NSW GOVERNMENT | Health
Central Coast
Local Health District

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Mr Gerard Hayes
Secretary
Health Services Union
Level 2, 109 Pitt Street
SYDNEY NSW 2000

Email: matthew.ramsay@hsu.asn.au

Dear Mr Hayes

**Re: Proposed Pharmacy Service Change Plan**

I wish to advise the Health Services Union (HSU) of proposed changes within the Central Coast Local Health District's (CCLHD) Pharmacy Service. CCLHD has now considered both the independent review of pharmacy services undertaken by PharmConsult and the feedback from staff and key stakeholders.

The District Executive have now formally endorsed 32 of the 34 recommendations from the review report for implementation. with two recommendations not supported.

1. A proposed change in the model of pharmacy from the current a district-wide approach to a site-based model under the General Managers (Recommendation 1b, 18a-c),
2. Restricting use of QUM pharmacy expertise to only to Drugs and Therapeutic Committee (DTC) activities (Recommendation 22b),

After careful consideration of the feedback from stakeholders it is proposed that a new service structure be implemented. This new structure will:

- Retain a district-wide leadership role,
- Flatten the existing structure into clinical services, operations and district-wide service streams removing issues of silo's with the current teams based structure,
- Pool pharmacy resources, technicians and pharmacists, within these streams for assignment guided by clinical prioritisation and pharmacists specialty. Streamlining clinical pharmacists away from these small teams into a larger clinical stream team will allow the service to flexibly respond where highest demand occurs,
- Rebalance resources between the two sites,
- Reduce Team Leader role requirements and recognise Pharmacist Specialists roles (grade 3s). This change will provide a clear pathway for pharmacists to be recognised for their expertise. This allows focus of their expertise being put into patient care and mentoring junior pharmacists rather than rostering and administration work,
- Reclassify the Pharmacy Procurement Manager role from a Health Services Manager grade to a pharmacist grade thereby maximising operational support during peak periods,
- Enhance support for community/hospital-in-the-home,
- Provide dedicated support for the implementation of the state-wide formulary.

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Other Impacts of this change include:

- The Deputy Director Wyong position (PHM5) will be required to supervise additional staff and undertake the prioritisation of clinical activity (16.1 FTE) with support of the specialist pharmacists,
- The Production, Clinical Trails & Cancer Services Team Leader will be retitled Clinical Services Team leader and will undertake the prioritisation of clinical activity at Gosford,
- Overall FTE will be reduced from the current establishment of 94.09 FTE to 84.5 FTE. No current permanent staff will be displaced as the reduction will be achieved by removing existing vacancies,
- There is no change to operating hours/coverage. Extended hours (recommendation 7) will need to be reviewed by the implementation group.

The proposed attached Change Plan, which has been provided to all pharmacy staff, also provides a framework for implementation which heavily involves pharmacy staff in all aspects.

Formal consultation and feedback are now sought on the proposed Change Plan.

Written feedback to Keeleigh Davison, Project Support Officer, Organisational Sustainability Program via email Keeleigh.Davison@health.nsw.gov.au by COB 12 August 2022

If you would like to meet and discuss this proposal or wish to raise any concerns please contact Mr Ron Pearson, A/Executive Director Acute Services on 02 4320 2086.

Yours sincerely

Ron Pearson
**A/Executive Director Acute Services**

Date: ~~22~~ 18 July 2022

cc: Mr Matthew Ramsey - HSU, Mr Greg O'Donohue - HSU

NSW GOVERNMENT | Health Central Coast Local Health District

# Central Coast Local Health District

# Pharmacy Services

# Change Plan 2022 (PROPOSED)

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## 1. Introduction

As part of the CCLHD Organisational Sustainability Program (OSP) a review of pharmacy services has been undertaken in two parts:

1. A benchmark review in August 2021 of pharmacy resourcing against similar regional Local Health District pharmacy services (Nepean Blue Mountains LHD and Illawarra Shoalhaven LHD) and the Society of Hospital Pharmacist Association guidelines for the provision of clinical pharmacy services. This review identified potential opportunity to reduce CCLHD pharmacy FTE in line with ISLHD pharmacy FTE (reduction in FTE potentially 15-20 FTE),
2. The engagement of independent pharmacy expertise (PharmConsult) in September 2021 to review the CCLHD pharmacy service model to identify efficiencies and service enhancements and to identify opportunities to realise benefits identified within the first review without compromising safety and quality of patient care. This review, under the executive sponsorship of the Executive Director Operations, has identified opportunities to improve consistency of service, access and flow, service coverage and meet the objectives of OSP through reducing service FTE in line with benchmarked peers.

The Change Plan outlines:

- Consultation approach undertaken with key stakeholders (pharmacy staff, unions, clinicians, managers etc.),
- Feedback received on review findings and recommendations
- Review recommendations to be implemented and considered as part of the Pharmacy Review Project Plan.

## 2. PharmConsult Review Findings

The key findings from the PharmConsult review included:

- Although there appears to be accountability at the Pharmacy team level, the line management structure is not as functional as envisaged by the 2018 restructure, and is top heavy.
- There is sometimes confusion, anxiety and some angst from ward medical and nursing staff when clinical pharmacy services are not available. There is inconsistency across the Directorate in the way pharmacists and especially clinical pharmacists prioritise the services they will provide and the patients they will review.
- There is some disparity between pharmacy resources and the pharmacy model operating at Wyong compared with Gosford, when considered from the perspective of number and acuity of patients and intensity of medical services provided.
- It was found that the way in which clinical pharmacists and technicians are allocated to meet demand, lacks consistency due mostly to the inconsistent way services and patients are prioritised for clinical pharmacy input and review.

- Although pharmacists and ward staff very strongly agree that medication reconciliation on admission and at discharge provides great value to patients and staff and the patient flow system, that despite best efforts only about 40% of Gosford patients receive medication reconciliation within 24 hours of admission, increasing to 60% within the admission, and 65% of Wyong patients receive medication reconciliation on admission rising to 90% during the admission.
- There is inconsistency in the way medications and counselling are provided at discharge and the timeliness of this process (which is not always the fault of Pharmacy due to the lack of discharge medication orders). Nevertheless, it was found that not infrequently patients had their discharge delayed, in some cases delayed until the next day because of the unavailability of discharge medications.
- Given that many discharges occur in the late afternoon and that there are many overnight admissions from ED, the current Pharmacy hours often do not meet the need for timely supply of discharge medications or new medications for patients admitted from ED, nor documenting an on-admission medication history or medication reconciliation.
- The balance of the number of pharmacists to technicians across the District is in line with good hospital pharmacy practice being 2:1; the balance of the number of clinical pharmacy staff (pharmacists and technicians), with operational pharmacy staff is appropriate, but for the future should be directed by the number and mix of staff required to perform the highest priority tasks as per agreement between the Pharmacy and each Hospital (and recommended by this Review).
- Although it is difficult to definitively assess without reviewing every imprest list for every imprest location across CCLHD, based on discussions with nurses and pharmacy staff at both Gosford and Wyong hospitals, it's reasonable to conclude that the balance between the products which need to be available in imprest for urgent use or very frequent use and those which need to be individually dispensed (because of restrictions based on indications, prescribers or cost) is appropriate.
- In regard to imprest management, discussions with ward and management staff revealed that nurses are performing pharmaceutical imprest tasks in some wards because Pharmacy has said that it has insufficient staff to perform these tasks in these wards.
- In regard to the model for pharmacy services, from discussions it was concluded that that current district-based model is not as flexible and agile as required to meet demand, or to be integrated more effectively with other services. In addition, the district model has increased a siloed approach to service provision and is less conducive to department wide teamwork / sharing of information and workload.

As a result of these finding PharmConsult provided CCLHD with 21 key recommendations to consider implementing in order to meet the key objectives of achieving service improvements and efficiencies through prioritising pharmacy services and patients (as there will be less staff available to provide the services), flattening and introducing a more facility-focused organisational structure (to spread the workload more evenly), communicating changes to key internal (within CCLHD) and external (e.g. community pharmacy) stakeholders, and using available technology.

# 3. Key Stakeholder Consultation

A comprehensive consultation process was undertaken with pharmacy staff and other key stakeholders.

### 3.2.1 Director of Pharmacy Services

Consultation with the Director of Pharmacy will be undertaken as follows:

- The Executive Sponsor and PharmConsult Consultant held a 1:1 with the Director of Pharmacy Services (DoP) prior to staff sessions. In this session all key findings and recommendations were discussed and an opportunity provided for the DoP to seek clarification from PharmConsult and provide feedback.
- Additional time has also been provided for the DoP to discuss the review findings with the Executive Director Operations (excluding PharmConsult).
- Employee Assistance Program support was also provided to support the Director of Pharmacy.

