BMA England

Focus on … NHS England neighbourhood provider consultation

Contents

What is the consultation about?

NHS England is consulting on two proposed contracting models intended to support the development of neighbourhood health services: a Multi-Neighbourhood Provider (MNP) Contract and a Single Neighbourhood Provider (SNP) Contract. The proposals sit alongside wider ambitions to shift care closer to home, improve prevention and support more integrated working across primary, community, mental health, acute, social care and voluntary sector services.

NHS England describes a neighbourhood as a local area organised around a defined population, commonly around 50,000 people, although local footprints may vary. ICBs, working with local authorities, health and wellbeing boards and other partners, are expected to agree neighbourhood footprints and develop integrated neighbourhood teams.

The outcome of the consultation could affect how enhanced neighbourhood services are commissioned, funded, governed and delivered. It may also affect the relationship between core GMS, PMS and APMS contracts, the PCN DES, locally commissioned services and future at-scale provider arrangements.

This guidance summarises the proposals set out within the consultation, along with key considerations when formulating a response, alongside the list of questions being asked.

The consultation closes on 10 Sep 2026 and submissions can be made here: A consultation on proposed Multi-Neighbourhood Provider (MNP) and Single Neighbourhood Provider (SNP) contracting models to support neighbourhood health services - NHS England - Citizen Space

It's expected that this consultation will be followed by further consultation on more detailed proposals. Given this we would strongly advise practices and PCNs from agreeing to neighbourhood working proposals until the consultation process is finished and full details are known

Why practices may be cautious about neighbourhood proposals

General practice has experienced successive waves proposed and actual organisational reform over the last two decades, including Darzi centres, new models of care 'vanguards', proposed multi-speciality counter provider models, PCNs and now proposed neighbourhood provider models. These have often been presented as a route to resolving pressure in primary care, yet the recurring problems of workload, workforce shortages, constrained premises, access pressures and underinvestment have remained substantially unresolved for many practices.

This context matters because confidence in further structural change has been weakened by previous promises. Practices were told that ARRS would relieve workload, but many have instead taken on additional supervision responsibilities while struggling to recruit GPs, with newly qualified GPs facing unemployment or underemployment in some areas. Digital access and online consultation systems were proposed to improve efficiency, but have often generated extra demand without requisite safeguards for workload or patient safety. Work also continues to be transferred into general practice without adequate funding or contractual support.

If practices are expected to be central to neighbourhood provider models, they **must** have certainty that this time will be different. NHS England and DHSC should demonstrate clearly how any model will improve patient outcomes, reduce avoidable GP workload, and protect core general practice before implementation is expanded.

NHS England's proposed contractual options

Multi-Neighbourhood providers

MNPs (multi-neighbourhood providers) are expected to work within multiple neighbourhoods, covering a footprint of approximately 250,000 people or more, designing and co-ordinating neighbourhood health services in this geography. This may include delivering NHS services across multiple neighbourhoods, or 'filling in' services within a neighbourhood when deemed necessary.

These contracts would be awarded to legal entities which could include primary care organisations (e.g. GP Federations), limited partnerships, community interest companies or NHS trusts. NHS England has proposed that the enhanced primary care elements of neighbourhood services would be subcontracted by MNPs to SNPs, with ICBs determining which SNPs would be subcontracted. The consultation document sets out two options for MNP commissioning arrangements, with a recommendation around implementing them sequentially. These options include commissioning MNPs to:

- Coordinate the delivery of services across existing contracts and resources
- Deliver all elements of neighbourhood services, sub-contracting SNPs and other providers.

Multi-Neighbourhood Provider Option 1: coordination model

What NHS England is proposing

Under the first MNP option, the MNP would act primarily as a coordinator across several neighbourhoods. Existing contracts with practices, PCNs, community providers and other organisations would remain in place. The MNP would help providers work together, support consistent service design, coordinate pathways across a larger population, and potentially fill gaps where a service needs to operate across more than one neighbourhood or where no single neighbourhood provider is able or willing to deliver it.

A key principle is that existing contracts should remain genuinely protected, including core GMS, PMS and APMS contracts, the PCN DES, QOF, ARRS funding and locally commissioned services. The protection of locally commissioned services is particularly important, as local general practice budgets should not be absorbed into wider MNP arrangements without explicit agreement and ringfenced resource.

This option is likely to be the least disruptive form of MNP because it does not require new corporate or commissioning structures. However, it would still create a new at-scale role above individual neighbourhoods and would need clear governance, funding flows and accountability arrangements.

Where there are established GP federations or other GP led structures these could put themselves forward for this role, coordinating local services on behalf of practices

Illustrative example: An ICB commissions an MNP across five neighbourhoods to coordinate urgent community response, care home support and access to diagnostics. Existing GP, PCN, community and voluntary sector contracts remain in place. The MNP convenes providers, agrees common pathways, manages shared data and reporting, and commissions limited “gap-filling” provision where a service needs to operate across several neighbourhoods.

