New South Wales

Special Commission of Inquiry into Healthcare Funding

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Name: Haematology Department, Children's Hospital Westmead

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Richard Bearsley SC
Commissioner
The Special Commission of Inquiry into Healthcare Funding

31st October 2023

Dear Mr Bearsley SC

On behalf of the Haematology Department of the Children's Hospital at Westmead. I wish to make the following submission to the Special Commission of Inquiry into Healthcare Funding. I am a Senior Staff Specialist in Paediatric Haematology at the Children's Hospital at Westmead (CHW) with over 30 years' experience in the NSW Health system. I am currently the Head of Haematology (having held this position from 2007 – 2014 and again since 2018), as well as Clinical Program Director for Diagnostics at CHW since December 2020. While the CHW, part of the Sydney Children's Hospital Network (SCHN), prides itself on providing excellence in care to the children of NSW, our ability to do this is being continually challenged by budgetary and financial constraints.

Our Paediatric Haematology team of specialised consultants, JRMOs, nurses and laboratory staff work tirelessly to provide care, not only to the patients of our service, but also through consultative advice to many clinicians caring for children that are inpatients and outpatients of CHW, as well as to external clinicians around the state of NSW. We guide the investigation, diagnosis and management of many patients through this consultative service.

When money is well spent it can make an enormous difference to the children and I would like to cite our Haemophilia Treatment Centre as an example of money well spent. In 2005/2006, largely through lobbying by parents with the NSW Ministry, funding was secured for two permanent nursing positions for Haematology. In addition, the same parents organised fundraising for funds to fit out a dedicated treatment space within the hospital. Additional philanthropic donations were also used to enable this project to be completed and the "Kids Factor Zone" Haemophilia Treatment Centre was opened in July 2007. To this day this space with dedicated nursing enables us to provide excellence in haemophilia care in a safe environment where the children are actually happy to come (despite the numerous injections these children receive). By having a dedicated space and nursing we have been able to train numerous families to perform venipuncture on their child (often as young as 2 years) thereby avoiding the need for surgically implanted venous access devices and their related complications. For those families whose children still need a venous access device we have a dedicated space to train the parents to access this device so that they can deliver the factor therapy at home. The Kids Factor Zone also provides us with a place to perform acute unplanned reviews on children who are having a bleeding

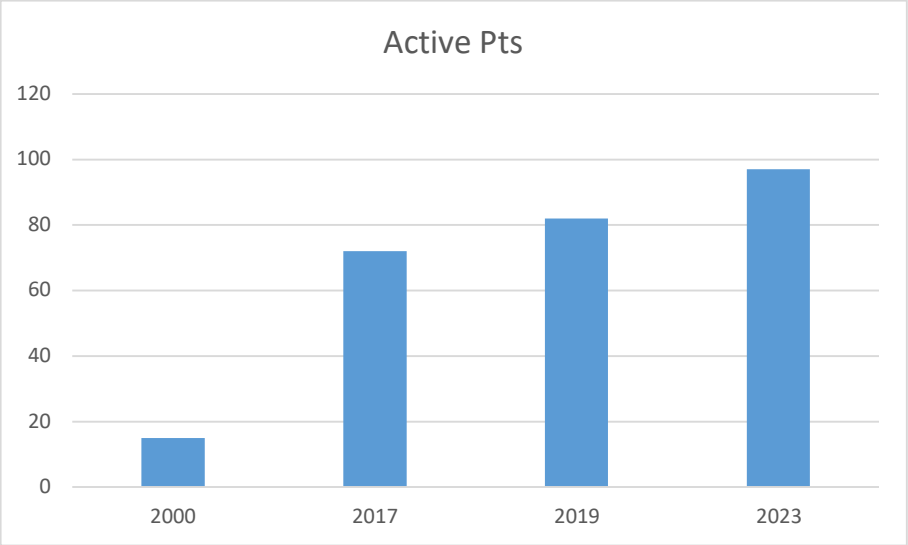
event so that they can receive timely treatment without delay that would be experienced if they were to attend the Emergency Department. We avoid numerous admissions by acute review and close follow up in this space. Whilst we know we are delivering the very best in haemophilia care by international standards, we are still limited in several areas – particularly funding for a physiotherapist and social worker. Our expert haemophilia physiotherapist was on soft funding donated by Pharma (not an ideal situation when considering the potential for conflicts of interest). This unreliable source of funding was withdrawn when that company was unsuccessful in the National Blood Authority's Factor Supply tender several years ago. At present we are using money derived from previous Pharma-sponsored Research trials to fund this physiotherapy position. This funding source is limited, not being replenished and will at some point be exhausted. Physiotherapy is considered a standard of care by the World Federation of Haemophilia for a Comprehensive Care Centre such as our that looks after over 220 children with bleeding disorders. Furthermore, there is not dedicated social work funding for the Haemophilia Service, and we are reliant on the general pool of hospital social workers. Having consistent permanent funding for physiotherapy and social work would be of great benefit to the patients and remove stress from the team by not having to continually look for sources of soft funds.

