



# Pharmacy First in Staffordshire

**June 2026**

# Contents

<b>Introduction.....</b>	<b>3</b>
<b>The Role of Pharmacy First .....</b>	<b>4</b>
Background Information: How it should work.....	4
Problems with Service Delivery .....	5
Previous Healthwatch Reports on the Subject..	6
<b>Project Research Aims .....</b>	<b>7</b>
Current Ongoing Research into Pharmacy First:	7
<b>Methodology .....</b>	<b>7</b>
<b>Patient Experience .....</b>	<b>8</b>
Awareness.....	8
GP Referrals.....	9
Pharmacy versus GP .....	10
<b>What We Found: The Pharmacists' Perspective .....</b>	<b>11</b>
How is the Pharmacy First Initiative Working? ....	11
Does 'Pharmacy First' benefit your business? ....	11
What do you see are the benefits of 'Pharmacy First' for patients?	11
What, if any, barriers have you experienced to the Pharmacy First initiative? .....	12
How Pharmacists are treated by Patients Using the Service.	16
How do Pharmacists feel about the Implementation of Pharmacy First? .....	16
Room for Improvement: Pharmacists' Perceptions of how the Service can be Improved. ....	17
Additional Findings at the University Campus Pharmacy	18
<b>What the GPs thought about Pharmacy First.....</b>	<b>18</b>

How often would you consider Pharmacy First as an option for referral? .....	18
How to improve GP’s confidence in the initiative	21
GP email response.....	21
Summing up the GP position.....	22
<b>Further Insight: Key Points &amp; Real-world Pressures</b>	<b>22</b>
<b>Conclusions .....</b>	<b>23</b>
<b>Acknowledgements.....</b>	<b>25</b>

## Introduction

Pharmacy First is an NHS England service launched on 31 January 2024 that aims to improve access to treatment for a range of common conditions through community pharmacies. The service enables patients to receive advice and treatment, and, where clinically appropriate, certain prescription-only medicines directly from a pharmacy, helping to reduce pressure on other parts of the health and care system.

In Staffordshire, Healthwatch became interested in how Pharmacy First was working in practice following Enter and View visits to two pharmacies in 2025, Whitehouse Pharmacy and Cornwell’s Chemist, Beaconside, Stafford. These visits formed part of Healthwatch Staffordshire’s early local work on the issue and provided an opportunity to gather feedback from pharmacy settings on how the service was operating in practice.

Healthwatch Staffordshire’s Annual Report 2024–2025 explains that concerns were raised at the local pharmacy committee in Burton that the Pharmacy First scheme was not being used effectively by local GP practices. These concerns were reported to the Integrated Care Board, and wider pharmacy Enter and View visits were then undertaken to better understand the extent of the issue across Staffordshire.

Following this initial work, Healthwatch Staffordshire also received feedback from Staffordshire-based pharmacists on the wider implementation of Pharmacy First. In response, broader evidence was sought across Staffordshire to accurately represent these views to the Integrated Care Board and to help improve the service and patient outcomes.

The wider research was designed to explore Pharmacy First from the perspectives of those



involved in the pathway, including patients, referring professionals and pharmacy teams. This was important because the effective delivery of Pharmacy First depends on several factors working together, including public awareness of the service, confidence and understanding among referring services, appropriate referral pathways and the capacity of pharmacies to deliver the service safely and effectively.

Early work suggested there may be wider issues relating to awareness, referral pathways and the consistency of local implementation. The purpose of the project was therefore to build a broader understanding of how Pharmacy First is functioning across Staffordshire.

## The Role of Pharmacy First

Pharmacy First has been in operation since January 31<sup>st</sup>, 2024, and it has now been operating for over 2 years.

The idea behind Pharmacy First is to ease some of the pressure on GPs by allowing pharmacies to provide services and medication to patients with minor ailments. The aim is to reduce the number of patients requiring GP appointments.

Pharmacy First covers the following minor ailments\*:

Clinical Pathway	Age Range
Acute Otitis Media	1 to 17 years
Impetigo	1 year and over
Infected insect bites	1 year and over
Shingles	18 years and over
Sinusitis	12 years and over
Sore throat	5 years and over
Uncomplicated urinary tract infections	Women aged 16-64 years

\*There are many potential exclusions to each condition where a patient would be advised to see a GP instead.

For a patient to be treated under the Pharmacy First Initiative, their symptoms, frequency of occurrence, age, and other exclusions must fall within the gateway criteria above, which essentially leads the pharmacist to decide whether they are able to treat the individual or to refer them to a GP, or back to a GP if they were referred to them.

## Background Information: How it should work

Pharmacy First was introduced nationally as part of wider efforts to improve access to care for common conditions and to reduce pressure on GP appointments and other NHS services. The service enables patients to access community pharmacies directly for clinical advice and, where clinically appropriate, treatment for selected conditions.

National reports and guidance indicate that the successful delivery of Pharmacy First depends on several factors working together effectively. A key issue is public awareness. Patients need to understand what the service is, which conditions can be treated through Pharmacy First, and when it may be appropriate to visit a community pharmacy rather than contact their GP.

When awareness is limited, patients may continue to use traditional routes to care, thereby reducing the service's potential impact.

Effective referral pathways are also important. Pharmacy First relies on appropriate referrals from GP practices, NHS 111 and other healthcare services. If referral processes are not applied consistently, or if professionals are unclear about when and how to refer patients, this may affect how widely and effectively the service is used.

Communication between community pharmacies and GP practices is also essential, particularly for updating patient records and sharing follow-up information after a consultation.

Our Principal Pharmacist contact highlights the importance of appropriate referral and maintains that clinical triggers and signposters in their practice are appropriately trained. Furthermore, historically poor Pharmacy First provision is a barrier to patient engagement with locum quality being an issue. When patients have a poor experience, they can be less likely to engage in future. At his GP sites the incentive is to increase capacity by appropriate signposting therefore freeing up additional GP appointments.

## **Problems with Service Delivery**

Community pharmacies may also face practical challenges in delivering the service. These include workforce pressures, staffing capacity, workload demands, digital systems, medicine availability and funding arrangements. These factors may affect how easily pharmacies can provide Pharmacy First alongside their existing responsibilities.

A recent article in the [Pharmaceutical-journal.com](https://www.pharmaceutical-journal.com) highlighted key issues with the service:

- GPs don't always make referrals (lack of Incentive) Possibility that re-imburement may improve referral rates.
- Possible issues with streamlining and connectivity across different IT systems between referral pathways (NHS 111), GPs, urgent healthcare providers and pharmacies. (software issues/incompatibility).
- Not all GPs wanting to refer.
- Areas that offered previous similar smaller schemes have a better uptake of Pharmacy First; this would suggest that familiarity of use plays a part in service user engagement.
- This suggests that better public education is needed as to how the scheme can be accessed.
- A positive correlation is reported between GP referrals to clinical pathways and uptake of pharmacy first.

*Reference: Community Pharmacy services, Joanna Robertson, 6 Aug 2025  
Pharmaceutical Press, Essential knowledge: Royal Pharmaceutical Society.*

Issues identified previously by The King's Fund & The Nuffield Trust report barriers encountered that hamper the implementation of moving some primary care services over to Pharmacies. Although not explicitly Pharmacy First, the barriers are highly templatable to the service:

- Insufficient resources across primary care as a whole, with new models of care is reliant on shifting resources from one part of primary care to another rather than overall investment.
- Finance and contracting arrangements that inhibit new models of pharmacy, with complex funding flows, atomised commissioning and fragmented contracts that are hard to manage.
- Perverse incentives that prohibit a shift away from dispensing.
- Poorly developed local relationships between professionals, which have continued to inhibit both integration and wider engagement.
- Insufficient management capacity and capability within community pharmacy and within ICBs.
- A lack of patient data and interoperability to allow pharmacy staff to see, document and share clinical information about patient care with the clinical records held by other health care professionals.
- The need to improve evidence on effectiveness, particularly cost-effectiveness.
- Some mistrust between primary care professionals, which can create a barrier to trust and collaboration.
- Public and patient expectations of community pharmacies that are limited to the dispensing of medications and retail.

*Reference: Research Report: September 2023 [A vision for community pharmacy](#)  
[A Vision for Community Pharmacy: The King's Fund & The Nuffield Trust.](#)  
Beccy Baird, Helen Buckingham, Anna Charles, Nigel Edwards and Richard Murray.*

## **Previous Healthwatch Reports on the Subject**

In their report [Pharmacy: what people want](#), Healthwatch England reported positive signs of Pharmacy First's success, with people generally open to attending a pharmacy rather than a GP. However, they maintain that a small portion of the population is less likely to visit a pharmacy than a GP. Furthermore, they highlight that public awareness poses an issue. Multiple Healthwatch regions collaborated and pooled data on patients' perspectives on how Pharmacy First is working for them. The report discusses what is working well and the barriers the public faces in accessing the service.

