



# Cross-Border Healthcare Between England and Wales



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Evidence,  
Patient  
Experience and  
Policy Implications:  
A Policy Report







**Cross-Border Healthcare Between England and Wales**  
*Evidence, Patient Experience and Policy Implications*

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## **Abbreviations**

**A&E** – Accident & Emergency

**ACP** – Advanced Clinical Practitioner

**ARRS** – Additional Roles Reimbursement Scheme

**CPCF** – Community Pharmacy Contractual Framework

**GP** – General Practitioner

**GPN** – Global Policy Network

**ICB** – Integrated Care Board

**NHS** – National Health Service

**NPs** – Nurse Practitioners

**PCN** – Primary Care Network

**POD** – Pharmacy, Optometry and Dentistry

**UK** – United Kingdom

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## **About Global Policy Network**

Global Policy Network (GPN) is an independent, global policy institute committed to advancing evidence-informed dialogue in global health, education, and sustainability. GPN combines research, stakeholder insight, and practical policy analysis to shape thoughtful, actionable conversations around some of today's most complex public policy challenges.

Through policy reports, forums, and collaborative programmes, GPN brings together voices from government, civil society, academia, and the private sector to identify solutions grounded in real-world experience. With a growing network of international practitioners and policymakers, the organisation works to bridge the gap between policy ideas and implementation, ensuring relevance, equity, and sustainability remain at the heart of systems change.

## Executive Summary

Cross-border healthcare between England and Wales presents distinct challenges arising from the structural differences between the two administratively separate health systems. England and Wales operate under different commissioning models, contractual frameworks, and data infrastructures, which together shape how patients access care, how information is shared, and how responsibility for continuity is assigned. While both systems share a commitment to universal, publicly funded healthcare, the practical experience of patients moving between them frequently signals fragmentation rather than seamless care.

This submission to the Welsh Health Select Committee, prepared by the Global Policy Network (GPN), draws on evidence from the UK Medicines Policy Series (2025-2026), a program of six stakeholder roundtables on medicines policy, workforce, and system integration, alongside broader research on primary care reform and health inequalities.

The submission identifies five interconnected challenges:

- 1) Access to non-emergency care remains gated behind the general practitioner (GP) registration and referral pathways, creating gaps during periods of patient movement across the border. Community pharmacy, which requires no registration, currently absorbs a disproportionate share of cross-border demand, yet its role is neither adequately funded nor consistently integrated into formal care pathways.
- 2) The absence of digital interoperability between English and Welsh systems undermines safe prescribing and care continuity; pharmacy professionals frequently lack real-time access to patient records, constraining clinical decision-making.
- 3) Despite the rapid expansion of pharmacist independent prescribing, structural barriers, particularly the absence of funded supervision pathways, mean that prescribing capacity remains significantly underutilised.
- 4) Recent reforms, including the shift towards neighborhood health models and the NHS 10 Year Plan's emphasis on care closer to home, offer a genuine opportunity to reduce cross-border demand. Still, risk stalling without resolution of underlying operational gaps.

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- 5) Equity dimensions are pronounced: Black and minority ethnic populations, individuals experiencing homelessness, and those with limited digital access face compounded barriers in cross-border settings, where administrative gaps interact with structural inequalities.

International evidence: from value-based primary care models in the United States, nurse-led care in Australia, and community paramedicine in Canada indicates that integrated, home-based, and multidisciplinary models can reduce avoidable hospital use and improve continuity when supported by shared records and aligned funding. The UK should adapt rather than replicate these models, building on existing Additional Roles Reimbursement Scheme (ARRS) infrastructure and expanding digital interoperability across both nations.

Taken together, the evidence points to the need for greater integration of community pharmacy into cross-border care pathways, a joint approach to digital interoperability across both nations, stronger workforce governance for independent prescribing, and access mechanisms designed to reach those most at risk of being left behind.

## **Key Insights**

- Cross-border healthcare between England and Wales is shaped by misalignment between systems.
- Access to services depends on registration and referral pathways, which limit continuity for patients moving between the two systems.
- Community pharmacy provides accessible care during periods when patients are not registered or are waiting for referral, but its role is not consistently integrated into care pathways.
- Patient information is not consistently shared across systems, which limits safe prescribing and continuity of care.
- Recent reforms emphasise prevention and care closer to home, but delivery depends on alignment of funding and operational structures.

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- International examples point to models such as expanded community pharmacy roles, multidisciplinary primary care teams, and home-based care delivery, which can reduce reliance on hospital services when supported by shared records and aligned funding.

## **Introduction**

At present, patients moving between England and Wales do not experience a joined-up healthcare system.

This submission is provided by the GPN, an independent policy research institute specialising in health system reform, access, and innovation. This submission is based on evidence generated through GPN's UK Medicines Policy Series, together with related work on primary care and health inequalities.

The border between England and Wales is a special case within the UK, where patients often receive care across two administratively separate health systems with different structures, commissioning models, and data infrastructures. This unique situation poses challenges, especially regarding continuity of care, prescribing, and data sharing, making it a critical area of focus for this inquiry.

