

# Appendix C

## Community Pharmacy Questionnaire

# Community Pharmacy Questionnaire

Southend-on-Sea Borough Council is refreshing its Pharmaceutical Needs Assessment (PNA). This is a statutory requirement set out in the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 and amended in 2014. The same Regulations require NHS England to use the PNA to consider applications to provide pharmaceutical services under the market entry system. The aim of this refresh is to enable the Council to gain an up to date record of community pharmacy services within the area. The new PNA will inform the way the Council and its partners, ensure appropriate local pharmaceutical services are available to meet the needs of local people.

The Council has established a Steering Group to oversee the development of the new PNA. This group has broad membership from a range of stakeholders. Karen Samuel Smith, Business Development and Contractor Support Manager sits on this group representing the Essex Local Pharmaceutical Committee.

It is important that your views and any specific thoughts you have as to how we can improve local pharmaceutical services in Southend are taken into account. To this effect I would be grateful if you could complete a short online questionnaire. Your responses will enable us to gain a picture of current pharmaceutical provision and map potential future need within Southend. It should take no longer than 15 to 20 minutes to complete.

We are working to a very tight timeline. We would, therefore, be grateful if you could complete the questionnaire by **Monday 13 February 2017**.

If you have any questions, please do not hesitate to contact Vanessa Lane, who is project manager for the Southend PNA, on 07880 602088.

Yours sincerely



**James Williams**  
**Deputy Director of Public Health**

## 1. Premises Details

1.1 Contract Code (ODS Code)

1.2 Company Name (i.e. Legal Entity)

1.3 Trading Name (i.e. the name on the signage etc)

1.4 Address where the services are provided

1.5 Post code

1.6 Name of pharmacist we should contact with any queries

1.7 Email address

*(We will use this to communicate with you about the PNA, including for the formal consultation)*

1.8 Telephone number

1.9 Please confirm we may store the above details and use these to contact you  
Please select one option only.

Yes [ ]

No [ ]

## 2. Type of Contract

2.1 Pharmacy Access Scheme: Has your pharmacy been given funding under the Pharmacy Access Scheme?

Please select one option only.

Yes [ ]

Applied but waiting decision [ ]

No [ ]

2.2 Other Relevant Information: Please indicate if the contract was granted under the following "Exempt" category?

Please select one option only.

100 Hour Pharmacy [ ]

Not applicable [ ]

### 3. Pharmacy Opening Hours

#### 3.1 Total opening hours

Please state the full opening hours for your pharmacy (i.e. your core and supplementary hours) in this section

When recording lunch time please record times that the pharmacy is closed to the public or where a full pharmaceutical service is not available

*Please use 24 hour clock and a decimal place instead of a colon e.g. 08.00 or 18.00*

*If any of the options are not applicable, please put a zero in the box*

	Opening time	Closing time	Lunchtime close	Lunchtime open
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

#### 3.2 Core hours

Please state your core hours in this section

*Please use 24 hour clock and a decimal place instead of a colon e.g. 08.00 or 18.00*

*If any of the options are not applicable, please put a zero in the box*

	Opening time	Closing time	Lunchtime close	Lunchtime open
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

#### 3.3 Are you considering changing your supplementary hours between now and December 2017?

Please select one option only.

Yes [ ]

No [ ]

*If response is "No" then go to 4.1*

It would be helpful if you could provide details in the box below:

#### **4. Advanced Service Provision**

**4.1 Do you currently provide Medicines Use Reviews (MURs)?**

**Please select one option only.**

**Yes [ ]**

**No [ ]**

**Do you intend to continue to provide this service?**

**Do you intend to provide this service in the future?**

**4.2 Do you currently provide the New Medicine Service (NMS)?**

**Yes [ ]**

**No [ ]**

**Do you intend to continue to provide this service?**

**Do you intend to provide this service in the future?**

**4.3 Do you currently provide Appliance Use Reviews (AURs)?**

**Yes [ ]**

**No [ ]**

**Do you intend to continue to provide this service?**

**Do you intend to provide this service in the future?**

**4.4 Do you currently provide a Stoma Appliance Customisation Service (SACS)?**

**Yes [ ]**

**No [ ]**

**Do you intend to continue to provide this service?**

**Do you intend to provide this service in the future?**

#### 4.5 Do you currently provide Flu Vaccinations?

Yes [ ]

No [ ]

Do you intend to continue to provide this service?

Do you intend to provide this service in the future?

