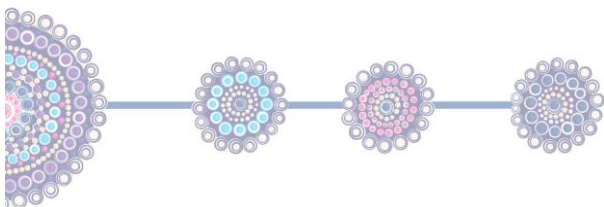




Health
Pathology

Anatomical Pathology Relative Workload Review 2023

Prof Wendy Cooper,
Anatomical Pathology
Clinical Stream Lead





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Executive Summary

- This workload review, sponsored by the Anatomical Pathology Clinical Stream and the NSW Health Pathology Medical Staff Council, has been conducted to provide a state-wide assessment of the workload for Anatomical Pathologists across all AP laboratories. It was conducted using the agreed modified 2018 Tool as set out in the body of this document.
- Pathologist staff shortages are being felt across the majority of laboratories in NSWHP leading to backlogs in reporting and risking patient and pathologist welfare, as well as exposing NSWHP to substantial medicolegal, reputational, staff retention and contestability risks.
- Pathologist staff shortages are predominantly at the major metropolitan sites (RPAH, JHH, Liverpool and Westmead), including laboratories that provide the bulk of regional support (Westmead and JHH).
- The 2 sites that were most impacted by COVID-19 (Westmead and Liverpool) are amongst the sites with highest workload/staff ratios.
- Regional sites are experiencing staff shortages to a lesser extent but struggle in periods of staff absences and vacancies. Due to prolonged pathologist vacancies at multiple regional sites, they are feeling significant workload pressures and widespread low morale.
- While pathologist recruitment has been difficult in regional sites, there is strong interest in positions at metropolitan sites, which can potentially take on backlogs of work from regional sites.

Key Recommendations

Additional pathologist staffing is critical to ensure clinically safe and equitable workloads, to prevent pathologist burnout, to avoid loss of pathologists to private sector, to facilitate recruitment into NSWHP and to facilitate transfer of specimens to support laboratories.

1. ***Additional fully funded pathologist positions are created for the laboratories with the highest needs. This could consist of:***
 - a. ***An extra 8.5 to 10.5 FTE pathologists across at least 5-8 sites (based on modelling provided in the review), or***
 - b. ***An extra 9.0 FTE pathologists to cover the unfunded MDT workload.***
2. Use detailed MDT data in negotiations with LHDs for increased funding.
 - a. MDTs at the 6 largest metro hospitals are all spending approximately 1 FTE performing MDTs (unfunded) and across NSWHP, MDTs make up a total of 9.0 FTE pathologist workload.
 - b. This would be assisted by having comparable historical data to demonstrate increased MDT workload but this data was unable to be collected in previous reviews. An audit of historical MDT workload at the 5 main sites in most need of additional staffing could be attempted but initial enquiries have indicated it is unlikely that reliable historical data is available.
 - c. Recommend using the detailed MDT data obtained in this review to apply a non-MBS fee to be paid by LHDs. This approach is favoured as most MDTs do not meet the Medicare requirements for the item number (243) which states: "Attendance by a medical practitioner, as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a *patient with cancer* to develop a multidisciplinary treatment plan, if the case conference is of *at least 10 minutes*, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers".



4. Not covered in this review but recommended:

- a. Review of staffing for state-wide paediatric AP services including POWH, JHH and Sydney Children's Hospital at Westmead.
- b. Review of capacity and investment requirements for the existing system to take on work not currently being provided by NSW Health Pathology, e.g., Wollongong and Cancer Genomics.

5. Repeat the AP Relative Workload Review in 2025 rather than in 3-years to assess non-COVID-19 impacted years and the impact of additional staffing from this current review. This could be undertaken as a desktop review rather than individual site visits.

Additional Recommendations outside the scope of this review

- Increase registrar positions to provide a larger pipeline of newly qualified pathologists to replace ageing pathologist workforce and meet growing needs of NSWHP.
- Utilise NSWHP/RCPA registrar cut-up diary to capture registrar work more accurately and consistently at each site.
- Ensure equitable distribution of registrars across laboratories relative to workload.
- Increased commitment to shifting all direct transfers and the majority of non-complex cut-up from registrars to dissection scientists.
 - This provides more career and training opportunities for scientific staff and provides more stable, long-term cut-up staffing for laboratories.
 - This is essential to ensure registrars meet RCPA cut-up requirements (which are becoming more stringent while AP workloads are increasing).
 - This will require further funded positions and consideration of training requirements.
 - Consider distribution of registrars and dissection scientists across state relative to workload and different needs (e.g., need more dissection scientists relative to registrars in regional sites).
- Implement state-wide cancer genomics program with careful planning to ensure return of work to NSWHP.



Introduction

This workload review, sponsored by the Anatomical Pathology Clinical Stream and the NSW Health Pathology Medical Staff Council, has been conducted to provide a state-wide assessment of the workload for Anatomical Pathologists across all AP laboratories. In late 2022 the Anatomical Pathology Clinical Stream (APCS) proposed a pathologist workload review due to reports of excessive workloads and the need for additional pathologist staffing. The last workload review had been undertaken in 2018 and was due to be repeated in 2021 but was delayed due to COVID-19. This review was based on the previously utilised AP Relative Workload Tool with minor pre-specified modifications to the non-diagnostic workload assessment that was approved by the APCS and the Medical Staff Council.

Unlike other disciplines in pathology, all anatomical pathology reporting is undertaken by pathologists who must microscopically examine each specimen and then provide a written report (with the only exception being cervical Pap smear screening undertaken at a single site only). The majority of an anatomical pathologist's workload consists of diagnostic reporting of specimens which cannot be automated. The ageing population of NSW and increasing incidence of cancer has contributed to the increasing workload for anatomical pathologists. In addition, the new NPAAC requirements for detailed structured reporting of all cancers (which make up the bulk of anatomical pathologist's workload), new and increasing requirements for incorporation of molecular testing in addition to immunohistochemistry, increasing need for subspecialty expertise and increasing multidisciplinary team meetings and cases has also created increasing workload for pathologists.

There is no universally accepted absolute tool to assess the workload for Anatomical Pathologists but with 19 Laboratories NSW Health Pathology can assess all laboratories and give a ranking of workload across the laboratories provided certain conditions are met. Those principles are:

1. All activities undertaken by the Anatomical Pathologists are measured identically in all laboratories.
 - The number of assessed activity units are the same across all laboratories.
 - The complexity scales for those activity units are the same across all laboratories.
 - Activity was that undertaken and reported by the pathologists at that site regardless of the referral site from which the specimen originated.
2. The MDT attendance is assessed in the same way across all laboratories.
3. The research, teaching and administrative activities are measured the same way across all laboratories.

