Independent Healthcare Providers Network

At scale independent healthcare providers: How can they help shift care to the community?

January 2026

Executive Summary

The Government's aim to shift more patient care into community settings is a fundamental part of its Ten Year Plan for Health in England. Its intention to create a "Neighbourhood Health Service" has placed the role of primary and community care providers under renewed focus. Moreover, with a significant rise in the numbers of children and adults waiting for more than a year for community health services, and an ambitious new target for 80% of patients to access community treatment within 18 weeks, it's vital that more capacity and resources are brought into the sector.

Independent health care providers working at scale are perfectly placed to apply their national-level understanding of what works when delivering services to local needs, supporting consistency of provision and improving patient outcomes and experiences.

The Ten Year Plan for Health reinforces the government's commitment to the 'three shifts' it wants to see the NHS make, including for more care to be delivered closer to patients' homes. Many independent sector organisations are already leading the way in this area, highlighting the role they can play in turning the Plan into practice.

The value at scale providers can offer is not only about the direct delivery of care. These organisations are well-placed to use their knowledge, experience and organisational resilience to act as anchor providers within a neighbourhood system, invest both financially and in new services and provide leadership and support to other primary and community providers. Beyond a single neighbourhood, these providers additionally have the experience to successfully manage multi level neighbourhoods bringing experience and knowledge including on how to effectively manage a complex supply chain.

This briefing highlights just some of the ways in which independent sector providers working at scale are already shaping neighbourhood working, to the benefit of both patients and NHS partners.

Introduction

In contrast to the NHS hospital sector, the delivery of the majority of primary and community care services – ranging from GPs to optometrists, pharmacists, allied health professionals and nurses – has often been carried out by independent healthcare providers. Traditionally these providers have been small businesses, such as the stereotypical GP partner-led doctor's surgery or local community provider.

As demand and pressures have grown on healthcare of all types, focus in recent years has shifted to how care can be delivered more consistently by larger footprints and structures, helping to provide additional resilience and expanding the services people receive. Many independent sector providers operate at scale – whether within regional geographies or nationwide, in order to better respond to business and patient need. Organisations such as Specsavers provide community audiology services across over 900 sites around the UK, while others such as Cora Health and One Medical Group work across multiple Integrated Care Boards, providing services in areas covering around 10% of the population nationally. Working at scale can also be seen in more geographically focused ways, meeting patient needs in particular counties, such as PHL Group's work supporting people in Hampshire and the Isle of Wight. In NHS policy, this has included the formation of primary care networks, neighbourhoods and place-based partnerships, all acting as smaller footprints closer to the delivery of care under overarching, strategic, integrated care systems.

This year alone, NHS England has set out the model blueprint for integrated care boards' operations in the future, moving from provider management to strategic commissioning and passing on responsibility for primary care services to new neighbourhood care providers, and published the Ten Year Plan for Health, which calls for multidisciplinary teams working within neighbourhoods, with specialists working closely together in local communities, in order to help create a 'Neighbourhood Health Service' and 'end outpatients as we know it by 2035'.

The plan has also set out two new forms of contract, the first to create 'single neighbourhood providers' that deliver enhanced services for groups with similar needs over a single neighbourhood (c.50,000 people), and the second to create 'multi-neighbourhood providers' (250,000+ people).

Multi-neighbourhood providers will be responsible for "unlocking the advantages and efficiencies possible from greater scale, working across all GP practices and smaller neighbourhood providers in their footprint. They will support sustainability and professional autonomy by delivering a shared back-office function, overseeing digital transformation and estate strategy, and by providing data analytics and a quality improvement function."

While the form of these providers remains to be determined, Integrated Care Boards will be expected to procure neighbourhood health services from a wide range of NHS and non-NHS providers. Independent sector providers are already working in many of the ways that NHS England sees these new organisations operating, in providing leadership, resilience, additional capacity, population level insights, and supply chain management.

This briefing highlights some of the ways in which independent sector organisations are working at scale to support patients, to shift care out of hospitals and to use data and insight to improve outcomes, and recommends actions for policy-makers and commissioners to take advantage of the benefits at-scale provision can offer.

What are at scale providers?

