The Royal College of Pathologists
Pathology: the science behind the cure

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

Introduction and Rationale:

The 2021 cellular pathology curricula (including Histopathology, Diagnostic Neuropathology, Paediatric Pathology and Forensic Pathology) highlight the principles of progressive independent practice as part of postgraduate training. This document builds upon previous College documents[1] pertaining to independent reporting which were arranged by level of competence and organ system respectively. The driving force behind the original frameworks was based on sound pedagogical principles of increasing learning experience and independence in a trainee's individual practice by increased exposure to responsibility for cases and therefore increased responsibility for patient care in preparation for Consultant practice. Progressive independent practice is an integral part of Entrustable Professional Activities and Capabilities in Practice currently directed by the General Medical Council.

This document sets out guidance for the implementation of progressive independent reporting during training in the cellular pathology specialties from ST2 (Integrated Cellular Pathology Training). The specimen templates are indicative for both the sample type and minimum number of cases that trainees should report satisfactorily prior to being signed off for independent reporting (IR). Gaining competence for independent practice is different for each individual trainee and trainees will progress at different rates in different aspects of their work. Assessing a trainee's readiness to progress requires appropriate clinical governance, transparent oversight and feedback between the trainers and trainee and should form part of the discussion at the trainees' ARCP.

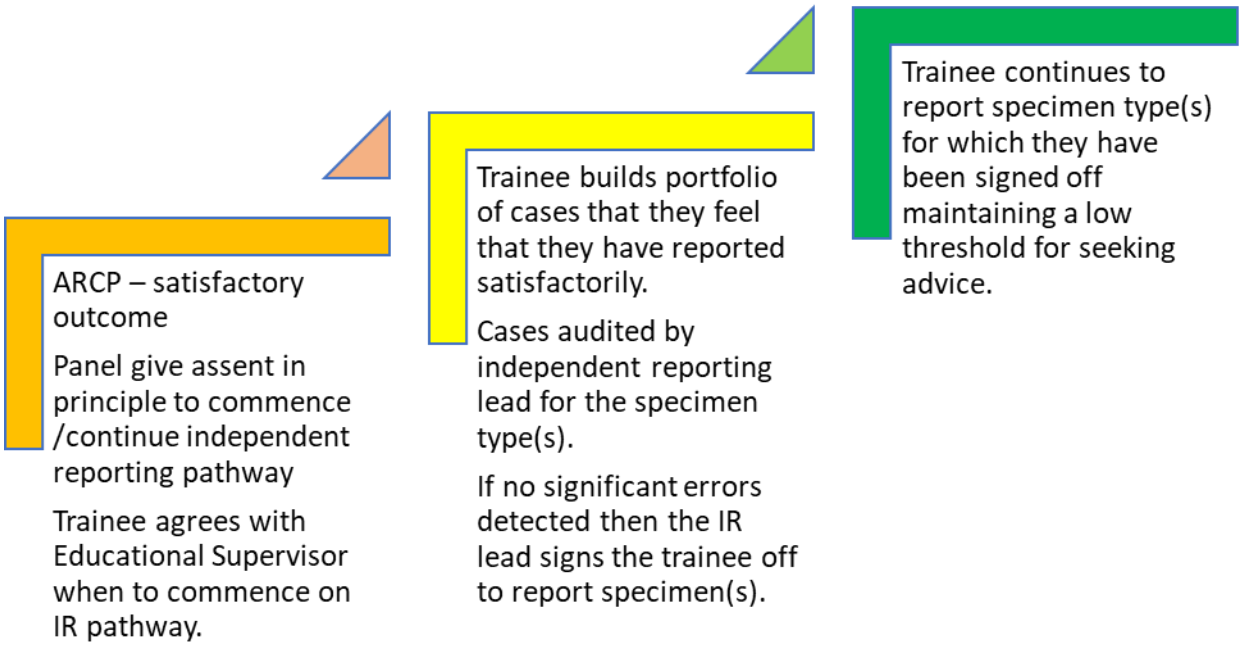
Pathway for Independent Reporting (Governance):

Some centres have established independent reporting pathways for their trainees in the Cellular Pathology specialties. These should continue and adapt as required for changes in governance guidance or curriculum requirements.

