Neighbourhoods and Integrated Health Organisations

BMA

BMA briefing

Neighbourhood health services and, eventually, IHOs are central to the UK Government's 10 Year Health Plan and its plans for the future of the NHS. These reforms will reshape the way the NHS is organised and how it operates, for patients and staff.

While shifting some care out of acute settings and into community or 'neighbourhood' services could be beneficial, the models proposed to achieve this carry major risks and could severely destabilise existing services. These concerns were central to the BMA policy passed at the September 2025 SRM (Special Representative Meeting) affirming the BMA's opposition to the 10 Year Health Plan as written.

This briefing note addresses the proposals set out by DHSC (Department of Health and Social Care) in its Neighbourhood Health Framework for the development of the neighbourhood health services and IHOs (Integrated Care Organisations) in England promised in the 10 Year Health Plan.

A detailed summary of the Neighbourhood Health Framework is also provided below, but it is important to note that many aspects of these models remain subject to consultation and guidance.

Major changes for the whole NHS

Significant questions remain regarding the development and future operation of neighbourhood models and IHOs, but the information provided in the neighbourhood framework has allowed us to pick out several overarching themes and headlines.

System leadership and the role of General Practice

- the prospect of secondary care-run general practice remains likely, particularly under IHOs and the MNP (Multi-Neighbourhood Provider) model
- SNPs propose a less immediate threat to the partnership model as it remains possible for them to be operated by groups of GPs at PCN level, but their development must still be scrutinised closely
- IHOs will be run by NHS trusts and only NHS organisations will be eligible to operate them
- no specific requirements have been set regarding clinical leadership of these models, with only limited references to GP leaders.

BMA View

The BMA remains clear that the prospect of secondary-run general practice is an enormous risk and would pose an existential threat to the partnership model of general practice, as well as to the vital continuity of care and value for money it provides. Likewise, the BMA is deeply sceptical of the capacity for secondary care organisations to effectively lead the organisation of primary care and general practice services they do not deliver or fully understand. On this basis, the Association remains strongly opposed to the development of IHOs and to the MNP model.

The BMA has also been consistently and strongly opposed to vertical integration within the NHS, which extends to IHOs as the latest attempt at this approach. However, while the Association remains opposed to IHOs, the clear commitment for them to be run exclusively by NHS organisations does alleviate prior concerns about them being vehicles for further privatisation of the NHS.

The lack of clear, defined clinical leadership roles within the framework is a serious point of concern. The BMA remains clear that doctors must play a central role in the leadership and decision-making structures of any NHS model, in order to ensure those organisations are informed by the experts that understand the services they deliver and the patients they serve. In respect of neighbourhood working, it is especially important that GPs and properly qualified and regulated public health specialists have key roles in the development and leadership of any structures.

The roles of PCNs (Primary Care Networks) and GP Federations remain unclear

- PCNs are mentioned only briefly in the framework, but it is stated that PCNs could eventually evolve into SNPs
- the timing, nature, or commissioning mechanisms for this approach are not set out within the framework, but will be subject to a future consultation

- GP Federations are not mentioned at all, leaving their role within neighbourhoods entirely unclear.

BMA View

The framework fails to fully address or clarify the future of important elements of the existing structure of general practice, thereby creating considerable uncertainty for many GPs, including those currently leading PCNs and GP federations. This only adds to wider concerns regarding the future of general practice and, as above, the partnership model in particular.

Despite this, the prospect of PCNs evolving into SNPs could, providing essential safeguards are secured, provide a more attractive alternative to the MNP model. Depending on its terms, this approach may also help to ensure neighbourhoods are GP-led, as the BMA has called for. Therefore, the BMA will be monitoring this proposal closely and will respond comprehensively to the promised consultation when it launches.

Neighbourhoods will have national objectives, but will develop individually

- ICBs will be responsible for commissioning all neighbourhood models and IHOs
- these models will not be rigidly set by DHSC or NHS England, with a permissive approach intended to allow ICBs to build and shape them based on local need
- neighbourhoods will be expected to deliver national – and arguably secondary care-focused objectives – as well as locally determined goals
- national objectives for neighbourhoods align with the 10 Year Health Plan and include:
    - improving health outcomes – with reduced hospital visits for high risk groups, like frailty patients
    - improving access to general practice – including more same-day appointments
    - improving patient experience of planned care – including meeting the 18 week waiting time standard
    - better UEC (urgent and emergency care) performance – including meeting A&E four and 12 hour targets
    - improving patient and staff satisfaction – to be measured via new metrics.
    - local goals will be established between NHS and partner organisations in a neighbourhood health plan.

