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Inquiry into impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales, November 2022

Supplementary questions directed to Dr Jonathan Penm, Chair, NSW Branch Committee, The Society of Hospital Pharmacists of Australia

1. Why is it necessary for NSW Health to become a signatory of the Pharmaceutical Reform Agreements?

Pharmaceutical Reform Agreements (PRA) are bilateral agreements between the Commonwealth and a jurisdiction, which enable the prescribing and dispensing of Pharmaceutical Benefits Scheme (PBS) subsidised medicines upon discharge from hospital, in outpatient clinics and in day treatment centres.

Currently in NSW public hospitals, upon discharge from a hospital admission, patients are only provided three to seven days' worth of medicines, thus requiring them to immediately seek an appointment with their general practitioner to ensure continuity of vital medicines that ensure they stay out of hospital. These could be important medicines that prevent another heart attack or stroke.

Given the current waiting times for general practitioner appointments, discharging patients from hospitals without enough medicines to last them until their next primary care appointment, is unsafe.

In the six jurisdictions which are signatories to the PRAs, patients discharging from public hospitals are able to be supplied PBS quantities of medicines, which is up to 30 days' worth for new and regular, ongoing medicines. This greatly reduces the immediate need to seek a general practitioner appointment when patients are still recovering from an inpatient stay, and when access to primary care appointments have been challenging for NSW patients, particularly in rural and regional areas.

The limited remuneration to public hospitals provided by the PRA by supplying PBS subsidised medicines, has also allowed in PRA jurisdictions, for more hospital pharmacists to be employed and provide clinical pharmacy activities to patients, as well as allow investment into specialised pharmacy services, such as pharmacists specialising in oncology, paediatrics, emergency medicine and geriatric medicine provided both to inpatients and outpatients. SHPA has heard from our NSW members that their hospitals are at risk of not meeting reaccreditation requirements as per the Medication Safety Standard in the National Safety and Quality Health Service (NSQHS) Standards, and this is directly tied to lack of commensurate hospital pharmacist workforce numbers which the PRA would have an impact on.

This all leads to NSW patients receiving a level of care that is below what patients in majority of Australians in other jurisdictions receive. Below are some examples of inherently inefficient and unsafe care for vulnerable patients that is not patient-centred, that could be resolved by NSW establishing a PRA:

- In emergency departments, patients are supplied very limited quantities of medicines upon discharge, if at all. These patients are then pushed onto the primary care system to see a GP right after discharge from emergency departments to obtain more medicines that would keep them out of hospital. Failure to do this greatly increases their risk of a medication-related readmission, which could have been prevented if a more appropriate medicine quantity could have been supplied if NSW was a PRA state
- For patients who are identified as palliative care patients and are discharged to spend their last days at home, medicines supply is a regular issue as NSW hospitals are unable to supply palliative care

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medicines on the Palliative Care Schedule on the PBS as they are not a PRA state. Our members tell us if a hospital supplies these medicines, out-of-pocket costs could cost well into the hundreds of dollars, and often patients and their carers are driving around to various community pharmacies to source these palliative care medicines to access them with PBS subsidy, even though they are extremely uncommon medicines for community pharmacies to have readily on demand. These medicines are more readily stocked in hospital pharmacies and not community pharmacies due to their limited use in primary care settings, and NSW hospitals would be able to supply these medicines to palliative care patients if they were a PRA state. These medicines include: clonazepam injections, fentanyl sublingual tablets, fentanyl lozenges, hydromorphone injections, hyoscine injections, methadone injections and metoclopramide injections.

- NSW Health patients who are COVID-19 positive cannot access PBS-subsidised COVID-19 antivirals as the hospital cannot dispense them with PBS subsidy. This is felt particularly in NSW Health Virtual Clinics where GPs are seeing patients with COVID-19 and wanting to prescribe COVID-19 antivirals, but are unable to do so on the PBS as the prescription originates from a NSW public hospital. Where the medicine would usually cost as little as $6.80 for a concessional patient, hospitals have to charge the full private price which is approximately $1000 just to cost recover, or tell the COVID-19 positive patient to seek a prescriber in the community who can prescribe it on the PBS. The patient populations most at risk from COVID-19 are also often least able to afford non-PBS prescriptions, and when they cannot source a PBS prescription in the community due to logistical issues, they go without vital COVID-19 antivirals that reduce their risk of hospital admission.

