NHS Confederation

# Forging strategic parnerships

Considerations for creating effective strategic partnerships to deliver the 10 Year Health Plan

In partnership with

DR SOLICITORS
part of Dow Schofield Watts

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# About us

## NHS Confederation www.nhsconfed.org

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

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We are an award winning, nationally recognised law firm working exclusively with primary care professionals. We understand your business and the regulatory landscape within which you work and that has several advantages for our clients:

- we only work with GPs, dentists, consultants and other primary care providers
- you only deal with one highly regarded, service oriented firm for all your legal needs
- we understand your business, we know many of the key people, businesses and statutory bodies associated with primary care and we are completely familiar with the current issues you are facing
- we are able to see the inter-relationships that others miss. For example, making changes to your legal entity can easily cause problems with your NHS Pensions or breach your GMS/PMS contracts
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- clients often come to us from generalist solicitors, having experienced problems resulting from advice and/or documentation which does not fully consider the relevant regulatory context.

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# About this guidance

The NHS's ambition to deliver more integrated, prevention-focused and community-based care, places a renewed emphasis on effective partnership working between those delivering services within primary care, community, mental health and acute providers. It's vital that integrated care boards (ICBs) are informed and involved as these partnerships form and mature as many of the partnerships will operate as delivery vehicles for neighbourhood health. As systems begin to implement the government's 10 Year Health Plan (10YHP), the ability of organisations to collaborate around shared priorities rather than operate through isolated structures on the neighbourhood health agenda has become essential.

This guidance shares insights of leaders from at-scale primary care organisations and NHS trusts on how strategic partnerships can improve patient outcomes, strengthen neighbourhood delivery models and use collective resources more efficiently. Through expert presentations, panel discussions and thematic workshops, participants reflected openly on the cultural, operational and structural factors that make-or-break partnership working today.

## What are strategic partnerships?

Strategic partnerships were initially defined as collaborations between at-scale primary care organisations and NHS trusts. In some areas, these have since expanded to formally include local government and voluntary sector organisations. In other places, they represent the formal evolution of existing place-based partnerships that previously had infrastructure provided by ICBs and which now sit with a host organisation. Elsewhere, they have emerged as a bottom-up movement driven by the ambitions of neighbourhood health to bring providers together strategically in advance of multi-neighbourhood provider contracts.

It was recognised that, given the broad scope a multi-neighbourhood contract could encompass, it would generally be more appropriate for them to be delivered through a collaboration of organisations sharing expertise, rather than a single organisation attempting to extend its remit and capabilities to take on this function.

The key themes emerging from the discussions are summarised, highlighting where progress is already being made and identifying persistent barriers spanning infrastructure, workforce, financial flows and governance. Our conclusion sets out practical recommendations for building partnerships that are agile, proportionate and genuinely enabling. While local contexts vary, a consistent message from NHS leaders is that meaningful integration begins not with organisational form but with shared purpose, aligned leadership and the confidence to act as one system.

This guidance is intended to support local leaders as they strengthen their own partnership arrangements. It offers insight into the conditions that enable collaboration to thrive and the approaches that help turn aspiration into sustained, system-wide improvement.

**How we learnt from leaders**

In early December 2025, we brought together 50 NHS leaders together with our partner, DR Solicitors, for an in-person event, inviting leaders of at-scale primary care organisations alongside counterparts from community, acute and mental health trusts to discuss how they can work more effectively together in the context of the government's 10YHP.

The event included expert presentations, panel discussions with audience participation and thematic discussions around the enablers: infrastructure, workforce, contracting and financial flows, and governance. These explored the practical challenges and opportunities for primary care to work more closely in partnership with NHS trusts, drawing on perspectives from leaders across acute, community and mental health services.

# Key points

- The government's **10YHP places strategic partnerships at the heart of delivering neighbourhood-level, integrated and preventative care**, requiring closer collaboration between primary care, community services, mental health and acute providers.

- **Effective partnerships start with relationships rather than structures**. Early informal collaboration, joint problem-solving and shared purpose are essential foundations before formalising any new organisational arrangements.

