Royal College of General Practitioners (RCGP) organisational response to NHS England's consultation on proposed Multi-Neighbourhood Provider (MNP) and Single Neighbourhood Provider (SNP) contracting models to support neighbourhood health services

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About RCGP

We are the professional membership body for GPs in the UK. Our purpose is to encourage, foster and maintain the highest possible standards in general medical practice. We support GPs through all stages of their career, from medical students considering general practice, through to training, qualified years and retirement.

Proposed Multi-Neighbourhood Provider (MNP) and Single Neighbourhood Provider (SNP) contracting models to support neighbourhood health services

NHS England

To support neighbourhood delivery models, the 10 Year Health Plan committed to developing new contracts based on population size. This consultation seeks views on two proposed contracting models: a Multi-Neighbourhood Provider (MNP) Contract and a Single Neighbourhood Provider (SNP) Contract. It sets out the proposed models and seeks views on their potential benefits, risks and practical implications, including how they would interact with existing contractual and commissioning arrangements.

The proposals do not change the core GP contracts (GMS, PMS or APMS), or the core services currently commissioned through them.

Consultation questions

Multi-Neighbourhood Provider Contract

1. **To what extent do you support or oppose the proposed approach of using the NHS Standard Contract with an additional "Neighbourhood" schedule for commissioning the Multi-Neighbourhood Provider?**

- **Strongly support**
- **Somewhat support**
- **Neither support nor oppose**
- **Somewhat oppose X**
- **Strongly oppose**

Please explain your answer (max 1250 characters):

We, the RCGP, support better integrated neighbourhood care but do not support the proposed contracting models in their current form. Adding another contractual layer risks increasing complexity without addressing the underlying barriers to effective neighbourhood working: workforce shortages, capacity constraints, funding pressures and fragmented operational systems.

We are particularly concerned that the lead provider model could weaken the role of general practice, moving practices from being contract-holding organisations responsible for their registered populations to subcontractors within an MNP, particularly where the lead provider is a non-primary-care organisation. There must be clear safeguards to ensure that primary care functions within MNP scope are designed around and protect the registered list and longitudinal and coordinating role of general practice.

The starting point must be a clear national vision for neighbourhood working, defining which functions need to be delivered at practice, neighbourhood and multi-neighbourhood level, and which problems cannot be addressed through existing arrangements. Organisational and contractual form should follow these functions, rather than precede them.

2. **Which of the following statements do you most agree with?**

- **There should only be one MNP for each geography covering all services that the commissioner wants to commission via the MNP Contract**
- **It should be for commissioners to determine the number of MNPs in each geography**
- **I do not agree with either of these statements X**

Please explain your answer (max 1250 characters):

We do not support the proposals in their current form. Our response considers their implications if they went ahead.

A single MNP for each geography could create a monopoly, while unrestricted commissioner discretion may favour administrative convenience over the most appropriate local arrangement. Population size, geography, provider landscape and existing relationships vary across systems, making a single mandated model unlikely to

work everywhere. Multiple MNPs in the same area could also create duplication, silos and friction rather than genuine integration.

The number and configuration of MNPs should reflect local geography, population need, the functions that genuinely require delivery or coordination at multi-neighbourhood scale, and existing provider relationships. Existing practice-led neighbourhood arrangements must be given significant weight.

Commissioners should consider viable practice- or federation-led alternatives before determining the number and configuration of MNPs. This would help avoid larger organisations being structurally advantaged.

The configuration should follow the functions required and local population need, rather than the organisational model determining how services are subsequently arranged.

3. **To what extent do you agree or disagree with the primary medical care elements of neighbourhood services being sub-contracted by the Multi-Neighbourhood Provider to Single Neighbourhood Providers?**

- **Strongly agree**
- **Somewhat agree**
- **Neither agree nor disagree**
- **Somewhat disagree X**
- **Strongly disagree**

Please explain your answer (max 1250 characters):

While there may be circumstances where coordinated delivery is helpful, primary medical care should not become a subcontracted component of a wider MNP contract, particularly where the MNP is not a primary care organisation. This risks weakening the direct relationship between practices and commissioners and creating additional layers of contractual and clinical accountability. Practices would remain responsible for the longitudinal care of their registered patients while potentially having less control over service design, workforce, resources and clinical governance. It could also create duplication between existing arrangements and an MNP subcontract.

