



Primary and Community Care Pharmacy
Network



London, Eastern and South East
Specialist Pharmacy Services

Pharmacy support for Community Health Services (CHS)-a toolkit

This toolkit has been written

- To give commissioners a broad understanding of the pharmaceutical support needed by the organisations/teams delivering community health services (CHS).
- To describe the pharmaceutical activities and competencies needed to ensure that services meet health care standards so that commissioners can build these into specifications when commissioning/contracting services for their population
- To give practical help to commissioners and service providers e.g. a proforma to help them develop contract/SLAs/service specs
- To look at organisational options to enable providers to access competent pharmacy support appropriately

What do we mean by community health services?

- Services generally delivered outside GP practices and secondary care by community nurses, therapists etc working from/in community clinics, community hospitals and other PCT sites.
- Services that reach across the PCT population such as childhood immunisation, district nursing, school health, podiatry, sexual health services etc
- Services that help people back into their own homes from hospital, support carers and prevent unnecessary admissions e.g. intermediate care, respite, rehabilitation, end of life care etc for care groups such as older people and those with learning disability
- Specialist services & practitioners e.g. TB clinics, community dental services, tissue viability specialist nurses etc
- Services that interface with social care

Who needs to read this?

- Commissioners of CHS in PCTs and practice based commissioning groups (PBC)
- PCT pharmacists involved with commissioning
- PCT staff responsible for service redesign and the development of care pathways.
- PCT staff responsible for contracting and service level agreements
- Pharmacists responsible for the provision of support to CHS
- Providers of CHS

Why do you need to read it?

Medicines are the most common intervention for the treatment of illness and for prevention of infectious disease i.e. immunisations. The use of medicines is associated with risk and it is estimated that approximately 10-20% of all adverse events relate to medicines. A study of 1014 admissions in two London teaching hospitals found that 10% of patients experienced an adverse event, of which half were preventable, adding a mean 8.5 days in hospital with additional costs of £290,000¹. In addition the percentage of admissions that relates to medicines has been estimated as 5-17%².

Medication errors are consistently reported to account for between 10 and 20% of all adverse events. It follows that the direct cost of medication errors in NHS hospitals may be £200-400 million per year. There are additional unknown costs of errors in primary and community care and indirect costs arising from litigation. The potential savings from reducing serious medication errors are therefore substantial.¹

Competent pharmacy support for CHS is needed to optimise the management of medicines for the benefit of patients and minimise associated risks wherever medicines are used. Organisations will be measured by the Healthcare Commission against Standard C4 -'Health care organisations keep patients, staff and visitors safe by having systems to ensure that: d) medicines are handled safely and securely'.

Better support for patients with long term conditions and prevention of unnecessary admissions is dependent on effective primary and community health care and good medicines management is a critical factor for success.

In England, the White Paper 'Our health, our care, our say' will mean more care being delivered 'outside hospital' in the community i.e. closer to patients and 'Commissioning a Patient Led NHS' is likely to result in a broader range of service providers e.g. private & voluntary sector. Commissioning and service specifications will need to ensure robust pharmaceutical support for medicines management including safe systems of work and education & training of the health & social care professionals involved. This support needs to be integrated within service redesign and the development of care pathways.

What do you need to do next?

Medicines are very likely to be a part of the care pathway for most clinical services. Medicines need to be considered and included in all service specifications you commission, contract, redesign, develop or provide. The systems that support medicines management should be consistent for all services.

Background

Primary Care Trusts (PCTs) have, to date, combined their roles as commissioners and providers of primary and community care to their population. Commissioning a Patient Led NHS may mean that some provider services will not continue to be managed by PCTs.

The recipients of CHS are often among the most vulnerable members of the community e.g. older people, children and people with long-term conditions. Patients are entitled to services that are appropriate to their needs, safe, of high quality and operating within a legal and clinical governance framework.

As the most common therapeutic intervention medicines are 'everyone's business' in the NHS. The increasing complexities of treatment regimens, adverse effects, inappropriate use, compliance difficulties and interactions between medicines can all be potential risks for patients.

It is imperative that health care professionals delivering CHS, have access to professional support from pharmacists with specialist CHS competencies to ensure that the prescription, supply, administration, storage, handling, transportation and disposal of medicines takes place within a safe structure that complies with best practice and legislation.

