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

Patient Safety Steering Group – committee profiles

Get to know our committee! Find out about their motivations for joining the PSSG, what experience they bring to the group and what they like to do in their spare time.

Dr Mike Eden	Chair
Professor Peter Johnston	Vice President for Workforce and Corporate Engagement
Dr Laszlo Igali	Vice President for Professional Practice
Jeff Allen	**Lay Advisory Group representative**
Dr Sarah Bell	Elected member
Dr Ryan Clark	Elected member
Dr Gillian Evans	Elected member
Ms Pandina Kwong	**Elected member**
Dr Vinita Mishra	**Elected member**
Dr Shruthi Narayan	Elected member
Dr Riina Richardson	**Elected member**
Dr John Tadross	**Elected member**
Jayne Wheway	**NHSE representative**
Dr Shubha Allard	National Blood Transfusion Committee representative
Gareth McKeeman	**Northern Ireland representative**
Alyson Bryant	UKAS representative
Jennifer Norman	UKAS representative (replacing Alyson Bryant)
Victoria Heath	Wales representative
Catherine Ross	Scotland representative

Jeff Allen – Lay Advisory Group representative

What inspired you to join the PSSG?

As a member of the Lay Advisory Group, which acts to provide constructive feedback on the work of the College, it is important for me to be involved in patient safety initiatives and support improvements in the quality and safety of pathology services.

What does patient safety mean to you personally?
We all use medical services to varying extents, so for me it is clear that recognising and responding to medical errors has impact on one's entire wellbeing. Therefore, mechanisms that minimise risks from diagnosis and treatment, while providing and promoting appropriate support for well-informed decisions, are paramount.

How does your current role or background inform your perspective on safety and quality in pathology services?
My career as a biomedical scientist, HE lecturer, leading in healthcare curricular development and, more recently, by serving on the Prospect Committee (which supports men living with prostate cancer), provides me insight into the significant role pathology services play and facilitates insight from patient and public perspectives.

What are the key patient safety challenges pathology services face today and how can we begin to address them?
There are clearly a number of challenges that could be addressed; one of the priorities would be appropriate workforce staffing to help address incident reporting and IT issues which impact apt reporting mechanisms.

In what ways do you hope the PSSG will drive positive change across the pathology workforce in the coming years?
Positive change can be achieved by being driven through effective safety initiatives that align with the College's Patient Safety and Quality Strategy, while complying with national and international safety standards, regulations and guidelines.

What one message would you like to share with colleagues across the UK about our shared responsibility for patient safety in pathology?
Through the College, colleagues should maintain a holistic view throughout the entire patient pathway that is sustained by teamwork and education.

When you're not working, how do you like to unwind or recharge?
My family is my priority and I have volunteering roles elsewhere that I like to engage in; one can use these as conduits for reducing stress and helping restore energy.

Pandina Kwong – Elected member

Consultant Clinical Lead Biochemist, Barking, Havering and Redbridge University Hospitals NHS Trust

What inspired you to join the PSSG?
I've always been passionate about improving systems to deliver safer and more reliable care for patients. Pathology plays a vital role in diagnosis and treatment, yet much of its safety work happens behind the scenes. The opportunity to collaborate with colleagues nationally and influence change that directly improves outcomes really inspired me.

What does patient safety mean to you personally?
Patient safety means minimising harm and ensuring patients receive accurate and timely results they can trust. This doesn't just involve avoiding errors; we need to create a culture of openness, learning and continuous improvement where everyone feels responsible for doing the right thing.

How does your current role or background inform your perspective on safety and quality in pathology services?
Working in pathology, I see firsthand the impact that accurate, timely and high-quality results have on patient care. My background has taught me the importance of effective standardisation, strong communication and robust systems across pathology services. I'm particularly interested in how technology, quality management and human factors intersect to enhance both safety and efficiency.

