Lakes DHB Application for a new Community Pharmacy Funding Agreement

Guidelines for Application Form 1

Lakes District Health Board (DHB) encourages anyone who may wish to apply for an Integrated Community Pharmacy Services Agreement (ICPSA) for a new community pharmacy to notify the DHB of that intention as soon as possible.

All requests for a new ICPSA with Lakes DHB must be made on this Application Form, and be submitted to: Strategy Planning and Funding – planning.funding@lakesdhb.govt.nz

Receipt of the application will be acknowledged by email by within five working days. Lakes DHB is not responsible for applications that are not received.

Applicants are strongly encouraged to complete this application process prior to seeking a license to operate a pharmacy from Medicines Control and prior to making any commitments which may be reliant upon this application being approved by Lakes DHB.

Applicants should note that describing a requirement as being "complied with" or stating that the services required "can be provided" (or words to such effect) is not sufficient. A full response to each question is required.

Additional documentation in support of your application can be attached to your Application Form. If supplementary information is provided, ensure that clear cross-referencing between the Application Form and supplementary material is provided. Lakes DHB may not review additional information if it considers that the information provided is outside the scope of the evaluation.

This document should be read in conjunction with:

- The terms and conditions specified at the end of this form.
- Lakes DHB Community Pharmacy Strategic Plan 2019-2025.
- Lakes DHB Community Pharmacy Commissioning Policy.
- Integrated Community Pharmacy Services Agreement as updated/amended from time to time.
- Medicines Act 1981 and Medicines Regulations 1984.
- Health and Disability Services Pharmacy Standards (New Zealand Standard NZS 8134.7: 2010) as updated/amended from time to time.

This Application Form is not an offer and does not constitute a process contract. It is an invitation to submit information that Lakes DHB will use to determine whether to commence contract negotiations. If Lakes DHB chooses to commence negotiations, it will not be bound in any way until the execution of a written agreement.

Lakes DHB will not be bound by any statement, written or verbal, made by any person other than Lakes DHB authorised representative in relation to this application.

Lakes DHB accepts no responsibility for any error in this Application Form or related documents.

Lakes DHB is under no obligation to check supplied information for errors.

Lakes DHB may withdraw or amend this Application Form at any time.

Lakes DHB reserves the right, in its sole discretion, to deviate from any stated process (including any stated evaluation process) at any time and for any reason.

All Applicants are required to confirm their acceptance of the terms and conditions listed above by signing the Agreement and Acknowledgements section of this form.

Application Form 1

Applicants should familiarise themselves with the criteria to be met and the Lakes DHB Pharmacy Quality Standards before preparing their application.

Organisation Details				
Legal entity name				
Trading name				
Legal entity type				
GST number				
Name, position and primary contact details of person(s) who is/are authorised to enter into agreements on behalf of your organisation				
Mailing address				
Physical Address of pharmacy (if different)				
Phone				
Fax				
Email				
Web address				
Contact person for queries relating to this application	Name:		Phone Number:	
	Position:		Email Address:	

Organisation experience	
Provide information about the governance and management structure of your organisation, including the relevant qualifications and experience of the members.	
Describe any experience that your organisation has had delivering community pharmacy services in New Zealand.	
Provide a business case that demonstrates that due diligence has been completed, and the proposed new pharmacy is expected to effective, efficient, and sustainable. This assessment is expected to include consideration of the financial viability of the proposed service.	

Indicate whether your organisation has been the subject of a breach finding of the Code of Health and Disability Services Consumers' Rights in the last 24 months. If yes, provide details.	
Has the applicant had a Ministry of Health licence that has had conditions applied or cancelled? If yes, provide details.	
Proposed Services and Location	
What communities and locations does your organisation intend to provide community pharmacy services to?	
Does your organisation intend to provide all PHARMAC Schedule non-section H medications to patients if requested and required - including high cost medications? Note: exemptions may apply as directed by Lakes DHB or PHARMAC.	
Specify the date your organisation proposes to commence provision of community pharmacy services within the Lakes DHB catchment area.	
Provide the names of other community pharmacy service providers that are currently operating within the area that you intend to provide services	
Provide information on co-located and nearby services and facilities relating to: • better population health outcomes, such as healthy eating, healthy exercise, social inclusion, etc. • alcohol, tobacco sales gambling facilities, or other services that oppose better population health outcomes.	
Provide information on how, in the context of co-located and nearby services, your organisation will increase positive health outcomes, and minimize and mitigate negative health outcomes.	

