NHSE: Fit for the Future – Population Health Delivery Models

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With reference to the Neighbourhood Health Framework

A General Practice Perspective

Why the proposed approach is unlikely to deliver for GPs or our patients

Background

The NHS proposes a system-wide redesign centred on the *Neighbourhood model of care*, delivered by organising services around people and local communities rather than institutions. It aims to strengthen prevention and proactive care, improve access, integrate NHS and local authority services and move care closer to home (by expanding urgent community response, virtual wards and enhanced intermediate care) via a "reform agenda".

It will be commissioned using new population-based contracts to align providers around shared outcomes.

National Targets (Summary)

Category	*Target / Outcome*
Outcomes	10% reduction in admissions/bed days (frailty & end-of-life) by 2029
	10% improvement in long-term condition outcomes
	10% reduction in children's outpatient activity
Planned Care	25% diversion via single points of access by 2027
	10% reduction in follow-ups
Urgent Care	Reduced ED attendance and conveyance in priority cohorts
	4-hour standard: 82% by 2027
General Practice	90% of urgent patients seen on the same day by March 2027
	Faster access for routine care. Improved patient satisfaction with access
Care Model	95% of people with complex needs to have a care plan by 2027
	Expanded diagnostics and pharmacy roles
	Reduced bureaucracy between primary and secondary care
	250 Neighbourhood Health Centres by 2035
Finance	ICBs expected to shift funding from acute to community settings
	No major new national funding

Proposed System Architecture

Key principle:
Nested populations aligning outcomes from system → neighbourhood → practice

Integrated Care Board (ICB)

Strategic Commissioner

- Sets the commissioning plan in partnership with system stakeholders and Health and Wellbeing Board (HWB)

Integrated Health Organisation (IHO)

- Holds a whole-population budget for a geographically defined population underpinned by a contract
- Responsible for resource allocation and service planning across the full care pathway
- Develops decision-making infrastructure to shift care and spend from acute to community settings
- Covers populations aligned with one or more MNP footprints

Contracting and eligibility:

- Contracts held only by "NHS organisations"
- Routes for neighbourhood providers to lead IHOs will be developed via:
    - Partnership (alliances/joint ventures) with a statutory NHS organisation
    - Working within an NHS organisation
    - Forming a new NHS organisation
- **Eligible contract holders include NHS trusts (community, mental health, acute)**
    - ***Initially limited to advanced foundation trusts***

Multi-Neighbourhood Providers (MNPs)

- Coordinate care across ~250,000 population
- Address gaps where services are not locally delivered
- Support management and sustainability of primary care

Contract model:

- Operate under a new MNP contract
- Includes risk-sharing mechanisms to reduce avoidable non-elective admissions in priority cohorts

Single Neighbourhood Providers (SNPs)

- Deliver enhanced primary care to ~50,000 population via a new SNP contract
- Enable primary care to take on additional neighbourhood services beyond GMS/PMS/APMS

GP Practices (GMS / PMS / APMS)

- Contracts remain nationally set

BUT:

- IHOs contract holders assume **local contract management responsibility** for:
  - GP contracts (GMS/PMS/APMS)
  - Pharmacy
  - Optometry
  - Dentistry

Why the Approach is Flawed

1. Unrealistic expectations

The model attempts to simultaneously:

- Reduce hospital demand
- Dramatically improve GP access
- Expand proactive and preventative care
- Improve outcomes across multiple domains
- Reduce follow-ups and outpatient activity
- Improve patient satisfaction

- Do all of this **without new funding or workforce**

2. Unrealistic financial assumptions

The model depends on moving resource / funding from hospitals to community care settings:

"In setting these contracts and the underlying payment mechanisms, the commissioning approach should address how existing resources will shift to enable more efficient, neighbourhood-based care."
"shift the balance of care and existing spend out of the acute sector"

Reality:

- Primary care is currently at or beyond capacity
- Community services are already stretched
- Acute demand continues to rise
- There is no funding for transition ("double running")

Result:
"Left shift" without capacity → system failure.
General practice will be expected to absorb activity before resources follow (if they ever do).

3. Overreliance on contractual change

"population-based contracts… align objectives across providers and incentivise the shift of care into the community"

The proposals assume that contracts will drive behavioural change.

But previous incentive-based schemes have had limited impact, and such contracts do not create:

- Workforce
- Time
- Estate capacity

4. Reliance on data capabilities that are not yet in place

The proposals require systems to:

"use joined-up, person-level data and intelligence"
"develop a deep and dynamic understanding of their local population"
"use real-time data to identify individuals at rising risk"

This requires:

- Real-time, integrated population data
- Advanced analytics

In practice:

- NHS data systems remain fragmented
- Interoperability is poor across primary/community/secondary care
- Real-time population analytics are not widely operational

The model assumes a **level of data maturity that is not present in most ICSs and the skilled workforce to monitor, interpret and act on that data.**

5. Workload expansion and reduction in autonomy for GPs

GPs are expected to:

- Deliver 90% same-day urgent access
- Improve routine GP access and patient satisfaction
- Provide proactive care for complex patients
- Focus on prevention
- Expand diagnostics and take on system coordination roles

This is a net expansion of GP workload, not a redistribution which depends on GPs:

- absorbing more risk
- managing more complexity in the community for longer
- providing additional monitoring and follow-up of patients

This shifts risk without matching resource.