BMA View

Although the prospect of local variation in neighbourhood structures and operating models is not inherently problematic, the prospect for so many different approaches across England could present significant challenges, particularly given ongoing challenges posed by ICB restructuring and unclear leadership at a local level. Without effective local commissioning of neighbourhood models, the proposed permissive approach could lead to unwarranted variation and post-code lotteries for patients, rather than the desired localised services. This further emphasises the need for local GPs to lead the development and operation of neighbourhood services, using their expert knowledge of local populations and their care needs.

The emphasis on national targets within the framework – while in part understandable given the focus on local development of objectives – may risk entrenching the view that neighbourhood working is seen as a means of supporting hospitals to meet secondary care targets, rather than ensuring the delivery of high quality primary care services. Clear goals on prevention and community care are needed to help to address this and to show that the proposed shift from hospital to community is genuinely about changing the way the NHS works.

Finances for neighbourhoods will come from existing funding, not from new money

- Resources will be redirected to enable the development of neighbourhood services, as part of the wider shift of care from hospitals to the community
- DHSC and NHS England aim to apply a permissive approach to neighbourhood finances, allowing ICBs to design and resource local neighbourhood contracts based on their determination of local need
- neighbourhood health will be funded by rebalancing existing resources, not by new funding
- ICBs, as the commissioner of neighbourhood services, will be responsible for determining the scope of their contracts and, therefore, their monetary value.
- nationally set funding allocations and expectations will be constructed on the basis of supporting a shift of resources from the acute sector and into neighbourhoods.

BMA View

The BMA's submission to the 10 Year Health Plan consultation stressed the importance of 'double-running' the funding of acute services and investment into the development of community services, to ensure that capacity within the community can be sufficiently enhanced to safely take on care transferred from

hospitals. However, the framework is clear that the funding intended to support the development of neighbourhood services will be redirected from secondary care. This decision risks undermining the funding of hospitals that face enormous pressure and an ongoing corridor care crisis, while making investment into neighbourhoods contingent on the immediate transfer of workload before capacity has been built - it should be urgently reconsidered.

Additionally, redirecting funding away from hospitals poses an equally severe risk to locally employed doctors, who do not have the same safeguards around pay as their colleagues on nationally negotiated contracts, and are therefore more vulnerable to exploitation should their place of work or terms and conditions be altered.

Investment into neighbourhood services should also be focused on properly funding the GP contract, to ensure that the family doctor can be restored and that practices are enabled to deliver the highest quality services. The value for money delivered by the partnership model is essential to the NHS and would ensure that this investment is used highly effectively.

A wider possible implication of this approach is for even more patients and elective care to be driven towards to the private sector, as it is a real possible that neither underfunded secondary care services or underprepared community services will be able to cope with demand. This could, in turn, increase costs for the NHS or for patients themselves, if they feel it is necessary to pay out of pocket for care to avoid waiting lists.

Private finance will be central to the development of neighbourhood estates

- NHCs (Neighbourhood Health Centres) are central to the planned development of neighbourhoods and are expected to move a range of services into single, co-located sites
- these NHCs are intended to be housed in a mixture of repurposed existing estate and new builds, this is in part framed as a means of overcoming problems presented by outdated and poor quality GP premises
- the first wave of NHCs is set to be largely based in pre-existing premises
- other NHCs are expected to rely heavily on public-private partnerships (a form of PFI (private finance initiative)) for their construction, with only 20% of new builds to be funded via public capital investment

BMA View

The BMA has opposed the use of PFI or similar tools for many years, given its excessive costs to the public purse and the wider problems this funding model has caused across the NHS, for example, evidence from IPPR shows that PFI hospitals in England have been left with a staggering bill worth £80 billion for just £13 billion

worth of investment. The Association has, therefore, argued that investment into neighbourhood estates must come from public capital, including in written evidence to a House of Commons Health and Social Care Select Committee inquiry into neighbourhood healthcare estates.

