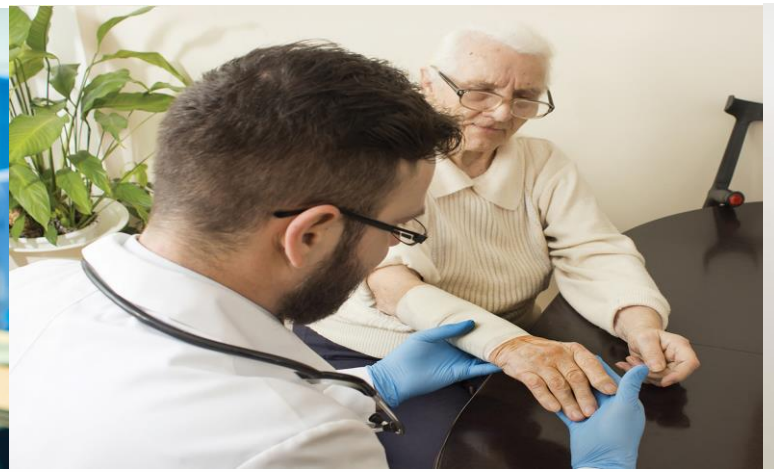
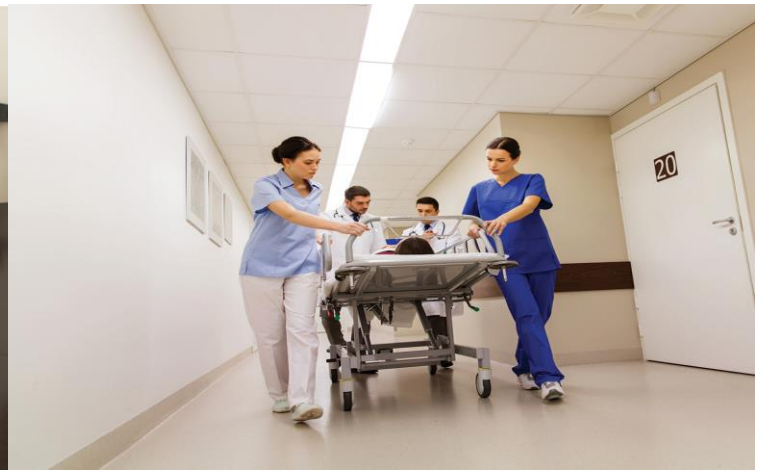
GETTING IT RIGHT FIRST TIME

# NHSE GIRFT Pathology

**Martin Myers**


GIRFT is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust and NHS Improvement

# Getting It Right First Time

- Started in orthopaedics, 2013
- Objective review of available evidence
- Seek out **unwarranted variation**
- Use evidence to improve quality
- Now > 40 specialties in England
- Led by senior clinicians
- Key Driver: Quality
- Savings - from improved quality
- NHS England

Professor Tim Briggs CBE
NHS England National Director for Clinical Improvement and Elective Recovery

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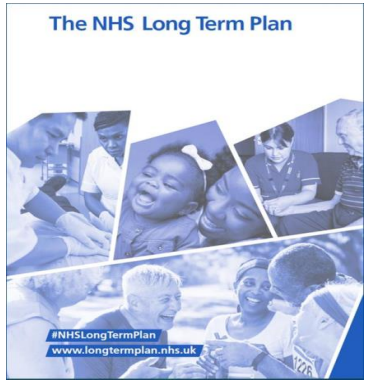
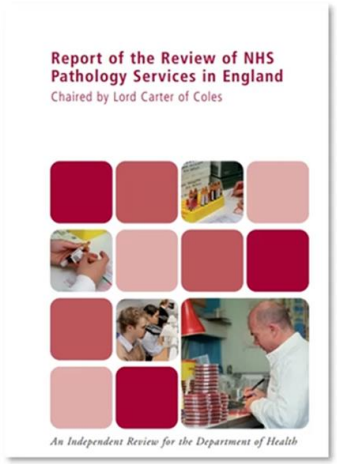
# Moving Forward:

## A balance of emphasis




**Fragmented**

**Integrated**





**Regulated**

**Improved**

- 7 Regions
- 44 ICSs

- **Right Test**
- **Right Place**
- **Right Time**

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"Our approach is to deliver clinically-led improvement and put the patient in the heart of the system. We deliver this through an approach called Getting It Right First Time (GIRFT)."

# The need for Total Pathology Quality Management

## The Patient's perspective


## The Laboratory's perspective


- What test?
  - appropriate requesting
  - intelligent requesting
- E-requesting
- NHS number
- What place?
- Phlebotomy quality
- Right tube, correct labelling
- Transport to the lab
- Sample integrity
- Use of POCT

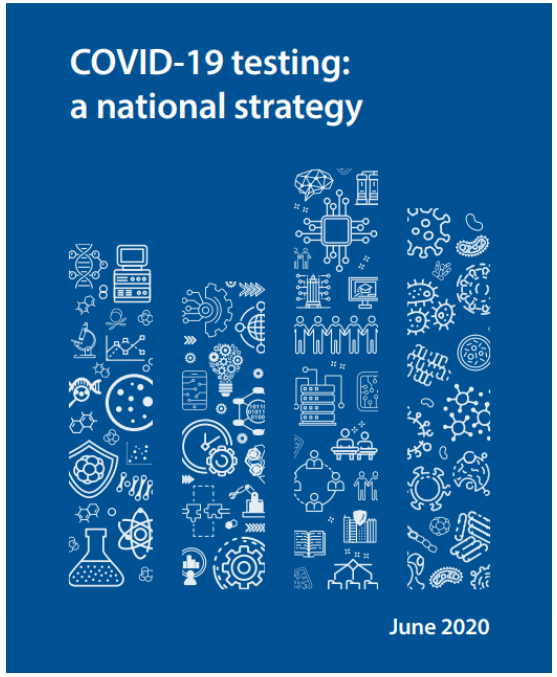
- Process quality
- Analytical quality
- Manpower quality
- IT quality
- What tests are included

- Turnaround time
- Urgent results
- Reference intervals
- Interpretation
- IT
- Harmonisation of language
- Where does the result go?

- **We found that the Laboratory, and Accreditors, had a "central focus" on Quality**
- **Who looks after the Total Pathology stuff?**

# Why do we need a Total Pathology Quality Management?

- *"Testing is not something that is just done and counted. It is a process with clinical purposes for individual patients, for those who care for them and for the population at large.*
- Professor Jo Martin President RCPath





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# GIRFT Methodology

1. Collect relevant data
   - National, e.g.: HES, professional bodies, national audits
   - **Questionnaire**: issued to all Trusts – ***crucial for Pathology***

2. Report (data pack) issued to each trust, prior to Visit (deep dive) with Path clinical staff, senior Trust managers
   - highlight best practice, unwarranted variation, challenges

3. Agree local action & implementation plan
   - support provided by regional GIRFT teams

4. National Report
   - highlight best practices, concerns, challenges
   - 21 key recommendations

5. Legacy-making it happen
   - discussion with stakeholders and setting up Task Forces

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# Deep Dives


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Pathology Review

Provider Level Report (Core)

NHSI Laboratory network :

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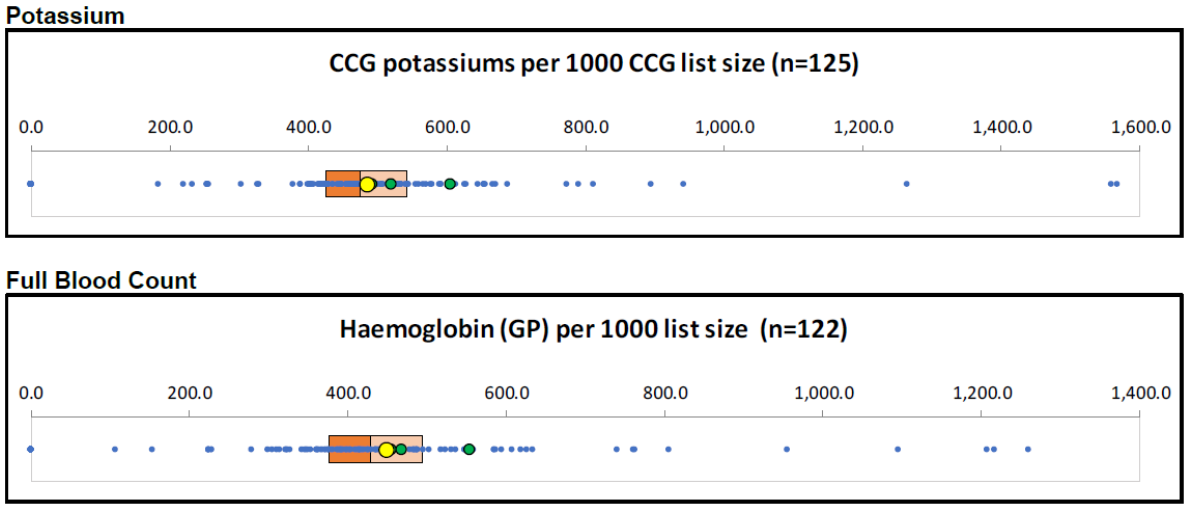
- Each Laboratory received a data-pack comparing their activity with all other English laboratories
- Every Lab in England had a Deep Dive (ish)
- At each Deep Dive we discuss the variation
- Made *local* recommendations on how to reduce unwarranted variation

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# Unwarranted Variation

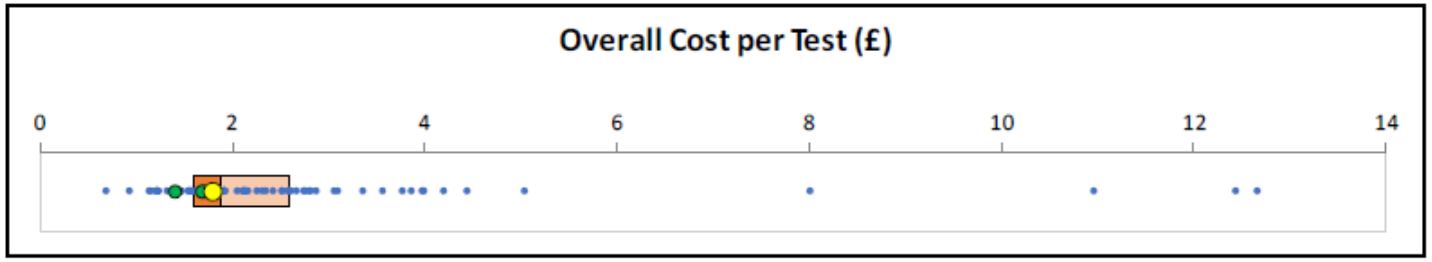
We looked at variation in the Pathology process

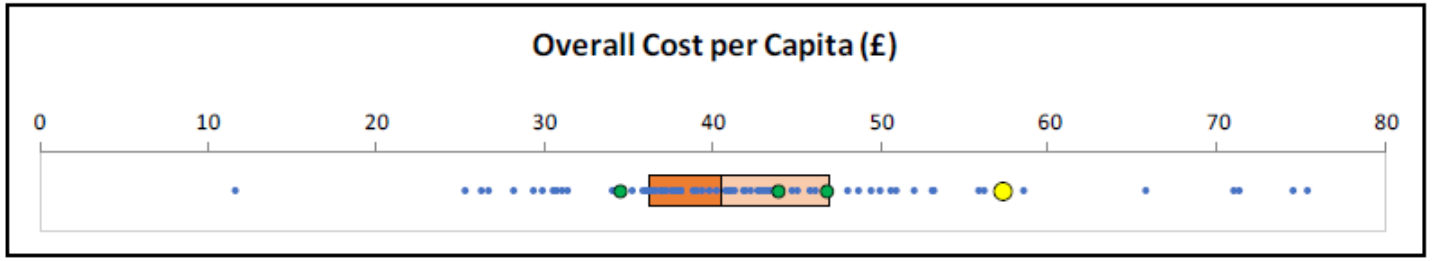
- Pre-analytical
- Analytical
- Post-analytical
- Point of Care
- Model Hospital

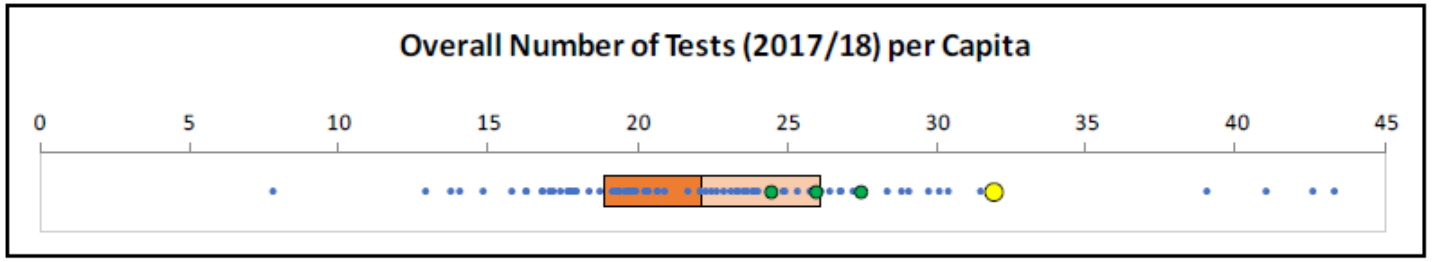
# Model Hospital

## 2. Model Hospital Indicators

NHSI/E Model Hospital - Pathology Compartment (April 2018 to March 2019)




