Minutes of Histopathology Working group

Date 26 January 2018
Venue The Grosvenor Hotel, 101 Buckingham Palace Road, SW1W 0SJ
Protective Marking OFFICIAL

Present

<table>
<thead>
<tr>
<th>Members</th>
<th>In attendance</th>
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<tbody>
<tr>
<td>HTA: Lorna Williamson (Chair), Andy Hall, Stuart Dollow (by telecom), Allan Marriott-Smith</td>
<td>Fiona Maleady-Crowe (Secretary)</td>
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<td>RCPath: Michael Osborn</td>
<td>Rachel Mogg</td>
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<td>Coroner’s Society of England and Wales: Fiona Wilcox</td>
<td>Emer O’Toole</td>
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<td>Home Office: Dean Jones (by telecom)</td>
<td>Amy Thomas</td>
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<td>AAPT: Debbie James</td>
<td>Lisa Carter</td>
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<td>IBMS: Andrew Usher</td>
<td>BMA: Anne Thorpe</td>
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Item 1 – Welcome and introductions

1. LW welcomed members to the first meeting of 2018.

2. Apologies were noted from The Right Reverend Graham Usher, Michael Ashworth, Guy Rutty, Derek Winter, John Pitchers, Jeff Adams, Adam Whittaker and Chris Birkett.

Item 2 – Terms of reference

3. LW directed the Group to the recently revised terms of reference for Advisory Groups at the HTA. LW asked members whether they felt it was appropriate to keep a member of INQUEST in the Group as there is no current representation, and this group might be appropriate for lay member
representation. The Group were in agreement that INQUEST might not be the most appropriate group for lay member representation, and it was felt that lay member representation is not necessarily required in the HWG. Members agreed that this would be reviewed on an ongoing basis, particularly to determine whether there is a particular group is underrepresented.

Item 3 – Review of minutes of last meeting (5 May 2017) and matters arising

4. Members had the opportunity to comment on the accuracy of the May 2017 meeting minutes prior to their publication on the HTA website. No further amendments were requested.

5. Actions from the May 2017 meeting were reviewed.

6. Action 1 – complete, the triennial review was emailed to the Group

7. Action 2 – AMS provided the Group with an update regarding the status of the proposed taphonomy facility, previously discussed at HWG. The academic institution who were leading on this facility have taken the decision to not pursue the proposal further. It is not clear at this point whether this is due to ethical considerations, or as a result of financial pressures. The HTA will seek clarity on this matter. The principle contact for the development of the taphonomy facility has offered to attend a future meeting.

    DJ highlighted work that the HTA had undertaken to date with the HO exploring the likely considerations in regulating such a facility. Extensive work has been done regarding the security of the establishment, the environmental implications, and what research should be done. DJ requested that the work that has been done to date is maintained so that if another establishment decides to go ahead with the activity, this work can be referenced. This was agreed. Action closed.

8. Action 3 – action ongoing, the Coroners’ Society recently undertook a survey to determine areas in the country where the issues with pathologist availability are particularly acute. The results are not yet available.

ACTION 1: FW to share results of the Coroner’s Society survey when available with the Group

9. Action 4 – MO and CB had previously met with UKAS and discussed its role in mortuaries. At the time, RCPath made it clear to establishments that the College supports regulation of mortuaries, however it should not increase the burden on establishments. The College are satisfied with the level of regulation provided by the HTA, and do not wish for establishments
to be subject to increased visits or assessments. FW is in agreement, and does not wish for anything which may further delay the delivery of coronial services.

10. MO made it clear that the mortuary can be removed from the laboratory’s accreditation without having an impact on the accreditation. The Group were in agreement that the mortuaries are not obliged to have UKAS accreditation. MO reported that many mortuaries are moving away from this, and that the College are happy clarify this issue where hospitals are uncertain.

11. Action 5 – The Group had no further comments on the survey.

12. Action 6 – Complete

13. Action 7 – Papers presented on the day

14. Action 8 (re untrained staff in mortuaries) ongoing. DJ will follow up with JP, however there are no further actions at present. MO mentioned that an AAPT Council meeting was held earlier in January where the issue of untrained staff was raised. AAPT are monitoring the issue and have made it clear to delegates who wish to sit the Diploma examinations that they must be in a recognised post.