More widely, the BMA agrees with the conclusion that many GP premises are outdated and in poor condition, as is much of the NHS estate as a whole, due to long-term underfunding. The BMA's 2025 GP premises survey emphasised these issues while calling for urgent funding, capacity expansion, and services charge reform to address them. It is crucial that any further development of neighbourhood estates is done in a way which enhances and best utilises existing GP practices and premises, while helping to overcome the significant challenges outlined above.

Workforce implications will be felt across the whole NHS

- the framework stresses that the implications of the neighbourhood reforms will be significant for doctors and staff **in all parts** of the health and care system
- these implications include the movement of many services currently provided in hospitals into community settings, along with the staff that provide them
- the pending 10 Year Workforce Plan is expected to set out in significantly more detail how these changes will impact the workforce and alter workforce planning.

BMA View

As the framework makes clear, the implications of the move to neighbourhood services will impact all doctors in all branches of practice, changing how, where, and even when they work. On this basis, it is essential that all doctors are actively engaging with these reforms, including with LNCs and LMCs.

The BMA is continuing to engage significantly with the development of the 10 Year Workforce Plan. This includes the submission of the BMA's priorities to DHSC and NHS England and ongoing engagement with senior stakeholders. The BMA's unemployment and doctor substitution steering groups are playing a leading role in this work.

The proposed neighbourhood structures could also mean that many of the doctors working within NHCs, MNPs, SNPs, or IHOs more generally, may be directly employed by the given provider organisation. Any doctor in this scenario should be employed on appropriate terms and conditions, in line with BMA standard contracts. This is particularly relevant for sessional GPs, who are likely to be a major part of the neighbourhood health service workforce, and we believe should only be employed on at least the terms of the BMA salaried model GP contract.

Regarding the potential transfer of doctors and NHS staff within the system, including from hospitals to neighbourhoods, we remain clear that any such moves must be made voluntarily and with agreement of staff trade unions.

The framework also assumes that workforce flexibility will be delivered seamlessly, without providing detail on how this will be meaningfully achieved, or how sufficient staffing, transitions, or protection of professional conditions will be achieved. The expectation that doctors will move seamlessly across settings risks ignoring the realities of clinical practice and could, if not managed correctly, could negatively impact workforce morale, with the potential to push doctors and other staff out of the NHS and into the independent sector, which has its own serious problems and structural flaws.

What doctors can do

Given the severity of the impact IHOs, MNPs, and SNPs may have in all parts of the health and care system, it is essential that doctors actively engage with this issue and that they endeavour to influence their development as much as possible.

To that end, the BMA has produced an initial set of suggested steps that doctors may wish to take, if they have not already done so:

- ensure IHOs and neighbourhoods are on the agenda for your LMC (Local Medical Committee) or LNC (Local Negotiating Committee) meetings
- engage with your PCN (Primary Care Network) and/or GP Federation partners to highlight and engage with this issue
- liaise with your local BMA Regional Council to share information and gain support
- request meetings with your local NHS trusts and ICBs to seek details of their plans around IHOs and neighbourhood models, including what governance arrangements they plan to deploy

In addition, doctors are also asked to let the BMA (at info.healthcare.delivery@bma.org.uk) know:

- what support you need?
- what developments have taken place – or are due to take place – in your local area?

An overview of the Neighbourhood Health Framework

The framework is made up of the following eight substantive sections:

Introduction to neighbourhood health

Neighbourhood health is very broadly framed as a means of delivering person-centred care by organising services in a way that enables them to collaborate in order to effectively serve a defined population, while providing care closer to people's homes. DHSC see this as a means of addressing the perceived over-emphasis on hospital care within the NHS by redirecting resources into primary and community services.

Each neighbourhood will be arranged differently, depending on local needs, but all are expected to be based on collaboration between the NHS, local government, and wider partners (e.g. voluntary services). These bodies will need to agree both a **joint vision and a plan to re-design service commissioning and delivery** at neighbourhood level.

The framework states that neighbourhood services should all include GP practices, community services, adult and children's social care, public health. Where deemed appropriate, urgent care, diagnostics, and outpatient services will also be included.