2. Can you tell us more about the innovative work some hospitals have undertaken in delivering virtual pharmaceutical services and is this something that could be rolled out more broadly?

Virtual Clinical Pharmacy Service (VCPS) models for inpatients have been used in some parts of rural and remote Australia to address the gaps in clinical pharmacist medication reconciliation, management and review.

Western NSW Local Health District provides VCPS to patients and staff in rural and remote hospitals in Bathurst, Dubbo and Orange Health Services. The service provides access to clinical pharmacists in these isolated and remote hospitals and clinics, providing high quality medication management and addresses medication safety issues. Prior to implementation of the VCPS, clinical pharmacy services were only available face to face in eight of 47 hospitals in Western NSW and Far West NSW Local Health Districts, which span an area of 450,000 square kilometres. The VCPS helped to overcome workforce challenges in these areas and supported reduced social contact requirements during the COVID-19 pandemic. Benefits also include equitable access for patients to pharmacy services across Western NSW and Far West LHDs as well as improving continuity of care by providing up to date medication information to prescribers and patients. The Agency for Clinical Innovation has also authored a Spotlight on Virtual Care: Virtual Clinical Pharmacy Service Report which contains more information about the VCPS.

Western NSW has recently undertaken a scalability study across eight of these rural and remote hospitals in NSW, to evaluate if virtual clinical pharmacy services are a feasible option in healthcare delivery and is expected to show a significant increase in best possible medication histories, medication reconciliation and detection of potential medication-related harms. Rural and remote patients should have the same access to clinical pharmacy services as their metropolitan counterparts and VCPS is a step to providing this.

This would increase the ability for the clinical pharmacist workforce to provide patient counselling and medicines review to optimise the quality use of medicines and achieve positive health outcomes. These virtual services can and should be scaled up more broadly to ensure all hospital inpatients have access to clinical pharmacy services, which can be facilitated by remote access to electronic medical records and fit-for-purpose. Key digital enhancements such as high-speed internet and wireless two-way conferencing

carts at the bedside have enabled a virtual model of care in these areas. Broad roll out could therefore be challenging due to internet connectivity in remote areas.

While it is a great benefit to patients that they can benefit from VCPS to improve the quality, safety and timeliness of there are, for acute patients especially, face-to-face care services are ideal, and virtual care models should only be implemented where face-to-face services are unable to be provided due to logistical challenges. Both VCPS and in-person hospital pharmacy services do not have sufficient investment by Local Health Districts and there are still many inpatients that are missing out on clinical pharmacy services that will make their care episode safer and reduce their length of admission.

3. How could embedding geriatric medicine pharmacists in aged care outreach services help prevent hospital admissions?

Embedding Geriatric Medicine pharmacists into broader hospital-based multidisciplinary aged care outreach services can provide better care for older people by supporting high-risk transitions of care and addresses access block by facilitating exit from, or preventing entry to, hospitals.

Geriatric Medicine Pharmacists working in collaboration with doctors and nurses, can promptly respond to older people at risk of hospital admission and deliver appropriate care to manage the individual in their place of residence. This service provides better care for the older person whilst placing less strain on hospital emergency departments.

Following an inpatient admission, discrepancies in the discharge summary can occur, with the potential for medication regimen discrepancies being continued along each step in the transitions of care. Pharmacists working in outreach teams can prevent these discrepancies from occurring and therefore prevent medication-related hospital admissions.

4. In addition to your testimony, can you please explain why NSW hospital pharmacists are the most under resourced in Australia?

NSW hospital pharmacy departments are the most under-resourced in Australia due to chronic underfunding and undervaluing of hospital pharmacists and hospital pharmacy departments.

