Pathology quality assurance dashboard: second edition

November 2019

NHS England and NHS Improvement

The NHS Long Term Plan says that when organisations work together they provide better care for the public. That is why on 1 April 2019 NHS Improvement and NHS England united as one – our aim, to provide leadership and support to the wider NHS. Nationally, regionally and locally, we champion frontline staff who provide a world-class service and constantly work to improve the care given to the people of England.

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Introduction

This second edition of the pathology quality assurance dashboard (PQAD) follows a review that took in feedback from pathology providers and representatives of the Pathology Alliance. Where possible, we have taken a similar approach to the Royal College of Pathologists as it refreshes its key performance indicators.

The first version of the PQAD was launched in response to Dr Ian Barnes' pathology quality assurance review,[1] which noted that:

> "The current pathology quality assurance framework lacks several key factors: transparency, integration, scrutiny, oversight and effective triggers for reward and sanction, without which we cannot say the best interests of patients and healthcare generally are truly being served".

The review, and reviews by Lord Carter,[2] recommended that a PQAD be developed, which would draw "transparent and meaningful information from existing data sources to provide a national picture of quality improvement across England, to enable trend analysis and the identification of opportunities for development of the system".

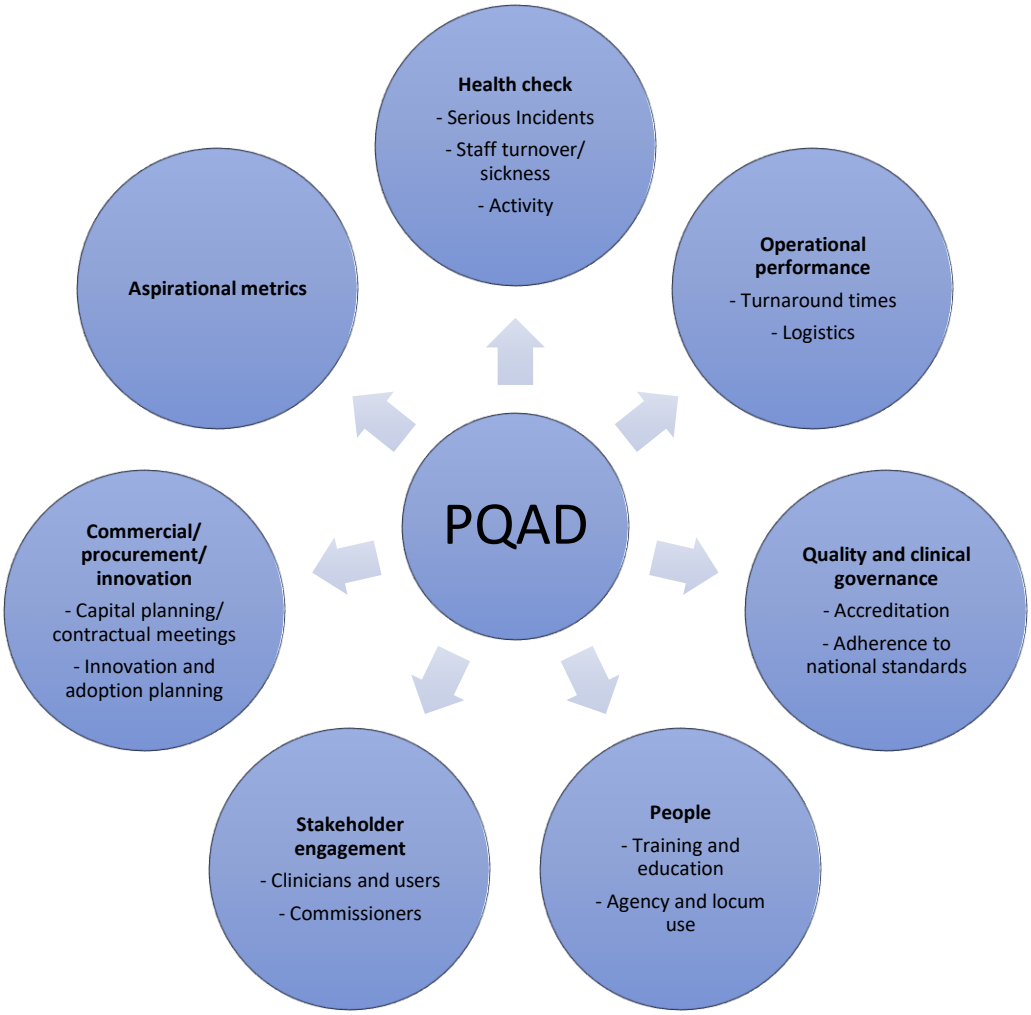
The original metrics, although useful for determining a pathology service's performance, did not test systems and provision when they were not owned by the host trust. They also collected data that was not timely or already assured through other routes (for example, via the laboratory's accreditation status).