The Kids Factor Zone space is so valuable to our Haematology Team we couldn't imagine operating without it. Whilst its primary intention was for children with bleeding disorders, we have expanded its use to all our haematology patients who need acute review or an ad hoc appointment that can't be scheduled into a regular outpatient clinic in a timely way. Thereby delivery enhanced care to an even broader group of patients. This model gives the patients easy access to the experts who know their child leading to better and quicker management decisions and avoidance of Emergency Department presentations. Similarly, while the two nursing positions were initially primarily funded for bleeding disorders, it was quickly apparent to us that our other big group of patients, those needing regular blood product transfusions, also needed the benefit of dedicated expert nursing. Therefore, we assigned one of the two nurses to primarily cover bleeding disorders and the other our transfusion patients (Thalassaemia, Sickle cell disease, bone marrow failure) with both backing each other up as required. This is how we make the funding dollars go as far as possible and support as broad a range of patients as possible. However, there is a limit, and our limit is really being tested now particularly in relation to increased numbers of haematology patients – with two patient populations really standing out as increasing our workload over the past 10 - 15 years. These are the children with Sickle Cell Disease and Bone Marrow Failure. I will highlight the issues of Sickle Cell disease as they are particularly pertinent in NSW now having been mentioned in Parliament in June this year by the Member for Liverpool, Ms Charishma Kaliyanda.

Sickle Cell Disease

The prevalence of sickle cell disease (SCD) has increased significantly due to changing patterns of migration. With more migrants arriving from Africa, the number of people living with this disease is steadily rising in Australia with an increasing number of affected babies born to migrant parents. The Children's Hospital at Westmead (CHW) has the largest number of patients with SCD (99 patients) for a single centre in Australia, this is compared to a patient load of just 15 active patients in 2000. (see graph 1). The care of patients with SCD centres around early diagnosis, education of families and patients, screening for complications, health maintenance, treatment of acute and chronic complications, and curative treatment may be feasible for some patients. It requires a whole of life multidisciplinary approach to optimise quality of life and lifespan which is achievable with appropriately resourced comprehensive treatment centres. At CHW we implemented transcranial doppler screening in 2014 and red cell exchange transfusion program in 2015. All this care has been provided without any additional staffing within our department. Our red cell exchange transfusion program and plasmapheresis are limited by lack of staff. We are utilizing 0.5FTE casual pool nursing staff (without any budget to do so) to meet clinical demand.