This review relies on agreement to the principles above and the following conditions, which were set by the co-sponsors in December 2022:

1. The Tool to be used was the 2018 Relative Workload tool that was previously approved by the APCS, Clinical Operations and agreed by ASMOF. This allows for consistency and comparison of these reviews. Minor modifications to the non-diagnostic workload assessment (administration, teaching, research) were approved by the Clinical Streams for use across all streams in 2022
2. The 3-year reassessment date, agreed in 2018, was set for 2021 but has been deferred until 2023 due to COVID-19 arriving in Australia in January 2020 and awaited the resolution of the COVID-19 emergency procedures in place that were lifted in December 2022 in NSW.
3. The activity database to be used was the 2020/2021 and 2021/2022 financial years activity-based costing provided by the planning and performance unit, being the last complete unified (across all 4 LIS's) and agreed set of data.
4. An assessment of the MDTs and other administrative, teaching and research activities over covered by the relative workload tool.
5. An initial assessment of the RCPA trainee registrar cut-up requirements was added in January 2023.



The Joint Sponsors acknowledged that the activity database was affected by COVID-19 but the alternative was to defer this review until the 2022/2023 financial year unified data was available and this would have deferred any recommendations until 2024.

This Relative Workload report provides a relative ranking of pathologist workload in AP laboratories in NSW Health Pathology. The findings of this review should not be considered on their own but should be considered in conjunction with other relevant reports including the NSWHP review of AP services in regional NSW and the recently published Public Pathology Australia benchmarking review. It is understood that any decisions for additional positions following on from this report require agreement from the relevant LHD.

Methods

The review team consisted of:

- Professor Wendy Cooper, Anatomical Pathology Stream lead
- Tracey Hoytink, Clinical Stream Manager
- Constantine Katz, Clinical Stream Project Officer
- Dr Michael Whiley, Chief Pathologist
- Supported by Alex Eigenstetter, Associate Director of Planning and Performance

Workload was assessed for the two most recent financial years for which data was available (2020-2021 and 2021-2022) using the pre-agreed revised AP Relative Workload Tool ([Appendix 1](#)). This tool assesses pathologist workload in each laboratory using Relative Time Units (RTU) for each MBS item numbers as well as an assessment of non-MBS workload (multidisciplinary team meetings/MDMs, teaching, research, and administration). The Tool provides a relative ranking of the average pathologist workload at each laboratory but does not assess performance or workload of individual pathologists.

1. Diagnostic workload - this was measured using MBS items from laboratory information systems multiplied by pre-approved relative time units (RTUs) as described in the Royal College of Pathologists of Australasia (RCPA) study, "Impact of Workload of Anatomical Pathologists on Quality and Safety", Royal College of Pathologists of Australasia, 2011.
 - RTUs were designed to provide a more accurate estimate of time taken to report pathology specimens of differing MBS complexity levels. Total RTUs can then converted to time in hours using the RCPA-derived formula $\text{Total RTU} \times 0.00783333 = \text{Total Diagnostic Work Hours}$.
 - All anatomical pathology diagnostic reporting including histology, cytology, frozen sections, immunohistochemistry and molecular testing with an MBS item number were multiplied by the predetermined RTU.
 - Reporting numbers for the 2-year review period were provided based on the equivalent MBS item number and laboratories had an opportunity to confirm or correct the numbers provided.
 - Current LISs do not enable uniform collection of unconed workload so only coned data was included.
2. Non-diagnostic workload – this was assessed using the Relative Workload tool with administration time based on the number of pathologists in each department and any additional pathologist roles in the department (e.g., Local Pathology Director). Teaching is based on academic appointments or diary entries of teaching, and research is based on publications and research projects ([Appendix 1](#) and [2](#)).

MBS reporting data for the 2-year review period was provided to each laboratory (data obtained by Alex Eigenstetter, Associate Director of Planning and Performance) and sent to the Clinical Director of each laboratory at least one week prior to their site visit to enable time for laboratories to review the numbers and



confirm or correct the numbers provided. A checklist of requested information was also sent to each Clinical Director at this time to enable them to gather the information prior to each site visit ([Appendix 2](#)).

All sites that formed part of the review were visited between February and July 2023 by Professor Wendy Cooper, Dr Michael Whiley and either Tracey Hoytink or Constantine Katz. The meeting with Wagga Wagga Laboratory was undertaken remotely by Teams due to weather related flight disruptions preventing travel on the day.

Exclusions from the Review

Sites that were excluded from the review were Lismore (subject of a separate review), Wollongong (subject to current contract negotiations) and Port Macquarie (not part of NSWHP during the review period).

This state-wide pathologist workload review does not directly cover:

- Current and ongoing support for laboratories with unfilled pathologist vacancies within the NSW Health Pathology network. That is the subject of a separate Anatomical Pathology Taskforce report.
- Utilisation of Dissection Scientists which is subject to a separate post implementation review of the investment of 10 additional positions across the State.

Results

Diagnostic Workload (excluding MDTs, teaching, research, administration)

Total relative time units spent on diagnostic work was highest in the large metropolitan tertiary referral hospitals and lowest in the regional hospital laboratories (figure 1).

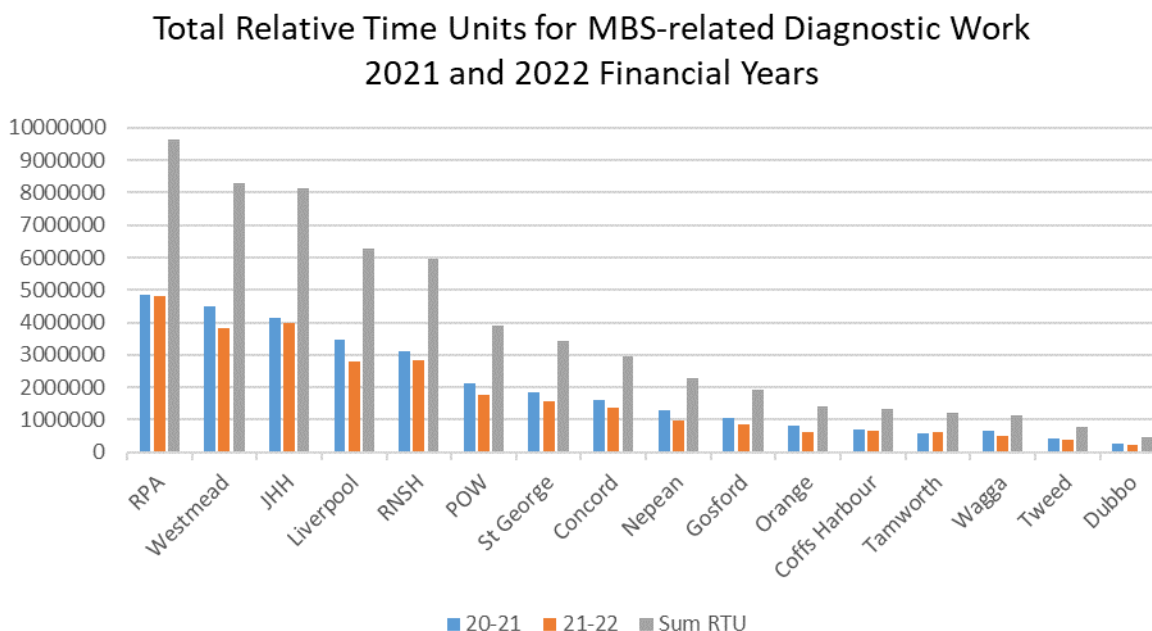


Figure 1. Total Relative Time Units spent on MBS-related diagnostic work during the 2021 and 2022 financial years across all laboratories.