The UK Medicines Policy Series (2025-2026) is a GPN-led research programme exploring the future of medicines, pharmacy, and integrated care across the UK. It brings together senior stakeholders across the health system to discuss structural challenges, transformation, integration, and service delivery.

This submission draws on evidence generated through this programme, including six roundtables focused on medicines policy, each examining different aspects of the workforce, prescribing, optimisation, and system integration. It also draws on a roundtable on primary care and wider work on health inequalities, including a dedicated report on black homelessness.

## **Challenges Identified**

### **1. The Most Pressing Issues in Accessing Cross-border Healthcare**

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The NHS remains one of the most unified healthcare systems among high-income countries. Its centralised financing and nationwide governance provide a coherence that decentralised systems, often without universal coverage, struggle to achieve. The current structure of the NHS masks a lack of cohesion across the care continuum, particularly within primary care services. In England, primary care is delivered through four main contractor groups: general practice, community pharmacy, optometry and dentistry (POD), each operating under distinct contractual, commissioning and funding models. General practice is funded primarily through capitation and quality-based payments and sits at the centre of care coordination, gatekeeping and referrals. Pharmacies are commissioned through a nationally agreed Community Pharmacy Contractual Framework (CPCF), optometry through a mix of NHS and private activity, and dentistry through activity-based contracts alongside private provision<sup>1</sup>. These different financial mechanisms create misaligned incentives, meaning that coordination is not built into the system but must be actively commissioned through referral pathways, triage processes, and local agreements. The issue is structural separation, which limits opportunities for shared planning, workforce integration, and digital connectivity across the primary care landscape<sup>2</sup>.

There is consistent evidence that healthcare delivery remains siloed. Patients move between general practice, hospital and specialist care, and community pharmacy, but their personal health information does not follow them. The result is repeated histories, delays in medicines optimisation, and clear safety risks for those managing complex conditions. Access across borders depends on how services are organised and who holds responsibility for care. Most services still depend on GP registration or referral, tying patients to a single system. Unless it is an emergency, hospital and specialist care are not easily accessible across the border. In practice, immediate entry points are limited to Accident & Emergency (A&E) departments and community pharmacies.

Community pharmacy, therefore, takes on a different role in this context. It sits across all parts of the system without requiring registration and often absorbs patients who fall between them. During periods

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<sup>1</sup> House of Commons, Library Research Briefing CBP-9597). House of Commons Library. <https://commonslibrary.parliament.uk/research-briefings/cbp-9597/>

<sup>2</sup> Anderson, M., Pitchforth, E., Edwards, N., Alderwick, H., McGuire, A., & Mossialos, E. (2022). United Kingdom: Health system review. *Health Systems in Transition*, 24(1), 1–194. Global Policy Network

of movement, it becomes the only place where continuity is possible. Its role is built into how the system functions, particularly in reducing avoidable A&E use and maintaining access to medicines. Interoperability and informatics remain major barriers. Pharmacists across England and Wales are often well placed to resolve issues, but inconsistent access to patient records and shared information restricts what they can safely do<sup>3</sup>.

A third issue is the underutilisation of pharmacist prescribing capacity. An increasing number of pharmacists are now trained as independent prescribers, but their role is not consistently embedded within local care pathways. Since their skills are not fully used, patients may be redirected to already-stressed GPs or hospital services for issues that could otherwise be resolved in a pharmacy setting. The issue here lies in Designated Prescriber Practitioner (DPP) funding; every other academic course comes with funded supervision except for pharmacy.

This concern was strongly echoed by a Clinical Lead (Primary Care Clinical Excellence Ltd), who noted that “*we’ve got loads of prescribers that are not prescribing,*” highlighting a growing disconnect between training expansion and the availability of structured roles to deploy these skills effectively.

Similarly, a Pharmacy Workforce Lead (Integrated Care Board; ICB) questioned whether the system is adequately prepared for the rapid rollout of pharmacist prescribing, warning that timelines remain tight and infrastructure uncertain.

The direction of policy is already moving here. Pharmacy First positions community pharmacy as a first point of contact for a defined set of conditions, supported by independent prescribing. In cross-border settings, this becomes more than a convenience. It provides a practical route for patients who are not yet registered with a GP or are waiting for a specialist referral. Used properly, it can absorb demand that would otherwise fall on general practice or hospital services.

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<sup>3</sup> Rutter, P., & Barnes, N. (2023). Facilitating self-care through community pharmacy in England. *Exploratory Research in Clinical and Social Pharmacy*, 13, 100404. <https://doi.org/10.1016/j.rcsop.2023.100404>  
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## 2. Data Digitalisation to Improve Patients' Experience in Cross-border Healthcare

Improving safe cross-border healthcare between England and Wales requires digital interoperability. Discussions with stakeholders consistently pointed to the same issue: patient records do not move across care settings, pharmacy professionals lack access to real-time clinical data, and systems do not communicate effectively across settings and between professionals.

