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

The Royal College of Pathologists' response to the NHS 10-Year Workforce Plan: Call for evidence

Response to section 3: Productivity gains from wider 10-Year Health Plan implementation

November 2025

Contents

1 Executive summary

Productivity gains by improving workforce productivity or reducing demand are vital to realise the ambitions of the 3 shifts in the NHS 10-Year Plan.

Other countries that have tried to make these shifts happen, such as Denmark and Ireland, have shown how important it is to invest in community services in parallel with hospitals.[1] Without additional funding this is extremely difficult.

The NHS estate and transport model is outdated, and modernising this provides huge opportunities. Investment in infrastructure – in buildings, IT systems, and workforce – will greatly enhance productivity across pathology and the wider healthcare system. Cutting edge technologies (and their associated efficiencies) could be introduced; staff wellbeing – and, therefore, retention rates – could be improved; and sample transfer delays could be reduced, improving cancer care pathways and outcomes for patients.

Modernisation efforts – including automation, digital pathology, AI integration and expanded roles for scientists – offer only partial mitigation and will not fully address existing workforce gaps. Diagnostic stewardship must also be prioritised and resourced to help manage demand and ensure sustainable service delivery. Significant investment is needed now to realise future gains.

The recommendations below focus specifically on this consultation topic – productivity gains. A full set of the College's recommendations across all 4 NHS England consultation papers – the 3 shifts, modelling assumptions, productivity, and culture and values – is provided at the end of each document.

2 College recommendations: Productivity gains

- Invest in administrative and support staff to reduce clinical burden and improve efficiency.
- Modernise IT systems and laboratory infrastructure to support digital pathology and interoperability.
- Centrally fund national rollout of digital pathology, recognising the different needs and the workforce implications for each pathology specialty.

- Improve interoperability of laboratory information management systems (LIMS) with electronic patient records and prescribing platforms.
- Standardise training and governance for AI integration, ensuring pathologists are equipped to validate and use digital tools safely.
- Establish more digital pathology fellowships to support and develop the workforce in the digital era, enabling greater impact.
- Support flexible research opportunities, including short clinical projects and multidisciplinary programmes in collaboration with universities, improving access to statistical and research governance support to streamline approvals.
- Expand protected academic training posts and increase the number of academically trained senior doctors to supervise and mentor trainees to ensure that the pathology workforce is adequately resourced to research and develop new innovative ways of working.
- Invest in laboratory services to support service development and innovation. Future roles must be equipped to provide clinical leadership from within laboratories, working collaboratively in multidisciplinary teams.
- Promote diagnostic stewardship to reduce unnecessary testing and improve resource use.
- Strengthen multidisciplinary collaboration across care pathways to support efficient diagnosis and treatment, especially in community settings.
- Continue improving pathology classifications and standards to support consistency and quality to reduce burden on the workforce.

3 Digital initiatives in pathology to increase workforce productivity

3.1 Digital pathology

The National Pathology Imaging Co-operative (NPIC) based in the Leeds Teaching Hospitals NHS Trust is bringing together NHS infrastructure, academia and industry to support digital pathology, whole-slide imaging and AI-based tools.[2] Oxford's cellular

pathology department became one of the first departments to digitise 100% of surgical histology and referral slides within the cellular pathology department, enabling virtual pathology training and remote work.[3] PathLAKE's is 1 of 5 UK Centres of Excellence in digital pathology and medical imaging. It provides education and training via modules and online courses aimed a trainees and pathologists to build reporting and digital competencies.[4]

Both the NPIC and PathLAKE have been funded with £50 million investment, which highlights the scale of the investment needed to realise benefits. While this investment is welcome, the impact would be amplified by establishing a greater number of digital pathology fellowships, supporting and developing the workforce in this area and enabling greater impact.

To expand digital pathology, investment is needed to build on NHS-funded centres of excellence, which can support wider rollout by sharing standards and expertise. Digital pathology requires a national strategy across all pathology specialties, recognising the different needs – including workforce implications – for each discipline. A nationally coordinated approach could strengthen standardisation – especially across networks – ensure equitable access, allow centres of excellence to focus on high-quality testing while supporting local adoption, and provide strategic oversight to promote consistency across the country. This approach would also facilitate integration with other national initiatives, such as genomic testing and future AI developments.

