FACULTY OF PATHOLOGY

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

National Histopathology Quality Improvement Programme

6th National Data Report

1 JAN - 31 DEC 2018

Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt

National Quality Improvement Team

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

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FOREWARD

The National Quality Improvement Programme in Histopathology was initiated in January 2009 as a matter of priority following high-profile cancer misdiagnosis cases in Ireland. The purpose of the programme is to document and improve the accuracy, consistency and quality of service with the aim of improving patient safety and enhancing patient care.

This is the sixth annual report and is composed of anonymised, national data collected from the reporting tool, National Quality Assurance and Improvement System (NQAIS), from 1 January to 31 December 2018. In 2018, 32 laboratories participated in the programme and contributed to the dataset. The report includes analysis on the first three rounds of targets and recommendations released by the programme. The report provides high quality data on a range of key quality indicators. 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 data illustrates continuing improvement in many domains but there are a number of areas where we have not yet seen improvements. Where the data suggests that there may be areas for improvement, the findings should be confirmed locally using local hospital data. It should be noted that the conclusions drawn in these reports are based upon the data recorded within hospitals. Whilst the data is mature and the programme is confident in the findings of the report, gaps in data collection on a hospital level may be due to a wide variety of factors and therefore local confirmation remains essential.

It is imperative that all participating hospitals continue to integrate the output of this programme into their day to day quality assurance/improvement functions. In addition, we would encourage your laboratory to consider how you can harness the findings in these reports to address any necessary improvements.

The Working Group of the National Histopathology Quality Improvement Programme 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 Faculty of Pathology Board and the Specialty QI Programme Steering Committee for their continuous support.

Dr Sine Phelan,

Chair of the HQI Programme Working Group

COMMENTS ABOUT THE HISTOPATHOLOGY QI PROGRAMME

'This year the National Histopathology QI Programme celebrates its 10th anniversary. I would like to take this opportunity to congratulate everyone involved in its initial and ongoing development, in particular the members of the NHQI Working Group and to all members of the pathology laboratories who have contributed through engagement with the programme. I would like to highlight the tremendous strides that Histopathology has taken to constantly improve and maintain Quality in Irish Laboratories and I look forward to the continued excellence of this programme in the years to come.'

Prof Louise Burke
Dean of the Faculty of Pathology

"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 Team

"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

"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

A MESSAGE FROM A PATIENT ADVOCATE

"I had a cancer diagnosis in 2006 and I have survived because of a team of scientists and my sister who was a match for a stem-cell transplant.

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, my confidence in our health system grows to the extent that a QI practice becomes more embedded in the workings of our hospitals and in the practices of their staff."

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

CHAPTER 1
INTRODUCTION TO THE PROGRAMME

1

CHAPTER 1:
INTRODUCTION TO THE PROGRAMME

ABOUT THE NATIONAL HQI PROGRAMME

The National Quality Improvement Programme in Histopathology (NHQI 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), RCPI. While the initial funding support was provided by the NCCP, the HSE Quality Improvement Team has been the programme's funding body since 2014.

The central goal of the NHQI Programme is 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 programme aims to:

- improve patient care by minimising diagnostic errors in Histopathology
- develop a standardised national quality improvement system for Histopathology
- enable individual laboratories to review their performance against national targets
- identify good practice and areas requiring improvement and share findings with participating laboratories
- provide evidence-based assurance to the public of the quality of Irish diagnostic services
- improve communication between participating institutions

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 and documentation of quality of service. The programme has also helped to identify opportunities for improved efficiency of services and has potentially caused reduction of unnecessary testing and errors.

THE PROGRAMME GIVES PATIENTS GREATER CONFIDENCE IN HISTOPATHOLOGY DIAGNOSES IN IRELAND

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

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 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

In 2018, 32 public and private hospital laboratories participated in the National Histopathology QI Programme and contributed their data to the programme's dataset.

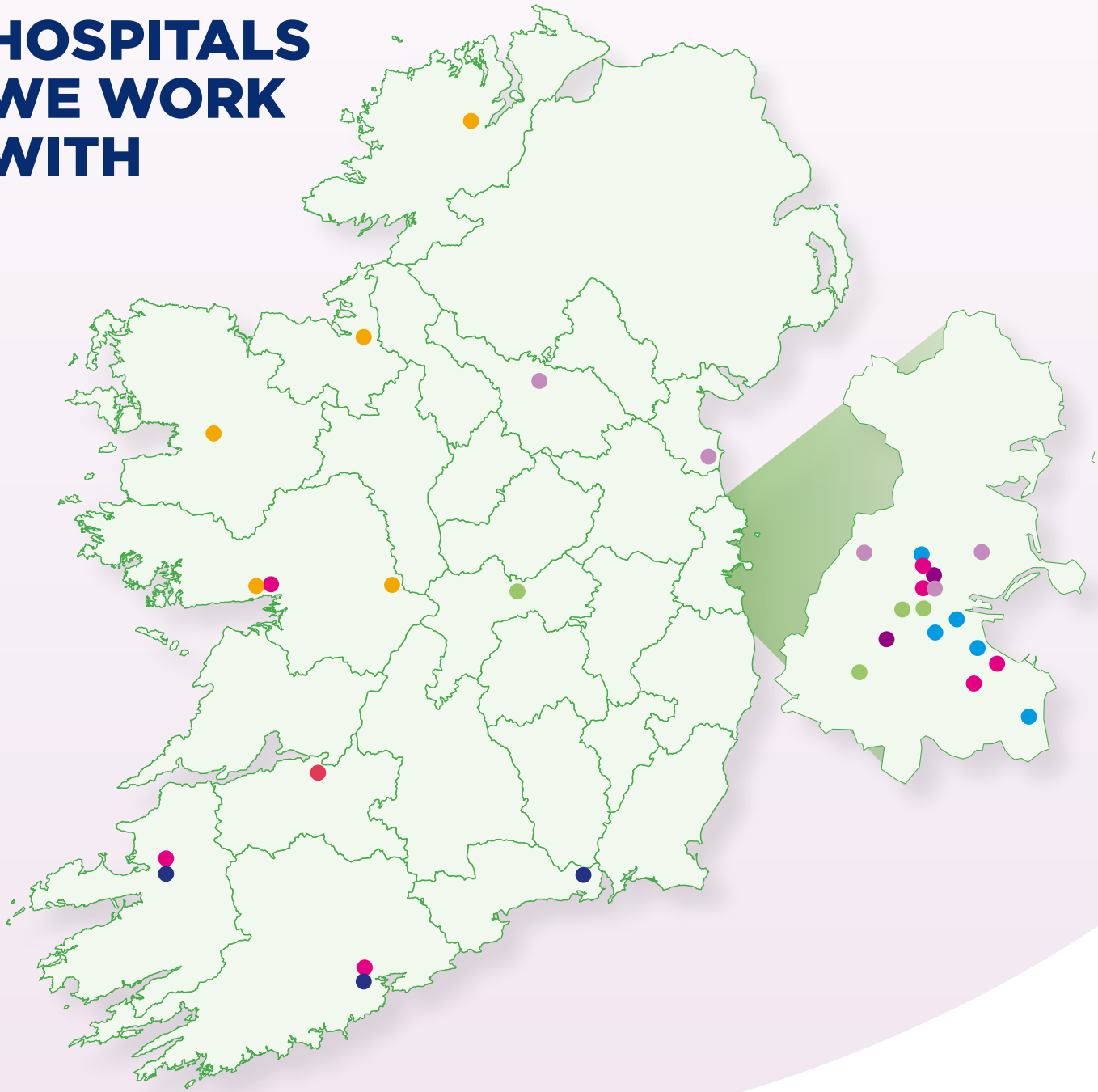
PURPOSE OF THIS REPORT

This report will allow informed decision making on the future steps to be taken to support the ongoing quality improvement processes within Irish Histopathology services. The National 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 colleagues in the laboratory, 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 QI data.

WHAT THIS REPORT CANNOT DO

This report cannot and should not be used to produce league tables or compare hospitals 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 invalid.

HOSPITALS WE WORK WITH



- DUBLIN MIDLANDS HOSPITAL GROUP
- IRELAND EAST HOSPITAL GROUP
- THE CHILDREN'S HOSPITAL GROUP
- UNIVERSITY OF LIMERICK HOSPITAL GROUP
- RCSI HOSPITAL GROUP
- PRIVATE HOSPITALS ASSOCIATION
- SAOLTA HOSPITAL GROUP
- SOUTH/SOUTH WEST HOSPITAL GROUP

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

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

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

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. Columcille's Hospital Histopathology has been moved to St. Vincent's University Hospital, however, they are still performing autopsy.*
*** St. Vincent's Private Laboratory participates in the programme and its date is included in SVUH uploads.*

KEY RECOMMENDATIONS FOR THE FUTURE

The information from this report should be used by histopathologists/medical scientists/healthcare professionals/management in hospitals to improve the quality of patient care

The NHQI WG should increase the engagement of the Histopathology QI Working Group with the participating laboratories and in doing so will become more responsive to the views of the wider pathology community

It is imperative that all participating hospitals continue to integrate the output of this programme into the day to day quality assurance/ improvement functions

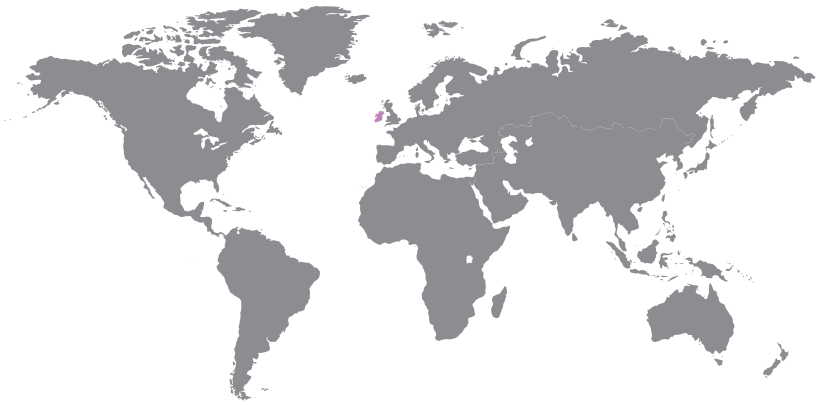
New procedural codes and Quality Activities/KQIs will be introduced to improve the quality of information in hospital records

CHAPTER 2
REPORT HIGHLIGHTS

2

CHAPTER 2

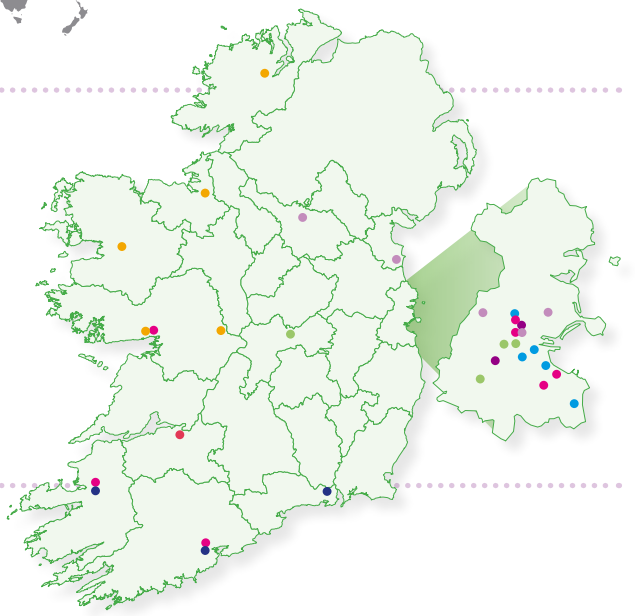
REPORT HIGHLIGHTS



FIRST
COUNTRY IN THE WORLD

that reports on national metrics in histopathology

32 Laboratories in Ireland
participate in the programme



6TH National Data Report

479,837 CASES

815,709 SPECIMENS

1,350,979 BLOCKS

PROCESSED IN 2018

14%

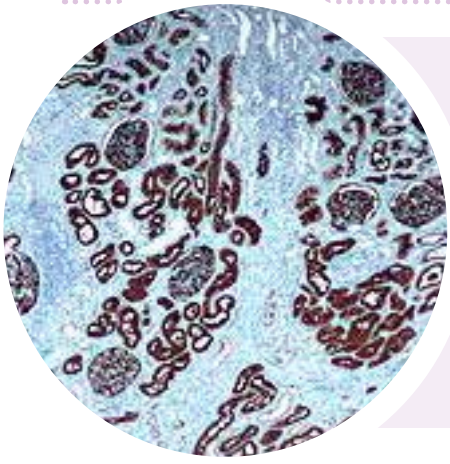
Increase in the number of
CASES EXAMINED
between **2013-2018**

20%

Increase in the number of
BLOCKS PROCESSED
between **2013-2018**

22.7%

Increase in
SPECIMENS EXAMINED
between **2013-2018**



55%

Increase in the volume of **CASES REQUIRING IMMUNOHISTOCHEMICAL STAINS** between 2013-2018

CHAPTER 3

INTRODUCTION TO ANALYSIS

3

CHAPTER 3:
INTRODUCTION TO ANALYSIS

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

It is known as the National Quality Assurance and Improvement System (NQAIS). It functions as a central repository for quality improvement data from each hospital's Laboratory Information System (LIS). It allows us to generate national reports on the accuracy and timeliness of diagnostic testing in hospital laboratories across Ireland. We use NQAIS to produce an annual report on national metrics in histopathology, making Ireland the first country in the world to do so. 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. In 2018, 32 laboratories participated in the programme and contributed to the dataset.

SAMPLING

Each laboratory records histology, cytology, autopsy, and other cases in their local Laboratory Information System (LIS). Information on these cases, including data on quality activities performed, are then extracted from the LIS on a monthly basis and uploaded to NQAIS-Histopathology.

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 a Local Operations Manager (local laboratory staff). Each laboratory's assigned QI Clinical Lead (Consultant Histopathologist) then reviews the data and signs it off, which triggers its addition to the national dataset. All data for January-December 2018 was added and signed off by April 2019 by the Clinical Leads in all participating laboratories. No patient identifiable information is collected within NQAIS-Histopathology, hospital identifiable data in the national dataset is anonymised. The same hospital identifier is used throughout this document and corresponds to the same Hospital ID structure used in the previous report (5th Annual National Data Report). This means that it is possible to track a laboratory's change over the two years.

DATA ANALYSIS

The national dataset was analysed by the National HQI Programme's Data Analyst between April and May 2019. Performance against the programme's Rounds one, two and three Targets and Recommendations (Tables 3.1 & 3.2) were analysed in this report. These included Intradepartmental Consultations, Multidisciplinary Team Review, Addendum Reports, Frozen Section 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 has also been supplied.

Data was analysed to establish trends across the various quality areas for three groupings: National (all sites), Cancer Centres (CCs) and General Centres (GCs). Each individual pathology case nationally is weighted equally in all statistics and trend charts in this report.

The areas of analysis are set out in the Guidelines for the Implementation of the National Quality Improvement Programme in Histopathology, which is available on the RCPI website. In some

quality areas, we also have sufficient data to analyse the performance over multiple years on a quarterly basis. Where this is possible, the multi-year data has been presented.

The 2018 data is presented on quarterly graphs, bar charts, tables and 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. 95% of data should fall within two (1.96 Confidence Interval) standard deviations of the mean, 99.7% of data should fall within three (2.57 Confidence Interval) standard deviations of the mean.

Figures (graphs, bar charts, funnel plots) and tables giving information as to each anonymised centre's performance against the minimum and achievable targets have been supplied. Where the graph element outline is green, it means that the laboratory exceeded the achievable target for 2018. Where the graph element is yellow, it means that the site exceeded the minimum target for the quality area but did not exceed the achievable target. Where the graph element is red, laboratories did not meet the minimum target.

Where a hospital does not have a particular procedure or KQI in the caseload, we have used N/A to highlight that this procedure code or KQI is not applicable. This also emphasises sites that performed a particular procedure but did not code in 2018 or 2017.

TARGETS AND RECOMMENDATIONS

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

TABLE 3.1: Targets set by HQI Working Group

Key Quality Area	Targets & Key Quality Indicators	Notes
Turnaround Time (TAT) **ROUNDS 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 zero.
Intradepartmental Consultation (IDC) **ROUNDS 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 **ROUNDS 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 3.2: Recommendations set by the Working Group

Key Quality Area	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 *Terms explained in chapter 7	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.

APPROVAL PROCESS

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

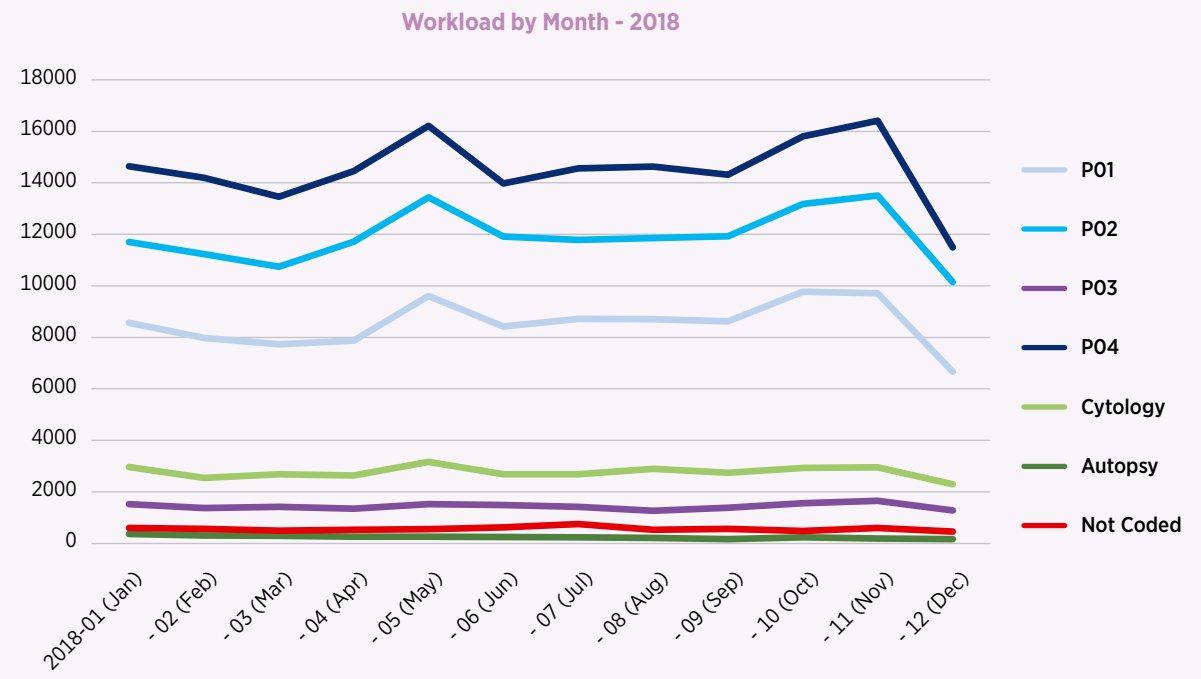
CHAPTER 4
WORKLOAD

4

CHAPTER 4
WORKLOAD

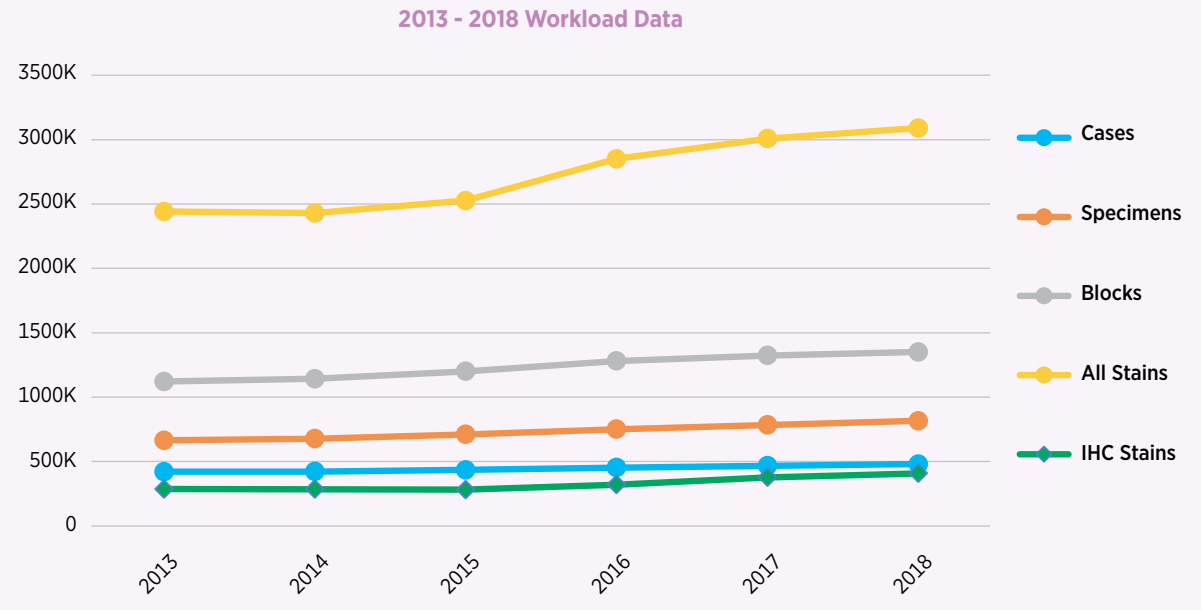
The following graphs show the workload nationally in 2018 and 2013-2018. There are no targets or recommendations set against volumes of cases completed, however, many statistics calculated in this report compare the number of quality activities completed against these figures.

FIGURE 4.1: The volume of cases by procedure code completed nationally in 2018



Explanation of procedure codes can be found in Appendix 2 Glossary.

FIGURE 4.2: 2013-2018 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 2018.

TABLE 4.1: 2013-2018 Workload Data

Type	No. (Cases) 2013	No. (Cases) 2014	No. (Cases) 2015	No. (Cases) 2016	No. (Cases) 2017	No. (Cases) 2018
Cases	420,790	422,220	435,276	452,036	466,429	479,837
Specimens	664,799	677,462	709,969	750,718	784,034	815,709
Blocks	1,121,696	1,142,906	1,200,053	1,281,374	1,323,937	1,350,979
All Stains	2,440,966	2,430,030	2,526,534	2,850,511	3,008,483	3,090,357
IHC stains	285,660 (43,865 cases)	285,039 (45,057 cases)	281,551 (49,200 cases)	320,439 (55688 cases)	376,639 (61804 cases)	407,637 (67967 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 (418,164 cases)	2,170,295 (431,903 cases)	2,225,001 (445,446 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)	319,027 (68,003 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)	137,230 (58,061 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)	25,085 (1,175 cases)
No. of units	33	32 (excludes unit that closed in 2013)	32	32	32	32

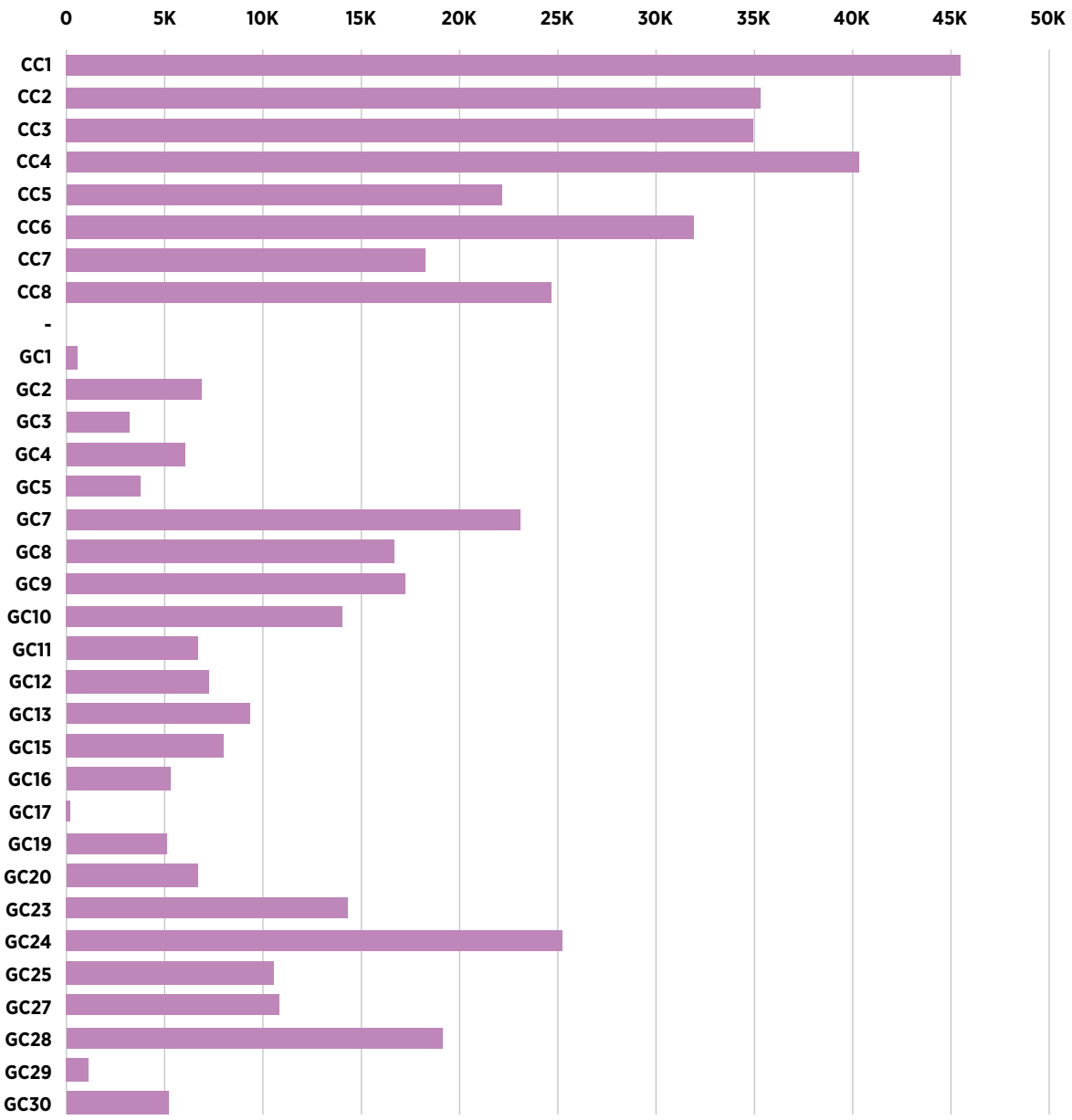
Between 2017 and 2018, the volume of cases nationally increased by 13,408 cases (2,9%), 27,042 blocks (2,0%) and 31,675 specimens (4,0%).

In the six years from 2013 to 2018 the national volume of cases has increased by 59,047 (14%), blocks have increased by 229,283 (20%), and the number of specimens received have increased by 150,910 (22,7%).

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

In the same six years from 2013 to 2018, the national volume of cases requiring Immunohistochemical stains (IHC stains) has increased by 55%, and the actual number of stains shows a 43% increase. This further reflects the increased complexity of diagnosis and the additional information that pathology can provide from tissue samples to guide patient care.

Table 4.2: Number of Cases by Hospital in 2018



The volume of work carried out at Cancer Centres ranged from 18,000 to over 45,000 specimens.

The volume of work carried out at General Centres ranged from 200 to over 25,000 cases. Laboratories varying in size and complexity face different challenges in implementing the National Histopathology QI programme and in meeting targets.

CHAPTER 5
INTRADEPARTMENTAL CONSULTATION

5

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: Targets 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%

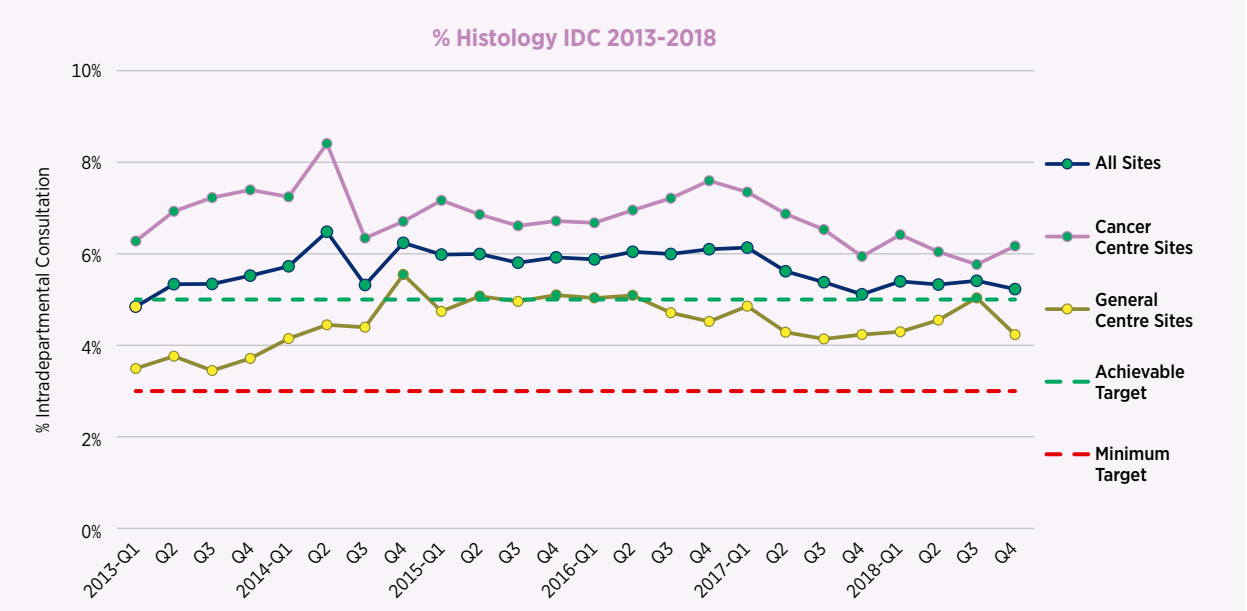
Intradepartmental Consultation Commentary - Histology (P01-P04)

In 2018, Histology Intradepartmental Consultation as a whole was consistently above both the minimum and achievable targets when data from Cancer Centres and General Centres are combined.