Graph 1. Nos of Active Sickle Cell Disease Patients (2000 – 2023)



Patients with SCD are among the most disadvantaged chronic patients across all health networks around the world, including here in Australia. Many of the patients with SCD are of low socioeconomic status coming from immigrant and non-English speaking backgrounds. They face discrimination in the health care setting by staff who do not understand the disease and can suffer acute and catastrophic complications when care is delayed. Because they have pain that occurs without precipitant injury and may have no other outward signs, they may be accused of opiate seeking behaviour. The impact of the disease when poorly managed with frequent crises and hospitalisations limits patients' work and educational opportunities, further disadvantaging these patients. This patient population also does not have a loud advocacy voice and thus it has been difficult to secure access to resources required to enable these patients to live their best lives possible. We compare the ability of our Haemophilia families to secure funding for the Kids Factor Zone – the Sickle Cell Patient Population just don't have the resources of advocacy voice that the Haemophilia group do, however their needs are probably even greater because while treatments are continuing to improve for haemophilia so that most children with haemophilia are living essentially normal lives, this is not the case for SCD. We still see children with Sickle cell disease suffering effects of repeated crises with e.g. damaged joints such as hips, cognitive decline and end organ dysfunction. Some of the issues relating to this increasing population of patients with SCD are highlighted below. This was provided to the NSW Minister for Health in July 2023.

Issues relating to NSW:

Early diagnosis – SCD is not amongst the diseases screened by Newborn Screening although its inclusion is currently being evaluated through MSAC and is being considered in the Commonwealth expansion of newborn screening. Without formal state-wide newborn screening, there is no standardised approach for the screening of at-risk newborns (born to carrier parents) with each Local Area Health having their own approach. Early diagnosis and education of their parents are essential as these save young children from dying from acute disease complications. There is also no standardised approach for the screening of carriers from at-risk communities.

Comprehensive treatment centres – patients with rare or uncommon diseases do best if cared for by comprehensive treatment centres where the expertise is. For paediatrics, comprehensive care is provided by CHW and Sydney Children's Hospital (SCH, Randwick). For adult patients, care for SCD is provided by RPAH, POWH, Liverpool Hospital and Westmead (adult) Hospital although they would likely be better off if cared for by 1 – 2 comprehensive treatment centres located in LGAs with the highest concentration of patients. Amongst SCD patients attending CHW, approximately ¾ patients reside in the

Liverpool LGA, and they will likely transition to Liverpool Hospital when they graduate from paediatric care. We propose that there should be one paediatric and at least one adult comprehensive treatment centre with appropriate staffing and funding to provide the expert care these patients deserve

Resourcing of treatment centres – although SCD is a disorder of red blood cells, it is a multisystemic disease that has the potential to affect multiple organs (as outline above). Sickle cell care does not only require haematologists skilled in this disease, it also requires other specialist physicians, highly skilled nurses and allied health staff, including social workers, counsellors, and teachers (during the childhood years). CHW is providing comprehensive SCD care, including implementing an exchange transfusion program since 2015 and has done so without enhancement in staff resourcing. The increasing numbers of patients without additional staff means is particularly challenging for our service and, frustratingly for staff, we cannot always provide the level of care we believe to be ideal. Most patients and families are not receiving input from social work/counsellors and most are also missing out from having a dedicated specialist nurse. CHW has one clinical nurse consultant who runs the Red Cell Apheresis Program for ~15 SCD patients receiving monthly exchange blood transfusions while the remaining patients have minimal contact from specialised nursing. In the past two years four young patients have suffered devastating orthopaedic complications in their hips secondary to sickle crises that will have life-long implications for these children. These patients would greatly benefit from specialised nursing input.

Transition of paediatric patients to adult care – with an increasing number of new patients each year, an increasing number of young adults are needing to transition to adult hospitals for ongoing care every year. Many CHW patients will transition to Liverpool Hospital but some patients would opt to travel longer distances to other centres which is not ideal. Some patients with severe more complex disease are managed with monthly exchange blood transfusions but adult hospitals are often reluctant to continue this form of treatment due to resourcing pressures despite it being the best form of treatment for those patients. Some patients have had their monthly exchange blood transfusions ceased after transitioning to adult care and would, hence, be at risk of more disease complications and an overall poorer outcome.