If at-scale coordination of primary medical care is required, we would favour direct arrangements between commissioners and SNPs or practice-led federations, with MNPs focusing on functions that genuinely benefit from multi-neighbourhood-level coordination. Any arrangement should ensure that funding, workforce, clinical responsibility, information governance and accountability are aligned, with practice involvement in service design and resource allocation.

If MNP contracts proceed, there should be an independent mechanism for resolving disagreements between practices and MNPs.

4. **To what extent do you agree or disagree that the proposed contracting model, and the interaction with Single Neighbourhood Providers would create more integrated commissioning arrangements?**

- **Strongly agree**
- **Somewhat agree**
- **Neither agree nor disagree**
- **Somewhat disagree X**
- **Strongly disagree**

The starting point must be to define which functions need to be delivered at practice, neighbourhood and multi-neighbourhood level, and which problems cannot be addressed through existing plans. Organisational and contractual form should follow these functions rather than precede them.

More integrated commissioning will depend on factors beyond contractual structure – leadership and collaboration, clear clinical responsibility and accountability, information sharing, adequate workforce and capacity, and interoperability. There must be clarity about the respective roles and accountabilities of ICBs, MNPs and SNPs, and which existing ICB functions, if any, are intended to transfer to MNPs and how such functions will be resourced.

There is a risk that MNPs become mechanisms for coordinating providers or transferring funding and activity, rather than improving patient care. Neighbourhood services must not shift secondary care activity into the community without the necessary workforce, infrastructure, funding, and GP leadership and codesign.

Without clarity about functions, responsibilities and accountability, the proposed model risks adding new contractual and organisational interfaces, not achieving more integrated commissioning.

Integrated Neighbourhood Team (INT) commissioning

5. **Which of the options would you favour in your geography?**

- **Option 1 - commissioning coordination and fill in provision through an MNP X**
- **Option 2 - commissioning through a lead provider**

Please explain your answer (max 1250 characters):

Option 1 offers greater scope to retain existing provider relationships, expertise and accountability, while allowing the MNP to coordinate functions that genuinely benefit from working at multi-neighbourhood scale.

Option 1 also preserves existing GMS, PMS and APMS contracts and allows the commissioner to retain a direct relationship with practices. This is preferable to Option 2, where a lead provider could concentrate control over commissioning, subcontracting and funding, potentially weakening general practice's influence. The lead provider model may also introduce an extra and costly layer of bureaucracy.

Before introducing any new contractual layer, there must be evidence showing which barriers to integration cannot be addressed through strengthened general practice, PCNs, federations, existing commissioning arrangements and contractual collaboration.

Our preference for Option 1 must not be interpreted as support for the proposed MNP contracting model in its current form. However, if it is to go ahead, the MNP should have a defined coordination and fill-in role, adding value where services genuinely require multi-neighbourhood-level coordination, while primary medical care remains directly commissioned and practice-held.

6. **Are there other options we should consider (max 1250 characters)?**

We believe a further option should be considered: strengthening existing primary care-led organisations and models of collaboration rather than creating additional organisational structures.

Practices, PCNs and federations already provide population-based neighbourhood care and, with appropriate budgets, authority and support, could take on a greater role in coordinating multidisciplinary teams and local services. Alternative models should therefore be explored, including whether appropriately designed capitated or delegated budgets for primary care-led organisations could provide greater flexibility to organise care around the needs of organisations' registered populations without creating additional organisational layers. This could enable resources and responsibility for defined neighbourhood functions to sit closer to the teams delivering and coordinating care, with appropriate safeguards for clinical accountability, population need and financial risk.

