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Heartbeats on the High Street

How Community Pharmacy can transform
Britain's Health, Wealth and Wellbeing

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R E S P U B L I C A R E C O M M E N D S



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About ResPublica

The ResPublica Trust (ResPublica) is an independent non-partisan think tank. Through our research, policy innovation and programmes, we seek to establish a new economic, social and cultural settlement. In order to heal the long-term rifts in our country, we aim to combat the concentration of wealth and power by distributing ownership and agency to all, and by re-instilling culture and virtue across our economy and society.

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Foreword

By the Rt Hon Sir Kevin Barron MP, Chair of the Health Select Committee 2005-2010 and Chair of the All-Party Pharmacy Group

The NHS is in need of radical change. As we face the prospect of another winter crisis, we cannot keep repeating the same old debate over GP capacity, long-term conditions and primary care reform. What we need is a vision that includes all of the resources we have at our disposal, and puts them to use in a truly integrated way.

Community Pharmacy is one of those resources. In this report, ResPublica renews the case for Community Pharmacy, and places it at the heart of the debate over primary care.

The report also makes the link between the healthcare benefits of Community Pharmacy and its “social capital”, highlighting its role as a people-centered and place-based network embedded in local communities. This rightly broadens the healthcare debate to include some of the big social and economic challenges facing our country today. One of these challenges is the inequality that undermines many deprived communities, and I am delighted to see that ResPublica recognises the role of Community Pharmacy in increasing access and education of healthcare for all.

I welcome the recommendations of this report, including: that Community Pharmacy should be encouraged to work more closely with local commissioners, as well as community leaders and partners; that a smarter use of the public health grant could enable Community Pharmacy to perform vital functions for local authorities; and that there is also a need for reform within the pharmacy sector itself.

This report makes a valuable contribution to the debate over how our healthcare institutions can better serve the wellbeing of society. I commend ResPublica for their important and timely intervention.



1. About this Paper

Even the most optimistic of its advocates now acknowledge the scale of the challenge facing the NHS.

Rising demand for services is stretching the capacity of healthcare providers. The population of England is projected to grow by over 4 million between now and 2024. The fastest-growing age group is people aged 65 and over, and the level of long-term conditions is on the rise.¹ At the same time, pressure on budgets is restricting the ability to hire, train and retain enough doctors and nurses to meet our population's health needs. NHS England's target to deliver an additional

5,000 GPs by 2020 is looking increasingly unattainable, with the workforce showing signs of contraction rather than growth.²

In other words, a dangerous combination of increased demand and reduced supply is pushing the NHS to breaking point.

Since the Acheson Report of 1998, research has shown that it is our most deprived communities that are disproportionately impacted by healthcare inequality. So when public services fail, it is the disadvantaged among us who feel the pinch the most. The failure to resolve systemic challenges in the NHS has

had a profound effect on these people, diminishing their access to preventative healthcare and health education.

The crisis is complex. There is no silver bullet. And yet, there exists a healthcare provider that could be transformative for our NHS: a provider that is embedded on high streets in almost every part of the country, including our most deprived neighbourhoods, that is staffed by a network of clinically-trained professionals, with a proven social value, who have the capacity to prevent illnesses which are costing the taxpayer billions of pounds each year.

This provider is Community Pharmacy.

In this report, we make the case for Community Pharmacy as the first port of call in primary care. We are not the first to say this. For years, healthcare leaders have talked about the “potential” of Community Pharmacy. In 2008 the Pharmaceutical Services Negotiating Committee argued that “pharmacists are undoubtedly the most accessible healthcare provider in the community at a time when NHS resources are increasingly under pressure”. Several recent reports have been published: NHS England launched the Murray Review of Community Pharmacy Clinical Services in 2016, at the same time as the national Community Pharmacy “Forward View” project and a PricewaterhouseCoopers report on the economic value of Community

Pharmacy. This year, the Secretary of State for Health has acknowledged that the Government has not “exploited the tremendous skills that pharmacists have nearly as effectively as we might.”³

Despite the evidence of these reports and the warm words of healthcare officials, the transformative potential and value of Community Pharmacy continues to be overlooked. Local commissioning structures like Clinical Commissioning Groups (CCGs) and Sustainability and Transformation Partnerships (STPs) rarely have a pharmacy representative making strategic decisions alongside GPs. There is a lack of parity in how the clinical role of Community Pharmacy is perceived. And in 2016, the Chancellor of the Exchequer announced a reduction in financial support to Community Pharmacy of £113m for the year – a figure that equates to a reduction of 4 per cent, rising to 7 per cent in the coming year when compared to previous levels.⁴

There are even signs that the recommendations of the Murray Review will not be adopted by NHS England. In 2016, the Parliamentary Under Secretary of State for Health, David Mowat, said during a debate in the House of Commons that “we regard pharmacies as vitally important to the NHS. One of the proposals that we shall announce shortly is a proposal for an integration fund of £300m, which will be used entirely to provide services and pay for pharmacies

to provide them. It will be informed by the review that is being conducted by David Murray⁵. But this year, NHS England has declined to publish a response to the Review, stating in an October All-Party Parliamentary Group (APPG) that “at present there is no need to have a formal response ... because we do feel that it’s by and large been taken into account.”⁶

The same month, Lloyds Pharmacy announced the closure of almost 200 stores across England, blaming “challenging market conditions” and government cuts.⁷

Community Pharmacy also struggles to communicate its own role, leading to a lack of recognition of its services and representation among policy makers. Too often, pharmacists are viewed as shop-keepers rather than qualified healthcare specialists. Too often, the social value of Community Pharmacy is poorly understood. Complex contracting structures and “establishment payments”, the fact that 95 per cent of their funding comes from the NHS, and a perception in Government that many pharmacies exist in inefficient “clusters”, have given rise to cuts and calls for reform.

Recognition needs to be earned, and it is clear that pharmacies themselves could do more to standardise their practice and scale up their offer. At present, there is an asymmetry in the way that different local pharmacy partnerships operate across the country. Organisations like

the British Medical Association (BMA) have advocated pharmacists working with GPs, but note that training for pharmacists varies. And there is no formal programme of quality improvement in Community Pharmacy to match the Quality and Outcomes Framework for GPs.

In the following pages, we argue that the time has come to turn the potential of Community Pharmacy into practice. The NHS simply can no longer afford to overlook the role that Community Pharmacy might play in reducing the cost burden on taxpayers and the capacity burden on GPs.

To achieve this will require two key changes in the way that Community Pharmacy is perceived.

First, **Community Pharmacy must be understood in terms of its social as well as its clinical value.**

There is a tendency to focus purely on the clinical benefits of Community Pharmacy. While these benefits are undoubtedly important, this focus has often proved reductive, leading to turf wars between pharmacists, GPs and commissioners. If we are to achieve a truly integrated National Health Service in this country, such turf wars must stop. Silos of public health no longer make sense. Britain is sitting on a time bomb of long-term conditions – in particular, rising levels of obesity, hypertension and diabetes – that risk the health not only of people but also of communities.

A public health crisis is, by definition, a social and economic crisis. It extends into employment, productivity, education and inequality, and it represents a range of long-term costs to our country. By helping to reduce those social and economic costs, Community Pharmacy can achieve savings that go far beyond the budget of the NHS.

Second, we make the case for a radical, recognisable and transformative role for Community Pharmacy.

For too long, there has been a culture of incrementalism in the debate over Community Pharmacy. The potential of pharmacy has been acknowledged, but typically in limited schemes of medicine use review, patient triage and self care advice. These schemes are reactive because they depend on patients coming to the pharmacist, rather than the other way around; and they are reductive because they limit the role of the pharmacist to a dispenser of medicines and guide of medicine use.