Alongside this, insightful recommendations for future action are highlighted in [One year on: Pharmacy First](#).

A Healthwatch article [What can the Pharmacy First scheme do for me?](#) outlines the services Pharmacy First can provide and how to access them.

Healthwatch Northumberland delivered a report [Your experiences of Pharmacy First](#) on the public's awareness of the Pharmacy First initiative. They highlighted a deficit in public awareness of the scheme, alongside promoting training and qualifications for pharmacists.

## Project Research Aims

These wider issues provide important context for Healthwatch Staffordshire's local work on Pharmacy First. By exploring the experiences of patients, pharmacy teams, and referring professionals in Staffordshire, the project can assess whether the challenges identified nationally are also experienced locally. This will help identify barriers, areas of good practice, and opportunities to improve the delivery of Pharmacy First across Staffordshire. The aim of this project is to evaluate barriers and restrictions to the effective implementation of the Pharmacy First initiative across Staffordshire. Furthermore, it seeks to understand pharmacy teams' experiences of implementing Pharmacy First in Staffordshire, including:

- Assess overall views of how Pharmacy First is working locally (Staffordshire).
- Identify perceived benefits for pharmacies and patients.
- Understand barriers to delivery (Awareness, referrals, staffing, funding, training).
- Pharmacy staff attitudes to the additional responsibility.
- Gather views on partnerships with GPs and the level of referrals.
- Identify practical suggestions to improve implementation locally.
- To better understand how the referral process works or is not working, could it be standardised?

## Current Ongoing Research into Pharmacy First:

Research has been commissioned by the National Institute for Health Research (NIHR) to evaluate the service's effectiveness in terms of impact, cost-effectiveness, and safety for service users. An independent evaluation of the service was commenced in February 2024 and is expected to run for 36 months, concluding in January 2027. The research is led by a team from the London School of Hygiene and Tropical Medicine (LSHTM) in collaboration with researchers from the University of Nottingham, the University of Manchester, the University of Oxford and experts at the UK Health Security Agency (UKHSA).

## Methodology

Based on issues raised during our Enter and View visits to pharmacies in Staffordshire, we decided to undertake this research project to gather information on how Pharmacy First was working in practice for pharmacists. We created a survey questionnaire to better understand what was working well and what issues were potential barriers to implementation, such as GP referrals, public awareness, training, and underfunding.

We obtained a full list of pharmacies across the region from Staffordshire ICB and contacted them via email with our survey and a short project outline; the

initial response was poor. At this stage, we decided to approach the pharmacies by visiting them and explaining who we are and the purpose of the project. The response we received was that most pharmacists were happy to speak with us and outline their views.

We conducted our surveys and noted down important points that came up in conversation. Of the 234 pharmacies listed in Staffordshire, we visited over 100 throughout February, March and April. We were careful to visit a range of pharmacies across the area, including small independents, larger chains, supermarket pharmacies, smaller chains, and a university campus pharmacy. Again, we ensured that the pharmacies we visited were spread throughout Staffordshire to provide a balanced cross-sectional view across the region, incorporating both rural and urban locations.

We decided to stop data collection at just over 100, as we were receiving consistent feedback on the same issues relating to the initiative across all types of pharmacies.

During early data collection, the decision was made to expand the project by creating a questionnaire to gauge public understanding and awareness of the initiative. 91 responses were recorded. Most of the public were surveyed during pharmacy visits, with the pharmacist's kind permission. Our data was usually collected by working in teams of two.



Alongside this, we designed a questionnaire to gather the GPs' perspective. This was sent to all GPs in Staffordshire via a list obtained by the Staffordshire ICB. Of the 142 GP practices in Staffordshire, we received 8 survey replies and 1 detailed email response.

The data we collected was analysed using Smart Survey to generate appropriate bar charts and graphs to display the quantitative information. Additionally, our notes were used to identify common themes that were often discussed with pharmacists and staff.

The research incorporates the perspectives of the public, pharmacists, and GPs, enabling Healthwatch Staffordshire to draw conclusions that triangulate Pharmacy First. Additionally, we involved a principal pharmacist at first draft stage who supported us with additional insight into issues present with the service.




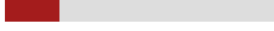
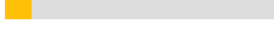
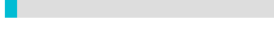
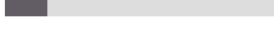

## Patient Experience

### Awareness

Our patient survey was conducted to determine the level of public awareness\* and experience of referral. Just over half of the patients surveyed were aware of the service, while just under half reported not knowing what it was. A lack of patient awareness was also evident from our consultations with pharmacists.

*\*Awareness may not mean knowing about self-referral or all conditions and gateway criteria.*

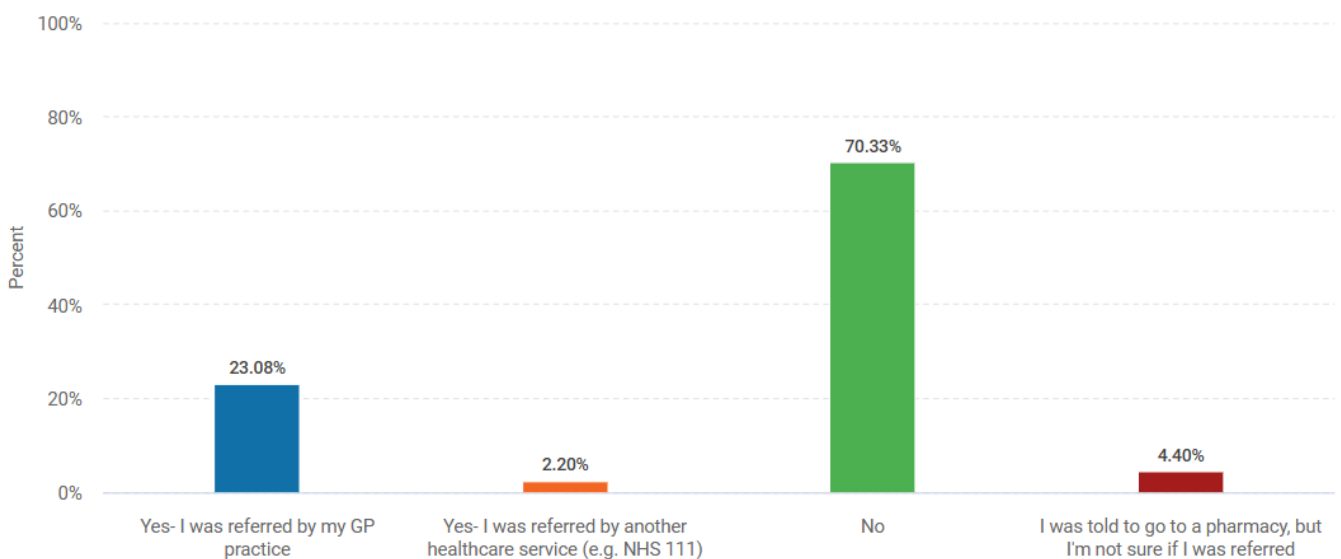
### How or where did you hear about Pharmacy First?

Answer Choices	Responses
GP Practice	 18.68% 17
Other healthcare provider, e.g. NHS 111	 2.20% 2
Pharmacy	 8.79% 8
Online	 19.78% 18
Word of mouth	 9.89% 9
Can't remember	 4.40% 4
Not heard of it	 15.38% 14
Today, through this survey	 30.77% 28

## GP Referrals

The responses below highlight GPs' reluctance to refer.