While exact definitions of at-scale working are purposefully loose, the principles behind working at scale encourage providers to manage the health of their local populations through an integrated, team-based approach, supporting communities of at least 50,000 people. At scale provision can often include elements of population health management, such as greater use of data and analytics, to identify and target those most in need of health interventions, and involves those outside the traditional general practice model, such as social prescribers, physiotherapists, and pharmacists, working in multi-disciplinary teams (MDTs). Depending on the organisation, working at scale can build upon the existing partnership model (sometimes known as "super-partnerships") or existing structures such as Primary Care Networks, GP federations or other collaboratives, as well as single providers working across multiple sites.

Why are independent healthcare providers well-placed to lead neighbourhood health providers?

In speaking to providers for this piece, we heard that many saw at-scale organisations as better able to meet the demands of a changing healthcare landscape than more traditional, smaller providers. **They described their organisations as being able to combine the best of a larger provider – in terms of back office functions, efficiency, and financial resilience – with a clear focus on patient engagement and outcomes.** The benefits of working at scale are not only felt by service users, as they are large enough to attract, employ and train a wide range of staff, built around the needs of the populations they serve.

At-scale providers are able to invest in systems, processes, and skills, sharing this cost across their organisation, at a level that would be impossible for smaller local providers - while demonstrating that delivery, supported by this investment, can still be tailored and delivered locally. The additional benefit is improved consistency of the elements of delivery that can and should be standardised.

In turn, providers argued that they are able to apply levels of consistency of service to different areas, understanding and applying what works in pathway design across multiple contracts and areas. In doing so, they are able to add additional value through functions beyond the delivery of direct patient care. This included using data and insight to understand population needs and direct activity to address health inequalities, providing remote services and expertise to support primary care colleagues, or working across large geographies with acute providers to shift healthcare out of hospitals and into the community.

In some areas, at scale organisations are already working in ways which the Ten-year Plan would like to see adopted more widely, including working currently in the way that multi neighbourhood providers are being conceived. They are well placed to fulfil not only the move to a neighbourhood health service that the Government wants to make, but also work as strategic partners to NHS providers in improving patient outcomes. The case studies that follow explore the different ways in which at scale providers are already working to make this happen, and include examples of delivering population health approaches, of multiple organisations working together to centre care around patients, and of taking services out of hospital, reducing pressure on acute sites and providing care closer to home.

Case Studies: At scale providers

CASE STUDY 1: Shifting care 'left' and reducing hospital admissions

Cora Health, one of the UK's largest independent community health providers, provides a range of services including mental health, musculoskeletal, chronic pain and diagnostics. They serve over 700,000 patients per year across 26 ICBs in additional to delivering primary prevention and health literacy campaigns.

Since 2019, they have worked with Northumbria Healthcare NHS Foundation Trust on a Joint Musculoskeletal and Pain Service (JMAPS). In working together they've been able to capitalise on the strengths of both organisations, and work across the community and secondary care interface to shift care left, acting preventively to avoid hospital admissions. Patients are offered self-referral options for physiotherapy, reducing the need for GP appointments and relieving pressure on family doctors. Rather than waiting lists being managed by individual MSK departments, administrative processes were centralised and treatment offered both digitally and in community settings, making it easier for people to access care closer to home. All of this supported by systems, processes and infrastructure built at national scale.

"The power of having two organisations collaborate has allowed us to combine our resources and knowledge to deliver outstanding patient care and drive clinical quality."
Sir Jim Mackey, then Chief Executive, Northumbria Healthcare NHS Foundation Trust

As a result, in its first year referrals to secondary care orthopaedics were less than half of the national average, and the need for diagnostics reduced from 17-20% to 5.6%. This demonstrates the benefit of being able to work collaboratively, understanding patient need and in acting preventatively, rather treating ill-health.

Benefits for patients are also clear in taking this approach. In accessing community care and not needing to attend hospital appointments, patient Did Not Attends (DNAs) went down from 10% to 3%, patient reported clinical outcomes were well above national averages, and over 90% of patients would recommend the service to Family and Friends.

Case Studies: At scale providers

CASE STUDY 2: Using data to improve outcomes

Operose Health provide primary care services to over 700,000 registered patients across 82 locations in 16 ICB areas. They see over 250,000 attendances at their urgent care centres and support some of the most vulnerable people through their specialist GP surgeries.