Haematology Consultative and Laboratory Service

In addition to providing a comprehensive integrated diagnostic and clinical service for children with primary blood diseases, the Haematology Department of the CHW provides a consultative service for clinicians of CHW and from around NSW, on all things related to patient's haematology such as lab result advice, diagnostic advice and clinical management advice. Furthermore, the Haematology Department runs a comprehensive specialized paediatric haematopathology laboratory service, recognized nationally as the Reference Laboratory for Red Cell Enzyme Assay and Telomere Length measurement. The CHW Blood bank, part of the Haematology Dept, provides critical support to major surgery, emergency, intensive care, oncology and transplant services at CHW. In 2023 this service is overseen by just 3.8 FTE Staff Specialist who are all dual trained with the Royal Australasian College of Physicians and the Royal College of Pathologists of Australasia. Since I took over as Head of Department in 2007 I have observed a significant increase and change in the nature of the patients we are involved with, along with a significant increase in complexity.

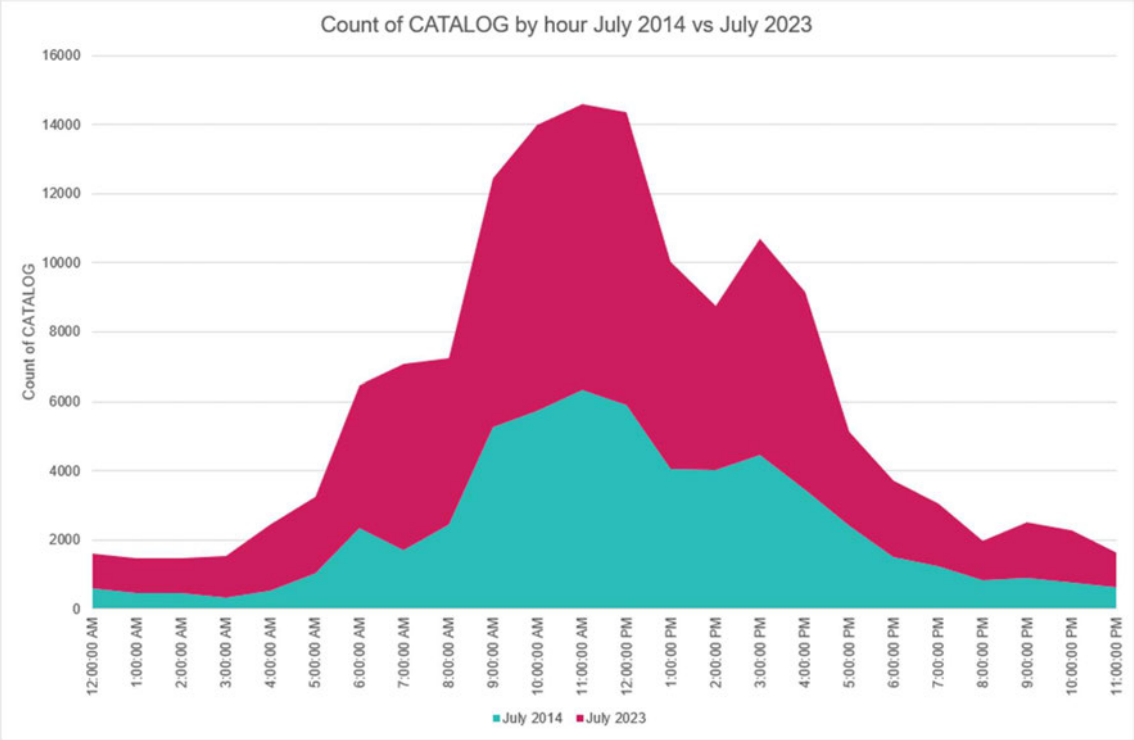
Increasing Test Numbers

On review of the data, the CHW pathology laboratory in July 2023 performed more than double the number of tests each day compared with the same period in July 2014. In this time in the Haematology laboratory there has been minimal staffing increase (essentially 1.0 FTE scientist). To date we have managed to cope with this increased demand through efficiency gains – particularly through automation and streamlining work processed. Paediatric laboratory samples are more resource intensive to handle primarily because of the small sample size and the preciousness of the sample (no one wants to recollect a child if we can avoid it). This means more shared samples, as well as adaptation of workflow processes to handle the very small samples. The funding models for pathology tests do not distinguish between

