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BMA England

Focus on ethical collaborations and GP federations

Summary

In alignment with recent national policy developments and the new NHS 10-year plan, this BMA GP Committee England (GPCE) paper outlines suggested key principles and provides initial strategic guidance for GP practices, federations and primary care networks (PCNs) as they navigate the evolving landscape of neighbourhood health.
To ensure the success of neighbourhood health plans and protect practices, General Practice must not only respond to these policy shifts but help lead them. GPs can do this by engaging swiftly, embedding the voice and values of General Practice in the design and implementation of any new models of care, and embodying the highest standards of clinical care, governance and financial stewardship.

Please read this guidance in tandem with our GPCE response to the Model ICB Blueprint, published in June 2025.

The 10-year plan, neighbourhood health and general practice

The plan confirms that two new GP contracts will be introduced from next year for 'single neighbourhood providers' and 'multi-neighbourhood providers'. As existing providers embedded within their local communities, GP practices, PCNs and federations are well placed to be the pivotal focal point for these attempts to develop neighbourhood health systems, acting as the 'conductor of the orchestra' of local healthcare providers and organisations within the area.
The Department for Health and Social Care (DHSC) and NHS England (NHSE) have already written to integrated care board (ICB) and local authority chief executives inviting 'places' to join the first wave of the National Neighbourhood Health Implementation Programme (NNHIP).

It is therefore important for GP practices, federations and PCNs to be thinking about how they may operate in such systems, by developing collaborative models that operate on transparent, ethical principles, and which work to protect the interest of all their member practices and the care of their patients.

GP-led providers working at scale often deliver efficiency gains by reducing duplication and coordinating care across settings. But when these efficiencies generate financial surpluses — whether from reduced hospital activity, innovation funding, contractual delivery or delegated commissioning — the current system offers no guarantee that this value is returned to the practices or teams responsible for it. Re-investment of such surplus back into member practices' services and staff will help generate even more gains by improving preventative and continuity of care.

Without ethical safeguards, we risk:

- **Perverse incentives**: Practices doing more with less but receiving no benefit and losing motivation / closing.
- **Extraction of value**: Surpluses flowing to higher tiers of the system or corporate entities with minimal transparency.
- **Staff demoralisation**: Clinicians and staff seeing no tangible improvement in income, workload, or conditions despite delivering transformation.

If GP-led organisations are to operate at scale without compromising professional integrity, they must be built on governance structures that respect:

- **Member practice sovereignty**
- **Operational transparency**
- **Equitable surplus distribution for onward investment**
- **Reinvestment in purpose: patient care and workforce wellbeing**

The importance for General Practice

As Integrated Care Systems (ICSs) across England deepen their commitment to population health, General Practice is being asked to lead transformation at scale. GP-led provider collaboratives, federations, and super-partnerships are increasingly central to ambitions around anticipatory care, proactive management of long-term conditions, and reducing unwarranted variation.

Yet, as a smaller player with unlimited liabilities, GMS contract-holding GP practices must be:

- preserved and protected to thrive
- within supportive well-led high-governance models
- ethically sound and
- financially sustainable
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General Practice is key to the neighbourhood health proposals, as the future direction and success of primary care delivery will hinge on whether GPs and their representative organisations have a meaningful voice in shaping the landscape.

Without strong aligned voices from GP practices, PCNs, and federations, there is a risk that the system will be designed by others and imposed from above — potentially leading to approaches that are misaligned with the realities and needs of day-to-day general practice.

For neighbourhood healthcare to be genuinely effective, it cannot simply be a top-down initiative driven by commissioners or by a handful of local enthusiasts. It must reflect the insights, strengths, and innovations of those delivering care on the ground. Engagement needs to be broad-based; not just the most enthusiastic or resourced practices, but involving the full spectrum of providers, so that solutions work for everyone rather than just the few.

General Practice can help shape neighbourhood models so they enhance local care, foster collaboration, and protect the professional autonomy and values that are central to high-quality, patient-centred primary care delivered by the care closest to home within individual general practices using the principle of subsidiarity.

Principles of engagement

Keep GP at the heart

As neighbourhood models evolve, it is vital that GPs maintain a central, coordinating role — as mentioned above, much like the 'conductor of an orchestra'. GP leadership in care pathway design, population health management, and multidisciplinary team development ensures that models are grounded in holistic, patient-centred care.