Digital tools promise efficiency and accessibility, but uneven adoption, gaps in digital literacy and limited interoperability risk reinforcing existing inequalities, particularly when patients move between the two nations. Approximately one-third of hospital trusts cannot access external patient data electronically. Shared care records implemented in London and Greater Manchester demonstrate transformative benefits when functional, but success remains inconsistent and geographically limited. True transformation requires embedding technology within service designs<sup>4</sup>. Pharmacy professionals require reliable access to shared care records to view essential clinical information such as current medications, allergies, prescribing history and discharge summaries. Without this, care becomes fragmented, and decision-making is constrained.

As a Senior Healthcare Strategy Consultant (Leeds Health & Care Partnership) noted, “people managing medicines are only as good as the data that they see.”

Equally important is the ability for pharmacy teams to contribute information back into the patient's record. When pharmacists make clinical interventions or adjust medicines, these actions should be visible to the wider care team, including across national boundaries, so that care remains continuous and coordinated.

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<sup>4</sup> Zhang, J., Sood, H., Harrison, O. T., Horner, B., Sharma, N., & Budhdeo, S. (2020). Interoperability in NHS hospitals must be improved: the Care Quality Commission should be a key actor in this process. *Journal of the Royal Society of Medicine*, 113(3), 101–104.

<https://doi.org/10.1177/0141076819894664>

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For cross-border healthcare specifically, policymakers should craft a cohesive digital equity strategy that recognises the different functional roles of primary care providers while ensuring interoperability across all settings, including community pharmacy, in both England and Wales. Inefficiencies in data sharing do not arise simply from disparities in digital readiness but from misaligned funding models, business functions, and technology priorities. General practice, pharmacy, optometry and dentistry each require different digital capabilities, yet they must still operate within a shared information environment across both systems. For example, community pharmacies are primarily designed around safe medicines optimisation and dispensing workflows, which create different digital needs from diagnostic or consultation-led services. Digital equity, therefore, requires not identical investment but aligned investment that enables each provider type to contribute effectively to a connected, cross-border system.

Interoperability should extend to integration between the NHS App, NHS 111 and local electronic patient records, with functionality that operates seamlessly across England and Wales. The NHS App is designed to serve as a centralised digital health gateway, enabling triage, appointment booking, access to medical records, prescription ordering, and integration with wearable devices. Realising this vision will require robust integration to ensure the app can pull data from and share information across systems in real time, regardless of national boundaries.

For cross-border care, interoperability must therefore be national in scope, standardised and supported by workforce training.

### **3. The Impact of Recently Announced Reforms on Cross-border Healthcare**

Recent reforms present a clear opportunity, but also a risk if underlying structural issues remain unresolved. The shift towards neighbourhood care and prevention offers a route to improve cross-border healthcare, particularly when viewed alongside the three shifts identified in our primary care work: hospital to community, analogue to digital, and treatment to prevention.

Pharmacy is a core component of this transition; it must evolve to become a strategic partner embedded within integrated care systems and neighbourhood health models.

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This was raised during our Roundtable on *Pharmacy Integration within Neighbourhood Health Systems*, where participants reflected on how previous reforms have unfolded in practice, but it's still largely transactional. There is a sense that structural change (abolishing NHS England, shifting towards neighbourhood care) risks sitting at a high level unless the operational pieces are addressed.

An Associate Director for Pharmacy Workforce (NHS ICB) argued that reform requires leadership able to “see beyond organisational boundaries.”

Alongside this, discussions from our roundtable, *Delivering Prevention in Primary Care*, and wider primary care-focused engagements pointed to parallel pressure. Delegates described a heavily reactive model, with prevention and early intervention constrained by workforce capacity, fragmented commissioning and limited coordination across services. Primary care is expected to absorb increasing demand without a corresponding shift in how care is organised<sup>5</sup>.

Our delegates stressed that expansion without subtraction simply overloads the system. This becomes clearer in cross-border settings. When patients move between England and Wales, those unresolved issues accumulate. So, while reforms point towards a more clinical pharmacy workforce, the infrastructure that would allow that to happen is still uneven. For example, while roles such as clinical pharmacists and other ARRS positions have expanded within primary care, supervision capacity, pathway integration and workload redistribution have not kept pace. Prevention cannot be delivered in isolation; it relies on coordination between primary care, pharmacy, community services, and social support.

The direction set out in the NHS 10 Year Plan for England, which emphasises care closer to home, greater use of digital systems and reduced reliance on hospital-based services, points towards more care delivered closer to home, greater use of digital systems, and reduced reliance on hospital-based services. In principle, this should reduce the need for cross-border care, as services become more locally accessible. This is unlikely to remove it. Cross-border care will still arise where services are unevenly distributed, where patients live along the border, or where individuals move between systems. Without

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<sup>5</sup> Shembavnekar NB, J.; Bazeer, N.; Kelly, E.; Beech, J.; Charlesworth, A.; McConkey, R.; Fisher, R. Projections: General practice workforce in England: The Health Foundation; 2022 Available from: <https://www.health.org.uk/publications/reports/projections-general-practice-workforce-in-england>  
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addressing these underlying differences, reforms may change where care is delivered, but not the conditions that create cross-border demand.

