intradepartmental Consultation Non Gynaecological Cytology FNA*



Six of eight Cancer Centre sites met the 9% achievable target in 2017, one better than 2016 (five CC sites).

Eleven of sixteen General Centre sites met the 9% achievable target for Intradepartmental Consultation in 2017. Three General Centre sites were below the minimum target in 2017. Also, three sites showed 0% rate of Intradepartmental Consultation.

Table 5.3 *2016/2017 full data Intradepartmental Consultation – Non-Gynaecological Cytology FNA (P06)*

Cytology non Gynae FNA P-Code P06	2016			2017		
	No. of Cases	No. Q006	% Q006	No. of Cases	No. Q006	% Q006
Cancer Centres	**7036**	**762**	**10.83%**	**7002**	**760**	**10.85%**
CC1	1802	237	13.15%	1794	213	11.87%
CC2	1144	155	13.55%	1097	134	12.22%
CC3	1873	72	3.84%	1903	79	4.15%
CC4	488	23	4.71%	443	44	9.93%
CC5	727	95	13.07%	737	147	19.95%
CC6	128	33	25.78%	129	18	13.95%
CC7	563	147	26.11%	482	125	25.93%
CC8	311	0	0.00%	417	0	0.00%
General Centres	**3093**	**510**	**16.48%**	**3389**	**520**	**15.34%**
GC1	0	0	0.00%	0	0	0.00%
GC2	0	0	0.00%	1	0	0.00%
GC3	4	0	0.00%	3	0	0.00%
GC4	9	0	0.00%	3	0	0.00%
GC5	9	2	22.22%	4	0	0.00%
GC7	551	139	25.23%	568	145	25.53%
GC8	366	22	6.01%	466	19	4.08%
GC9	235	21	8.94%	286	17	5.94%
GC10	460	62	13.48%	467	61	13.06%
GC11	117	23	19.66%	117	30	25.64%

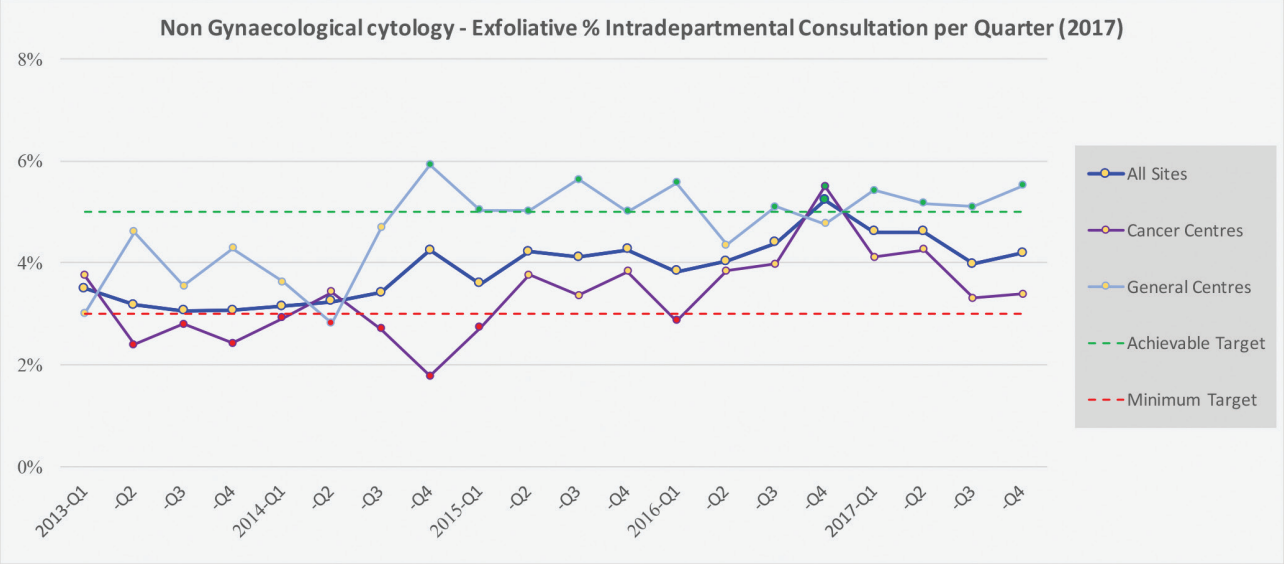
Cytology non Gynae FNA P-Code P06 (Continued)	2016			2017		
	No. of Cases	No. Q006	% Q006	No. of Cases	No. Q006	% Q006
GC12	95	2	2.11%	139	8	5.76%
GC13	65	8	12.31%	68	0	0.00%
GC15	58	11	18.97%	51	11	21.57%
GC16	164	36	21.95%	153	14	9.15%
GC17	0	0	0.00%	0	0	0.00%
GC19	0	0	0.00%	0	0	0.00%
GC20	0	0	0.00%	0	0	0.00%
GC23	68	6	8.82%	54	12	22.22%
GC24	364	40	10.99%	383	64	16.71%
GC25	267	17	6.37%	328	35	10.67%
GC27	94	58	61.70%	114	59	51.75%
GC28	34	6	17.65%	70	12	17.14%
GC29	103	57	55.34%	80	33	41.25%
GC30	30	0	0.00%	34	0	0.00%
All Sites	**10129**	**1272**	**12.56%**	**10391**	**1280**	**12.32%**

INTRADEPARTMENTAL CONSULTATION COMMENTARY–NON GYNAECOLOGICAL CYTOLOGY EXFOLIATIVE (P07)

The annual average for all sites was 4.3%, above the minimum target (3%).

Cancer Centres averaged a rate of 3.8% for Intradepartmental consultations in 2017, similar to the 2016 data which was 4%. General Centres averaged 5.3% which is above the achievable target of 5%, and above last year's rate of 4.9%.

Figure 5.7: *Quarterly graph–Intradepartmental Consultation Non Gynaecological Cytology Exfoliative*



There is a general upward trend for all sites combined since 2015, which drops off slightly in 2017.

Figure 5.8: *Funnel plot – Non gynaecological cytology exfoliative % Intradepartmental consultation*

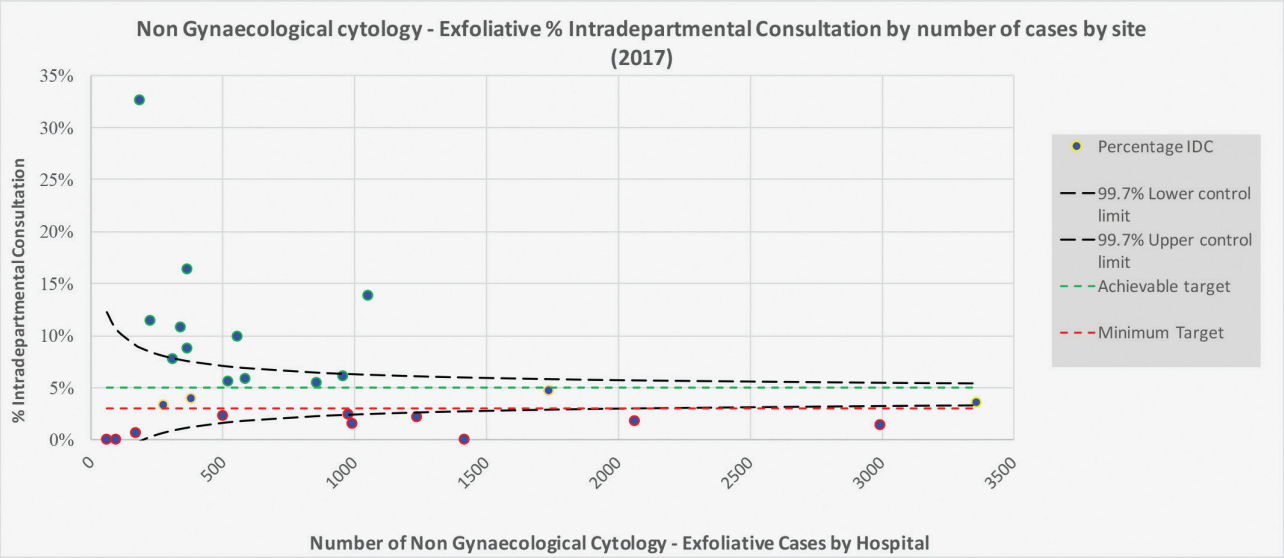
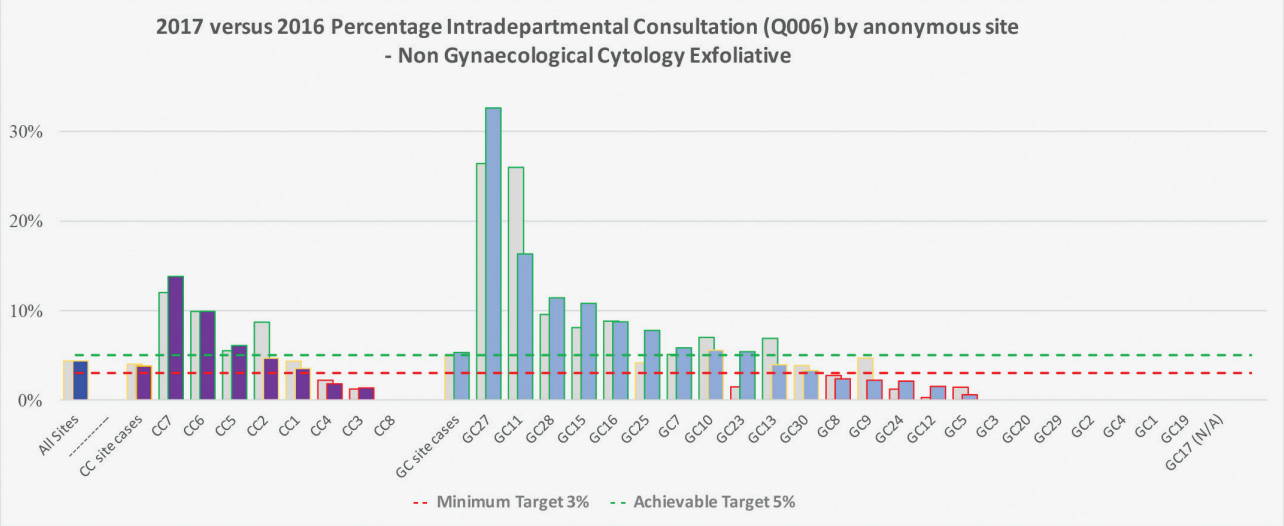


Figure 5.9: *Bar graph–2016/2017 % Intradepartmental consultation Non Gynaecological Cytology Exfoliative*



Five of eight CC sites met the 3% minimum target in 2017, which is the same number that reached the target in 2016. Three sites were above the 5% achievable target.

Eleven of eighteen GC sites met the 3% minimum target in 2017. This is the same as the previous year. Nine sites were above the 5% achievable target. Three sites recorded 0% Q006, including one cancer centre.

Table 5.4: *2016/2017 full data Intradepartmental Consultation – Non Gynaecological Cytology Exfoliative*

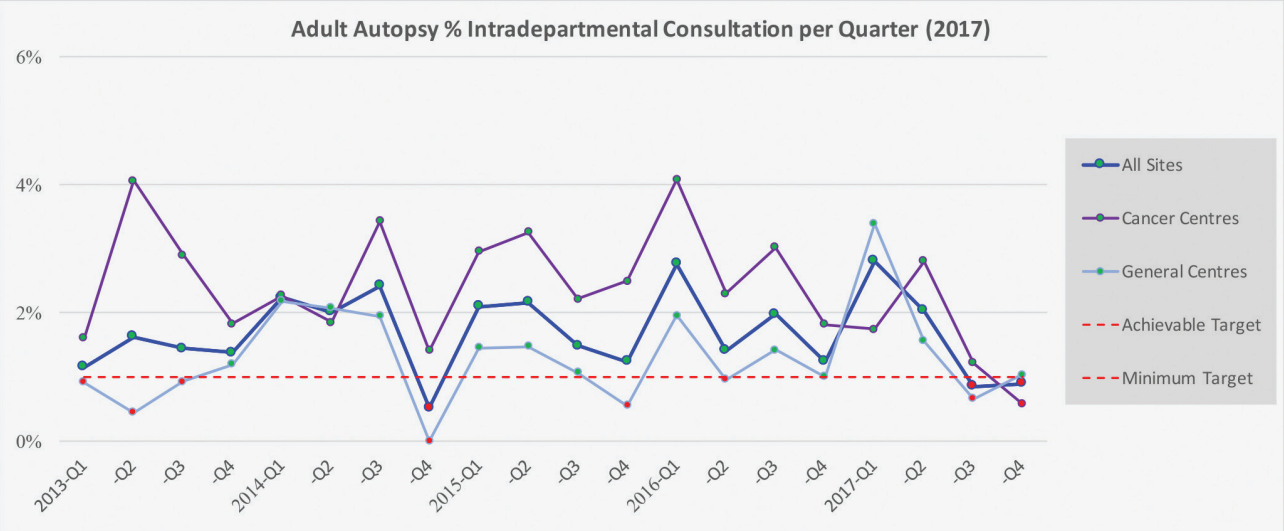
Cytology non Gynae Exfoliative (P-Code P07)	2016			2017		
	No. of Cases	No. Q006	% Q006	No. of Cases	No. Q006	% Q006
Cancer Centres	**14696**	**587**	**3.99%**	**14134**	**534**	**3.78%**
CC1	3114	135	4.34%	3359	118	3.51%
CC2	1566	136	8.68%	1740	81	4.66%
CC3	3785	46	1.22%	2994	40	1.34%
CC4	2044	45	2.20%	2063	37	1.79%
CC5	837	46	5.50%	955	58	6.07%
CC6	526	52	9.89%	556	55	9.89%
CC7	1059	127	11.99%	1051	145	13.80%
CC8	1765	0	0.00%	1416	0	0.00%
General Centres	**8461**	**418**	**4.94%**	**8455**	**448**	**5.30%**
GC1	0	0	0.00%	0	0	0.00%
GC2	0	0	0.00%	0	0	0.00%
GC3	66	0	0.00%	98	0	0.00%
GC4	0	0	0.00%	0	0	0.00%
GC5	141	2	1.42%	173	1	0.58%
GC7	610	31	5.08%	584	34	5.82%
GC8	1100	30	2.73%	976	23	2.36%
GC9	470	22	4.68%	499	11	2.20%
GC10	444	31	6.98%	523	29	5.54%
GC11	385	100	25.97%	368	60	16.30%
GC12	1109	3	0.27%	993	15	1.51%
GC13	291	20	6.87%	382	15	3.93%
GC15	359	29	8.08%	343	37	10.79%
GC16	341	30	8.80%	367	32	8.72%
GC17	0	0	0.00%	0	0	0.00%
GC19	0	0	0.00%	0	0	0.00%
GC20	72	0	0.00%	60	0	0.00%
GC23	756	11	1.46%	855	46	5.38%
GC24	1328	16	1.20%	1239	26	2.10%
GC25	361	15	4.16%	309	24	7.77%
GC27	178	47	26.40%	184	60	32.61%
GC28	241	23	9.54%	228	26	11.40%
GC29	1	0	0.00%	0	0	0.00%
GC30	208	8	3.85%	274	9	3.28%
All Sites	**23157**	**1005**	**4.34%**	**22589**	**982**	**4.35%**

The annual average for Intradepartmental Consultation – Non Gynaecological Cytology Exfoliative at all sites was 4.3%, above the minimum target (3%).

INTRADEPARTMENTAL CONSULTATION COMMENTARY — AUTOPSY (P10, P11)

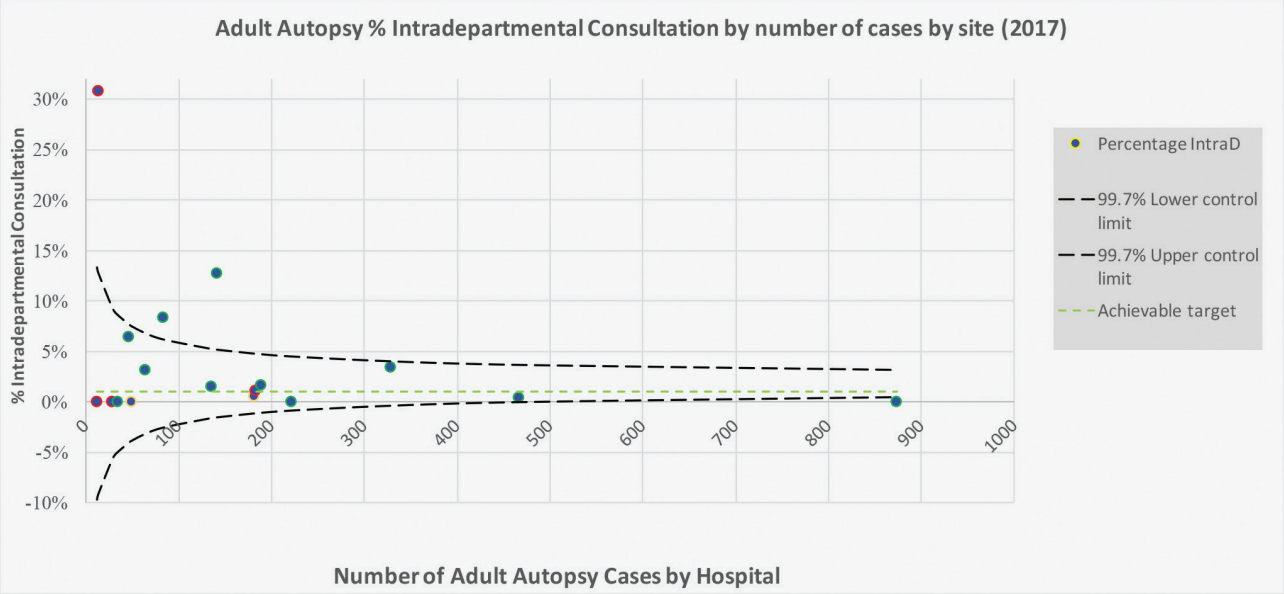
The minimum target of 1% Intradepartmental Consultation was met in 2017, with a yearly average of 1.8%. The Q006 rate for autopsy was 1.9% in 2016.

Figure 5.10: *Quarterly graph–% Intradepartmental Consultation Adult Autopsy*



On a quarterly basis, since 2013 the percentage of Q006 for Autopsy (P10, P11) had remained above the target, but has dropped below the target for the last two quarters of 2017.

Figure 5.11: *Funnel plot – Adult Autopsy % Intradepartmental Consultation by number of cases*



One GC site accounted for a large number of the GC autopsy cases with IDCs. Without this site, the rest of the GC sites combined would be below the national 1% target.

Figure 5.12: *Bar graph – 2016/2017 % Intradepartmental Consultation (Q006) – Adult Autopsy*

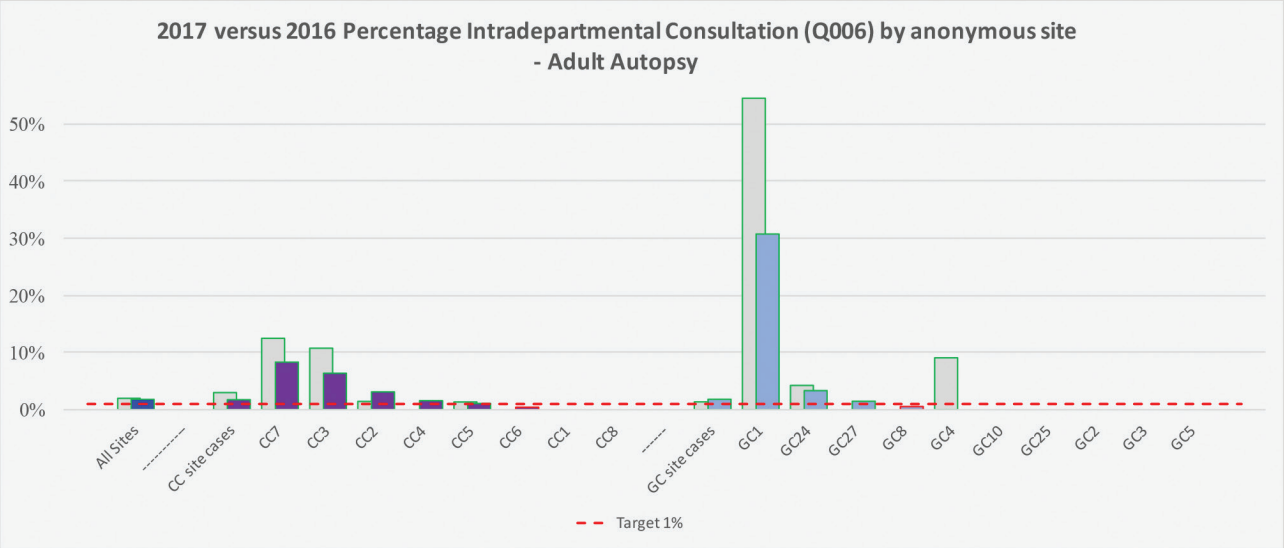


Table 5.5: *Full data 2016/2017 Intradepartmental consultation–Adult Autopsy*

IDC Autopsy (P-Codes P10-P11)	2016			2017		
	No. of Cases	No. Q006	% Q006	No. of Cases	No. Q006	% Q006
Cancer Centres	**1033**	**31**	**3.00%**	**1083**	**19**	**1.75%**
CC1	49	0	0.00%	50	0	0.00%
CC2	69	1	1.45%	64	2	3.13%
CC3	130	14	10.77%	47	3	6.38%
CC4	0	0	0.00%	189	3	1.59%
CC5	222	3	1.35%	183	2	1.09%
CC6	459	0	0.00%	466	2	0.43%
CC7	104	13	12.50%	84	7	8.33%
CC8	0	0	0.00%	0	0	0.00%
General Centres	**1971**	**27**	**1.37%**	**1971**	**36**	**1.83%**
GC1	11	6	54.55%	13	4	30.77%
GC2	4	0	0.00%	0	0	0.00%
GC3	71	0	0.00%	35	0	0.00%
GC4	55	5	9.09%	12	0	0.00%
GC5	21	0	0.00%	29	0	0.00%
GC8	166	0	0.00%	181	1	0.55%
GC10	895	0	0.00%	874	0	0.00%
GC17	895	0	0.00%	142	18	12.68%
GC24	376	16	4.26%	329	11	3.34%
GC25	193	0	0.00%	221	0	0.00%
GC27	0	0	0.00%	135	2	1.48%
All Sites	**3004**	**58**	**1.93%**	**3054**	**55**	**1.80%**

CHAPTER 6:

MULTIDISCIPLINARY TEAM REVIEW

Multidisciplinary Team (MDT) meetings form an essential part of the clinical care of patients with cancer, 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.

The target set for this form of peer review is greater than or equal to 95% MDT agreement between the primary pathologist authorising the report and the pathologist presenting the case at the MDT meeting. The codes applied are Q017 for MDT case review and this defaults to MDT review agreement unless the code Q019 is entered for MDT review disagreement. Some laboratories also use Q018 to indicate MDT agreement and Q019 to indicate disagreement.