The stated aims of this approach are to:

- **improve people's health and care outcomes, reduce health inequalities and help them stay well at home**
- **organise services around the person with more convenient, personalised and joined-up care**
- **reduce pressure on more acute services – including hospitals and care homes**
- **cut waste and duplication**
- **help the NHS deliver against core targets.**

Measuring the overall success of neighbourhood health

The framework establishes that neighbourhoods will be subject to national targets, as set out in the document, and local targets that will be determined in the future.

National targets

The framework states that neighbourhood health services will have clear national minimum goals and objectives to be delivered across the lifespan of the 10 Year Health Plan (2025-2035). These targets will be based on the NHS Medium Term

Planning framework and initial progress against them is expected between April 2026 and March 2029.

Goal 1: improve health outcomes:

- reduce non-elective admissions and bed days of one or more days by 10% for people with mid-to-severe frailty (in a care home or housebound) and for patients in the end of life cohort
- improve evidence based clinical outcomes by 10% for CVD (cardiovascular disease), diabetes, COPD (chronic obstructive pulmonary disease), mental health conditions, and dementia
- increase the percentage of patients with diabetes receiving all eight parts of the diabetes care process bundle (in the preceding 12 months) by 10%
- reduce acute outpatient appointments for children under 16 by 10%
- make substantial progress towards reducing community waits for children, in line with the Medium Term Planning Framework.

Goal 2: improve access to general practice:

- 90% of clinically urgent patients are expected to be seen on the same day by their GP practice team by March 2027
- during 2026/27, DHSC will collect data to establish a baseline for the speed of access to GP practice services and use this to create future targets – with ICBs setting local goals in the meantime
- DHSC will also collect patient satisfaction data during 2026/27 to set a baseline and inform future targets.

Goal 3: improve experience of planned care

- improve patient experience of cancer care and planned care, including supporting delivery of the 18-week waiting time standard
- reduce variation in referrals to outpatient services by deploying a single point of access and multidisciplinary team model
- aiming for a diversion rate (i.e. referrals being redirected back to general practice) of 25% for 10 high volume specialities by March 2027
- reduce secondary care follow-up outpatient appointments by 10% by March 2027, while providing more outpatient care in the community.

Goal 4: better UEC (urgent and emergency care) performance

- improve UEC performance (i.e. four and 12-hour wait targets) and ambulance response times – in line with the NHS England UEC plan
- improve the coordination of reactive care for high priority cohorts (mid to severe frailty, in a care home, housebound, or receiving end of life care) to reduce non-elective admissions and A&E attendances for these groups
- reach 82% performance on the four-hour wait A&E target by March 2027
- reduce category 3 and 4 ambulance conveyances in high-priority cohorts
- improve discharge times for all acute adult patients via strong coordination of processes and planning between health and social care.

Goal 5: improve patient and staff satisfaction:

- introduce a new patient experience and outcome measures in 2026/27
- by 2027, all people with complex needs should have a care plan
- introduce neighbourhood staff experience measures in 2026/27, to ensure teams working in neighbourhoods feel motivated.

Local targets

These national targets will be complemented by **locally developed aims and outcomes.** These are expected to be based on the health and social care needs of the local community and will be agreed by HWBs (Health and Wellbeing Boards).

These outcomes will also need to be defined in a **neighbourhood health plan,** which local partners will be required to develop over 2026/27 and 2027/28.

DHSC recommends that in developing their local outcomes ICBs, local authorities, and HWBs should:

- consider the metrics established in the Local Outcomes Framework on health and wellbeing, social care, early life, neighbourhood health, and integration
- work with partners to identify how neighbourhood health can help improve outcomes for adult social care, including:
  - the proportion of people enabled to live in their homes or with family
  - the number of adults with long-term support needs met by residential and nursing care homes
  - overall satisfaction with care, support, and social services.
- consider how neighbourhood health can contribute to wider public service reform, for example the Pride in Place programme.