If the healthcare system is in serious crisis, it needs radical ideas for change. Key to this is giving Community Pharmacy a more proactive role in public health. In this report, we make a recommendation to give Community Pharmacy leadership in preventing and managing long-term conditions, by making NHS health surveillance for the over-40s universal to include the whole adult population. As hypertension is a key factor in a range of

these long-term conditions, from diabetes to dementia, we argue that an affordable, targeted way of achieving large-scale and transformative change in public health is through regular blood pressure checkups for everyone over the age of 18.

And as research has shown that these long-term conditions are linked to both social wellbeing and economic vitality, such a scheme would also unlock a range of benefits from increasing levels of employment and productivity to reducing social inequality and exclusion. Just the single example of cardiovascular disease alone costs £8bn to the productivity of the British economy⁸ – a cost that could be reduced through regular Community Pharmacy checkups.

In other words, as long-term conditions continue to harm Britain's health, wealth and wellbeing, we renew the case for Community Pharmacy as a provider of both care and capital. Through better understanding of its services, greater recognition of its value, and with a flagship role at the heart of public health, our vital place-based network of community pharmacies can play a significant role in solving the crisis facing us today.



2. The Crisis in Primary Care

The Rise of Long-Term Conditions

At the heart of the crisis facing the NHS is a crisis of primary care, the day-to-day healthcare that all of us rely on for our minor and long-term ailments.

Primary care is under strain for two key reasons: an increased demand on the NHS through a growing population, and an extended demand on the NHS through an ageing population. With rising birthrates and immigration, more people are living in the UK than ever before. The lifestyles of these people are changing, and the population is getting older.

The nature of disease and public health is changing too. In general, mortality rates have fallen steadily over the past 60 years. Deaths from infectious diseases have declined through better sanitation, immunisation and the use of antibiotics. And while cancer remains a major killer, changes in smoking habits have led to a recent decline in the rate of lung cancer. However, with an ageing population and changes in our lifestyles, new risks to public health have emerged. There has been a 60 per cent increase in the rates of death from dementia and Alzheimer's disease. Death from liver disease has risen by 12 per cent, due in part to increased

rates of cirrhosis from alcohol misuse. Deaths from heart disease have fallen in recent decades, but some modifiable risk factors, such as high body mass index, diabetes and hypertension, have not declined. And levels of Type 2 diabetes are increasing rapidly – a trend that is reflected in rising rates of obesity.⁹

In other words, people are living longer but unhealthier lives. Non-communicable diseases have replaced communicable diseases as the leading cause of death in the UK today. Most of these deaths are concentrated in an increasingly ageing population, and many are preventable through changes to lifestyle – a factor in public health data analysis that is known as the “social determinants of health”, including socio-economic status, living and working conditions, and the cultural and environmental context.

This rise in long-term conditions is increasingly focused around a group of closely related health problems – obesity, hypertension and diabetes – from which stem a range of serious and potentially life-threatening conditions, including dementia and cardiovascular diseases like heart attacks and strokes.

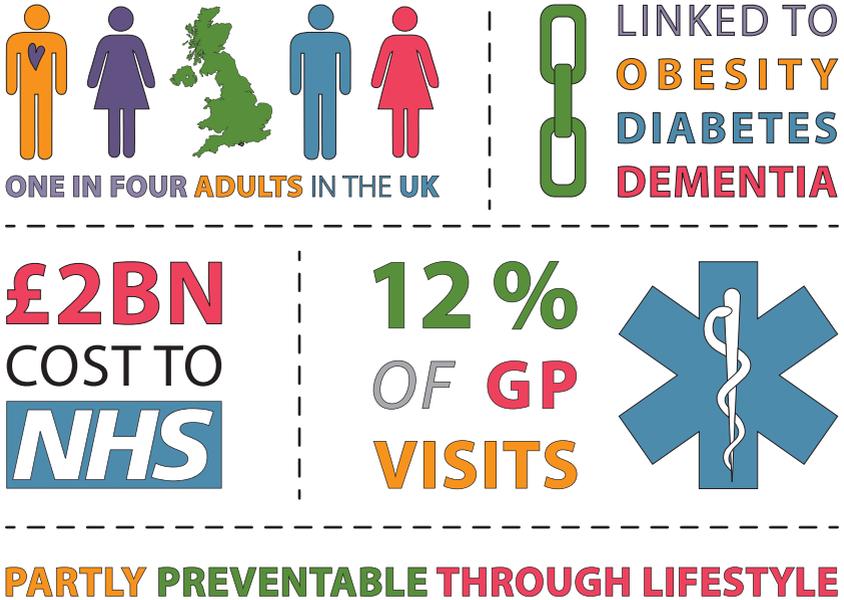
The UK is sitting on a multi-morbidity time bomb. But it is important to remember that we still have control over the detonator.

First, we have a root cause of many of these conditions: hypertension, or high blood pressure. Hypertension now affects over 1 in 4 adults in England, and is becoming one of the biggest risk factors for premature death and disability, costing the NHS around £2bn every year. It also represents 12 per cent of visits to GPs.¹⁰

Yet hypertension can be detected by blood pressure screening before it becomes a risk factor. At the moment, NHS health checks are available to people over the age of 40. The Blood Pressure Association recommends that all adults should have a blood pressure check at least once a year. But this is not happening. According to the Blood Pressure Association, around 15 per cent of adults who have been diagnosed with high blood pressure are not receiving treatment for it. According to Public Health England data, an estimated 5.6 million adults aged 18-64 have undiagnosed hypertension.¹¹ Likewise, the British Heart Foundation estimates that 500,000 people with atrial fibrillation – another heart disease that is detectable through screening – remain undiagnosed.¹²

Detecting high blood pressure is not the silver bullet for solving our primary care crisis. But it is clear that better screening would unlock preventative ways of reducing the rise of connected long-term conditions, from dementia to cardiovascular disease, that are currently placing a huge burden on the NHS, on communities and on the economy.

Figure 1: Hypertension in the UK - Key Statistics



Source: Public Health England

Second, just as these conditions can be detected through proper screening, they are also determined to a significant extent by lifestyle. A lack of exercise, sleep, an excess of visceral fat, and the additive effects of dietary salt, alcohol and physical inactivity are all linked to the rise in hypertension.¹³

This is a key point in the debate over primary care today. As the risks to public health change from communicable to

non-communicable disease, related to age, preventative screening and lifestyle, it is clear that the future of public health depends to a great extent on the habits of the public itself.

Long-Term Conditions and Social Deprivation

The social determinants of our primary care crisis are striking. In the UK today,

there is a strong correlation between levels of obesity and socio-economic deprivation.¹⁴ Specifically, the data shows an association between the urban environment and obesity: the greater the urbanisation, the greater the odds of being classified as obese. Public Health England have demonstrated that there is an almost linear relationship between obesity prevalence in children and the area where they live, showing that child obesity prevalence in the most deprived ten per cent of local areas is almost double that in the least deprived ten per cent.¹⁵

Likewise, research shows that there is a correlation between cardiovascular disease and socio-economic circumstance, with early deaths from the disease most common in poorer parts of the UK, including the north of England, central Scotland and the south of Wales, and least common in the south of England. In 2015, the highest premature cardiovascular disease death rates by local authority were for Manchester and Glasgow¹⁶ – two cities that rank in the top percentile of Indices of Multiple Deprivation.¹⁷

In Table 1, we see that the local authorities that make up the top six areas for premature deaths from cardiovascular disease in England and Scotland also rank in the top percentile for deprivation. (It should be noted that Scotland scores deprivation differently from England, as bands rather than numerical ranking.)

