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

Paediatric and perinatal pathology workforce report

Foreword

Dr Clair Evans, Chair of the Royal College of Pathologists' Specialty Advisory Committee for Paediatric and Perinatal Pathology

Paediatric and perinatal pathology (PPP) is in crisis. 2 decades since the recognition of the workforce crisis, increased demand has not been matched with an appropriate training and recruitment strategy. This is demonstrated by the inability of the PPP workforce to meet existing workload, the substantial number of vacant consultant posts and the dwindling number of resident doctors coming into the specialty.

Data gathered by the College highlights the dire extent of the situation. 37% of PPP consultant posts in the UK are currently vacant. Only 3% of PPP consultants believe that current staffing levels are adequate to ensure the long-term sustainability of their service.

Services have totally collapsed in Northern Ireland, and in the South West and Midlands areas of England. Parents and families in these areas are relying on tests being outsourced to other services around the UK – services that are already struggling themselves under the demand from their own regions.

It is telling that over the 5 past years, there has been no growth in the number of paediatric and perinatal post-mortem examinations undertaken. This is not reflective of lack of demand. On the contrary, families regularly report long and harrowing waits. There is just simply not the workforce available to undertake this work.

Immediate action is needed to address a situation that has been worsening for years. This report provides solutions to address these challenges through investment and commitment from all 4 UK governments. The College is eager to contribute to clear workforce planning to enable the provision of resilient and sustainable services in PPP for UK families for the foreseeable future.

I would like to thank everyone who has made this report possible. From the College members who completed the 2025 Workforce Census, to the consultants who responded to our service surveys and the Workforce team at the College who brought the data together. Thank you to the charities who supported us and the families who kindly gave us their stories. They have helped us to highlight the immense challenges facing the PPP workforce.

Acknowledgments

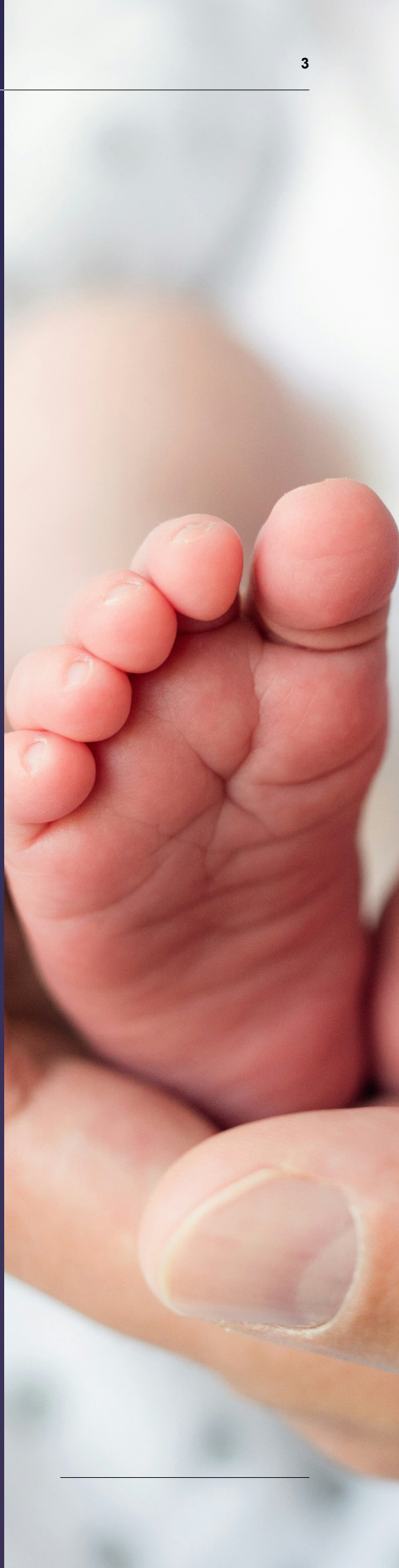
We very gratefully received a selection of case studies from SUDC UK (www.sudc.org.uk) and Sands (www.sands.org.uk) and all of these helped inform the report.

Thank you to every family who took the time to share their experiences with the College to help make meaningful improvements for those have died, who are bereaved and for our professional membership. These accounts are always reviewed and discussed with careful consideration.

Supported by

sands
Saving babies' lives.
Supporting bereaved families.

SUDC UK
Sudden Unexplained Death in Childhood
an affiliate of the SUDC Foundation



Introduction

This report highlights the crisis across UK PPP services. Severe workforce shortages prevent consultants from meeting demand, causing unacceptable delays for families awaiting test results and increased waiting times or transfer out of region for post-mortem examinations of babies and children. Urgent, long-overdue workforce strategies are needed to resolve this worsening situation.

Our findings are drawn from data gathered through our 2025 Workforce Census,[i] PPP centre data collection[ii] and Freedom of Information (FOI) requests.[iii]

Key findings

52

The UK has 52 PPP consultants working 46.35 whole-time equivalents (WTE). This comprises 43 in England, 7 in Scotland and 2 in Wales.

0

There are no PPP consultants in Northern Ireland, and in the South West and Midlands areas of England, causing total service collapse in these areas.

A quarter of the PPP consultant workforce is likely to retire in the next 5 years.

37% (30) of consultant PPP posts in the UK are vacant.

3%

Only 3% of PPP consultants believe current staffing levels are adequate to ensure the long-term sustainability of their service.

Recruitment is almost impossible due to a national shortage of qualified candidates; 83% of PPP consultants report issues with recruitment in their departments.

Only 13 resident doctors are in approved PPP specialist training. This is insufficient for current let alone future workforce needs.

By 2030, 37 (31.1 WTE) additional PPP training posts need funding to fill vacancies and help ensure succession planning.

[i] Responses from the 2025 Workforce Census give us a 95% confidence level, with a 4% margin for error to speak on behalf of the UK paediatric and perinatal workforce.

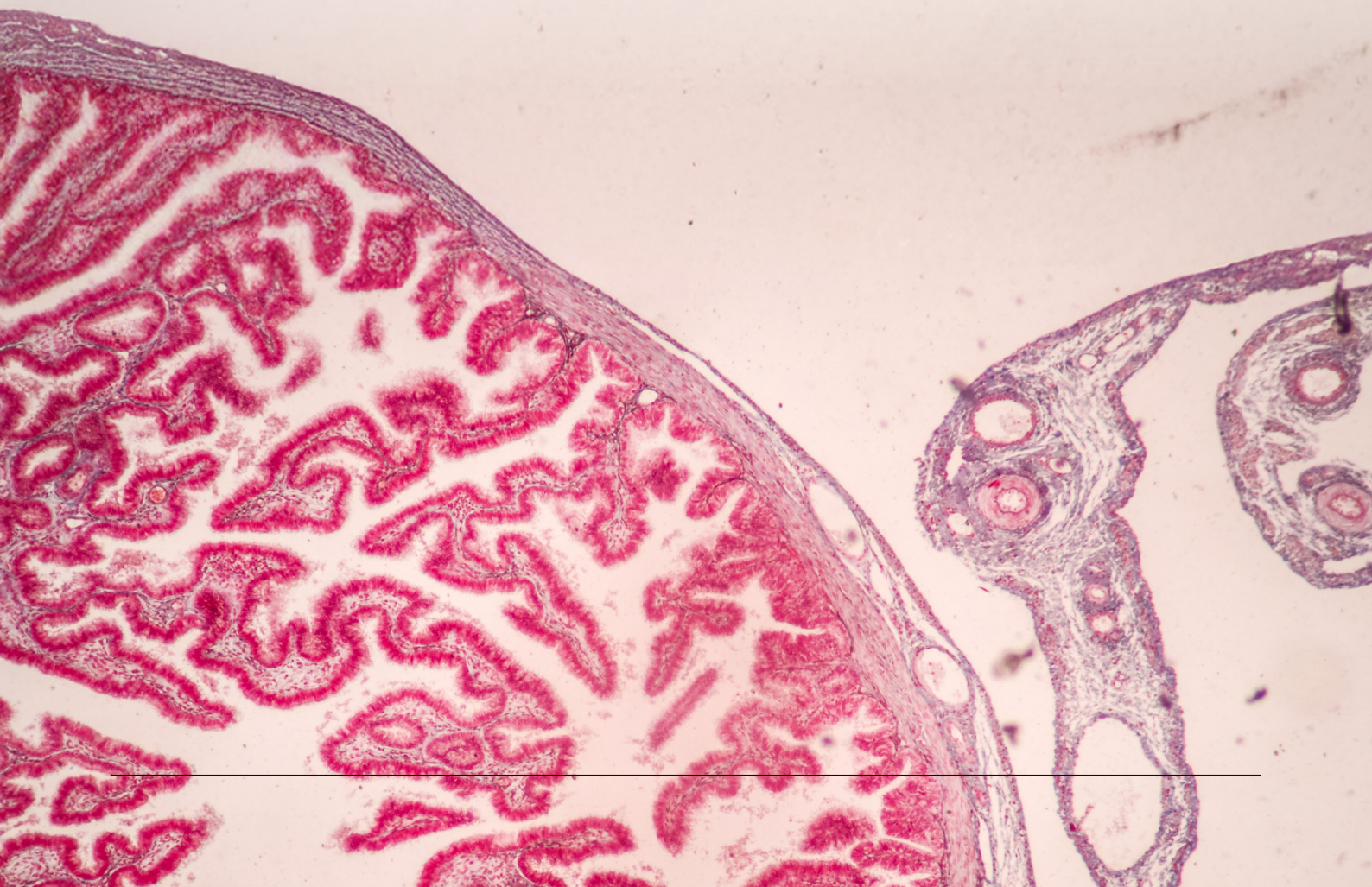
[ii] A survey was sent to all paediatric and perinatal NHS services (n=24) in the UK with consultant medical posts – we received a 100% response rate.