Delivering neighbourhood health

The framework establishes three reform agendas, which it sets out as being essential to the delivery of neighbourhood health. These are summarised below:

Reform agenda 1: improve services for people who need routine healthcare, so neighbourhood health benefits everyone

- the Framework pledges to deliver better GP access (as measured by new targets), with increased digital tools
  - specifically, the NHS will continue to tackle outliers, ensure that all practices are open during core hours (all modes), and improve the online experience.
- GPs will be empowered to better manage the health of their population – namely through risk stratification, long-term condition (LTC) management, secondary prevention, and better continuity of care
- GP efforts will be backed by improved access to specialist opinions (i.e. via advice and guidance)
- NHS England will review direct access to diagnostics by GPs, mapping existing and planned CDC capacity over the next three years, to make it easier for patients to receive a diagnosis

- ICBs should implement the 'Red Tape Challenge', which seeks to reduce bureaucracy for GPs and improve the primary-secondary care interface, including via interventions such as:
    - full national implementation of GIRFT (Get It Right First Time)
    - new EPRs (electronic patient records), increasing access to shared care records
    - direct prescribing to community pharmacy
    - structured medication information
    - prescriptions issued for 28 days in outpatients unless clinically inappropriate.
- GP practices will be supported to boost productivity by increasing the use of technology, which is expected to free up clinical time and assist flow
    - specifically, the NHS will roll out ambient voice technology (AVT), expand AI-assisted triage pilots, embed access to online consultation tools via the NHS App, and make the App the default for messaging with practices.
- NHSE will work with ICBs to reform out-of-hours (OOH) services, establishing common minimum standards across all systems, including the relationship to 111. Full details will be set out in the forthcoming urgent and emergency care strategy
- ICBs will strengthen the role of pharmacists in delivering care and, from September 2026, all newly qualified pharmacists will be able to independently prescribe
- The ambition is for pharmacies to become a first point of contact, offering services such as Pharmacy First, contraception, blood pressure checks and smoking cessation – thereby reducing demand on general practice.

Reform agenda 2: improve proactive care for people

- Integrated Neighbourhood Teams (INTs), which bring together different professions and partners, will support people (particularly those with complex conditions) to stay healthier for longer. Specifically, INTs will deliver assessment, care planning, co-ordination and follow-on support.
- The Framework explicitly states that the NHS will not define nationally what should constitute an INT. Rather, this will vary based on local population need and will be decided locally.
- To support this, the NHS will amend national contracts and funding flows so that ICBs can ensure the provision of INTs is commissioned effectively. As part of this, ICBs will work closely with Local Authorities and other partners (e.g. in the voluntary sector) on how the teams may be best set up.
- INTs are seen as an opportunity to align mental and physical healthcare delivery, as most treatment for such patients occurs in primary care.
- Initially, NHSE will ask ICBs to ensure that INTs focus on:
    - **People with frailty and those in need of end-of-life care –** whilst this cohort accounts for only 3-5% of the population, they represent over 25% of non-elective admissions and 50% of hospital bed days.
    - **Multiple long-term conditions,** particularly those which have the highest impact – such as CVD, diabetes, COPD and dementia.
    - **Children and young people –** GPs will use INTs to provide timely

paediatric expertise in the community and support families to manage conditions at home (if clinically appropriate), thereby reducing ED admissions. The aim is for every child who needs an INT to have access by 2028/29.
    - **Cancer –** INTs will seek to improve quality of life for those living with cancer over the next 3 years (in line with the National Cancer Plan).
- Where possible, ICBs will go "*further and faster*" by establishing INTs for other conditions, population groups and communities.
- NHSE will publish a best practice guide for frailty pathways, setting out essential actions for ICBs and providers – spanning identification, assessment, proactive care and urgent care.
- The guide will be grounded in system-wide evidence of what works, providing ICBs with a baseline to improve local pathways in line with the upcoming modern service frameworks.
- ICBs will maintain and expand access to women's health services as part of neighbourhood care, ensuring that women's health hubs align with any new neighbourhood health pathways and structures
- ICBs will improve access to core community services by increasing capacity (~3% per year nationally) to meet demand growth
- ICBs will work with providers to reduce waiting times – aiming for at least 78% of community health service activity to occur within 18 weeks by 2026/27, and at least 80% by 2028/29
- the NHS will re-design planned care in line with the 10 Year Health Plan commitment to 'end outpatient care as we know it', with GPs taking greater control over referral decisions to reduce unnecessary hospital attendances and shift care closer to home
- specialists will provide advice through SPoAs (single points of access), expanding to at least 10 specialties across all providers from 2026/27
- follow-up care for patients requiring specialist input will increasingly move into neighbourhood settings, delivered by professionals in the community and underpinned by new digital pathways
- systems that are ready to progress faster will have access to devolved budgets and reformed funding flows, in exchange for credible delivery plans
- data sharing expectations between hospitals and neighbourhood health services (including social care) will be standardised, to enable more proactive care and reduce unnecessary referrals to secondary care.