Potential benefits for general practice

- Could support better coordination across services without immediately dismantling existing practice, PCN or community service contracts.
- May give practices a clearer route to influence wider pathways that currently sit outside their control, such as community response, frailty, diagnostics or mental health interfaces.
- Could help standardise access and referral routes across neighbourhoods, reducing variation for patients and administrative complexity for practices.

- May create opportunities for GP federations or GP-led provider organisations to undertake coordination or gap-filling functions, if procurement and governance requirements are proportionate.

Potential risks for general practice

- The MNP could become an additional management layer, adding meetings, reporting and bureaucracy without removing existing contractual complexity.
- Practices may be expected to participate in new pathways or provide additional activity without separately funded capacity.
- If the MNP is hosted by a trust or large incumbent provider, GP influence may be limited unless governance safeguards are explicit.
- Unclear accountability could lead to practices being blamed for pathway failures caused by services or providers they do not control.
- "Gap-filling" functions could expand over time into de facto service transfer without proper consultation, funding or contractual protection.
- Over time it could move towards a stronger contractual model, which may impact on core GP contracts

Multi-Neighbourhood Provider option 2: lead provider model

What NHS England is proposing

Under the second MNP option, the MNP would act as a lead provider across multiple neighbourhoods. It would take responsibility for delivering a wider set of neighbourhood services, potentially through an outcomes-based NHS Standard Contract. Existing neighbourhood service contracts could be brought together under the MNP over time, where existing contractual terms allow or as contracts expire. The MNP would then sub-contract with SNPs, GP organisations, community providers and other partners.

This is the more significant MNP option. It could give one organisation greater control over resources, delivery and outcomes across several neighbourhoods. It could also shift commissioning risk and service accountability into a single at-scale contract.

A particular concern is that budgets could be devolved to an MNP and then subcontracted onwards, leaving general practice dependent on decisions made by the lead provider and potentially disadvantaged if funding is absorbed elsewhere in the wider system. Any lead provider model would therefore need transparent funding flows, ringfenced general practice resource and clear safeguards against the loss of practice income or influence.

Illustrative example: An ICB awards a lead provider MNP contract for a 300,000 population covering enhanced access, urgent community response, proactive frailty care, long-term condition support and elements of community nursing coordination. The MNP holds the NHS Standard Contract and sub-contracts with SNPs, GP federations, community services and voluntary sector partners. Funding and performance requirements are held in the lead contract, with local providers delivering specified elements.

Potential benefits for general practice

- Could bring together fragmented local services into a clearer, population-based contract with more coherent funding and delivery expectations.
- May support stronger at-scale GP leadership if a GP federation or GP-led collaborative is able to hold or meaningfully shape the lead provider contract.
- Could enable investment in services that relieve pressure on practices, such as community response, diagnostics, enhanced access or specialist advice, if properly funded.
- May provide more leverage over non-GP providers than practices currently have when trying to resolve pathway failures.

Potential risks for general practice

- Large trusts or other incumbent providers may be better placed to bid for and hold lead provider contracts, with practices relegated to sub-contractor status.
- Practices could lose influence over funding and service design if resources flow through an organisation that is not GP-led.
- Sub-contracting arrangements could transfer delivery obligations, financial penalties or performance risk to practices without adequate control or funding.
- Outcomes-based requirements could expose GP organisations to risks driven by wider system pressures, workforce shortages or social care capacity.
- Existing local services could be reconfigured or terminated without sufficient protection for practice income, workforce stability or patient continuity. For example, local contracts could be withdrawn from practices and commissioned ‘at scale’ with the MNP.

Single Neighbourhood Providers

SNPs (single neighbourhood providers) are expected to deliver enhanced primary medical services through INTs (integrated neighbourhood teams) within a single defined neighbourhood of around 50,000 people. For context, a primary care network (PCN) typically covers 30,000 – 50,000 patients.

The aim of SNPs would be to take on new neighbourhood services not currently covered by or contracted for through existing GP contracts, and work with practices to ensure service delivery.

The SNP (Single neighbourhood provider) contract is intended to be an "evolution" from the PCN DES (primary care network direct enhanced service). It is proposed that SNP contracts be awarded to "all eligible providers", subject to eligibility criteria (of which having access to the patient registered patient list is likely to be a part).