CHS Pharmacy

CHS Pharmacy (CHSP) is a specialism within pharmacy, developed over the last 20 years. As well as around 200 specialist CHS pharmacists in England, many pharmacy staff e.g. prescribing advisors working in PCTs, incorporate elements of this work in their roles.

The competencies of CHS pharmacists and technicians are complementary to those in the NPC Primary care competency framework³. However, the knowledge base and experience of CHS pharmacy staff relates more to support for whole services, multidisciplinary teams, community health staff & social care and is described in detail in Primary & Community Care Pharmacy Network (PCCPN) competency framework⁴.

The role of a CHS pharmacist can be summarised as reducing the risks associated with the use of medicines in CHS by;

- Applying understanding of the legal framework for medicines to systems for safe handling by other health & social care professionals e.g. developing and implementing policies, standard operating procedures, Patient Group Directions, etc.
- Using understanding of how other health & social care professionals work in relation to medicines to identify their training needs and provide training as needed
- Applying understanding of issues that can arise for patients at interfaces of care to resolve problems and develop safe systems e.g. at admission to intermediate care
- Applying clinical skills to optimise the use of medicines e.g. prescription monitoring in community hospitals, support for community matrons
- Using knowledge and experience of public health to contribute to e.g. the childhood immunisation programme in the PCT
- Applying management skills and experience to the development and monitoring of service level agreements/contracts where aspects of the pharmacy support for CHS are provided by other agencies
- Actively contributing to the PCT's clinical governance agenda

A day in the life of a community health services pharmacist

Attends a meeting of the PCT Immunisation group and agrees to provide a training session for practice nurses, health visitors and school nurses on the safe handling of vaccines including the 'cold chain'.
Answers a query from a community matron re confusion about discharge medication and communicates with the PCT medicines review pharmacist to investigate further.
Writes the pharmaceutical content of a Patient Group Direction (PGD) for an antibiotic for the local Walk in Centre and arranges a meeting with a microbiologist from the local acute trust to discuss the choice of antibiotic and get the PGD approved.
Carries out a clinical pharmacy review of the prescriptions on an intermediate care ward. Investigates a supply issue and identifies the need for revision of the nursing policy for ordering & receipt of medicines. Contacts the pharmacy department in the hospital trust who supply within a service level agreement to resolve the immediate problem.
Works on an option appraisal for a pharmacy service to the local young offenders institute.
Works with a multidisciplinary group to develop an audit of use of medication compliance aids to help address an issue highlighted in the PCT's risk register

Some CHSP staff are integrated within PCT pharmacy teams, but much of this input is provided within service level agreements (SLAs) with acute and mental health trusts, and this complicating factor needs to be considered when looking at options for the delivery of provider services in the future.

Although pharmacy input is crucial for the safe use and handling of medicines in PCT provider services, it is often under recognised, particularly by commissioners, as it may be costed as an overhead or infrastructure cost across the provider services and/or within SLAs.

Pharmaceutical support for community health and other PCT provider services varies widely with the level of resource inherited by PCTs from the former community trusts or NHS Trust providers. This resource ranges from dedicated specialist CHS pharmacy staff integrated within the prescribing/medicines management team of the PCT, to a minimal, mainly medicines supply-based service, contracted with a local acute trust. New resources have been identified in some PCTs to address identified risks e.g. the need for pharmaceutical advice and clinical input to community hospitals, and others have successfully integrated this work within their pharmacy teams. However in other PCTs there is no pharmacy resource to cover CHS and gaps remain. Audits across London, East of England, South Central and South Coast have identified risks associated with inadequate resources similar to those described below.

The clinical input to a community hospital provided by the local hospital trust within a SLA has not been reviewed/monitored and is inadequate to meet the faster throughput of patients and the move to intermediate care-resulting in antibiotic prescriptions not being reviewed, lack of pharmacy support for nursing staff and an increase in 'missed' doses.

The 'cold chain' is not adequately monitored and clinic staff are not supported with E&T-result can be that a fridge is found to have exceeded the recommended temperature over a considerable period and as the quality of vaccines cannot be assured, children may have to be recalled.

There is no resource to monitor appropriateness of stock medicines on PCT sites-result can be that there is overstocking, date expired medicines and use of medicines does not comply with best practice

Some outcomes of the pharmacy resource being insufficient or inappropriate to current needs are described in the Commission for Health Improvement report on Gosport War Memorial Hospital⁵.