What are the key patient safety challenges you believe pathology services face today and how can we begin to address them?
Some of the biggest challenges include workforce pressures, increasing demand, the digital transition and variation in processes across pathology services. To address these, we need to focus on system design, making it easier for people to do the right thing, alongside investing in training, robust quality system and fostering a just and learning culture. Collaboration between clinical, technical and informatics teams is also key.

In what ways do you hope the PSSG will drive positive change across the pathology workforce in the coming years?
I hope the PSSG will help embed a shared safety culture across pathology. By sharing best practice and learning, it can support consistent and sustainable improvement.

What one message would you like to share with colleagues across the UK about our shared responsibility for patient safety in pathology?
Patient safety is everyone's responsibility and every role in pathology matters. Speaking up and learning together helps keep patients safe.

When you're not working, how do you like to unwind or recharge?
When not working, I like to listen to music and spend time with family and friends.

Gareth McKeeman – Northern Ireland representative

Consultant Clinical Scientist, Belfast Health and Social Care Trust

What inspired you to join the PSSG?
I have previously been involved with patient safety initiatives, organised by the College, as part of my role as NI Regional Council chair and I have had a keen interest in this area and in promoting the role laboratory medicine plays, along with the staff who work in this field, in the patient journey.

What does patient safety mean to you personally?
I see patient safety as an integral component of my job, as many of the strands of my work are linked to ensuring the ongoing provision of accurate patient test results. This also extends beyond the oversight of internal laboratory operations and quality management but also incorporates oversight of testing performed outside the laboratory by clinical teams. We know that each process in the total testing pathway and sample journey carries a risk of error, so a key aspect of patient safety is continually reviewing and monitoring the steps in the pathway, and then taking steps to reduce risk and any errors detected that would negatively affect the patient. We have a role as lab leaders to promote high standards and provide the required governance and oversight for all patient test results used for patient management, including point-of-care testing.

How does your current role or background inform your perspective on safety and quality in pathology services?
I am currently working as a consultant clinical scientist within clinical biochemistry (automation lab) and as trust POCT lead. I am involved in the governance and oversight of these areas. I attend the lab governance meeting and chair the clinical biochemistry risk management meeting and the automation section incident review meeting. These meetings involve the review of recent occurrences and incidents raised and discussion around necessary corrective and preventative actions required. I have also been involved with a number of SEA and SAI investigations across the Trust and work with laboratory colleagues to maintain a UKAS accredited laboratory service to ISO15189 (2022) standards.

What are the key patient safety challenges you believe pathology services face today and how can we begin to address them?
Some of the key challenges relate to the steps and processes conducted beyond the lab, where there is less oversight from pathology professionals and where we have less control of what happens. This relates to pre-analytical challenges around accurate sample collection and handling of samples, as well as the provision of all the required patient, sample and clinician information. There are also post-analytical challenges that can impact patient safety, which can include loss of important interpretative advice and result comments due to IT constraints. There are also challenges with how the various IT systems that accept patient information display and pass on these key facts across different display systems. We also have the challenge of more patient testing being performed in home or community settings, including use of point-of-care tests purchased by patients, leading to an increase in patient-generated data with a reduced level of clinical governance in how such data

has been produced. There are also significant challenges around the pathology workforce and the loss of experienced staff that take many years to train.

Ideally, we need laboratories to have governance and oversight of all aspects of sample collection and transport, and have access to new technology to help improve the oversight of sample logistics. National standardisation initiatives will be important in terms of IT solutions and how these should be implemented, with guidance on how such systems should interface with other software handling laboratory reports. In addition, we need to educate patients and the public in general around the use of diagnostics and what factors can affect results and how to seek help and advice for adequate interpretation and follow-up. We need to engage and encourage the next generation of students to train in laboratory medicine and to have a career in pathology labs.