Beyond our testimony response discussing the impact of whether pharmacy departments report to allied health or to medical departments, another compounding factor is that NSW Health does not recognise or made commitments to achieving pharmacist-to-patient ratios for hospital services which are described in professional practice standards, such as SHPA's Standards of Practice for Clinical Pharmacy Services and SHPA's Standard of Practice Series, which also describe best-practice pharmacist-to-patient ratios in specialised clinical areas, such as cardiology, critical care, emergency medicine, geriatric medicine, infectious diseases, nephrology, cancer, surgery and perioperative medicine.

Overall, NSW Health has a limited understanding of the breadth and complexity of pharmacy services in hospitals, which contributes to its under resourcing. Our members often report when new medical or patient services are established, there is often no funding for pharmacists or even a consideration of the anticipated pharmacy needs of the patient cohort which the new service is to provide care for. Many aspects of these considerations are neglected and go well beyond the basic understanding of medicine supply to patients, it also involves the other supporting aspects that are also required, such as medication chart review, logistics of medicines delivery, imprest medicines management and other services described in the Standard of Practice for Clinical Pharmacy Services. When pharmacy services are not funded when new medical services are established, invariably pharmacy needs arise and hospital pharmacy departments find themselves stretching

their already under resourced departments to provide additional services that were not funded in the first place.

These issues are also further compounded by the Health Employees' Pharmacists (State) Award 2022 pay scales which do not appropriately acknowledge the skill and remuneration level for senior pharmacists in Director of Pharmacy or Deputy Director of Pharmacy roles, particularly in rural and regional sites, where by virtue of being smaller sites, can be remunerated at the Grade 3 or Grade 4 level, when Deputy Director and Director roles of larger sites are remunerated at the Grade 5 or Grade 6 or Grade 7 level in recognition of their responsibility. When only Grade 3 or Grade 4 roles can be offered for Director of Pharmacy or Deputy Director of Pharmacy roles, it makes these roles extremely difficult to recruit for in rural and regional areas where recruitment is already a challenge. These gradings remove incentive for existing staff to progress to management roles, and diminishes the value of leadership positions for potential candidates.

The Health Employees' Pharmacists (State) Award 2022 also states *"A Pharmacist who has after registration not less than three years' experience in hospital pharmacy and can demonstrate competency in at least one of the essential competency criteria and 3 other competency criteria will be classified as a Pharmacist Grade 2",* which makes it even more difficult for rural and regional hospitals to attract hospital pharmacists as they are often recruiting from a pool of pharmacists with only community pharmacy experience, where their salaries in community pharmacy exceed Pharmacist Grade 1 pay rates, making it unattractive to seek positions in NSW hospital pharmacy departments.

5. Are you able to provide any examples of hospital pharmacies that are poorly under resourced?

In the main, all NSW hospital pharmacy departments are poorly under resourced when compared against professional standards with respect to pharmacist-to-patient ratios, or against similar sized hospitals in other states. For example, when comparing the pharmacy departments of similar sized hospitals in NSW, Queensland and Victoria, NSW hospitals on average have a third to a half of hospital pharmacist FTE allocations compared to Queensland and Victorian hospital pharmacy departments. The table below illustrates these disparities between the three largest Australian states in hospital pharmacist workforce to population ratios.

	METRO Hospital Pharmacist to Population	REGIONAL Hospital Pharmacist to Population
NSW	1:5517	1:8516
VIC	1:3741	1:6706
QLD	1:3367	1:5436

Table 1. Ratio of hospital pharmacist to population & hospital beds along comparable Eastern seaboard states
Data source: National Health Workforce Data Set (2019), Australian Bureau of Statistics

The following examples of hospitals are anonymous from a recent SHPA survey relating to this Inquiry. The names of hospitals are unable to be provided or were not collected, as our members are not able to identify the health services where they work in assisting SHPA with responding to this Inquiry.