As an at-scale provider, all of their locally-delivered services have access to centralised back-office functions, expertise, and technology that provider greater resilience and efficiency, including data and analytic support. This has included a study using Artificial Intelligence (AI) and big data analytics to identify at-risk patients.

They set up a polypharmacy case study, seeking to improve patient outcomes with proactive, structured medication reviews.

Their project found that AI improved patient outcomes by pre-emptively identifying high drug burdens, identified high-risk patient clusters using real world data, and allowed them to more quickly identify at-risk groups compared to manual methods. This AI-driven approach reduced labour intensity, enabling their teams to devote more time to high-risk patient support.

Further achievements using this population data led approach included:

- In 10 months they narrowed the blood pressure control gap between black ethnic and white ethnic patients from 12% to 3% in a neighbourhood.

- Risk stratified patients and produced personalised care plans for 95% of their high risk patients. These cases are reviewed in Multi-Disciplinary Team meetings to prevent hospital admissions by improving continuity of care. resulting in a 38% reduction in hospital admissions.

"Here at the Operose Health business intelligence team, we are pro-actively innovating and championing AI-aided health analytics for primary care. This latest study achievement confirms that our approach and investment will deliver better patient care and more effective use of clinical time and resources. This is a potentially game-changing study for patients and the NHS, and we will now look at how future studies will incorporate other measures such as age, gender, and location to enhance outcomes."

Case Studies: At scale providers

CASE STUDY 3: Working closely with other providers and reducing admissions

HomeLink Healthcare, a community healthcare provider specialising in Hospital at Home services, has worked across four trusts across a single ICS footprint to develop flexible ward pathways — both to help keep patients out of, and support timely discharge from, hospital.

The Norfolk & Waveney Integrated Care System (ICS) covers a largely rural area in the East of England. The widely dispersed population and long travel times, on mainly country roads, creates challenges in providing consistent community and home-based care. In addition, the relatively isolated location makes it hard to attract and retain sufficient numbers of community nurses, physiotherapists and healthcare assistants. Gaps in access to community care led to delays in discharging patients from hospital, with the inevitable impact on emergency admissions and electives.

The ICB commissioned HomeLink to provide pathways for patients who had no need to remain in hospital.

"***HomeLink gave us the ability to quickly respond to demand, flex up and down, and were invaluable in enabling us to meet varying complexity of needs***" NHS Trust Chief Operating Officer

A Virtual Ward was developed at Norfolk and Norwich University Hospitals in 2019 and findings were used to improve subsequent service development. Since 2020, HomeLink have worked with a team from the Trusts and ICB to design and create additional Hospital at Home services including treating patients with more complex needs. They have also provided short term wrap-around support to frail patients, to reduce hospital attendance, and to support independence.

Key achievements include:

- Over 67,000 hospital bed days saved across two Trusts
- 37,000 at Norfolk and Norwich University Hospital (Jan 2019 – Aug 2024)
- 30,000 at James Paget University Hospital (Mar 2020 – Aug 2025)
- Forecast £250,000+ cost savings over the current agreement period
- 24% improvement in patient-reported outcomes across all services in Norfolk & Waveney footprint
- 99% of patients would highly recommend the service (patients scoring them 8+ out of 10)

The collaboration has shown how pan-ICS contracting results in better value for the NHS and an excellent patient experience and outcomes.

Case Studies: At scale providers

CASE STUDY 4: Adopting population health management approaches within neighbourhoods

One Medical Group, a provider of primary care services across England, has recognised the need to treat wellbeing needs as well as medical ones through the establishment of Corby Urgent Care Centre (CUCC). Since 2019, CUCC has hosted a dedicated Wellness Hub within a repurposed consulting room, with the aim of reducing health inequalities, improving mental and physical health, and empowering patients to improve their overall wellbeing.

Corby's health profile highlighted that local residents experience significantly poorer health compared to the national average, with elevated rates of self-harm, alcohol-related hospital stays, sexually transmitted infections, obesity, and child poverty. CUCC identified that many patients attending had wider unmet needs beyond their urgent clinical presentations, including anxiety, low mood, social issues, and a lack of access to suitable support networks. A proportion of these individuals were also repeat attenders, reflecting systemic gaps in the wider healthcare and wellbeing infrastructure.