Although GP contracts remain nationally determined,

- IHO contract holders will take on **"local contract management responsibility"** for GP contracts (GMS, PMS, APMS), pharmacy, optometry and dentistry contracts

- IHO contract holders will gain control over **"system resource allocation, priorities and service design"** for neighbourhoods

Result:

- Acute Trusts manage the GP Contract at a local level with general practice less able to be innovative and responsive to their patients' needs.
- IHO contract holders have greater influence on neighbourhood working with Advanced Foundation Trusts being the first to hold these contracts

- GPs hold greater clinical risk, managing patients in the community for longer as outcomes focus on reduced hospital admissions, follow up and secondary care referrals.

7. Workforce constraints

Integrated Neighbourhood Teams (INTs) are central to delivery for frailty, end-of-life, LTCs, Children and Young people and cancer.

But:

- these teams draw from the same limited workforce pool
- many roles are already understaffed

INTs rely on staff who are already in short supply including those from general practice teams.

Scaling nationally is not currently feasible.

8. Demand is not controllable

The model assumes that prevention will reduce demand and that community care will replace some hospital activity.

Evidence suggests:

- Ageing and multimorbidity are increasing demand on all services
- Improved access increases utilisation
- Proactive care often uncovers unmet need

Result:

Demand will **rise not fall**, particularly in primary care.

9. Increased system complexity

Implementation of new models "does not require disruptive organisational change"

Despite claims of simplification, the model introduces:

- New organisational structures (IHOs, MNPs, SNPs)
- New contracts, subcontracting and governance layers

Result:

More interfaces, more potential for duplication, more ambiguity, more meetings and governance requirements. **In short, more bureaucracy.**

10. Uneven system capability

The proposed model relies upon the presence of **"highly capable providers"** and **"highly performing advanced foundation trusts"**

Reality:

- Capability is highly variable across England
- Many systems are struggling operationally with Acute Trusts that are in financial deficit and opportunities for GP provider organisations to hold IHO Contracts are limited/ delayed.

Result:

Further widening of health inequalities

The Implications for General Practice

Role expansion

- More responsibility for prevention, complex care and system coordination without matching resource / funding
- Expect incremental change layered onto existing PCN/ICS structures
- Increased GP workload and supervision of staff

Access pressure

- Same-day demand dominates workflow
- IBCs will increasingly monitor access metrics with local targets likely to tighten over time
- Greater pressure to reduce referrals and manage risk in the community

Reduced autonomy

- System level priorities set by ICBs/ IHOs
- Increasing alignment to neighbourhood models
- Increasing performance management of the GP contract by IHO contract holders

Loss of continuity

- Driven by same-day access targets over quality of care, pooled workforce models and neighbourhood team structures

Administrative burden

- More data collection and reporting, participation in neighbourhood governance, and contractual complexity.

Next steps on neighbourhood health and new delivery models

On 18th March 2026, NHS England wrote to ICBs and PCN CDs regarding "Next steps on neighbourhood health and new delivery models" outlining how ICBs will work in partnership with health and wellbeing boards in 2026/2027.

Key Points

- Neighbourhood health is central to the NHS 10 Year Health Plan, aiming to deliver more personalised, integrated care closer to home and improve prevention and population health outcomes.
- The aim of the **Neighbourhood Health Framework** and **Fit for the Future** documents is "to create the conditions for local leaders to systematise those examples in a way that best suits their local communities – setting clear expectations on what services should aim to achieve and articulating the commissioning and delivery models required to achieve them."
- **2026/27** will be a development year, during which ICBs and local authorities are expected to:
    - Agree neighbourhood boundaries ("footprints")
    - Plan and begin establishing Integrated Neighbourhood Teams (INTs) for high-priority patient cohorts
    - Confirm intention to use pooled funding (e.g., Better Care Fund) and consider how devolving care budgets could work in their area
    - Put data-sharing arrangements in place
    - Confirm organisational responsibilities for delivery
- From **2027/28**, each area must produce (working through Health and Wellbeing Boards) a "**local neighbourhood health plan"** describing:
    - How national NHS objectives will be delivered locally through the three reform agendas
    - How services will improve outcomes and reduce health inequalities
    - Which organisations are responsible for different elements of delivery, what arrangements will in place and the geographies that partners will work within

    - How services will align with other local initiatives (e.g., housing, mental health, employment support)

- All systems are expected to deliver a minimum set of core neighbourhood health interventions over the next three years to establish the foundations of integrated neighbourhood services.
- The NHS is transitioning towards population-based and outcome-based commissioning models, with by new payment approaches and contracts led by ICBs. Co-designed payment approaches will be outlined for all ICBs soon. ICBs are to set out how they will have begun implementing some outcome-based contracts within 3 years, with a view to IHO contracts becoming the norm.
- General practice and other primary care contracts (GMS, PMS, APMS, etc.) will continue to be set nationally and commissioned locally.
- NHS England will work with Integrated Health Organisation (IHO) and advanced foundation trust front runners, and their commissioners, to ensure that contracts and financial flows support the shift of resources into neighbourhoods.
- National support will be provided through implementation programmes to build capability, infrastructure, and evaluation frameworks for new neighbourhood models.