#	Feedback from HSU Members	Response
1	The Document states VCP's rollout in May 2022 has this actually occurred?	Document amended.
2	The deadlines for feedback in all stages are extremely tight and should be extended to ensure it is done properly not rushed. Further one of AMS substantives who could be significantly affected is on leave and would have only had 24 hrs to respond by the deadline. – a plan for staff to be involved especially when on leave needs to be in place.	Feedback on reviewed proposal extended as outlined in version 2.
3	Will clinical leads be LHD wide and will the positions to tied to particular locations or be able to be flexible? Further will these roles be combined with their current substantive role or will they have two PD's and if so what are they.	Yes positions are LHD wide and not tied to a particular location The PDs circulated will replace the current PD.
4	Concerns re the AMS workload in the proposal expecting staff who are 1 fte to do the same work in less hours with the prosed role being .6 fte.	The current PD for the AMS role in Dubbo incorporates the provision of an AMS role across all former Northern Sites (now Northern, part of Central and part of Southern Sectors). The implementation of the VCPS team with dedicated AMS time means that the clinical portion of the Dubbo role can be focussed on Dubbo. The current PD indicates that the purpose of the role is to provide AMS program to Dubbo and its network facilities. The AMS Pharmacists undertake Baxter infusor dispensing at this point in time for the associated hospitals and as such the allocation of FTE has been revised in this version of the realignment proposal to 0.8FTE Dubbo and 0.2FTE AMS Pharmacist Lead.
5	Currently AMS are located and tied to Dubbo and MH and Critical care are located is tied to Orange is there flexibility if it is identified that for example critical care lead would be better suited in Dubbo or Orange?	Addressed in themed feedback and point three above.
6	Training to Pharmacy Technicians is not specified. i.e. the document states "to become a Pharmacy Technician specialist training is required in Hospital Pharmacy" what is the specialist training required?	Addressed in paragraph referred to and added to the particular sentence within version 2.
7	If travel is required for the Pharmacy Technician lead will .2 be sufficient time to cover the duties described?	Minimal travel required.
8	In realignment of Pharmacy Technician fte the concerns are that many duties will still be required to be done in site despite direct delivery including Returns, Non-imprest supply, patient packs – manufacture of these and distribution, baxter infusers, emergency orders, some facilities send under 1 order per week others do daily orders.	Will be addressed through the Direct to Facility Supply Steering Committee and associated change management.
9	The PD's are ambiguous and there are issues over how the FTE will work.	Duty Statements will be developed to support the PD's which will outline the difference between Grade 1 and 2 Pharmacists duties.
10	Technician lead duties need more FTE.	This is a challenge with any role. We will need to work collaboratively with the person in this role to

		ensure adequate allocation of tasks. The Position Description will also be reviewed annually as part of the Annual Performance Development Plan which is an opportunity to address any issues that may arise.
11	Sections of the proposal lack detail.	Noted
12	Members dispute the statement of availability of Hospital Pharmacists applying for positions. Facilities are still struggling to recruit to vacancies. Also backfilling to cover vacancies and Maternity leave for example in Dubbo is of serious concern. Dubbo for example has low application rate for vacancies.	At Dubbo one permanent FTE and two temporary FTE have been advertised in the last 12 months. There were 10 applicants across these three advertisements (6,3,1 respectively). The first round of advertising did not appoint any applicants however the multigrade PD will mean that the applicants will not need as much experience as they would to be a grade 2 Pharmacist. The NSW Health incentive and retention policy could also be applied if this was identified as an issue.
13	Errors throughout the proposal. – these refer to spelling, grammatical errors along with reporting line for example for Director in Mudgee reporting to themselves.	Amended in document
14	Paragraph 3 refers to realigning 3 fte which 3 fte is referred to? Will the positions be made a technician grade 1 or 2? *Amended in document*. Some substantive Technician grade 2 have been given this grading as a result of Grandfathering clause in the commencement of the Award change.	There is no effect on current employees that are Pharmacy Technicians Grade 2 including those Grandfathered into this role. The proposal outlines people currently employed as a Pharmacy Assistant or Pharmacy Technician Grade 1 transitioning to the Multigrade PD so they have the opportunity to progress as they gain further qualifications.
15	Paragraph 4 refers to Pharmacy Grading Committee can more detail be provided on this committee? Who sits on the committee? What happens if an appeal is lodged by someone before going to the committee?	Addressed in themed feedback
16	There is NO PD for the new procurement officer for VCP's.	The proposal outlined in version two is that the position is appointed under a Pharmacy Assistant/Technician award which will allow flexibility in the role, as well as the potential for development of new skills by other interested staff.
17	Consideration could be given to aligning on call responsibilities and renumeration for base Hospitals.	*Unclear what this refers to? Is the feedback suggesting we have one on call service across the LHD?*
18	Concerns over who has been consulted in developing this document, as the Paxton Partners review would have to be considered outdated based on the fact it was published in 2016 some 6 years ago. No copy of this document has been provided to staff to review and so no ability to ensure the points are referenced and actually in context. Members have tried to locate this document without success.	A copy of the Paxton review will be provided with version 2 of proposal and concern with age addressed in themed feedback.
19	If no current staff are to be made redundant how is the redistribution of current Dubbo Technicians/Assistants FTE going to occur? Ie the 1.5 FTE to be increased in VCPs, Mudgee and Lead Technician role?	The intent is to redistribute through natural attrition once the Direct to Facility Supply is at a point where this is appropriate.
20	Serious concerns regarding the proposed realignment and workload and the proposal to increase work	Addressed above at point 4. In addition there is currently 0.2FTE dedicated to AMS within the VCPS

