



**Nottingham**  
**City Council**



## **Nottingham City Health and Wellbeing Board**

### **Pharmaceutical Needs Assessment (PNA) 2025**

### **Public Questionnaire**

**Tell us how you access and use pharmacy services in Nottingham City**

We want to hear how you access and use community pharmacy / local chemist services in Nottingham City. Everybody's views are important to ensure the pharmacy services in Nottingham City meet your needs. Your views will help us to develop future pharmacy services.

We would be grateful if you would answer some questions about your own experience and views. It takes approximately 5 minutes to complete.

**The information you provide in the questionnaire is confidential.** Please see the privacy statement below. Your responses and comments will be published in the Pharmaceutical Needs Assessment (PNA) on the council website, but your personal information will not.

For a paper copy, easy read version or other languages please contact:  
[engage@nottinghamcity.gov.uk](mailto:engage@nottinghamcity.gov.uk)

If you would like to complete this online, please scan the QR code below or follow the link  
<https://forms.office.com/e/L1LujKVvHF>



**The survey closes on 31 December 2024**

N.B. All responses and respondent details are anonymous. Any information provided will be kept in line with GDPR (General Data Protection Regulation). The information will be held securely and used for the purpose of planning appropriate services for all communities. It will not be passed on to any third party. For more detail on the Public Health privacy notice please visit: <https://www.nottinghamcity.gov.uk/media/fagjxcaa/overarching-privacy-notice-21-12-2023.pdf>

All questions below refer to your community pharmacy / local chemist

**1) Why do you usually visit a pharmacy?**

<b>Options</b>	<b>Please tick all that apply</b>
To buy over-the-counter medicines	<input type="checkbox"/>
To collect prescriptions for myself	<input type="checkbox"/>
To collect prescriptions for somebody else	<input type="checkbox"/>
To get advice from a pharmacist	<input type="checkbox"/>
To get NHS support and treatment for a minor illness	<input type="checkbox"/>
Referred by NHS 111 for an urgent medicine supply	<input type="checkbox"/>
To get regular oral contraceptive pill	<input type="checkbox"/>
To get emergency contraception (also known as the “morning after pill”)	<input type="checkbox"/>
To use the blood-pressure test service	<input type="checkbox"/>
To use a privately funded service	<input type="checkbox"/>
Other, please specify _____	<input type="checkbox"/>

**2) How often have you visited or contacted a pharmacy in the last six months?**

<b>Options</b>	<b>Please tick one option</b>
Once a week or more	<input type="checkbox"/>
A few times a month	<input type="checkbox"/>
Once a month	<input type="checkbox"/>
Once every few months	<input type="checkbox"/>
Once in six months	<input type="checkbox"/>
I have not visited/contacted a pharmacy in the last six months	<input type="checkbox"/>

**3) What time and day is most convenient for you to use a pharmacy?** (Please tick one day for each time that applies to you)

<b>Please tick one day for each time that applies to you</b>	<b>Weekday</b>	<b>Saturday</b>	<b>Sunday</b>
Before 9am	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9am - 1pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1pm - 7pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After 7pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It varies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No preference	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4) Do you have a regular local community pharmacy?**

<b>Options</b>	<b>Please tick one option</b>
Yes, a community pharmacy / local chemist shop or building	<input type="checkbox"/>
Yes, an internet/online pharmacy - (This pharmacy, also referred to as a distance selling pharmacy, is one which operates partially or completely online. Prescriptions are received electronically or by paper and dispensing medication is sent via a courier to your home)	<input type="checkbox"/>
Yes, a combination of both	<input type="checkbox"/>
No	<input type="checkbox"/>

**5) Is there a specific reason you prefer your current pharmacy, even though there might be others nearby or more convenient?**

<b>Options</b>	<b>Please tick one option</b>
No	<input type="checkbox"/>
Yes, please specify _____	<input type="checkbox"/>

**6) What influences your choice of pharmacy?** (Please tick one level of importance for each reason)

<b>Reason for choice of pharmacy</b>	<b>Very important</b>	<b>Important</b>	<b>Not important</b>
Quality of service (expertise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Customer service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Location of pharmacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opening times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accessibility (wheelchair/ buggy access)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication (languages/ interpreting service)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Space to have a private consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Availability of medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services provided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**7) How do you usually travel to the pharmacy?**