[1] A competency-based framework for graded responsibility for Specialist Registrar and Specialty Registrars in Histopathology and Cytopathology, Royal College of Pathologists 2009.
[2] Guide to conducting an investigative audit of cellular pathology practice, RCPath 2017

Below is a suggested pathway for the establishment of independent reporting within a training programme:

Pathway for Independent Reporting (Trainee):



The trainee's pathway repeats for each specimen type agreed for independent reporting. The trainee should keep a clear record of all cases reported as part of their IR sign-off portfolio as well as all cases reported independently. These records should be submitted to the ARCP panel.

- Trainees should liaise with their educational supervisors (who in turn must liaise with the trainee's supervising consultants) to have competencies signed off as they progress.
- As a 'stepping stone' to IR, trainees working on a particular specimen type can put through cases to their supervising consultant with fully completed reports for authorising by the consultant as a way of showing competence for that particular specimen type. The trainees will record these cases in the IR form and the supervising consultant will sign, add comments and allocate a review score in the record.

- Trainees must not independently report any specimens for which they have not had that competency signed off by their trainers.
- Trainees should not be forced to independently report a case that they are not confident with or that would require further opinion(s). The trainee should report such cases with their supervising consultant.
- Failure to complete all competencies for a particular specimen type should not necessarily in itself be considered an indicator of unsatisfactory progress at ARCP, as trainees progress at different rates.
- In order to maintain continuity, when starting a new placement within the same training region, it is essential that a 'Transfer of Educational Plan or Assessment of Performance' form be sent to the new educational supervisor. This should be updated with a section clearly indicating the competency levels achieved.

Audit:

The locally agreed governance protocols should be sufficient to monitor and minimise independent reporting errors. The governance protocols should include appropriate review and audit of cases. An indicative percentage of post sign-off independently reported cases to audit is between 10 and 20% (minimum of 10 cases). The audit should follow the principles outlined in the College guidelines for conducting an investigative audit[2].
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)

If a trainee makes a clinically significant error then the governance protocols should include a review of previously independent reported cases, as well as formal incident reporting and a consideration of retraining in the specimen type. This audit must be submitted at the subsequent ARCP for review. It is suggested that any major or significant errors/oversights should prevent that trainee progressing to the next level of competencies. Any minor errors or oversights can be discussed at ARCP and the panel will decide if progress to the next level of competencies is appropriate.

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, Clinical Supervisors and Educational Supervisors have sessional time allocated for these activities.

Independent Reporting Record and Internal Audit Form

Review score:
1 = No error
2 = Minor error (not requiring supplementary report)
3 = Significant error (requiring supplementary report)

Path No.	Specimen type	Date report authorised	Reviewing consultant	Review score	Action required

Trainee: Specialty: Date:

Indicative Specimen Grid for independent reporting:

1. Integrated Cellular Pathology

Indicative year of training	Suggested specimen types	Indicative minimum number of satisfactory reports prior to sign off for I.R.
ST2	Normal appendix Acute appendicitis Appendix – enterobius infestation Normal gallbladder Acute / chronic cholecystitis/ Cholelithiasis Epidermoid cyst Pilar cyst Fibro-epithelial polyp (skin) Fibro-epithelial polyp (Oral cavity) Simple allergic nasal polyp Normal vas deferens (urology)	20 20 20 20 20 10 10 10 10 10 10 10 10

2. Histopathology

Indicative Year	Suggested specimen types	Indicative minimum number of satisfactory reports prior to sign off for I.R.
ST3	**Skin and Soft Tissue:** Molluscum contagiosum Pilonidal sinus Dermatofibroma Haemangioma/pyogenic granuloma Squamous papilloma Seborrhoeic keratosis Lipoma/angiolipoma **GI:** Normal GI mucosal biopsies Haemorrhoids **Gynae:** Benign cervical polyps Benign endometrial polyps Uterus, cervix and vagina for prolapse **Head and Neck:** Mucocele (oral cavity) Apical cyst (jaw) Chronic siladenitis	 2 10 20 20 10 10 20 20 10 20 20 20 10 20 20