The two financial years examined included COVID-19-related restrictions on non-urgent elective surgery and lockdowns that may have impacted patient presentations and subsequent pathology workload. There was a reduction in total RTUs in the second financial year examined (2022) across all but one site and this primarily effected Westmead and Liverpool Hospital laboratories (figure 2). Both of these sites experienced a downturn of >15%.

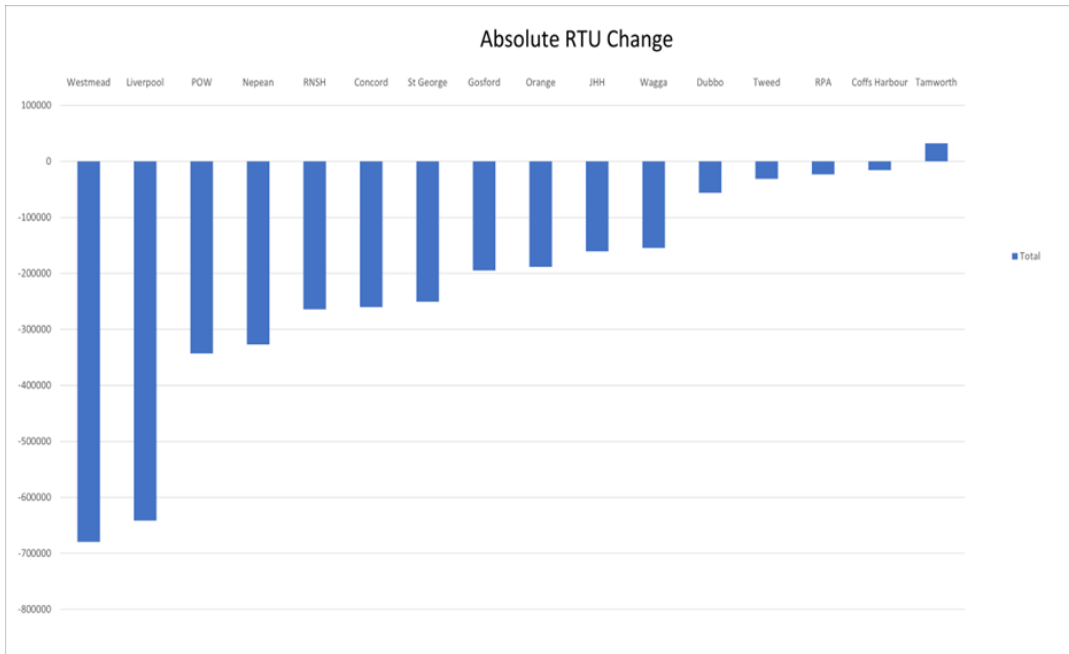


Figure 2. Change in Relative Time Units in 2022 financial year compared to 2021 financial year across all laboratories.

Despite the impacts of COVID-19, the overall RTUs for 2021 and 2022 combined represented an average workload increase of 11.5% in the five largest metropolitan laboratories compared to the previous two financial years (2019 and 2020) that were not yet significantly impacted by COVID-19 (figure 3).

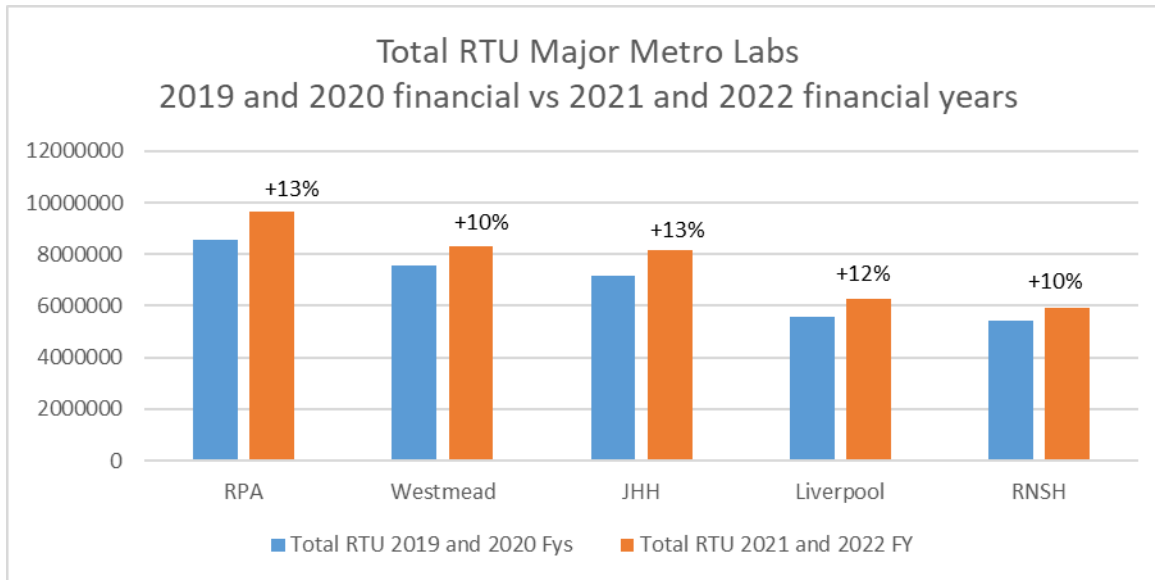


Figure 3. Increase in Relative Time Units in 2021 and 2022 financial years compared to 2019 and 2020 financial years in the 5 major metropolitan laboratories.

To calculate the average relative pathologist workload at each site (uncorrected for non-diagnostic work), the total RTUs at each site were divided by the funded full time equivalent (FTE) pathologist staffing at each site (total RTU divided by total pathologist FTE). This showed an inequitable workload across the different AP laboratories in NSWHP (figure 4). The mean RTU per pathologist across all the sites was 44×10^5 . Using the conversion factor of 0.00783333 to convert RTUs into work hours ($RTU \times 0.00783333 = \text{total work hour}$), gives an average of 7.3hrs diagnostic workload for pathologists across the state with pathologists at the busiest laboratory performing excessive hours of 10.6hrs diagnostic work per day (based on a 47-week working year accounting for annual leave and TESL but not the full entitlement which is rarely all taken) (table 1). This calculation does not consider the significant non-diagnostic workload of multidisciplinary team meetings, registrar and other teaching, research and pathologist administration.