### Have you ever been referred to the Pharmacy by your GP practice when calling for an appointment?

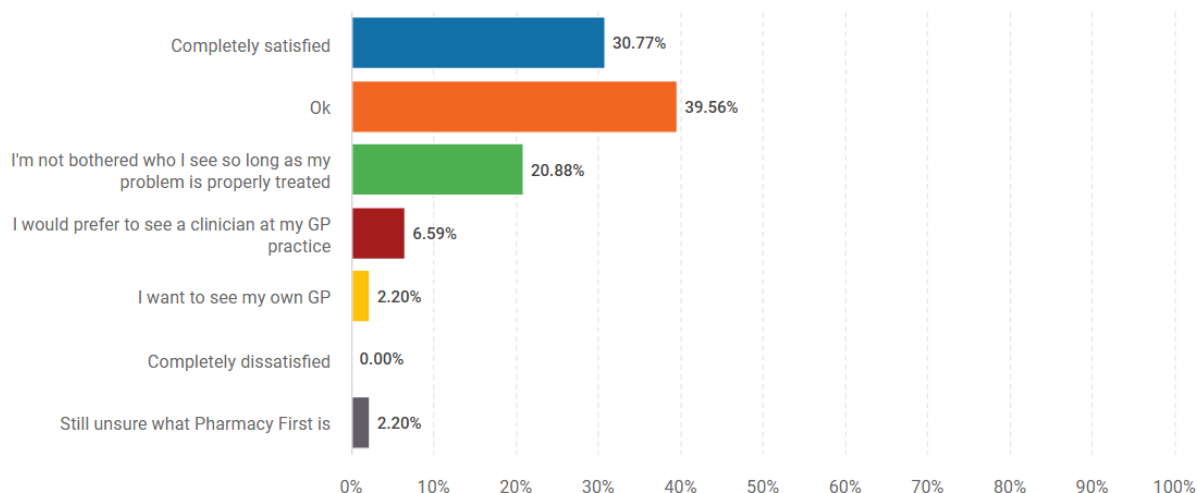


Much more needs to be done towards raising public awareness of the initiative and how it works. People are not aware that they can self-refer.

## Pharmacy versus GP

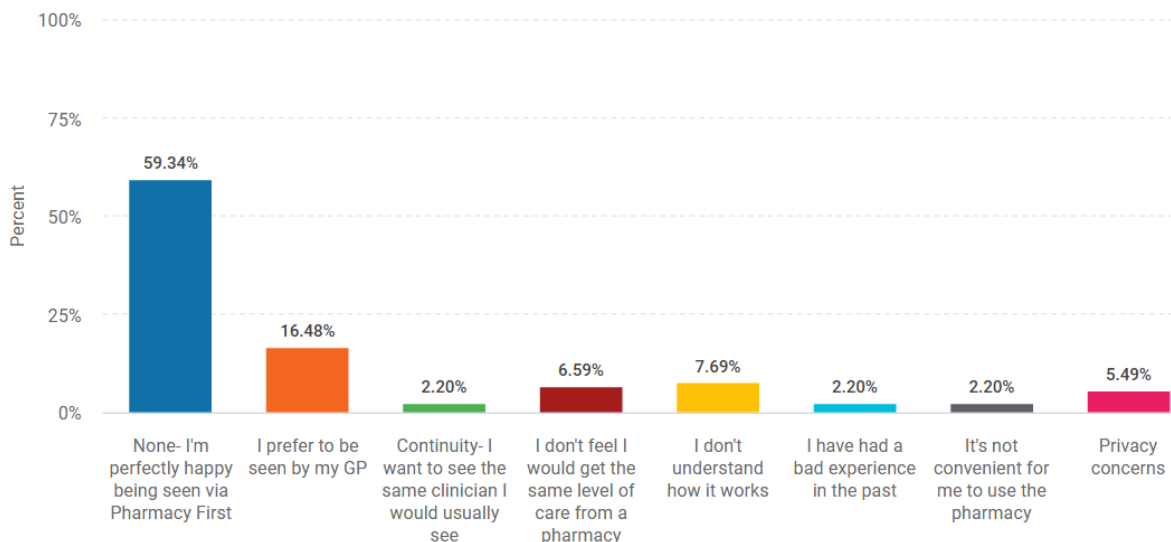
Our patient survey data indicate that many patients are happy to be seen by a pharmacist rather than a GP.

How did/ would you feel about being referred to a Pharmacy instead of a clinician at your GP practice? (select all that apply)



Some of the patients' reasons for not wishing to attend a pharmacy rather than a GP are highlighted below.

What reasons might make you not want to use Pharmacy First? (select all that apply)

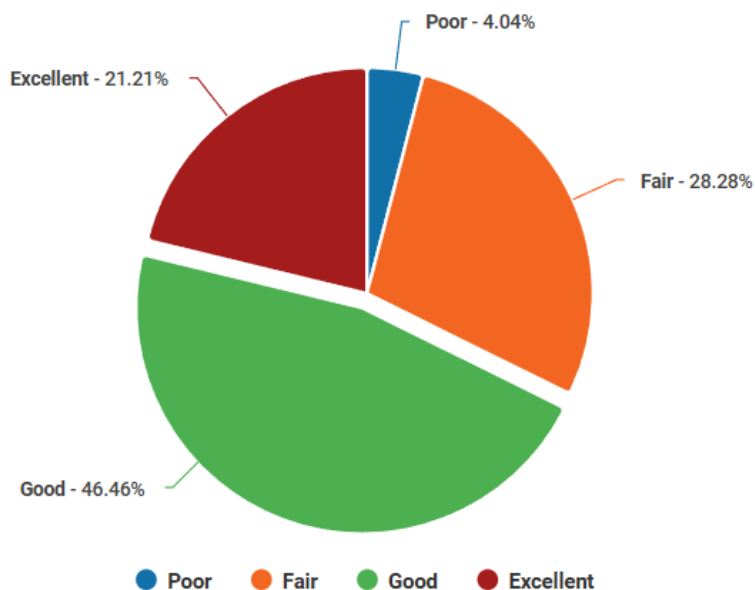


The major factors highlighted are an insistence on seeing a GP, which may be due to Complex Long Term Health Conditions (LHTCs), and a desire for continuity of care or regular GP personnel. Furthermore, concerns about privacy, pharmacist competence and lack of understanding can also reduce engagement.

# What We Found: The Pharmacists' Perspective

## How is the Pharmacy First Initiative Working?

Question 2

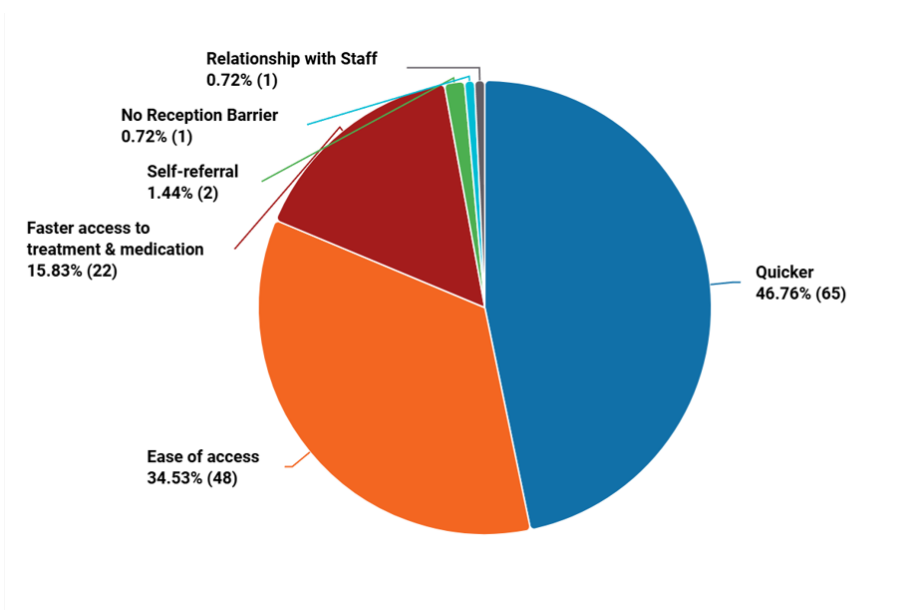


## Does 'Pharmacy First' benefit your business?

Question 3 - Most pharmacists reported that the Pharmacy First initiative benefited their business, with 78.79% answering yes, 20.20% answering somewhat and 1.01% answering no.

## What do you see are the benefits of 'Pharmacy First' for patients?

Question 4



The three dominant themes all highlight how the service can provide much quicker and easier access to healthcare for the seven treatable conditions. This removes the need to: contact GP reception, wait in a telephone queue, wait for a callback, wait to be triaged at 8 am, or ring later to find out that no appointments are available. An important point to consider is that the medication can be supplied immediately after the appointment, without waiting for a GP to send a prescription request to the pharmacy.