The average rate of Intradepartmental Consultation for all centres was 5.34% in 2018. The achievable target was met for all 12 months of the year. Cancer Centres achieved a yearly average of 6.1% while General Centres averaged 4.5% in 2018.

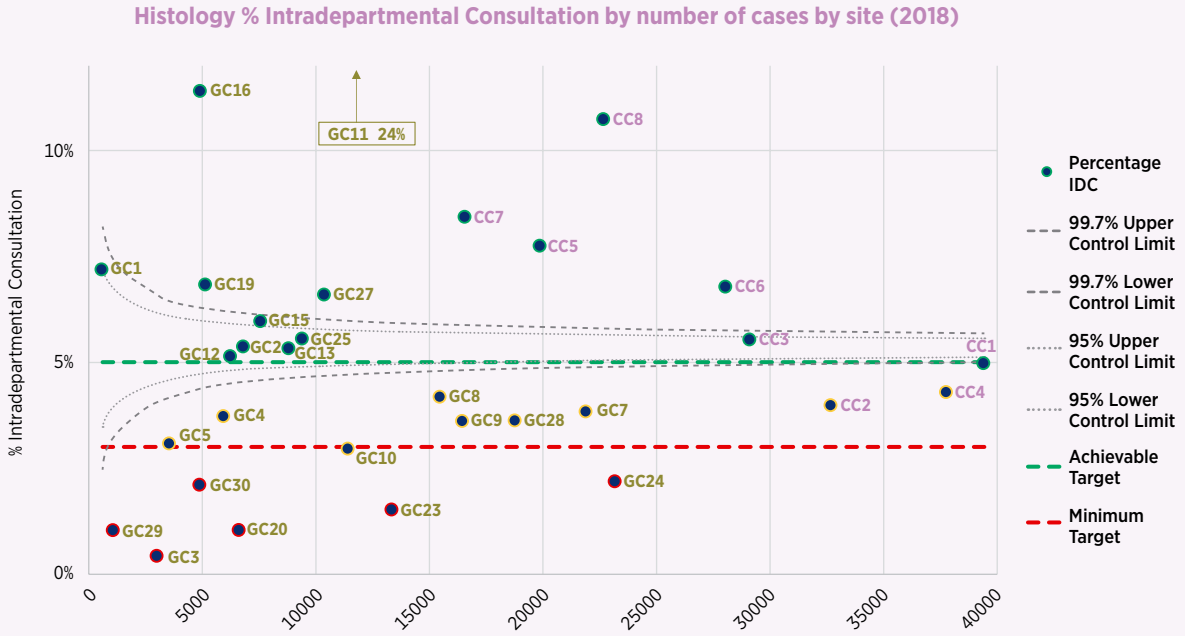
While for the last 6 years, on a quarterly basis, the rate of Interdepartmental Consultation (Q006) has been consistently above the achievable target, there has been a decline from an average of over 6% from 2015 to 5.34% in 2018. This decrease affected both Cancer Centre and General Centre rates.

FIGURE 5.1: Histology % Intradepartmental Consultation (IDC) per Quarter 2013-2018



In 2018, Histology Intradepartmental Consultation as a whole was consistently above both the minimum and achievable targets, at 5.34%

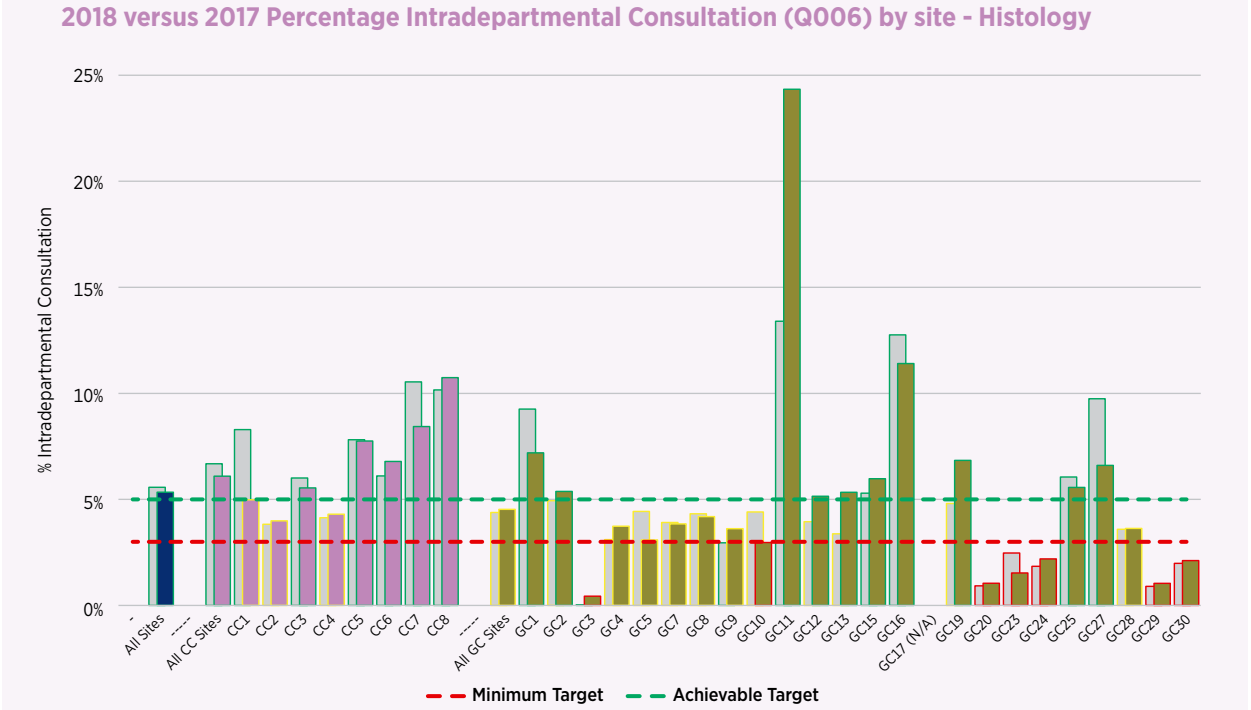
FIGURE 5.2: Funnel Plot - Histology % Intradepartmental Consultation in 2018



The above funnel plot shows the percentage of Interdepartmental Consultation for each hospital. The number of histology cases is shown on the X-axis and the percentage of Interdepartmental Consultations on the Y-axis. There is a wide variation in Intradepartmental Consultation rates which may relate to different workload and profile of pathology cases in different hospitals. As you can see one GC has a very high percentages of Intradepartmental Consultation (GC11-24%) which is much higher than any other laboratory.

In many cases, the laboratories with the lowest percentage of IDC which are also below the minimum target are mostly those with low numbers of cases. Conversely, those with the highest numbers of cases are all above the minimum target.

FIGURE 5.3: Bar graph - 2018 versus 2017 in Grey: Histology % Intradepartmental Consultation by site



All the eight Cancer Centre sites and 16 of the 23 General Centre sites were above the minimum target for Intradepartmental Consultation in 2018. 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. One General Centre site had an intradepartmental consultation rate of less than 1% of cases having an IDC. One General Centre (GC17) had zero Non-Autopsy Histology cases, thus N/A (Not Applicable) has been used.

"Members of the working group 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: 2017 v 2018 - Full Data Intradepartmental Consultation – Histology

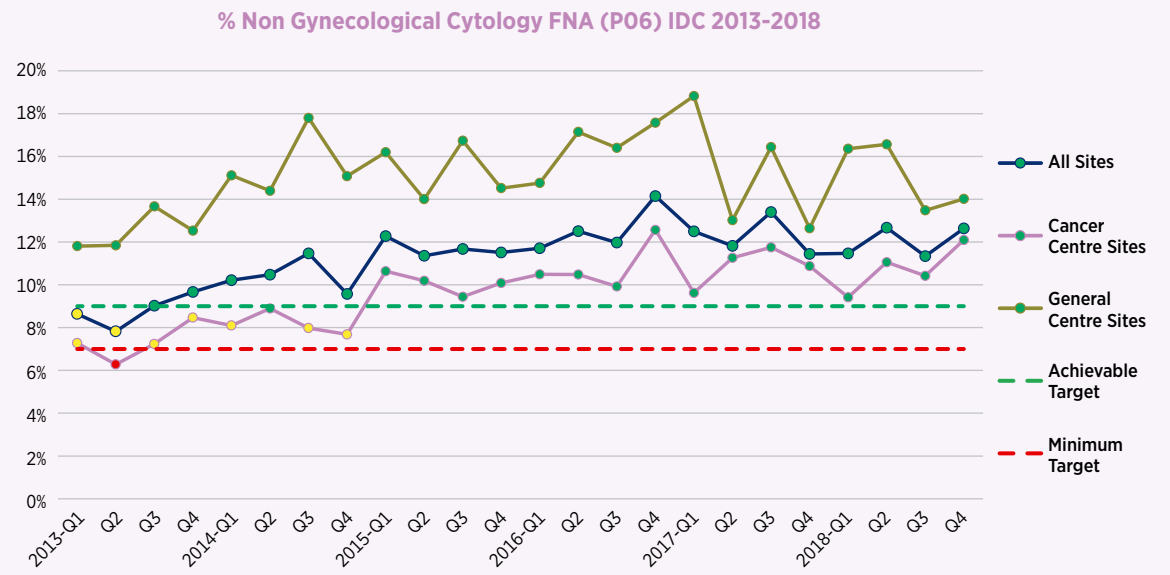
Histology P-Codes P01-P04	2017 IDC - Histology			2018 IDC - Histology		
	No. of Cases	No. Q006	% Q006	No. of Cases	No. Q006	% Q006
All Cancer Centres	**218539**	**14599**	**6.68%**	**225966**	**13772**	**6.09%**
CC1	37108	3078	8.29%	**39383**	**1962**	**4.98%**
CC2	33001	1263	3.83%	**32666**	**1303**	**3.99%**
CC3	27808	1671	6.01%	**29090**	**1612**	**5.54%**
CC4	36251	1499	4.14%	**37748**	**1624**	**4.30%**
CC5	19045	1488	7.81%	**19850**	**1539**	**7.75%**
CC6	27087	1654	6.11%	**28029**	**1903**	**6.79%**
CC7	15783	1664	10.54%	**16550**	**1396**	**8.44%**
CC8	22456	2282	10.16%	**22650**	**2433**	**10.74%**
All General Centres	**205307**	**8998**	**4.38%**	**210990**	**9559**	**4.53%**
GC1	864	80	9.26%	**556**	**40**	**7.19%**
GC2	6783	335	4.94%	**6788**	**365**	**5.38%**
GC3	3026	1	0.03%	**2983**	**13**	**0.44%**
GC4	6668	207	3.10%	**5917**	**221**	**3.74%**
GC5	3046	135	4.43%	**3530**	**109**	**3.09%**
GC7	19969	781	3.91%	**21875**	**841**	**3.84%**
GC8	14578	630	4.32%	**15445**	**647**	**4.19%**
GC9	15477	457	2.95%	**16438**	**595**	**3.62%**
GC10	11208	494	4.41%	**11395**	**338**	**2.97%**
GC11	7686	1030	13.40%	**5998**	**1460**	**24.34%**
GC12	5901	233	3.95%	**6216**	**320**	**5.15%**
GC13	8054	272	3.38%	**8791**	**469**	**5.34%**
GC15	7387	391	5.29%	**7548**	**451**	**5.98%**
GC16	4617	589	12.76%	**4892**	**558**	**11.41%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19	4682	225	4.81%	**5117**	**350**	**6.84%**
GC20	6172	57	0.92%	**6598**	**69**	**1.05%**
GC23	12218	302	2.47%	**13326**	**204**	**1.53%**
GC24	23038	425	1.84%	**23159**	**508**	**2.19%**
GC25	10255	621	6.06%	**9381**	**522**	**5.56%**
GC27	10230	997	9.75%	**10358**	**684**	**6.60%**
GC28	17688	635	3.59%	**18753**	**681**	**3.63%**
GC29	1224	11	0.90%	**1056**	**11**	**1.04%**
GC30	4536	90	1.98%	**4870**	**103**	**2.11%**
All Sites	**423846**	**23597**	**5.57%**	**436956**	**23331**	**5.34%**

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 (9%) targets, at 12%, and was above the achievable targets for 11 of 12 months in 2018.

Cancer Centres (CCs) averaged 10.8% Intradepartmental Consultations in 2018. General Centres (GCs) averaged at 15.1% both well above the achievable target. It is interesting to note that the GC group have a 4% higher rate of IDC in 2018.

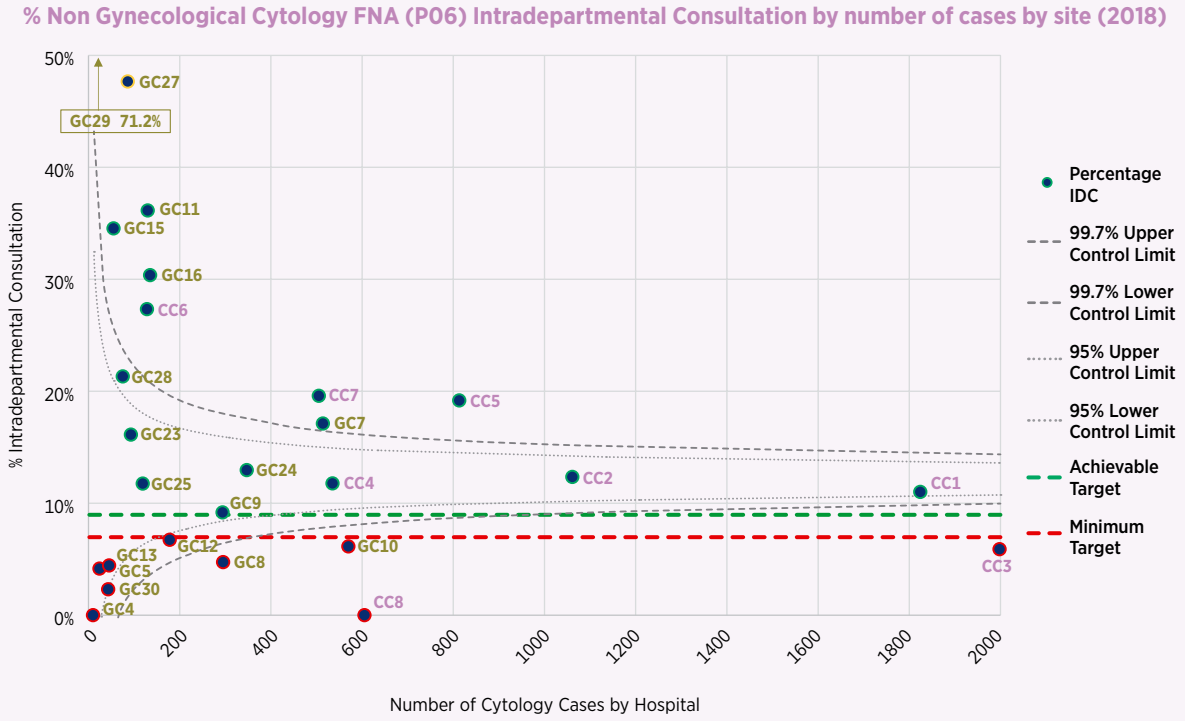
FIGURE 5.4: Intradepartmental Consultation Non Gynaecological Cytology FNA – 2013-2018



The 6-year quarterly data shows CC and GC centres above the minimum target since Q3 2013 and CCs above achievable target consistently since 2015, stabilising at 12%.

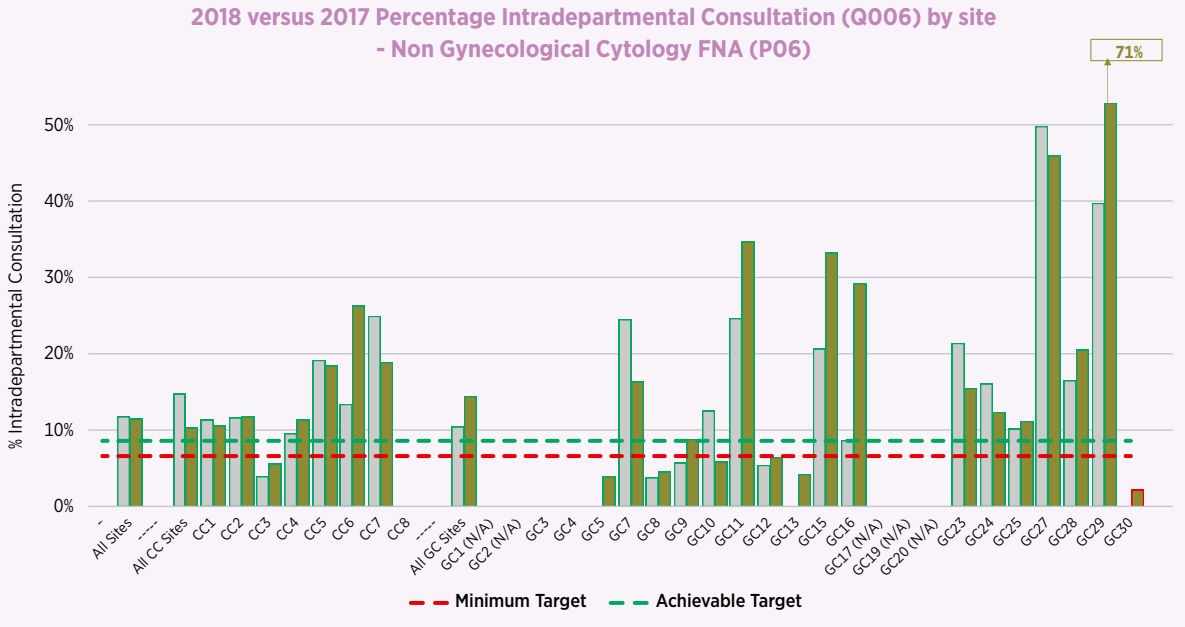
In 2018 Non Gynaecological Cytology FNA Intradepartmental Consultation as a whole was consistently above both the minimum and achievable targets

FIGURE 5.5: Funnel Plot - Non Gynaecological Cytology FNA % Interdepartmental Consultation



The above funnel plot shows that most of the laboratories that are below the minimum IDC target have low numbers of cases. One CC had over 600 cases, but no IDCs coded. A second CC site that has 2000 cases is just 1% below the minimum 7% IDC target.

FIGURE 5.6: Bar chart - % of Intradepartmental Consultation Non Gynaecological Cytology FNA, 2018 v 2017 in Grey



Six of eight Cancer Centre sites met the 9% achievable target in 2018, similar to 2017. The site CC8, which had zero P06 IDCs in 2018 also had zero IDCs in 2017. CC6 has 5.9% IDC in 2018, the number increased from 4.1% in 2017. CC8 has zero recorded P06 IDCs for 3 years in a row.

Eleven of 18 General Centre sites met the 9% achievable target for Intradepartmental Consultation in 2018, the same as 2017. Six General Centre sites were below the minimum target in 2018.

TABLE 5.3: 2017/2018 Full Data Intradepartmental Consultation – Non-Gynaecological Cytology FNA

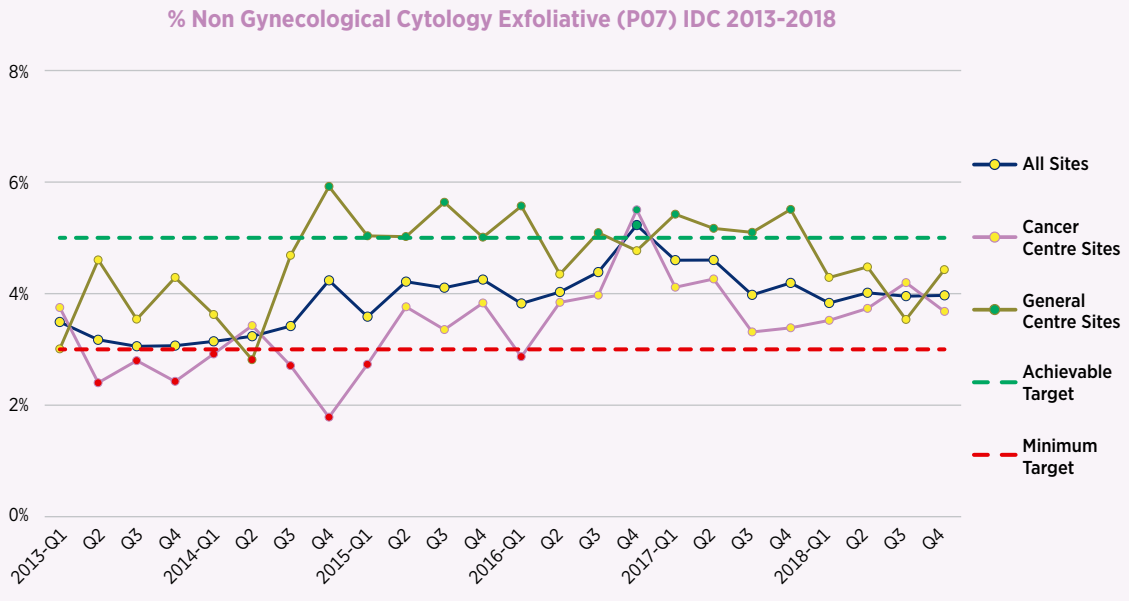
Cytology non Gynae FNA P-Code P06	2017 IDC - Non Gynaelogical Cytology FNA			2018 IDC - Non Gynaelogical Cytology FNA		
	No. of Cases	No. Q006	% Q006	No. of Cases	No. Q006	% 006
Cancer Centres	**7002**	**760**	**10.85%**	**7469**	**803**	**10.75%**
CC1	1794	213	11.87%	**1824**	**201**	**11.02%**
CC2	1097	134	12.22%	**1061**	**131**	**12.35%**
CC3	1903	79	4.15%	**1998**	**118**	**5.91%**
CC4	443	44	9.93%	**535**	**63**	**11.78%**
CC5	737	147	19.95%	**813**	**156**	**19.19%**
CC6	129	18	13.95%	**128**	**35**	**27.34%**
CC7	482	125	25.93%	**505**	**99**	**19.60%**
CC8	417	0	0.00%	**605**	**0**	**0.00%**
General Centres	**3389**	**520**	**15.34%**	**3079**	**465**	**15.10%**
GC1 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC2 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC3 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC4	3	0	0.00%	**10**	**0**	**0.00%**
GC5	4	0	0.00%	**24**	**1**	**4.17%**
GC7	568	145	25.53%	**514**	**88**	**17.12%**
GC8	466	19	4.08%	**295**	**14**	**4.75%**
GC9	286	17	5.94%	**294**	**27**	**9.18%**
GC10	467	61	13.06%	**570**	**35**	**6.14%**
GC11	117	30	25.64%	**130**	**473**	**6.15%**
GC12	139	8	5.76%	**178**	**12**	**6.74%**
GC13	68	0	0.00%	**45**	**2**	**4.44%**
GC15	51	11	21.57%	**55**	**19**	**34.55%**
GC16	153	14	9.15%	**135**	**41**	**30.37%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC20 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC23	54	12	22.22%	**93**	**15**	**16.13%**

Cytology non Gynae FNA P-Code P06 Continued	2017 IDC - Non Gynaelogical Cytology FNA			2018 IDC - Non Gynaelogical Cytology FNA		
	No. of Cases	No. Q006	% Q006	No. of Cases	No. Q006	% Q006
GC24	383	64	16.71%	**347**	**45**	**12.97%**
GC25	328	35	10.67%	**119**	**14**	**11.76%**
GC27	114	59	51.75%	**86**	**41**	**47.67%**
GC28	70	12	17.14%	**75**	**16**	**21.33%**
GC29	80	33	41.25%	**66**	**47**	**71.21%**
GC30	34	0	0.00%	**43**	**1**	**2.33%**
All Sites	**10391**	**1280**	**12.32%**	**10548**	**1268**	**12.02%**

Intradepartmental Consultation Commentary - Non Gynaecological Cytology Exfoliative (P07)

In 2018 the annual average for all sites was 3.9%, above the minimum target (3%). Cancer Centres averaged a rate of 3.8% for Intradepartmental consultations in 2018, similar to the 2017 rate. General Centres averaged 4.2% which is above the achievable target of 5%, down a percentage point since last year. P007 IDC was above the achievable targets for all 12 months in 2018.

FIGURE 5.7: Quarterly Graph - % Intradepartmental Consultation Non Gynaecological Cytology Exfoliative



There was a general upward trend for all sites combined from 2014 reaching a peak of over 5% by Q4 2016, before beginning to decrease to below the achievable target consistently. It then stabilised in early 2018 to 4%, which is 1% above the minimum target.

FIGURE 5.8: Funnel Plot – % Intradepartmental consultation Non Gynaecological Cytology Exfoliative

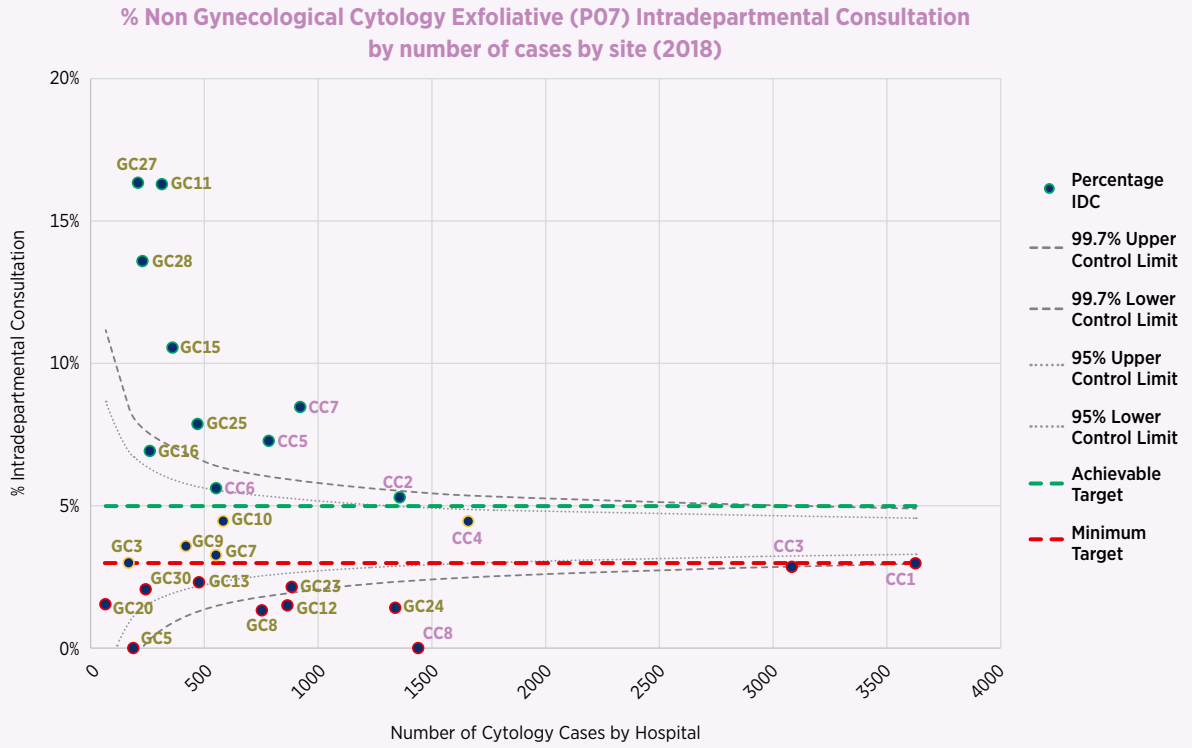
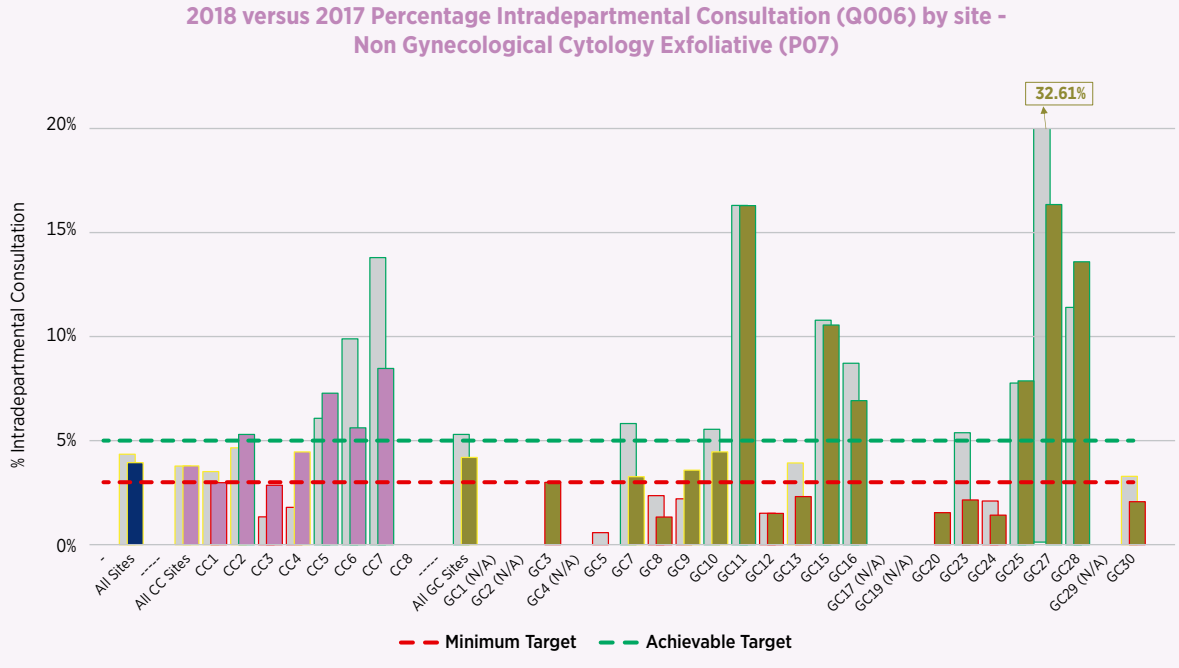


FIGURE 5.9: Bar Chart – 2018 v 2017 in Grey: % Intradepartmental Consultation Non Gynaecological Cytology Exfoliative



Five of eight CC sites met the 3% minimum target in 2018, which is the same number that reached the target in 2018. Four sites were above the 5% achievable target. These are the same three sites as in 2017. CC8 has zero recorded P07 IDCs for 3 years in a row.

