Global Policy Network

Global Primary Care Series 2025

Shaping The Future of Primary Care- Priorities and Challenges for The Next Decade

Health System: United Kingdom

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Abbreviations:

ACP – Advanced Clinical Practitioner

AI – Artificial Intelligence

API – Application Programming Interface

ARRS – Additional Roles Reimbursement Scheme

CSO – Clinical Safety Officer

ED – Emergency Department

GMS – General Medical Services

GP – General Practitioner

GPN – Global Policy Network

ICB – Integrated Care Board

ICS – Integrated Care System

LTC – Long Term Condition

NHS – National Health Service

OLS – The Office for Life Sciences

PCN – Primary Care Network

POD – Pharmacy, Optometry, and Dentistry

UK – United Kingdom

VCS – Voluntary and community sector

VCSE – Voluntary, Community, and Social Enterprise

About Global Policy Network

The Global Policy Network (GPN) is an independent, global policy institute dedicated to promoting evidence-informed dialogue in global health, education, and sustainability. GPN combines research, stakeholder insights, 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.

About the Series

The Primary Care Transformation Series explores how the United Kingdom's (UK's) healthcare system can effectively manage rising clinical demand through community-based care. Through inspiring roundtables that bring together multiple stakeholders, the series looks ahead to the future of prevention-oriented healthcare.

Roundtable 1: *Shaping the Future of Primary Care: Priorities and Challenges Over the Next Decade*

The UK's primary care system is at an inflection point — although this pressure is not new, the macroeconomic pressure is shifting. Years of stagnant economic growth, shrinking public finances, the constant threat of industrial action, and the quiet pull of national priorities elsewhere have begun to affect the everyday work of general practitioners (GPs), nurses, and pharmacists.

These pressures have intensified questions about the long-term viability of the current National Health Service (NHS) delivery model and, within that, the future of General Practice. They have also sharpened the consequences of a long-standing false economy created by the separation of health and social care: a structural problem that has existed for decades. That is now felt more acutely as an ageing population, persistently full hospitals, and a poorly remunerated, market-led care home sector place pressure on primary care. Current conditions amplify the impact of a system that has long lacked the political will to address this divide.

This transfer has developed insidiously as needs have multiplied, leaving primary care to carry a greater burden without the commensurate resources. This situation has resulted in financial stress, leading smaller practices to close or be acquired by larger organisations and provider groups. Evidence from organisations such as the Health Foundation shows that consolidation has accelerated as practices struggle, seeing that funding is constrained[1].

This was one factor behind the development of neighbourhood teams and community providers taking on General Medical Services (GMS) contracts. For instance, Surrey Heath Community Providers has taken over a GMS contract, anchoring care locally as of January 2025[2]. The arrangements are pragmatic responses to system pressure and not a uniform shift towards preventative models. Their success relies on credible implementation pathways rather than scale alone.

The rise in private-sector use reflects a steady increase in out-of-pocket spending, driven by a lack of timely access to healthcare. This signals a population turning elsewhere when NHS routes fail. This has led to a renewed debate about the sustainability of the partnership model and the independent contractor status, prompting questions about whether future resilience may require drawing elements of primary care more structurally into the NHS architecture.

It is within this landscape that frontline clinicians, pharmacists, Integrated Care Board (ICB) leads, industry representatives, patient representatives, and community health leaders gathered for the roundtable. It centred on one question: *How can primary care evolve sustainably into its next phase without losing its foundations?*

A recurring theme throughout the roundtable was that change is not new to primary care. What feels new is the pace and the limited support accompanying it, which is straining the system to the breaking point. Although workforce availability, technological advancements and access to care are present, they remain unevenly distributed.

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[1] Rosen, R. (2024, July 3–4). The organisation and delivery of general practice [Symposium presentation]. General Practice Symposium, The Health Foundation, London, England. https://www.health.org.uk/sites/default/files/2024-07/General%20practice%20symposium%20-%20The%20organisation%20and%20delivery%20of%20general%20practice%20-%20Dr%20Rebecca%20Rosen.pdf.

[2] "Health Services - Surrey Heath Community Providers." *Surrey Heath Community Providers*, 3 June 2025, surreyheathcommunityproviders.co.uk/services/.

Acknowledgments

We extend our sincere thanks to the Chair and participants for their valuable contributions to this roundtable discussion. Their candid reflections formed the backbone of this policy report. We are particularly thankful to Dr Sheikh Mateen Ellahi for chairing the wonderful sessions and to the speakers, Yousaf Ahmad, Dr Matea Deliu, and Dr Jihad Malasi, whose ideas contributed to the depth of our analysis.

Our appreciation goes to the GPN team for coordinating the series and creating the space to bridge all these perspectives across primary care.

Foreword by Dr Jihad Malasi, GP, NICE MedTech Committee, ICS Mental Health Lead

It was a privilege to contribute to the discussions that informed this report when primary care faces unprecedented strain and opportunity. Bringing together perspectives from frontline clinicians, system leaders, policymakers, and innovators, these conversations reflected the kind of cross-sector dialogue that is essential if reform is to be both credible and lasting.

As a GP and healthcare leader working across clinical practice, mental health, and system transformation, I have seen that successful primary care reform depends as much on relationships and trust as it does on policy design or digital capability. Innovation and technology offer powerful tools, but we must implement them to strengthen continuity of care and patient confidence. This report effectively captures that balance, recognising that human connection remains the foundation on which effective, modern primary care is built.

The insights presented here move beyond abstract ambition to address the practical realities of governance, data, workforce capability, and collaboration. They reflect a shared determination to modernise primary care without losing sight of its core purpose. The direction of travel is clear. The challenge now is to translate insight into sustained action.

Foreword by Ameneh Ghazal Saatchi, Founder and CEO, Global Policy Network

Global Policy Network convenes policy work that translates evidence and frontline insight into actionable reform. This roundtable, *Shaping the Future of Primary Care: Priorities and Challenges Over the Next Decade,* examines how to deliver meaningful integration across primary care services. GPN prioritises primary care because it is the main site of contact, coordination, and risk management in the NHS, where demand is first seen, long-term conditions are managed, and system performance is shaped through decisions about access, continuity, and pathway design.

