

Pharmacy First is changing what patients can get from their local pharmacy—and what pharmacy teams need to do to deliver it. In England, the NHS service launched on 31 January 2024. It allows community pharmacies to assess and, where appropriate, treat people for seven common conditions without a GP appointment. The service also includes urgent repeat medicine supply and blood pressure checks.

For patients, that can mean quicker access to care close to home. For pharmacy owners and managers, it means a bigger clinical role, more complex workflows and new demands on staffing. The central challenge is not simply to recruit more people. It is to build a workforce with the skills and capacity to deliver the service reliably, alongside dispensing and other day-to-day work.

What is the Pharmacy First service?

Pharmacy First is an NHS England service delivered through participating community pharmacies. It provides assessment and treatment for seven conditions through defined clinical pathways:

- Acute otitis media (earache) in eligible patients
- Impetigo
- Infected insect bites
- Shingles
- Sinusitis
- Sore throat
- Uncomplicated urinary tract infections in eligible women

The pharmacist follows the relevant pathway, checks whether the patient is suitable for pharmacy care, gives advice and, where clinically appropriate, supplies treatment. Some patients will need referral to another service instead. Pharmacy First is not a guarantee of a prescription or a substitute for emergency care.

The service also incorporates urgent supply of some repeat medicines and NHS blood pressure case-finding. These elements add to the clinical work pharmacies may provide, but they are distinct from the seven condition pathways.

Why introduce Pharmacy First?

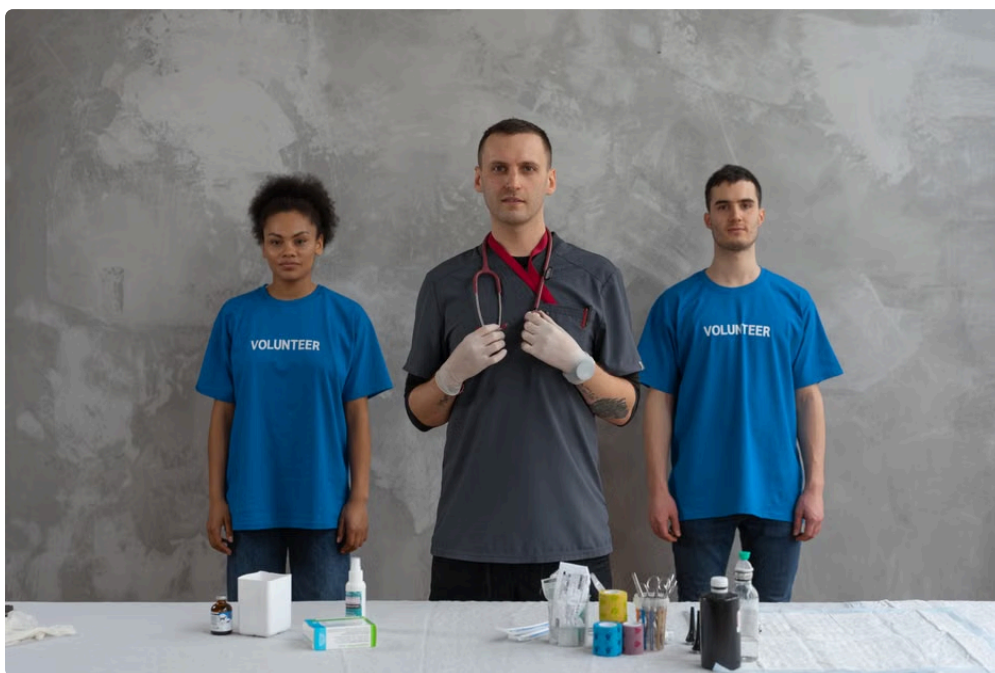
Pharmacy First is part of a wider effort to make better use of community pharmacy and improve access to primary care. Pharmacies are often easy to reach, and many patients can seek advice without first securing a GP appointment. For suitable conditions, a trained pharmacy team can assess the patient and help them access appropriate treatment or onward care.

This matters in a system where GP practices and other primary care services face heavy demand. A pharmacy consultation can provide another route for care, but it does not make the underlying workload disappear. It moves some work into a different setting and requires the pharmacy to have the people, time, systems and clinical support to manage it.

How Pharmacy First is changing the community pharmacy role

The community pharmacy role change is significant because it puts more emphasis on assessment, clinical decision-making, consultation and referral. Dispensing remains essential, but teams also need to create space for

conversations that cannot always be predicted or completed in a few minutes.



That shift affects the whole operation, not only the pharmacist. A consultation may involve checking eligibility, gathering a history, documenting the outcome, explaining treatment and arranging a referral when needed. Support staff may help manage patient flow and routine tasks, while working within their training and scope of practice. Everyone needs to know when to escalate a concern.

Workload does not arrive one patient at a time

Pharmacy First activity can overlap with dispensing peaks, phone calls, deliveries, stock problems and staff breaks. A patient who arrives with a clinical concern may need prompt attention, while the rest of the queue keeps moving. If a pharmacist has to leave the dispensary for a consultation, the team needs a workable plan for maintaining safe services.

This is where the primary care pharmacy workload becomes visible at shop-floor level. The consultation itself is only part of the job. Teams also need to handle documentation, referrals, follow-up where required and communication with other services. These tasks need time in the rota, not just a place in a service specification.

Clinical work needs dependable cover

A service is difficult to provide consistently if it depends on one person being available every day. Annual leave, sickness, training and unexpected demand all affect cover. Managers need to plan who can take on which responsibilities, what happens when the pharmacist is occupied and how staff can ask for clinical support.