	demands and duties to the current AMS Pharmacist in Dubbo. Currently the Dubbo base roles and responsibilities of the AMS Pharmacist requires full-time hours, not the proposed .6. Due to inadequate resources and funding for AMS Pharmacist/s within the LHD, historically Dubbo has been the only base facility to have an AMS Pharmacist. As a result Dubbo has developed and now has a successful AMS system which should act as a Model for the rest of the LHD. Should a reduction in FTE occur this could seriously jeopardise the successful operation currently in place for Dubbo and its many associated small regional hospital sites.	team and 0.6FTE dedicated to AMS across Orange and Bathurst Health Services.
21	It should also be noted Dubbo has been 1 FTE and there have been no recent changes or plans to change as alluded to in the realignment document. And due to COVID the roles and responsibilities of the AMS have increased not decreased.	Addressed in point 4.
22	The proposed realignment suggestion that the Virtual Pharmacy services for WNSWLHD (VCPs service) while potentially saving time for in other pharmacy areas will do little to reduce the workload of the AMS Pharmacist. While direct supply of antimicrobials to regional hospital sites as proposed in the realignment document may be potentially reasonable for unrestricted or imprest antimicrobials, supply of all prescribed restricted antimicrobials (to Dubbo and its many associated small regional hospital sites) should continue to follow clinical review and dispensing. This is important to ensure antibiotic use is appropriate, which not only avoids patient harm but also prevents over-use & resistance, and enables us to reach accreditation requirements. Legally, dispensing of all medication requires a clinical review by the dispensing pharmacist prior to dispensing (regardless of possible earlier reviews by the VCPS team). This is evidenced in the Pharmacy Board of Australia (2015) Guideline on the dispensing of medicines which states "In dispensing a prescription, a pharmacist has to exercise an independent judgement to ensure the medicine is safe and appropriate for the patient, as well as that it conforms to the prescriber's intentions"(1). Currently, clinical review and dispensing of AMS prescriptions for Dubbo and its many associated small regional hospital sites is completed by the AMS Pharmacist. Additionally, all outpatient antimicrobial (OPAT)/hospital in the home (HITH) dispensing including supply of baxter infusors for Dubbo and its many associated small regional hospital sites continues to fall to the AMS Pharmacist in Dubbo.	Ceftriaxone is one of the most often used restricted antimicrobials in the Rural facilities and is available on imprest in the Rural sites, this means it does not get dispensed from the Dubbo Pharmacy. The appropriateness of the antimicrobial is being clinically reviewed by the VCPS team. Most of the antimicrobials from Dubbo Pharmacy to the rural facilities are issued either as imprest stock or via distributions. A report run in Pharmalytix shows that less than 3% of antimicrobials issued since 1/1/22 were dispensed to individual patients the majority of the remaining supply (89%) are requisitions this means that they are not dispensed and the statement regarding dispensing requirements does not apply.
23	Other current duties and responsibilities of the AMS Pharmacist Dubbo include : Review of all inpatient prescribed restricted antimicrobials (via AMS patient ward list) - Entry of electronic antibiotic stewardship system (eASY) notifications, eASY program up keep	Noted