	Urological pathology	
	Scrotum, inflammation	10
	Hydrocele	10
	Testis: abscess/infarction	10
	Foreskin: balanitis, NOS	10
	Foreskin: balanitis xerotica obliterans without dysplasia or PeIN	20
ST4	**Skin and Soft Tissue:**	
	Benign Intradermal naevus	20
	Schwannoma	20
	Neurofibroma	20
	Glomus tumour	20
	Chronic synovitis	20
	Fractured head of femur (non-malignant pathology)	20
	GI:	
	Hyperplastic colonic polyps	10
	Adenomas with low grade dysplasia	10
	Anal skin tags (with no AIN)	10
	Partial and subtotal villous atrophy (Excluding immunocompromised cases)	10
	Resections for-	
	Diverticular disease	10
	Acute bowel ischaemia/infarction	10
	Sigmoid volvulus	10
	Colostomy/ileostomy closure	10
	Gynae:	
	Normal proliferative, secretory or menstrual endometrium	20
	Lichen planus	20
	Lichen sclerosus	20
	Vulval skin tags	10
	Head and Neck:	
	Oral Candidiasis	10
	Dentigerous cyst (jaw)	10
	Oral Lichen planus	20
	Tonsil Normal/inflamed (No neoplasia)	10
	Laryngeal Squamous papilloma Warthin's tumour	20
	Pleomorphic adenoma	10
	Thyroid gland Colloid goitre/cyst	20
		20
	Breast:	

	Breast reduction Gynaecomastia **Urological pathology:** Benign nephrectomy, obstruction/calculus Benign Transurethral resection of prostate (TURP)/Holmium Laser resection of prostate (HoLEP) specimens	10 10 10 20
ST5 (post Part 2 FRCPath Examination)	**Skin and Soft Tissue:** Actinic keratosis Bowen's disease Granular cell tumour Benign junctional/compound/blue naevus Leiomyoma **GI:** Oesophageal biopsies for Barrett's oesophagus (excluding dysplasia) Gastric biopsies for gastritis Gastric biopsies for fundic gland polyps Colonic biopsies for confirmation of IBD in patients with known history (excluding dysplasia) Colectomy for known inflammatory bowel disease (excluding dysplasia) **Gynae:** Functional ovarian cysts Endometrial hyperplasia **Head and Neck:** Granular cell tumour Giant cell granuloma Inverted nasal papilloma	 10 10 10 20 10 20 10 10 20 10 10 20 10 10 10
In addition to the above, specimens in this category can be reported post Part 2 FRCPath Examination but should be reported with a consultant prior to the trainee authorising the reports	**Skin and Soft Tissue:** Melanomas and atypical melanocytic lesions Squamous carcinoma Basal cell carcinomas Mycosis fungoides and suspected mycosis All other malignant diagnoses Inflammatory skin pathology Chondroma	

	Osteoma **GI:** Adenomas with high grade dysplasia Biopsies for primary diagnoses of malignancy Oesophagectomy for cancer Gastrectomy for cancer Colectomy for cancer **Gynae:** VIN Resections for previously diagnosed vulval carcinoma VAGIN Resections for previously diagnosed vaginal carcinoma CIN Resection for previously diagnosed cervical carcinoma Ovarian epithelial neoplasia Ovarian sex cord tumours Ovarian germ cell tumours First diagnosis of vulval, squamous or endometrial invasive neoplasia Fallopian tube neoplasia Trophoblastic neoplasia **Head and Neck:** Oral biopsies to assess for dysplasia/malignancy Other salivary gland tumours Major Resections eg. Larynx, Neck dissection **Urological pathology:** Prostate biopsies Bladder biopsies Transurethral resection of bladder tumour Radical prostatectomy Cystoprostatectomy Malignant partial/radical nephrectomy	

Cytology and Adult Autopsy pathology: Those trainees who have completed the Certificate of Higher Cervical Cytopathology Training and or the Certificate of Higher Autopsy Training should discuss progressive independent practice and reporting with their trainers following the above pathway for independent reporting (Governance). Non-cervical cytology progressive independent reporting may be implemented as per the governance pathway above tailored to local programmes, typically post-Part 2 examination.