Lakes DHB Community Pharmacy Quality Standards Provide information about how the organisation will meet the Community Pharmacy Quality Standards: (Found in the Lakes DHB Community Pharmacy Commissioning Policy)	
Person Centred Care To ensure that the right services are in the right place at the right time	
Describe the population(s) your organisation is intending to service. Outline unmet needs your organisation has identified or improvements/innovations your services could make for patients.	
Describe how your organisation will provide person-centred care as per the Lakes DHB Pharmacy Quality Standards.	
Provide a simple plan of your organisation's facility describing the purpose of each area in relation to the services identified above. The plan should identify a private consulting area, and how this is accessed, where service-related conversations cannot be overheard by other clients in the pharmacy.	
What are your organisation's proposed operating hours?	
Service Delivery To provide users with a pharmacy home that has the ability to support all their medicines/pharmacy-related needs	
Describe your organisation's service philosophy.	
List the services that your organisation intends to provide to meet the needs of the population you intend to serve.	
Will your pharmacy participate in local/national health promotion initiatives and/or other pharmacy initiatives?	

Capacity and Capability To ensure the pharmacy has the capacity to take ownership of medicines-related outcomes and the capability to deliver high quality professional services as part of a multidisciplinary programme of care	
Outline the proposed IT setup and intended approach to ensuring communication with key providers in the primary care team.	
How many pharmacists, interns, technicians does your organisation propose to employ based on your business plan? Include staffing ratios and qualifications.	
Describe the credentials of the pharmacist who will be responsible for day to day delivery of professional services (Include years since graduation, previous experience managing a pharmacy, hours of attendance at the pharmacy). Are any conditions attached to the responsible pharmacist's APC?	
Provide a summary or attach a copy of your organisation's quality plan.	
Collaboration To ensure users receive a high quality professional service as part of a multidisciplinary programme of care	
Describe any collaboration you have had in previous community pharmacies (or that you have now) which you may have owned/managed and what engagement you have already had with primary care providers, PHOs or other community providers in the area.	
Describe how your organisation plans to use technology/online services to support integrated care.	

Pharmacy Standards Describe how you intend to ensure compliance with the Pharmacy Standards: NZS 8134.7:2010 (as updated or amended from time to time):	
'Consumer Rights' *Pages 15-23 of Pharmacy Standards: NZS 8134.7:2010*	
'Organisational Management' *Pages 25-33 of Pharmacy Standards: NZS 8134.7:2010*	
'Continuum of Service Delivery' *Pages 33 to 43 of Pharmacy Standards: NZS 8134.7:2010* *Please insert relevant Standard Operating Procedures (SOPs)*	
'Safe and Appropriate Environment' *Pages 45 to 49 of Pharmacy Standards: NZS 8134.7:2010* *Please insert relevant SOPs*	
'Dispensing, Compounding, Repackaging and Batch Preparation' *Pages 51 to 95 of Pharmacy Standards: NZS 8134.7:2010* *Please insert relevant SOPs*	
'Aseptic Dispensing of Sterile Products in Community Pharmacies' *Pages 97 to 107 of Pharmacy Standards: NZS 8134.7:2010* *Please insert relevant SOPs*	

Referees

List two referees that we can contact to discuss your application. Family members of governance group members, management staff or other staff members will not be accepted as Referees. Similarly, family members of the spouses of such individuals will not be accepted as Referees.