### 3.2.2 Stakeholder Sessions

Dedicated review findings and feedback sessions were facilitated by the PharmConsult Lead Consultant.

The purpose of these sessions were to:

1. Explain to stakeholder why changes are needed
2. Explain the objectives of the changes
3. Explain the benefits of the changes
4. Explain how the changes are likely to positively impact Pharmacy and non-Pharmacy staff, and patients, and
5. Answer participant questions.

Sessions were held on Monday 28th, Tuesday 29th and Wednesday the 30th of March 2022.

1. Monday 28 and 30 April: Pharmacy Leadership Team session - Gosford
2. Monday 28 April: Staff session – Gosford (x2)
3. Monday 28 April: Staff session – Wyong (x2)
4. Monday 28 April: Senior Clinical and Operations Directorate Leadership team – Wyong
5. Tuesday 29 April: Senior Clinical and Operations Directorate Leadership team – Gosford
6. Tuesday 29 April: Staff Session (for staff unable to attend other sessions) – (x2)
7. Tuesday 31 April: Union Session

Employee Assistance Program support was provided to support all pharmacy staff post the facilitation of these consultation and feedback sessions.

### 3.2.3 Review Report

A copy of the review report was provided to all stakeholders at the completion of the feedback sessions.

# 4. Review Feedback

Formal feedback on the review findings was undertaken as follows.

### 4.2.1 Formal Feedback Phase

A total of twelve feedback sessions were facilitated from 28 -31 March 2022 with staff, stakeholders and unions followed by a two-week formal feedback process. At the request of the union this feedback timeframe was extended to 28 April 2022. Feedback was received via written submissions and via verbal feedback through one-to-one appointments. At the close of the formal feedback timeframe a total of 26 individual submission and one combined pharmacy Team Leaders group submissions were received. Seven individual 1:1 sessions were also provided to staff wanting to provide face-to-face feedback. There was one feedback submission received from the Health Services Union.

Overall, stakeholder feedback was supportive of the majority of Review recommendations, noting no proposed structure was presented. There was strong support for key recommendations relating to:

- *Flattening the pharmacy service structure to reduce existing silos:*
    - Realigning FTE under functional streams of clinical services, operations services and district-wide functions,
    - Reducing the work allocation responsibilities to a few designated positions as opposed to the current team leader structure,
    - Recognising specialist pharmacist roles (pharmacy grade 3),
    - Maintaining the balance of pharmacists to technicians,
    - Redistributing pharmacy FTE between the sites based on bed numbers and complexity (approx. 70% of total FTE to Gosford, 30% to Wyong)

- *Implementing a work prioritisation model which prioritises patients with complex health conditions and those at most risk of medication harm*
    - Is understood by all pharmacy staff that they may be allocated to wards and specialty care areas to support these priority patients first before their home service/ward non-priority patients,
    - Is understood by Heads of Department and Service Managers, and why there may be changes to the levels of pharmacy provided to their service,
    - Supporting criteria led discharge which identifies patients who can receive a pre-defined discharge supply,
    - Supported by use of a decision support tool.

- *Pharmaceutical Supply*
    - Prescribing of PBS medicines in outpatients, for patients in hospital less than 72 hours and if for any reason discharge medication cannot be provided to any medium or low priority patient prior to the scheduled time of discharge with advice that they have the prescription dispensed by a community pharmacy on their way home,
    - Introducing imprest-box preferred supplier model.

There were also a number of key review recommendations that received mixed feedback/support.

- *Pharmacy Service Reporting Lines:*
    - Whilst there was some support for implementing a site-based reporting model (i.e. to General Managers) there were are number of stakeholder concerns expressed that this will make it difficult for other services requiring pharmacy to negotiate appropriate access (i.e. Mental Health, Community)
    - Further concerns expressed related to a possible inconsistent service approach emerging between sites and that there are a number of district-wide functions that pharmacy perform which may not be prioritised by a site (i.e. policy, quality use of medicines, procurement and formulary).

- *Extending Service Hours:*
    - General support for extended hours by senior stakeholders whereas some pharmacists provided feedback that extending hours has been tried before and demand does not warrant the extended times. In particular this was trialled during a past 'winter surge' strategy whereby longer hours weekdays and longer weekend hours were utilised, which demonstrated zero additional impact on discharge numbers resulting instead in workload being spread across a longer workday.

A Thematic Analysis of stakeholder feedback is provided in attachment A

## 5. Endorsed Recommendations

As a result of the consultation phase and consideration of the feedback received the District Executive has endorsed 32 of the 34 recommendations made for implementation. The District Executive do not support two recommendations provided:

1. A proposed change in the model of pharmacy from the current a district-wide approach to a site-based model under the General Managers (Recommendation 1b, 18a-c). To ensure district-wide consistency of service, to provide a single point of accountability and in recognition of the district-wide functions performed the service will remain a district-wide model.
2. Restricting use of QUM pharmacy expertise to only to Drugs and Therapeutic Committee (DTC) activities (Recommendation 22b) as QUM expertise is wider than just DTC activities and would have an impact on other services if restricted.

A summary of the recommendations and the ELT position is provided in attachment B.

## 6. Proposed Pharmacy Structure

After careful consideration of the feedback from stakeholders and the two reviews a proposed new structure will be implemented. This new structure will:

- Retain a district-wide leadership role,
- Flatten the existing structure into clinical services, operations and district-wide service streams removing issues of silo's with the current teams based structure,

- Pool pharmacy resources, technicians and pharmacists, within these streams for assignment guided by clinical prioritisation and pharmacists specialty. Streamlining clinical pharmacists away from these small teams into a larger clinical stream team will allow the service to flexibly respond where highest demand occurs.
- Rebalance resources between the two sites,
- Reduce Team Leader role requirements and recognise Pharmacist Specialists roles (grade 3s). This change will provide a clear pathway for pharmacists to be recognised for their expertise. This allows focus of their expertise being put into patient care and mentoring junior pharmacists rather than rostering and administration work.
- Reclassify the Pharmacy Procurement Manager role from a Health Services Manager grade to a pharmacists grades/PDs to maximise operational support during peak periods.

Overall FTE will be reduced from the current establishment of 94.09 FTE to 84.5 FTE. No current permanent staff will be displaced as the reduction will be achieved by removing existing vacancies. The proposed structure by site is outlined in appendix C.

## 7. Implementation

Post consultation of the proposed change plan the District will transition the review into an implementation phase. The implementation is summarised as follows:

- Executive Sponsor

  The Executive Director of Acute Care Services

- Pharmacy Services Implementation Working Group

  Chaired by the executive sponsor a working group will be established to oversee implementation. Membership will include:

  - Executive Director Acute Care Services (Chair),
  - Director of Pharmacy,
  - Deputy Director of Pharmacy Gosford,
  - Deputy Director of Pharmacy Wyong,
  - District Clinical Director
  - Manager Organisational Programs.

  The working group will report on implementation progress to the OSP Steering Committee.

- Project Work Streams

  Implementation will be broken into three work streams:

  1. Clinical Service Model

| Membership: Director of Pharmacy, District Clinical Director, Deputy Director Wyong, Clinical Services Team Leader Gosford, Clinical Pharmacist x2, QUM Pharmacist, Technician x1. |
|---|
| Key Deliverables:<br>• Prioritisation Model<br>• Decision Support Tool*<br>• Allocation of clinical resources/FTE process through prioritisation<br>• Communication to Heads of Department and service managers on model impacts<br>• PBS discharge opportunities<br>• JMO support<br>• Pharmacy Guild and community pharmacy engagement<br>• Extended hours review |

*ICT resources required to support this deliverable

## 2. Supply and Procurement

| Membership: Director of Pharmacy, Procurement Team Leader, Director of Nursing representative, Operations Pharmacists x2, Technician x1, State-wide Formulary Project Officer, Contracts & Leasing Team x1, |
|---|
| Key Deliverables:<br>• Chemotherapy contract review and rebates<br>• Satellite pharmacy opportunities<br>• Imprest Box<br>• Imprest Transition to Pharmacy<br>• State-wide Formulary<br>• Pre-packs for criteria led discharge<br>• Outpatient PBS opportunities |