- **Shared data, digital systems and interoperable infrastructure are critical enablers**. Current fragmentation, including GP data controller liabilities, misaligned digital procurements and inconsistent estate planning, restricts integration and undermines neighbourhood working.

- **Creating 'one workforce' across organisational boundaries was a common theme**. This would depend on clear agreements on clinical risk ownership, joint operational leadership, protected time for joint working and aligned objectives that encourage teams to act as a single system.

- **Contracting and financial flows must support the shift of activity into neighbourhoods**. Current mechanisms create stranded costs in acute settings and disincentivise collaboration. Population-based payments, better risk-sharing and reinvestment of savings can accelerate integration.

- **Governance should enable, not constrain**. Partnership boards with proportionate delegated authority, transparent risk-sharing and consistent decision-making frameworks provide confidence for partners to act collectively and innovate safely.

- **Local authorities and the voluntary, community and social enterprise (VCSE) sector are essential strategic partners**. Their roles in prevention, housing, community engagement and wider determinants of health make them critical to effective neighbourhood models.

- **Strategic partnerships must be agile** enough to support emerging contracts, including neighbourhood and multi-neighbourhood contracts.

- **Organisational form should follow function**, with flexibility to use primary-care-led, trust-led or joint-venture models depending on service need.

- Commissioners are increasingly expected to co-design service specifications with strategic partners, **focusing on the outcomes that matter for local populations**. This includes shifting from activity-based funding towards population-based payment models that incentivise measurable improvements in outcomes.

- **Developing shared estates, digital platforms and clinical pathways requires coordinated planning across providers**. Shadow budgets, pooled investment and jointly managed estate and digital strategies can unlock efficiencies and improve patient access.

- Successful partnerships must **balance formal governance with strong interpersonal relationships, shared leadership, visible accountability and a clear long-term purpose** that aligns partners around improved outcomes for local communities.

# Emerging themes

## Shared infrastructure

### What we heard

**The absence of shared infrastructure, particularly interoperable data and digital systems, was consistently identified by leaders as a major barrier to delivering integrated care**.

Leaders described a ‘black hole’ in which key patient groups are adversely affected by fragmented systems across local providers. One example frequently raised was maternity care: pregnant women often have two parallel records, one held by their GP and another held by secondary care, sometimes supplemented by paper notes, resulting in duplication, gaps, and delays. Leaders noted that this fragmentation is reinforced by the short-termism of annual contracting cycles, which operate on differing timelines across providers. This leads to large digital procurements, such as electronic patient records and general practice triage tools being renewed out of sync rather than through coordinated, system-wide planning.

Compounding this is the personal legal liability borne by individual GP partners as ‘data controllers’, which can discourage data-sharing due to the risks associated with breaches, information commissioner’s office (ICO) investigations, or litigation.

Leaders also spoke of an ‘innovation trap’, where outdated digital tools and paper systems are rarely retired, leaving staff to navigate multiple platforms simultaneously, creating inefficiency and preventing meaningful integration.

Alongside digital challenges, leaders highlighted significant systemic rigidity within the NHS estate and capital system that inhibits collaborative working. While leaders acknowledged the value of co-location, they stressed that genuine

integration, not merely sharing a building, is what delivers real benefit. Current estate budgets are viewed on a provider-by-provider basis, which discourages collective planning and contributes to void space, poor use of public assets, and unnecessary costs. Leaders contrasted this with the private sector, where assets can be moved more flexibly between divisions, compared with NHS processes and perverse incentives that promote organisational rather than system thinking.

Several recommendations from leaders aligned with the NHS Confederation's recent work on accelerating the delivery of neighbourhood health centres, calling for the Department of Health and Social Care to:

- simplify estate planning processes
- streamline notional rent reimbursement
- allow systems to retain and reinvest proceeds from unused estate
- remove barriers to recycling capital
- enable cross-departmental coordination to align neighbourhood health centre investment with national programmes such as the New Hospital Programme and community diagnostic centres.