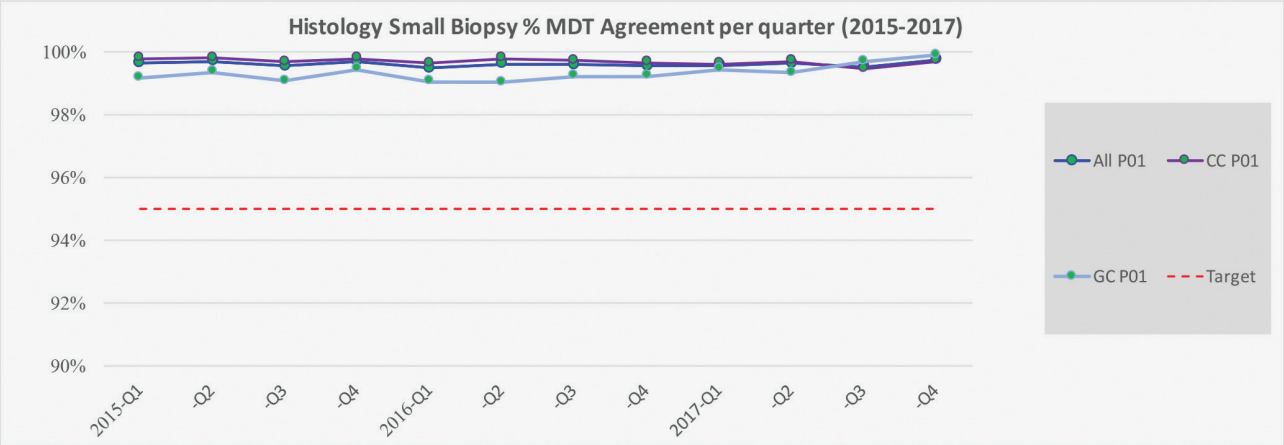
Table 6.1: *MDT Targets*

Case Type	Target
% MDT Agreement	Greater than or equal to 95%

MDT AGREEMENT–SMALL BIOPSY (P01) COMMENTARY

In 2017 nationally, with a yearly average of 99.6%, the target of 95% is met for all Small Biopsy (P01) cases with an MDT having an agreement (Quality Codes Q017).

Figure 6.1: *Quarterly graph–Histology Small Biopsy % MDT agreement*



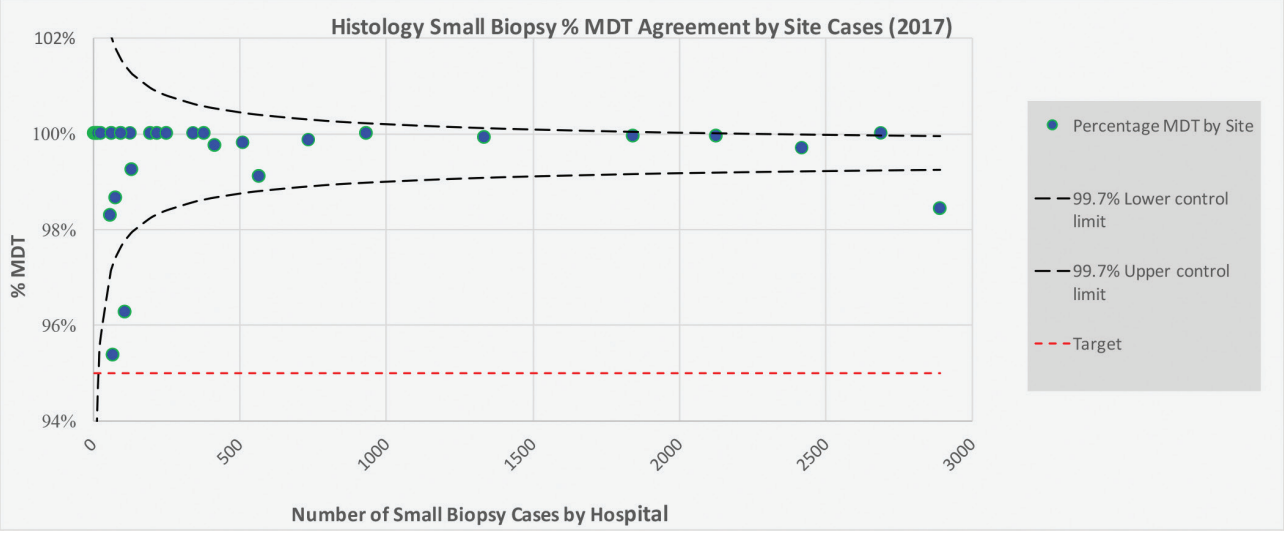
On a quarterly basis, from Q1 2015 to Q4 2017, the percentage of MDT Agreement for Small Biopsy MDTs had been consistently around 99.6%.

19% of all Small Biopsy (P01) cases were reviewed at MDT meetings in 2017; 31.1% of Cancer Centre P01 cases and 8.2% of General Centre P01 cases.

Twenty eight of thirty one hospitals were within or above the control limits. One hospital with a very large number of Small Biopsy MDTs (over 2800) was below the control limits, but still above the target for MDT agreement.

There were also 2 hospitals that had very low numbers of Small Biopsy and were below the control limits for MDT agreement, but also still above the target.

Figure 6.2: *Funnel Plot–2017 Histology Small Biopsy % MDT Agreement*



Seventeen of thirty one sites have 100% MDT agreement.

Figure 6.3: *Bar Graph–Histology Small Biopsy 2017 v 2016 MDT Agreement by site*

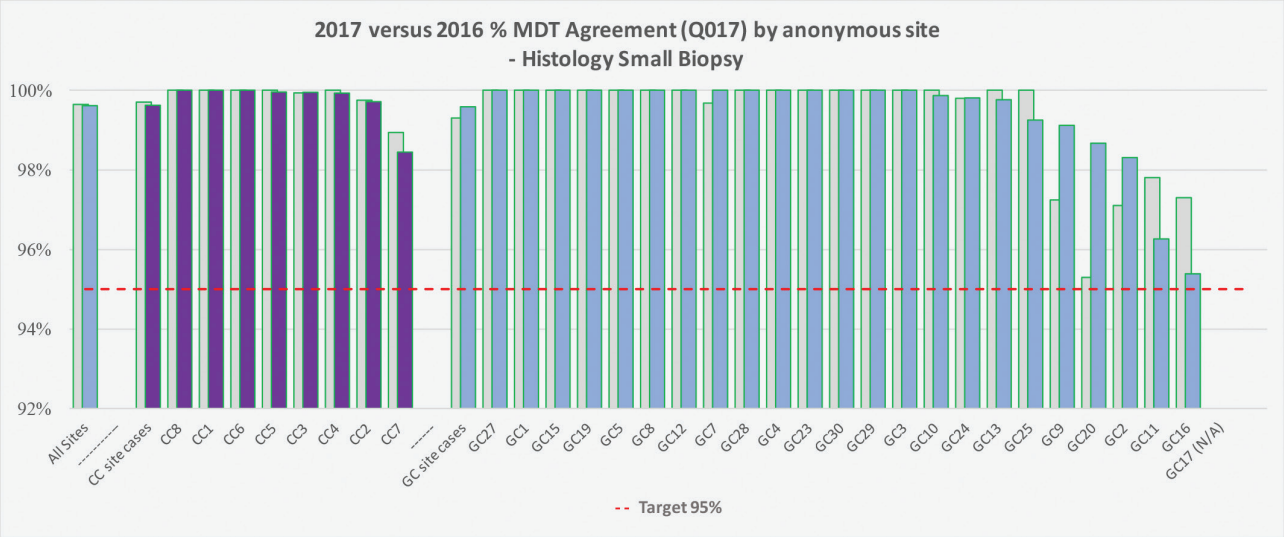


Table 6.2: *Full Data MDT Agreement 2016/2017*

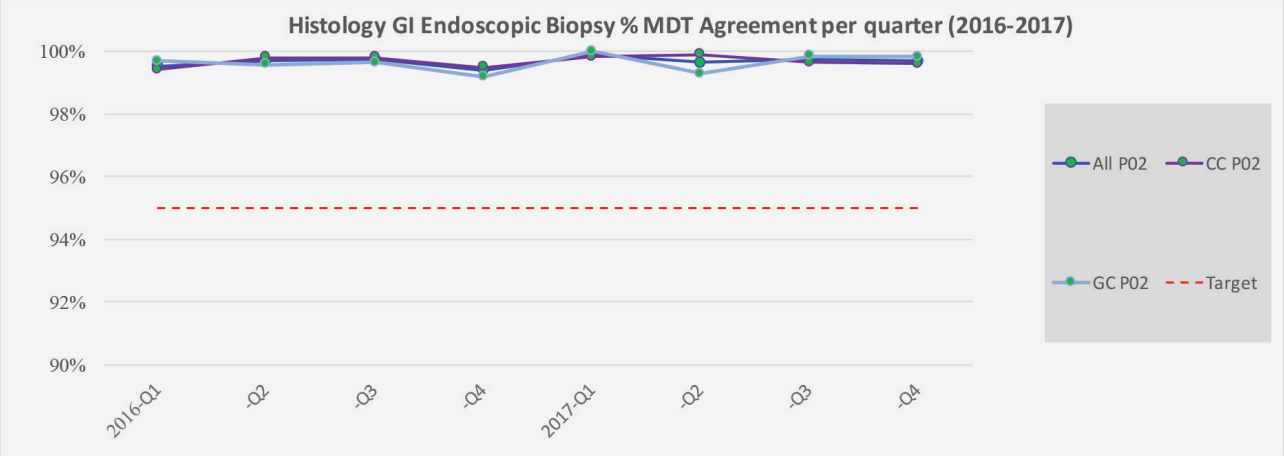
P-Codes P01	2016 MDT Agreement P01			2017 MDT Agreement P01		
	No. of MDTs	No. Q019	% Q017	No. of MDTs	No. Q019	% Q017
Cancer Centres Sites	**14099**	**36**	**99.7%**	**14484**	**55**	**99.62%**
CC1	2583	0	100.0%	2689	0	100%
CC2	2373	6	99.7%	2419	7	99.71%
CC3	1437	1	99.9%	1843	1	99.95%
CC4	1656	0	100.0%	1336	1	99.93%
CC5	2064	0	100.0%	2125	1	99.95%
CC6	1058	0	100.0%	931	0	100%
CC7	2726	29	98.9%	2890	45	98.44%
CC8	202	0	100.0%	251	0	100%
General Centre Sites	**4004**	**29**	**99.3%**	**4308**	**18**	**99.58%**
GC1	6	0	100.00%	14	0	100%
GC2	69	2	97.10%	59	1	98.31%
GC3	12	0	100.00%	7	0	100%
GC4	108	0	100.00%	95	0	100%
GC5	188	0	100.00%	193	0	100%
GC7	308	1	99.68%	378	0	100%
GC8	39	0	100.00%	24	0	100%
GC9	616	17	97.24%	565	5	99.12%

P-Codes P01 (Continued)	2016 MDT Agreement P01			2017 MDT Agreement P01		
	No. of MDTs	No. Q019	% Q017	No. of MDTs	No. Q019	% Q017
GC10	706	0	100.00%	736	1	99.86%
GC11	91	2	97.80%	107	4	96.26%
GC12	225	0	100.00%	219	0	100%
GC13	357	0	100.00%	415	1	99.76%
GC15	85	0	100.00%	127	0	100%
GC16	74	2	97.30%	65	3	95.38%
GC17						
GC19	63	0	100.0%	62	0	100%
GC20	85	4	95.3%	75	1	98.67%
GC23	233	0	100.0%	342	0	100%
GC24	490	1	99.8%	513	1	99.81%
GC25	85	0	100.0%	133	1	99.25%
GC27	98	0	100.0%	95	0	100%
GC28	49	0	100.0%	63	0	100%
GC29	1	0	100.0%	3	0	100%
GC30	16	0	100.0%	18	0	100%
All Sites	**18103**	**65**	**99.6%**	**18792**	**73**	**99.61%**

MDT AGREEMENT–GI ENDOSCOPIC BIOPSY (P02) COMMENTARY

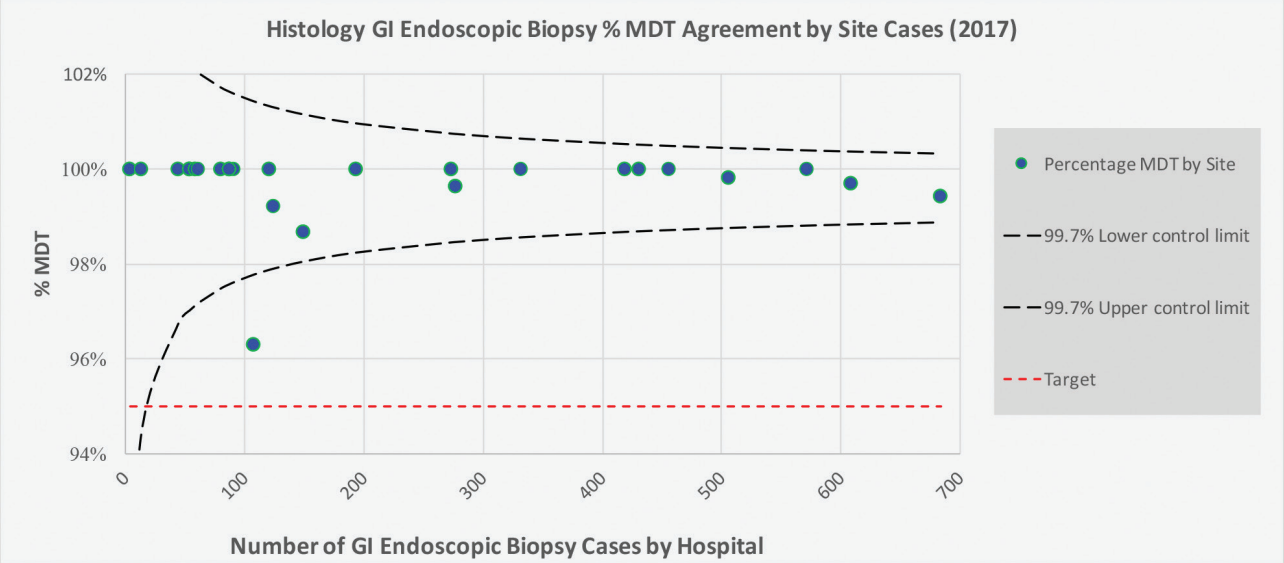
4.3% of GI Endoscopic Biopsy (P02) cases were reviewed at an MDT meeting in 2017: 5.4% of Cancer Centre P02 cases and 3.3% of General Centre P02 cases.

Figure 6.4: *Histology - GI Endoscopic Biopsy % MDT Agreement per quarter from 2016-2017*



Thirty out of thirty one hospitals were within the Control Limits. One hospital with a small number of GI Endoscopic Biopsy MDTs (circa 100) was below the control limits, but still above the target.

Figure 6.5: *Funnel Plot–Histology GI Endoscopic Biopsy % MDT Agreement by Site Cases*



Nineteen sites had 100% MDT agreement in 2017.

Figure 6.6: *Bar Graph–Histology GI Endoscopic Biopsy 2017 via 2016 % MDT agreement by site*

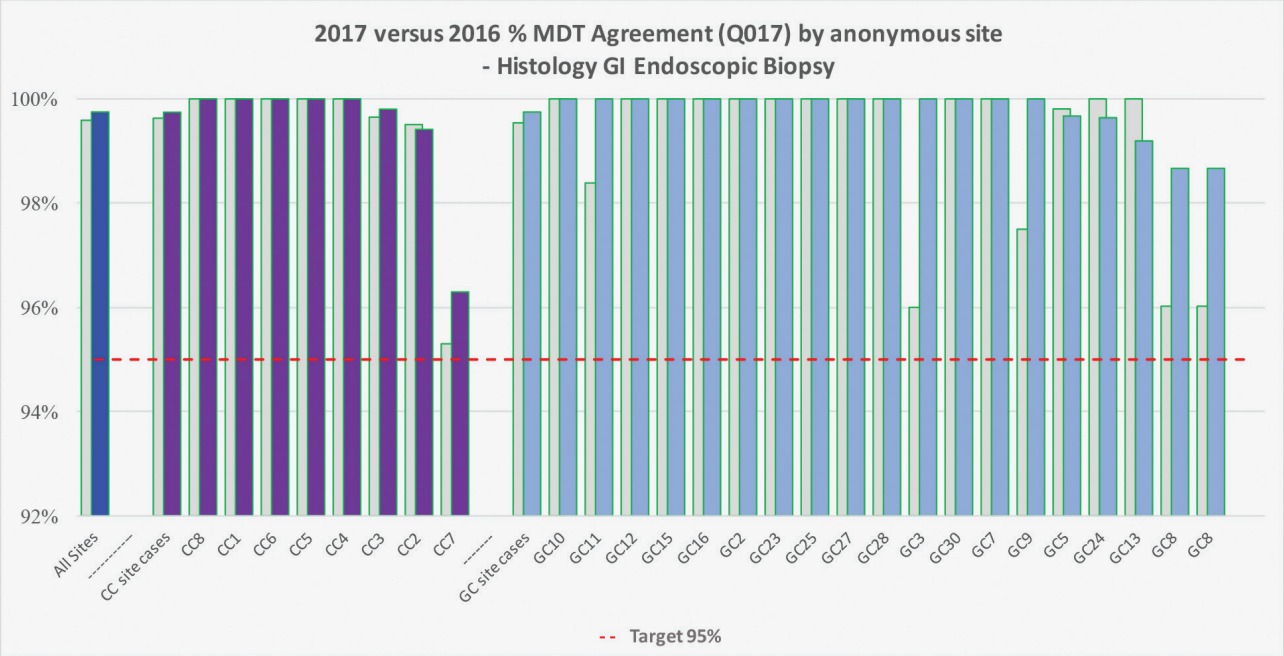


Table 6.3: *Full Data 2016/2017 MDT Agreement Histology GI Endoscopic Biopsy*

P-Codes P02	2016 MDT Agreement P02			2017 MDT Agreement P02		
	No. of MDTs	No. Q019	% Q017	No. of MDTs	No. Q019	% Q017
Cancer Centres Sites	**3757**	**14**	**99.63%**	**3508**	**9**	**99.74%**
CC1	425	0	100%	431	0	100%
CC2	1016	5	99.5%	684	4	99.42%
CC3	571	2	99.6%	506	1	99.80%
CC4	473	0	100%	332	0	100%
CC5	569	0	100%	572	0	100%
CC6	260	0	100%	456	0	100%
CC7	149	7	95.3%	108	4	96.30%
CC8	294	0	100.0%	419	0	100%
General Centre Sites	**2366**	**11**	**99.54%**	**2385**	**6**	**99.75%**
GC1						
GC2	50	0	100%	61	0	100%
GC3	25	1	96.0%	4	0	100%
GC4						
GC5	520	1	100%	609	2	99.67%
GC7	62	0	100%	91	0	100%
GC8	176	7	96.0%	150	2	98.67%
GC9	40	1	97.5%	54	0	100%
GC10	177	0	100%	194	0	100%
GC11	62	1	98.4%	59	0	100%
GC12	35	0	100%	54	0	100%
GC13	156	0	100%	124	1	99.19%
GC15	48	0	100%	45	0	100%
GC16	5	0	100%	14	0	100%
GC17						
GC19						
GC20						
GC23	105	0	100%	121	0	100%
GC24	337	0	100%	277	1	99.64%
GC25	316	0	100%	274	0	100%
GC27	79	0	100%	87	0	100%
GC28	81	0	100%	80	0	100%
GC29						
GC30	92	0	100%	87	0	100.00%
All Sites	**6123**	**25**	**99.59%**	**5893**	**15**	**99.75%**

MDT AGREEMENT–NON BIOPSY CANCER RESECTION (P03) COMMENTARY

53.9% of Non Biopsy Cancer Resection cases (P03) were reviewed at MDT meetings in 2017– 58.9% of Cancer Centre P03 cases and 39.4% of General Centre P03 cases. In 2017 nationally, with a yearly average of 99.4%, the target of 95% is met for all Cancer Resection (P03) cases with an MDT having an agreement (Quality Codes Q017).

Figure 6.7: *Histology – Non Biopsy Cancer Resection % MDT Agreement per quarter*

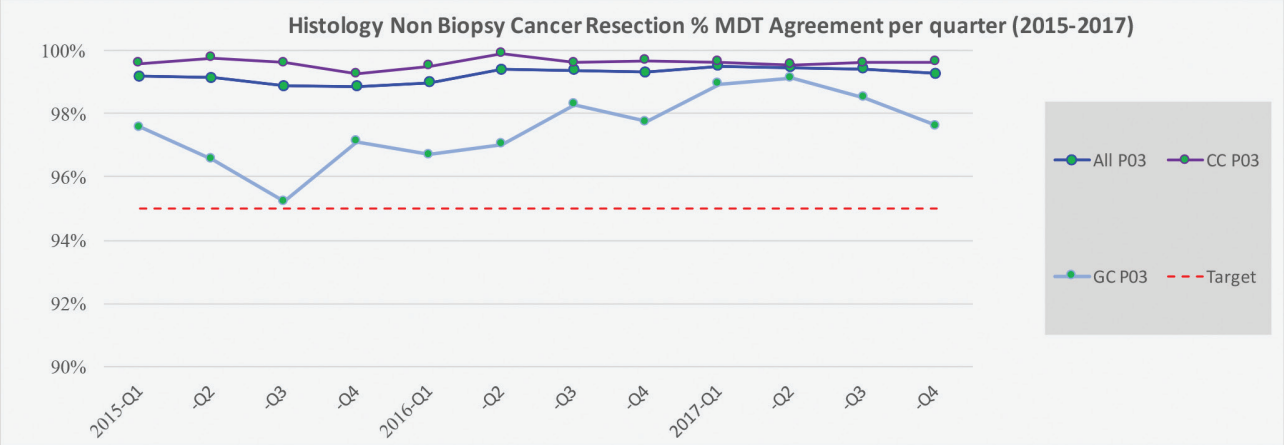
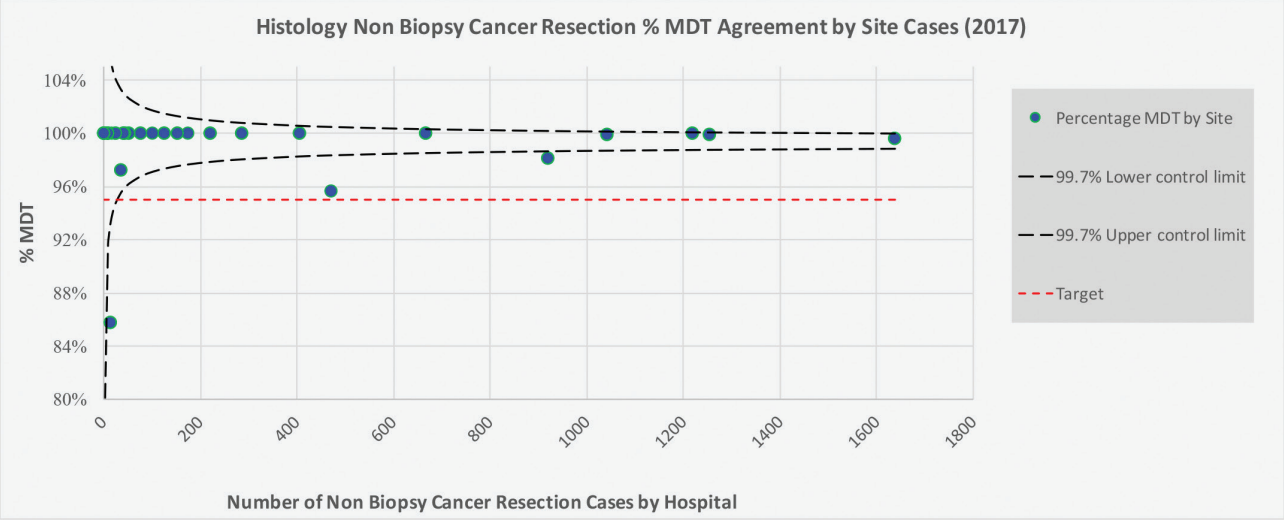


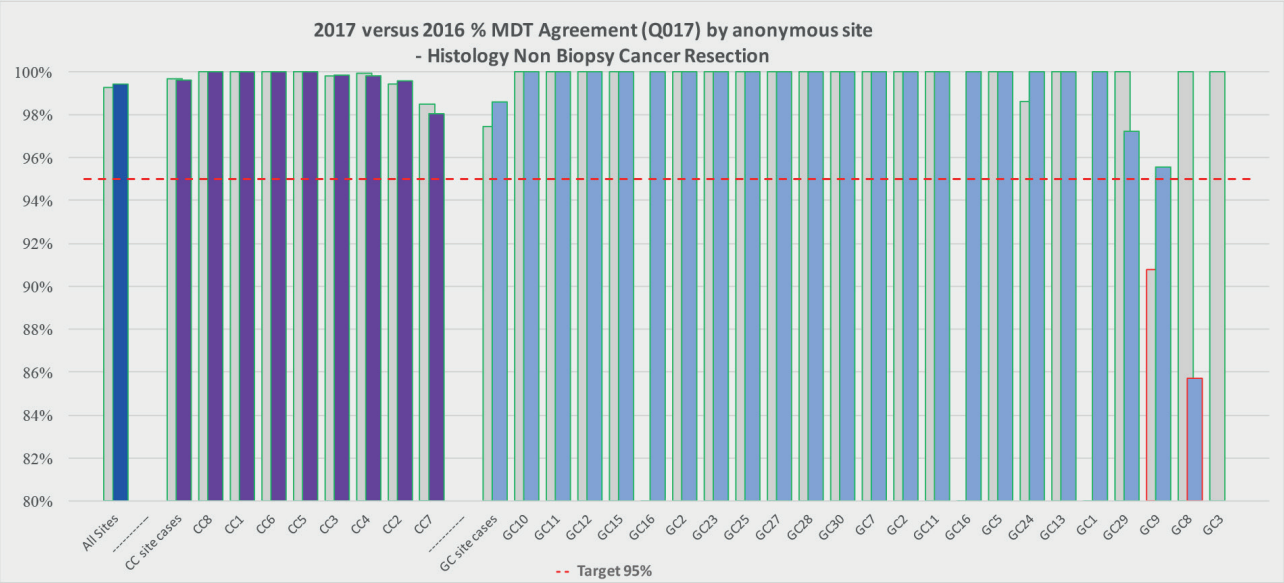
Figure 6.8: *Funnel plot–histology Non Biopsy Cancer Resection % MDT Agreement*



Three of thirty hospitals were below the Control Limits. However, two of the three were above the target of greater than or equal to 95% MDT Agreement. One hospital with a large number of Cancer Resection (P03) MDT reviews (920 cases) was below the control limits, but still above the target for MDT agreement. One hospital site was below the control limits for MDT agreement, but at 96% agreement–still above the target. There was also a hospital that had very low numbers of Cancer Resection cases, below the control limits and target for MDT agreement.