3. <u>Neuropathology</u>

For further detail please refer to *Non-Mandatory Guidance on Independent Reporting in Diagnostic Neuropathology. RCPath 2020*

Indicative Year	Suggested specimen types (examples only)	Indicative minimum number of satisfactory reports prior to sign off for I.R.
ST3	Acellular / virtually acellular CSFs Very basic types of specimens or supplementary reports in order to practice the process of independent reporting (as determined by individual departments)	10-20 10-20
ST4	Tumours: schwannoma, meningioma (WHO grade I), metastatic carcinoma (with straightforward immunopanel and known primary Vascular lesions: straightforward malformations (AVM, cavernoma) and haemorrhages Temporal artery biopsies: either florid giant cell arteritis or no inflammation (avoid grey areas)	10-20 5-10 5-10
ST5	Tumours: all meningiomas and straightforward primary CNS tumours (e.g. glioblastomas), common metastases, common pituitary adenomas, straightforward integrated reporting Intraoperative smears: gradual support to independent reporting based in individual level of confidence Post mortem neuropathology: straightforward cases	10-20 20 (gradual process) 10
ST6	Other specialist areas depending on trainee's specialist interest More complex cases depending on individual trainee's level of confidence / competence	20 10-20

4. Paediatric and Perinatal Pathology

Indicative year of training (continuing from ICP I.R.)	Suggested specimen types	Indicative minimum number of satisfactory reports prior to sign off for I.R.
ST3	Skin -dermoid cyst	10
	Skin- pilonidal sinus	3
	Skin – accessory auricle, accessory digit	10
	Skin – Molluscum contagiosum	2
	Skin – pyogenic granuloma	10
	GI – Normal mucosal biopsies from a range of sites	20
	GI -meckel's diverticulum	4
	Placenta – Acute chorioamnionitis	15
	GU- foreskin Balanitis xerotica obliterans	10
	POC – known genetics 1st trimester loss	10
	H&N – mucocele (oral cavity)	10
ST4	GI – resection necrotising enterocolitis	10
	GI – Stomas from known diagnosis	10
	GI – follow-up mucosal biopsies of known pathology for MDT discussion	20
	Skin – infantile haemangioma	5
	Skin – Benign intradermal naevus	20
	Placenta – Pre-eclampsia/pregnancy inducted hypertensive changes / maternal vascular malperfusion	15
	Placenta- Chronic villitis (VUE / Infective)	15
	H&N – tonsil normal / inflamed (no neoplasia)	15
ST5 (post Part 2 FRCPath Examination)	Skin- benign congenital melanocytic naevi / benign compound naevi (not Spitz)	20
	Post mortem – Spontaneous second trimester loss (including histology and ancillary investigations)	5
	Post mortem – Growth restricted stillbirth (including histology and ancillary investigations)	5
	GI- resections for biopsy proven inflammatory bowel disease	3
	GI -Upper GI mucosal biopsies for eosinophilic oesophagitis / Helicobacter-associated gastritis	10

Examples of policy documents from departments currently undertaking trainee pathologist independent reporting

The following examples given below are excerpts from SOPs (in use at the time of writing this document) based on the Histopathology curriculum published in 2015. The 2021 curricula for the cellular pathology specialties have the principle of trainees developing their independent practice from day 1 of their specialty training. It applies to all aspects of their learning and training. Some trainees will be ready to independently report some cases within the first year of training, others will not.

Example 1:

GLASGOW: STANDARD OPERATING PROCEDURE FOR INTERNAL QUALITY ASSURANCE (IQA) OF TRAINEE INDEPENDENTLY REPORTED PATHOLOGY CASES

- 20% of all cases independently reported by the trainee will be audited by a consultant from the appropriate team.
- The trainee should record all cases that they have independently reported on the appropriate speciality form. (Separate forms will be provided for gyn, skin and GI).
- The trainee should keep the independently reported cases on their desk until after they have been audited.
- Each week, the designated auditing pathologist for a particular team will examine the lists for their speciality from all the trainees and choose 20% of the cases at random for review. The designated pathologist will be named on the audit rota for each speciality.
- The trainee will then provide the consultant with the designated cases.
- The consultant should use one hour fixed session for approximately 10 cases.
- The histology should be examined and the report and coding reviewed on telepath.
- A simple scoring system should be used (in line with Consultant IQA and trainee independent reporting log scoring).

(a) No error	1
(b) Minor error	2 (e.g. typos not causing interpretative problem)
(c) More significant error	3 (possibly requiring supp. Report)

- The findings should be recorded on the trainee's sheet. Any errors should be discussed with the trainee.
- If the trainee disagrees with the auditing consultant's interpretation of the case, a second consultant should be approached for an opinion.
- If a supplementary report is required, this should be generated by the trainee and supervised by the auditing consultant. If the error has clinical significance the clinician should be contacted directly by the auditing consultant and informed of the change to the report. It is the responsibility of the auditing consultant to assess whether the error represents a significant incident requiring datix forms etc.
- The supplementary report should be introduced with the words "This case has been reviewed as part of a routine internal quality assurance process. The report is amended to read as follows:"
- The trainee sheet should be copied and stored by that trainee's educational supervisor. The trainee should also retain a copy of the sheet for their own portfolio.

