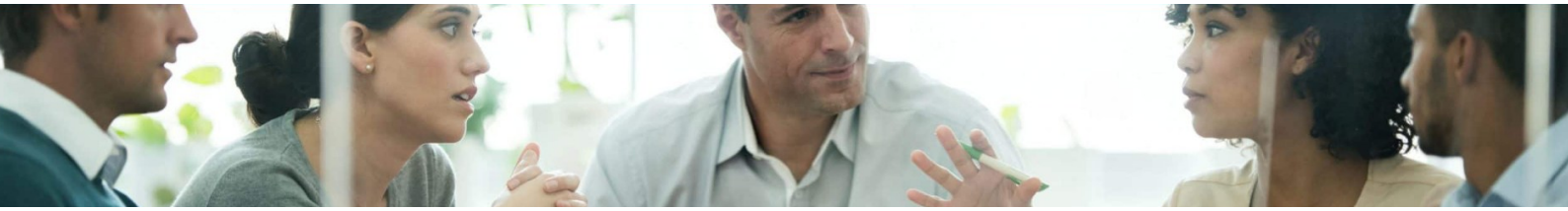
Insight

April 2026



Opportunities ahead

As the implementation of the 10 Year Health Plan starts to gain momentum opportunities to make real change are presenting themselves. The door is open to those who want to grasp thinking and working differently. However, many organisations are still managing swathes of organisational change, pressures of day to day work, and may be blinded by the metrics to be met.

The publication of the Neighbourhood Health Framework is most welcome with the system wide approach with the person at the centre. The aim to improve people's health and care outcomes, reduce health inequalities and help them stay well at home with services organised around the person should lead to a central role for primary care services. For the future of primary care as a system leader and driver, influencing their own future there is a need to collaborate, join up thinking, and grasp opportunities.

The metrics in the Neighbourhood Health Framework give a focus on areas to address, in partnership with other stakeholders. The intention to develop Integrated Health

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Organisations is clear – with the contract holder being an NHS statutory body. The opportunity for primary care to collaborate at scale, look for gain share opportunities with trusts that address system problems now will set them in a good position for the future.

Solution focused, problem solving collaboration can start to enable change that can benefit people, and organisations. In this edition of PCC Insight we consider taking a systems approach, working with local partners in a collaborative way, focusing on outcomes. This is a theme for a new workshop we have scheduled as part of our Strategic Commissioning and Integrated Care Delivery series, which we are running again from May. Others in the series include outcomes and value based commissioning, population health management, neighbourhood development and leadership for collaboration. These have been extremely popular workshops – so book early.

Other articles in this edition include a case study of the benefits of a single practice partnership across a primary care network, a patient's perspective on neighbourhood health, an article from Community Orientated Integration Network, a blog by Professor David Colin-Thomé, PCC's chair, on the 2026/27 GMS contract and questions from our helpdesks.

I hope you enjoy reading this edition.

Author
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Why command-and-control doesn't work in complex healthcare systems — and what to do instead

The assurance meeting is in two days. The team is gathered around a draft slide deck, not to ask what we can learn, change or adapt, but how to explain the position without being shouted at or appearing weak.

That is the point at which blame starts to overtake learning.

Because when assurance becomes performance, honesty becomes harder. And when honesty becomes harder, complex change becomes slower, more defensive and less effective. Worse, issues and risks are not surfaced early enough, and patients can be harmed.

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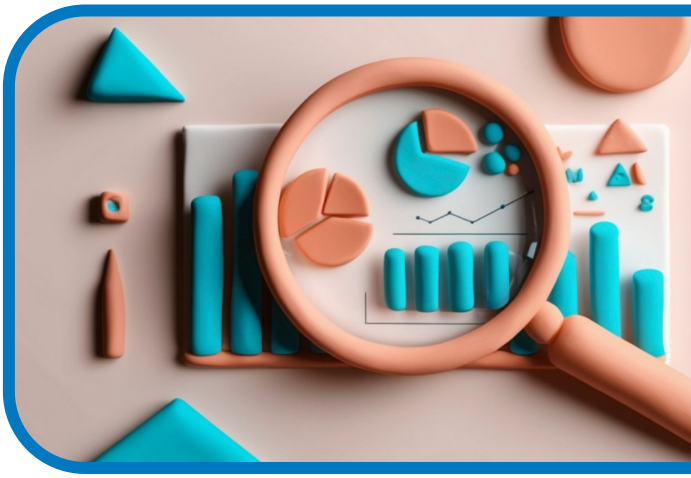
That is not because people do not care or are not capable. It is because of the culture and the approach to change.

In simple environments, pushing harder can work. Cause and effect are more visible, however most healthcare systems are not simple. They are complex and adaptive. Multiple teams, professions, organisations, incentives and constraints interact at the same time. Actions in one part of the system create consequences elsewhere, often with delay, and what appear to be similar circumstances do not reliably produce the same outputs or outcomes.

This is where a systems lens matters.

Donella Meadows taught us that to understand a system, we need to look beyond events and notice patterns over time, feedback loops, delays, constraints and information flows. In healthcare, that means asking different questions. Not “Who failed?” but “What conditions made this outcome likely?” Not “Why didn’t that work?” but “What is the system reinforcing, rewarding, delaying or making difficult to see?” In complex systems, even the best-planned outputs do not always produce the outcomes we intended, because the system is complex.

Once you understand that, many “people problems” start to look more like system effects. A service repeatedly missing targets may not primarily have a motivation problem. It may be trapped in a reinforcing loop of unclear priorities, delayed decisions, hidden dependencies and poor feedback.