Further, the way capital is allocated in the NHS, often through rigid national programmes, limits local leaders' ability to combine funding streams to achieve best value, even in areas where significant capital is flowing into hospitals, community diagnostic centres, GP premises and developer-funded projects. Restrictions such as Capital Departmental Expenditure Limits (CDEL) penalties for trusts seeking to move services into community facilities also limit flexibility, as do complexities in repurposing commercial spaces for health use.

Leaders additionally noted that many suitable buildings owned by local councils or community organisations cannot be easily mapped or accessed due to uncertainty over leasing and reimbursement models.

Finally, system-level incentives often reinforce siloed organisational priorities, leaving estates teams disconnected from those leading partnership work at neighbourhood or place level–further impeding efforts to build integrated, multi-purpose health and care infrastructure.

## What needs to happen

- **Create a shadow budget** covering revenue and capital estate and digital spend across partners.
- **Develop a single estates strategy**, supported by joint appointments or a shared estates team and a system wide view of premises risk sharing and funding.
- **Align chief information officers** (CIOs) from across all providers behind a shared, cross-organisational digital strategy. This strategy should prioritise interoperability, reduce reliance on costly bolt-on products, and remove barriers to efficient and secure data-sharing.
- **Adopt a high-trust model of data-sharing**, focused on reducing the individual risk carried by GP practices through system-level data-sharing agreements.
- **Coordinate digital transformation by aligning contract end dates** and implementing a phased, jointly-managed migration plan.
- **Develop a partnership-wide change process that assesses risks and opportunities for all parties** when introducing new systems.
- **Use the combined collective size, scale and purchasing power to set higher standards for digital products and procurements**, securing better-quality tools, greater interoperability and significant cost savings.

## Case study: **Managing risk and enabling data sharing in Herefordshire**

### Overview

Herefordshire has a long-established history of effective data sharing, which has delivered significant benefits for patients across the area. As the health and care system increasingly moves towards data-driven service models, the relevance and importance of robust data-sharing arrangements have never been greater.

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## What the system faced

A key challenge arises from the position of general practice as the data controller, carrying unlimited personal liability on one side, while the wider system relies heavily on primary care data to drive transformation on the other. Expecting individual GPs to shoulder unlimited risk for activity that delivers clear system-wide benefits is neither reasonable nor sustainable.

## What the system did

To address this, the Local Medical Committee (LMC) negotiated an arrangement whereby the former clinical commissioning group (CCG) accepted responsibility for associated risks, provided practices adhered to established best practice. This represented a shift towards shared accountability, with the system recognising and absorbing risk in support of broader system gain.

## Results and benefits

Work is currently under way with Herefordshire and Worcestershire ICB to establish processes for population health management (PHM) linked datasets. As part of this work, a similar clause has been agreed within the relevant data-sharing agreements, ensuring that the ICB assumes a significant proportion of the associated risk. This approach is once again expected to facilitate safe and effective data sharing for the benefit of patients.

Given the scale of data sharing required to enable neighbourhood working and integrated care, it is unrealistic to expect individual practitioners to carry all associated liabilities. A shared-risk approach across system partners is essential both for the common good and for building trust, confidence and a collective sense of purpose.

# Creating one workforce

## What we heard

**NHS leaders highlighted the ongoing challenge of fostering a genuine sense of a one team culture and collaboration, particularly where uncertainty exists regarding the ownership of clinical risk**.

Examples raised by leaders included uncertainty about:

- **who holds responsibility for reviewing abnormal test results** when patients are managed across multiple services (for example general practice, community teams and hospital specialties)

- **which organisation is accountable for prescribing or deprescribing decisions**, especially when care transfers between providers or when shared-care arrangements are unclear

- **who carries the risk for home-based monitoring or digital triage outcomes**, where a patient may be assessed remotely by one provider but followed up by another

- **who oversees safeguarding or deterioration risks** when several teams are concurrently involved in a patient's care.

This uncertainty on ownership can hinder the ability of staff to make timely clinical decisions or to share relevant information that is required to support the delivery of effective, safe and high-quality patient care. It can also lead to delays, duplication or overly cautious workflows, undermining the confidence that clinicians need to operate as part of an integrated team.