Commissioning Primary Care Networks and Single Neighbourhood Providers

7. **Which of the following do you most agree with?**

- **All three options should be available to commissioners**
- **Only options 1 and 2 should be available to commissioners**
- **Only options 2 and 3 should be available to commissioners**
- **Only option 1 should be available to commissioners**
- **Only option 2 should be available to commissioners**
- **Only option 3 should be available to commissioners**
- **I don't agree with any of the options X**

Are there other options we should consider (max 1250 characters)?

An alternative approach would be to build neighbourhood health on the foundations of strong general practice and existing primary care-led organisations, rather than relying primarily on new provider contracting models to drive transformation. This should include strengthening the capacity of practices, PCNs and federations to deliver and coordinate defined neighbourhood functions, with appropriate resources and authority.

This should be supported by a national primary and community care investment standard that sets out a published trajectory for increasing the proportion of NHS resources reaching general practice, primary and community care, alongside protected investment in core general practice, appropriate transformation funding, and a limited set of realistic, measurable and independently evaluated outcomes against which progress can be monitored.

This approach would provide a more consistent national framework while allowing local systems flexibility in how they organise and deliver neighbourhood services. It would also address the underlying capacity and investment constraints facing primary and community care, rather than assuming that changing contractual structures will create additional capacity or improve outcomes.

8. **To what extent do you agree or disagree with practices being given the ability to "opt into" Single Neighbourhood Provider arrangements (noting that we do not think Primary Care Networks and Single Neighbourhood Providers should co-exist in the same geography)?**

- **Strongly agree**
- **Somewhat agree**
- **Neither agree nor disagree X**
- **Somewhat disagree**
- **Strongly disagree**

Please explain your answer (max 1250 characters):

We are not convinced that the proposed arrangements constitute a neutral choice for practices. The consultation suggests that where a practice does not opt into part of the SNP Contract, the MNP would be required to provide those services to that practice's patients. Non-participation does not therefore necessarily preserve existing arrangements. Plus, the proposed non-co-existence of PCN DES and SNP arrangements within the same geography could remove existing alternatives.

We understand the GMS Contract will remain; our concern relates to wider services currently delivered through the PCN DES. There should also be clarification that SNPs would be GP-led and could not be taken on by other organisations.

It is helpful to know that an MNP must have the support of subcontractors to secure the contract, but clarity is needed on how this support will be defined – how many supporting subcontractors are required – and how practices can decline participation without services being transferred by default.

Where practices do not wish to move to an SNP, there should be a clear process for addressing the reasons and, where appropriate, for the ICB to support and incentivise locally agreed change – not relying on contractual pressure.

9. **Are there other options we should consider (max 1250 characters)?**

An alternative would be to allow practices, PCNs and federations to participate at different levels according to local readiness and capability, with neighbourhood arrangements evolving over time rather than through wholesale structural replacement.

If SNPs are to be developed, they should be genuinely primary care-led, with meaningful GP ownership and leadership. This should include the opportunity to bring together services that are complementary to primary care, including relevant community services, where this would improve continuity and coordination of care.

This would build on existing primary care relationships rather than transferring responsibility to large organisations with limited experience of neighbourhood-based primary care. It would also preserve the clinical leadership, professional autonomy and population-based accountability that are strengths of general practice and remain essential to attracting and retaining a high-quality GP workforce.

Procurement and overall feedback

10. **What might we need to do to make procurement as fair and as simple as possible (max 1250 characters)?**

Before considering how to make procurement fair and simple, commissioners should establish whether procurement is necessary and whether the anticipated benefits justify its financial and administrative costs. Where existing primary care-led arrangements can deliver the required functions effectively, these should be built upon rather than creating avoidable procurement and transaction costs.

Procurement, where required, should be proportionate and transparent, with standardised documentation, clear national guidance and proportionate eligibility and evaluation criteria. Requirements should recognise existing partnerships, community relationships, clinical integration and delivery capability, and should not structurally disadvantage smaller, practice-led organisations in favour of organisations with greater scale and infrastructure.

There should be safeguards against conflicts of interest and excessive provider concentration. Where direct award routes are used, the rationale and criteria should be transparent. Existing GMS, PMS or APMS contracts should not be put at risk through procurement for neighbourhood services. Triple bottom line assessment for spending in line with Treasury Green Book guidance should be ensured.