Core primary medical services will continue to be delivered through nationally determined GP contracts, and SNPs will be expected to work closely with GP practices to ensure that primary care services are delivered to all patients in the neighbourhood. The consultation sets out three options for ICBs (integrated care boards) commissioning services at the single neighbourhood level, which include:

- ICBs continuing to commission the PCN DES but requesting national approval to vary elements of the service to better reflect local need. PCNs will have the option of opting in to local variation, with ICBs maintaining responsibility for population care coverage.
- ICBs use the SNP Contract to commission enhanced neighbourhood level primary medical services directly from SNPs. This would involve practices voluntarily switching from a PCN DES contract to an SNP contract. ICBs would also have the power to increase the scope and value of SNP services, such as introducing other services commissioned to support the development of neighbourhood healthcare, without requiring national approval.
- ICBs would commission an MNP to coordinate delivery on neighbourhood services, which would then sub-contract neighbourhood level primary medical services to SNPs. Where practices choose not to opt into an SNP service, the MNP would deliver the services directly to patients.

Within all three options, the consultation sets out a requirement to maintain a minimum investment equivalent to the PCN DES (including Additional Roles Reimbursement Scheme staff) for SNPs or the varied PCN DES.

Single Neighbourhood Provider option 1: ICB commissions a local service specification through PCNs

What NHS England is proposing

To vary elements of the PCN DES locally, rather than move commission a separate SNP Contract. This could allow commissioners and practices to adapt aspects of neighbourhood

service delivery while retaining the national DES framework, avoiding further procurement and ensuring that practices are at the heart of SNPs. This approach has been enabled by recent changes to allow local variation of the PCN DES and with the first example of this approach agreed in Kent.

Whilst existing conference policy calls for the PCN DES to be retired and funding put into the core contract (thus winding up existing PCN models, this is likely to be the least disruptive SNP route for general practice if it is genuinely voluntary, locally negotiated and supported by additional funding. Existing PCNs should be recognised as neighbourhoods, and the PCN DES should be protected as an important source of practice income rather than treated simply as a transitional mechanism.

The precise scope of any variation would need to be clearly defined and agreed, and should have the active involvement of the relevant LMC, as the representative body for GPs within the area, as well as PCNs and their member practices.

Provided any such variations are fully voluntary and that appropriate resourcing is provided for any additional requirements agreed in a variation of the DES, this is likely to be the 'best' of the options set out, maintaining existing practice led organisations and avoiding adding additional layers of contracting and commissioning.

Illustrative example: An ICB and local practices agree to vary local delivery requirements for specific neighbourhood services, eg. linked to care coordination and proactive frailty support, while keeping the PCN DES as the contractual base. Additional local funding is provided for service delivery, management time, and clinical leadership. The variation should be time-limited and reviewed annually, in line with national amendments to the PCN DES.

Potential benefits for general practice

- Ensures that SNPs are practice led and avoids the need for additional commissioning and practices bidding for the new contracts.
- Avoids the need to develop new business structures by embedding SNPs within PCNs
- May provide a stepping stone towards neighbourhood working while retaining existing PCN governance and core PCN funding.
- Should enable additional local funding to be attached to specific service developments.

Potential risks for general practice

- Local variation could erode the consistency and protections of the national PCN DES, especially around service requirements.
- Practices may face additional reporting, governance or service requirements without adequate recurrent funding.

- Variations could be used as a transition mechanism towards SNP Contracts in the future
- Different local approaches could create inequity between practices across different areas.

Single Neighbourhood Provider option 2: ICB commissions each SNP

What NHS England is proposing

The full SNP option would create a contract for a single neighbourhood, commonly aligned to a PCN-sized population of around 50,000 people. NHS England describes the SNP Contract as an evolution and strengthening of PCNs. It would commission enhanced neighbourhood-level primary medical services that sit outside core GMS, PMS or APMS obligations. Practices should have the option to remain in the PCN DES or take up an SNP Contract if their commissioner proposes it.

The SNP Contract could be held by an existing or new provider vehicle, depending on local arrangements. NHS England has indicated that minimum funding requirements should protect existing PCN funding, including ARRS funding, but practices will need clarity on how funding, staff, liabilities and governance would transfer or be managed.

This option may be workable in some areas, but only if practices actively choose to move to an SNP Contract and are not disadvantaged for remaining within the PCN DES. ARRS staff should remain under general practice control, whether through PCN ARRS arrangements or any future core general practice funding route, and any locally commissioned service budgets should remain ringfenced for general practice-led delivery.

Illustrative example: Four practices covering 52,000 patients establish a neighbourhood provider company to hold an SNP Contract. The contract covers care coordination, enhanced access, proactive long-term condition reviews, anticipatory care, additional roles and links with social care. Each practice retains its core GMS, PMS or APMS contract, while the SNP Contract covers only additional neighbourhood services with defined funding, workforce and governance arrangements.

Potential benefits for general practice

- Could provide a clearer route for practices to lead neighbourhood services rather than having those services commissioned around or away from them.
- Ensures that SNP requirements are kept entirely separate to the core contract.
- May consolidate PCN and locally commissioned service arrangements into a more coherent contract, if funding and accountability are transparent.
- May strengthen/formalise neighbourhood working and create a more stable platform for neighbourhood service delivery.

