Community Pharmacy Application Form

Application guidelines

Northland 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 Northland DHB must be made on this Application Form, and be submitted to: [communitypharmacy@northlanddhb.org.nz](mailto:communitypharmacy@northlanddhb.org.nz). Receipt of the application will be acknowledged by email by within five working days. Northland 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 Northland 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. Where supplementary information is provided, ensure that clear cross-referencing between the Application Form and supplementary material is provided. Northland 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
* [Strategic Vision for Community Pharmacies and Pharmacists In Northland: 2019-2026](https://www.northlanddhb.org.nz/assets/Communications/Publications/WEB-Strategic-Vision-for-Community-Pharmacy-and-Pharmacist-Services-in-Northland-2019-2026.pdf), and the [Community Pharmacy Contracting Policy](https://www.northlanddhb.org.nz/home/community-pharmacy-contracting-policy/).
* [Integrated Community Pharmacy Services Agreement](https://tas.health.nz/dhb-programmes-and-contracts/community-pharmacy-programme/icpsa/) as updated/amended from time to time.
* [Medicines Act 1981](http://www.legislation.govt.nz/act/public/1981/0118/latest/DLM53790.html) and [Medicines Regulations 1984](http://www.legislation.govt.nz/regulation/public/1984/0143/latest/DLM96863.html).
* 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 Northland DHB will use to determine whether to commence contract negotiations. Where Northland DHB chooses to commence negotiations, it will not be bound in any way until the execution of a written agreement.

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

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

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

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

Northland 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

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| 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: |  |

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| Philosophy | |
| Describe the organisation’s philosophy with regard to community pharmacy services. |  |
| Explain how the proposed services will meet the relevant national and local strategic priorities for pharmacy services. |  |
| Provide details about how the applicant will contribute to providing best practice advice and services so that the people of Northland achieve better and more equitable health outcomes. |  |

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| Organisation experience | |
| Provide information about the governance and management structure of the 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 staffing ratios and qualifications, and 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. |  |
| Provide all applicants’ Annual Practicing Certificate/s (APC) (including any conditions), police check and good character information.  Provide details of any conditions imposed on an APC, or if an APC has ever been cancelled. |  |
| Has the applicant had a Ministry of Health licence have conditions applied or cancelled?  If yes, provide details. |  |

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| Proposed Services and Location | |
| What communities and locations does your organisation intend to provide community pharmacy services to? |  |
| What community pharmacy services does your organisation intend to provide? |  |
| Do you 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 Northland DHB or PHARMAC. |  |
| Set out your organisation’s proposed operating hours (days and times). |  |
| Specify the date you propose to commence provision of community pharmacy services within the Northland DHB catchment area. |  |
| How will you consider the aspirations of Māori, and meet the needs of Māori in relation to the delivery of service? |  |
| Describe the needs (including unmet needs) of the Service Users who are likely to access your services. |  |
| Describe how your organisation’s proposed approach to service delivery will meet the needs of Service Users who are likely to access your services (having regard to the specific needs of the population residing within the area you intend to operate in).  Describe any unmet needs that you consider your organisation will be able to meet and how your organisation proposes to meet them. |  |
| Provide the names of other community pharmacy service providers that are currently operating within the area that you intend to provide services |  |
| Provided 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, the organisation will increase positive health outcomes; and minimize and mitigate negative health outcomes. |  |

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| Monitoring and Quality | |
| Have you prepared all quality plans/documents required by the Integrated Community Pharmacy Services Agreement? (Yes/No) |  |
| Provide evidence of systems and processes for continuous quality improvement (including Quality Improvement Plan, and how you will bring the perspective of Māori to the provision of services). |  |
| Provide information about how the organisation will meet the Community Pharmacy Quality Standards:  (Found in the [Community Pharmacy Contracting Policy](https://www.northlanddhb.org.nz/home/community-pharmacy-contracting-policy/)) | |
| *Access to the right services in the right place at the right time* |  |
| *Services that target addressing inequities* |  |
| *An environment that is inviting with good access regardless of my level of mobility, or cognitive or other abilities* |  |
| *To have a pharmacy close to home where I have a good relationship and where all my medicines and pharmacy-related needs can be met* |  |
| *Access to pharmacy services regardless of where I live* |  |
| *A pharmacy that provides expertise and leadership in medicines/pharmacy related services* |  |
| *To know that I am getting current, evidence based expert advice on pharmacy and medicine related services* |  |
| *To receive a high quality professional service as part of a multidisciplinary programme of care* |  |
| *Access to my medication list online that is current* |  |
| *A safe and efficient system for prescriptions and dispensing* |  |
| 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* |  |

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| Integration | |
| Provide the names of primary health care providers that are currently operating within the area that you intend to provide services and indicate how you will develop relationships with those providers. |  |
| Provide the names of the Age Related Residential Care (ARRC) facilities that are currently operating within the area that you intend to provide services and indicate how you will develop relationships with those providers. |  |
| Provide evidence of support from primary health care providers in the proposed location. |  |

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| 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 Northland DHB can contact to discuss your application and suitability to provide community pharmacy services. | Name | Occupation | Contact Details (Phone and Email) | Relationship to Referee: |
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| 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 Northland 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 Northland DHB to provide community pharmacy services; * understands that Northland 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 Northland DHB approval of this application in no way indicates that Northland 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 Northland DHB and your organisation before your organisation is permitted to provide community pharmacy services for Northland DHB and receive payments under the terms of that Agreement; * understands that Northland DHB does not generally make payments against draft Agreements; * understands that while Northland DHB will endeavour to process your application in a timely manner, Northland DHB makes no commitment to approve this application in time for your proposed pharmacy opening date (indicated above).   Consent for Northland DHB enquiries:   * The organisation submitting this proposal give permission for Northland 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 |
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| Declaration of Conflicts of Interest | | | | | | |
| Applicants must disclose in writing to Northland 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 Northland DHB; * You, or a senior member of your organisation, has an immediate family member or relative employed by Northland DHB; * You, or a senior member of your organisation, currently sits on the Northland DHB Board or a Northland DHB Advisory Board; * You, a senior member of your organisation or your organisation has given gifts, donations or sponsorship to Northland DHB or a particular Northland DHB employee; or * Your organisation is currently providing consultancy or advisory services to Northland DHB or is otherwise directly associated in any way with Northland DHB.   Appropriate management of conflicts of interest varies depending on the nature and type of conflict involved. Serious conflicts of interest may result in Northland 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: | | |  | | (If Yes, please declare interests below) | |
| Individual / Organisation | | Description of Interest | | | | |
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| 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 |
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**Please return your completed application to:** [communitypharmacy@northlanddhb.org.nz](mailto:communitypharmacy@northlanddhb.org.nz)

Northland 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 submit these two pages as scans.