paediatric and adult samples and the complexity involved in the testing. As an example the Medicare rebate for a full set of red cell enzymes – a test which takes a senior scientist 3 full days to complete is rebated at just $51.90. The rebate is the same if we just do one enzyme assay or the whole panel. As the Red Cell Enzyme Reference laboratory we are the only lab doing the full panel of assays for Australasia, and we are therefore performing this role at a financial cost to our department. Improved funding models for paediatric pathology tests are required to ensure sustainability.

Numbers of laboratory tests.

Graph2: Change in numbers of laboratory tests between July 2014 and July 2023 across the hours of the day.



There has been an increase of up to 220% of laboratory workload at various times of the day.

Complexity

With the increasing ability of the various teams to save the lives of children, the Haematology team are providing advice around increasingly complex patients. The cardiac surgery and ECMO patients are just some examples. Previously babies born with hypoplastic left heart were not offered surgery, but now this is standard of care. These patients have a complex course over many months and from a haematological perspective we are required to provide advice around the bleeding and clotting risk in these patients. Furthermore, ECMO is being used with increasing frequency in the sickest of children. These patients also have to have a very fine balance between bleeding and clotting and the haematology team are frequently required to provide advice in their management. Recently the haematology team have also been required to perform plasma exchange on two patients on ECMO for the first time ever. One of these patients was a 3.6 kg neonate. This is a very complex procedure, not without risk and requires the expertise of our haematology nurses in collaboration with the PICU nurses and perfusionists to safely perform. Of course, these procedures almost always occur out of hours, and at present there is no funding for an on-call pheresis service, so these critically ill children are at the mercy of the good will of staff who come in, or stay late, to perform the procedure to save their lives. Permanent funding for

a dedicated apheresis unit is required with sufficient trained nurses to provide a 24/7 on call roster for this service.

Workforce and Sustainability

The change in workforce numbers in the Haematology Department has not kept pace with the increasing patient and test numbers. Our complement of senior medical staff has only increased 0.3 FTE since I started as HOD in 2007. It is unrealistic to think that this is an acceptable increase given the increased workload as well as complexity of the patients we manage. These 3.8 FTE provide a 24 hour on call service and this on call is particularly onerous given we are receiving calls from many external hospitals and clinicians, parents as well as the clinicians and lab staff of CHW. On average our team receives 15 – 20 consults during working hours, and an average evening on call equates to ~6 calls, with an average weekend day call averaging to about 10 - 20 calls. Of course, sometimes it is much more than this. With only 3.8 FTE to provide this 24/7 roster this equates effectively to a 1 in 3 on call over the year. This meets the criteria for onerous on call as per the Staff Specialists award. The Henry review indicated that 5 Full time equivalent paediatricians are required to provide a 24/7 on call roster.

The sustainability of this workforce is also challenging. The Haematology Department is only funded for two Haematology Advanced Trainee registrar positions and has over the years utilised soft funding sources to secure a third registrar. Of course, when these funding sources dry up, we are forced to manage with one less registrar (see attached email brief). We need to be training the workforce of the future. This also is important for the diagnostic laboratory scientists. At present there is no clear pathway of progression and training and these needs to be funded and developed. Our two trainee hospital scientists were rolled in one technical officer some years back because at that time we valued service over training. But if we are to consider the long-term sustainability of our haematology lab we need to be taking on trainees, getting them interested in paediatric haematology and providing a training framework. In regard to nursing, we have been advocating for some time to convert our unfunded casual pool utilisation to a permanent 0.5 FTE nursing salary without success. We have also advocated over the years for reinstatement of the Transfusion nurse – now referred to as a Blood Management Nurse. This was initially funded though the Clinical Excellence Commission and then through some soft funds, but we have not had this position funded now for over 10 years. This position is vitally important to maintain patient safety regarding transfusion of blood and blood products. The failure to fund such a vital position directly impacts on patient safety as highlighted in 2019 when two patients received blood crossmatched for someone else. Despites these incidents and subsequent investigations, a Blood Management nurse has yet to be funded.