## 3. People and Structure

| Membership: Director of Pharmacy, HR Business Partner, Deputy Director Pharmacy Gosford, Deputy Director Pharmacy Wyong, Education/Woy Woy Operations Pharmacist |
|---|
| Key Deliverables:<br>• New structure implementation<br>• HSM PD to pharmacy role transition<br>• Rostering and Payroll<br>• Wage Subsidy Grant opportunities<br>• Intern Contracts |

## Appendix A: Review Feedback Thematic Analysis

A thematic analysis of the feedback submissions identified the following key themes:

Clinical - Patient Prioritisation

- Strong agreement from staff for the introduction of a consistent prioritisation model for pharmacy patients, although some staff felt there was a need for reordering of the Review recommended criteria.
- Support for a fair and equitable distribution of patient workload and increased flexibility of clinical staff to provide assistance to services/wards where there are a higher number of high-priority patients on the day. General feeling and acknowledgement of the review finding that the current pharmacy model has created team silos which inhibits flexibility.
- Some feedback questioning the practicality of the prioritisation process commencing with discharge patients. Prioritising discharge may result in this being the only activity undertaken by staff.
- Non-pharmacy stakeholders generally supported the prioritisation model if it is consistently applied and the impact is well communicated to NUMs and Heads of Department
- Support for the automation of the prioritisation tool, although a number of stakeholders provided feedback on their concerns that there would be ICT barriers to acquiring a commercially available product which would lead to delays in implementing the prioritisation recommendation. Some stakeholders also expressed concern that ICT service would be unable to produce what is needed internally and/or that there needs to be a guarantee that ICT can produce something as effective and on time. In general though, regardless of the software solution, there was strong support for an electronic system which produced priority patient lists based on patient age, number of medications, number of risk medications and renal function.
- Some feedback queried whether there would be a risk that the proportion of patients being categorised as high risk (particularly at Gosford where acuity of patients is higher) will mean more patients required to be serviced than perhaps anticipated. If this does occur, the benefit of Dynamic or any other prioritisation system will be minimal.
- Whilst acknowledging that medication reconciliation is important and contributes to achieving accreditation standards, it is acknowledged that the service is already restricted largely to 8.30am to 4.30pm on Mondays to Fridays and currently the services achieve only 60-65% reconciliations against this KPI.

Clinical - Junior Medical Officers

- A constraint that will have to be overcome is that there needs to be increased autonomy of JMOs who are over-reliant on clinical pharmacists. Medical Officers accuracy of discharge prescriptions must be improved and requires concerted support by senior doctors, who currently are totally reliant on pharmacists to correct mistakes.
- Some feedback that JMOs rely far too much on pharmacists, to the extent that some pharmacists are actually doing the work of the JMOs (which also interferes with JMOs' learning).

Clinical - Discharge

- Support for criteria lead discharge for low and potentially (simple) moderate risk patients if criteria can be agreed too. Some feedback indicated there are many simple scripts for standard orders that could be

developed and not needed to be reviewed by pharmacy. In turn these pharmacy resources can be allocated to more complex patients.

- Several staff provided feedback that late discharges are often due to consultants undertaking their rounds late in the afternoon.
- Staff feedback that they support the review recommendation of patients for discharge be identified via the Patient Flow Portal and via the pharmacy technician's check with each NUM each morning. That this is in line with practice at Wyong.
- Suggestion of implementing a dedicated discharge pharmacist in line with some other hospitals. The role is based in the discharge lounge and is responsible for ensuring patients are leaving on time with their medications or scripts as well as picking up any patients who have fallen through the gap

Pharmacy Structure - Teams

- Strong support for a change in structure which removes silos and creates workload equity. Many staff, in-line with the Review findings, indicated that some teams had an inequitable patient load and that there was no consistent approach or willingness for other teams to assist. Furthermore, it has been difficult to have management (or their willingness) to intervene in these situations.
- A number of staff provided feedback that the proposed structure could be flattened further than that suggested by the Review through removing all existing team structures and aligning staffing under the proposed Clinical, Operational and Quality streams. In this case the Team leader or Manager of the stream would assign the workload and resources based on prioritisation. Grade 3 pharmacists not assigned management duties would be recognised for their specialism. The HSU also stressed this point.
- Another staff provided a suggestion that staff could be rotated between the Clinical and Operations streams to create further flexibility. This endorsement of creating flexibility extended to supporting the recommendations of ensuring that roles not currently patient facing could be used if demand was high (i.e. pharmacy procurement roles, IMT pharmacist role, QUM and AMS pharmacists).
- Support for the recommendation of re-focusing Team leaders on clinical work by removing where possible rostering activities.
- Support for flattening the structure as long as this does not mean significant regrading of positions. Most grade 3 positions reflect the pharmacists specialisation.
- Recommendation to realign some existing management roles into managing the clinical streams or to provide additional clinical/patient facing resources (i.e. Deputy Director role into Clinical Stream Manager role). Also, that educational pharmacists should work on wards with interns assigned to provide interns with patient facing clinical experience.
- Another recommendation was for intern pharmacists to be rotated onto wards with Clinical Educators. This was seen as an opportunity to enhance the intern clinical pharmacy learnings and have educators also provide clinical pharmacy support.
- Concern with the current ratio of AMS pharmacists and ID staff specialists resulting in a reduction in face-to-face AMS interventions when a staff member is absent. These roles ensure the promotion of safe, appropriate and compliant antimicrobial prescribing, as well as ongoing monitoring for patients in both the inpatient and outpatient settings. A reduction in staffing these teams will impact patient care.

Pharmacy Structure - Wyong and Gosford FTE Distribution

- There was general support for a fair distribution of pharmacy FTE between the sites based on bed numbers and complexity. It was however noted that if Cancer Services pharmacy FTE is grouped as part of Gosford this distorts the allocation split to Gosford. If removed, an imbalance between Wyong and Gosford is evident.

Pharmacy Structure - Other

- Some feedback that pharmacy services should not be benchmarked and that CCLHD pharmacy department is not comparable to either the Nepean Blue Mountains LHD pharmacy department or the Illawarra Shoalhaven LHD pharmacy department.
- The raising of revenue and drug cost savings should be considered, not simply the reduction of expenses (i.e. FTE cuts).
- One recommendation that clinical trials is funded out of operating budget with revenue to off-set this expenditure.

Pharmacy Service Reporting Lines

- Some staff and stakeholders supported aligning service sites under the General Managers (GMs) to ensure the services become more integrated into meeting the acute site's needs and involvement in access and flow problem solving.
- There were also several stakeholders concerned with aligning services under the GMs as it was felt that this would create an additional layer of complexity for negotiating access to pharmacy for non-Wyong or Gosford services. Other issues raised with this recommendation was that there would still be required District-wide functions such as policy, procurement, governance, administration, payroll, on-call duties, recruitment and managing the state-wide formulary. Feedback included that this approach could also be detrimental to service standardisation across the District.
- One submission requested that if pharmacy moves to the GM reporting recommendation that the cancer services pharmacists report directly to the Cancer Directorate.
- The HSU provide feedback that while it does not intend to dictate managerial prerogative, it should be highlighted that such a move will restrict the ability to utilise resources where needed on a needs-basis, potentially reduce the capacity to deliver a consistent pharmacy service throughout the District and may have an impact on gradings of pharmacists in senior roles.

Service Hours

- General support for extended hours by senior stakeholders whereas some pharmacists provided feedback that extending hours has been tried before and demand does not warrant the extended times.
- Some feedback from pharmacists that this was trialled during a past 'winter surge' strategy whereby longer hours weekdays and longer weekend hours were utilised, which demonstrated zero additional impact on discharge numbers resulting instead in workload being spread across a longer workday.
- A concern of some staff and the union is that extending hours could create shift work which would in turn be a change in staff existing employment conditions.

- Support for improved work flexibility, job sharing and/or use of compressed hours i.e. where a staff member works their full week over less days but over more hours.
- One pharmacist expressed concern that if patients are discharged in the evening, many pharmacies are closed anyway. That many staff that work here travel long distances to get here using public transport, which could cause inconveniences and build-up of fatigue, which would ultimately impact on the patients.
- Feedback that the Grade 3 Technicians at Wyong are aligned to the activities that they perform with significant work put into developing these roles to align with the SHPA standards to assist clinical pharmacists with non-clinical duties where possible to free up their time to focus on clinical duties.
- Feedback from the HSU stated that the provision of providing an adequate after hours or extended hours service has never been properly funded by CCLHD. An ad hoc arrangement of on-call or volunteers has led to a totally inadequate service that has continued to flounder. The HSU is not opposed to having an effective after-hours service, but it needs to be properly funded and staffed. Just simply changing start and finish times will only reduce the limited services at peak times and cannot be achieved with staff designated as day workers. The only way this proposal could work is if additional staff are recruited as shift workers which the HSU has advocated for quite some time.