Impact of Commissioning a Patient-Led NHS

The change in functions and geographical boundaries of PCTs in England and the disappearance of most small PCTs gives the opportunity to consider the optimal skill mix needed by the PCT & PBC Pharmacy Teams to meet the needs of their population, their core provider services and specialist teams/services.

Pharmaceutical input will be needed to inform the process by which new service providers are commissioned, e.g. service specifications and contracting. This will be key in relation to prescribing policies, drug costs, and standards for management of medicines by all staff delivering CHS. In addition service providers will need to demonstrate that they can meet the Healthcare Commission's core health standards in relation to medicines⁶.

The CHS pharmaceutical support required for provider services in the future will need to be identified across each of the new PCTs by examining the following parameters:

- Which CHS services use medicines and is the necessary pharmacy support & systems for this in place e.g. does it comply with the guidance in 'The Safe and Secure Handling of Medicines-a team approach'⁷.
- What is the likely configuration of these services in the future?
- How is pharmacy support currently commissioned and provided for example within a service level agreement or by a pharmacist with CHS competencies employed by the PCT (or a mixture of the two).
- What CHS pharmacy skills and competencies are likely to be needed to support the provider services within new management arrangements and/or when provided by alternative organizations and partnerships?
- Options for future delivery of CHS pharmacy support. Appendix B

Commissioners will need advice from a senior pharmacist who understands CHS when determining this parameter. The SLA framework in Appendix A will help with this process.

References

1. Building a safer NHS- improving medication safety
<http://www.dh.gov.uk/assetRoot/04/08/49/61/04084961.pdf>
2. NSF for Older People <http://www.dh.gov.uk/assetRoot/04/07/12/83/04071283.pdf>
3. NPC Primary care competency framework
http://www.npc.co.uk/publications/pctResp/pct_responsibilities.pdf
4. Primary & Community Care Pharmacy Network (PCCPN) competency framework
<http://www.pccpnetwork.org/publications.asp>
5. Commission for Health Improvement report on Gosport War Memorial Hospital
<http://www.healthcarecommission.org.uk/db/documents/04005353.pdf>
6. Healthcare Commission's core health standards in relation to medicines
<http://www.dh.gov.uk/assetRoot/04/08/66/66/04086666.pdf>
7. The Safe and Secure Handling of Medicines-a team approach.
<http://www.rpsgb.org.uk/pdfs/safsechandmeds.pdf#search='The%20Safe%20and%20Secure%20Handling%20of%20Medicinesa%20team%20approach%277.'>

Appendix A

What needs to be in a Service Level Agreement (SLA)-a basic framework

This tool has been developed to help Primary Care Organisations (PCOs) to draw up a workable SLA that is responsive to the needs of the PCO, deliverable by the service provider and reflects activity and costs.

The content also applies to service specifications and contracts and may be useful for Practice Based Commissioning groups that commission services needing pharmacy support.

Audits of pharmacy support for CHS (CHS) in Primary Care Trusts (PCTs) in London, Eastern and South East England have highlighted the need for such a framework. Many PCTs have an SLA with a local NHS Trust for e.g. pharmacy services to the PCTs community hospital/s and/or the supply service to community clinics. In some cases the entire support to CHS is via an SLA.

This tool identifies factors that appear to be critical to ensure clarity between the SLA partners and the consistent delivery of a quality service. These factors need to be embedded in any new arrangement for future provision of services driven by Commissioning a Patient Led NHS.

Features of the SLA	Explanation
1.Format	The pharmacy SLA may have to fit a format used by the organisation for other SLAs e.g. there may be standard statements re complaints, disputes between the partners, risk sharing etc
2.Signatories	Generally the lead pharmacist in the PCO and the Senior Pharmacy Manager of the provider NHS Trust or alternative provider are the signatories. The Finance Directors of both organisations need to be involved and aware of the costs at an early stage. There may be someone in Finance who leads on SLAs and s/he needs to be involved as appropriate e.g. an external contracts manager. The names and titles of the signatories and their contact details need to be included.
3.Summary of services provided	There needs to be a clear summary that can be understood by finance and management as well as pharmacy near or at the beginning of the document e.g. <ul style="list-style-type: none">• The overall aims of the service• Where the service will be provided from, by whom and where to • Summary of critical areas to be covered e.g. X Trust will provide a dispensing and clinical pharmacy service to Y and Z wards in the community hospital of the PCT