The discussion focused on defining and measuring success over the next decade across four critical domains: workforce, efficiency, patient experience, and prevention. Delegates identified the most urgent priorities: strengthening neighbourhood-level coordination across primary care, stabilising voluntary and community sector partnerships, developing a digital equity strategy across all primary care settings, and establishing a shared outcomes framework.

Executive Summary

This policy report presents recommendations from the first roundtable in the Global Policy Network's Primary Care Series, convened on the 8th of October 2025. The session was titled "Shaping the Future of Primary Care: Priorities and Challenges Over the Next Decade", and it gathered senior clinicians and pharmacists to examine how we can smoothly and rapidly embed the implementation of preventative care. Primary care in Britain is facing sustained structural pressure.

The need for this report is immediate. In recent years, many publications, including the NHS Long Term Workforce Plan[3], sketched ambitions for what's to come without fully resolving how these ambitions can be implemented locally. This report attempts to fill that gap by grounding this intent in lived system experience.

Although the system is undergoing a shift towards preventative care with digital-enabled access, obstacles remain. Variation in GP numbers, estate readiness, workforce capacity and digital preparedness remains significant, shaping how unevenly that shift is felt across the country. The roundtable revealed a movement toward neighbourhood models and earlier intervention, yet it also showed how fragile that progress can be when the foundations are unbalanced.

Community pharmacy's contribution is clear, but the broader system structures that would allow that contribution to reach its full potential are still lacking. Rather than introducing new protective frameworks, delegates stated that Voluntary, Community, and Social Enterprise (VCSE) and faith organisations need to be trusted by NHS providers to hold risk and deliver substantial contracts. This shift requires confidence in the value these groups already bring to local systems.

Participants agreed that the NHS's future depended on three movements: re-centring prevention, building connected services, and developing digital systems that serve patients and practitioners without adding administrative strain. The dialogue was promising; pilot schemes in integrated neighbourhoods, such as Whitstable Medical Practice, Bromley by Bow Centre or Folkestone Hythe and Rural Primary Care Network (PCN), show positive results. However, workforce shortages and fragile voluntary partnerships, whose instability stems largely from inconsistent funding rather than organisational weakness, continue to hinder the system. Building on frameworks that precede it, this report goes further by identifying what must shift and, most importantly, what must be protected as primary care enters its next decade.

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[3] Department of Health & Social Care. *Fit for the future: 10-Year Plan for England (accessible version).* London: GOV.UK; 2024.

Key Challenges:

- Structural and contractual misalignments, together with operational fragmentation across primary care, limit opportunities for shared planning, workforce integration, and digital connectivity across the primary care landscape.
- Voluntary, community and faith organisations are increasingly recognised as essential partners in providing broad upstream prevention, delivered through social and behavioural interventions. However, they are limited by inconsistent funding.
- Digital transformation risks can widen inequalities if not implemented evenly.
- Human connection is essential for reforms to succeed.

Key Recommendations:

- Considering a Primary Care Integration Framework within broader system-level planning, closely aligned with the NHS Long-term Plan to support Integrated Care Boards in developing shared outcome measures encompassing prevention, chronic disease management, and population health across all primary care contractor groups.
- Strengthening the stability of funding arrangements for voluntary and community sector partners, whose contributions are increasingly integral to modern primary and mental healthcare. Consistent joint health-and-social-care funding for the voluntary sector should therefore be considered and protected, especially given weak legislative safeguards.
- Providing a cohesive digital equity strategy that recognises and supports the different functional roles of primary care providers, while ensuring interoperability across all settings, including community pharmacy.
- Building collaboration by supporting, rather than trying to mandate, "at-scale" federated general practice models and similar arrangements for other providers, using aligned commissioning opportunities and by removing barriers to working together.

Introduction

Several moments revealed the complex tapestry of the current system. An illustrative clinical case of an older woman whose leg ulcer worsened because she could not travel for assessment, and was unable to upload a photograph of her wound, was outlined. This situation shows how rapidly a manageable condition can escalate when access is limited. What she needed at that moment was proactive intervention before a crisis. Instead of receiving early support, she entered the system only once she became acutely unwell, illustrating how, despite technology being present, it was not available to her. Numerous examples were woven through the discussion. Technological advancements are only meaningful when clinically validated, meet patient needs, and provide added value within the pathway. Otherwise, we observe wider inequality gaps. Digital tools are only effective when they are properly implemented and adapted to local needs. In others, they hinder the process by excluding people who need it most. Collaboration follows a similar pattern. Across the UK, all local systems operate within formal governance arrangements, but the effectiveness of coordination often depends on the strength of relationships within those structures.

As the roundtable highlighted, three interconnected challenges now define the landscape of primary care reform: disconnected primary care systems, instability in the voluntary and community sector, and obstacles to the digital shift.

Challenges Identified

In its effort to modernise and transform, the NHS is undergoing significant reforms and has published numerous proposals for legislative changes. Some shifts may further destabilise an already vulnerable system, while others may reduce existing challenges. While reform holds promise, the roundtable discussion identified several challenges that constrain the future of primary care.

1. Malaligned Primary Care

The NHS remains one of the most unified healthcare systems among high-income countries[4]. Its centralised financing and nationwide governance provide a coherence that decentralised systems, often without universal coverage, struggle to achieve. The current arrangement masks a lack of cohesion across the care continuum, particularly within primary care. 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

[4] 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.

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)[5], optometry through a mix of NHS and private activity, and dentistry through activity-based contracts alongside private provision[6]. 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.