## Productivity versus inappropriate testing

- Post Carter, it was mostly about making the test cheaper (to save money)
- Post GIRFT it is about doing the right thing for the patient (and save money)

- We need a balance of them both

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# National Specialty Report

## Main themes:

- Quality
- Data and Digital Delivery
- Service Delivery

## Our 5 principals

- Focus on the patient
- Prioritise Quality
- Support best clinical practice
- Build Clinically Led integrated service
- Improve data interoperability


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# Unwarranted Variation

- We found significant unwarranted variation in all elements of the service
- Unwarranted variation in service delivery leads to a poorer service and confusion amongst users
- Removing unwarranted variation will:
  - lead to savings
  - improve patient care
  - contribute to green and sustainable laboratories
- In order to reduce the unwarranted variation, we have made 21 key recommendations
- The recommendations embed quality into the Pathology Service and to ensure that pathology is an integrated service and not an isolated service

# Implementing our Recommendations:

| Recommendations: | 21 |
|---|---|
| Clinical Quality: | 6 |
| Data Quality: | 6 |
| Process Quality: | 7 |
| Workforce Quality: | 1 |
| Financial Quality: | 1 |

- Identify the “owners”
  - Individuals
  - Networks
  - National Pathology Board
  - Learned Societies
- Suggest timescale
- Work collaboratively to co-produce system change
- Report progress to NHS England
- This has already started
- Not enough time today for too much detail, but will highlight a few issues

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# Create flexible Pathology networks that reflect local needs

## Pathology as an integrated national clinical service

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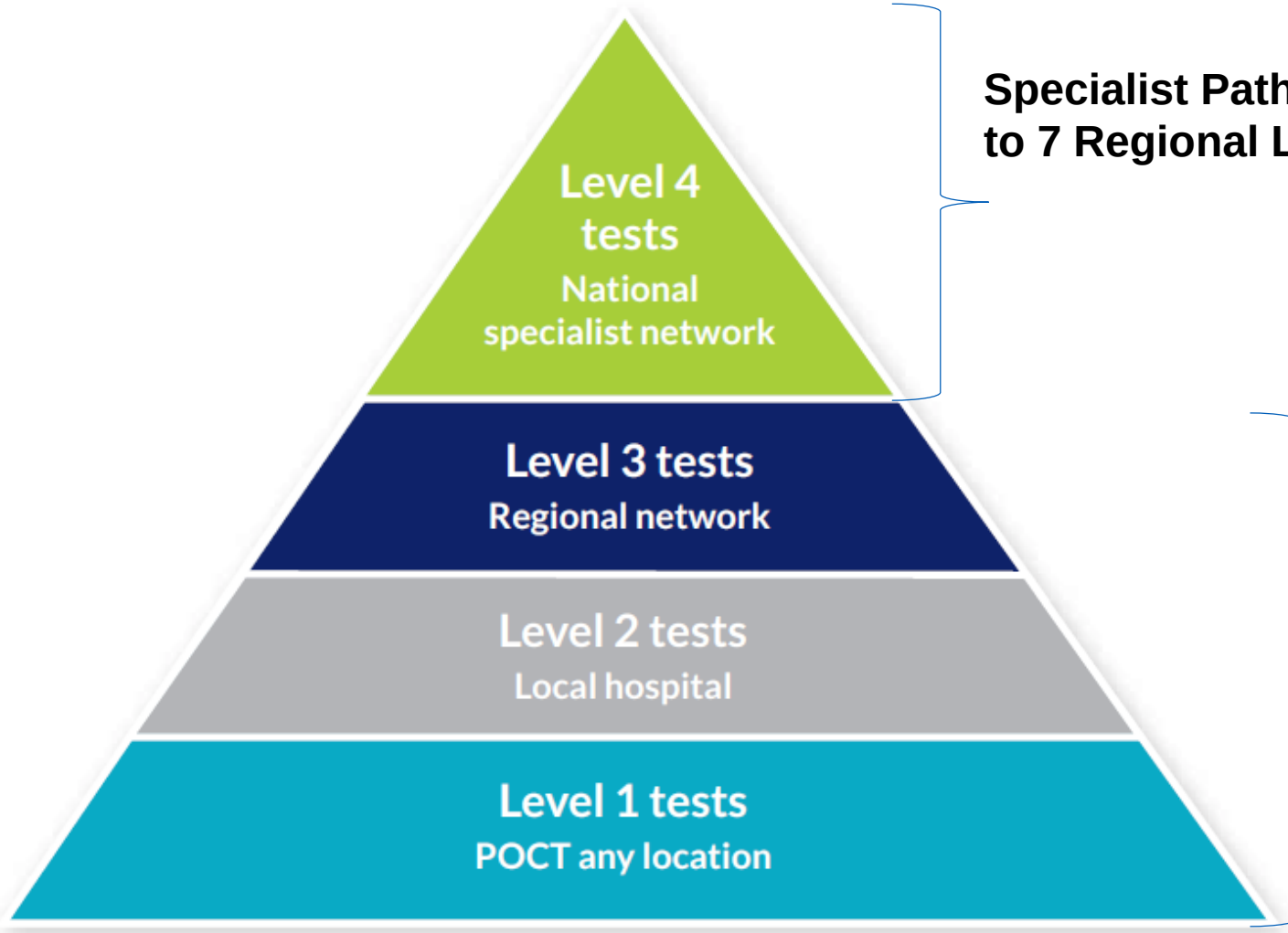


**Specialist Pathology at up to 7 Regional Locations**

**Pathology Systems in the 44 ICBs**

# Embed Clean Framework in Quality Governance


UKAS

- **Clean Framework:**
  - Clean in: pre-analytical — ISO 15189:2012 **- 5.4**
  - Clean through: analytical — ISO 15189:2012 - **many**
  - Clean out: post-analytical — ISO 15189:2012 **- 5.7**

- GIRFT has data on the variation of pre- and post-analytical processes and on the analytical process
- GIRFT support a risk-based, patient-focussed, accreditation process
- ISO 15189 allows us to look at a risk-based quality framework
- GIRFT has asked for an accreditation process that uses the ISO standards for all phases of the pathology process

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# Clean in

**Are the tests appropriate?**

- There is a valid clinical question.
- The tests are necessary, appropriate and sufficient to address that clinical question.

**Are the samples collected, labelled and stabilised correctly?**

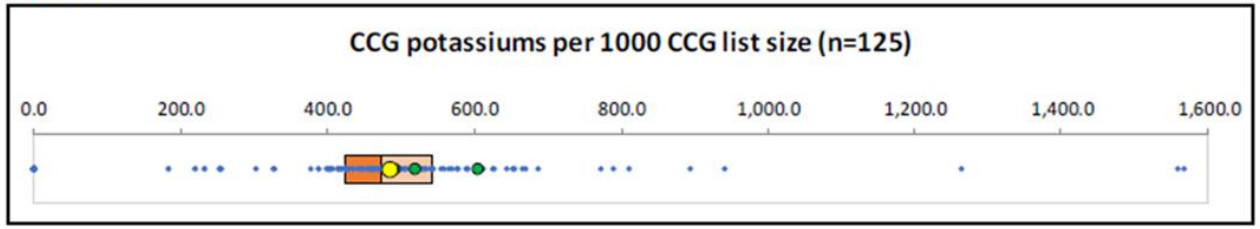
- The samples are collected correctly.
- The samples are labelled appropriately.
- The samples are stabilised at the right time.

**Are the samples delivered to the lab on time?**

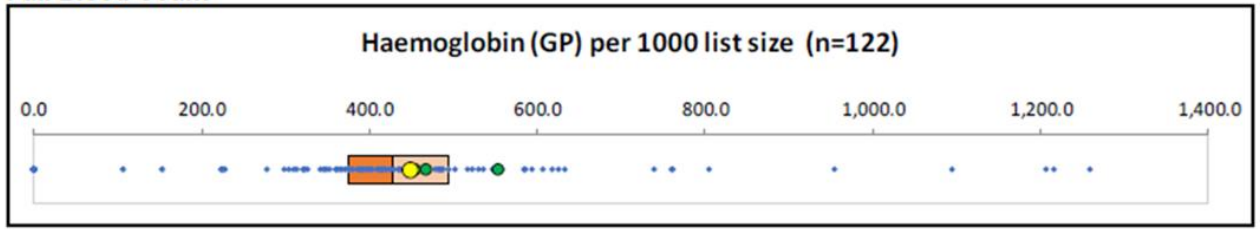
- The samples are delivered to the point of testing on time.

# Demand Optimisation: are tests appropriate?

Potassium

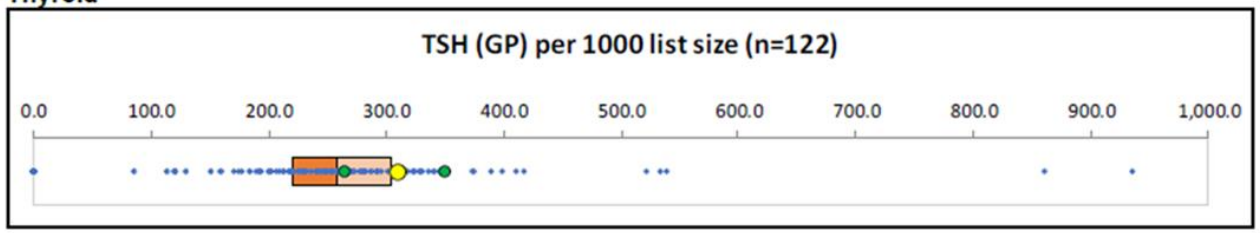



Full Blood Count




Liver


Thyroid




- For every test we found 3-5 fold variation in requesting rates
- Variable use of demand optimisation
- Why are we doing this test?
- Excessive testing:
  - Costs money
  - May be harmful
  - Increases waste and carbon footprint
  - Up to 20% of Pathology testing may be unnecessary

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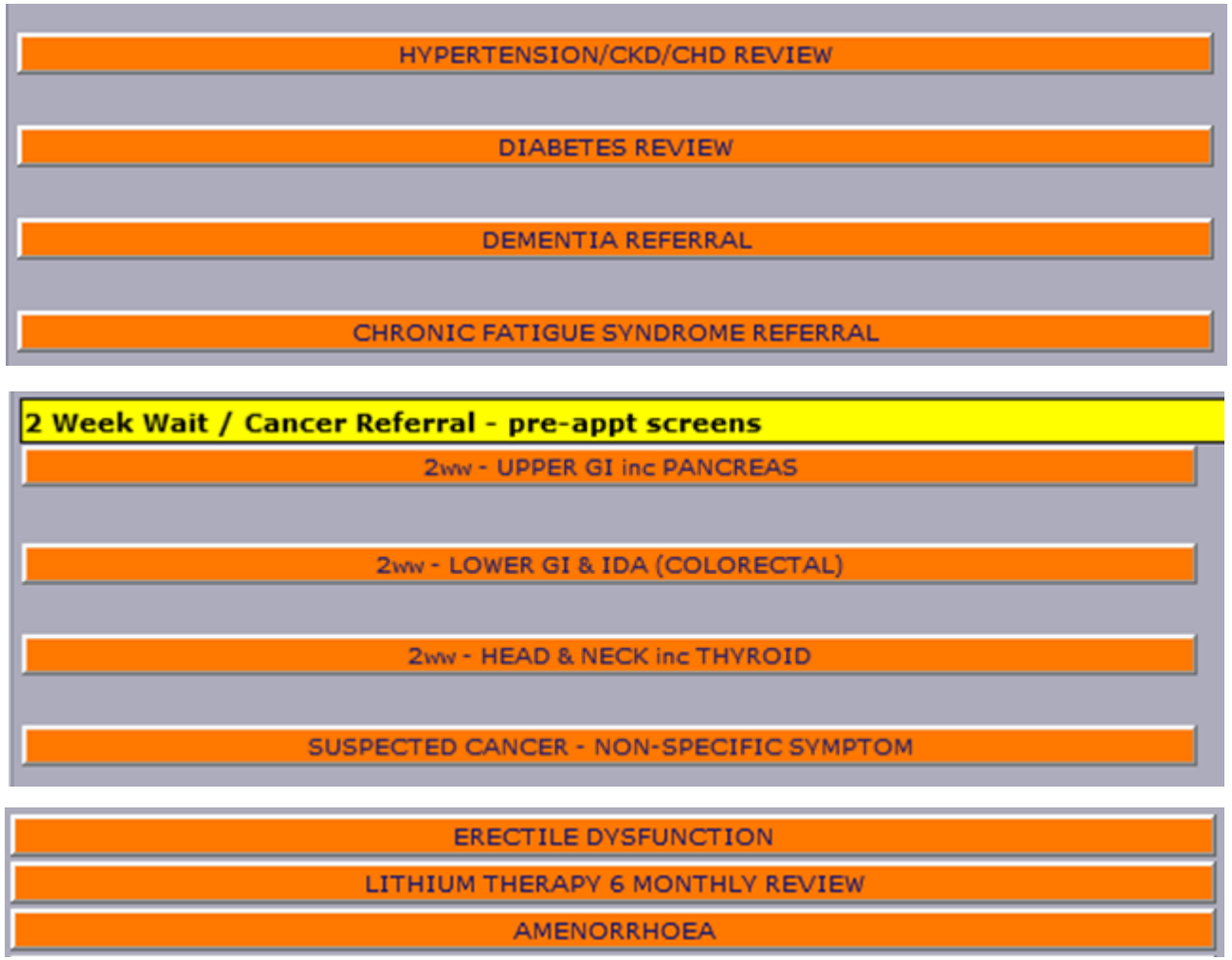
# Demand Optimisation: Patient-focussed requesting