It was also noted that differing organisational terms and conditions, coupled with variations in organisational culture, ranging from highly hierarchical structures to those where operational teams have considerable autonomy, can further complicate efforts to work collaboratively. Additionally, leaders recognised the difficulties associated with matrix management and the merging of reporting lines across multiple organisations.

The growing pressure on individual organisations to improve operational and financial performance can lead to teams becoming fragmented and authority being gradually withdrawn from partnership boards. It is essential that the partnership board continually assesses where decision-making may be removed from operational managers and considers the impact this has on wider workforce integration.

It is also essential that staff working on the frontline and in management roles have protected time to work together to redesign how care is delivered and to align this with workforce plans.

Wherever possible, the partnership should offer mutual aid to individual organisations when they are under pressure to ensure the long-term viability of the strategic partnership. It was emphasised that there is a growing need to bring professionals together, particularly when supporting patients with multimorbidity. The current tendency to manage patients through a condition-specific lens limits opportunities for collaborative working and contributes to inefficiency.

Leaders cited successful examples of integrated approaches, including breathlessness pathways that have brought together GPs with extended roles, together with cardiologists, respiratory consultants, specialist community teams and voluntary sector partners. These multidisciplinary pathways support patients through diagnostics and treatment while also exploring the social determinants underpinning their presentation.

> There was shared agreement that collaborative working is beneficial both for patients and for staff. Many leaders reflected fondly on earlier periods when it was common practice to seek timely support and advice directly from specialist teams. This experience, for many, now feels increasingly remote.

## What needs to happen

- **Clarify clinical risk ownership through shared agreements** covering test results, prescribing, remote monitoring and safeguarding responsibilities.
- **Align operational leadership** by keeping staff with their host employer but reporting into a shared neighbourhood or multi-neighbourhood structure.
- **Reinforce collaborative working** with shared objectives, joint training and consistent cross-organisational messaging.
- **Organise teams around population need**, focusing on patient groups rather than organisational or specialty silos.
- **Ensure equitable delegated authority** so operational managers across organisations can make timely decisions.
- **Provide protected time for joint working to redesign care** and strengthen cross-organisational relationships.
- **Use mutual aid arrangements to support providers under pressure** and maintain service continuity.
- **Support multidisciplinary learning** by building on successful integrated pathways and shared models of care.

# Contracting and financial flows

## What we heard

**Contracting and financial flows present a distinct set of challenges for partnership working between trusts and primary care. These challenges span both the 'hard' mechanics of contracting, legal frameworks and budgeting, and the 'soft' but equally important factors of leadership, culture and trust, all of which influence the extent to which organisations can genuinely work together**.

One of the central ambitions of the 10YHP is to shift resources out of acute services and into primary and community care. For this shift to happen, integration cannot remain fragmented or small-scale. Financial flows must support activity moving into neighbourhoods rather than penalise it. At present, acute providers can be left carrying fixed costs even as activity reduces, resulting in 'stranded costs' and disincentives for collaboration.

## Overcoming the barriers to financial flows

The NHS Confederation's Reforming Financial Flows report on financial flows highlights that current payment mechanisms remain a major barrier to delivering integrated, preventative and neighbourhood-based care. It emphasises that ICBs, as strategic commissioners, must design simpler, population-based payment mechanisms that align incentives across partners, support outcomes-focused delivery and encourage risk-sharing rather than risk-shifting. The report also underscores the importance of using data to build compelling cases for change and ensuring that financial incentives enable, rather than constrain, system integration.

A more mature understanding of 'resource' is also needed within partnerships. With the majority of NHS spend tied up in the workforce, redeploying people into new, integrated and preventative models of care can often be as impactful as additional financial investment. Shared infrastructure, particularly digital systems and estates, also offers substantial opportunities to improve performance. Transparency around procurement decisions, planned capital developments and shared assets can create mutual benefits and reduce duplication.

## Enhancing contracting

Improving productivity across the system requires a shift away from metrics that narrowly count patient-present interactions towards measures that capture value, outcomes and reduced duplication. Many leaders noted that service redesign, which removes unnecessary steps from pathways, is often the strongest route to productivity improvement, yet current contracting mechanisms rarely recognise or reward this work.