Pharmaceuticals Supply - PBS

- There was general support from pharmacy and other stakeholders for the use of PBS scripts for patients being discharged where they do not require non-PBS or cost prohibitive medicines and are low risk. Some acknowledged that this is a very grey at best area of practice, and many LHDs would not agree with the approach but if implemented would reduce dispensary workload.
- Whereas some pharmacists were concerned that PBS is not supported by Ministry of Health policy position due to NSW not being a signatory to the Commonwealths PBS reforms and that Drugs and Therapeutics Committee would need to be consulted to provide the support organisationally should this be implemented.
- Some feedback suggested that the Drugs and Therapeutics Committee develop a PBS formulary for JMOs.
- Many clinicians over the past several years have shifted dispensing from hospital to community with the introduction of community codes via PBS. More activity in this area is possible to reduce outpatient pharmacy load further. Note already for outpatient clinics, PBS prescriptions are already utilised e.g. fracture clinics, aged care clinics, endocrine clinics. Especially renal, clozapine, and SHC could increase community acquisition of PBS items.
- Support for the increased engagement of community pharmacy in supporting discharged patients and/or for conducting home medicine reviews.

Pharmaceuticals Supply - General

- One feedback questioned the recommendation to establish a dedicated satellite pharmacy at high demand ward as processes currently exist to utilise dispensed medications and / or imprest medications via the discharge stations as well as innovative practices like tubing to wards are in place.
- There was feedback received that current service model has transferred some imprest supply onto clinical teams and that this should be, as per the Review recommendations, transferred back to the procurement pharmacy team.

- Some staff feedback was that nursing should be involved in packing pharmacy supplied imprest onto shelves, which would then provide some resource to procurement team to be proving increased service to more imprest areas.

Pharmaceuticals Supply - Imprest Box and Satellite Ward Pharmacy

- Support for the implementation of an imprest-box preferred supplier. Noting one respondent indicated that they did not feel the savings would be as significant as the consulting team propose and one staff feedback concern that this would create a monopoly situation.
- The satellite pharmacy would need to be large to hold all of the medications needed and additional resource would be required to manage the stock holdings.

Committees and Accreditation

- A number of pharmacists supported the reduction of their involvement in organisational committees to increase clinical availability whereas some stakeholders were concerned that this would withdraw an important expertise from decision or policy making.
- Feedback also received that committee representation has always been a challenge for pharmacy as they are constantly asked to represent at different levels on various work parties. Besides those committees specifically mentioned in the recommendation there are others (such as eMAGG) where representation should be considered as critical.
- There does need to be a 'rethink' organisationally of Accreditation activities when committee representation is at a peak, and pharmacy has been the lead (almost exclusively) in both Standard 4 Medication Safety and also Standard 3. Perception that nursing and senior medical over the years have depleted their resources involvement with Policy and Procedure, which has necessitated other departments (e.g. pharmacy) taking greater presence in supporting.
- Feedback from another stakeholder concerned if pharmacy expertise limited on designated committees as they are experts on quality use of medicines.
- One staff member reported concern that if you reduce our involvement in governance activities, education that this will diminish our ability to participate in multidisciplinary care.
- Other feedback included that there needs to be an electronic reporting system to meet the District's needs for meeting the National Standards for accreditation and the Antimicrobial Clinical Care Standards, automating the reporting of non-compliance and inappropriate prescribing, where possible. This would allow current AMS staffing levels to remain stable whilst continuing to contribute to other clinical areas such as the dispensary.

## Appendix B Recommendations Endorsed for Implementation

| | Issue | The Review recommends that: | Comment | Project Implementation Stream |
|---|---|---|---|---|
| 1. | Clarification of line management and responsibilities | 1. a flatter organisational structure be implemented to achieve:<br>- clearer and more effective line management<br>- greater clarity and acceptance of responsibilities<br>- improved co-ordination of activities<br>- decreased activity within 'silos'<br>- increase accountability<br>- greater contingency<br>a) with a facility-based focus at each of Gosford and Wyong hospitals<br>b) with three broad activity-based groupings, these being: clinical, operations and quality<br>c) with a small number of teams in each grouping, and<br>d) with a larger number of pharmacists and technicians in each team. | ELT Endorses:<br>• A new structure that reduces team silos and allocates staffing into broad teams of clinical, operations and district-wide functions<br>ELT **Do <u>Not Support</u>**:<br>• Facility based reporting model/focus. A District approach will be retained.<br>• Rec 1a | Structure & People |
| 2. | the impact on specialty services (e.g. renal services) when specialty clinical pharmacists are unavailable | 2. a prioritisation strategy be introduced using change management principles<br>3. clinical pharmacists provide the required clinical pharmacy services throughout CCLHDaccording to services and patients being prioritised in the following way:<br>a) in regard to services:<br>i) discharge medication and discharge medication reconciliation for high priority patients being discharged<br>ii) discharge medication for medium and low priority patients (and triaging | ELT Endorse:<br>• the utilisation of a prioritisation framework which is used to allocate clinical pharmacy resources | Clinical Model |

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| | medium priority patients for discharge medication reconciliation)<br>iii) new medications ordered overnight<br>iv) medication reconciliation on-admission for high priority patients<br>v) medication reconciliation on-admission for medium priority patients<br>vi) clinical pharmacist review of medication orders for high priority patients<br>b) in regard to patients: using a report of patients most at risk of medication-related harm:<br>list the name and ward / unit location of every patient in each hospital (for which thedata are available) categorised into one of three categories for clinical pharmacy review these being, high priority, medium priority, and low priority using an approachto prioritisation such as the *PharmConsult* Risk-Based Prioritisation Approach (see Appendix 5) or an approach developed by the CCLHD Pharmacy Department (but not assessed during this Review), and automated via the Dynamic Ward Lists® (by Kraken Code - see Appendix 4)<br>ii) assign staff to provide clinical pharmacy services after determining the patients at highest risk from medication related harm<br>iii) investigate further any risks associated with non-compliance with Standard 4(Medication Safety) if a prioritisation strategy is applied.<br>c) and involving:<br>i) clinical pharmacy technicians visiting patient units first thing every day to identify:<br>- patients being discharged (and their requirements) using the Patient Flow Portal and discussions with NUMs<br>- new overnight medication orders, and<br>ii) then commence dispending both<br>iii) Patient Flow Portal reporting, and technicians ward round reporting (for discharges) | | |

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| | iv) clinical pharmacists meeting each morning with Pharmacy Leadership at Gosfordand Wyong to assign staff to patients and activities. | | |
| 3. the disparity between pharmacy resources and the pharmacy model operating at Wyong compared with Gosford | 4. the perceptions of disparity in the allocation of pharmacist and technician resource beaddressed by:<br>a) implementing the amended organisational structure (as described in recommendation 1)<br>b) allocating 70% of FTE clinical and operational staff to Gosford and 30% to Wyong (on the basis of bed numbers, casemix and acuity)<br>c) sharing a number of quality services (such as QUM, AMS, IMT, policies and procedures,<br>DTC support, medication safety, education and training) across the District<br>d) prioritising services and patients at each facility (as described in recommendation 3)<br>5. clinical pharmacist be allocated patients using a ward-based model because the physicallayout of Gosford Hospital and restrictions imposed by the need to isolate patients with suspected or diagnosed Covid-19, makes the application of speciality-based model is impractical for the time being (albeit it that in an ideal world, is the specialty team-based model optimises the application of clinical pharmacist skills). | ELT Endorse:<br>• the re-balancing of FTE between the two sites. | Structure and people |