All CC sites with Non Biopsy Cancer Resections were above 95% Cancer Resection MDT agreement

Figure 6.9: *2017 versus 2016 % MDT Agreement by anonymous site*



Twenty three of thirty sites have 100% MDT agreement.

Table 6.4: *Full Data 2016/2017 MDT Agreement P03*

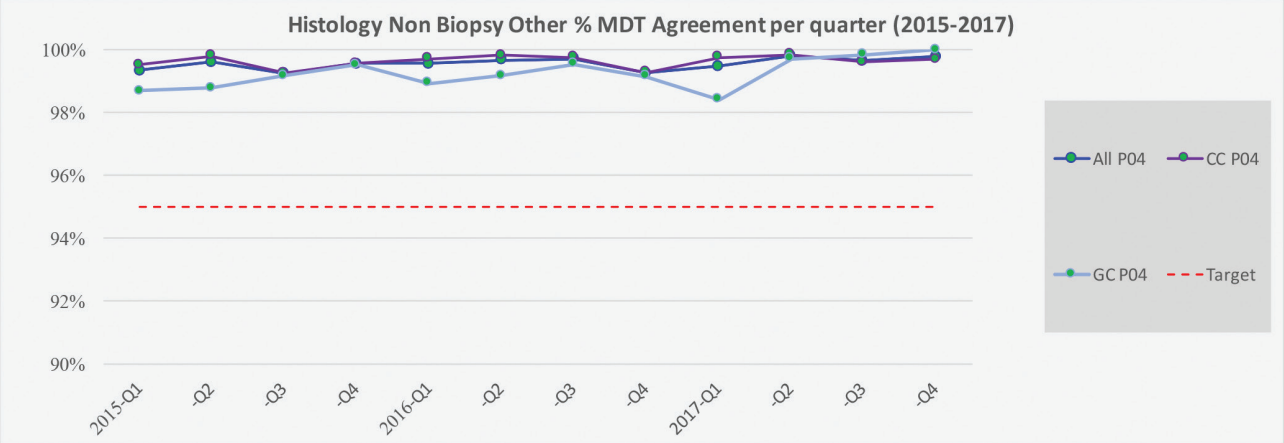
P-Codes P03	2016 MDT Agreement P03			2017 MDT Agreement P03		
	No. of MDTs	No. Q019	% Q017	No. of MDTs	No. Q019	% Q017
Cancer Centres Sites	**7349**	**24**	**99.67%**	**7371**	**29**	**99.61%**
CC1	1159	0	100%	1220	0	100%
CC2	1566	9	99.4%	1638	7	99.57%
CC3	1011	2	99.8%	1256	2	99.84%
CC4	1357	1	100%	1042	2	100%
CC5	710	0	100%	667	0	100%
CC6	562	0	100%	406	0	100%
CC7	786	12	98.5%	920	18	98.04%
CC8	198	0	100.0%	222	0	100%
General Centre Sites	**1606**	**41**	**97.45%**	**1705**	**24**	**98.59%**
GC1				1	0	100%
GC2	59	0	100%	78	0	100%
GC3	2	0	100.0%			
GC4	13	0	100%	10	0	100%
GC5	47	0	100%	25	0	100%
GC7	48	0	100%	53	0	100%
GC8	13	0	100.0%	14	2	85.71%
GC9	423	39	90.8%	473	21	96%
GC10	307	0	100%	286	0	100%
GC11	7	0	100.0%	9	0	100%
GC12	151	0	100%	103	0	100%

P-Codes P03 (Continued)	2016 MDT Agreement P03			2017 MDT Agreement P03		
	No. of MDTs	No. Q019	% Q017	No. of MDTs	No. Q019	% Q017
GC13	133	0	100%	127	0	100%
GC15	35	0	100%	42	0	100%
GC16	0	0		10	0	100%
GC17						
GC19				1	0	100%
GC20						
GC23	86	0	100%	176	0	100%
GC24	144	2	99%	154	0	100%
GC25	16	0	100%	19	0	100%
GC27	23	0	100%	45	0	100%
GC28	2	0	100%	1	0	100%
GC29	58	0	100.0%	36	1	97.22%
GC30	39	0	100%	42	0	100%
All Sites	**8955**	**65**	**99.27%**	**9076**	**53**	**99.42%**

MDT AGREEMENT–NON BIOPSY OTHER (P04) COMMENTARY

Non biopsy other cases subjected to MDT review as a whole were consistently above the target.

Figure 6.10: *Histology Non Biopsy Other % MDT Agreement per quarter (2015-2017)*

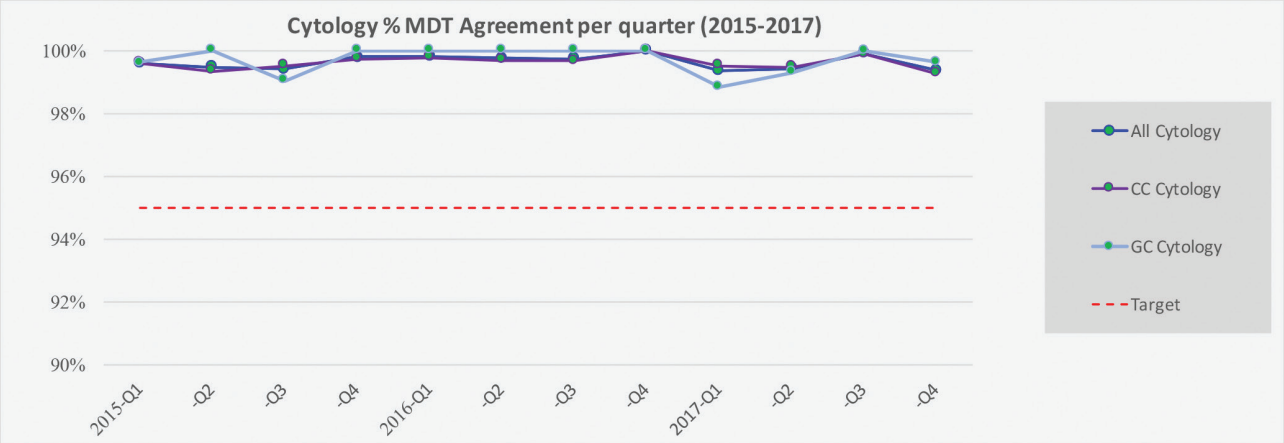


MDT AGREEMENT–CYTOLOGY COMMENTARY

15% of Cytology (P06 and P07) were reviewed at MDT in 2017; 17% of Cancer Centre Cytology cases and 10% of General Centres Cytology cases.

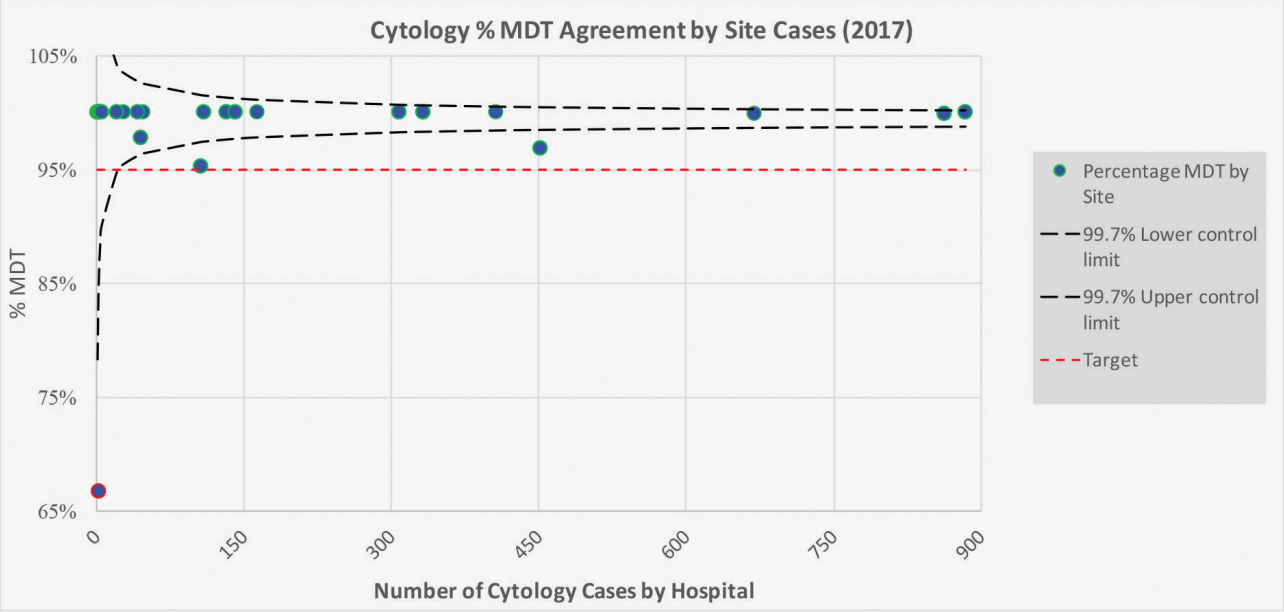
Cancer Centres (CCs) averaged at 99.5% MDTs agreement for the year, slightly below 2016 data which was 99.8%. General Centres (GCs) averaged at 99.4%, slightly down from 100% for the previous year. GC sites had 100% for MDT agreement for 7 of 12 quarters over the past 3 years.

Figure 6.11: *Cytology % MDT Agreement per quarter (2015-2017)*



Cytology MDT agreement as a whole was consistently above the target

Figure 6.12: *Funnel plot – Cytology % MDT Agreement by site cases (2017)*



There was one site well below the control limits, but this site had very few cytology MDTs recorded (three cases in total during 2017).

Figure 6.13: *2017 versus 2016 % MDT Agreement by anonymous site – cytology*

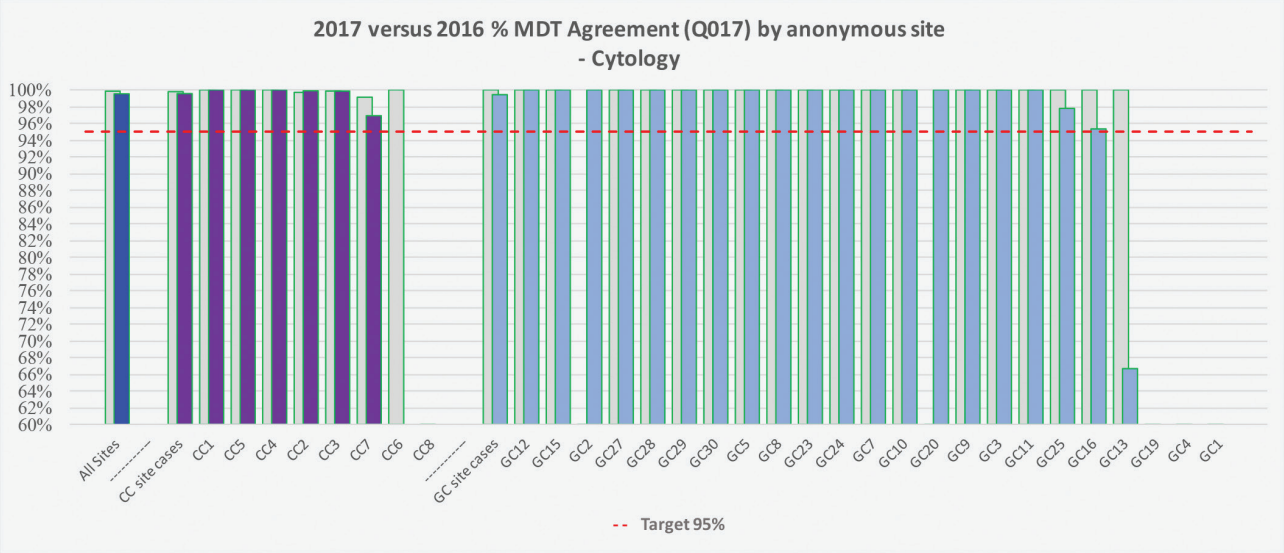


Table 6.5: *Full Data 2016/2017 MDT Cytology*

Cytology-P06, P07	2016 MDT Agreement Cytology			2017 MDT Agreement Cytology		
	No. of MDTs	No. Q019	% Q017	No. of MDTs	No. Q019	% Q017
Cancer Centre Sites	**3684**	**8**	**99.78%**	**3585**	**16**	**99.55%**
CC1	789	0	100%	884	0	100%
CC2	975	3	99.69%	863	1	99.88%
CC3	676	1	99.85%	671	1	99.85%
CC4	351	0	100%	308	0	100%
CC5	422	0	100%	407	0	100%
CC6	18	0	100%	0	0	
CC7	453	4	99.12%	452	14	96.90%
CC8	0	0		0	0	
General Centre Sites	**991**	**0**	**100.00%**	**1200**	**7**	**99.42%**
GC1	0	0		0	0	
GC2	0	0		1	0	100%
GC3	2	0	100%	2	0	100%
GC4	0	0		0	0	
GC5	2	0	100%	4	0	100%
GC7	110	0	100%	164	0	100%
GC8	12	0	100%	4	0	100%
GC9	101	0	100%	133	0	100%
GC10	316	0	100%	333	0	100%
GC11	51	0	100%	48	0	100%
GC12	8	0	100%	21	0	100%
GC13	3	0	100%	3	1	66.67%
GC15	15	0	100%	42	0	100%
GC16	109	0	100%	107	5	95.33%
GC17	0	0		0	0	
GC19	0	0		0	0	
GC20	0	0		3	0	100%
GC23	48	0	100%	109	0	100%
GC24	126	0	100%	141	0	100%
GC25	52	0	100%	45	1	97.78%
GC27	18	0	100%	29	0	100%
GC28	5	0	100%	2	0	100%
GC29	11	0	100%	5	0	100%
GC30	2	0	100%	4	0	100%
All Sites	**4675**	**8**	**99.83%**	**4785**	**23**	**99.52%**

CHAPTER 7:

ADDENDUM REPORTS

An addendum report refers to any pathology report issued subsequent to the original report and should be classified as amended, corrected or supplementary. There are three recommended quality activity codes pertaining to Addendum reports.

AMENDED REPORTS – Q021

A change to the pathologic interpretation occurs that may give rise to a change in treatment/ prognosis[1]

This is the report issued when the final report diagnosis changes due to a change in interpretation 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, because an amended report may significantly affect patient care.

CORRECTED REPORTS – Q022

A transcription or identification error, without a change to the diagnostic information[1]

A report issued when transcription, patient identification, specimen site, or other related reporting errors occur. Corrected reports do not change original interpretive diagnosis.

SUPPLEMENTARY REPORTS – Q020

A report issued when new information becomes available after the final report has been submitted[1]

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 consultations may be included in a supplementary report.

When issued following a provisional report, the supplementary report acts as the final report. If the original report does not indicate further studies/opinions are being sought and the subsequent supplementary information changes the original diagnoses, the addendum report should be classified as amended.

Table 7.1 *Addendum Reports Recommendations*

Key Quality Area	Recommendations	Notes
Addendum Reports	% Amended Reports 1. Histology cases 1% or less 2. Cytology cases 1% or less % Corrected Reports 3. Histology cases 2% or less 4. Cytology cases 2% or less % Supplementary Reports 5. Histology cases 10% or less 6. Cytology cases 10% or less	1%/2% or less Classification of amended / corrected reports is to be further reviewed with a view to setting a target. Case mix can impact supplementary report rate and should be noted on NQAIS reports as applicable.

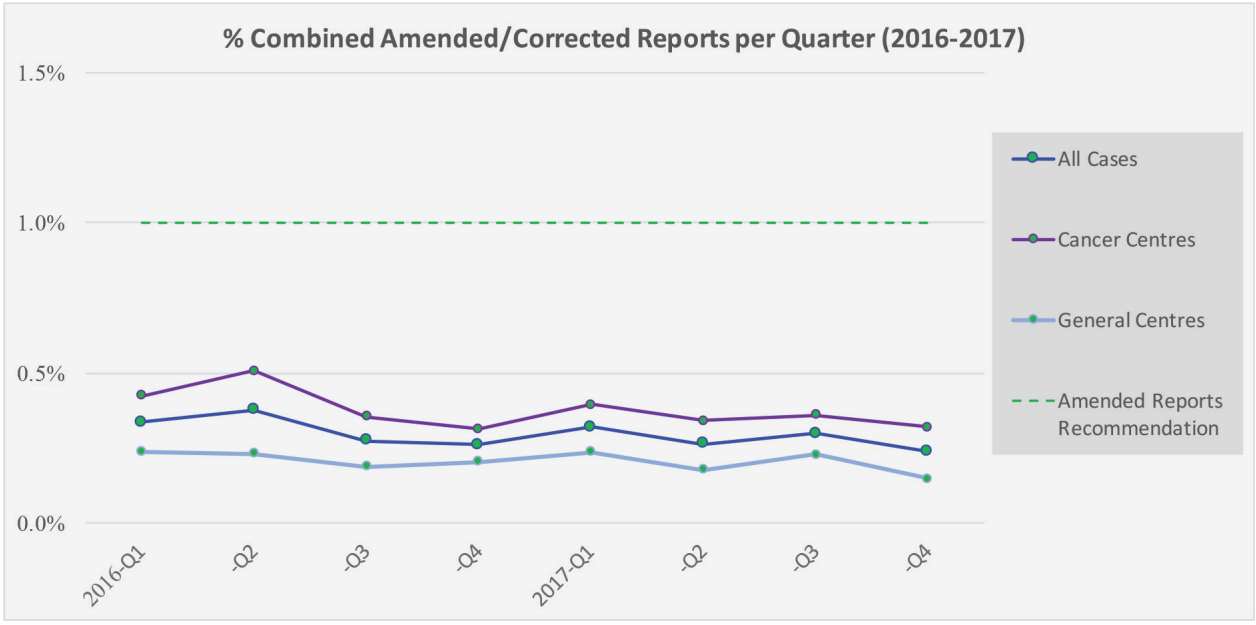
1 A multi-institutional audit of amended and corrected reports at three participating laboratories showed significant misclassification of these two categories. We have therefore combined the two for data purposes.

Monitoring Error in Histopathology-A Multi-Institutional Audit of Addendum Reports, USCAP Vancouver 2018, S.Phelan et al

COMBINED AMENDED/CORRECTED REPORTS COMMENTARY-ALL HISTOLOGY/CYTOLOGY (P01-P09)

In 2017 nationally, the combined yearly average for corrected and amended reports was 0.28%. This is within the recommendation of 1% for all non-autopsy Histology/Cytology (P01, P02, P03, P04, P05, P06, P07, P09) (Quality Codes Q021, Q022).

Figure 7.1: *% Combined Amended/Corrected Reports per Quarter 2016 and 2017*

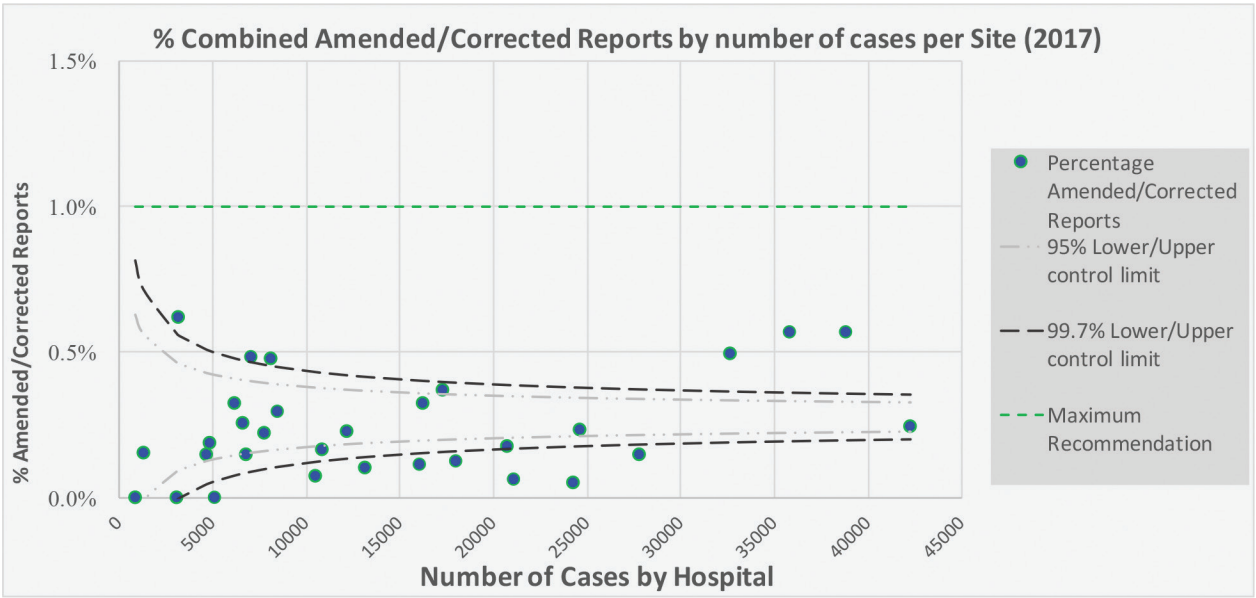


On a quarterly basis, from Q1 2016 to Q4 2017, the percentage of combined amended and corrected reports have been steadily declining from 0.34% in Q1 2016 to 0.24% in Q4 2017.