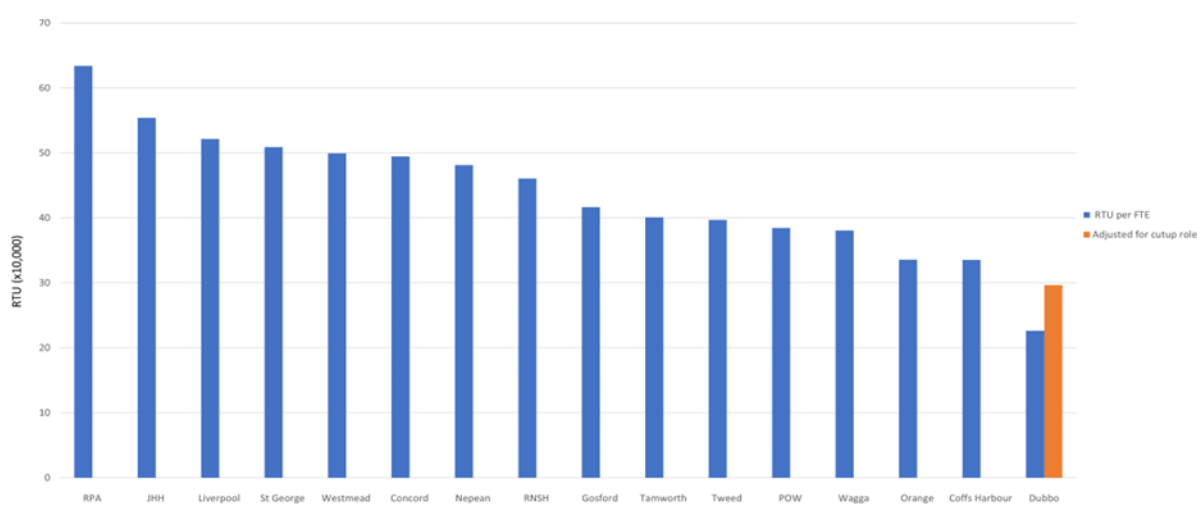


Figure 4. Total Relative Time Units per Funded FTE Pathologists across all laboratories.

Table 1. Average Hours per day pathologists spend performing diagnostic work (excluding MDTs, teaching, administration and research).

	Average time per day on diagnostic work alone (hours)**
RPAH	10.6
JHH	9.2
Liverpool	8.7
St George	8.5
Westmead	8.3
Concord	8.2
Nepean	8.0
RNSH	7.7
Gosford	6.9
Tamworth	6.7
Tweed	6.6
POW	6.4
Wagga	6.3
Orange	5.6
Coffs Harbour	5.6

*Dubbo excluded as pathologists also spend significant time performing cut-up.

**Calculated based on RTUs and presuming pathologists work 47 weeks per year. (Five weeks is less than the full entitlements for annual leave and TESL for staff specialists but the full amount is rarely taken).

Non-Diagnostic Workload

The workload tool was also used to calculate non-diagnostic workload consisting of multidisciplinary team meetings (MDTs), teaching, research and administration.



Multidisciplinary Team Meetings

The workload for MDTs using the pre-specified workload tool is shown in figure 5 and using a more detailed analysis in figure 6. Based on the more accurate data in the detailed MDT analysis, MDTs across the state make up a total of 361hrs per week (equivalent to 9.0 FTE pathologist workload across the state).

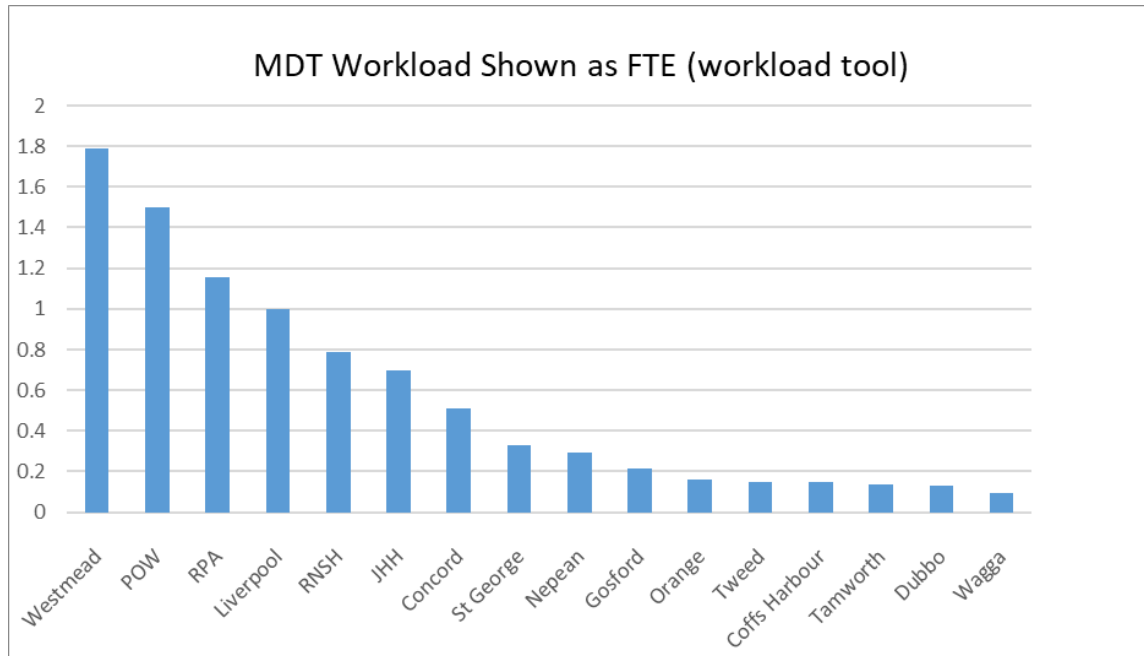


Figure 5. Multidisciplinary team workload across each site shown as FTE staffing (total hours per week divided by 40).

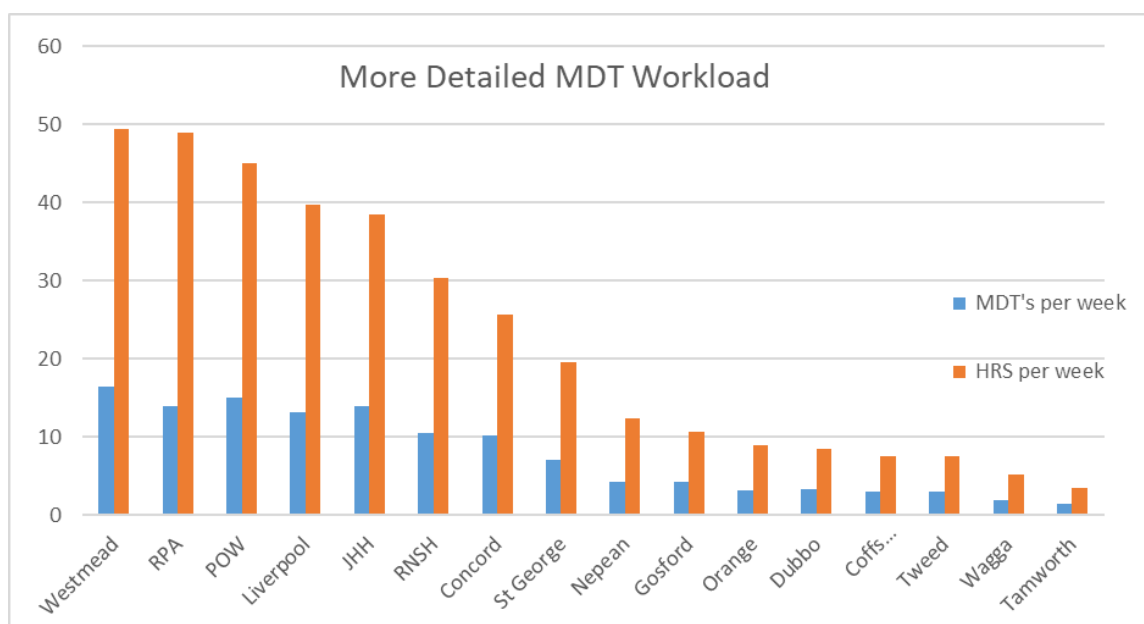


Figure 6. More detailed analysis of multidisciplinary team workload across each site shown as total number of MDTs per week (blue bars) and total pathologist hours per week (orange bar).