Nine of 18 GC sites met the 3% minimum target in 2018. This is two less than the previous year. Six GC sites were above the 5% achievable target.

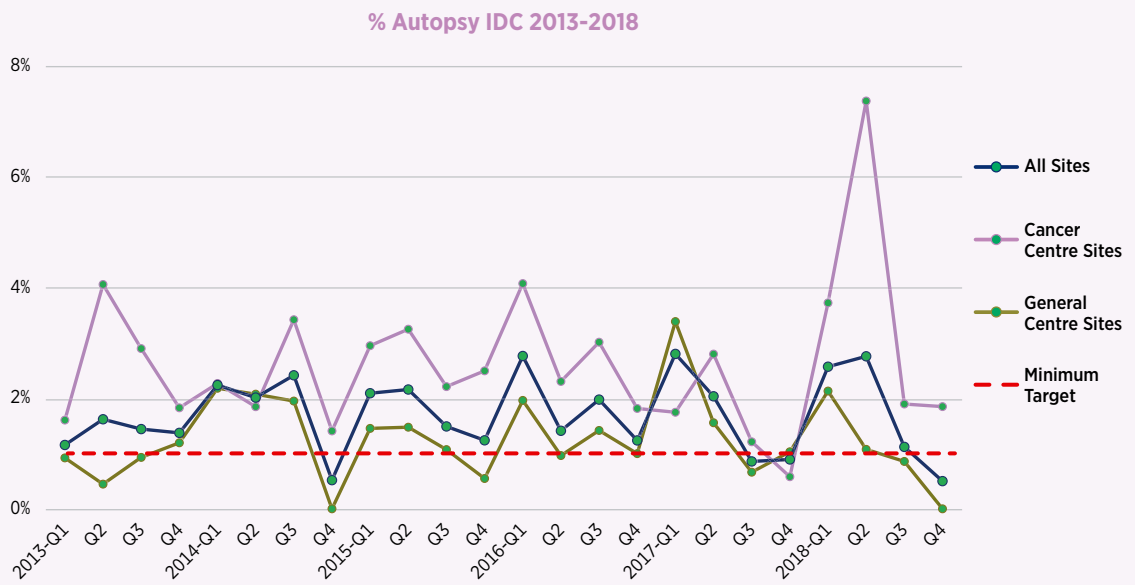
TABLE 5.4: 2017/2018 Full Data Intradepartmental Consultation – Non Gynaecological Cytology Exfoliative

Cytology non Gynae Exfoliative (P-Code P07)	2017 IDC - Non Gynaecological Cytology			2018 IDC - Non Gynaecological Cytology		
	No. of Cases	No. Q006	% Q006	No. of Cases	No. Q006	% Q006
Cancer Centres	**14134**	**534**	**3.78%**	**13422**	**508**	**3.78%**
CC1	3359	118	3.51%	**3625**	**108**	**2.98%**
CC2	1740	81	4.66%	**1359**	**72**	**5.30%**
CC3	2994	40	1.34%	**3082**	**88**	**2.86%**
CC4	2063	37	1.79%	**1660**	**74**	**4.46%**
CC5	955	58	6.07%	**783**	**57**	**7.28%**
CC6	556	55	9.89%	**552**	**31**	**5.62%**
CC7	1051	145	13.80%	**921**	**78**	**8.47%**
CC8	1416	0	0.00%	**1440**	**0**	**0.00%**
General Centres	**8455**	**448**	**5.30%**	**8371**	**351**	**4.19%**
GC1 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC2 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC3	98	0	0.00%	**167**	**5**	**2.99%**
GC4	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC5	173	1	0.58%	**188**	**0**	**0.00%**
GC7	584	34	5.82%	**551**	**18**	**3.27%**
GC8	976	23	2.36%	**753**	**10**	**1.33%**
GC9	499	11	2.20%	**419**	**15**	**3.58%**
GC10	523	29	5.54%	**583**	**26**	**4.46%**
GC11	368	60	16.30%	**313**	**51**	**16.29%**
GC12	993	15	1.51%	**865**	**13**	**1.50%**
GC13	382	15	3.93%	**476**	**11**	**2.31%**
GC15	343	37	10.79%	**360**	**38**	**10.56%**
GC16	367	32	8.72%	**260**	**18**	**6.92%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC20	60	0	0.00%	**65**	**1**	**1.54%**
GC23	855	46	5.38%	**884**	**19**	**2.15%**

Cytology non Gynae Exfoliative (P-Code P07)	2017 IDC - Non Gynaecological Cytology			2018 IDC - Non Gynaecological Cytology		
	No. of Cases	No. Q006	% Q006	No. of Cases	No. Q006	% Q006
GC24	1239	26	2.10%	**1339**	**19**	**1.42%**
GC25	309	24	7.77%	**470**	**37**	**7.87%**
GC27	184	60	32.61%	**208**	**34**	**16.35%**
GC28	228	26	11.40%	**228**	**31**	**13.60%**
GC29	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC30	274	9	3.28%	**242**	**5**	**2.07%**
All Sites	**22589**	**982**	**4.35%**	**21793**	**859**	**3.94%**

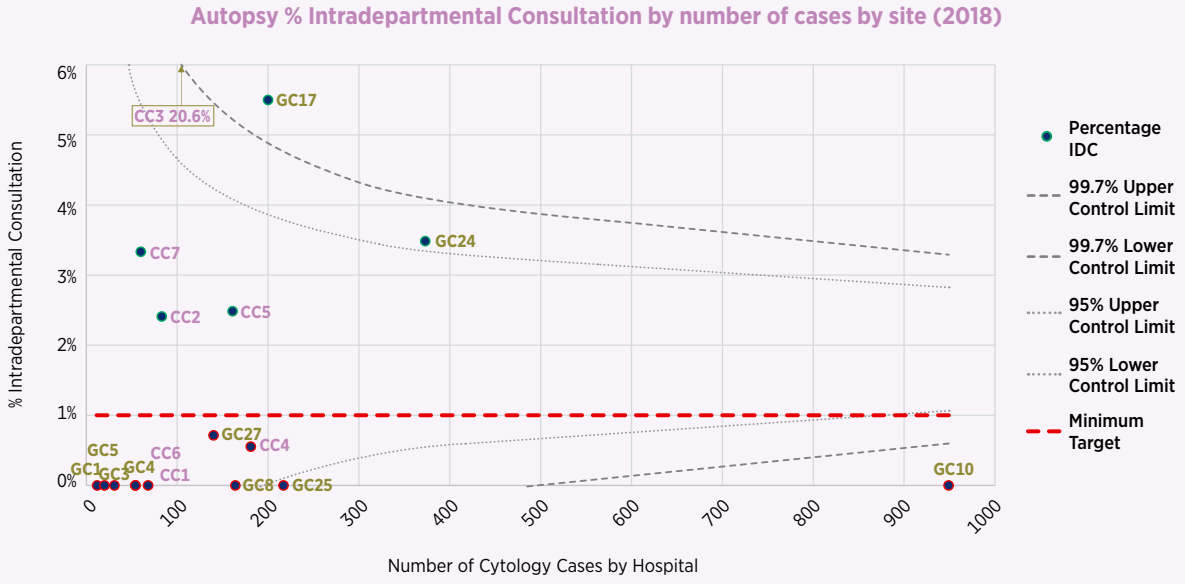
Intradepartmental Consultation Commentary — Autopsy (P10, P11)

FIGURE 5.10: Quarterly Graph - % Intradepartmental Consultation Adult Autopsy



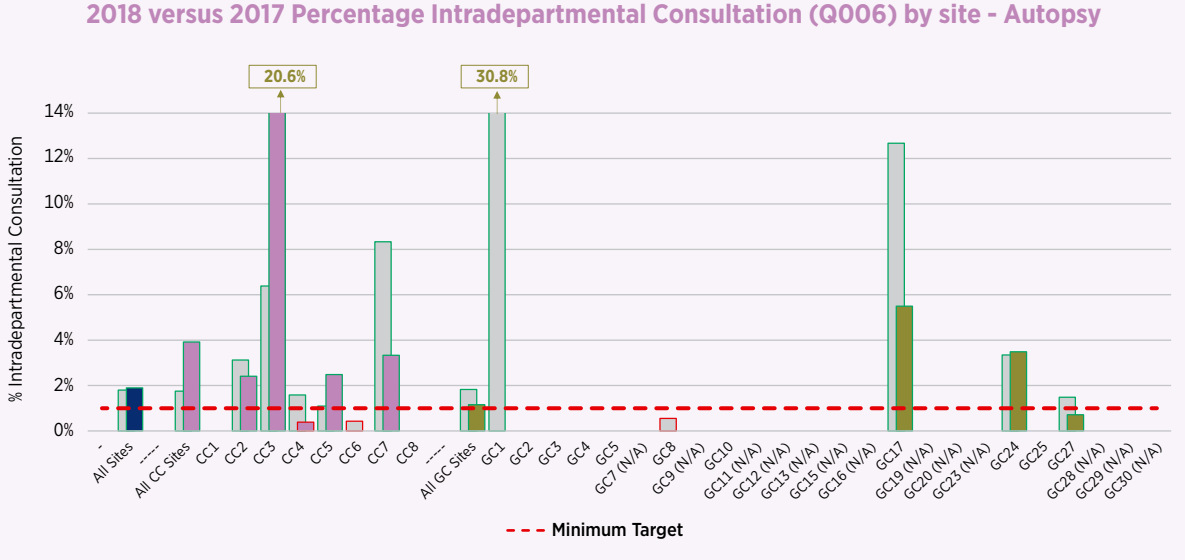
On a quarterly basis, since 2013 the percentage of Q006 for Autopsy (P10, P11) in All Sites had generally remained above the target, but had dropped below the target in Q4 2014 and Q3 and Q4 of 2017, before rising above the minimum target again in 2018. This falls below the target for Q4 2018, but this could be partially due autopsy timeframes and a percentage of autopsies that have not been completed prior to creating the NDR.

FIGURE 5.11: Funnel Plot – Autopsy % Intradepartmental Consultation by number of cases



Only eight sites have provided Autopsy for the NDR in 2018. CC sites accounted for a large percentage of sites with autopsy IDCs. One CC has a very high percentages of Intradepartmental Consultation (CC3-20%) which is much higher than any other laboratory.

FIGURE 5.12: Bar Chart – 2018 v 2017 in Grey: % Intradepartmental Consultation (Q006) – Autopsy



The minimum target of 1% Intradepartmental Consultation for Autopsy was met in 2018, with a yearly average of 1.9% compared with a Q006 rate of 1.8% in 2017. However, four hospitals make up 90% of these IDC percentage figures

TABLE 5.5: Full data 2017/2018 Intradepartmental consultation - Autopsy

IDC Autopsy (P-Codes P10-P11)	2017 IDC - Adult Autopsy			2018 IDC - Adult Autopsy		
	No. of Cases	No. Q006	% Q006	No. of Cases	No. Q006	% Q006
Cancer Centres	**1083**	**19**	**1.75%**	**791**	**31**	**3.92%**
CC1	50	0	0.00%	68	0	0.00%
CC2	64	2	3.13%	83	2	2.41%
CC3	47	3	6.38%	107	22	20.56%
CC4	189	3	1.59%	258	1	0.39%
CC5	183	2	1.09%	161	4	2.48%
CC6	466	2	0.43%	54	0	0.00%
CC7	84	7	8.33%	60	2	3.33%
CC8	0	0	0.00%	0	0	0.00%
General Centres	**1971**	**36**	**1.83%**	**2160**	**25**	**1.16%**
GC1	13	4	30.77%	12	0	0.00%
GC3	35	0	0.00%	31	0	0.00%
GC4	12	0	0.00%	54	0	0.00%
GC5	29	0	0.00%	20	0	0.00%
GC8	181	1	0.55%	164	0	0.00%
GC10	874	0	0.00%	949	0	0.00%
GC17	142	18	12.68%	200	11	5.50%
GC24	329	11	3.34%	373	13	3.49%
GC25	221	0	0.00%	219	0	0.00%
GC27	135	2	1.48%	140	1	0.71%
All Sites	**3054**	**55**	**1.80%**	**2953**	**56**	**1.90%**

One hospital accounts for two thirds of all cancer centre autopsy cases. If this hospital was not included, the CC autopsy rate would be reduced from 3.92% to 1.2%.

CHAPTER 6
MULTIDISCIPLINARY TEAM REVIEW

6

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 key participants in these meetings and play an important role in patient management. Organisation of MDT meetings and determining cases for review is the responsibility of the MDT coordinator or clinical teams within the hospital. The reviewing pathologist should prepare the cases assigned for review at MDT, reconcile any discrepancies noted prior to MDT and attend the MDT meetings to present and discuss cases.

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.

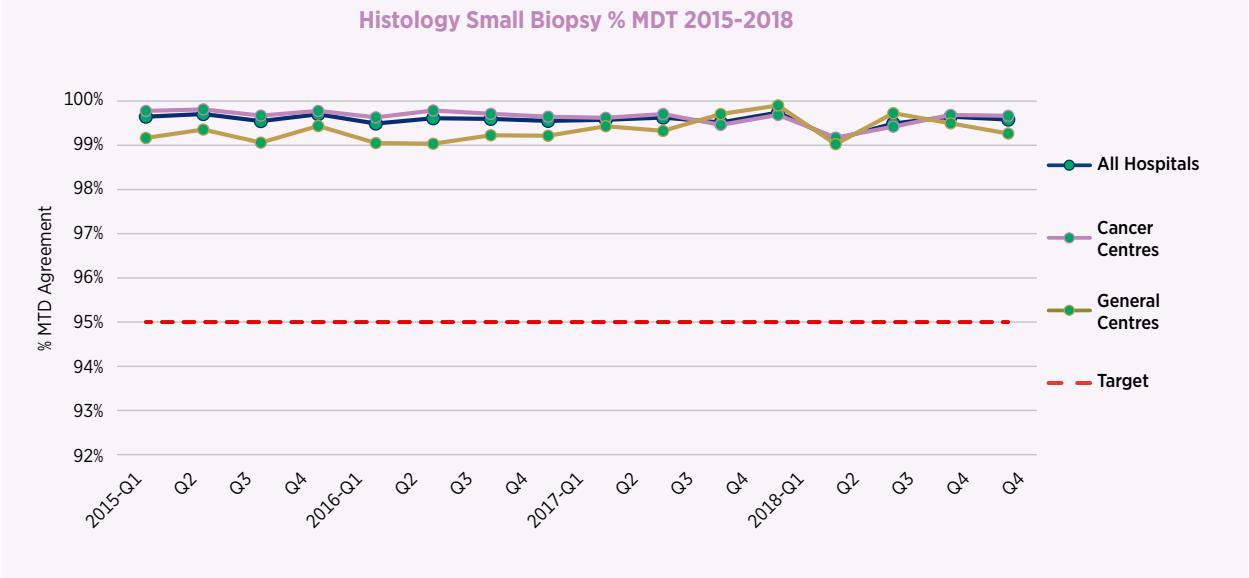
TABLE 6.1: MDT Targets

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

MDT Agreement - Small Biopsy (P01) Commentary

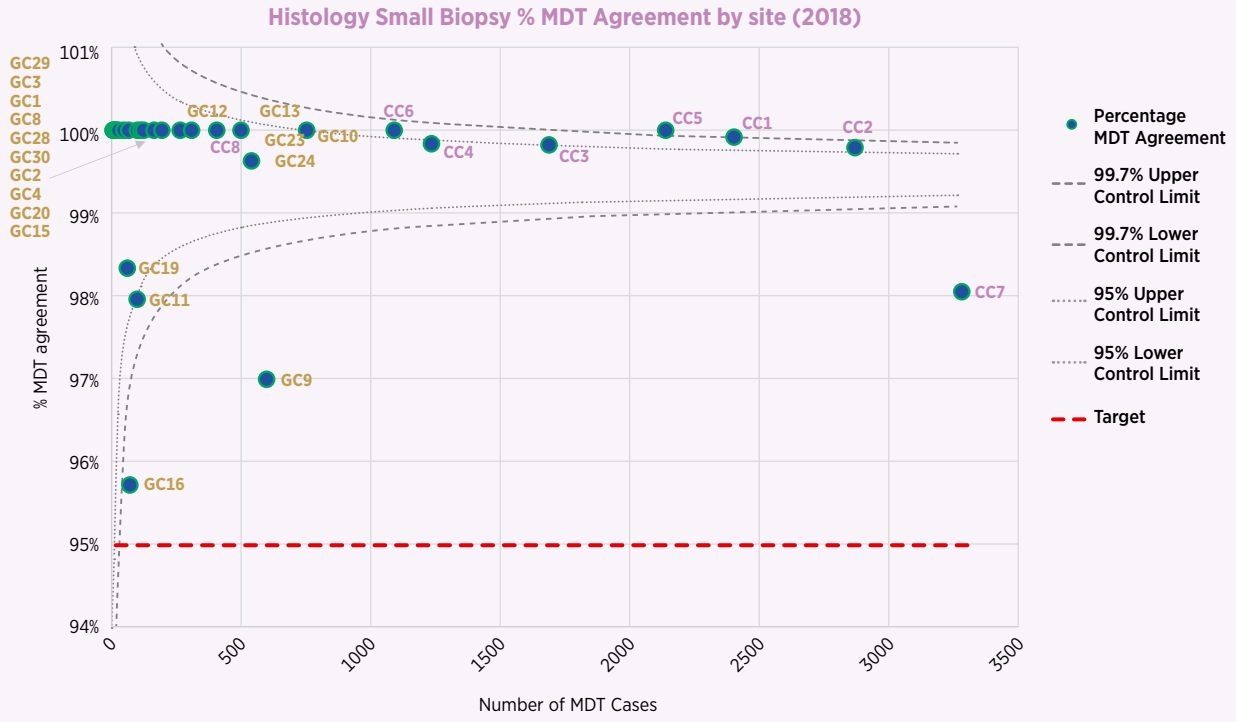
On a quarterly basis, from Q1 2015 to Q4 2018, the percentage of MDT Agreement for Small Biopsy MDTs has been consistent at 99.6%.

FIGURE 6.1: Histology Small Biopsy % MDT agreement per quarter (2015 – 2018)



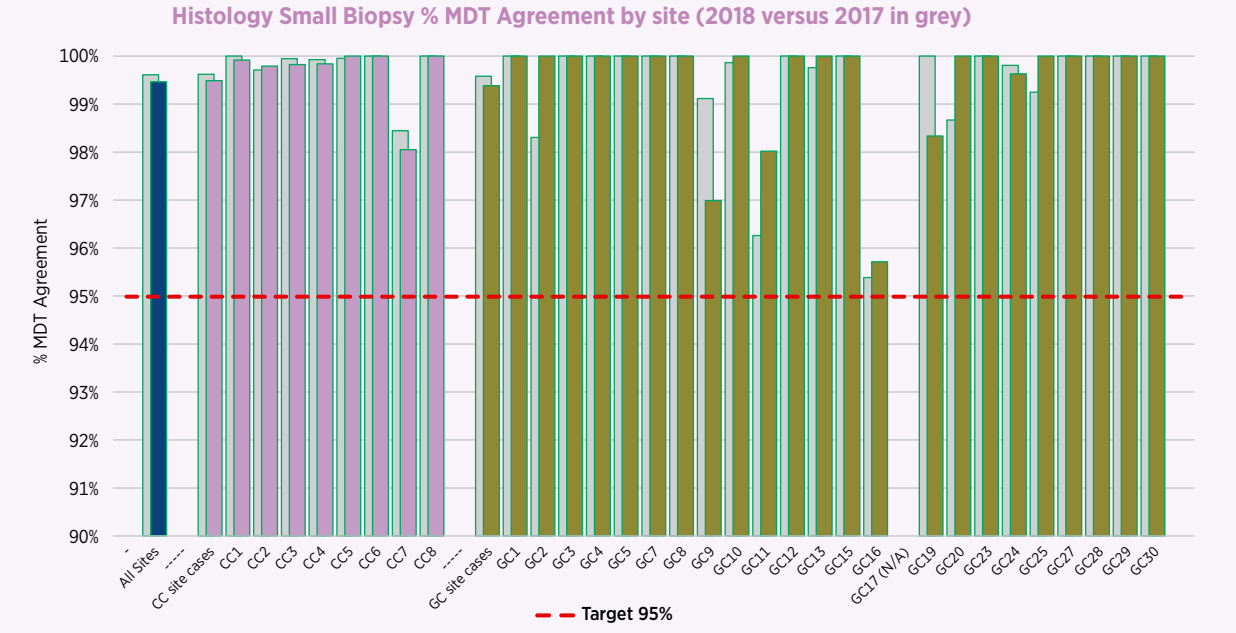
In 2018 nationally, with a yearly average of 99.46%, the target of 95% is met for all Small Biopsy (P01) cases with an MDT reaching agreement (Q017). 18.8% of all Small Biopsy (P01) cases were reviewed at MDT meetings in 2017; 31% of Cancer Centre P01 cases and 7.7% of General Centre P01 cases.

FIGURE 6.2: Funnel Plot - 2018 Histology Small Biopsy % MDT Agreement



Twenty-eight of 31 hospitals were within or above the control limits. One Cancer Centre with a very large number of Small Biopsies MDTs (over 2800) was below the control limits, but still above the target for MDT agreement. There were also two GCs that had very low numbers of Small Biopsies were below the control limits for MDT agreement, but still above the target.

FIGURE 6.3: Bar Chart - 2018 v 2017 in Grey: Histology Small Biopsy % MDT Agreement by Site



Twenty-one of 31 sites have 100% MDT agreement. All the remaining sites are also above the target of 95% MDT agreement.

TABLE 6.2: Full Data 2017/2018 P01 MDT Agreement

P-Codes P01	2017 MDT Agreement P01			2018 MDT Agreement P01		
	No of MDTs	No. Q019	No. Q017	No of MDTs	No. Q019	No. Q017
Cancer Centre Sites	**14484**	**55**	**99.62%**	**15021**	**77**	**99.49%**
CC1	2689	0	100%	**2402**	**2**	**100%**
CC2	2419	7	99.71%	**2870**	**6**	**99.79%**
CC3	1843	1	99.95%	**1696**	**3**	**99.82%**
CC4	1336	1	99.93%	**1235**	**2**	**99.84%**
CC5	2125	1	99.95%	**2138**	**0**	**100%**
CC6	931	0	100%	**1090**	**0**	**100%**
CC7	2890	45	98.44%	**3282**	**64**	**98.05%**
CC8	251	0	100%	**308**	**0**	**100%**
General Centre Sites	**4308**	**18**	**99.58%**	**4207**	**26**	**99.38%**
GC1	14	0	100%	**10**	**0**	**100%**
GC2	59	1	98.31%	**27**	**0**	**100%**
GC3	7	0	100%	**6**	**0**	**100%**
GC4	95	0	100%	**50**	**0**	**100%**
GC5	193	0	100%	**193**	**0**	**100%**
GC7	378	0	100%	**163**	**0**	**100%**
GC8	24	0	100%	**28**	**0**	**100%**
GC9	565	5	99.12%	**598**	**18**	**96.99%**
GC10	736	1	99.86%	**752**	**0**	**100%**
GC11	107	4	96.26%	**101**	**2**	**98.02%**
GC12	219	0	100%	**265**	**0**	**100%**
GC13	415	1	99.76%	**499**	**0**	**100%**
GC15	127	0	100%	**99**	**0**	**100%**
GC16	65	3	95.38%	**70**	**3**	**95.71%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19	62	0	100%	**60**	**1**	**98.33%**
GC20	75	1	98.67%	**65**	**0**	**100%**
GC23	342	0	100%	**405**	**0**	**100%**
GC24	513	1	99.81%	**539**	**2**	**99.63%**
GC25	133	1	99.25%	**123**	**0**	**100%**
GC27	95	0	100%	**112**	**0**	**100%**
GC28	63	0	100%	**18**	**0**	**100%**

P-Codes P01 Continued	2017 MDT Agreement P01			2018 MDT Agreement P01		
	No of MDTs	No. Q019	No. Q017	No of MDTs	No. Q019	No. Q017
GC29	3	0	100%	**5**	**0**	**100%**
GC30	18	0	100%	**19**	**0**	**100%**
All Sites	**18792**	**73**	**99.61%**	**19228**	**103**	**99.46%**

MDT Agreement - GI Endoscopic Biopsy (P02) Commentary

5% of GI Endoscopic Biopsy (P02) cases were reviewed at an MDT meeting in 2018, an increase of almost 1% from 2017. 6.6% of Cancer Centre P02 cases and 3.5% of General Centre P02 cases, both increased from 2017.

As a whole, both Cancer Centres and General Centres were above the target in 2018. All Cancer Centres were above the target, same as in 2017. Eighteen out of 19 General Centres were above the target, a drop of one centre since 2017. Twenty-four of 27 hospitals were within the control limits. One General Centre with a very small number of GI Endoscopic Biopsy cases was below the target and the control limits.

Nineteen sites had 100% MDT agreement for GI Endoscopic Biopsies in 2018. One General Centre had a number of P02 cases below target, which had been 100% the previous year. This is due to the low number of GI Endoscopic Biopsy cases at this hospital, where even one MDT Disagreement will put this hospital below target.