Government policy has acknowledged these differences but has not been explicit in attempting to resolve them. The differences between contractor models are embedded in the historical architecture of the NHS and reinforced by the way primary and secondary care interact. Structural reform alone, therefore, cannot deliver integration; it requires mechanisms that deliberately create shared incentives and shared ways of working. Integrated Care Boards (ICBs), which replaced Clinical Commissioning Groups (CCGs), were primarily designed to reduce fragmentation and competition at the commissioning level, not to integrate the day-to-day delivery of care across independent contractors. While ICBs influence population-level strategy and resource allocation, they have limited levers to reshape operational collaboration between practices, pharmacies, dentists, and optometrists. Primary Care Networks (PCNs), meanwhile, were introduced as a contractual mechanism to help GP practices work together through a shared workforce and funding. They have strengthened collaboration within general practice, but they were not designed to integrate across primary care. Other contractors remain largely outside this framework, aside from limited interfaces such as ARRS-funded clinical pharmacists, whom in practice are often embedded within GP teams rather than operating across sectors. As a result, policy instruments have, to some extent, deepened integration within general practice while leaving the wider primary care ecosystem structurally unchanged.

These structural features are experienced disproportionately by patients and communities, revealing a deeper health equity challenge. Urban systems with stronger digital infrastructure, greater availability of highly qualified staff, and a higher concentration of provider networks adapt more quickly, while rural and coastal areas face slower integration due to limited connectivity and workforce constraints. This creates what clinicians described as an "invisible geography of care", where access is shaped by local structures rather than patient need. Patients moving between services encounter

[5] 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.2023.10Anderson,0404.

[6] House of Commons, Library Research Briefing CBP-9597). House of Commons Library. https://commonslibrary.parliament.uk/research-briefings/cbp-9597/.

friction, repetition, and delays that were never intended but have become routine. The result is a system aligned to structures and governance rather than patient need — coherent at the centre, but fragmented at the frontline.

The implication is clear: meaningful primary care integration cannot rely on structural reform alone. It requires a considered and focused alignment of incentives, digital infrastructure, and professional relationships across contractor groups, while protecting the continuity and trust that define general practice. Without this, the NHS risks continuing to modernise its architecture without repairing the connections that make integrated, patient-centred care possible.

2. Economic Misalignment: Drift Towards Private Care

During roundtable discussions, GPs broadly felt that the system was unified. Other practitioners expressed frustration with their daily experiences. While there are working and contractual differences, there are also inherent financial realities that play a role. Current incentives make private work more attractive and profitable. With little supplementary funding to soften the impact, many dental practices have reprioritised their patient lists in favour of 'out of pocket' clients. Primary care, as we have traditionally understood it, has slowly but surely separated into private and publicly funded models. There is evidence that due to the increasing waits for Primary or secondary care appointments, GPs are increasingly offering private health services alongside GMS.

3. Lack of Consistent Funding in the Voluntary and Community Sector

Voluntary and community sector (VCS) partners are essential in delivering prevention and crisis response services, particularly in mental healthcare, where they offer compassionate, flexible and socially orientated support that complements statutory services effectively. Evidence shows that well-funded voluntary sector crisis services, such as Mental Health Matters and Hestia's crisis houses, improve patient outcomes and reduce hospital admissions, offering relational safety and peer support highly valued by users[7]. Funding for the voluntary sector comes from the NHS, social care, and other sources. While the Department of Health and Social Care exists within a single ministry, funding settlements have historically prioritised the NHS, leaving social care comparatively underfunded and more exposed to local electoral pressures. This has made voluntary sector funding linked to social care particularly vulnerable. The resulting precarious and inconsistent resourcing can disrupt continuity of care and limit long-term

[7] Butt, M. F., Walls, D., & Bhattacharya, R. (2019). Do patients get better? A review of outcomes from a crisis house and home treatment team partnership. *BJPsych Bulletin*, *43*(3), 106–111. https://doi.org/10.1192/bjb.prioritised2018.105.

planning for safeguarding and workforce development[8]. Consistent, joint health-and-social-care funding for the voluntary sector should therefore be considered and protected, especially given weak legislative safeguards.

4. Obstacles in the Digital Shift

While digital tools promise efficiency and accessibility, uneven adoption, gaps in digital literacy, and limited interoperability risk reinforcing inequalities. Approximately one-third of hospital trusts cannot access external patient data electronically[9]. Shared care records implemented in London and Greater Manchester demonstrate transformative benefits when functional, but success remains inconsistent and geographically limited[10]. True transformation requires embedding technology within service design – not layering it on top of outdated workflows.

Digital adoption across the NHS remains uneven, as many organisations are unable to implement digital health technology due to concerns about safety assurance and governance. While persistent data and system fragmentation still mean many trusts cannot read or edit patient records beyond their own systems[11] limitations on data sharing are not purely technical failures; they reflect well-considered safeguards designed to protect patient confidentiality and maintain public confidence. The use of foundational data infrastructure as the Federated Data Platform demonstrates that insight generation can occur safely, although not without challenge from key stakeholders. The system is also wrestling with outdated or absent compliance in digital health technologies (DHTs), with innovation outpacing regulatory and legal standards. Around 70% of digital health technologies reportedly lack documented compliance with mandatory clinical safety standards[12] and workforce gaps in digital and AI literacy, such as Clinical Safety Officer (CSO) training, continue to constrain adoption.

Digital transformation is also constrained by access to innovation: NHS organisations face uncertainty navigating regulation, while developers encounter fragmented approval pathways and limited routes to real-world evaluation. Recent policy shifts—including the

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[8] Newbigging, K., Rees, J., Ince, R., Mohan, J., Joseph, D., Ashman, M., ... Coto stello, B. (2020). The contribution of the voluntary sector to mental health crisis care: a mixed-methods study. *Health Services and Delivery Research*, *8*(29), 1–200. https://doi.org/10.3310/hsdr08290.

[9] 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.

[10] Ibid.

[11] Department of Health & Social Care. *Fit for the future: 10-Year Plan for England (accessible version).* London: GOV.UK; 2024.