The Marmot Review highlighted the social determinants of health inequality in 2010. It showed that people living in the poorest neighbourhoods of England die on average seven years earlier than people living in the richest neighbourhoods, and that health inequalities arise from an interaction of various social factors, including income, education, housing and isolation.¹⁸

Ethnicity is another factor in health inequality, with Afro-Caribbean (high blood pressure) and South Asian (diabetes) groups showing higher rates of these long-term conditions. But ethnicity cannot be separated from either good screening or socio-economic circumstance. Research from the Joseph Rowntree Foundation and University of Manchester shows that ethnic minority groups in England are more likely to live in deprived neighbourhoods than the White British majority. And among these communities, there is a lower uptake of cardiovascular screening.¹⁹

These figures demonstrate that the crisis of primary care is not just a crisis of public health. It is also a crisis of social significance, because it affects some of our most deprived communities. Low screening rates are linked to inequality; BMI is linked to being fit for work. This is the added cost of poor public health. When income, taxation and welfare are factored, the net cost of elevated BMI and obesity to the UK government has been calculated at £2.47bn.²⁰

Table 1: UK Premature Cardiovascular Disease Death Rate Ranking, compared to Deprivation Indices in England and Scotland

Local Authority	CVD Death Rate Ranking in UK	Indices of Deprivation Ranking in Scotland (2016) or England (2015)
Glasgow City	1st	Top 5 per cent
City of Manchester	2nd	5th
West Dunbartonshire	3rd	Top 20 per cent
East Ayrshire	4th	Top 5 per cent (Altonhill)
North Lanarkshire	5th	Top 5 per cent (Craigneuk Wishaw)
Blackpool	6th	1st

Sources: British Heart Foundation (2016), Scottish Index of Multiple Deprivation (2016) and DCLG (2015)

Primary Care Reform

The rise of these long-term conditions has led health experts and NHS officials to concede that the system is at breaking point. For Professor Terence Stephenson, the UK has become the “Fat Man of Europe” – adding that “it is no exaggeration to say that it is the biggest public health crisis facing the UK today.”²¹ Secretary of State for Health, Jeremy Hunt, has described childhood obesity as a “national emergency.” Many GPs are observing that the vast majority of their consultations are now dominated by conditions such as diabetes and heart disease, linked to lifestyle and diet, with one writing in the *Guardian* that 50-70

per cent of costs to the NHS would not just be reduced but eliminated if patients’ diet and exercise regimes improved.²²

This “national emergency,” already putting primary care under enormous strain, is compounded in winter when illnesses including influenza (as well as the cost and logistics of administering flu jabs) affect our ageing population. In 2017, faced with what some experts are calling “the worst winter in recent history,” the Chief Executive of the NHS Confederation said that “it is becoming hard to overstate the perilous state of the health and care system in England.” According to his figures, 92 per cent of healthcare leaders are “concerned”

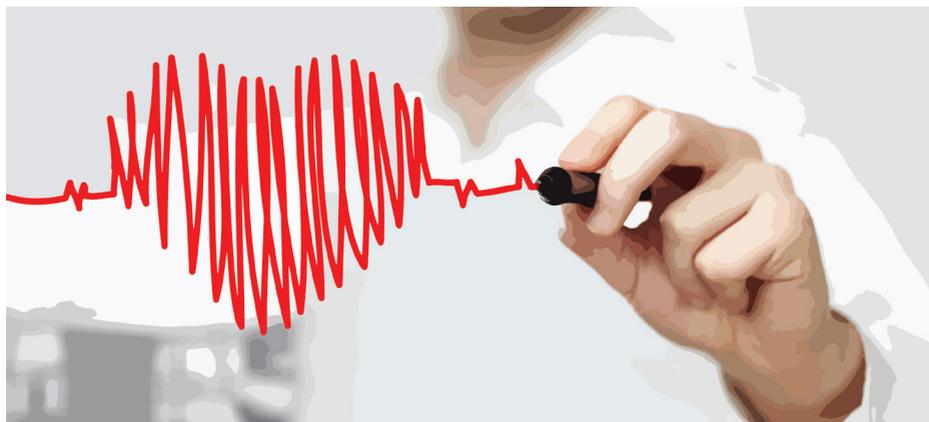
about their ability to cope this winter, and 62 per cent are “very concerned.”²³

The situation has led to increasing calls for the reform of primary care. NHS England’s General Practice Forward View of 2016 has set out a blueprint for achieving this through four key objectives: accelerating the funding of primary care; supporting GPs and expanding wider primary care staffing; reducing practice burdens; and developing primary care estate while investing in better technology. Part of the “Forward View” is to enable patient self care through better use of the wider workforce, including nurse practitioners, practice pharmacists and medical assistants.²⁴

Local schemes are also exploring alternative pathways to reform. In Greater Manchester, an urban area which has a unique system of healthcare, the Health and Social Care Partnership Board is looking at ways of enabling 24/7 primary care through “neighbourhood hubs.” In Sheffield, a recent pilot scheme in which Community Pharmacy took over some functions of a local general practice saw over 18,000 services

offered by pharmacists, including face-to face triage, case reviews and medicine reviews – saving an estimated 3,000 hours of GP time, and leading to increased patient satisfaction over the quality of service.²⁵ And in counties like Hertfordshire, a controversial scheme is being implemented in which non-urgent surgery will be rationed for smokers and the obese.

These calls for primary care reform demonstrate the extent to which healthcare providers are looking to innovate through better use of the workforce, skill, time and technology. And yet many of the main drivers of our public health crisis – namely, increasing rates of hypertension, obesity and Type 2 diabetes through unhealthy lifestyle choices – keep on rising. The Forward View for GPs is welcome, but it continues to look for solutions in the same place, fixed around a model of general practice. There is a danger that such reform becomes incremental, at a time when our health system needs radical change: change that must be based around people, their networks and their communities.



3. The Social Value of Community Pharmacy

The Value of Community Pharmacy: People, Networks, Savings

Community Pharmacy is embedded in almost every part of the country, including some of our most deprived neighbourhoods, and is staffed by a network of clinically-trained professionals who have the capacity to prevent long-term conditions that cost the taxpayer billions of pounds each year. There are an estimated 11,700 community pharmacies across England.²⁶

On face value, the benefits of Community Pharmacy at a time of austerity are clear: by diverting more people to their services for non-urgent health problems and long-term conditions, they take pressure off both GPs and A&E departments and reduce the burden on our primary care system. There is also a financial rationale: the cost of an 11-minute visit to a GP is estimated at £45, while the cost of a visit to an Accident and Emergency department of a hospital can cost the NHS up to £124.²⁷

In other words, Community Pharmacy is a vital part in the jigsaw of primary care reform: a network of local clinicians who can prevent and treat expensive conditions at source.

In 2008, the Labour government published a White Paper that proposed new roles for pharmacy, looking beyond the dispensing of medicines to incorporate an expanded range of clinical services. This White Paper proposed a greater role for Community Pharmacy in improving public health through education and prevention, the support of long-term conditions, and the expansion of clinical choice, stating that “pharmacists remain a significant untapped resource for delivering accessible services to the people who need them the most.”²⁸ Recent reports have echoed this view. The Murray Review and the Community Pharmacy Forward View, both published in 2016, set out pathways for policy change in integrated healthcare, and argued that pharmacies should play an active role in sector reform, skills and technology. The then-Health Minister, David Mowat, concurred by saying that “we must ... move away from 90 per cent of [pharmacy] income coming from dispensing. Far more must come from services, which are separately commissioned by CCGs and others. The Murray Review ... sets out a road map for that, and NHS England is determined to implement it.”²⁹

The value of Community Pharmacy can therefore be summarised in three ways. It is **clinical** in its service, it is **personal** in its interaction and it is **local** in its network. This blend of clinical, personal and local is at the heart of the “primary” element in primary care, and no model of primary care reform can function without it.