- Recommend the introduction of **Care Set** requesting and move away from "test" requesting
- We are working with the RCPath to set up **National Care Sets** which could be integrated into electronic requesting
- Co-produced with Pathology and GPs

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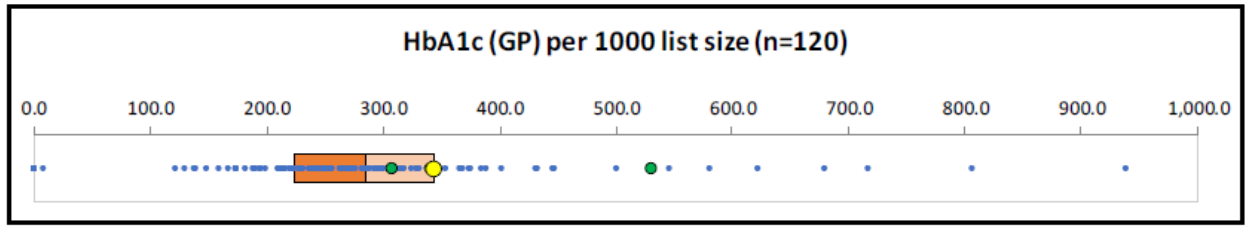
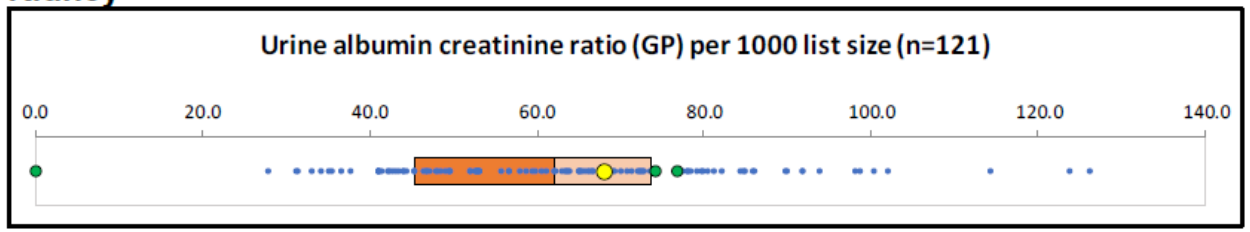
# Demand Optimisation: are tests appropriate?

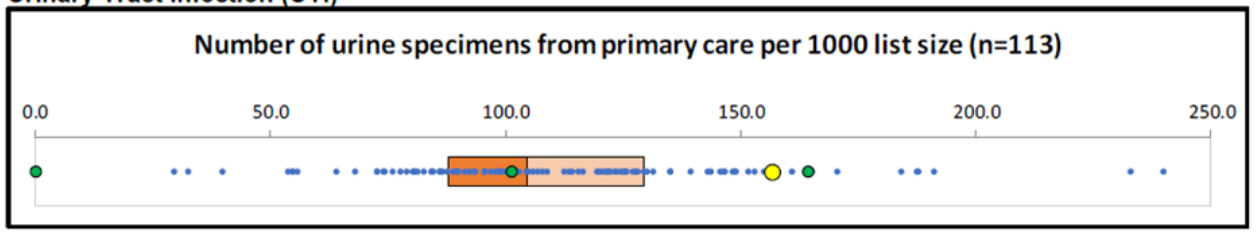
**Diabetes**




**Kidney**




**Urinary Tract Infection (UTI)**




- Are we doing enough HbA1cs and ACRs (probably not)?
- Are we doing too many urine testing for UTI (probably)?

**Recommend that national guidelines to be taken up locally**

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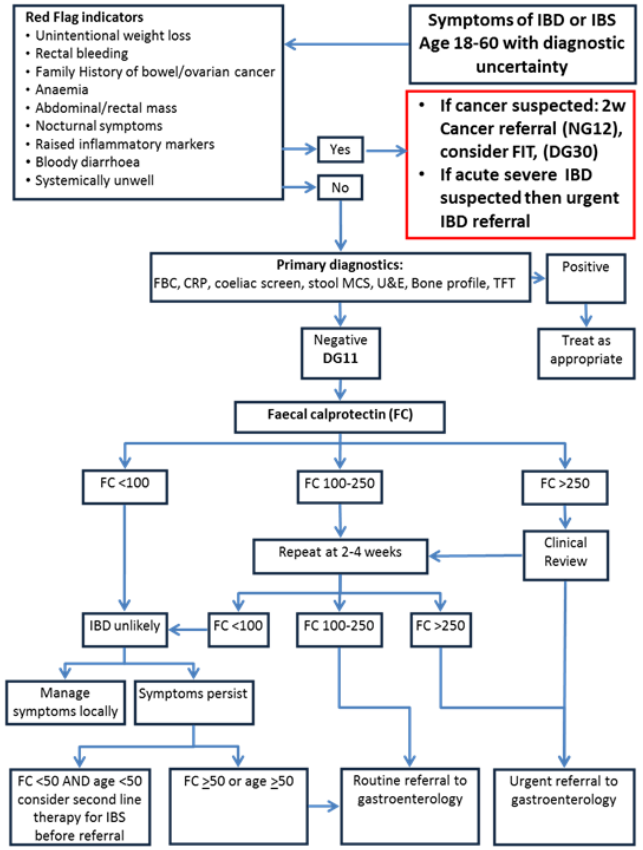
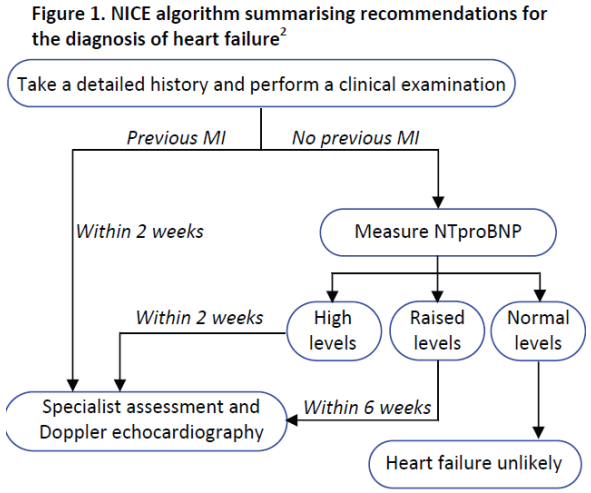
# Demand Optimisation: Diagnostic Pathways




- FIT Testing to reduce colonoscopy
- Calprotectin to reduce colonoscopy
- NTProBNP to reduce echo (and diagnose earlier)
  - 80% of patients with HF diagnosed in ED
  - ?access to testing issue
- NAFLD pathway to diagnose earlier and reduce fibroscan
- Tumour Marker Pathways
- Vitamin B12 insufficiency

- Introduce **more diagnostic pathways** and ensure adoption
- We are working with the **Diagnostic Demand Advisory Group** to create National Diagnostics Pathways
- These have potential to reduce secondary care referrals for further diagnostics

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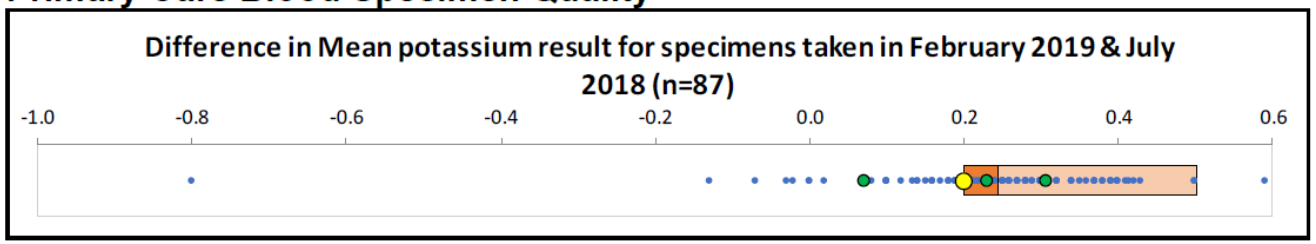
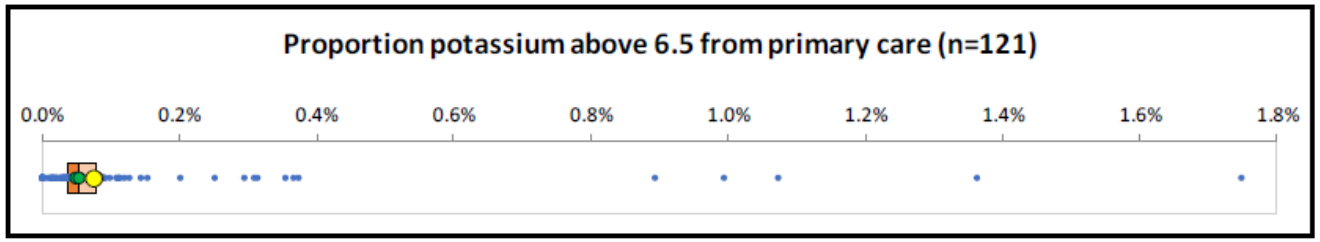
# Are the samples collected, labelled and stabilised correctly?

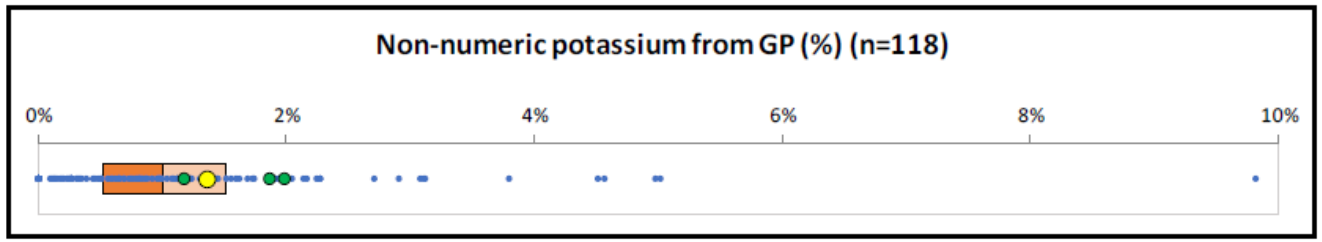
**Primary Care Blood Specimen Quality**



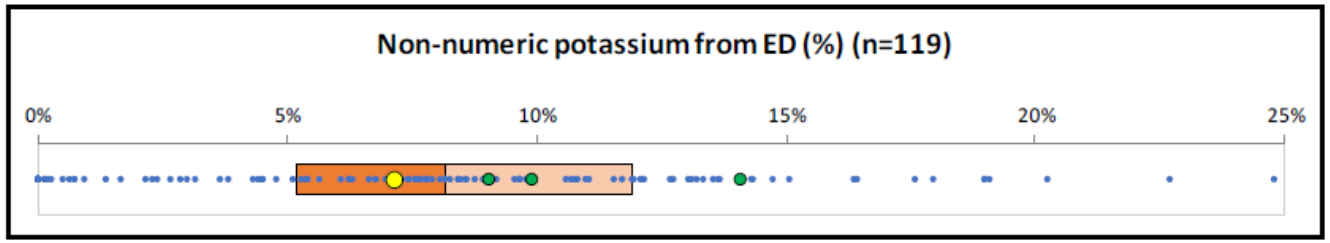

- Some labs have a mean potassium difference of 0.4 mmol/L between February and July




- The percentage of GP samples with a potassium >6.5 mmol/L varied between 0.01% and >1%




- The percentage of GP samples rejected varied from 0.01% to over 4%




- The percentage of ED samples rejected varied from 0.01% to over 20%

# Are the samples collected, labelled and stabilised correctly?

## Significant variation in the quality of the pre-analytical phase

- Delays in transport
- No control of temperature of transport
- No real debate about sample stabilisation during transport
- Errors in phlebotomy

## GIRFT have recommended that

- The pre-analytical process must be better designed, monitored and controlled
- KPIs are developed for the time from needle to centrifuge KPI
- KPIs are developed for transport temperature
- Systems are introduced to measure and audit against the KPIs, and to mitigate if KPIs are failed
- The pre-analytical process should be accredited under ISO15189:X
- Discussions between GIRFT, ACB and EFLM on pre-analytical phase

# Clean through

In this section, we have focused on:

- understanding variation and minimising error;
- processing results in a clinically relevant timeframe;
- improving lab oversight of POCT.