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| 4. the way in which the required number of clinical pharmacists is calculated and the way in which clinical pharmacy resources are allocated | 6. for the purposes of contributing to meeting the objectives of the Organisation-wideSustainability Plan that:<br>a) the number of Pharmacy FTE be reviewed, with the split being:<br>i) 70% of total FTE to Gosford, 30% to Wyong<br>ii) broadly in line with the current split of staff across the various Pharmacy functionsand activities i.e. management, clinical, dispensary, combining, quality etc.<br>iii) QUM, education, IMT, and procurement, have District-wide responsibilitiesregardless of where they are based, and<br>b) the allocation of staff be carried out in conjunction with the implementation of prioritisations of services and of patients (recommendation 3), and a preferred wholesaler model which incorporates a District-wide imprest box distribution model (see recommendation 16b) | ELT Endorse:<br>• the re-balancing of FTE between the two sites and in conjunction with implementing a preferred wholesaler imprest model | Clinical Model and Procurement and Supply |
| 5. the involvement of Pharmacy staff in medication reconciliation on admission and at discharge | 7. medication reconciliation on admission and at discharge remain a priority with prioritisationfor<br>a) patients on discharge: according to those patients deemed high priority via therecommended implementation of a prioritisation of patients tool<br>b) patients on admission according to those patients deemed high priority<br>c) patients admitted via the Emergency Department, and<br>d) medium priority patients | ELT Endorse:<br>• prioritisation of medication reconciliations | Clinical Model |
| 6. Pharmacy's role in timely discharge of patients | 8. discharges be made a priority as per recommendation 8, and that the following process be used in regard to the supply of discharge medications and information:<br>a) patients for discharge be identified via the Patient Flow Portal and via the Pharmacytechnician's check with each NUM each morning | ELT Endorse:<br>• PBS practices where these can be adopted,<br>• Criteria-based discharge is in concert | Clinical Model and<br>Procurement and Supply |

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| | b) high priority patients (as per the daily Dynamic Ward List® report) from the Patient Flow Portal list especially those waiting for medication on the 'Waiting for what?' list, be prioritised for the provision of medication reconciliation at discharge, and the supply ofdispensed medication and a medication profile<br>c) if for any reason discharge medication cannot be provided to any medium or low prioritypatient (as listed by the Dynamic Ward List report) prior to the scheduled time of discharge, that a PBS prescription be written by the medical officer responsible for authorising the discharge and given to the patient or their carer, with advice that they have the prescription dispensed by a community pharmacy on their way home<br>9. consider implementing criteria-based discharges (which will allow Pharmacy to preparedischarge medications for many patients potentially the day before discharge)<br>10. consider establishing a satellite Pharmacy in the ward with the highest number of patients requiring discharge medication, specifically for dispending discharge medication in a moretimely and responsive way<br>11. consider not dispensing a new supply of a patient's regular medication at discharge to patients whose admission lasts less than 72 hours and instead provide to them the medication they brought in with them, and suggest that for ongoing supply they obtain aprescription from their GP. | with the work being done by the expert District Working Group already underway,<br>• Suitable wards for piloting the satellite pharmacy concept can be identified and stock holdings are manageable | |
| 7. opportunities to enhance the after-hours service services and the need for a 7-day a week pharmacy service (and the costs associated with both) | 12. current Pharmacy hours[1] be extended to supply new orders for patients admitted overnightand discharge medication for high priority patients being discharged late in the afternoon, in the following way:<br>a) Monday to Friday 0730 to 1900, Saturday, Sunday and public holidays: 0800 to 1500 withED continuing as is from 0830 to 1700, and<br>b) be staffed by introducing shift rosters i.e. without paying overtime, in conjunction with the amended organisational structure and the prioritisation of services and patients. | ELT Endorse<br>• the recommendation to enhance hours **subject** to a review of hours, time of scripts and discharge to identify where this benefit would be realised. | Structure and People |

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| 8. the balance of the number of clinical pharmacists and distribution / manufacturing pharmacists including workforce substitution (pharmacist to technician) balance/optimisation | 13. the balance of pharmacists and technicians in each of the main functional areas of Pharmacy (i.e. clinical, distribution, compounding and quality) be retrained, as this is appropriate to meet CCLHD requirements assuming the changes that have been recommended throughout this report are implemented, particularly in regard to prioritisingservices and patients, providing PBS prescriptions to many discharge patients, and introducing the imprest box distribution model<br>14. technicians with the appropriate skills conduct the first round to inpatient units each day totriage orders for urgent discharge medication orders and new inpatient medication orders to ensure these are dispensed and provided to patients as quickly as possible | ELT Endorse:<br>• balance of technicians to pharmacist recommendations and role of technicians in identifying urgent discharge and new orders | Structure and People and Clinical Model |

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| 9. the balance of individually dispensed items and imprest items, the models associated with these different methods of medication distribution and the implications for Pharmacy staffing | 15. no recommendations are made in regard to balance of individually dispensed items and imprest items as:<br>a) feedback from medical officers and nurses was positive in this regard, and<br>b) the procedures used by Pharmacy staff to determine which medicines should be dispensed individually (which mainly seem to be and should continue to be restricted toantimicrobial agents, high-cost medicines and those for which special supply arrangements exist e.g. SAS medicines) is appropriate<br>16. the management of imprest medicines (excluding IV fluids, irrigation fluids, haemodialysis fluids, antiseptics which should be transferred to the Supply Department):<br>a) be the responsibility of Pharmacy in all imprest locations throughout CCLHD<br>b) be organised under a Preferred Wholesaler Agreement (established after a Preferred Wholesaler Request for Proposal) using an imprest box distribution model for all imprestlocations and Pharmacy dispensaries at all CCLHD hospitals (see Appendix 6 for more information on the benefits of imprest box provided under a Preferred Wholesaler Agreement including the freeing up of Pharmacy Stores staff and a reduction on inventory holding). | ELT Endorse:<br>• the management of medicine imprests be the responsibility of pharmacy | Procurement and Supply |
| 10. any opportunities to consider aseptic compounding / manufacturing based on the costing model review being currently undertaken by CCLHD and the implications for Pharmacy staffing; and | 17. although there has been a recent extensive internal review of the Pharmacy's aseptic compounding processes to maximise the outsourcing of compounded products, and although HealthShare NSW has a tender for Chemotherapy Reconstitution Service out at the moment (Tender 861) for a target commencement date of 1 January 2022, that depending on the outcome of the HealthShare NSW Tender 861, that consideration be given to:<br>a) reviewing the rebate paid by the current supplier of ready-to-administer chemotherapy to restructure this on the basis of a fixed rebate for each outpatient PBS chemotherapy item compounded:<br>i) by the outsourced provider and<br>ii) in-house (where the outsourced provider also claims the PBS benefit) | ELT Endorse:<br>• reviewing the rebate provided by the Chemo provider<br>• negotiating a biosimilar fee | Procurement and Supply |

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| | b) negotiating a contract rights fee in consideration of the exclusivity CCLHD provides to the outsourced provider on PBS chemotherapy (and other) items which required to be aseptically compounded<br>c) negotiating an annual 'biosimilar fee' (i.e. a sharing of the profit the outsourced provider makes by using the biosimilar of their choice when the have the opportunity to substitute a biosimilar for an originator biologic – which is most of the time)<br>d) ensuring that the outsourced compounder is responsible for obtaining all 'owing' PBS prescriptions (and also carries the bad debt if a prescription is not supplied). | | |
| 11. the model for pharmacy services | 18. a facility-focussed model be introduced as this model provides the greatest opportunity to:<br>a) facilitate a more multidisciplinary and team-based approach to patient care and problem- solving e.g. discharge planning, and as a result more effectively meet the needs of patients and staff<br>b) introduce greater accountability of Pharmacy to the general managers of Gosford and Wyong hospitals, and<br>c) introduce a more functional operating model within Pharmacy by encouraging a greater sense of 'team', spreading of workload and providing contingency. | ELT **Do Not Support**<br>• adoption of a facility based model. | Not applicable |
| Other issues | | | |
| 12. Communication | 19. <u>within CCLHD</u>, individual meetings between the Director of Pharmacy and the head ofeach medical speciality / medical unit and each nurse unit manager at each site be organised, for the Director of Pharmacy to:<br>a) explain the steps Pharmacy needs to take under the proposed FTE<br>b) explain the approach Pharmacy is taking to prioritising services and patients as result of decreased resources (see recommendation 3)<br>c) discuss the implications for patients and staff of each medical speciality / unit | ELT Endorse:<br>• communication of changes to service model internal and external pharmacy<br>• communication with the Pharmacy Guild and community pharmacists | Structure and People And Clinical Model |