[12] Oskrochi, Y., Roy-Highley, E., Grimes, K., & Shah, S. (2025). Digital health technology compliance with clinical safety standards in the National Health Service in England: National cross-sectional study. Journal of Medical Internet Research, 27, Article e80076. https://doi.org/10.2196/80076.

NICE/MHRA rules-based pathway, the National AI Commission, updated MHRA guidance on digital mental health technologies, and ongoing WHO–MHRA knowledge exchange—signal a move toward greater regulatory clarity, though differences across UK, EU, and US markets persist and are unlikely to fully align until 2026. High-profile controversies, such as the use of millions of patient records without clear permissions, underline why governance and consent remain central to digital reform. Hence, sustainable adoption would have to depend as much on trust and legitimacy as on technological capability.

The NHS digital transformation faces several challenges and interconnected obstacles. The NHS Federated Data Platform (FDP) is a large-scale initiative that provides secure, federated access to patient data across organisations, addressing challenges related to data governance, transparency and legal compliance. Similarly, the Foresight AI platform, trained on routinely collected, de-identified NHS data such as hospital admissions and Covid-19 vaccination rates, has been subject to legal and professional scrutiny raised by many professional bodies regarding data privacy and transparency. Digital health tools classified as medical devices and subject to evaluation by the Medicines and Healthcare products Regulatory Agency (MHRA) and the National Institute for Health & Care Excellence (NICE) make the process more complex, lengthy, and costly, particularly for small innovators.

The last few years have seen an acceleration in practical and policy initiatives designed to enhance national capability, reduce regulatory friction and support economic growth. Initiatives such as Centres of Excellence for Regulatory Science and Innovation (CERSI), which emphasise AI and digital health, and national programmes like the AI Ambassadors Network to support clinician engagement, are in a capacity- and knowledge-building phase. The multi-agency approach taken by NICE, NHS England and The Office for Life Sciences (OLS), known as the 'National Healthtech Access Programme' (previously called the Rules-Based Pathway), is also a strong national signal of intent. Finally, the National Commission on AI, led by Professor Alistair Denniston, will publish its findings in 2026.

Recommendations: Policy Pathways

Our report proposes various policy pathways to ease the transformation of primary care in the short and long term. Focusing on each actor separately, we recommend three main shifts: moving from treatment to preventative care, i.e., community-based care, expanding multisector networks, and establishing digitally enabled systems.

1. Strengthening Neighbourhood-Level Coordination Across Primary Care

Policymakers should take the lead in strengthening the way existing services work together with patient groups, such as Healthwatch or Patient Participation Groups (PPGs), and at the neighbourhood level, using a more systematic and data-driven approach to understand population needs. This would enable moving away from the narrow focus on general practice to include community pharmacy, optometry and dentistry as equal partners in population health. These providers already form part of the "primary care family", and recognition in policy and funding would enable more coordinated, community-based delivery — without restructuring the contractor model.

As an implementation step, the Department of Health and Social Care (DHSC) could develop a national *Primary Care Integration Framework* to propose that local Integrated Care Boards (ICBs) incorporate all contractor groups into shared outcome measures and funding mechanisms. The delegation of pharmacy, optometry, and dental services to ICBs from April 2023 represents a structural opportunity to integrate these contractor groups. Early adopter ICBs, including Shropshire, Telford and Wrekin, and Suffolk and North East Essex, demonstrate that local commissioning control enables more coordinated, community-based delivery.[13] Indeed, NHS England's 2024/2025 assessment notes that Suffolk and North East Essex displayed exemplary financial management and became the only ICB in the country to be upgraded to segment 1 of the NHS Oversight Framework, whereas Shropshire, Telford and Wrekin's Highley Community Hub succeeded in bringing multiple teams together with a common goal of delivering integrated community care[14].

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[13] Pharmacy, optometry and dentistry services to be planned locally from April - NHS Shropshire, Telford and Wrekin. (2023, January 27). Retrieved November 12, 2025, from NHS Shropshire, Telford and Wrekin website: https://www.shropshiretelfordandwrekin.nhs.uk/features/pharmacy-optometry-and-dentistry-services-to-be-planned-locally-from-april/.

[14] NHS England. (2025, December 17). *Annual assessment of integrated care board performance 2024/25 – summary report*. NHS England. https://www.england.nhs.uk/long-read/an,nual-assessment-of-integrated-care-board-performance-2024-25-summary-report/,.

The Pharmacy First initiative provides a glimpse of what targeted collaboration can achieve. These findings are meaningful but should not be overstated; their success sits within a small clinical window. A Northern Ireland pilot of Pharmacy First for uncomplicated urinary tract infections (UTIs) treated 1,032 patients across 62 community pharmacies between July and December 2021. General practitioners reported that 56% rated the service as being very well or well-received by patients, with 66% citing it as beneficial, particularly due to quicker access to advice and treatment (reported by 66% of GPs) and reduced inappropriate antibiotic prescribing through urine dipstick testing (44%).[15] However, the scheme relies on relatively straightforward presentations and becomes less reliable as clinical complexity increases. According to a Scottish study on Pharmacy First for impetigo, urinary tract infections (UTIs), and chronic obstructive pulmonary disease (COPD), the number of GP appointments reduced[16]. In Wales, 91% of sore throat patients were tested and treated by pharmacists, and only 9.3% of cases were referred to GPs or Accident and Emergency (A&E)[17]. This extended role for community pharmacies has been shown to improve access to healthcare in socioeconomically deprived areas. The government estimates over 10 million appointments were released in a year due to pharmacy first services, allowing GPs to give patients with more complex and urgent needs faster access[18].

Evidence from federated and neighbourhood-based primary care models demonstrates that coordinated governance and resource pooling can improve quality, access and efficiency when implemented locally and pragmatically. Examples include Modality Partnership, one of England's largest GP super-partnerships, which has used shared infrastructure, standardised pathways and population health analytics to deliver consistent care at scale; Bromley by Bow Health, which integrates primary care with community and voluntary services around neighbourhood need; and long-standing models such as Whitstable Medical Practice, which has operated as a single-practice network for over two decades with sustained quality improvement. More recently, national neighbourhood pilots – spanning 40 sites across England – illustrate how

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[15] An Evaluation of Pharmacy First UTI Pilot Service. (2022). Retrieved from https://bso.hscni.net/wp-content/uploads/2022/11/MOIC-Template-Pharmacy-First-UTI.pdf.

