Appendix 1

SERVICE SPECIFICATION FOR THE COMMUNITY PHARMACY LOCALLY COMMISSIONED SERVICE FOR EMERGENCY PALLIATIVE CARE DRUGS

Palliative Care Drug Stock

In order that staff working in the community can always have access to essential Palliative Care drugs the following list of items should be stocked in their respective minimum stock quantities:

Drug Name	Strength	Minimum Quantity to be kept
Cyclizine Injection	50mg/ml	5 x 1ml
Dexamethasone Injection	4mg/1ml	10 x 1ml
Diamorphine Injection	10mg	1 x 5 amps
Diamorphine Injection	30mg	3 x 5 amps
Diamorphine Injection	100mg	1 x 5 amps
Glycopyrronium Injection	200mcg/ml	10 x 1ml
Haloperidol Injection	5mg/ml	5 x 1ml
Hyoscine Butylbromide Injection	20mg/ml	10 x 1ml
Levomepromazine Injection	25mg/ml	10 x 1ml
Metoclopramide Injection	10mg/2ml	10 x 2ml
Midazolam Injection	10mg/2ml	10 x 2ml
Morphine Sulphate Injection	10mg	1 x 5 amps
Morphine Sulphate Injection	30mg	5 x 5 amps
Morphine Sulphate Solution	10mg/5ml	2 x 100ml
Water for Injection	BP	10 x10ml

Current Drug Tariff and Mims prices represent the total acquisition costs.

** Based on mims March 2008 prices (Hypnovel, Robinul)*

Appendix 2

SERVICE SPECIFICATION FOR THE COMMUNITY PHARMACY LOCALLY COMMISSIONED SERVICE FOR EMERGENCY PALLIATIVE CARE DRUGS

Annual expression of interest in providing this service.

Please complete this form to express an interest in continuing to provide this service

Name of Pharmacy:	……
Address: **Postcode:**	…… …… …… ……

Annual Payment	**£200**

Printed name of Contractor OR on behalf of the Contractor (Pharmacist in charge):

……

Signature: …….. **Date**:…….

Please complete this claim form and return it to Jaclyn Foster at the address below

CWS CCG
1 The Causeway
Goring by Sea
, Goring-by-Sea, Worthing, West
Sussex BN12 6BT

Appendix 3 SERVICE SPECIFICATION FOR THE COMMUNITY PHARMACY LOCALLY COMMISSIONED SERVICE FOR EMERGENCY PALLIATIVE CARE DRUGS

Monthly Stock Check Form – FOR IN-HOUSE USE ONLY

Drug Name	Strength	Quantity	Month/Yr _____	Month/Yr _____	Month/Yr _____	Month/Yr _____	Month/Yr _____	Month/Yr _____
Cyclizine Injection	50mg/ml	5 x 1ml						
Dexamethasone Injection	4mg/1ml	10 x 1ml						
Diamorphine Injection	10mg	1 x 5 amps						
Diamorphine Injection	30mg	3 x 5 amps						
Diamorphine Injection	100mg	1 x 5 amps						
Glycopyrronium Injection	200mcg/ml	10 x 1ml						
Haloperidol Injection	5mg/ml	5 x 1ml						
Hyoscine Butylbromide Injection	20mg/ml	10 x 1ml						
Levomepromazine Injection	25mg/ml	10 x 1ml						
Metoclopramide Injection	10mg/2ml	10 x 2ml						
Midazolam Injection	10mg/2ml	10 x 2ml						
Morphine Sulphate Injection	10mg	1 x 5 amps						
Morphine Sulphate Injection	30mg	5 x 5 amps						
Morphine Sulphate Solution	10mg/5ml	2 x 100ml						
Water for Injection	BP	10 x10ml						

Please use this form at least once a month to check that items are in stock and in date. Any missing items will have been dispensed and should be ordered immediately.

INCIDENT MONITORING FORM

Please note, this is a generic form designed for a variety of incidents and it may not always exactly fit the incident you wish to describe. If this is the case, please complete the sections where you can and include a separate sheet detailing the incident.

FORM completed by*: ……

Date: ……..

Name of Pharmacy*: ……..

NATURE OF THE INCIDENT:

Continue on extra sheet if required…

WHO WAS INVOLVED e.g. client and pharmacist (can be anonymous)

DETAILS OF INCIDENT:
(Please continue on an extra sheet if required and attach to this form)

……

……

……

* This is optional, but would be useful in order to follow-up for more details / feedback

Please return to Coastal West Sussex Quality Team

CWS CCG
1 The Causeway
Goring by Sea
, Goring-by-Sea, Worthing, West Sussex BN12 6BT

Appendix 5

SERVICE SPECIFICATION FOR THE COMMUNITY PHARMACY LOCALLY COMMISSIONED SERVICE FOR EMERGENCY PALLIATIVE CARE DRUGS

Change of Pharmacist-In-Charge Notification

Name of Pharmacist-In-Charge that is leaving or has left: ……..

Date Leaving: ……..

Name of Pharmacy: ……..

Address of Pharmacy: ……..

Signed by Pharmacist-In-Charge: ……..

Date: ……..

Will there be a new Pharmacist-In-Charge who is willing to take responsibility for this Enhanced Service? **YES / NO**

Name of new Pharmacist-In-Charge: ……

Date of when new Pharmacist-In-Charge is due to start: ……

Please return to the Coastal West Sussex Primary Care Development Team

CWS CCG
1 The Causeway
Goring by Sea
, Goring-by-Sea, Worthing, West Sussex BN12 6BT