That planning matters for patients as well as staff. A rushed consultation, unclear handover or lack of time to record an outcome can undermine the service. The practical test is whether the pharmacy can deliver the pathway safely on an ordinary busy day—not only when the rota is fully staffed and the workload is quiet.

Workforce numbers and capacity are under pressure

Community pharmacy faces persistent recruitment and retention challenges, but it is important to be precise about what “workforce numbers are falling” means. Pharmacy workforce figures differ by role, geography and data source, and a count of pharmacy premises is not the same as a count of staff. A pharmacy that closes, for example, does not tell us exactly how many pharmacists or technicians have left the profession.

What owners and managers encounter locally is often more immediate: difficulty filling a vacancy, limited access to locum cover, competition for experienced staff and the loss of time when a team member leaves. Those pressures reduce capacity even when a national headcount does not capture the problem clearly. Before using a workforce statistic, check its date, the roles it covers and whether it measures people, full-time equivalents, vacancies or premises.

Pharmacy First adds to that capacity challenge. It creates more clinical work at a time when many teams already have to balance dispensing, service delivery and business operations with limited cover. Recruiting more people may be necessary, but recruitment alone does not resolve a shortage of suitably prepared staff or the time needed to develop them.

Why recruitment-only strategies fail in a tight labour market

When vacancies are hard to fill, “advertise again” is not a workforce plan. A pharmacy may need to recruit externally, but every employer in the local area may be pursuing the same small group of experienced candidates. Repeated adverts can consume management time without improving the supply of skilled people.

Recruitment-only strategies also overlook retention. A new employee is more likely to settle when the job has clear expectations, a supportive manager, realistic workloads and a route to develop. If an employer advertises career progression but cannot explain the next step, who provides support and how learning fits around shifts, the promise is hard to trust.

Nor should apprentices be treated as cheap labour. An apprentice needs a structured role, protected learning and appropriate supervision. They contribute to the workplace while developing competence; they do not replace a qualified professional or instantly solve a rota gap. The business case is longer term: develop skills in the team and create a more reliable source of future recruits.

How apprenticeships create a staffing pipeline

A useful staffing pipeline is specific. It identifies the roles a pharmacy needs, the skills those roles require, who can learn them and what support will help that person progress. In practice, that means connecting training to real tasks and reviewing progress regularly—not simply enrolling someone and hoping that learning will happen around the edges of a busy shift.

Apprenticeships can support that approach by combining employment with structured learning. Depending on the programme and the learner's role, pharmacy apprentices may develop knowledge and skills relevant to pharmacy services, customer care, dispensing support or technician training. The right programme depends on the work the employer needs, the learner's starting point and the applicable training and regulatory requirements.

Make the plan practical

1. **Start with a skills gap.** Identify the work that is difficult to cover now, and the roles the pharmacy expects to need over the next few years.
2. **Choose a suitable programme.** Check entry requirements, the qualification or standard, the expected time commitment and how the training fits the learner's job.
3. **Protect learning time.** Agree how the learner will complete off-the-job training and who will help them apply new knowledge at work.
4. **Assign supervision.** Name the person responsible for regular check-ins and make sure supervision fits the learner's role and scope.
5. **Review progress.** Discuss what the learner has practised, what they need next and whether the rota gives them a fair chance to develop.

Owners considering training options can review the pharmacy apprenticeship training category at tendtraining.co.uk. Use the category as a starting point for comparing relevant programmes, then confirm the current entry criteria, funding position, delivery arrangements and employer responsibilities directly with the provider. These details can change, so check them for the planned start date rather than relying on an old advert or assumption.

Build Pharmacy First into the workforce plan

Pharmacy First will not produce sustainable change if the service sits on top of existing work without a staffing plan. Managers can start by mapping the week: when consultations tend to arrive, which dispensing periods are busiest, who can cover key tasks and where breaks or training time are most likely to be squeezed.

A simple review can make the pressure visible. Track service activity alongside staffing and routine workload for a set period, such as four weeks. Record when the pharmacy turns away or redirects a patient, when consultations compete with dispensing and when the rota lacks cover. Use that evidence to decide whether the answer is a different shift pattern, task allocation, additional recruitment, training—or a combination.

Workforce question What to check Why it matters Can we staff consultations? Pharmacist availability, peak periods and planned absence Clinical appointments need safe cover for other pharmacy work Can the wider team support the service? Task allocation, role boundaries and escalation routes Clear responsibilities help the team manage patient flow safely Can we grow skills internally? Training needs, supervision and protected learning time Development can reduce dependence on repeated external hiring Are we retaining trained staff? Workload, development conversations and reasons for leaving Recruitment adds little capacity if skilled employees quickly depart

What pharmacy owners should take away

Pharmacy First is both a service change and a workforce challenge. It gives community pharmacies a larger part in the delivery of primary care, with more assessment, treatment and referral work taking place in the pharmacy. That

can improve thebusinessdesk.com access for suitable patients, but it also brings extra pressure on staff, rotas and consultation capacity.

Recruitment remains part of the answer, especially where a pharmacy has an immediate vacancy. But in a tight labour market, employers also need to retain experienced staff and develop new capability. A well-supported apprenticeship can contribute to that longer-term plan when the role, training, supervision and time commitment are clear.

The practical question is not only whether a pharmacy can offer Pharmacy First today. It is whether it can keep delivering the service safely next month, during a busy week, when someone is away and the usual workload has not paused. That is where a credible workforce plan—and a training pipeline built around real roles—makes a difference.