[16] Stewart, D., McCallum, S., Mason, P., Blenkinsopp, A., & Wright, D. (2018). Building capacity in primary care: The implementation of a novel "Pharmacy First" scheme for the management of UTI, impetigo and COPD exacerbation. Primary Health Care Research & Development, 19(6), 531–541. https://doi.org/10.1017/S1463423618000126.

[17] Mantzourani, E., Wasag, D., Cannings-John, R., Ahmed, H., & Evans, A. (2023). Characteristics of the sore throat test and treat service in community pharmacies (STREP) in Wales: Cross-sectional analysis of 11 304 consultations using anonymized electronic pharmacy records. Journal of Antimicrobial Chemotherapy, 78(1), 84–92. https://doi.org/10.1093/jac/dkac358.

[18] *International Journal of Pharmacy Practice*, Volume 33, Issue 2, April 2025, Pages 152–161, https://doi.org/10.1093/ijpp/riaf004.

collaboration across practices can support workforce sharing and health equity.[19] The Hythe and Rural Folkestone digital hub in Kent and Medway, linking seven coastal practices, demonstrates how federated models can also address geographic isolation and access disparities.

The lesson from these models is not that they should be replicated wholesale, but that carefully designed coordination can unlock performance gains without structural reorganisation. Elements of these approaches could inform closer working between general practice and POD providers, but this would require difficult choices in a financially constrained system. With no new money entering primary care, scaling integration will depend on reallocating existing resources, decommissioning low-value activity and shifting investment toward shared infrastructure and prevention. In this context, integration is not only a technical challenge but a political one and will require explicit decisions about what the system stops doing to enable new forms of collaboration.

A Primary Care Integration Framework should be considered within broader system-level planning, closely aligned with the NHS Long-term Plan to support ICBs in developing shared outcome measures encompassing prevention, chronic disease management, and population health across all primary care contractor groups. This framework should mandate integration pathways, such as shared care models, multidisciplinary teams, and joint outcome monitoring, providing guidance and incentives that promote integration.

2. Stabilising Voluntary and Community Sector Partnerships

Policymakers should strengthen the stability of funding arrangements for voluntary and community sector partners, whose contributions are increasingly integral to modern primary and mental healthcare. Commissioned models such as Mental Health Matters and Hestia's crisis houses and safe havens in Kent and Medway ICB exemplify this model. Developed in partnership with Pears, a philanthropic organisation, and local partners, it provides an 'alternative crisis pathway' in the community for mental health patients. The units provide a continuum of care between the Emergency Department (ED), psychiatric liaison teams, community home treatment teams and crisis houses, resulting in positive outcomes for patients in both mental health and safety domains. The Safe Havens have seen a fall in ED footfall where they are co-located with local hospitals. The government's

[19] HM Treasury. (2025, November 24). Chancellor to double down on drive to cut NHS waiting times and rollout of new Neighbourhood Health Centres. GOV. UK. https://www.gov.uk/government/news/chancellor-to-double-down-on-drive-to-cut-nhs-waiting-times-and-rollout-of-new-neighbourhood-health-centres.

£150 million investment in mental health crisis response funded over 30 new crisis houses and similar safe spaces, alongside crisis cafes and mental health ambulances[20].

The Better Care Fund has, for years, ring-fenced NHS and local authority money for integrated care at the local level, demonstrating the NHS's willingness to allocate budgets for integration, even though it is not specifically focused on VCSE. Many Integrated Care Systems (ICSs) have established VCSE Leadership Alliances or similar forums, enabling voluntary organisations to influence strategy. However, what is often missing – and which the report highlights – is actual commissioning power and funding security for these organisations. Despite operating within NHS contracting and safeguarding frameworks, many voluntary organisations still face short contracting cycles and recurrent uncertainty over renewal. A more predictable funding environment would enable voluntary partners to strengthen their role within integrated care pathways and sustain the high-quality support they already provide.

A ring-fenced *Community Integration Fund* could provide a sustainable mechanism for Integrated Care Boards (ICBs) to commission voluntary and community sector (VCS) organisations with clear quality, safeguarding and accountability requirements embedded within contracts. A useful precedent already exists in the NHS through the Mental Health Investment Standard (MHIS), which has protected mental health spending for over a decade and created a degree of financial stability that enabled long-term service development. A similar approach for community integration would give ICBs greater confidence to commission VCS partners for prevention, outreach and wrap-around support without exposing them to short contracting cycles that undermine workforce planning and service continuity.

However, embedding such a fund within integrated care strategies will not, on its own, guarantee consistent partnership working across England. The success of any commissioning mechanism ultimately depends less on national design and more on local relationships and leadership. The experience of social prescribing illustrates this clearly: while it is nationally funded and mandated, its effectiveness varies widely depending on the strength of local VCSE networks, the maturity of relationships between link workers and community organisations, and the willingness of statutory services to share ownership of outcomes. Similar variation can be expected with a Community Integration Fund. Differences in how statutory bodies engage with voluntary organisations and the

[20] Department of Health and Social Care. (2023, January 2 consistent partnership across England, mirroring the structured approach already adopted in national mental health commissioning). Mental health services boosted by £150 million government funding. Retrieved from GOV.UK website: https://www.gov.uk/government/news/mental-health-services-boosted-by-150-million-government-funding.

extent to which local leaders prioritise co-production will ultimately determine whether funding translates into meaningful collaboration or remains a transactional exercise.

3. Digital Equity Strategy Across All Primary Care Settings

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. 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. 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 system.