**Item 4 – HTA update**

15. AMS updated the Group on the HTA strategy, drawing the Group’s attention to new qualitative research regarding public confidence. The research confirmed that the public have confidence in the work we do. The next strategy will not fundamentally change how the HTA works.

16. The HTA is facing a number of emerging pressures in the Human Application (HA) and Post Mortem (PM) sectors. The increased number of critical and major shortfalls has resulted in increased post-inspection follow-up, putting more pressure on staff. The new strategy will need to take this into account, alongside cost pressures, including accommodation rent increases. The organisation aims to be more flexible and agile, focusing more on home working by design, to increase the pool of people we can hire. A focus of the coming year will be to increase the pace and quality of our induction so we can get Regulation Managers up to speed more quickly.

17. Our current Chair has taken up a new position but will remain in post until a new Chair is appointed. With the departure of both the Director of Regulation and Director of Policy, Strategy and Communications, the structure of the senior team is being reviewed. In the meantime, two interim Directors have been appointed. In addition, the Head of Regulation for the Post Mortem sector recently moved on from the HTA. AMS made reference to her many years with the organisation and her invaluable input
to developing positive relationships with those who work in the sector.
AMS provided the Group with assurance that the Board are considering
the recent loss of staff and are working together with staff to ensure a
smooth transition.

**Item 5 – RCPPath update**

18. LW congratulated MO on being elected to the RCPPath Council. Professor
Jo Martin, an experienced Histopathologist, specialising in muscle
disorders, took up position as RCPPath President in November 2017.

19. LW brought the Group’s attention to the RCPPath Bulletins of October 2017
and January 2018 on the theme of ‘Learning from the Deceased’, which
had previously been shared with the Group.

20. MO provided an update regarding pacemakers and when they should be
sent for scrutiny, as requested by the Medicines and Healthcare products
Regulatory Agency (MHRA). The MHRA were seeking specific guidance
from the College regarding when an implanted medical device should be
sent for scrutiny. College guidelines are already in place which state that if
there is concern that the implantable device has been involved in the death
then it needs to be investigated. SD highlighted the manufacturer’s
obligation to investigate a device under guidance from MHRA. The
investigation may be performed independently. MHRA can look at trend
analysis. MO clarified that all pacemakers are batched together and
routinely returned to the manufacturer if they have been removed at PM,
and not deemed to be directly responsible for the death. Where the
implanted device is considered to have contributed to, or caused the
death, then this individual device will be investigated.

21. The autopsy guidelines are close to being finalised, and will likely be
released after the summer, following consultation. MO should be in a
position to bring the agreed guidelines to the Autumn meeting.

22. MO discussed the expected roll out of the Medical Examiners in April
2019. The creation of Medical Examiners aims to reduce the requirement
for coroners’ PM examinations. However, there is a concern that the
Medical Examiner system will increase resource pressures for coroners
and their teams. FW had contacted the Chief Coroner and is awaiting a
response. In many areas where pilots have been rolled out, an increase in
complex medical cases has been noted which results in an increase in
resources and cost required. FW indicated that more work is required with
regards to how the Medical Examiners and the Coronial service work
together. FW believes the Coroner should be involved in the recruitment of
Medical Examiners in their specific areas.

**ACTION 2: Update on Medical Examiners to be added to the agenda for the
next meeting.**
23. MO provided the group with an update regarding the development of autopsy guidelines. There are a number of guidelines which have recently been drafted and will be going for consultation imminently. RCPath will be holding a training day in May, where authors will discuss the guidelines with those working in the sector.

24. DIG held the second meeting in December 2017, and the third is scheduled for the end of April. The meetings have been successful to date, providing a platform for different specialities allied with the PM sector. Further information was provided in the RCPath Bulletin as above.

