First published: 25/07/2025

BMA England

Focus on the National Neighbourhood Health Implementation Programme

What is the National Neighbourhood Health Implementation Programme?

The NNHIP is a "large-scale change programme" from NHSE (NHS England) that is proposed will "accelerate the roll-out of neighbourhood health services" across communities. Applications must come from a collaborative of different provider organisations – from general practices to local government and the voluntary / charity sector. Whilst trusts can also apply to form part of the Place collaborative, the invitation published on 9 July excluded them specifically (but did include ICBs).

The programme is the brainchild of Sir John Oldham, a retired GP and DHSC (Department of Health and Social Care) advisor who maintained that each application must secure the approval and agreement of every PCN (primary care network) CD (clinical director) covered by the application footprint, to ensure that local GP support can be used to shape and define the suggestions, rather than be enforced by, for example, ICBs (integrated care boards) and lead Trusts. Applications for the 'first wave' of the NNHIP should be submitted by 8th August 2025.

Should local general practices not intend to submit an application, we encourage the local profession of a need to be aware of the potential impact of the programme for themselves and their local area, considering the short, medium, and longer term. We would recommend seeking alignment between practices, PCN CDs, the LMC and any local GP Federation. Map out the pros and cons and consider how practices may negotiate and 'lock-in' external agreements to safeguard the future sustainability of individual general practices within any new or emerging landscape.

What is it for?

The NNHIP is a national rollout, launched on **9 July 2025**, forming part of the NHS England 10 Year Health Plan to accelerate the creation of integrated, community-based care models known as **Neighbourhood Health Services.**

Its objective is to shift care from hospitals to community settings, emphasising **prevention, continuity, and proactive management** for people with complex needs such as multiple long-term conditions or social vulnerabilities, in line with the Government's 'three shifts'.

- Core pillars include:
    1. **Population health management tools** (data-driven targeting)
    2. **Improved GP access and continuity**, including digital elements
    3. **Integration of community services** (social care, mental health, therapy)
    4. **Multi-disciplinary teams (MDTs)** involving GPs working alongside nurses, social care, specialists, community health workers, pharmacists, etc.
- The programme is said to be designed to be flexible and **locally adapted**, following a **'test, learn, and grow'** approach across successive Places , aligned with unitary authorities.
- It is overseen by a joint DHSC–NHSE task force chaired by Sir John Oldham, with participation from local leaders and frontline networks.

Opportunities and risks

Whilst practices may come under significant pressure from ICBs and other providers to participate in the NNHIP, this is not a mandatory programme. As such, practices will need to consider the risks and opportunities that the programme may present.

Any decision subsequently taken should be based upon their own individual assessment, taking into consideration personalised circumstances and the wider local contextual landscape.

Opportunities

Structural and contractual opportunities

- GPs and practices are well versed in community focuses holistic, out of hospital care. Active clinical GP leadership helps prevent the marginalisation of traditional continuity of care focused general practice and primary care. A vacuum may favour Trusts and other large providers.
- Neighbourhood health should evolve as a true extension of general practice, rather than practices becoming subcontractors within hospital-dominated systems.
- Within a changing contract and funding environment, governance structures and agreements must enable practices to maintain their autonomy and influence.

Securing access to potential new 'neighbourhood' funding streams

- The 10-year plan emphasises increased support for and investment in out-of-hospital care. A lack of GP and practice involvement and input risks the leftward shift of hospital to community care, and instead risks a 'right drift', shifting funding and commissioning

powers toward hospital trusts, which could further facilitate the introduction of hospital-led community care models.

- When directly asked by GPCE, Stephen Kinnock MP, minister for care, responded thata hospital-led community care model is not the Government's intention, and they do not want vested interests to lead the NHS down this path.
- Cautious engagement could and should therefore enable GPs to access new funding streams and infrastructure.
- Proactive participation may help GPs retain a central role in future contracting, commissioning, and service delivery.

Protection of patient care

- If hospital-led models dominate, fragmented patient care are likely to become more transactional, undermining continuity and patient relationships central to general practice and doctor-patient trust.