The digital shift remains essential for moving primary care from reactive to proactive care by using existing clinical data to identify risk and intervene earlier. Analogue systems fragment records and obscure clinical urgency, whereas integrated records allow clinicians to prioritise need, coordinate care and avoid duplication. Digital navigation can guide patients to the appropriate level of care, while safe online consultations extend the reach of primary care into homes and communities. However, these benefits will only be realised if digital design reflects the realities of different provider settings and is informed by frontline users, including pharmacists, whose workflows and safety requirements need to be embedded into system architecture rather than retrofitted later.

The NHS is currently adopting a strategy for the effective detection and management of Long Term Conditions (LTCs). Abtrace, for example, is a healthcare startup in partnership with the NHS, launched in 2018, that utilises machine learning to change the way clinicians detect and monitor LTCs. Abtrace reduced Healthcare Assistant (HCA) appointments by 30%[21] and improved the overall experience for both clinicians and patients. Abtrace is only one example of the digital tools beginning to shape clinical practice. Across the UK, other systems are already in use. These tools connect GPs to patients' electronic health records (EHRs). This enables them to make informed decisions by accessing patients' complete medical histories. These platforms aim to embed advanced machine learning technology to detect medical conditions more accurately and earlier. These technologies can improve efficiency and reduce duplication of effort. They

[21]Williams, T. (2021, September 10). *Abtrace raises £2.1 m to deliver game-changing AI tech to GP surgeries*. HealthTech Digital. https://www.healthtechdigital.com/abtrace-raises-2-1m-to-deliver-game-changing-ai-tech-to-gp-surgeries/.

reduce repetitive appointments that include duplications of various tests by using existing stored data to create intelligent proactive frameworks that can save lives.

Digital pathways succeed only when matched to the appropriate context. Tools that don't meet practitioners' needs – and instead introduce hesitation or extra workload – are unlikely to be used in day-to-day care. The digital shift must therefore be implemented in ways that actively support staff, including protected time for onboarding, workflow adjustment, and confidence-building alongside technical training.
NHS digital leads and ICS technology directors have influence here, through procurement choices, implementation planning, and standard-setting across organisations. When designing and deploying platforms, they should also account for people who are less digitally confident, particularly older adults.

A large part of the digital shift is digital education through self-monitoring: the ability to precisely track symptoms by looking at heart rate or blood sugar. Self-monitoring gives patients control over their data and access to it from the comfort of their homes. However, this may lead to increased patient anxiety and mental health distress. It also results in unnecessary patient contacts - further straining medical resources[22]. Health professionals tend to be cautious of any treatment that is not evidence-based. Although this data can sometimes be helpful for practitioners, most doctors prefer conducting tests themselves instead of trusting these new devices[23]. It is worth recognising that digital interventions can generate broad behavioural and contextual data streams that may be more revealing than traditional clinical records, posing a higher risk if data are misused or poorly handled. Technological capability can also outpace governance frameworks and infrastructure, creating systemic risk unless safeguards keep pace with innovation[24].

Interoperability should extend to integration between the NHS App, NHS 111 and local electronic patient records. 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

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[22] Kleinman, Z. (2024, December 2). *Why are doctors wary of wearables?* https://www.bbc.com/news/articles/c79zpzdv4vno.

[23] Keeling, A., Downey, J., Halkes, M., & Wei, Y. (2025). Patient-generated mHealth data collected outside clinical settings: A narrative scoping review of how patient-generated mHealth data are used and influence clinical decision-making for adults with long-term conditions in outpatient care. Journal of Medical Internet Research, 27, e77359. https://doi.org/10.2196/77359.

[24] Singh, S., Kenny, A., Ospina-Pinillos, L., Bucci, S., & Wellcome–Google Working Group. (2025). Reflecting on lived experience expertise in digital mental health research. The Lancet Digital Health. Advance online publication. https://doi.org/10.1016/j.landig.2025.100920.

integration to ensure the app can pull data from and share information across systems in real time[25].

4. Shared Outcomes Framework

ICBs sit at the interface between national ambition and local delivery, but their ability to shape collaboration should account for the autonomy of primary care contractors. Local federated GP models – such as Community Interest Companies (CICs), Limited Liability Partnerships (LLPs), or other incorporated structures – create a shared "at-scale" vehicle for practices to coordinate delivery and shared processes[26]; similar structures could be extended to other providers. These are not structures ICBs can mandate, but they can support them by offering aligned commissioning opportunities and by removing barriers to shared delivery.

Rather than proposing that ICBs establish new Primary Care Collaboratives that pool contracts, a more feasible approach is to strengthen collaboration through existing contractual forms that are given time to mature. Voluntary alliances can enable innovation but remain fragile, as they depend on individual partner commitment and leadership continuity. The experience of Primary Care Networks (PCNs) shows that effective collaboration develops over years, not months, a reality reflected in NHS England's *PCN Maturity Matrix*, which recognises staged progression from early formation to system-level integration. ICBs can accelerate this maturation by aligning incentives, providing facilitative support and protecting time for relationship-building rather than creating new organisational structures. At the same time, learning from mature neighbourhood and network models should be captured and shared nationally, with ICBs working alongside the NHS Confederation and NHS Providers to curate a living repository of collaboration approaches that have moved beyond formation into sustained delivery.

Local systems should continue commissioning integrated care pathways that incorporate voluntary and community sector (VCS) organisations within clear governance and risk parameters. Existing partnerships – such as ICBs commissioning MIND for crisis support – show how structured VCS involvement can reduce admissions and offer earlier intervention.

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[25] Verhoog, K. (2025, February 5). How Integration and Interoperability Will Unlock the UK Government's Vision for the NHS App - Integrella. Retrieved from Integrella website: https://integrella.com/how-integration-and-interoperability-will-unlock-the-uk-governments-vision-for-the-nhs-app/.

[26] McDonald, R., Riste, L., Bailey, S., Bradley, F., Hammond, J., Spooner, S., Elvey, R., & Checkland, K. (2020). The impacts of GP federations in England on practices and on health and social care interfaces: four case studies. NIHR Journals Library. https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr08110.