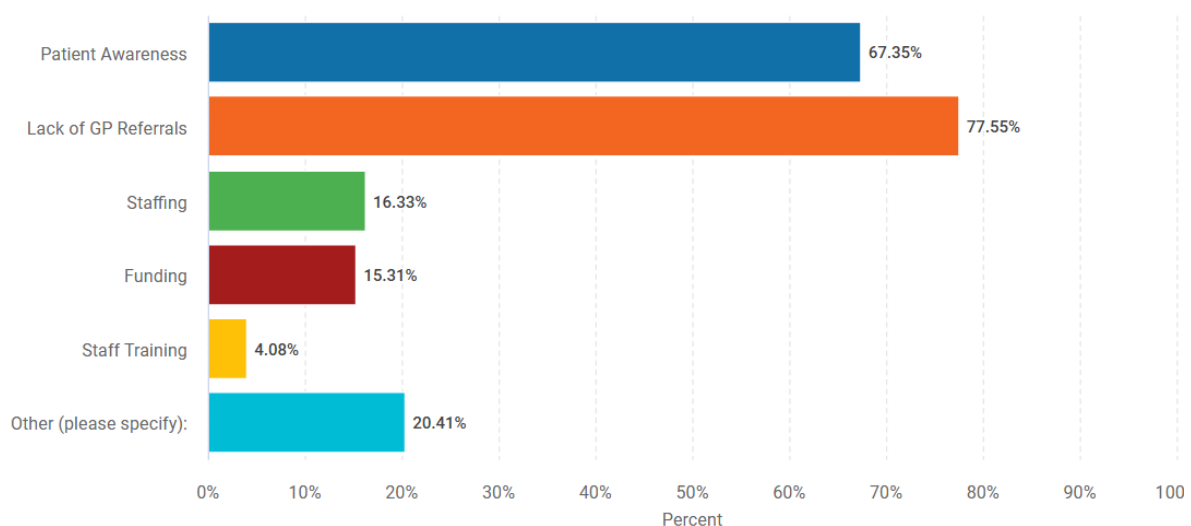
Self-referral was also mentioned, but this must be considered in light of our findings of a significant lack of public awareness. If people are unaware of the service, they are also unaware that they can self-refer.

The absence of a reception barrier was also a very good point, as pharmacy staff are immediately available, although a patient may have to wait or book an appointment to see the pharmacist.

A strong relationship with staff was noted at an independent pharmacy we visited where the whole team, including the pharmacist, worked there every day. The staff had been trained in dispensing and checking, freeing up time for the pharmacist to diagnose and treat patients. During data collection, we observed a very good rapport between staff and customers, with first names used. During our discussion with staff and the pharmacist, they explained how this helped them deliver patient-centred care. Customers were very responsive, and it was much easier for older patients and single mums with children.

## What, if any, barriers have you experienced to the Pharmacy First initiative?

### Question 5



The biggest barrier highlighted by pharmacists was a lack of GP referrals, followed closely by patient awareness. Across all the pharmacies we visited, a range of descriptions of 'referrals' was offered to us, such as a patient walking in, the pharmacist overhearing a conversation with staff and identifying the patient as suitable for Pharmacy First, and GPs making an official referral through PharmOutcomes.

PharmOutcomes is the software programme that all the pharmacists we visited use to manage enquiries and referrals. Some of the pharmacies we visited reported a good level of referrals from GPs and public walk-ins and were achieving second-tier payments. A patient can either be referred or self-refer.

### How Pharmacies are Paid for Pharmacy First

If the patient's symptoms, frequency, and age fit the gateway criteria, a pharmacist will be paid £17.00 per consultation.

For fulfilling 20-29 clinical pathways (Gateway) consultations per month, the pharmacy will receive £500.

For 30+, the pharmacy receives £1000 per month.

Pharmacy First payments are capped by NHSBSA based on previous activity to ensure consistent access to and even national distribution of the service. After 30, the tier is capped, so the pharmacist would only be eligible to claim the £17.00 consultation fee for each consultation thereafter.

#### **a) GP & NHS 111 Referrals**

Some of the pharmacies we visited described a good working relationship with their GPs and received regular referrals, some through PharmOutcomes, but also many ad hoc via GP reception. Many of the pharmacies we visited had not or rarely received official referrals from their local GPs, with many receiving none through PharmOutcomes. A huge issue highlighted during the discussion with the pharmacists is the number of referrals that are incorrect or inappropriate for Pharmacy First, not just from GPs but also from NHS 111.

Many pharmacists described patients being sent by GPs for chest infections, with an expectation of antibiotics, and outside of the gateway criteria, such as over 17 for Otitis Media or over 64 for UTIs, and many other reasons that would exclude them.

NHS 111 referrals were official through PharmOutcomes but were often vague, lacking detail, and inappropriate. Based on discussion notes, our findings show that the pharmacies bearing the brunt of poor NHS 111 referrals are supermarket pharmacies, as they are open later and are usually open on Saturdays and Sundays.

The referrals are not all for Pharmacy First; some are for emergency medication supply, which can take a pharmacist a while to check patient eligibility/identity before supplying or refusing. This can take a substantial amount of unpaid time and affect the pharmacist's availability to provide Pharmacy First services during periods of limited access and possible lower weekend staffing levels.

Thirteen of the pharmacies we visited were attached to, or in the same building as, a GP's surgery. Of the thirteen surgeries, twelve had not received a referral from the adjoining GP. One of the thirteen pharmacists described having a great relationship with 'next door', explaining that patients flow freely and that, if they can't treat them, they take them back to the GPs. The majority are referred ad hoc. Many pharmacists reported requesting meetings with GPs, only for nothing to change or for them to be ignored. Some of the pharmacists believed there may be trust issues with the GPs.

Given that one of the major issues is inappropriate referrals, which lead to patients being sent back to their GPs for treatment, 'next door' would be the ideal scenario for ease of access for patients. In a rural setting, an inappropriate referral can mean a substantial delay in treatment, inconvenience and cost implications for a patient.

Some pharmacists believed that GPs were using them as an overflow service, fulfilling their appointment quota for the day even when the patient qualified for a Pharmacy First consultation, and then sending patients to the pharmacy thereafter. Our principal pharmacist contact provides contrast to this viewpoint:

*"As principal pharmacist in primary care, my personal opinion on this is completely opposite. I value the services that community pharmacy offers, and I am an advocate for them. We use the criteria for Pharmacy First in our initial triage process, after triaging the patient, if we deem them suitable for community pharmacy then they are referred there as first line. Not as an overflow service".*

Many pharmacists believed that GPs were holding on to patients, either for financial reasons or to enhance QOF (Quality and Outcomes Framework) points. Our principal pharmacy contact did not see that GPs would benefit from retaining patients.

Numerous pharmacists reported seeing patients come in regularly for medication prescribed by GPs to treat Pharmacy First conditions. In question 10 we asked pharmacists whether they were receiving the number of referrals they would expect from GPs. 27.27% said yes, with 72.73% saying no.

## **b) Pharmacist Staffing Levels and Funding**

A lack of funding has shifted the responsibility for promoting Pharmacy First squarely onto the pharmacist. Printable resources are available on the Community Pharmacy England website. In a pharmacy with many information leaflets, the message can be lost. Many pharmacists report that improving awareness through patient engagement is a key factor in increasing patient numbers at their pharmacy over time.

## **c) Staff Training**

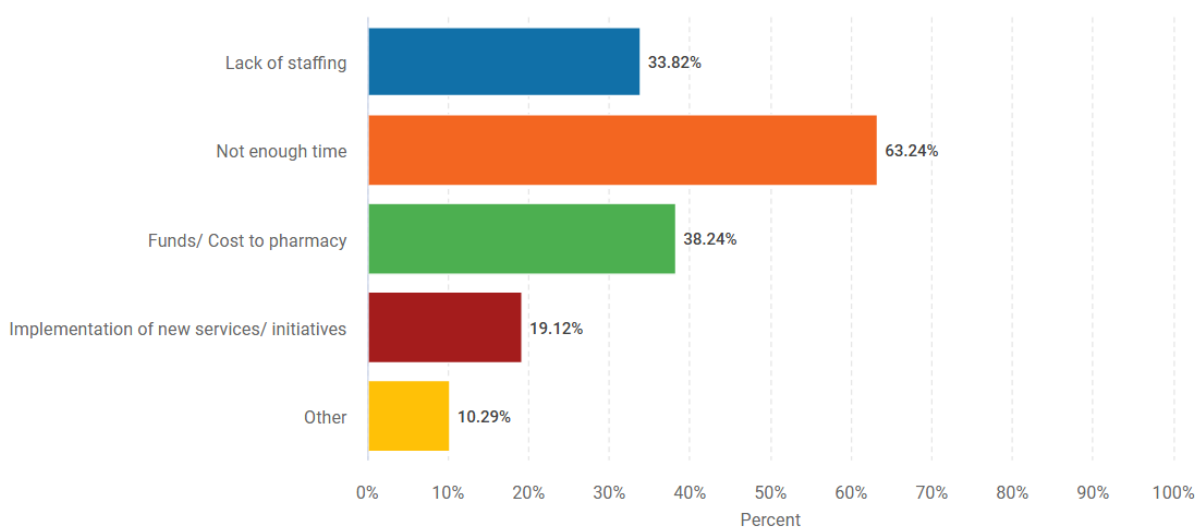
Staff training and funding remain an issue across all healthcare settings. Pharmacists report having to complete Pharmacy First training in their own time, such as at weekends and in the evenings. Some of the pharmacists we spoke to described colour-coding medications and flagging till items to identify Pharmacy First-suitable medications to support wider staff.

