

The local Pharmaceutical Needs Assessment is being reviewed at the moment. This is a document that says what our need for pharmacies in Derbyshire and Derby is. The document is used to decide whether new pharmacies should be given permission to open.

The results from this questionnaire will feed into the review and will help us understand what local people need. The survey asks questions like:

- Are you able to get to the pharmacy of your choice?
- What services would you like to see available in your pharmacy?
- How satisfied are you with your pharmacy?

Please complete the questionnaire by **Monday 5th January 2014**

Your response will be treated as confidential. Our survey report will be written in a way that means that individual responses cannot be identified.

Please return your completed questionnaire to your line manager or if you prefer it can be returned by post to:

**Derbyshire County Council
BUSINESS REPLY SERVICE DY76
County Hall
Matlock
DE4 3AG**

*This is a freepost address.
No stamp is required.*

You can also complete this questionnaire on-line at:
www.derbyshire.gov.uk/pharmacyservices

INSTRUCTIONS

Each survey form is scanned electronically so it is important to complete your form in the following way:-

Write clearly using BLOCK CAPITALS like this

J O E B L O G G S

Use black or blue pen not pencil. Use a cross and please keep the mark in the box

like this

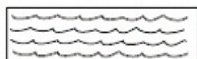


not like this

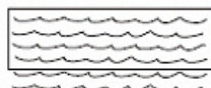


Ensure your comments are written inside the boxes provided, text outside the boxes will not be picked up when the forms are scanned,

like this



not like this



If you make a mistake, just cross it out and mark the right box like this



If the question or page is not applicable, please leave it BLANK

Please mark one box only for each question unless otherwise stated.



We will treat all information that you give in the strictest confidence.
Your identity will never be revealed.

Pharmacy services

Q1. Which of the following services do you use? (Please X one box only)

- | | |
|--|---|
| <input type="checkbox"/> A community pharmacy | <input type="checkbox"/> Other (Please X and specify) |
| <input type="checkbox"/> A dispensing appliance contractor | |
| <input type="checkbox"/> An internet/distance selling pharmacy | |

Q2. What methods do you use to communicate with your usual pharmacy?

(Please X all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Face to Face | <input type="checkbox"/> I don't usually communicate with my pharmacy |
| <input type="checkbox"/> Telephone | <input type="checkbox"/> Other (Please X and specify) |
| <input type="checkbox"/> Internet/Website | |
| <input type="checkbox"/> Email | |

Q3. How often would you say you use a pharmacy for health purposes?

(Please X one option only)

- | | |
|---|--|
| <input type="checkbox"/> More than once a week | <input type="checkbox"/> Once a month |
| <input type="checkbox"/> Once a week | <input type="checkbox"/> Once every couple of months |
| <input type="checkbox"/> Once every couple of weeks | <input type="checkbox"/> Less often |

Q4. Do you usually use the same pharmacy?

- | | | |
|---|---|---|
| <input type="checkbox"/> Yes (If 'Yes', go to Q5) | <input type="checkbox"/> No (If 'No', go to Q6) | <input type="checkbox"/> I don't use a pharmacy |
|---|---|---|

Q5. How long have you been using your usual pharmacy?

- | | | | |
|---|------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Less than a year | <input type="checkbox"/> 1-4 years | <input type="checkbox"/> Over 4 years | <input type="checkbox"/> I don't have a usual pharmacy |
|---|------------------------------------|---------------------------------------|--|

Q6. In the last 12 months have you been offered and/or had a medicines use review with your usual pharmacist?

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't take any prescribed medicines |
|------------------------------|-----------------------------|--|

Q7. Why do you use your usual pharmacy? (Please X all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Near to work | <input type="checkbox"/> The staff speak my first language |
| <input type="checkbox"/> Near to home | <input type="checkbox"/> They offer a collection service |
| <input type="checkbox"/> Near to my doctors | <input type="checkbox"/> They offer a delivery service |
| <input type="checkbox"/> In town/shopping area | <input type="checkbox"/> They offer another service which I use |
| <input type="checkbox"/> In the supermarket | <input type="checkbox"/> Other (Please X and provide details) |
| <input type="checkbox"/> The staff are friendly | |
| <input type="checkbox"/> The staff are knowledgeable | |

Q8. Are you able to get to a pharmacy of your choice? (Please X all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Yes (independently) | <input type="checkbox"/> No (I am housebound) |
| <input type="checkbox"/> Yes (with help) | <input type="checkbox"/> No (my preferred pharmacy does not have suitable access for my needs) |
| <input type="checkbox"/> No (I have mobility issues) | |