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| | d) reach agreement on the service levels (which should be formalised with an email)<br>e) provide a mechanism to discuss the rollout and any unforeseen outcomes<br><br>20. within the Pharmacy Department:<br>a) the frequency of communication within the Pharmacy Department be increased todevelop a greater sense of a 'one Pharmacy team' instead of teams operating as individual entities<br>b) the practice of thinking of FTE positions as 'funded positions' be replaced with considering the total number FTE positions as those available to Pharmacy as a team tomeet CCLHD needs using a prioritised approach to activities and patients within the constraints of limited resources which need be used as effectively as possible<br><br>21. external to CCLHD, a meeting between Pharmacy and the Pharmacy Guild of Australia NSW Branch Central Coast District, be organised to explore ways to more effectively meet the medication needs of patients / customers through closer cooperation between CCLHD Pharmacy and community pharmacists; in regard to:<br>a) PBS prescriptions given to patients at discharge<br>b) dose administration aides<br>c) the Opioid Treatment Program,<br>d) Home Medication Reviews, and<br>e) medication requirements of mental health patients (may be modelled on the pharmacy component of the North Western Mental Health model to avoid the need for patients toreturn to the hospitals for medication | | |
| 13. Committee involvement and QUM activities | 22. in order to support the clinical and operational activities of the Pharmacy under the proposed FTE, that:<br>a) in regard to committee involvement: as part of the prioritisation strategy, that Pharmacy limits its involvement in the 53 committees on which it is currently represented to only those where Pharmacy staff are either:<br>i) a decision-maker, or | ELT Endorse:<br>• pharmacy reviewing their participation and restricting committee participation where risk is mitigated | Structure and People |

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| | ii) a provider of information critical to a decision being made, and<br>b) in regard to QUM activities: that these be limited to those which are formally requested by the Drug and Therapeutics Committee, the Antimicrobial Stewardship Committee, or the Medication Safety Committee (in relation to requirements of the National Safety and Quality Health Service (NSQHS) Standards (for medication safety and antimicrobial stewardship)). | ELT **Do Not Support**:<br>• Restricting use of QUM pharmacy expertise to only DTC | |
| 14. Outpatient prescriptions | 23. all outpatients be provided with PBS prescriptions (from outpatient 'MBS clinics') to have dispensed by a community pharmacy unless there are reasons a patient won't or can't obtain the medicine from a community pharmacy e.g. the prescription is for a high-cost non-PBS medicine, or for a medicine that is hard to obtain in community pharmacy. | ELT Endorse:<br>• Use of PBS scripts where possible | Procurement and Supply |
| 15. Dose administration aides e.g. Webster- Pak® | 24. Pharmacy staff (preferably a technician) liaise with the patient's community pharmacist (with the patient's permission) to organise a supply of medication packed by the community pharmacy into a dose administration aide such as a Webster Pak or Dose- Aid® or other medicine sachets | ELT Endorse:<br>• Pharmacy reviewing opportunity for community pharmacy to supply Webster Pak and Dose Aid | Procurement and Supply |
| 16. Junior Medical Officers | 25. that as part of JMOs orientation to CCLHD, that JMOs be advised of the tools available for obtaining reliable medication-related information, to lessen their reliance of clinical pharmacists for this | ELT Endorse:<br>• Education of JMOs to lessen reliance on clinical pharmacists for reliable medicine-related information | Clinical Model |
| 17. Pharmacy Procurement | 26. in regard to the operation and staffing of the Pharmacy Procurement and Inventory activity, that to more effectively use the pharmacist resource currently employed as the Manager Pharmacy Procurement and Inventory and to bring additional professional procurement expertise to a critical aspect of Pharmacy and Districts' operations, consideration be given to restructuring the Pharmacy Procurement and Inventory activity such that: | ELT Endorse:<br>• pharmacy procurement recommendations<br>• Endorse transitioning Pharmacy Procurement Manager role from HSM to | Procurement and Supply |

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| | a) pharmacy procurement staff who are on HSM classifications be transitioned to pharmacist grade positions in order to provide additional capacity to assist in clinical and operational activity<br>b) the partnership between Pharmacy and the Contracts and Leasing unit in the procurement of medicines and pharmacy supplies be strengthened including establishing a pharmacy procurement and contracting work plan, and<br>c) through the introduction of the imprest box distribution model, Pharmacy resources currently managing imprest are reviewed to assess reallocation to other Pharmacy operations e.g. dispensing or clinical activities | Pharmacy Grade. Review assistant role only if becomes vacant or certificate 4 achieved. | |
| 18. Policies and procedures | 27. in regard to policies and procedures, that the number of Pharmacy staff involved in updating existing or drafting new medication-related policies and procedures be reduced to a maximum of two pharmacists for each new policy which needs to be drafted (i.e. one to draft, one to review) and to one pharmacist for each existing policy which needs to be reviewed. | ELT Endorse:<br>• Pharmacy numbers involved in updating or drafting medication policies | Structure and People |
| 19. Antimicrobial stewardship | 28. in regard to technology to assist the antimicrobial stewardship program that consideration be given to replacing the Guidance® system with Kraken Coding's AMS system (which is being used in a number of major WA public hospitals). | ELT Endorse:<br>• Pharmacy to explore technology available to replace the AMS Guidance system | Clinical Model |
| 20. Benefits Realisation Plan | 29. a Benefits Realisation Plan be developed and implemented to track implementation, and measure and report the extent to which the proposed benefits have been realised. | ELT Endorse:<br>• Benefits realisation plan being developed<br>• Consider the use of an Improvement Partner if required<br>• Rec 29, | Project Management |
| 21. other staff related matters | 30. in regard to rostering and payroll: that advice from Workforce & Culture be | ELT Endorse: | Structure and People |