[iii] 24 NHS services across the UK were sent FOI requests to capture paediatric and perinatal pathology workload data – 22 responded, a response rate of 92%.

The role of a paediatric and perinatal pathologist

Paediatric and perinatal pathologists focus on the study of diseases and pathogenic mechanisms in fetuses, infants and children up to the age of 18 years. They have a crucial role in the diagnosis and treatment of a variety of conditions.

This specialty is key to the diagnosis of a variety of conditions that may have an infectious, metabolic, neoplastic or immunologic nature and/or which may be secondary to chromosomal defects or to molecular alterations. In many cases, diagnoses can help to screen other family members who may be affected. Paediatric and perinatal pathologists not only undertake post-mortem examinations, but continue to support the ongoing investigative and communication process during fetal, infant and child loss. Perinatal post mortems provide information about the cause of death and give information that aides treatment in subsequent pregnancies.



The workforce

The PPP workforce is made up of medically trained pathologists. It is one of the UK's smallest medical specialties.

PPP consultants provide 3 key services: paediatric histopathology (encompassing a very broad range of specimens), paediatric post mortems (hospital-consented cases and medicolegal cases – coronial in England, Wales and Northern Ireland and procurator fiscal in Scotland) and placental pathology. Although some pathologists specialise in either perinatal or paediatric pathology, most work across both fields diagnosing diseases and conditions affecting unborn babies through to older children.

In the UK it is estimated that 10–20% of pregnancies end in early miscarriage (less than 12 weeks), 3–4% of pregnancies end in mid-trimester miscarriage and 4 in 1,000 pregnancies end in stillbirth between 24 weeks and delivery.[1] The role of the PPP consultant in these cases of baby loss that come to post mortem is to establish – as far as possible – a cause for the death and any problems that may affect future pregnancies.

Biomedical scientists and secretarial staff work alongside medically trained pathologists. Those involved in post mortems are supported by anatomical pathology technicians (APTs) with expertise in perinatal and paediatric cases. This report focuses on the medically trained consultant workforce. However, the crisis in pathology is parallel to workforce problems affecting APTs, which also limits the capacity of the consultant workforce. APTs play a key role in providing a high-quality service to patients and families. Mortuary staff receive and release bodies following Human Tissue Act requirements, helping with the initial radiological investigations (X-ray skeletal survey / CT / MRI), evisceration at post mortem, ancillary investigation specimen handling, reconstructing and preparing the body for viewing and – importantly – running the bereavement suite and supporting relatives of the deceased.

> "APT vacancies are a huge issue in many mortuaries, which impacts on the ability of pathologists to work."
>
> **PPP consultant**

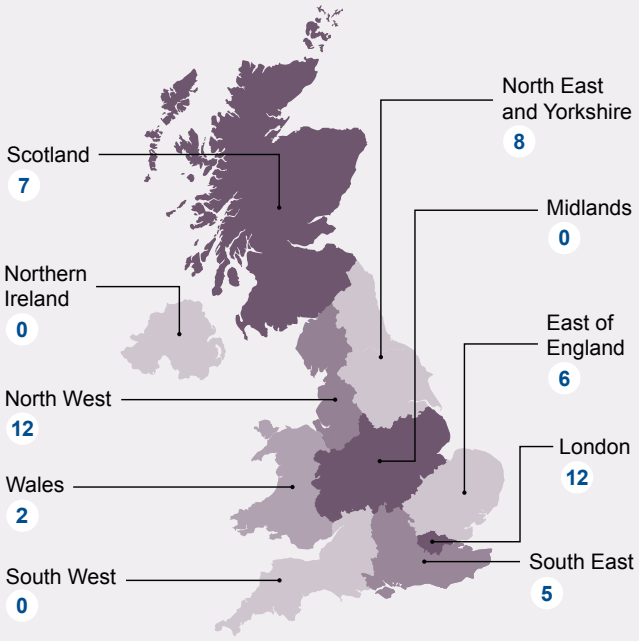
> "I am [the] singlehanded paediatric and perinatal pathologist in a busy department … I am not sure how much longer I can continue working like this."
>
> **PPP consultant**

Consultant workforce

There are 52 PPP consultants (headcount) in the UK, working 46.35 WTE.

These are unevenly distributed. For some regions, the impact of workforce shortages is dire. There are no PPP consultants in post in Northern Ireland, or the South West and Midlands areas of England, leading to the collapse of the whole service in those regions.

Figure 1: PPP consultant (headcount) by region.



Vacancies

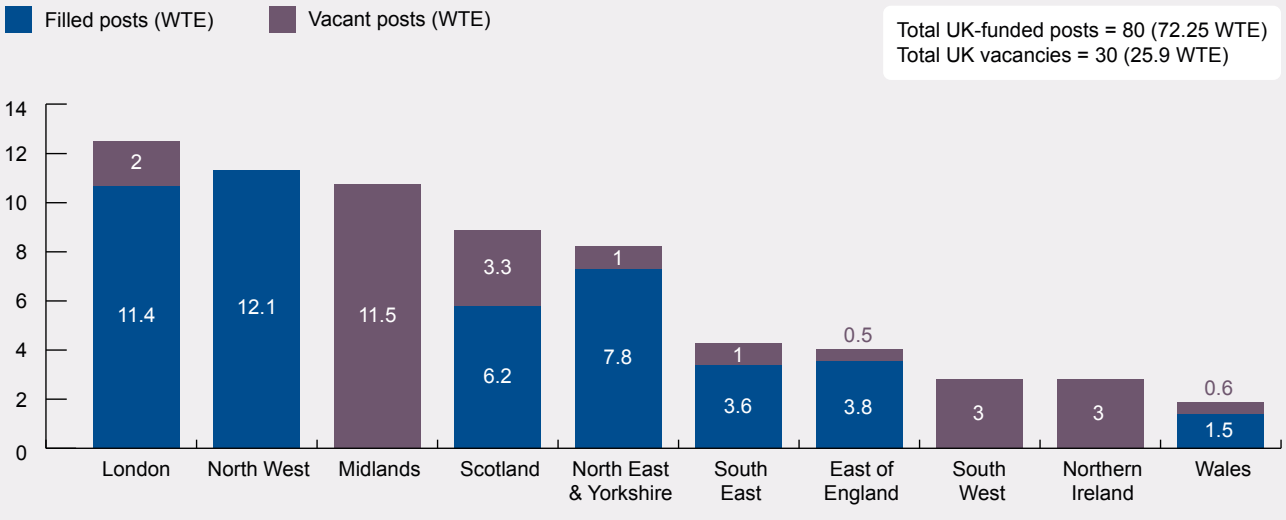
In total, 37% of all funded PPP consultant posts in the UK remain vacant.