Information flows are one of the most powerful ways to unlock the “black box” of systems thinking. They make system signals visible, shared and useful. A statistical process control (SPC) chart, for example, is not just a performance graph; it is a way of seeing what may be happening in the system over time. Its value lies not in proving failure, but in helping people interpret variation, flow, stability, emerging constraints and where deeper inquiry is needed. That is the shift from command-and-control to systems thinking: from asking who is to blame, to asking what the system is showing us, and what that means for action.

Yves Morieux makes a similar point in Smart Simplicity. In complex organisations, the answer is not more layers, more rules or more control. It is making cooperation

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easier. In healthcare, that means creating the conditions in which teams, services and organisations can see the same signals, work from the same intent, and respond to the same constraints together. If the system cannot see itself clearly, it cannot adapt intelligently.

This also changes accountability. In complex healthcare systems, accountability cannot remain purely one-way and upward. There is still clear individual accountability for delivering stages and outputs, but there is also system accountability. If leaders sign up to shared outcomes, they are responsible too: for removing barriers, resolving dependencies, improving information flows and enabling delivery across organisational boundaries. This requires a genuine sign-off at the beginning, not nominal approval. If a board, commissioner or leadership group is going to hold the system to account for outcomes, it has to understand the work, the logic and the dependencies well enough to own its part in making success possible.

When information flows are clear and trusted, decision-making can also be devolved closer to where change is happening, so teams can act quickly rather than waiting for avoidable approval. In that kind of system, escalation becomes more about seeking help to solve a problem. In complex systems, review is not a meeting in a boardroom; it is an ongoing process of interpretation and sense-making.

Horizontally, the same logic applies. Learning spreads when projects and programmes are described in a more consistent way. Otherwise, every team is effectively speaking its own language, and the system cannot compare progress, see patterns, manage dependencies or spread learning at pace. This creates awareness, understanding, and knowledge, which, if managed right, creates emergence. In systems thinking terms, emergence is the creation of ideas and approaches that would never have happened if acting in isolation.

This is one of the strongest arguments for structured approaches such as Outcomes Key Results and Stages (OKRs). By creating a common spine for stages, outputs, dependencies, intended differences and review, OKRs make delivery, impact, constraints and learning visible in a comparable way. That supports better sponsorship vertically, but also faster learning horizontally.

As John Doerr has shown, clear objectives help very different parts of a system understand how their work connects to a larger mission. In healthcare, that matters even more. Complex outcomes rarely depend on one team alone. They depend on shared purpose, visible logic, clearer information flows and a system that can learn faster than

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the problems it is trying to solve.

Through my research and practical work with NHS teams, I have developed an approach that combines OKRs, logic modelling and AI-supported coaching. The Outcomes Key Results and Steps (OKRSs) help make stages, outputs, dependencies and intended differences more visible, strengthen review, The AI coaching enables faster, better, more considered development and review.

To find out more join our workshop on 19 May 2026 “Strategic commissioning and integrated care delivery: Facilitative commissioning for system accountability”. You can book your place on https://www.pccevents.co.uk/pcc/3545

This workshop is one in a series of workshops on strategic commissioning and integrated care delivery you can find more details of these workshops at https://www.pccevents.co.uk/pcc/3554

We are also able to provide support to individual ICBs please contact enquiries@pcc-cic.org.uk to find how we can work with your system.

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Case Study: Brownlow Health – Leadership in a Single-Partnership PCN

Brownlow Health offers an interesting perspective on neighbourhood working and primary care network (PCN) leadership. Our model brings together four practices, one GMS and three APMS contracts, operating under a single partnership and serving approximately 94,000 patients across Liverpool. As a single-partnership PCN, our experience highlights both the opportunities and practical advantages of operating at this scale.

One of the most significant benefits is the simplicity of governance and decision-making. Because all four practices sit within the same partnership, leadership structures are

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already aligned. Decisions that in many PCNs require negotiation between multiple independent practices can be made more quickly and implemented more consistently. This allows us to move at pace when responding to operational pressures, workforce challenges, or service redesign opportunities.

Communication is another clear strength. With a shared organisational culture and established leadership structure, information flows more easily across the network. This helps maintain alignment between clinical teams, operational leaders, and strategic priorities. Rather than creating additional PCN governance layers, our PCN functions largely as an extension of the partnership itself, which reduces duplication and streamlines leadership responsibilities.

A further advantage of this model is the ability to direct PCN resources towards frontline services. Because the partnership already has a well-developed organisational infrastructure—including leadership, management, and operational support—we have not needed to invest PCN funding into additional governance or administrative capacity. Instead, funding can be focused on expanding multidisciplinary teams and strengthening direct patient-facing services. This has supported the integration of new roles and services in a way that complements existing practice teams rather than creating parallel structures.

From a leadership perspective, the scale of a single-partnership PCN also creates opportunities for strategic planning across a large and diverse patient population. With nearly 94,000 patients, we can think at neighbourhood scale while still maintaining organisational cohesion. This enables more coordinated workforce planning, service development, and engagement with system partners.

That said, the model also requires thoughtful leadership. Maintaining strong engagement across multiple sites and teams remains essential, and it is important that decision-making processes remain inclusive despite the organisational simplicity. Ensuring that the voices of clinicians and staff across all practices are heard is critical to sustaining the benefits of the model.

