ROYAL PHARMACEUTICAL SOCIETY

Major conditions strategy: call for evidence

Royal Pharmaceutical Society response

Cardiovascular disease

Cardiovascular disease (CVD) is a general term for conditions affecting the heart or blood vessels. It is one of the main causes of death and disability in the UK, and includes coronary heart disease, strokes, peripheral arterial disease and aortic disease. Atrial fibrillation (an irregular, and sometimes fast heartbeat), high blood pressure and high cholesterol are all risk factors for CVD. Evidence suggests taking action on these 3 risk factors will significantly reduce the number of strokes, heart attacks and other types of CVD.

Question

In your opinion, which of these areas would you like to see prioritised for CVD? (Select up to 3)

- ***Preventing the onset of CVD through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)***
- ***Stopping or delaying the progression of CVD through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)***
- ***Getting more people diagnosed quicker***
- ***Improving treatment provided by urgent and emergency care***
- ***Improving non-urgent and long-term treatment and care to support the management of CVD***

Question

How can we successfully identify, engage and treat groups at high risk of developing CVD through delivery of services that target clinical risk factors (atrial fibrillation, high blood pressure and high cholesterol)? (Please do not exceed 500 words)

Pharmacists working in primary care have a significant role to play in this area. Community pharmacies, in particular, are situated in the heart of communities and can be commissioned to provide services that focus on prevention of CVD including smoking cessation, weight loss, alcohol reduction and wider liftestyle interventions. Community pharmacies are easily accessible. Adults in England visit a pharmacy on average 16 times a year and 1.2 million daily visits to pharmacies are for health-related reasons, making pharmacy the pefect place to identify, engage and treat those at high risk.

Community pharmacists are also ideally placed to recognise early signs and symptoms of long-term conditions, including CVD, and are able to have a discussion with the person and provide advice on self-care as well as refer to a prescriber if appropriate. Community pharmacies are already being commissioned to provide blood pressure checks but this could be expanded to other areas including detection of atrial fibrillation and monitoring of murmurs to detect heart valve disease. A pilot study in Farnborough showed that community pharmacists can play an important role in the detection of heart valve disease.

The expansion of the blood pressure case finding service for community pharmacy was confirmed in the primary care recovery plan, showing the important role that pharmacy teams can play in detecting and then managing high blood pressure in community settings.

In the future we would see people have walk in access to health improvement services that meet local needs, such as, provision of advice, digital therapies and prescribing of medicines for communicable and non-communicable diseases, women's health and vaccination programmes via their community pharmacy. Pharmacy teams would proactively provide people with opportunities for early detection of ill health through targeted interventions that use population health data and maximise ongoing advances in technology, such as wearables, 'inside-ables' and point of care testing.

Chronic respiratory diseases

Chronic respiratory diseases (CRDs) affect the airways and other structures of the lungs. Some of the most common are chronic obstructive pulmonary disease (COPD), asthma, occupational lung diseases and pulmonary hypertension. Respiratory diseases contribute to around 8,000 preventable deaths in the under 75s in England each year, and the UK has the highest prevalence of asthma in the world at around 9 to 10% of the adult population.

Question

In your opinion, which of these areas would you like to see prioritised for CRD? (Select up to 3)

- ***Preventing the onset of CRDs through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)***
- ***Stopping or delaying the progression of CRDs through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)***
- ***Getting more people diagnosed quicker***
- ***Improving treatment provided by urgent and emergency care***
- ***Improving non-urgent and long-term treatment and care to support the management of CRD***

Dementia

Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of brain functioning. There are many different causes of dementia, and many different types. We recognise that dementia is a growing challenge. The number of people in England estimated to have dementia is set to rise to almost 900,000 in 2025 and to more than 1.3 million by 2040.

Question

In your opinion, which of these areas would you like to see prioritised for dementia? (Select up to 3)

- ***Preventing the onset of dementia through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)***
- ***Delaying the progression of dementia through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)***
- ***Getting more people diagnosed quicker***
- ***Improving treatment provided by urgent and emergency care***

- ***Improving non-urgent and long-term treatment and care to support the management of dementia***

Musculoskeletal conditions

Musculoskeletal (MSK) conditions affect the bones, joints, muscles and spine, and are a common cause of severe long-term pain and physical disability. There are 3 groups of MSK conditions:

- conditions of MSK pain, for example, osteoarthritis and back pain
- inflammatory conditions, for example, rheumatoid arthritis
- osteoporosis and fragility fractures, for example, a fracture after a fall from standing height

Each year, 1 in 5 people in the UK consult a doctor about an MSK problem, and MSK is the leading cause of disability.

