Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

# Service Level Agreement for an enhanced service

## Independent Prescribing for Acute Conditions Service: Experiential learning and clinical links.

This SLA is to be submitted to the Local Health Board (LHB) by a pharmacy or contractor wishing to provide the above Enhanced Service

Agreement Period:

The agreement will commence on 1st April 2022, or the date on which this agreement is authorised by the relevant Local Health Board, where this is after the above date.

The agreement will continue unless terminated by one or both parties. The agreement may be terminated without penalty if either party gives the other party three months' notice in writing.

Pharmacy details

| | |
|---|---|
| Name of pharmacy contractor | |
| Correspondence address | |
| Postcode | |
| Branch e-mail address<br>(this should not be person specific, and should be accessible to pharmacy staff) | |
| Proposed pattern of sessions<br>(full or half days, days of week, number of weeks) | |
| Pharmacy Prescribing Service Unit number | |
| Pharmacy address | |

Declaration on behalf of the contractor:

I / We agree to participate in the Pharmacy Enhanced Service described above, under the Pharmaceutical Services (Advanced and Enhanced Services) (Wales) Directions 2005 (Amended) Part 4 (1) for the specified agreement period and in accordance with the service specification.

I / We confirm that the pharmacy contractor has an acceptable system of clinical governance and is compliant with their obligations under Schedule 2 to the Pharmaceutical Services Regulations to provide pharmaceutical essential services

I / We confirm that the pharmacy contractor will comply with any relevant service specification relating to the provision of this Enhanced Service

I / We confirm that I / We shall notify the Medical Director of the relevant LHB of any significant adverse incident that arises due to, or related to, provision of this Enhanced Service

I / we declare to the best of my/our belief that the information on this form is correct and request that the contractor named herein be included in the list of contractors who may provide this Enhanced Service.

| **Signed for and on behalf of the contractor** | |
|---|---|
| Signature: | Date: |
| Name: | |
| Position: | |

**Please submit this form to BCU Community Pharmacy Team at:**

BCU.communitypharamcy@wales.nhs.uk

Agreement on behalf of the Local Health Board

| **Signed for and on behalf of the Local Health Board** | |
|---|---|
| Authorised: YES ☐ NO ☐ | Reason if not authorised: |
| Signature: | Date: |
| Name: | |
| Position: | |