GLASGOW: POLICY FOR TRAINEE INDEPENDENT REPORTING OF SKIN BIOPSIES

1. The trainee should keep a log book of skin biopsy cases submitted as "sure box" cases and felt suitable for independent reporting; these should be scored 1 (no error)/2 (minor error)/3 (significant error) by assessor.

2. The trainee should have a copy of the RCPath Competency Based Framework document obtained from the Royal College of Pathologists' website. Each trainee's copy of this should be used as their portfolio in which they are signed off as 'entrusted' to report each individual category of specimen independently.

3. For ST3 and above, below are listed the skin biopsy specimen diagnoses (RCPath level 1 and 2 specimens) which are felt to be appropriate for independent reporting once the minimum number of satisfactory reports have been recorded and scored as score 1 in their log book:

Diagnosis	*Min. no. of satisfactory logged reports*
Sebaceous cyst (epidermoid/pilar)	*10*
Fibroepithelial polyp	*10*
Pilonidal sinus	*3*
Seborrhoeic keratosis	*10*
Lipoma	*10*
Molluscum contagiosum	*2*

4. For ST4 trainees and above, listed below are the skin biopsy specimen diagnoses (Level 2 specimens) which are felt to be appropriate for independent reporting once the minimum number of satisfactory reports have been recorded and scored as score 1 in their log book:

Diagnosis	*Min. no. of satisfactory logged reports*
Dermatofibroma	*10*
Excised Intradermal naevus	*10*
Haemangioma	*10*

5. Once the trainee has achieved the minimum number of satisfactory logged reports for *any* of the above listed skin diagnosis types, then that trainee should approach the Skin Team Clinical Supervisor(s) with their log book evidence for that specimen type(s) so that it(they) can be signed off in their copy of the RCPath Competency Framework document by that Supervisor. The trainee can then start independently reporting suitable specimens with that diagnosis.

6. For ST4 and above, the trainee can discuss the possibility of independently reporting certain Level 4 specimens ie. solar keratoses and Bowen's with the Skin team Clinical Supervisor(s).

7. For trainees who have successfully completed part 2 FRCPath Histopathology a progression to report Junctional/compound/blue naevi and Basal cell carcinomas and Squamous cell carcinomas once agreed by their named Educational Supervisor and Skin team Clinical Supervisor. Independent reporting of other types of skin biopsies such as inflammatory skins should also be discussed with the above Supervisors and may be reported under the department's "Extended post Part 2 Independent Reporting" procedure as documented elsewhere.

8. At the present time, all melanomas and atypical melanocytic lesions are felt not to be appropriate for independent reporting during pathology training. Whilst participation in their reporting is actively encouraged, all of these lesions should be supervised by a Consultant Pathologist.

9. Once the trainee has been authorised to do *any* independent skin biopsy reporting, the trainee should record all cases that they have independently reported on the appropriate specialty IQA form (in this case Skin) in that 20% of these cases can then by audited as per the Standard Operating Procedure for Internal Quality Assurance (IQA) of Trainee Independently Reported Pathology Cases.

Discontinuous service
If a trainee has had a prolonged service break (e.g. due to illness, maternity leave etc), independent reporting status will be reviewed. The trainee may be asked to re-log a number of sure box cases or be re-instituted to independent reporting with increased (or normal) IQA surveillance of their reporting, to be agreed between their Educational Supervisor and relevant Clinical Supervisors, taking account of relevant circumstances, length of break, previous reporting records etc. (See also Academy of Medical Royal Colleges Guidelines on Return to Practice, April 2012).

Suboptimal performance
Sure Box
Should a trainee make significant errors in their "sure box log" in preparation for independent reporting, the trainee should bring this to the attention of their educational supervisor. The trainee may be asked to re-log the requisite number of sure box cases taking account of relevant circumstances.

