Written evidence to the Housing, Communities and Local Government Committee inquiry into Revitalising High Streets

About this submission

1. This submission is made on behalf of:

    - Community Pharmacy England (CPE) – the representative body for all community pharmacy owners in England;
    - The National Community Hearing Association (NCHA) – the professional representative body for primary care audiology providers in the UK; and
    - The Optometric Fees Negotiating Committee (OFNC) for primary eye care – the recognised negotiating body for NHS General Ophthalmic Services.

2. This submission focuses on an aspect of high street policy which has historically received too little attention: the role that primary care, embedded in communities, can play in sustaining and revitalising high streets and town centres.

3. High streets should not be considered simply as retail destinations. They are places where people carry out their lives - shop, work, access services and interact with their communities. As traditional retail has changed, the challenge for policymakers is not to recreate the high street of the past, but to create a sustainable mix of services and businesses which gives people reasons to visit their town centres regularly.

4. Primary care services are anchor destinations and should be central to that vision. High street pharmacies, opticians, audiologists and other health providers are already embedded in communities across England. They provide essential services, including on a 'walk-in' basis, generate regular and resilient footfall, employ local people and can help make high streets healthier and more useful places.

5. We recommend that the Government's forthcoming High Streets Strategy explicitly recognises primary healthcare as an important component of

successful high streets and that health policy, planning policy and regeneration funding are aligned accordingly.

High streets as places for health

5. There is a substantial body of evidence demonstrating the connection between the health of places and the health of the people who live in them.
6. Public Health England's 2018 report ***Healthy High Streets: Good Place-Making in an Urban Setting*** described high streets as occupying a distinctive position within communities and having an important influence on local health. It argued that well-designed and well-resourced high streets can help build the social, environmental and economic capital which supports better health outcomes.
7. Crucially, the report argued that high streets should be treated as existing community assets through which health professionals and other stakeholders can improve local health and reduce health inequalities. It also warned that interventions focusing solely on retail would struggle to reverse the decline of failing high streets.
8. The Royal Society for Public Health reached similar conclusions in its ***Streets Ahead: Building Health on the High Street*** work. Its analysis recognised community pharmacies and other healthcare providers as positive features of healthy high streets. The central insight remains highly relevant: the mix of organisations occupying a high street affects not only its economic performance, but the health and wellbeing of the community around it.
9. This suggests that the political debate about the proliferation of "unwanted" businesses on high streets should be accompanied by a parallel discussion about which businesses or high street destinations policymakers actively want to encourage and how they should go about that.
10. Primary care is one of the destinations that policy makers should want to encourage.

Primary care as an anchor for the modern high street

11. The structural changes affecting high streets are well understood. Online shopping has reduced the need for some forms of physical retail, while changing working patterns and competition from out-of-town destinations have further altered traditional patterns of footfall.

12. A successful high street strategy cannot therefore depend solely on attempting to restore retail demand which has permanently moved elsewhere. High streets need a broader purpose.

13. Healthcare offers part of the answer because, unlike many retail transactions, much healthcare in the community cannot simply be displaced online. Patients continue to need vaccinations, diagnostic tests, clinical consultations, medicines, eye examinations, audiology assessments, dental treatment and other face-to-face services.

14. These are also services which people need throughout their lives and which generate repeat visits. A community pharmacy, optician, audiologist, dental practice or other primary care provider therefore represents a particularly valuable form of high street occupancy: one providing an essential service while generating reliable footfall.

15. This matters to neighbouring businesses. Someone visiting a pharmacy to collect a medicine, attending an eye or hearing examination or accessing another health service may also visit a café, supermarket or other retailer. Successful primary care providers act as local anchors rather than as isolated destinations and encourage associated health outlets to set up, e.g. health food stores or Best Start centres, rather than unhealthy outlets.

16. There is an important distinction between simply filling vacant units and creating sustainable reasons for people to visit high streets. The objective of regeneration policy should not be occupancy for occupancy's sake. It should be to establish a mix of uses capable of generating repeated activity throughout the day and supporting a wider local ecosystem.

17. Primary care is particularly well placed to fulfil this role because it combines economic activity with a direct social purpose.

The neighbourhood health agenda creates an opportunity

18. This approach would also support the direction of national health policy.

19. The Government's ambition to shift healthcare from hospitals into communities requires greater provision of care closer to where people live. The question is where and how that care should be delivered.

20. Re:State's 2025 ***Future-fit NHS: the next ten years***, produced following discussions supported by Community Pharmacy England, considered what a community-centric NHS should look like. It identified a broad consensus around the need to move from fragmentation towards integration, align incentives across the health system and enable community providers to do more.
21. High streets are a natural location in which to deliver that ambition.
22. Instead of assuming that new community healthcare requires new NHS estates, policymakers should make greater use of the physical infrastructure which already exists in communities. High street pharmacies, opticians and audiologists and other primary care providers already have premises, workforces, trusted relationships with patients and accessible locations.
23. There is therefore an opportunity to bring together two important public policy objectives which are too often pursued separately.
24. Health policy needs to move more activity out of hospitals and closer to patients. High street policy needs sustainable services which generate regular footfall and give people reasons to visit town centres.
25. Primary care can help achieve both.

