**BAC response to RCPath discussion document in interpretative EQA arrangements**

The BAC fully understands the professional and public need for measures that can educate, promote quality and help raise standards. The use of quality measures in pathology is well known and accepted, and both internal quality and external quality measures play vital, but differing, roles in this.

The use of individual interpretative EQA (iEQA) is well accepted within cellular pathology, as noted in the document. The ideas on scheme oversight, acceptance and operation seem well thought though and in general we would support. Whilst mostly written with interpretative histology based EQA in mind, it does, as it notes, also apply to any pathology discipline where individual interpretative reporting occurs e.g. cytology, biochemistry, immunology. Historically this would have been largely the preserve of medically qualified Pathologists, holding RCPath examination qualifications, but it has also historically applied to Clinical Scientists in Biochemistry.

Any iEQA scheme must allow for all those reporting that material to take part and be educated with in it and also be able to deal in a consistent manner all those within that relevant scheme, irrespective of background or qualification. The development of advanced practitioners in cervical cytology, holding the ASD in cervical cytology, reporting out "positive" reports is long established, and the advent of a similar ASD qualification in diagnostic cytology will allow this in this area too. The development of histology reporting, with RCPath and IBMS support, will also lead to similarly suitably qualified biomedical scientists being able to report certain areas of histology. In the area of Cytology, it must be remembered that the Cervical Screening Programme (CSP) has had a mandatory iEQA for many years, which all staff, irrespective of background or grade, must take part in. This has an agreed protocol and defined actions.

It is imperative that any iEQA scheme can accommodate all relevant staff, and be able to deal with any issues in as consistent a manner as possible. It is obvious that issues relating to medically qualified pathologists could be dealt with by the RCPath and the relevant regulatory body, i.e. GMC. However it must be acknowledged that not all Pathologists will be RCPath members despite holding RCPath or equivalent qualifications. The mechanism for other grades of staff (advanced practitioner biomedical scientists, biomedical scientists, screening staff and clinical scientists) is less clear. For biomedical scientists of any grade this could be via the Health and Care Professions Council, possibly via the IBMS. Whilst the cytology screener grade numbers have diminished given changes in CSP delivery, many will still be in post of several years at least. Any potential performance issues with such staff may best be dealt with via the employing Trust, with QA advice if available, in the absence of any national professional regulatory body for this group of staff.

It is unclear whether the RCPath proposals in setting up the oversight of iEQA schemes is for all schemes or only those which would be of relevance to medical staff? If so, how are Clinical Scientists accommodated within this? Again, does the suggested PPP deal only with medical staff or would it deal with others in the scheme, possibly through a joint oversight function with other relevant professional bodies, irrespective of background?

It strikes us that it would be highly illogical and dangerous to suggest that two schemes should exist (one for medical staff and one for other staff) or that the RCPath, if it is to effectively be the approving body for iEQA schemes, might approve one for medical staff and not one for other staff just because they are not medically qualified. The cervical screening iEQA is an example of a well established scheme covering all grades of staff within the CSP. Whatever decisions are made now about the future if iEQA must be inclusive, consistent and be able to allow for the changing face of service provision.

We agree that whatever process is agreed there must be adequate resources to allow it to operate properly. Inevitably this will fall on the employing Trust to fund. If an iEQA scheme that is appropriate for staff to take part in exists then they will have to enter it to allow them to operate professionally.

We note the proposal to move from a definition of poor performance from 2.5% to 5%. This appears pragmatic, but must be kept under review as indicated.

The report by Dr Barnes proposed the public sharing of individual iEQA data, not just in appraisal type situations as suggested in this document. The BAC is not against the public release of such iEQA data, but does equally acknowledge that non-professional interpretation of such data could be incorrect without suitable supporting explanations.

It should be made more obvious that any iEQA process is primarily educational. Any identification of poor performance is a secondary process, but we must consider and allow for this in the set up of any scheme, and not as an after thought.

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