Currently, most sites are not routinely entering MDT cases into the LIS so data extraction cannot readily occur. Data was obtained during site visits from rosters, MDT patient lists and interviewing clinical directors and pathologists. Although there is an MBS item number (item number 243) available for cancer multidisciplinary case conference, not all MDT patients have a cancer diagnosis and there are multiple non-pathology-related criteria that must be met including at least 10 minutes discussion time per patient.

- Most MDTs at many sites have >6 patients per hour so they do not fulfil the MBS criteria. This is a reflection of the increasing number of patients presented at each MDT. Not all MDTs or all patients in MDTs are for cancer treatment plans (e.g., non-neoplastic liver and renal, interstitial lung disease etc).
- Laboratories have insufficient clerical or other staff to check if MBS criteria are being met or not.
- Only one laboratory in NSWHP is currently billing MDT cases (John Hunter Hospital). Other sites report insufficient staff to check Medicare criteria or insufficient MDTs with <6 patients per hour to warrant billing.
- The MBS item number was developed for clinicians who provide a verbal history and/or treatment suggestions at an MDT and not for pathologists who need to retrieve, review and present slides during an MDT, requiring significant preparation time prior to the meeting. At several sites, pathologist presentations at multiple MDTs are required to be PowerPoint presentations, resulting in additional significant workload of photographing multiple slides and creating a presentation.
- At tertiary referral sites (major metropolitan laboratories), pathologists are required to review the external pathology of many or all patients who have been referred to the major centre for subsequent treatment, creating additional significant workload. The workload is often more than reflected by the MBS item numbers available for external reviews (item numbers 72851 and 72852).
- The high numbers of MDTs and patients listed for each MDT also places a high burden on clerical staff who are required to identify relevant patient reports (often only a patient name and MRN is provided and not the specific pathology accession number), print reports and find slides from filing. Often there is insufficient clerical staffing resulting in pathologists or registrars having to identify patient reports and find the slides.

Teaching, Research and Administrative Workload

Pathologist's non-diagnostic workload based on teaching, research and administration as determined by the Relative Workload Tool shows a similar distribution with highest workload at the major metropolitan laboratories (figure 7). RPAH, Westmead, and POW were all found to perform >2 FTE worth of teaching, research and administrative work.

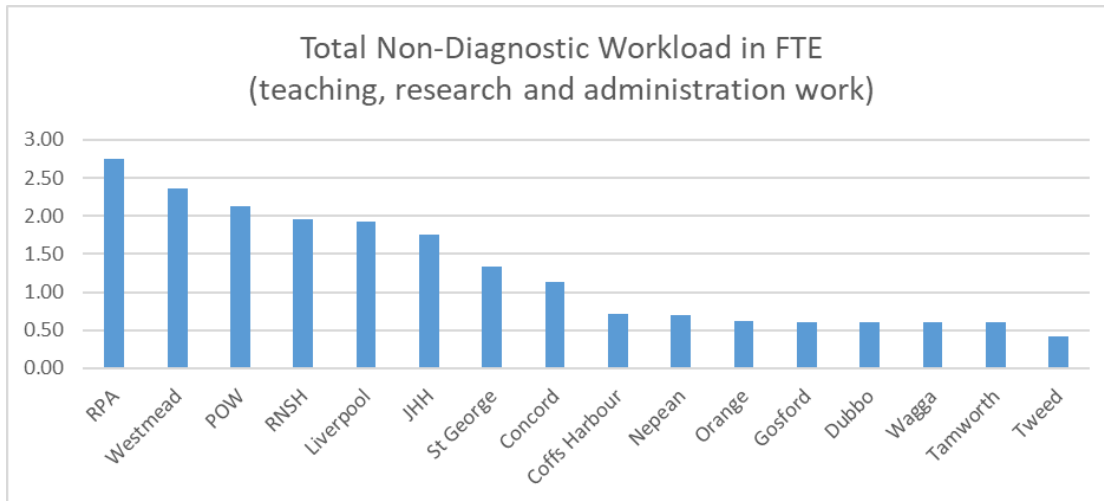


Figure 7. Non-diagnostic workload calculated by the Relative Workload Tool at each site (shown as FTE staff required to fulfil the duties).

Pathologist Total Workload (Diagnostic and Non-Diagnostic Duties)

To calculate the average relative pathologist workload at each site (corrected for non-diagnostic work), the total RTUs at each site were divided by pathologist staffing at each site corrected for non-diagnostic workload (total funded pathologist FTE less FTE workload for MDT, teaching, research, administration). Again, this showed an inequitable workload across the different AP laboratories in NSWHP (figure 8).

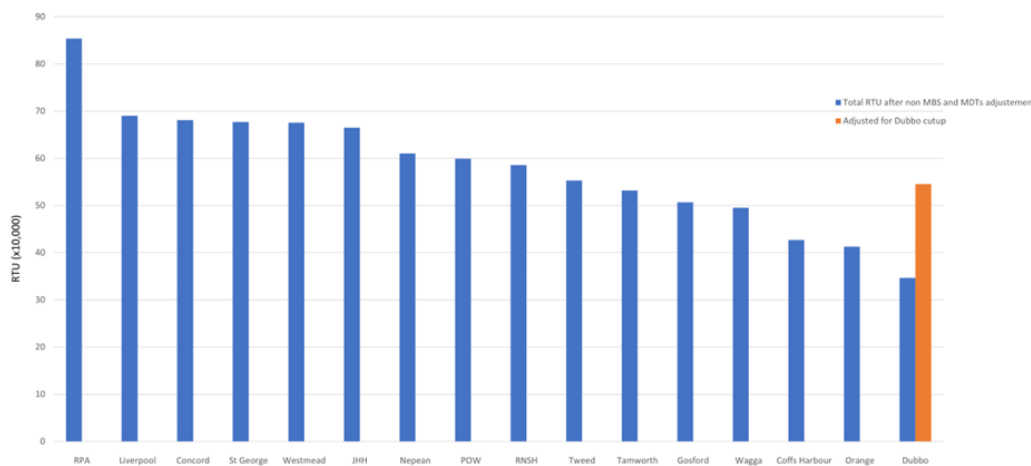


Figure 8. Total Relative Time Units per adjusted pathologist FTE (funded FTE minus non-diagnostic FTE workload at each site) across all laboratories.