In what ways do you hope the PSSG will drive positive change across the pathology workforce in the coming years?
I am hoping we can highlight the lab pathology career as a rewarding one and encourage more students to study in this area and come and work in labs. We need to highlight the positive impact pathology specialists have on the patient journey and showcase how we use our quality management systems and experiences in these areas to drive innovation and continue to adopt best practices and a learning culture. Hopefully, this will encourage greater government funding into pathology, allowing us to increase the workforce in line with increasing service demands.

What one message would you like to share with colleagues across the UK about our shared responsibility for patient safety in pathology?
Let’s continue to promote the great job the pathology workforce does on a daily basis, which often goes unseen, to keep patients safe. We need to increase awareness of what goes on in pathology labs and the quality, regulation and governance structures we work under and continue to record and learn from incidents and share improvement actions and ideas with each other.

When you're not working, how do you like to unwind or recharge?
I do a lot of walking (mostly with our family dog) and listen to podcasts and audiobooks to try to switch off.

Dr Vinita Mishra – Elected member

Consultant Chemical Pathologist, NHS University Hospitals of Liverpool Group

What inspired you to join the PSSG?
To improve my knowledge and understanding by sharing learning

What does patient safety mean to you personally?
It means a lot to me as I am involved in patient management in my clinics and lab management.

How does your current role or background inform your perspective on safety and quality in pathology services?
Being the clinical lead, patient safety is a priority.

What are the key patient safety challenges you believe pathology services face today and how can we begin to address them?
Pre-analytical, where most errors happen. Analytical errors are less frequent but potentially more serious. Post-analytical can be caused by delayed communication or miscommunication, misinterpretation, failure to act on results, wrong diagnosis or treatment, staff fatigue and a lack of safety culture.

In what ways do you hope the PSSG will drive positive change across the pathology workforce in the coming years?
Analysing the errors by collecting data and supporting the pathologists by producing guidelines to prevent such errors.

What one message would you like to share with colleagues across the UK about our shared responsibility for patient safety in pathology?
We must show leadership by embedding patient safety principles into the DNA of pathology services and integrating pathology into governance structures.

When you're not working, how do you like to unwind or recharge?
Practicing mindfulness through meditation and reflecting by going on walks.

Dr Riina Richardson – Elected member

Consultant Medical Mycologist and Senior Clinical Lecturer in Infectious Diseases and Medical Education, Manchester University NHS Foundation Trust; President, British Society for Medical Mycology

What inspired you to join the PSSG?
It is an important topic and what we do can have a major impact on patient safety.

What does patient safety mean to you personally?
Clear communication between the lab and clinicians, working together holistically and interpreting and actioning test results appropriately.

How does your current role or background inform your perspective on safety and quality in pathology services?
On a daily basis.

What are the key patient safety challenges pathology services face today and how can we begin to address them?
Silo working, isolation from the clinical services and becoming factories producing test results with no relevance to the clinical situation. Misinterpretation of tests results leading to overuse of antibiotics. Staffing restrictive of working more jointly with the clinical services (no time to attend MDTs or do joint audits or QIPs).

In what ways do you hope the PSSG will drive positive change across the pathology workforce in the coming years?
Setting standards that include the patient in the heart of it all.

What one message would you like to share with colleagues across the UK about our shared responsibility for patient safety in pathology?
We must work together to improve our services, care pathways and communication.

When you're not working, how do you like to unwind or recharge?
Walking, hiking, small trips and meeting with family.

Dr John Tadross – Elected member

Consultant Pathologist, Cambridge University Hospitals NHS

What inspired you to join the PSSG?
The opportunity to help shape safety culture across pathology – moving the dial from finding problems after the fact to building safer systems by design.

What does patient safety mean to you personally?
It means shifting from reactive incident response to a proactive, engineered approach that prevents harm – using human factors, data and real-time signals to make care safer every day.

How does your current role or background inform your perspective on safety and quality in pathology services?
I'm a histopathologist, HTA-designated individual and molecular pathology lead. Working across complex, organically grown NHS systems has taught me that robust governance, clear accountability and interoperable digital infrastructure are essential for safe, reliable services.