Workforce

Below is a table showing the very limited expansion we have received since 2007. This failure to acknowledge the importance of the workforce is demoralising for staff. New buildings and new equipment can be funded but it seems extremely difficult to fund staff to actually do the work.

Table 1: Haematology Department Workforce 2007 to 2023

Position	2007	2023	Change	Comments
Senior Medical Officers – Staff Specialists	3.5 FTE	3.8 FTE	0.3 FTE Increase	A 24 hour on-call Service is rostered taking calls from clinicians from all over NSW in addition to CHW, as well as from parents of patients known to the service.

				The current funded FTE is insufficient, resulting in an onerous on-call roster of 1 in 3 across the year.
JRMO- Advanced trainees	2.0 FTE	2.0 FTE	**No change**	Over the years we have been able to secure temporary soft funding for a third haematology trainee registrar position, however this is not guaranteed and the position is not continued when the funding dries up. The workload requires the services of 3.0 FTE advanced trainees to ensure we are meeting the training requirements of the trainees as well as providing a service to the patients.
JRMO – basic trainee	0.2 FTE	0.5 FTE	0.3 FTE increase	This basic trainee is a shared role and from 2021 the number of teams sharing the trainee has been reduced from 5 to 2 meaning an effective increase in Haematology workforce
Nursing	3.0 FTE	2.0 FTE	Decrease 1.0 FTE	This decrease is due to the loss of a transfusion nurse position that was initially funded through the CEC blood watch program and then temporarily funded by CHW. It has not been reinstated despite multiple requests. To meet our patient's needs the Haematology Department consistently relies on Casual Pool nursing staff to assist with the sickle cell exchange program. There is no additional funding for these casual pool staff which equate to 0.5FTE) so the department operating budget continues to operate further into the red.
Administration officer	1.0 FTE	1.0 FTE	No change	
Haematology/Blood bank Laboratory staffing				
Senior Hospital Scientists	3.0 FTE	3.0 FTE	No change	
Hospital Scientists	4.0 FTE	5.0 FTE	1.0 FTE increase	Funding for this position secured from the limited funding available for the Block K opening.
Technical Officers.	4.4 FTE	5.4 FTE	1.0 FTE (but not real increase in personnel)	The increase was at the cost of the loss of the 2.0 trainee positions.
Trainee Hospital Scientists	2.0 FTE	0 FTE	Decrease 2.0 FTE	These positions were converted to 1.0 FTE TO

It is evident that funding for these vital services that save children's lives has not been adequate and this limits options of care we can provide.

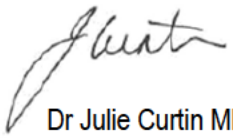
Activity Based Funding

I would like to make a comment in relation to Activty Based Funding (ABF) Model. This system may be a way to control health expenditure and, in some sectors, it may actually prove useful and beneficial. However, in our department this model is not fit for purpose. We do not have any ability to control the number of patients or consults presenting to our service or requiring our expert care. Furthermore, a large proportion of our work is done as telephone advice to the treating team. This is not captured in the data, even our outpatient model disadvantages our team for funding enhancement because we are very good at keeping patients out of hospital – only to see other departments receive enhanced funding because they have so many bed days. There is no equity in the system. Also, with ABF the idea that SCHN is penalised for seeing more patients than was agreed to is ludicrous. It goes completely against the concept of providing excellence in patient care. The change in the global pathobiome and the nature of the diseases we have seen (increased autoimmunity and immune activation) was not predicted. Block funding for paediatric services such as our Haematology Service which serves so many patients around the state should be considered. Indeed, I would argue block funding for all of paediatric pathology should be the future. Patient's care and diagnostic journey should not be determined by a particular departments ability to pay for the tests rather than by clinical need.