Question

In your opinion, which of these areas would you like to see prioritised for MSK? (Select up to 3)

- ***Preventing the onset of MSK through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)***
- ***Stopping or delaying the progression of MSK through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)***
- ***Getting more people diagnosed quicker***
- ***Improving treatment provided by urgent and emergency care***
- ***Improving non-urgent and long-term treatment and care to support the management of MSK***

Tackling the risk factors for ill health

The condition groups we are focusing on are often driven by preventable risk factors, with nearly half (42%) of ill health and early death being due to them. This includes tobacco, alcohol, physical activity and diet-related risk factors. Action on preventable risk factors is also central to our work on tackling health disparities, since people living in more deprived areas are more likely to partake in these behaviours.

Question

Do you have any suggestions on how we can support people to tackle these risk factors?

- ***Yes***
- ***No***

Question

How can we support people to tackle these risk factors? (Please do not exceed 500 words)

You might consider suggestions on how we could:

- ***make changes at a local level to improve the food offer and support people to achieve or maintain a healthy weight and eat a healthy diet***
- ***identify and support inactive people to be more physically active***
- ***support people to quit smoking, including through increasing referrals to stop smoking support and uptake of tobacco dependency treatment***

- ***support people who want to drink less alcohol to do so***

Community pharmacies help mitigate health inequalities through the provision of a range of public health services, particularly primary disease prevention and management: vaccination and infection prevention; health screening and self-care; healthy lifestyle, diet and weight management; prevention, management and cessation of substance dependence; management of chronic conditions such as cardiovascular and respiratory disease, diabetes, pain; and supporting mental health and wellbeing. There are numerous examples of preventative services, provided by community pharmacists, that address weight loss, smoking cessation, alcohol reduction and being more physically active. However, an issue is that community pharmacy is not currently fully integrated into the wider NHS system. Processes need to be established that enable the formal referral of people in to, and from, community pharmacies to other parts of the health and care system.

In 2022, Public Health England stated that they would like to see "People using community pharmacies are routinely encouraged to use early detection programmes to help detect early signs of illness and to use prevention programmes for long-term conditions as part of a systems approach to improving the public's health that uses the expertise and accessibility of community pharmacy teams".

The use of social prescribing is a key factor in this area. Again, if there were formal structures and processes in place, community pharmacists could refer people to social prescribing link workers. We would like to see pharmacy teams increasingly linking with their social prescribing teams to help people with the social issues that can impact on health and wellbeing. Mental health, housing, social isolation, poverty and debt support services can be identified often via local, voluntary or charitable organisations. Community pharmacies should also be enabled to refer people for debt management support or to groups that support isolated and underserved communities.

Community pharmacies are more prevalent in deprived areas. Overall, 89.2% of the population is estimated to have access to a community pharmacy within a 20-minute walk. An estimated 99.8% of people from the most deprived areas live within just a 20-minute walk of a community pharmacy. For areas of lowest deprivation 90.2% of the population have access to a community pharmacy within 20-minute walk.

Community pharmacies are ideally placed to further develop into health and wellbeing community centres, building on the development of the Healthy Living Pharmacy model and following "The 'Making Every Contact Count' approach to improve and protect health and to reduce health inequalities. Community pharmacies could help identify patients requiring social care and offer a range of public health services, predominantly focus on primary disease, such as smoking cessation, weight management, and vaccination services.

In the future we would like to see people being referred by community pharmacy teams directly to other services, such as, diagnostic services, other healthcare professionals, social prescribing or social care as part of integrated local care pathways. This referral can also happen the other way around.

We would like to see community pharmacies routinely used by the public as easily accessible 'health hubs', for example, for women's health, minor illnesses, monitoring of long-term conditions and administration of medicines. They would be able to provide people with rapid access to health improvement services that meet local needs such as accessible diagnostics (such as point of care testing) and prevention programmes. Pharmacists and their teams can give people the information and tools to make positive lifestyle choices and to engage in self-care which empowers patients and is an essential step in maintaining good health and preventing illness. Shifting resources to support people to stay in the prevention stage of the long-term condition will support this.