3.2 AI

AI has to potential improve efficiency and productivity in pathology including for cancer diagnosis, automating routine tasks, increasing capacity, enabling remote collaboration and supporting clinical decision-making to improve patient outcomes.[5] Further details and case studies are provided in our *Response to section 1: The 3 shifts.*

3.3 Forensic and coroner-based death investigations

Autopsy services contribute to community health by informing disease trends, supporting bereaved families and guiding public health interventions, including monitoring infections and drug toxicity. Sustaining these services strengthens the NHS's role in serving local communities and contributes to national safety. However, autopsy services are facing

significant workforce and infrastructure challenges. Digital innovations, including post-mortem imaging and virtual training programmes could help maintain service delivery and improve productivity.

Data from the RCPath Workforce Census 2025 ('Census') found that nearly a quarter (24%) of consultants who currently undertake autopsy work intend to give it up in the next 5 years, and fewer residents pursue autopsy work. Among those intending to stop performing autopsies in the next 5 years, 43% cited workload pressures from their wider histopathology duties, and 43% identified inadequate remunerations as a key factor. Training opportunities in autopsy practice are declining, with many histopathology residents (56%) not intending to take the Certificate in Higher Autopsy Training (CHAT). Residents reported lack of interest (61%), high curricula workload (66%), inadequate support or supervision for training (33%) and insufficient case exposure (26%) as reasons.

The introduction of dedicated autopsy training – the CHAT – ensures that only residents who wish to pursue autopsy practice received focused experience. While structured national programmes and digital learning resources – such as virtual autopsy case libraries, simulation-based learning, and interprofessional modules with radiology – can support training in regions struggling with workforce shortages or case exposure, these tools should complement, rather than replace, practical autopsy experience.

Similar concerns are raised around cervical cytology, with centralisation of services meaning residents only gain hands-on experience or chose to complete the Certificate in Higher Cervical Cytology Training (CHCCT) if they are based near a centre that offers this service.

3.3.1 Post-mortem imaging

Post-mortem CT and MRI are being adopted in hospital and coronial settings, enabling minimally invasive autopsy.[6] Successful implementation of post-mortem CT services requires alignment with local needs and careful consideration of challenges related to access, funding, and data security.[7] Programmes in Oxford, Leicester, Sheffield and Manchester have demonstrated that virtual autopsy can, in some instances, reduce the need for full invasive procedures while maintaining diagnostic accuracy and speeding up turnaround times for the coroner. In some scenarios, this approach is also preferred by patients and family.

While digital post-mortem imaging offers efficiency, it also will contribute to continuing decline in traditional autopsy numbers, reducing opportunities for hand-on training as described above. It is critical to retain a small, highly dedicated workforce of specialists who can correlate imaging with post-mortem tissue findings. Such expertise ensures that complex cases are accurately interpreted and that training quality is maintained.

Not all cases may be suitable for post-mortem imaging. For example, if there is any suggestion of criminal conduct or neglect leading to the death it is likely that a full invasive post-mortem will be requested at the outset. Scaling these technologies into standard mortuary practice requires national commissioning, workforce training, digital infrastructure, robust governance and clinical leadership to ensure safe, clinically appropriate and meaningful use.

Case study 1: Digital post-mortem imaging in paediatric and perinatal pathology.

For many years it has been standard practice to perform an X-ray (radiograph) before perinatal (and some paediatric) post-mortems, but, more recently, there has been increasing interest in other radiology imaging techniques to examine the internal organs, both as an adjunct to 'traditional' post-mortems, and also as a form of 'digital' post-mortem. These modalities include ultrasound, computed tomography (CT) post mortem, magnetic resonance imaging (MRI) and micro-CT. There is also ongoing research into high-field MRI. The images are reported by a radiologist with special expertise in this field.

There is some evidence to suggest that digital post-mortems may be more acceptable to some parents. Digital post-mortems are not complete in themselves. As in traditional post-mortems, the imaging needs full integration with the clinical history, external examination, placental examination and other investigation results to produce the final report – and therefore can be a valuable adjunct to providing accurate diagnosis. The use of digital post-mortem techniques still needs to be tailored to the clinical scenario and availability of resources/expertise.

Post-mortem MRI was first introduced at Sheffield Children NHS Foundation Trust, and now this procedure is used in 30% of the perinatal post-mortem caseload at this trust, improving the efficiency, reducing the time taken for autopsy and maintaining quality.

Further investment in this area has potential for increased productivity by adding value and accuracy to a post mortem.

3.4 Infrastructure and automation

High-quality infrastructure, IT systems and administrative support are essential for safe, efficient and productive pathology services. Our Census shows only 36% of pathologists feel adequately resourced for administrative tasks, and just 40% stated their employer provides effective facilities. Outdated infrastructure, fragmented IT systems and limited interoperability are repeatedly cited as barriers to productivity by our members.