Cultural factors can further impede progress. In many areas, even minor logistical or operational changes still require multiple layers of sign-off, which slows improvement and dampens innovation. In contrast, partnerships that empower staff to operate confidently within an agreed legal and governance framework tend to adopt more agile ways of working. Strong clinical strategies, supported by clear data, can help overcome organisational resistance by uniting partners around a shared, evidence-based case for change.

Effective partnership boards also play a crucial role in reducing tensions over leadership and accountability. Joint decision-making helps avoid dominance by any single organisation and accelerates progress. This is particularly important when engaging local government and VCSE partners, whose expertise in prevention, community engagement and tackling health inequalities is essential to neighbourhood working.

Partnerships will need to agree system-wide priorities, such as reducing avoidable admissions, improving outcomes for specific cohorts or accelerating discharge, and establish clear mechanisms for reinvesting any resulting savings back into the services that delivered the improvement.

**The power of agreed system-wide priorities**

Examples from local areas demonstrate the potential of agreeing priorities: in Hillingdon, for instance, the council and primary care are working together through their place-based partnership to strengthen public health campaigns. They are using digital triage platforms to reach underserved communities with targeted, multilingual health messages, significantly improving uptake of preventative interventions such as immunisation.

## What needs to happen

- **Ensure local authorities and VCSE organisations are core partners in commissioning, planning and investment**, using their strengths in housing, prevention and population health to shape neighbourhood models.

- **Explore opportunities to share functions across local government and the NHS**, particularly with primary care, where doing so could streamline processes or strengthen neighbourhood working.

- **Service specifications should be developed with partnership boards**, ensuring they clearly articulate the outcomes that high-quality care must deliver for local communities, with a stronger focus on population health and measurable impact.

- **With national support, commissioners should streamline and reform payment systems**, so they incentivise delivery of agreed outcomes, shifting towards population-based and outcomes-focused models.

- **Establish equitable approaches to risk-sharing** so that no single organisation, particularly those with smaller footprints, carries disproportionate financial or clinical risk.

- **Develop joint financial arrangements that encourage all partners to deliver more activity in community settings**, with safeguards to ensure the partnership's overall income is not adversely affected as care shifts out of hospital.

# Getting the governance right

## What we heard

**Across all groups, leaders emphasised that effective governance must reflect the values and diversity of the partnership and should enable, rather than constrain, collaborative working**.

Governance arrangements should provide colleagues from all partner organisations with the confidence and authority to make decisions, supported by clear delegated limits and a proportionate, risk-based approach. Leaders also highlighted the importance of consultative decision-making and noted that partnerships must be prepared to maintain their strategic direction when external pressures arise, for example, in relation to urgent and emergency care performance or elective backlogs. Doing so will help ensure that the collective focus on neighbourhood working, prevention and improving population health remains central and is meaningfully connected to these wider operational challenges. Leaders highlighted that **improving core operational performance and the enablement of neighbourhood health can work in tandem and enable each other**.

Leaders also highlighted that **transparency around commercial arrangements is essential**, particularly where primary care organisations are involved. Trust leaders raised concerns about how profit, risk and accountability are managed within primary care-led vehicles. It was noted that many at-scale primary care organisations have responded by strengthening their governance and operating as community interest companies to improve accountability. Alongside this, several participants reflected that different organisations perceive risk differently, and that misunderstandings, particularly between trusts and primary care, can easily frustrate progress without open discussion and clear documentation.

A recurring theme was the need for governance arrangements that **actively enable**, rather than inhibit, **innovation**. Some primary care leaders initially expressed concern that closer working with trusts might constrain creativity, largely due to differences in organisational culture, risk appetite and decision-making processes.  Leaders noted that establishing a **strong and**

**well-functioning partnership board is central to enabling innovation and maintaining accountability**. When the board provides clear delegated authority, applies proportionate and consistent risk-management frameworks, and sets out transparent lines of accountability, it **creates the conditions in which partners can act confidently and collaboratively**. Under these arrangements, innovation and accountability are not competing pressures; instead, they reinforce each other, allowing teams to test new approaches while ensuring appropriate oversight across all partners.