- Metropolitan Hospital with Emergency Department with 70,000 presentations a year
  - Only employs 1 FTE Emergency Medicine Pharmacist, but actually requires 3-4 FTE Emergency Medicine Pharmacists to meet SHPA's Standard of practice in emergency medicine for pharmacy services
  - Also issue with physical infrastructure with lack of space to store medication in the Emergency Department imprest, leading to delays in timely medication supply.
- Metropolitan Tertiary Referral Centre with Emergency Department
  - No funding for an Emergency Medicine Pharmacist at all
- Level A Regional Tertiary Referral Hospital

    - Emergency Department with ~78,000 presentations a year: Had a 3.2 FTE Emergency Medicine Pharmacist over 7 days per week which would broadly meet SHPA's Standard of practice in emergency medicine for pharmacy services pharmacist-to-patient ratios, but this was cut to 1.2 FTE over 6 days.
    - Real FTE figure is lower as sick leave is not covered by another pharmacist.
    - More broadly in the hospital pharmacy department, a total of ten pharmacist positions were recently cut by hospital executive due to review into financial efficiency.
    - Further pharmacy staff resignation followed due to staffing pressures and stressful work environment.
- Regional Hospital with 220 beds
    - Hospital pharmacist resource funding focussed on facilitating quick discharge rather than clinical pharmacy activities that ensure a safe discharge.
- Metropolitan principal referral hospital with over 600 beds
    - Temporary funding was provided to employ an evening Emergency Medicine pharmacist from 1.30pm-10pm, seven days a week to supplement existing Emergency Medicine pharmacist during the day which was a 8am-4.30pm, seven days a week service.
    - This has allowed pharmacists to contribute to stroke calls and Partnered Pharmacist Medication Charting (PPMC) to ease pressures on medical staff.
    - However, this evening service recently lost funding and is no longer being continued, despite being valued by emergency department doctors and nurses.
- Regional Referral Hospital with 300 beds
    - Recent funding provided for an Emergency Medicine pharmacist in the Emergency Department.
    - However, staffing deficits and recruitment issues for all hospital staff mean that this position is difficult to fill. Recruitment for this position will likely need to occur internally as they are unable to attract staff to regional areas and community pharmacist roles are remunerated more favourably. In job advertisements, 'incentives' are not described fully or attractive enough to relocate, as well as there being a lack of funding for education allowance.

6. Are you able to provide any examples of requests for additional resources that have been refused?

It has been difficult to obtain specific examples of requests due to a reluctance of publicly employed hospital pharmacists speaking out and identifying their hospitals. What hospital pharmacists are routinely told when requesting additional resources, is that additional hospital pharmacist positions are unable to have their funding approved unless there are specific allocations from NSW Health. Below are examples of a service that was cut when it was requested for it to continue, or where applications to the LHD for additional resources were not funded. These funding requests are often made to meet pharmacist-to-patient ratios in professional standards such as SHPA's Standards of Practice for Clinical Pharmacy Services and SHPA's Standard of Practice Series.

- Regional LHD north of Sydney made several funding requests to hospital management for the positions below, all of which were refused without rationale, and in some cases, not even an acknowledgement of funding request was provided
    - Regrading the Oncology and Haematology Pharmacist role from a 1.0 FTE rotational Grade 1/Grade 2 pharmacist role, to a 1.0 FTE Senior Oncology and Haematology Grade 3 pharmacist role in recognition of the expertise and specialised nature of cancer services
        - This was estimated to cost between $20,000-$25,000 per annum

