**The North West Histopathology Specialist Registrar Pathway to Independent Reporting and Independent Reporting Policy and Guide**

**1 Policy Statement**

To allow NW Histopathology Resident Doctors (RD) to achieve independent reporting (IR) curriculum competencies, without putting patient safety at risk.

**2 Policy Summary**

This policy outlines the procedures and responsibilities for IR by trainers and RDs.

**3 Policy Purpose**

To clarify the purpose of IR.

To clarify the procedure for IR.

To clarify required RD competencies and qualifications for independent reporting.

To clarify the responsibilities and roles of consultant Histopathology trainers and RD in independent reporting.

**4 Policy and/or Procedural Requirements**

1. IR is being implemented to achieve Histopathology curriculum competencies.
2. The IR pathway and reporting policy is applied to trainees in their 2nd year of training and beyond.
3. While there is no fixed start time for IR, it is envisaged that most RDs in their third year of training will have gained sufficient competencies to start IR.
4. As a ‘stepping stone’ to IR, trainees working on a particular specimen type can put through cases to their supervising consultants with fully completed reports for authorising by the supervising consultants, as a way of showing competence for that specimen type. The RCPath Specimen Grid for independent reporting should guide the case selection.
5. The RD should keep a clear record of all cases reported as part of their IR competency portfolio. These records should be submitted to the ARCP panel for assessment of progression.

1. Trainees should liaise with their Educational Supervisor (ES) who in turn must liaise with the trainee’s supervising consultants (CS) to ensure their competencies are signed off as they progress.
2. As a regional policy IR is divided into two categories. **Category 1 IR** is where the RD can sign out the reports after achieving RCPath indicative numbers and sign off competencies for the same. The more complex cases that are not covered in the RCPath portfolio can also be counted towards IR. These cases are designated as **Category 2 IR** and **MUST** be
3. co-signed by the supervising consultant. Category 2 IR is recommended for the more senior post FRCPath part 2 RD.
4. Both Category 1 IR and Category 2 IR will be counted towards IR, but they should be recorded separately in the IR portfolio.
5. Once signed off for Category 1 IR, the RD should liaise with their ES to discuss with the respective teams, arrangements for access to cases they are competent and ready to report independently.
6. The RD should hand all Category 1 IR cases to the auditing /supervising consultant promptly. The Consultant should select cases for the audit, examine the slides with the report and ensure that it is correct for diagnosis, sense, grammar and SNOMED code.
7. The RD should also document Category 1 IR cases in the RCPath IR internal Audit form and pass the form to the supervising consultant to allocate a review score in the record, using the RCPath Independent Reporting Record and Internal Audit Form.
8. For Category 1 IR cases that have been reviewed as part of the audit process, it is suggested that the supervising consultant adds a note or supplementary to state this case has been reviewed in accordance with the regional IR protocol.
9. Category 2 IR cases do not need to be audited.
10. For Category 2 IR cases, which are not covered by the RCPath competency framework, there should be a consensus between the ES and the CS on the trainee’s ability to report these cases independently. Documentation of this agreement should be included in an assessment of performance form (AOP).
11. Trainees must not independently report any specimens for which they have not had their competencies, or an agreement signed off by their trainers.
12. Even if the RD has achieved competencies for IR, if there is any uncertainty around a case the RD should have a low threshold for requesting an opinion from the supervising consultant. If the supervising consultant decides to take over the case it should not be counted towards IR.
13. RDs should not be forced to independently report any case that requires further opinion(s) or they are not confident to report.
14. RDs should only expected to undertake IR that is part of their PDP and or a requirement of the curriculum. RD IR competencies should not be used as a means to clear any department backlogs.
15. The Educational Supervisors Structured Report (ESSR) should include a section on IR to confirm engagement with pathway for IR, competency levels achieved and any IR.
16. To maintain continuity, when starting a new placement within the same training region, it is essential that a ‘Transfer of Educational Plan” for IR is included in the final AOP or the ESSR at the end of the placement.
17. While there are no specific IR targets for ARCP progression at present, all RD are expected to demonstrate engagement with the IR pathway as a minimum. The IR portfolio and ESSR comments will be used as evidence for the same.
18. Audit: Governance protocols are in place to monitor and minimise independent reporting errors. 10-20% is the indicative percentage of post sign-off independently reported cases to audit.
19. Each case in the audit should be assessed and categorised as follows:

• No cause for concern

• Minor diagnostic error or oversight, unlikely to have affected clinical outcome and/or management

• Major diagnostic error or oversight, likely to have affected clinical outcome and/or management (e.g. benign/malignant discrepancy)

1. If a significant error is detected, the case will be shown to the trainee for feedback and learning. Appropriate clinical governance procedures including formal incident reporting should be undertaken with the guidance and support of the supervising consultant. A review of previously independent reported cases should also be considered.
2. The results of the audit review should be submitted for the subsequent ARCP assessment. Any major or significant errors/oversights may prevent that trainee progressing to the next level of competencies for IR. Any minor errors or oversights can be discussed at ARCP and the panel will decide if progress to the next level of competencies for IR is appropriate.
3. As the trainee gradually builds up their portfolio of cases for sign off, Consultants will be supervising and auditing the trainee’s work. It is therefore essential that Supervising Consultants including both CS and ES have sessional time allocated for these activities.
4. At the end of the attachment the trainee should audit their own cases with respect to number, type, errors, amended reports and turnaround time. This will form part of the general assessment and should also be kept as independent evidence in the trainee’s portfolio.
5. If any cases are deemed unsuitable for IR this should be stated clearly by the Specialty lead (SL) at the start of the placement.

**6 Roles and responsibilities**

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| **Responsibility** | **Description of role** |
| Histopathology RD | Perform independent reporting |
| Specialty Lead (SL) | Supervise and provide support & training |
| ES and CS | Supervise and provide support & training |

**7 Training Requirements**

Histopathology Resident Doctors in their 2nd year of training and beyond who have been awarded outcome 1 (satisfactory performance) at their last annual assessment (ARCP).

**8 References**

1. Independent Reporting for trainees in Cellular Pathology Specialties including Histopathology, Diagnostic Neuropathology and Paediatric Pathology. 2021.

**9** **Abbreviations**

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| RD | Resident Doctor (trainee) |
| ES | Educational Supervisor |
| CS | Clinical Supervisor |
| SL | Speciality Lead |
| ARCP | Annual Review of Competency Progression |
| ESSR | Educational Supervisors Structured Report |
| AOP | Assessment of performance |