Independent Reporting
Should a trainee be found to make significant errors in the IQA of their independent reporting, the trainee should bring this to the attention of their educational supervisor. The trainee may:
a. be asked to re-log a number of sure box cases
b. retain independent reporting in simpler or perceived "safe" categories
c. be re-instituted to independent reporting with increased IQA surveillance of their reporting.
d. A combination of these approaches may be taken, to be agreed between the trainee's Educational Supervisor and relevant Clinical Supervisors, taking account of circumstances; all action should be decided on the basis of the circumstances pertaining to that individual trainee and on review of all available reporting records.

Example 2:

OXFORD: INDEPENDENT REPORTING IN GASTROINTESTINAL PATHOLOGY

PURPOSE & PRINCIPLE:
Skills in independent reporting are developed during the stage D training of histopathology registrars who have passed the part 2 FRCPath exam. This document provides guidance on independent reporting of gastrointestinal pathology cases and addresses the following questions:

- Which cases are suitable for independent reporting?
- How to decide if a trainee is ready for independent reporting?
- How many of the independently reported cases should be reviewed, and by whom?
- What to do if the review of cases indicates poor performance?

The range of cases will be determined on an individual basis based on the trainee's previous performance on the GI rota and subjective assessment of the supervising GI consultants.

Trainees should not feel pressurized for independent reporting just because they have the FRCPath

In line with good medical practice, any doubtful findings/cases should be discussed with the GI pathologist on rota prior to reporting.

SCOPE / LIMITATIONS:

- GI pathology includes a large number of specimens with relatively low complexity, but even within these there are areas of recognised difficulty and many potential pitfalls. Careful supervision of independently reporting registrars is therefore required.
- There are some cases which are NOT suitable for independent reporting. These include
  - Cancer resections
  - Malignant GI biopsies
  - Core biopsies (e.g. pancreas)
  - Any case with suspected/confirmed malignancy
  - Dysplasia in the stomach or oesophagus
  - Barrett's oesophagus and inflammatory bowel disease with dysplasia
- The amount of time that an individual registrar spends on GI will vary, and therefore the exact schedule followed by the registrar will be developed on an individual basis.

VALIDATION / VERIFICATION:

The procedure has been validated for use, provided that approved suppliers, reagents, equipment are used by trained, competent staff exactly as instructed. Objective evidence is available through audit, training records and the FileMaker Inventory.

Verification is through effective quality control as detailed at the end of this procedure (individual elements will be detailed within the inventory) and/or through audit at time of review

All anomalies must be recorded as directed in SOPQ03 (Error Logging) for auditing and risk management purposes.

PROCEDURE:

A limited number of histopathology cases are suitable for independent reporting, as judged on an individual basis. These could include all or some of the following:

- Gallbladders
- Appendices
- Stomas
- Perianal specimens – haemorrhoids, anal polyps, mucosal prolapse, pilonidal disease
- Resections for diverticular disease
- Resections for ischaemia where the cause is known (hernias, volvulus, adhesions)
- Normal mucosal biopsies

Other cases may be given to the trainee for independent reporting based on individual assessment.

Review of independent reporting:

The designated mentor will retain all independently reported cases and will review 10%. Any significant errors will be relayed to the trainee and will be dealt with as per departmental procedure. This may or may not result in withdrawal of independent reporting pending additional training.

Example 3:

A Competency Based Framework for Graded Responsibility for Specialty Registrars in Histopathology in Wessex.

- From August 2015, independent reporting based on the RCPath document "A competency-based framework for graded responsibility arranged by level of competence" will be encouraged from ST2 level. Trainees at ST1 level should not be expected to report any cases independently.
- Trainees can commence working towards specific competencies from the beginning of their attachments, with the aim of completing one whole level of competencies by the end of that rotation. However, it is recognised that not all trainees progress at the same rate and this may not be possible.
- Trainees must demonstrate competence in reporting a particular specimen (and have that particular competence signed off by their Educational Supervisor) before commencing independent reporting of that specimen type.
- **Trainees must not independently report any specimens for which they have not had that competency signed off by their educational supervisor.**
- **Trainees should be under no pressure to report cases independently and must maintain a low threshold for seeking consultant advice**.
- Permission to move on to the next level of competencies (e.g. from level 1 to level 2) should be agreed at ARCP. This will be subject to the ESSR, educational supervisor's report, the trainee providing evidence of achieving all competencies for their current level, and evidence of audit of their independent reporting performance (see audit section below).
- Failure to complete all competencies for a particular level should not necessarily be considered an indicator of unsatisfactory progress at ARCP as trainees progress at different rates. However, the trainee would not be permitted to move on to the next level of competencies until all at that particular level have been achieved.
- When starting a new placement, it is essential that the 'Transfer of Educational Plan' form be sent to the new educational supervisor. This should clearly indicate the current competency levels for histopathology independent reporting.
- It is envisaged that once demonstration of competence for a particular specimen type has occurred, **this will not have to be repeated at the beginning of each placement and will be accepted by the new host Trust**. This will be subject to receipt of the 'Transfer of Educational Plan' form from the previous Educational Supervisor stating that these competencies have been achieved.