Individual trusts must understand how pathology services can be more effective and efficient. That means the PQAD needs to be an effective board-reporting tool, with metrics that allow timely interventions focused on delivering high quality patient services and driving improvement. This edition is intended to fulfil that purpose.

[1] Pathology quality assurance review, chaired by Dr Ian Barnes, January 2014. https://www.england.nhs.uk/publications/reviews-and-reports/ind-rev/
[2] *Operational productivity and performance in English NHS acute hospitals: unwarranted variations*. https://www.gov.uk/government/publications/productivity-in-nhs-hospitals

The indicators

This guidance has been compiled using laboratory management experience and expertise, by reviewing case studies of pathology consolidation and input from trust executives who have been through the consolidation process, both successfully and unsuccessfully. It has been reviewed and approved by the National Pathology Optimisation Delivery Group, which has broad representation from the pathology profession organisations including the Royal College of Pathologists (RCPath), the Institute of Biomedical Science (IBMS) and the Association of Clinical Biochemistry. Metrics are broken down into sections that describe where they are testing the system.



Performance should be monitored locally as part of the quality management governance structure and reviewed at board level as a formal recurring agenda item. A bi-annual in-depth investigation of the service should also take place.

1. Health check

Indicator reference	Indicator	Comment	Target
H1	Number of Serious Incidents assigned to pathology	Record the number of Serious Incidents assigned to pathology.	0
H2	Number of outstanding Datix (incident) reports over 30 days old	Important when issues are identified that rapid and appropriate action is taken. The number of incidents is not a good marker of service quality, as a well-run service will always identify issues as part of the audit process. Trusts are asked to record the number of incidents where pathology is the identified lead.	0
H3	Number of RIDDORs reported	Record the number of RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reportable incidents associated with pathology.	0
H4	Staff sickness rate	Record staff sickness rate for whole pathology service. This is an overarching metric that will provide a health check of the service.	3.96%
H5	Staff turnover	Record staff turnover for the whole pathology service. This is an overarching metric that will provide a health check of the service.	14.4%
H6	Overall activity trend	Record of activity trend.	-
H7	Headline risk for pathology service	Main risks identified for the pathology service.	-
H8	Confirmation that services currently meet statutory requirements	Medicines and Healthcare products Regulatory Agency, Human Tissue Authority, Human Fertilisation and Embryology Authority, Health and Safety Executive, Department of Health and Social Care point-of-care testing (POCT) guidelines.	All services should meet legal and statutory standards