<b>Options</b>	<b>Please tick one option</b>
Walk	<input type="checkbox"/>
Car	<input type="checkbox"/>
Public transport	<input type="checkbox"/>
Taxi	<input type="checkbox"/>
Bicycle	<input type="checkbox"/>
Wheelchair/ mobility scooter	<input type="checkbox"/>
Someone goes for me / takes me	<input type="checkbox"/>
I don't travel, I use an online pharmacy	<input type="checkbox"/>
I don't travel, I utilise a delivery service	<input type="checkbox"/>
Other, please specify _____	<input type="checkbox"/>

**8) Approximately how long does it take you to travel to the pharmacy?**

<b>Options</b>	<b>Please tick one option</b>
Less than 20 minutes	<input type="checkbox"/>
20-30 minutes	<input type="checkbox"/>
30-40 minutes	<input type="checkbox"/>
More than 40 minutes	<input type="checkbox"/>
N/A- I don't travel to the pharmacy	<input type="checkbox"/>

**9) Are there any services you would like pharmacies to be able to offer?**

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**10) Do you have any other comments that you would like to add regarding services provided by pharmacies in Nottingham City?**

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**About you**

Nottingham City Council is committed to equality of opportunity. The information you provide will be treated confidentially, in accordance with the UK General Data Protection Regulations and used to ensure that no one is unlawfully discriminated against. You do not have to provide the information requested, but it would help us greatly if you did.

**11) What is your age?**

<b>Options</b>	<b>Please tick one option</b>
Under 18	<input type="checkbox"/>
18-24	<input type="checkbox"/>
25-34	<input type="checkbox"/>
35-44	<input type="checkbox"/>
45-54	<input type="checkbox"/>
55-64	<input type="checkbox"/>
65-74	<input type="checkbox"/>
75+	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

**12) What is your gender?**

<b>Options</b>	<b>Please tick one option</b>
Male	<input type="checkbox"/>
Female	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>
Prefer to self-describe, please specify _____	<input type="checkbox"/>

**13) What is your ethnic origin?**

<b>Options</b>	<b>Please tick one option</b>
White - English/Welsh/Scottish/ Northern Irish/British	<input type="checkbox"/>
White - Irish	<input type="checkbox"/>
White - Gypsy or Traveller	<input type="checkbox"/>
White - any other background, please specify _____	<input type="checkbox"/>
Mixed - Black Caribbean & White	<input type="checkbox"/>
Mixed - Black African & White	<input type="checkbox"/>
Mixed - Asian & White	<input type="checkbox"/>
Mixed - any other mixed background, please specify _____	<input type="checkbox"/>
Asian/Asian British - Indian	<input type="checkbox"/>
Asian/Asian British - Pakistani	<input type="checkbox"/>
Asian/Asian British - Bangladeshi	<input type="checkbox"/>
Asian/Asian British - Chinese	<input type="checkbox"/>
Asian/Asian British - Any other Asian background, please specify ____	<input type="checkbox"/>
Black/Black British	<input type="checkbox"/>
Black/Black British - African	<input type="checkbox"/>
Black/Black British - Caribbean	<input type="checkbox"/>
Black/Black British - Any other Black, background, please specify ____	<input type="checkbox"/>
Arab	<input type="checkbox"/>
Any other ethnic group, please specify _____	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

**14) Please tick the statement that best describes you**

<b>Options</b>	<b>Please tick one option</b>
I consider myself to be disabled	<input type="checkbox"/>
I consider myself not to be disabled	<input type="checkbox"/>
Other, please specify _____	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

**15) What is your religion or belief?**

<b>Options</b>	<b>Please tick one option</b>
Buddhist	<input type="checkbox"/>
Christian	<input type="checkbox"/>
Hindu	<input type="checkbox"/>
Jewish	<input type="checkbox"/>
Muslim	<input type="checkbox"/>
Sikh	<input type="checkbox"/>
No religion or belief	<input type="checkbox"/>
Other, please specify _____	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

**16) What is your sexual orientation?**

<b>Options</b>	<b>Please tick one option</b>
Heterosexual/straight	<input type="checkbox"/>
Bisexual	<input type="checkbox"/>
Gay	<input type="checkbox"/>
Lesbian	<input type="checkbox"/>
Other, please specify	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>