11. What barriers may smaller organisations face bidding for an MNP Contract and how could these be resolved (max 1250 characters)?

Smaller organisations may face significant barriers compared with NHS Trusts and larger providers, such as limited procurement and bid-writing capacity, lack of specialist legal and contract-management expertise, difficulty demonstrating financial resilience at scale, and the cost and complexity of forming partnerships and preparing bids.

There is a risk that procurement criteria favour organisational size, balance sheet strength and experience of managing large contracts, rather than clinical quality, financial discipline, ability to deliver continuity of care and existing relationships.

These barriers could be addressed through appropriate procurement support for GP-led bidders, proportionate financial and capability requirements, allowing federations to bid as consortia without requiring unnecessary organisational restructuring, and evaluation criteria that recognise existing patient relationships and neighbourhood expertise. Reasonable procurement timeframes would help ensure that smaller organisations are not disadvantaged.

Commissioners should avoid designing contracts that could realistically only be held by large organisations. The ability to deliver high-quality, integrated neighbourhood care should be key.

12. How should MNPs be required to demonstrate the support of general practice in the procurement process (max 1250 characters)?

If MNPs proceed, they should be required to demonstrate genuine, broad and informed support from general practice across the relevant neighbourhood, rather than relying on support from a small number of practices.

This should include:

- meaningful GP representation and influence in MNP governance and decision-making, including appropriate GP leadership or co-leadership;
- evidence of support across all constituent practices through a transparent and agreed process;
- evidence that practices have had meaningful involvement in developing the service specification and have agreed the proposed funding, workforce, governance and clinical responsibility arrangements before providing support;

- clear arrangements for information sharing, interoperability and resolution of disagreements; and
- ongoing GP representation and influence throughout the contract, with support reviewed at renewal.

The process for demonstrating support should be transparent, independently verifiable and based on current, documented evidence. This would help ensure that GP support is substantive and informed, rather than simply a procedural endorsement of a proposed MNP model.

13. What additional support may commissioners require (max 1250 characters)?

If the proposals proceed, commissioners will need national guidance and practical support on contract management, governance, procurement, risk-sharing, workforce implications, performance measurement and financial modelling. This should include clarity on the respective roles and accountabilities of ICBs, MNPs and SNPs, including any transfer of ICB functions to MNPs, and their interaction with GMS, PMS, APMS and existing PCN arrangements, including the proposed minimum investment equivalent to the PCN DES, and how its value will be maintained over time.

Dedicated procurement and ongoing contract management capacity will be needed, including expertise in primary care and the Provider Selection Regime. National consistency will be vital to avoid differing interpretations between ICBs, supported by clear legal guidance and an escalation route where agreed safeguards or contractual requirements are not being upheld.

Commissioners will need guidance on how resources, workforce and activity can move from secondary care into neighbourhood settings while maintaining system stability. They would also benefit from access to population health intelligence, public health expertise and national guidance on health inequalities and equity.

14. Is there anything else we should be considering in relation to Multi-Neighbourhood and Single Neighbourhood Contracts (max 1250 characters)?

Without additional investment for these arrangements, and appropriate funding for double-running costs, there is a risk that scarce resources are diverted into procurement, contract management, re-organisation, administration and provider overheads. The costs of establishing and operating these new structures should be assessed against their anticipated benefits.

The relationship between neighbourhood contracts and nationally negotiated GMS, PMS, APMS and PCN arrangements must be carefully considered. Increasingly moving primary care funding and responsibilities into locally determined contracts could increase geographical variation and weaken consistent national entitlements and safeguards for practices and patients.

There must be robust contingency arrangements in place if an MNP was to become financially or operationally unviable, including protection of essential services and continuity of care. Practices should have a clear, time-limited route to exit arrangements that are not delivering.

MNP and SNP models must be piloted and independently evaluated before wider implementation. Evaluation should establish whether they improve patient care and outcomes and add value beyond strengthening existing arrangements.