The University of Manchester

This questionnaire should only take you 20 minutes to complete

Evaluation of the Community Pharmacy Care Plan Service

IMPORTANT – PLEASE READ

We are interested in finding out what you think about the Community Pharmacy Care Plan service you have taken part in. In particular we are interested in how useful you found the goal-setting and the regular meetings with your pharmacists. We would like your opinions on the strengths and weaknesses of the Care Plan service. Everything you say in this questionnaire will remain ***strictly confidential and will not be shared with the pharmacy you visited or the pharmacist you saw***

PLEASE RETURN TO:

DR LIZ SESTON,

FREEPOST MR9661, THE UNIVERSITY OF MANCHESTER, DIVISION OF PHARMACY & OPTOMETRY,, STOPFORD BUILDING, 1ST FLOOR, OXFORD ROAD, MANCHESTER M13 9HL

1. **Which <u>ONE</u> of the following statements best describes how often you visit the pharmacy (chemist) where you received the Care Plan service?**

   This is the pharmacy I visit most often ❒
   I do not visit this pharmacy more often than any other ❒
   This is the first time I have visited this pharmacy ❒

2. **Did you see the same pharmacist (chemist) on each of the (four) Care Plan service consultations?**

   Yes ❒

   No ❒

3. **In addition to the arranged consultations you had to discuss your Care Plan and goal-setting, did you visit the pharmacy (chemist) without an appointment to talk about the care plan/goals?**

   No ❒

   Yes ❒

   If yes, how many times did you visit _____times

4. **How many goals did you set as part of your Community Pharmacy Care plan?**

   One goal ❒ Three goals ❒
   Two goals ❒ Four or more goals ❒

5. **Do you feel you successfully met the goal(s) you and the pharmacist set for your during the plan?**

	Goal 1	**Goal 2**	**Goal 3**	**Goal 4**
No, not at all	❒	❒	❒	❒
Yes, partially	❒	❒	❒	❒
Yes, fully	❒	❒	❒	❒

6. What type of goal(s) did you set? Please describe

_____
_____
_____
_____

7. How useful did you find any medical checks you had such as blood pressure and cholesterol readings done as part of the service?

1	2	3	4	5
Not at all useful				Very useful

8. Did the pharmacist make any recommendations to your GP?

Yes ❒
No ❒
Not sure/Don't know ❒

9. Do you know if your GP (or hospital doctor) made any of the changes your pharmacist recommended to them?

Yes ❒
No ❒
Not sure/Don't know ❒

10. Overall, how satisfied are you with the Community Pharmacy Care Plan service (Please circle one number)

1	2	3	4	5	6	7	8	9	10
Very dissatisfied									Very satisfied

11. We would like you to think about your recent experience of the Community Pharmacy Care Plan service.

How likely are you to recommend our service to friends and family if they needed similar care or treatment?

Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know
❒	❒	❒	❒	❒	❒

12. Do you feel that the taking part in the care plan service has helped you to manage your illness(s) better?

Yes ❒

No ❒

Comments

Please use this space if you wish to make any other comments about the Community Pharmacy Care Plan service

BACKGROUND INFORMATION

13. Gender: Male ❒ Female ❒

14. Age: _____ years

15. How would you describe your ethnic origin? *(Please tick **ONE** box only).*

White			
English/Welsh/Scottish/Northern Irish/British ❒	Irish ❒	Gypsy or traveller ❒	Any other white ❒
Mixed/multiple ethnic groups			
White/Black Caribbean ❒	White/Black African ❒	White/Asian ❒	Other mixed ❒
Asian/British Asian			
Indian ❒	Pakistani ❒	Bangladeshi ❒	Other Asian ❒
Black/African/Caribbean/Black British			
Black African ❒	Black Caribbean ❒	Black other ❒	
Other ethnic group			
Chinese ❒	Arab ❒	Any other ❒	

16. Have you been diagnosed with any of the following long-term medical conditions?
*(Please tick **ALL** those that apply, **including those that you do not currently take medicine for**)*

Cardiovascular disease	❒	Epilepsy/other neurological	❒
Respiratory disease	❒	Eye problem	❒
Diabetes	❒	Mental health problems	❒
Alzheimer's disease/other dementia	❒	Skin problem	❒
Arthritis/ joint problems	❒	Stomach or bowel problem	❒
Back musculoskeletal problem	❒	Thyroid disease	❒
Cancer	❒	Other, please describe	❒

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THANK YOU FOR COMPLETING THE QUESTIONNAIRE. PLEASE RETURN TO:

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