	<p>X Trust will provide pharmacy advice and contribute to clinical governance in relation to use of medicines in PCT provider services</p> <p>X Trust will provide a procurement and distribution service to the community clinics in the PCT</p> <p>X Trust will be responsible for recruiting and training the staff providing this service</p> <ul style="list-style-type: none"> • These services will conform to legal requirements and good practice • There must be mutual and clear understanding of all terminology used especially when tendering/contracting a service to a provider that does not have an NHS background. • The details of the service are best included in appendices.
4. Staff	<p>The responsibility of the provider as the employer needs to be stated to include</p> <ul style="list-style-type: none"> • Staffing requirement to deliver services including WTEs, minimum grade/s and knowledge, experience & competencies required. These need to be reflected in the job descriptions and person specifications. • Substantive or fixed term contract i.e. term of employment for dedicated staff may need to reflect the duration of the SLA • Education and training- where there is a service development in the PCT that requires additional specific training, there needs to be agreement re who pays • Liability for injury, indemnity etc • Cover arrangements for annual leave & sickness need to be agreed • Arrangements re vacancies need to be agreed • How objectives relating to the SLA will be set and monitored
5. Resources to support delivery of the service	<p>Provision of and responsibility for accommodation, transport, necessary equipment including access to a telephone and IT facilities, need to be stated.</p>
6. Responsibilities of the PCT	<p>Generally to inform the provider, with a reasonable period of notice, of service developments and any other changes that impact on the SLA.</p>
7. Communications	<p>There needs to be a statement re what needs to be communicated between the partners e.g. action re vacancies that can't be filled, service changes. Include right of access either way to briefing meetings etc</p> <p>The name of the main operational contact point/s and contact details needs to be stated in the SLA.</p>
8. Service Planning	<p>The elements of service within the SLA need to be integrated into the overall service plan of the pharmacy team in the PCO. This will ensure that changes in PCO service configuration, discontinuation of services, development of new services etc, are reflected in the SLA</p>
9. Objectives	<p>The service objectives need to be led by the commissioner of the service e.g. the PCT.</p>

10. Monitoring the SLA	<p>State the requirement and frequency of any two way meetings to monitor outcomes or developments.</p> <p>The frequency of monitoring reports required by the PCO, of the provider, needs to be stated in the SLA along with a description of what is expected to be in the report. Reports usually need to be fairly brief with an agreed data set of performance key indicators e.g. number of actual clinic audit visits against agreed standard. The PCO will need to have this data as evidence of meeting core health standards in it's declaration to the Healthcare Commission.</p> <p>The level of detail needs to be proportionate and it is in no- one's interest for it to be too onerous.</p> <p>The expected detail and frequency of financial reporting needs to be stated for value of issues, top 20 etc for pharmaceuticals used. There needs to be discussion with PCT service managers to establish what will be meaningful to them.</p> <p>There needs to be a statement about what happens if there is a variation in year e.g. the provider cannot deliver all of the activity or a new service is required by the PCT.</p>
11. Costing the SLA	<p>This can be complex but it is worthwhile to make the costing method and amounts contributing to the bottom line as transparent as possible.</p> <p><u>Staff</u> For dedicated staff, use the actual salary plus on-cost (pro-rata where necessary). Add additional costs as agreed e.g. cover for that post for AL. Around 2 weeks additional cover is sometimes added into the cost to allow for study leave and sickness etc.</p> <p>For other pharmacy services provided via the SLA it may be more appropriate to use activity to identify the proportion of costs for that section that would relate to the SLA e.g. for procurement, distribution and medicines information</p> <p>A cost for managing the SLA also needs to be negotiated.</p> <p><u>Non-pay costs</u> An appropriate proportion of costs such as computer hardware & maintenance, equipment, containers etc needs to be identified. Some elements of this may be costed by using activity to identify the proportion of costs relating to the SLA.</p>
12. Charging process	<p>Your finance dept should advise on the mechanism for this. This can be a problematic issue and needs to be clear to all concerned when the SLA is drawn up/reviewed. Often the monthly cost will appear as a debit in your budget statement and as income in the statement of the provider.</p> <p>State payment within x period or PCT norm.</p>
13. Termination	<p>This will generally be a standard process across SLAs commissioned by the PCT</p>
14. Review	<p>The review date needs to be stated.</p>
15. Annual uplift of costs	<p>This will generally be advised by Finance by a factor determined across the sector/patch</p>