2. Operational performance

Indicator reference	Indicator	Comment	Target
T1	Proportion of diagnostic tests agreed between the requestor and provider as reported within locally agreed turnaround times (from 'receipt of sample' to 'arrival of result at the requestor')	A candidate marker test, covering acute and routine patients from the blood science laboratory, from core biochemistry and core haematology repertoire should be selected and the turnaround time (TAT) recorded against target.	>95%
T2	Proportion of diagnostic histopathology cases requested for patients on a cancer pathway that are reported within 10 calendar days of the procedure taking place	Diagnostic histopathology turnaround times should be recorded against the standard of seven and 10 days. TAT recorded from 'receipt of sample' to 'arrival of result at the requestor' for all cancer pathway samples.	>90%
T3	Proportion of diagnostic gynae-cytology cases requested for the investigation of cancer that are reported within seven calendar days of the procedure taking place	For screening services turnaround times should be recorded against the prevailing standard as set by the commissioner.	>90%
		For diagnostic service, turnaround times should be recorded against the prevailing standard as set by the commissioner.	>90%
T4	Local patient pathways, agreed with requestors, shall include anticipated turnaround times for all laboratory investigations	All diagnostic tests should have an agreed turnaround time. Trusts should list all tests that fail that target time, together with the reason. This helps organisations to identify issues around timeliness, capacity and opportunities to collaborate with other providers.	>95%
T5	Proportion of non-emergency or prophylactic administered antibiotics issued to inpatients without a confirmatory diagnostic test	To meet the 2016 O'Neill requirements that all antibiotics should be issued only with empirical evidence of a bacterial infection. Regular audit should be used to assess compliance and support clinical practice.	100%

T6	Effectiveness of the acute sepsis pathway [as measured by adoption and adherence to NICE guidelines]	Rapid identification of sepsis is a national priority. Trusts need to ensure clinical teams and patients benefit from effective pathways as described by NICE guidelines NG51 and CG151. Regular audit should be used to assess compliance and support clinical practice.	100%

3. Quality and clinical governance

Indicator reference	Indicator	Comment	Target
Q1	Number of investigations available and reported by pathology that are not accredited to the ISO15189:2012 standard or equivalent	All diagnostic tests provided to NHS patients must be accredited. NHS Improvement must be informed of all tests being performed without accreditation, together with the reason.	0%
Q2	Number of investigations referred to third party providers that are not accredited to the ISO15189:2012 standard or equivalent	All diagnostic tests provided to NHS patients must be accredited. NHS Improvement must be informed of all tests being performed without accreditation together with the reason.	0%
Q3	Pathology services shall participate in accredited technical external quality assessment (EQA) schemes, if available, covering all analytical technical areas of the service repertoire.	All diagnostic tests provided to NHS patients must be subject to a recognised proficiency scheme. Boards should consider how they are alerted to proficiency scheme failures and be assured of mitigating steps taken by the laboratory.	100%
Q4	Number of NICE guidelines that have been commissioned and funded locally that require action by the pathology service and which have not been completed	Adoption of new technology and guidelines is critical for responsive pathology services. Trust boards should be aware of delays or issues that prevent implementation.	0%

Q5	Number of applicable field safety notices not yet implemented, where the notice was received more than 21 days ago	All corrective action should be taken promptly to ensure the correct diagnostic results are always provided.	0%
Q6	Number of community POCT audits performed to support primary care	To support programmes such as antimicrobial resistance stewardship and safe technology adoption. Trusts and pathology networks should support the appropriate use of technology that can improve access to patient pathways and reduce unplanned admission and avoidable conveyances.	2 per year
Q7	Number of transport delays recorded as non-conformances	To focus on logistics as a key to success in networked provision.	<1%

4. People

Indicator reference	Indicator	Comment	Target
P1	Proportion of pathology staff whose annual appraisals have been completed on time	Retention and development of staff are predicated on a clear job plan and career path, together with the right development opportunities.	100%
P2	Proportion of locum and bank staff per substantive from all staff groups	Trusts should always review numbers of agency staff. Data collected nationally for 2017/18 shows that £20 million savings could be made nationally by moving agency staff onto trust bank contracts.	5.5%
P3	All senior staff providing laboratory oversight and clinical advice at consultant or consultant-equivalent level (ie independent practice, clinical and scientific staff) shall have completed annual appraisal or shall have documented approval from their responsible officer or clinical line manager to defer. The annual appraisal will include discussion of ongoing competency.	Retention and development of staff are predicated on a clear job plan and career path, together with the right development opportunities.	100%
P4	Proportion of staff in training-grade posts shall be enough to sustain and develop the service, but not so high that the quality of training or service is compromised	Trusts should ensure that succession and continuity planning is factored into the pathology service's day-to-day operation. Training of staff will ensure stability and continuity of services.	5%