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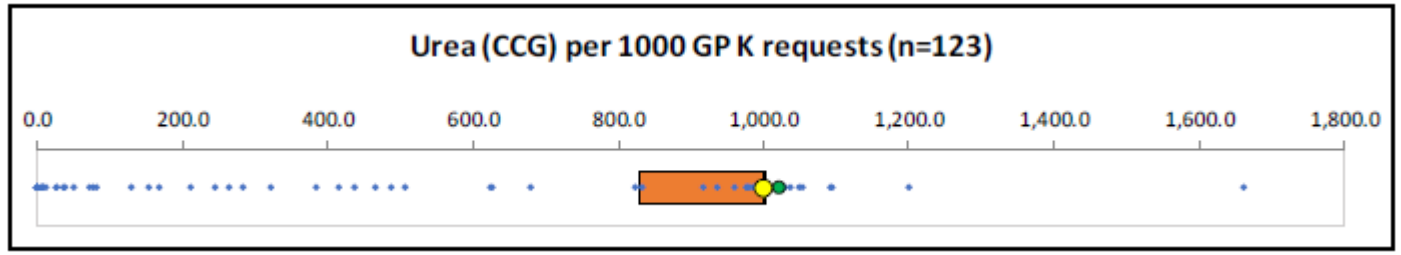
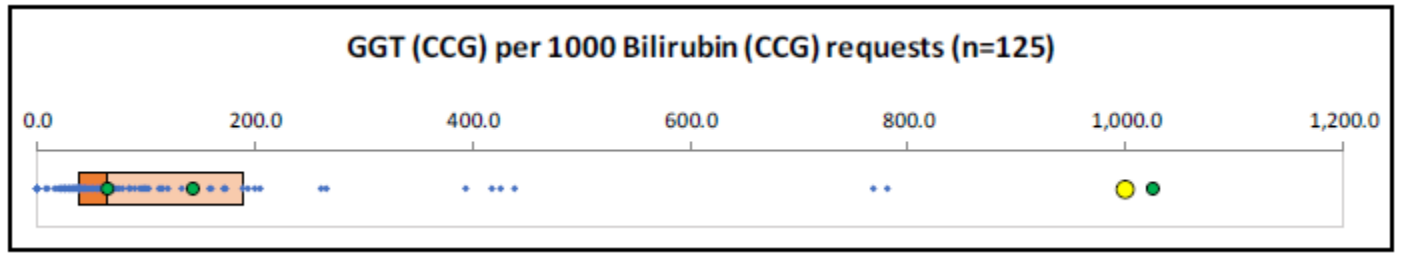
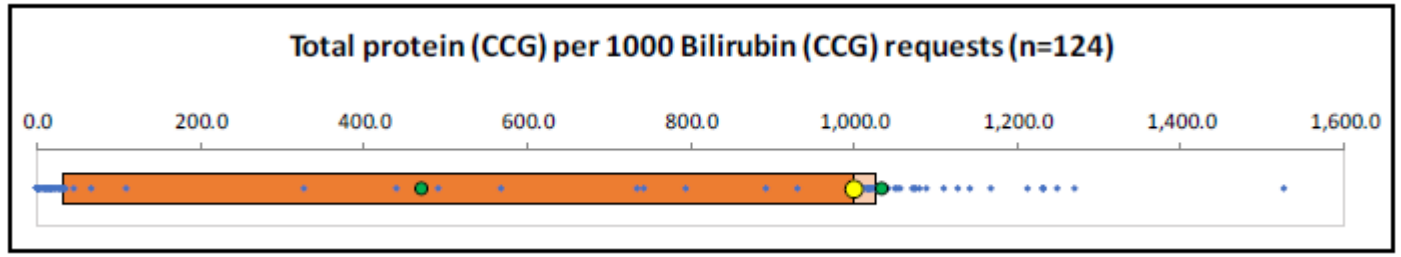
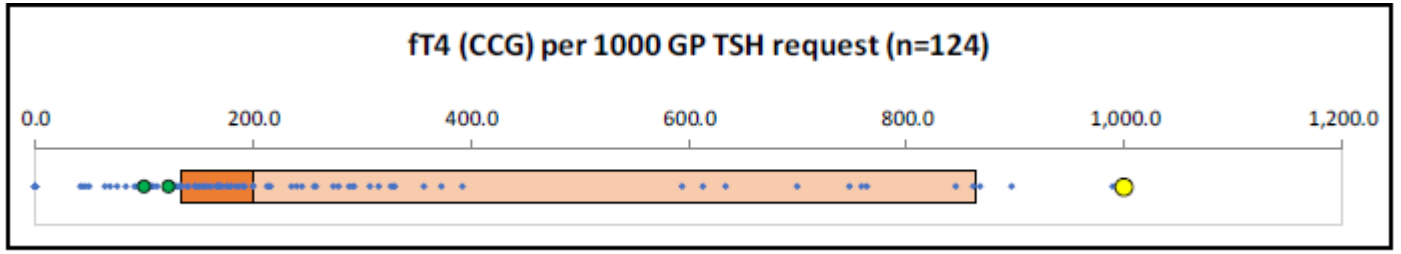
# What's in a profile?

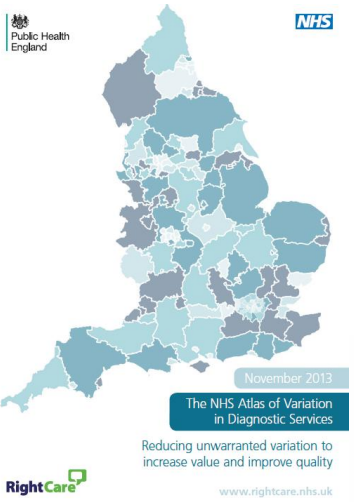



- Variation about what is in a profile
- Many labs do not have a Urea in Primary Care U&E!
- Intelligent requesting and Smart IT to guide appropriate testing e.g. TFT
- Why do we do what we do?
- Too much variation in name, test code, UoM. This needs to be harmonised to create a harmonised Data Lake

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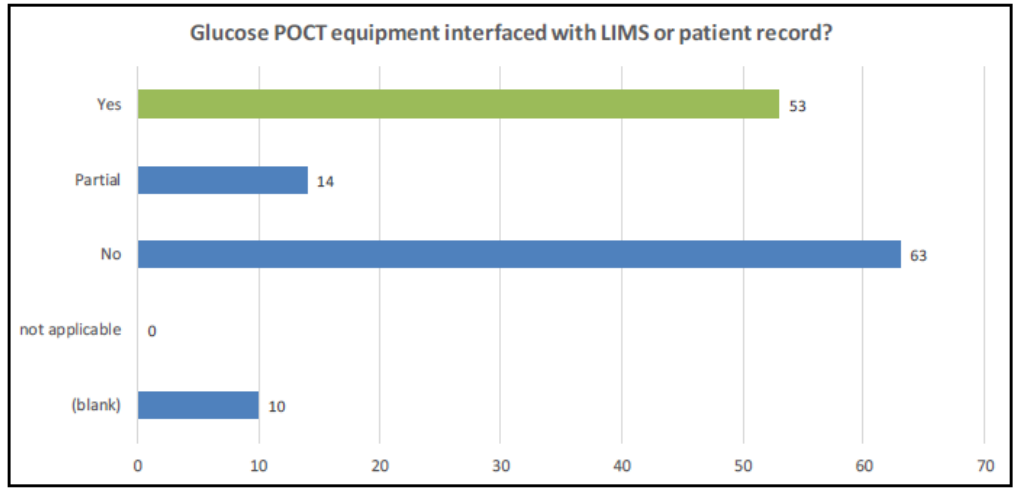
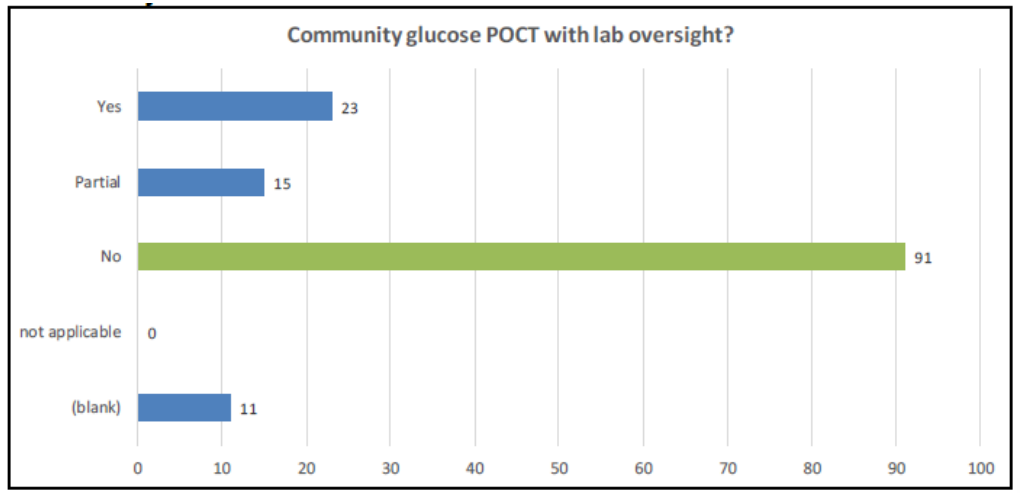
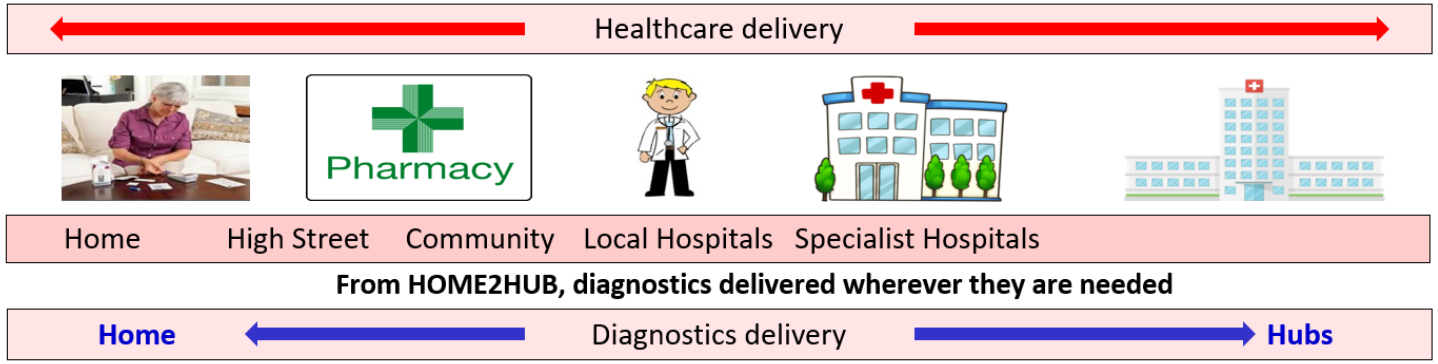
# Increased use and better governance of Tier 1 POCT




## POCT needs to:

- operate under a Governance Framework
- include competence, training, analytical quality, result capture etc
- Involve laboratory for MHRA and ISO accreditation
- embed diagnostics in the patient journey
- patient-focussed diagnostics, not building-focussed diagnostics