Other Comments

I believe there should be serious consideration given to the balance of health spending in the private and public sectors. Public hospitals if funded appropriately to deliver timely care to patients ultimately cost the public purse less because less money is going into the profit arm of the private health industry. Bring back appropriate funding for staff specialists and bring back full time senior medical staff employees and reduce the push to the private system which ultimately costs more. The better the public system is funded the better the health of the people of NSW will be.

Yours sincerely



Dr Julie Curtin MBBS (Hons I) PhD, FRACP, FRCPA
Senior Staff Specialist in Haematology

SICKLE CELL DISEASE

Ms CHARISHMA KALIYANDA (Liverpool) (18:30): Today I speak about an issue that recently was raised with me by constituents of mine. Earlier this week, on 19 June, we marked World Sickle Cell Awareness Day. Sickle cell disease, or SCD, is an inherited condition that affects the production of haemoglobin in red blood cells, which carry oxygen around the body. As it is relatively rare in Australia, it is not well understood. However, the genes for SCD are more often found in people with any of the following ethnic backgrounds: African, Middle Eastern, southern European, South Asian, South American and Caribbean. In a patient with SCD, rather than healthy round cells, a C-shaped cell is formed, similar to a traditional farming tool called a sickle. The shape and limited lifespan of sickle cells lead to an ongoing shortage of red blood cells and may also cause blood vessels to be blocked.

It can be a life-threatening condition and causes chronic pain, infections and other medical complications. It can be managed with regular blood transfusions and medication. A bone marrow transplant is the only known cure. Australian Sickle Cell Advocacy, or ASCA, was founded in 2014 by Agnes and Preston Nsofwa to provide education, information and support for patients with SCD and their families. Recently, the ASCA held an information and support session in the Liverpool area in recognition of the fact that an increasing number of those living with SCD have made Liverpool their home. I congratulate Dillys Chi on organising such an important event. The evening featured a presentation on the latest treatments available for those with SCD by Dr Annmarie Bosco, a haematologist specialising in blood disorders at the Prince of Wales Hospital, and a session on looking after mental health and wellbeing by Dr Winnie Foley. The evening also featured lived experience speakers, or warriors, entertainment and food.

Importantly, I was advised by ASCA that New South Wales does not have systematic data collection of those who have been diagnosed with SCD to better understand factors impacting quality of life and the level of interaction with the healthcare system. This also means that we do not even know where those who live with SCD are located around our State. It is of vital importance that we better understand the circumstances of those who live with SCD so that we can better plan and deliver the services that are required for their care. ASCA is advocating for the introduction of a newborn screening process for Australia. Newborn blood spot screening aims to identify babies at risk of developing certain rare conditions and metabolic disorders where early intervention can improve health outcomes. This is available for SCD in many countries, but currently not in Australia.

Often the only way that some parents know to request in utero genetic testing for SCD when they fall pregnant is because they have previously been identified as genetic carriers in their country of origin. Others are not so lucky and are only diagnosed after experiencing a crisis. Early testing would ensure that diagnosis is made when a range of different treatment options is available. We know that when it comes to chronic illness early intervention is crucial to improving quality of life, and it reduces the impact on the healthcare system down the track from further complications. Furthermore, a number of healthcare professionals who attended the evening identified that there is a disconnect between the location of services used to help manage SCD, such as thalassaemia and sickle cell haemoglobinopathy, and where the population living with SCD is concentrated. This means that while those who live with SCD live and often work in south-west Sydney, such services currently are concentrated in central and eastern Sydney.

When people are forced to travel great distances for vital healthcare treatment, they may encounter many barriers, including the cost of transport, time to travel and undergo treatment, lack of childcare options while receiving treatment, and other barriers. We are very fortunate in New South Wales that our healthcare system offers wraparound treatment and support for many chronic conditions to ensure that people in our communities have the opportunity to live their best lives, all for the cost of their Medicare card. However, as our community in south-west Sydney rapidly grows and changes, we must pay attention to the changes required on the ground for our community to access much-needed services. Our increasingly multicultural and geographically dispersed communities deserve equity in access to life-changing and life-preserving interventions and services.