FIGURE 6.4: Histology GI Endoscopic Biopsy % MDT Agreement per quarter from 2015-2018

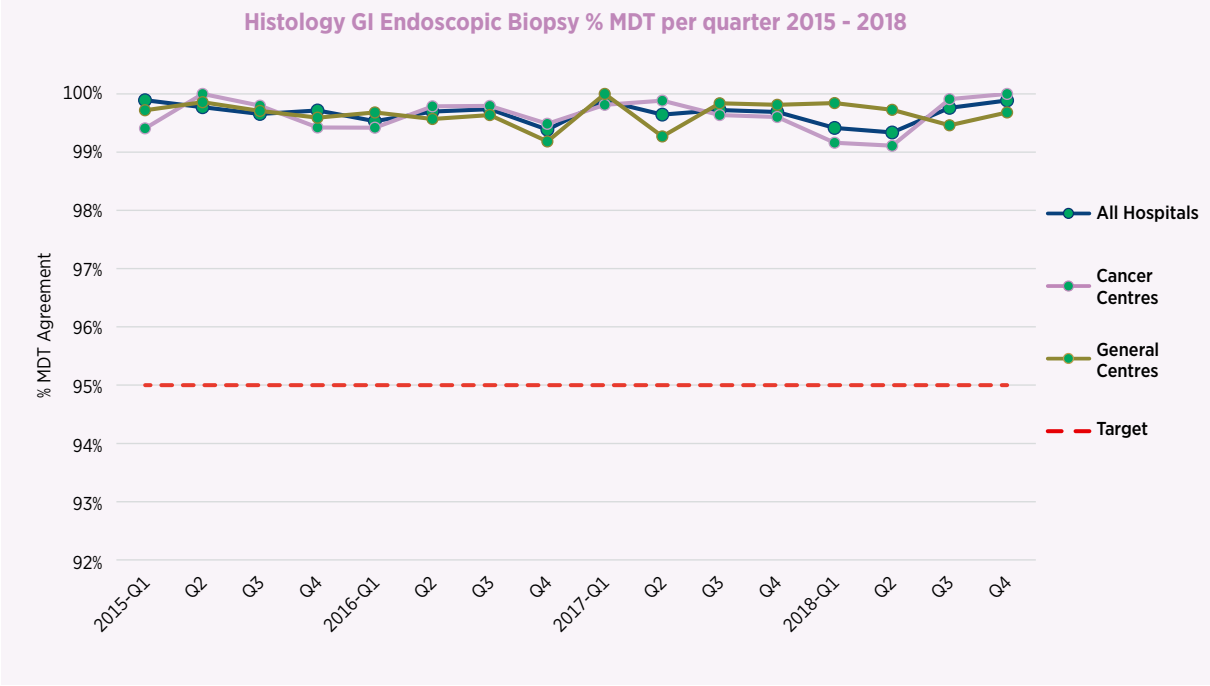


FIGURE 6.5: Funnel Plot - Histology GI Endoscopic Biopsy % MDT Agreement by Site Cases (2018)

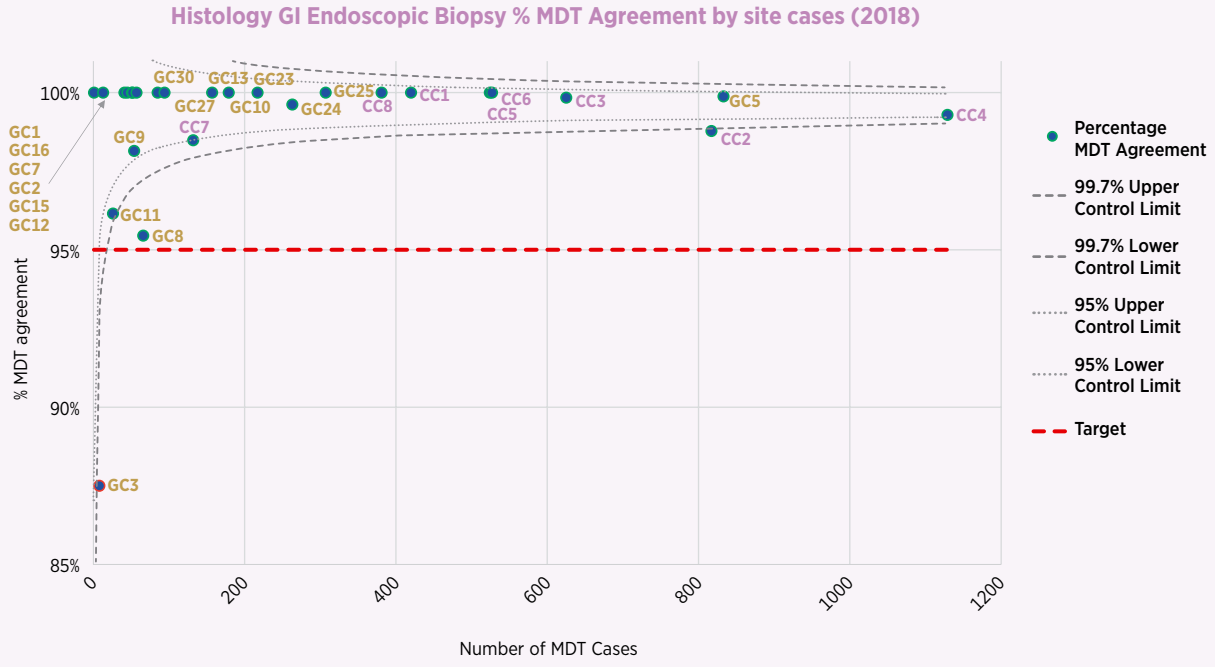


FIGURE 6.6: Bar Chart – 2018 v 2017 in Grey: Histology GI Endoscopic Biopsy % MDT agreement by site

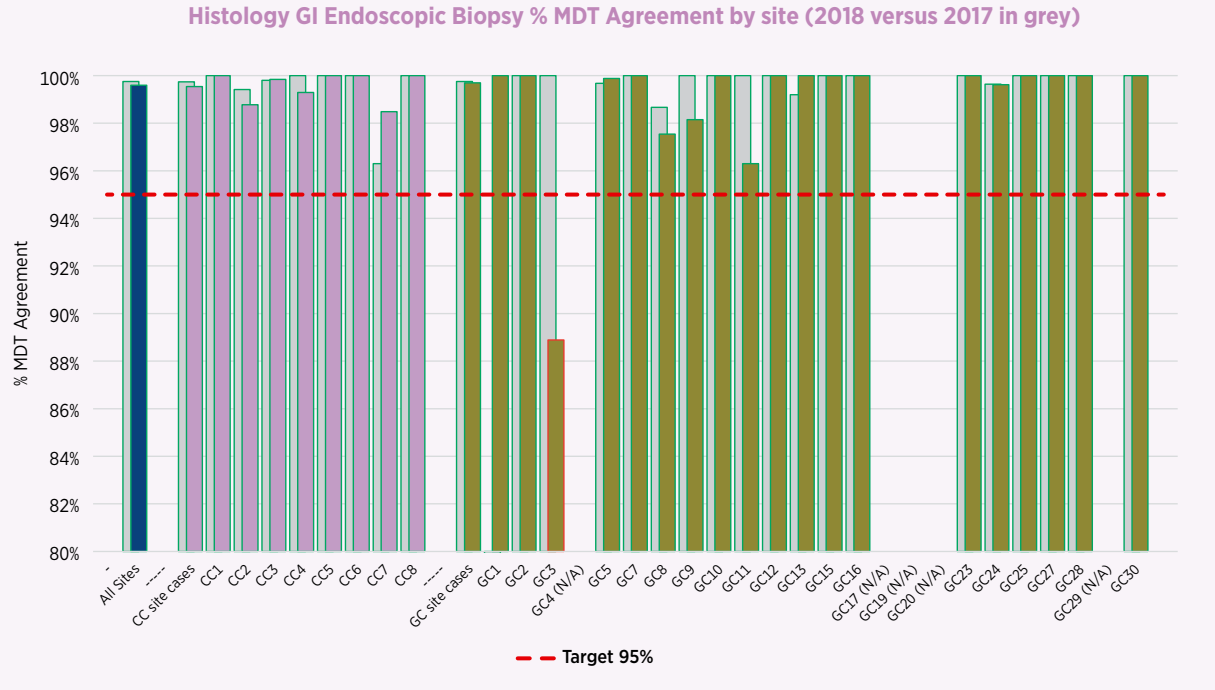


TABLE 6.3: Full Data 2017/2018 GI Endoscopic Biopsy MDT Agreement

P-Codes P02	2017 MDT Agreement P02			2018 MDT Agreement P02		
	No of MDTs	No. Q019	No. Q017	No of MDTs	No. Q019	No. Q017
Cancer Centre Sites	**3508**	**9**	**99.74%**	**4560**	**21**	**99.54%**
CC1	431	0	100%	**420**	**0**	**100%**
CC2	684	4	99.42%	**817**	**10**	**98.78%**
CC3	506	1	99.80%	**630**	**1**	**99.84%**
CC4	332	0	100%	**1129**	**8**	**99.29%**
CC5	572	0	100%	**527**	**0**	**100%**
CC6	456	0	100%	**524**	**0**	**100%**
CC7	108	4	96.30%	**132**	**2**	**98.48%**
CC8	419	0	100%	**381**	**0**	**100%**
General Centre Sites	**2385**	**6**	**99.75%**	**2608**	**8**	**99.69%**
GC1	N/A	N/A	N/A	**1**	**0**	**100%**
GC2	61	0	100%	**45**	**0**	**100%**
GC3	4	0	100%	**9**	**1**	**88.89%**
GC4 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC5	609	2	99.67%	**833**	**1**	**99.88%**
GC7	91	0	100%	**41**	**0**	**100%**
GC8	150	2	98.67%	**122**	**3**	**97.54%**
GC9	54	0	100%	**54**	**1**	**98.15%**
GC10	194	0	100%	**179**	**0**	**100%**
GC11	59	0	100%	**27**	**1**	**96.30%**
GC12	54	0	100%	**52**	**0**	**100%**
GC13	124	1	99.19%	**157**	**0**	**100%**
GC15	45	0	100%	**51**	**0**	**100%**
GC16	14	0	100%	**13**	**0**	**100%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC20 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC23	121	0	100%	**217**	**0**	**100%**
GC24	277	1	99.64%	**263**	**1**	**99.62%**
GC25	274	0	100%	**307**	**0**	**100%**
GC27	87	0	100%	**95**	**0**	**100%**
GC28	80	0	100%	**57**	**0**	**100%**
GC29 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC30	87	0	100%	**85**	**0**	**100%**
All Sites	**5893**	**15**	**99.75%**	**7168**	**29**	**99.60%**

MDT Agreement - Non Biopsy Cancer Resection (P03) Commentary

55.8% of Non-Biopsy Cancer Resection cases (P03) were reviewed at MDT meetings in 2018, 61.4% of these cases in Cancer Centres. In 2018 nationally, with a yearly average of 99.3% MDT Agreement, the target of 95% was met for all Cancer Resection cases with an MDT having an agreement (Q017).

FIGURE 6.7: Histology Non Biopsy Cancer Resection % MDT Agreement per quarter

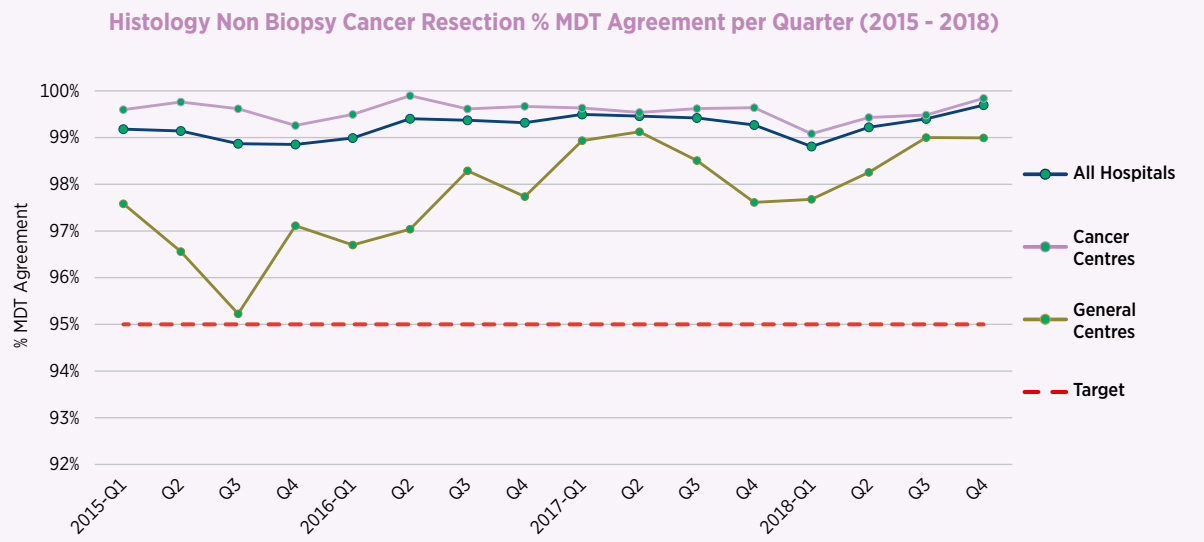
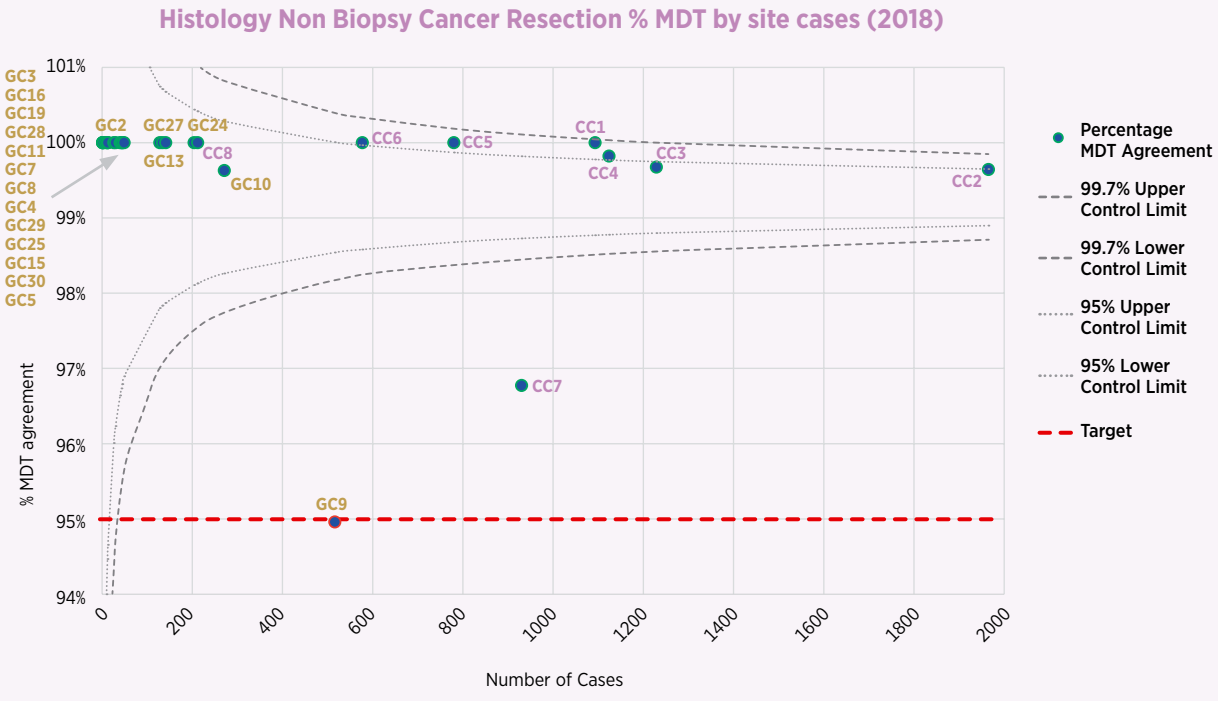


FIGURE 6.8: Funnel Plot - Histology Non Biopsy Cancer Resection % MDT Agreement

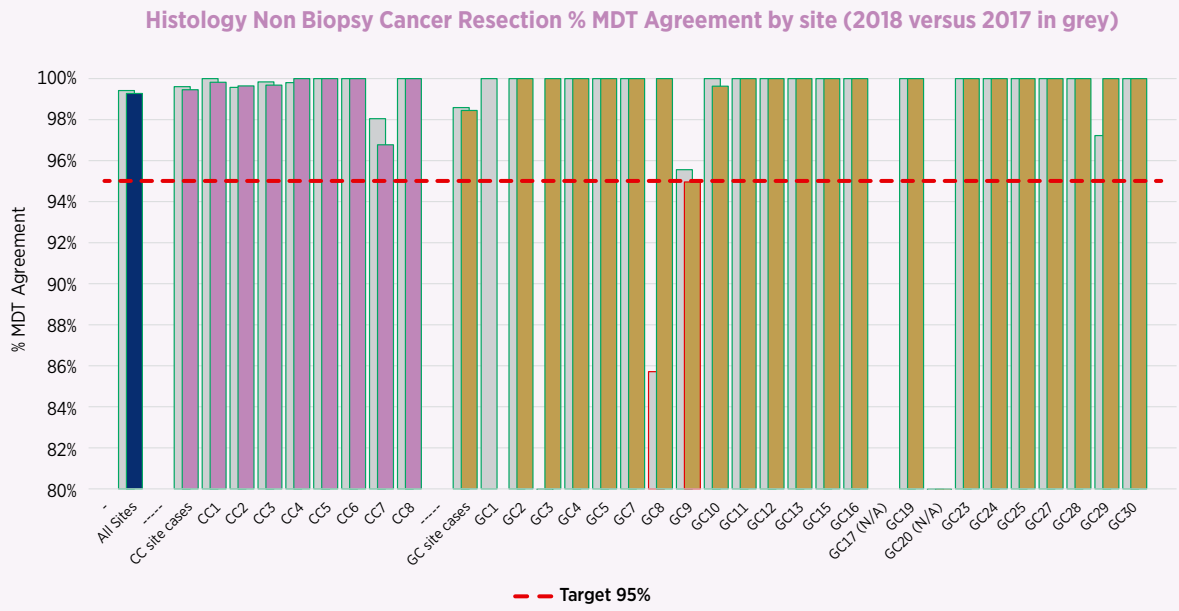


Since 2015, the Cancer Centres have consistently remained above 99% MDT agreement, and the General Centres have been gradually increasing over the last three years from just over 95% to 99% by Q4-2018.

Two of 27 hospitals were outside the control limits, one of which is also below the 95% MDT Agreement Target. One Cancer Centre with a large number of Cancer Resection (P03) MDT reviews (930 cases) was below the control limits, but still above the target for MDT agreement. There was also one General Centre, below the control limits and also below the target for MDT agreement at 94.96%.

All Cancer Centre sites with Non Biopsy Cancer Resections were above 95% Cancer Resection MDT Agreement

FIGURE 6.9: 2018 versus 2017 in Grey: Histology Non Biopsy Cancer Resection % MDT Agreement by site



Twenty-three out of 29 sites have 100% MDT agreement. Similar to 2017, one General Centre was below target in 2018.

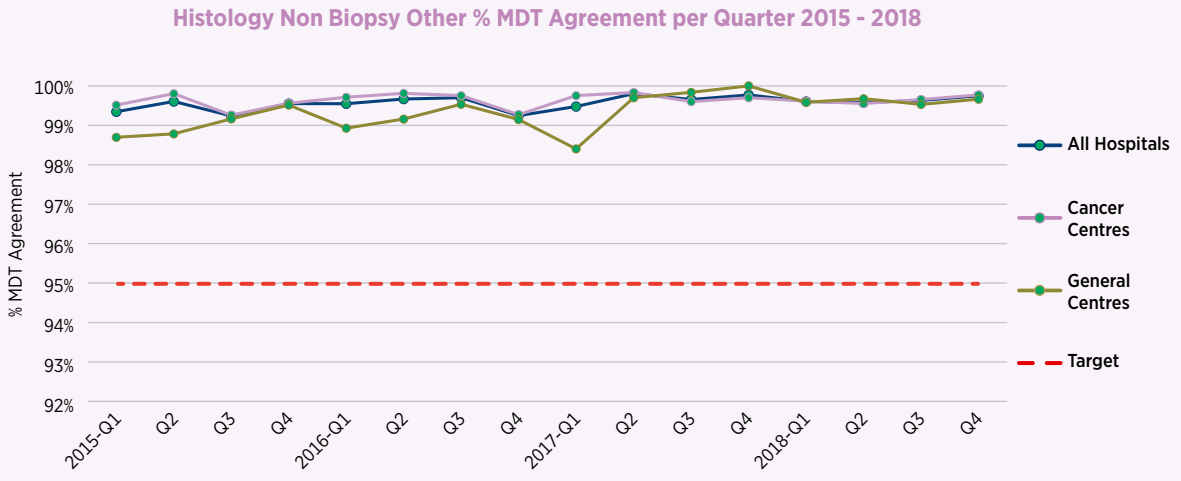
TABLE 6.4: Full Data Non Biopsy Cancer Resection 2017/2018 MDT Agreement

P-Codes P03	2017 MDT Agreement P03			2018 MDT Agreement P03		
	No of MDTs	No. Q019	No. Q017	No of MDTs	No. Q019	No. Q017
Cancer Centre Sites	**7371**	**29**	**99.61%**	**7936**	**43**	**99.46%**
CC1	1220	0	100%	**1125**	**2**	**99.82%**
CC2	1638	7	99.57%	**1967**	**7**	**99.64%**
CC3	1256	2	99.84%	**1260**	**4**	**99.68%**
CC4	1042	2	99.81%	**1093**	**0**	**100%**
CC5	667	0	100%	**780**	**0**	**100%**
CC6	406	0	100%	**577**	**0**	**100%**
CC7	920	18	98.04%	**930**	**30**	**96.77%**
CC8	222	0	100%	**204**	**0**	**100%**
General Centre Sites	**1705**	**24**	**98.59%**	**1739**	**27**	**98.45%**
GC1	1	0	100%	**0**	**0**	**-**
GC2	78	0	100%	**45**	**0**	**100%**
GC3	0	0	-	**1**	**0**	**100%**
GC4	10	0	100%	**14**	**0**	**100%**
GC5	25	0	100%	**49**	**0**	**100%**
GC7	53	0	100%	**12**	**0**	**100%**
GC8	14	2	85.71%	**19**	**0**	**100%**
GC9	473	21	95.56%	**516**	**26**	**94.96%**
GC10	286	0	100%	**271**	**1**	**100%**
GC11	9	0	100%	**8**	**0**	**100%**
GC12	103	0	100%	**134**	**0**	**100%**
GC13	127	0	100%	**128**	**0**	**100%**
GC15	42	0	100%	**40**	**0**	**100%**
GC16	10	0	100%	**3**	**0**	**100%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19	1	0	100%	**1**	**0**	**100%**
GC20	0	0	-	**0**	**0**	**-**
GC23	176	0	100%	**212**	**0**	**100%**
GC24	154	0	100%	**141**	**0**	**100%**
GC25	19	0	100%	**30**	**0**	**100%**
GC27	45	0	100%	**45**	**0**	**100%**
GC28	1	0	100%	**1**	**0**	**100%**
GC29	36	1	97.22%	**26**	**0**	**100%**
GC30	42	0	100%	**43**	**0**	**100%**
All Sites	**9076**	**53**	**99.42%**	**9675**	**70**	**99.28%**

MDT Agreement - Non Biopsy Other (P04) Commentary

Since Q1 2015 Non Biopsy Other cases subjected to MDT review as a whole were consistently above the 95% target.

FIGURE 6.10: Histology Non Biopsy Other % MDT Agreement per quarter (2015-2018)

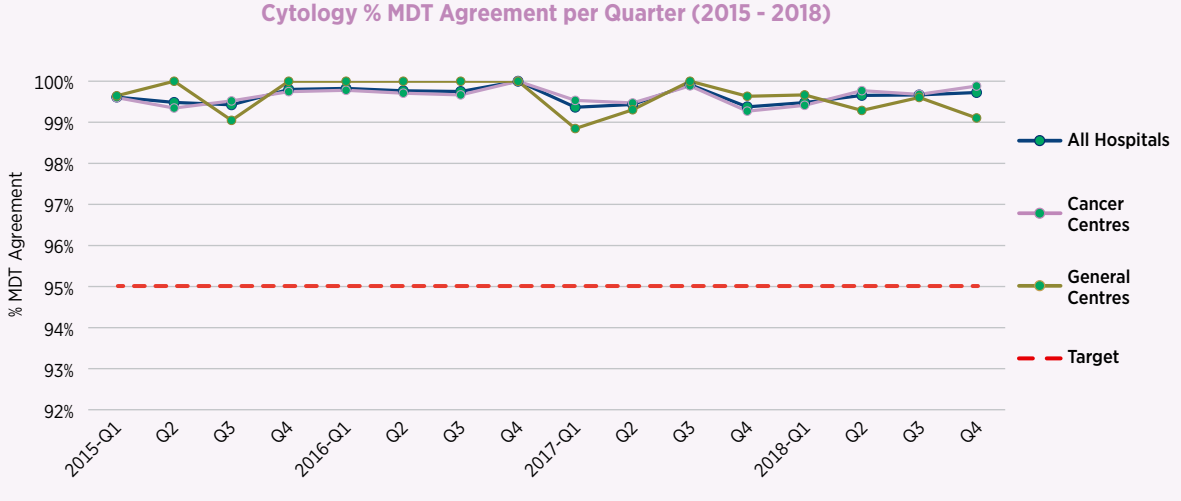


6.8% of Non Biopsy Other (P04) cases were reviewed at MDT in 2018: 9.7% of Cancer Centre P04 cases and 3.3% of General Centres cases.

MDT Agreement - Cytology Commentary

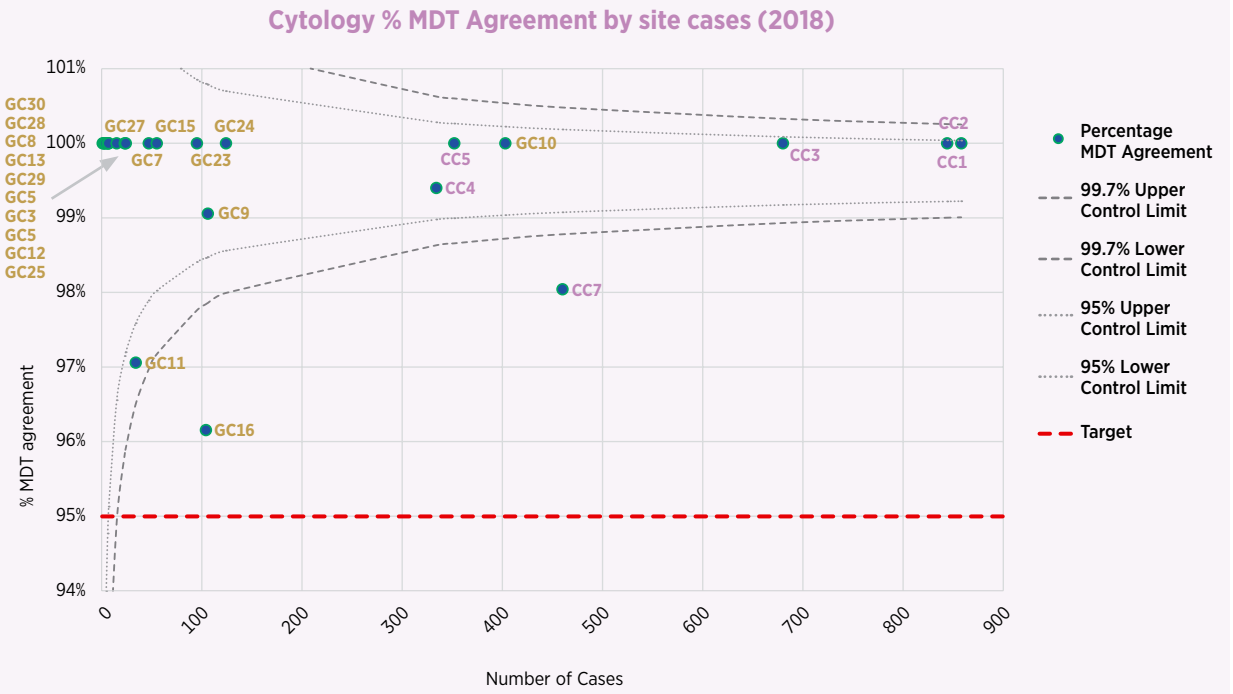
14% of Cytology (P06 and P07) were reviewed at MDT in 2018; 17% of Cancer Centre Cytology cases and 9.3% of General Centres Cytology cases.

FIGURE 6.11: Cytology % MDT Agreement per quarter (2015-2018)



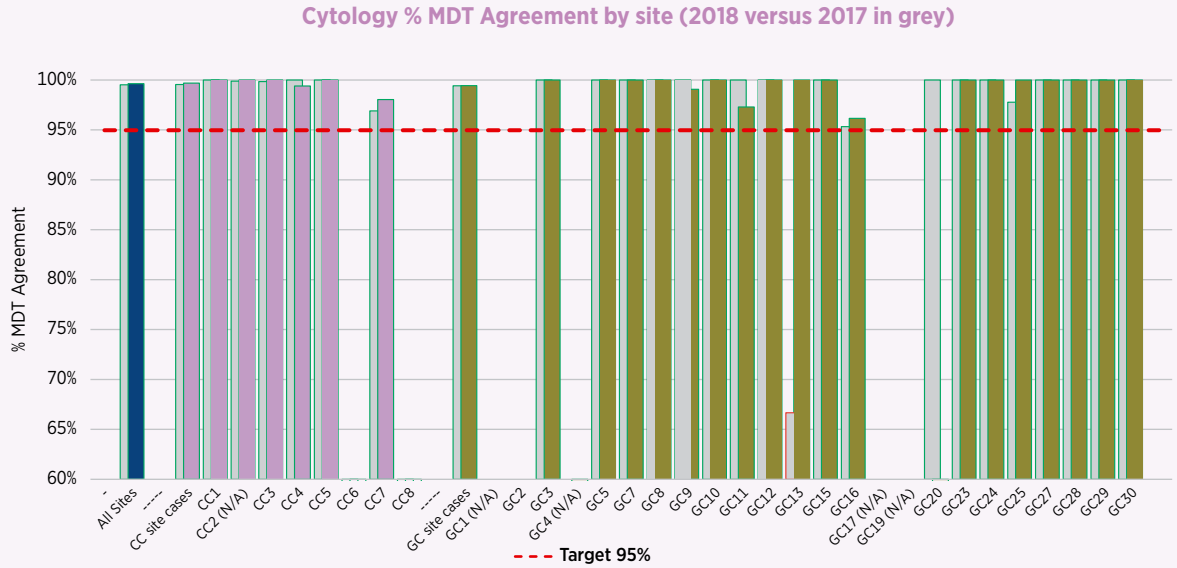
Cytology MDT agreement, as a whole, was consistently above the 95% target. It was consistently above 99% for both Cancer and General Centres for the whole year, rarely dropping below 99% over the last four years. GC sites had 100% for MDT agreement for seven of 12 quarters over the past three years.

FIGURE 6.12: Funnel Plot – Cytology % MDT Agreement by site cases (2018)



There were two General Centre sites below the control limits in 2018, but all sites are above the target.

FIGURE 6.13: 2018 versus 2017 in Grey: Cytology % MDT Agreement



Cancer Centres averaged at 99.7% cytology MDTs agreement for 2018, slightly higher than 2017 data which was 99.6%. General Centres averaged at 99.4% in 2018, the same as the previous year. All sites are above target for 2018, which is an improvement from 2017, where one site was below target.

TABLE 6.5: Full Data 2017/2018 Cytology MDT Agreement

P-Codes Cytology	2017 MDT Agreement Cytology			2018 MDT Agreement Cytology		
	No of MDTs	No. Q019	No. Q017	No of MDTs	No. Q019	No. Q017
Cancer Centre Sites	**3585**	**16**	**99.55%**	**3554**	**11**	**99.69%**
CC1	884	0	100%	**844**	**0**	**100%**
CC2	863	1	99.88%	**859**	**0**	**100%**
CC3	671	1	99.85%	**705**	**0**	**100%**
CC4	308	0	100%	**334**	**2**	**99.40%**
CC5	407	0	100%	**352**	**0**	**100%**
CC6	0	0	0%	**0**	**0**	**0%**
CC7	452	14	96.90%	**460**	**9**	**98.04%**
CC8	0	0	0%	**0**	**0**	**0%**
General Centre Sites	**1200**	**7**	**99.42%**	**1070**	**6**	**99.44%**
GC1 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC2 (N/A)	1	0	100%	**N/A**	**N/A**	**N/A**
GC3	2	0	100%	**7**	**0**	**100%**
GC4 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC5	4	0	100%	**7**	**0**	**100%**
GC7	164	0	100%	**47**	**0**	**100%**
GC8	4	0	100%	**7**	**0**	**100%**
GC9	133	0	100%	**107**	**1**	**99.07%**
GC10	333	0	100%	**403**	**0**	**100%**
GC11	48	0	100%	**37**	**1**	**97.30%**
GC12	21	0	100%	**15**	**0**	**100%**
GC13	3	1	66.67%	**4**	**0**	**100%**
GC15	42	0	100%	**55**	**0**	**100%**
GC16	107	5	95.33%	**104**	**4**	**96.15%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC20	3	0	100%	**0**	**0**	**-**
GC23	109	0	100%	**96**	**0**	**100%**
GC24	141	0	100%	**124**	**0**	**100%**
GC25	45	1	97.78%	**24**	**0**	**100%**
GC27	29	0	100%	**24**	**0**	**100%**
GC28	2	0	100%	**2**	**0**	**100%**
GC29	5	0	100%	**6**	**0**	**100%**
GC30	4	0	100%	**1**	**0**	**100%**
All Sites	**4785**	**23**	**99.5%**	**4624**	**17**	**99.63%**

CHAPTER 7
ADDENDUM REPORTS

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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.