In these reports, the value of Community Pharmacy is typically measured in terms of its clinical benefits. The 2016 PWC report demonstrates the savings achieved when Community Pharmacy reduces the burden of long-term conditions on other parts of the NHS. The report estimates these savings to be around £3bn, and breaks them down as follows: £1.3bn of cost efficiencies to the NHS; £1bn to other public sector bodies; and £600m to patients.³⁰ Likewise, the BMA points to a case study of medication reviews in Northumbria nursing homes, where an audit of medicine use was carried out by pharmacists which enabled an average of 1.7 medicines to be stopped for each patient, resulting in savings of £184 per person reviewed.³¹

Measuring the Value

These savings are not limited to clinical outcomes. As we have argued, the benefits of Community Pharmacy also extend to social and economic issues including inequality, unemployment, productivity, mental health and exclusion.

Social and economic issues can also be costed. For example, the cost of unemployment to the Treasury can be calculated per unemployed person per year, by factoring lost tax revenues to Government as well as the direct costs of worklessness and other benefits. Data from the Office for National Statistics and Bloomberg shows that the number of people in employment since 2010 has risen in correlation with levels of both GDP per head and the size of the UK economy.³²

Such figures provide an economic context to research that assesses the connection between obesity or BMI and being fit for work,³³ as well as the data that we have compared in this report between levels of obesity and deprivation. Similarly, it is possible to calculate the costs of social exclusion to the economy, at the same time as making the connection between social exclusion and mental health.³⁴

Studies also show that poor population health has a negative impact on productivity. The World Health Organisation highlights the importance of investing in a healthy population as a mechanism for stimulating or sustaining economic growth.³⁵ And good population health is described as “a direct source of human welfare and also an instrument for raising income levels ... worker productivity, children’s education, savings and investment, and demographic structure” – attributes of health that Bloom and Canning describe as “Human Capital”.³⁶

The wider savings of preventative healthcare have also been acknowledged by the BMA, which highlights “the longer-term benefits of health prevention for the effective use of NHS funds and the wider economy”³⁷ – while adding that this kind of preventative approach makes up only a small proportion of the NHS budget.

Poor public health is therefore a cost to productivity. And reducing poor public health, including cardiovascular disease, has a benefit to the British economy. Drawing on data from the Treasury, the Department for Work and Pensions and the British Heart Foundation, research shows that 140 million days are lost to sickness every year, costing UK businesses an estimated £29bn. The productivity loss as a direct cost of cardiovascular disease is £8bn per year.

In this way, the clinical savings of Community Pharmacy become understood in terms of social and economic benefits: by contributing to levels of employment and productivity, Community Pharmacy helps achieve a range of additional long-term savings for the public purse.

However, measuring this social value depends on good data. Organisations like the BMA have noted that data on preventative healthcare is not always available, and that quantifying the effects of public health investment over the medium to long term can be difficult.³⁸ Without enough data, policy makers struggle to make strategic decisions.

For example, one criticism made of Community Pharmacy is that it can operate in clusters. But when looked at in terms of the “inverse care law,” relating to places where fewer providers of primary care exist in areas of highest need, evidence from the University of Durham shows that this law does not apply to Community Pharmacy distribution.³⁹ Likewise, a common complaint among pharmacists is that they have access to and knowledge of their local population, but this knowledge, or data, cannot be harnessed or efficiently shared with other healthcare providers.

This need for joined-up data – through which the cost benefits of reducing long-term health conditions can be compared to indices of deprivation, including patterns in employment, productivity, housing and education – has already been recognised in other policy areas. For example, the second annual report published by the Inclusive Growth Analysis Unit gives each Local Enterprise Partnership a score on 18 different indicators based on prosperity (skills, jobs and economic output) and inclusion (incomes, employment and the cost of living).⁴⁰ A similar exercise would be beneficial to local healthcare organisations, particularly Sustainability and Transformation Partnerships (STPs) and Local Pharmaceutical Committees (LPCs). At present, STPs provide a list of their main resources,⁴¹ but none of them explicitly relate to the social and economic determinants of health.

From Cost Benefit to Social Capital

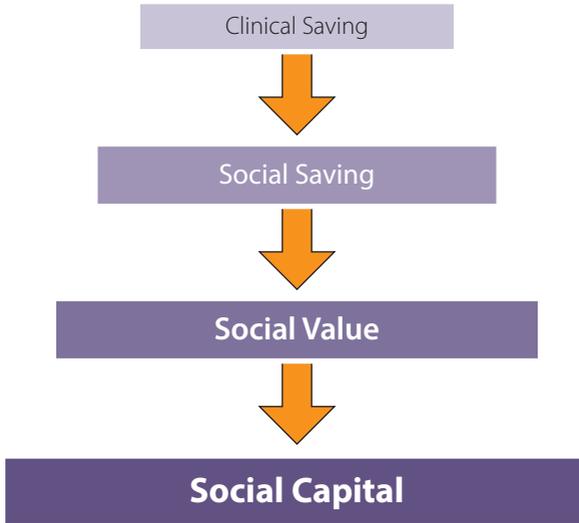
The social value of Community Pharmacy can be understood as a trajectory, as illustrated in Figure 2. Its clinical benefits equate to savings to the taxpayer. These clinical benefits have social benefits, which also equate to economic savings. These social benefits are the social value of Community Pharmacy. They operate through networks of people in the community. It is therefore possible to talk of Community Pharmacy’s **social capital**.

This is an important political point, because the social capital of Community Pharmacy reflects the direction of Government over the past seven years.

While it is clear that the vision of Labour’s 2008 White Paper has not been realised since the change of Government, the Conservatives have nevertheless established a culture of care in recent legislation – notably, in the 2012 Health and Social Care Act and the 2011 Localism Act – that continues to reflect the social capital of Community Pharmacy: based around the principles of decentralising government, empowering local networks and the plural provision of services.

We believe that a Government which promotes social capital in its legislation should welcome and encourage local high street institutions such as Community Pharmacy.

Figure 2: The Social Value Trajectory of Community Pharmacy



Source: ResPublica

Community pharmacies are independent businesses, working through networks to provide services at a local level. The social capital of Community Pharmacy reflects recent Conservative rhetoric, from David Cameron’s “Big Society” programme to the Government’s present vision of social reform for the “Just about Managings” of Britain – a vision that underpinned Theresa May’s 2017 manifesto and was reinforced in the recent Conservative Party conference.

So Community Pharmacy should be seen not just in terms of how it can supplement GP services, but as a central part of primary care that unlocks a range of social benefits and savings. As part of wider Government thinking about social reform and the “Just About Managings”, the value of Community Pharmacy can be linked to job centres, places of work, social care and civil society institutions – key drivers of what Theresa May referred to as “the British Dream”.

Social capital is a determinant of economic development, alongside formal institutions and geography. Research shows that higher levels of social capital can lead to improved economic performance: these include the resolution of collective problems without recourse to government intervention, less time spent monitoring workers, more innovation and a greater number of transactions taking place.⁴² Social capital has been described as “facilitating the achievement of goals that could not be achieved in its absence or could be achieved only at a higher cost.”⁴³

It is often said that you know social capital when you see it, and notice when it is gone. That is why it depends on anchor institutions and flourishes on diverse high streets. Sectors beyond pharmacy have

also acknowledged this. A recent report for the Association of Convenience Stores highlights the impact of local shops on their communities, showing that the high street anchors of “most positive impact on local area” are post offices, convenience stores and pharmacies.⁴⁴ Key to this are networks through which, according to Robert Putnam, local institutions like pharmacies act not just as facilities but also a space for individuals to develop trust.⁴⁵

For this reason, we believe that **Community Pharmacy should be seen by Government as an essential anchor institution** that both reflects and drives forward Government’s vision of localism, entrepreneurialism and social reform.