Demonstration of competence

- Trainees must demonstrate to their supervising consultants (and hence educational supervisor) that they are competent in assessing a particular specimen type before being signed off for that particular specimen type.
- At the beginning of an attachment, following a general assessment of the trainee's abilities by supervising consultants, the trainee may then be given the go-ahead to start working towards sign-off of the appropriate level of competencies.
- Once trainees have been given approval to start working towards achieving competencies by their Educational Supervisor, a 'stepping-stone' stage is advised:
    - In this stage, the trainee completes reports ready for authorisation by the consultant for any cases in which they would be entirely happy to report out independently. These are then given to the supervising consultant with the

slides to double-check, and the consultant then authorises the report. Feedback on performance and in particular any amendments to the reports must be given to the trainee.
    - Regular discussion between supervising consultants, the educational supervisor and the trainee regarding their performance in this 'stepping-stone' stage must occur. Once the Educational supervisor is of the opinion a particular competence has been demonstrated, they may then sign-off that competence for the trainee.

Independent Reporting Practice

- Once trainees commence reporting of specimens independently, they take full responsibility for the reports they issue. Only the trainees name will be included on the report.
- It is the trainee's responsibility to ensure they follow departmental guidelines and protocols for reporting, and to follow these Wessex STC guidelines for independent reporting.
- Trainees should ensure they have appropriate cover with a medical indemnity organisation.
- Trainees must keep a record in their portfolios of cases they have reported independently (this should include specimen number to allow identification for audit).
- As stated previously:
    - **Trainees must not independently report any specimens for which they have not had that competency signed off by their educational supervisor.**
    - **Trainees should be under no pressure to report cases independently and must maintain a low threshold for seeking consultant advice**.
- Assessing a trainee as competent for a certain specimen type and signing-off that competency does not mean that the individual consultant or department that gave approval are considered liable if a problem arises related to that competency. If a trainee has a problem in an area previously signed off, then this can be addressed after discussion between the trainee and their educational supervisor.
- Approval of certain competencies can be removed if there are concerns over a trainee's performance.

Audit of performance

- Trainees must perform an audit of their independently reported cases. It is suggested that 20% of their cases (or a minimum of 20 cases, whichever is greater) are reviewed by their educational supervisor (or other supervising consultant).
- Each case in the audit should be assessed and categorised as follows:
    - **Category 1** - Major diagnostic error or oversight (e.g. benign/malignant discrepancy)
    - **Category 2** - Significant diagnostic error or oversight, likely to have affected clinical outcome and/or management
    - **Category 3** - Minor diagnostic error or oversight, unlikely to have affected clinical outcome and/or management
    - **Category 4** - No issues
- If any cases are detected with major or significant errors/oversights, consideration should be given locally to review of a greater percentage of the trainee's independently reported cases. Local adverse event reporting procedures should be also followed.
- This audit must be submitted at ARCP for review. It is suggested that any major or significant errors/oversights should prevent that trainee progressing to the next level of competencies. Any minor errors or oversights can be discussed at ARCP together

with the other ARCP documentation and the panel will decide if progress to the next level of competencies is appropriate.

Review of Wessex guidelines

- These guidelines will be reviewed following publication of new RCPath guidance on independent reporting by trainees.

APPENDIX A

- The RCPath document "A competency-based framework for Graded Responsibility for Specialist Registrar and Specialty Registrars in Histopathology and Cytopathology (Arranged by Level of Competence" can be viewed here: http://www.rcpath.org/NR/rdonlyres/BAF3683F-B326-4871-867D-B7A5D39E824A/0/A_competency_based_framework_for_graded_responsibility_arranged_by_level_of_competence.pdf