There are several vacant senior posts in Scotland. The detrimental implications of the lack of these specialists in Scotland has been acknowledged when discussing the investigation of neonatal and maternal death in Scotland.[2]

Only 3% of PPP consultants believe that current staffing levels are adequate to ensure the long-term sustainability of their service.

3%

Figure 2: Filled vs vacant paediatric and perinatal pathology consultant posts (WTE).

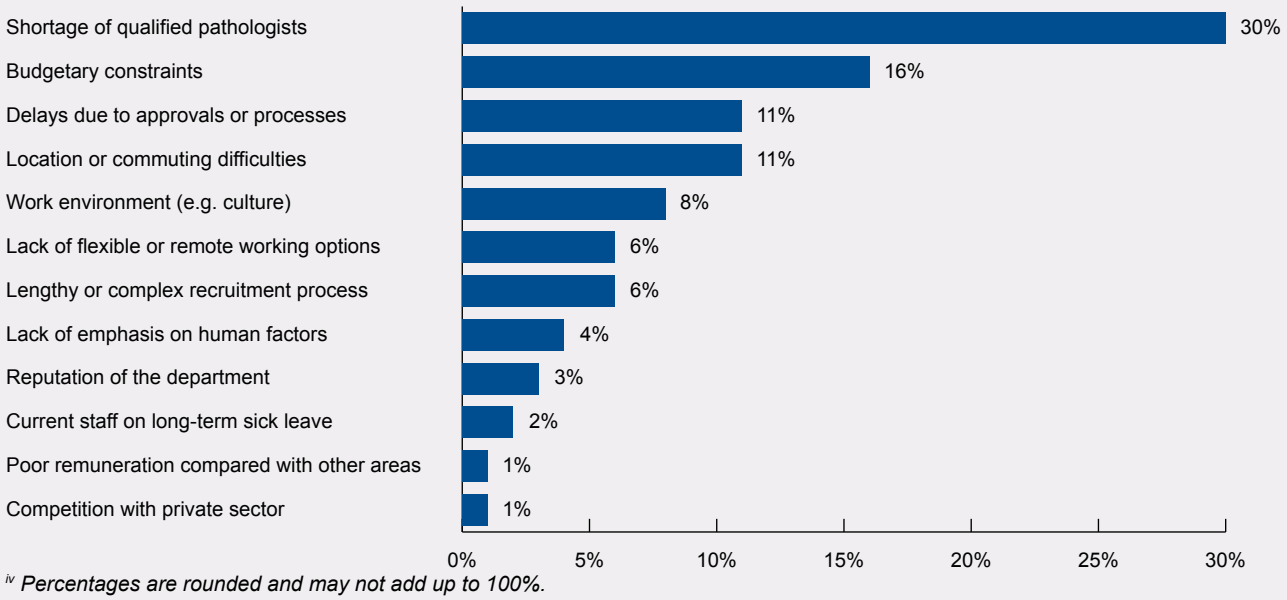


A lack of investment and support for the workforce has made recruitment of PPP consultants almost impossible. Among respondents to our 2025 Workforce Census, 83% reported difficulties with recruitment, citing shortages of qualified pathologists as the primary reason (30%).

Where services have collapsed, there is a direct impact on neighbouring services.

> "Collapsed services are only holding on because several consultants [in neighbouring areas] are doing a considerable amount of extra work there on top of more than full-time jobs in their own trusts."
>
> **PPP consultant**

Figure 3: Main barriers to recruitment.[iv]



[iv] *Percentages are rounded and may not add up to 100%.*

Real workforce gap

While vacancy rates tell part of the story, the real workforce gap is bigger. Even if these vacancies were filled, there would not be enough consultants to deliver safe and effective care to the population. To meet current demand, the UK needs 47.65 WTE more PPP consultants – more than double the number currently in post.

No specific assessment has been made of the adequacy of the number of qualified PPP consultants required to provide a resilient service by governments across the UK.

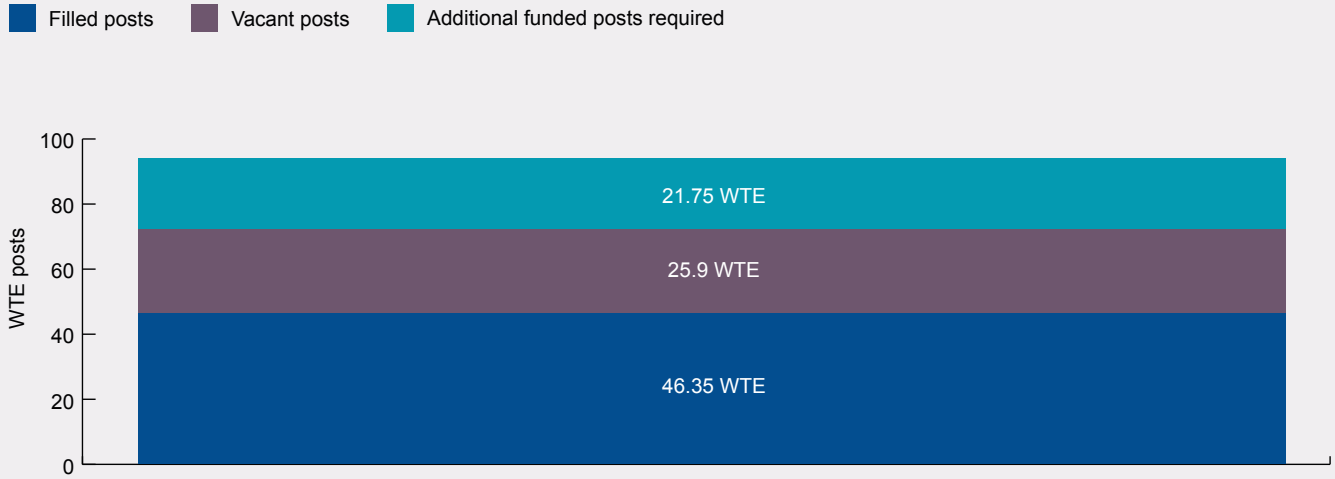
The College has estimated the increase in workforce required to meet current clinical need over and above the currently available funded posts, informed by feedback from services based on demand.

Our estimate is that one PPP consultant is required per 720,000 total population to meet current needs.[v] **For PPP, this means across the UK at least an additional 21.75 WTE posts are required on top of the current PPP consultant establishment (funded filled and vacant posts).**

The workforce crisis in PPP is acute, and there are many gaps within services. This figure indicates the number of consultants needed to deliver a safe and effective service, based on current expectations of the workforce. PPP workload demand is often driven by the availability of the service; for example, in departments where there is good access, the workload – particularly for post mortems – is higher. This figure may therefore be an underestimate.

[v] *It is noted for PPP that a calculation other than total population could be more usefully applied, e.g. birth rate. Accurate data is not available to usefully make an estimate based on these factors, which may vary over time and accordingly total population has been used.*

Figure 4: Number of PPP consultant posts filled, vacant and required (to meet service demand at 1 PPP consultant per 720,000 population).



Source: Office for National Statistics (ONS) Population Estimates.[3] RCPath internal workforce data.

This figure is an average across the UK and should be used with caution owing to the fragile nature of the PPP workforce. Geographically, there is need for PPP consultants in every centre with a paediatric hospital, and sufficient contingency should be built in to ensure that if a single consultant were to leave the service, that service would not be compromised. In areas of lower populations, running services with one consultant brings inherent risks for safety, wellbeing and training and this should also be considered in the context of considering minimum consultant numbers required per service and how these services are networked to local advantage.

Currently in England, 43 (38.7 WTE) PPP consultants are providing services to a population of over 46 million.