#### 4.6 Do you currently provide the NHS urgent medicine supply advanced service (NUMSAS)?

Yes [ ]

No [ ]

Do you intend to continue to provide this service?

Do you intend to provide this service in the future?

If you have answered no to any of the previous questions about the Advanced Service Provision, we would like to understand why and invite you to provide your reason(s) below.

The Advanced Service Provision Services listed were:

- Medicines Use Reviews (MURs)
- New Medicine Service (NMS)
- Appliance Use Reviews (AURs)
- Stoma Appliance Customisation Service (SACS)
- Flu Vaccination
- NHS Urgent Medicine Supply Advanced Service (NUMSAS)

*\*Please note that this information will be non-attributable and will be used for the purposes of planning and commissioning services*

## 5. Locally Commissioned Services

This section relates to:

*Locally commissioned public health services commissioned directly by Southend-on-Sea Borough Council (i.e. Stop Smoking, Supervised Consumption, Needle & Syringe Programme, Seasonal Influenza vaccine for Social Care Staff) or under a sub-contracted arrangement by South Essex Partnership University NHS Foundation (applies to Sexual Health only)*

### 5. Locally Commissioned Services - Stop Smoking Service

#### 5.1 Are you commissioned to provide a Stop Smoking Service?

*In order to answer "Yes", you must have signed an SLA with the relevant commissioner*

**Please select one option only.**

Yes [ ]

No [ ]

**Is there a willingness to continue OR to commence provision in the future?**

**Please select one option only.**

Yes [ ]

No [ ]

## 5. Locally Commissioned Services - Supervised Consumption

### 5.2 Are you commissioned to provide Supervised Consumption?

*In order to answer "Yes", you must have signed an SLA with the relevant commissioner*

**Please select one option only.**

Yes [ ]

No [ ]

**Is there a willingness to continue OR to commence provision in the future?**

**Please select one option only.**

Yes [ ]

No [ ]

**For pharmacies providing a service or willing to provide a service in the future, it would be helpful to understand what support you may require to deliver the service\***

*\*Please note that this information will be non-attributable and will be used for the purposes of planning and commissioning services*

**It would be helpful to understand why pharmacies may not wish to provide a given service. We invite you to provide your reason(s) below.**

## 5. Locally Commissioned Services - Needle & Syringe Programme

### 5.3 Are you commissioned to provide a Needle & Syringe Programme?

*In order to answer "Yes", you must have signed an SLA with the relevant commissioner*

**Please select one option only.**

Yes [ ]

No [ ]

**Is there a willingness to continue OR to commence provision in the future?**

**Please select one option only.**

Yes [ ]

No [ ]

**For pharmacies providing a service or willing to provide a service in the future, it would be helpful to understand what support you may require to deliver the service\***

*\*Please note that this information will be non-attributable and will be used for the purposes of planning and commissioning services*

It would be helpful to understand why pharmacies may not wish to provide a given service. We invite you to provide your reason(s) below.

## 5. Locally Commissioned Services - Sexual Health Services

### 5.4 Are you commissioned to provide Sexual Health Services (i.e. Emergency Hormonal Contraception, Chlamydia Screening and Treatment)?

*In order to answer "Yes", you must have signed an SLA with the relevant commissioner*

Please select one option only.

Yes [  ]

No [  ]

Are you willing to provide this service in the future?

Please select one option only.

Yes [  ]

No [  ]

For pharmacies providing a service or willing to provide a service in the future, it would be helpful to understand what support you may require to deliver the service\*

*\*Please note that this information will be non-attributable and will be used for the purposes of planning and commissioning services*

It would be helpful to understand why pharmacies may not wish to provide a given service. We invite you to provide your reason(s) below.

## 5. Locally Commissioned Services - Seasonal Influenza Vaccine for Care Home Staff & Domiciliary Care Workers

### 5.5 Are you commissioned to provide the Seasonal Influenza Vaccine for Care Home Staff & Domiciliary Care Workers?

*In order to answer "Yes", you must have signed an SLA with the relevant commissioner*

Please select one option only.

Yes [  ]

No [  ]

Is there a willingness to continue OR to commence provision in the future?

Please select one option only.