The recommendation of achieving less than the 1% maximum for all Histology-Cytology Amended/Corrected reports was met in all 32 sites for all months of 2017

A very low level of corrected/amended reports raises a concern over completeness of coding in some centres. Summary of percentage of cases with revised Reports: For 2017–(CC–0.35%, GC–0.20%), compared with 2016 (CC–0.40%, GC–0.21%).

Figure 7.2: *Funnel Plot % Combined Amended/Corrected Reports*



From the funnel plot we can see that seventeen sites were within the control limits for 2017. Three sites with large numbers of cases were above the control limits. Eight sites were below the control limits, having low levels of amended and corrected reporting recorded.

Figure 7.3. *Histology/Cytology % Combined Amended/Corrected Reports (2017 v 2016 in Grey)*

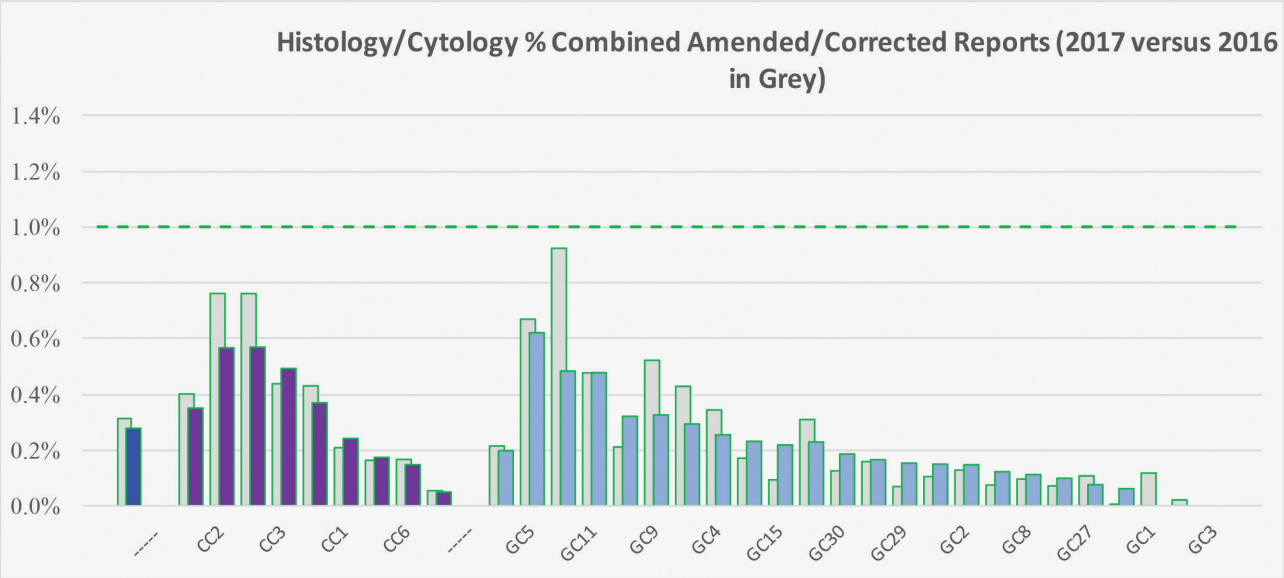


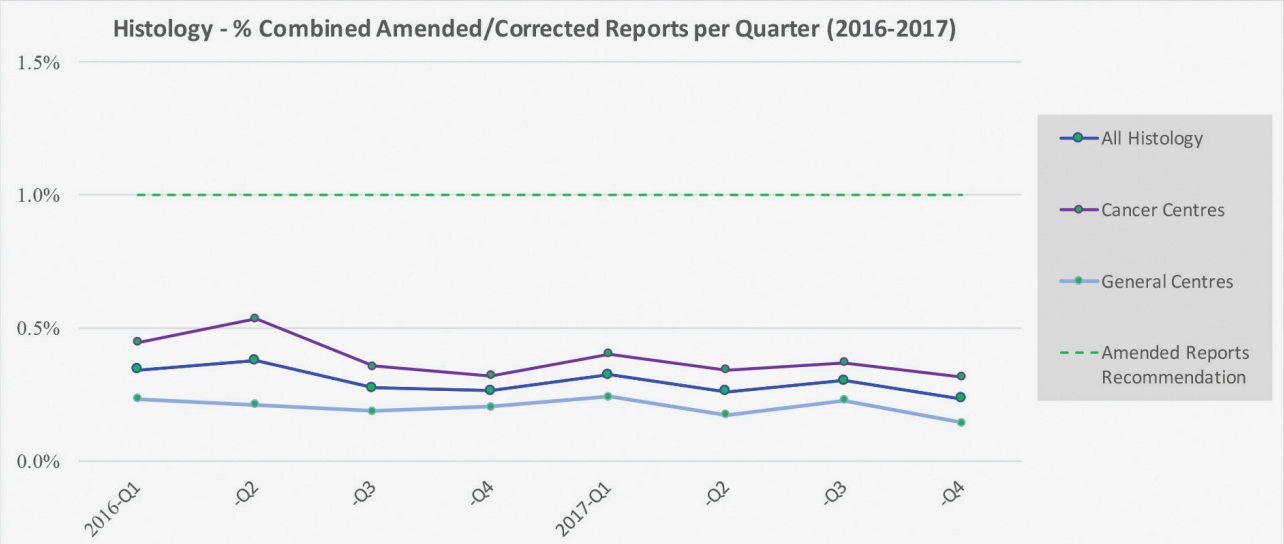
Table 7.2: *All Data Amended/Corrected Reports 2016/2017*

All P-Codes	2016 Amended/Corrected Reports			2017 Amended/Corrected Reports		
	No. of Cases	No. Q021/ Q022	% Q021/ Q022	No. of Cases	No. Q021/ Q022	% Q021/ Q022
CC Sites	**231849**	**930**	**0.40%**	**239777**	**840**	**0.35%**
CC1	40315	84	0.21%	42261	102	0.24%
CC2	33236	253	0.76%	35838	203	0.57%
CC3	33121	145	0.44%	32705	161	0.49%
CC4	37333	284	0.76%	38859	221	0.57%
CC5	19613	32	0.16%	20737	36	0.17%
CC6	27640	46	0.17%	27772	41	0.15%
CC7	16974	73	0.43%	17316	64	0.37%
CC8	23617	13	0.06%	24289	12	0.05%
GC Sites	**211157**	**453**	**0.21%**	**217223**	**430**	**0.20%**
GC1	851	1	0.12%	864	0	0.00%
GC2	12930	40	0.31%	12230	28	0.23%
GC3	8185	39	0.48%	8171	39	0.48%
GC4	7475	69	0.92%	7038	34	0.48%
GC5	8637	37	0.43%	8523	25	0.29%
GC7	7505	7	0.09%	7784	17	0.22%
GC8	4701	1	0.02%	5137	0	0.00%
GC9	0	0	0.00%	0	0	0.00%
GC10	4764	5	0.10%	4682	7	0.15%

All P-Codes (Continued)	2016 Amended/Corrected Reports			2017 Amended/Corrected Reports		
	No. of Cases	No. Q021/ Q022	% Q021/ Q022	No. of Cases	No. Q021/ Q022	% Q021/ Q022
GC11	7021	9	0.13%	6784	10	0.15%
GC12	6164	13	0.21%	6232	20	0.32%
GC13	11207	8	0.07%	13127	13	0.10%
GC15	25180	43	0.17%	24660	57	0.23%
GC16	10084	16	0.16%	10892	18	0.17%
GC17	10248	11	0.11%	10528	8	0.08%
GC19	16098	12	0.07%	17986	22	0.12%
GC20	1443	1	0.07%	1304	2	0.15%
GC23	3144	0	0.00%	3127	0	0.00%
GC24	4783	6	0.13%	4844	9	0.19%
GC25	6108	21	0.34%	6671	17	0.25%
GC27	2840	19	0.67%	3223	20	0.62%
GC28	21012	1	0.00%	21121	13	0.06%
GC29	15628	15	0.10%	16032	18	0.11%
GC30	15149	79	0.52%	16263	53	0.33%
All Sites	**443006**	**1383**	**0.31%**	**457000**	**1270**	**0.28%**

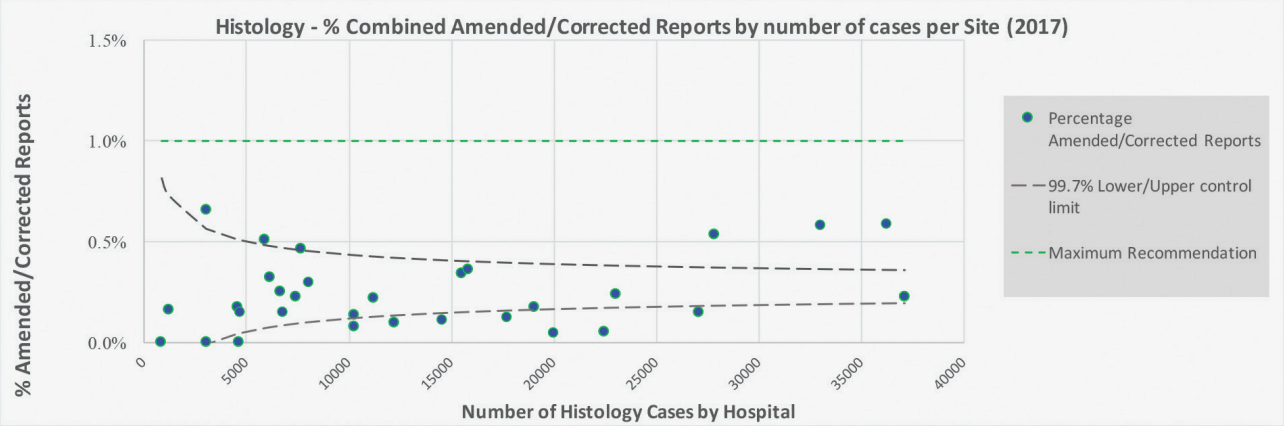
COMBINED AMENDED/CORRECTED REPORTS–ALL HISTOLOGY (P01-P04)

Figure 7.4: *Histology only % Combined Amended/Corrected Reports per quarter (2016-2017)*



For Histology Amended/Corrected Reports all 32 sites were below the maximum 1% target, stabilising around 0.30%

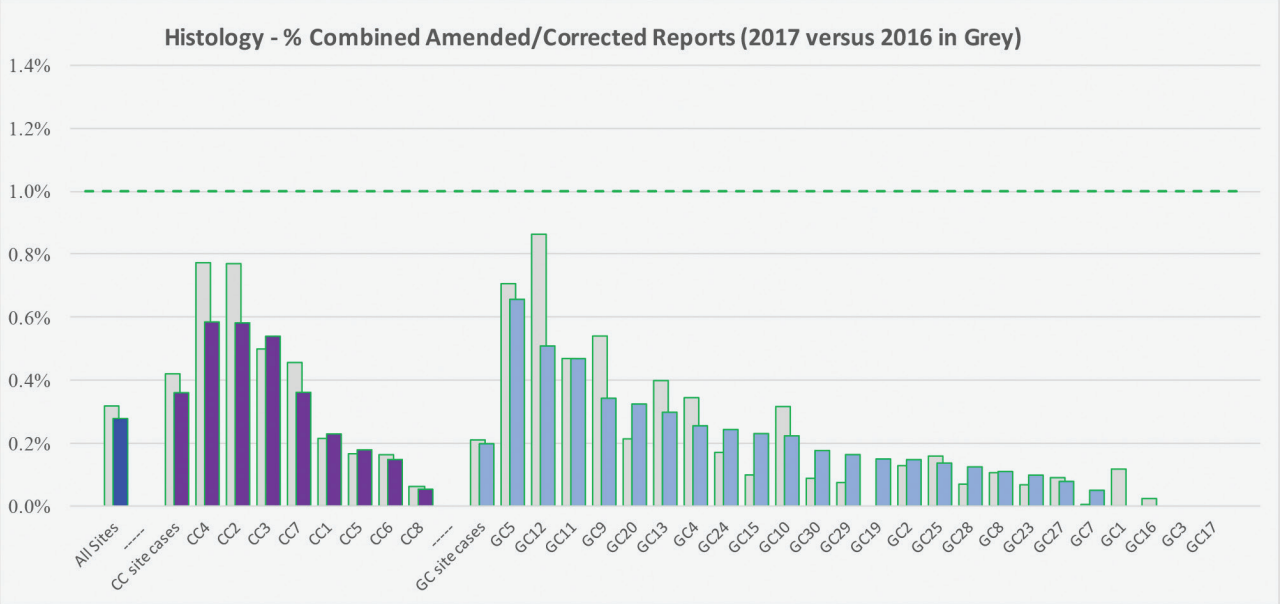
Figure 7.5: *Funnel Plot–Histology only % Combined Amended/Corrected Reports*



From the funnel plot we can see seventeen hospitals were within the control limits. Three sites with large numbers of cases were above the control limits, as well as eight sites that were below the control limits.

These had very low levels of histology revised reporting, as outlined in the previous combined Histology/Cytology section.

Figure 7.6: *Histology only % Combined Amended/Corrected Reports 2017 v 2016*



Histology amended/corrected reporting as a whole were consistently below the maximum target of 1.00%. While remaining below the maximum target, Histology nationally stabilised approximately at 0.30% of cases with combined amended and corrected reports, ranging from 0.38% to 0.23% during 2017.

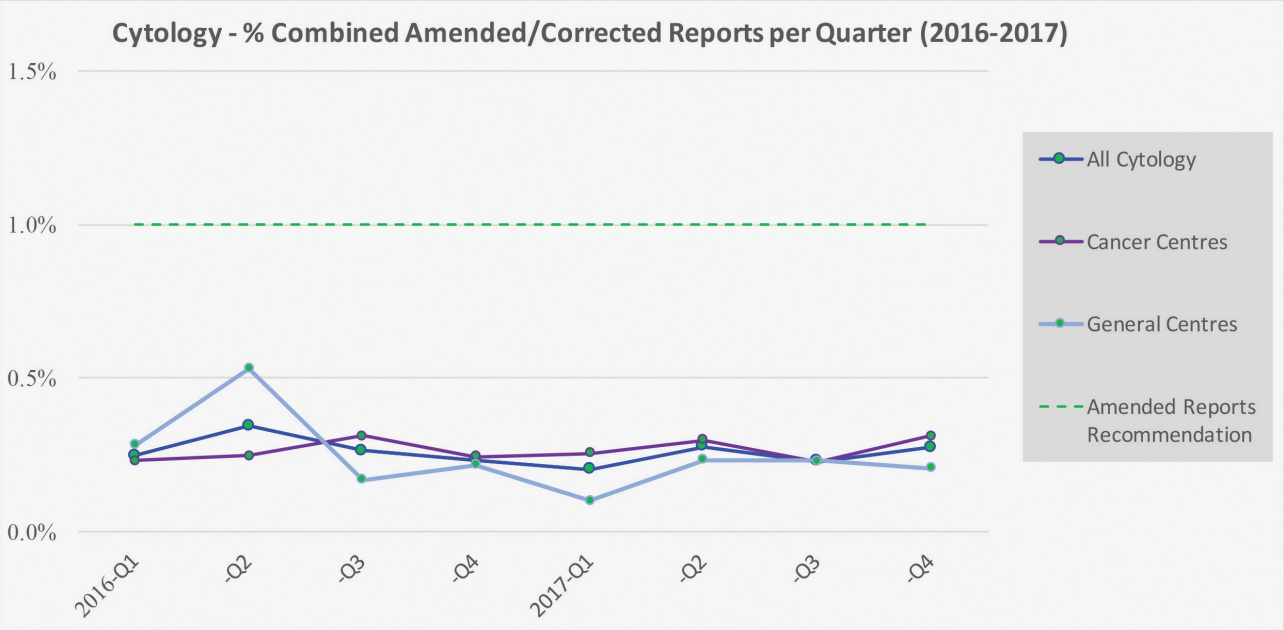
Cancer Centres (CCs), met the 1% target for all 12 months of 2017, having on average a lower percentage of amended and corrected reports for 2017, 0.36%, compared with the 0.42% for 2016 General Centres (GCs) also met the target for all 12 months of 2017, averaging at 0.20% for the year, which was just below last year's 0.21%.

Table 7.3: *Histology Data Amended/Corrected Reports 2016/2017*

Histology P-Codes	2016 Amended/Corrected Reports			2017 Amended/Corrected Reports		
	No. of Cases	No. Q021/ Q022	% Q021/ Q022	No. of Cases	No. Q021/ Q022	% Q021/ Q022
CC Sites	**210117**	**874**	**0.42%**	**218539**	**782**	**0.36%**
CC1	35399	76	0.21%	37108	85	0.23%
CC2	30526	235	0.77%	33001	192	0.58%
CC3	27463	137	0.50%	27808	150	0.54%
CC4	34801	269	0.77%	36251	212	0.58%
CC5	18049	30	0.17%	19045	34	0.18%
CC6	26986	44	0.16%	27087	40	0.15%
CC7	15352	70	0.46%	15783	57	0.36%
CC8	21541	13	0.06%	22456	12	0.05%
GC Sites	**199580**	**418**	**0.21%**	**205307**	**407**	**0.20%**
GC1	851	1	0.12%	864	0	0.00%
GC2	7021	9	0.13%	6783	10	0.15%
GC3	3074	0	0.00%	3026	0	0.00%
GC4	6099	21	0.34%	6668	17	0.25%
GC5	2690	19	0.71%	3046	20	0.66%
GC7	19851	1	0.01%	19969	10	0.05%
GC8	14162	15	0.11%	14578	16	0.11%
GC9	14444	78	0.54%	15477	53	0.34%
GC10	12026	38	0.32%	11208	25	0.22%
GC11	7683	36	0.47%	7686	36	0.47%
GC12	6255	54	0.86%	5901	30	0.51%
GC13	8281	33	0.40%	8054	24	0.30%
GC15	7088	7	0.10%	7387	17	0.23%
GC16	4196	1	0.02%	4617	0	0.00%
GC17	0	0	0.00%	0	0	0.00%
GC19	4764	5	0.10%	4682	7	0.15%
GC20	6092	13	0.21%	6172	20	0.32%
GC23	10378	7	0.07%	12218	12	0.10%
GC24	23488	40	0.17%	23038	56	0.24%
GC25	9455	15	0.16%	10255	14	0.14%
GC27	9976	9	0.09%	10230	8	0.08%
GC28	15823	11	0.07%	17688	22	0.12%
GC29	1339	1	0.07%	1224	2	0.16%
GC30	4544	4	0.09%	4536	8	0.18%
All Sites	**409697**	**1292**	**0.32%**	**423846**	**1189**	**0.28%**

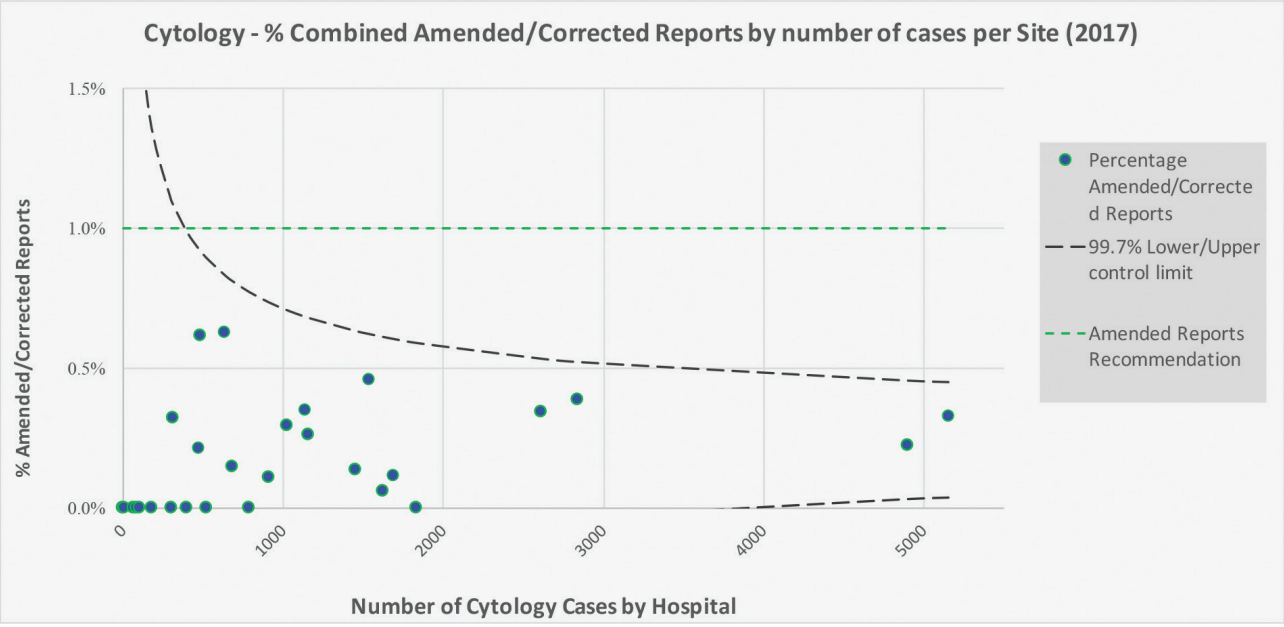
COMBINED AMENDED/CORRECTED REPORTS–ALL CYTOLOGY (P05-P09)

FIGURE 7.7: *CYTOLOGY ONLY, % COMBINED AMENDED/CORRECTED REPORTS PER QUARTER (2016-2017)*



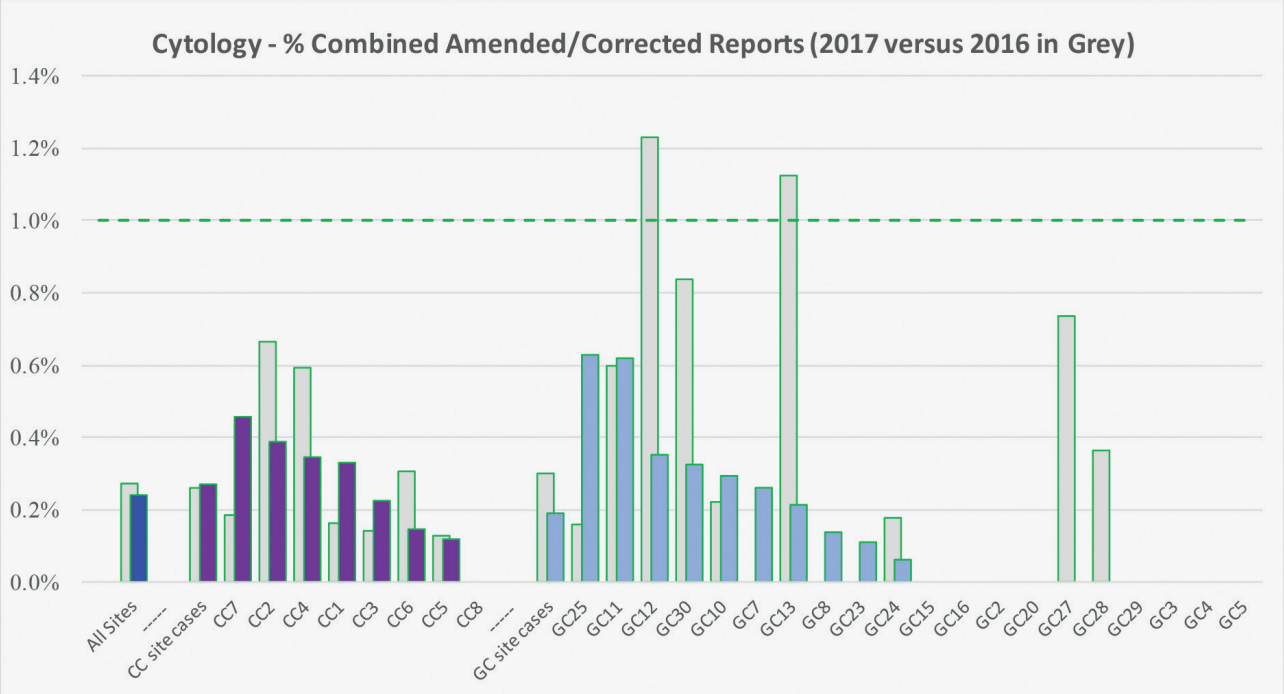
Eight GC sites and one CC site have 0% of Cytology cases with amended/corrected reports. This low level of amendments and corrections may reflect a lack of coding. Summary of percentage of cases with amended/corrected reports for 2017 (CC: 0.27%, GC: 0.19%), compared with 2016 (CC: 0.26%, GC: 0.30%).