4. The Recognition of Community Pharmacy

Despite evidence pointing to the clinical, economic and social benefits of Community Pharmacy, the message is still struggling to get across. Recent Government cuts are taking their toll, and many local pharmacies are struggling to keep open. In 2017, Lloyds Pharmacy announced the closure of almost 200 stores across England, blaming “challenging market conditions” and government cuts.

Two barriers continue to hold Community Pharmacy back: first, the lack of full

recognition of their value, leading to a lack of equal representation; and second, the lack of a clear, targeted, transformative role. In the next two chapters, we shall examine these barriers.

The Representation Problem

Once the wider social and economic benefits of Community Pharmacy are understood, there arises a question over the need for greater representation

within the healthcare sector, within communities and within Government.

At the moment, Community Pharmacy does not have parity with other healthcare providers such as GPs in the decision-making processes of local commissioning structures like CCGs and STPs. If pharmacies are to share the load of frontline integrated healthcare, this lack of representation must be redressed.

To achieve parity requires greater coordination. Systems already exist that are designed to serve this purpose – notably, Local Pharmaceutical Committees (LPCs) that operate across all English local authorities under the guidance of the Pharmaceutical Services Negotiating Committee (PSNC). In terms of public health, local Health and Wellbeing Boards are also designed to serve STPs.

More could be done to coordinate these structures under the rubric of integrated care. Specifically, this would mean standardising some of the activity of LPCs, scaling up the pharmacy workforce, giving Community Pharmacy a proper seat at the commissioning table (at present, the overwhelming majority of CCGs have no Community Pharmacy representation in their decision-making), and harmonising the work of pharmacy with other health and social care providers. Community Pharmacy also needs a stronger voice on Health and Wellbeing Boards, working with a range of stakeholders for the benefit of their local community wellbeing.

The Murray Review referred to this need for greater representation of Community Pharmacy in local commissioning structures, building on exemplars from the *Five Year Forward View* for how Community Pharmacy can be fully integrated into new models of care. Specifically, the Review looked at integrated Primary and Acute Care systems (PACs) that combine GP, hospital, community and mental health services; Multi-speciality Community Providers (MCPs) that move specialist care out of hospitals into the community and establish better out-of-hospital integration; and enhanced “Vanguards” that offer older people joined-up health, care and rehabilitation services.

Crucially, the Murray Review noted that as the need to develop a more integrated, population-based approach to health and care planning has led to the creation of STPs, “these have involved bringing together health and care stakeholders to develop ‘place-based plans’ showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency,” concluding that “these STPs could hold great opportunity for Community Pharmacy ... they offer the opportunity to provide a coherent strategy toward the commissioning of pharmacy services, currently split across multiple commissioners. Along with other services, they also offer the chance to

develop coherent, system-wide services and pathways to deliver better care.”⁴⁶

To achieve this, there is a need to see the value of Community Pharmacy beyond healthcare, as part of the wider political debate over localism and public services. Reinforcing the Murray Review’s vision of “place-based” plans, we believe that there is an opportunity for Community Pharmacy to demonstrate to Government how its unique networks and social capital can help build a system of public health through community assets, integration and coordination with other services.

Parity for Community Pharmacy

If this is to happen, there needs to be a strategic vision that drives forward the recognition and representation of Community Pharmacy. Such a vision should facilitate coordinated action both within the healthcare sector and with local authorities and community leaders. Specifically, it should:

- build on the work of LPCs by encouraging individual pharmacies to come together in a way that maximises their potential, creating partnerships that go beyond purchasing arrangements;
- support PSNC to enable greater standardisation and scalability of Community Pharmacy partnerships across all local authorities;

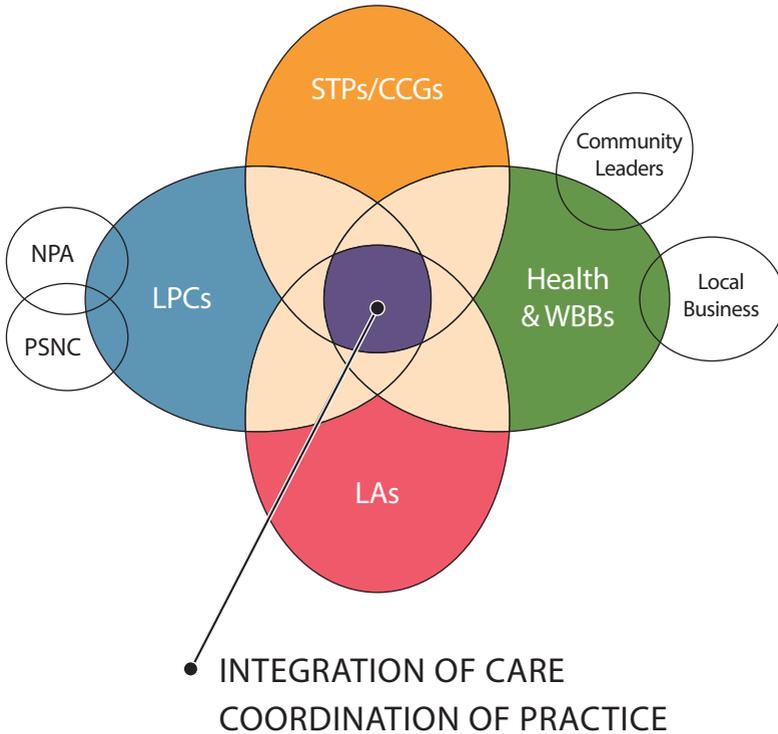
- further coordinate the work of pharmacies with other community leaders and anchor institutions, particularly in Health and Wellbeing Boards, thereby building a forum for truly integrated healthcare in all local authorities;
- achieve parity for Community Pharmacy with other healthcare representatives, particularly GPs, in local commissioning structures like CCGs and, crucially, STPs;
- ensure that CCGs and STPs pay due consideration to provider intentions being established by LPCs as part of the 2018/19 Commissioning and Contracting Round.

By enhancing the role of Community Pharmacy in local Health and Wellbeing Boards, and enabling parity for Community Pharmacy in local commissioning structures like CCGs and STPs, we argue that public health would benefit from a truly integrated, place-based system of care.

The Venn diagram in Figure 3 shows the interactions of such a system.

Health and Wellbeing Boards are central to this vision, as they include primary care service providers and people from the community sector, voluntary organisations, criminal justice agencies and universities. These Boards consider factors that impact on community health and wellbeing, best suited to local circumstance, through which “other public sector organisations in the area can also

Figure 3: The Role of Community Pharmacy Within An Integrated Care System



Source: ResPublica

provide relevant evidence on deprivation which may help Boards develop a detailed understanding of deep inequalities in the area, such as the association between health and employment inequalities.⁴⁷ Vitality, they provide a forum for the social capital of Community Pharmacy to be integrated and represented.

Of equal importance is the need for better representation of Community Pharmacy at the commissioning level of CCGs, STPs and Accountable Care Systems. We believe that a pharmacy representative should be a mandatory requirement for these commissioning organisations, selected in consultation with PSNC and a local authority's LPC.