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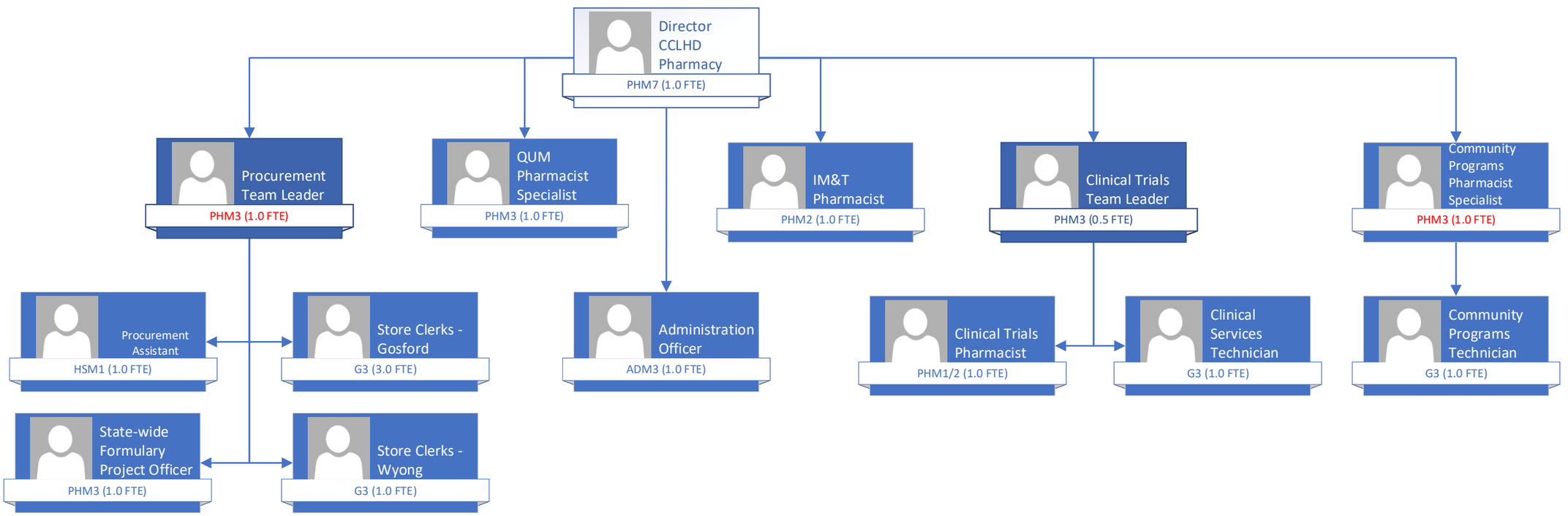
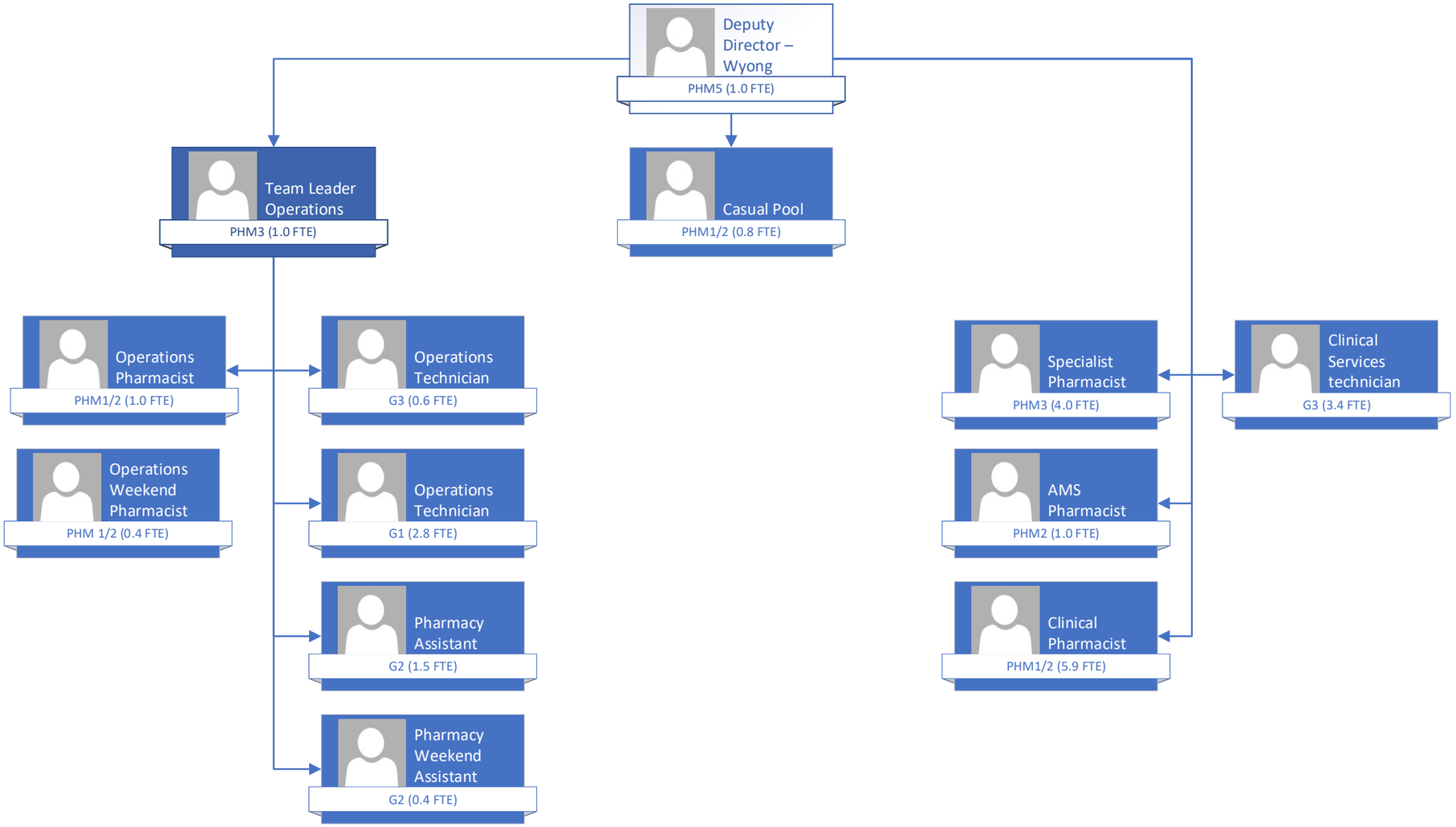
| | sought on introducing alternative ways for rostering and signing off time sheets to remove these tasks from team leaders<br><br>31. in regard to support with implementation of the recommendations of the Review, that assistance from an Improvement Partner be sought<br><br>32. in regard to wage subsidies for pharmacy technicians, that CCLHD continue to utilise Apprenticeship Support Australia subsidies to facilitate the training of pharmacy technicians to Certificate IV standard<br><br>33. in regard to recruitment of pharmacists: that consideration be given to offering pharmacy interns a 18-24 month contact to retain them for at least 6-12 months after they have completed their internship in order to fill vacancies with Garde 1, Year 1 pharmacists without the need for recruitment, induction, and orientation<br><br>34. in regard to more objective ways of assessing the appropriateness of expertise for higher grading under respective industrial awards that an internal credentialling process be implemented where pharmacist and technicians need to be credentialled as possessing and applying formal and applied specific knowledge and skills, as a pre-requisite for grading to a higher grade (in addition to the Competency Criteria described in the Health Employees' Pharmacist [State] Award 2021). | • Working with Workforce to review sign off task opportunities, continue to access where eligible wage subsidy schemes.<br>• Consider the use of an Improvement Partner if required to support project implementation<br>• Implementing 18-24 month contracts for future interns<br>• Work with Workforce to explore opportunities for a more objective system of assessing regarding applications | |

## Appendix C: Proposed Pharmacy Structure

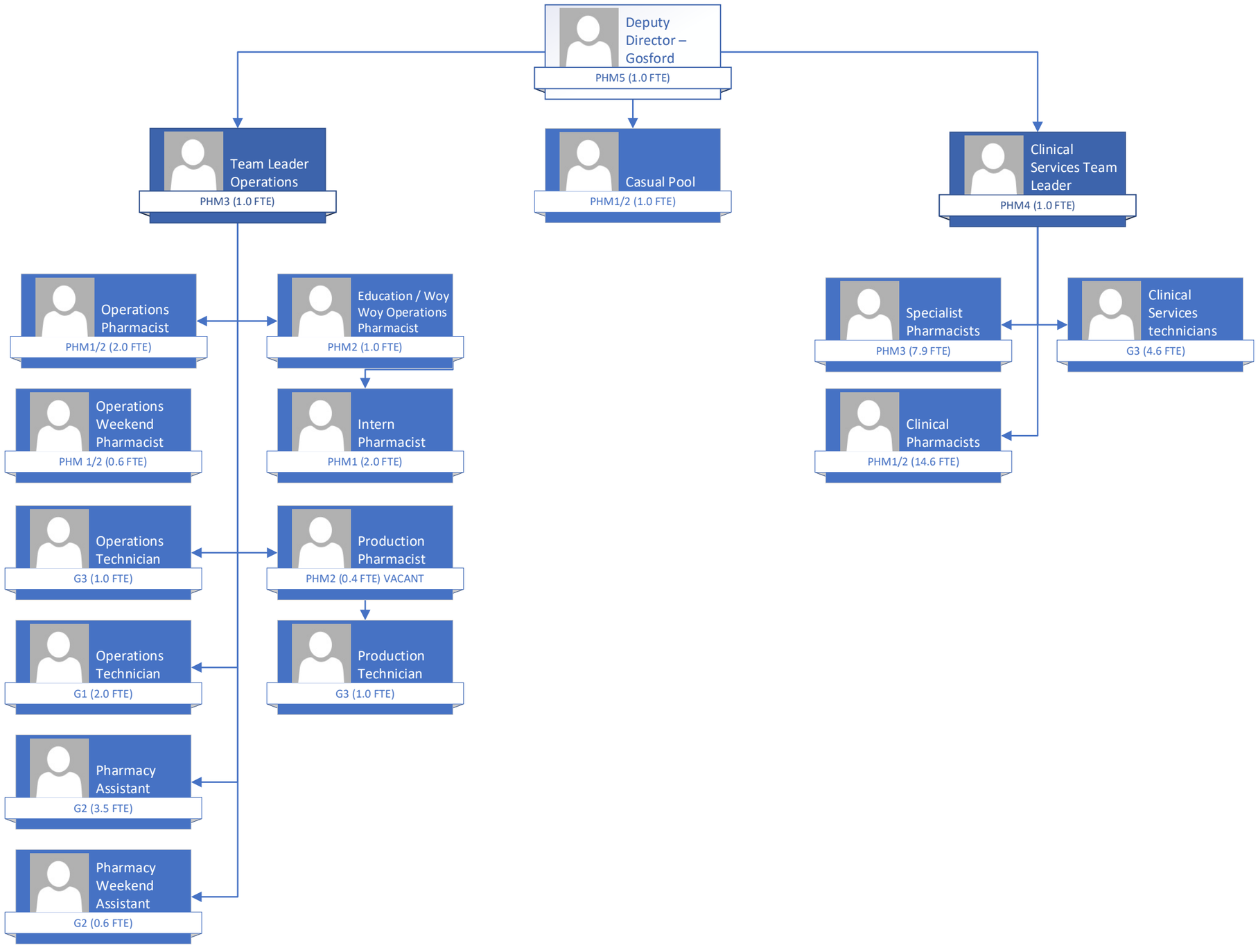
District Pharmacy Services – 15.5 FTE



## Wyong Pharmacy Service – 23.8 FTE



## Gosford Pharmacy Service – 45.2 FTE



## District-wide Services Profile

| Change Plan Proposed Position | Area | Proposed Grade | Proposed FTE |
|---|---|---|---|
| Director of Pharmacy, Gosford | District | PHM7 | **1** |
| Administration | District | ADM3 | **1** |
| QUM & Education Pharmacist Specialist | District | PHM3 | **1** |
| IM&T Pharmacist | District | PHM2 | **1** |
| Procurement Team Leader | District | PHM3 | **1** |
| Procurement Assistant | District | HSM1 | **1** |
| Stores Clerks, Gosford | District | ADM4 | **0.6** |
| Stores Clerks, Gosford | District | ADM4 | **1** |
| Stores Clerks, Gosford | District | ADM4 | **1** |
| Stores Clerks, Gosford | District | ADM4 | **0.4** |
| Stores Clerks, Wyong | District | ADM4 | **1** |
| Clinical Trials Pharmacist Lead | District | PHM3 | **0.5** |
| Clinical Trials Pharmacist | District | PHM1/2 | **1** |
| Clinical Trials Tech | District | G3 | **1** |
| Community Programs Pharmacist Specialist | District | PHM3 | **1** |
| Community Programs Technician | District | G3 | **1** |
| State wide formulary pharmacist | District | PHM3 | **1** |
| | | **FTE** | **15.5** |