Yes [  ]

No [  ]



**For pharmacies providing a service or willing to provide a service in the future, it would be helpful to understand what support you may require to deliver the service\***

*\*Please note that this information will be non-attributable and will be used for the purposes of planning and commissioning services*

**It would be helpful to understand why pharmacies may not wish to provide a given service. We invite you to provide your reason(s) below.**

## **6. The Pharmacy as a Whole - Meeting the Needs of Those with Disabilities**

**Please provide details of arrangements which are in place to meet the needs of those with disabilities.**

### **6. The Pharmacy as a Whole - Meeting the Needs of Those with Disabilities**

#### **6.1 Can wheelchair users access all public areas and services within your premises?**

**Please select one option only.**

**Yes** [  ]

**No** [  ]

**If no, please describe below which areas or services are inaccessible:**

#### **6.2 Do you have facilities to aid those who are hearing impaired (e.g. hearing loop, signing etc)?**

**Please select one option only.**

**Yes** [  ]

**No** [  ]

#### **6.3 Do you have facilities to aid those who are visually impaired (e.g. Braille, large print labels etc)?**

**If yes, please indicate which facilities you have:**

**Please tick all that apply.**

**Hearing Loop** [  ]

**Signing** [  ]

**Other** [  ]

**Please specify**

**6.3 Do you have facilities to aid those who are visually impaired (e.g. Braille, large print labels etc)?**

**Please select one option only.**

**Yes** [  ]

**No** [  ]

**6.4 What support do you offer for those with cognitive impairment eg:**

- **People with dementia**
- **People with learning disabilities etc.?**

**If yes, please indicate which facilities you have:**

**Please tick all that apply.**

**Braille** [  ]

**Large print labels** [  ]

**Other** [  ]

**Please specify**

**6.4 What support do you offer for those with cognitive impairment eg:**

- **People with dementia**
- **People with learning disabilities etc.?**

**Please tick all that apply.**

**'Aide memoire' for their medicines** [  ]

**Monitored Dosage Systems** [  ]

**Easy to read information** [  ]

**Large print labels** [  ]

**Other** [  ]

**Please specify**

**6.5 Does your pharmacy offer a dementia friendly environment?**

**See [Appendix A](#) for information**

**Please select one option only.**

**Yes** [  ]

**No** [  ]

**Working towards this** [  ]

**Please give details**

**6.6 How many patient facing staff are trained "Dementia Friends"?**

(See [www.dementiafriends.org.uk](http://www.dementiafriends.org.uk) and the Quality Payments Scheme for Community Pharmacy 2017/18)

Number of patient facing staff:

Number of trained "Dementia Friends":

Percentage of patient facing staff trained:

**7. Languages spoken within the Pharmacy**

Please provide details of any languages, other than English, spoken by you or your staff to a level that you are able to respond to queries and provide information to patients:

**8. Consultation Area(s)**

Please provide details of your consultation area and its characteristics and facilities.

**8.1 Does your pharmacy have one or more private consultation areas?**

Please select one option only.

Yes - on site

Yes - off site

No - but planned in next 12 months

No - and no plans for one

**8.2 How many consultation areas does your pharmacy have?**

**8.3 Is/are the consultation area(s) a closed room?**

Please select one option only.

Yes

No

**8.4 Are you willing to provide consultations within a patient's home?**

Please select one option only.

Yes

No

## 8.5 Characteristics of the consultation area

Please indicate which features apply and select at least one response:

Please tick all that apply.

- Computer terminal [ ]
- PMR access [ ]
- Telephone [ ]
- Internet access [ ]
- nhs.net email [ ]
- An N3 connection [ ]
- Wheelchair access [ ]
- Hearing loop [ ]
- Sink with hot water [ ]
- Patient toilet facilities nearby [ ]
- Space for a chaperone [ ]
- Examination couch [ ]
- Panic button [ ]
- CCTV [ ]

## 9. Non-NHS Healthcare Related Services provided in your Pharmacy

Please provide an overview of services which you offer within your pharmacy, which are NOT commissioned by an external agency such as NHS England, Public Health, the CCG, Local Government etc.

Non-NHS services may include repeat prescription collection & delivery services; travel advice; "health checks" e.g. BP measurement etc.

*Please include the service title and a brief description of the service.*

Service	Description

## Final Thoughts or Comments

If you have any final thoughts or comments, which you think would be relevant to the Pharmaceutical Needs Assessment, please describe them in the box below e.g. taking into account opportunities based on the [Sustainability and Transformation Plan](#)

Thank you for your time in completing this questionnaire. The information provided will be used as part of a data validation exercise as well as informing the analysis and assessments for the PNA refresh.