A few pharmacists we spoke to wished for more/better training on ear infections (Otitis Media). A couple of pharmacists reported that free online training resources previously available through Community Pharmacy England were no longer free and had to be paid for. This was described as a barrier to upskilling their trainee staff.

The staff previously mentioned who had trained in dispensing and checking to support the pharmacist in diagnosing and treating informed us that this incurred a cost to the pharmacy of around £200 per staff member, and the qualification required renewal every 2 years.

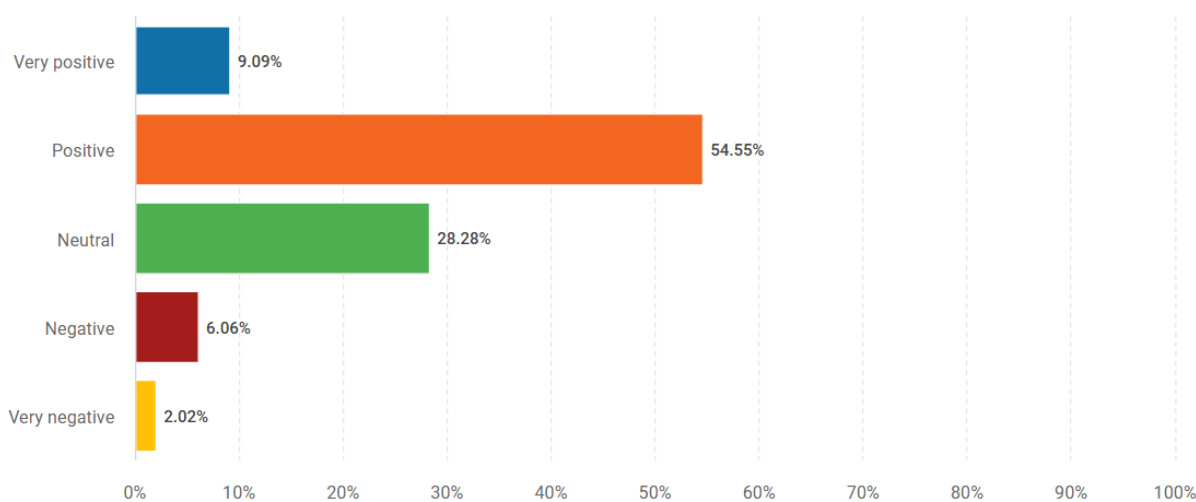
#### d) Barriers to Staff Training

Over 82.82% of pharmacists reported the need for additional staff training to implement the service effectively. The barriers to meeting these training requirements are highlighted below.



During many of our discussions with pharmacists, many staff were comfortable with the changes and saw them as part of their work. Alongside this, pharmacists supported staff by colour-coding and flagging medications at the till to help identify suitable patients.

How staff felt about the additional responsibilities is represented below:



#### e) Locum Pharmacists

Many of the pharmacists we visited used locums on the day, who sometimes worked regular hours/days across stores or covered pharmacist annual leave. The small independent pharmacists who used locums for cover experienced Pharmacy First cases being left on the system for their return to work, and some had timed out on PharmOutcomes. We enquired why this happens and were informed that many locums do not want to do the training to support Pharmacy First, as it's unpaid and in their own time. During discussions with larger chain pharmacies, they insisted that management will not employ locums who don't do Pharmacy First.

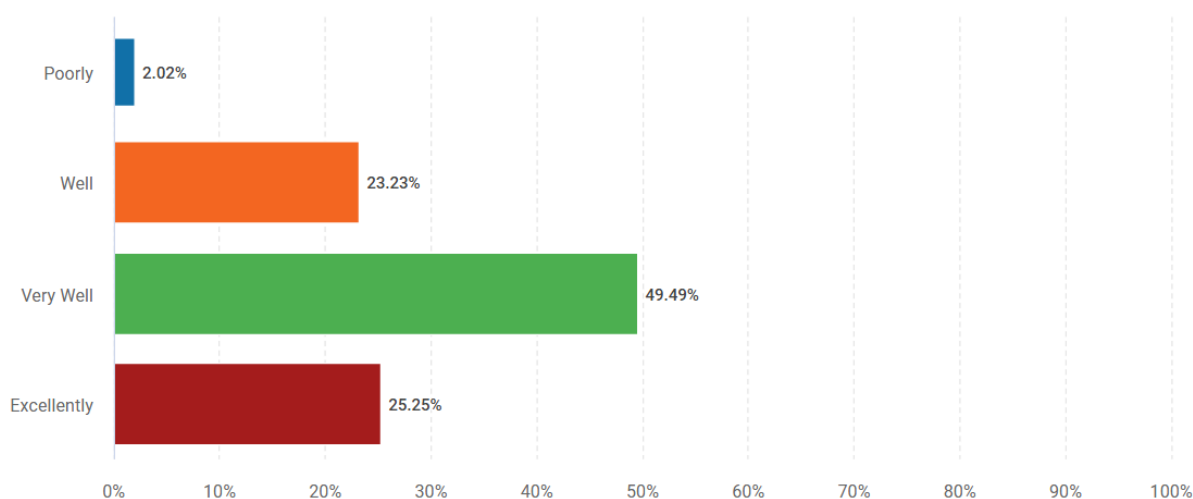
## f) Others/Additional Barriers concerning Q5:

A further significant category, representing 20.1%, was barriers to Pharmacy First, including GPs withholding patients, inappropriate referrals, and receptionists unaware of the gateway criteria and therefore of suitability for a Pharmacy First consultation.

## How Pharmacists are treated by Patients Using the Service.

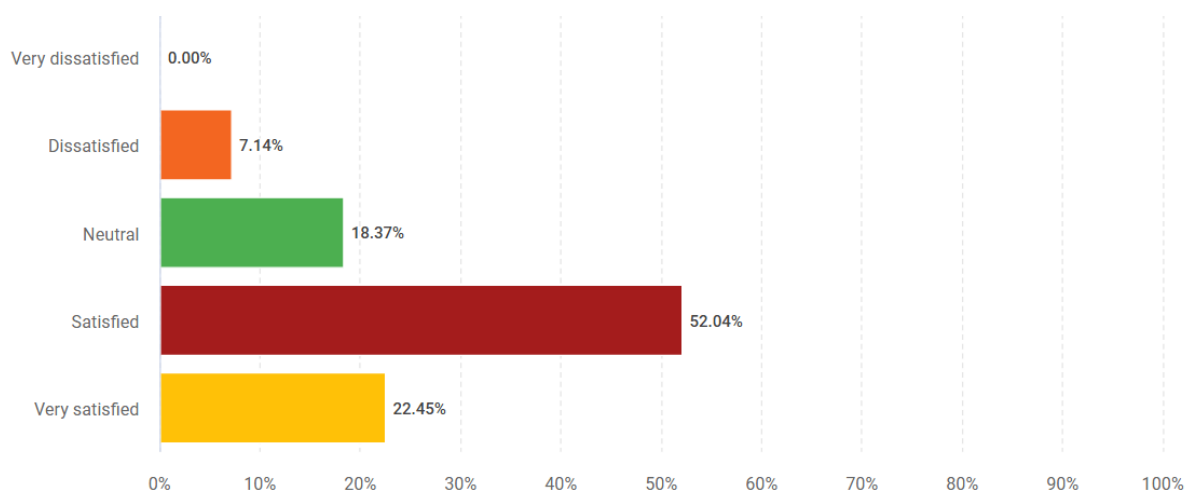
Many pharmacists reported being treated well by patients using the services. An important contextual factor to consider is that many patients are sent incorrectly or inappropriately by GP reception or NHS 111, with the expectation that they will be treated. When they realise this is not the case, they can become frustrated or annoyed. Many of the pharmacists we spoke to described supporting patients in securing an appropriate GP appointment or providing guidance on what to do next. This support, which enhances patient-centred care, can take as long as a consultation under Pharmacy First and is unpaid.

How do you feel you are treated by patients using Pharmacy First?