- 12.5 FTE for a team of Cancer Services Pharmacists and Pharmacy Technicians to support bringing cancer services back into the hospital as an in-house service, as analysis of current subcontracted services did not meet requirements or expectations set by NSW Legislative Council (as a result of [2016 inquiries into off-protocol prescribing of chemotherapy] and related investigations) and the Clinical Oncology Society of Australia (COSA) for the provision of clinical oncology pharmacy services
- 1.0 FTE x Senior Palliative Care Pharmacist and Hospital-In-The-Home pharmacist to provide pharmacy services to vulnerable patient groups with high risk of medicines adverse events
  - This was estimated to cost ~$150,000 per annum
- 1.5 FTE x Senior Cardiology Pharmacist to support a new cardiology ward with a mixture of high dependency inpatient beds and regular inpatient beds
  - This was estimated cost ~$90,000 from when the new cardiology ward opening in April 2022 until the end of the financial year
- 1.0 FTE x eMeds Application Specialist to be shared across two LHDs, to support medication safety and safe work flows in NSW Health's digital health ecosystem.
  - There was no FTE for this role at all at this particular LHD, despite the New South Wales Coroners Court highlighting the important role of pharmacists in eHealth in the [Inquest into the death of Paul Lau]
- 0.4 FTE Grade 3 Pharmacist for Weekend Admissions and Discharge Pharmacy Services, 0.4 FTE x Grade 3 Pharmacist for Weekend Dispensary Pharmacy Services and 1 x On Call Allowance
  - The existing limited service has not been funded for the ten years it has been operational, and has only been made possible by the pharmacy department's budget rearrangement at the expense of weekday services
- 0.4 FTE x Outpatient Pharmacist to support medication and pharmacy needs for patients in General Medicine, Endocrinology, Anaesthetics and Infectious Diseases Outpatient Clinics
- 1.0 FTE x Pharmacy Purchasing Manager for the LHD to improve efficiency and maximise savings for pharmacy and medicines procurement across the three pharmacy purchasing warehouses
- 3.0 FTE x Pharmacy Purchasing Officer for each three pharmacy purchasing warehouses in the LHD to support the Pharmacy Purchasing Manager

- Metropolitan principal referral hospital with over 600 beds
  - Temporary funding was provided to employ an evening Emergency Medicine pharmacist from 1.30pm-10pm, seven days a week to supplement existing Emergency Medicine pharmacist during the day which was a 8am-4.30pm, seven days a week service.
  - This has allowed pharmacists to contribute to stroke calls and Partnered Pharmacist Medication Charting (PPMC) to ease pressures on medical staff.
  - However, this evening service recently lost funding and is no longer being continued, despite repeated requests and being valued by emergency department doctors and nurses.
  - These pharmacists were able to assist by facilitating prompt medication reconciliation, facilitate discharge supply and patient education for those with anaphylaxis, or commenced on new anticoagulation.
  - The temporary funding also allowed the pharmacy department to expand pre-existing programs whereby a pharmacist attends all stroke calls and pharmacists perform partnered pharmacist medication charting for complex patients on admission, which further reduced pressures on Emergency Department medical staff and improved medication-related errors on admission.

7. **In addition to your testimony, can you please explain how increased hospital pharmacists can assist with access block?**

Emergency Medicine pharmacists can assess if an Emergency Department presentation is due to medication-related issues. These issues can be resolved by the pharmacist, and discharge of patients can be facilitated and then managed in the community with the patients GP. Emergency Medicine pharmacists also work collaboratively and provide expert pharmacological advice to their medical and nursing colleagues, facilitate access to critical medicines, and work with the teams to facilitate transitions and continuity of care to an inpatient unit or to the community.

Patients who are at risk of readmission can be referred by a hospital pharmacist to a transitions of care pharmacist to prevent further readmissions, but the transition of care pharmacist roles need to be developed and funded.

Pharmacists are often the holdup to discharges and the last clinician patients need to see. The lack of hospital pharmacists means discharges take longer to process to ensure medication supply and appropriate discharge counselling and handover to primary care providers. This contributes to access block as discharges by pharmacy can take up to six hours, whereas this can be achieved in an hour or less if hospital pharmacy departments are staffed according to pharmacist-to-patient ratios in SHPA's Standards of Practice for Clinical Pharmacy Services.

8. **Can you please explain how NSW differs from other states in terms of quantity of medications that can be provided to patients on discharge?**

Due to NSW being a non-signatory of the Pharmaceutical Reform Agreements (PRA), patients being discharged from public hospitals in NSW are currently supplied 3-7 days' worth of discharge medicines, which contrasts with the other jurisdictions who are signatories of the PRA and are therefore able to supply a months' worth of discharge medicines. These jurisdictions are Victoria, Queensland, Tasmania, Northern Territory, Western Australia and South Australia.

With such small quantities of discharge medicines, patients are then forced to see a GP within days of leaving hospital which can be challenging depending on where patients are geographically located. Where this is not possible, especially given the current issues with GP shortages and waiting times for GP appointments being up to three or four weeks, patients may have to re-present to Emergency Departments.

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