In practice, cross-border care tends to arise in a limited number of scenarios: when patients move residence between England and Wales, when they live in one system but work in another, or when they access services across the border due to proximity or service availability. In most cases, patients remain registered with a GP in one system, while elements of their care may be delivered in the other. This creates a disconnect in how funding, accountability, and responsibility are assigned. While care is delivered across borders, commissioning and financial flows remain largely tied to the place of registration, meaning that services providing care are not always aligned with where funding sits. Without clearer mechanisms to support cross-border funding flows, these risks can lead to fragmentation and limit the effectiveness of wider system reforms.

This aligns with findings from our work on Black homelessness, where barriers to accessing services build over time rather than appearing as isolated issues. These are not only administrative. They are also racial, cultural and social. Evidence shows that Black and ethnic minority groups are less likely to access primary care, mental health services and social housing, even where need is comparable. For example, only around 10% of Black applicants secure social housing, compared to 24% of white applicants. In practice, this is reflected in delayed or inconsistent GP registration and limited access to mental health support, with individuals often moving between services without continuity of care.

Registration delays, documentation requirements and uneven service access do not affect everyone in the same way. For those already navigating unstable housing or precarious conditions, these gaps carry more weight. Where access to primary care and mental health support is already limited, the effect compounds. These matters highlight the link between mental health and homelessness. If access to these services is not designed to reach those most at risk, it becomes part of the problem rather than the solution. In that context, cross-border gaps are not just administrative. They reflect a wider pattern where access breaks down, and with it, stability becomes harder to maintain.

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#### **4. Welsh Language in the Context of Cross-border Healthcare**

While this was not a primary focus of the discussions, effective communication remains central to safe care delivery. In cross-border settings, variation in language provision may introduce additional barriers, particularly in consultations involving medicines management or complex care decisions.

#### **5. Patients' Experience in England and Wales Using Healthcare Services on the Other Side of the Border**

Patient experience is inconsistent and often shaped by informal coordination between services. Moving between England and Wales frequently involves delays, repeated assessments and unclear responsibility for follow-up care.

In practice, there are limited formal mechanisms to support continuity during movement across the border. Patients may be able to obtain documentation from primary care, such as medication lists or summary records, but this is not consistently structured for cross-border use and often depends on local processes rather than system design. During these transitions, community pharmacy can provide a degree of continuity, particularly for urgent medicines supply and clinical advice. However, this remains constrained by limited access to complete patient records and variation in prescribing authority, so continuity relies more on professional discretion.

Participants also proposed practical efforts to make access more workable, including translating patient information and medicine instructions, and adapting services for those less able to engage with digital systems. In cross-border settings, these gaps are more apparent, as patients may encounter different systems, languages and service formats depending on where they access care. Welsh, alongside other commonly spoken languages, would need to be consistently available to ensure that information is understood and can be acted on safely.

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## Lessons Learned from Other Cross-border Health Arrangements

This evidence is based on in-depth research conducted by our policy research team: *Lessons for the UK from Global Primary Care Innovations*.

### Advanced Primary Care Models and Value-Based Reimbursement (United States)

In the United States, telehealth experienced rapid expansion during the COVID-19 pandemic, supported by permanent changes to reimbursement policies in Medicare and Medicaid. The Centres for Medicare & Medicaid Services (CMS) introduced the Making Care Primary (MCP) Model in 2024, a value-based payment structure<sup>6</sup>. This model emphasises reimbursement aligned with patient outcomes rather than volume, enabling practices to invest in multidisciplinary teams and digital infrastructure. Early results indicate improved chronic disease management and reduced hospital admissions, highlighting how payment reforms linked to innovation can transform primary care delivery<sup>7</sup>.

### UK Implication

In England, primary care funding for general practice is based on a weighted capitation model (per patient), supplemented by performance payments (Quality Outcomes Framework) and specific service fees, whereas pharmacy and dentistry are paid per item of service. In Wales, while general practice is also largely capitation-based, quality frameworks and contractual arrangements have evolved

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<sup>6</sup> Making Care Primary (MCP) Model | CMS. (2025). Retrieved from [www.cms.gov](https://www.cms.gov/priorities/innovation/innovation-models/making-care-primary) website: <https://www.cms.gov/priorities/innovation/innovation-models/making-care-primary>.

<sup>7</sup> *Developing Primary Care Population-Based Payment Models in Medicaid: A Primer for States*. (2024). <https://www.chcs.org/media/Developing-Primary-Care-Population-Based-Payment-Models-in-Medicaid-A-Primer-For-States.pdf>.

differently, with a greater emphasis on locally designed quality improvement and cluster-based working rather than nationally standardised performance incentives. Secondary care contracting remains predominantly activity-based, although block contracts and blended variants also exist, particularly following pandemic reforms. This creates structural misalignment with value-based approaches, which aim to reward outcomes rather than volume. Value-based contracting has been implemented with varying degrees of success in other high-income health systems and represents a model the UK could cautiously adapt rather than replicate wholesale.