"***The Wellness Hub is here to support and empower our community to address life's challenges and meet their own wellbeing goals. We work collaboratively with patients and clinical staff to ensure person-centred, compassionate care is at the heart of everything we do.***" Patient Advisor, Corby Urgent Care Centre

Using a population health management approach, CUCC analysed patient presentations and designed an integrated response through its Wellness Hub. The service operates daily from 8am to 8pm and is staffed by two Patient Advisors with extensive experience and training in mental health, smoking cessation, pain management, domestic abuse, substance misuse, and more.

The Wellness Hub supports patients through:

- Wellbeing assessments and personalised goal-setting, using SMART planning and social prescribing techniques
- Direct support for issues such as anxiety, stress, and social isolation
- Connection with community services, including financial, housing, bereavement, and safeguarding support
- Liaison with clinical teams, ensuring cohesive care planning and continuity across services

The service has resulted in:

- Over 100 consultations per month, with steady demand since April 2020
- Positive patient feedback, citing empowerment, personalised care, and practical support
- Improved mood scores from initial consultation to final contact
- Reduction in inappropriate CUCC attendances via development of specialist pathways for frequent attenders
- Better continuity and engagement with specialist mental health services through joint planning and liaison

Case Studies: At scale providers

CASE STUDY 5: Supporting neighbourhood working through the Special Allocation Service

PHL Group, a UK leading independent healthcare provider, deliver the Special Allocation Service (SAS) across Hampshire and the Isle of Wight, ensuring vulnerable patients are able to access primary care across the county.

SAS exists to provide primary medical services to vulnerable patients who have been removed from mainstream GP services due to incidents of violence or aggression. SAS offers these individuals a safe, structured, and supportive environment in which they can continue to receive necessary healthcare. PHL Group's delivery of the SAS exemplifies how independent providers can act as 'anchor organisations' within a neighbourhood system. By investing in services that others may be unable to deliver alone, the SAS complements broader neighbourhood health goals.

This integration offers significant benefits:

- Resilience and continuity of care: SAS is not isolated, PHL Group ensures seamless referrals, coordinated care and wrap-around support for patients through its broader network.
- Multi-disciplinary support: Patients accessing SAS often have complex needs. PHL Group's wider clinical teams provide mental health, safeguarding and nursing input, reducing the risk of deterioration and hospital admission.
- Consistent governance and quality assurance: Operating at scale enables PHL Group to apply robust governance frameworks, shared learning and innovation across services and regions.

"By bringing together different services around the needs of our most vulnerable patients, PHL demonstrates what fully integrated, patient centred services can look like in action, helping people to receive treatment where they need it and when they need it."

A Patient Story

- A patient with a chronic leg ulcer had a brief stay in hospital due to infection.
- On discharge, his summary reported he was reviewed by the tissue viability (TV) team, and he was medically fit for discharge. On returning home he made an appointment with the SAS to say he had not been seen by TV and felt he needed help to prevent further deterioration.
- The TV team would usually see patients at their GP surgery. However, as an SAS referral there was no 'home clinic'. The TV nurse and the GP risk-assessed the patient and he was visited by TV at home where he was recommended in-clinic therapy.
- PHL's Out Of Hours service loaned a clinic room for his treatment and the district nursing and Tissue Viability teams worked together to treat the patient, integrating care around his needs and preventing further deterioration.
- Through joint working across PHL, the GP, TV, and district nursing teams, the patient received timely, coordinated treatment in the right setting, which not only prevented hospital readmission but also improved his confidence in managing his condition.

Recommendations

1: Governmental and NHS England policymakers, alongside ICBs, should work with the IHPN and its members to ensure their involvement in the implementation and delivery of both neighbourhood and multi neighbourhood provider contracts. Over and above this, as set out in the latest planning guidance, Integrated Care Boards should engage with independent and non-NHS providers to support effective system planning.

2: Governmental and NHS England policymakers should work with the IHPN and its members to ensure their involvement in the implementation and delivery of the 250 Neighbourhood Health Centres as well as the broader Ten Year Plan for Health and National Neighbourhood Health Implementation Programme (NNHIP).

3: Commissioners should further consider how they can encourage service innovation and contracts based on outcomes, in order to make the best use of the capability and capacity at-scale providers can offer.

4: Commissioners should work with at scale providers and other stakeholders to determine how minimum community standards look in practice, in terms of levels of service provision, scale and patient outcomes, and aim to collect and publish data nationally.

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