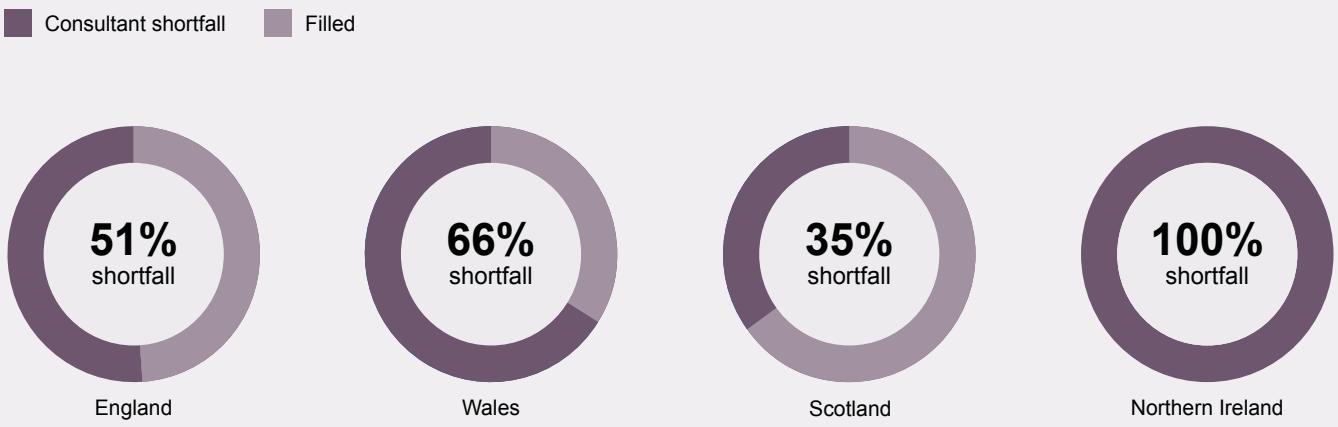
The service needs more than double this number.

The actual headcount needed is likely higher, estimated to be a least 20% more owing to the number of residents and consultants working less than full time (LTFT). Furthermore, it is important to note that only a proportion of each WTE consultant's time will be available to provide direct clinical care.

Based on this, figure 5 illustrates the consultant shortfall by country. England currently requires 79.5 WTE and Wales needs 4.4 WTE. Scotland requires at least 9.6 WTE – its current funded establishment. Northern Ireland, which currently has no service at all, requires at least 3 WTE as a minimum to restore it to its previous WTE value.

The immediate priority is to focus on filling existing vacancies.

Figure 5: Consultant paediatric and perinatal pathologist shortfalls across the UK.



Increasing demand

Paediatric surgical pathology requests are increasing by 4% per annum, and placenta specimens processed per year are increasing by 5% per annum across the UK. There has been no commensurate growth in workforce.

UK PPP services are seeing increases in service demand across the board and these increases cannot be met by the current workforce.

The NHS collects workload data in different ways, and we cannot track accurately where services are supporting work from other areas. Some services were unable to provide complete data in response to FOI requests, and some did not have data across all financial years. We cannot be sure what is being done or the number of people doing the work or where they are located. This is a consequence of inconsistent data coding across the NHS, which creates barriers to successful workforce planning.

These challenges aside, the data collected through FOI requests suggests that across the UK, PPP services are seeing increases in workload across the board.

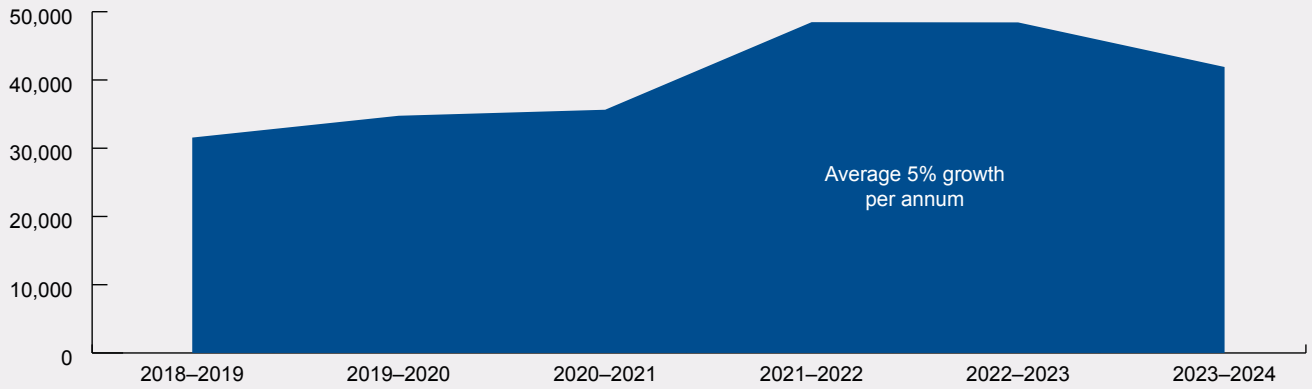
Diagnostic workload

Data sought on the total number of paediatric surgical pathology requests and placenta specimens processed per year, for the last 5 financial years, confirmed:

- total growth per annum across placenta specimen workload is estimated at 5% across the UK
- total growth per annum across paediatric surgical specimen workload is estimated at 4% across the UK.

These annual growth figures have been inconsistent year-on-year.

Figure 6: Placenta specimens workload growth (UK total).

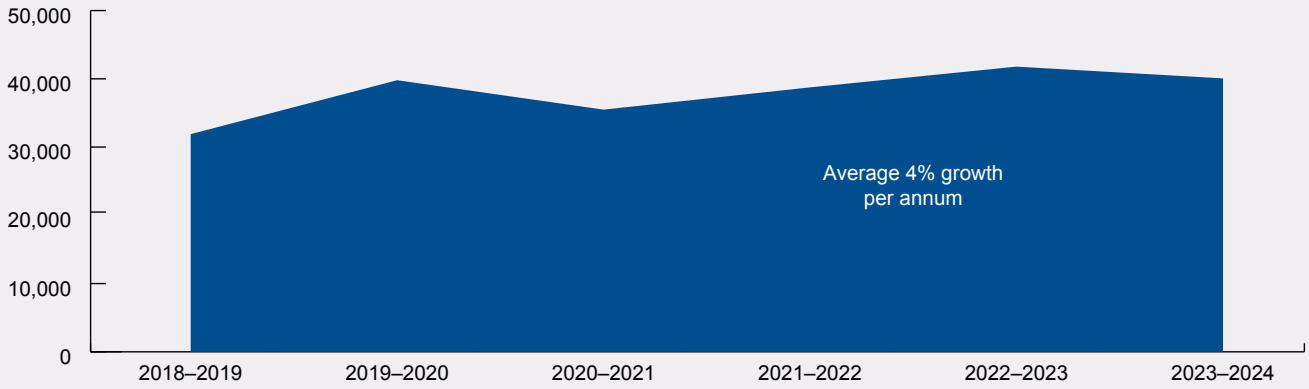


Growth varies by region. For example, the North West has the highest growth per annum for placenta specimens at 20% over 5 years. This is the only region with no vacancies, and it may represent the additional work they are undertaking on behalf of Northern Ireland. Conversely, Wales has seen decreased output (-8% growth) for placenta specimens. This is likely to be a direct impact of the service collapse in the South West, as the consultants in Wales – equivalent to 1.5 WTE – are covering their own service as well as much of the work from the South West. This is adding to workload and impacting on their ability to provide timely services to families in Wales.

The South West itself saw the highest negative growth (-11%) suggesting that, owing to severe the workforce shortage, both services are struggling to process the same number of specimens as they have in the past. However, it is difficult to draw conclusions from the data without making assumptions.

These figures also only represent request numbers, which is not necessarily an accurate reflection of increasing complexity and work done per case.

Figure 7: Paediatric surgical requests workload growth (UK total).



Post-mortem workload

Data on the total number of paediatric and perinatal post-mortem examinations per year for the last 5 financial years was less robust, due to issues in how collection varied by service. We asked for splits by paediatric coronial (procurator fiscal in Scotland) and hospital, and perinatal coronial and hospital post mortems, but 5 NHS authorities did not differentiate between the two. If all post-mortem work is added together (paediatric and perinatal post mortems – both hospital and coronial/procurator fiscal), this indicates zero growth over 5 years across the UK. Figure 8 shows indexed trends in the number of PPP post mortems completed by year, illustrating the level of change across the UK since 2018–2019 regardless of the different volumes in each country. Table 1 provides the absolute numbers.