What are the key patient safety challenges pathology services face today and how can we begin to address them?
Resourcing the shift from retrospective audit to real-time intelligence, embedding safety requirements in digital transformation and commissioning, and ensuring staffing, standards and data flows are fit for purpose. We need clear guidance, better data and procurement that hard-wires safety in from the start.

In what ways do you hope the PSSG will drive positive change across the pathology workforce in the coming years?
By championing a culture that empowers proactive safety – supporting data-driven improvement, practical guidance and standards, and workforce wellbeing so teams can consistently deliver safe care.

What one message would you like to share with colleagues across the UK about our shared responsibility for patient safety in pathology?
Be curious and be bold – surface risks early, share learning (including near-misses) and test improvements collaboratively. Small changes, widely adopted, save lives.

When you're not working, how do you like to unwind or recharge?
I've got a 1- and a 3-year-old – ask me again in 5 years and I might have an answer!

Jayne Wheway – NHS England representative

Patient Safety Clinical Lead for Human Factors and Children & Young People, NHS England

What inspired you to join the PSSG?
My role in the national patient safety team in England has enabled me to work on patient safety with many groups and colleges, and I have enjoyed working with the Royal College of Pathologists in the past. So, I'm pleased to be the team's representative on the Steering Group. I have been encouraged by the group's eagerness to share current experiences across practice, to seek data and intelligence for improvement and drive change.

What does patient safety mean to you personally?
In complex systems like healthcare, patient safety requires a continuous examination and improvement of patient care by learning from the systems, the risks and the resilience in healthcare, which is forever changing and adapting. We must also embrace all people's experiences within the system (all staff, patients and carers).

How does your current role or background inform your perspective on safety and quality in pathology services?
I have worked in the patient safety team in England for almost 20 years. I am a registered nurse (in mental health), patient safety expert and human factors specialist, so I hope I can bring those perspectives into the work around patient safety in pathology. My current work includes clinical review of patient safety incident data, human factors assessment of patient safety data and intelligence, systems analysis, risk and resilience management, and patient safety improvement. As a visiting fellow at Loughborough University, I also teach as part of the faculty on the patient safety syllabus training.

What are the key patient safety challenges pathology services face today and how can we begin to address them?
Pathology seems to be a large and varied discipline, and includes a distinct group of subspecialties. As someone not working in pathology, I hear about the professions, processes and place of pathology in the system more and more. So, I hope that colleagues feel that growing significance too. I think the challenge may be to keep that momentum and visibility. We know that there are concerns from colleagues within pathology services around diagnostic delays due to a range of issues and a desire for clear mechanisms for reporting and reviewing patient safety concerns. The first step to being to address this is to ensure the College and the group are collecting these data insights and intelligence across the UK to fully discover and define the issues while starting action now in areas that are known.

In what ways do you hope the PSSG will drive positive change across the pathology workforce in the coming years?
The group and the College have developed a clear plan to start the change with a focus that includes workforce staffing, best practice guidance and staff wellbeing, as well as pathology data insights and alignment with the (English) National Patient Safety Strategy. The group includes a range of stakeholders from across and outside pathology, adding support, representation and expertise. So, I think it has the best start to enable positive change in the year ahead and beyond.

What one message would you like to share with colleagues across the UK about our shared responsibility for patient safety in pathology?
As we improve our knowledge of patient safety and embrace all people's expertise within the system of healthcare, we can continually adapt to the changing conditions we face and understand how safety is maintained in our everyday work, and learn from events and systems when patient care is compromised or patients are harmed. We all have skills and experience to bring within this system framework.

When you're not working, how do you like to unwind or recharge?
I'm a member of a local running club – I love ParkRun (almost finished the alphabet of ParkRuns…) and completed my first triathlon last year!