Hospital infrastructure also presents challenges. For example, poor ventilation, limited isolation capacity, and ageing estates hinder infection prevention and control. Services with investment in modern estates, laboratories and interoperable IT systems report improved efficiency. Standardisation and integration of digital platforms across NHS Trusts are critical to enabling effective diagnostics and workforce optimisation.

Where investment has been made in modern estates and digital systems, measurable improvements are evident. When it comes to automation, high-throughput automated laboratories require a different staff skill mix than conventional settings. For example, additional recruitment of higher banded staff (e.g. AFC Band 7 and above) is needed to troubleshoot and maintain complex automated equipment. Alongside dedicated staff, having a sufficient number of instruments is essential to ensure resilience, e.g. if 1 machine fails, others can take over the workload, preventing disruption. Reducing workforce support or failing to provide adequately trained staff while investing in modernisation can put the entire service at risk. Strategic workforce planning and investment are, therefore, critical to maintain operational safety, efficiency and continuity of services when shifting from analogue to digital to improve productivity.

Case study 2: Histopathology automation in Cambridge.

Where investment has been made in modern estates and digital systems, measurable improvements are evident. In Cambridge, locating histopathology services to a new, automation ready laboratory – designed to accommodate high-throughput analysers and integrated digital systems – led to marked improvements in workflow, turnaround times

and staff morale. The previous facility lacked the physical space and environmental infrastructure to implement automation.

3.5 Intelligent laboratory approaches

The Intelligent Liver Function Test developed in Scotland, is an example of how 'intelligent' laboratory medicine can not only provide accurate and reliable test results, but aid directly with interpretation and diagnosis results.[10]

Such intelligent platforms should be trialled and expanded to appropriate new disease areas and into routine practice as appropriate as a matter of priority – to aid the wider range of professionals ordering and interpreting lab results, to increase healthcare efficiency by reducing unnecessary and duplicate testing and, ideally, to provide results directly to patients, alongside patient – appropriate interpretations.

Expanding intelligent diagnostics to areas such as full blood count (iFBC) and diabetes (iDiabetes) offers significant benefits. iFBC, for example, reduces laboratory workload and costs while improving patient experience through timely, targeted testing. There is need to support the integration of innovations – such as ceramide profiling from the CERT trials.[11]

These approaches are essential to meet the needs of an ageing, multimorbid population and should be prioritised in future service development and workforce planning.

4 Training and workforce initiatives needed to support productivity

4.1 Impact of technology on pathology training

Training must evolve alongside technological advancements, supported by investment in equipment and protected time for staff to learn and apply new tools effectively. A survey of histopathologists in training evidence the need for provision of training and support during the transition to digital pathology, and for consideration of their need to maintain competence and confidence with glass slide reporting.[12]

Despite the growing importance of digital pathology, training remains inconsistent. Disparities exist between digital and traditional microscopy-based learning, both within the UK and internationally. As services transition to fully digital laboratories, a mismatch is emerging between trainees prepared for digital environments and those trained in conventional settings.

Pathologists must develop the skills to critically interpret AI-generated outputs, understanding how inputs correspond to results, when outputs are plausible and when additional testing is required. This includes awareness of validation, limitations and safe integration of AI into diagnostic workflows. While AI can offer clear benefits in efficiency and productivity, concerns have been raised that its use may reduce opportunities for experiential learning by automating straightforward cases typically used to build familiarity with normal tissue morphology. Concerns have also been raised that AI could diminish structured training opportunities by replacing cases traditionally used for early reporting experience, a challenge that parallels issues arising from outsourcing primary reporting.

Training curricula must incorporate foundational AI knowledge to enable pathologists to collaborate effectively with data scientists and contribute to clinical research. While pathologists may not lead AI development, they should be equipped to engage in informed dialogue and guide its clinical application.

Development of pathology leadership within laboratories is also important. For example, chemical pathologists, with other senior laboratory professionals, are expected to lead on quality assurance, regulatory compliance, incident management and workforce development, often while providing real-time clinical advice. Bridging the gap between laboratory data and its clinical application requires more than technical knowledge; it demands experience, clinical judgement and the ability to liaise effectively across departments. This hybrid role is not only intellectually rewarding but increasingly necessary as diagnostics become more central to patient pathways.