If total perinatal post mortems and paediatric post mortems are split (and the 5 services that do not distinguish between these are omitted), there has been a 7% growth in paediatric post mortems and a -3% (negative) growth in perinatal post mortem.

Owing to the limited validity of this data, it is difficult to draw conclusions about this lack of growth in post mortems, which could be attributed to a combination of factors. However, the decline in perinatal post mortems is likely to be indicative of the current workforce supply. The workforce has always been in demand, but the diminishing numbers means there are simply not enough consultants to undertake this work, and bereaved families are waiting longer for answers.

The figures represent only post mortems that have been completed, rather than demand. Anecdotal evidence and case studies indicate that there is a huge backlog of cases or reports that are not getting processed because of the chronic workforce shortage, and a major increase in waiting times for post-mortem examination of babies and children. A recent report in Wales found one family had been waiting for 14 months and they had still not received a report from a post-mortem examination.[4]

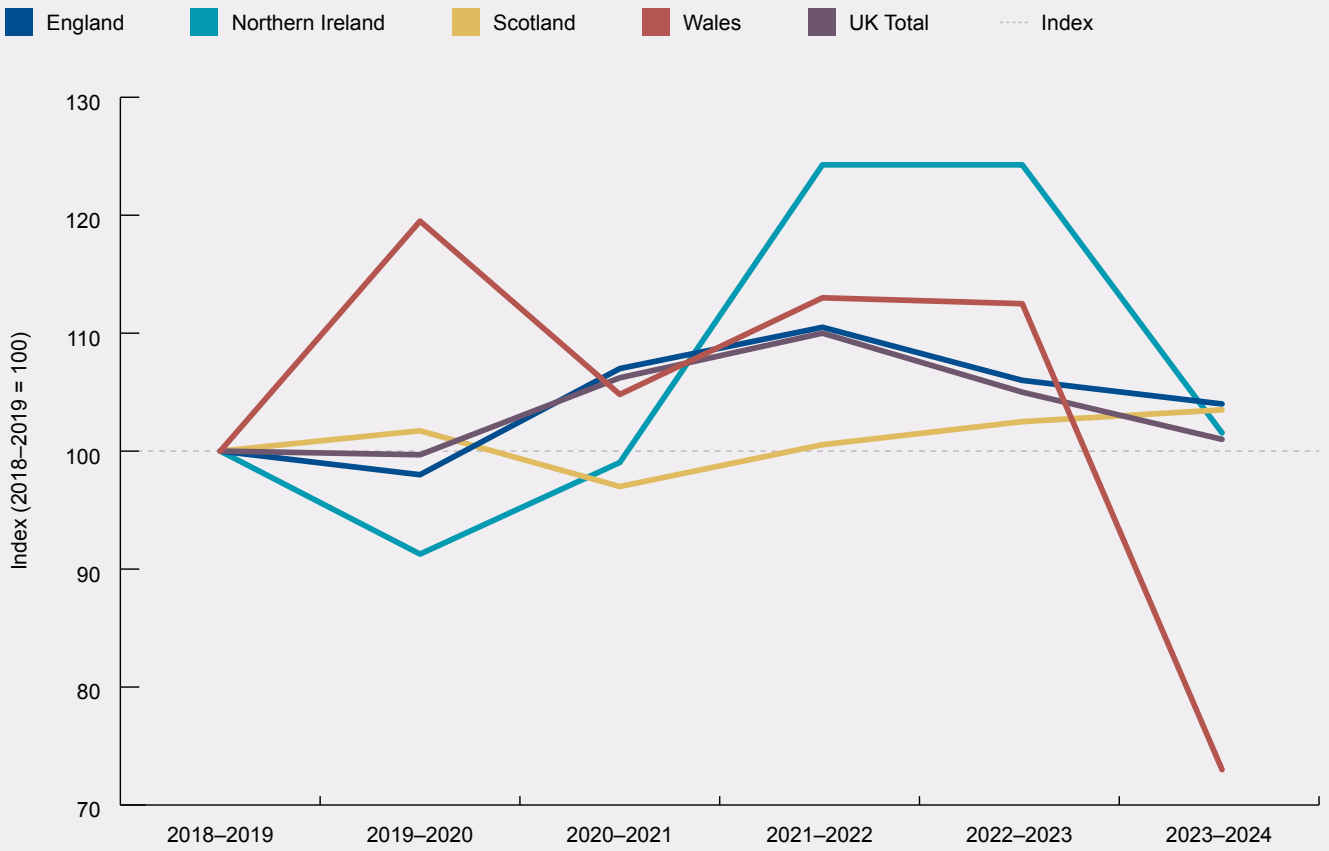
Table 1: Total reported paediatric and perinatal post mortems (coronial and hospital).

Country	2018–2019	2019–2020	2020–2021	2021–2022	2022–2023	2023–2024	Average annual growth
England	4,721	4,627	5,058	5,219	5,017	4,913	1%
Northern Ireland	173	158	170	215	215	176	0%
Scotland	623	634	605	628	576	582	-1%
Wales	226	270	237	257	254	165	-5%
UK Total	5,743	5,689	6,070	6,319	6,062	5,836	0%

Table 2: Total reported paediatric and perinatal post mortems (UK) – excluding services that did not split between paediatric and perinatal.

Post-mortem type	2018–2019	2019–2020	2020–2021	2021–2022	2022–2023	2023–2024	Average annual growth
Paediatric post mortem	436	531	560	593	600	652	7%
Perinatal post mortem	3,668	3,442	3,811	3,783	3,499	3,011	-3%

Figure 8: Indexed trends in paediatric and perinatal post mortems (2018–2024).



Why is workload and demand increasing in PPP?

Children present with a different range of conditions from adults, and paediatric pathologists are experts in unique childhood diseases. The increase in complexity and greater knowledge of the different types of conditions that affect children requires increased input from pathologists. More children than ever are surviving childhood cancer and other diseases, partly due to advances in diagnostic techniques pioneered by pathologists. This, however, has an impact on pathologists' workload through increased monitoring of patients and management of diseases and providing comprehensive information to guide patient care.

The management of surgical pathology cases has increased in complexity considerably over the past 15 years. Research and translational medicine have played a crucial role in providing better and more detailed categorisation of disease processes, expanding molecular diagnostic techniques used for cancer diagnosis and driving decision-making on personalised therapies. Technical advances that paediatric pathologists now use provide much more detailed and comprehensive molecular data on the causes of death from genetic conditions and infectious agents. This, in turn, has led to increased expectations from families and clinicians and increased requirements by legal processes to undertake much more extensive and detailed post-mortem investigations. All of this increases the workload of the reporting PPP consultant.

A recent focus by governments and other agencies to improve care for families after baby loss, improve safety in maternity services and reduce the risks has raised awareness of what more can be done. Pathologists have a crucial role in investigating baby loss and supporting this work.

How is excess demand managed?

- Some NHS authorities have managed to maintain paediatric surgical pathology services with support from general histopathologists with an interest or previous experience in paediatric pathology. However, this has not been possible for perinatal pathology – a very specialist area dedicated to the study of the fetus, neonate and placenta – nor for paediatric medicolegal (single or double-doctor forensic) post mortems.
- The specialty's breadth of scope, together with the dedication of its workforce, means it is a highly innovative and forward-thinking specialty.[5] For example, digital pathology, as part of the National Pathology Imaging Co-operative, supports faster diagnosis for children throughout the UK by enabling easy sharing of digital images between paediatric pathology centres. However, there are serious limitations in the adaptation of digital and artificial intelligence (AI) solutions without the adequate workforce, appropriate funding (including capital investment in IT infrastructure) and adequate time to oversee and train in these developments.
- Workforce challenges have led to 'mutual aid' arrangements in which centres with more capacity take cases to help those centres with less capacity. As an example, Leeds Teaching Hospitals NHS Trust has been performing fetal post mortems (including stillbirths) for Bristol, Leicester and Birmingham. While beneficial to supporting areas where services have collapsed, owing to complexities within the system, there is still limited availability of the service to support coronial post mortems. For example, not all PPP consultants perform coronial post mortems and NHS employers have varying rules on whether this work is managed within consultant job plans. It is also space / facilities dependent and relies on an adequate APT and radiology workforce, available funding and agreed costs – particularly as funding frequently does not match the workload.
- Outsourcing is another option but, as for mutual aid, relies on services being provided by an already seriously depleted workforce, or a less qualified workforce. These will not lead to stability unless they are combined with addressing the underlying workforce shortages. Outsourcing providers also express concerns about the overall PPP workforce.
- Utilisation of hub laboratories and local prioritisation are identified as effective ways of managing excess workload. For example, using interim guidance from NHS England,[6] which sets out the criteria for perinatal post-mortem investigation of fetal and neonatal deaths in England and Wales, has been helpful.

