

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

Royal College of Pharmacy response:

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**
- Strongly oppose

Please explain your answer (max 1250 characters):

- We understand the change from reactive to integrated outcome-based population health management and the ambition to integrate services at scale while maintaining local delivery and protecting the interest of providers.
- Neighbourhood arrangements must complement, not replace or destabilise, existing national contracts for community pharmacy and other primary care professions. National contracts for all primary care providers should be reviewed so they complement each other as clinical services delivered in primary care expand and as professionals take on evolving roles
- The proposals are too centred on general practice and NHS providers. Community pharmacy, dentistry, optometry, external specialist providers, social care, public health, the voluntary, community and social enterprise sector, and local communities must be equal partners in design, governance and delivery. None of these are explicitly mentioned. Pharmacy should have a key role in strategic commissioning
- The proposals need much greater detail including a detailed framework on how existing and new contracts will interact, how transition will be managed or supported, where financial and legal risk sit, and how these, including performance or non-delivery, will be addressed.
- No clear funding is identified for legal, procurement, digital, data-sharing, administrative and workforce infrastructure. VAT implications and the administrative burden of subcontracting also requires assessment.

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**

Please explain your answer (max 1250 characters):

- We agree with the direction of travel to enable the consolidation of multiple contracts within an area into one single contract.
- However, ICBs need a toolbox of contractual mechanisms for flexibility rather than a single mandated model. Arrangements should be co-designed with providers and communities, including external specialist providers, and reflect local population needs and build on mature partnerships and infrastructure already in place so as not to inadvertently widen inequalities.
- Connectivity between the commissioner (ICB) and those providers delivering at the front line could be reduced by MNP and SNP models of contracting.

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**
- Strongly disagree

Please explain your answer (max 1250 characters):

- Eligibility requirements such as access to registered patient lists risk excluding community pharmacy and other providers by design, despite reach, expertise and contribution to prevention, medicines optimisation and population health of providers.
- Community pharmacies play a significant role within neighbourhoods contributing to prevention, improved access, reducing GP demand, urgent care, medicines optimisation and supporting the left shift into communities.
- Including and integrating community pharmacy into NH teams will lead to improved access, reduced hospital demand, increased prevention, medicines optimisation, earlier intervention and reduced inequalities.
- Including and integrating partnerships with external specialist providers e.g. clinical homecare providers will support medicines optimisation, financial savings (from better use of biosimilars and generic medicines), reduced hospital length of stay and reduced Emergency Department attendance
- Lead-provider and subcontracting models could concentrate power, marginalise smaller providers, blur accountability and weaken frontline engagement. Governance needs to be in place and must protect provider rights and support genuine partnership working.
- These models could encourage system wide outcome alignments and include a list of providers to co-deign with.

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
- Strongly disagree

Please explain your answer (max 1250 characters):

- The proposals need much greater detail on how existing and new contracts will interact, how transition will be managed, where financial and legal risk sit, and how these including performance or non-delivery will be addressed.
- Lead-provider and subcontracting models could concentrate power, marginalise smaller providers, blur accountability and weaken frontline engagement. Governance must be in place and protect provider rights and support genuine partnership working.
- Consolidating fragmented service-by-service contracts into population-based MNP contracts should reduce duplication and clarify accountability, but integration depends on execution.
- If, within an area, some general practices transition to a SNP model, but a similar proportion choose to continue to deliver services via a PCN DES, this could lead to significant variation within a locality.
- Significant variation in contracting models across England could destabilise partnership collaboration with external specialist providers

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

Please explain your answer (max 1250 characters):

- Consultees need to make informed choices on the information provided and unfortunately the information provided has been unclear in places, hence people may not fully understand repercussions of their chosen option.
- Additionally what equalities impact assessments have been considered by NHSE for these proposed changes?
- Local populations can be very diverse so different models will suit different neighbourhoods. We believe that commissioners need a toolbox of contractual mechanisms for flexibility rather than a single mandated model.

