



**Bolton Council**

**PHARMACEUTICAL  
NEEDS ASSESSMENT:  
APPENDIX 5**

**2014/15**

**PHARMACY CONTRACTOR SURVEY TEMPLATE**

**Bolton  
Council**



**Bolton LPC**

**NHS** Bolton

## Pharmaceutical Needs Assessment Pharmacy contractor Questionnaire (to be primarily used as an online version)

### Premises

**1 What is the name of your pharmacy?\***

[Pick from list including OCS code]

**2 Please give the name & contact details of the person completing this questionnaire, in case questions arise:**

Name .....

Job title .....

Email .....

Tel .....

**3 What are your pharmacy's core opening hours?\***

*This should add up to either 40 or 100 hours*

	Open from	To	Lunchtime close	Lunchtime reopen
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

**4 What are your pharmacy's total opening hours?\***

	Open from	To	Lunchtime close	Lunchtime reopen
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

**5 Is there a separate room within the pharmacy for consultations with patients and customers, meeting the criteria for Medicines Use Review?**

- Clearly signposted as a private consultation area within the pharmacy
- Conversations in the consultation room cannot be overheard when talking at normal speaking volumes by other patients and staff
- Seating is available for patients and staff within the room

Yes ➔ go to next question       No, planned within the next 12 months       No, not planned

**6 How many consultation rooms do you have?**

Rooms: .....

**7 For each of the following statements, please indicate if you have or have not or are planning to have in the consultation area?**

Repeat if there are multiple rooms/ areas

	Yes	No	Planned within the next 12 months
There is a sink within or near the room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is a computer connected to your PMR and with access to the internet within the room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Accessibility**

**8 Which of the following languages other than English do you offer customers access to?**

- |  |                                  |
|--|----------------------------------|
| <input type="checkbox"/> Arabic          | <input type="checkbox"/> Oromo   |
| <input type="checkbox"/> BSL             | <input type="checkbox"/> Polish  |
| <input type="checkbox"/> Czech           | <input type="checkbox"/> Slovak  |
| <input type="checkbox"/> Farsi (Persian) | <input type="checkbox"/> Somali  |
| <input type="checkbox"/> Gujarati        | <input type="checkbox"/> Swahili |
| <input type="checkbox"/> Hindi           | <input type="checkbox"/> Urdu    |
| <input type="checkbox"/> Hungarian       | <input type="checkbox"/> None    |
| <input type="checkbox"/> Other           |                                  |
- .....

**9 How do customers who use a wheelchair access the pharmacy?**

- Wheelchair users can access the pharmacy Independently with level access       No level access, wheelchair users alert staff to their needs e.g. using a bell

**10 Do you have a hearing loop available?**

Yes       No       Don't know

- 11 **Do you offer assistance for customers with visual impairment?**  
*E.g. do you print labels in large print, provide braille printing on packaging*
- Yes                                       No                                       Don't know

**Staff**

- 12 **How many pharmacists practice in the pharmacy in total?**  
*(Please include full time, part time, and regular locums)*

Number of people: .....

Number of Whole Time Equivalent (WTE) posts: .....

- 13 **How many Pharmacy Technicians are employed by the pharmacy?**

Number of people: .....

Number of Whole Time Equivalent (WTE) posts: .....

- 14 **How many Dispensing Assistants are employed by the pharmacy?**

Number of people: .....

Number of Whole Time Equivalent (WTE) posts: .....

- 15 **How many of the pharmacy's Dispensing Assistants have completed or are working towards an NVQ level 2 or equivalent?**

Already completed: ..... Working towards: .....

- 16 **How many of the pharmacy's Dispensing Assistants have completed or are working towards an NVQ level 3 or equivalent?**

Already completed: ..... Working towards: .....

- 17 **How many of the pharmacy's Dispensing Assistants have completed or are working towards an accuracy checking technician course?**

Already completed: ..... Working towards: .....

**Medicines and prescription services**

- 18 **Does your pharmacy provide prescription collection from GP practices?**

Yes ➔ go to question **Error!**     No ➔ go to question 19  
Reference source not found.

- 19 **Does your pharmacy provide medicines delivery service?**

Yes ➔ go to next question     No ➔ go to question 31

**20 Is it available just for a specific patient group?**

No  Yes ➔ If yes, which group? .....

**21 Do you manage repeat prescription requests for patients?**

No  Yes

**22 Is your pharmacy set up to receive EPS2 prescriptions?**

No  Yes

**23 Does your pharmacy provide medicines use reviews?**

No ➔ go to next question  Yes ➔ go to question 31

**24 Do you plan to start this service?**

No  Yes ➔ If yes, when? .....

**25 Does your pharmacy provide the New Medicines Service?**

No ➔ go to next question  Yes ➔ go to question 31

**26 Do you plan to start this service?**

No  Yes ➔ If yes, when? .....

**Other services**

**27 Does your pharmacy dispense Part IX appliances?**

No ➔ go to next question  Yes ➔ go to question 29

**28 Do you plan to start this service?**

No ➔ go to question 31  Yes ➔ If yes, when? .....

**29 Does your pharmacy provide Appliance Use Reviews?**

No ➔ go to next question  Yes ➔ go to question 31

**30 Do you plan to start this service?**

No  Yes ➔ If yes, when? .....

**31 Does your pharmacy provide any of the following services, if not, is your pharmacy willing to provide in the future?**

*(Please note willingness to provide a service does not mean it will be commissioned from a pharmacy; the decision to commission will be based on local need and affordability)*

\* = required question

	Yes	No but willing to provide	No and not willing to provide
Minor ailment scheme (Pharmacy First)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needle exchange scheme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Observed consumption scheme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicines Administration Record scheme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provision of EHC under PGD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia screening service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia treatment service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintenance of palliative care medicines scheme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stop smoking counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stop smoking counselling + NRT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stop smoking counselling + NRT + provision of varenicline/ bupropion under PGD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**32 Does your pharmacy provide any of the following services, and is a charge made?**

	Not offered	Yes free service	Yes chargeable service
EHC through OTC sales	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure measuring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glucose testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**To develop community pharmacy we need your views about the possible services that could be introduced or extended.**

**33 Which of the following services would you be willing to provide now, or in future?**

*The information you give us is confidential. It will be used in the development of our Pharmaceutical needs assessment. It will not be disclosed to anyone else.*

	Could do now & willing to do now	Could do & would be willing to do with further training	Could do & would be willing to do with changes to premises	Could do & would be willing to do with appropriate equipment	Would not want to do this	Not sure
Management and provision of gluten free products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency supply of prescription medicines scheme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* = required question

	Could do now & willing to do now	Could do & would be willing to do with further training	Could do & would be willing to do with changes to premises	Could do & would be willing to do with appropriate equipment	Would not want to do this	Not sure
Weight management service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol awareness service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's/ dementia medicines management service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicines assessment & compliance support service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Screening service:						
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. pylori	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HbA1C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please state)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal influenza vaccination service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular risk assessment service (NHS health check)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**34 Which would be your top 3 priorities?**

	Top priority	Second priority	Third priority
Management and provision of gluten free products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency supply of prescription medicines scheme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight management service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* = required question

	Top priority	Second priority	Third priority
Alcohol awareness service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's/ dementia medicines management service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicines assessment & compliance support service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Screening service:			
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. pylori	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HbA1C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please state)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal influenza vaccination service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular risk assessment service (NHS health check)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>