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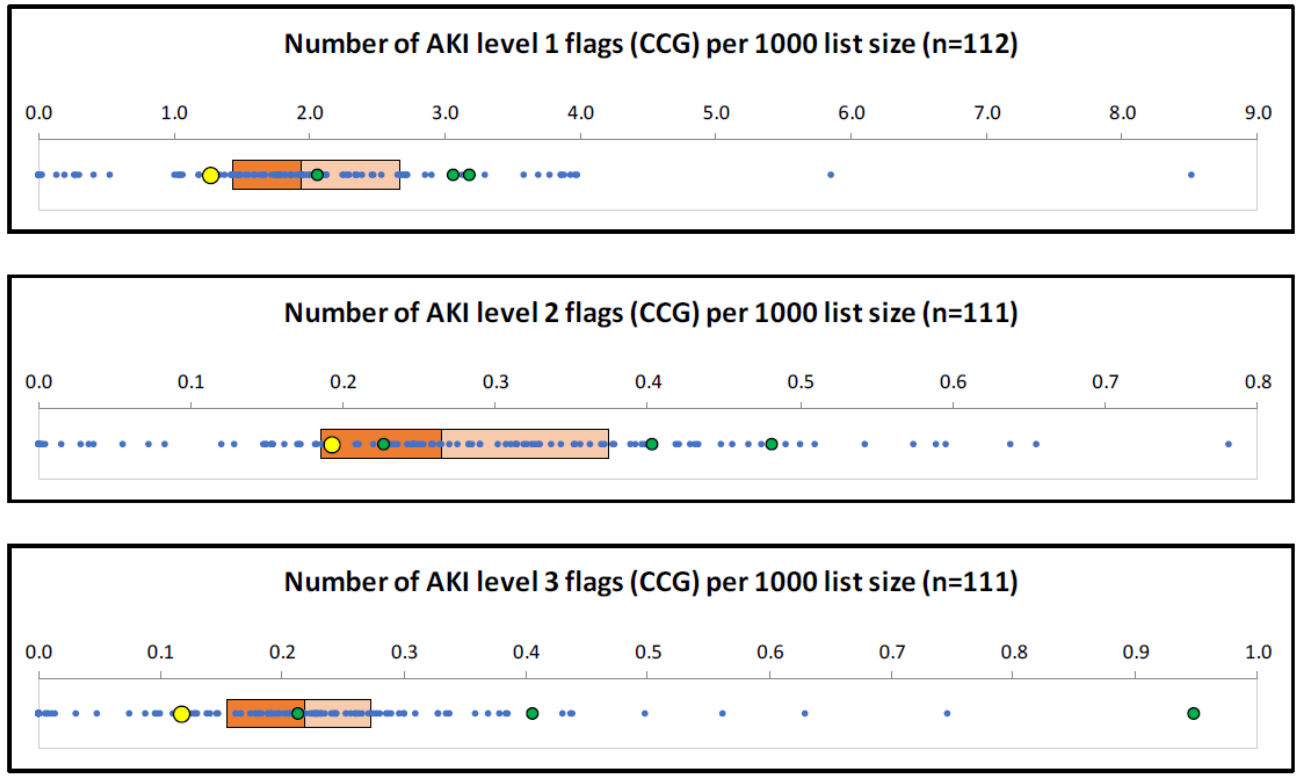
# Urgently investigate AKI




## Significant variation in AKI reporting

- 4-5 fold variation in AKI reporting
- We discussed this during our Deep Dives:
  - Methodology
  - LIMS
  - Equation
  - No post-market surveillance in place
- This was also noted by NHSE GIRFT Renal and the UKKA
- Something not quite right!

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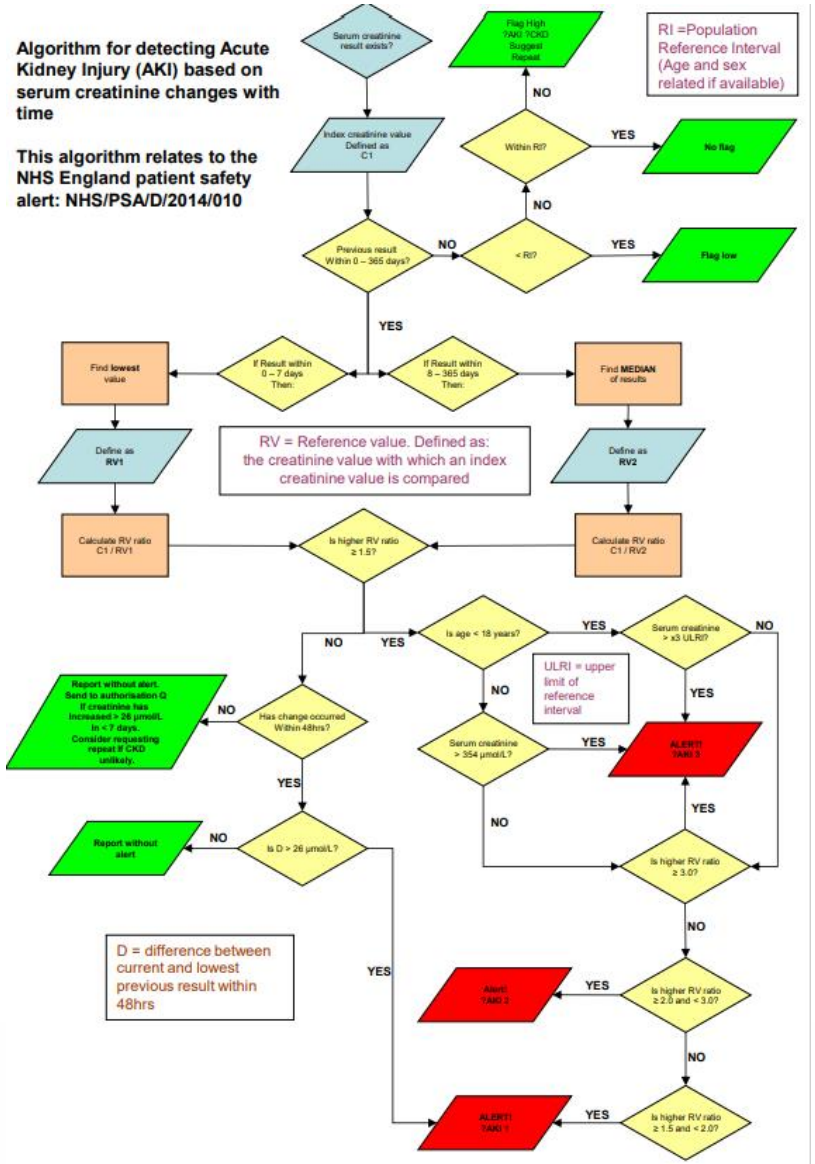
# Urgently investigate AKI

- *AKI Task Force:*
  - NHSE GIRFT Pathology
  - NHSE GIRFT Renal
  - ACB
  - UKNEQAS
  - UKKA
  - NHSE

# 1. LIMS algorithm

- ***NHS/PSA/D/2014/010 Algorithm for detecting Acute Kidney Injury (AKI) based on serum creatinine with time***
- 30% of AKI algorithms wrong in LIMS
- NHSE GIRFT (MAM and Will McKane) had discussions
- Resulted in a LIMS update
- But there are options
- Strongly advise that the NHS England algorithm is used

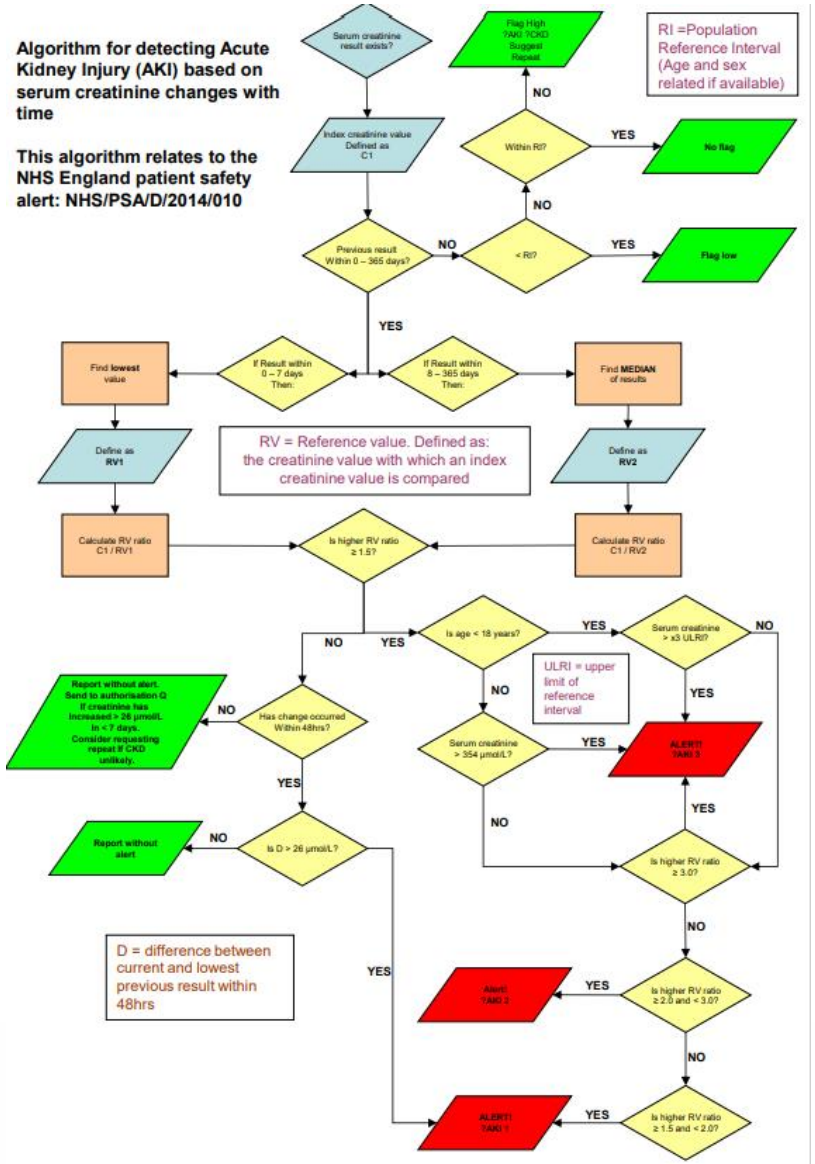


# 2. Aligned NICE and NHS Algorithm

- NICE focussed on only one arm (7 days) and did not include the right hand arm
- NHSE GIRFT (MAM and Will McKane) had discussions
- Resulted in a NICE update

1.3.1 Detect acute kidney injury, in line with the (p)RIFLE (paediatric Risk, Injury, Failure, Loss, End stage renal disease), AKIN (Acute Kidney Injury Network) or KDIGO (Kidney Disease: Improving Global Outcomes) definitions, by using any of the following criteria:

- a rise in serum creatinine of 26 micromol/litre or greater within 48 hours
- a 50% or greater rise in ~~serum creatinine known or presumed~~ to have occurred within the past 7 days (see also an algorithm for early identification of acute kidney injury, endorsed by NHS England)
- a fall in urine output to less than 0.5 ml/kg/hour for more than 6 hours in adults and more than 8 hours in children and young people
- a 25% or greater fall in eGFR in children and young people within the past 7 days. **[2013]**

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# 3. Post market surveillance on AKI service

- There were no mechanisms in place to monitor the quality and variation of the AKI alert
- NHSE GIRFT asked UKNEQAS to introduce an EQA scheme for AKI

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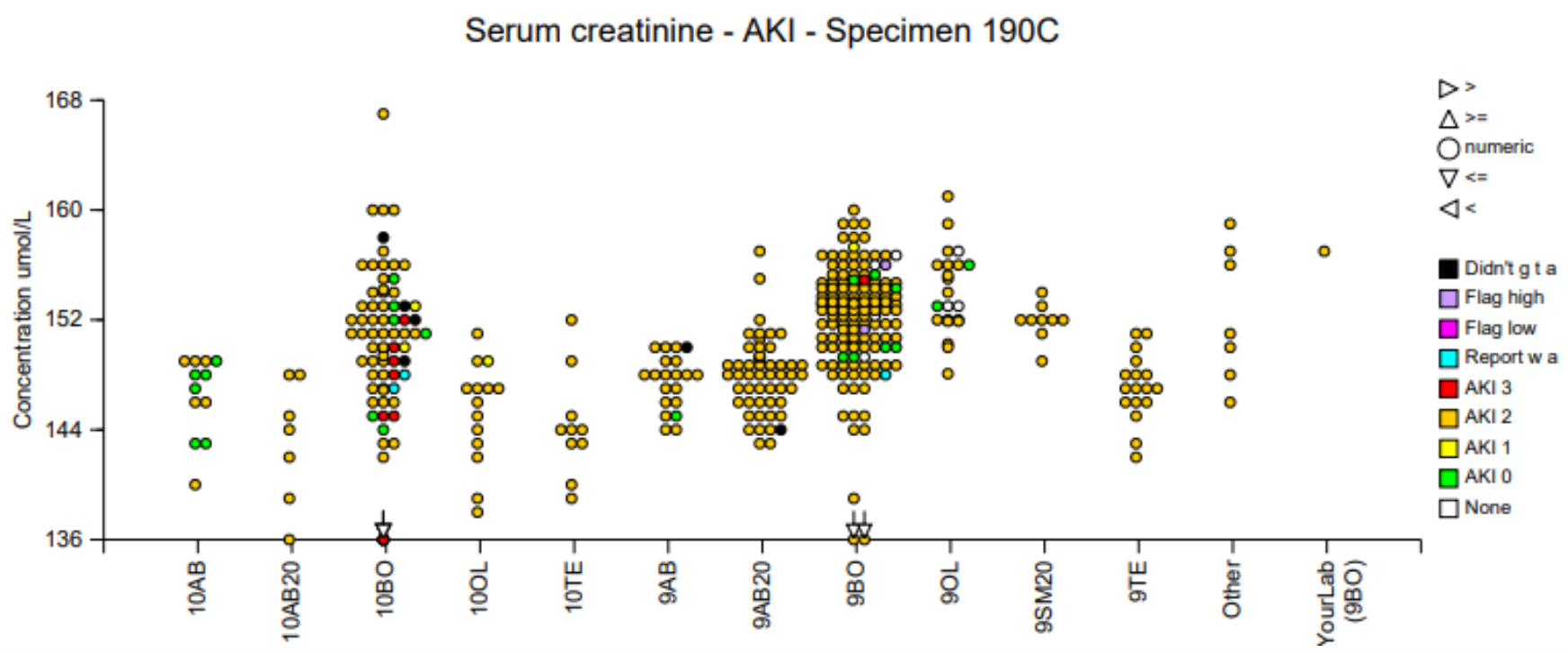