Overall, our experience suggests that single-partnership PCNs can offer a pragmatic and efficient approach to neighbourhood working, particularly where a mature

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organisational structure already exists. By reducing governance complexity and focusing resources on patient care, this model can help primary care organisations deliver coordinated services at scale while retaining clear and accountable leadership.

PCC has been working to support Brownlow's leadership team through the delivery of development sessions and coaching.

If you would like to chat about how we can support your team, contact helen.ellis@pcc.nhs.uk

Author
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Brownlow Health

Improving access to same day care

This programme established local GP hubs to increase capacity, improving patient access and generating financial savings.

Background

The system comprises 30 GP practices organised into seven primary care networks (PCNs) covering a population of circa 350,000. The A&E department is based at the Royal London Hospital, Whitechapel under the management of Barts Health and the Urgent Treatment Centre which is on the Royal London Hospital Site is under the management of the local GP Federation.

Aim

The aim of the programme was to establish local GP hubs to provide additional GP primary care capacity, in the form of booked appointments, during core hours to receive patients.

a) redirected from NHS 111

c) redirected from GP practices when practice same day slots were exhausted, and

b) streamed from the local A&E department

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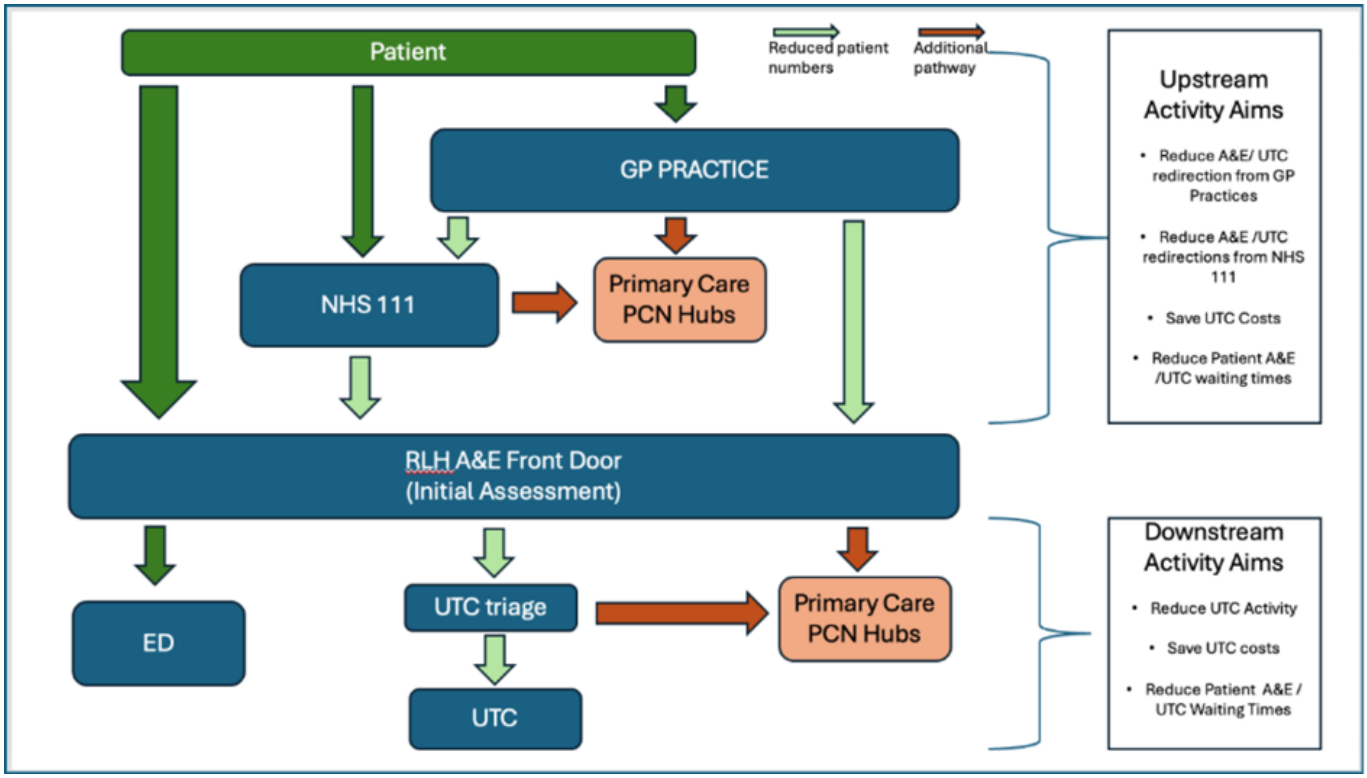
Approach

The Same Day Access (SDA) Programme Team worked with PCNs to establish three pilot Same Day Access Hubs across the borough, providing coverage for the entire population during the core hours of weekdays and at weekends.

The hubs were integrated with an existing separate seven-day borough service run by the local GP Federation that offered 30 appointment slots per day to receive patients streamed from A&E.

Summary of PCN Hub Functions



Pilot Activities upstream of Royal London Hospital A&E

The pilots offered additional GP practice capacity for receiving patient redirections from NHS 111. This capacity provided was beyond the level that individual GP practices were required to provide under their GMS contract to accommodate patient redirections from NHS 111.

Results: an analysis of NHS 111 PEM data indicated that c66% of NHS 111 appointment demand for patients with a Primary Care Disposition had been managed by the practices and the pilot hubs (rising to 75-80% for the best performing hub and associated PCN member practices.) This Hub activity is estimated to result in the avoidance of c50

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A&E attendances each weekday.