Suggested format for the description of the service to be provided

Item	Explanation
Sites, services and units receiving the service	<p>Names of clinics and the services in the clinics e.g. community nursing, children's services, chiropody, family planning, dental etc (need to be aware that in some areas all services may be based in health centres with GPs)</p> <p>Names of community hospital sites, bed numbers and types of patients. Specialist services such as intermediate care teams, continence, tissue viability etc</p>
Details of staff involved with services in the SLA	<p>There should be specified posts for the lead functions e.g. CHS pharmacist and/or technician.</p> <p>Functions such as procurement, distribution and medicines information may also contribute a proportion of their staff time to the SLA. In some cases this will be small but it should appear in the SLA.</p> <p>A staffing structure is useful especially for a substantial SLA to clarify joint responsibilities and lines of communication.</p> <p>The provider chief pharmacist is normally responsible for deployment of appropriately trained staff to perform these services. There may need to be a shared responsibility for aspects of induction.</p> <p>There should be a statement about covering absences and who should be notified re any necessary change in service.</p>
Communication	<p>There should be stated contact point/s both via telephone and e-mail for PCT staff to access advice etc from 'SLA' pharmacy staff Relevant pharmacy contacts should be available e.g. in clinics, ward pharmacy information folders etc.</p>
Procurement	<p>e.g. Procurement of pharmaceuticals will be timely, at optimum cost to the commissioner and provide a range and quantity of products in line with usage and best practice.</p>
Distribution	<p>Frequency of supply of pharmaceuticals e.g. weekly.</p> <p>How stock will be provided e.g. against a pre-printed or nurse generated order.</p> <p>How items can be requested if needed outside of the usual stock supply day.</p> <p>Where copies of the current stock lists will be available for reference e.g. in the ward pharmacy folder.</p> <p>Frequency of review of stock lists and who will agree them</p> <p>Details of charging the PCT for stock and crediting for suitable returned items.</p> <p>Details of support for stock management e.g. technician stock top –up service to monitor stock rotation, volume & check expiry dates.</p>

Transport-arrangements	Needs may vary for different locations Times for collection and delivery of Pharmacy clinic/ward boxes, sealed bags. Arrangements for items required at weekends or urgently out of hours
Dispensing prescriptions- generally only relevant when the SLA includes services to community beds	Individual patient items will be supplied by the dispensary at X Trust in accordance with the pharmacy's dispensing procedure. Frequency of dispensing regular non-stock medication How the nursing staff should request additional items required between the pharmacist's visits e.g. by faxing the drug chart to pharmacy and phoning to confirm receipt of fax. Arrangements for dispensing discharge medication e.g. must be requested 48 hours in advance of the planned discharge time. The in-patient drug chart must accompany the discharge form when sent to pharmacy. The discharge form must be clearly annotated if a compliance aid is required. How much discharge medication will be supplied
Clinical Pharmacy Services -especially when the SLA includes services to community beds and/or intermediate care	Frequency of visits of pharmacist to wards/units. Quality statements e.g. <ul style="list-style-type: none"> • The Senior Pharmacist Clinical Services will ensure that the ward pharmacist is suitably trained and competent to provide a quality service in accordance with the X Trust pharmacy procedure. • All prescription charts will be clinically monitored for optimal therapy, dose, duration and form. Interventions will be made as necessary, verbally or in writing, to the appropriate doctor and/or nursing staff. • All significant interventions will be recorded within pharmacy records. • How interventions will be communicated to the prescriber/s • How written information re the pharmacy service will be available for nursing and other staff e.g. information folders re access to services and current policies. • Clarity re which meetings the Clinical Pharmacist needs to attend
Education and Training of PCT Staff	Contribution of pharmacy to induction training for nursing and other staff Contribution of pharmacy to specified clinical update sessions e.g. for immunisation training, therapeutic updates Distribution of bulletins, posters and guidelines
Medicines Information	Details re access to a dedicated medicines information department and opening hours
Clinical governance and legal aspects	There needs to be a clear lines of accountability between the SLA and the clinical governance structure of the PCT There needs to be clarification as to which policies and procedures the SLA pharmacy staff will work to. There needs to be clarification re the process for incident reporting-usually the SLA pharmacy staff will complete the PCT process when doing PCT work. There needs to be clarification re any info that the PCT's clinical governance requires and clear lines of accountability re the safe management of Controlled Dugs