Embedding value-based incentives could mean progressively linking payment to whole-pathway results (such as functional status, complications, and readmissions) rather than discrete tasks or episodes, with shared metrics spanning primary, community and hospital care. For example, instead of paying orthopaedic services mainly per joint replacement, a value-based contract might pay for achieving and maintaining patient mobility six months post-operation, requiring joint-up optimisation of the entire pathway, from pre-operative assessment and risk modification, through the inpatient procedure, to post-acute rehabilitation and community follow-up. To make this workable, providers (or collaboratives) would need responsibility and some budgetary control over most of the pathway, supported by risk-adjusted outcome measures so that services caring for more complex, “suboptimal” patients are not unfairly penalised. The key design questions for the UK would include how to apportion rewards and penalties across organisations within the chain, how to protect access for high-risk patients, and how to phase in blended payment models (capitation plus outcome-based bonuses or withholds) that incentivise prevention, digital innovation, and rehabilitation without destabilising already stretched services.

### **Nurse-Led Primary Care (Australia)**

Australia established primary care through Nurse Practitioners (NPs) with expanded prescribing rights across medication schedules<sup>8</sup>. Evidence demonstrates that NP-led models achieve outcomes equivalent

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<sup>8</sup> Liotta, M. (2024). newsGP - Registered nurses’ prescribing powers expanded. Retrieved from NewsGP  
Website: <https://www1.racgp.org.au/newsgp/professional/registered-nurses-prescribing-powers-expanded>.

to or superior to those of physician-led care. A systematic review found that NP patients incurred 6% lower healthcare expenditures, experienced significantly fewer hospitalisations for ambulatory care-sensitive conditions, and reported higher satisfaction with extended consultation times and enhanced chronic disease management support. This multidisciplinary team model, integrating NPs with GPs, clinical pharmacists, and allied health professionals, has achieved improved guideline adherence and reduced preventable emergency department visits.

### **UK Implication**

While the UK already employs extensive task-shifting across ARRS roles, the Australian experience highlights what high-autonomy nursing roles can achieve when supported by a clear scope and prescribing ability. The challenge in the UK is not the absence of multidisciplinary roles but rather the variation in training, supervision capacity, and clarity of scope across them. Practices often struggle to provide adequate supervision, and inconsistent competency frameworks mean some practitioners are either pushed beyond their scope, creating risks of clinical error, or remain under-utilised.

Building on international lessons, the UK could strengthen effectiveness by standardising ACP (Advanced Clinical Practitioner) education against the Multi-Professional Framework to ensure transparent scope-of-practice definitions and expanding prescribing rights only where robust governance and supervision exist. Targeted deployment in rural and high-demand areas, coupled with structured mentorship and clearer accountability pathways, would help ensure multidisciplinary teams operate as intended: enhancing access and reducing duplication while addressing the UK's projected shortfall of 18,900 full-time equivalent GPs by 2030/31<sup>9</sup>.

### **Community Paramedicine for Home-Based Care (Canada)**

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<sup>9</sup> Shembavnekar NB, J.; Bazeer, N.; Kelly, E.; Beech, J.; Charlesworth, A.; McConkey, R.; Fisher, R. Projections: General practice workforce in England: The Health Foundation; 2022 [Available from: <https://www.health.org.uk/publications/reports/projections-general-practice-workforce-in-england>].

Canada has pioneered community paramedicine programmes where paramedics provide in-home primary care outreach, chronic disease monitoring, and post-discharge follow-up. The CP clinic program in Ontario achieved substantial cost-effectiveness: the incremental cost per quality-adjusted life year (QALY) was \$C2,933, well below Canada's \$C50,000 willingness-to-pay threshold, with the program generating a net resource gain of \$C256,583 through avoided emergency medical services (EMS) calls<sup>10</sup>. Secondary outcomes demonstrated that programme attendance was associated with significantly higher primary care visit rates, increased access to home care services and reduced long-term care transfers. Qualitative research found patients valued community paramedics as highly trusted advocates who provided holistic, relationship-centred care addressing social determinants of health<sup>11</sup>. In 2025, Ontario invested \$89 million to make community paramedicine programmes permanent, reflecting a commitment to expansion across Canada<sup>12</sup>.

### UK Implication

The UK can adapt elements of community paramedicine by incentivising, rather than directly commissioning, home-based clinical roles through national workforce schemes. Due to the independent contractor status of general practice, ICBs cannot commission individual staff within scale practices nor manage contracts across hundreds of small providers. Instead, any expansion of home-based paramedic functions must be enabled through NHS England-led mechanisms, in the same way Primary

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<sup>10</sup> Agarwal, G., Pirrie, M., Angeles, R., Marzanek, F., Thabane, L., & O'Reilly, D. (2020). Cost-effectiveness analysis of a community paramedicine programme for low-income seniors living in subsidised housing: the community paramedicine at clinic programme (CP@clinic). *BMJ Open*, 10(10), e037386. <https://doi.org/10.1136/bmjopen-2020-037386>.