The pilots also provided appointments for patients when individual PCN member practices had no available same-day appointments.

Results: It is estimated that the Hubs' provision of capacity during such times prevents c20 A&E attendances per weekday.

Pilot Activities downstream of Royal London Hospital A&E

The pilots offered GP capacity for receiving patients streamed from the Royal London A&E.

Results: Latest figures indicate an average of c100 patients (c20 per weekday) being streamed from A&E/UTC (urgent treatment centres) to the pilots. This is in addition to an average of c25 per day streamed to the existing borough service run by the GP Federation.

The Programme proved that 50-60 patients per day would be both suitable and willing to be streamed from A&E to a GP Hub Service. (Approximately 20% of the daily UTC activity)

Overall financial impact

We estimate that based on current data and full implementation of the service, the pilots are currently generating a net saving of £40,000 to £50,000 per month for the integrated care board.

NB: While the system has not experienced a reduction in A&E/UTC activity, the upstream functions described above are playing a role in containing growth in A&E/UTC attendances, which positively impacts patient waiting times at these services.

Non-financial benefits of the same day service

- The scheme offers c41,500 additional primary care appointments per annum (133 per day) to improve patient access to a same day primary care appointment, in their local area. If this were allocated to individual practice this would only be equivalent to c4.5 appointments per day. Much more has been achieved by creating a critical mass of appointment slots through the establishment of Hubs.
- Where patients are booked into the Hubs by NHS 111 or local practices,

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patients are seen closer to home rather than attend A&E/ UTC.

- Patients do not have to wait in A&E/UTC but can have a booked appointment on the same day.
- Patients are seen by a local clinician with full access to their medical records.
- Patients receive a more comprehensive service than at A&E/ UTC. Hubs can order tests, make specialist referrals and act on clinical record flags e.g. to remind patient they are due health screening appointment
- Better links to social prescribers and other relevant primary care services
- Reduces likelihood of patient having to reattend their own GP practice following an A&E/UTC attendance saving clinical time and benefiting patients. An audit completed during the programme indicated patient reattendance rates following a pilot consultation at 5-10% compared with c40% following UTC attendance.
- Patient Survey feedback of the service has been very positive
- Improved relationships between GP PCNs, the GP Federation and Barts Health, forming good foundations for future collaborations, particularly integrated neighbour-hood teams

The Future

This programme was a pilot and despite favourable outcomes its future is not guaranteed. However, we remain optimistic as the collaborating organisations have significantly invested time in the programme, and our data is showing positive outcomes.

Contact PCC to discuss how we can work to redesign care in your area
enquiries@pcc-cic.org.uk

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What will neighbourhood health mean for patients?

William Greenwood's PCC blog rightly says that last Year's 10 Year Plan was "more aspirational than true planning". That's fine as far as it goes. But with implementation of neighbourhood health to be delivered "at pace", including an expectation of plans to manage high priority cohorts by April 2026[1], the recipients of this localisation of integrated health and social care might like clarity about what it could mean for their care beyond the broad ambitions. They might also like to play a part in the design of their own neighbourhood healthcare.

What is neighbourhood health?

Professor David Colin-Thomé, in his article for the February 2026 edition of Insight quotes the executive summary of the 10 Year Plan:

"At its core, the neighbourhood health service will embody our new preventative principle that care should happen as locally as it can: digitally by default, in a patient's home if possible, in a neighbourhood health centre when needed, in a hospital if necessary."

Already, there has been a considerable amount (too much?) written about what neighbourhood health is and might look like, which arguably risks obscuring rather than illuminating the basic principles. And, after some delay, we now have the Neighbourhood Health Framework (NHF)[2]. My sense is that the objectives tend to be conflated with the processes and tools to achieve them.

In my view, the fundamentals are to use relatively local geographical areas as the basis for achieving objectives through improved processes employing various tools. Thus

- Objectives: deliver the three shifts in the 10 Year Health Plan, thereby improving services for patients and efficiencies for the health and care sector
- Processes: achieve the objectives by improved integration/working together of services and service providers in a way that's appropriate to each neighbourhood
- Tools: these include maximising digital opportunities, physical neighbourhood health centres, neighbourhood contracts, and measures to prevent ill-health and reduce hospital use.

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I see no value debating whether, for example, this is largely a repeat of previous attempts at integration. Indeed, the Ministerial foreword to the NHF acknowledges there have been previous integration efforts. Or whether what is called a neighbourhood is the best scale for taking this forward and whether it works in both urban and rural settings. And I'll set aside the promotional stuff about neighbourhood health - about "creating a collaborative high-support, high-challenge culture, to develop a shared vision and outcomes" (Neighbourhood Health Guidelines – NHG)[3] or tackling "fragmentation" with a "simpler approach" (10 Year Health Plan)[4] - however much it is hoped that the promises will be fulfilled. Fundamentally, neighbourhood health is about bringing together all parts of the health and social care sector (including the Voluntary Community Faith and Social Enterprise sector) at local level to achieve the benefits envisaged by the 10 Year Health Plan through locally-tailored deployment of the Plan's three shifts.

Stripping back even further, it seems to me that the core focus of each neighbourhood should be on achieving integration. All parties should be working together to decide on the best tools to deploy to improve prevention, keep people away from hospitals and improve patient services, and then deliver together.

Processes – how to do the integration bit?