		- Follow up of patient’s without approvals for restricted antibiotics or declined approvals - Addressing antimicrobial drug queries from medical officers, nursing and other pharmacy staff - Regular discussion with the infectious disease physician - Stock management and ordering of COVID medications and compounded baxter infusors for OPAT/HITH at Dubbo and its many regional hospital sites. - Organising logistics of ongoing clinical monitoring and supply of antimicrobials to regional hospital sites. - Provision of AMS related education to medical, nursing and pharmacy staff - Dispensary cover: approx. 1hr daily for morning tea and lunch -Completing AMS audits & reports - including eASY, SAP, NAPs, NAUSP reports - Attendance at local and district AMS committee meetings (and associated secretarial responsibilities) - Participation in the development and update of protocols and procedures such as Surgical Antibiotic Prescribing Guidelines - Preparation of AMS newsletters, bulletins and memos - Preparation and implementation of Antimicrobial Awareness Week Activities - Design and participation in quality improvement projects such as the antimicrobial allergy documentation project - Addressing COVID drug queries, COVID drug clinical review for inpatients and outpatients, COVID drug stock management and medication supply - Patient ward list/review patients on restricted antimicrobials (enter eASY notifications, follow up patients without approvals for restricted antimicrobials) - Update and follow up on eASY approvals/declines (enter in easy approval numbers, follow up declined orders) - Conduct clinical reviews and dispense non-impress or restricted antimicrobial orders from network facilities - Regional antimicrobial outpatient administration and Baxter infusors for Dubbo HITH and network facilities: ensure process is followed prior to ordering stock, order stock when required, organise logistics for ongoing administration, ensure clinical monitoring is completed	

	- Liaise with ID, medical officers, nursing and other pharmacy staff for antimicrobial drug enquiries - AMS meetings (local and district): prepare agenda, attachments, take minutes, distribution lists - AMS audits: SAP, NAPS - NAUSP reports - AMS protocols and procedures - AMS newsletters and bulletins - Preparing, planning and implementing activities during Antimicrobial Awareness Week - Education: JMO orientation, PUSH, CE, AMS orientation for pharmacy staff, students and pharmacy interns	
24	Staff believe the current position should remain as 1 FTE and any additional proposed area/lead AMS position at Dubbo be a new position that is funded over the current FTE. If the LHD plans to remove hours ie reduce FTE with the current duties/workload what does the LHD plan to remove and to whom or where will this be allocated? Again could potentially lead to High Workload for other staff.	Noted workload changes addressed above.
25	Concerns also relate to proposed new AMS Lead position description (PD). As confirmed during discussion regarding the proposed realignment, the new Lead AMS PD is intended to replace the pre-existing PD/role for Antimicrobial Stewardship Pharmacist (AMS) – Dubbo (attached). The new PD however does not align with the proposed changes as outlined in the distributed pharmacy realignment proposal document. The new PD instead has been written as an area position with only area/district roles and responsibilities. In error, there is also no mention of Dubbo within the new PD. Consequently as written, the new proposed PD poses several potential risks including future loss of a Dubbo based AMS pharmacist, if the position (based on the current PD) was to be readvertised at any time in future. Additionally, uncertainty for the AMS pharmacist regarding roles and responsibilities of their position as described in the new PD.	The intent is to develop Duty Statements in collaboration with the incumbent to provide further detail regarding specific tasks.
26	The current AMS program at Dubbo Hospital continues to meet the National Standards in Quality and Safety as well as the AMS Clinical Care Standards. The Northern sector Infectious Diseases Physician attends Dubbo Hospital once a month for meetings and outpatient clinics and day to day ID consultations are done over the phone. We do not have an ID physician available on site (unlike many other metropolitan hospitals) and the AMS program heavily relies on a full time AMS pharmacist to sustain AMS initiatives such as the eASY program. The AMS pharmacist and ID physician also work very closely together to uphold the successful AMS program at Dubbo Hospital and recent National	Noted

	Antimicrobial Usage Surveillance Program (NAUSP) reports (see Appendix 1) supports this. Research has shown inappropriate antimicrobial prescribing is higher in rural and regional areas than in major metropolitan hospitals1. Significant gaps include persistent staff shortages, geographical isolation and competing priorities to AMS. The current staff resources are the bare minimum required to continue the AMS program. By reducing the number of AMS pharmacist hours for Dubbo and its network facilities, the sustainability of the AMS program will be greatly impacted. There may be increased misuse of antimicrobials, increased risk of resistance to antimicrobials which can therefore reduce quality patient care.	
27	No point 27	
28	Additionally due to this, regardless of the outcomes of the proposed pharmacy realignment, members strongly advocate for the assistance of support staff for AMS such as a dedicated AMS pharmacy assistant may relieve some of the non-clinical work load. An assistant or technician could assist not only with preparation of prescriptions, but also with non-clinical duties such as stock management and ordering. The addition of a dedicated AMS pharmacy assistant may relieve some of the non-clinical work load. Duties may include dispensing and ordering Baxter infusors for outpatient antimicrobial orders for HITH and ambulatory care units for Dubbo and network facilities, organising logistics to ensure medication is accessible to patients in a timely manner, stock maintenance for Covid medications, amongst other duties.	The Pharmacy Service needs to operate within its current profile.
29	The following suggestion regarding concerns for AMS has been included in feedback recommendation a new area position, and accompanied PD (separate to the pre-existing Dubbo AMS Pharmacist Position) should be created to cover area wide/lead AMS pharmacist responsibilities. This would provide clarity regarding location, reporting, as well as roles and responsibilities. This would also ensure equity within the pharmacy clinical stream system, as all aspiring pharmacists within WNSWLHD could apply for the new separate lead area AMS pharmacist role if advertised now or in the future. However, this is not possible if there is direct appointment to this new lead AMS position, or it is linked to the AMS job at Dubbo as proposed. Furthermore, creating a new separate lead/area pharmacist position also ensures that any additional proposed area/lead AMS work does not fall to the current AMS Pharmacist in Dubbo, thus guaranteeing (unburdened by further work) that the highly successful AMS system at Dubbo can continue to operate smoothly and effectively as it has done for many years.	The Pharmacy Service needs to operate within its current profile.
30	No point 30	