Potential risks for general practice

- The SNP Contract could rebadge existing PCN or locally commissioned funding without providing meaningful additional resource, pulling it away from the practices that do not sign up.
- May require practices to form new corporate structures in order to hold the contract (eg. Ltd companies) which could have significant accountant and VAT implications.
- Practices/PCNs could have to take on take on new legal, employment, indemnity, estates or financial liabilities associated with the contract without sufficient support being provided.
- Contractual requirements could become more onerous than the PCN DES, increasing administrative and workload burden.
- Non-participating practices could be disadvantaged or excluded from neighbourhood decision-making unless safeguards are built in.
- A separate SNP contract could draw away ARRS funding/staff from PCNs.
- Local variation between contracts could create a postcode lottery in funding, expectations, workload and GP influence.

Single Neighbourhood Provider Option 3: ICB commissions an MNP and the MNP subcontracts to SNPs

What NHS England is proposing

Under this model, the ICB commissions a Multi-Neighbourhood Provider (MNP) to hold responsibility for neighbourhood services across a number of neighbourhoods. The MNP then enters into subcontracting arrangements with Single Neighbourhood Providers (SNPs) and other local providers to deliver services within individual neighbourhoods.

NHS England presents this as a more integrated commissioning approach that enables commissioning and accountability to operate at a larger population level while retaining neighbourhood-level delivery through SNPs. The MNP would hold the overarching contract and accountability for outcomes, performance and resource allocation across multiple neighbourhoods, while SNPs would deliver enhanced neighbourhood-level primary medical services and other agreed neighbourhood functions locally.

This approach effectively creates a layered model, with strategic responsibility sitting at MNP level and delivery responsibility sitting at SNP level. It is intended to support consistency across neighbourhoods while maintaining local delivery arrangements and neighbourhood leadership.

For general practice, this is the highest-risk SNP option. It risks placing practices and SNPs at a distance from the commissioner while allowing funding and decision-making power to sit at MNP level. In practical terms, this could make it harder for practices to protect income, influence service design or ensure that neighbourhood delivery reflects local GP priorities.

The MNP provides strategic oversight, data reporting, workforce planning and performance management across the wider footprint, while SNPs adapt delivery to local population needs within their neighbourhoods.

Illustrative example: An ICB awards an MNP contract covering a population of 300,000 people across six 'neighbourhoods'. The MNP is responsible for delivering neighbourhood health outcomes, contract performance and financial management. It subcontracts with six SNPs, each serving approximately 50,000 people, to deliver additional neighbourhood services (eg. enhanced access, anticipatory care, care coordination, multidisciplinary neighbourhood team activity and population health programmes). Individual practices retain their core GMS, PMS or APMS contracts while participating in the SNP arrangements.

Potential benefits for general practice

- Could allow neighbourhood-based GP leadership to continue through SNPs rather than all decision-making moving to system level.
- May improve consistency of services, infrastructure, digital capabilities and workforce support across neighbourhoods.
- Could enable SNPs to focus on local delivery while the MNP undertakes wider contract management, reporting and system coordination functions.
- May create opportunities for stronger integration between practices, community providers and wider system partners.

Potential risks for general practice

- GP practices and SNPs could become two steps removed from commissioning decisions, with key decisions being made by the MNP as contract holder.
- May require practices to form new corporate structures in order to hold the contract (eg. Ltd companies) which could have significant accountant and VAT implications.
- Funding and accountability arrangements may become less transparent where resources flow through multiple contractual layers before reaching frontline services.
- Subcontracting arrangements could pass financial, contractual or performance risks to SNPs without equivalent influence over decision-making.
- Larger provider organisations (i.e Trusts) are more likely to hold MNP contracts, potentially reducing direct general practice influence over strategic priorities unless governance safeguards are explicit.

- Additional governance, reporting and assurance requirements may emerge at both MNP and SNP level, increasing administrative burden.
- There is a risk that priorities are standardised across multiple neighbourhoods even where local populations have different needs or operating models.

This model potentially offers a compromise between neighbourhood-level GP leadership and system-level integration, but much will depend on the balance of power, funding flows, governance arrangements and contractual protections between the MNP, SNPs and participating practices.

Issues practices and LMCs may want to consider in responses

Protecting core general practice

Any MNP or SNP model must not undermine the national GP contract, the registered list, patient choice, continuity of care, or the independent contractor model. Additional neighbourhood services must be separately specified, separately funded and clearly distinguished from core contractual requirements. Practices and LMCs should ask NHS England to confirm that GMS, PMS and APMS contracts will remain untouched and that no neighbourhood model will dilute national contractual rights or patient registration arrangements.