Again, the nitty gritty. This doesn't work if all the health and care players locally are not bought in. Structures and information-sharing come into it, but at its root it's about all the players wanting to work together and overcome barriers to doing so in order to create something better. It's not about presenteeism: representatives of different organisations turning up to meetings just in case, rather than because they want to contribute together to the new ways of working and jointly buy in to whatever is the agreed direction of travel. So neighbourhood health needs to be founded on common ownership and harnessing relationships, not simply dropping the words "neighbourhood health" into all conversations or sitting around tables and eventually agreeing to small, single-issue initiatives to attempt to satisfy the powers that be and offer a story to tell.

As the National Neighbourhood Health Implementation Programme (NNHIP) welcome pack's first "primary driver" puts it: "Build shared multi-organisational leadership, common purpose and common way of working, accountable to communities for what matters to them"[5]. The pack quotes Sir John Oldham, chair of the NNHIP Taskforce: "Successful implementation of neighbourhood health depends on more than policy or structure" and references relationships as a key to tackling problems.

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Tools – how to choose the right tools for each neighbourhood

To achieve integration, I would argue again that the tools need to be chosen by everyone involved and affected, informed by knowledge of the existing design of services, population health data, the views of the community etc.

Beyond that, there will doubtless be plenty of discussion of the practical options for delivering the three shifts having regard to the circumstances of each neighbourhood. How to promote prevention to ensure that populations facing health inequalities are included; how to monitor and support patients at home to reduce the likelihood of hospital admission; how to operate hospital at home that works for different patients; how to structure a multi-disciplinary team (MDT) in different situations; what the role is of the new single and multi-neighbourhood providers (SNP/MNP); how to manage any impact from SNPs and MNPs on patients' current expectations from their GP practice; how to achieve continuity of care with MDTs; and much more. And, of course, there's the dependency on the 10 Year Health Plan commitment "over the course of this Plan" to shift the pattern of health spending from hospitals to out-of-hospital care.

What does the new Neighbourhood Health Framework (NHF) say?

From a patient perspective, does the 11,671-word NHF shed more light on the sort of care we can expect into the future?

Disappointingly, there's no mention of the public, patients or representative organisations being involved in producing the NHF, nor insights into how to build the relationships and culture change that Sir John Oldham acknowledges as a key element.

Beyond that, my expectation was that the NHF would put some flesh on the bones of the 10 Year Health Plan, without being too prescriptive.

The covering post from DHSC says the NHF "defines neighbourhood health". In practice, I'm not sure I'm a lot wiser. Nor am I sure why I should believe that the contents of the NHF will prompt the integration that is acknowledged to have hitherto been elusive.

This is not the place for a full review of the NHF. I struggled to form a clear picture of what is envisaged, as distinct from a collection of component parts and aspirational outcomes. And I struggled to understand the changes patients should be looking out for and how we can expect to be bought in.

In brief, we are offered five national goals which I believe are newly minted. You then have to turn to MHCLG's Local Outcomes Framework[6] (LOF – 20,378 words) to get

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a substantive feel for the part social care is expected to play. Exploring further, the LOF references the Pride in Place Initiative (PIP – 6,994 words) which involves setting up neighbourhood boards for 284 communities with no stated link to the neighbourhood health geographies and a local MP at the helm. Then there's a link to the DWP's Guidance for Developing local Get Britain Working plans[7] (6,089 words), which requires each local authority to produce a plan and to involve integrated care boards. The NHF next moves from goals to examples of local initiatives and reform programmes which include reference to various hubs - up to 1,000 best start family hubs, 50 young futures hubs, a tackling loneliness digital hub – and other central initiatives, such as a relating to GP access. We have broad-brush statements that the NHS and local authorities need to transform how they work together and stuff about delivery using new contractual approaches. And we have an instruction to ICBs to "implement a series of minimum interventions in every community over the next 3 years", which are described in terms of three reform agendas all tied in to the pre-existing three shifts. And there's mention of integrated health organisations (IHOs) and mayoral strategic authorities.

Will integrated neighbourhood healthcare work?

Who knows? What's the basis for the claim that this is now "the environment in which local services can work together" (NHF)? Is there a clear, public/patient-focused narrative from the various government departments involved?

There is, and has never been, a perfect solution to providing the best, equitable health and care service possible that is also nationally affordable. Views on the best way forward will always differ and outcomes will always be mixed.

Personally I worry that this is yet another distracting reconfiguration. Also that NHS administrators can be adept at taking a 'Yes Minister' approach: nominal compliance to avoid sanction, rather than genuinely embracing any new approach. On the other hand, seasoned administrators will have seen so many new initiatives, it's no wonder if there's a certain amount of jaundice around.

I worry too about whether the views of other key players – local authorities and primary care in particular – will be given equivalent weight to those of ICBs and the secondary care sector despite a role being given to local authority Health and Wellbeing Boards and the NHF's reference to "primary care clinical leadership in IHOs"? The Local Government Association, for example, says "Adult social care will be central to the success of neighbourhood health, through its role in neighbourhood teams, centres, and wider neighbourhood working"[8]. The National Association of Primary Care (NAPC) "strongly supports the direction towards neighbourhood-based models of care" but advises

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on the steps needed for "collaboration to be meaningful"[9].

And I worry about whether funding will actually be realigned enough from hospitals to neighbourhoods. And whether the public and patients will be genuinely engaged in the design of neighbourhood care for their local area. On the latter, I'm accustomed to brief, positive-sounding commitments to public/patient engagement that end up not being delivered[10]. Where, for example, is the reference in the NHF to NHSE's statutory guidance Working in partnership with people and communities[11], and is the passing mention of DCMS's Civil Society Covenant[12] meaningful?