FIGURE 7.8: *CYTOLOGY ONLY % COMBINED AMENDED/CORRECTED REPORTS PER SITE (2017)*



There is big variation in the sites numbers and percentages but all sites are within the control limits.

Figure 7.9: *Cytology only, % Combined Amended/Corrected Reports (2017 v 2016 in Grey)*



In 2017 nationally, the combined amended and corrected report rate was 0.24% for all cytology cases (P05, P06, P07, P09), (Quality Codes Q021, Q022). This is well within the recommendations and key indicators set by the Histopathology QI working group. In addition, this achievable target was met every month of 2017. All 32 sites were below the maximum 1% recommendation, an improvement on 2016 where 30 of 32 sites were below the maximum recommendation. In 2016 five sites (one CC and four GCs) had more than 0.6% of cases with amended or corrected Report, while in 2017 only two GCs have.

For Cytology amended/corrected reports in all 32 sites were below the maximum 1% recommendation, at 0.24%

Table 7.4: *Cytology Only All Data Amended/Corrected Reports 2016/2017*

Cytology P-Codes	2016 Amended/Corrected Reports			2017 Amended/Corrected Reports		
	No. of Cases	No. Q021/ Q022	% Q021/ Q022	No. of Cases	No. Q021/ Q022	% Q021/ Q022
CC Sites	**21732**	**56**	**0.26%**	**21238**	**58**	**0.27%**
CC1	4916	8	0.16%	5153	17	0.33%
CC2	2710	18	0.66%	2837	11	0.39%
CC3	5658	8	0.14%	4897	11	0.22%
CC4	2532	15	0.59%	2608	9	0.35%
CC5	1564	2	0.13%	1692	2	0.12%
CC6	654	2	0.31%	685	1	0.15%
CC7	1622	3	0.18%	1533	7	0.46%
CC8	2076	0	0.00%	1833	0	0.00%
GC Sites	**11577**	**35**	**0.30%**	**11916**	**23**	**0.19%**
GC3	70	0	0.00%	101	0	0.00%
GC4	9	0	0.00%	3	0	0.00%
GC5	150	0	0.00%	177	0	0.00%
GC7	1161	0	0.00%	1152	3	0.26%
GC8	1466	0	0.00%	1454	2	0.14%
GC9	705	1	0.14%	786	0	0.00%
GC10	904	2	0.22%	1022	3	0.29%
GC11	502	3	0.60%	485	3	0.62%
GC12	1220	15	1.23%	1137	4	0.35%
GC13	356	4	1.12%	469	1	0.21%
GC15	417	0	0.00%	397	0	0.00%
GC16	505	0	0.00%	520	0	0.00%
GC20	72	0	0.00%	60	0	0.00%
GC23	829	1	0.12%	909	1	0.11%
GC24	1692	3	0.18%	1622	1	0.06%
GC25	629	1	0.16%	637	4	0.63%
GC27	272	2	0.74%	298	0	0.00%
GC28	275	1	0.36%	298	0	0.00%
GC29	104	0	0.00%	80	0	0.00%
GC30	239	2	0.84%	308	1	0.32%
Grand Total	**33309**	**91**	**0.27%**	**33154**	**81**	**0.24%**

CHAPTER 8:

TURNAROUND TIME

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 its impact on the clinical management of patients. Turnaround time is measured from the time the laboratory receives the specimen to the time the final report is authorised. Turnaround time is calculated based on working days and does not include weekends or bank holidays.

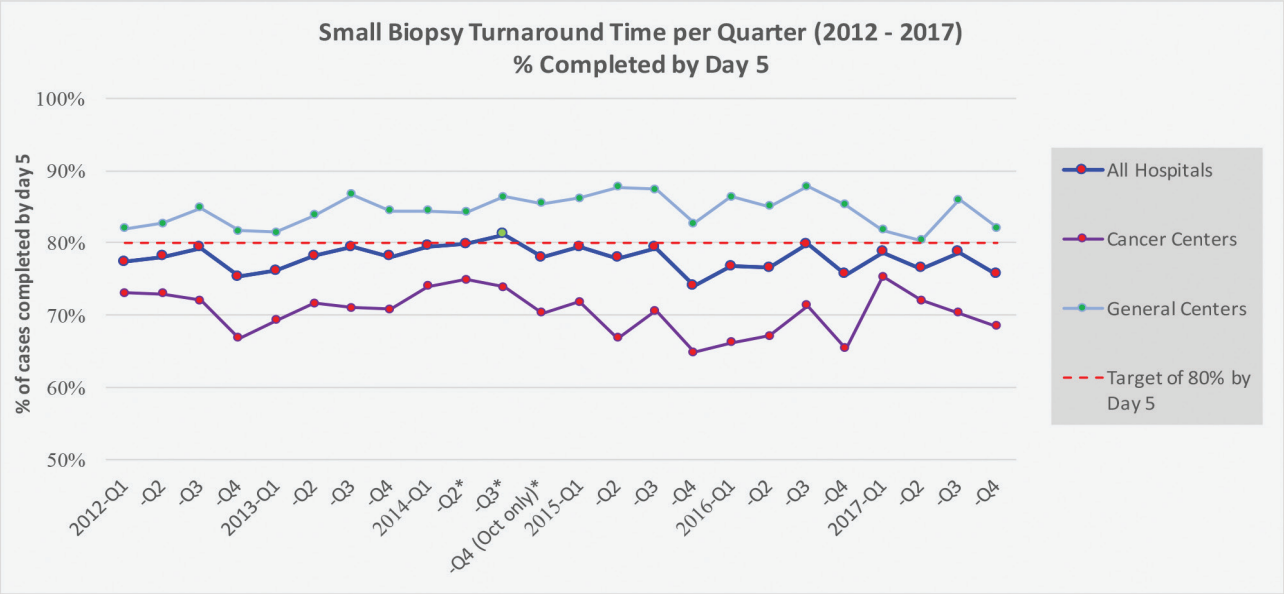
To ensure a meaningful representation of hospital case turnaround time, separate classification of Biopsy TAT and Non Biopsy TAT is recommended. Non-Biopsy cases should be further classified into Cancer Resections (by organ/site) and into all other cases.

Table 8.1: *Turn Around Time Achievable Targets*

Case Type	Achievable Target
Small Biopsy	80% of cases Turned Around in 5 days or less
GI Biopsy	80% of cases Turned Around in 5 days or less
Non Biopsy–Cancer Resection	80% of cases Turned Around in 7 days or less
Non Biopsy–Other	80% of cases Turned Around in 7 days or less
Cytology FNA	80% of cases Turned Around in 5 days or less
Cytology Exfoliative	80% of cases Turned Around in 5 days or less

SMALL BIOPSY (P01) TAT COMMENTARY

Figure 8.1: *Small Biopsy (P01) TAT per Quarter (2012-2017) % completed by Day 5*



*One CC was not providing QI data during this period

In 2017 nationally, the 80% Completed Day 5 Target for Small Biopsy (P01) cases was not met. The national average for the year was 77.4%, less than 3% below target. The target was met in hospitals outside of the main Cancer Centres, this may relate to case complexity.

The performance against this target of 80% of cases to be completed by day 5 was very similar to that in 2016 (up 0.2%).

The number of Cancer Centre cases Turnaround Time by day 5 was up by over 4% from 2016 figures from 67.5% to 71.6%.

The number of General Centre cases Turnaround by day 5 was down by over 3% from 2016 figures from 86.1% to 82.5%, but is still above the target.

Nationally, TAT for P01 was stable but just under the target for the last 6 years.

If data is split out by CC and GC sites, then the GC sites surpassed the target for all 12 months of 2017 and the CC sites did not (GC: 82.5%, CC: 71.6%), when compared with 2016 (GC: 86%, CC: 67.5%).

Figure 8.2: *Small Biopsy (P01) TAT % completed by day 5 (2017)*

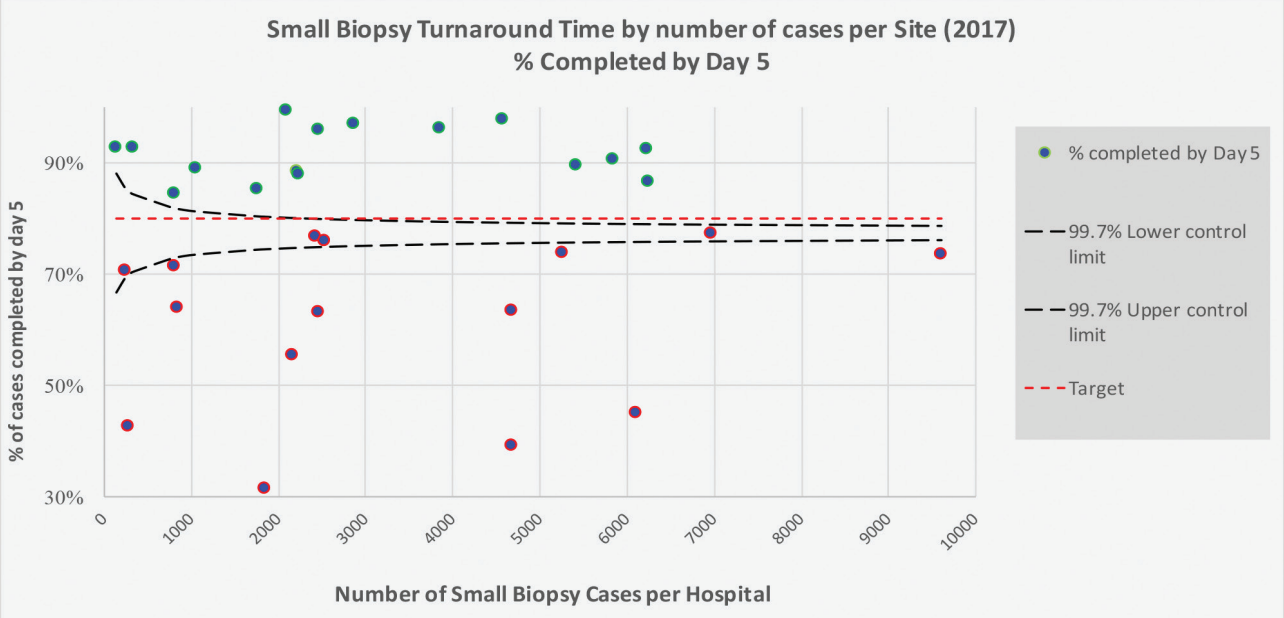


Figure 8.3: *TAT per Quarter of Small Biopsy % Completed by day 5 2017/2016*

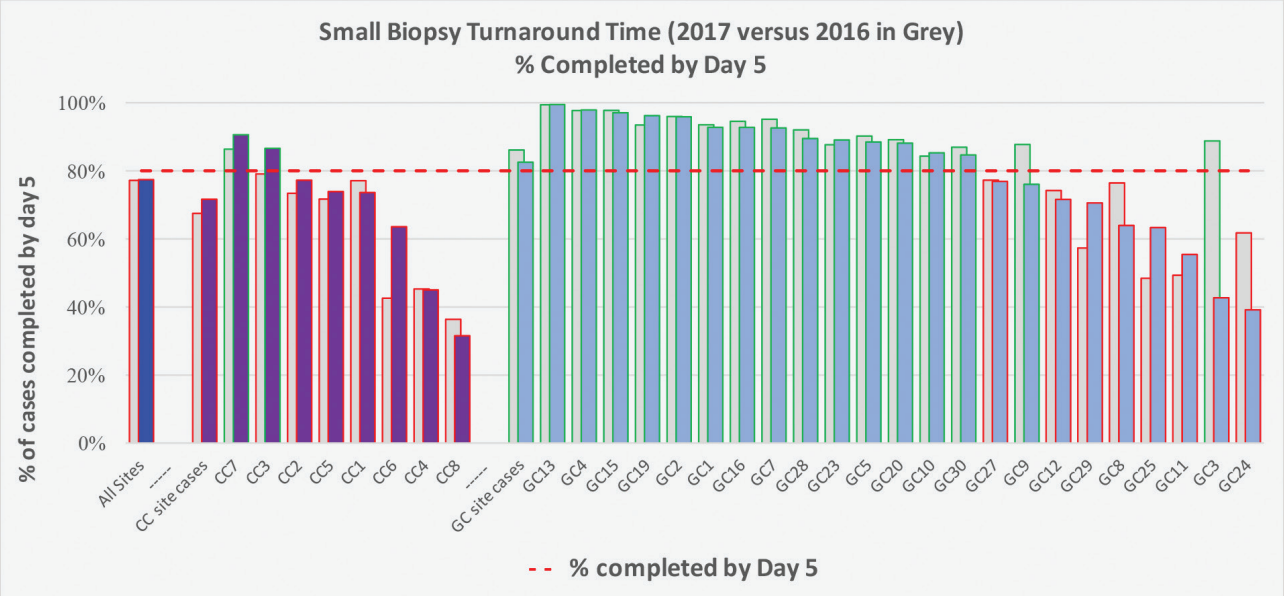


Table 8.2: *Full Data Set TAT Small Biopsy (P01) % Completed by day 5, 2016 and 2017*

Small Biopsy (P01) Turnaround Time % Complete by Day 5	% completed by Day 5–2016	% completed by Day 5–2017
All Sites	**77.2%**	**77.4%**
——-		
CC site cases	**67.5%**	**71.6%**
CC7	86.4%	90.6%
CC3	79.1%	86.6%
CC2	73.4%	77.2%
CC5	71.7%	73.9%
CC1	77.1%	73.6%
CC6	42.6%	63.6%
CC4	45.3%	45.0%
CC8	36.4%	31.5%
——-		
GC site cases	**86.1%**	**82.5%**
GC13	99.4%	99.5%
GC4	97.7%	97.9%
GC15	97.8%	97.1%
GC19	93.5%	96.2%
GC2	96.0%	95.9%
GC1	93.5%	92.8%
GC16	94.5%	92.7%
GC7	95.1%	92.6%
GC28	92.0%	89.5%

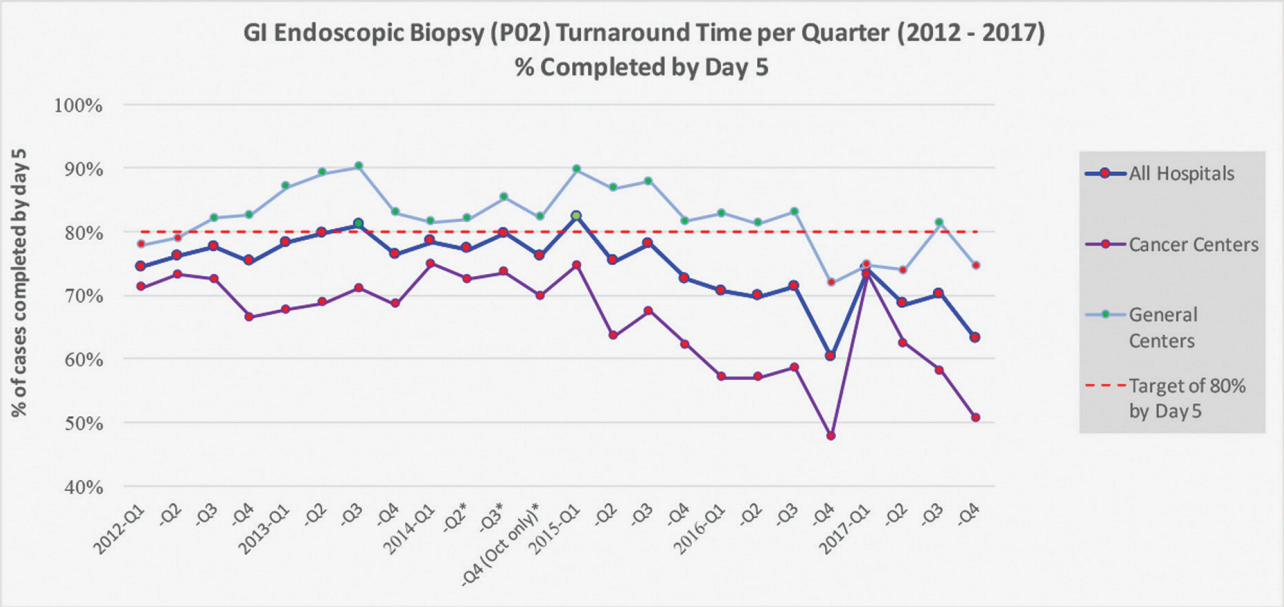
Small Biopsy (P01) Turnaround Time (Continued) % Complete by Day 5	% completed by Day 5–2016	% completed by Day 5–2017
GC23	87.7%	89.0%
GC5	90.2%	88.5%
GC20	89.1%	88.1%
GC10	84.3%	85.3%
GC30	86.9%	84.7%
GC27	77.2%	76.9%
GC9	87.7%	76.0%
GC12	74.4%	71.6%
GC29	57.3%	70.6%
GC8	76.6%	63.9%
GC25	48.6%	63.3%
GC11	49.3%	55.4%
GC3	88.8%	42.7%
GC24	61.8%	39.2%

GI ENDOSCOPIC BIOPSY (P02) TAT COMMENTARY

The performance against the target of 80% of cases to be completed by day 5 was up by 1% (from 68% to 69%) compared to 2016. This is still 11% short of the target. However, the number of Cancer Centre cases that were turned-around by day 5 was up by over 6% from 2016 figures (from 55.1% to 61.2%).

The number of General Centre cases turned-around by day 5 was down by over 3% from 2016 figures (from 79.8% to 76.1%).

Figure 8.4: *GI Endoscopic Biopsy (P02) TAT per Quarter (2012-2017) % completed by Day 5*



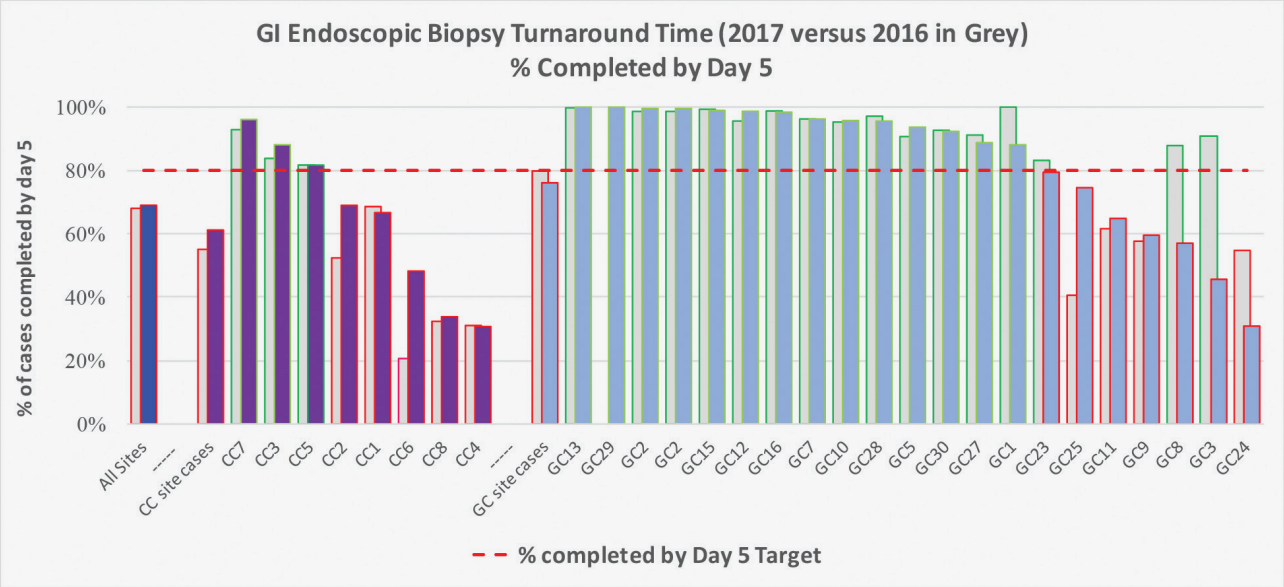
*One CC was not providing QI data during this period

There has been a pronounced decreasing trend in the number of cases meeting the target over the past two years from a point where it looked like sustaining close to and meeting the target in 2015. This was mainly driven by the decrease in target meeting by Cancer Centres over the past 2 years, while more recently General Centres have been falling below target, having sustained above target activity for most of the last 4 years. This may relate to the significant increase in endoscopy activity nationwide.

Fifteen out of twenty one General Centre sites met the target for 2017, similar to 2016 (fourteen out of twenty sites). Two of these nine below target General Centre sites were below 50%.

Three of the eight Cancer Centres met the target, the same as 2016. Three CCs had less than 50% of cases turned around in 5 days or less, the same as 2016 when also three CC sites were below 50% TAT by day 5.

Figure 8.5: *GI Endoscopic Biopsy (P02) TAT (2017 v 2016 in grey) % completed by day 5*



If data is split out by CC and GC sites, then the GC sites in general met the target for all 12 months, and the CC sites in general did not (GC: 82.5%, CC: 71.6%), compared with 2016 (GC: 86%, CC: 67.5%).