For community pharmacies to be fully effective they would need access to the local population health data. They need to understand the needs of their local population so they can be involved in local decision making. They have the ability to reach out to community and faith leaders and advocate for their population to help address the social determinants of health and health inequalities, preventing ill health and promoting healthy behaviours. Where community pharmacy sits within the ICS means it is in a good position to support the collection of population health data that would benefit the overall

system. People accessing community pharmacies are not always particularly unwell as they may be accessing for health and wellbeing advice or a minor ailment. Data on these interactions is not currently captured or shared with the wider system. This would help to build the bigger picture around the health of a local population and also capture public health interventions

Pharmacy teams need to be integrated into the wider health system and, as part of a multidisciplinary team. They need to be able to refer seamlessly to other health (including pathology, blood, diagnostics/imaging etc), social care and third sector providers. They need to have access to relevant clinical records to support patient care.

Supporting those with conditions

This part of the survey seeks to understand how we can improve outcomes for people with any of the major conditions, or a combination of them, across their life course.

For these questions, we ask for you to consider the following in your responses:

- how we can improve outcomes for people across the life course, from pre-conception, early years, childhood and young adulthood, into adulthood and older age
- how we can target population groups most in need - including addressing disparities in health outcomes and experiences by gender, ethnicity and geography
- what could be adopted and scaled quickly (that is, in the next 1 to 2 years) with impact
- what we can learn from local, national and international examples of good practice, and what wider factors are either enabling them to be a success or are blocking them from being even more successful
- if you've tried a particular approach with success, please indicate the cost and be as specific as possible about how the approach was implemented

You have the option of suggesting ideas for:

- multiple conditions
- CVD
- CRDs
- MSK conditions
- dementia

Question

How can we better support local areas to diagnose more people at an earlier stage?

You might consider suggestions to increase capacity available for diagnostic testing or identify people who need a diagnosis sooner.

When someone first starts to experience the symptoms of ill health, they may initially attempt to self-manage. At this stage, people will often seek advice from a pharmacy; this is an ideal opportunity for pharmacists to detect the early warning signs of what could potentially be diagnosed as a long term condition. The regularity with which pharmacists see patients means that they are well placed to detect signs and symptoms of some long term conditions on an opportunistic basis.

Currently, the primary health care system includes barriers to direct referral from one health professional to another. When someone presents at a pharmacy with symptoms which require referral, the pharmacist has few options other than the traditional route of recommending that they visit their GP. The pharmacist may have already recognised that the patient would benefit from direct access to another healthcare professional, such as a dietician or physiotherapist, but this currently

requires onward referral from a GP. This adds additional burden to the already overstretched GP network and can lead to delays in access to treatment. Furthermore, if a person does not follow up on their pharmacist's advice to contact their GP, it risks that individual being lost to the health service and not receiving a diagnosis and support they need for a long term condition.

To streamline referral processes, we recommend that formal referral protocols/pathways should be developed for pharmacy teams to make direct referrals to other services. Their aim should be to remove burden from patients themselves and allow them to move through the health system more rapidly and efficiently. These protocols/pathways should be developed with input from across multidisciplinary team and patients' representatives so that they are tailored to what patients need and expect.

Pharmacists already conduct a number of screening programmes for long term conditions. More opportunities for simple testing for long term conditions should be explored as part of a preventative approach to healthcare, for example atrial fibrillation detection and testing blood sugar levels for diabetes.

Question

How can we better support and provide treatment for people after a diagnosis?

You might consider suggestions that help people to manage and live well with their conditions, with support from both medical and non-medical settings.

Medicines spend is the largest spend in the NHS after staff wages. The use of medicines is the most common intervention made in patient care. The total expenditure on medicines in England by the NHS in 21/22 was estimated to be £17.2 billion. For patients medicines can be life-prolonging and life-saving. However, they can also cause harm and lead to unnecessary wastage if used incorrectly.

Pharmacists are experts in medicines and their use and should be available at all points in the patient pathway where medicines are procured, prescribed, optimised, dispensed and supplied, as well as being there to support the person taking the medicine. Involving pharmacists and pharmacy teams more in the optimisation of medicines for individuals will lead to better outcomes for patients and better value for the wider system. Consistent use of pharmacists' expertise will also help reduce adverse reactions to medicines, minimise avoidable harm and un-planned admissions to hospital.

Once a patient has been diagnosed with a long-term condition and stabilised, ongoing support should be provided by an appropriate multidisciplinary team, including community pharmacists, which provides patient-centred, integrated care. As part of a multidisciplinary approach, pharmacists should take overall responsibility for the medicines management aspect of this care.