I do, however, think that it's the right focus to continue to look at ways to integrate services, both for the benefit of patients so they are not pushed from pillar to post, and with the aspiration that it will lead to efficiencies and better use of whatever funding exists. It's another matter whether integration can truly work when, for example, the culture and funding streams for the health and social care sectors seem to be very different and, in my view, require more than plans and frameworks to change. And just stating in the NHF "Integrated neighbourhood teams (INTs) will help people stay healthier, for longer" doesn't cut it for me.

What this particular patient would like to see

I would like to see three things emerging from neighbourhood health:

A. Outcomes: patients and the public noticing improvements in the services they receive, measured not only by data but by personal experience. And with transparent accountability for improvements being to local users, not just administratively and behind the scenes to NHS England and the Department of Health and Social Care

B. Processes (integration): a seamless experience - barriers being broken down both within and between the health and the social care sectors at all scales (via more relationship-building and people skills, less paperwork and fewer written plans?

C. Processes (transparency and involvement): patients and the public knowing what's going on locally. Seeing whatever steps are proposed to deliver neighbourhood health, so we can be aware of, and contribute to shaping (and supporting?), the local changes to our services. And trusting they'll be genuine compliance with the Working in partnership with people and communities guidance. As the King's Fund describes one component of neighbourhood care: "Community-led approaches to care: making the voices of people and communities central to how health and care services are designed, delivered and evaluated"[13].

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Final comment – top down v. bottom up

The 10 Year Health Plan says

“Neighbourhood services will be designed in a way that reflects the specific needs of local populations. While we will be clear on the outcomes we expect, we will give significant licence to tailor the approach to local need”.

From a local patient perspective, there has to be a question-mark over whether this principle of subsidiarity will be fully manifested when the NHSE’s 2025/26 Neighbourhood Health Guidelines (NHG) say

“The focus in 2025/26 should be supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations”

followed by a list of nine strategic actions to be taken in the year that many neighbourhoods were just being established and an extensive list of six core components of a neighbourhood health service with all sorts of supporting guidance?

The NHF specifies an initial focus on four things: people with frailty and those needing end of life care, multiple long-term conditions, children and young people, and cancer (interestingly not entirely aligned with the NHG). It then says NHSE will produce, among other things, a best practice guide for frailty pathways, a new model for planned care, a model NHC (neighbourhood health centre) definition, and a series of modern service frameworks on core conditions for ICB commissioning.

This article was originally published on 19 December 2025 but has recently been updated and now includes consideration of the Neighbourhood health framework.

Mike Etkind is among other things chair of a GP surgery patient participation group, a volunteer with his local Healthwatch, formerly a representative on NHSE’s Primary Care Community Engagement Strategy Group, a public contributor for various healthcare research, and a member of the expert by experience group for the primary care curriculum at Oxford University medical school. All views are his own.

[1] Medium Term Planning Framework – delivering change together 2026/27 to 2028/29 . The MTPF also talks about taking steps “this winter”. And the 10 Year Plan says single and multi-neighbourhood contracts will be introduced by early 2026. On the other hand, the NNHIP refers to a “test-and-learn approach in partnership with communities” which suggests a more measured pace.

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[2]Neighbourhood health framework policy paper, published 17 March 2026

[3]Neighbourhood health guidelines 2025/26

[4]10 Year Health Plan for England: fit for the future

[5]NNHIF welcome pack. NNHIP is led by DHSC and NHSE in partnership with PPL (management consultancy), NAPC, and the NHS Confederation.

[6]Local Outcomes Framework, updated 12 February 2026, Ministry of Housing, Communities & Local Government.

[7]Guidance for Developing local Get Britain Working plans (England), Department for Work & Pensions, 3 April 2025

[8]Local Government Association Health and Wellbeing Committee 14 October 2025

[9]The Future of General Practice: NAPC's Perspective - NAPC

[10]February 2025 article for NHS Networks We said, we didn't

[11]NHS England » Working in partnership with people and communities: Statutory guidance

[12]Civil Society Covenant, Department for Culture, Media & Sport, 24 October 2025 states "We will… Promote participation and inclusion by involving people in decisions that affect their lives, ensuring their voices are heard".

[13]What Is Neighbourhood Health? | The King's Fund

Author
Mike Etkind

Developing Neighbourhoods - What is Health?

This blog can be seen as a video podcast at https://youtu.be/buE8E53bY2g

Multidisciplinary teams are needed in healthcare, to do different jobs. But high-performing teams need more than jobs to do. They need shared vision and shared projects that develop team-skills with respect for, and understanding of, each other. HEALTH is meant to be that shared vision. But different people mean different things by health.

As Julian Tudor Hart pointed out, a major obstacle to answering the question: What is Health? is the reductionist approach to thinking that imagines that things exist as isolated fact(or)s, and change is a linear process of cause & effect. This leads to a disease-focused mindset. But health is much more than the absence of disease.

The reductionist mindset imagines that things are static – at times this can be useful. But it does not help to see the co-creative nature of life, nor how to collaborate for care, nor how to stimulate inner healing. It sees diseases, but not Health.

Anyone of experience knows that health is whatever people need to navigate the dynamic nature of life, recognising that different things are inter-linked, and people see what they want to see. Heisenberg said - what we see is nature filtered by our way of looking. Kierkegaard said - most people mistake the certainty seen with hindsight with the uncertainty of living life forwards. Donne said: Send not to know for whom the bell tolls…. Yet, many people (and many doctors) **still** expect to find simple, 'logical', linear relationships between specific causes and specific effects.

