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| **Barnet Pharmaceutical Needs Assessment****Consultation Response Form**  |

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| 1. About you - please provide the details requested below. *This is very important in case we have any questions with respect to the feedback you provide*
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| Name |  |
| Job Title |  |
| Pharmacy Name OrOrganisation Name |  |
| Address |  |
| Telephone No. |  |
| Please confirm that you are happy for us to store these details in case we need to contact you about your feedback? | *Please indicate response using \* or delete as applicable*

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| Yes |  | No |  |

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| 1. Has the purpose of the PNA been explained sufficiently within section 1.1 of the draft PNA document?
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| *Please indicate response using \* or delete as applicable* |
| Yes |  | No |  | Not sure |  |

If “No” or “Not sure”, please explain why in the box below:

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| 1. Does Section 1.3 clearly set out the scope of the PNA?
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| *Please indicate response using \* or delete as applicable* |
| Yes |  | No |  | Not sure |  |

If “No” or “Not sure”, please explain why in the box below:

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| 1. Does Section 2 clearly set out the local context and implications for the PNA?
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| *Please indicate response using \* or delete as applicable* |
| Yes |  | No |  | Not sure |  |

If “No” or “Not sure”, please explain why in the box below:

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| 1. Do you think that the pharmaceutical needs of the population have been accurately reflected within the PNA?
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| *Please indicate response using \* or delete as applicable* |
| Yes |  | No |  | Not sure |  |

If “No” or “Not sure”, please explain why in the box below:

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| 1. For each of the services below, please indicate if you agree that the PNA has provided a reasonable description of the service and if you agree with the conclusions?
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| *Please indicate response using \* or delete as applicable for each service* |
| Section 3.2.1: Essential Services | Yes |  | No |  | Not sure |  |
| Section 3.2.3.1: Medicines Use Reviews | Yes |  | No |  | Not sure |  |
| Section 3.2.3.2: New Medicine Service | Yes |  | No |  | Not sure |  |
| Section 3.2.3.3: Appliance Use Review Service | Yes |  | No |  | Not sure |  |
| Section 3.2.3.4: Stoma Appliance Customisation Service | Yes |  | No |  | Not sure |  |
| Section 3.2.4.1: London Pharmacy Vaccination Service | Yes |  | No |  | Not sure |  |
| Section 3.3.2: Emergency Hormonal Contraception | Yes |  | No |  | Not sure |  |
| Section 3.3.3: Stop Smoking | Yes |  | No |  | Not sure |  |
| Section 3.3.4: Supervised Consumption  | Yes |  | No |  | Not sure |  |
| Section 3.3.5: Needle and Syringe Programme | Yes |  | No |  | Not sure |  |
| Section 3.3.6: Alcohol IBA | Yes |  | No |  | Not sure |  |

If you have answered “No” or “Not sure” to one or more of the above please explain why in the box below:

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| 1. Do you agree with the “Looking to the Future” section as set out in section 3.4?
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| *Please indicate response using \* or delete as applicable* |
| Yes |  | No |  | Not sure |  |

If “Yes”, please explain why in the box below:

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| 1. Are you aware of any pharmaceutical services, which have been commissioned, but which have not been included in the PNA?
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| *Please indicate response using \* or delete as applicable* |
| Yes |  | No |  | Not sure |  |

If “Yes”, please explain why in the box below:

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| 1. Is there any additional information which you think should be included in the PNA (and which you have not mentioned above)?
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| *Please indicate response using \* or delete as applicable* |
| Yes |  | No |  | Not sure |  |

If “Yes”, please explain why in the box below:

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| 1. **NHS England only**:

Has the PNA provided you with enough information to inform market entry decisions  |

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| *Please indicate response using \* or delete as applicable* |
| Yes |  | No |  | Not sure |  |

If “Yes”, please explain why in the box below:

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| 1. **Service Commissioners only**:

Has the PNA provided you with enough information to inform how you may commission services from pharmacy in the future?  |

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| *Please indicate response using \* or delete as applicable* |
| Yes |  | No |  | Not sure |  |

If “Yes”, please explain why in the box below:

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| 1. **Community Pharmacies only**:

Has the PNA provided you with enough information to help your own future service provision and plans?  |

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| *Please indicate response using \* or delete as applicable* |
| Yes |  | No |  | Not sure |  |

If “Yes”, please explain why in the box below:

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| 1. **Community Pharmacies only**:

Please review the information in Appendix E (Opening Hours) and Appendix F (Service Provision) for accuracy? If you identify any issues please provide details below |

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|  | Is the information Accurate?*Please indicate response using \* or delete as applicable* | If “No”, please provide details: |
| Opening Hours | Yes |  | No |  |  |
| Service Provision | Yes |  | No |  |  |

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| 1. If you have any further comments, please detail these in the box below
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Please return this feedback form, by email, to pna-consultation@webstar-lane.co.uk, noting that the deadline for submitting comments is midnight on 26 March 2015.