Ensuring input as the key provider stakeholder

- GP practices have a crucial opportunity to lead the design of neighbourhood teams and care models focused on continuity, prevention, and personalised care.
- General practice can cement its place as a strategic partner in developing and delivering neighbourhood models, rather than as simply a delivery arm.
- Any partnership forum of system providers must be able to demonstrate how it maximises the voice of general practice and VCSE leadership. Examples where this has been proven e.g. delegated Place budgets or QI capability should be used to evidence a demonstration of commitment to developing neighbourhood health and spreading learning across peers and other neighbourhoods/Places.
- Geographical spread and how support is focused on the areas of greatest deprivation is key.

Risks

Structural and Contractual Risks

- Left unchecked, the 10-year plan's proposed structural and contractual changes could begin a move toward salaried or integrated provider models, e.g. "Neighbourhood Care Providers".
- This may challenge or undermine the traditional independent contractor model, and, for GP partners, it could mean losing autonomy over practice finances and governance.

Funding and Capital Constraints

- There is significant investment expected in infrastructure, e.g. health centres, diagnostics, digital tools etc, but uncertainty over funding sources and whether existing estates or GP partnerships will absorb costs or face funding shortfalls. There must be local GP contractor voices in the decision-making processes.

Loss of Clinical Autonomy and Traditional Continuity of Care

- Standardisation of processes (six core components) may reduce flexibility in care delivery and undermine holistic GP-led, personalised approaches.
- Larger bureaucratic models may dilute continuity, reduce motivation for GP partners, and create inefficiencies unless team incentives are aligned.

Operational and Workforce Pressures

- Implementation will require addressing workforce variability, interoperable digital tools, and safeguarding service continuity during organisational change. GP practices may find managing this alongside day-to-day demand challenging. The use of OpenSAFELY may be a safer data-sharing option, and the DPNs for this are now available to practices to switch on as the local data controller for the GP patient record.
- Risk of role dilution or professional mismatches, especially if supervisory structures rely heavily on non-GP staff, e.g. ARRS roles seeing unscreened patients.
- NHS England are pushing the initial programme at a pace which many practices will not be comfortable, or able, to fully participate in. Especially given the lack of detail on longer-term funding and contractual arrangements in the plan.

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Checklist for Practices Before Signing Up to the NNHIP

Area	Key Questions
Governance & Model	• What provider model (single or multi-neighbourhood) is being proposed? Will traditional partnership-models of general practice remain in control or risk being absorbed into larger entities? • What governance, legal, and financial changes are required to safeguard practice autonomy? (MOU, TOR, etc) • Ensure the LMC are sighted and at the table
Employment & Contracts	• What protections are secured for GPs to remain under GMS/PMS/APMS contracts, as opposed to salaried roles / trust employed positions? How will locum and sessional roles be preserved and staff supported? • What will happen to non-GP staff?
Funding & Infrastructure	• What capital investment is committed? • Who owns, funds, or upgrades estates and infrastructure? • Are funding agreements for digital tools, staff training, and MDT support detailed and guaranteed? • Is the data-sharing going to put GP partnerships under risk of increased liabilities? Can OpenSAFELY be used for GP data sharing to mitigate risks? • Will Trusts move to EPS as per national objectives to move from analogue to digital?
Clinical Autonomy & Continuity	• How will continuity and personalised GP-led care be protected in multidisciplinary models? • What safeguards exist to avoid over standardisation or bureaucratic restrictions?
Workforce & Staffing	• Is there a clear plan for workforce distribution, capacity planning, and digital/data integration? • How will roles like ARRS staff, community health workers, or non-GP clinicians be supervised?
Risk & Transition Management	• Are there system-wide plans for supporting practices at risk of failure, without contract takeover? • Is leadership and accountability clearly mapped across Place and ICB levels? • Where/what is the GP/practice leadership? • MOUs or agreements to protect against deleterious competitive behaviours from at-scale organisations
Evaluation & Metrics	• What performance metrics, e.g. admission rates, preventive care outcomes etc, will be used? How will GP practices be measured and benchmarked? How will that be equitable with other system partners? • Are regular sense checks and feedback loops designed into the process? • Is there transparency around feedback, corrective action, and iteration?

Area	Key Questions
Stakeholder Inclusion	• Have all GP roles been consulted? • Ensure LMC input included in planning and oversight • Ensure community and patient groups are engaged