



Community Pharmacy England's response to the consultation on Multi Neighbourhood Provider (MNP) and Single Neighbourhood Provider (SNP) contracting models to support neighbourhood health services

August 2026

Background

The proposed **Multi-Neighbourhood Provider (MNP)** and **Single Neighbourhood Provider (SNP)** models are intended to support the NHS 10 Year Health Plan by creating more integrated neighbourhood-based services, improving population health outcomes, reducing fragmentation and shifting care closer to home. Neighbourhoods will typically serve circa 50,000 people (SNP level), while MNPs would cover multiple neighbourhoods (circa 250,000+ population).

For community pharmacy, the proposals present potential opportunities to become a more embedded part of neighbourhood care teams, but also carry significant risks, with several questions and issues remaining. Community pharmacy could become a subcontracted delivery partner with limited influence over service design and resource allocation. Any SNP contract holder must have access to a registered patient list therefore this contract will inherently be driven by general practice rather than primary care as a collective.

The consultation acknowledges community pharmacy's role as a local provider and that both SNPs and MNPs would work closely with them and other local providers however, there is no guarantee of pharmacy representation within governance structures, nor any requirement for pharmacy-led service delivery.



Our responses to the consultation questions

Question 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? (Required)

- Strongly support
- Somewhat support
- Neither support nor oppose
- Somewhat oppose
- Strongly oppose

Please explain your answer (max 1250 characters):

Our response:

The proposal provides a practical mechanism for integrating community, primary and neighbourhood services under a common and well recognised contractual framework.

However, our support is tempered by the need for explicit recognition of community pharmacy as a strategic delivery partner and representation within MNP governance structures.

Transparent funding arrangements and protection against excessive bureaucracy for smaller healthcare providers must also be required from MNPs. Without these safeguards, there is a risk that pharmacy participation becomes inconsistent and locally variable.

Patients are unlikely to have a view on contract mechanics but will support anything that makes services more joined up and leads to simpler access and clearer accountability. They need confidence that organisations work together rather than passing responsibility between providers and success should be judged by patient outcomes and experience, rather than organisational arrangements.

Question 2: Which of the following statements do you most agree with? (Required)

- 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

Please explain your answer (max 1250 characters):

Our response:

We have cautiously selected the option that allows commissioners to determine the number of MNPs in each geography as we recognise that different systems have differing population needs and provider landscapes. A flexible approach allows area-specific solutions which are likely to be different, e.g. in rural, more sparsely populated areas compared to urban and densely populated areas. Commissioners may also want to consider whether to award service-specific MNPs based on their population health needs. They may also want to consider who potential providers could be and what skills and experience they already have in particular service areas.

However, the risk of a multiplicity of MNPs is that this introduces fragmentation that could dilute accountability or create complexity for patients and also for providers operating across multiple footprints.

We are also cautious because NHS England is proposing to be deliberately permissive about the size of an MNP stating '*an MNP contract ... could work well at a footprint of around 250,000 people or more, but we do not propose to mandate a national size.*' This may lead to variability in system-approach causing confusion for providers working across multiple MNP areas.

Question 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? (Required)

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree

- Strongly disagree

Please explain your answer (max 1250 characters):

Our response:

Subcontracting may preserve local neighbourhood ownership and avoid over-centralisation. Patients value care remaining local and responsive to community needs and benefit when services are delivered by organisations that know their local population. Community pharmacies are the most accessible provider of healthcare services, located in the heart of communities. They are typically open for longer hours than GP surgeries and offer walk-in access to a healthcare professional.

As a critical community asset within neighbourhoods, similar sub-contracting protections and assurances must apply to community pharmacy providers. MNPs must be required to engage pharmacy providers (through Local Pharmaceutical Committees (LPCs)) in strategic planning and local service design.

National guidance must also ensure that pharmacies and other providers can access neighbourhood contracts fairly. There must also be a clear expectation at all levels (national, system and local MNP and SNP contract holders) that other providers including pharmacies contribute both strategically and operationally to neighbourhood service delivery, not simply support it.

Question 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? (Required)

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

Please explain your answer (max 1250 characters):



Our response:

Creating more integrated commissioning arrangements depends on ensuring genuine inclusion of all providers, including community pharmacy, within strategic and operational structures, supported by the new contract models. These models alone will not create more integrated commissioning arrangements.

There has always been competition and tension amongst providers, both intra-profession and inter-profession because a sustainable financial business model is required to underpin each provider.

The aims of SNP and MNP to help local organisations work together are worthy but require a change in mindset and behaviours leading to greater trust. Where relationships and trust develop, there is an opportunity to use the contracts to improve integration by bringing providers together around shared outcomes supporting multi-disciplinary working, pathway-based commissioning and inclusion of aligned incentives.