<sup>11</sup> Dainty, K. N., Seaton, M. B., Drennan, I. R., & Morrison, L. J. (2018). Home Visit-Based Community Paramedicine and Its Potential Role in Improving Patient-Centered Primary Care: A Grounded Theory Study and Framework. *Health Services Research*, 53(5), 3455–3470. <https://doi.org/10.1111/1475-6773.12855>.

<sup>12</sup> Fast, T. (2025, September 4). Community Paramedicine in Canada: The Future of Paramedic Services. Retrieved November 14, 2025, from ImageTrend website: <https://www.imagetrend.com/blog/community-paramedicine-canada/>.

Care Networks (PCNs) and the ARRS were established. Within this framework, practices and PCNs could be encouraged to expand the use of ACPs and Advanced Paramedic Practitioners in Critical Care (APP-CC), who already conduct acute home visits, urgent responses, and complex case management. Although NHS policy already supports paramedic integration, reflected in the doubling of paramedics in general practice between 2016 and 2017 and wider prescribing rights, implementation has been uneven and underfunded<sup>13</sup>. Embedding a community-paramedicine-style function into PCNs, backed by dedicated ARRS investment, could strengthen access and reduce avoidable admissions. However, the UK must adapt rather than replicate the Canadian model. Canada's geography and population distribution make community paramedicine uniquely cost-effective, whereas in the UK, similar functions are already delivered by ACPs drawn from nursing and paramedic backgrounds, supported by master 's-level training. The policy focus should therefore be on coordinating and scaling these existing roles rather than importing a parallel model. Emerging experiments, such as community liaison workers commissioned in cities like Bristol, inspired by Brazil's community health worker model, show how place-based outreach could complement clinical home visiting and strengthen prevention if supported through national incentives and local leadership.

Insights from our Nigeria Medicines Policy Series highlight how fragmentation can lead to parallel systems operating side by side, with participants describing a system that has historically been donor-driven and poorly integrated. As one participant noted, "every donor wants to bring in their product... parallel supply chain system?" The result is duplication, weak coordination and inconsistent continuity of care. Although the UK operates within a far more integrated system, cross-border care reveals similar pressures. Where patient records are not shared, and access remains tied to GP registration or referral, services can function in parallel rather than as a single pathway.

## Conclusion

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<sup>13</sup> Mahtani, K. R., Eaton, G., Catterall, M., & Ridley, A. (2018). Setting the scene for paramedics in general practice: what can we expect? *Journal of the Royal Society of Medicine*, 111(6), 195–198. <https://doi.org/10.1177/0141076818769416>.

The challenges documented in this submission are not new, nor are they unique to the England and Wales border. What the cross-border setting does is make it harder to ignore. When patients move between systems, the gaps in registration, data sharing, and care coordination become immediate and practical rather than theoretical. Community pharmacy, digital infrastructure, and the clinical workforce all offer realistic routes to improvement. None of them, however, can be addressed in isolation. Progress on one without the others risks shifting pressure rather than reducing it.

What is needed is a deliberate policy effort to align the operational conditions: funding flows, data standards, and workforce governance that determines whether integrated care is possible in practice, not just in principle. The current reform agenda in both England and Wales provides a foundation to build on. Whether it translates into meaningful change for patients living and moving along the border will depend on the choices made at commissioning and system level in the months and years ahead.

## **Roundtable Participants and Contributors**

### **Roundtable The Role of Medicines in the 10-Year Plan**

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14. Joanne Goode- Chief Pharmacist, Humber Health Partnership
15. Rachel Knight- Chief Pharmacist/Clinical Director Lewisham & Greenwich NHS Trust
16. Bisola Sonoiki- Designated Prescribing Practitioner/Education Supervisor, NHS England
17. Pedro Martins- Lead Pharmacist for Integrated Urgent Care Service, Practice Plus Group; Medicines Management and Optimisation Lead, Devon IUC
18. Laura Laiglesia- Specialist Pharmacist for PCN Engagement and South Lead, NHS Cambridgeshire and Peterborough ICB
19. Marina Khan- Clinical Pharmacist, General Practice Peer Support Team, NHS Birmingham and Solihull ICB
20. Amna Khan-Patel- Chief Pharmaceutical Officer's Clinical Fellow, NHS England
21. Jignesh Patel- Independent Prescribing Pharmacist, Rohpharm Limited; Community Pharmacy PCN Lead Manager, Community Pharmacy NE London
22. Pritesh Bodalia- Chief Pharmacist & Clinical Director for Medicines Optimisation, Bedfordshire Hospitals NHS Foundation Trust; ICS Chief Pharmacist, Bedfordshire, Luton and Milton Keynes ICB
23. Jessica Yap – Chief Pharmaceutical Officer's Clinical Fellow, SEL ICB NHS England; NHS Clinical Entrepreneur
24. Farzana Mohammed – ICS Pharmacy Faculty Workforce Project Lead, Herefordshire and Worcestershire ICB
25. Shilpa Shah- Chief Executive Officer, Northeast London Local Pharmaceutical Committee
26. Dilesh Khandhia- Senior Pharmacy leader, Royal United Hospitals, Bath