Community pharmacy

26. Community pharmacy provides a very clear example.
27. Pharmacies are located at the heart of communities and provide access to medicines, healthcare and advice without the need for an appointment. Their role is also changing. Alongside the safe supply of medicines, pharmacies increasingly provide clinical and preventative services, including vaccinations, blood pressure checks and treatment for common conditions.
28. Pharmacy is simultaneously a healthcare provider, employer, source of footfall and community institution.
29. The expansion of clinical services through community pharmacy strengthens the case for considering pharmacies as part of high street infrastructure. As more care moves from hospitals and general practice into community settings, pharmacies can increasingly operate as accessible neighbourhood health hubs.

30. However, this opportunity depends upon the underlying network remaining financially sustainable. Government policy should recognise the wider value created by community pharmacies rather than viewing them solely through the lens of NHS transactional activity.

Primary eye care and ear and hearing care

31. Opticians and primary care audiologists are well-embedded in their communities, providing accessible services for patients from practices on high streets up and down the country.

32. In addition to sight testing services, many opticians are also able to offer enhanced eye care services – assessing and treating minor and urgent eye conditions – and most, if not all, will carry out minor spectacle repairs for all-comers.

33. Primary care audiologists provide high-quality care for patients experiencing hearing loss, often with drop-in access for replacement batteries and parts. In some areas of England, NHS patients can access primary care audiology for hearing assessments, hearing aids and aftercare avoiding the need for hospital visits and long waiting times. Where they have a choice, the evidence shows that patients value being able to access care closer to home on the high street.

34. Opticians and primary care audiology practices are already firmly part of the high street and neighbourhood healthcare infrastructure. However, there is the potential for more patients to be able to access care closer to home. High street and health policy should support the movement of care from hospital into primary care, recognising the role practices play as healthcare providers, employers and in driving footfall to high streets.

Stronger health, stronger high streets

35. A recent Healthy High Streets report by Boots into how high street healthcare can power communities and stronger local economic growth, indicated that people want more healthcare services on their high street and providing it would deliver real benefits - for public health and local economies. Better provision would support a healthier, more productive workforce. The footfall and spend generated would keep high streets healthy in turn.

36. The report also concluded that there is significant unmet demand for a broader range of services and stated that:

> *While some healthcare services are already widely available, our research finds significant unmet demand for a broader range of care to be delivered locally. Expanding the range of healthcare services available on local high streets would drive significant increases in service use:*
>
> • *62% would be more likely to use dental care if made more available on the high street.*
>
> • *57% would use health screening and diagnostic services more often.*
>
> • *56% would be more likely to use support for minor conditions, and 52% vaccination services.*
>
> • *Demand also extends to managing long-term conditions (43%), eye care (53%), hearing care (40%) and weight management and healthy living support services (38%). These findings point to the potential for high streets to support a broader model of community-based care.*

Successful regeneration requires a mix of uses

38. The Committee asks what factors and approaches have led to successful high street regeneration and what conditions would allow these approaches to be replicated.

39. In our view, one important condition is diversity of use.

40. Public Health England's work found that a lack of diversity in the retail offer can contribute to unhealthy high streets. It also highlighted the concentration in deprived communities of businesses associated with poorer health outcomes.

41. The appropriate policy response is not simply to restrict particular businesses. Local authorities also need the ability and incentives to attract and support uses which make high streets more resilient.

42. Health services should form part of that mix alongside retail, hospitality, leisure, cultural, civic and residential uses. One policy option we would support would be reducing, or preferably removing, business rates for all primary care providers.

43. Primary care providers can be sources of high street footfall, create activity at different times of day, provide services people genuinely need, strengthen the

connection between town centres and surrounding communities, and makes productive use of premises which might otherwise remain vacant.

44. It can also create a virtuous circle. Accessible healthcare attracts people into town centres. Greater footfall supports other businesses. A more diverse and successful high street encourages investment and increases community pride. Improved public spaces can in turn make it easier and more attractive for people to access healthcare and other services.

Planning and regeneration

45. Planning and regeneration policy should explicitly recognise primary care as a desirable high street use.

46. Local authorities developing high street strategies should be encouraged to assess the availability of primary care alongside conventional measures such as retail occupancy, public realm and transport.

47. Where substantial vacant retail space exists, councils, NHS bodies and primary care providers should consider whether some of that space could accommodate further or expanded primary care services.

48. This should not mean replacing established primary care providers with large new publicly funded facilities. Wherever possible, regeneration policy should build upon and strengthen the network of existing providers. New investment should complement rather than inadvertently displace pharmacies, opticians, dentists, audiologists and other providers which are already embedded in their communities.

49. There is also a case for stronger collaboration between local government and NHS organisations when regeneration plans are developed. Public Health England's 2018 work highlighted the problems created by fragmented responsibilities across local authorities, planners, public health professionals, businesses and other organisations.