PCN and Practice pharmacists working in GP practices, care homes and other primary care and community service settings have a significant role in supporting people with their medicines, ensuring value for money and better patient outcomes. They can help to join up secondary and primary care, supporting the safe transfer of patients and medicines between care settings.

The more medicines an individual is prescribed, the greater the risk of drug interactions and adverse drug reactions, as well as impaired adherence to medication and a reduced quality of life. As the number of individuals with multiple morbidities become more prevalent, the challenges associated with prescribing the right medicines and supporting patients to use them effectively should not be underestimated. This increase in complexity means that besides developing and maintaining prescribing competency for individual conditions, prescribers have the challenge of keeping up to date with new medicines, manage the risk of adverse events and the potential for interaction between medicines prescribed for different conditions. Managing polypharmacy is where the expertise of the pharmacist is essential as part of multidisciplinary approaches to care. The in-depth pharmacology, therapeutics and medicines expertise of the pharmacist is essential when considering the optimal medicines regimen for a person with multiple morbidities. Following condition specific guidelines may not always be the most appropriate course of action for the individual. Pharmacists must therefore play a leading role in the optimisation of medication regimens for patients with long term conditions.

This will ensure appropriate use of medicines, stopping inappropriate medicines as well as considering opportunities for lifestyle changes and non-medical therapies.

The National Overprescribing Review made a number of recommendations to reduce the number of medicines prescribed and to ensure that people were only receiving the medicines appropriate for them and their condition(s). RPS is working with RCGP to develop a repeat prescribing toolkit to maximise the effectiveness of the supply of repeat medications and to ensure patients are only receiving the medicines they need.

When prescribed and used effectively medicines have the potential to significantly improve quality of life and improve outcomes for individuals with a long term condition. By focusing on a holistic approach to pharmaceutical care, pharmacists can support individuals to maintain good health and wellbeing and avoid complications of their existing long term condition, as well as working to prevent the development of further conditions.

From 2026, all graduating pharmacists will be independent prescribers and the processes and systems need to support and enable pharmacists to prescribe in all care settings.

Question

How can we better enable health and social care teams to deliver person-centred and joined-up services?

You might consider suggestions to improve the skill mix and training of the health and social care workforce.

We need health and care systems to recognise the place of pharmacists and their teams in supporting people in their health and care journeys and are hopeful that integrated care systems will recognise the value pharmacists and their teams can bring in delivering positive patient outcomes.

It is essential that all those providing care to patients and the public have a good understanding of personalised care and what this means in terms of the care they are providing. In terms of pharmacists and their teams, much of their interactions with patient and the public is around the medicines they are taking or in providing health and lifestyle advice. Being able to have shared decision-making conversations with patient and the public will lead to people having a better understanding about their medicines and enable individuals to make informed decisions about their care. In the longer term this will lead to better patient outcomes.

Joined up care relies on joined up systems and digital infrastructure and communication between healthcare settings. Having access to a single set of information, for all health and care staff as well as patients themselves, via a Shared Care Record (ShCR) is essential to optimising patient care. Pharmacists in all care settings must be able to view and write to the ShCR.

The Discharge Medicines Service enables communication between hospital pharmacy teams and community pharmacy teams to identify support for patients on an individual basis after discharge. Whilst this is part of the community pharmacy contractual framework it is not yet adopted by all NHS Trusts.

Pharmacists working in primary care have a significant role to play in supporting the social care agenda. This is particularly apparent in care homes where pharmacists support residents and staff around medicines. Pharmacists are also working in local communities and have a significant role in supporting people to be able to access their care closer to home. Many frail and elderly people, people with complex care or those with multiple LTCS are often taking several medicines and may be struggling to manage them all. Enabling pharmacists to support patients in their own homes in terms of medicines optimisation will help to provide better outcomes for these patients and potentially prevent them needing more advanced care.

Changes in the supervision requirements for community pharmacies could enable pharmacy technicians to take further responsibility for the supply of medicines, allowing pharmacists to focus on direct patient care and interactions with patients and the public.

Question

How can we make better use of research, data and digital technologies to improve outcomes for people with, or at risk of developing, the major conditions?