## How do Pharmacists feel about the Implementation of Pharmacy First?

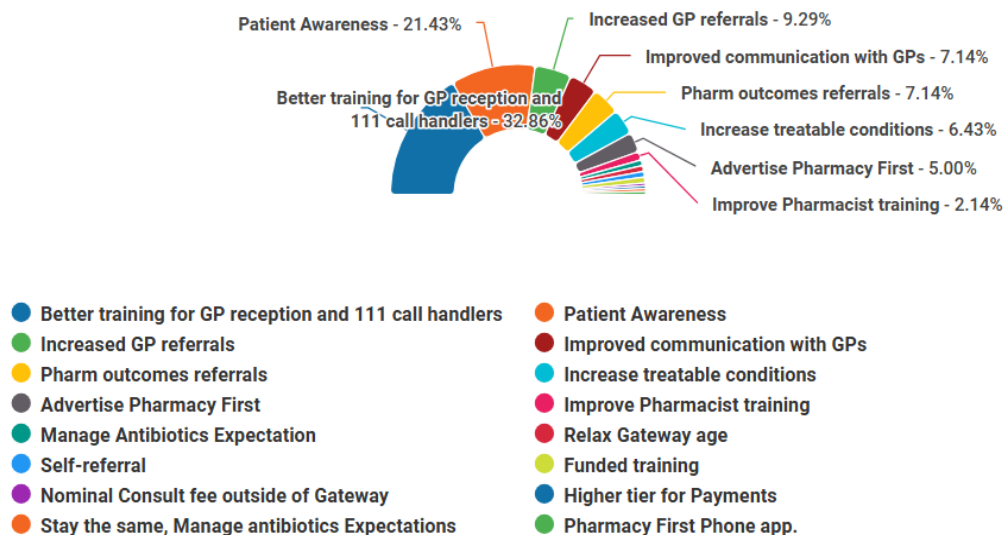
Overall, many of the pharmacies we visited were satisfied or very satisfied with the service's implementation (74.49%), with 18.37% reporting neutrality and 7.14% dissatisfied.



This must be considered in the context of many pharmacies expressed views on what was and was not working, as well as suggestions on how to improve the service.

## Room for Improvement: Pharmacists' Perceptions of how the Service can be Improved.

What do you think could be done to improve the implementation of Pharmacy 'First'? Sentiment Analysis



Many pharmacists reported that GP receptionists and NHS 111 call handlers were completely unaware of the gateway criteria framework for the seven treatable conditions under Pharmacy First. This was identified as an area requiring much greater training support for the appropriate people to understand what is referable and what is not. This would help reduce the number of patients being referred only to be found ineligible and then sent back to the GPs.

Raising patient awareness was another key factor, as people would then be able to self-refer without even contacting their GP. Raising public awareness would not only support pharmacy income but also reduce pressure on GP appointments.

Greater synchronicity between GPs and pharmacists was described as necessary to improve the service, including official referrals through PharmOutcomes, better connection with staff, and working together to improve awareness of the gateway framework.

Other factors mentioned included improved training for pharmacists, managing antibiotic expectations, expanding the range of treatable conditions, relaxing the gateway ages, and funding pharmacist training.

A further interesting idea arose from a discussion with a pharmacist. A major issue is that GPs or NHS 111 do not identify patients as eligible or ineligible, which leads to multiple patients ending up in the wrong place. We wondered whether an NHS phone app might solve the triage gateway protocol problem, making suitable patients identifiable before they arrive at the pharmacy.

The pharmacist directed us to a QR code on his counter and said, 'This is it', after explaining that it was a QR code for patients to scan, enabling them to determine suitability through PharmOutcomes. This was the only pharmacy we visited that was aware of this service. Many others we asked thereafter knew nothing.

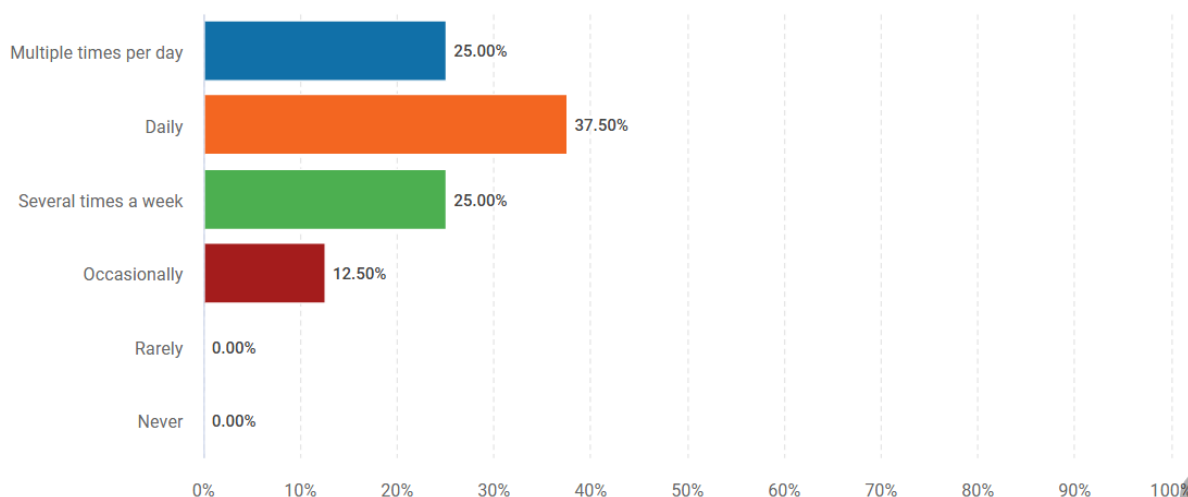
### Additional Findings at the University Campus Pharmacy

One of the pharmacies we visited was situated on a University Campus. The feedback we gathered by talking to the pharmacist enlightened us to a situation that could apply to any Pharmacy or relate to Pharmacy First medication dispensing. The pharmacist informed us that many international students when using a pharmacy are not aware that antibiotics and medications need to be paid for, as in many different countries they are free. If the student is eligible, costs can be claimed back. Furthermore, certain medications are not available in the UK that are in other countries.

### What the GPs thought about Pharmacy First

An important point to consider about the GP response we received is that the response rate was very low, with only 8 online and 1 via reply email. This can be interpreted in several ways: the GPs may be too busy, indifferent to Pharmacy First, or holding on to patients or mistrusting pharmacists. Some of the data presented below conflicts with the picture built from our pharmacy and patient data.

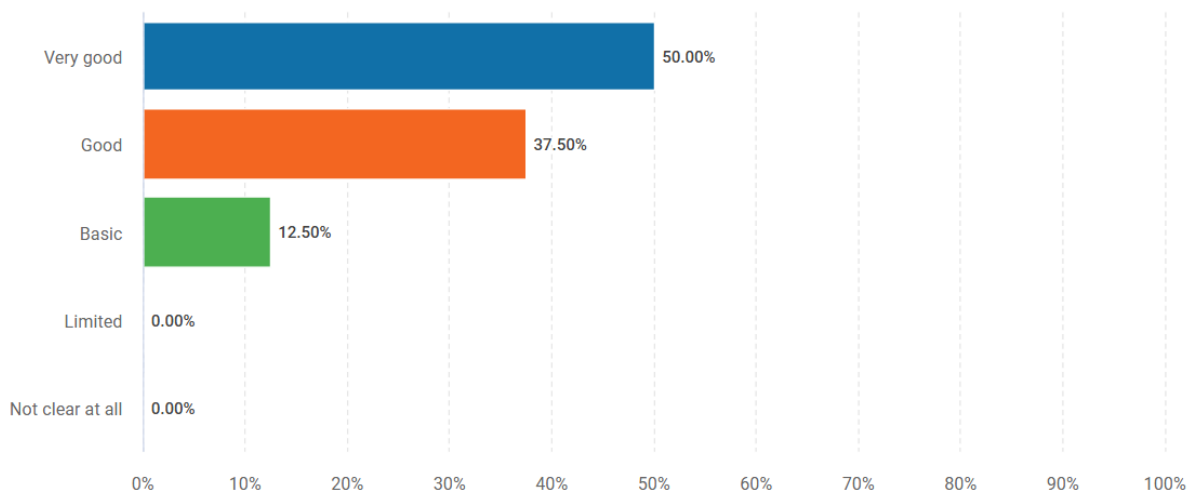
### How often would you consider Pharmacy First as an option for referral?



This may be more congruent with the situation we discussed with some Pharmacies, where the initiative is working well, but not with what was described by many Pharmacies we visited.