Impact on patients

The work of paediatric and perinatal pathologists has a huge effect on families, providing vital information during the most difficult periods of their lives, such as the loss of a baby or diagnosis of a child with cancer.

The impact of inadequate staffing and increasing demand within PPP services are already having a distressing impact on patients and their families.

- Workforce shortages in PPP have led to longer turnaround times for hospital post-mortem reports in some areas. 1 in 5 recently bereaved parents are now waiting 6 months or more for their babies' post-mortem results.[7]
- Plans such as mutual aid and outsourcing have not been able to avoid the increasing backlog, and in some non-urgent cases, waits for post-mortem reports are longer than 12 months.

1 in 5 recently bereaved parents are now waiting 6 months or more for their babies' post-mortem results, some more than 12 months.

- The lack of consultant staff is impacting services' ability to produce post-mortem reports in line with national guidance.[8,9]
- Northern Ireland has not had a PPP consultant in post since 2019. This means that if a baby or child needs a post mortem, their body must be transported to England. All parents should have the option to know why their baby has died, and the process of moving a baby or a child's body long distances brings significant distress for families. A lack of available consultants to recruit to vacant posts means this 'interim' arrangement has now been in place for over 6 years.
- Since perinatal pathologists in short-staffed centres struggle to find time for reporting placentas, they are frequently outsourced to private companies or may be reported by non-specialist general pathologists. In some cases, limited training and variable reporting can impact on the quality of reports provided.

> "Because I do considerably more cases than is normal for a full-time consultant, there is a massive impact on turnaround times and many families have to wait an unacceptable length of time for results (the only alternative would be to compromise quality for speed, which is usually worse). The clinicians also notice a lower standard of service – there is not a complete onsite or on-call service available, which affects fresh tumour sampling for example."
>
> **PPP consultant**

> "We have to triage our paediatric surgical pathology cases to ensure that urgent cases and cancer cases are not delayed, however, this leads to a backlog of less urgent surgical pathology cases and a resultant backlog of placenta cases in our department. This means that clinicians and patients have a longer wait for some of their pathology reports, which creates unnecessary stress and anxiety."
>
> **PPP consultant**

Family stories

Addy, died aged 2 in 2022

"Thank you for giving me the chance to speak up, something that has felt almost impossible in a society such as ours. It's not the speaking that's hard, it's getting the right people to truly listen and act.

I've had to dig deep to remember the time we spent waiting for our son's pathology results. I now realise that I'd buried much of that pain, probably just to survive. Our son, Addy, was 2 years old when he passed away in his sleep on the 20 November 2022. Just like that our world was destroyed.

The initial post mortem was inconclusive, and we were told further pathology testing would be needed, but that wait only added to our pain.

In that long wait, the questions I asked myself never stopped: Did Addy eat something? Was he allergic? Was it something we missed? Did the NHS miss something? Something I still believe to this day and I hope I'm proved wrong.

These thoughts weren't occasional, they were constant, minute by minute. I didn't sleep and still struggle to this day. In fact, I'm now writing this while in bed, awake at 5am.

The calls to the coroner's office only made it worse. We may have called two or three times in the first month, desperate for answers, only to be told, "I've never had a case where we haven't found the cause of death." The tone, the lack of compassion felt like we were being told to shut up and wait. Like we didn't matter. Again, more pain added to our grief.

We learned that we were waiting for [the consultant paediatric pathologist], a brilliant woman doing great work but surely she is overwhelmed?

There simply aren't enough paediatric pathologists. One woman carrying the weight of so many grieving families. The system is not equipped. It is overstretched, under resourced and cruelly slow.

We urgently need more pathologists. But more than that, we need fully supported teams who can give families the answers they deserve, quickly and compassionately.

This isn't just about my child, it's about your children, nephews and nieces. If you're a parent, ask yourself, what would you do to protect your child?

This could happen to anyone, it could happen to you. We never thought it would be us. You do not want to see your child's lifeless body in their cot. That image will haunt me forever. Tomorrow morning when you walk into the bedroom to wake your child, please think of us."

SUDC★UK
Sudden Unexplained Death in Childhood
an affiliate of the SUDC Foundation

Family stories

Harry, died aged 13 in 2023

"Our youngest son, Harry, died in his sleep aged 13 years in July 2023. It was sudden and unexpected as he went to bed a healthy, happy teenager and nothing was wrong with him. It was very clear that he had already gone and CPR was not going to work. The emergency teams were so kind while doing their jobs.

It is very important for us as a family to find out what happened and we were in shock due to the suddenness. It is key that the information to investigate what happened is explained clearly and in layman's terms, not technical, as our brains couldn't take any more in. We have an elder son and want to know if he will be affected as well as our nieces and nephews."

Laurellie, bereaved mother

Laurellie and her husband, Gareth, lost their little girl at 18 weeks, having gone into spontaneous labour on the 17 September 2022, turning their world upside down.

She told the pregnancy and baby loss charity Sands that trying to navigate this trauma, grief and loss was the hardest thing either of them has ever been through.

"We decided an hour after I gave birth to our perfect, tiny little girl that we needed to know why this had happened, and opted for a full post-mortem investigation. We both understood that quite often, no clear reasons can be found. However, we both knew we would want some assurances if we were to consider trying again. At the time, we were advised that the results tend to take around 3 months.

It took us a day before 40 weeks following our loss for us to finally get our answers – that there appeared to be a possible infection in a swab taken, but otherwise there was nothing clear on why we lost our baby, who appeared healthy and growing as she should have been for her gestation.

Results delays are a postcode lottery, with those in certain areas getting them within the 3 months, others still waiting for results over 12 months from their loss. The inequity is so impactful for those waiting and waiting, their lives in limbo, like ours was."

How the workforce feels

The PPP workforce has been in crisis since the early 2000s, and it continues to worsen each year.

Longstanding vacancies across the UK and increasing workloads are leaving the workforce stretched and stressed, with little time for professional development. The workforce is facing worsening conditions, and their inability to provide high-quality care to their patients due to severe resourcing issues is leaving them feeling stretched, stressed and burnt out. Retention will prove impossible the longer this goes unaddressed.

In line with findings from our 2025 Workforce Census, and consistent with the wider pathology workforce, more than half of PPP consultants are regularly working extra hours beyond the requirements of their contact, mostly without pay – i.e. the system is relying on goodwill. This is impacting morale and wellbeing, with pressures particularly pronounced in PPP owing to the chronic workforce shortages.

Work pressures

- Only 13% of PPP consultants said there was sufficient time within each working day to get through their daily workload. The three biggest factors negatively affecting wellbeing at work were reported to be excessive workload, administrative burden and staff shortages.
- Many PPP consultants report undertaking two or three times a normal consultant workload for a considerable time. Continued long hours, without relief due to long-term vacancies, has led to low levels of satisfaction and increased rates of burnout across the profession.
- Many report that their contributions to the health system, as well as stressors facing the service, are largely going unrecognised and undervalued by their employers.