Having access to a single set of information, for all health and care staff as well as patients themselves, via a Shared Care Record (ShCR) is essential to optimising patient care. Pharmacists in all care settings must be able to view and write to the ShCR. Currently, quite often the interventions that pharmacists make are recorded in their individual systems but are unable to be shared with the wider healthcare team. This will become even more critical as all pharmacist graduates will be prescribers from 2026. Many people are now living with multiple long-term conditions, and from a medicine's safety perspective, it is essential to know all of the medicines a person is taking, any reasons for changes to these medicines as well as what conditions they have been diagnosed with in order to improve patient and medicines safety. The ability to see test results will also support clinical decision making across healthcare professions. Patients are often the only ‘constant ‘in their healthcare and currently carry the burden of information sharing between multiple medical teams and organisations The lack of joined up systems poses massive risks for medicines related harm especially in vulnerable older people e.g., 1 in 3 older people will suffer medicines-related harm after care transition.

Consideration also needs to be given to the data collection burden. Data collection comes at a cost, and this cost is often underestimated in the design and development of services. Data should only be collected if the use of the data has been defined and it has a purpose. Pharmacists, like many healthcare professionals, are being put under a lot of pressure to provide information some of which could be 'passively' collected.

Data and information need to be used to personalise care, including medicines usage, to drive service improvements to meet population health needs, and improve outcomes. Population-based decisions need to be informed by data, including from pharmacy interventions. This data needs to support decisions made at system and local level to tackle health inequalities, plan services and prioritise resources in response to local needs. Analysis can help to determine what can potentially be put in place to prevent certain outcomes, for example, if the population in an area has a higher than normal rate of CVD, this could be linked to smoking so smoking cessation services could be commissioned. Where community pharmacy sits within the ICS means it is in a good position to support the collection of population health data that would benefit the overall system.

The availability of real time clinical and prescribing information, available in a single patient electronic record, would drive improvement in clinical decision making by pharmacy and the wider multidisciplinary team and improve quality of care.

It is important that digital technology is used to support health and care professionals to deliver optimum care for patients and not seen as a replacement to staff. A key area of development during the pandemic was the use of technology to enable consultations with patients to be undertaken remotely. Whilst this type of consultation is not suitable for everyone it provides a different route to advice and support for those who are able and want to use it.

Technology could be utilised to empower people to prevent ill health and get the best from medicines.

Pharmacy teams will need to adapt their services to incorporate new healthcare technology, such as, Artificial Intelligence, 3D printing of medicines, nanotechnology.

As pharmacogenomics becomes more prevalent, the risks of getting a long term condition may become more apparent via genome sequencing for individuals.

Question

How can we improve access to palliative and end of life care?

You might consider suggestions for how best to involve individuals in conversations about their future care.

People with palliative care and end of life care needs must be treated with dignity and respect and empowered to shape their own patient journey. Pharmacists should be embedded in all multidisciplinary palliative care teams to input expertise on prescribing, deprescribing and use of medicines

Medicines can be of significant benefit during end of life care to control pain, alleviate symptoms and stabilise conditions. This is an area in which patients can benefit significantly from the support and expertise of a pharmacist to help them make decisions about their medicines and healthcare. Pharmacists across a system can support the provision of pain treatment, special nutrition, and management of chemotherapy side-effects for palliative patients. Community pharmacists can provide a prompt and continuous service to patients by ensuring that a supply of specialist palliative care medicines is in stock in the pharmacy in order that prescriptions can be dispensed in a timely manner. Effective communication between the specialist palliative care prescriber / team and the community pharmacist should try to anticipate a patient's need for medication and plan accordingly.

RPS have recently published Daffodil Quality Improvement Standards for Community Pharmacy which are part of the RPS and Marie Curie UK Community Pharmacy Standards for Palliative and End of Life Care. The standards provide a free, evidence-based framework with continuous learning and simple quality improvement steps which support pharmacy teams to gradually build on their existing palliative care provision.

There are often problems in accessing palliative care medicines in the last few days of life as the needs of the patient change rapidly, especially for opioids or for injectables for syringe drivers. Access to medicines needs to be effectively managed to avoid medicines wastage. Within an area, a network of pharmacists could be established that hold such supplies and have expertise within this area of care.

Pharmacists and pharmacy technicians should keep up to date with best practice approaches and be equipped to confidently and competently discuss options about care in the end of life phase with patients.

Cancer

The cancer call for evidence published in 2022 provided useful insights that will shape the development of the major conditions strategy. However, if you wish to, we wanted to provide an opportunity to provide any further insights in this call for evidence.

Question

How can we better support those with cancer? (Please do not exceed 500 words)

The pharmacy workforce has a lot to offer in terms of supporting people who have cancer. A more detailed review of what pharmacists can offer can be found here.

