

COMMUNITY PHARMACY ENHANCED SERVICE FOR SHEFFIELD CARE HOMES



Sheffield Family Health Services
Brincliffe House
90 Osborne Road
SHEFFIELD
S11 9BD

Tel: 0114 305 1855 / Fax: 0114 305 1856

HOME AGREEMENT FORM

DECLARATION BY MANAGER/PERSON IN CONTROL OF HOME

I (name) _____ manager/person in control of _____ (care home name) care home, _____ (care home address and postcode) which is registered under Part II of Chapter 14 of the Care Standards Act 2000 as amended request _____ (pharmacy name), _____ (pharmacy address and postcode) to provide advice and support to the residents and staff within the care home, over and above the Dispensing Essential Service, to ensure the proper and effective ordering of drugs and appliances and their clinical and cost effective use, their safe storage, supply and administration and proper record keeping. There are (number of) _____ places at (date) _____. The agreement will run from _____ until **31 March 2012***.

I understand that the Action Plan developed as part of this service will be made available for inspection by the pharmacy to NHS Sheffield and the GP supporting this home under the Local Enhanced Service (if applicable). I agree to provide documentation, access to equipment and facilities as necessary for the provision of the service.

I agree to complete an evaluation of this service provided by NHS Sheffield following the 6 month update visit.

I consent to the disclosure of relevant information on this form for the purposes of fraud prevention, detection and investigation.

Signed

Manager/Person in control

Name (print)

(date) _____

_____/____

DECLARATION BY PHARMACIST

In accordance with the Service Level Agreement with Sheffield PCT I agree, on behalf of _____
(*pharmacy name*), _____ (*pharmacy address and postcode*) to provide advice
and support to the residents and staff within _____ (*home name*) care home, over and above the Dispensing
Essential Service, to ensure the proper and effective ordering of drugs and appliances and their clinical and cost effective use, their safe
storage, supply and administration and proper record keeping of drugs. The agreement will run from _____ **until 31 March
2012***.

Services provided will be in accordance with the Service Specification and will include:

- (i) the preparation and submission to NHS Sheffield of an Action Plan and avoidable medication waste analysis by 10 June 2011.
- (ii) following up the first visit with the advice and signposting to the Care Home if required.
- (iii) a review visit six months after the first assessment visit to monitor progress against the Action Plan and update it accordingly, with submission of the updated plan to NHS Sheffield by 9 December 2011.

I declare that the information given on this agreement form is true and complete to the best of my knowledge.

I understand that action may be taken against me if I make an incorrect claim.

I consent to the disclosure of relevant information on this form for the purposes of fraud prevention, detection and investigation.

Signed

Pharmacist

Name (print)

(date)

EARLY TERMINATION OF AGREEMENTS

*If this agreement is to be terminated before 31 March one month's notice in writing **MUST** given by either party to the other
and to NHS Sheffield.

_____ / _____