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.

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

Supplementary Reports – Q020

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.

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.

Rationale for combining amended and corrected reports: 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.[1]

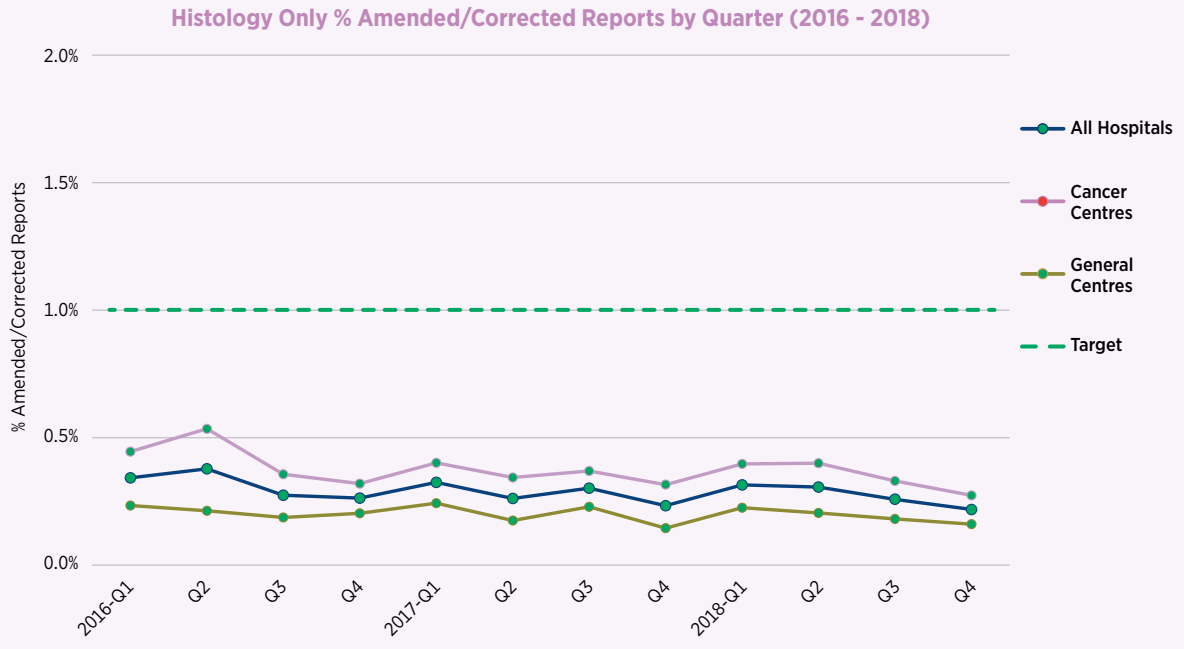
[1] S.Phelan et al "Monitoring Error in Histopathology-A Multi-Institutional Audit of Addendum Reports", USCAP, Vancouver 2018.

TABLE 7.1: Addendum Reports Recommendations

Key Quality Area	Recommendations
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

Combined Amended/Corrected Reports - Histology (P01-P04)

FIGURE 7.1: Histology Only % Combined Amended/Corrected Reports per quarter (2016-2018)

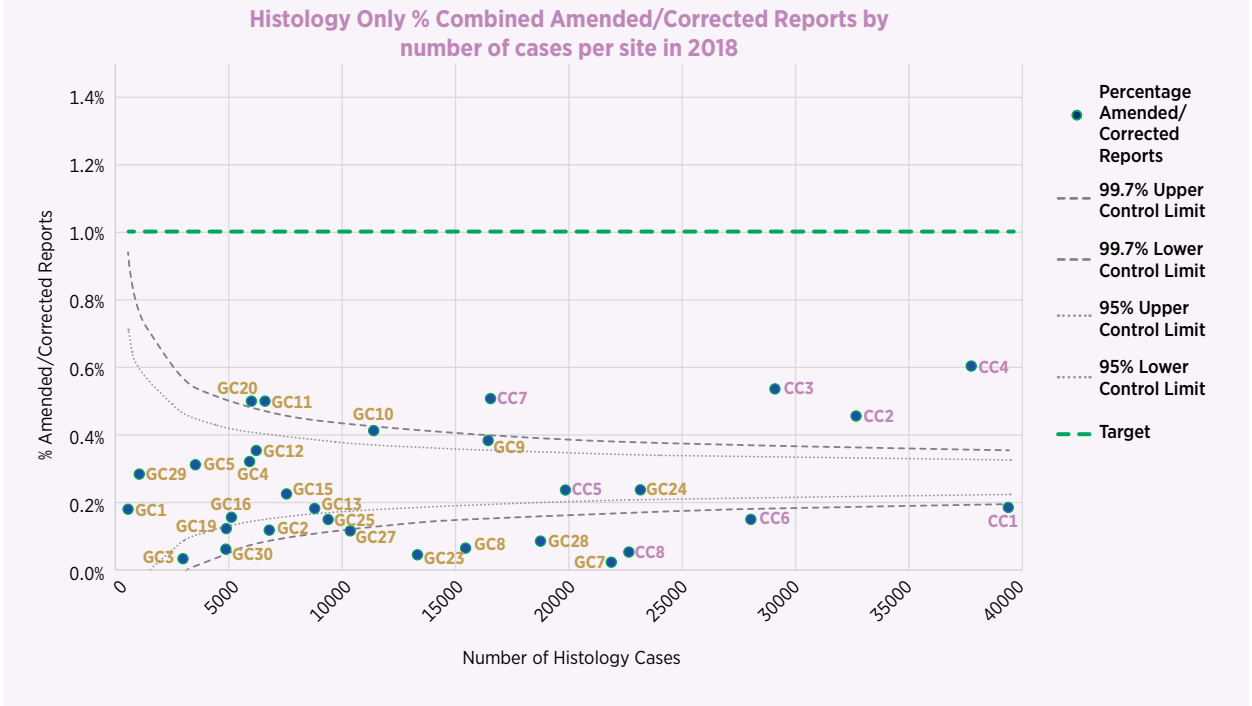


The recommendation of achieving less than 1% for Histology Only Combined Amended/Corrected Reports was met in all 32 sites in 2018, stabilising at 0.27%

On a quarterly basis from Q1 2016 to Q4 2018, the percentage of combined amended and corrected reports have been steadily declining from 0.34% in Q1 2016 to 0.22% in Q4 2018. A very low level of corrected/amended reports raises a concern regarding completeness of coding in some centres.

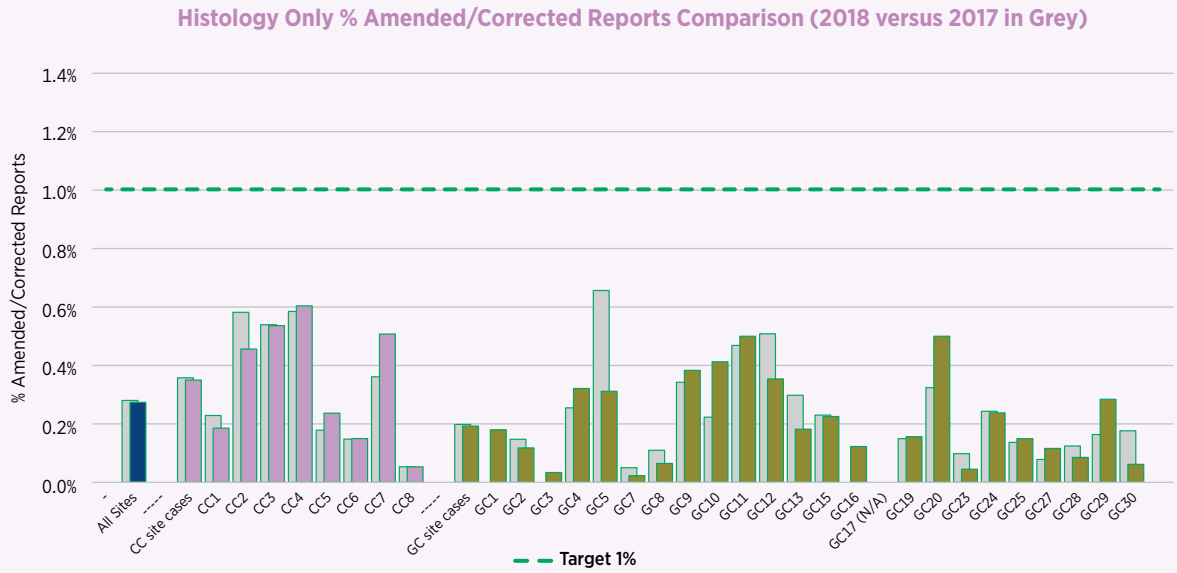
Cancer Centres (CCs), met the 1% target (1% or less for amended reports) for all 12 months of 2018, averaging at 0.35% for the year, compared to 0.36% in 2017. General Centres (GCs) also remained below the target (as recommended) for all 12 months of 2018, averaging at 0.19% for the year, which was just below 0.20% in 2017.

FIGURE 7.2: Funnel Plot - Histology Only % Combined Amended/Corrected Reports (2018)



The funnel plot shows that 17 hospitals were within the outer control limits. Four sites with large numbers of cases (greater than 15000) were above the control limits, and eight sites were below the outer control limits. These had very low levels of histology revised reporting.

FIGURE 7.3: Histology Only % Combined Amended/Corrected Reports 2018 v 2017 in Grey



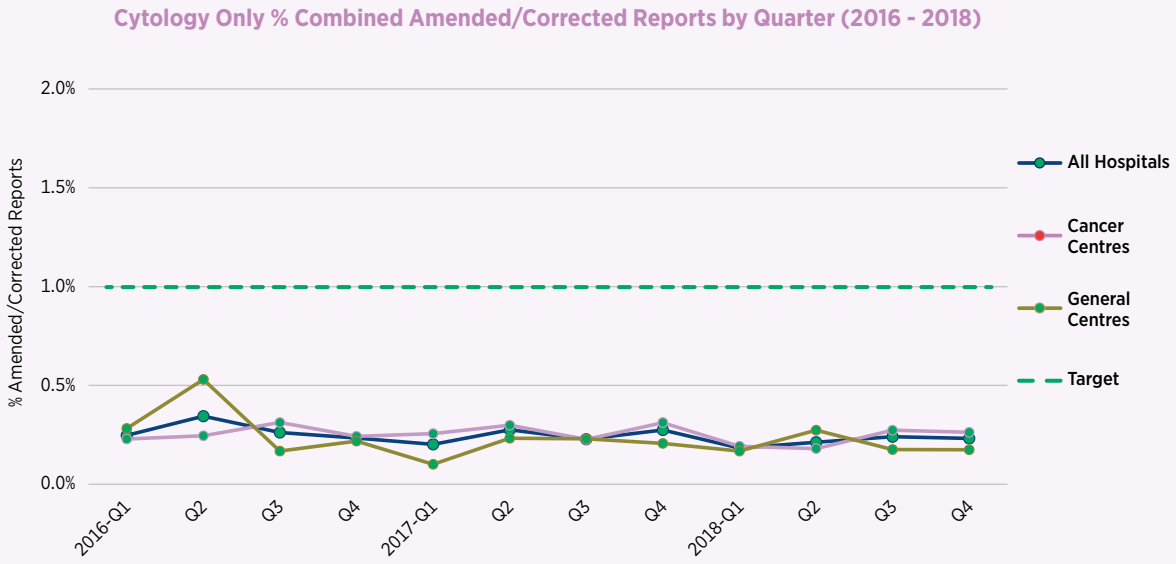
Histology Amended/Corrected reporting as a whole were consistently below the maximum target of 1.0% (as recommended for amended reports). While remaining below the maximum target, Histology nationally stabilised at approximately 0.27% of cases with combined amended and corrected reports, ranging from 0.19% to 0.35% during 2018.

TABLE 7.2: Histology Only All Data Amended/Corrected Reports 2017/2018

Histology P-Codes	2017 Amended/Corrected Reports			2018 Amended/Corrected Reports		
	No. of Cases	No. Q011/Q022	% Q011/Q022	No. of Cases	No. Q011/Q022	% Q011/Q022
Cancer Centre Sites	**218539**	**782**	**0.36%**	**225966**	**791**	**0.35%**
CC1	37108	85	0.23%	**39383**	**73**	**0.19%**
CC2	33001	192	0.58%	**32666**	**149**	**0.46%**
CC3	27808	150	0.54%	**29090**	**156**	**0.54%**
CC4	36251	212	0.58%	**37748**	**228**	**0.60%**
CC5	19045	34	0.18%	**19850**	**47**	**0.24%**
CC6	27087	40	0.15%	**28029**	**42**	**0.15%**
CC7	15783	57	0.36%	**16550**	**84**	**0.51%**
CC8	22456	12	0.05%	**22650**	**12**	**0.05%**
General Centre Sites	**205307**	**407**	**0.20%**	**210990**	**406**	**0.19%**
GC1	864	0	0.00%	**556**	**1**	**0.18%**
GC2	6783	10	0.15%	**6788**	**8**	**0.12%**
GC3	3026	0	0%	**2983**	**1**	**0.03%**
GC4	6668	17	0.25%	**5917**	**19**	**0.32%**
GC5	3046	20	0.66%	**3530**	**11**	**0.31%**
GC7	19969	10	0.05%	**21875**	**5**	**0.02%**
GC8	14578	16	0.11%	**15445**	**10**	**0.06%**
GC9	15477	53	0.34%	**16438**	**63**	**0.38%**
GC10	11208	25	0.22%	**11395**	**47**	**0.41%**
GC11	7686	36	0.47%	**5998**	**30**	**0.50%**
GC12	5901	30	0.51%	**6216**	**22**	**0.35%**
GC13	8054	24	0.30%	**8791**	**16**	**0.18%**
GC15	7387	17	0.23%	**7548**	**17**	**0.23%**
GC16	4617	0	0%	**4892**	**6**	**0.12%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19	4682	7	0.15%	**5117**	**8**	**0.16%**
GC20	6172	20	0.32%	**6598**	**33**	**0.50%**
GC23	12218	12	0.10%	**13326**	**6**	**0.05%**
GC24	23038	56	0.24%	**23159**	**55**	**0.24%**
GC25	10255	14	0.14%	**9381**	**14**	**0.15%**
GC27	10230	8	0.08%	**10358**	**12**	**0.12%**
GC28	17688	22	0.12%	**18753**	**16**	**0.09%**
GC29	1224	2	0.16%	**1056**	**3**	**0.28%**
GC30	4536	8	0.18%	**4870**	**3**	**0.06%**
All Sites	**423846**	**1189**	**0.28%**	**436956**	**1197**	**0.27%**

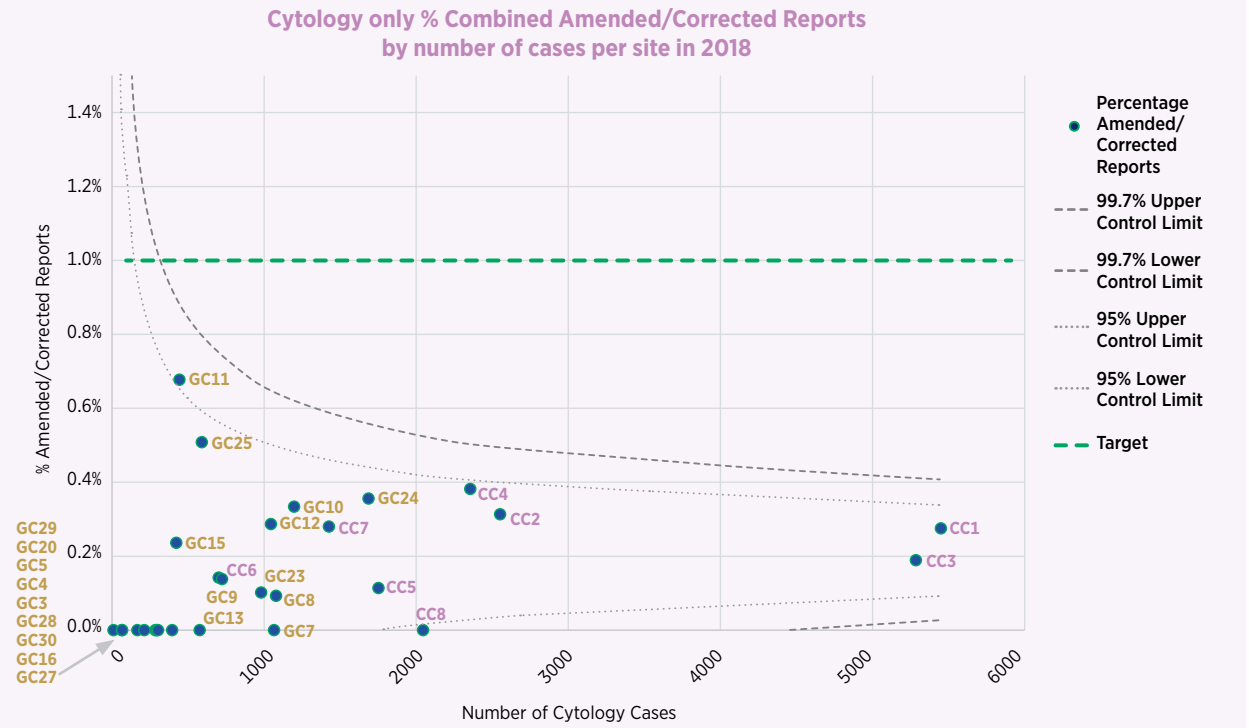
Combined Amended/Corrected Reports - Cytology (P05-P09)

FIGURE 7.4: Cytology only % Combined Amended/Corrected Reports per quarter (2016-2018)



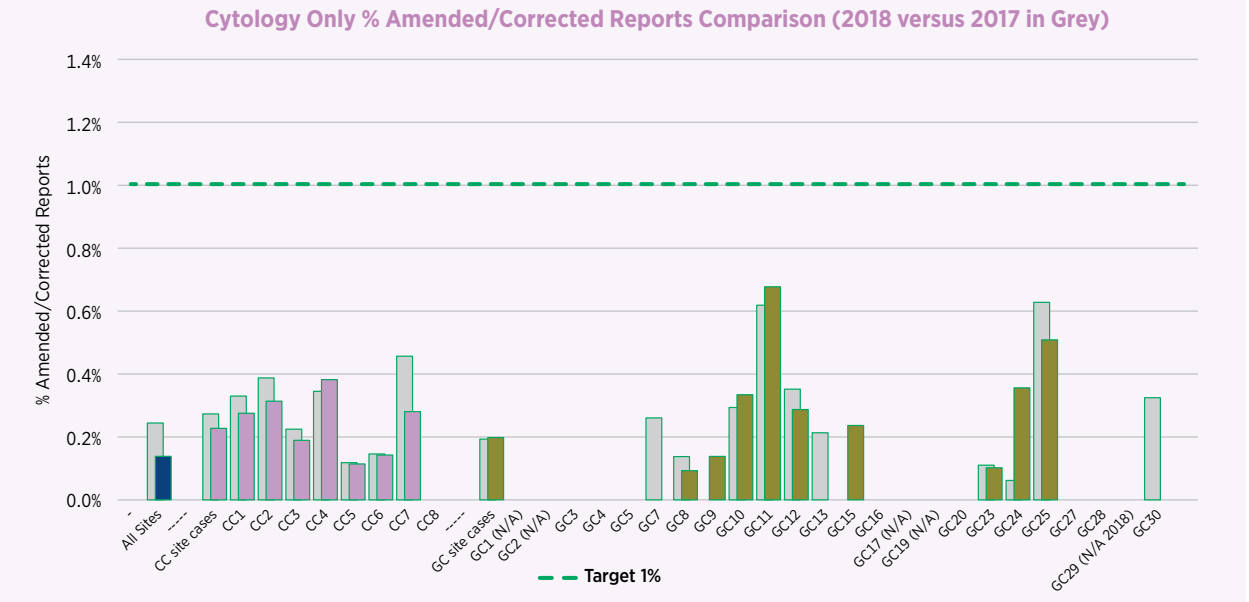
For Cytology Only Amended/Corrected Report all 32 sites were below the maximum 1% recommendation, at 0.22%

FIGURE 7.5: Cytology Only, % Combined Amended/Corrected Reports per site (2018)



The funnel plot shows that there is considerable variation in the numbers and percentages but all the sites are within the control limits.

FIGURE 7.6: Cytology Only, % Combined Amended/Corrected Reports (2018 v 2017 in Grey)



In 2018, the rate of the national combined Amended and Corrected report was 0.22% for all cytology cases (P05, P06, P07, P09). This is well within the recommendations and key quality indicators set by the Histopathology QI Working Group. In addition, all sites were below the maximum recommended target in 2018.

TABLE 7.3: Cytology Only All Data Amended/Corrected Reports 2017/2018

Cytology P-Codes	2017 Amended/Corrected Reports			2018 Amended/Corrected Reports		
	No. of Cases	No. Q011/Q022	% Q011/Q022	No. of Cases	No. Q011/Q022	% Q011/Q022
Cancer Centre Sites	**21238**	**58**	**0.27%**	**21565**	**49**	**0.23%**
CC1	5153	17	0.33%	**5449**	**15**	**0.28%**
CC2	2837	11	0.39%	**2551**	**8**	**0.31%**
CC3	4897	11	0.22%	**5285**	**10**	**0.19%**
CC4	2608	9	0.35%	**2355**	**9**	**0.38%**
CC5	1692	2	0.12%	**1752**	**2**	**0.11%**
CC6	685	1	0.15%	**702**	**1**	**0.14%**
CC7	1533	7	0.46%	**1426**	**4**	**0.28%**
CC8	0	0	0%	**2045**	**0**	**0%**
General Centre Sites	**11915**	**23**	**0.19%**	**11603**	**23**	**0.20%**
GC1 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC2 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC3	101	0	0%	**167**	**0**	**0%**
GC4	3	0	0%	**10**	**0**	**0%**
GC5	177	0	0%	**212**	**0**	**0%**
GC7	1152	3	0.26%	**1065**	**0**	**0%**
GC8	1454	2	0.14%	**1078**	**1**	**0.09%**
GC9	786	0	0%	**723**	**1**	**0.14%**
GC10	1022	3	0.29%	**1197**	**4**	**0.33%**
GC11	485	3	0.62%	**443**	**3**	**0.68%**
GC12	1137	4	0.35%	**1045**	**3**	**0.29%**
GC13	469	1	0.21%	**576**	**0**	**0%**
GC15	397	0	0%	**423**	**1**	**0.24%**
GC16	520	0	0%	**395**	**0**	**0%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC20	60	0	0%	**65**	**0**	**0%**
GC23	909	1	0.11%	**980**	**1**	**0.10%**
GC24	1622	1	0.06%	**1686**	**6**	**0.36%**
GC25	637	4	0.63%	**590**	**3**	**0.51%**
GC27	298	0	0%	**294**	**0**	**0%**
GC28	298	0	0%	**303**	**0**	**0%**
GC29	80	0	0%	**66**	**0**	**0%**
GC30	308	1	0.32%	**285**	**0**	**0%**
All Sites	**33154**	**81**	**0.24%**	**33168**	**72**	**0.22%**

In 2018, 11 General Centre sites and one Cancer Centre site had no cytology cases with Amended/Corrected reports, compared to 10 General Centre sites and one Cancer Centres site the year before. This low level of amendments and corrections may reflect a lack of coding.

CHAPTER 8
TURNAROUND TIME

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Turnaround Time (TAT) is a key in monitoring the overall function of the laboratory service and is considered an important 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. It is calculated based on working days and does not include weekends or bank holidays.

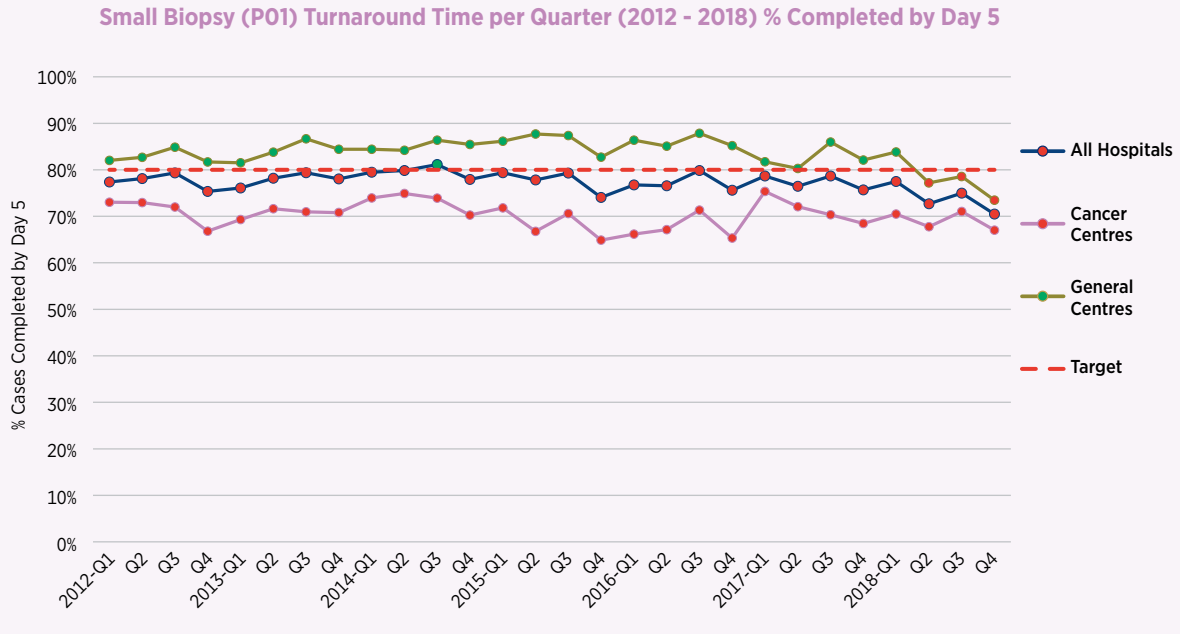
To ensure a meaningful representation of hospital case Turnaround Time, separate classification of Biopsy TAT and Non Biopsy TAT is recommended. Non-Biopsy cases should be further classified into Cancer Resections (by organ/site) and into all other cases.

TABLE 8.1: Turnaround Time Achievable Targets

Case Type	Target
Small Biopsy P01	80% of cases Turned Around in 5 days or less
GI Biopsy P02	80% of cases Turned Around in 5 days or less
Non Biopsy - Cancer Resection P03	80% of cases Turned Around in 7 days or less
Non Biopsy – Other P04	80% of cases Turned Around in 7 days or less
Cytology FNA P06	80% of cases Turned Around in 5 days or less
Cytology Exfoliative P07	80% of cases Turned Around in 5 days or less

Small Biopsy (P01) TAT Commentary

FIGURE 8.1: Small Biopsy (P01) TAT per Quarter (2012-2018) % completed by Day 5

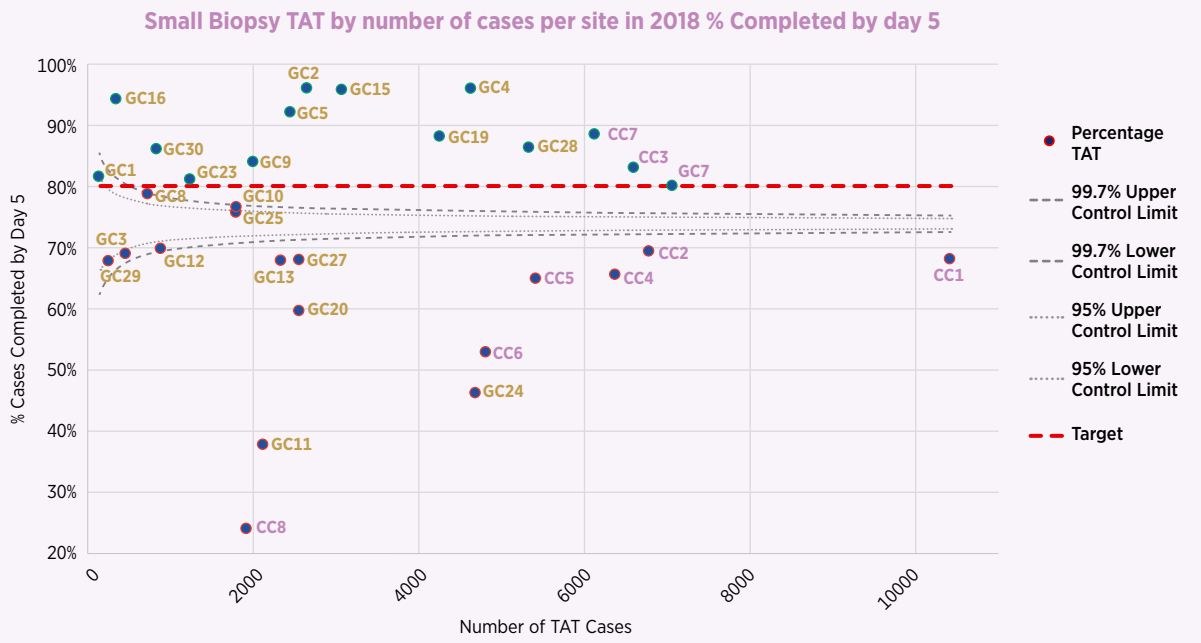


Nationally, TAT for P01 was stable but just under the target for the last seven years.

In 2018, the target for Small Biopsy (P01) cases (80% completed by day five) was not met by either Cancer Centres or General Centres. The national average for the year was 73.8%, which is 6% below the target and also 3.6% below last year's national average of 77.4%.