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# 4. National Audit on AKI

To understand the variation in AKI delivery, we undertook a National Audit on AKI and have made 10 recommendations

1. All Laboratories should use enzymatic creatinine assay
2. All Laboratories should participate in EQA for AKI
3. All Laboratories must use the NHSE AKI Algorithm
4. All LIMS providers in the UK must install the NHSE AKI Algorithm
5. All LIMS providers must make the NHSE AKI Algorithm un-editable locally
6. The NHSE Algorithm must be used for primary and secondary care
7. AKI reporting should be applied to everyone over the age of 28 days
8. AKI2 and AKI3 must be reported within 6 hours
9. All of the NHSE Algorithm must be used, including the “?AKI/?CKD” arm
10. Paediatric reference intervals need to be harmonised

## 5. Embedding the recommendations into the NHSE Toolkit

- Our 10 recommendations are being added to the RSTP Template and will part of the NHSE Toolkit and Service specification
- This will encourage laboratories to follow our guidance
- Encourage clinicians to have discussions with the laboratory
- Enable audits on compliance with National Service Specification for embedding quality into service delivery and for accreditation of services

# 6. Kidney Failure Risk Equation

1. It is essential to use the 2009 CKD-EPI equation for eGFR as the input to the KFRE, omitting the ethnicity correction factor as per NG203. The 2021 equation was not used in the original validation and subsequent recalibration studies for KFRE as it was published after the NG203[5]. The 2021 equation has also not been validated for use in the UK. UKNEQAS has demonstrated that use of CKD-EPI 2021 results in a clinically significant bias that might lead higher risk patients not being referred to nephrology services. Likewise, use of the older MDRD eGFR equation is inappropriate[1].
2. It is essential to use the UK validated version of the equation[1,3,6] not the "North American" and not the "Non-North America" versions. The latter two are widely available and typically found by clinicians using web searches for KFRE in the UK, increasing the likelihood of this error. The appropriate equation to be used has been published in NG203 ("Terms used in this guideline" section).
3. It is essential that laboratories are aware of analytic errors associated with their serum creatinine and eGFR methods through internal QA and participation in an external QA scheme. Specifically, an enzymatic method should be used for eGFRs being used to calculate KFRE[2]. UKNEQAS data demonstrates that Kinetic Jaffe method creatinine assays can underestimate risk when used in KFRE.
4. To reduce the risk of a non-standard implementation, we recommend that the LIMS is the primary site for KFRE implementation in the long term. We acknowledge that implementation within primary and secondary care EHRs is already in progress. Implementation within primary care EHRs has merit as an initial strategy because it may be delivered more quickly than in LIMS in some regions, and primary care is the most important place for early KFRE adoption.

# Make better use of EQA information at national level

NICE National Institute for Health and Care Excellence

## Ovarian cancer: recognition and initial management

Clinical guideline [CG122] Published: 27 April 2011

### 1.1.2 Asking the right question – first tests

1.1.2.1 Measure serum CA125 in primary care in women with symptoms that suggest ovarian cancer (see section on awareness of symptoms and signs).

1.1.2.2 If serum CA125 is 35 IU/ml or greater, arrange an ultrasound scan of the abdomen and pelvis.

**CA125**

UK NEQAS International Quality Expertise

Sheffield Teaching Hospitals NHS NHS Foundation Trust

Distribution : **225** Date : 01-Nov-2022 Page 1 of 2

Analyte : Ovarian Cancer Antigens CA125 (kU/L)

319 / 350 (91%) laboratories returned results for this distribution.
Samples 225-0 and 225-1 were made from pooled sera from patients with elevated concentrations of ovarian cancer antigens.

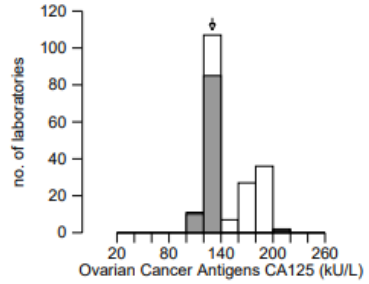
All methods
Roche Elecsys/E-170

Your MRVIS is 24
Your MRBIS is -2
Your SDBIS is 27

Target value (Roche)

**Specimen : 225-0**

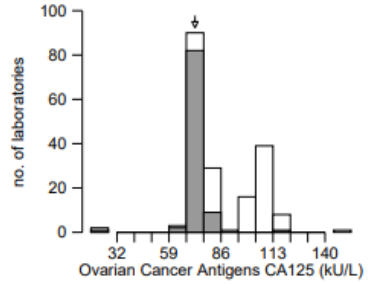
| | n | Mean | SD | CV(%) |
|---|---|---|---|---|
| All methods [ALTM] | 190 | 146 | 26 | 18.1 |
| Abbott Alinity | 16 | 188 | 8 | 4.3 |
| Abbott Architect | 20 | 188 | 4 | 2.2 |
| Beckman Access/DxI | 23 | 136 | 5 | 3.9 |
| Centaur-SMS Diag. Ltd | 14 | 173 | 6 | 3.6 |
| Roche Elecsys/E-170 | 96 | 126 | 5 | 3.6 |
| Siemens Atellica IM | 12 | 172 | 4 | 2.1 |




Your result 121
Target value 126
Your BIS -39
Standard Uncertainty 0.56
CCV 10

**Specimen : 225-1**

| | n | Mean | SD | CV(%) |
|---|---|---|---|---|
| All methods [ALTM] | 189 | 86 | 16 | 18.8 |
| Abbott Alinity | 16 | 112 | 4 | 3.1 |
| Abbott Architect | 20 | 110 | 3 | 2.3 |
| Beckman Access/DxI | 23 | 80 | 4 | 4.7 |
| Centaur-SMS Diag. Ltd | 14 | 106 | 5 | 4.6 |
| Roche Elecsys/E-170 | 95 | 74 | 3 | 3.5 |
| Siemens Atellica IM | 12 | 103 | 3 | 2.8 |




Your result 73
Target value 74
Your BIS -14
Standard Uncertainty 0.33
CCV 10

- NICE have a decision level of 35 IU/L
- Unwarranted variation between laboratories
- Unwarranted variation between methods
- How can the laboratory support the NICE Guideline?

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**CA125 Task Force and discussion with NICE on the value of a single cut-off**

# Make better use of EQA information at national level.

NICE National Institute for Health and Care Excellence

**Table 1 Age-specific PSA thresholds for people with possible symptoms of prostate cancer**

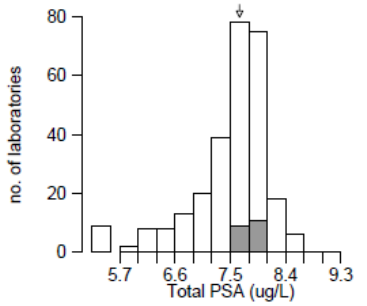
| Age (years) | Prostate-specific antigen threshold (micrograms/litre) |
|---|---|
| Below 40 | Use clinical judgement |
| 40 to 49 | More than 2.5 |
| 50 to 59 | More than 3.5 |
| 60 to 69 | More than 4.5 |
| 70 to 79 | More than 6.5 |
| Above 79 | Use clinical judgement |

**PSA**

NHS UK NEQAS International Quality Expertise

Specimen : 2211-1

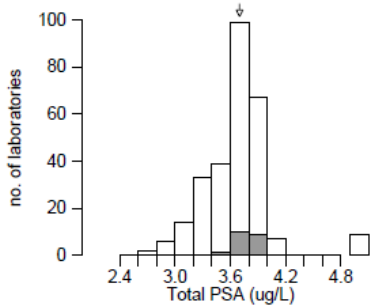
| | n | Mean | SD | CV(%) |
|---|---|---|---|---|
| All methods [ALTM] | 276 | 7.6 | 0.5 | 7.0 |
| Abbott Alinity | 39 | 7.2 | 0.7 | 9.3 |
| Abbott Architect | 25 | 7.7 | 0.3 | 4.2 |
| Beckman Access-Hybritech standard. | 6 | 7.9 | 0.4 | 5.1 |
| Beckman Access-WHO standard. | 26 | 6.5 | 0.4 | 6.3 |
| Roche ELECSYS | 20 | 7.9 | 0.1 | 1.8 |
| Roche-COBAS e | 120 | 7.8 | 0.3 | 3.6 |
| Siemens Atellica IM | 14 | 7.4 | 0.3 | 4.3 |
| SMS Diagnostics-ADVIA Centaur | 18 | 7.7 | 0.5 | 6.7 |




| | |
|---|---|
| Your result | 7.52 |
| Target value | 7.6 |
| Your BIS | -14 |
| Standard Uncertainty | 0.04 |
| CCV | 6 |

Specimen : 2211-2

| | n | Mean | SD | CV(%) |
|---|---|---|---|---|
| All methods [ALTM] | 276 | 3.6 | 0.3 | 7.4 |
| Abbott Alinity | 39 | 3.7 | 0.9 | 23.9 |
| Abbott Architect | 25 | 3.6 | 0.2 | 4.8 |
| Beckman Access-Hybritech standard. | 6 | 3.7 | 0.2 | 4.5 |
| Beckman Access-WHO standard. | 26 | 3.1 | 0.2 | 8.0 |
| Roche ELECSYS | 20 | 3.8 | 0.1 | 2.9 |
| Roche-COBAS e | 120 | 3.8 | 0.1 | 3.5 |
| Siemens Atellica IM | 14 | 3.5 | 0.2 | 5.8 |
| SMS Diagnostics-ADVIA Centaur | 18 | 3.7 | 0.3 | 7.9 |




| | |
|---|---|
| Your result | 3.62 |
| Target value | 3.6 |
| Your BIS | -12 |
| Standard Uncertainty | 0.02 |
| CCV | 6 |

- NICE have a age related reference ranges
- Many labs do not use them
- Unwarranted variation between laboratories and methods
- How can the laboratory support the NICE Guideline?

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**Tumour Marker Task Force and discussion with NICE on the value of cut-off**

# Make better use of EQA information at national level.

## Vitamin B12

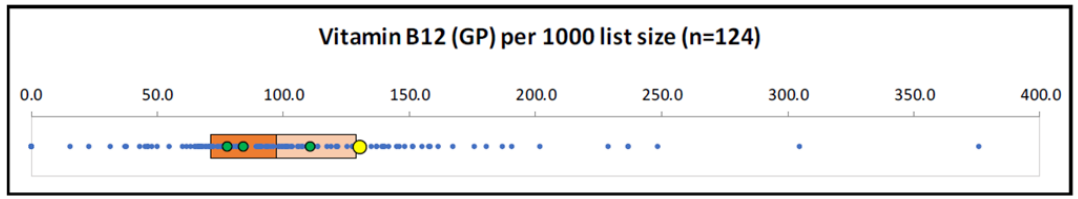
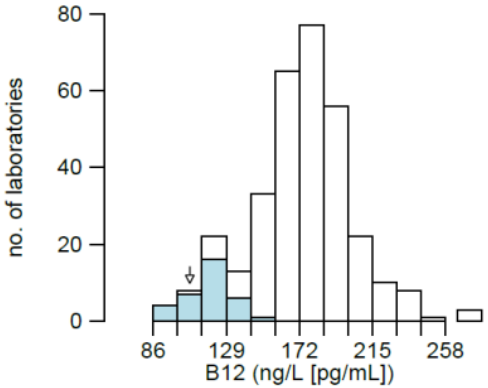



**Figure 1** shows an individual laboratory's result (indicated by the arrow) related to laboratories using the same technology (shaded histogram, Beckman DxI in this example) or all methods (open histogram). There is a significant variation ranging from 86 to 258 ng/L depending on the assay used, with an overall standard deviation of 28 and CV of 16.0%.