Q9. How do you usually travel to your pharmacy? (Please X one option only)

- | | | |
|----------------------------------|--|--|
| <input type="checkbox"/> Walk | <input type="checkbox"/> Car (driver) | <input type="checkbox"/> I don't know, I use the pharmacy delivery service |
| <input type="checkbox"/> Bicycle | <input type="checkbox"/> Car (passenger) | <input type="checkbox"/> Other (Please X and specify) |
| <input type="checkbox"/> Bus | <input type="checkbox"/> Taxi | |

Q10. How far do you currently travel to your usual pharmacy?

- | | |
|---|--|
| <input type="checkbox"/> Less than half a mile | <input type="checkbox"/> 2-3 miles |
| <input type="checkbox"/> Between half a mile and one mile | <input type="checkbox"/> More than 3 miles |
| <input type="checkbox"/> 1-2 miles | <input type="checkbox"/> I don't have a usual pharmacy |

Q11. How far would you be willing to travel to a pharmacy?

- | | | |
|---|------------------------------------|--|
| <input type="checkbox"/> Less than half a mile | <input type="checkbox"/> 1-2 miles | <input type="checkbox"/> More than 3 miles |
| <input type="checkbox"/> Between half a mile and one mile | <input type="checkbox"/> 2-3 miles | |

Q12. Are you able to access all the services your pharmacy offers in a way you would choose to?

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> I don't know what pharmacy services are available to me |
|------------------------------|-----------------------------|--|

If you answered 'No', please specify why not

Q13. Does your usual pharmacy offer a prescription delivery service?

- | | | |
|------------------------------|-----------------------------|-------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
|------------------------------|-----------------------------|-------------------------------------|

Q14. Please tell us how important (or otherwise) the following community pharmacy features and services are to you. (Please **X one** box on **each** row)

	Very important	Fairly important	Neither	Fairly unimportant	Not at all important	Don't know
Early morning opening (before 9am)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Late night opening (after 7pm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Saturday opening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sunday opening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convenient location	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledgeable staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendly staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff that take time to listen to my needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private consultation area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic prescription service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delivery of medicines to my home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ordering repeat prescriptions on my behalf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collection of prescription from my surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buying over the counter medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription dispensing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advice on my prescribed/over the counter medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disposal of waste medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having the medicines and products in store when I need them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicine use reviews (sometimes called medicines checkup/MOT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advice on managing my/my family's minor ailments/illnesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long term condition advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Signposting me to other health/social care services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flu vaccination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advice on leading a healthy lifestyle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health tests e.g. cholesterol, blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stop smoking service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance misuse services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buying medicines to protect against malaria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency hormonal contraception (morning after pill)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Satisfaction with the service

Q15. Overall, how satisfied or dissatisfied are you with the service you receive from your usual pharmacy?

☐ Very satisfied ☐ Fairly satisfied ☐ Neither ☐ Fairly unsatisfied ☐ Very unsatisfied

About you

The following questions are about you and are designed to help us understand the views of different demographic groups. Please answer all questions as fully as you can.

Q16. What is your home postcode?

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Q17. What is your gender?

☐ Male

☐ Female

Q18. What was your age at your last birthday?

--	--	--

 years

Q19. A disabled person is someone who has a physical or mental impairment which has a substantial and long term adverse effect on their ability to carry out normal day-to-day activities. Do you consider yourself to have a disability?

☐ Yes

☐ No

Q20. If you answered 'Yes', what type of disability do you have? (Please **X all** that apply)

☐ Disability affecting mobility

☐ Disability affecting hearing

☐ Disability affecting vision

☐ A learning disability

☐ Other (Please specify)

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Q21. What is your ethnic group?

☐ White

☐ Black/Black British

☐ Chinese

☐ Mixed

☐ Asian/Asian British

☐ Other (Please specify)

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Q22. Which of the following best describes your working situation? (Please **X one** box only)

☐ I am unemployed

☐ I am a carer

☐ I am not working due to sickness or disability

☐ I work as a volunteer

☐ An internet/distance selling pharmacy

☐ Prefer not to say

☐ I am retired

☐ Other (Please X and specify)

☐ I am working full-time

☐ I am working part-time

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Thank you for completing this questionnaire