Recognising that what we see, and do, are snapshots of complex stories-in-evolution could resolve the tension between static and co-creative images of the world. Fritjof Capra shows that everything is constantly adapting to everything else - if things look still, we are watching slow movement. Neuroscientists like Candace Pert and Bessel van der Kolk show that external stimuli, like stress or friendship, stimulate neuro-chemicals that can harm or heal. Laughter may, after all, be the best medicine!

But if health is more than the absence of disease, what is it?

MacIntyre argues that humans are 'storytelling animals'. Each of us has multiple story-strands running through us and we jump between them and intertwine them, to define who we are. Bio, and psycho, and social, and spiritual, and environmental

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aspects of health can all help or hinder my efforts to develop my meaningful life story. This chimes with the idea put forward by Seedhouse - health is the foundations for achievement; and Antonovsky - health is rising above adversity.

I like to think that I am the lead actor in the 'feature film' that is my life story, and the co-actor in the 'feature films' of others. When strands in my life story resonate or entwine with others, I start to consider myself to be part of them – my 'family', my 'friends', my 'tribe'. It can be called 'love'. Health is whatever helps me to make good next steps in my life story.

Reductionist mindsets lead to a belief that things can be improved simply by **fighting against** a dis-ease. But life is more complex than this, and combat is often self-defeating. Certainly, there are bad things to fight against, and some people want to blame other(s) when things don't go the way they want; but we must also recognise that health means being able to make good come out of difficult situations, including **meaningful** stories; addressing **many problems** at the same time; helping **hope** to flourish and **'I's' to become 'We's'.** The importance of meaning, coordinated initiatives, hope and community is particularly obvious in difficult situations.

Truth and Reconciliation Commissions have worked in difficult situations in over 50 countries to resolve conflict. They dramatically show the health-promoting effects of moving from a sense of 'I' to a sense of 'We'. Using the theory and practice of Restorative (perhaps better termed Transformative) Justice, they devise ways for victims and perpetrators to see each other's points of view. In less dramatic ways, Neighbourhoods can use difficult situations to develop communities of hope.

End-of-life care is always difficult. A healthy death helps all involved to develop a community of hope around the situation. Students, practitioners and citizens can contribute, and learn what health means at a deep level. When my wife was dying, support from my children's friends & their parents, teachers, friends and many others, helped us to develop a community of hope around our home. Parties, music and rotas of helpers helped 100 people to develop as a community of hope and contribute to a 'healthy death'.

Neighbourhoods could support health workers and Carers (not just end-of-life Carers) to develop communities of hope around their homes. This would help Carers to do their difficult jobs with greater confidence, help professionals to build multidisciplinary teams for those who most need their help, save overall costs, and develop community-oriented integrated practice throughout society.

Continued...

Further Resources:

Julian Tudor Hart. A New Kind of Doctor

Fritjof Capra. The Web of Life

Candace Pert. Molecules of Emotion

Bessel van der Kolk. The Body Keeps the Score

Alasdair MacIntyre. After Virtue

List of truth and reconciliation commissions - https://en.wikipedia.org/wiki/List_of_truth_and_reconciliation_commissions

Paul Thomas. Facilitating healthy deaths at scale www.magonlinelibrary.com/doi/full/10.12968/bjcn.2022.27.9.432 .

PCC is supporting neighbourhood development. We provide action learning sets for groups to work through challenges and learn with and from one another; facilitated sessions to help establish and develop collaborative working and leadership development training to increase confidence and competencies in the skills required to work together differently. Additionally, we've developed a new training programme for those working across neighbourhoods to focus on recognising the value and strength of collaboration and the behaviours required. Our coaches are also on hand to work with you – providing a space to explore new ways of working and your place in the changing environment.

Message helen.ellis@pcc.nhs.uk today to find out more.

Author
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in collaboration with the Journal of Holistic Healthcare & Primary Care Commissioning

GMS contract 2026/2027 – reflections

Consultation on the recent GMS contract was managed by NHS England (NHSE) and the Department of Health and Social Care as usual with the BMA hosted GPC the trade union for all GPs, though unusually this year was the first to include a wider stakeholder consultation with the Institute for General Practice Management, Royal College of GPs (RCGP), National Association of Primary Care (NAPC), Healthwatch England, National Voices, and the NHS Confederation. I won't reprise the lengthy contract details which no doubt you will have read.

To summarise:

- includes a 3.6 per cent cash uplift (£485 million) to the core GP contract: a smaller increase than the £969 million (7.2 per cent) increase in 2025/26.
- Funds from the PCN-level Capacity and Access Payment have been repurposed to a practice-level reimbursement scheme, aimed at increasing GP capacity, worth £292 million.
- Practices must provide a same-day response for clinically urgent patient requests and may not ask patients to contact practices at a later date.
- In 2026, NHS England will collect practice-level data on access and demand to evidence future interventions.
- New requirements have been introduced for patient choice and practice-level communication with community pharmacy.
- PCN responsibilities regarding vaccinations, cancer screening, continuity of care, and neighbourhood geography have been more clearly defined.
- The Additional Roles Reimbursement Scheme is expanding to include greater flexibility of roles, and to remove restrictions around employing GPs on the scheme.

The contract rejected by the BMA will be imposed in England on 1 April 2026, which inevitably has produced a hostile response from many trade union oriented GPs.