Finlay MacKenzie[1] and Vinod Devalia[2] Birmingham Quality [UK NEQAS],

Specimen : 248A

| | n | Mean | SD | CV(%) |
|---|---|---|---|---|
| All methods [ALTM] | 322 | 173 | 28 | 16.0 |
| Abbott Architect [AB13] | 88 | 172 | 19 | 10.8 |
| Beckman Access [SF6] | 8 | 123 | 5 | 4.4 |
| Beckman DxI [SF5] | 34 | 118 | 13 | 10.7 |
| Ortho Vitros [AM12] | 6 | 201 | 8 | 3.9 |
| Roche Cobas/Modular [BO5] | 128 | 177 | 16 | 9.0 |
| Siemens Centaur XP/CP [CO10] | 55 | 199 | 26 | 13.0 |
| Siemens Imm 2000/XPi [DC11] | 3 | 303 | | |
| non-numeric results | 1 | | | |




- Unwarranted variation between laboratories
- Unwarranted variation between methods
- Role of the laboratories and the manufacturers (link to Recommendation 2)

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# Vitamin B12 Clinical Group

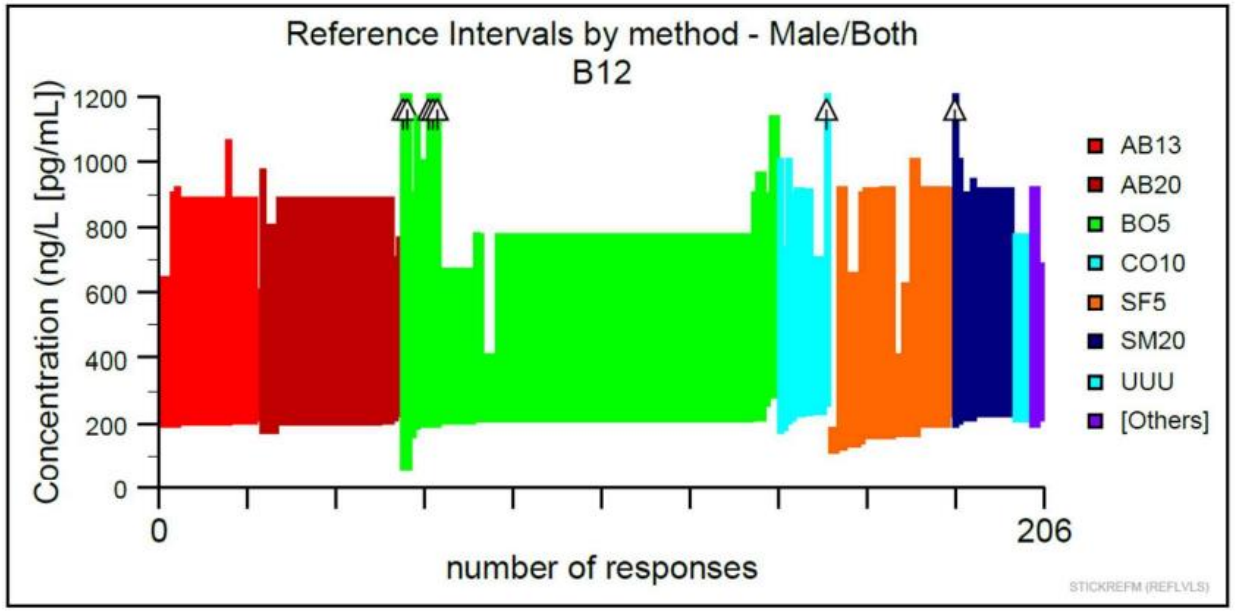
## Purpose of Group

- Receive data on assay performance
- Review multiple biomarkers (TB12, Holotranscobalamin, Methylmalonic acid, Homocysteine)
- Audit the reference intervals being used
- Undertake an interpretative exercise on B12 results
- Carry out a National Audit of the Vitamin B12 Service
- Produce a patient pathway Best Practice, through the GIRFT Academy
- Produce informative interpretative comments
- Ensure that the correct tests are used for the investigation of Nitrous Oxide abuse

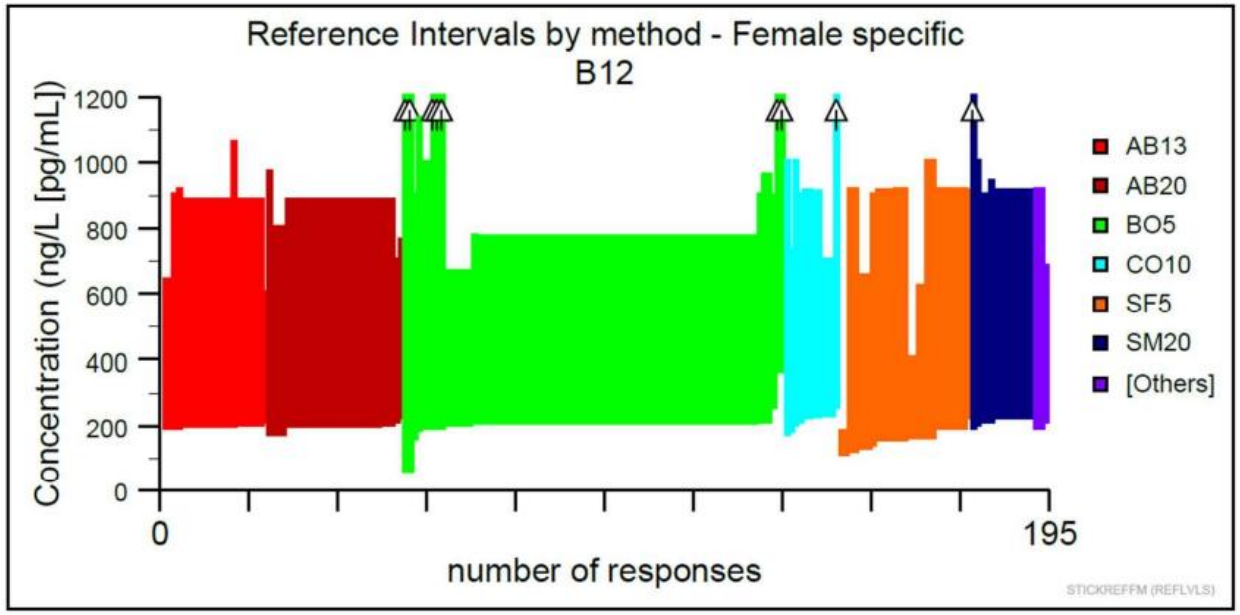
# Reference intervals: Initial Findings

UK NEQAS for Haematinic Assays

B12 [Male] from August 2022, Dist 296




B12 [Female] from August 2022, Dist 296




**<u>The method biases do not match the Reference Ranges</u>**. For example Both Abbott methods, [AB13] Architect and [AB20] Alinity, tend to have higher Hi-ends than Roche, yet it is Roche that is the slightly positively biased method in the Scheme. The Beckman systems [SF5] DXi and [SF6] Access, give low results but their ranges do not reflect this. There are issues of selectivity/specificity which we need to be aware of, but the example shown below in the Rainbow Trout Plot for 293A is just an un-manipulated serum, so there should be only a small possibility of commutability issues. For this reason, I would suggest this represents the true picture. (For completeness, [CO10] is the Siemens Centaur and [SM20] is the Siemens Atellica.)

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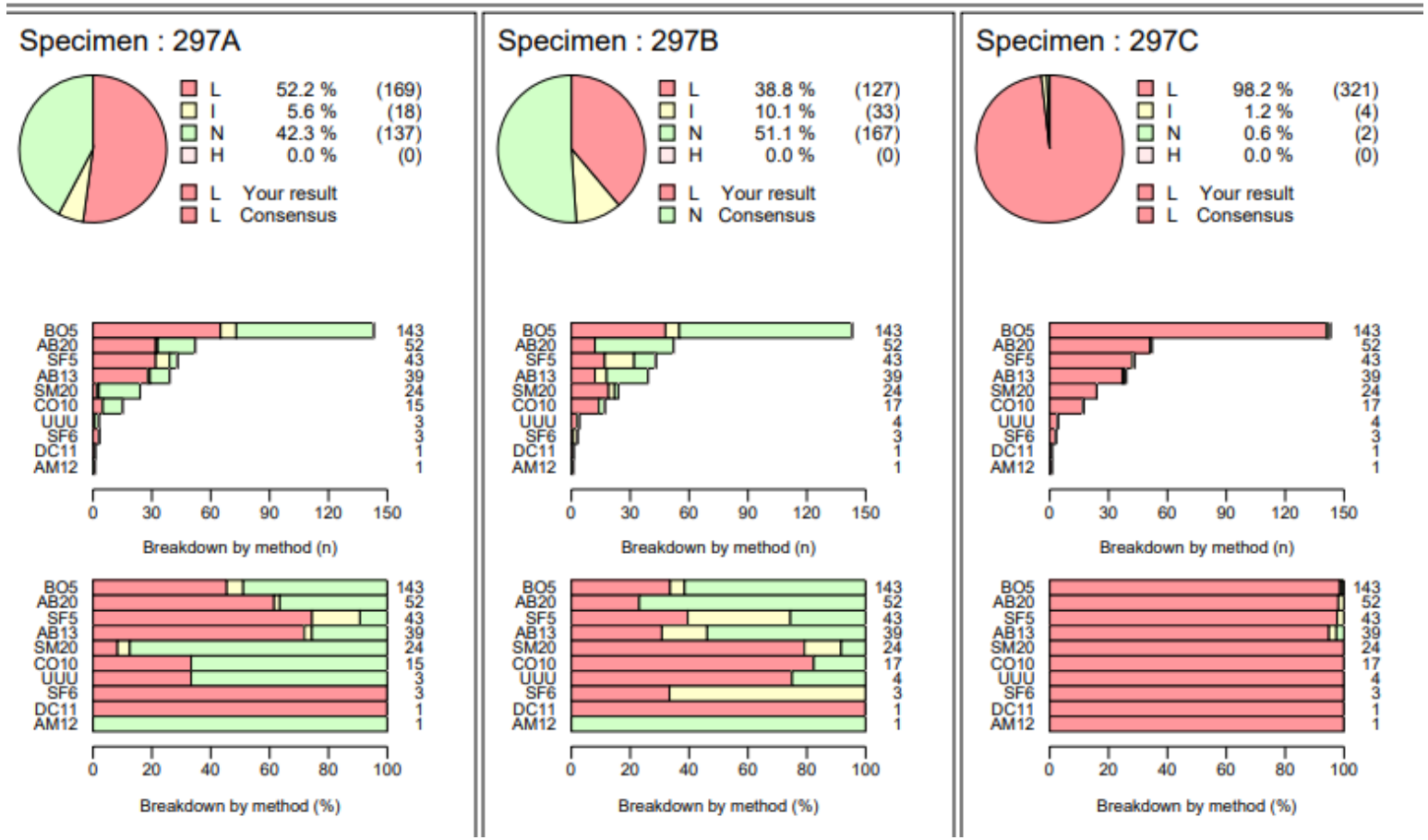
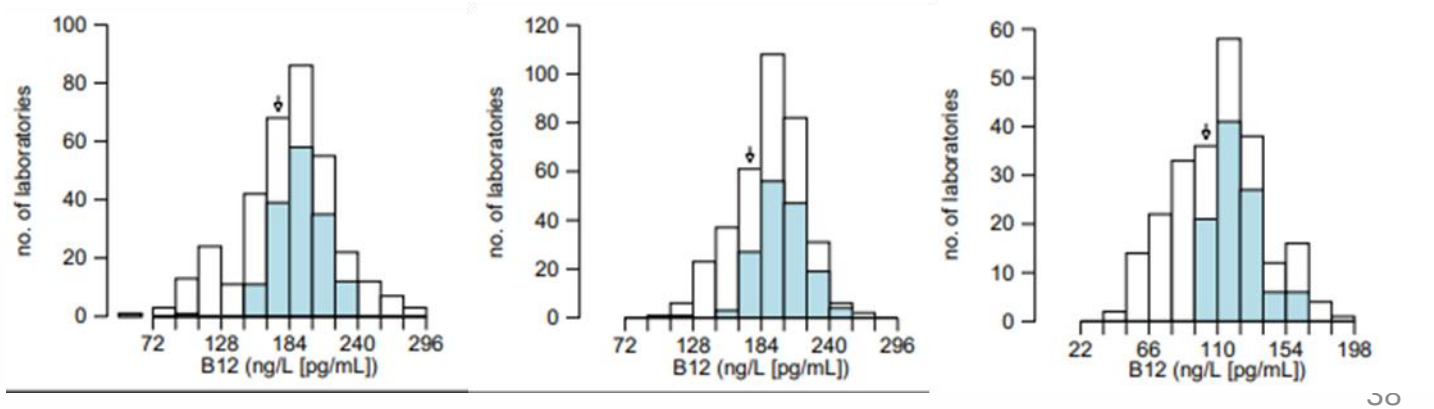
- Significant variation in result
- Significant variation between platforms
- Significant variation within same platform
- Significant variation in reference intervals
- Significant variation in interpretation

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# Make better use of EQA information at national level