Provide two referees that Lakes DHB can contact to discuss your application and suitability to provide community pharmacy services.	Name	Occupation	Contact Details (Phone and Email)	Relationship to Referee:

Agreements and Acknowledgements

By signing below, the signatory represents that he/she:

- ✓ has reviewed the responses provided to each question in this Application Form and is satisfied that the information is true and correct;
- ✓ has satisfied himself/herself as to the correctness and sufficiency of their proposals;
- ✓ understand and accepts that he/she is responsible for the accuracy of the information in this application;
- ✓ understands that if any information provided in this proposal is found to be false, either prior to or after entering a service agreement, this will be grounds for Lakes DHB to remove the provider from the application process or cancel the agreement;
- ✓ has read and understood all referenced documents;
- ✓ has read and understood the terms and conditions listed in this Application Form and referenced documents;
- ✓ accepts and agrees to the terms and conditions listed in this Application Form and referenced documents;
- ✓ is duly authorised to make this application;
- ✓ can confirm that the organisation's constitutional documents allow the organisation to make this offer and enter into an agreement with Lakes DHB to provide community pharmacy services;
- ✓ understands that Lakes DHB approval of this application does not necessarily mean that a License to Operate a Pharmacy will be granted by the Licensing Authority;
- ✓ understands that Lakes DHB approval of this application in no way indicates that Lakes DHB considers the pharmacy will be commercially viable or successful;
- ✓ understands that a formal written Integrated Community Pharmacy Services Agreement must be executed by authorised signatories of Lakes DHB and your organisation before your organisation is permitted to provide community pharmacy services for Lakes DHB and receive payments under the terms of that Agreement;
- ✓ understands that Lakes DHB does not generally make payments against draft Agreements; and
- ✓ understands that while Lakes DHB will endeavour to process your application in a timely manner, Lakes DHB makes no commitment to approve this application in time for your proposed pharmacy opening date (indicated above).

Consent for Lakes DHB enquiries:

- The organisation submitting this proposal gives permission for Lakes DHB to make any enquiries or request from any person any information (including personal information about anyone who might have a role in providing the service) which may have a bearing on its/their ability to provide the service proposed. This includes persons not specifically listed as referees in the Application Form.

Confidentiality of Information:

- The information contained in this application will be treated as strictly confidential by the DHB, its agents and its advisors. The DHB will not, except as required by law, or for the purposes of obtaining references, disclose any of the information provided in your application to any other person without your prior written consent. The DHB may, however, disclose the fact that your organisation submitted an application for a Community Pharmacy Services Agreement AND may disclose all or part of the information provided, in response to a request under the Official Information Act 1982 without reference to you.

Signed on behalf of the organisation submitting this proposal

Name	Signature*	Position	Date

Declaration of Conflicts of Interest

Applicants must disclose in writing to Lakes DHB, any interests which they are aware of, or become aware of, that could conflict with the submission of this application for an Integrated Community Pharmacy Services Agreement. Interests that must be disclosed include (but are not limited to) the following:

- You, or a senior member of your organisation, is or has recently been employed by Lakes DHB;
- You, or a senior member of your organisation, has an immediate family member or relative employed by Lakes DHB;
- You, or a senior member of your organisation, currently sits on the Lakes DHB Board or a Lakes DHB Advisory Board;
- You, a senior member of your organisation or your organisation has given gifts, donations or sponsorship to Lakes DHB or a particular Lakes DHB employee; or
- Your organisation is currently providing consultancy or advisory services to Lakes DHB or is otherwise directly associated in any way with Lakes DHB.

Appropriate management of conflicts of interest varies depending on the nature and type of conflict involved. Serious conflicts of interest may result in Lakes DHB refusing to consider an application from an organisation.

Name:		Organisation:	
Services:	Community Pharmacy Services	Date:	
I have interests to declare for the purpose of this request for proposal:		☐ Yes ☐ No	(If Yes, please declare interests below)

Individual / Organisation	Description of Interest

I have read and understood the above Conflict of Interest information. I confirm that at the date of signing this form, that the information I have disclosed is true and complete. I agree to declare any conflicts of interest that may arise in relation to this service during the request for proposal process.

Name (printed)	Signature*	Position	Date

Please return your completed application to: : planning.funding@lakesdhb.govt.nz

Lakes DHB's preferred means of return is via email, with all information contained in this document. All other formats take longer to assess and won't leave you with an approved application for future assessments.

* Where signatures are required, please insert a digital signature. If you prefer you can scan and submit these two pages.