The growing availability of large-scale laboratory and clinical datasets is creating demand for clinicians equipped to harness big data in diagnostic innovation. Pathologists are increasingly expected to contribute not only to test interpretation but also to the design of data-driven pathways that embed pathology within clinical decision-making, moving beyond the traditional perception of the laboratory as a passive data provider.

To support this broad skillset, pathology training must remain robust, structured and accessible. Frontloading laboratory-based teaching and experience earlier in specialty training can assist in enabling specialty registrars to achieve core competencies more efficiently, freeing up time in the latter years of training to focus on generalist and subspecialist expertise, clinical leadership and innovation.

Case study 3: Ensuring chemical pathology training is evolving with modern healthcare demands

A good example of recent progress in the area of training is the MetMed initiative, created and maintained by Imperial College Healthcare NHS Trust. This provides free access to a growing set of teaching resources in laboratory medicine, including recordings from FRCPath training days and introductory lectures in analytical chemistry hosted through www.metmed.info and the Pathology Portal. This offers a promising model for how national collaboration can support equitable, high-quality training across regions and promote greater consistency in laboratory education.[13] As pathology continues to evolve to be both a laboratory and clinical specialty, training must reflect this – especially in chemical pathology will play a crucial role in delivering aims for preventative medicine around cardiometabolic disease crucial to the success of the 10-year plan.

4.2 Impact on shift to community on pathology training

As healthcare delivery shifts from hospital to community models, pathology training must adapt to ensure future consultants are equipped to provide high-quality diagnostic and clinical services across laboratory, hospital and community settings. The 10-Year Health Plan's emphasis on community care highlights the need for pathology specialists to gain sufficient experience within outpatient environments during training.

Although current curricula include provision for outpatient experience, opportunities can be inconsistent across regions. Increasing inpatient demands and procedural workloads – such as bone marrow biopsies in haematology – can limit residents' exposure to outpatient management. This imbalance, driven by service pressures within hospital-based care, risks leaving newly qualified consultants less prepared to deliver comprehensive outpatient services or provide effective advice and guidance in community settings.

The College will continue its ongoing process of curriculum review to improve and maintain the highest standards of workforce development uniformly.

4.3 Diagnostic stewardship

Pathologists play a central role in diagnostic stewardship by advising clinicians and patients on appropriate test selection, interpretation, and the broader diagnostic process. Their expertise ensures testing is clinically justified and results are contextualised to support effective decision-making. Further details and case studies are provided in our *Response to section 1: The 3 shifts*. As highlighted in that section, Scotland's commitment to 'realistic medicine' – a model of personalised, equitable care – demonstrates how shared decision making between patients and clinicians can improve resource use and outcomes. Adopting similar principles in England could enhance workforce efficiency and reduce unnecessary testing.

4.4 Turnaround times and efficiency

Turnaround time is a key performance indicator in pathology and a marker of service quality and efficiency. However, delays often occur when capacity, volume and staffing are exceeded. A major challenge is the overuse of urgent requests, which can disrupt workflow, delay genuinely urgent cases and increase pressure on both ward and laboratory staff.

The Eastern Pathology Alliance undertook a project to review turnaround time challenges, highlighting the need for better prioritisation, improved communication and more efficient systems.[14] Lessons from this initiative should be shared and adopted more widely to support service improvement.

4.5 Multidisciplinary team working

Pathology services rely on a multidisciplinary workforce – including medical, scientific, clinical support staff and administrative staff – to deliver safe, high-quality care. Optimising skill mix within integrated teams improves productivity, efficiency and service resilience. Investment in laboratory services is essential to allow pathologists to be equipped to provide clinical leadership from within laboratories, working collaboratively in multidisciplinary teams.

For example, as cancer care becomes increasingly complex, effective multidisciplinary team (MDT) working is essential. MDTs must evolve beyond case review to become spaces for service redesign, quality improvement, and collaborative care planning. The College has called for reform of MDT meetings through joint advocacy with the Royal College of Radiologists and other professional bodies.[15]

Strengthening multidisciplinary collaboration across care pathways – particularly in community settings – supports timely diagnosis and treatment. Evidence from an Irish national study highlights the value of MDT review in detecting pathology errors before treatment, while also recognising the significant workload involved.[16] This reinforces the need to account for MDT participation in workforce planning and to acknowledge the critical role pathologists play in enhancing patient safety.