[redacted]

From: Julie Curtin (SCHN) [redacted]
Sent: Thursday, 20 June 2019 3:28 PM
To: [redacted]
Cc:
Subject: Additional Haematology Registrar argument

Hi [redacted]

The case for the additional haematology registrar

1) Workload for collecting and reporting bone marrow examinations is up 125% this year compared with last year (ie we have done 292 marrows already and last year at the same time we had done 232). This increase has been consistent every month for 2019
2) Each bone marrow now has additional investigations performed so it is not just the collection, but also the sending out of all the additional samples, collating results as they come back in that adds to the registrars workload
3) It is not uncommon for two patients to require bone marrows at the same time (eg one in CT scan and one in theatres) –If haematology are unable to provide a registrar to meet this need it causes delays on the emergency list and other lists, with subsequent ramifications for everyone concerned.
4) The haematology registrars take all the phone calls from the wards for advice about tests and film reviews etc. As the hospital workload increases so too do these consults.
5) Haematology previously had three registrars for many years but the third registrar was on soft funds which ultimately dried up. Since ~2013 we have struggled since with two registrars. The reduction in registrars has meant we have not be able to provide as good a service as previously. This has led to increased tension between oncology and haematology partly caused by haematology's inability to meet Oncology's needs. This tension has even led to formal complaints between the departments. Currently all marrow requests for patients outside of the dedicated oncology GA procedural lists must be approved by me – which adds to my workload. It is rare for me to decline a marrow (because it is unusual for unnecessary procedures to be ordered) so almost all marrows are approved. Sometimes I need to defer/delay a marrow because of our staff availability.
6) At diagnosis, many patients require multiple procedures under the one GA and this is quite a logistical process, if we delay a marrow because of staff unavailability it impacts on many other teams – anaesthetics, oncology, interventional radiology, surgeons
7) Having an additional registrar eases some of the workload from the consultant staff.
8) Current registrars are typically here well after 6 pm (often 8 pm) to manage their work load – this is not acceptable or sustainable.
9) Current registrars do not have time to perform any small projects and frequently are unable to evening teaching sessions that are part of the RCPA haematology training program because they can't get away from here on time.
10) Current registrars are frequently unable to attend routine department meetings (eg Monday am handover), reporting meetings (eg Hb EPG meeting) or team meetings (eg Hirmadology meeting) because they are busy collecting marrows or seeing consults or patients.

My proposal for this additional haematology registrar position is for it to be funded in Haematology and to have Oncology fellows rotating through the position changing every 6 months. This has multiple benefits for both teams

1) Haematology has an additional registrar to manage all of the above
2) The Oncology Fellow could do the oncology lists as a single proceduralist which has previously been shown to make these lists more efficient – potentially allowing more patients to be done on the Oncology List and freeing up time on the Emergency list
3) For emergency list cases requiring both Bone marrow and LP this registrar would be able to do both procedures improving efficiency
4) The Oncology Fellows gain experience in the laboratory aspects of diagnosing malignant disorders.

5) Expected improved interactions between Haematology and Oncology because we are all working together
6) The Oncology Fellows have an improved training program by being exposed to all the Haematology.

In regard to the flow cytometry and needing now asking for additional staff – The registrar plays no role in the performing or reporting of the flow cytometry. With the registrars' current workload there is no way we could expect them to be involved with this test. Ultimately once flow cytometry is established we will have a weekly reporting meeting which the registrars would attend when able.

If we could put together a business case for this that would be great.

Regards
Julie

Julie Curtin | Senior Staff Specialist, Department Head | Haematology
[redacted] **w:** www.schn.health.nsw.gov.au

the children's hospital at Westmead

The Sydney children's Hospitals Network

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