## Wyong Profile

| Change Plan Proposed Position | Area | Proposed Grade | FTE |
|---|---|---|---|
| Deputy Director of Pharmacy, Wyong | Site Leadership | PHM5 | **1** |
| | | | |
| Team Leader | Operations | PHM3 | **0.6** |
| Team Leader | Operations | PHM3 | **0.4** |
| Pharmacist | Operations | PHM1/2 | **1** |
| Pharmacist Weekend | Operations | PHM1/2 | **0.1** |
| Pharmacist Weekend | Operations | PHM1/2 | **0.3** |
| Technician | Operations | G3 | **0.6** |
| Technician | Operations | G1 | **1** |
| Technician | Operations | G1 | **1** |
| Technician | Operations | G1 | **0.2** |
| Technician | Operations | G1 | **0.6** |
| Pharmacy Assistant | Operations | G2 | **1** |
| Pharmacy Assistant | Operations | G2 | **0.5** |
| Pharmacy Assistant Weekends | Operations | G2 | **0.1** |
| Pharmacy Assistant Weekends | Operations | G2 | **0.3** |
| | ***Operations FTE*** | ***7.7*** | |
| | | | |
| Specialist Pharmacist | Clinical Services | PHM3 | **1** |
| Specialist Pharmacist | Clinical Services | PHM3 | **1** |
| Specialist Pharmacist | Clinical Services | PHM3 | **1** |
| Specialist Pharmacist | Clinical Services | PHM3 | **0.4** |
| Specialist Pharmacist | Clinical Services | PHM3 | **0.6** |
| AMS Pharmacist | Clinical Services | PHM2 | **0.6** |
| AMS Pharmacist | Clinical Services | PHM2 | **0.4** |
| Pharmacist | Clinical Services | PHM1/2 | **0.8** |
| Pharmacist | Clinical Services | PHM1/2 | **0.4** |
| Pharmacist | Clinical Services | PHM1/2 | **1** |
| Pharmacist | Clinical Services | PHM1/2 | **0.3** |
| Pharmacist | Clinical Services | PHM1/2 | **1** |
| Pharmacist | Clinical Services | PHM1/2 | **1** |
| Pharmacist | Clinical Services | PHM1/2 | **0.8** |
| Pharmacist | Clinical Services | PHM1/2 | **0.6** |
| Technician | Clinical Services | G3 | **0.6** |
| Technician | Clinical Services | G3 | **0.8** |
| Technician | Clinical Services | G3 | **1** |
| Technician | Clinical Services | G3 | **1** |

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| | ***Clinical Services FTE*** | ***14.3*** | |
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| Pharmacist Casual Pool | Site | PHM1 | **0.8** |
| | | | |
| | | **TOTAL FTE** | **23.8** |

## Gosford Profile

| **Change Plan Proposed Position** | **Area** | **Proposed Grade** | **FTE** |
|---|---|---|---|
| Deputy Director of Pharmacy, Gosford | Site Leadership | PHM5 | **1** |
| | | | |
| Team Leader | Operations | PHM3 | **1** |
| Pharmacist | Operations | PHM1/2 | **0.6** |
| Pharmacist | Operations | PHM1/2 | **0.4** |
| Pharmacist | Operations | PHM1/2 | **1** |
| Pharmacist Weekend | Operations | PHM1/2 | **0.2** |
| Pharmacist Weekend | Operations | PHM1/2 | **0.1** |
| Pharmacist Weekend | Operations | PHM1/2 | **0.3** |
| Education Pharmacist / Woy Woy | Operations | PHM2 | **1** |
| Intern Pharmacist | Operations | PHM1 | **1** |
| Intern Pharmacist | Operations | PHM1 | **1** |
| Pharmacist Production | Operations | PHM2 | **0.4** |
| Technician | Operations | G3 | **1** |
| Technician | Operations | G1 | **0.6** |
| Technician | Operations | G1 | **0.6** |
| Technician | Operations | G1 | **0.8** |
| Technician Production | Operations | G3 | **1** |
| Pharmacy Assistant | Operations | G2 | **1** |
| Pharmacy Assistant | Operations | G2 | **1** |
| Pharmacy Assistant | Operations | G2 | **0.45** |
| Pharmacy Assistant | Operations | G2 | **0.45** |
| Pharmacy Assistant | Operations | G2 | **0.2** |
| Pharmacy Assistant | Operations | G2 | **0.4** |
| Pharmacy Assistant - Weekend | Operations | G2 | **0.6** |
| | ***Operations FTE*** | ***15.1*** | |
| | | | |
| Team Leader | Clinical Services | PHM4 | **1** |
| Specialist Pharmacist | Clinical Services | PHM3 | **0.7** |
| Specialist Pharmacist | Clinical Services | PHM3 | **0.6** |
| Specialist Pharmacist | Clinical Services | PHM3 | **1** |
| Specialist Pharmacist | Clinical Services | PHM3 | **1** |
| Specialist Pharmacist | Clinical Services | PHM3 | **1** |
| Specialist Pharmacist | Clinical Services | PHM3 | **1** |
| Specialist Pharmacist | Clinical Services | PHM3 | **0.6** |
| Specialist Pharmacist | Clinical Services | PHM3 | **1** |
| Specialist Pharmacist | Clinical Services | PHM3 | **1** |
| Pharmacist | Clinical Services | PHM1/2 | **1** |
| Pharmacist | Clinical Services | PHM1/2 | **0.6** |
| Pharmacist | Clinical Services | PHM1/2 | **0.6** |
| Pharmacist | Clinical Services | PHM1/2 | **0.4** |
| Pharmacist | Clinical Services | PHM1/2 | **0.6** |
| Pharmacist | Clinical Services | PHM1/2 | **1** |
| Pharmacist | Clinical Services | PHM1/2 | **0.4** |
| Pharmacist | Clinical Services | PHM1/2 | **1** |
| Pharmacist | Clinical Services | PHM1/2 | **1** |
| Pharmacist | Clinical Services | PHM1/2 | **0.6** |
| Pharmacist | Clinical Services | PHM1/2 | **0.4** |
| Pharmacist | Clinical Services | PHM1/2 | **1** |
| Pharmacist | Clinical Services | PHM1/2 | **0.5** |
| Pharmacist | Clinical Services | PHM1/2 | **0.5** |
| Pharmacist | Clinical Services | PHM1/2 | **1** |
| Pharmacist | Clinical Services | PHM1/2 | **0.4** |
| Pharmacist | Clinical Services | PHM1/2 | **1** |
| Pharmacist | Clinical Services | PHM1/2 | **1** |
| Pharmacist | Clinical Services | PHM1/2 | **1** |
| Pharmacist | Clinical Services | PHM1/2 | **1** |
| Pharmacist | Clinical Services | PHM1/2 | **0.2** |
| Technician | Clinical Services | G3 | **1** |
| Technician | Clinical Services | G3 | **0.6** |

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|---|---|---|---|
| Technician | Clinical Services | G3 | **0.6** |
| Technician | Clinical Services | G3 | **0.4** |
| Technician | Clinical Services | G3 | **0.8** |
| Technician | Clinical Services | G3 | **0.2** |
| Technician | Clinical Services | G3 | **0.4** |
| Technician | Clinical Services | G3 | **0.6** |
| | ***Clinical Services FTE*** | ***28.1*** | |
| | | | |
| Pharmacist Casual Pool | Site | PHM1 | **1** |
| | | | |
| | | **TOTAL FTE** | **45.2** |