Finally, if the system is to accommodate parity for Community Pharmacy, then pharmacies themselves need to do more to standardise and scale up their offer. At present, there is significant variation between the activities of different LPCs. The BMA advocates pharmacists working with GPs, but also notes that training for pharmacists varies.⁴⁸ There is clearly scope for greater consistency of skills and capacity in the pharmacy workforce – to this end, other reports have also highlighted the need among pharmacies for “standard services to position themselves favourably with commissioners.”⁴⁹

We therefore argue that Community Pharmacy would benefit from establishing a quality improvement programme for LPCs, led by PSNC, with two main objectives: first, to support and develop

Community Pharmacy in its engagement with commissioners; and second, to support and develop Community Pharmacy’s delivery of service. Such a programme would require training for pharmacy teams, not dissimilar to the Quality and Outcomes Framework for GPs.

In short: with a standardised offer and with equal representation, Community Pharmacy can flourish at the heart of a place-based, integrated healthcare system. This would achieve four things. It would **aid inter-professional services**; it would **break down silos**; it would **enable local needs to be determined locally**; and it would **achieve a scaled-up pharmacy workforce**.



5. A Flagship for Community Pharmacy

In this report, we have outlined the benefits of Community Pharmacy, making the link from its clinical potential to its social capital. We have also outlined the barriers to the perception and communication of these benefits.

In order to overcome these barriers, there remains a need to demonstrate the value of Community Pharmacy to policymakers, the public and other parts of the health economy. At the heart of that value is the question of health and social inequality: differing levels of education, access and support.

Health inequality harms the NHS, in terms of both capacity and cost. It puts strain on providers and drains budgets through waste. Furthermore, it locks many of our most deprived communities into a vicious circle where poor education and a lack of health literacy become causal factors in disease. As we have argued, this means that people who have the greatest health needs often have the least access to health services – the so-called inverse care law – and long-term conditions such as obesity, hypertension and Type 2 diabetes continue to rise in disadvantaged communities.

Because inequality is connected to socio-economic status, access to healthcare reflects the circumstances of individuals rather than the needs of the population. Those with money can pay for private providers. Many public sector workers enjoy access to care as part of their working rights. And some sections of the population with particular needs have access to regular checkups – for example, the 5-year NHS health check for people aged over 40, or the 3-year cervical screening for women aged over 25.

These schemes all have value for those who can benefit from them. But just like hidden poverty, there are also people who fall into hidden health inequality, like the young men who statistically tend not to visit their GP;⁵⁰ or the so-called “ghost patients” who have undiagnosed long-term conditions.

The NHS was founded on the principle of being comprehensive, universal and free at the point of delivery. But health inequality in the UK tells us a different story. For this reason, Community Pharmacy has a vital role to play, operating through its local networks and building on its capacity to be the “first port of call” for primary care.

The Roles of Community Pharmacy

There are various ways that the NHS can benefit from the services of Community Pharmacy. The PricewaterhouseCoopers report shows that in terms of savings

achieved from these services, activities related to self care support contributed the largest share (40 per cent), followed by medicines support (31 per cent) and public health (29 per cent).⁵¹ This reflects the “candidate areas” identified by David Mowat in advance of the Murray Review, “including long-term conditions, minor ailments, better care home support and more medicine reviews, as well as the work that pharmacists do in public health.”⁵²

Key among these areas is Medicines Use Reviews. Non-adherence of medicine-taking, poor use and waste⁵³ costs the NHS hundreds of millions of pounds. According to the Department of Health, waste alone costs £300m a year.⁵⁴ The British Medical Association argues that the effective use of medicine could be improved by regular reviews, involving a range of healthcare professionals in a multi-disciplinary setting. They point to the value of pharmacists, estimating that better medicine review with pharmacists can save £184 per person reviewed.⁵⁵ And a review of the New Medicines Service delivered by community pharmacists in England has shown that, in its first five years, it has saved the NHS £75.4m.⁵⁶

Such benefits also go beyond medicine review. Community Pharmacy offers services designed to address locally-defined needs and can adapt to public demand, leading to positive outcomes. For example, the Community Development & Health Network in Northern Ireland has recently launched a “Building the Community

Pharmacy Partnership” programme that demonstrates perceived improvements in health, positive changes in how people use pharmacies and better relationships between pharmacists and communities. 81 per cent of participants in this programme said that they feel more in control of their health as a result of their participation.⁵⁷

One LPC has summarised the roles of Community Pharmacy as follows:

- Surveilling and assessing population health;
- Medicine review;
- Promoting health and wellbeing;
- Developing communities, advocating for health and reducing inequalities;
- Managing self care.⁵⁸

While these various roles are vital to primary care, we believe that **Community Pharmacy also needs a flagship initiative: a clearly-defined, universally-recognised role that the whole adult population uses regardless of socio-economic status or age.** Without such an initiative, there is a risk of continuing incrementalism whereby Community Pharmacy is seen as a supplement to other providers without having a defining function of its own.

This role should build on the capacity and social capital of Community Pharmacy, while being practical and financially achievable. It should also be at the heart of a vision for primary care reform, unlocking a range of health and social benefits.

A Flagship Role for Community Pharmacy: Leading Health Checks for the Adult Population

In this report, we have argued that the UK is sitting on a time bomb of co-morbidity, clustered around rising levels of hypertension. Not only do long-term conditions damage the health of people, they also damage the social and economic fabric of communities, affecting levels of productivity, employability, inequality and isolation. This costs our country billions of lost pounds a year.

Hypertension is the key factor here. And it is both detectable and manageable. With the right screening, many of the long-term conditions that stem from hypertension can be mitigated, including obesity, diabetes and dementia.

Detecting hypertension is a straightforward and cost-effective process. At present, this process is carried out by a range of healthcare providers for patients who make themselves available for screening. Unlike cervical screening, it is not carried out proactively. Unlike NHS health checks for the over-40s, it is not promoted as universally available. And because more people who have cardiovascular disease come from deprived communities, screening at present is failing to access the hard-to-reach patients that Community Pharmacy is best-placed to serve – a vicious circle that further exacerbates inequality.

Furthermore, as data from both the Health Survey for England and the Blood Pressure Association shows, rates of hypertension and cardiovascular disease increase with age from 16 years old. Over 1 in 10 adults aged 25-34 have untreated hypertension.⁵⁹ Compounded with a 12 per cent rise in obesity in young people since 1993, together with a rise in Type 2 diabetes,⁶⁰ it is clear that there is a need to identify the risk of heart-related long-term conditions before the NHS health check age of 40.

We therefore argue that a regular health check should be made available to all adults over the age of 18.

This programme should be proactive, universal and affordable: scaling-up the NHS health check to reach all adults, while targeting its function to test the hypertension levels of the population. Because of its unique local network, its social capital and its clinical capacity, Community Pharmacy is the best-placed vehicle to manage this programme, coordinated by Local Pharmaceutical Committees or other local pharmacy leadership bodies.

In order to be consistent with existing health checks, this intervention should be carried out every 5 years – a similar frequency to the NHS health check for over-40s, although slightly less frequent than 3-year cervical screening. The data collated by Community Pharmacy should then be shared with GPs and

specialists, as part of an integrated and multi-disciplinary approach, in the fight against obesity, diabetes and dementia, including bodies like the National Diabetes Prevention Programme. Those adults who display hypertension in their 5-year checkup could then be identified and seen every year, as recommended by the Blood Pressure Association.

Using data from Public Health England, we calculate that if all community pharmacies in England screened just one patient a day, it could lead to 3 million of these cost-effective tests a year, with 750,000 undiagnosed cases of hypertension detected. Such an intervention would lead to a reduction in stroke admissions of 30-40 per cent, and a reduction in heart failure admissions of 50 per cent.⁶¹ In one clinical trial in Canada, the results of which were published by peer review, it was demonstrated that intervention and the management of the factors contributing to hypertension by Community Pharmacy led to a similar reduction in cardiovascular disease, equating to a saving of 15.7bn Canadian dollars.⁶²

Crucially, then, this scheme would be cost-effective. Instead of adding to the burden on GPs, Community Pharmacy would relieve the pressure. A blood pressure test at a Community Pharmacy typically costs around £20 – less than half the £45 cost of a visit to the GP. And as we have argued in this report, savings to the NHS are reflected in wider

savings to the economy. For example, the economic productivity loss as a direct cost of cardiovascular disease is estimated at £8bn a year. A Community Pharmacy-led health check of the working-age population would reduce some of this cost.

