Theme of Feedback	Response
Formation of Clinical Streams within Pharmacy	
• Good to know who can be contacted for advice in particular areas	
Clinical Lead Roles	
• Fixed locations doesn't allow for progression of staff across all sites	These positions could be considered site negotiable for internal applicants if the position become vacant.
• 0.2FTE doesn't seem like enough to undertake the role	This is a risk with any role. We will need to work collaboratively with the people in these roles to ensure adequate allocation of tasks. The Position Descriptions will also be reviewed annually as part of the Annual Performance Development Plan which is an opportunity to address any issues that may arise. Part of the change to working more collaboratively across the Service will mean that communication strategies with the Directors of Pharmacy including the District Director and other Clinical Leads will be established to support the Clinical Leads and to provide an opportunity to refine these roles within the broader context of working as a team across all sites to deliver equitable, high quality care to our patients across the District, and to support our staff to develop their clinical expertise. The Clinical Stream Lead roles will work collaboratively with educators, peers and other clinicians to lead and support the Pharmacy clinicians working in their area.
• Will the Clinical Lead Roles be advertised?	No. The current Grade 3 roles will have their duties changed to accommodate district Pharmacy Service focus.
• Will the lead be reachable all days?	The support provided by the lead roles will be guided by the Grade 1 and 2 Pharmacists requirements. Consultation will need to be undertaken to develop support model, however my vision for our Pharmacy Service clinical leaders will facilitate pharmacists within their streams to achieve better patient outcomes through: -Sharing experiences and resources to develop professionally -Identifying gaps and supporting quality improvement activities -Collaborating on the development of standardised processes -Being a point of contact to ensure all aspects of medication management are included in procedure and service development. These are responsibilities already undertaken by Grade 3 Pharmacists as local leaders in their field. The realignment is proposing that all Pharmacists have the opportunity to engage with this.
• What will the Clinical Lead Support look like?	
• Will the Leads have two Position Description's (PD's)	The PDs circulated will replace the current PD.

Dubbo AMS Role	
• AMS requires increased input from Pharmacy at Dubbo as the Microbiologist is not on site	Requested further information
• Propose 0.8/0.2 FTE split to be in line with the other lead positions	Feedback taken on board and increased ratio to match other lead roles.
• What is the responsibility of the virtual team/ward pharmacist vs pharmacist dispensing in the pharmacy?	Seeking advice from Pharmaceutical Service.
• Position Description requires more detail including Dubbo vs LHD responsibility	The intent is to develop Duty Statements in collaboration with the incumbent to provide further detail regarding specific tasks.
• Outpatient dispensing of antimicrobials (i.e. Baxter infusors) currently undertaken by AMS Pharmacist	FTE allocation reviewed to allow for this
Lead Technician Role	
• Excited for the opportunity to progress as a technician	
• **Multigrade tech – cert ¾ remuneration**	
Direct to Facility Supply (DFS)	
• Centralisation of imprest will make it easier for staff working across sites	
• Definitely the way forward as will reduce the volume of stock held within pharmacy departments and free staff to perform other jobs.	
• Requires significant input by staff to perform all tasks associated with it and am concerned that this needs to be looked at in more detail	Initiating roll out in Orange has allowed an understanding of some of the tasks required to set up DFS. Each site will have unique challenges to implementing DFS, and significant change management is required to achieve this large system change.
• Rolling this out in Orange, Bathurst first will not give a realistic view to this task.	By beginning this change in sites that have less distance to cover we can establish the fundamental processes required which we can refine as we identify new and unique differences that are inherent in a large organisation like ours. If DFS is to be implemented a Project Plan will be written and a Steering Committee implemented which will have input from key stakeholders including Pharmacists and Technicians from all sites and the Rural sites who will be affected by this change. The impact on staffing has been estimated from the Paxton review which I acknowledge is 6 years old however the number of distributions to the rural hospitals from a three month period in 2016 compared to the same three month period in 2022 has increased by 1000 distributions. This is an estimated 4000