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27. Mojgan Sani- Non-Executive Director, NHS Hampshire and Isle of Wight ICB, and Sussex Community NHS Foundation Trust
  28. Azuka Okeke- CEO, Africa Resource Centre for Excellence in Supply Chain Management
  29. James Malgwi- Director, Pharmaceutical Services, Borno State Hospitals Management Board
  30. Hamisu Hassan- Senior Procurement Supply Management (PSM) Specialist, Global Fund
  31. Kareem Mohamed- Clinical Pharmacist and co-founder, Stratosphere Health
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## **Roundtable 2- Scaling Independent Prescribing in Community Pharmacy**

1. Shilpa Shah- Chief Executive Officer, Community Pharmacy North-East London
  2. Reena Barai- Community Pharmacist & Owner, S.G. Barai Pharmacy
  3. Jignesh Patel- Independent Prescribing Pharmacist & Chair, NEL ICB Pharmacy Provider Group
  4. Lauren Reber- Workforce Development Pharmacist, Northeast London ICB
  5. Olivier Picard- Chair, National Pharmacy Association; CEO, NewDay's Pharmacy Ltd
  6. Danny Bartlett- Pharmacist, NHS England (Workforce Training & Education)
  7. Ravijyot Saggi- Clinical Fellow, NHS England
  8. Nasrin Khan- Head of Clinical Services & Chief Pharmacist, GPS Healthcare
  9. Emily Turner- Lead Pharmacist, Aire Valley Surgery
  10. Stephen Riley- Deputy Regional Chief Pharmacist, NHS England
  11. Nirusha Govender- Associate Director for Pharmacy Workforce, NHS Kent and Medway ICB
  12. Sarah Trust- Chief Pharmacist, Primary Care Network
  13. Clare Temple- Product Manager, Redmoor Health
  14. David Tamby Rajah- Pharmacy Consultant
  15. Bisola Sonoiki- Pharmacist, NHS England
  16. Pedro Martins- Clinical Pharmacist, Townsend House Medical Centre
  17. Laura Laiglesia- Specialist Pharmacist (PCN Engagement), NHS Cambridgeshire and Peterborough ICB
  18. Sadie Pinkney- Chief Pharmaceutical Officer, Clinical Fellow, CPPE
  19. Amna Khan-Patel- Clinical Fellow, NHS England
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20. Pritesh Bodalia- Chief Pharmacist & Clinical Director, Bedfordshire Hospitals NHS Foundation Trust
  21. Farzana Mohammed- Pharmacy Workforce Lead, Herefordshire and Worcestershire ICB
  22. Jessica Yap- Chief Pharmaceutical Officer's Clinical Fellow, NHS England / South East London ICB
  23. James Malgwi- Director of Pharmaceutical Services, Borno State Hospitals Management Board
  24. Lena Samuels- Chair, NHS Hampshire and Isle of Wight ICB
  25. Akash Patel- Superintendent Pharmacist
  26. Kofi Karikari- Superintendent Pharmacist, Dev's Chemist
  27. Muthulingasarma Chandramohan- Pharmacist
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### **Roundtable 3 – Making the Most of the Pharmacy Workforce**

1. Sarah Trust- NHS
2. Ines Sadoc Pereira- NHS Grampian
3. Maria Nasim- Free Radical Network
4. Julie Lonsdale- Lancashire and South Cumbria ICB
5. Alison Scowcroft- Greater Manchester ICB
6. Nirusha Govender- NHS Kent and Medway Integrated Care Board
7. Ravijyot Saggi- NHS portfolio
8. Lamia Bezer- CEMEC
9. Rachel Lemo- Lemon Aid
10. Siti Syed Jalal- NHS Phoenix Health Group
11. Elsie Chijide- Westrop Medical Practice
12. Molly Benson- Closer Still Media
13. Halima Usman Alkhamis- State Primary Health Care Board
14. Shilpa Patel- NHS England
15. Dr, RR Gandechea-NHS
16. Tony Amanah- Nigeria Global Fund 4PL Services  
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17. David Tambay Rajah- David Tamby Rajah Management and Consulting
  18. Shabina Azimi- The Confederation Hillingdon
  19. Caroline Quinn- Community Pharmacy Avon and Wiltshire
  20. Danielle McMahon- E4 PCN
  21. Ahmed Danjuma- SFH-CARE2
  22. Pamela Soo- Cheshire and Mersey ICB
  23. Mojgan Sani- NHS New Hampshire and Isle of Wight
  24. Bisola Sonoiki- NHS England
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#### **Roundtable 4 – The Future of Pharmacy: Innovation, Integration and Impact**