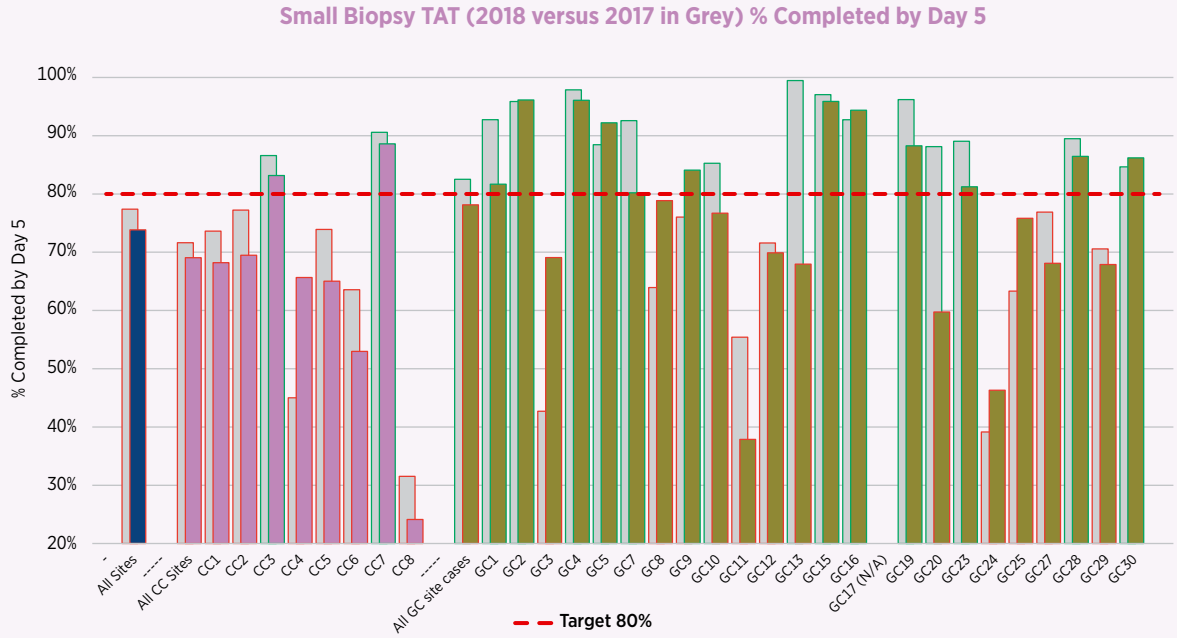
While Cancer Centre figures remain stable compared to 2017, there is a marked decrease in figures of General Centres - from 83% to 77.8% - which are now below the target for the first time since we began reporting.

FIGURE 8.2: Small Biopsy (P01) TAT % completed by day 5 (2018)



This target was met in 12 General Centres and two Cancer Centres.

FIGURE 8.3: Small Biopsy TAT % Completed by day 5 (2018 versus 2017 in grey)



Comparing the target (80% cases to be completed by day five between 2018 and 2017, there was a reduction in performance by almost 4%.

Only two Cancer Centres exceeded the target in 2018. These are the same two labs that exceeded the target in 2017.

Twelve General Centres met the target in 2018, compared to 14 in 2017.

TABLE 8.2: 2017/2018 Total Data Set TAT Small Biopsy (P01) % Completed by day 5

P-Codes P01	2017 TAT P01			2018 TAT P01		
	No. of Cases	No. < 5days	% < 5days	No. of Cases	No. < 5days	% < 5days
Cancer Centre Sites	**46501**	**33309**	**71.6%**	**48373**	**33406**	**69.1%**
CC1	9606	7071	73.6%	**10408**	**7099**	**68.2%**
CC2	6958	5374	77.2%	**6773**	**4706**	**69.5%**
CC3	6236	5400	86.6%	**6589**	**5480**	**83.2%**
CC4	6090	2741	45.0%	**6366**	**4180**	**65.7%**
CC5	5261	3888	73.9%	**5407**	**3516**	**65.0%**
CC6	4676	2972	63.6%	**4802**	**2544**	**53.0%**
CC7	5831	5282	90.6%	**6117**	**5420**	**88.6%**
CC8	1843	581	31.5%	**1911**	**461**	**24.1%**
General Centre Sites	**52250**	**43117**	**82.5%**	**53997**	**42184**	**78.1%**

P-Codes P01 Continued	2017 TAT P01			2018 TAT P01		
	No. of Cases	No. < 5days	% < 5days	No. of Cases	No. < 5days	% < 5days
GC1	138	128	92.8%	**131**	**107**	**81.7%**
GC2	2447	2346	95.9%	**2642**	**2540**	**96.1%**
GC3	267	114	42.7%	**453**	**313**	**69.1%**
GC4	4565	4468	97.9%	**4622**	**4441**	**96.1%**
GC5	2209	1954	88.5%	**2441**	**2251**	**92.2%**
GC7	6222	5761	92.6%	**7056**	**5659**	**80.2%**
GC8	843	539	63.9%	**719**	**567**	**78.9%**
GC9	2520	1916	76.0%	**1993**	**1676**	**84.1%**
GC10	1745	1488	85.3%	**1790**	**1373**	**76.7%**
GC11	2153	1193	55.4%	**2112**	**800**	**37.9%**
GC12	806	577	71.6%	**877**	**613**	**69.9%**
GC13	2081	2070	99.5%	**2328**	**1582**	**68.0%**
GC15	2851	2767	97.1%	**3063**	**2937**	**95.9%**
GC16	317	294	92.7%	**338**	**319**	**94.4%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19	3846	3700	96.2%	**4245**	**3747**	**88.3%**
GC20	2224	1960	88.1%	**2548**	**1522**	**59.7%**
GC23	1041	927	89.0%	**1231**	**1000**	**81.2%**
GC24	4669	1828	39.2%	**4678**	**2166**	**46.3%**
GC25	2462	1559	63.3%	**1787**	**1355**	**75.8%**
GC27	2414	1856	76.9%	**2548**	**1735**	**68.1%**
GC28	5404	4836	89.5%	**5323**	**4602**	**86.5%**
GC29	231	163	70.6%	**246**	**167**	**67.9%**
GC30	795	673	84.7%	**826**	**712**	**86.2%**
All Sites	**98751**	**76426**	**77.4%**	**102370**	**75590**	**73.8%**

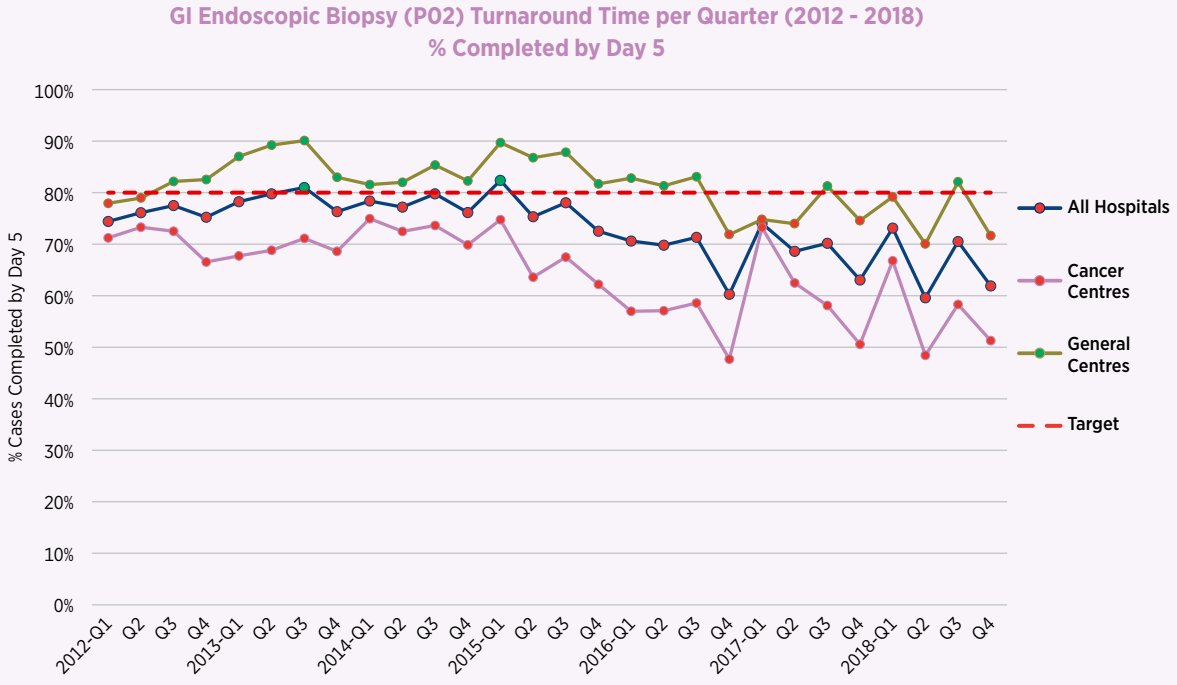
GI Endoscopic Biopsy (P02) TAT Commentary

In 2018, the target for GI Endoscopic biopsy (P02) cases (80% completed by day five) was not met by either Cancer Centres or General Centres. The national average for the year was 66.1% down from 69% for 2017.

However, the data from Cancer Centres show that targets were down by 6% compared to 2017 figures - from 61.2% to 56%), which is similar to 2016 figures.

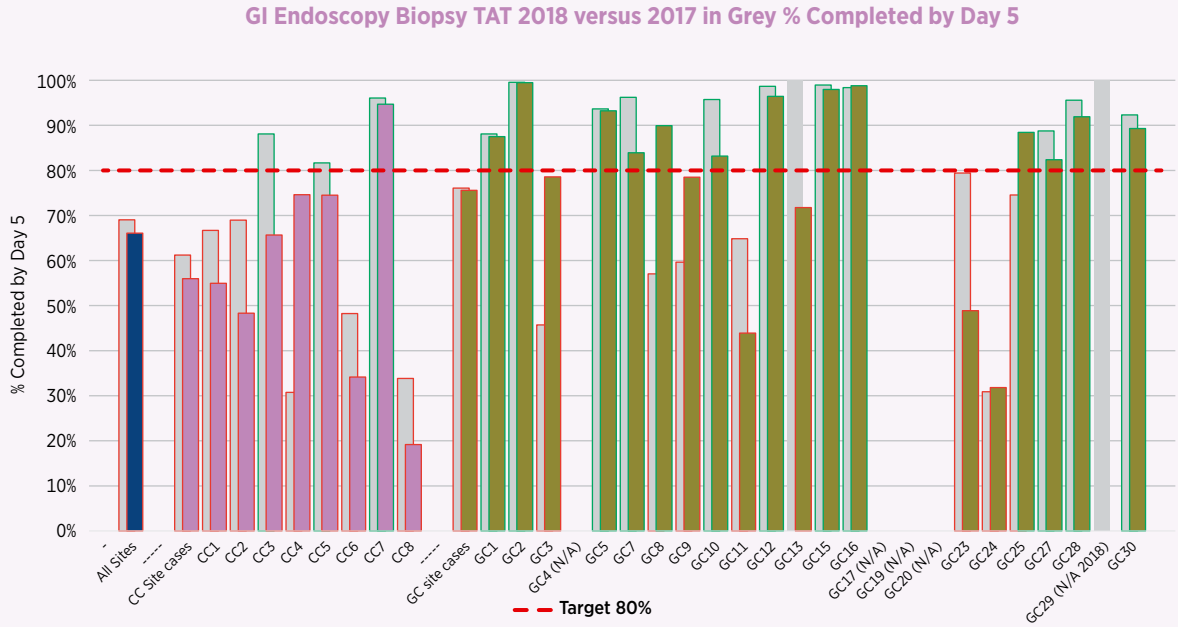
The figures from General Centres have remained stable over the last two years at between 75% and 76% cases completed by day five.

FIGURE 8.4: GI Endoscopic Biopsy (P02) TAT per Quarter (2012-2018) % completed by Day 5



There has been a pronounced decreasing trend in the number of centres meeting this target over the past two years, reflecting the decrease in Cancer Centres meeting this target over the past three years. Over the past two years, General Centres have begun falling below target, having sustained above target activity for most of the previous four. This may relate to the significant increase in endoscopy activity nationwide.

FIGURE 8.5: GI Endoscopic Biopsy (P02) TAT (2018 v 2017 in grey) % completed by Day 5



Thirteen out of 20 General Centres met this target for 2018, similar to 2017 figures (13 out of 21 sites).

One of the eight Cancer Centres met this target, down from three in 2017. Three Cancer Centres had less than 50% of cases turned around in five days or less and had similar figures for 2017. One of those Cancer Centres that was below 50% completed by day five in 2017, had increased to 74% in 2018.

TABLE 8.3: 2017/2018 Total Data for GI Endoscopic Biopsy (P02) TAT % completed by Day 5

P-Codes P02	2017 TAT P02			2018 TAT P02		
	No. of Cases	No. < 5days	% < 5days	No. of Cases	No. < 5days	% < 5days
Cancer Centre Sites	**65197**	**39902**	**61.2%**	**69316**	**38801**	**56.0%**
CC1	10338	6893	66.7%	**11255**	**6185**	**55.0%**
CC2	11062	7630	69.0%	**11184**	**5404**	**48.3%**
CC3	8896	7837	88.1%	**10305**	**6767**	**65.7%**
CC4	10258	3154	30.7%	**10938**	**8161**	**74.6%**
CC5	5761	4705	81.7%	**5946**	**4430**	**74.5%**
CC6	8136	3926	48.3%	**8703**	**2972**	**34.1%**
CC7	3407	3273	96.1%	**3676**	**3481**	**94.7%**
CC8	7339	2484	33.8%	**7309**	**1401**	**19.2%**
General Centre Sites	**72436**	**55110**	**76.1%**	**73843**	**55801**	**75.6%**
GC1	42	37	88.1%	**16**	**14**	**87.5%**

P-Codes P02 Continued	2017 TAT P02			2018 TAT P02		
	No. of Cases	No. < 5days	% < 5days	No. of Cases	No. < 5days	% < 5days
GC2	2688	2676	99.6%	**2513**	**2500**	**99.5%**
GC3	1135	519	45.7%	**1055**	**829**	**78.6%**
GC4 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC5	693	649	93.7%	**916**	**854**	**93.2%**
GC7	5663	5449	96.2%	**6224**	**5223**	**83.9%**
GC8	5631	3212	57.0%	**5891**	**5298**	**89.9%**
GC9	5421	3233	59.6%	**5889**	**4622**	**78.5%**
GC10	4244	4063	95.7%	**4245**	**3531**	**83.2%**
GC11	2271	1473	64.9%	**1194**	**524**	**43.9%**
GC12	2690	2654	98.7%	**2803**	**2703**	**96.4%**
GC13	3308	3308	100.0%	**3675**	**2637**	**71.8%**
GC15	2380	2355	98.9%	**2364**	**2316**	**98.0%**
GC16	1973	1941	98.4%	**2241**	**2214**	**98.8%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC20 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC23	5567	4421	79.4%	**5944**	**2906**	**48.9%**
GC24	10670	3297	30.9%	**10700**	**3404**	**31.8%**
GC25	5752	4288	74.5%	**5218**	**4615**	**88.4%**
GC27	2732	2425	88.8%	**2627**	**2164**	**82.4%**
GC28	8260	7895	95.6%	**8590**	**7895**	**91.9%**
GC29	1	1	100.0%	**N/A**	**N/A**	**N/A**
GC30	1315	1214	92.3%	**1738**	**1552**	**89.3%**
All Sites	**137633**	**95012**	**69.0%**	**143159**	**94602**	**66.1%**

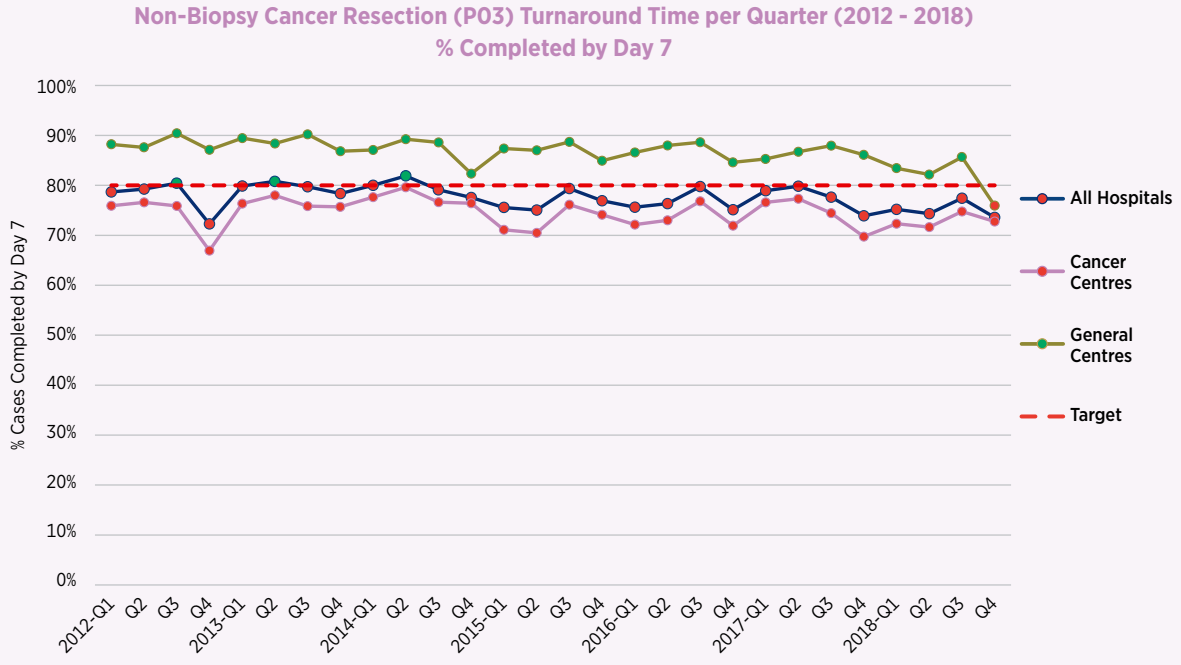
Non Biopsy - Cancer Resection (P03) TAT Commentary

In 2018, the target for Non Biopsy Cancer Resection (P03) cases (80% completed by day seven) was not met. The national average for the year was 75.1%, which is 4.9% below the target and 2% below last year's national average of 77.6%. In Cancer Centres, the number of cases turned around in seven days or less is down from 74.6% in 2017 to 72.9% in 2018.

The trend over the last seven years, has shown the national TAT for Non Biopsy Cancer Resections generally ranging between 72% and 80% cases completed by day seven.

General Centres have ranged between 82% and 90%, only dipping below the target in Q4 2018, while Cancer Centres ranged between 72% and 78%.

FIGURE 8.6: Non Biopsy Cancer Resection TAT per quarter 2012-2018 % completed by Day 7



Two of the eight Cancer Centres met this target, down from three in 2017. One Cancer Centre had less than 35% of cases turned around in seven days or less. Twelve of 22 General Centres reached this target for 2018, down two from 2017.

FIGURE 8.7: Non Biopsy Cancer Resection TAT 2018 v 2017 in Grey, % completed by Day 7

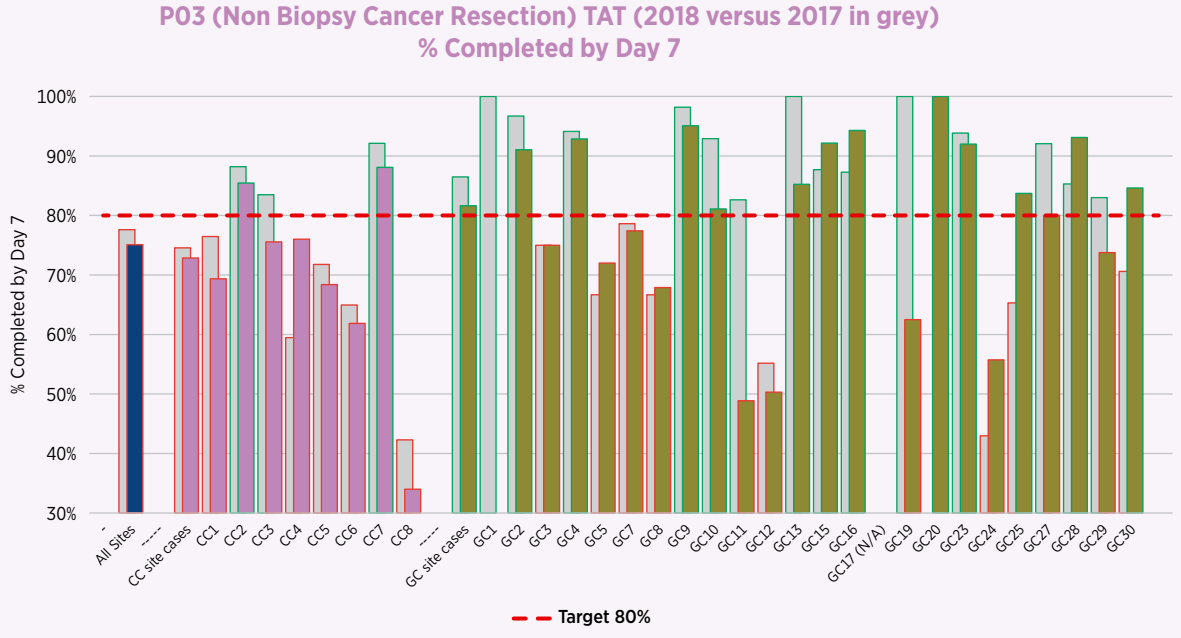


TABLE 8.4: 2017/2018 Total Data for Non Biopsy Cancer Resection (P03) TAT % completed by Day 7

P-Codes P03	2017 TAT P03			2018 TAT P03		
	No. of Cases	No. < 5days	% < 5days	No. of Cases	No. < 5days	% < 5days
Cancer Centre Sites	**12514**	**9330**	**74.6%**	**12878**	**9382**	**72.9%**
CC1	2119	1620	76.5%	**2232**	**1548**	**69.4%**
CC2	2347	2070	88.2%	**2487**	**2125**	**85.4%**
CC3	1847	1542	83.5%	**1841**	**1391**	**75.6%**
CC4	2178	1295	59.5%	**2022**	**1537**	**76.0%**
CC5	1126	808	71.8%	**1322**	**904**	**68.4%**
CC6	662	430	65.0%	**763**	**472**	**61.9%**
CC7	1244	1146	92.1%	**1208**	**1064**	**88.1%**
CC8	991	419	42.3%	**1003**	**341**	**34.0%**
General Centre Sites	**4325**	**3740**	**86.5%**	**4379**	**3575**	**81.6%**
GC1	1	1	100%	**N/A**	**N/A**	**N/A**
GC2	91	88	96.7%	**67**	**61**	**91.0%**
GC3	4	3	75.0%	**4**	**3**	**75.0%**
GC4	17	16	94.1%	**28**	**26**	**92.9%**
GC5	48	32	66.7%	**75**	**54**	**72.0%**
GC7	145	114	78.6%	**208**	**161**	**77.4%**
GC8	111	74	66.7%	**137**	**93**	**67.9%**
GC9	1103	1083	98.2%	**1197**	**1138**	**95.1%**
GC10	1015	943	92.9%	**1116**	**905**	**81.1%**
GC11	236	195	82.6%	**176**	**86**	**48.9%**
GC12	145	80	55.2%	**163**	**82**	**50.3%**
GC13	136	136	100.0%	**149**	**127**	**85.2%**
GC15	65	57	87.7%	**51**	**47**	**92.2%**
GC16	110	96	87.3%	**35**	**33**	**94.3%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19	1	1	100%	**8**	**5**	**62.5%**
GC20	N/A	N/A	N/A	**1**	**1**	**100.0%**
GC23	276	259	93.8%	**312**	**287**	**92.0%**
GC24	277	119	43.0%	**244**	**136**	**55.7%**
GC25	49	32	65.3%	**135**	**113**	**83.7%**
GC27	63	58	92.1%	**70**	**56**	**80.0%**
GC28	34	29	85.3%	**29**	**27**	**93.1%**
GC29	347	288	83.0%	**122**	**90**	**73.8%**
GC30	51	36	70.6%	**52**	**44**	**84.6%**
All Sites	**16839**	**13070**	**77.6%**	**17257**	**12957**	**75.08%**

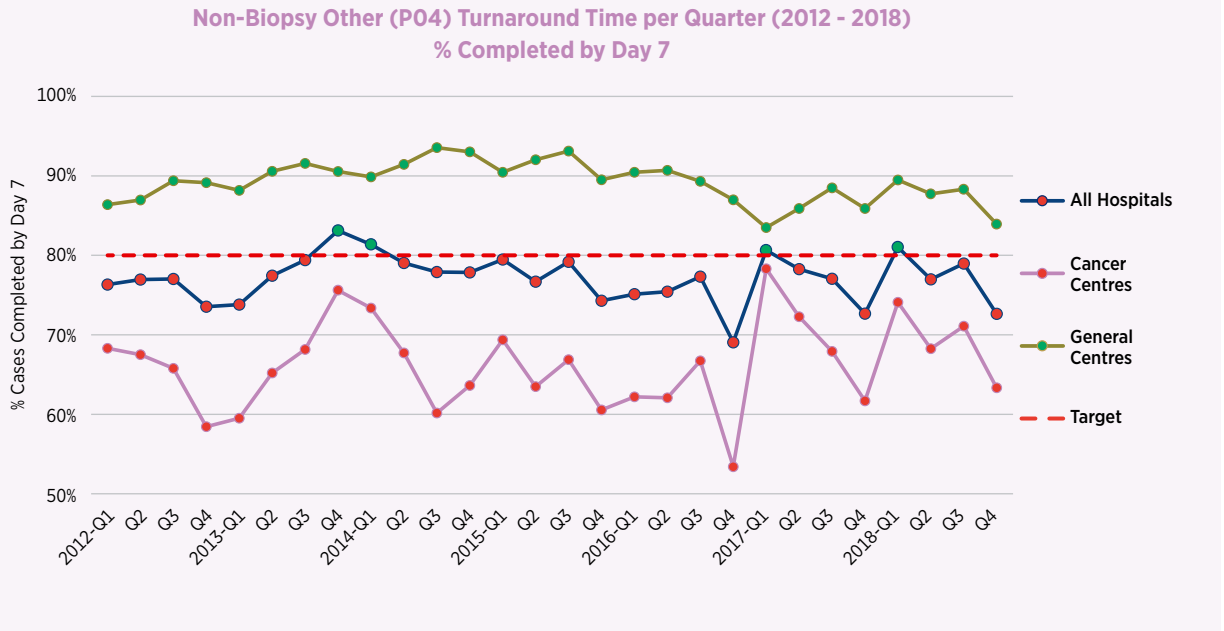
Non Biopsy Other (P04) - TAT Commentary

In 2018, the target for Non Biopsy Other (P04) cases (80% completed by day seven) was not met. The national average for the year was 77.4%, less than 3% below the target. There was a slight improvement, compared to the 2017 figures (77.2%). Cancer Centres cases did not meet this target for any month in 2018, the figures were overall stable compared to 2017 figure of 70.1% and an improvement from the 2016 figure of 61.1%.

General Centres met the target for all 12 months of 2018. The number of General Centres cases that were reported in seven days or less was up by 1.5% compared to the 2017 figures from 85.9% to 87.3%.

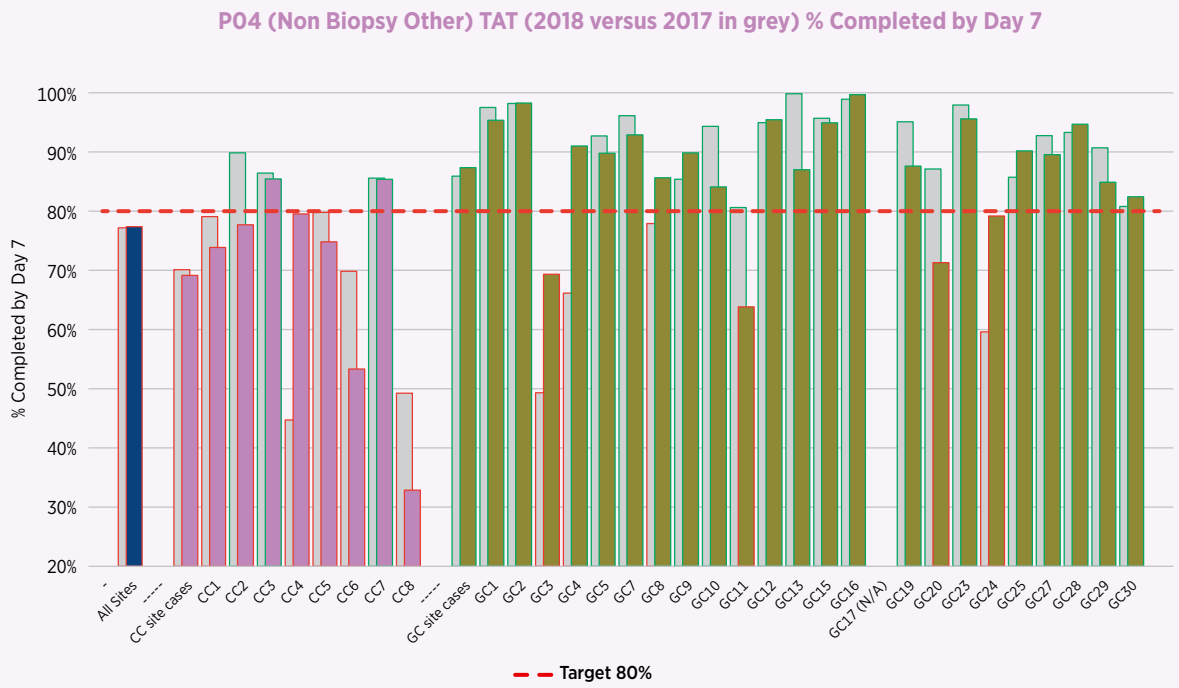
The national percentage by day seven has remained relatively stable over the last six years, generally between 75% and 80%, only dipping in the last quarters of each of 2016, 2017 and 2018 to below 73%.