Reform agenda 3: deliver better alternatives to hospital care

- the framework pledges to expand urgent community response services via the new community INTs, which will seek to prevent avoidable attendances
- the NHS will increase the capacity and efficiency of virtual wards, reducing the need for patients to go to hospital
- the NHS will expand intermediate care (step-up and step-down), working with local authorities and partners to prevent admissions and improve discharges
- home-based care will also be expanded where possible, reducing reliance on community beds and length of stay.

The providers of neighbourhood health

The framework states that care will continue to be provided by those who know local communities the best, specifically: GPs, nurses, therapists, pharmacists, community health service providers, hospitals, social care providers, and public health services.

However, it is also clear that the way these services are currently commissioned and contracted will change significantly under the framework.

Crucially, the exact nature of this change will also vary from area to area, with DHSC and NHS England taking a deliberately open, non-prescriptive approach that is intended to allow local neighbourhoods to develop individually. This means that, while there are some clear national guidelines and red lines for neighbourhoods, their structure, size, footprints, operating models, providers, and exact contractual arrangements will not be mandated nationally, will depend on agreements with local authorities and HWBs, and could vary significantly across England.

The framework does, however, state that these changes will be enacted via commissioning arrangements in the short-term (i.e. not via legislation), and that hospital care and general practice will continue to be delivered under existing contracts (respectively, the hospital standard contract and general medical service contract).

NHS England and DHSC plan to consult on how the various models and contracts proposed will interact in practice, including the potential for neighbourhood models to nest under broader integrated contracts.

Broad overviews of how the three specific models being introduced are expected to work are also set out.

SNPs (single neighbourhood providers) should:
- deliver services via INTs (Integrated Neighbourhood Teams) within a defined, single neighbourhood covering a population of around 50,000.
- enable primary care providers to take on new neighbourhood services not currently covered by or contracted for through existing general practice contracts
- work with practices within the defined neighbourhood area to ensure they can deliver care to the registered patient lists of the local population
    - NHS England intends to consult on both how the collaboration required within SNPs could work, and how PCNs (Primary Care Networks) might evolve into SNPs.

MNPs (Multi-neighbourhood providers) should:
- cover populations of around 250,000 or more and to coordinate the delivery of services across multiple neighbourhoods
- design and coordinate neighbourhood health services within their footprint, which could include directly providing services where needed and

agreed locally, for example, where the service might cover more than one neighbourhood
- work with GP practices and SNPs to deliver care to their area's registered population list – the nature of these relationships will also be subject to consultation in the near future.

IHOs (Integrated Health Organisations) should:
- see an NHS trust – only NHS organisations will be eligible to hold an IHO contract – hold a whole population health budget for a geographically defined population, underpinned by a contract commissioned by an ICB
- be run by high-performing AFTs (Advanced Foundation Trusts, a new stepping stone towards full IHO status) – i.e. those NHS trusts considered to be the best performing – which could include community, mental health, and acute NHS trusts
- NHS England has announced the first six NHS trusts to achieve AFT status:
    - Northumbria Healthcare
    - Alder Hey Children's
    - Berkshire Healthcare
    - Dorset Healthcare University
    - Northamptonshire Healthcare
    - *Central London Community Healthcare (as it is currently an NHS Trust, not an FT, CLCH has only been approved as a prospective AFT at this time)
- allocate resources, plan services, and hold responsibility for meeting the needs of the population within their footprint
- work with and contract other providers, including MNPs, in order to deliver services
- develop a decision-making infrastructure that enables a shift of care and resources away from hospitals and into community services, with an emphasis on cost effectiveness
- be coterminous with one or more MNPs, to align their planning and care delivery
- work with local partners and communities to incorporate local insight and ensure patient-centred design of governance arrangements and planning – primary care clinical leadership is explicitly cited as a vital source of this
- pending future work from DHSC, be enabled to work with mature neighbourhood providers to develop a jointly led IHO incorporating alliances, joint ventures, and the involvement of general practice
- will, subject to an ICB delegating their authority, commission all primary care contract types (including GP, dental, community pharmaceutical, and general ophthalmic services) in line with national contracts
    - NHS England will be consulting on how MNPs, SNPs, GMS (General Medical Services), and the PCN DES (Direct Enhanced Service) will work together, as well as how primary care networks may evolve into SNPs.
- incorporate strong clinical leadership, particularly from GPs
- be data-led, with a strong analytical approach that informs proactive care
- involve close collaboration between ICBs, local authorities, and providers, including via HWBs
    - including to determine whether any local authority-commissioned services (i.e. social care or sexual health services) into their neighbourhood system

– be subject to nationally set minimum requirements for their governance, leadership, and financial discipline.