Costing

This universal health check would need to be costed, and pharmacies properly remunerated. As we have shown, Community Pharmacy is experiencing cuts from central Government, and we recognise that it is unrealistic to ask for more money from the Treasury at a time when efficiency and “smarter” spending is key to Government’s agenda.

We therefore advocate a smarter allocation of the public health grants provided by central Government to local authorities.

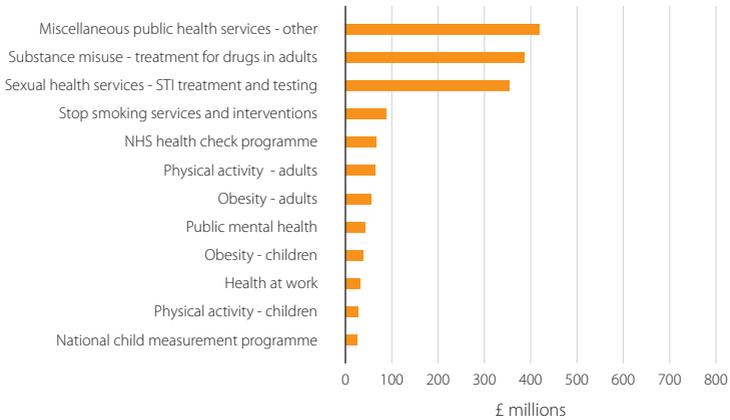
For 2017-18, the public health grant to local authorities is £3.3bn, ring-fenced until 2021 with additional funding of £16bn. This fund is designed to support the public health priorities of local authorities – namely, interventions in sexual health, obesity, physical activity, drugs and alcohol use and smoking cessation. However, these figures should be understood alongside a £200m in-year cut in Government funding which, according to the King’s Fund based on DCLG figures, leads to a 9 per cent reduction in like-for-like planned spending for local authorities on public health.⁶³

These cuts have meant that local authorities are changing the amount that they now spend on some areas of public health. One of the main areas of reduced spending is on obesity-related conditions.⁶⁴

Figures 4 and 5 show parts of the allocation of planned local authority public health budgets for 2017-18 (in £millions spent), with an emphasis on obesity-related conditions, alongside the change in spending compared to 2016/17.

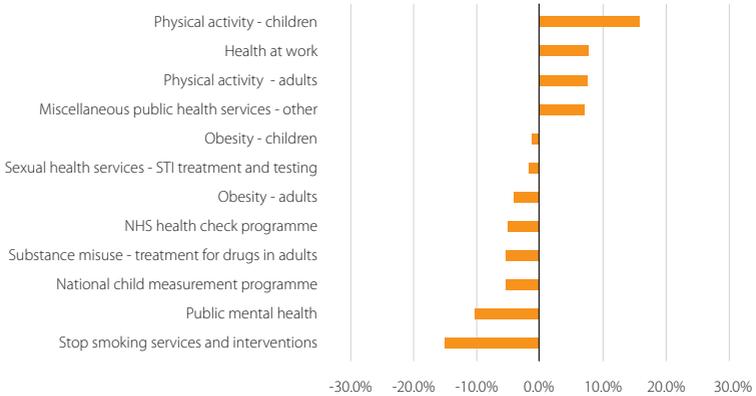
These reductions in public health spending are not insignificant and, ideally, they would be reversed. Failing that, given the present political climate, we believe that there still remains a degree of flexibility within the budget that allows for the “smarter” allocation of diminishing funds. This flexibility is fourfold: first, the amount allocated on “Miscellaneous Public Health Services” has increased and represents one of the higher categories in the overall budget. Second, local authorities still have ownership over the allocation of these funds depending on their interpretation of local need. Third, the Department of Health and Public Health England will continue to review the primary purpose of the public health grant during the period until 2020/2021. And fourth, there is allowance with the budget allocated to each local authority that any unspent money can be carried over into the next financial year as long as it still meets the conditions of public health. This unspent money is called a “public health reserve.”⁶⁵

Figure 4: Planned Local Authority Public Health Budgets: 2017/18



Source: The King's Fund (2017)

Figure 5: Percentage Change in Local Authority Planned Public Health Budgets: 2017/18 compared to 2016/17



Source: The King's Fund (2017)

We therefore recommend that this flexibility is maximised to support the provision of a universal health check – spreading the cost between local authorities, drawing on the combined funds allocated for obesity-related conditions and “Miscellaneous Public Health Services”, and making use of the “public health reserve” as and when it exists.

The most efficient way of managing this programme would be to operate within the existing structures of LPCs. In many parts of the country LPCs cover two or more local authorities, meaning that they could also perform this function across administrative boundaries.

Table 2 provides an example of how this would work, taken from a sample of public health allocations to unitary and upper tier local authorities in England for 2017-2018.

For some LPCs – for example, in Coventry, Warwickshire, Norfolk or Suffolk – there is only one corresponding local authority. In these instances, there would be scope for collaboration between local authorities with single LPCs, depending on local need: Norfolk and Suffolk could combine, for example, as could Coventry and Warwickshire. There would also need to be similar dialogue in places where there are combined authorities. In each of these places, both local authorities and LPCs should work closely together to ensure that strategic decisions are made in a joined-up and accountable manner.

In short, we believe that a universal health check focussed on working-age adult hypertension would have six key advantages:

- It would collate data on the population’s blood pressure, enabling better detection of priority parts of the population – for example, a top 10 per cent, or certain patient profiles – who can then be supported by yearly care plans coordinated by both pharmacists and GPs;
- It would lower the rising rates of cardiovascular disease, particularly in some of our most deprived communities, and would achieve long-term savings for the Treasury in terms of its health, social and economic benefits;
- It would enable Community Pharmacy to have a flagship role and become perceived as a producer, not a taker of resources from NHS budgets, putting pharmacy at the centre of public health;
- It would remain flexible in terms of local needs and local cost, by using a shared proportion of the public health grant depending on the circumstances of local authorities;
- It would enable greater coordination between local authorities and LPCs;
- It could initially be trialled in a select group of local authorities, before being rolled out nationally.

Table 2: Public Health Grants for a Sample of Local Authorities and Corresponding LPCs

Local Authority	2017-2018 Allocations (£000s)	LPC
Barnet	17,609	Barnet, Enfield and Haringey
Enfield	17,272	Barnet, Enfield and Haringey
Haringey	20,742	Barnet, Enfield and Haringey
Northamptonshire	35,702	Northamptonshire and Milton Keynes
Milton Keynes	11,700	Northamptonshire and Milton Keynes
Herefordshire	9,467	Herefordshire and Worcestershire
Worcestershire	29,898	Herefordshire and Worcestershire
Gateshead	16,952	Gateshead and South Tyneside
South Tyneside	14,124	Gateshead and South Tyneside

Source: Department of Health (2016); PSNC



6. Conclusion and Key Recommendations

In this report, we have argued that Community Pharmacy is a transformative solution for a healthcare system in crisis.

We can no longer afford to continue the culture of incrementalism that has held back the NHS in the past. And if we want to build a truly integrated system, we can no longer afford to lock out one of the key providers from our vision for the future. The Chief Executive of the NHS Confederation has called on Government for “a comprehensive review looking at the funding of health and social care across the UK.”⁶⁶ In this report, we argue that

at the forefront of such a review should be the role of Community Pharmacy.