Summary of Findings

- Pathologist staff shortages are being felt across the majority of laboratories with most reporting significant workload stress.
- Pathologist staff shortages are predominantly at the major metropolitan sites (RPAH, JHH, Liverpool and Westmead), including laboratories that provide the bulk of regional support (Westmead and JHH).
- The 2 sites most impacted by COVID-19 (Westmead and Liverpool) are amongst the sites with highest workload/staff ratios.
- Of the smaller metropolitan laboratories, St George Hospital has the highest workload per pathologist, similar to the large metropolitan laboratories. The data shows Concord also has a high workload although this includes significant EM work that has a large reporting contribution from scientific staff.
- Regional sites are experiencing staff shortages to a lesser extent but struggle in periods of staff absences/vacancies. Pathologists in regional sites are also more commonly required to train registrars in cut-up (and perform excess cut-up) when they have first-year registrars as there are typically no senior registrars to train them.
- There are a higher proportion of high complexity cases at multiple major metropolitan laboratories that are not captured by the workload tool (e.g. placentas from high risk pregnancies at POWH/RHW and other maternal tertiary referral sites, skin specimens at RPAH from melanoma unit, peritonectomies at St George/RPAH, bone and soft tissue tumours at RPAH, paediatric cases at POWH and JHH, complex lymphomas referred to metropolitan laboratories, complex cases referred to metropolitan laboratories etc).
- MDTs
 - The 6 largest metropolitan hospitals are all spending ~1 FTE performing MDTs (unfunded workload).
 - Across NSWHP, MDTs make up a total of 9.0 FTE pathologist workload.
- Tension of private work supporting trust funds (e.g., RNSH) but requiring sufficient staffing to remain competitive (e.g., fast TATs, regular frozen sections out of routine work hours).
- High numbers of fractional appointments for pathologists – some reportedly to manage high workload, others for parental responsibilities or personal reasons. NSWHP needs to be aware of the shift to fractional work in workforce planning.

Risks Associated with Inadequate Pathologist Staffing

- Risk to patient welfare – failure to receive current standard of care pathology, backlog of cases leading to delayed diagnoses, higher risk of diagnostic errors.
- Risk to pathologist welfare – burnout, medicolegal risk.
- Risk to NSWHP – medicolegal risk, reputational risk due to prolonged TAT or diagnostic errors, loss of staff to private sector (three clinical directors have moved to the private sector within the past two years) or interstate, unsustainable and uncontestable public sector pathology in NSW.

*These risks have been categorised by the NSWHP Chief Pathologist as Risk Category E: **Major Risk Likely to Occur.***



Proposed Options for More Equitable Workload Distribution to Meet Patient Needs

Several options are presented to distribute pathologist staffing more equitably across NSWHP laboratories to meet patient needs and avoid risks associated with inadequate staffing outlined above. Additional fully funded pathologist positions are required for the laboratories with the highest needs. **It is estimated that up to an extra 8.5 to 10.5 FTE pathologists across at least 5-8 sites are required to meet current and immediate future needs. Alternatively, an option would be to fund 9.0 FTE anatomical pathologist positions to account for pathologist MDT workload as calculated within this review.** Additional pathologists should be appointed to sites with the highest workload need as identified in this review unless other factors need to be considered (e.g. paediatric pathology workforce).

Model 1 involves an additional 10.5 FTE across 8 sites with 4 at RPAH, 2 at JHH, 1 each at Liverpool, Westmead and RNSH and 0.5 each at St George and Nepean Hospitals (figure 9), creating a more even workload across NSWHP.

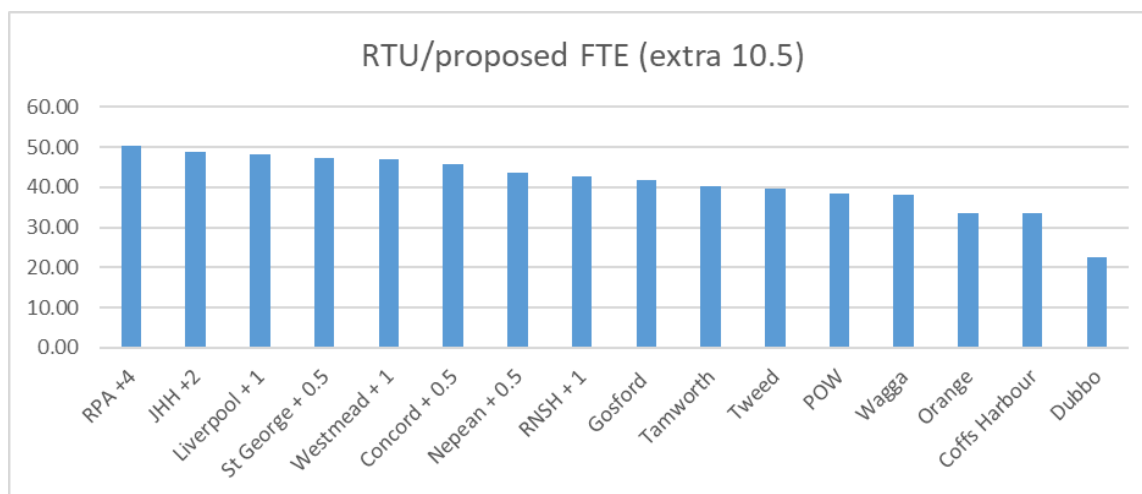


Figure 9. Total Relative Time Units per Funded FTE pathologists across labs with 10.5 additional FTE.

Model 2 involves an additional 8.5 FTE across 5 sites with 4 at RPAH, 2 at JHH, 1 each at Liverpool and Westmead and 0.5 at St George (figure 10), also creating a more even workload across NSWHP.

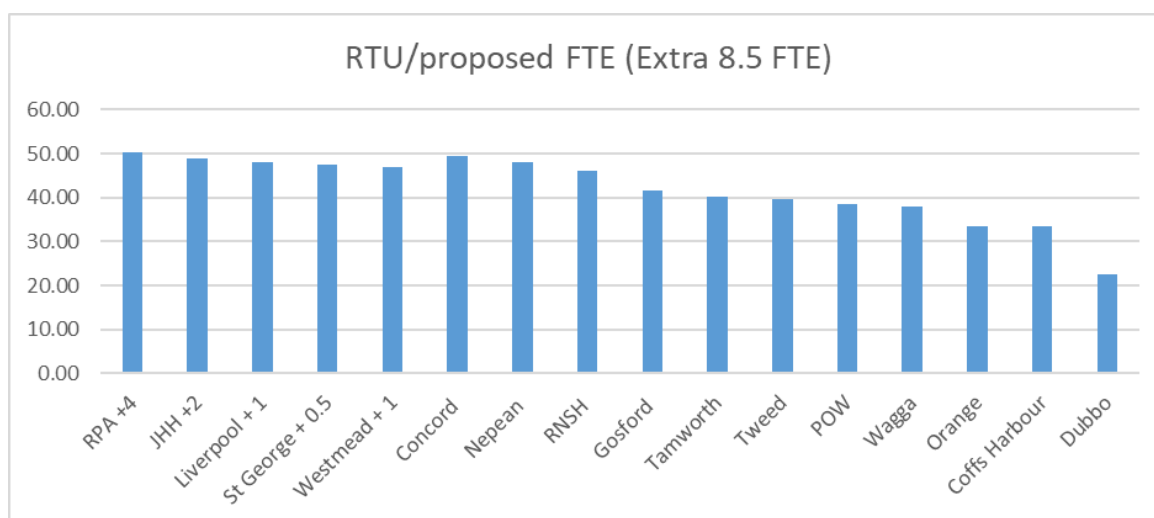


Figure 10. Total Relative Time Units per Funded FTE Pathologists across laboratories with 8.5 additional FTE.