This should include explicit protection for QOF, PCN DES funding, ARRS funding and locally commissioned general practice services. There should be no additional requirements attached to accessing any minimum PCN funding, and no left shift of work into general practice unless the corresponding recurrent resource, workforce and infrastructure are provided. This should be used as an opportunity to ensure commissioning gaps do not persist by ensuring certain services that are universally required such as phlebotomy or shared care are commissioned on a national footprint, freeing local funding for genuine local priorities.

Funding and workload

Minimum funding protections must be explicit, enforceable and inflation proofed. Any transfer of locally commissioned services, PCN funding or ARRS funding must not reduce practice income or create unfunded workload. New services must be accompanied by recurrent funding for clinical time, management costs, estates, digital infrastructure, indemnity and employment liabilities. Practices and LMCs should ask NHS England to guarantee that PCN and ARRS funding will be protected in full, and that any new or expanded neighbourhood services will be funded over and above existing resources.

Prerequisites for practice participation

Practices should not be asked to rely on promises of future benefit. If they are expected to participate in MNP or SNP arrangements, there should be clear prerequisites agreed in advance, including recurrent funding that genuinely follows workload, absolute protection of the independent contractor model, an end to unfunded workload transfer from secondary care, investment in GP premises and estates, funding to employ more GPs as well as wider multidisciplinary staff, contractual safeguards preventing general practice funding from being diverted elsewhere, and independent evaluation showing that neighbourhood provider models improve outcomes before national roll-out.

This should also include a clear position that general practice support cannot be assumed on the basis that neighbourhood models are “going to happen anyway”. If models require the active participation, workforce, registered lists, estates and leadership of practices, then NHS England and DHSC must set out what general practice gains, how the proposals will reduce rather than add to daily workload, and how patients will benefit in practical terms.

Complexity of proposals

Many of the proposals set out are likely to significantly increase the complexity of commissioning and contracting for practices, particularly at local level. Rather than simplifying existing arrangements, the creation of MNP and SNP models could add further contractual layers alongside GMS, PMS, APMS, the PCN DES, locally commissioned services and other community or system contracts. This risks making it harder for practices to understand where responsibility sits, how funding flows, what obligations apply, and which organisation is accountable for delivery or failure. Some options (MNP option 2, SNP option 2 &3) will require practices to form new corporate entities in order to be able to hold the new contracts. Multiple local variants could also make it more difficult for LMCs to support practices consistently across an area, while increasing the time practices must spend on due diligence, governance, subcontracting, reporting and negotiation. Without clear national safeguards and simple, transparent contractual routes, the proposals could therefore increase administrative burden and uncertainty, rather than supporting more straightforward neighbourhood delivery.

Governance and GP voice

GP support must be a meaningful safeguard, not a tick-box exercise. There should be clear requirements for early engagement with LMCs and practices, transparent decision-making, representation of all practices in a neighbourhood, and effective mechanisms to resolve disputes. Where an MNP is proposed, practices must be able to understand who holds the contract, who controls resources, and how GP input influences decisions. Practices and LMCs should ask NHS England to make evidenced support from affected practices and early LMC engagement a prerequisite for any local move to an SNP or MNP model.

Local negotiations should formally involve LMCs as the recognised local representative bodies for general practice. Engagement with practices should not be limited to individual provider discussions or system-led workshops; it should include collective local negotiation through LMCs, clear routes for practices to raise concerns and sufficient time for LMCs to advise their constituents. MNP contracts must require formal signoff by all affected GP practices, it should be explicit that organisations cannot take on MNP contracts without GP practice support.

Voluntariness, procurement and transition

NHS England should confirm that practices will not be compelled, directly or indirectly, to join an SNP or participate in an MNP, and that remaining in the PCN DES will be a genuine option where practices choose it. Transition arrangements must include sufficient time for legal, financial, workforce and governance due diligence. Procurement rules should be proportionate and should not favour large incumbent providers over GP-led organisations. Practices and LMCs should ask for fair procurement and governance arrangements so that GP federations and other GP-led organisations can bid for, hold or participate in contracts where they wish to do so.

Risk, liability and accountability

There must be clarity on how clinical, financial, employment, estates, information governance and performance risks would be allocated. Accountability should sit with the organisation that has the resources, levers and contractual authority to deliver the relevant service. Practices must not be held responsible for failures in community, social care, acute,

mental health or voluntary sector services that they do not control. Practices and LMCs should ask NHS England to publish detailed national implementation guidance on procurement, pensions, VAT, indemnity, employment liabilities, subcontracting, information governance, dispute resolution and exit arrangements before local implementation begins.

Protecting non-participating practices and managing local variation

Practices that do not join an SNP or MNP must not be disadvantaged in funding, access to services, patient pathways or local decision-making. NHS England should also maintain national oversight of local implementation to prevent unacceptable variation in funding, workload, contractual expectations and GP influence. Practices and LMCs should ask for clear safeguards for non-participating practices and transparent monitoring of local variation.