Neighbourhood health estates and locations

The development of neighbourhood health services is framed as being in line with the 10 Year Health Plan's commitment for services to be delivered:
– as locally as they can
– digitally by default
– in a patient's home if possible
– in an NHC (Neighbourhood Health Centre) when needed
– in a hospital if necessary.

On this basis the framework sets out that, while a significant amount of care will continue to be provided in the same locations, some services will move online, while others may move from a hospital to a GP practice, a pharmacy, or an NHC.

This move is posited as a means of overcoming challenges posed by often poor quality, outdated GP premises and the complex array of other buildings used for community care, mental health services, primary care, and acute care. Bringing these services into single, co-located sites is framed as a means of improving their efficiency and accessibility. It is also seen as an opportunity for wider support services - such as Best Start Family Hubs, food banks, housing services, and employment support - to sit alongside healthcare providers.

NHCs are DHSC and NHS England's central means of achieving this co-location and are a key aspect of the 10 Year Health Plan. The framework provides some additional details on how they are expected to work.

NHCs (Neighbourhood Health Centres) are expected to:
– be in place in 250 sites by 2035, with 120 of those in operation by 2030 – a first wave is intended to come into operation in 2026/27 and be focused on areas of high deprivation
– serve as the 'place to go' for most health and wider needs in every community
– bring together GP services and a mix of community, local authority, civil society, and VCSE (Voluntary, Community and Social Enterprise) services, to enable staff to join-up patient care
– be housed in a mixture of repurposed existing estate and new builds - the first wave of NHCs is set to be largely based in pre-existing premises
– rely heavily on public-private partnerships (a form of PFI (private finance initiative)) for their construction, with only 20% of new builds to be funded via public capital investment
– be aligned with NHMCs (Neighbourhood Mental Health Centres) and CDCs (Community Diagnostic Centres)
– be located where ICBs determine them to be most effective.

NHS England has separately published additional guidance on how NHCs will operate and on the services the centres will be expected to provide, this sets out that:
– NHCs are expected to operate at least 12 hours a day and 6 days a week

- the minimum services and facilities necessary for a centre to be designated an NHC include:
    - general practice
    - community health and immediate care teams
    - clinics (for services like ENT (Ear, Nose, and Throat), gynaecology and other community clinic)
    - shared spaces including meeting rooms, kitchen and break areas, and changing facilities
- additional services are also set to be provided in NHCs, based on local need and service delivery models, including:
    - mental health services (e.g. primary care-based support and talking therapies)
    - services for babies, children and families – including support for healthy development and emotional wellbeing in child-friendly spaces
    - UTCs (Urgent Treatment Centres) for minor injuries, with dedicated waiting areas and treatment rooms
    - non-health services like debt advice, Work and Health Hubs, and healthy living hubs
    - out-of-hours services using existing spaces to provide access outside of core hours.
- NHS Regions are expected to work with their ICBs to develop individual NHC strategic pipelines by **28 May 2026**. This will include how neighbourhoods are to be defined geographically, articulation of the proposed neighbourhood health estate, any upgrade and new build schemes, and a list of disposals to be enabled through investment and improved utilisation.
- NHS England aims to hold approval panels from **early June** with view to have an agreed pipeline of schemes during summer 2026.

The neighbourhood health workforce

The implications of neighbourhood working for the entire NHS workforce are set to be significant, with the framework stating that the shift should be felt by staff working in all parts of the health and care system.
The exact implications of the shift to neighbourhoods are expected to be set out in detail in the coming 10 Year Workforce Plan. However, the framework points to several aspects of how neighbourhood working will change how and where doctors work:

- the shift to neighbourhood working will involve a 'fundamental reimagining' of roles, skills, and ways of working in health and social care over the next 10 years
- staff are expected to work together seamlessly across boundaries between services as part of MDTs
- careers should develop fluidly through different parts of the system
- consultants are expected to work more closely with GPs and community health services
- GPs should work with INTs alongside district nurses and others
- as new services are created in neighbourhood settings, new roles will be created at local level
- neighbourhoods are intended to be great places to work for NHS staff

- system (i.e. ICB) level workforce planning will need incorporate the changes in where care is delivered and by who – allocating resources accordingly.