4.6 Research to support productivity

Strengthening research capacity in pathology is essential to drive innovation, improve productivity and translate advances – such as whole genome sequencing – into clinical practice. Coordinated partnerships between universities, industry, and the NHS – potentially supported by the Medical Schools Council – are needed to support academic trainees and reverse the decline in clinical academic posts.

Pathologists must have ringfenced time for research, training, clinical trials, and innovation. Stronger collaboration between academia, NHS pathology services and industry will be vital to accelerate the adoption of new diagnostic and digital tools, improving efficiency and productivity.

Current barriers, including lengthy ethical approval processes, fragmented governance and limited clinician time all hinder progress. Investment in supportive infrastructure is needed to enable meaningful research, including better use of NHS data and a unified medical record system to facilitate patient follow-up and data sharing.

Future service models must go beyond test delivery to embed teaching, training, research and innovation as core functions of pathology.

5 College recommendations

Immediate action is needed to develop a pathology workforce fit for the future. Investment in infrastructure, technology, IT, automation, digital pathology and advanced roles will enable pathology to increase productivity, reduce demand and improve patient pathway. But investment is needed first to realise these goals.

To ensure that these investments translate into sustainable improvements, centralised workforce planning for pathology is essential. This should include modelling based on current establishments, vacancies, projected retirements, workforce attrition, less-than-full-time (LTFT) working, service redesign, and centrally collected and analysed pathology diagnostic data to inform workforce planning.

Responding to NHS England's 4 consultation requests – the 3 shifts, modelling assumptions, productivity and culture and values – the College makes the following recommendations.

5.1 Train

- Fund at least 150 additional medical training posts across all pathology specialties, aligned with population needs. Commit funding for equivalent consultant posts to ensure employment opportunities for those completing training.
- Invest in dedicated UK training pathways for pathologists and scientists to secure safe and sustainable service provision now and in the future.
- Reinstate locum appointment for training posts to support flexible and LTFT training pathways.
- Expand the multidisciplinary workforce, including clinical scientists, biomedical scientists and bioinformaticians, as well as the medical workforce to meet the identified shift to precision medicine.
- Embed genomics and AI training into Scientist Training Programme (STP) and Higher Specialist Scientist Training (HSST) programmes to future-proof the workforce.
- Introduce effective incentives for recruitment in hard-to-fill specialties and underserved regions.

- Fund training and resources to support implementation of genetic and molecular testing.
- Develop strategies to attract medical students and scientists into pathology, promoting the specialty as offering excellent work–life balance and career flexibility.
- Expand protected academic training posts and increase the number of academically trained senior doctors to supervise and mentor trainees to ensure that the pathology workforce is adequately resourced to research and develop new innovative ways of working.

5.2 Retain

- Provide protected time in job plans for professional development, research, teaching, innovation and national professional contributions and ensure these are honoured in practice.
- Invest in administrative and support staff to reduce clinical burden and improve efficiency.
- Support flexible, LTFT and remote working across all pathology grades, and address pension-related disincentives for doctors approaching retirement to support retention.
- Develop clear career pathways for locally employed (LE), specialty, associate specialists and specialist (SAS) doctors and overseas-trained professionals entering via Portfolio Pathway.
- Correct the current exclusion of CPD funding for healthcare scientists in the 2024–2025 year to ensure equitable support in line with other regulated clinical professions.
- Formal job planning for consultant scientists should be endorsed to ensure consistent recognition of their clinical and scientific contributions and equitable access to professional development opportunities.

5.3 Reform

- Deliver a dedicated pathology workforce plan, informed by accurate data, with a focus on filling current pathology vacancies.
- Modernise IT systems and laboratory infrastructure to support digital pathology and interoperability.

- Centrally fund national rollout of digital pathology, recognising the different needs and the workforce implications for each pathology specialty.
- Improve interoperability of LIMS with electronic patient records and prescribing platforms.
- Standardise training and governance for AI integration, ensuring pathologists are equipped to validate and use digital tools safely.
- Establish more digital pathology fellowships to support and develop the workforce in the digital era, enabling greater impact.
- Support flexible research opportunities, including short clinical projects and multidisciplinary programmes in collaboration with universities, improving access to statistical and research governance support to streamline approvals.
- Prioritise equitable access to training and services, especially in remote and deprived areas.
- Support culturally tailored outreach and diagnostic services to address health inequalities.
- Develop cohesive NHS England strategy for coordinating patient-centric sampling (PCS) and integrating direct-to-consumer testing into clear clinical pathways with clear clinical governance.
- Promote PCS and community-based diagnostics only with appropriate workforce planning.
- Invest in laboratory services to support service development and innovation. Future roles must be equipped to provide clinical leadership from within laboratories, working collaboratively in multidisciplinary teams.