Table 8.3: *Total Data for GI Endoscopic Biopsy (P02) TAT % completed by day 5 2016 – 2017*

GI Endo Biopsy (P02) Turnaround Time % Complete by Day 5	% completed by Day 5 - 2016	% completed by Day 5 - 2017
All Sites	**68.0%**	**69.0%**
——-		
CC site cases	**55.1%**	**61.2%**
CC7	92.9%	96.1%
CC3	83.8%	88.1%
CC5	81.7%	81.7%
CC2	52.4%	69.0%
CC1	68.6%	66.7%
CC6	20.7%	48.3%

GI Endo Biopsy (P02) Turnaround Time (Continued) % Complete by Day 5	% completed by Day 5 - 2016	% completed by Day 5 - 2017
CC8	32.4%	33.8%
CC4	31.1%	30.7%
——-		
GC site cases	**79.8%**	**76.1%**
GC13	99.7%	100.0%
GC29	0.0%	100.0%
GC2	98.6%	99.6%
GC2	98.6%	99.6%
GC15	99.3%	98.9%
GC12	95.6%	98.7%
GC16	98.8%	98.4%
GC7	96.2%	96.2%
GC10	95.3%	95.7%
GC28	97.1%	95.6%
GC5	90.7%	93.7%
GC30	92.7%	92.3%
GC27	91.2%	88.8%
GC1	100.0%	88.1%
GC23	83.2%	79.4%
GC25	40.6%	74.5%
GC11	61.6%	64.9%
GC9	57.7%	59.6%
GC8	87.9%	57.0%
GC3	91.0%	45.7%
GC24	54.8%	30.9%
GC4		
GC19		
GC20		

NON BIOPSY-CANCER RESECTION (P03) TAT COMMENTARY

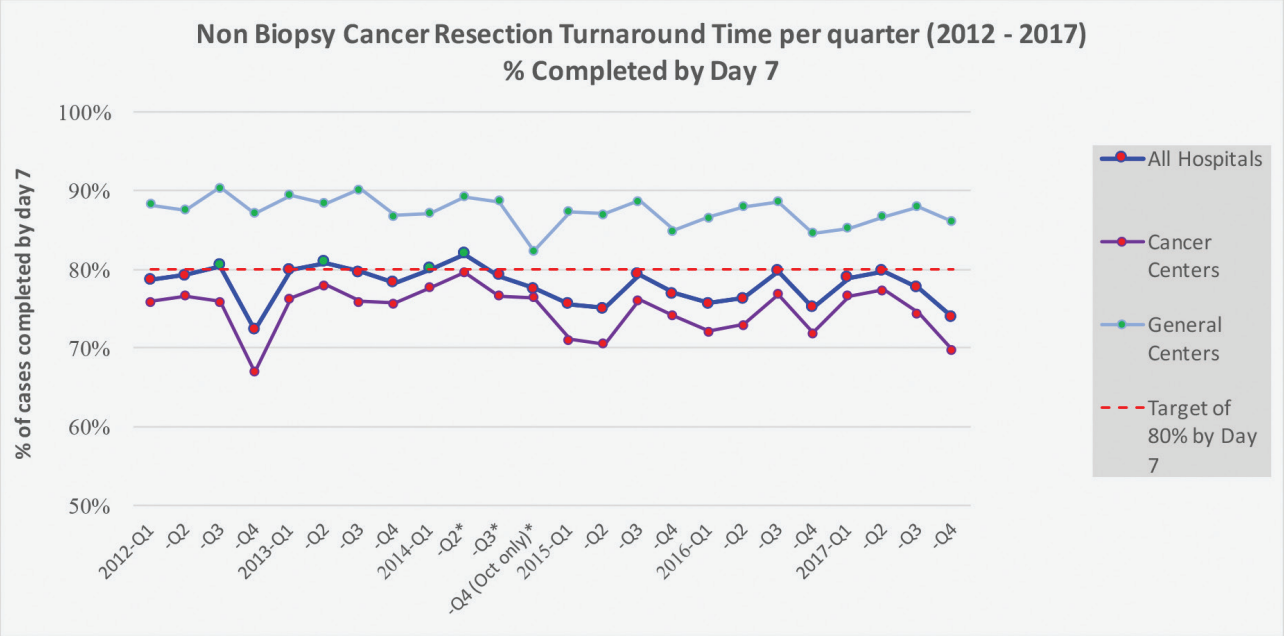
In 2017 nationally, the 80% Completed Day 7 Target for Non Biopsy Cancer Resection (P03) cases was not met. The national average for the year was 77.6%, less than 3% below target for the year.

The performance against the target of 80% of cases to be completed by day 7 was a slight improvement from 2016.

The number of Cancer Centre cases turned around in 7 days or less is also up by over 1% from 2016 figures: from 73.4% to 74.6%.

There was a consistency in trend over the last 6 years, with national TAT ranging between 75% and 80% completed by day 7 over the last 6 years. General centres ranged consistently between 80% and 90%, above target, while Cancer Centres ranged between 72% and 78%, always within 10% of target.

Figure 8.6: *Non Biopsy Cancer Resection TAT per quarter 2012-2017 % completed by day 7*

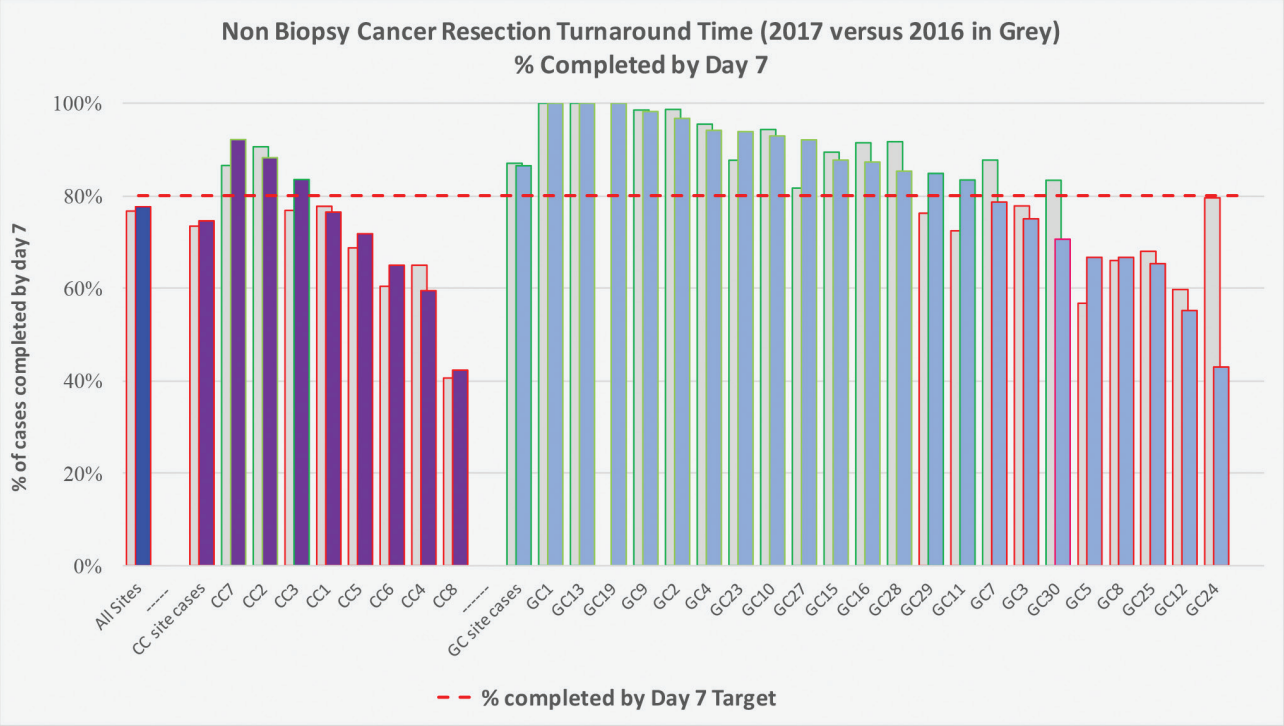


*One CC was not providing QI data during this period

The number of General Centre cases turned around in 7 days or less was very similar to 2016 figures down from 87% to 86.5%, but was still over the target.

Three of the eight CCs met the target. This is the same as the three target meeting sites in 2016. Also, of those five below the target, three of these were over 70% of cases completed by day 7. One Cancer Centre had less than 50% of cases turned around in 7 days or less. This was an improvement on 2016, when 2 sites were below 50% TAT by day 7.

Figure 8.7: *Non Biopsy Cancer Resection TAT 2017 v 2016 in Grey, % completed by day 7*



Fourteen of twenty two General Centres reached the target for 2017, the same as 2016. Three of these eight below the target General Centres were over 70% TAT by day 7, while one site was below 50%.

Table 8.4: *Total Data for Non Biopsy Cancer Resection (P03) TAT % completed by day 7 2016 - 2017*

Non Biopsy Cancer Resection (P03) % Complete by Day 7	% completed by Day 7 - 2016	% completed by Day 7 - 2017
All Sites	**76.7%**	**77.6%**

CC site cases	**73.4%**	**74.6%**
CC7	86.5%	92.1%
CC2	90.6%	88.2%
CC3	76.8%	83.5%
CC1	77.7%	76.5%
CC5	68.7%	71.8%
CC6	60.4%	65.0%
CC4	65.0%	59.5%
CC8	40.6%	42.3%

GC site cases	**87.0%**	**86.5%**
GC1	100.0%	100.0%
GC13	100.0%	100.0%
GC19	0.0%	100.0%
GC9	98.5%	98.2%
GC2	98.6%	96.7%
GC4	95.5%	94.1%
GC23	87.7%	93.8%
GC10	94.3%	92.9%
GC27	81.6%	92.1%
GC15	89.4%	87.7%
GC16	91.4%	87.3%
GC28	91.7%	85.3%
GC29	76.2%	84.8%
GC11	72.4%	83.4%
GC7	87.7%	78.6%
GC3	77.8%	75.0%
GC30	83.3%	70.6%
GC5	56.7%	66.7%
GC8	65.8%	66.7%
GC25	68.0%	65.3%
GC12	59.7%	55.2%
GC24	79.6%	43.0%

NON BIOPSY OTHER (P04)–TAT COMMENTARY

In 2017 nationally, we did not meet the 80% Completed Day 7 Target for Non Biopsy Other (P04) cases. The national average for the year was 77.2%, less than 3% below target over the year.

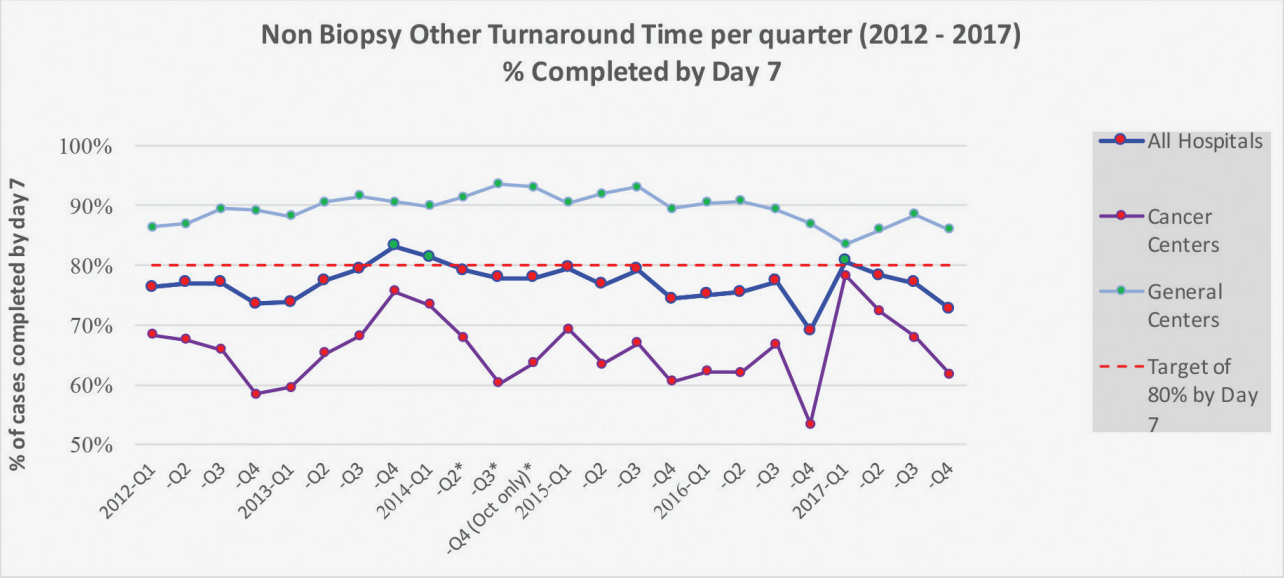
The performance against this target of 80% of cases to be completed by day 7 was an improvement on that of 2016. For the year, the percentage of cases turned around in 7 days or less was 77.2%, up 3% on 2016 (74.3%).

CC cases did not meet this target for any month in 2017. However, the number of Cancer Centre cases turned around in 7 days or less was up by over 9% from 2016 figures from 61.1% to 70.1%.

GC cases met the target for all 12 months of 2017. The number of GC cases that were turned around in 7 days or less was down by over 3% from 2016 figures from 89.4% to 85.9%, but were still well over the target.

The percentage by day 7 has remained relatively stable over the last 6 years, generally between 75% and 80%, but dipping in the last quarters of both 2016 and 2017 to below 73%.

Figure 8.8: *Non Biopsy Other (P04) TAT per quarter 2012-2017 % completed by day 7*



*One CC was not providing QI data during this period

If data is split out by CC and GC sites, then the GC sites cases met the target for all 12 months and the CC site cases did not (GC: 85.9%, CC: 70.1%), compared with 2016 (GC: 89.1%, CC: 70.1%).

Figure 8.9: *Non Biopsy Other (P04) TAT % Completed by Day 7 2017 V 2016 in Grey.*

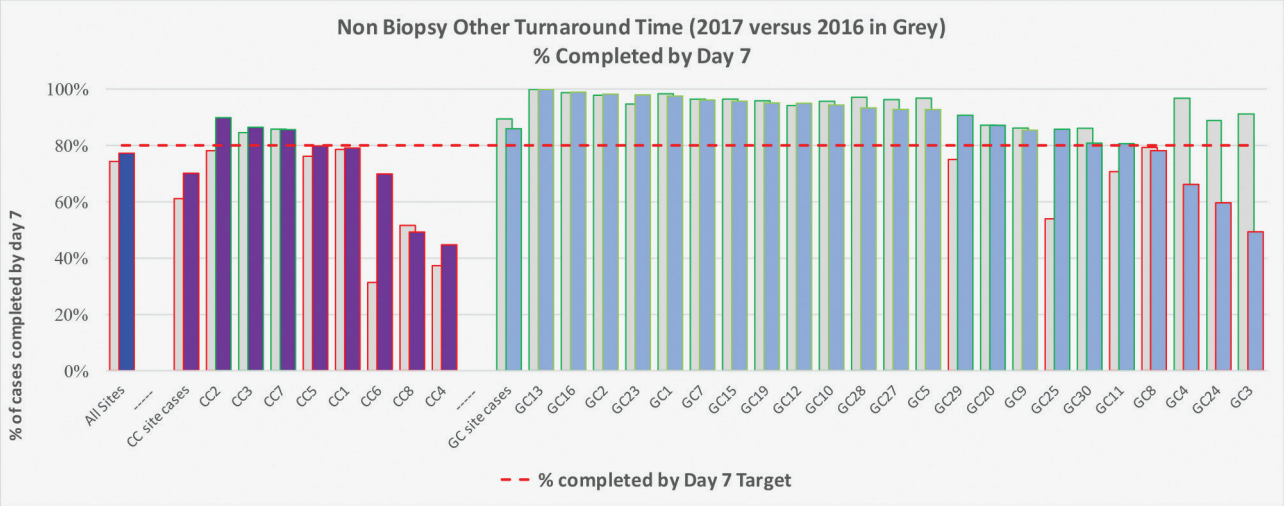


Table 8.5: *Total Data for Non Biopsy Other (P04) TAT % completed by day 7 2016–2017*

Non Biopsy Other (P04) % Complete by Day 7	% completed by Day 7 - 2016	% completed by Day 7 - 2017
All Sites	**74.3%**	**77.2%**
——		
CC site cases	**61.1%**	**70.1%**
CC2	78.1%	89.8%
CC3	84.5%	86.4%
CC7	85.8%	85.6%
CC5	76.1%	79.8%
CC1	78.6%	79.1%
CC6	31.3%	69.8%
CC8	51.6%	49.2%
CC4	37.3%	44.7%
——		
GC site cases	**89.4%**	**85.9%**
GC13	99.9%	99.8%
GC16	98.7%	98.9%
GC2	97.8%	98.2%
GC23	94.7%	97.9%
GC1	98.3%	97.5%
GC7	96.4%	96.1%
GC15	96.4%	95.7%
GC19	95.8%	95.1%
GC12	94.1%	95.0%
GC10	95.7%	94.3%

Non Biopsy Other (P04) (Continued) % Complete by Day 7	% completed by Day 7 - 2016	% completed by Day 7 - 2017
GC28	97.1%	93.3%
GC27	96.3%	92.8%
GC5	96.8%	92.7%
GC29	75.0%	90.7%
GC20	87.2%	87.1%
GC9	86.2%	85.4%
GC25	53.9%	85.7%
GC30	86.1%	80.8%
GC11	70.7%	80.6%
GC8	79.3%	77.9%
GC4	96.7%	66.2%
GC24	88.8%	59.6%
GC3	91.1%	49.3%

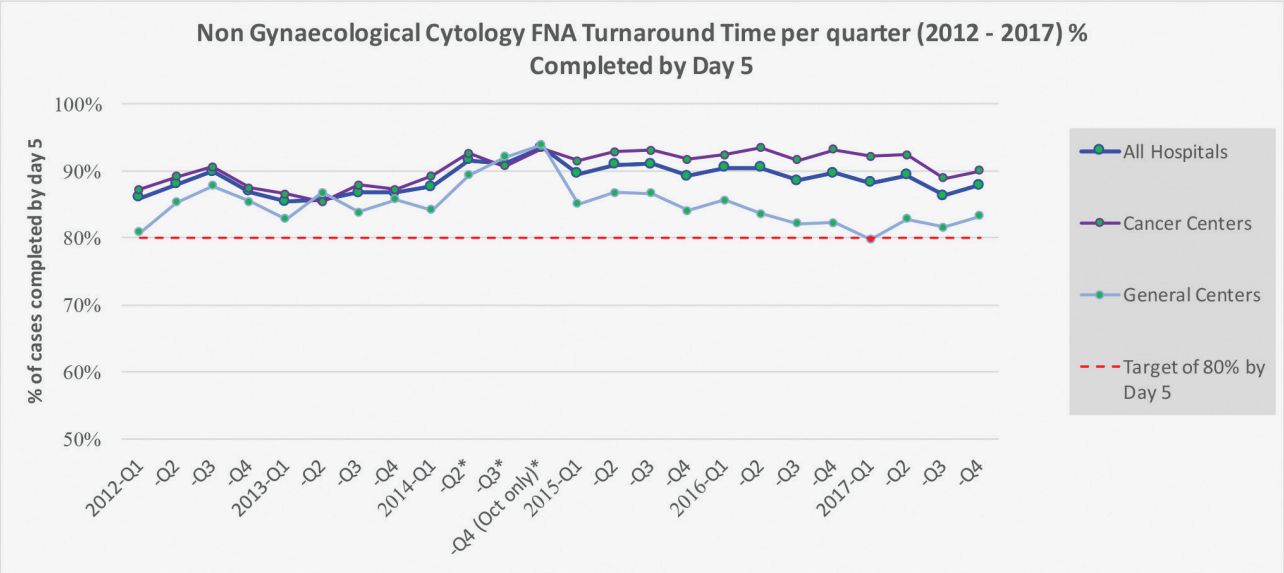
NON GYNAECOLOGICAL CYTOLOGY FNA (P06) TAT COMMENTARY

In 2017 nationally, we met the 80% Completed Day 5 Target for Non Gynaecological Cytology FNA (P06) cases. The national average for the year was 87.9%, 8% above target for the year.

The performance against this target of 80% of cases to be completed by day 5 was similar to that in 2016, which was 89.8% for the year.

In 2017 nationally, we met the 80% of cases completed by day 5 Target for Non Gynaecological Cytology FNA (P06) cases

Figure 8.10: *Non Gynaecological Cytology FNA (P06) TAT % Completed by Day 5 per quarter for 2012 to 2017*

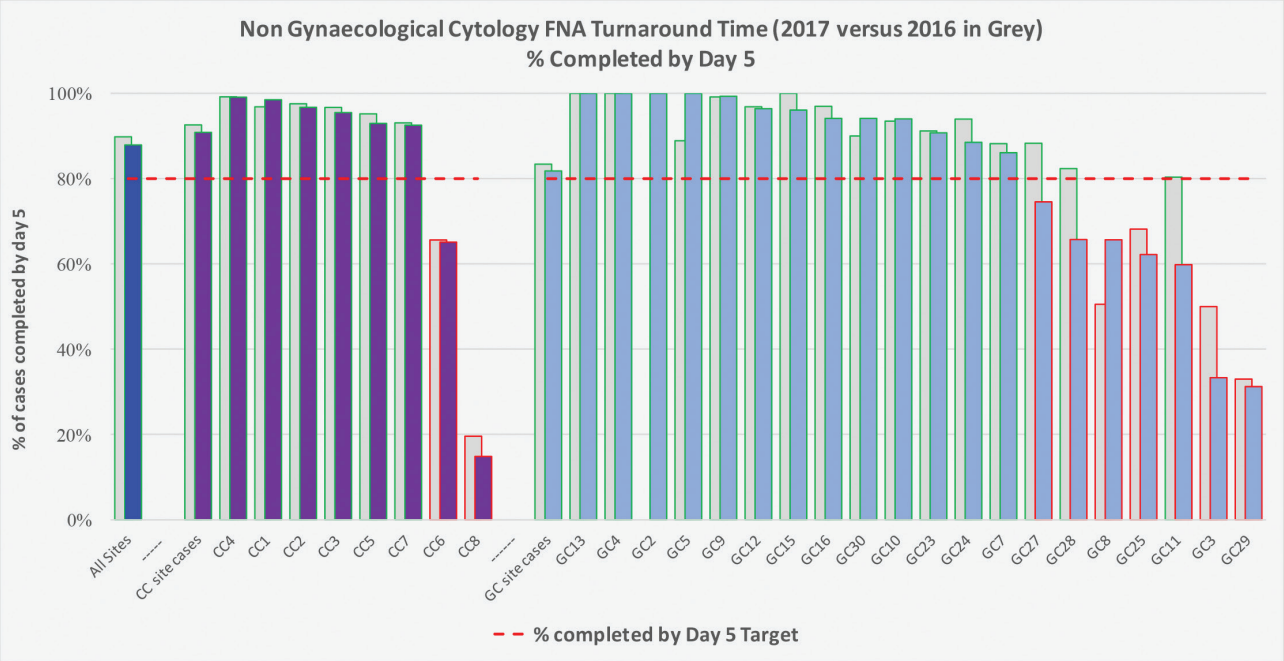


*One CC was not providing QI data during this period

From 2012 to 2015 there was a steady increase in cases completed by day 5 from 85% to over 93%, and then they began to decline slightly over the last three years to 87% by Q4 2017, however it remained above the 80% Target.

The number of GC cases turned around in 5 days or less was down by 1.6%; to 81.8% in 2017, from 83.4% in 2016 but was still over the target.

Figure 8.11: *Non Gynaecological Cytology FNA (P06) TAT % Completed by Day 5. Comparison of 2017 v 2016 in grey*



Six of the eight CCs reached the target in 2017. One of the below target CCs had less than 20% of cases turned around in five days or less. This was the same as 2016.

Thirteen of twenty GCs met the target for 2017, three less than last year (16). Two of these seven below target General Centre sites are below 50%.

If data was split out by CC and GC sites, then the CC sites met the target for all 12 months and the GCs reached the target for 10 months. By year (GC: 81.8%, CC: 90.8%), compared with 2016 (GC: 83.4%, CC: 92.6.5%). This was mainly driven by the decrease in GCs over the past few years, while still hovering just above the target percentage.