Federations and neighbourhood providers should empower GPs to lead innovation and drive quality improvement, ensuring that the core values and expertise of general practice remain at the forefront of care delivery.

Work alongside the LMC

For GP practices and federations embarking on developing neighbourhood care models, close collaboration with Local Medical Committees (LMCs) is essential. The LMC's expertise in representing the interests of General Practice and dealing with local commissioning bodies will help in navigating often complex, shifting waters, whilst safeguarding the interests of member practices. Early and sustained engagement with the LMC will help in working through contractual, workforce, and governance considerations, smoothing the path for model adoption, and ensure that neighbourhood models are shaped by those who know general practice best.

Develop widespread practice support and engagement

The success of neighbourhood care models depends heavily on the active involvement and support of individual GP practices. Federations must foster an inclusive culture, allowing for all practices to contribute ideas, raise concerns, and co-design solutions. Regular communication, transparent decision-making, and access to peer networks can build trust and ensure that care models are genuinely responsive to local needs. By investing in early engagement with their member practices and others in their area, federations can ensure the neighbourhood approach reflects the diversity and strengths of all the practices it serves.

Set a sustainable pace

While there is momentum for change and pressure from NHSE and ICBs to push ahead at speed, it is important for GP practices and federations to try and manage the pace of development thoughtfully. Rapid, top-down implementations risk disengagement and burnout, whereas a measured, stepwise approach allows for iterative learning, adaptation, and consolidation. Ensuring that changes to ways of working are graduated appropriately, and responsive to feedback and evaluation ensures that new neighbourhood care models are robust, sustainable, and meet the needs of patients and practices alike.

Ministers themselves advise that history tells us top-down transformation does not work. They wish to see a bottom-up approach to this transformational change to the NHS, so that those at the coalface, i.e. *you* as GPs and your practice teams, need to be driving it rather than anyone else, e.g. those with little to no experience of continuity of care in community settings.

Ensure resources will shift

A fundamental principle for federations and GP practices is to insist that any extension of service provision is matched by a commensurate shift in resources. The much vaunted 'left shift' of care into the community cannot happen without a similar movement of funding.

To safeguard practices and GPs working within them, neighbourhood care models should be underpinned by clear financial arrangements, workforce planning, and infrastructure support. This means that new expectations—whether in terms of hours, service breadth, or population coverage—must be accompanied by appropriate funding, staffing, and access to digital and estate resources. Only with this foundation can neighbourhood care thrive without placing unsustainable burdens on practices and teams.

Principles for implementation

Subsidiarity and Member Voice

Decision-making should sit as close to practices and patients as possible. Boards should include elected practice representatives, with decisions on, for example, use of surplus subject to member vote or delegated authority structures.

Ringfencing Surplus for Purpose

Any surplus generated should be:

- Ringfenced for reinvestment into member services and staff development.
- Prohibited from external dividend extraction (where not community-owned or mutualised).

Transparency and Accountability

A published annual "Surplus Reinvestment Statement" should:

- Set out how any surplus was generated.
- Detail how it was allocated across member practices, workforce initiatives, or service development.
- Include staff and patient voices.

Incentivising Collective Performance

Reinvestment should be weighted to reward collaboration, quality, and outcomes—rather than activity alone. This supports practices to work together for population benefit, not individual gain.

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Possible Organisational Models

There are a range of models that could be utilised to implement collaborative working. Each of these has particular advantages and disadvantages, and practices should consider closely what works best for their locality and circumstances.

Community Interest Companies (CICs)

- **Advantages**: Asset lock, social purpose built-in, surplus reinvestment mandated by law.
- **Governance fit**: Ideal for organisations seeking to protect community benefit and staff interests long-term.
- **Risks**: Can be perceived as complex; needs robust internal democracy.

Mutuals / Cooperatives

- **Advantages**: Fully member-owned, democratically governed.
- **Governance fit**: Ensures GP practices retain control and share in decision-making.
- **Risks**: Requires high levels of engagement and governance maturity.

Limited Companies with Shareholder Agreements

- **Advantages**: Familiar model, adaptable, can define reinvestment rules in shareholder or operating agreements.
- **Governance fit**: Suitable if members retain control and explicit reinvestment policies are embedded.
- **Risks**: Risk of profit extraction if governance is not tightly specified.

Ethical Surplus Reinvestment

Ethical reinvestment is not an administrative add-on—it is a moral imperative.
If done right, it creates a virtuous cycle: local innovation, local value, and local reinvestment—sustaining general practice and GMS practices as the beating heart of the integrated neighbourhood team.