We invited GPs to provide an opinion on the relevant referring staff's understanding of the Pharmacy First gateway framework:

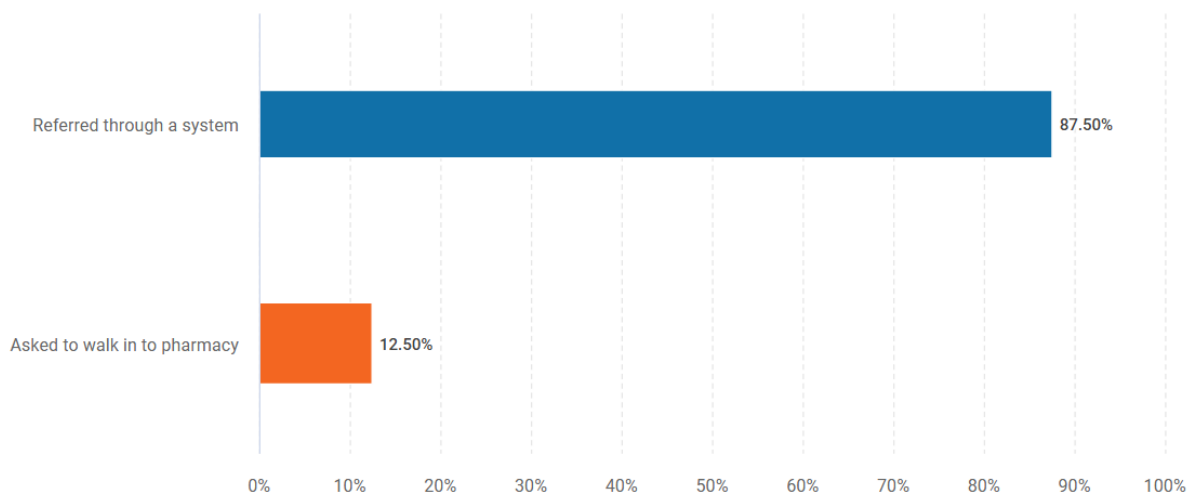
How would you rate relevant/referring staff's understanding of the Pharmacy First initiative and it's intended purpose?



This directly conflicts with the feedback we received from many pharmacies about continuous referrals of patients who are not suitable for treatment, as they are outside the gateway. In many cases, these referrals are from GP surgeries for chest infections that are not covered under Pharmacy First and require stethoscope training to administer diagnosis and treatment.

A further divergence in our findings is that the GP position is that a high number of the referred patients are appropriately referred through an appropriate programme (PharmOutcomes).

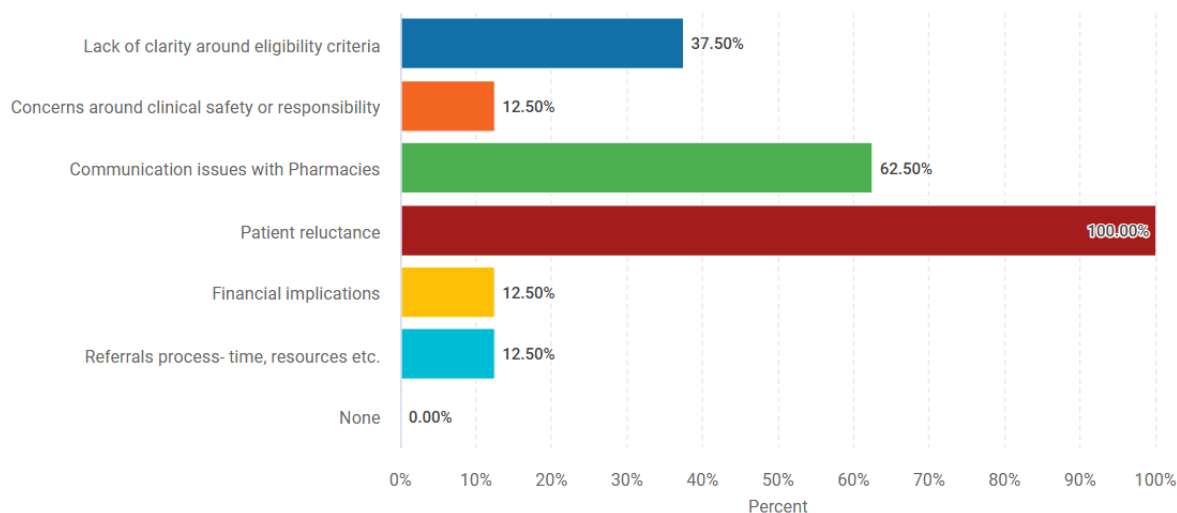
Are patients referred through a system, or asked to walk in to a pharmacy?



This contradicts our data from the pharmacists, who described that most patients are referred ad hoc and, in many cases, are simply told to go to the pharmacy.

The following chart provides interesting information on the GP's barriers to referring patients to a pharmacy and, in part, conflicts with a previous answer on staff confidence in gateway criteria.

What are the main barriers to referring to Pharmacy First in your practice? (select all that apply)



The reporting of a lack of clarity surrounding gateway criteria (37.50%) conflicts with the previously reported 87.50% of referral staff knowledge, described as very good (50%) or good (37.5%). The difficulties are highlighted in this excerpt:

*“Patients referred to the Pharmacy First under the guidelines are treatable, but when patient goes, they are referred back to the doctors saying they can't treat. No clear guidelines on what conditions can be seen”.*

Concerns about clinical safety support the pharmacist's previously discussed perspective of mistrust. Communication is an issue for both GPs and pharmacists and can only be resolved by talking and working together to improve the situation. Patient reluctance described by GPs sits directly at odds with the reported pharmacist and public perceptions of the initiative's acceptance.

The financial implications of referring to a pharmacist are highlighted by one GP below:

*“We are a surgery with our own pharmacy, so we only ask patients to attend a pharmacy when we are unable to get the medication they have requested. We would not do this all the time only when there is a shortage. We would, however, advise patients to attend with children with ear pain, rash, need for paracetamol only etc when our doctors are unable to see them. Anything else then this would cause a financial problem for our surgery”.*

A further point to consider is that proper referrals through PharmOutcomes require a staff member to input details, send the referral, manage it thereafter, and document an outcome. This process puts a strain on already busy GP practices.

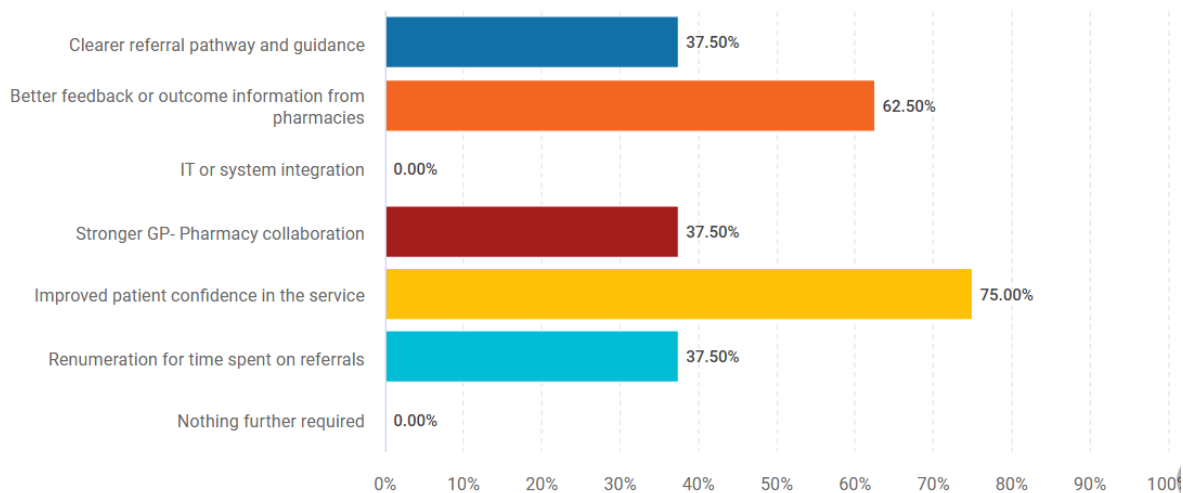
An additional excerpt supports the difficulties locums who refuse to train in Pharmacy First create:

*“When the Pharmacy we refer to has a locum Pharmacist who does not do all of the schemes and sends the patients back to the practice.”*

Largely, the issues reported by Pharmacists, patients, and GPs converge, but they are experienced differently from each perspective.

## How to improve GP’s confidence in the initiative

Which of the following would most improve your confidence and use of Pharmacy First by your practice? (select all that apply)



This further supports the need for better communication and closer relationships to enhance the bidirectional relationship required for the initiative’s greater success. Improvements in IT system integration have been mentioned in many previous reports. In Staffordshire, it doesn’t seem to be reported as an issue by GPs, as above, or by pharmacists, as they all stated that they use PharmOutcomes and, when they do receive referrals, that is how they receive and process them. Patient confidence can only be improved by raising public awareness, as people cannot have confidence in something they are not aware of or don’t understand properly.

## GP email response

One GP practice contacted us via email to provide a longer response. They outlined difficulties they face, with many patients initially being contacted by the pharmacist by telephone only to be told “that sounds like a chest infection” and then sent back to the GP with the expectation of antibiotics. The surgery reported this as a regular occurrence, and, after patient assessment, the cases are simple viral or self-limiting illnesses that require only reassurance and self-care.