Leaders noted that **excessively rigid governance can become a barrier**, particularly in digital transformation, where multiple layers of sign-off often delay even minor operational changes. To avoid this, partnerships require governance models that set clear direction and standards while still allowing flexibility. Rather than imposing restrictive controls, governance should provide supportive guide rails that give teams the confidence to act, encourage experimentation within agreed limits and ensure decisions can be made at the most appropriate level.

**Strong leadership, clarity of purpose and a positive organisational culture** were seen as essential components of effective governance. Clinical governance was highlighted as a central pillar within this, but leaders emphasised that robust governance requires an appropriate balance across clinical, financial and operational factors.

Across the discussion, leaders underscored the importance of **clear and coherent accountability mechanisms**, both within individual organisations and across partnerships. Several noted that partners must ensure their own internal governance arrangements, such as decision-making structures, quality oversight processes and financial controls, are sufficiently robust before they can fully participate in system-level collaborations. Others stressed the need for accountability that is visible to local populations, including through transparent communication, co-production with communities and clear explanation of how decisions affect local services.

Leaders also noted that joint ventures and shared partnership structures **require explicit frameworks for decision-making**, conflict resolution and mutual accountability. When managed well, constructive approaches to conflict were viewed not only as safeguards but as potential enablers of innovation, helping partners navigate differences and maintain momentum in service transformation.

Finally, leaders noted that **relationships remain central to whether governance arrangements succeed in practice**. NHS leaders emphasised that effective governance depends on shared leadership that leverages each partner's strengths, alongside a clear understanding of the partnership's long-term goals. Many agreed that a fundamental early question for any partnership is: what is the end goal? Only with this clarity can governance be designed to support, rather than hinder, the work ahead.

## What needs to happen

- Leaders should **establish a strong partnership board with clear delegated authority, proportionate risk-management processes and transparent lines of accountability** to enable safe, confident innovation across partner organisations.
- **Agree delegated decision-making limits** through the partnership board, enabling local teams to act without unnecessary escalation.
- **Use a shared risk register and streamlined sign-off processes** to support safe, timely innovation.
- **Standardise key reporting**, such as activity, workforce pressures and quality indicators, to give all partners a consistent view of system pressures.
- **Use independent or rotating chairs for partnership boards and sub-groups** to ensure balanced oversight and avoid dominance by any one partner.
- **Embed community voices within governance structures**, for example through patient panels or neighbourhood advisory groups.
- **Provide clear, accessible governance information** outlining roles, responsibilities and decision-making routes.
- **Agree scheduled review points** to assess whether the partnership form remains appropriate or should evolve.

# The vehicles for delivery

It was noted that the **strategic enablers** outlined throughout this report: shared infrastructure, a more integrated workforce, aligned contracting and financial flows, and proportionate governance **are far more important determinants of successful strategic partnerships than organisational form alone.** These enabling functions will create the foundation upon which collaboration can thrive. However, in areas where partners have already made strong progress in developing these capabilities, there may be value in exploring how their partnership could be formalised to hold new contractual responsibilities, particularly in relation to the neighbourhood-level contracts set out in the 10YHP.

## The role of primary care networks

This section outlines the role of primary care networks (PCNs) and at-scale general practice organisations in strengthening strategic partnerships between primary care and NHS trusts. As primary care provider collaboratives emerge, bringing together the whole primary care sector (general practice, community pharmacy, optometry and dentistry) into a single organisation with a unified voice and legal personality, often as a community interest company, there is also potential for mature at-scale general practice organisations to expand and incorporate the strengths of the wider primary care family. This shift will be particularly valuable in moving from competition to collaboration, especially in areas such as vaccinations and immunisations.

Bringing together the full breadth of primary care offers significant benefits for outpatient transformation, while also extending the partnership's physical footprint, skill mix and infrastructure. The high footfall and accessibility of community pharmacy and optometry providers create important opportunities to enhance coverage and improve integration across neighbourhoods.