1. Reena Patel- Leeds Health & Care Partnership- West Leeds PCN
2. Neil Hardy- NHS Hampshire and Isle of Wight
3. Aris Saoulidis- NHS East Genomics
4. Gemma Quinn- University of Bradford
5. Sarah Trust- NHS
6. Nirusha Govender- NHS Kent and Medway Integrated Care Board
7. Akash Patel- Pharmacy
8. Nabeel Syed- Great Ormand Street Hospital
9. Shahzan Zafar- Wye Valley NHS Trust
10. Sonia Bhangu- Churchill Healthcare
11. Marina Khan- NHS Birmingham and Solihull ICB
12. Amna Patel-Khan- NHS England
13. Hemant Patel- Black Country ICB
14. Faisal Bokhari- Greater Manchester ICB
15. Bisola Sonoiki- Kingswood Medical Centre

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16. Yahya Ahmad- Kano
  17. Ruth Dauda- PCN
  18. Saidu Lawal Burji- Pharmacy Council of Nigeria
  19. Halima Usman Alkhamis- State Primary Health Care Board
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### **Roundtable 5 – The Future of Medicines Optimisation**

1. Reena Patel- Leads Health & Care Partnership, West Leeds PCN
  2. David Edeson- West Yorkshire ICB
  3. Arrash Yassaee- NHS England
  4. Laura Boyd- Health Innovation Yorkshire & Humber
  5. Marina Khan- NHS Birmingham and Solihull ICB
  6. Sonia Bhangu- Churchill Healthcare
  7. Aditya Aggarwal- Chelsea & Westminster Hospital
  8. Facundo Calcagno- Globant
  9. Ben Jeeves- T-Pro
  10. Baldur Johnsen-PRSONAS Software
  11. Ahmad Bismillah- NHS Innovation Accelerator
  12. Ari Billig- Peili Vision Oy
  13. Olivia Chigbu- Lewisham and Greenwich NHS Trust
  14. Andrew Davies- ABHI
  15. Yasmin Karsan- NHS England
  16. Nigel Brokenshire- Norfolk and Norwich University Hospitals NHS Foundation Trust
  17. James Rose- Health Innovation Oxford and Thames
  18. Shoshana Bloom- Equiti Health
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### **Roundtable 6; A Pharmacy Lens on Cardiovascular-Renal-Metabolic and Obesity – Integrated Neighborhood Care Global Policy Network**

1. David Edeson- West Yorkshire ICB
  2. Stephen Riley- NHS England
  3. Alistair Gray- East Lancashire Hospitals NHS Trust
  4. Nasrin Khan- GPS Healthcare
  5. Minesh Parbat- NHS Shropshire, Telford, Wrekin
  6. Samira Osman- University of Birmingham
  7. Amna Khan-Patel- NHS England
  8. Anisa Islam- Walsall Manor Hospital, Walsall Healthcare Trust
  9. Min Na Eii- South Tyneside and Sunderland NHS Foundation Trust
  10. Mehvosh Akhtar- MFT NHS Foundation Trust
  11. Kenny Li- NHS Greater Manchester
  12. Anneka Wan- Blackpool Hospital
  13. Stacey Davidson- Viaduct Care CIC
  14. Shannon Nickson- Leeds Teaching Hospitals NHS Trust
  15. Raman Sharma- Undercliffe Health Centre and University of Huddersfield
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## **Primary Care; Shaping the Future of Primary Care: Priorities and Challenges Over the Next Decade**

1. Sheikh Mateen Ellahi- GP Partner, Elm Tree Medical Centre and Leading Healthcare Consultant
2. Yousaf Ahmad- ICS Chief Pharmacist and Director of Medicines Optimisation, NHS Frimley Health
3. Jihad Malasi- GP, NICE MedTech Committee, ICS Mental Health Lead, East Kent & ICB Clinical Mental Health
4. Matea Deliu- Clinical Lead, Primary Care Digital Delivery, Digital Health Leadership Fellow, NHS South-East London Integrated Care Systems
5. Arrash Yassaee- Deputy Director, MedTech Innovation, NHS England

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6. Adrian Chamberlin- Consultant in Health and Social Care Policy and Strategy, Health Strategist
7. Ragu Rajan- GP, PCN Clinical Director & Board Member, NHS Sussex ICB
8. Sanobar Sheikh- Health Consultant, Neutral Coder AI
9. Fabienne Thompson- Non-Executive Director, Nottinghamshire Healthcare NHS Foundation Trust
10. Olivia Burns- Founder, Hypoplas
11. Robert Hull- Health Operations Manager, WM5G
12. Sumaiyah Sumar- Pharmacist, NHS England
13. Henriikka Halinen- Chief Operating Officer, Abomics
14. Justyna Ulanska-Poutanen- Business Development Manager, Abomics
15. Meri Westlake- Research Associate, University of Nottingham
16. Shilpa Shah- Chief Executive Officer, North-East London LPC
17. Yinka Kuye- Head of Pharmacy Care Transformation Medicines Optimisation, Frimley Health NHS Foundation Trust
18. Chinyere Hatton- Healthcare Business Payments Specialist, Modulr
19. Isobel Filipova- Founding Consultant, Product Sustainability Design, Cheltenham Borough Council
20. Jenni West- Associate Director of Digital Transformation, Innovation Agency (AHSN North-West Coast)

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# **Homelessness and Racial Inequality in England**

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and Solutions: A Policy Report**

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