Where safeguards are not met, practices and LMCs may wish to consider whether disengagement from neighbourhood implementation is necessary as part of a wider collective position. This should be framed carefully: GP involvement is essential and constructive engagement is the preferred approach, but participation cannot be assumed where funding, contractual protections, GP leadership and local negotiation are absent.

Protecting terms and conditions of salaried GPs

Any move to MNP or SNP models must include explicit safeguards for GPs employed within, new neighbourhood provider arrangements. Employed GPs should not experience a deterioration in pay, contractual entitlements, pension access, indemnity arrangements, professional autonomy or workload protections as a result of changes to commissioning or provider structures.

Any new SNP or MNP contract must require providers and subcontractors to protect the terms and conditions of salaried GPs, including where staff are employed by a GP practice, PCN, GP federation, SNP vehicle, MNP lead provider or subcontracted organisation, including pay, access to the NHSE Pension Scheme and continuity of service.

These protections are particularly important where neighbourhood models involve staff moving from PCN or practice-based arrangements into a separate SNP vehicle, GP federation, trust-led MNP or other lead provider structure. Without clear safeguards, there is a risk that contractual change could fragment employment arrangements, weaken professional autonomy, create unequal terms between GPs doing similar work, or make it harder for practices to recruit and retain salaried GPs.

Consultation questions and key considerations

The below sets out the questions included in the consultation, alongside some key considerations that you may wish to take into account when formulating your response. Each question with multiple choice answers also comes with a 1250-character free text box to 'explain your answer'.

Consultation question	GPCE key points
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?	• Using the NHS Standard Contract would avoid the need to develop a bespoke contracting model and is already used in some areas. • This approach may benefit existing large providers that are already familiar with the contract. • NHS England should define clearly what would sit within the "Neighbourhood" schedule and confirm that no core GMS, PMS or APMS obligations would be reclassified as neighbourhood services. • National safeguards and minimum standards should be published before local implementation to avoid unacceptable variation in funding, workload, accountability and GP influence.
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	• MNP geographies should be determined by the needs of local patients and providers, with full and meaningful involvement from practices. • This must include discussions with LMCs as the recognised local representative bodies for general practice. • There should be collective local negotiation through LMCs, clear routes for practices to raise concerns, and sufficient time for LMCs to advise constituents.

	• NHS England should require clear evidence of support from affected practices before decisions are made on any SNP or MNP model. • The impact on LMC capacity should be recognised, with sufficient time and support for LMCs to scrutinise local proposals and advise practices.
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?	• Subcontracting risks complicating commissioning and contracting arrangements by adding further layers for services that could be commissioned directly with SNPs. • More detail is needed on what the proposed primary medical care elements would entail. • Substantive safeguards are needed to ensure that general practice does not have additional financial, performance or workload risks transferred to it by the MNP without adequate funding or control. • There must be clear dispute resolution and exit arrangements where subcontracting creates disagreement over funding, responsibility, performance or risk. • It should be recognised that where a service is needed across all practices, within an MNP, subcontracting directly with Practices may be more appropriate to reduce complexity and ensure services are delivered by the most appropriate layer of scale.
4. To what extent do you agree or disagree that the proposed contracting model, and the interaction with Single Neighbourhood Providers, would create	• The model could support more integrated commissioning by bringing primary care and wider neighbourhood services together and enabling planning for a registered local population.

more integrated commissioning arrangements?	• However, subcontracting elements of services could increase bureaucracy and complicate commissioning and funding arrangements. • There is a risk of unclear roles and accountability, and of practices becoming subordinate to large MNPs. • Integrated working must include clear safeguards on information governance, data controllership, reporting burden, patient consent and the use of practice-held data. • Patients must be able to understand who is responsible for services, how access routes may change, and how continuity will be protected.
5. Which of the options would you favour in your geography? • Option 1 - commissioning coordination and fill in provision through an MNP • Option 2 - commissioning through a lead provider	• Both options could introduce an additional management layer, increasing bureaucracy and reporting requirements for general practice without additional resource. • Existing funding for practices, including funding through locally commissioned services, must be protected in order to avoid destabilising general practice. • Under a lead provider model, practices could become subordinate to a larger non-GP provider commissioned to provide the MNP and could be excluded or distanced from decision-making. • Where existing services are being delivered well by GP-led organisations, commissioners should support those organisations to continue rather than displacing them through Trust-led or system-level models.
6. Are there other options we should consider?	• Practices/LMC may wish to consider any local experiences that may provide a