## Forming single neighbourhood contracts

Single neighbourhood contracts are designed to deliver enhanced services for groups of people with similar needs within a population of around 50,000. In many areas, PCN footprints already provide a strong foundation for this approach, however the majority of PCNs lack legal personality and therefore cannot hold neighbourhood contracts directly. If practices choose to contract jointly for neighbourhoods, they risk inadvertently creating super-partnerships, which would introduce further complexity to the primary care landscape and fragmentation of existing structures.

To enable neighbourhood-level contracting, several alternative organisational options exist:

- a lead practice model
- a PCN- or neighbourhood-owned company (PCN incorporation)
- a third-party vehicle such as a GP federation or a local NHS trust.

The key differences between these options centre on governance and control, but most single-neighbourhood models would likely be predominantly primary-care-led in a similar way as PCNs.

## Serving at multi-neighbourhood provider level

As the system evolves, larger multi-neighbourhood providers (MNPs), serving populations of more than 250,000, will be established. These organisations will co-ordinate the consistent delivery of across multiple neighbourhoods, such as end-of-life care and other aspects of the left shift in the 10YHP, and for unlocking the efficiencies that scale can offer across all GP practices within their footprint. In some areas, mature GP federations are already playing much of this role effectively. As strategic commissioners for the system, ICBs will also have the flexibility to contract neighbourhood services through NHS trusts or other providers. To make the most of this opportunity, whether delivering services that require coordination across neighbourhoods, unlocking the efficiencies that come from operating at scale, or shaping how future MNP contracts are held,

primary care will need to articulate a single, credible voice at MNP level, supported by joined-up governance and the capability to hold or meaningfully influence contracts.

Several issues need to be addressed to establish a viable primary-care-led MNP. First and foremost, maintaining trust, both among GP practices and between primary and secondary care, is essential. Leaders described this as a two-way process: primary care must feel confident that its voice, local insight and connection to communities will be valued, while trusts and other partners need assurance that primary care can operate at scale, hold financial risk and deliver consistently.

**Clear governance**

To support this, partnership structures must remain agile, with clear governance arrangements that allow the primary care provider entity to retain sufficient autonomy while still working closely with trust-based organisations. In practice, this will require clarity about roles, responsibilities and decision-making authority, ensuring that neither side feels overshadowed or exposed.

True integration may also involve staff working across organisational boundaries, for example, community teams aligned to neighbourhood footprints or specialists supporting multi-disciplinary pathways. Leaders noted that this can introduce complexities, such as differing supervision models or variations in terms and conditions, but also emphasised the benefits: shared expertise, improved continuity and more efficient use of clinical capacity.

In some cases, where MNP services span both primary and community care, partners may benefit from using a not-for-profit lead provider model, such as a community interest company (CIC). This can help ‘bridge the gap’ between NHS, voluntary and community organisations, provide a neutral space for shared decision-making, and reassure partners that no single organisation is positioned to take over the whole model.

### Local population knowledge

Leaders also highlighted the importance of 'give and take' in early partnership development. For example, trusts may bring established governance, HR and training infrastructure, while primary care contributes deep population insight, continuity of care and access to registered lists. Making these mutual benefits explicit can help alleviate concerns, such as fears of trust dominance or worries about primary care having to scale too quickly, creating a more balanced and sustainable foundation for an MNP.

## Contracting models

Three main contracting models exist (fully summarised on page 25):

- A **primary care-led model** provides clear accountability but raises questions about whether GP providers can scale sufficiently and develop the credibility needed to subcontract to large NHS trusts.

- A **trust-led model** places funding and service control with a trust, leaving no obvious delivery role for GP-provider companies and risks the loss of primary care's 'single voice'. Primary care may also feel it has less control over its income as it no longer negotiates directly with commissioners.

- **Joint venture (JV) models** provide shared ownership and control as well as the flexibility for the providers themselves to determine whether a particular service should be more led by one provider or the other. However, governance will be critical to their success, to avoid the risk that no-one feels real 'ownership'.