**Item 6 – PM sector overview**

25. AT provided the Group with some background information regarding a project being undertaken looking at a number of areas in the PM sector. The HTA committed to reviewing inspection outcomes following the implementation of the revised Codes and Standards in April 2017. The review included data analysis of four broad themes: inspection scheduling and approach; the impact of the new standards; inherent or cyclical issues; and the use of other data sources to evaluate risk, such as compliance updates and HTARIs.

26. The project will produce recommendations which are anticipated to address the following: risk-based inspection scheduling; management of shortfalls against the new standards; use of signalling data to maintain a risk-based approach; targeted application of other regulatory tools (e.g. advice and guidance); plan of learning, training and communications activities.

27. RM presented the initial analysis of the inspection findings since April 2017. Establishments inspected in that time period included some that had themed inspections last time, or had a long period between inspections.

28. Overall an increase in the number and severity of shortfalls was noted, with over half of establishments inspected having major shortfalls. The shortfalls were identified against all standards.

**Item 7 – HTARI**

A HTARI report. The key findings were presented by members of the HTA team. The group were appreciative of the work which goes into the collection and analysis of this data. No specific issues were identified which required immediate action.
Action 3: FMC to send HTARI slides to the Group and add to agenda for the next meeting.

B. Review of HTARI category ‘Loss, disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family’.

29. EOT described the number of HTARIs reported to the HTA regarding fetus or fetal tissue with a gestational age less than 24 weeks which do not involve mortuary staff. While these are serious incidents for the Trust, and should be investigated appropriately, they may not necessarily need to be reported to the HTA. EOT proposed altering the guidance for this category to make it clear to establishments which incidents of this nature will fall under the HTA’s remit.

30. The Group were in agreement with the proposed changes, and suggested that the need for an internal hospital investigation of each incident should be emphasised, whether HTA reportable or not.

Action 4: EOT to amend guidance for HTARI category regarding fetal remains.

Item 8 – AOB

31. LW made the Group aware of a recent Freedom of Information request regarding HTARIs. A number of newspapers had reported on these findings, and subsequently, Mrs Isaacs, a long time campaigner with a personal interest in the circumstances which gave rise to the HT Act, contacted the HTA to discuss the findings and to discuss the actions taken to reduce such incidents. AMS raised this with the Group to highlight the severity of her concerns.

32. LW asked whether it would be worthwhile adding denominator data so that the incidence of these incidents can be calculated and tracked with time. Providing numerical values may help contextualise the number of incidents reported when communicating with the media and the public.

33. The Group discussed the issues with mortuary capacity over the winter months. AU commented that this year has been particularly challenging. Over Christmas the HTA received five enquiries or concerns regarding establishments reaching capacity, and these included some using their contingency storage as routine.

34. FW described an establishment in London which has a large number of fridges, but due to pressures over the winter period, found it necessary to use their temporary storage routinely. FW raised concerns regarding the
availability of storage if death rates were to rise suddenly e.g. due to an epidemic. Single mass fatality incidents create different issues and are generally well dealt with.

35. MO highlighted that the lack of pathologists available to undertake PM examinations exacerbates the storage issues. In addition, funeral directors often do not have sufficient capacity to store bodies and will leave them at the establishment. The Group discussed places where funeral directors are charged for excessively long mortuary storage, and instances where this has worked well. AU highlighted that this charge is often passed on to the family. EOT suggested providing advice to establishments to contact the family to see if they require assistance as they are often not aware that the body is in the hospital and not with the funeral director.

**ACTION 5: LW to raise concerns about lack of pathologists to perform PM examinations; capacity at funeral directors; and winter pressures at the Authority meeting.**

36. MO discussed the potential impact of a non-emergency mass fatality, such as influenza-related deaths. This increase in numbers will impact significantly on mortuary capacity.

37. FW will be attending an excess deaths working Group, and requested that a representative from RCPath attends.

**ACTION 6: FW to feed back to the Group about the excess deaths working Group in next meeting.**

38. LW informed the Group of new ministerial appointments and advised the Group that the Minister for HTA has not changed.

**Next meeting: the secretariat will contact members to suggest dates.**