	more suitable alternative to the ones set out by NHSE within the consultation.
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	• Option 1 offers the least disruptive route to introducing single neighbourhood providers by using existing practice-led structures, avoiding the need for complex new contracts and provider arrangements. • Using different models in different areas could create a postcode lottery of implementation, with confusion and lack of clarity for commissioners and practices. • Minimum investment equivalent to the PCN DES is not sufficient if the model creates expanded requirements; any new or shifted work must be funded over and above existing PCN DES, ARRS, QOF, core contract and locally commissioned service resources.
8. To what extent do you agree or disagree with practices being given the ability to "opt into" Single Neighbourhood Provider arrangements?	• Any neighbourhood model must be opt-in only and entirely voluntary. • Practices that choose not to join an SNP must not be disadvantaged in funding, access to services, patient pathways or local decision-making. • NHSE/DHSC should maintain national oversight to avoid unacceptable variation in workload, funding, contractual expectations and GP influence. • There must be genuine local GP and practice support for moving into SNP arrangements. • Practices should have clear routes to withdraw from SNP or MNP participation without financial penalty, loss of core funding, destabilisation of ARRS staff or disruption to patient services.

9. Are there other options we should consider?	• Practices/LMCs may wish to consider any local experiences that may provide a more suitable alternative to the ones set out by NHSE within the consultation.
10. What might we need to do to make procurement as fair and as simple as possible?	• Procurement processes and decisions must be transparent and commissioners must engage fully and genuinely with GPs, practices and LMCs. • Procurement documentation should be proportionate and avoid unnecessary legal, financial or governance barriers for GP-led organisations. • Clear national rules are needed on subcontracting, funding flows, risk allocation, dispute resolution and exit arrangements before procurement begins.
11. What barriers may smaller organisations face bidding for an MNP Contract and how could these be resolved?	• Practices may lack the time and capacity needed to participate in complex bidding processes. • Requirements to establish new corporate structures could disadvantage practices and GP-led organisations compared with larger providers. • Support, simplified requirements and fair procurement criteria would be needed to enable smaller GP-led organisations to participate. • Smaller GP-led organisations may face accounting, VAT, legal, governance, pensions and indemnity issues that larger providers are better placed to absorb. • Commissioners should provide practical support, template documentation and sufficient lead-in time for smaller providers to complete due diligence.

12. How should MNPs be required to demonstrate the support of general practice in the procurement process?	• This should include early and meaningful engagement with LMCs and practices and support should not be inferred from system-level endorsement alone, or from 'leadership groups' . • Evidence of support should include how concerns raised by practices and LMCs have been addressed, not merely that engagement has taken place. • There should be clear requirements for representative practice involvement in governance, service design, resource allocation and decision-making.
13. What additional support may commissioners require?	• Commissioners may need clear national guidance on procurement, funding flows, contracting, subcontracting and risk allocation. • They should also be required to engage LMCs and practices consistently before developing or implementing any local model. • Commissioners will need guidance to provide to practices on employment, pensions, indemnity, estates, VAT, information governance, dispute resolution and exit arrangements.
14. Is there anything else we should be considering in relation to Multi Neighbourhood and Single Neighbourhood Contracts?	• Any MNP or SNP model must protect core general practice, the registered list, the independent contractor model and national GP contract rights. • National contracts and/or specifications should be fully discussed and agreed with the BMA dn the GPCE before publication. • New neighbourhood services must be separately funded and clearly distinguished from core contractual requirements. • There should be a requirement to assess the impact on general practice capacity,

	continuity of care and local service stability before proceeding. • NHS England and DHSC should demonstrate what general practice and patients will gain from these proposals before implementation, rather than expecting support on the basis of future promises. • Funding, workload, liability, governance, employment and accountability safeguards must be resolved before implementation. IT should not be left to providers to resolve as they go. • National safeguards should cover information governance, data use, patient communication, employment liabilities, pensions, VAT, indemnity, procurement, subcontracting, dispute resolution and exit rights. • There must be a national route for practices and LMCs to raise concerns where local proposals risk undermining core general practice, the registered list or practice-led neighbourhood delivery.

At a glance summary of the proposed models

	What it would do	Potential benefits for general practice	Potential risks for general practice	Key points
	Multi-Neighbourhood Providers			
Option 1: coordination model	• Creates an at-scale coordinating function across several neighbourhoods. • Existing contracts remain in place. • Supports common pathways, provider collaboration, data and reporting. • May fill gaps where services need to operate across more than one neighbourhood.	• The least disruptive model for practices, and likely the preferential approach for most. • Could improve coordination between practices/PCNs and other providers, without needing new contracting models. • Could reduce variation and simplify referral routes. • Could give practices a route to influence wider pathways, reducing variation and simplifying referral routes. • Does not require immediate changes of existing contracts.	• Could add another management layer if not carefully implemented. • Could create additional unfunded expectations on practices. • GP influence may be limited if MNP is hosted by a large non-GP provider.	• Least disruptive MNP option, provided existing GMS, PMS, APMS, PCN DES, QOF, ARRS and locally commissioned services are protected. • May help align services and pathways across neighbourhoods without dismantling current contracts. • Requires clear GP and LMC involvement, separately funded practice participation, transparent governance and accountability. • “Gap-filling” must not become unfunded service transfer or a route into a stronger lead-provider model by default.