Community pharmacists play a key role in identifying patients with 'red flag symptoms' and referring patients to their GPs for a potential early diagnosis of cancer as well as supporting patients through all stages of their cancer journey. This represents an opportunity to use community pharmacy services to support wider NHS strategic objectives and inform improvements in patient care.

Practice pharmacists will play a significant role in optimising medicines for patients with cancer, looking at the person holistically, including any other long term, or acute conditions, that the person may have. This may be part of a formal Structured Medication Review or as part of a general appointment with the practice 2 pharmacist. This will also apply to PCN pharmacist who are working in other care settings such as care homes, or in hospices providing end of life care.

Specialised oncology pharmacists play an important role in hospitals and have moved away from the traditional operational role of production and manufacture of anti-cancer medicines. They work with

the medical and nursing staff to maximise the benefits of drug therapy while trying to minimise toxicities and educate people with cancer about what to expect during treatment and the associated side-effects. They also provide advice on how to manage complications of cancer treatment and can often independently review patients on systemic anticancer therapies (SACT) and prescribe both anticancer medicines and supportive medicines. In the inpatient setting the specialised oncology pharmacist is integral in the management of the inpatient medication plan, right through to the medication plan that a patient will be discharged with.

Granting access for treating healthcare professionals, including pharmacists, to all relevant patients' health information and the list of medication via the establishment of integrated eHealth solutions and digital communication tools, while respecting data protection and privacy rules is one of the key solutions to improving patient care

Mental health

The mental health call for evidence published in 2022 provided useful insights that will shape the development of the major conditions strategy. However, if you wish to, we wanted to provide an opportunity to provide any further insights in this call for evidence.

Question

How can we better support those with mental ill health? (Please do not exceed 500 words)

Pharmacists can play a vital role in providing accessible services to support people's mental health, not only to help people get the most from their medicines, but also around looking after their general health and wellbeing. Whether it is spotting early signs of mental health problems, managing long-term conditions, providing expert medicines advice to colleagues or signposting to other forms of support, pharmacists working across the system are ideally placed to ensure people get the help they need. Pharmacists can play a crucial role in the optimisation of medicines taken for mental health conditions, particularly for those people taking antidepressants. They can support a patient when they are initially prescribed an anti-depressant by providing guidance around side effects and what to expect. This is currently being considered as part of the extension to the New Medicine Service for community pharmacies in England. They can also support people to safely reduce antidepressants. The RPS response to the Mental Health and Wellbeing Plan can be found here.

Specialist pharmacists working in mental health services already contribute to the provision of expert mental health care and provide valued expertise and training in the use of medicines to professional colleagues. This specialist expertise needs to be made much more widely available to enable services to be developed across other settings.

There are opportunities to further help people with serious mental illness improve their physical health, through the provision of physical health checks and an environment focussed on wellbeing. Community pharmacists and their teams could play an increasing role by ensuring they are trained as mental health champions and in mental health first aid.

Community pharmacists and their teams are well placed to recognise early signs and symptoms of poor mental health in the people they see on a regular basis. Through vigilance and rapport with their patients and the public, pharmacists are well placed to identify changes in behaviour and early signs of mental health problems including anxiety, depression, post-traumatic stress disorder, and substance or alcohol abuse. They can also recognise early signs and symptoms of relapse and worsening of existing symptoms, which are very individual and can be subtle.

To ensure parity of care, mental health patients can be equally supported by existing services such as Healthy Living Pharmacies, which all community pharmacies in England now are. Community pharmacists and their teams can conduct physical health checks for patients with mental health problems. Supporting patients with physical activity, smoking cessation, alcohol and substance misuse advice / signposting and diet as part as a multidisciplinary team.

Any services offered by pharmacy should routinely take into account mental health, it is crucial that in a generalist setting mental health is not separated out and treated as something different to other

care. Community pharmacists should consider mental health problems when talking to patients newly diagnosed with a long-term condition (LTC) and understand the risk of having both a LTC and mental health condition worsening the outcomes for both.

Specialist pharmacists working in mental health services already contribute to the provision of expert mental health care and provide valued expertise and training in the use of medicines to professional colleagues. This specialist expertise needs to be made much more widely available and linked to GPs, practice-based pharmacists, community pharmacy, and health and justice settings if services are to be developed across systems. Every mental health team should have access to a specialist mental health pharmacist whether the team is based in the community, in a mental health hospital or in an acute hospital.

More work needs to be done to join up the pathways between specialist mental health services, general practice and community pharmacy so that people with mental health conditions are fully supported across systems.