## Reported practical challenges observed and heard concerning the service:

- Variation in how consistently Pharmacy First is applied across different pharmacies
- IT and communication limitations between general practice and community pharmacy

- Medication supply issues, which can limit what pharmacies can offer under the scheme
- Workforce pressures across both primary care and community pharmacy
- Patient expectations regarding antibiotics, which can influence redirection back to the GP

The practice was keen to emphasise that they regarded it as a shared-system endeavour and remained committed to building relationships, improving communication, and working collaboratively.

## Summing up the GP position

It's hard to draw concrete conclusions about the GP position given the poor engagement, but when considered in the context of this report saying nothing, that silence says something. This may be interpreted as a majority's indifference to the service, being under unsustainable time pressures, or a wish to retain patients either for financial reasons or out of mistrust.

## Further Insight: Key Points & Real-world Pressures

The following insights were provided by our principal pharmacist contact who works in Primary Care across several GP practice groups in the NHS Combined Trust.

- **The PharmOutcomes System:** A massive barrier that isn't really captured in the report is how clunky and time-consuming the PharmOutcomes system is for a pharmacist to use. Inputting a patient consultation is often an overwhelming process because of the sheer volume of alerts, warnings, and contraindications that you have to click through. It feels like the system is designed to "cover every single eventuality" to an extreme clinical degree, rather than allowing for and trusting the professional discretion of the pharmacist.
- **Wider Training for GP Teams:** While I know the Staffordshire Local Pharmaceutical Committee or LPC (as they were previously known) did offer support with this, a more visible, easily accessible training package is definitely needed. Implementing a wider training programme—where GP practice teams could perhaps come in for a dedicated training day, get physical materials, and receive practical advice on how to embed the pathways into their daily workflows—would be much better received.
- **Remuneration and Gateway Restrictions:** Funding for community pharmacy is always a massive issue. The restrictions on payments when a patient doesn't meet specific gateway criteria points are highly contentious. Pharmacists are still carrying out the clinical triage and doing the actual work, but they end up not getting paid for their time if the criteria aren't met. This is exactly why getting triage and referrals right at the surgery level is so vital.
- **The Legacy of CPCS:** The Community Pharmacist Consultation Service (CPCS) that came before Pharmacy First unfortunately laid some pretty bad foundations, especially in deprived areas. As a forward-thinking practice, we always wanted to engage with local incentives and actively pushed for CPCS uptake—like referring patients for over-the-counter

verruca treatments a few years back. However, patients were referred to the pharmacy only to turn back up at the GP surgery because the service wasn't free and they couldn't afford the retail cost. Granted, the new Pharmacy First service successfully offers free medications to those who qualify for free prescriptions, but the damage to patient trust was already done, and many of these patients still don't want to be referred there now. This is further compounded by current teething issues, like locum coverage inconsistencies where the service is temporarily unavailable.

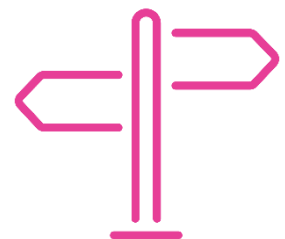
- The Pharmacy Contraception Service Success: To highlight where integration *is* working brilliantly, we are huge advocates for the NHS Pharmacy Contraception Service. Our practice actively routes patients to community pharmacies for oral contraception reviews, initiations, and management rather than booking them into the surgery for first-line care. This is having a genuinely positive impact on our practice, successfully freeing up vital appointments so our practice nurses can focus their time on comprehensive, complex Long-Term Condition (LTC) reviews.
- The Impact of the October 2025 GP Contract Changes.

General practice is currently undergoing massive changes following the October 2025 contract updates, which aren't mentioned in the report. These changes are fundamentally shifting the dynamics between general practice and community pharmacy. With requirements enforcing longer core opening hours for GPs up until 6:30 PM, the pressure on our appointment capacity has intensified significantly. This contract shift represents a powerful opportunity: now, more than ever, general practice *needs* a highly functioning, reliable Pharmacy First service to act as a vital release valve for acute care.



## Conclusions

The present report highlights several key issues concerning the effective implementation of Pharmacy First. Connectivity and communication between GPs and pharmacists are often poor and will require open, honest conversations to build relationships and trust. The referral process lacks a defined framework and, in many cases, is as simple as telling a patient to go to the pharmacy. GP and NHS 111 staff are unsure of the gateway criteria, so they refer inaccurately and inconsistently, resulting in many patients being referred back to their GP. As reported, some pharmacists are assessing patients over the phone and referring them to GPs for antibiotics for a low-



level viral condition. Furthermore, some locums are sending patients back to GPs because they are not trained to treat them. This creates confusion and frustration for patients, and, to avoid this in future, they may well choose to insist on a GP appointment next time. This one issue alone is leading to many patients having a poor experience of the initiative. In a rural setting, time, access, and cost implications can be exacerbated further.

The findings from both the pharmacist and GP data demonstrate the need for improved training and awareness among referring staff about the Pharmacy First gateway criteria, to clarify eligibility before referral and reduce inappropriate referrals. If communication improves, the ideal solution would be to engage pharmacists to train GP referring staff on the gateway criteria, as they know them intimately. If funding were improved, this could be implemented alongside better training for pharmacists and by making Pharmacy First training mandatory for locums. Furthermore, funded training resources for pharmacists would enable them to upskill staff.



Since its introduction in 2024, the Pharmacy First initiative has been advertised nationally, yet there remains a distinct lack of public awareness of the service and how it works. This uncertainty and lack of awareness around the service and self-referral reduce the number of patients a pharmacy can treat, limiting their ability to meet tiered threshold payments in many cases, as some pharmacies receive no GP referrals to support the walk-in numbers they see.

The issue surrounding official referrals needs clarification. Pharmacists believe GPs are retaining patients because there is a financial incentive to do so, whereas GPs are not officially referring in most cases because of the time cost to them, as a staff member is required to type out, send and manage the referral via PharmOutcomes and record the resulting information on return. Official referrals would provide greater detail on what was treated and when in patient records. Consideration could be given to incentivising GPs to refer officially. The need for correct patient referral and an efficient Pharmacy First service is needed now more than ever due to increased pressure placed on GP practices as a result of the GP contract changes introduced. The changes have increased pressure on appointment capacity for GP practices. If the issues of communication, trust, connectivity between GPs and Pharmacies are not addressed this may result in sustained long-term pressure on GP practices.

An important part of the NHS 10-year plan is to improve digital connectivity, enhancing patient healthcare connections alongside intra-healthcare connections across services. This digital enhancement may be used to confirm patient eligibility for the service at the point of access. If a phone app were developed, or if a QR code were included on all advertising, it would direct users to a gateway triage for the 7 treatable conditions, such as the PharmOutcomes pathway mentioned earlier. Patients, referring staff, and pharmacists would be able to determine eligibility in most cases and, in addition, support people who are not digitally literate. Alongside this, many social media platforms could be used to advertise the service and support gateway eligibility determination. It could also be incorporated into the NHS digital app.

The issues remain complex, many have been previously reported concerning limited primary care functions transferring to pharmacist and still exist now years later. The same issues also affect the Pharmacy First implementation. There is no easy fix, raising public awareness, making eligibility easier to determine, and improving GP and pharmacist relationships. Alongside supporting with funded training for allied healthcare staff on the gateway, diagnostics, and support for pharmacists to upskill staff, would go a long way toward improving the situation, locally and nationally.

This would reduce confusion and frustration for patients experiencing fragmented, back-and-forth care, enabling many to access quicker, more efficient healthcare and reducing their frustrations surrounding access to and availability of GP appointments on any given day. Furthermore, pharmacies will be able to provide more efficient care alongside maximising their income stream and easing the pressure on GP practices by freeing up appointments for patients in need.

## Acknowledgements

We would like to give a big thank you to everyone who has helped with this report:

- Ashley Heath the Principal Pharmacist who gave us additional insights.
- Students Areesha Qazi and Aliza Toor supported with planning and data collection while Diana Mukheisin supported with planning, data collection and drafting the introduction and background information.
- Support Staffordshire staff who visited pharmacies with us for data collection.
- All the pharmacists, patients and GPs who kindly responded to our survey.

Healthwatch Staffordshire  
Stafford Civic Centre  
Riverside  
Stafford  
ST16 3AQ

**healthwatch**  
Staffordshire

[www.healthwatchstaffordshire.co.uk](http://www.healthwatchstaffordshire.co.uk)  
t: 0800 051 8371  
e: [enquiries@healthwatchstaffordshire.co.uk](mailto:enquiries@healthwatchstaffordshire.co.uk)  
@HWStaffordshire  
@HWStaffordshireOfficial