> “Everyone in the department feels undervalued…”
>
> **PPP consultant**

Dwindling time for important continuing professional development and trainer activities

- Fewer than a quarter of PPP consultants agree that they are given sufficient contracted time for supporting professional activities (SPAs). Time allocated to a consultant for continuing professional development (CPD), quality improvement, research, training and service development is dwindling and, in some cases, non-existent.
- The average number of SPAs for a paediatric and perinatal pathologist is 1.66, lower than the pathology average of 1.8, and the 2.5 recommended by the Academy of Medical Royal Colleges and in model consultant contacts for NHS consultants.[10] Given most are single handed or in small units, the need for SPAs is disproportionately greater to allow for all activities to be covered.
- Consultants are currently working into and beyond their already limited contracted SPA time meaning that other supportive activities such as CPD and revalidation are put at risk. Many complete these fundamental requirements in their own time, but this risks reliance on outdated processes and tools where there is simply insufficient time to keep up with new developments.

> “There seems to be consistent lack of understanding about the needs of a small specialty and a reluctance to support the measures suggested to improve the service.”
>
> **PPP consultant**

Leaving the profession

We predict that 25% of the PPP consultant workforce will retire in the next 5 years, and more may leave for issues other than retirement in response to unsustainable workloads and service pressures.

We know from the data we gathered that the average age for retirement of a pathologist is 63. Based on this we predict that:

- 13% of the PPP consultant workforce will retire in 2 years
- 25% of the PPP consultant workforce will retire in the next 5 years
- 38% of the PPP consultant workforce will retire in the next 10 years.

It is possible that depletion in the workforce is likely to happen earlier, as responses to our 2025 Workforce Census indicate that the PPP consultant intended retirement age is 61, lower than the pathology average. Data also shows that, in general, doctors opting for voluntary early retirement has increased by an average of 9.3% year on year.[11]

Additional losses to the workforce are likely to materialise from some of the workforce emigrating to other countries, as well as other personal circumstances. Currently, data specific to PPP consultant leavers for reasons other than retirement is limited. However, this is still an important factor to consider in workforce planning.

> “I am a youngish member of the consultant body but am actively considering exit strategies should there be an ongoing deterioration.”
>
> **PPP consultant**

Joining the profession

There are not enough resident doctors currently in approved specialist training posts for PPP.

Without urgent efforts and investment to increase the number of residents, more services will collapse.

Doctors in training and trainers

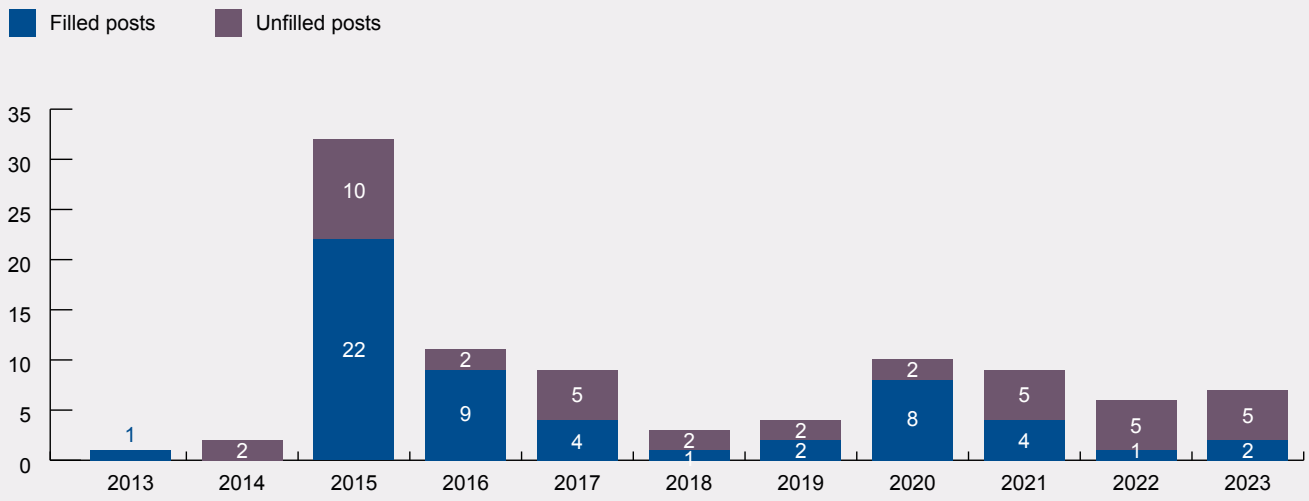
There are only 13 residents currently in an approved specialist training programme for PPP.

Applications to PPP training continue to be low, with large volumes of unfilled posts around the UK since 2015. Competition ratios are also low,[12] despite high competition ratios for specialty training places across other medical specialties. This indicates issues with the attractiveness of posts – such as location, workload and working environment – and/or a lack of awareness or understanding about PPP as a specialty training option. Residents in well-staffed centres are likely to choose to stay in these centres for employment, compounding issues in the poorly resourced areas further.

In 2023, of the 6 specialist training (ST3) posts available in England, only 2 were accepted.[13] There were only 6 applications for these 7 posts. The only ST3 post available in Scotland remained unfilled. In 2024, 7 applications were made for 3 posts – representing an increase in competition level. However, fill rates at the time of publication of this report have not been published.

> [There needs to be] enough consultant capacity, enough and varied case load, national training numbers allocated, and the space and infrastructure to support trainees consistently.
>
> **PPP consultant**

Figure 9: ST3 PPP post fill rates 2013–2023 (UK).



Source: NHS England Fill Rates.[13]

Barriers to recruitment of PPP specialty training posts

Over the past 20 years there has simply not been enough residents applying to fill training posts that are available. Governments are aware of workforce shortages in PPP and initiatives are underway to review the training pathway, develop advanced practitioner roles and implement a retention strategy for existing staff. However, these do not seem to be progressing at any pace and the impact of inaction cannot be understated. A number of issues remain.

- A previously introduced £20,000 recruitment incentive for new residents has now stopped. Funding for specialty training posts in England relies on deaneries funding 50% of residents' wages and the employing NHS trust funding the other half. This has led to a decrease in the number of PPP resident posts being offered due to difficulties with NHS trusts funding their component of salaries.
- PPP residents are drawn from the pool of histopathology residents who have completed Integrated Cellular Pathology Training (ICPT) at ST1 and ST2 level. These residents on average have only a 2-week exposure to PPP during this training, and this experience is variable with some receiving only brief exposure rather than practical experience.
- Of those who responded to our 2025 Workforce Census, only 4% of histopathology residents indicated an interest in pursuing ST3+ training options in PPP. Residents are put off because they see colleagues under huge amounts of stress and unstainable workloads. Coupled with that, the central recruitment process at ST3 level is not fit for purpose as it disincentivises residents from histopathology applying when they are already in a run-through training programme. Localised input to national recruitment is needed to address these issues. A pathway to allow a PPP stream 5-year run-through programme could assist as a further recruitment pathway.
- PPP specialist meetings are frequently held outside of the UK. Residents are limited by study budgets and some deaneries will not fund overseas courses, which may be the only way for PPP residents to access specific learning opportunities. This reflects the international community of a small specialty that operates across national borders.
- Underinvestment for over 20 years has compounded the workforce crisis, which means that, even with additional investment in training posts, there are simply not enough consultants to train the new workforce. Lack of succession planning has resulted in too few – or no – residents to replace retiring or departing consultants, ultimately leading to a breakdown in service provision. It is now impossible to host residents in services that are collapsed (Northern Ireland, and the Midlands and South West of England). Consultant recruitment and training will require significant overhaul to restore these services.
- There has been an effort to set up a conversion fellowship in England for histopathologists to move to PPP. There is only a limited number of training places and funding for 5 years is via specialised commissioning. The numbers of people recruited via this non-CCT route is also very small and not currently sufficient to meet service requirements.

Required expansion of specialty training posts

To manage the current vacancies for PPP consultants, based on RCPath modelling,[vi] 37 (31.1 WTE) new training posts need to be established across the UK by 2030. PPP services identify a further gap in the UK workforce of 21.75 PPP consultant posts. This needs to be met by an additional 31 (26.1 WTE) PPP training posts within the next 10 years. In total, there is need for at least 68 headcount (57.2 WTE) training posts over the next 10 years to provide a safe and effective service.