5.4 Contingency

- Promote diagnostic stewardship to reduce unnecessary testing and improve resource use.
- Prepare for cybersecurity threats and infrastructure failures with robust contingency planning and workforce capacity.

- Support One Health initiatives, integrating veterinary and human pathology for joint surveillance and response.
- Promote international workforce collaboration to tackle global health threats and improve pandemic preparedness.
- Strengthen multidisciplinary collaboration across care pathways to support efficient diagnosis and treatment, especially in community settings.
- Continue improving pathology classifications and standards to support consistency and quality to reduce burden on the workforce.

6 References

1. The Nuffield Trust. *From hospital to community: International lessons on moving care closer to home*. 2025. Available at: www.nuffieldtrust.org.uk/research/from-hospital-to-community-international-lessons-on-moving-care-closer-to-home
2. The Leeds Teaching Hospitals NHS Trusts. *Digital pathology*. Accessed October 2025. Available at: www.leedsth.nhs.uk/services/pathology/digital-pathology/
3. Oxford Academic Health Partners. *OUH's cellular pathology department achieves 100% digitisation of surgical histology slides*. 2020. Available at: www.oahp.org.uk/news/ouhs-cellular-pathology-department-achieves-100-digitisation-of-surgical-histology-slides/
4. PathLAKE. Accessed October 2025. Available at: www.pathlake.org
5. Hospital Healthcare Europe. *The histopathology dashboard helping clinicians translate AI research into oncology practice*. 2025. Available at: https://hospitalhealthcare.com/clinical/oncology/the-histopathology-dashboard-helping-clinicians-translate-ai-research-into-oncology-practice/
6. Robinson C, Deshpande A, Richards C, Rutty G, Mason C, Morgan B. Post-mortem computed tomography in adult non-suspicious death investigation—evaluation of an NHS based service. *BJR Open* 2019;1:20190017.
7. Davendralingam N, Brookes, AL, Shah MA, Shelmerdine, SC. Post-mortem CT service structures in non-suspicious death investigations. *BJR Open* 2024;6:tzae036.

8. Cohen MC, Whitby E, Fink MA, Collett JM, Offiah AC. Running a postmortem service – a business case and clinical experience. *Ped Radiol* 2015;45,501–508.

9. RCPath. *Innovation in paediatric and perinatal pathology*. 2025. Available at: www.rcpath.org/resource-report/innovation-in-paediatric-and-perinatal-pathology.html

10. Nobes J, Leith D, Handjiev S, Dillon JF, Dow E. Intelligent liver function testing (ILFT): an intelligent laboratory approach to identifying chronic liver disease. *Diagn* 2024;14:960.

11. Papazoglou AS, Stalikas N, Moysidis DV, Otountzidis N, Kartas A *et al*. CERT2 ceramide-and phospholipid-based risk score and major adverse cardiovascular events: A systematic review and meta-analysis. *J Clin Lipid* 2022;16:272–276.

12. Browning L, Winter L, Cooper RA, Ghosh A, Dytor T, Colling R *et al*. Impact of the transition to digital pathology in a clinical setting on histopathologists in training: experiences and perceived challenges within a UK training region. *J Clin Pathol* 2023;76:712–718.

13. RCPath. *Ensuring chemical pathology training is evolving with modern healthcare demands*. 2025. Available at: www.rcpath.org/resource-report/ensuring-chemical-pathology-training-is-evolving-with-modern-healthcare-demands.html

14. NHS England. *Case study: improving turnaround times in pathology*. Accessed October 2025. Available at: www.england.nhs.uk/long-read/case-study-improving-turnaround-times-in-pathology/

15. The Royal College of Radiologists. *Proposals for the reshaping of cancer services in England: Patient pathways and decision making*. 2025. Available at: www.rcr.ac.uk/media/xkalybyb/multisociety-proposals-for-reforming-patient-pathways-and-decision-making.pdf

16. O'Connor E, Treacy A, Mitchell A and Swan N. The role of multidisciplinary team meeting histopathology review and its impact on revised reports: Analysis of a national quality improvement program. *Am J Clin Pathol* 2024;161:579–585.

7 Contact details

This response was collated by the Workforce and Engagement team within the Professional Practice Directorate of the College, informed by feedback from Specialty Advisory Committees.

Please contact the College if you have any questions: workforce@rcpath.org.

8 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, dentally 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.