Ultimately, form should follow function. As the content and scope of MNP contracts are not yet defined and are likely to evolve, flexibility is essential. Primary care-led models may be difficult to scale, while trust-led models risk reducing primary-care autonomy and agility, but it is important to remember that primary care-led, trust-led and JV models are not mutually exclusive; some services may be best contracted directly to at scale primary care providers, while more integrated MNP-wide services may be better awarded through a JV. Achieving the right balance will be critical to creating a sustainable, scalable, and influential primary-care presence within future multi-neighbourhood arrangements.

| Model | Strengths | Risks and limitations | Best use and considerations |
|---|---|---|---|
| **Primary care-led model** | • Clear accountability within primary care<br>• Maintains autonomy and preserves a strong 'primary care voice'<br>• Direct negotiation with commissioners | • Questions about scalability and operational capacity<br>• May lack credibility/ assurance when subcontracting to large NHS trusts<br>• Potentially limited influence in wider system decisions | • Works best where primary care is already well organised at scale<br>• Suitable for services that are clearly primary care-centric<br>• May struggle to support large, integrated or complex MNP-wide services |
| **Trust-led model** | • Clear governance and delivery structures already established in trusts<br>• Ability to manage large budgets and system-wide service change | • Reduces primary care's direct control over income and contracting<br>• Primary care provider organisations may be left without a meaningful delivery role<br>• Risks loss of primary care's 'single voice' and agility | • May suit large, integrated services requiring scale and complex infrastructure<br>• Important to mitigate risks of primary care disengagement and loss of influence |
| **Joint venture (JV) model** | • Shared ownership and decision-making<br>• Flexibility to allocate service leadership to whichever provider is best placed<br>• Strengthens collaboration and joint accountability | • Governance complexity – risks 'everyone involved but no-one accountable'<br>• Requires high trust and mature relationships<br>• Slower to establish | • Best suited to integrated, MNP-wide services involving multiple partners<br>• Enables joint investment and shared risk<br>• Governance design is critical to success |

# Conclusion

Forming effective strategic partnerships between primary, community and secondary care providers has become increasingly important following significant reductions in ICB running costs and programme budgets. These reductions will mean limited local convening capacity and the support previously available for system-wide improvement activity. As a result, greater pressure now falls on leaders across the system to build collaborative approaches that bring organisations (commissioners and providers) closer together, enhance patient care and support delivery of the ambitions within the 10YHP.

> ...meaningful progress is possible where partners share a collective vision and focus on a clear set of practical enablers

The discussions captured in this guidance demonstrate that, although local systems face persistent challenges relating to infrastructure, workforce, financial flows and governance, meaningful progress is possible where partners share a collective vision and focus on a clear set of practical enablers. Strengthening shared infrastructure, developing a more integrated workforce across organisational boundaries, aligning financial incentives to support care closer to home, and establishing transparent and proportionate governance arrangements can together create the conditions for genuine integration. These approaches help shift partnerships away from fragmented or piecemeal collaboration and towards more coherent, system-wide delivery that can improve outcomes for local communities.

> ...there is clear value in shared learning and in addressing inherent challenges...through a partnership lens rather than that of a single organisation

It is important that this focus remains on how primary care and NHS providers can integrate core functions before considering organisational form. In several of the interventions explored, organisations working together not only benefit

reconfiguration in a constrained environment. Whether it is an NHS trust providing digital support to a large-scale primary care organisation, or primary care providing urgent treatment centres to handle more risk and improve hospital flow, there is clear value in shared learning and in addressing inherent challenges in the health service through a partnership lens rather than that of a single organisation.

As partnerships mature, they will also be better placed to determine the most appropriate vehicle for delivery, whether primary care-led, trust-led, or a joint venture, ensuring that form follows function and remains flexible in anticipation of future developments in neighbourhood and multi-neighbourhood contracting.

Ultimately, the success of any strategic partnership will depend on its ability to act collectively, share risk, and remain focused on the shared goal of improving care for local communities. With aligned leadership, clear governance, and a commitment to working as one system, partnerships can move from aspiration to action, strengthening their readiness to deliver integrated, population-focused care at scale.

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