50. That fragmentation remains a barrier. Decisions about NHS estates, primary care commissioning and high street regeneration can still be made through separate processes despite having significant implications for one another.

51. The Government should therefore encourage Integrated Care Boards and relevant local NHS bodies to participate in local high street and town centre

strategies, with local authorities similarly involved when major changes to community healthcare estates are considered.

Public realm and accessibility

52. The Committee is also considering the benefits and drawbacks of public realm improvements including pedestrianisation, design codes and street furniture.

53. Primary care providers have an important perspective on these questions because a significant proportion of their users are older people, people living with disabilities, parents with young children and people with reduced mobility.

54. They also put considerable effort into making their practices safe, attractive and comfortable environments – often in the face of enormous financial pressures which reduce their ability to invest - but are often let down by the public spaces surrounding them. These need also to be attractive and health-giving with small green spaces, evident security, seating and public toilets.

55. Public Health England has rightly identified inclusive design, safe pedestrian environments, places to stop and rest, ease of navigation and accessibility as characteristics of a healthy high street.

56. Regeneration schemes should consequently be assessed not simply according to their appearance but according to whether people can continue to access essential services.

57. Pedestrianisation and other public realm interventions can deliver substantial benefits, including safer and more attractive town centres. But schemes need to make appropriate provision for disabled access, car parking, patient drop-off, public transport, deliveries and people who cannot walk significant distances.

58. As an example, as critical healthcare infrastructure, community pharmacies require premises that can accommodate frequent medicine deliveries throughout the day to support safe dispensing, manage medicine shortages, and ensure continuity of patient care.

59. Accessibility to primary care should therefore be explicitly considered in the design and assessment of major high street public realm schemes.

Business rates

60. Business rates are particularly important for premises-based community healthcare because providers cannot respond to increases in property costs by moving their services entirely online. Where NHS services are being provided, they also cannot pass costs on to consumers.

61. The tax system should recognise the wider public value generated by essential healthcare services occupying high street premises.

62. The Government should review whether the business rates system supports or discourages healthcare providers in communities, and whether the treatment of such providers is consistent with the Government's objectives both for neighbourhood healthcare and high street regeneration. For example, the NHS should reimburse community pharmacies, opticians and primary care audiology practices for the proportion of their business rates costs that relate to their NHS work, as they already do with GP Practices and NHS Dentists. The Government should also review current arrangements for business rate tax relief which exclude standalone primary care audiology practices from benefiting from relief.

63. More broadly, government should avoid a situation in which regeneration funding is being used to attract desirable services into town centres while the tax system simultaneously increases the cost of maintaining a physical high street presence.

Pride in Place and future regeneration funding

64. The Government should use the Pride in Place Programme and future high street funding to encourage the development of healthy high streets.

65. Funding criteria should recognise health and access to essential services as indicators of successful regeneration alongside conventional measures such as vacancy rates, investment and retail footfall.

66. Local areas should be encouraged to consider how regeneration funding can help create clusters of complementary services in communities and how vacant or underused premises could support the shift towards neighbourhood healthcare.

67. Primary care providers should also be represented in local partnerships determining regeneration priorities. They have substantial knowledge of local populations and frequently serve residents who may engage less often with other civic institutions.

Recommendations

68. We recommend that the Government:

    a. explicitly recognises primary care and community healthcare as anchor uses within its forthcoming High Streets Strategy;

    b. incorporates access to healthcare and the concept of the "healthy high street" into national and local approaches to high street regeneration;

    c. requires stronger engagement between local authorities, Integrated Care Boards and primary care providers when high street strategies and significant NHS estate changes are developed;

    d. encourages the reuse of appropriate vacant high street premises for community and neighbourhood healthcare while ensuring that new provision complements rather than displaces established providers;

    e. ensures Pride in Place and future regeneration programmes recognise improved access to health and other essential community services as measures of successful regeneration;

    f. ensures public realm schemes protect access for older and disabled people and others who need to reach healthcare services in the community;

    g. reviews the impact of business rates on premises-based primary care providers in the context of the Government's objectives for high streets and neighbourhood health; and

    h. ensures primary care providers are represented in relevant local high street regeneration partnerships.

Conclusion

69. The decline of traditional retail does not have to mean the decline of the high street. But successful regeneration requires a clearer view of what high streets are for.

70. They should increasingly be health-giving places where people can access the services they need as part of their everyday lives. Healthcare should be central to that model.

71. The case for doing so is unusually strong because it brings together two government objectives. A neighbourhood health service needs to move more care out of hospitals and closer to people's homes. High streets need sustainable uses which generate regular footfall, support surrounding businesses and strengthen their role at the centre of communities.

72. Primary care providers already provide much of the infrastructure required to achieve this. Rather than treating high street regeneration and neighbourhood health as separate policy agendas, the Government should use each to support the other.

73. The high street of the future should therefore not simply be a revitalised shopping street. It should be a centre of community life, with accessible healthcare as one of its anchors.