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NHS England dispassionately comments ‘changes to the contract continue to build on the changes you have made over recent years, particularly those that have improved access for patients; three-quarters of patients now say it is easy to contact their GP. Our focus this year is GP capacity, supporting the shift from treatment to prevention through changes to the Quality and Outcomes Framework (QOF) and vaccinations and enabling practices to prioritise clinically urgent needs’. Of the consultees the two most GP related organisations and of which I am a member expressed cautious support. NAPC talks of an opportunity to signal realism and reciprocity, welcoming ‘some important feedback from across the system has been heard’. The RCGP the GP college, has a positivity about the direction of travel although wishing more resources. Every official body perennially has the urge to caveat usually about money. The context currently is a government cash strapped in a world heading for serious recession who has disproportionately monied the NHS and offers primary care a historically lead role. If I was an unretired GP I would approve this contract.

I was a GP for 36 years in an area of deprivation and usually found, as did my GP partners, the GMS contract usually of only cursory significance. Content with income and focused on trying to ensure the practice offered quality care when many in poor economic environments were and indeed still are not well served. We majored on long term conditions (LTC) a cause of significant health inequality, particularly those with co-morbidities. We pioneered in UK general practice a nurse case manager for this group of patients which eventually became government policy as community matrons. The 1990 contract produced huge GP negativity, yet our practice received payments for our previously unfunded LTC work. We supported the contract and I welcomed the clear accountability inherent in it. Subsequently the 2004 contract introduced the Quality and Outcomes Framework strongly supported by the GPC which incentivised better Long-Term Conditions care. This also met with the opprobrium of many GPs and academics for being too directive. So, the usual GMS negotiations ‘bun fight’ leaves me unmoved. Many policy developments are opposed by some part of the GP oppositionist movement – for example fundholding and the current NHS 10 Year Health Plan with its three abiding principles, despite those policies offered/offering GPs empowerment and fulfilment. It’s clear there are two groups of GPs at different ends of a spectrum with the majority somewhere in the middle. The trade union end focusing on pay and conditions with a sense of grievance and a feeling of entitlement, and on the other end those driven by a more visionary view of primary care within which population based general practice is the bedrock. Even the latter can be divided between those that oppose co-operating with ‘the government’ and those who recognise many policies are supportive of GP practices. Engaging GPs across the whole spectrum presents a conundrum for policy

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makers, the NHS, support services such as PCC and even on occasions the BMA/GPC itself.

Attempting to address the conundrum, I am currently working with GPs and academia to explore what may further advance primary care and are surprised that the only GP contract apparently on offer seems to be GMS. For most of general practice that contract certainly suffices once the noise evaporates, but the energetic innovators and social entrepreneurs who will push policy on would wish a more empowering contract. PMS and APMS contracts should be retained to reinforce subsidiarity and release the energy that previous policies achieved. I find involvement in policy development exciting; well aware this is not a majority view but then I as others of that ilk 'always look on the bright side of life'. Why not it's more fulfilling?

This blog contains personal views of Professor David Colin-Thomé, chair of PCC. PCC supports primary care providers and commissioners for more information contact enquiries@pcc-cic.org.uk or visit www.pcc-cic.org.uk

Author
David Colin-Thomé
Chair of PCC

Event services

Are you planning a small event or a major conference?

Whether it be an in-person, online or hybrid event, let PCC take the strain of planning, logistics and on-the-day support.

Our services include but are not limited to:

- Event design and programme development
- Virtual and hybrid event platforms
- Speaker liaison and management
- Event marketing and promotion
- Stakeholder engagement
- Venue search and contract negotiation
- Delegate registration and online booking systems
- On-site event management
- Health and safety management
- Facilitation and chairing support
- Event evaluation and reporting
- Supplier sourcing and management

Questions from our primary care helpdesk

- Do you know the answers?

Premises

When dealing with the rent review determination for GP practices, if a practice has not responded within the 12 week timeframe are there any actions which can be taken? Do we assume acceptance and amend the payments?

Dental

What is the difference between a dental corporation and a company limited by shares in relation to the Personal Dental Services (PDS) Agreement?

Pharmacy

An application for inclusion in a pharmaceutical list in respect of distance selling premises (DSP) was received before the regulations were amended last year. It was granted and we are waiting for the applicant to submit their notice of commencement.

The applicant has been in touch asking to open in different premises to the one included in the application. Can they do that?

For answers to these questions download the helpdesk FAQ here.

Our contracting helpdesk is open to commissioners who are annual contract holders with helpdesk included in their contract. For details on annual contracts visit https://www.pcc-cic.org.uk/annual-contracts/. Our experts can work with ICBs to manage contracting issues. To discuss contact enquiries@pcc-cic.org.uk.

Upcoming PCC Events

GP premises reimbursement explained: requirements and practical application

Tuesday 28 April and Thursday 30 April

Online training session

https://www.pccevents.co.uk/3517

The confident leader programme

Thursday 30 April to Wednesday 25 November

Online training session

https://www.pccevents.co.uk/3511

Building confident leading women programme

Wednesday 27 May to Tuesday 10 November

Online training session

https://www.pccevents.co.uk/3514

Strategic commissioning and integrated care delivery programme

Tuesday 2 June to Tuesday 18 August

Online training session

https://www.pccevents.co.uk/pcc/3554

Full events calendar https://www.pccevents.co.uk/calendar

PCC welcomes your news for future editions of PCC Insight—if you have something to share or would like to contribute an article please let us know enquiries@pcc-cic.org.uk

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