31	What roles and responsibilities do clinical leads have with Clinical Streams?	Is this referring the Multi-disciplinary District wide Clinical Streams? If so they could represent Pharmacy of the Stream related to their area of expertise or they could support a Grade 2 Pharmacist to be the Pharmacy representative during their rotation in the area.
	What roles and responsibilities do clinical leads have with the LHD? How readily available/contactable do they have to be in the working week?	Addressed in themed feedback.
	The proposed clinical pharmacist lead structure is based on the role of the District Clinical Nurse Consultant (CNC) - please provide more detail about this current CNC structure and how it is successful.	*Attached*
	"There are a number of key specialty areas within the WNSWLHD pharmacy service that would benefit from consistent senior clinical pharmacy leadership…" Surgical is not a speciality listed despite all base hospitals having a surgical department and often have pharmacist cover on surgical wards. Should a surgical lead pharmacist be considered?	The realignment proposes changes within our current FTE, unfortunately we don't have any other Grade 3 Clinical positions within the LHD at this time.
	"Fulfilling a role similar to a CNC" - CNC mentioned again, please provide more detail about this role.	*PD provided as an example of the principles for the Pharmacy Lead Position*
	"These positions will continue to provide a clinical service at their "home" site with an estimated 8-10 hours per week of Clinical lead work across the LHD" - will staff be freed up from their usual clinical duties to be able fulfil the lead roles? If a clinical pharmacist usually covers ICU full-time, who will be responsible for covering their ward when they are doing the Lead role? If another staff is expected to cover their usual role, this will mean more staff handovers will have to occur, which may lead to disjointed care and can negatively affect patient care (i.e. not the same pharmacist looking after the same ward at all times).	Grade 3 Clinical Pharmacists are already performing these types of duties in their current role as outlined in the Pharmacists Award. From the current award: *"Pharmacist Grade 3" means a Pharmacist who is responsible to the Director of Pharmacy or Deputy Director of Pharmacy for the management and efficient performance of a specific unit or function of the hospital's pharmacy Department.*
	What if the clinical lead responsibilities are not able to be completed within the 8-10 hour time window?	Addressed in themed feedback
	Does that also mean clinical leads are not available as "leads" for the other 30 hours of the working week?	Addressed in themed feedback
32	No point 32	
33	Comments re the "impact of positions table In Orange's section, the "Senior Clinical Pharmacist" is listed as 0.5FTE, and the proposed change is for 0.2FTE - critical care lead and 0.8FTE - senior clinical, pharmacist, should the proposed senior clinical pharmacist be "0.3FTE" instead of 0.8FTE?"	Amended

	Should all base hospitals have a "Procurement Officer"? It appears that only Orange has this role. Currently in Dubbo, one technician does the procurement amongst many other technician/assistant duties. –	The staff member undertaking these tasks at Dubbo and other sites also undertake assistant and technician role.
34	attached is a document to support the role of the AMS Pharmacist **Chart 15: 3rd/4th generation cephalosporins (ceftriaxone and cefotaxime grouped together)**	Is this Dubbo data or from one of the Rural Facilities? The graph supplied by HSU is from July 2020. Most recent NAUSP data provided below for DHS. **Chart 9: 3rd/4th generation cephalosporins (ceftriaxone and cefotaxime grouped together)**
35	The following reference was also supplied References: 1. Bishop JL, Schulz TR, Kong DCM, James R, Buising KL. Similarities and differences in antimicrobial prescribing between major city hospitals and regional and remote hospitals in Australia. Int J Antimicrob Agents 2019; 53: 171–6.	Noted