Services outside of normal hours-generally only relevant when the SLA includes services to community beds	<p>Details re access to an on-call pharmacist or pharmacy service including what is provided e.g. information, advice and urgent medication.</p> <p>Details re access to Saturday, weekend and bank holiday arrangements including prescription transfer and transport.</p> <p>Details re access to e.g. an emergency drug cupboard and how contents are checked, replenished and reviewed.</p>
Service Standards-some of these will be general and some service specific	<p>The service will be prompt and reliable conforming to professional and legal requirements.</p> <p>Further examples include</p> <p>Frequency of review of e.g. stock lists</p> <p>Pharmacy audits e.g. of controlled drugs, stock levels and drug storage conditions.</p> <p>Frequency of accompanied visits by the Senior Pharmacist Clinical Services with the SLA pharmacist.</p> <p>Communication e.g. for supply problems, drug recalls etc</p> <p>Other audits that will be undertaken</p>
Health Promotion	e.g. that Patient Information Leaflets are available to all patients
Equipment & Materials	<p>There needs to be a statement re who provides stock boxes, transport bags and appropriate seals.</p> <p>Also monitoring equipment for the cold chain.</p> <p>Prescription charts</p>
Responsibilities of PCT staff	<p>Examples may include</p> <p>It is the responsibility of designated staff to store medication in an appropriate, tidy manner and ensure items are in-date before use.</p> <p>It is the responsibility of designated staff to unpack and check received items and report any discrepancies to the pharmacy distribution section</p>
Monitoring Arrangements	<p>There needs to be agreement on the service indicators that will be monitored by the PCT. These will be a range of activity and financial performance measures.</p> <p>Examples may include –</p> <p>Clinical pharmacy visits to PCT wards</p> <p>Audit visits to community clinics</p> <p>Number of recorded interventions</p> <p>Drug usage</p> <p>Complaints</p> <p>Financial information e.g. top - 30 drugs by expenditure per unit.</p>
Communications – any regular attendance at team meetings	State this explicitly e.g. attendance at monthly or quarterly team meetings
Service Developments	The review process needs to identify any PCT developments that could impact on the SLA so that the provider can calculate additional costs or a decrease in the SLA

Appendix B

What are the options for the future?

Any of these models could apply across a PCT or there could be a mix within a PCT

Arrangement for service provision	Possible benefits	Possible risks
PCTs continue to manage all provider services or specialised services and teams that serve an area larger than a PBC locality.	There is a degree of stability & continuity. Staff are aware of clinical governance structures, policies etc. Service developments can be safely supported by experienced staff where CHS pharmacy support is adequately resourced.	Less drive to re-engineer services CHS pharmacy support remains inadequately resourced.
Integrated working with social services.	Opportunity to capitalise on existing working relationships and knowledge of CHS pharmacy staff to support service developments. A more seamless service can be delivered eg medicines support on discharge from hospital to home. Joint training of care staff and HCAs.	Different cultures & priorities & time to develop true joint working may slow progress. Social services managers/staff may have difficulty in understanding the risks relating to health care.
PCT commissions alternative providers to manage CHS eg voluntary organisations, private sector, charities.	Potential for new ways of working & a flexible approach. Advisory CHS services could be retained within the PCT structure for economy of scale and be made available to new 'providers' to minimise risk.	The need for CHS pharmacy support may be overlooked in the commissioning process. There may be no input into the commissioning process by a pharmacist who understands the infrastructure issues. Small providers may lack the pharmacy skills needed for CHS. Resources will be needed to monitor the quality of service.
Some services are managed within PBC groups eg community nurses, HVs.	Integration into primary care Evidence of risk & waste minimisation may get strong support from GPs	Not clear how the infrastructure eg SOPs, E&T for staff to support these services would be managed. Commissioning at locality level may miss some of the 'big picture' and systems issues thereby increasing risk to patients.
PCT commissions CHS services from a local acute/MH Trust or a Community/Foundation Trust.	There is a common understanding of the NHS. There is a robust SLA that includes accountabilities, funding flows and is regularly monitored.	The service is not 'core' business for the Trust and may become low priority especially if there is pressure on resources. The SLA is 'weak' eg accountabilities and funding flows are unclear

References

1. Building a safer NHS- improving medication safety <http://www.dh.gov.uk/assetRoot/04/08/49/61/04084961.pdf>
2. NSF for Older People <http://www.dh.gov.uk/assetRoot/04/07/12/83/04071283.pdf>