To address digital inequities, ICBs should ensure parity of funding across all primary care contract groups. Local digital investment plans should explicitly account for non-GP providers, where all use interoperable systems linked to the NHS App and 111.

System leaders play crucial roles in driving cultural change, but this needs to be framed in pragmatic rather than idealistic terms. Currently, the practices' funding is based on the Carr- Hill formula, which calculates a GP practice's core "global sum" by taking its registered patient list and then adjusting (weighting) it to reflect expected workload. Those weights are based on factors such as the population's age profile and deprivation, so practices with similar list sizes can receive different core payments[27]. While the notion of a "family culture" stresses the value of shared learning, primary care financial structures mean that practices inevitably compete for patients, contracts and services. Integration, therefore, requires reshaping current structures to induce collaboration despite competitive pressures. Importantly, any future redistribution should avoid digital exclusion by paying for hands-on support that helps patients use online services and by keeping accessible non-digital options accessible, since unequal digital access adds workload for practices and can deepen existing health inequalities.

Leaders should therefore prioritise mechanisms that foster learning in practical, low-friction ways – such as joint education sessions, shared significant-event analyses and cross-sector improvement collaboratives within each ICS. National bodies do not need to invent new systems, as strong models already exist. For example, the Peer Ambassador Network, the General Practice Improvement Programme (GPIP) and the NextGen GP initiatives demonstrate the value of locally embedded peer-to-peer leadership. Similarly, GP Training Hub leadership programmes for Clinical Educator Facilitators (CEFs) show how development embedded within PCNs can create trusted connectors across organisations. Policy should strengthen and scale these localised, practice-proximate leadership infrastructures. These are the environments where integrated behaviours can realistically take root and where leaders can model shared learning without ignoring the structural realities of primary care.

Workforce readiness remains a major barrier to digital transformation. Digital success depends on investing in staff capability and confidence. Thus, system leaders should allocate protected learning time for digital literacy and change management by embedding this in workforce plans. The NHS Digital Academy has been commissioned by NHS England to fund a postgraduate diploma (PGDip) in digital health leadership at Imperial College London, which is one such programme among others. NHS England

[27] Hutchinson, J., Hammond, J., Sutton, M., & Checkland, K. (2021). Equity and the funding of Primary Care Networks. British Journal of General Practice, 71(710), 422–424. https://doi.org/10.3399/bjgp21X717029.

could make digital training a national standard within Continuing Professional Development (CPD) budgets[28].

In parallel, mandatory training requirements should evolve to reflect the realities of a digitised health service. Every Primary Care Network and GP practice should have access to clinicians trained as CSOs, with structured pathways to develop competence in digital clinical risk management. Prioritising CSO training over some of the less impactful mandatory modules would strengthen digital safety culture and ensure that frontline teams are equipped to use new technologies confidently and safely.

Universities and training providers should evolve curricula to reflect modern interdisciplinary practice. Embed interdisciplinary education modules where medical, pharmacy and optometry students learn about integrated pathways together. For example, joint placements between GPs and pharmacies can foster understanding of shared patient management. Joint placements between general practice and pharmacies remain valuable today, but curricula must also anticipate a future where some traditional roles, such as routine optometry or basic radiography tasks, may be substantially automated or reconfigured by AI. To build this future, the practice and policymakers must ensure that the deployment of new pieces of technology complies with legal and clinical safety requirements to mitigate risks to patients.

Educational institutions should therefore embed digital competence, data literacy and AI fluency as core professional skills. Modules on telemedicine, algorithmic decision-support, digital ethics and human oversight of automated diagnostics should sit alongside clinical content. The NHS Clinical Fellowship in AI is a valuable initiative that empowers early-career clinicians to understand, evaluate, and responsibly implement AI in clinical practice. The NHS Digital Academy could partner with universities to co-develop microcredentials that prepare an “AI-ready” generation of clinicians who can safely integrate emerging technologies into care while preserving relational, judgement-based elements. A future-focused approach like this would ensure graduates are both clinically capable and equipped to thrive in a health system being fundamentally reshaped by AI. As UK community practice becomes the main setting for more care delivered closer to home and increasingly accessed through online routes, the real benchmark of this technological paradigm shift is whether it measurably frees clinician time for complex judgement while narrowing inequalities in access for patients.

[28] NHS England. (n.d.). Talent management resource tool. https://www.england.nhs.uk/long-read/talent-management-resource-tool/.

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[29]. 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[30].

UK Implication

The UK's primary care current core funding for general practices is 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. 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

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

[30] *Developing Primary Care Population-Based Payment Models in Medicaid: A Primer for States Developing Primary Care Population-Based Payment Models in Medicaid: A Primer for States*. (2024). Retrieved from https://www.chcs.org/media/Developing-Primary-Care-Population-Based-Payment-Models-in-Medicaid-A-Primer-For-States.pdf.

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 2-8[31]. Evidence demonstrates that NP-led models achieve outcomes equivalent 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 Additional Roles Reimbursement Scheme (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

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[31] 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.

intended: enhancing access and reducing duplication while addressing the UK's projected shortfall of 18,900 full-time equivalent GPs by 2030/31[32].

Community Paramedicine for Home-Based Care (Canada)

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[33]. 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[34]. Qualitative research found patients valued community paramedics as highly trusted advocates who provided holistic, relationship-centred care addressing social determinants of health[35]. In 2025, Ontario invested $89 million to make community paramedicine programmes permanent, reflecting a commitment to expansion across Canada[36].

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 Care Networks (PCNs) and the ARRS were established. Within this framework, practices and PCNs could be encouraged to expand the use of Advanced Clinical Practitioners (ACPs) and Advanced

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[32] 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.

[33] Agarwal, G., Pirrie, M., Angeles, R., Marzanek, F., Thabane,scale practices 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.