Limitations of Review

The main limitations of this workload review are:

- Diagnostic workload is based on MBS item numbers and assigned RTU factor which is a good approximation of workload but does not necessarily capture the nuances of different caseloads at different sites. Comparison of sites with significantly different scopes of practice to other sites is imperfect and has some biases (e.g., the relative complexity of paediatric work is not captured at all, and EM may be over-valued for pathologist workload). The impact of delivering complex statewide services (e.g., bone and soft tissue tumours, peritonectomies, pelvic exenterations) may not be adequately captured.
- Collection of unconed diagnostic data. As multiples specimens from one patient are grouped together with “coning” of specimens as per MBS specifications, the absolute amount of pathologist work is underestimated. This is applied across all laboratories, however, so the relative workload is unlikely to be significantly impacted.
- The measurement of non-diagnostic workload, especially teaching and research is only a rudimentary estimation of this workload but there is no other simple way to measure this type of work. However, non-diagnostic work only represents a minority of the overall pathologist workload.
- The workload tool method for measuring MDT workload was found to be too rudimentary given the significant and increasing impact of this workload, so a more detailed method was also used to capture the workload more accurately.
- The two financial years assessed included COVID-19 restrictions on non-urgent elective surgery and lockdowns that appears to have impacted pathology workload in the second financial year (2022), especially at Westmead and Liverpool Hospitals. Despite this, there was still an overall growth in workload of at least 10% at the five largest metropolitan laboratories compared to the previous two financial years.
- Northern NSW – the review excluded Lismore Hospital which has no onsite pathologists. Some of the Lismore workload is distributed among other sites in Northern NSW. The complex nature of shifting workload across Northern NSW laboratories justifies the separate ongoing review of pathology services across this area.
- Inter-laboratory support – cases are transferred between laboratories at times due to staff shortages and while this could be seen as artificially increasing the workload of the recipient sites, it also reflects their actual workload performed at each site and their likely willingness to take on additional overflow cases in the future.

Findings Outside Scope of Review

- Lack of sufficient staffing across the entire laboratory – Many sites report staff shortages across multiple positions, not just pathologists, especially laboratory staff and clerical staff. Many reported a general lack of redundancy of staffing (e.g., even one staff member on leave having significant impact on service delivery) and lack of suitably qualified staff performing tasks (e.g., pathologists or laboratory staff getting slides for MDTs, scientists need to cut slides so can't perform dissection roles).
- Registrar cut-up and workload
 - Five of 13 laboratories with registrars are operating at the 50% cut-up limit and this will only be exacerbated by year-on-year increases in AP workload without significant investment in registrar and/or dissection scientist staffing and training.
 - There is inequitable distribution of registrars across sites (relative to workload) and dissection scientist staffing, and this needs to be addressed.



- There is capacity for increased dissection scientists to perform more non-complex cut-up at all but one site. These sites report insufficient staffing to either train or release scientific staff from other duties or both.
- Lack of ICT support - Most laboratories reported insufficient ICT support to effectively perform and manage laboratory duties (not just from Fusion recruitments).
- Most genomic testing is being referred outside NSWHP – the majority of laboratories are referring specimens for predictive and diagnostic genomic testing outside NSWHP (11 of 16 laboratories; all but RPAH/ JHH/Liverpool/Concord - refers to RPAH/St George - refers to Liverpool). Most refer cases either to SydPath or interstate to Victoria.

Feedback from Laboratories

A PowerPoint presentation of the overall findings of the AP workload review was shown to AP Clinical Directors and Laboratory Managers during a meeting on 4 August 2023 and they were given a week to provide any feedback. A summary of the feedback received is included in Appendix 3.



Appendices

Appendix 1 – Anatomical Pathology Relative Workload Tool

2022 RELATIVE ASSESSMENT WORKFORCE TOOL:

Custodianship and Ongoing Management

- 1] This tool is under the custodianship of the NSW Health Pathology Clinical Stream (CS). This document should be reviewed every THREE (3) years or should there be a material change to the MBS schedule and item numbers upon which this tool relies.
- 2] It can only be used to assess a whole Laboratory or site for total workforce requirements and can not be used for, by or in conjunction with individual Pathologists.
- 3] A Diary from all Pathologists and Clinical Scientists is required and should encompass at least 1 month of activities as defined in the diary spreadsheet
- 4] It must be used in conjunction with a site visit having collected additional data as set out in the related Site visit proforma. This will ensure the whole service is reviewed in conjunction with the assessment of Pathologists requirements.
- 5] The site visit team is to be approved by the Clinical Stream and must be independent of the sites being reviewed. Generally it is the Stream Lead, one independent Pathologist Specialist / Stream Coordinator and a Project Officer
- 6] It is to be used by each Laboratory *once per year* to assess Pathologist workforce and at such a time as to be able to inform the Budget discussions for the following financial year. The review must occur with the support and involvement of the Local Pathology Management and Chair of the Clinical Stream.
- 7] It should be reviewed for those sections outlined in the ISSUES FOR FURTHER DISCUSSION section, when these have reached a Statewide consensus.
- 8] With these conditions, it has ASMOF support.

RELATIVE Workforce Tool and Site Visit:

The Tool calculates the hours needed to undertake the work recorded, it does not assess the current hours available (see later section).

This is a RELATIVE ASSESSMENT Tool and relies on the following:

- 1] All aspects used in this TOOL are based on experiential assessment, cross checked across several Labs to determine that they provide a consistent but relative assessment of need. They are not based on a true Gold Standard external metrics.
- 2] The formula used in the activity calculation is designed to assess the input required by <insert discipline> Pathologists and Clinical Scientists. It does not reflect the Lab capacity (equipment, staffing etc). It was cross checked for <insert discipline> Pathology at 2- 4 Labs to assess its consistency across various sized Labs. Two refinements to this include:
 - a. Extra time allowances for our Cat Gy Labs and Major Metropolitan Labs (per the Clinical Services Plan) to reflect their extra volume and complexity of service. They are counted at 2 x Cat B time allocation



- b. Supervision of NON Lab POCT on an LHD x LHD footprint was assessed as being equivalent to supervising a Cat B Lab and MLHD, WNSWLHD and HNELHD are recognised as having 2 x service work of other LHDs.
- c. Supervision of non Chemistry tests on Chemistry analysers in Chem or Core Labs is recognised to be equivalent of supervision of a Cat B Lab

3] The classes of activity allow for more complex tests diseases and being assessed as well as ease of extraction from the Database managed by Alex Eigenstetter. This allows for a statewide review (removing the individual LIS by LIS variations) but is post coned data so does not truly reflect actual activity.