FIGURE 8.8: Non Biopsy Other (P04) TAT per quarter 2012-2018 % completed by Day 7



If Cancer Centres and General Centres are grouped and compared, the General Centres met the target for all 12 months and the Cancer Centres site did not meet the target for any month.

FIGURE 8.9: Non Biopsy Other (P04) TAT % Completed by Day 7, 2018 V 2017 in Grey



Two Cancer Centre sites reached this target compared with three in 2017. One site, CC4, has increased their percentage completed by day seven from 44.7% in 2017 to 79.5%, to only 0.5% below target.

Only four General Centres were below target in 2018, the same number of sites as the previous year.

TABLE 8.5: 2017/2018 Total Data for Non Biopsy Other (P04) TAT % completed by Day 7

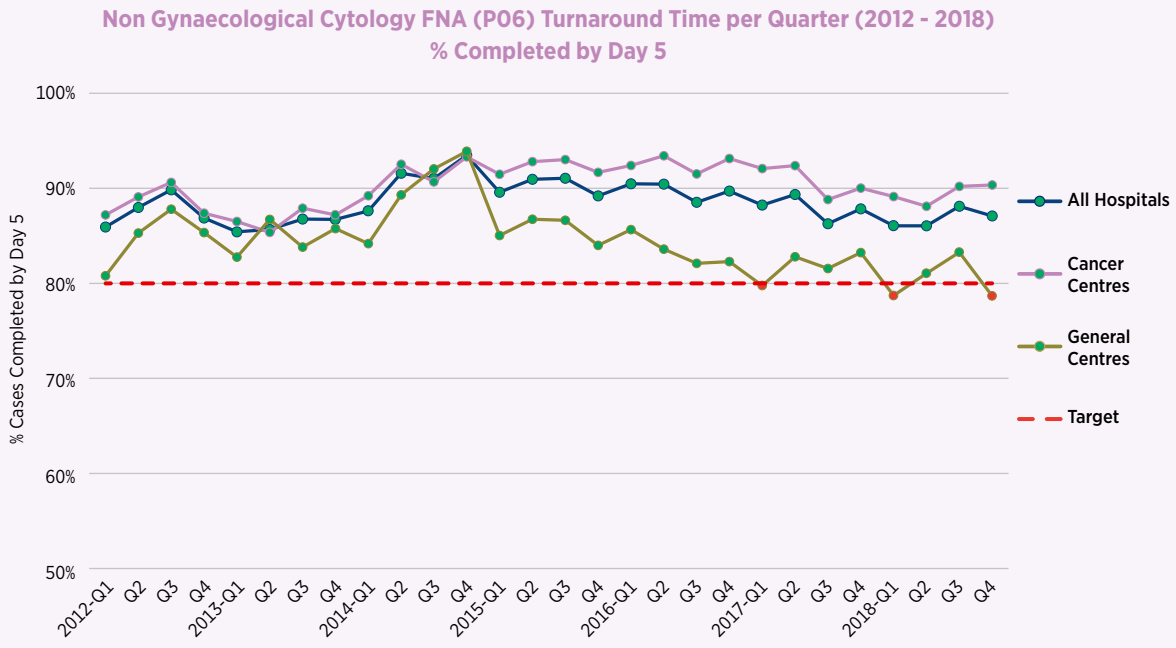
P-Codes P04	2017 TAT P04			2018 TAT P04		
	No. of Cases	No. < 5days	% < 5days	No. of Cases	No. < 5days	% < 5days
Cancer Centre Sites	**94327**	**66132**	**70.1%**	**95399**	**65965**	**69.1%**
CC1	15045	11898	79.1%	**15488**	**11441**	**73.9%**
CC2	12634	11351	89.8%	**12222**	**9496**	**77.7%**
CC3	10829	9360	86.4%	**10355**	**8848**	**85.4%**
CC4	17725	7926	44.7%	**18422**	**14651**	**79.5%**
CC5	6897	5503	79.8%	**7175**	**5368**	**74.8%**
CC6	13613	9508	69.8%	**13761**	**7339**	**53.3%**
CC7	5301	4537	85.6%	**5549**	**4738**	**85.4%**
CC8	12283	6049	49.2%	**12427**	**4084**	**32.9%**
General Centre Sites	**76296**	**65559**	**85.9%**	**78771**	**68805**	**87.3%**
GC1	683	666	97.5%	**409**	**390**	**95.4%**
GC2	1557	1529	98.2%	**1566**	**1539**	**98.3%**
GC3	1620	799	49.3%	**1471**	**1020**	**69.3%**
GC4	2086	1380	66.2%	**1267**	**1153**	**91.0%**
GC5	96	89	92.7%	**98**	**88**	**89.8%**
GC7	7939	7631	96.1%	**8387**	**7790**	**92.9%**
GC8	7993	6227	77.9%	**8698**	**7449**	**85.6%**
GC9	6433	5493	85.4%	**7359**	**6613**	**89.9%**
GC10	4204	3966	94.3%	**4244**	**3569**	**84.1%**
GC11	3026	2439	80.6%	**2516**	**1606**	**63.8%**
GC12	2260	2146	95.0%	**2373**	**2265**	**95.4%**
GC13	2529	2525	99.8%	**2639**	**2296**	**87.0%**
GC15	2091	2001	95.7%	**2070**	**1965**	**94.9%**
GC16	2217	2193	98.9%	**2278**	**2271**	**99.7%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19	835	794	95.1%	**864**	**757**	**87.6%**
GC20	3948	3440	87.1%	**4049**	**2887**	**71.3%**
GC23	5334	5224	97.9%	**5839**	**5582**	**95.6%**
GC24	7422	4424	59.6%	**7537**	**5968**	**79.2%**
GC25	1992	1708	85.7%	**2241**	**2021**	**90.2%**
GC27	5021	4658	92.8%	**5113**	**4578**	**89.5%**
GC28	3990	3723	93.3%	**4811**	**4556**	**94.7%**
GC29	645	585	90.7%	**688**	**584**	**84.9%**
GC30	2375	1919	80.8%	**2254**	**1858**	**82.4%**
All Sites	**170623**	**131691**	**77.2%**	**174170**	**134770**	**77.4%**

Non Gynaecological Cytology FNA (P06) TAT Commentary

In 2018, the target for Non Gynaecological Cytology FNA (P06) cases (80% completed by day five) was met nationally. The national average for the year was 86.8%, almost 7% above target for the year.

In 2018 nationally, we met the 80% of cases completed by day 5 Target for Non Gynaecological Cytology FNA (P06) cases

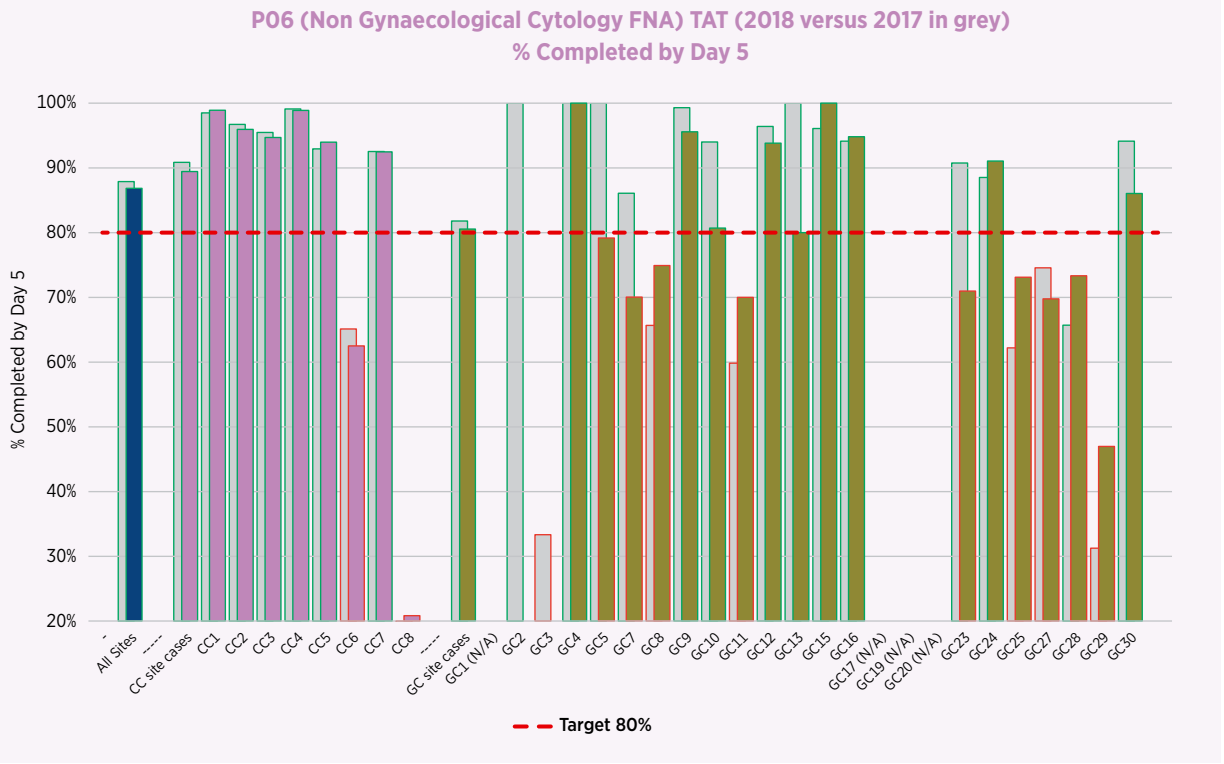
FIGURE 8.10: Non Gynaecological Cytology FNA (P06) TAT % Completed by Day 5 per quarter for 2012 to 2018



From 2012 to 2015 there was a steady increase in cases completed by day five from 85% to over 93%. There has been a slight decline over the last three years to 86.7% by Q4 2018, however this remains well above the 80% Target.

The number of General Centres reporting cases in five days or less was reduced from 81.8% in 2017 to 80.5 % in 2018 (reduction of 1.3%).

FIGURE 8.11: Non Gynaecological Cytology FNA (P06) TAT % Completed by Day 5. Comparison of 2018 v 2017 in grey



Six of the eight Cancer Centres reached this target in 2018. Five of which are over 90% completed by day five. One of the Cancer Centres that was below the target has just above 20% of cases turned around in five days or less, similarly to 2017 and 2016.

Nine General Centres met the target for 2018, four less than last year (13) and six less than 2016 (15).

If Cancer Centres and General Centres are grouped and compared, the Cancer Centres met this target for all 12 months and the General Centres reached this target for seven months.

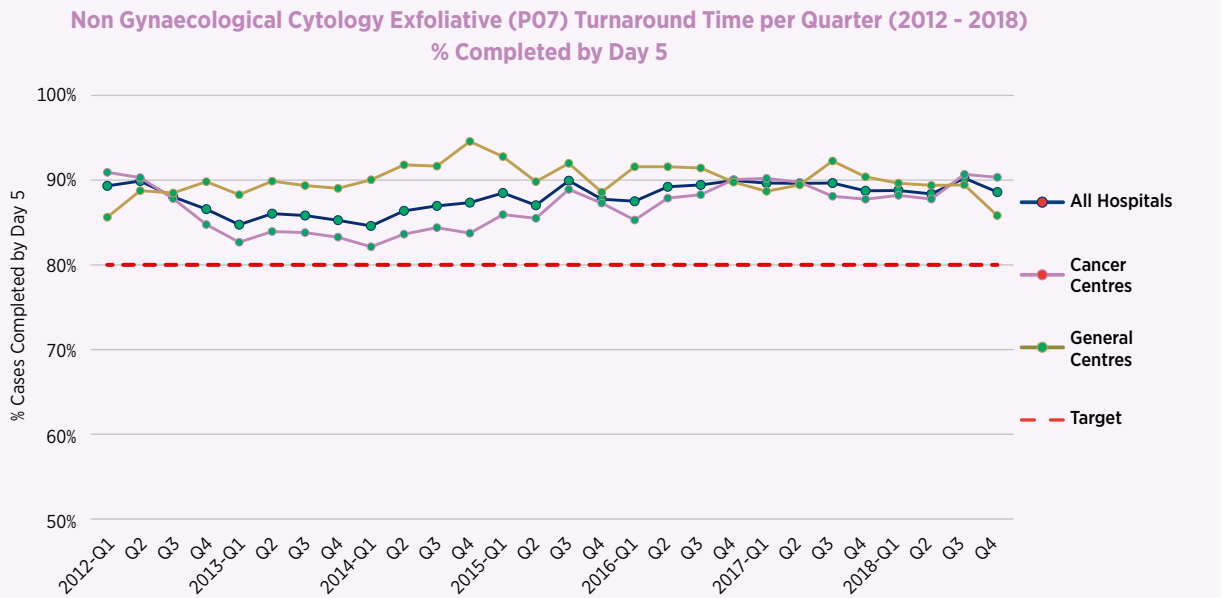
TABLE 8.6: 2017/2018 Total Data Non Gynaecological Cytology FNA (P06) TAT % Completed by Day 5

P-Codes P06	2017 TAT P06			2018 TAT P06		
	No. of Cases	No. < 5days	% < 5days	No. of Cases	No. < 5days	% < 5days
Cancer Centre Sites	**7002**	**6361**	**90.8%**	**7469**	**6680**	**89.4%**
CC1	1794	1767	98.5%	**1824**	**1804**	**98.9%**
CC2	1097	1061	96.7%	**1061**	**1018**	**95.9%**
CC3	1903	1817	95.5%	**1998**	**1892**	**94.7%**
CC4	443	439	99.1%	**535**	**529**	**98.9%**
CC5	737	685	92.9%	**813**	**764**	**94.0%**
CC6	129	84	65.1%	**128**	**80**	**62.5%**
CC7	482	446	92.5%	**505**	**467**	**92.5%**
CC8	417	62	14.9%	**605**	**126**	**20.8%**
General Centre Sites	**3389**	**2772**	**81.8%**	**3079**	**2480**	**80.5%**
GC1 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC2	1	1	100.0%	**N/A**	**N/A**	**N/A**
GC3	3	1	33.3%	**N/A**	**N/A**	**N/A**
GC4	3	3	100%	**10**	**10**	**100%**
GC5	4	4	100%	**24**	**19**	**79.2%**
GC7	568	489	86.1%	**514**	**360**	**70.0%**
GC8	466	306	65.7%	**295**	**221**	**74.9%**
GC9	286	284	99.3%	**294**	**281**	**95.6%**
GC10	467	439	94.0%	**570**	**460**	**80.7%**
GC11	117	70	59.8%	**130**	**91**	**70.0%**
GC12	139	134	96.4%	**178**	**167**	**93.8%**
GC13	68	68	100%	**45**	**36**	**80.0%**
GC15	51	49	96.1%	**55**	**55**	**100%**
GC16	153	144	94.1%	**135**	**128**	**94.8%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC20 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC23	54	49	90.7%	**93**	**66**	**71.0%**
GC24	383	339	88.5%	**347**	**316**	**91.1%**
GC25	328	204	62.2%	**119**	**87**	**73.1%**
GC27	114	85	74.6%	**86**	**60**	**69.8%**
GC28	70	46	65.7%	**75**	**55**	**73.3%**
GC29	80	25	31.3%	**66**	**31**	**47.0%**
GC30	34	32	94.1%	**43**	**37**	**86.0%**
All Sites	**10391**	**9133**	**87.9%**	**10548**	**9160**	**86.8%**

Non Gynaecological Cytology Exfoliative (P07) TAT Commentary

In 2018, the target for Non Gynaecological Cytology Exfoliative (P07) cases (80% completed by day five) was met. The national average for the year was 89%, 9% above target.

FIGURE 8.12: Non Gynaecological Cytology Exfoliative (P07) TAT per Quarter (2012-2018) % completed by Day 7

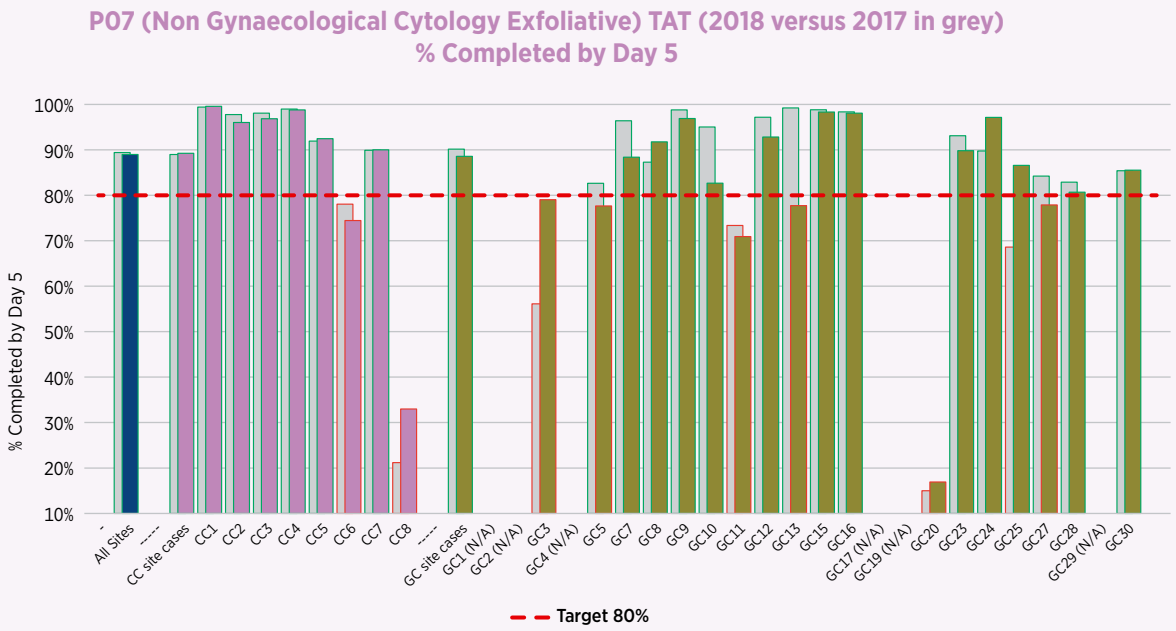


From 2013 to 2015 there was a steady increase in cases completed by day five from 85% to 90%, and has stabilised there since mid-2016.

Cancer Centres met this target for every quarter in 2018, ranging mostly between 86% and 93%.

General Centres met this target for every quarter in 2018, ranging mostly between 85% and 91%.

FIGURE 8.13: Non Gynaecological Cytology Exfoliative (P07) TAT % completed by Day 5 (2018 versus 2017 in Grey)



Six of the eight Cancer Centres met this target. One Cancer Centre has 33% of cases turned around in five days or less. This site had approximately 20% completed by day five in 2017 and 2016.

Twelve out of 18 General Centres met this target for 2018, two less than in 2017. One of these below target General Centres was below 20%.

TABLE 8.7: 2017/2018 Full Data Non Gynaecological Cytology FNA % Completed by Day 5

P-Codes P07	2017 TAT P07			2018 TAT P07		
	No. of Cases	No. < 5days	% < 5days	No. of Cases	No. < 5days	% < 5days
Cancer Centre Sites	**14134**	**12576**	**89.0%**	**13422**	**11979**	**89.25%**
CC1	3359	3339	99.4%	**3625**	**3610**	**99.59%**
CC2	1740	1701	97.8%	**1359**	**1305**	**96.03%**
CC3	2994	2937	98.1%	**3082**	**2985**	**96.85%**
CC4	2063	2042	99.0%	**1660**	**1640**	**98.80%**
CC5	955	878	91.9%	**783**	**724**	**92.46%**
CC6	556	434	78.1%	**552**	**411**	**74.0%**
CC7	1051	945	89.9%	**921**	**829**	**90.01%**
CC8	1416	300	21.2%	**1440**	**475**	**33.0%**
General Centre Sites	**8455**	**7624**	**90.2%**	**8371**	**7414**	**88.57%**
GC1 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC2 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC3	98	55	56.12%	**167**	**132**	**79.0%**
GC4 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC5	173	143	82.66%	**188**	**146**	**78.0%**
GC7	584	563	96.40%	**551**	**487**	**88.0%**
GC8	976	852	87.30%	**753**	**691**	**92.0%**
GC9	499	493	98.80%	**419**	**406**	**97.0%**
GC10	523	497	95.03%	**583**	**482**	**83.0%**
GC11	368	270	73.37%	**313**	**222**	**71.0%**
GC12	993	965	97.18%	**865**	**803**	**93.0%**
GC13	382	379	99.21%	**476**	**370**	**78.0%**
GC15	343	339	98.83%	**360**	**354**	**98.0%**
GC16	367	361	98.37%	**260**	**255**	**98.0%**
GC17 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC19 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC20	60	9	15.0%	**65**	**11**	**17.0%**
GC23	855	796	93.1%	**884**	**794**	**90.0%**
GC24	1239	1112	89.7%	**1339**	**1301**	**97.0%**
GC25	309	212	68.6%	**470**	**407**	**87.0%**
GC27	184	155	84.2%	**208**	**162**	**78.0%**
GC28	228	189	82.9%	**228**	**184**	**81.0%**
GC29 (N/A)	N/A	N/A	N/A	**N/A**	**N/A**	**N/A**
GC30	274	234	85.4%	**242**	**207**	**86.0%**
All Sites	**22589**	**20200**	**89.4%**	**21793**	**19393**	**88.99%**

CHAPTER 9
FROZEN SECTION

9

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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% and greater than 1%
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.

In 2018, 89.9% of FS cases had a FS Correlation Code (either Q007, Q008, Q009 or Q051).

Broken down by hospital type, General Centres do marginally better at 95.1%, in their correlation coding of FS cases, than Cancer Centres at 88.9%.

From a Frozen Section Correlation Concordance perspective, broken down by hospital type both CCs (99%, the same as 2017 figures) and GCs (98.4%, increased by under 1% from 2017 figures) meet the target.

From a Frozen Section Correlation Concordance perspective broken down by hospital type, both Cancer Centres and General Centres, as an aggregate, met the target in 2018

From a quarterly perspective, over the past four years, Frozen Section Correlation Concordance increased and is currently sustained above the 97% target, from previously moving around the 97% target.

FIGURE 9.1: % Frozen Section Concordance per Quarter (2011-2018)

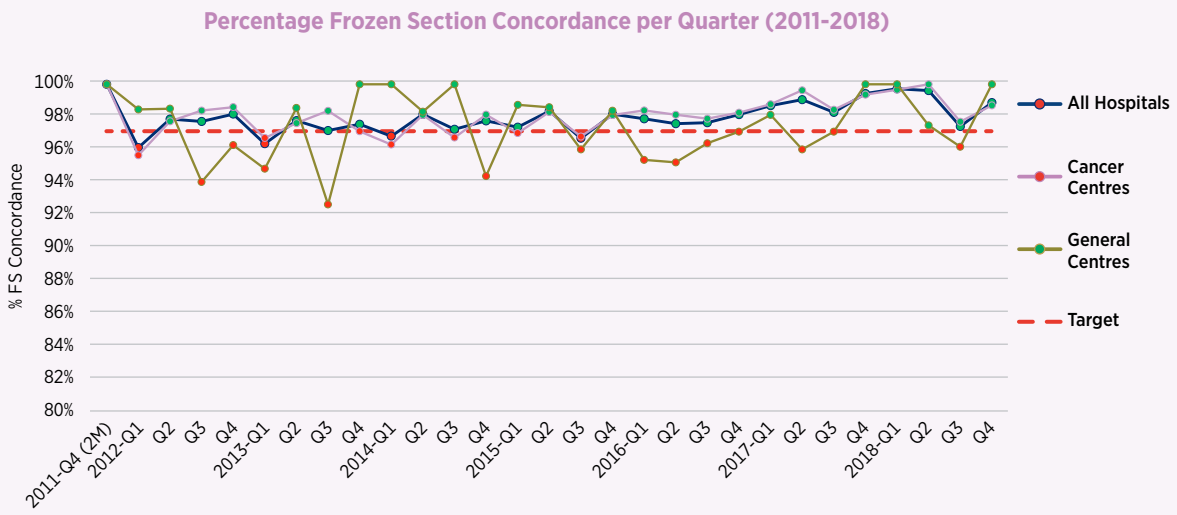
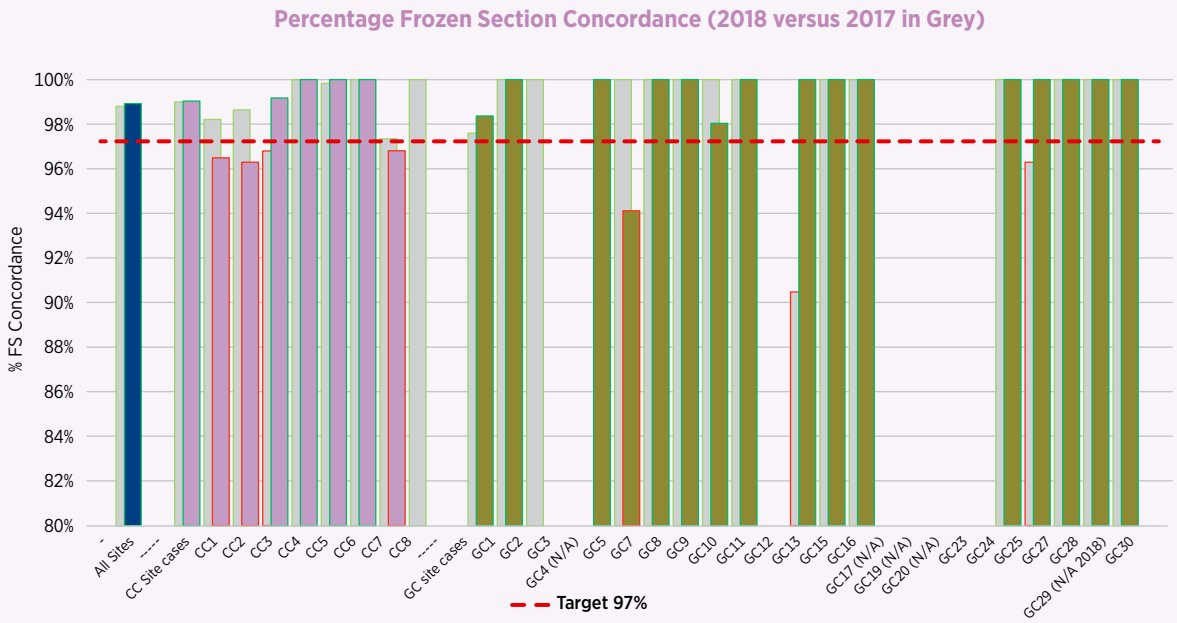


FIGURE 9.2: % Frozen Section Concordance by Site (2018 v 2017 in Grey)



Eighteen of the 23 sites (83%) with Frozen Section cases reached the 97% Frozen Section concordance target for 2018, similar to 2017.

In 2018, three out of seven Cancers Centres did not meet the target of 97%, all by less than 1% below target. This is in comparison with one CC site which missed the target in 2017. In addition, one CC site recorded zero FS Correlation cases in 2018.

One out of 15 GC sites did not meet the target of 97% for 2018, which is an improvement on 2017 where three GC sites missed the target.

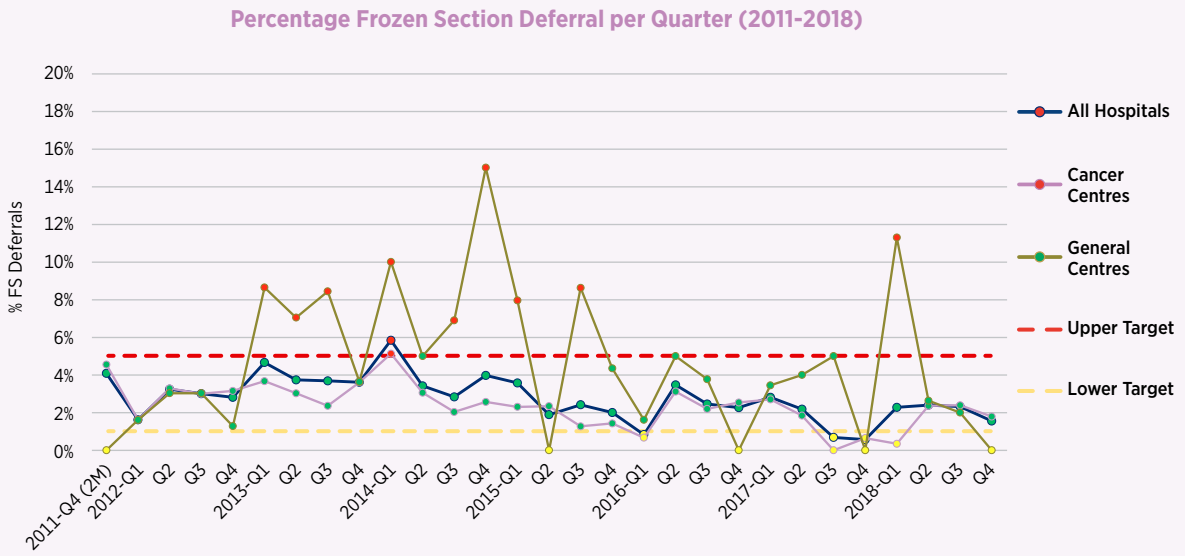
TABLE 9.2: 2017/2018 Total Data Set for FS Concordance

FS Concordance	2017 FS Concordance Data			2018 FS Concordance Data		
	No. of FS Correlation Cases	No. Q007	% Q007	No. of FS Correlation Cases	No. Q007	% Q007
Cancer Centre Sites	**1120**	**1109**	**99.00%**	**933**	**924**	**99.04%**
CC1	56	55	98.21%	**57**	**55**	**96.49%**
CC2	147	145	98.64%	**81**	**78**	**96.30%**
CC3	125	121	96.80%	**121**	**120**	**99.17%**
CC4	77	77	100%	**59**	**59**	**100%**
CC5	589	588	99.83%	**511**	**511**	**100%**
CC6	11	11	100%	**10**	**10**	**100%**
CC7	113	110	97.35%	**94**	**91**	**96.81%**
CC8	2	2	100%	**0**	**0**	**0%**
General Centre Sites	**170**	**166**	**97.60%**	**184**	**181**	**98.37%**
GC1	5	5	100%	**1**	**1**	**100%**
GC2	1	1	100%	**0**	**0**	**-**
GC3	0	0	-	**0**	**0**	**-**
GC4	0	0	-	**1**	**1**	**100%**
GC5	45	45	100%	**34**	**32**	**94.12%**
GC7	7	7	100%	**13**	**13**	**100%**
GC8	12	12	100%	**12**	**12**	**100%**
GC9	20	20	100%	**51**	**50**	**98.04%**
GC10	5	5	100%	**2**	**2**	**100%**
GC11	0	0	-	**0**	**0**	**-**
GC12	21	19	90.48%	**7**	**7**	**100%**
GC13	1	1	100%	**3**	**3**	**100%**
GC15	7	7	100%	**7**	**7**	**100%**
GC16	0	0	-	**0**	**0**	**-**
GC17 (N/A)	(N/A)	(N/A)	(N/A)	**(N/A)**	**(N/A)**	**(N/A)**
GC19	0	0	-	**0**	**0**	**-**
GC20	0	0	-	**0**	**0**	**-**
GC23	1	1	100%	**2**	**2**	**100%**
GC24	27	26	96.30%	**31**	**31**	**100%**
GC25	1	1	100%	**3**	**3**	**100%**
GC27	3	3	100%	**2**	**2**	**100%**
GC28	13	13	100%	**15**	**15**	**100%**
GC29	1	0	0%	**0**	**0**	**-**
GC30	0	0	-	**0**	**0**	**-**
All Sites	**1290**	**1275**	**98.80%**	**1117**	**1105**	**98.93%**

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 2.1% (1.6% for CCs and 4.7% for GCs).