Table 8.6: *Total Data Non Gynaecological Cytology FNA (P06) TAT % Completed by Day 5 2016 & 2017*

Non Gynaecological Cytology FNA (P06) % Complete by Day 5	% completed by Day 5–2016	% completed by Day 5–2017
All Sites	**89.8%**	**87.9%**
CC site cases	**92.6%**	**90.8%**
CC4	99.2%	99.1%
CC1	96.8%	98.5%
CC2	97.6%	96.7%
CC3	96.7%	95.5%
CC5	95.2%	92.9%
CC7	93.1%	92.5%
CC6	65.6%	65.1%
CC8	19.6%	14.9%
GC site cases	**83.4%**	**81.8%**
GC13	100.0%	100.0%
GC4	100.0%	100.0%
GC2	0.0%	100.0%
GC5	88.9%	100.0%
GC9	99.1%	99.3%
GC12	96.8%	96.4%
GC15	100.0%	96.1%
GC16	97.0%	94.1%
GC30	90.0%	94.1%
GC10	93.5%	94.0%
GC23	91.2%	90.7%
GC24	94.0%	88.5%
GC7	88.2%	86.1%
GC27	88.3%	74.6%
GC28	82.4%	65.7%
GC8	50.5%	65.7%
GC25	68.2%	62.2%
GC11	80.3%	59.8%
GC3	50.0%	33.3%
GC29	33.0%	31.3%
GC1	0.0%	0.0%
GC20	0.0%	0.0%
GC19	0.0%	0.0%

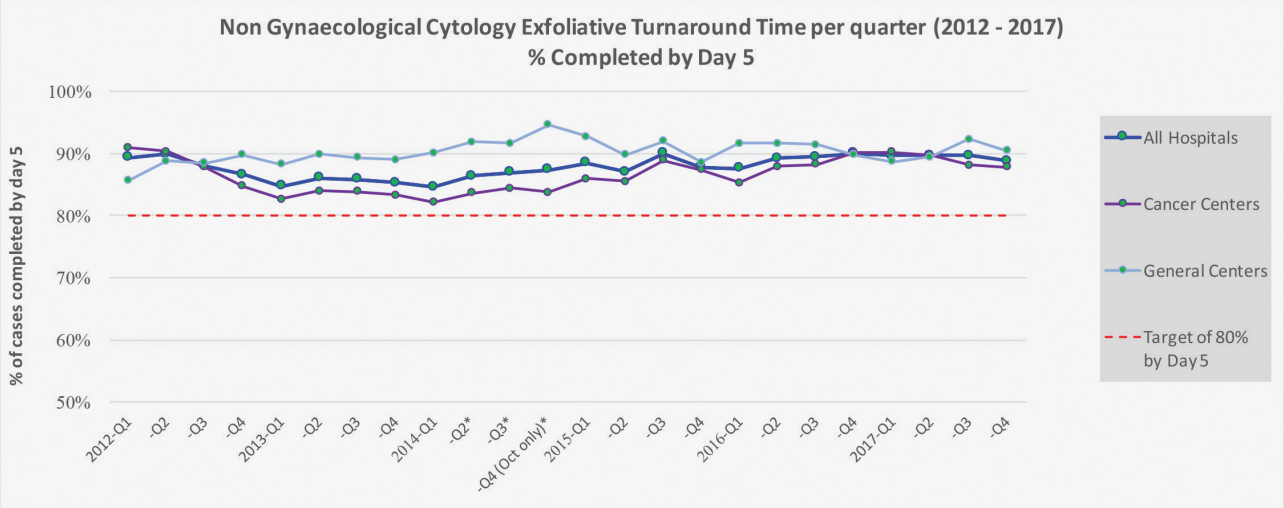
NON GYNAECOLOGICAL CYTOLOGY EXFOLIATIVE (P07) TAT COMMENTARY

In 2017 nationally, the 80% of cases completed by day 5 Target for Non Gynaecological Cytology Exfoliative (P07) cases was met. The national average for the year was 89.4%, almost 10% above target for the year.

In addition, the target of 80% of cases by Day 5 was met for every month of 2017. The performance against this target of 80% of cases to be completed by day 5 was similar to that in 2016, which was 89% for the year.

From 2013 to 2015 there was a steady increase in cases completed by day 5 from 85% to 90%, and has stabilised there since mid 2016

Figure 8.12: *Non Gynaecological Cytology Exfoliative TAT % Completed by Day 5 per quarter for 2012 to 2017*



*One CC was not providing QI data during this period

CC cases met this target for every quarter in 2017, ranging mostly between 87% and 92%.

GC cases met this target for every quarter in 2017, ranging mostly between 86% and 94%.

Six of the eight CCs met the target. One of the two hospitals behind target was at 78% completed by day 5, less than 2% below target. One CC has less than 20% of cases turned around in 5 days or less. This was the same as 2016.

Fourteen out of eighteen GC sites met the target for 2017, one more than 2016 (thirteen sites). One of these below target GC sites was below 20%.

If data is split out by CC and GC sites, then both GC and CC sites reached the target for all 12 months.

Figure 8.13: *Non Gynaecological Cytology Exfoliative (P07) TAT % completed by day 5 (2016 & 2017)*

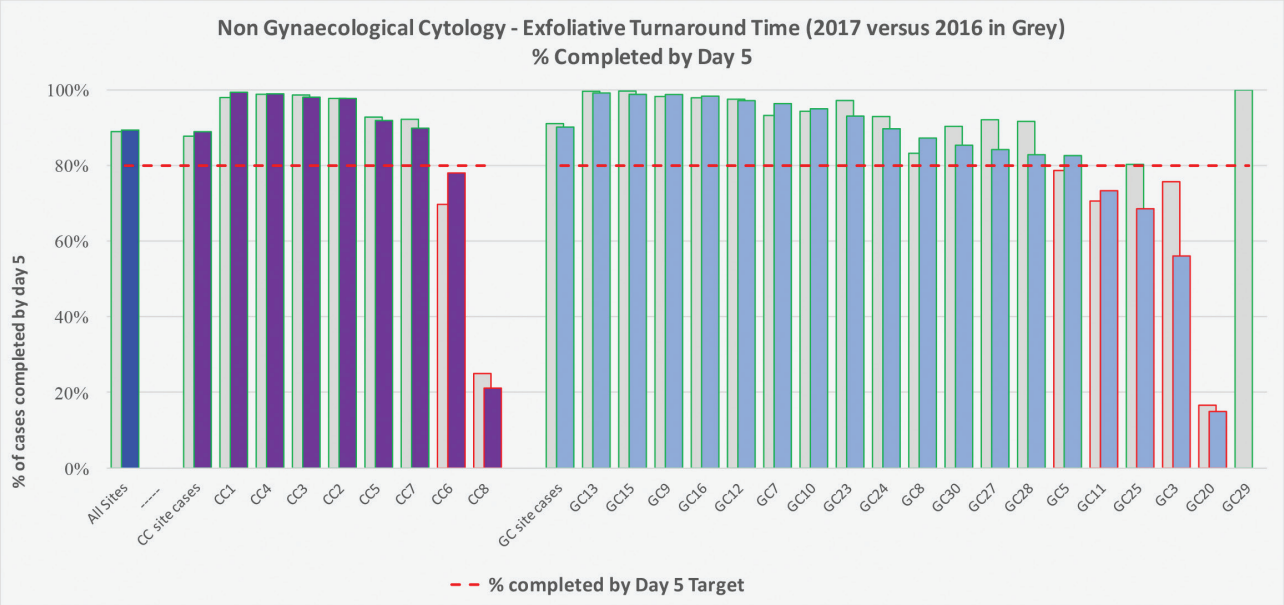


Table 8.7: *Full Data Non Gynaecological Cytology Exfoliative % Completed by Day 5 2016 & 2017*

Non Gynael Cytology-Exfoliative (P07) % Complete by Day 5	% completed by Day 5-2016	% completed by Day 5-2017
All Sites	**89.0%**	**89.4%**
——-		
CC site cases	**87.8%**	**89.0%**
CC1	98.0%	99.4%
CC4	98.9%	99.0%
CC3	98.7%	98.1%
CC2	97.8%	97.8%
CC5	92.8%	91.9%
CC7	92.3%	89.9%
CC6	69.8%	78.1%
CC8	25.0%	21.2%
GC site cases	**91.1%**	**90.2%**
GC13	99.7%	99.2%
GC15	99.7%	98.8%
GC9	98.3%	98.8%
GC16	97.9%	98.4%
GC12	97.6%	97.2%
GC7	93.3%	96.4%
GC10	94.4%	95.0%
GC23	97.2%	93.1%
GC24	93.0%	89.7%

Non Gynael Cytology–Exfoliative (P07) (Continued) % Complete by Day 5	% completed by Day 5–2016	% completed by Day 5–2017
GC8	83.3%	87.3%
GC30	90.4%	85.4%
GC27	92.1%	84.2%
GC28	91.7%	82.9%
GC5	78.7%	82.7%
GC11	70.6%	73.4%
GC25	80.3%	68.6%
GC3	75.8%	56.1%
GC20	16.7%	15.0%
GC29	100.0%	0.0%
GC4		
GC1		
GC22		
GC19		

SUMMARY COMMENTARY

In 2017 nationally, 80% Completed Day 5 Target was met for:

➡ Non Gynaecological Cytology FNA (P06) cases and

➡ Non Gynaecological Cytology Exfoliative (P07) cases

However, in 2017 nationally, the 80% Completed Day 5 Target was not met for:

➡ Small Biopsy (P01) cases

➡ GI Endoscopic Biopsy (P02)

Additionally, nationally the 80% Completed Day 7 Target was not met for:

➡ Non Biopsy Cancer Resection (P03) cases

➡ Non Biopsy Other (P04) cases

This is likely to relate to challenges around resource deficits in histopathology laboratories, including recruitment and retention of Consultant Histopathologists.

CHAPTER 9:

FROZEN SECTION

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

Table 9.1: *Achievable Targets*

Case Type	Achievable Target
FS Concordance rate	Greater than or equal to 97%
FS Deferral rate	Less than or equal to 5%
FS Turnaround time	Greater than or equal to 85% within 20 minutes

FROZEN SECTION CORRELATION – CONCORDANCE RATE

Monitoring the correlation of frozen section diagnosis and permanent section diagnosis is an integral component of the histopathology QI programme. It is recommended that permanent section slides should be analysed with the accompanying frozen section slides to establish if any discrepancy exists.

It is recognised that certain frozen section activities have a high discordance rate and that errors may arise due to sampling or interpretative issues.

Frozen section discordances should be reconciled in the final pathology report and should be reviewed and discussed at the departmental discrepancy conference.

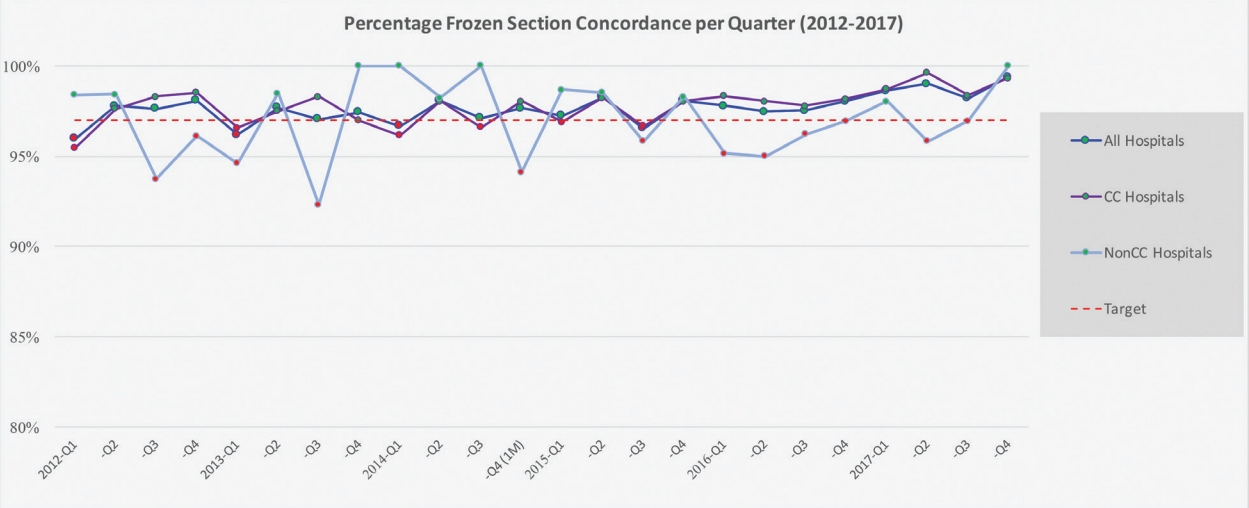
96.5% of FS cases have a FS Correlation Code (either Q007, Q008, Q009 or Q051), this is slightly better than 2016 data with 95.8% of FS cases with a FS correlation code

Broken down by hospital type, CCs do marginally better at 97.1%, in their correlation coding of FS cases, than GCs (92.6%).

From a Frozen Section Correlation Concordance perspective, broken down by hospital type both CCs (99%, up 1% for 2016 figures) and GCs (97.65%, up just under 1% from 2016 figures) meet the target. This is an improvement from 2016 when GCs missed the target.

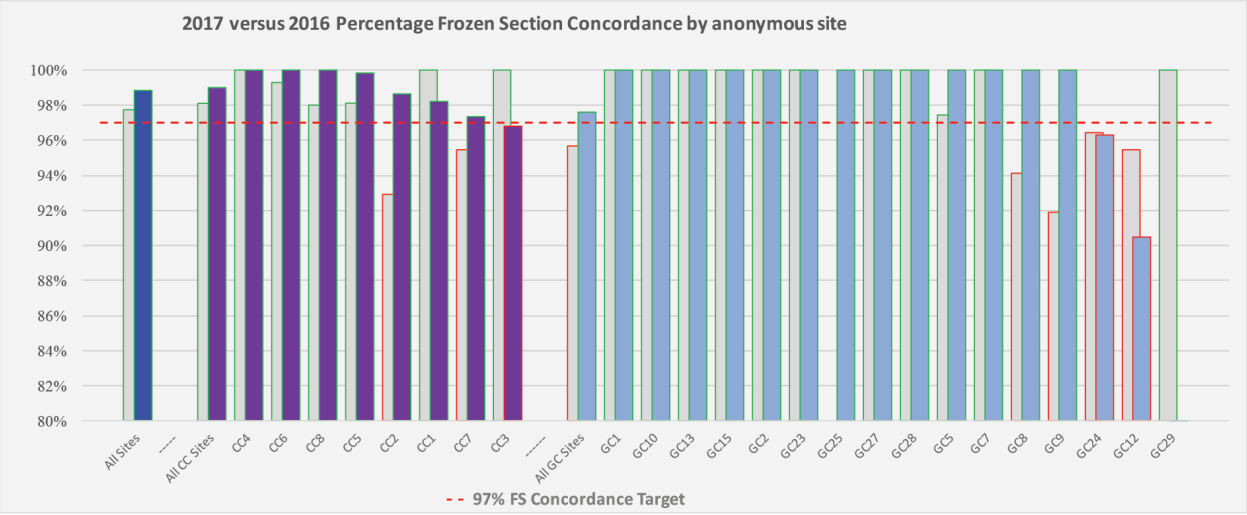
From a Frozen Section Correlation Concordance perspective broken down by hospital type, both Cancer Centres and General Centres met the target

Figure 9.1: *% Frozen Section Concordance per Quarter from 2012 to 2017*



From a quarterly perspective, over the past 3 years, Frozen Section Correlation Concordance increased to being sustained above the 97% Target, from previously pivoting around the 97% target.

Figure 9.2: *% Frozen Section Concordance by Site 2017 v 2016 (in grey)*



In 2017, one out of eight Cancers Centres (CC) did not meet the target of 97% for 2016. This site only missed the target by 0.2%, at 96.8%. Two CCs did not meet the target in 2016.

The two CCs that missed the target in 2016 met the target in 2017, the CC that missed the target in 2017 had met the target in 2016.

Twenty of the twenty four sites (83%) with Frozen Section cases attained the 97% Frozen Section concordance target for 2017. In 2016, seventeen out of twenty four sites met this target. Three out of sixteen GC cases did not meet the target of 97% for 2017. Five missed the target in 2016.

Table 9.2: *Full Data Set for FS Concordance (Q007) 2016 and 2017*

	2016 FS Concordance data			2017 FS Concordance data		
	# FS Correlation Cases	No. Q007	% Q007	# FS Correlation Cases	No. Q007	% Q007
CC Sites	**1106**	**1085**	**98.1%**	**1120**	**1109**	**99%**
CC1	66	63	95.5%	56	55	98.2%
CC2	159	156	98.1%	147	145	98.6%
CC3	100	98	98.0%	125	121	96.8%
CC4	73	73	100.0%	77	77	100.0%
CC5	563	559	99.3%	589	588	99.8%
CC6	17	17	100.0%	11	11	100.0%
CC7	127	118	92.9%	113	110	97.3%
CC8	1	1	100.0%	2	2	100.0%
GC Sites	**208**	**199**	**95.7%**	**170**	**166**	**97.6%**
GC1	2	2	100.0%	5	5	100.0%
GC10	3	3	100.0%	5	5	100.0%
GC12	44	42	95.5%	21	19	90.5%
GC13	4	4	100.0%	1	1	100.0%
GC15	9	9	100.0%	7	7	100.0%
GC2	2	2	100.0%	1	1	100.0%
GC23	2	2	100.0%	1	1	100.0%
GC24	28	27	96.4%	27	26	96.3%
GC25	5	4	80.0%	1	1	100.0%
GC27	5	5	100.0%	3	3	100.0%
GC28	1	1	100.0%	13	13	100.0%
GC29	6	6	100.0%	1	0	0.0%
GC5	39	38	97.4%	45	45	100.0%
GC7	4	4	100.0%	7	7	100.0%
GC8	17	16	94.1%	12	12	100.0%
GC9	37	34	91.9%	20	20	100.0%
All Sites	**1314**	**1284**	**97.72%**	**1290**	**1275**	**98.8%**

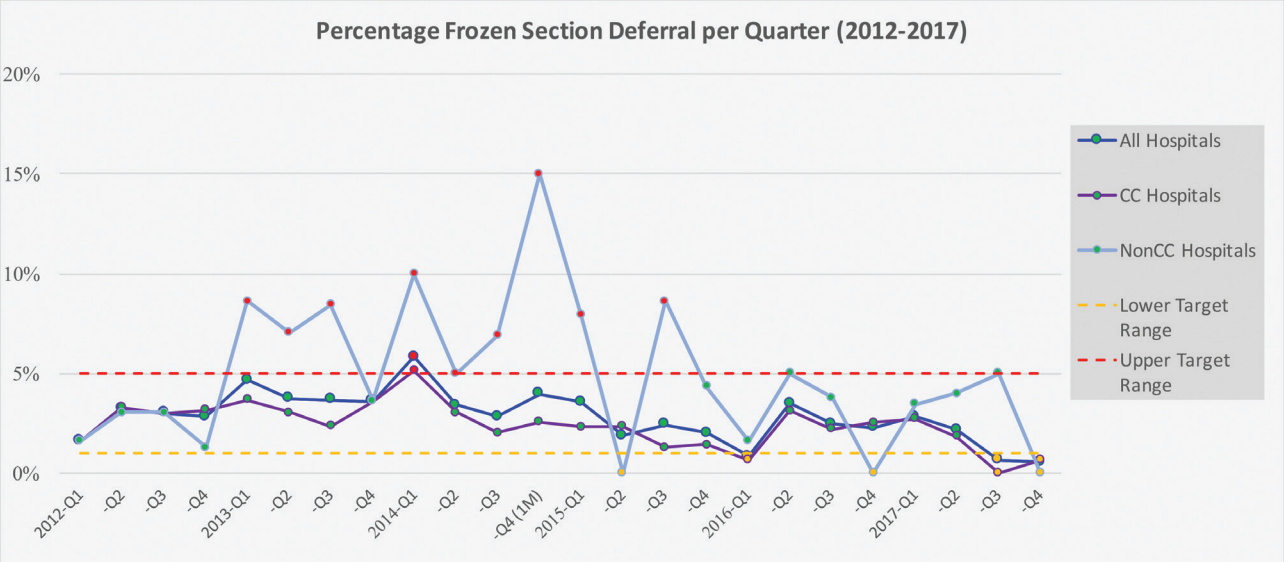
Over the past 3 years Frozen Section Correlation Concordance has increased to being sustained above the 97% Target

FROZEN SECTION CORRELATION – DEFERRAL RATE – Q008

The number of cases where frozen section diagnosis was deferred until final diagnosis was reached on permanent section review.

Overall, both CCs and GCs are between the target limits of 1% to 5% for the year, at 1.62% (1.37% for CCs and 3.2% for GCs).

Figure 9.3: *% Frozen Section Deferral (Q008) per Quarter 2012 through 2017*



From a quarterly perspective, Frozen Section Deferral has been stable between the targets for the last two years, but over the last two quarters of 2017, the trend dropped marginally below the target range 0.7% and 0.6% for Q3 and Q4 respectively.

Table 9.3: *Comparison table for Frozen Section Deferral 2016/2017*

	2016 FS Deferral data			2017 FS Deferral data		
	# FS Correlation Cases	No. Q008	% Q008	# FS Correlation Cases	No. Q008	% Q008
All CC Sites	**1181**	**23**	**1.9%**	**1168**	**16**	**1.4%**
CC1	68	2	2.9%	59	0	0.0%
CC2	168	10	6.0%	159	12	7.5%
CC3	105	1	0.95%	127	1	0.8%
CC4	77	3	3.9%	80	1	1.3%
CC5	604	4	0.7%	607	2	0.3%
CC6	17	0	0.0%	11	0	0.0%
CC7	138	3	2.2%	116	0	0.0%
CC8	4	0	0.0%	9	0	0.0%
All GC Sites	**217**	**6**	**2.8%**	**190**	**6**	**3.2%**
GC1	2	0	0.0%	5	0	0.0%
GC10	5	0	0.0%	9	0	0.0%
GC12	47	1	2.1%	24	0	0.0%
GC13	4	0	0.0%	2	1	50.0%
GC15	9	0	0.0%	7	0	0.0%

	2016 FS Deferral data (Continued)			2017 FS Deferral data (Continued)		
	# FS Correlation Cases	No. Q008	% Q008	# FS Correlation Cases	No. Q008	% Q008
GC2	2	0	0.0%	1	0	0.0%
GC23	2	0	0.0%	1	0	0.0%
GC24	29	1	3.4%	28	1	3.6%
GC25	5	0	0.0%	1	0	0.0%
GC27	5	0	0.0%	4	1	25.0%
GC28	1	0	0.0%	16	1	6.3%
GC29	7	1	14.3%	1	0	0.0%
GC5	40	1	2.5%	45	0	0.0%
GC7	4	0	0.0%	7	0	0.0%
GC8	17	0	0.0%	18	1	5.6%
GC9	38	2	5.3%	21	1	4.8%
All Sites	**1398**	**29**	**2.1%**	**1358**	**22**	**1.6%**

Cancer Centres and General Centres were below the target limit of 5% for the year, at 1.62% for Frozen Section Correlation–Deferral Rate

FROZEN SECTION TURNAROUND TIMES (FS TAT)

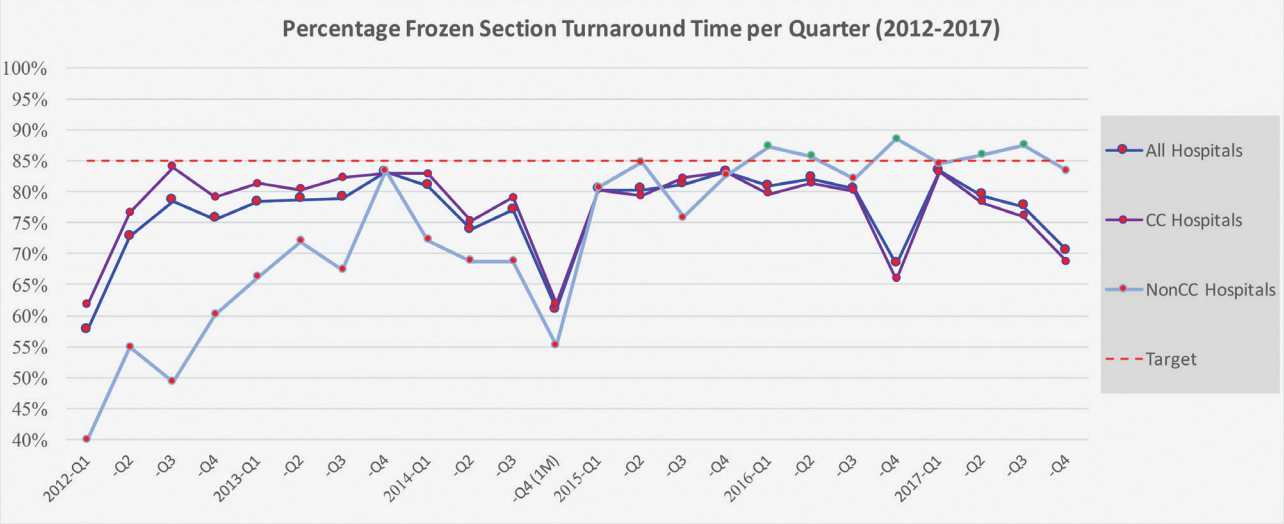
The Turnaround Time (TAT) for a Frozen Section is an important parameter due to the intraoperative nature of the consultation with real time clinical decisions being made on FS results.