Success for patients means better access, continuity and coordination resulting in improved experiences and outcomes.

Success will also depend on shared governance, equitable data access and shared outcomes for all providers. Without these, integration risks becoming GP-centric rather than genuinely neighbourhood-based.

Question 5: Which of the options would you favour in your geography? (Required)

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

Please explain your answer (max 1250 characters):

Our response:

We favour an initial coordination model as it provides benefits of integrated working without immediate disruption to existing provider contracts. This approach allows providers, including pharmacies, to develop collaborative ways of working while retaining



existing contractual arrangements.

The coordination model provides a lower-risk route to establishing INTs allowing time to build trust, governance arrangements and shared outcome measures. It also creates opportunities to test enhanced pharmacy integration through pharmacy-led prevention and urgent care services utilising the nationally commissioned Advanced services before moving to a more comprehensive lead-provider model where innovative services could be considered.

A phased transition from Option 1 to 2 may be appropriate where local systems can demonstrate mature provider relationships, robust governance and equitable participation of all providers, including pharmacy. The involvement of all local representative committees, including LPCs, must be mandated before any transition is approved or begins.

Patients are more likely to favour a gradual change that minimises disruption. It will be important that existing services are not destabilised during any transition.

Question 6: Are there other options we should consider? Max 1250 characters:

Our response:

A hybrid approach could be considered whereby an MNP coordinates neighbourhood outcomes but while allowing direct local commissioning of specific services using National and Local Enhanced Services from community pharmacies and other providers where population health data supports this approach to commissioning. This retains a direct contractual relationship for some services, encouraging innovation and complementing services commissioned under national contracts such as the CPCF.

This option would enable commissioners to avoid unnecessary organisational restructuring, while still delivering integrated care.

Community pharmacy providers must be able to participate directly in neighbourhood contracts either autonomously, through provider collaboratives or local community pharmacy provider companies, where appropriate. Such an approach could reduce



procurement burden while ensuring smaller providers are not disadvantaged compared with larger provider organisations.

For maximum patient benefit, local services should be flexible enough to reflect community needs while maintaining consistency of standards and contracting arrangements should allow the involvement of community organisations, pharmacies and voluntary groups.

Question 7: Which of the following do you most agree with? (Required)

- 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

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

Our response:

We've cautiously selected that all 3 options be available to commissioners to retain maximum flexibility required to support variable neighbourhood maturity. Allowing all 3 options supports local innovation and phased implementation across different provider landscapes and levels of system readiness and is likely to lead to better patient outcomes.

There are concerns about the GP-centric nature of SNPs and risks these may create for pharmacy engagement in service delivery.

These risks could be mitigated if pharmacy is recognised as a core strategic and delivery partner in neighbourhood services. National surveys highlight the value of pharmacy to patients: national guidance must ensure pharmacies have equitable opportunities to engage in local commissioned services irrespective of the chosen commissioning route.

National safeguards, e.g. through a maturity matrix, must be introduced to ensure universal



development and prevent unwarranted variation in pharmacy involvement between systems irrespective of the model chosen by commissioners.

Other options to consider: A formal requirement in the neighbourhood directions that community pharmacy representation is included within SNP and MNP governance structures.

Question 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)? (Required)

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

Please explain your answer (max 1250 characters):

Our response:

Providing practices with flexibility to opt into SNP arrangements supports local ownership and engagement. However, neighbourhood services rely on comprehensive population coverage and integrated multidisciplinary delivery. Therefore, excessive variation in participation may undermine service consistency and create inequity for patients and cause confusion about where they can access services.

Any opt-in arrangements should be accompanied by clear participation expectations, defined service standards, population coverage requirements and most importantly, mechanisms to ensure continuity where organisations choose not to participate. Guidance to date has been silent on the considerations if a practice chooses to 'opt out' of SNP arrangements.



The same principles should also apply to community pharmacy providers where services are commissioned through neighbourhood arrangements.

Commissioners should ensure neighbourhood contracts encourage collaboration rather than create fragmentation between participating and non-participating providers.

Question 9: Are there other options we should consider?

Our response:

Rather than a simple opt-in or opt-out model, consideration should be given to graded participation arrangements.

This could include core mandatory neighbourhood functions and optional enhanced services. Participation models must balance local flexibility with consistency of care and access to patient care services. There may be situations where flexible 'opt into' options should be afforded to providers, especially when thinking about specialist services where only one or two providers are necessary within a neighbourhood.

Consideration could also be given to outcome-based shared incentive schemes involving all providers to improve engagement and collaboration.

Wider provider collaborative models involving general practice, community pharmacy and community services should also be considered. These would provide greater flexibility while protecting consistent access to neighbourhood services across the whole population.