FIGURE 9.3: % Frozen Section Deferral (008) per Quarter (2011-2018)



From a quarterly perspective, since mid-2014, Frozen Section Deferral has been stable between the target range, except for the last two quarters of 2017, where the trend dropped marginally below the lower target range to 0.7% and 0.6% for Q3 and Q4 respectively. Since then it has re-established between the target range for all quarters of 2018.

The greater variation in the number of GC cases referred may be due to low numbers of FS cases in GC hospitals.

TABLE 9.3: 2017/2018 Total Data Set for FS Deferral

FS Deferral	2017 FS Deferral Data			2018 FS Deferral Data		
	No. of FS Correlation Cases	No. Q008 - Deferral	% Q008 - Deferral	No. of FS Correlation Cases	No. Q008 - Deferral	% Q008 - Deferral
Cancer Centre Sites	**1168**	**16**	**1.37%**	**948**	**15**	**1.58%**
CC1	59	0	0%	**59**	**2**	**3.39%**
CC2	159	12	7.55%	**82**	**1**	**1.22%**
CC3	127	1	0.79%	**125**	**4**	**3.20%**
CC4	80	1	1.25%	**59**	**0**	**0%**
CC5	607	2	0.33%	**515**	**4**	**0.78%**
CC6	11	0	0%	**10**	**0**	**0%**
CC7	116	0	0%	**98**	**4**	**4.08%**
CC8	9	0	0%	**0**	**0**	**0%**
General Centre Sites	**190**	**6**	**3.16%**	**193**	**9**	**4.66%**
GC1	5	0	0%	**1**	**0**	**0%**
GC2	1	0	0%	**0**	**0**	**-**
GC3	0	0	-	**0**	**0**	**-**
GC4	0	0	-	**1**	**0**	**0%**
GC5	45	0	0%	**35**	**1**	**2.86%**
GC7	7	0	0%	**13**	**0**	**0%**
GC8	18	1	5.56%	**12**	**0**	**0%**
GC9	21	1	4.76%	**51**	**0**	**0%**
GC10	9	0	0%	**2**	**0**	**0%**
GC11	0	0	-	**0**	**0**	**-**
GC12	24	0	0%	**8**	**1**	**12.5%**
GC13	2	1	50.00%	**3**	**0**	**0%**
GC15	7	0	0%	**7**	**0**	**0%**
GC16	0	0	-	**0**	**0**	**-**
GC17 (N/A)	(N/A)	(N/A)	(N/A)	**(N/A)**	**(N/A)**	**(N/A)**
GC19	0	0	-	**0**	**0**	**-**
GC20	0	0	-	**0**	**0**	**-**
GC23	1	0	0%	**2**	**0**	**0%**
GC24	28	1	3.57%	**32**	**1**	**3.13%**
GC25	1	0	0%	**9**	**6**	**66.67%**
GC27	4	1	25.00%	**2**	**0**	**0%**
GC28	16	1	6.25%	**15**	**0**	**0%**
GC29	1	0	0%	**0**	**0**	**-**
GC30	0	0	-	**0**	**0**	**-**
All Sites	**1358**	**22**	**1.62%**	**1141**	**24**	**2.10%**

Cancer Centres and General Centres were below the recommended target limit of 5% for the year, at 2.1% for Frozen Section Correlation - Deferral Rate

Frozen Section Turnaround Times (Fs Tat)

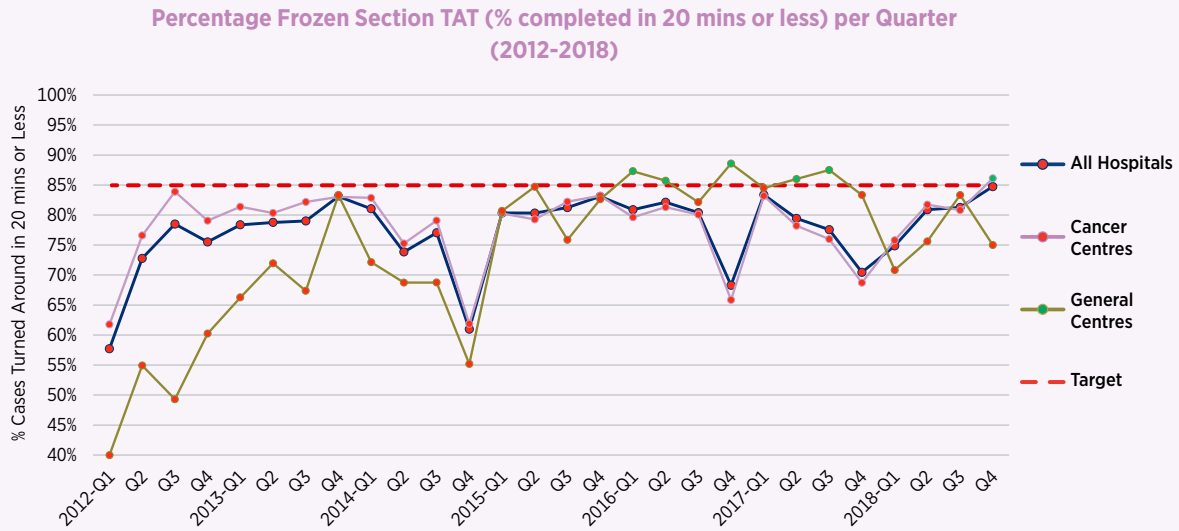
The Turnaround Time (TAT) for a Frozen Section (FS) is an important parameter due to the intraoperative nature of the consultation with real time clinical decisions being made on FS results.

95.2% of FS cases had a FS TAT Code (either Q061, Q062), 3% higher than 2017 data with 91.2% of FS cases with an FS TAT Code.

Broken down by hospital type 95.9% of Cancer Centres and 91.6% of General Centres had a FS TAT code.

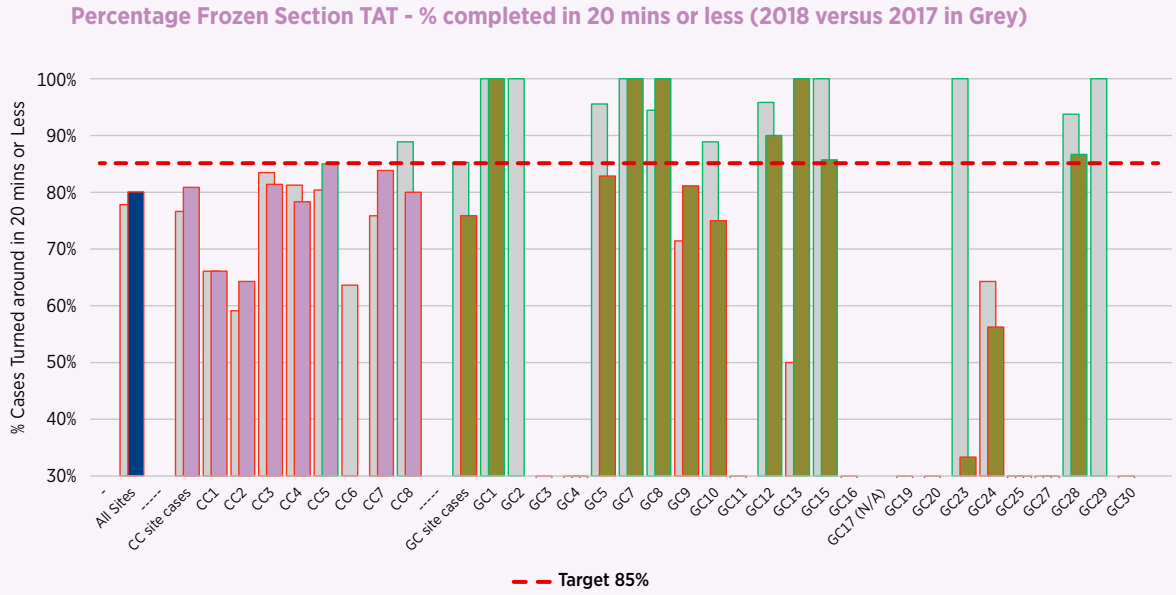
As a whole, neither CCs nor GCs met the recommended 85% less than 20 minutes Frozen Section TAT target for the year – with CCs at 80.9% and GCs at 75.9%.

FIGURE 9.4: % Frozen Section TATs per Quarter (2012-2018)



In 2018, all sites combined had 80.06% Frozen Section TAT less than 20 minutes, this has increased over 2% from 77.84% in 2017.

FIGURE 9.5: % Frozen Section TATs by Site (2018 v 2017 in Grey)



Eight of the 23 sites (43.5%) with Frozen Section cases met the target of 85% for 2018, four less than 2017.

Seven of eight CCs did not reach the target, the same number as 2017. Seven of eight CCs had at least 60% of FS cases turned around in 20 minutes or less.

Seven of the 15 GCs met the target. Five of the eight GCs that did not reach the target in 2018 had less than 10 Frozen Section cases.

TABLE 9.4: 2017/2018 Total Data Set for FS TAT (% cases completed in 20 minutes or less)

FS TAT	2017 FS TAT Data			2018 FS TAT Data		
	No. of FS Cases	No. Q061	% Q061	No. of FS Cases	No. Q061	% Q061
Cancer Centre Sites	**1168**	**895**	**76.63%**	**1066**	**862**	**80.86%**
CC1	59	39	66.10%	**59**	**39**	**66.10%**
CC2	159	94	59.12%	**84**	**54**	**64.29%**
CC3	127	106	83.46%	**129**	**105**	**81.40%**
CC4	80	65	81.25%	**60**	**47**	**78.33%**
CC5	607	488	80.40%	**620**	**527**	**85.00%**
CC6	11	7	63.64%	**10**	**3**	**30.00%**
CC7	116	88	75.86%	**99**	**83**	**83.84%**
CC8	9	8	88.89%	**5**	**4**	**80.00%**
General Centre Sites	**190**	**162**	**85.26%**	**203**	**154**	**75.86%**
GC1	5	5	100%	**1**	**1**	**100%**
GC2	1	1	100%	**0**	**0**	**-**
GC3	0	0	-	**0**	**0**	**-**
GC4	0	0	-	**1**	**0**	**0%**
GC5	45	43	95.56%	**35**	**29**	**82.86%**
GC7	7	7	100%	**13**	**13**	**100%**
GC8	18	17	94.44%	**15**	**15**	**100%**
GC9	21	15	71.43%	**53**	**43**	**81.13%**
GC10	9	8	88.89%	**4**	**3**	**75.00%**
GC11	0	0	-	**0**	**0**	**-**
GC12	24	23	95.83%	**10**	**9**	**90.00%**
GC13	2	1	50.00%	**3**	**3**	**100%**
GC15	7	7	100%	**7**	**6**	**85.71%**
GC16	0	0	-	**0**	**0**	**-**
GC17 (N/A)	(N/A)	(N/A)	(N/A)	**(N/A)**	**(N/A)**	**(N/A)**
GC19	0	0	-	**0**	**0**	**-**
GC20	0	0	-	**0**	**0**	**-**
GC23	1	1	100%	**3**	**1**	**33.33%**
GC24	28	18	64.29%	**32**	**18**	**56.25%**
GC25	1	0	0%	**9**	**0**	**0%**
GC27	4	0	0%	**2**	**0**	**0%**
GC28	16	15	93.75%	**15**	**13**	**86.67%**
GC29	1	1	100%	**0**	**0**	**-**
GC30	0	0	-	**0**	**0**	**-**
All Sites	**1358**	**1057**	**77.84%**	**1269**	**1016**	**80.06%**

CHAPTER 10
REPORT SUMMARY POINTS

10

CHAPTER 10

REPORT SUMMARY POINTS

Workload:

- ✓ Between 2017 and 2018, the volume of cases nationally increased by 13,408 cases (2.9%), 27,496 blocks (2.1%) and 31,675 specimens (4.0%).

- ✓ In the six years from 2013 to 2018 the national volume of cases has increased by 59,047 (14%), blocks have increased by 229,283 (20.4%), and the number of specimens received have increased by 150,910 (22.7%).

Intradepartmental Consultation:

- ✓ In 2018, Histology Intradepartmental Consultation as a whole was consistently above both the minimum (3%) and achievable targets (5%), at 5.34%.

- ✓ Non Gynaecological Cytology FNA (Fine Needle Aspiration) Intradepartmental Consultation as a whole was consistently above both the minimum (7%) and achievable (9%) targets, at 12%.

- ✓ In 2018, Non Gynaecological Cytology Exfoliative Intradepartmental Consultation for all sites was above the minimum target (3%) but below the achievable target (5%), at 3.9%.

- ✓ The minimum target of 1% Intradepartmental Consultation for Autopsy was met in 2018, with a yearly average of 1.99%.

Multidisciplinary Team Review:

- ✓ In 2018 nationally, the target of 95% MDT Agreement was met for all case types (P01, P02, P03, P04 and cytology).

Addendum Reports:

- ✓ The recommendation of achieving less than 1% for Histology Combined Amended/Corrected Reports was met in all 32 sites in 2018, stabilising at around 0.27%.

- ✓ For Cytology Only Amended/Corrected Report all 32 sites were below the maximum 1% recommendation, at 0.22%.

Turnaround Time:

- ✓ In 2018 nationally, 80% Completed Day five target was met for: Non Gynaecological Cytology FNA (P06) cases and Non Gynaecological Cytology Exfoliative (P07) cases.

- ✓ However, in 2018 nationally, the 80% Completed Day five target was not met for Small Biopsy (P01) cases and GI Endoscopic Biopsy (P02)

- ✓ Additionally, nationally the 80% Completed Day seven target was not met for Non Biopsy Cancer Resection (P03) cases and Non Biopsy Other (P04) cases[1]

[1] This is unchanged since 2017 and most likely reflects the ongoing challenges around resource deficits in histopathology laboratories, including recruitment and retention of Consultant Histopathologists and laboratory scientists.

Frozen Section:

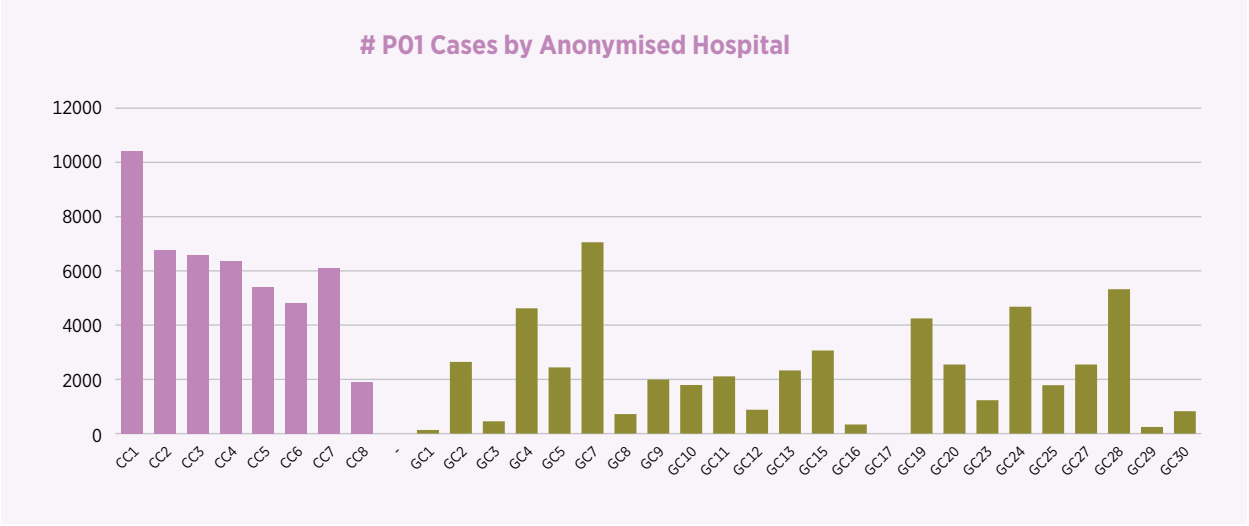
- ✓ From a Frozen Section Correlation Concordance perspective broken down by hospital type, both Cancer Centres and General Centres, as an aggregate, met the target in 2018. Over the past four years Frozen Section Correlation Concordance has increased and is currently sustained above the 97% Target.

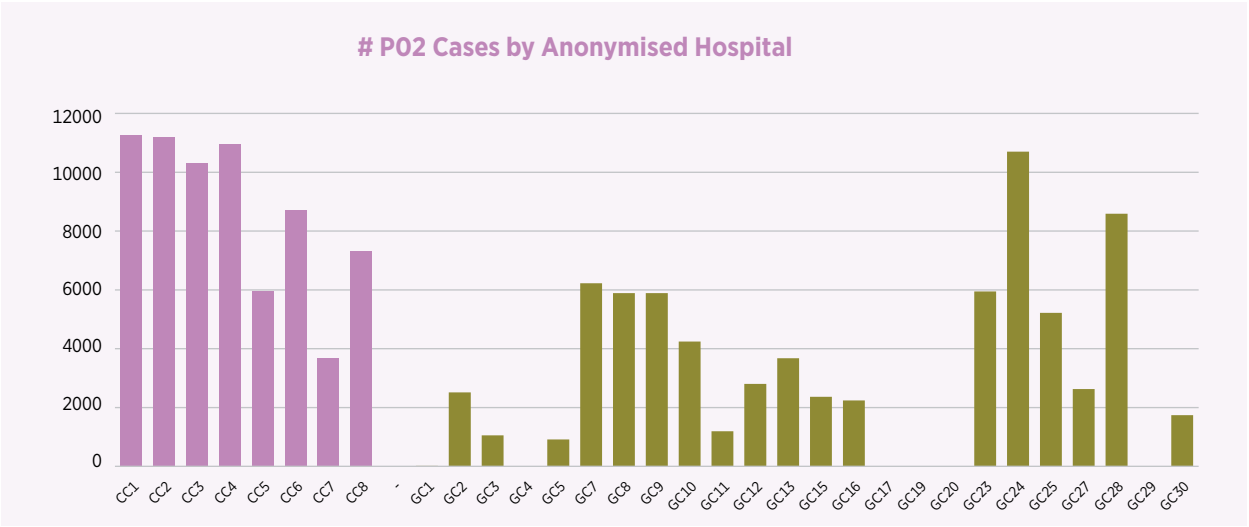
- ✓ Cancer Centres and General Centres were between the recommended target range of 1% to 5% for the year, at 2.1%, for Frozen Section Correlation - Deferral Rate.

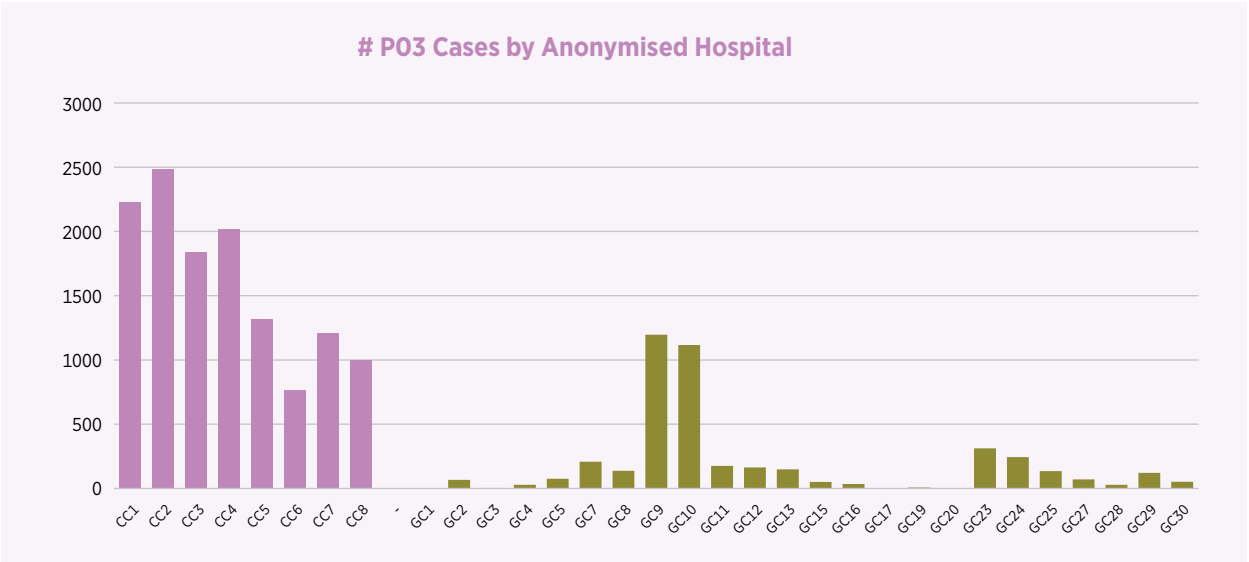
- ✓ As a whole, neither CCs nor GCs met the recommended 85% less than 20 minutes Frozen Section TAT target for the year – with CCs at 80.9% and GCs at 75.9%.

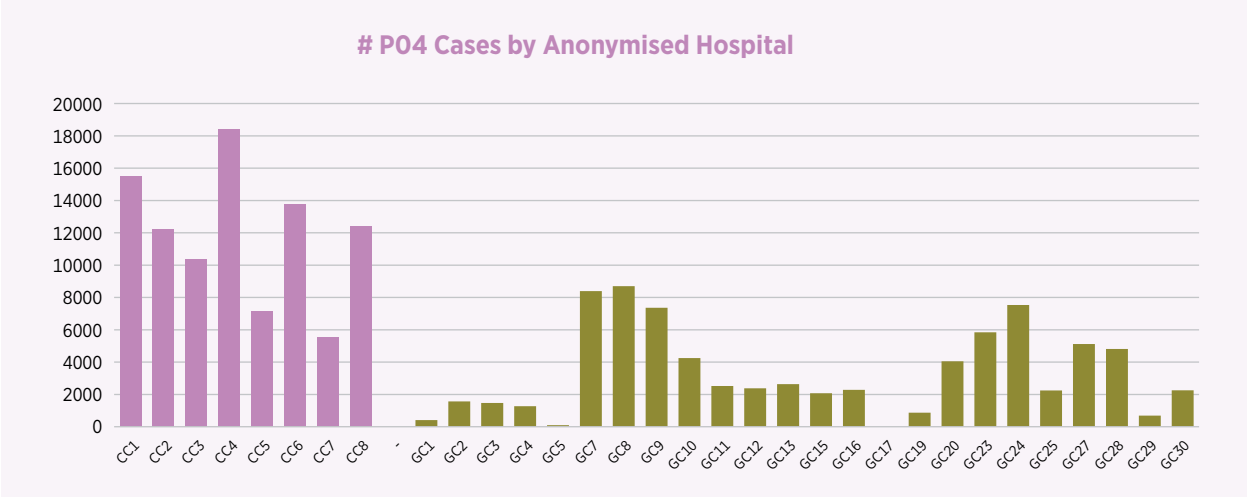
APPENDICES

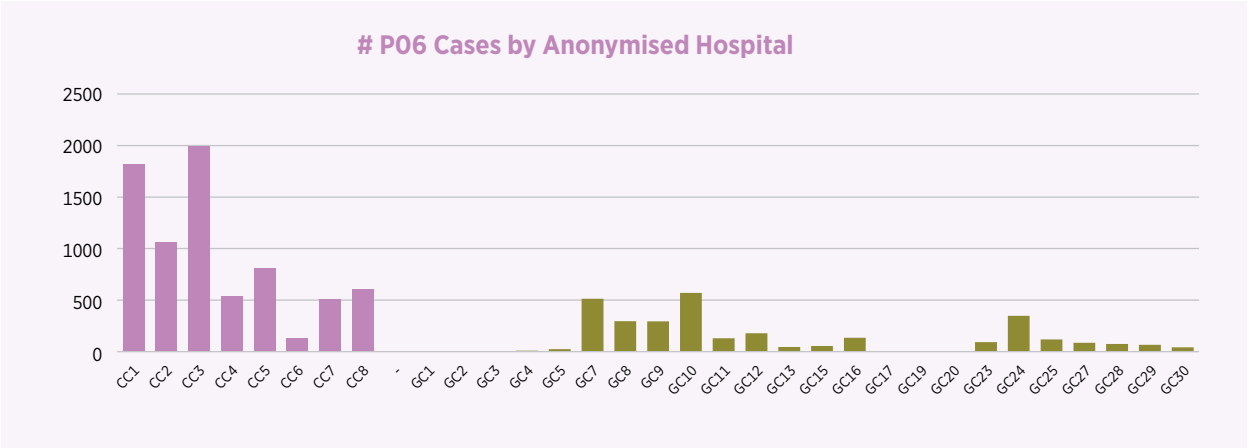
APPENDIX 1:
CASES BY ANONYMISED HOSPITAL

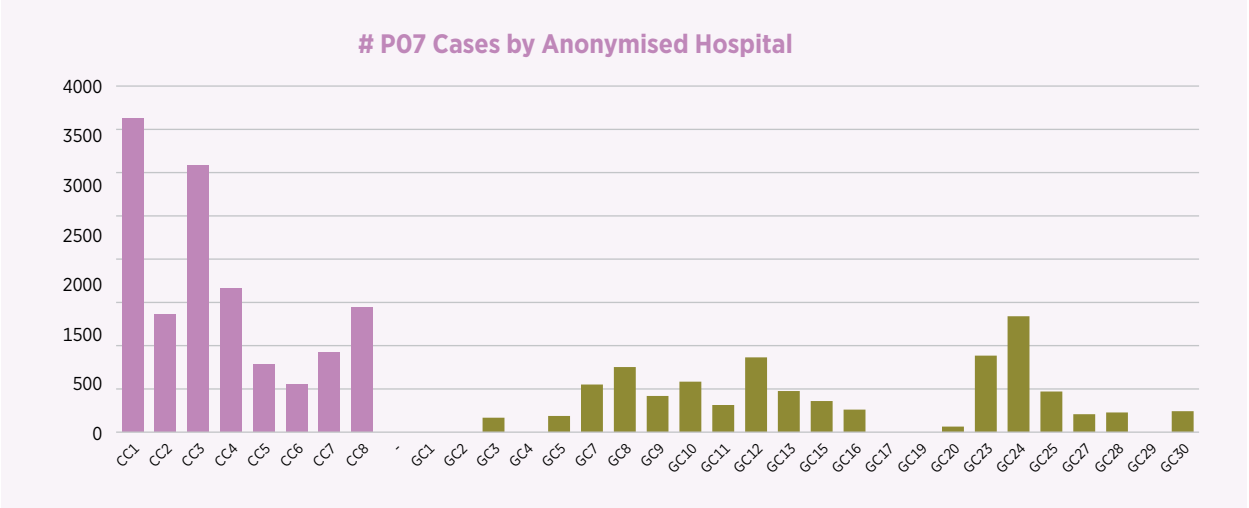







P04 Cases by Anonymised Hospital
20000
18000
16000
14000
12000
10000
8000
6000
4000
2000
0
CC1 CC2 CC3 CC4 CC5 CC6 CC7 CC8 - GC1 GC2 GC3 GC4 GC5 GC7 GC8 GC9 GC10 GC11 GC12 GC13 GC15 GC16 GC17 GC19 GC20 GC23 GC24 GC25 GC27 GC28 GC29 GC30


P06 Cases by Anonymised Hospital
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


P07 Cases by Anonymised Hospital
4000
3500
3000
2500
2000
1500
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 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.
Cytopathology	The examination of cells to determine the cause or the nature of disease.
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)	A sample of tissue taken from the gastrointestinal tract during an endoscopic procedure for diagnosis.
Histopathology	The examination of tissue to determine the cause or the nature of disease.
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 Operational 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 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 examines cells to determine the cause or the nature of disease.
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 sample of tissue taken from anywhere other than the gastrointestinal tract during a procedure for diagnosis.
Specimen	A piece of tissue received into the pathology laboratory for analysis and diagnosis. A 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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National Quality Improvement Team

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