91.2% of FS cases had a FS TAT Code (either Q061, Q062), slightly lower than 2016 data with 92.8% of FS cases with an FS correlation code.

Broken down by hospital type 92.2% of Cancer Centres and 95.9% of General Centres had a correlation code.

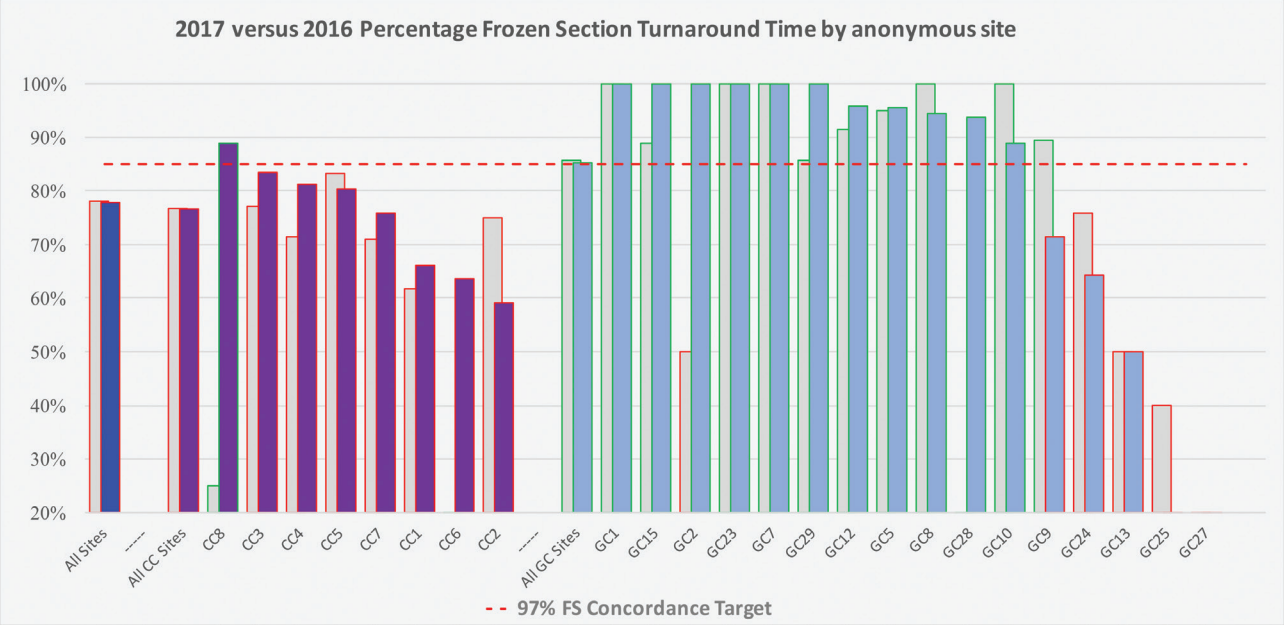
As a whole, GCs met the 85% less than 20 mins Frozen Section TAT target for the year (85.3%), but CCs did not (76.6%).

Figure 9.4: *% Frozen Section TATs per Quarter (2012-2017)*



In 2017, all sites combined had 77.84% Frozen Section TAT less than 20mins, this has fallen incrementally from 2016's 78.1% rate.

Figure 9.5: *% Frozen Section TATs by site (2017-2016)*



Eleven of the twenty four sites (45.8%) with Frozen Section cases met the target of 85% for 2016.

Seven of eight CCs did not reach the target. All CCs had at least 50% of FS cases turned around in 20 mins. This is an improvement on 2016 where two CCs had less than 30% of cases completed in 20 mins or less.

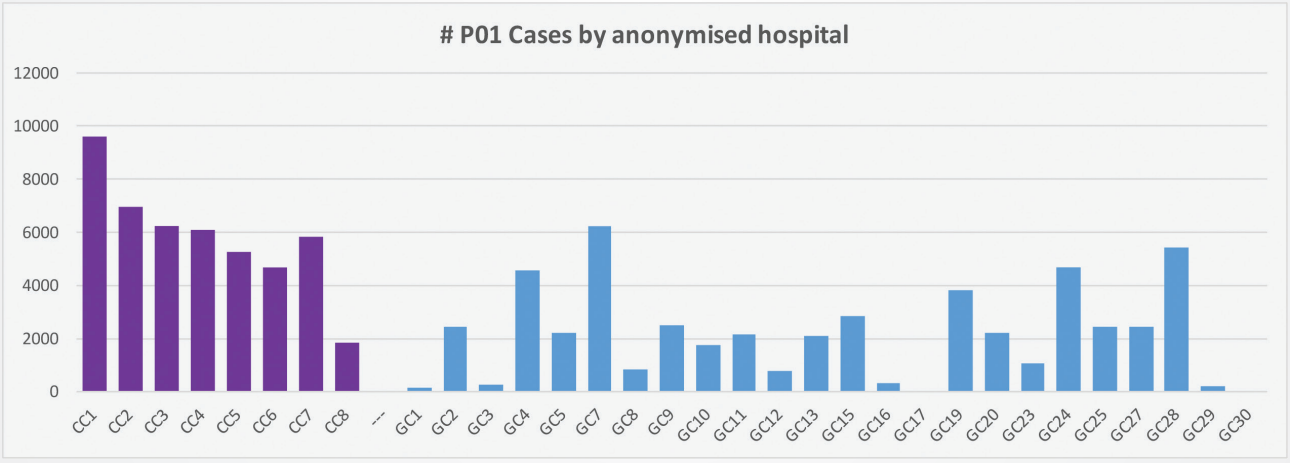
Ten of the sixteen GCs met the target. Three of the six GCs that did not reach the target in 2016 had less than ten Frozen Section cases.

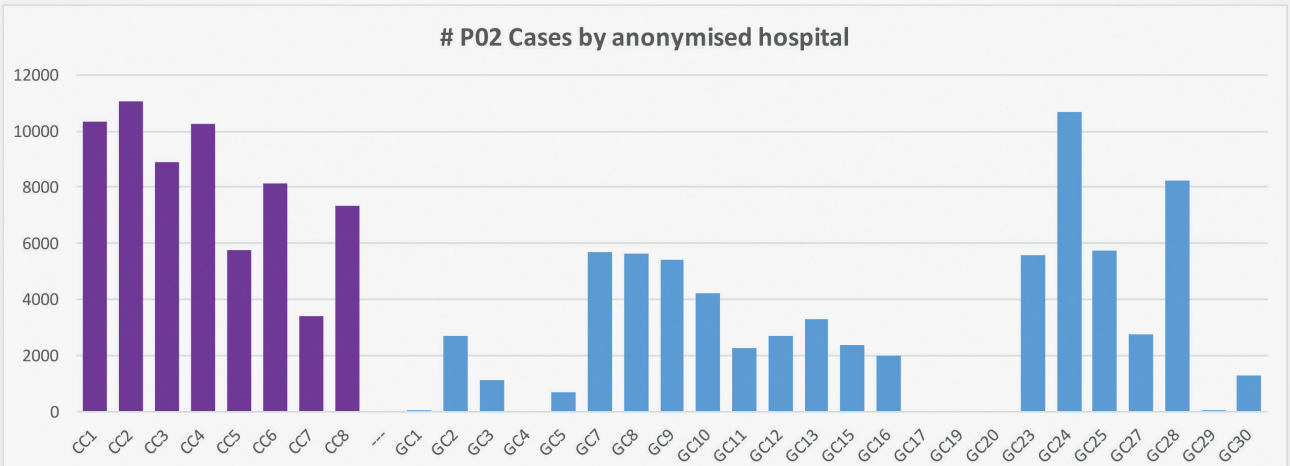
Table 9.4: *2016 & 2017 Frozen Section TAT Data*

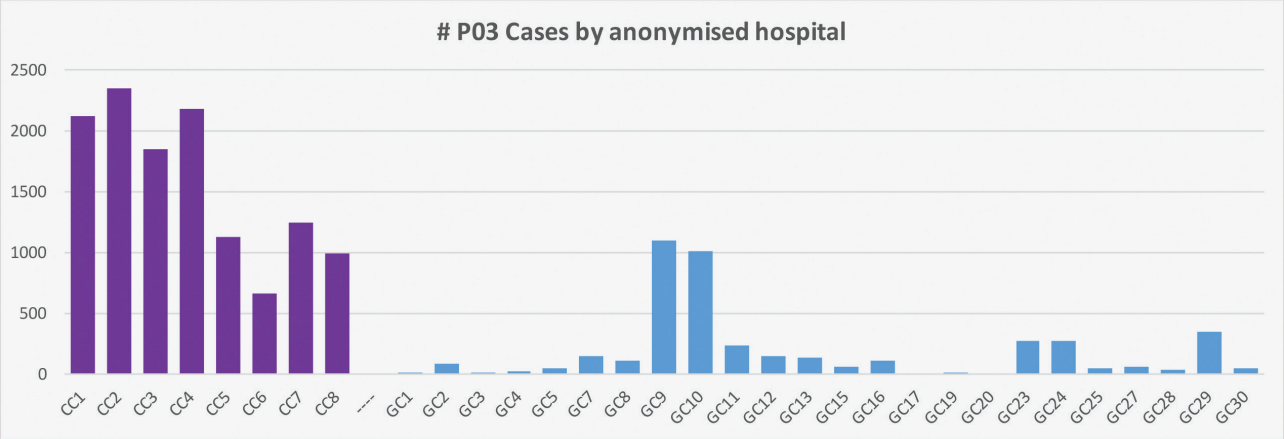
	2016 FS TAT Data			2017 FS TAT data		
	# FS TAT Cases	No. Q061	% Q061	# FS TAT Cases	No. Q061	% Q061
All CC Sites	**1181**	**906**	**76.7%**	**1168**	**895**	**76.6%**
CC1	68	42	61.8%	59	39	66.1%
CC2	168	126	75.0%	159	94	59.1%
CC3	105	81	77.1%	127	106	83.5%
CC4	77	55	71.4%	80	65	81.3%
CC5	604	503	83.3%	607	488	80.4%
CC6	17	0	0.0%	11	7	63.6%
CC7	138	98	71.0%	116	88	75.9%
CC8	4	1	25.0%	9	8	88.9%
All GC Sites	**217**	**186**	**85.7%**	**190**	**162**	**85.3%**
GC1	2	2	100.0%	5	5	100.0%
GC10	5	5	100.0%	9	8	88.9%
GC12	47	43	91.5%	24	23	95.8%
GC13	4	2	50.0%	2	1	50.0%
GC15	9	8	88.9%	7	7	100.0%
GC2	2	1	50.0%	1	1	100.0%
GC23	2	2	100.0%	1	1	100.0%
GC24	29	22	75.9%	28	18	64.3%
GC25	5	2	40.0%	1	0	0.0%
GC27	5	0	0.0%	4	0	0.0%
GC28	1	0	0.0%	16	15	93.8%
GC29	7	6	85.7%	1	1	100.0%
GC5	40	38	95.0%	45	43	95.6%
GC7	4	4	100.0%	7	7	100.0%
GC8	17	17	100.0%	18	17	94.4%
GC9	38	34	89.5%	21	15	71.4%
All Sites	**1398**	**1092**	**78.11%**	**1358**	**1057**	**77.8%**

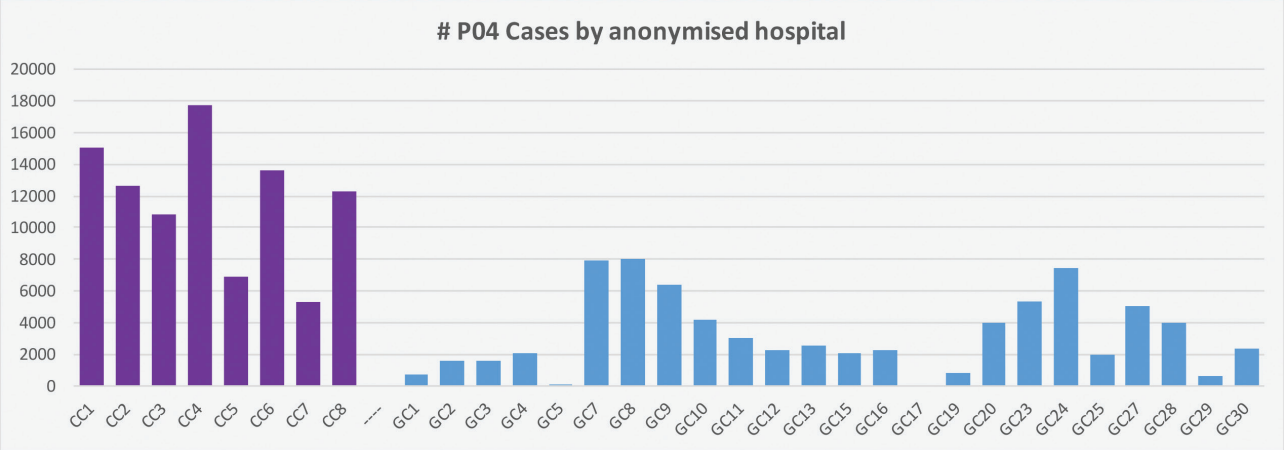
APPENDIX 1:

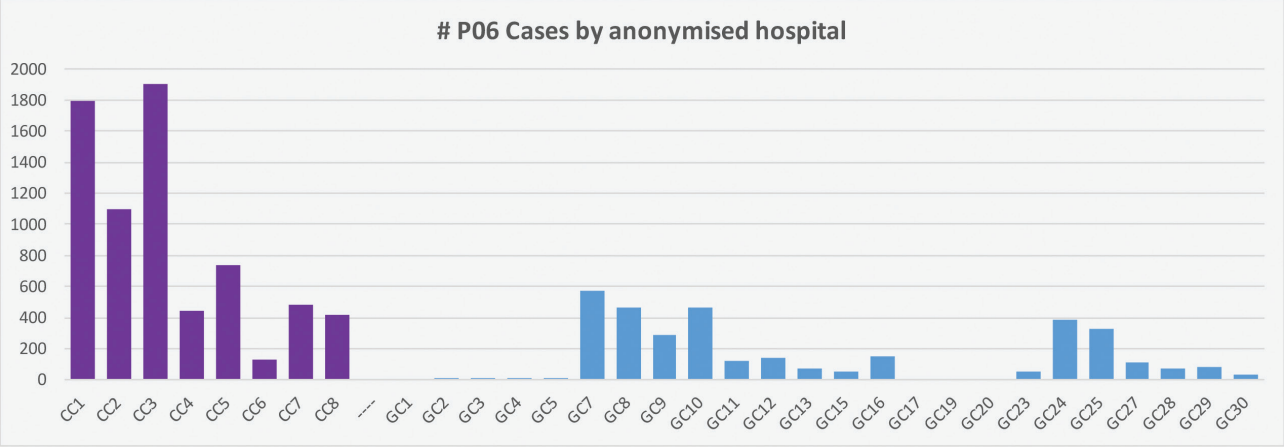
CASES BY ANONYMISED HOSPITAL

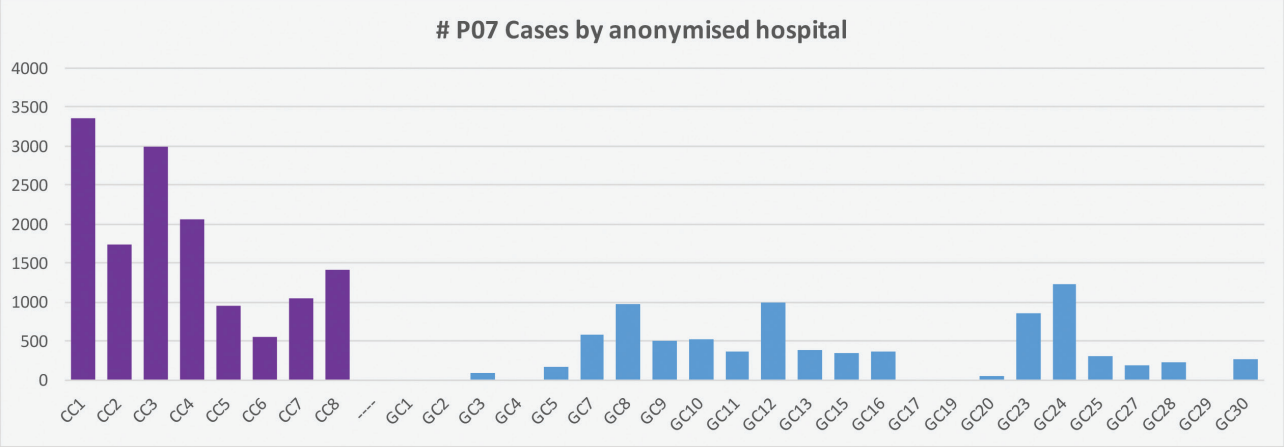





P03 Cases by anonymised hospital
2500
2000
1500
1000
500
0
CC1 CC2 CC3 CC4 CC5 CC6 CC7 CC8 --- GC1 GC2 GC3 GC4 GC5 GC7 GC8 GC9 GC10 GC11 GC12 GC13 GC15 GC16 GC17 GC19 GC20 GC23 GC24 GC25 GC27 GC28 GC29 GC30


P04 Cases by anonymised hospital
20000
18000
16000
14000
12000
10000
8000
6000
4000
2000
0
CC1 CC2 CC3 CC4 CC5 CC6 CC7 CC8 --- GC1 GC2 GC3 GC4 GC5 GC7 GC8 GC9 GC10 GC11 GC12 GC13 GC15 GC16 GC17 GC19 GC20 GC23 GC24 GC25 GC27 GC28 GC29 GC30


P06 Cases by anonymised hospital
2000
1800
1600
1400
1200
1000
800
600
400
200
0
CC1 CC2 CC3 CC4 CC5 CC6 CC7 CC8 --- GC1 GC2 GC3 GC4 GC5 GC7 GC8 GC9 GC10 GC11 GC12 GC13 GC15 GC16 GC17 GC19 GC20 GC23 GC24 GC25 GC27 GC28 GC29 GC30


P07 Cases by anonymised hospital
4000
3500
3000
2500
2000
1500
1000
500
0
CC1 CC2 CC3 CC4 CC5 CC6 CC7 CC8 --- GC1 GC2 GC3 GC4 GC5 GC7 GC8 GC9 GC10 GC11 GC12 GC13 GC15 GC16 GC17 GC19 GC20 GC23 GC24 GC25 GC27 GC28 GC29 GC30

APPENDIX 2:

GLOSSARY

Addendum report	Refers to any pathology report issued subsequent to original report and should be classified as amended, corrected or supplementary.
Amended report	A change to the pathologic interpretation occurs that may give rise to a change in treatment/prognosis. This is the report issued when the final report diagnosis changes due to a change in interpretation or other important pathologic information becomes available that results in a significant change in diagnosis and/or treatment.
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	Refers to a patient's pathological material. This may comprise of a single sample or multiple samples (specimens) from the same patient.
Case ID	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
CL	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).

Corrected report	A transcription or identification error, without a change to the diagnostic information. A corrected report is issued when transcription, patient identification, specimen site, or other related reporting errors occur. Corrected reports do not change the original interpretive diagnosis.
Frozen section (FS)	A specimen of tissue that has been quick-frozen, cut by microtome, and stained immediately for rapid diagnosis. A specimen processed in this manner is not optimal for detailed study of the cells, but can be used to guide intra-operative decision making.
Funnel Plots	Have the ability to present additional layers of information that traditional bar charts cannot. They make it easier to identify outliers relative to other data points.
GC	General Centre
GI Endoscopic Biopsy (P02)	Gastrointestinal Endoscopic Biopsy is taken during an endoscopic procedure.
HPSIR	Hospital Patient Safety Indicator Report. This was created to assure the public that the indicators selected and published for this report are monitored by senior management of both the hospital and hospital group as a key component of clinical governance.
IHC	Immunohistochemistry (IHC) is a special test, widely used in pathology. It involves the process of identifying antigens (proteins) in cells of a tissue section by exploiting the principle of antibodies binding specifically to antigens in biological tissues. It can provide the pathologist with useful information about tumours, including the subtype of the tumour and what types of treatment it might respond to.
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.
LIS	Laboratory Information System
LOM	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.
Multidisciplinary Team Meetings (MDT)	Form an essential part of the clinical care of patients with cancer, suspected cancer or other clinical conditions and involve specialists in many areas including medical oncology, radiation oncology, radiology, pathology, surgery etc. coming together to agree on the best treatment options for individual patients. Histopathologists have a key role in such meetings and thereby contribute to patient management.
NQAIS	The National Quality Assurance and Improvement System is a platform for the generation of national reports to allow for the review of the accuracy of diagnostic testing from hospital laboratories. The NQAIS system is being used in the Histopathology Quality Insurance Programme to centrally monitor the practices involved in analysing and interpreting patient tissue samples.
Non Biopsy – Cancer Resection (P03)	Partial or total resections of organs involved by cancer. Examples include Mastectomy for the treatment of breast cancer, Colectomy for the treatment of colon cancer.
Non Biopsy – other (P04)	All other surgical specimens which are neither small biopsies nor cancer resections.

Non Gynaecological Cytology – FNA (P06)	Fine Needle Aspiration (FNA) involves using a needle attached to a syringe to collect cells from lesions or masses in various body organs. These small samples are examined by Cytopathologists. Cytopathology is a branch of pathology that studies and diagnoses diseases on a cellular level.
Non Gynaecological Cytology – Exfoliative (P07)	These are samples of cells that are collected after they have been either spontaneously shed by the body or manually scraped/brushed off of a surface in the body. They are examined by cytopathologists.
Recommendation	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 extremely 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.
Small Biopsy (P01)	A small procedure performed to obtain a small tissue sample (biopsy).
Specimen	A piece of tissue received into the pathology laboratory for analysis and diagnosis. One patient may have one or more samples submitted at any one time.
Stain	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).
Supplementary report	A report issued when new information becomes available after the final report has been submitted. 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 consultations may be included in a supplementary report.
Target	Refers to the target associated with Quality Indicators.
QI	Quality Improvement in healthcare is a science that uses sophisticated tools and techniques to systematically introduce and embed changes to healthcare delivery. An important aspect of quality improvement is the use of accurate and powerful measurement tools to make sure patient outcomes are improving as a result of the change.

NOTES

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