## When is poor performance of a method unacceptable?

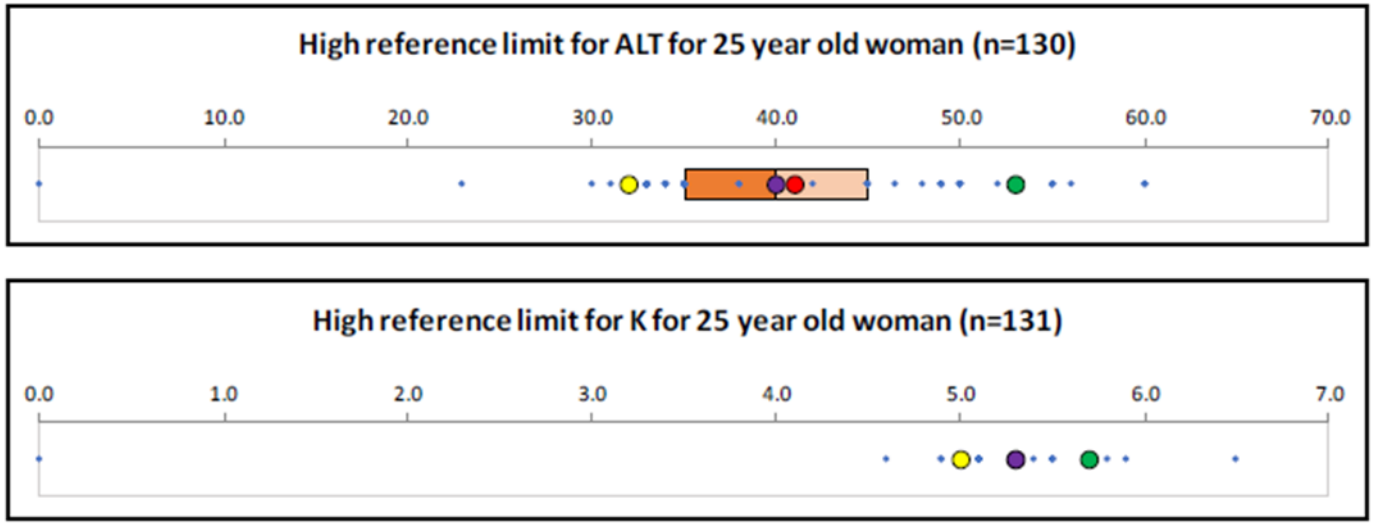
- GIRFT is working with the RCPath to ensure that existing EQA Oversight Board can make national recommendations
- GIRFT will liaise with Manufacturers to reduce unwarranted variation in results; reference material, reference intervals etc
- When is a test an acceptable test?

# Clean out:

To deliver diagnostic tests in a way that aligns to what matters to patients, we need to focus on:

- results that describe normality for that patient;
- results that help to define next actions clearly;
- results that are visible to clinicians when they are needed.

# What reference interval to use




**Reference ranges:**

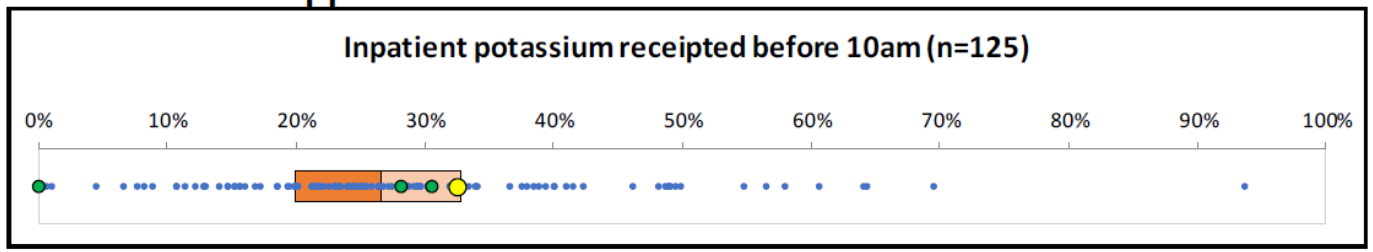
- Unwarranted variation in reference ranges
- Impact on patient algorithms, NICE guidelines, patient focussed pathology
- Pathology Harmony has already undertaken a significant amount of work on this

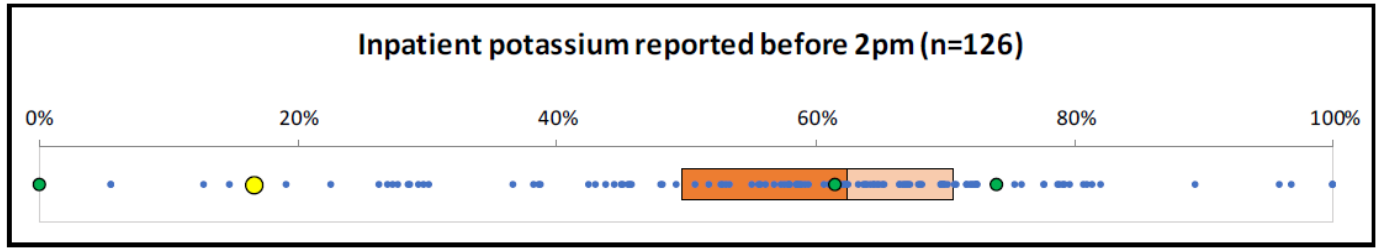
**Reporting units:**

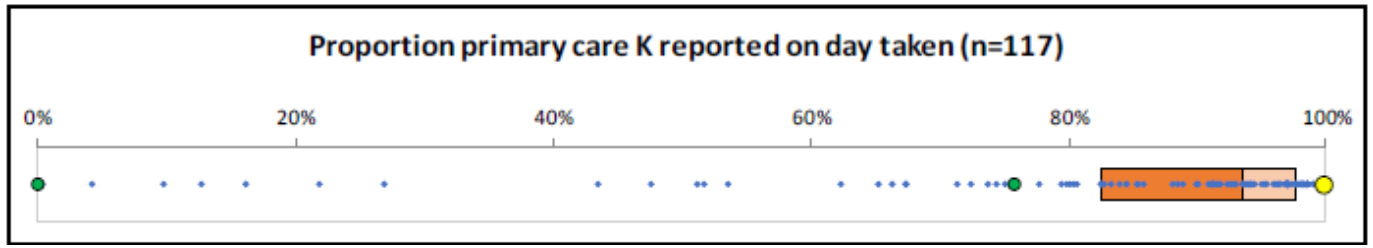
- GIRFT working with the British Heart Failure Society to harmonise units of measurement for NTproBNP
- We have produced a discussion document on units of measurement and decimal points

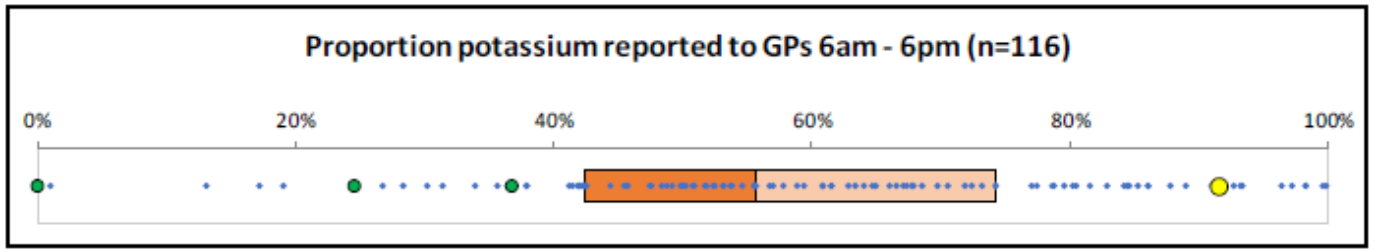
# Turnaround time

## Timeliness of Support for IP flow




**In-patients:**

- Align pre-analytics with analytics

**GP samples:**

- Align reporting with the requirement to act
- Pressure on out of hours GP services

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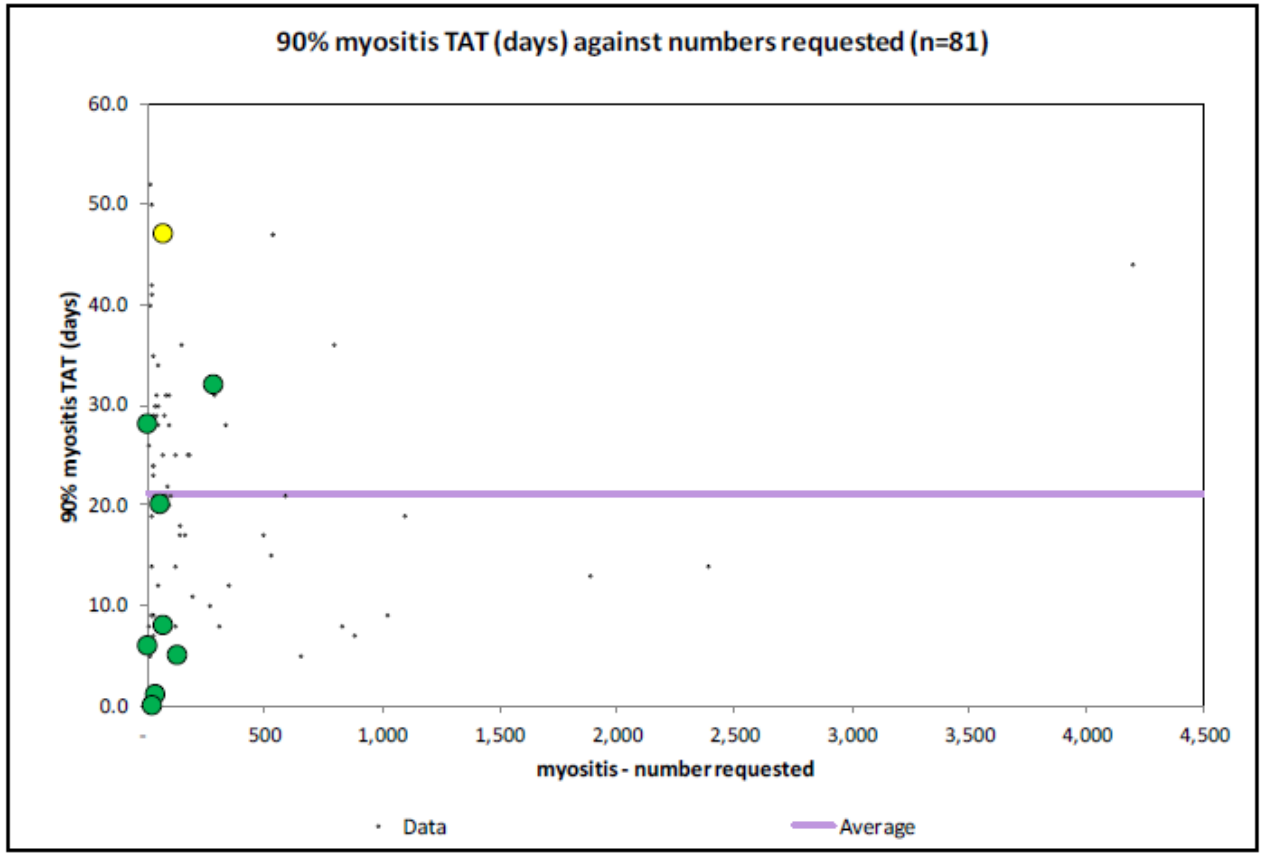
# Turnaround time




## What is an acceptable turnaround time?

- We showed significant variation
- In house/low numbers
- Referred not using electronic referral
- Referred, unacceptable TAT

## Summary: Clinically led Quality Change Management

- NHSE GIRFT Pathology has provided evidence on unwarranted variation in the way that Pathology is delivered
- We have recommended ways to reduce this variation Locally and Nationally
- We have set up workstreams to ensure adoption of our recommendations
- Reduction in unwarranted variation and optimising process will
  - improve total pathology quality management
  - improve the service
  - save money
- GIRFT is about gathering the evidence, harmonising the service and improving the clinical and analytical quality of Pathology
- The GIRFT report has specific recommendations that will be addressed but the GIRFT Report should also be used as a framework for a paradigm shift in Pathology delivery, based on the patient

## GIRFT Project team

- Tom Lewis: Microbiology
- Martin Myers: Clinical Biochemistry
- Marion Wood: Haematology
- Simon Knowles:Cellular Pathology
- Olu Akinremi / Caroline Ager-project managers
- Andrew Daniel, Abi Searle Jones
- Julie Renfrew - data manager

## Vitamin B12 Task Force

- Martin Myers
- Julian Owen
- Beverley Oakes
- Ian Davidson
- Geraint Fuller
- Adrian Hopper
- William McKane
- David Richmond
- Marion Wood
- Tom Lewis
- Dominic Harrington (G&ST)
- Rachel Mannington (UKNEQAS)
- Emma Stevenson (ACB)

## AKI Task Force

- Martin Myers
- William McKane
- Alex Yates
- Rachel Marrington
- Finlay MacKenzie
- Nicolas Selby
- Jonathan Murray
- James Medcalf
- Rupert Major
- Nitin Kolhe