SUBJECT TO UPGRADE from Billing to Activity Based Data collection

- 4] The Clinical Director and Supervision of Medical Trainees as well as the research and Teaching Requirements are based on those agreed by all Clinical Streams to maintain statewide standards.
- 5] The Diary entries are collated for 1 month (Feb or Sept are representative months) and multiplied up to a 12 month total to minimise diary requirements. Necessarily this means only those that are diarised are captured so it is incumbent on diary owners to enter data.
- 6] The activity adjustment for Hospital type is based on the classification for the Public Pathology Australia Benchmarking Programme. *The per cent applied is completely arbitrary* and are designed to show the impact of high complexity patients in those hospitals. This will need to be assessed overtime to determine if it is of the correct magnitude.
- 7] Medical Staff with both Pathology and Physician Qualifications/Duties. An assessment on site was used to allocate the FTE to each category. This delineates the Laboratory available hours for use with the spreadsheet. Physician duties and times are quantified and will need separate discussion
- 8] This TOOL does not consider the Revenue, Rights of Private Practice and Overall Lab Expenditure. Due consideration of the Physician Duties and who pays for these or how they are acquitted with the LHD is also not covered.

Current Hours Available, assessed at the Site Visit:

The total working hours needed for the department is then calculated from the workload and takes account of:

- I. current funded FTE (hours) available from existing staff
- II. For non Lab Administrative Duties the following are to be deducted from the current funded hours:
 - a. Clinical Stream Lead: 0.3 FTE (*subject to 2022 adjustment*)
 - b. Local Pathology Director: 0.2 FTE (*subject to 2022 adjustment*)
- III. Current rosters
- IV. Current allowances for all types of leave

FINDINGS AND RECOMMENDATIONS:

Use of the RELATIVE ASSESSMENT TOOL and Current Hours available will allow Local Management to assess the response to this review.

Any recommendations for additional resources will affect the Pathology price to LHD's and this must be considered when making a determination.



Appendix 2 – Workload Checklist and Diary

2023 Pre-visit Checklist

Metric:	Lab Response:	VISIT NOTES:
Laboratory current Standard Case TAT (from collection to reporting) agreed with LHD/Hospital and actual if different: <i>[measured in Hours]</i>	Simple Cases: Moderate Cases: Complex Cases:	Lab to provide
Time of day at which slides are delivered to consultants for reporting on a normal working day <i>[using the 24 hr clock]</i>	Based on an average week: 0730 – 0900 – 1030 – 1200 – 1330 – 1530 –	% delivered of the average daily workload at each time specified
No of Staff Specialists who are full time:		Lab to provide



No of Staff Specialists who are part time and what fraction each of them holds		Lab to provide
Weekly or Monthly Staffing Roster for Specialists (this is not the distribution of cases on a daily basis)		Lab to provide
Recuts and Additional Stains <i>On average - time taken from when requested to delivery back to the pathologist</i>		Lab to provide
Lab Operational Hours		Lab to provide
Are Scientists involved in Cut Up, if so how much? No of sessions per week		Lab to provide
Lab Infrastructure		To be reviewed at site visit
Do you have a Sat or weekend Cut up session rostered?	Yes/ No If Yes for how long	Lab to provide



Do you have Automated Slide Staining Equipment?	Yes /No It does cover certain Special Stains and all IHC's?	
Medical Typist Support	Do you have Winscribe or equivalent? Do you have enough Medical Typists for the activity required in your Lab? Do you use Dragon Dictate or equivalent - in Cutup? -with Pathologists?	Lab to provide
Off Site Locations / Hospitals supported by this Lab		Lab to provide
Monthly MDT meeting schedule		Lab to provide
Off Site Attendance required regularly (eg for MDTs)		Lab to provide
Research/Teaching <ul style="list-style-type: none"> - Pathologist publications 2022 calendar year - Academic appointments of Pathologists 		



<ul style="list-style-type: none"> - Number of trainees - Complete attachment- <i>2023 AP RWT Diary_Template</i> 		
<p>Any Other Documents/Issue you wish to raise</p>		<p>Lab to provide</p>



2023 AP RWT Diary

Laboratory	Meeting	Pathologist	Registrar	Preparation - YES/NO	Presentation - YES/ NO	Frequency	Patients/ Cases per meeting	Total/Year
MDTs								
Total Hours								0
Teaching and Education Sessions attended. Include in house training, education of your and other staff								
TOTAL HOURS								0
Book Chapters/National and International Guideline/Standards/Research Publications [Peer reviewed journals]: Capped at 20 per annum(note if you are first/last author) and who holds a clinical academic title - only 2022 data								



Appendix 3 – Summary of Feedback on Pathologist Workload Review from Clinical Directors and Laboratory Managers

The review was overall seen as a positive approach but there were concerns with the accuracy of the data and its ability to reflect the needs of individual sites.

- Concerns of under-representation of workload due to rebound of workload in 2023 post-COVID-19. This was raised by multiple Clinical Directors.
- Concerns workload not a true reflection in North Coast NSW due to support provided to other sites (eg Lismore, PM, Taree) and due to significant flooding events in early 2022.
- Concerns that future needs not being addressed (e.g., new hospital at Tweed Heads, new private hospital referrals at RNSH).
- Concern regarding lack of union involvement (despite consultation prior to 1st review).
- There was a desire for an absolute workload assessment to determine what is an appropriate workload rather than a relative assessment. This was raised by multiple Clinical Directors.
- Concern that some metropolitan sites have insufficient pathologists for subspecialisation beyond maintaining areas of interest and responsibility for particular MDTs. This requires the additional burden of maintaining functional and relevant reporting capability across all AP reporting disciplines, contrasting with sites where pathologists focus on fewer sub-specialty areas.
- Concerns that review doesn't adequately reflect the time taken to report higher complexity cases undertaken at metropolitan sites including pancreatic neoplasms, gynae-oncology, renal biopsies, soft tissue sarcomas and paediatric/perinatal pathology.
- Concerns that paediatric and perinatal workload has not been adequately assessed.
- Concerns that considerable workload support provided by metropolitan sites for regional sites despite their own significant workload pressures is not captured and that sites providing this support are not rewarded for helping out.
- Concerns that the information and comparison between metro and rural sites will make it difficult for Clinical Directors to accept work to support R&R without significant pushback from some of their pathologists who will see they already have some of the highest workload across the state.
- Concerns that NSWHP and the R&R labs do not appreciate how stretched the metropolitan laboratories really are.
- Concerns that some sites are unable to double check the data due to constraints of their LIS.
- Concerns that workload review doesn't reflect challenges of regional sites when staff go on leave or there are vacancies.
- A need to look at the strengths and weaknesses of the workload review approach and refine it for the next round.

Feedback that was not within the scope of the review has not been included.