P5	Quality of training provided for trainees in each professional group shall meet the requirements of the relevant professional regulatory bodies (General Medical Council, Health and Care Professions Council, General Dental Council) and include relevant interprofessional learning opportunities	Trusts should ensure that succession and continuity planning are factored into the pathology service's day-to-day operation. Training of staff will ensure stability and continuity of services.	>5% of staff enrolled in active training programmes

5. Stakeholder engagement and operational delivery

Indicator reference	Indicator	Comment	Target
S1	The laboratory provider shall survey a random sample of patients at least annually to assess their opinions on the quality of the pathology service. There shall be evidence that the responses to the survey are analysed, distributed and used to improve the quality of the service.	Friends and Family Test. Service users can be drawn from clinics, outpatients and primary care.	One survey per year
S2	All current users of the laboratory service shall be invited to participate in a user satisfaction survey, of a type that generates quantitative and qualitative results annually	Trusts should ensure that service users are involved in shaping the service so that pathology services meet the evolving need but can also forge links within services to influence pathways through better use of diagnostics.	One survey per year
S3	The clinical review and decision-making process of the multidisciplinary team (MDT) shall be supported where appropriate, by advice and interpretation of diagnostic reports provided by pathologists and other life science professionals who attend the meetings	Trusts should ensure that pathologists and healthcare scientists can attend MDT meetings. They could attend remotely or virtually. Job plans for pathologists and senior scientists should include time for MDT preparation and attendance.	100% attendance at identified MDTs
S4	Making the NHS the best place to work. Making full use of staff feedback and engagement	An annual staff survey should be completed if not completed as part of the NHS staff survey. A review by the pathology leadership team should be undertaken and actions identified. This should form part of the audit process.	One audit per year

S5	Number of business review meetings held in the last quarter with the primary pathology provider, where the service is not provided by the trust	Regular review of outsourced services (including those outsourced to a trust-owned joint venture) is vital for a full understanding of the services provided, contractual obligations and performance.	One per quarter
S6	The number of business review meetings held in the last quarter with diagnostic suppliers (for example, to review managed service contracts or long-term supply agreements)	Regular review of contracts, such as managed service contracts and other high value contracts, is important to ensure best value and performance. Trust boards should be able to satisfy themselves that meetings are productive and focused on ensuring high quality service provision. Meetings should include review of contract pricing, terms and duration as well as enacting contractual penalties if required.	One per quarter
S7	Number of equipment contracts in effect that are over original term agreement	Regular review of service requirements and contract end dates can prevent costly extension and rushed procurement activities. Trust boards should be alerted to any contract that is over term as this is likely to be financially disadvantageous and, with due planning, avoidable.	0%
S8	The laboratory shall actively engage in demand optimisation, designed both to reduce the number of unnecessary tests and to help ensure that appropriate tests are used	Trusts should regularly review the current test panels offered, best practice advice and outputs from programmes such as Getting It Right First Time, RCPath and NICE. Requesting patterns from clinical users in primary and secondary care should be audited looking for unwarranted variation.	In date policy document

S9	Laboratories shall demonstrate commitment to sustained innovation in their services through continuous quality improvement (CQI), which may include conducting formal academic research and evaluating novel approaches aimed at improving patients' health and the wider population's wellbeing.	Trust boards should review this against laboratory policies on number of CQIs, clinical audits and pathology-led interventions across the organisation. Innovation and rapid adoption of new approaches, tests and protocols improve patient outcomes and can lead to pathway efficiencies.	In date policy document

6. Future metrics

The PQAD, in keeping with all quality monitoring and improvement tools, will be periodically updated to include relevant and useful metrics. These will be drawn from the sector and from improvement initiatives such as the Getting It Right First Time (GIRFT) programme. These will be published as future metrics at least one quarter before becoming part of the mandatory PQAD.

Indicator reference	Indicator	Comment	Target
F1	The proportion of inpatient results required for discharge available at time of need	Improving the way that pathology is used to support discharge.	
F2	The number of blood draws per patient episode	Reducing the number of routine blood draws. Demand management and optimisation of testing. Ensuring the patient is not burdened with providing additional samples to support a logistic solution.	

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