



# Evidence from the Royal College of Pathologists to the Health and Social Care Committee Expert Panel: evaluation of the Government's commitments in the area of maternity services in England

5 May 2021

The College welcomes the opportunity to contribute to this evaluation. The College evidence relates to and would help achieve the Government commitments under evaluation:

Government commitments:

- **By 2025, halve the rate of stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth.**
- **Achieve a 20% reduction in these rates by 2020.**
- **Reduce the pre-term birth rate from 8% to 6% by 2025.**

## College recommendations

### The role of medical examiners in investigating baby deaths

Medical examiners are part of a national network of specifically trained independent senior doctors (from any specialty). Overseen by a National Medical Examiner, they scrutinise all deaths that do not fall under the coroner's jurisdiction across a local area.

- As the lead medical royal college, the College supports the view that medical examiners (MEs) should work with coroners to investigate stillbirths and neonatal deaths. This would help identify unusual patterns, such as high numbers of deaths at one hospital, which can be a strong indicator of poor care.

- The 2015 Report of the Morecambe Bay Investigation by Dr Bill Kirkup recommended that the role of medical examiners should be extended to stillbirths as well as neonatal deaths.
- We recommend that investigating stillbirths be added to the remit of medical examiners, who would then make an initial assessment of a stillbirth death in the same way that they do for adult deaths. MEs would refer only those stillbirths they think need further investigation. Coronial investigation of full-term macerated stillbirths is less likely to reveal acute failings in care than investigation of intrapartum stillbirths. However, review of antepartum stillbirths may reveal failings in wider antenatal care.
- There could be specifically trained regional MEs who could review stillbirth cases and refer those deemed appropriate for coronial investigation. However, it will be important to ensure that there are enough medical examiners in post with adequate resources to be able to take on this additional role.
- Most recently, medical examiners have started providing independent scrutiny of the deaths of health service and adult social care workers from COVID-19 in England. They have been speaking to relatives, providing an opportunity for them to give their views, and have already identified deaths which need consideration of further action, for example by coroners.

**Government commitment: Safe staffing – “Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm.”**

- Was the commitment met overall? or (in the case of a commitment whose deadline has not yet been reached) Is the commitment on track to be met?
- Was the commitment effectively funded (or resourced)?
- Did the commitment achieve a positive impact for patients?
- Was it an appropriate commitment?

## Paediatric and perinatal pathology workforce concerns

- There are currently 62 paediatric and perinatal pathology consultants in post (comprising 39 full time and 23 part time roles, so a whole time equivalent of 49.9 posts) in the UK, with an additional 15 vacant consultant posts. The number of current trainees is insufficient to fill these vacancies.
- Therefore, to cope with any increase in demand and to ensure quality of care, a rapid and significant increase in consultant numbers would be needed. Increased numbers of consultants would be needed in several different units.
- Pathology trainees have a two-week exposure to perinatal pathology during their training. This short exposure, combined with the high-volume workload and limited private practice opportunities in perinatal pathology, affects speciality choices for pathologists in training.
- Recruitment and retention salary premiums may need to be paid to encourage trainees to undertake specialist training in perinatal pathology. Work life balance and opportunities for flexible working would also be valued by trainees.
- Additional training posts require funding to ensure succession planning for consultant positions.
- If coronial investigations of stillbirths were to be introduced, consideration also needs to be given to which other staff groups need to be involved in investigating and their existing capacity and workload. This would involve biomedical scientists, radiologists, anatomical pathology technologists and secretarial staff. Additional testing may also be needed by other medical



specialties, such as genetics, toxicology or microbiology. Allowance would need to be made for costs to increase in line with inflation.

## Placental histology services in England

- The College met the Healthcare Safety Investigation Branch (HSIB) in December 2020. The HSIB has observed through the maternity investigation programme that there is insufficient availability of specialised placental histology in England.
- Many placentae from babies born that meet their referral criteria are not being sent for histopathology. This is not in line with [RCPATH guidance](#). There are concerns about maternity units facing difficulties in providing paediatric histopathology. This is in part due to local pathology services being unable to meet the demand or not having the required expertise to provide placental histology. HSIB are in dialogue with NHSE&I Maternity Transformation Programme Board about these concerns.

## College response to proposals on Coronial investigation of stillbirth cases in England and Wales

- The Royal College of Pathologists responded to a consultation published on 26 March 2019 by the Ministry of Justice and Department of Health and Social Care on proposals for introducing coronial investigations of stillbirth cases in England and Wales. [Our full response](#) is published on the College website.
- The College recommends that Coroners should be adequately resourced to ensure full post mortems can be carried out.
- The activities of Coroners should also link in to the other groups who already investigate stillbirth and perinatal death.
- We are awaiting the Government response which we understand will be published in due course; it is disappointing to see the lack of progress in this investigation.



## Contact details

This evidence was compiled by Janine Aldridge, Public Affairs Officer.

E: [janine.aldrige@rcpath.org](mailto:janine.aldrige@rcpath.org)

T: 020 7451 6769

## About the Royal College of Pathologists

The Royal College of Pathologists is a professional membership organisation with more than 11,000 fellows, affiliates and trainees, of which 23% are based outside of the UK. We are committed to setting and maintaining professional standards and promoting excellence in the teaching and practice of pathology, for the benefit of patients.

Our members include medically and veterinary qualified pathologists and clinical scientists in 17 different specialties, including cellular pathology, haematology, clinical biochemistry, medical microbiology and veterinary pathology.

The College works with pathologists at every stage of their career. We set curricula, organise training and run exams, publish clinical guidelines and best practice recommendations and provide continuing professional development. We engage a wide range of stakeholders to improve awareness and understanding of pathology and the vital role it plays in everybody's healthcare. Working with members, we run programmes to inspire the next generation to study science and join the profession.

