**Contractor survey to support the PQS 2020/21 PCN Domains**

**Introduction and data sharing confirmation**

Completing this short survey will assist you and your Pharmacy PCN Lead to complete the actions necessary to meet the PCN Domain requirements within the PQS 2020/21 Part 2.

Please return the completed survey to [**insert.email@address.co.uk**](mailto:insert.email@address.co.uk) by **deadline date**.

This survey is an electronic form and will allow answers to entered electronically in the spaces provided if completed in Microsoft word. Forms can then be saved and emailed to your Pharmacy PCN Lead at the above email address. PDF versions of this form cannot be completed electronically and will need to be completed in writing.

Contractors acknowledge and confirm that by providing the data in this survey, they consent to the information being shared with the Local Pharmaceutical Committee, their PCN Pharmacy Lead, the PCN Clinical Director and the general practices within the PCN.

The minimum dataset required is indicated by an \*. Contractors must provide this information as a minimum and attend the PCN Pharmacy Lead organised contractor discussion to be able to declare against the appropriate PQS PCN Domains. Contractors are however encouraged to complete the survey as fully as possible to assist your PCN Pharmacy Lead to build the best possible PCN community pharmacy flu plan to share with the PCN Clinical Director.

Contractors unwilling to share any data or who do not participate in either the data capture or the subsequent discussions with the PCN Pharmacy Lead, despite three attempts to follow up, via two separate methods of communication, will not be deemed to have participated in either of the PQS PCN domains and will not be eligible to claim payment for completion of either of the two PQS PCN Domains.

**Pharmacy details**

*\**Name of person submitting survey: Click or tap here to enter text.

*\**Pharmacy Name: Click or tap here to enter text.

*\**ODS code: Click or tap here to enter text.

*\**Address: Click or tap here to enter text.

*\**Postcode: Click or tap here to enter text.

*\**Telephone number: Click or tap here to enter text.

*\**NHSmail shared mailbox address: Click or tap here to enter text.

**PCN flu dataset**

1. ***\**Will you be, or have you been, offering NHS flu vaccinations this season between 1st September 2020 and 31st January 2021?**

Yes No

*If your answer is No, and you will not be vaccinating any patients aged 65 and over by 31st of March 2021, you will not be eligible to declare against the PQS 2020/21 Part 2 - Primary Care Network (PCN) Flu vaccination Domain (Please go to question 8).*

1. **How will you be offering NHS flu vaccinations this season? (between 1st September 2020 & 31st January 2021)** **(*Please tick all that apply*)**

**For all selected choices please indicate if any of these are new this year. (*Please tick all that apply*)**

**New this year?**

By appointment

Walk-in (no appointment needed)

Evenings (after 5pm)

On Saturdays

On Sundays

1. **Will you be providing any off-site vaccinations (i.e. off the pharmacy premises)?**

Yes No Not yet sure

*If you are providing vaccinations other than in your pharmacy during usual opening hours, then please give more details (venue & date, if confirmed)*:

* Click or tap here to enter text.
* Click or tap here to enter text.
* Click or tap here to enter text.
* Click or tap here to enter text.
* Click or tap here to enter text.

1. **Have you provided, or are you able to provide if requested, domiciliary vaccinations this season?**

Yes No  Not yet sure

**If Yes, did you provide** **domiciliary vaccinations last year?**

Yes No

1. **Have you provided, or are you able to provide if requested, care home vaccinations this season?**

Yes No  Not yet sure

**If Yes, did you provide** **care home** **vaccinations last year?**

Yes No

1. **Have you discussed provision of the flu service this year with your local GP practice(s)?**

Yes No

1. **Are you currently providing, or planning to provide, flu vaccinations as part of a general practice or PCN organised event?**

Yes No

**If Yes, please provide details and the date(s): ­­­­­­­­­­­­­­­­­­**

* Click or tap here to enter text.
* Click or tap here to enter text.
* Click or tap here to enter text.

**PCN Business Continuity Plan dataset**

1. **\*In the case of unplanned closure of your pharmacy, please provide the initial point of contact for queries (*This can be the pharmacy, where staff will be available to answer phone calls*):**

­­­­­­­­­­­­­­­­­­­­­­­­­­Click or tap here to enter text.

1. **\*Please describe your high-level business continuity plan or any arrangements that have been put in place which could be activated in the case of needing to temporarily close your pharmacy.**

­­­­­­­­­­­­­­­­­­­­­­­­­­

1. **\*Please provide the role and contact number for the first point of escalation, where no contact with the initial point of contact can be made (*this contact will not be for public use*):**

Role: Click or tap here to enter text.

Contact number: Click or tap here to enter text.

1. **\*Name the local pharmacies which are expected to be the most impacted in the event of an unplanned closure of your pharmacy *(minimum 1 and maximum of 4 pharmacies):***

Pharmacy Name and postcode: Click or tap here to enter text.

Pharmacy Name and postcode: Click or tap here to enter text.

Pharmacy Name and postcode: Click or tap here to enter text.

Pharmacy Name and postcode: Click or tap here to enter text.

1. **\*****Having identified pharmacies** **that could be impacted in the event your pharmacy had an unplanned closure, what actions, or arrangements would you be able to put in place to support service provision in your pharmacy in the event of one or several of the above identified pharmacies needing to close for any protracted period?**

***e.g. Additional staffing you can bring in etc.***

­­­­­­­­­­­­­­­­­­­­­­­­­­

1. **\*Name the main general practices which are expected to be the most impacted in the event of an unplanned closure of your pharmacy:**

Surgery name: Click or tap here to enter text.

Surgery name: Click or tap here to enter text.

Surgery name: Click or tap here to enter text.

Surgery name: Click or tap here to enter text.

1. **\*Having identified practices that could be impacted in the event your pharmacy had an unplanned closure, what actions, or arrangements would you be able to put in place to support service provision in your pharmacy in the event of one or several of the above identified practices needing to close for any protracted period?**

­­­­­­­­­­­­­­­­­­­­­­­­­­