For PPP, these numbers are proportionally high because of the major workforce crisis, but tiny in terms of overall headcount of the medical workforce. As there are only 52 consultants currently in post, greater support is needed (e.g. SPA time) to allow for increased training provision. The first priority is to fill existing consultant posts. Consultant posts should remain funded to ensure that those completing training are able to secure employment. To address low fill rates, dedicated recruitment strategies are needed. Many residents will come through ICPT, so the impact on the wider histopathology workforce should be carefully considered. Reliance on this pathway alone will not meet PPP workforce needs and alternative sources of PPP residents coming into consultant practice are also needed.

[vi] *RCPath has modelled the number of additional residents needed across all specialties based on existing vacancy rates, and the required workforce number to meet current demand. WTE figures have been adjusted to account for attrition rates (including those who enter training who do not complete training, and those who, on completion of training, do not take up a substantive post in the NHS). Attrition rate is estimated as 20% based on internal College data and responses to the 2025 Workforce Census. Headcount has been uplifted to account for both consultants and residents working LTFT. These are working numbers based on the best available data. This methodology will develop over time as our data becomes more accurate and available and will be revisited periodically to ensure it remains fit for purpose.*

College recommendations

The PPP workforce is in severe crisis now. Longer term, this will drive more services across the UK to collapse. The future of high-quality and sustainable PPP services for babies, children and their families is dependent on investment in the workforce. Unless the multiplicity of issues are resolved, the PPP service provision crisis will deepen even more. The time to act is now.

Train

- A phased expansion of PPP training posts up to 37 (31.1 WTE) across the UK by 2030 to help manage current consultant vacancies and help ensure succession planning. Funding must be committed for consultant posts to ensure that those completing training are able to secure employment. Recruitment should focus on centres or regions with workforce gaps, ensuring that high-quality supervision and practical PPP experience can be realistically delivered; where local opportunities are limited, flexible approaches should be considered.
- Governments must commit funding and resources for continued development of Fellowship in Paediatric and Perinatal Pathology and fund 10 fellowships in the next 10 years, with committed support for training sites and a clause for graduates to stay working in the NHS for a specified period of time included in the contract.
- Continue ongoing process of curriculum review for PPP to improve and maintain the highest standards of PPP workforce development, so that staffing does not affect quality of training. This includes supporting access to practical PPP experiences where feasible, with flexible approaches to accommodate centre capacity and trainee needs. This requires funding and educational support from all 4 governments to substantiate curricular delivery and attract doctors into the specialty.
- Review the routes of entry for PPP and consider implementation of localised and more frequent recruitment to support local interested candidates. This includes committed funding by NHS organisations to training posts allocated by deaneries to areas that are underserved so that these posts can be taken up.
- Increased financial support through study leave budgets for residents to attend specialist meetings and training overseas, which may be the only way for PPP residents to access educational opportunities.

Retain

- Increased workforce support with dedicated biomedical scientists, APTs and administrative support in each paediatric pathology unit – delivered flexibly to meet the needs of the service, together with managerial support that recognises the unique pressures facing PPP.
- Greater support for funding via study leave budgets to recognise the additional expenses of maintaining high-quality care in PPP where education and learning opportunities are frequently outside the UK.
- Dedicated protected time for professional development to enable PPP consultants to have time to train the next generation and support their own personal development. As a minimum, consultants should be provided with 2.5 SPAs in line with guidance from the Academy of Medical Royal Colleges.

Reform

- Create a cadre of additional workforce by upskilling biomedical science/science graduates to do a 2-year Diploma Course in Placenta Reporting (to be jointly developed by the Institute of Biomedical Science [IBMS] and RCPath) so they can be appointed as consultant healthcare scientists, supervised by medical consultants.
- Create opportunity for histopathologists – for example gynaecological pathologists – engaged in placenta reporting to enrol in a funded short online placenta reporting course (3–6 months) with opportunities for external quality assurance (EQA) and CPD by their respective employing departments.
- Collaboration between the College, the 4 governments and employers to support the targeted recruitment of 25 WTE consultant level paediatric and perinatal pathologists with calls to the EU and EEA. Approach suitably trained consultants through national and international advertising and provide support to ensure candidates meet General Medical Council (GMC) and RCPath requirements to take up vacant posts. Recruitment should be phased according to service need.
- Invest in digital pathology and research projects to aid the progress of AI as part of transformation programmes – timely technological developments can help transform pathology services in the NHS and beyond.

- Work should continue across the UK to include clear workforce planning to determine the number of qualified paediatric and perinatal pathologists required to provide a resilient service now and in the future.
- Governments to improve and standardise data collection, commissioned across the 4 nations, to capture the extent of the backlog of paediatric and perinatal cases to inform this planning.
- In England, the Department of Health and Social Care (DHSC) should continue to progress work previously set up under NHS England's Perinatal Pathology Transformation Programme to implement interventions to increase perinatal pathology service capacity over time and improve the post-mortem reporting time in England.

Contingency

- Continued development of guidance, such as the placental pathway publication,[14] which revised the indications for placenta requiring histopathological examination, to reduce the number of referrals to where it makes the most valuable contribution to maternal care.
- Continued identification of prioritisation and hub working as effective ways of managing excess workload, such as the interim guidance from NHS England, which sets out the criteria for perinatal post-mortem investigation of fetal and neonatal deaths in England and Wales.
- Continued support for mutual aid as long as this is supported by concurrent efforts to increase the workforce more broadly.

References

1 Data sourced from Tommy's – the pregnancy and baby charity. Available at: www.tommys.org/baby-loss-support/pregnancy-loss-statistics

2 Health Improvement Scotland. *Neonatal mortality review: February 2024*. Available at: www.healthcareimprovementscotland.scot/publications/neonatal-mortality-review-february-2024/

3 Office for National Statistics. *UK population estimates.* Accessed August 2025. Available at: www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates

4 BBC News. Accessed 8 August 2025. Available at: www.bbc.co.uk/news/articles/c5yprkme5y4o

5 RCPath Bulletin January 2025. *Innovation in paediatric and perinatal pathology*. Accessed August 2025. Available at: www.rcpath.org/resource-report/innovation-in-paediatric-and-perinatal-pathology.html

6 NHS England. *Post-mortem investigation of fetal and neonatal deaths (England and Wales)*. Updated December 2024. Accessed August 2025. Available at: www.england.nhs.uk/long-read/perinatal-post-mortem-investigation-of-fetal-and-neonatal-deaths-england-scotland-and-wales/

7 Sands – Saving babies' lives. *Supporting bereaved families.* Accessed August 2025. Available at: www.sands.org.uk/about-sands/media-centre/news/2023/10/sands-calls-end-baby-post-mortem-delays

8 NHS England. *NHS Standard Contract for Perinatal Pathology 2013/14*. Accessed August 2025. Available at: www.england.nhs.uk/wp-content/uploads/2013/06/e12-perinatal-path.pdf

9 Royal College of Pathologists. *G191 Guidelines on autopsy practice: sudden unexpected deaths in infancy and childhood.* Published November 2023. Available at: https://www.rcpath.org/static/57243bdd-ee48-40ca-8199540e77b29892/G191-SUDIC.pdf

10 Academy of Medical Royal Colleges. *Advice on Supporting Professional Activities in consultant job planning.* Published February 2010. Accessed August 2025. Available at: www.aomrc.org.uk/wp-content/uploads/2024/10/Advice_on_SPA_in_job_planning_0210.pdf

11 Moberly T. More doctors are choosing to retire early. *BMJ* 2023;381:1450. Accessed August 2025. Available at: www.bmj.com/content/381/bmj.p1450

12 NHS England. *Competition ratios.* Accessed August 2025. Available at: https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/competition-ratios/2024-competition-ratios

13 NHS England. *Fill rates*. Accessed August 2025. Available at: https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/fill-rates

14 Royal College of Pathologists. *G108 Tissue pathway for histopathological examination of the placenta.* Published September 2022. Available at: www.rcpath.org/static/ec614dfa-007c-4a93-8173cb202a071a72/a8b51280-edf3-4414-9197ab58d641bafd/G108-Tissue-pathway-for-histopathological-examination-of-the-placenta.pdf

The Royal College of Pathologists

Pathology: the science behind the cure

The Royal College of Pathologists, 6 Alie Street, London E1 8QT

Tel: +44 (0) 20 7451 6700 | Email: info@rcpath.org