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Option 2: lead provider model	• Places responsibility for a wider set of neighbourhood services with one lead provider. • Lead provider would hold an outcomes-based NHS Standard Contract across multiple neighbourhoods. • Lead provider would sub-contract SNPs, GP organisations, community providers and other partners.	• Possibility that could be held by a GP federation • Could consolidate fragmented services. • Could support more coherent population-based funding. and enable investment in services that relieve pressure on practices. • Could give GP led organisations a route to shape at-scale delivery if procurement is fair.	• Likely to favour providers already operating across large footprints, such as Trusts. • Could reduce practices to sub-contractors and weaken GP influence over resources. • Could transfer financial, contractual or performance risks without adequate funding or levers.	• Higher-risk MNP option because resources, delivery and accountability would sit within a single at-scale lead contract. • May favour large incumbent providers and reduce practices to subcontractor status unless GP leadership is built in. • Funding flows, locally commissioned service budgets and general practice resources must be transparent, ringfenced and protected. • Financial, performance, workforce and service-design risks must not pass to practices without equivalent funding, control and contractual protections.
	Single Neighbourhood Providers			
Option 1: ICB commissions a local service specification through PCNs	• Allows local variation of elements of the PCN DES. • Avoids immediate movement to a separate SNP Contract. • Retains GMS and the PCN DES as the contractual base.	• Ensure that SNPs operate through existing, practice led structures	• Could erode national DES protections if there's too much local variation allowed. • Could add service requirements without additional recurrent funding. • Could be used as a transition mechanism to pull practices	• Least disruptive and 'best' of the proposed SNP routes if genuinely voluntary, locally negotiated and supported by additional recurrent funding. • Keeps the PCN DES and existing practice-led structures as the

		• Retains existing governance and contracting structures. •	into new neighbourhood structures.	contractual base, avoiding new provider vehicles or procurement. • Any local variation should be clearly defined, time-limited, separately funded and agreed with participating practices and LMCs. • Should not erode national DES protections, create unfunded requirements or move practices towards separate SNP Contracts by default.
Option 2: ICB commissions each SNP	• Creates a Single Neighbourhood Provider Contract for a defined neighbourhood. • Typically covers around 50,000 people. • Commissions enhanced neighbourhood level primary medical services. • Services sit outside core GMS, PMS or APMS obligations. • SNP and PCNs should not overlap	• Would give practices a more straightforward route to lead neighbourhood services. • Keeps SNPs contractually separate from GMS • Could more directly support multidisciplinary teams. • Could strengthen local population health work.	• Could increase complexities of legal, employment, pensions, VAT, indemnity, estates or financial liabilities, especially as requires a legal entity to hold the contract. • Could draw funding for locally commissioned services away from practices and PCNs • What happens if practices/PCNs in a locality do not wish to participate? • Would add additional contractual layers and management.	• May be workable only where practices actively choose to move to an SNP Contract and are not disadvantaged for remaining in the PCN DES. • Could give practices a clearer route to lead neighbourhood services, provided SNP activity remains separate from core GMS, PMS and APMS obligations. • PCN DES funding, ARRS resources and locally commissioned service budgets must remain protected and ringfenced for general practice-led delivery.

			• Could disadvantage non-participating practices. •	• Legal, employment, pensions, VAT, indemnity, estates, governance and non-participation issues must be resolved before implementation.
Option 3: ICB commissions an MNP and the MNP subcontracts to SNPs	• ICB commissions an MNP to hold the overarching contract and accountability. • MNP operates across multiple neighbourhoods. • MNP subcontracts with SNPs and other local providers. • SNPs and local providers deliver enhanced neighbourhood services locally.	• Could provide opportunities for improved infrastructure and workforce support via the MNP. • Would support greater consistency across neighbourhoods within a local area. • Would allow SNPs to focus on local implementation and service delivery rather than pathway design etc.	• Likely to leave practices and SNPs two or three steps removed from commissioning decisions, complicating contracting processes. • Could make funding flows less transparent. • MNPs could pass risk down to PCNs and practices through subcontracts. • Could increase governance and reporting burden.	• Highest-risk SNP option because funding and decision-making sit at MNP level while SNPs and practices deliver locally. • Could combine system-level coordination with neighbourhood delivery only if GP leadership, practice influence and LMC engagement are protected. • Funding flows, responsibilities, performance requirements and subcontracting terms must be transparent and enforceable. • Subcontracts must not pass financial, contractual, workforce or performance risk to practices without equivalent funding, control, governance rights and exit protections.