To ensure surpluses are used fairly and transparently, GP-led organisations should adopt the following mechanisms:

Local Reinvestment Boards

- Multi-stakeholder (clinical, operational, staff) boards to decide on use of surplus.
- Priority areas: workforce pay/uplift, staff development, innovation, estates, digital tools, or addressing access gaps.

Staff and Patient Reinvestment Votes

- Empower members of staff and patient representatives to participate in prioritisation.
- Use digital platforms or facilitated workshops to gather input.

Earnings Uplift or Bonus Mechanism

- Use surplus to reward staff (clinical and non-clinical) through discretionary bonuses or pay uplifts linked to quality or outcomes—not just productivity.

Annual Reinvestment Report

- A mandatory report detailing:
    - Surplus generated and its source, e.g. efficiency, contract performance.
    - Breakdown of reinvestment by category and geography.
    - Outcomes achieved, e.g. improved access, reduced vacancies, patient satisfaction.

While reinvestment must be accountable, it should not be so complex that it deters innovation or delays value delivery. GP-led organisations should aim for:

- **Standardised but simple templates** for reporting reinvestment
- **Peer-review panels** across ICBs to validate ethical reinvestment and share learning and
- **System alignment**, ensuring ICB commissioners respect local reinvestment rights and do not claw back surplus unfairly.

Reinvestment is not a reward — it is a restoration of fairness. Where GPs generate value, they must be trusted to retain it and reinvest it in the GMS practices, their patients and teams that made it possible.

Challenges to consider

As these new models of governance and collaboration emerge for general practice, a range of significant challenges must be considered and carefully navigated. The process of changing established ways of working — while seeking to preserve core values and ensure robust, democratic decision-making — brings both operational and cultural hurdles. Below are some of the principal obstacles that organisations may face as they move towards more integrated, neighbourhood-based care.

Complexity in Collaboration

Bringing together multiple GP practices, PCNs, and wider neighbourhood partners can create a lot of operational complexity. Aligning different systems, priorities, and cultures often requires significant time and effort, and may encounter resistance from those wary of change or loss of autonomy.

Resource Constraints

Securing sufficient funding, workforce, and infrastructure to support expanded services is a persistent challenge. Without guaranteed new or reallocated resources, practices may struggle to meet increased expectations, risking staff burnout and service dilution / ineffiency.

Managing Change Fatigue

The pace and volume of transformation initiatives can lead to disengagement and fatigue among clinicians and staff. If changes are perceived as imposed or unsupported, morale and buy-in may suffer, undermining the sustainability of new care models.

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Data Sharing and Digital Integration

Neighbourhood health relies on robust data sharing and digital connectivity across organisations. Technical barriers, differing systems, and data governance concerns can impede seamless communication and coordinated care.

Maintaining Core GP Identity

As neighbourhood models evolve, there is a risk that the distinct values and holistic approach of general practice could be diluted. Ensuring that GPs remain central to leadership and decision-making is crucial to preserve the essence of patient-centred care.

Next steps

General practice is the foundation of the NHS. As it increasingly leads population health transformation, GP-led organisations must embody the highest ethical standards — not only in clinical care but in governance and financial stewardship.
To do otherwise is to risk disillusioning the very workforce the system depends on. GPs quickly need to:

- **Initiate Collaborative Discussions**: Arrange meetings with local practices, PCNs, and other organisations to build relationships and foster shared understanding of collaborative working and possible neighbourhood objectives.
- **Develop Joint Working Principles**: Co-create and formally agree on a set of guiding principles for joint working, ensuring that all partners are aligned on values, expectations, and responsibilities.
- **Map Opportunities and Risks**: Systematically identify opportunities for collaboration, innovation, and resource optimisation, while also recognising and planning for potential threats or barriers.
- **Clarify Roles and Decision-Making Structures**: Define clear roles for each partner and establish transparent decision-making mechanisms to support effective governance and leadership.
- **Establish Communication and Data-Sharing Protocols**: Agree on standards and processes for robust data sharing and digital integration to support seamless, coordinated care.
- **Engage and Support Staff**: Develop strategies to engage clinicians and staff in the transformation process, addressing change fatigue and maintaining morale through regular communication, training, and support.
- **Monitor Progress and Adapt**: Set up regular review points to monitor progress against objectives, gather feedback, and adapt strategies as needed to ensure sustainability and continuous improvement.