Community pharmacies should also have opportunities to participate within neighbourhood service delivery structures using similar principles to those proposed for general practice.

Question 10: What might we need to do to make procurement as fair and as simple as possible?

Our response:

There are a number of principles that procurement arrangements must follow:

- Mandate that appropriate procurement regulations are implemented consistently and fairly across commissioners while balancing this with avoiding unnecessarily complex procurement requirements.
- Be proportionate to contract value and risk.
- Support participation by smaller providers.
- Enable consortium and lead provider bids.
- Include standardised contract templates.
- Minimise duplication of assurance processes.
- Use transparent scoring methodologies.
- Advertise / communicate opportunities in innovative ways to maximise visibility to all potential providers.

Commissioners should explicitly recognise community pharmacy, VCSFE and other small providers as potential lead or partner organisations, as strong relationships with communities are likely to already exist. Supporting all potential providers to have visibility of opportunities is important.

Neighbourhood procurement should focus on provider capability, outcomes, local relationships and patient benefit rather than organisational size alone. Providers must also demonstrate how they will reduce inequalities and improve access.

Question 11: What barriers may smaller organisations face bidding for an MNP Contract and how could these be resolved?

Our response:

Potential barriers for smaller organisations can be categorised into 3 areas:

- Financial – the total contract value may be too high or too risky for smaller organisations; or financial risk transfer from the ICB may be unmanageable
- Procurement process – complex requirements for a new or inexperienced organisation may result in a no-bid decision or poor-quality submission
- Resource may not exist for complex and time-consuming bids

- Implementation / delivery – governance and reporting requirements may create excessive burdens on small organisations, especially with limited organisational capacity. Insufficient access to data and limited analytical support may be problematic

Potential solutions include permitting consortium bids and supporting lead provider models. Commissioners should ensure bid documentation is simple and contractual assurance requirements are proportionate to contract value and clinical complexity.

While smaller organisations may face challenges linked to scale and capacity, larger organisations may also encounter barriers, e.g. where contracts are highly localised. The pharmacy sector is diverse with ~30% of the market operating as entities with >100 pharmacies and ~50% are single or small groups (1–5 pharmacies)

Question 12: How should MNPs be required to demonstrate the support of general practice in the procurement process?

Our response:

Support from general practice is important but should not be the sole determinant of neighbourhood legitimacy. MNPs should demonstrate support from the wider neighbourhood provider network including general practice, community pharmacy, community health providers, local authorities, VCSFE partners and patient representatives. MNPs should also be required to demonstrate the support of local representative committees.

Evidence could include meeting agendas and minutes, Terms of Reference for specific committees and statements of support from, in particular, all local representative committees on behalf of individual providers.

Neighbourhood health services should be based on multidisciplinary partnership rather than exclusive endorsement by any single provider group. Patient engagement and co-production should be considered alongside provider support.

Question 13: What additional support may commissioners require?



Our response:

Commissioners are likely to require significant support from the national team to ensure consistency and efficiency in their approach to these contracting models. Support includes resources such as national implementation guidance, standard contract templates, governance frameworks and data sharing agreements. Expertise to call upon for procurement support, legal advice and evaluation methodologies may be necessary.

Commissioners may also benefit from national guidance on the role of each primary care discipline, including community pharmacy, within Integrated Neighbourhood Teams and their national contracts to support consistent implementation and avoid variation between systems. ICB restructures have resulted in significant loss of expertise and corporate memory which creates a significant risk.

There should be a strong emphasis on patient involvement throughout implementation and evaluation; support may be required to measure patient outcomes and experience and engage with health inclusion groups.

From a pharmacy perspective, clear commissioner expectations regarding NHS pharmaceutical services would strengthen delivery, along with clarity on national contractual frameworks and NES and LES guidance and templates.

Question 14: Is there anything else we should be considering in relation to Multi Neighbourhood and Single Neighbourhood Contracts?

Our response:

Community pharmacy is one of the most accessible healthcare assets within neighbourhoods and should be recognised explicitly throughout the MNP and SNP models and neighbourhood directions.

NHS England must implement national safeguards to ensure consistent pharmacy involvement in neighbourhoods. They must also consider mandatory community pharmacy representation within MNP and SNP governance through LPCs and membership of INTs.



The consultation documents suggest that local organisations, would decide how most services in the contracts are designed and funded and state that under an SNP general practices must not see a drop in funding. This must not create risks for community pharmacy by redeploying existing pharmacy services funding.

Pharmacies should have equitable access to participation in outcome-based incentive schemes, access to local shared care records and population health data as key enablers for effective service delivery.

If implemented well neighbourhood contracting could enable accelerated prevention, delivery of improved services and more joined up care for patients focused on improving people's health and outcomes. Maximising the contribution of community pharmacy will be essential if these ambitions are to be achieved