For too long, in the words of Professor David Taylor, the role of Community Pharmacy “has become narrowed to one of medicines supply, coupled with the provision of services that critics say are too frequently of rhetorical, rather than material, value.”⁶⁷ By reducing pharmacies to solely the dispensers of medicine, we neglect their added value as place-based institutions embedded in local communities, operating through unique networks and generating a range of social and economic benefits.

In our report, we call this value the social capital of Community Pharmacy.

This value can be seen in one of the biggest challenges facing our country today. Britain is sitting on a time bomb of long-term conditions that cluster around rising levels of obesity, diabetes and dementia. At the heart of this is hypertension: a disease affecting 1 in 4 of our adult population, a rising cause of premature death and disability, which costs the NHS billions of pounds a year.

These long-term conditions are not just a health problem. As we have shown, they correlate with levels of deprivation in a place, and disproportionately harm our most disadvantaged communities. In other words, our health crisis is a social and economic crisis, extending into levels of employment and productivity, inequality and isolation, and creating a range of long-term costs to our country.

Community Pharmacy is a vital piece in the jigsaw of tackling these connected challenges facing our healthcare system, economy and society. But to achieve the change we need will require a paradigm shift in the way that policy makers and the public think about pharmacies.

This paradigm shift can be achieved in three ways.

First, in our report we have argued that Community Pharmacy should be seen not just in terms of how it can supplement

GP services, but in also in terms of how it can unlock a range of social benefits and economic savings. Community Pharmacy embodies a culture of localism, small business and social capital – precisely the qualities that Theresa May has praised as central to the “British Dream”. **We therefore call on Government to place Community Pharmacy at the heart of its social reform agenda for the country.**

Second, Community Pharmacy should be seen as a vital part of integrated care. For too long, services have been divided into silos, leading to turf wars between providers. In this report, **we argue that Community Pharmacy should be encouraged to work more closely with local commissioning structures like CCGs and STPs, as well as community leaders and partners.**

We recognise that this will also require reform within the Community Pharmacy sector itself. We have argued that pharmacies could do more to standardise their practice and scale up their offer. At present, there is an asymmetry in the way that many of them operate, and training for pharmacists varies. There is also no programme of quality improvement in Community Pharmacy to match the Quality and Outcomes Framework for GPs. In order to justify an enhanced role for Community Pharmacy, we have therefore advocated a quality improvement programme designed to better coordinate the work of pharmacists with commissioners and deliver clinical services.

Third, we have argued that Community Pharmacy should be given a flagship role in promoting public health. **Drawing on its unique local networks and capacity, we believe that Community Pharmacy should be at the frontline of the fight against long-term conditions** – particularly hypertension, a major contributor not only to conditions like diabetes and dementia, but also problems in employment, productivity and social inequality. We propose that this could be achieved by making NHS health surveillance available to the whole adult population, not just the over-40s, led by Community Pharmacy and supported by the public health grant.

In this way, we believe that a paradigm shift is possible, enabling Community Pharmacy to fulfil its natural role: as the guardian of heartbeats on our high streets, and an anchor institution in the health, wealth and wellbeing of our country.

Recommendations

To achieve this, we therefore make the following three policy recommendations for change: for local commissioners; for local authorities; and for Local Pharmaceutical Committees.

1. Parity for Community Pharmacy at the strategic level is essential. **We call on local commissioning structures such as CCGs and STPs to incorporate a pharmacy representative as a mandatory part of their strategic**

decision-making. This representative should be chosen in consultation with the Local Pharmaceutical Committee.

2. This report has highlighted the large-scale and transformative benefits of **a health check for all working-age adults in England, focussed on hypertension and led by Community Pharmacy.**

In order to facilitate this, **we call on local authorities to channel a percentage of the public health grant to LPCs, depending on their calculation of local need.** We have highlighted areas of the public health grant that could be reallocated to assist such a health check, and have demonstrated how this cost could be spread across local authorities.

3. In order to respond to this enhanced role, Community Pharmacy itself would benefit from standardising its offer and scaling up. **We therefore call on LPCs to establish a quality improvement programme, led by PSNC, with two main objectives: first, to support and develop Community Pharmacy in its engagement with commissioners; and second, to support and develop Community Pharmacy's delivery of services.**

Such a programme would be similar to the Quality and Outcomes Framework for GPs. It would achieve greater consistency across LPCs in terms of output, boundaries and the relationship with local authorities and other local partnerships.

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RESPUBLICA
society · prosperity · virtue

Society

The UK has one of the most centralised states in the developed world and one of the most disaffected and politically passive populations in Europe. We hold our leaders in contempt, but despair of doing anything for ourselves or our community. The dysfunction at the highest level of society stems from the collapse of our social and personal foundation. There is little doubt that we are becoming an increasingly fragmented and individualist society and this has deep and damaging consequences for our families, our communities and our nation state.

Starting from the bottom up, the collapse of the extended family and the ongoing break-up of its nuclear foundation impacts on all, but disproportionately so on the poor and on their offspring. Too many children at the bottom of our society are effectively un-parented as too much is carried by lone parents who are trying to do more and more with less and less. We know that the poorer you are, the less connected with your wider society you tend to be. Lacking in both bridging and bonding capital and bereft of the institutions and structures that could help them, too many poorer families and communities are facing seemingly insurmountable problems alone, unadvised and without proper aid.

Based on the principle of subsidiarity, we believe that power should be devolved to the lowest appropriate level. Public services and neighbourhoods should be governed and shaped from the 'bottom up', by families and the communities. These neighbourhoods need to be served by a range of providers that incorporate and empower communities. Moving away from a top-down siloed approach to service delivery, such activity should be driven by a holistic vision, which integrates need in order to ascertain and address the most consequent factors that limit and prevent human flourishing. Local and social value must play a central role in meeting the growing, complex and unaddressed needs of communities across the UK.

The needs of the bottom should shape provision and decision at the top. To deliver on this, we need a renewal and reform of our major governing institutions. We need acknowledgement of the fact that the state is not an end in itself, but only one means by which to achieve a greater end: a flourishing society. Civil society and intermediary institutions, such as schools, faith groups and businesses, are also crucial means to achieving this outcome. We also need new purpose and new vision to create new institutions which restore the organic and shared society that has served Britain so well over the centuries.

The NHS is under unprecedented strain from the rise of long-term conditions and an increasing population. As doctors and hospitals struggle to meet capacity, this report makes the case for Community Pharmacy as a transformative solution for the health and wellbeing of our country.

A system in crisis needs radical ideas for change. Doctors and hospitals are vital in the fight against disease, but they cannot be expected to carry the burden of unhealthy lifestyles and long-term conditions like obesity, hypertension and diabetes. We need a local, people-focussed resource that can tackle these conditions at root. And because many of these conditions are linked to problems of social and economic deprivation, we need an institution that is already connected with our most disadvantaged communities.

Community Pharmacy is embedded on high streets in almost every part of the country, including our most deprived neighbourhoods. It is staffed by a network of clinically-trained professionals who have the capacity to prevent illnesses that cost the taxpayer billions of pounds each year. This report calls for a greater role for pharmacies in the fight for good public health. It recommends giving Community Pharmacy leadership in preventing and managing long-term conditions, by making NHS health checks for the over-40s available to the whole adult population. Because these conditions harm employment and productivity, and lead to inequality and isolation, the report shows how a greater use of Community Pharmacy reduces social inequality and increases economic savings.

This report highlights the unique role and “social capital” of Community Pharmacy. By putting pharmacies at the heart of public health, we argue that they can become vital institutions of localism, care and social reform.