Neighbourhood health finances

DHSC and NHS England aim to apply a permissive approach to neighbourhood finances, allowing ICBs to design and resource local neighbourhood contracts based on their determination of local need. However, the development of neighbourhoods is expected to be supported by national planning and policy changes. The framework providers some limited details of how neighbourhood working will work be financed:

- neighbourhood health will be funded by rebalancing existing resources, not by new funding
- ICBs, as the commissioner of neighbourhood services, will be responsible for determining the scope of their contracts and, therefore, their monetary value
- nationally-set funding allocations and expectations will be constructed on the basis of – and to support – the shift of resources from the acute sector and into neighbourhoods
- the financial framework will be adjusted from 2026/27, including changes to block contracts and payment flows, to support investment in the 'left shit' (i.e. hospital to community)
- national plans for reductions in UEC attendances and non-elective admissions, with the general aim of freeing-up resources within local systems
- there will be national support for the testing of population, risk, or outcome-based contracting approaches, which may allow systems to strengthen incentives for prevention, improve value for money, and encourage the overall shift from hospital to community
- although neighbourhood contracts may contain or involve changes to some local authority-led services, the relevant local authority will retain accountability and financial responsibility for those services.

Next steps

As DHSC and NHS England work to establish exactly how ICBs should proceed with the development of neighbourhoods, they have also committed to:

- publishing the model NHS definition, that will set out different archetypes of provision of neighbourhood services and the development of their premises
- supporting and incentivising the goals of neighbourhood health in wider national reform agendas, including via new GP access targets, the development new payment approaches, and the publication of a series of modern service frameworks to inform ICB's commissioning.

The framework also sets out a two-stage approach for the ongoing development of neighbourhoods, which will run in overlapping timeframes. These are:

Stage 1: immediate changes in 2026/27

ICBs and HWBs are expected to develop and begin embedding new ways of working

with local government and wider partners in 2026/27, while starting the joint development of their approach to local neighbourhood services.

Alongside this, ICBs will be expected to deliver the minimum basic requirements for neighbourhood working in 2026/27:

- agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of neighbourhood-based urgent, rehabilitation, and reablement services, based on analysis of patient risk registers
- agree a plan for addressing unwarranted variation in – and improving access to – general practice, ensuring core hours and urgent access requirements are met
- agree neighbourhood footprints based around natural communities
- agree plans to establish INTs focused on high priority groups, including the potential devolution of care budgets
- begin planning for a new neighbourhood-based approach for elective care pathways that can help meet RTT standards – including a specific plan to meet 18-week community waits and eliminate 52-week waits
- confirm how ICBs and local authorities will use pooled funding arrangements under the BCF (Better Care Fund)
- improve the interface between primary and secondary care, tied to the red tap challenge
- confirm which organisations are responsible for which planned deliverables
- confirm arrangements for the appropriate sharing of data between partner organisations.

Stage 2: longer-term reform (April 2027 – March 2029)

Over the longer-term, and from at least April 2027, ICBs and HWBs are expected to work with local partners in the development of a locally owned neighbourhood health plan.
This plan will need to:

- provide a broad overview of how national NHS objectives will be delivered via the three reform agendas (as set out above)
- set out how neighbourhood health will improve health outcomes and reduce health inequalities locally
- establish how local objectives have been informed by the local JSNA (Joint Strategic Needs Assessment) or any other assessments made by the ICB or HWB
- confirm the final geographies that partners will work within
- confirm which organisations will deliver which aspects of the plan
- confirm governance arrangements
- confirm how other initiatives (i.e. Better Start Family Hubs, housing, mental health, Pride in Place, and employment support) align with the plan.

Once agreed, this plan is expected to be incorporated into the ICBs wider, refreshed 5-year strategic commissioning plan, which itself will need to align with a national strategic commissioning framework.

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