[34] Agarwal, G., Pirrie, M., Angeles, R., Marzanek, F., Paterson, J. M., Nguyen, F., & Lehana Thabane. (2024). Community Paramedicine Program in Social Housing and Health Service Utilization. *JAMA Network Open*, *7*(10), e2441288–e2441288. https://doi.org/10.1001/ja,manetworkopen.2024.41288.

[35] 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.

[36] 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/.

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[37]—implementation has been uneven and underfunded. Embedding a community-paramedicine-style function into Primary Care Networks, 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.

Closing Remarks

This roundtable discussed the interplay between ambition and the challenges it poses. Speakers concurred that the system is heading in the direction of preventative and integrated care. However, the path remains fragile. Although the NHS has proven its commitment to its new vision, it is missing the alignment to make the innovative system work. Primary care is the front line of health, but for it to work, it cannot be the first and last resort. The future of healthcare depends on whether we view integration as a genuine redesign. What was made clear during the conversation was the need to protect the human nature of care while also making it more intelligent. From the perspective of collective care, the NHS must focus less on creating new structures and more on making the existing ones speak to each other.

Attendees of Roundtable 1

The insights and recommendations in this report were informed by a roundtable event held on October 8, 2025, under the Chatham House Rule. A diverse group of 20 delegates from across the different sectors within primary care shared their expertise and insights to inform this policy report.

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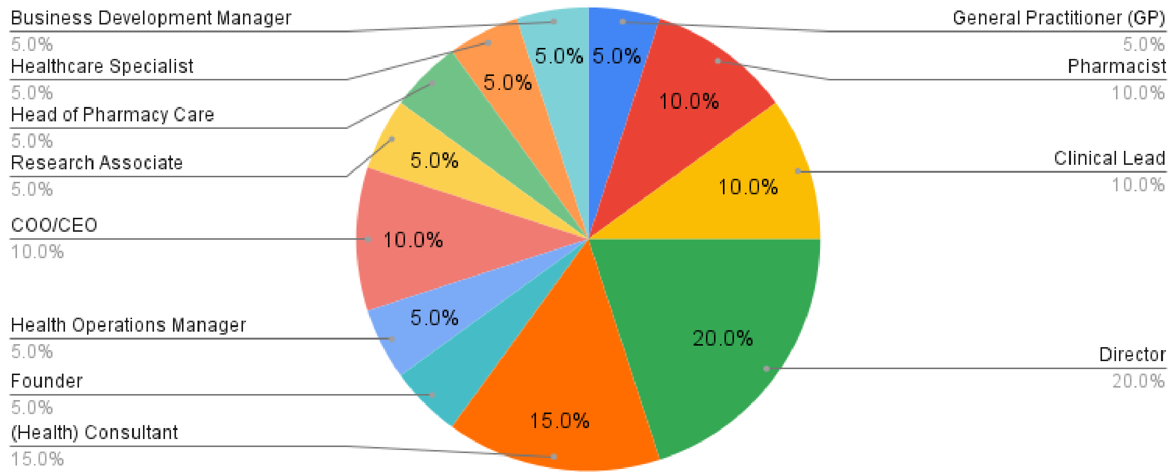
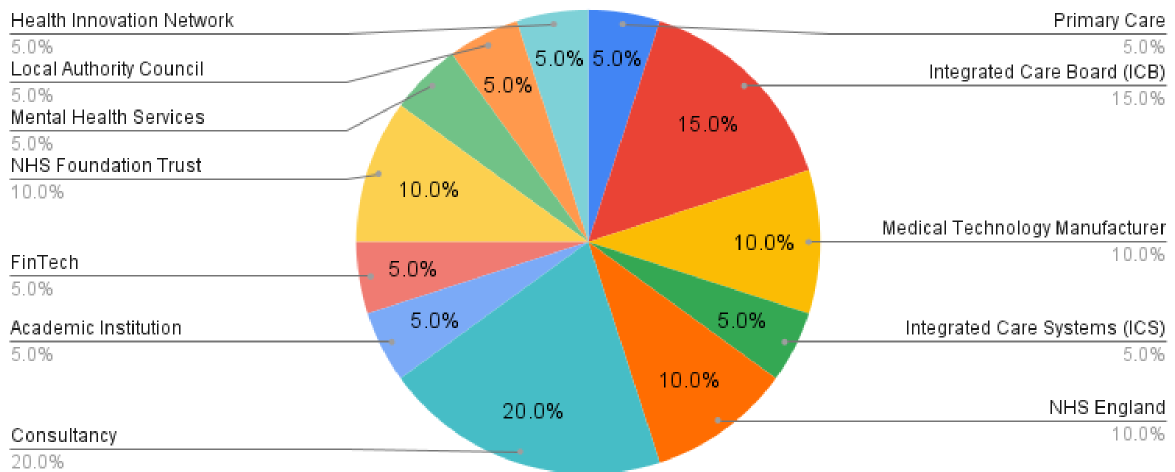

Participants Job Category
Business Development Manager
5.0%
Healthcare Specialist
5.0%
Head of Pharmacy Care
5.0%
Research Associate
5.0%
COO/CEO
10.0%
Health Operations Manager
5.0%
Founder
5.0%
(Health) Consultant
15.0%
General Practitioner (GP)
5.0%
Pharmacist
10.0%
Clinical Lead
10.0%
Director
20.0%


Participants Organisational Background
Health Innovation Network
5.0%
Local Authority Council
5.0%
Mental Health Services
5.0%
NHS Foundation Trust
10.0%
FinTech
5.0%
Academic Institution
5.0%
Consultancy
20.0%
Primary Care
5.0%
Integrated Care Board (ICB)
15.0%
Medical Technology Manufacturer
10.0%
Integrated Care Systems (ICS)
5.0%
NHS England
10.0%

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11. Robert Hull - Health Operations Manager, WM5G
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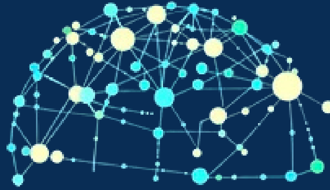

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