	more distributions per year that are being completed in 2022 than six years ago when the Paxton Review estimated 72 hours per week would be saved by introducing Direct to Facility Supply. Direct to facility supply has been implemented for a number of years in other Rural LHDs such as Murrumbidgee and Hunter New England with similar challenges in relation to remoteness of facilities.
• Consider a team of people undertaking this task which will allow for cover of leave	Great idea. 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.
• What award will the person undertaking this role work under	
• What will still be supplied from Dubbo to the Rural facilities?	These details will need to be determined as part of the project plan with different options considered. Other LHDs using DFS provide any individually dispensed medication and prepacked medications.
• Will facilities still be allowed to swap and return short dated stock?	This will need to be considered on a cost vs benefit ratio as part of the project plan
Technicians Dubbo	
• With the movement of FTE to Mudgee, will Mudgee take on the work being done with Gulgong and Rylstone?	This movement of FTE is dependent on the successful role out of DFS and vacancies that arise from natural attrition. DFS will account for some of the work being undertaken at Gulgong and Rylstone and oversight of medication management issues in these sites would fall to Mudgee and the VCPS teams.
• Dubbo Service 20 peripheral hospitals within the LHD and reducing staffing will impact patient care	This can be monitored through ims+ and can be added as a measure within the Direct to Facility project plan
• Reallocating FTE from Dubbo will mean that Dubbo are unable to undertake extended technician roles and these positions Direct supply, lead technician and Mudgee hospital should be new positions	Direct to facility supply is expected to reduce the work at Dubbo by at least the proposed 1.6FTE.
• Many duties still will need to be done despite direct delivery: o Returns o Non-imprest supply o Patient packs – manufacture of these and distribution o Baxter infusors o Emergency orders, most hospitals currently send >1 order per week, some do daily orders.	These can all be monitored before, during and post implementation. If this is considered to be equivalent to the work of currently managing and distributing stock to the peripheral sites and strategies to overcome these challenges are not able to be identified then the DFS project would not be of any benefit and would need to be reviewed. The supply of Emergency orders will continue however work will be undertaken to ensure that this is minimised.
• Unclear how the roll out will be staged and when the FTE will be reallocated	This would be confirmed as part of the project plan, however I imagine that the staff would not be able to be released until Dubbo have successfully transferred at least half of the sites to DFS. The remaining staff changes would occur once the project is completed.

• How will the reduction in assistants/technicians be achieved	The intent is to manage the reduction in FTE through natural attrition once the DFS service is at a point that will allow the transition of tasks.
Multi- Grade Pharmacist Position	
• Short staffing requires cover for multiple wards which leads to exhaustion	Agree, it is important that we look at how we can prioritise our functions and use the staff we have to gain maximum benefit to our patients. This is a large piece of work that we need to look at and consider all options as to how we can address this. This is something we can work on with the Clinical Leads to try to develop prioritisation strategies and work collaboratively with all of our teams to make sure that the highest need patients are seen as our first priority.
• Difficult to attract staff to Dubbo without offering Grade 2 pay, pharmacist employed as Interns are unlikely to stay if they aren't offered high rate of pay	NSW Health recognises the challenges of recruiting and retaining staff in Rural locations and has recently released PD2022_025 Rural Health Workforce Incentive Scheme. Positions considered by the Chief Executive to meet the definition of a hard to fill position outlined in the Policy may be eligible for the incentive. If this become evident with future recruitment, we can look to implementing incentives as outlined in this Policy Directive for roles that meet the criteria.
• There is no clear delineation between the two grades in the PD.	Agree. The Directors of Pharmacy will work through this in the next Leadership meeting to provide collaboratively determined delineation that can be outlined in a Statement of Duties for each Grade.
• There should be two separate Capability Framework for each grade. This can also help justify grading of the applicant / regrading. The expected level of capabilities would be different	
• It's disheartening to see newly registered pharmacists paid the same as Grade 2 and require significant amount of support from more senior pharmacists	The Grade 1 and 2 Mutligrade position description will address this.
• Introduction of multigrade positions may provide some stability to staffing	
• What are the different pay scales?	The award criteria and pay scales are outline in the NSW Health Pharmacist Award.
• Are existing staff affected or only new staff	The change in Position Description would only affect Grade 1 Pharmacists currently employed, they will move to a Multigrade 1-2 Position Description which will allow them to progress to Grade 2 once they meet the requirements. All positions advertised moving forward will be advertised using the Grade 1-2 Multigrade Position Description.
Multigrade Assistant/Technician	

• The award for Assistants /technicians has the wording '….or has qualifications deemed by the employer to be equivalent' when referring to grading. I feel that this is a very valid point as often staff have very valuable skills that are not in any course certificate and should be considered	The grading committee will define what other qualifications or experience may be considered relevant.
• Happy that the study they have undertaken/undertaking will be recognised	
Other Feedback	
• Consider staffing equity based on bed numbers	This is the long term plan however will take time
• Leave cover for Pharmacists is required	Leave cover would be ideal however at the moment we have acute wards that do not have a regular clinical pharmacy service. This is a large piece of work that we need to look at and consider all options as to how we can address this. Working collaboratively across our teams and with our Clinical Leads to develop strategies to see our highest need patients as first priority may be one way we can use to address gaps that occur from planned and unplanned leave.
• Further detail needed regarding grading committee and what the appeals process will be	The membership of the Grading Committee will be determined by the Directors of Pharmacy, it will likely include two Directors of Pharmacy independent to the facility the position is at and a Human Resources representative. Appeals could be made to the Executive Director of People and Culture.
• The Document states VCPS rollout in May 2022 has this actually occurred?	Yes. This was completed in April 2022 and all facilities now have core clinical pharmacy functions undertaken such as medication reconciliation, medication review and discharge review.
• Time frames for review and feedback are very short, request these are extended	Agree. These will be extended and outlined in version 2 of the document.