6. Are there other options we should consider?

Max 1250 characters

- A hybrid approach could be considered whereby an MNP coordinates neighbourhood outcomes 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.
- Any implementation of a new contracting model should be phased in over a transition period.
- 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, and partnership with, community organisations, pharmacies, external specialist providers and voluntary groups.

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

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

- It is impossible to pick any of these options as a transition period is needed to enable any of the suggested options to take place.
- Systems are at genuinely at different levels of maturity and should be able to sequence 1 to 2 to 3 or move directly. Removing options forces artificial uniformity on systems whose contracts, providers and relationships differ.
- The constraint that matters is the one already proposed: the options should not run in parallel in the same geography, and minimum SNP funding equivalent to the PCN DES (including ARRS) must hold under all three.
- Providers will be taking on the liability of the ICB and there is little detail around how this will be supported legally and how the back-office infrastructure will be funded and how IT infrastructure will support or be interoperable with the new models and associated digital systems.
- ICBs require flexibility in contracting models with a period of assessment of success of any new model

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**
- Somewhat disagree
- Strongly disagree

Please explain your answer (max 1250 characters):

- This again focuses on general practice and is not inclusive of all other primary care providers, including community pharmacy. It reads as an extension of general practice rather than a true neighbourhood model encompassing all of primary care plus social care and voluntary sector.
- Community Pharmacy, Optometry and Dentistry often reach people who do not access other NHS services and therefore have a key role in reducing inequalities and improving outcomes. Arrangements for such providers need to be explicit and not implied
- There is a need to bring all primary care providers along on the journey and for them to understand what the new contracting models mean and what they might be able to deliver to improve patient outcomes. There is a risk that if primary care providers do not understand the new models, they will opt out and not get involved.
- Local communities can be very diverse and their needs will reflect this. Community pharmacies are well placed to support the diversity of local populations. This is a significant asset in the development of neighbourhood health teams.
- There is a need to permit partnerships with external specialist providers of care closer to home (e.g. clinical homecare providers, virtual ward), social care providers and educators. If NHSE are to achieve prevention of sickness housing, transportation, self-care education and other factors must be considered.

9. Are there other options we should consider?

Max 1250 characters

- Systems vary greatly in maturity and capacity. A phased approach is needed to avoid widening variation, overloading providers or disrupting existing services and relationships.
- Mechanisms need to be put in place to facilitate and encourage shared learning between different ICBs and also MNPS and SNPs across the country.
- The models need to reduce, not increase, administration and non-essential work and focus on delivery and outcomes for patients.
- The models must avoid creating additional organisational or contractual barriers between providers. The success of neighbourhood health should ultimately be judged by whether it improves outcomes and access for local populations, and reduces health inequalities, rather than simply by the organisational structure through which services are delivered.
- The MNP proposal envisages outcome-based incentives, potentially including measures such as reducing non-elective admissions for particular populations. Community pharmacy can play a significant role in improving population health outcomes.
- There is a need to clarify how the wider primary care contractors (community pharmacy, dentistry, optometry etc) participate in neighbourhood delivery: through membership of Integrated Neighbourhood Teams and referral pathways, rather than by absorbing their contracts

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

Max 1250 characters

- Success measures, evaluation arrangements and mechanisms for sharing learning are needed. Existing local models and pilots should be tested and evaluated before wider rollout.
- Integrated neighbourhood working will only succeed if all providers have appropriate (digital) access to patient information, shared records and population health data. This is a key enabler.

- Primary care providers, other than general practice, should be considered as a potential contract holder, delivery lead and strategic partner, not simply a stakeholder that is consulted or subcontracted.
- Community pharmacies do not operate through registered patient lists and therefore may need different approaches to leadership, commissioning and accountability than those proposed for general practice.
- There should be sufficient flexibility within either model to enable local circumstances to determine the most appropriate approach, while maintaining clear accountability and ensuring that the full breadth of pharmacy expertise is incorporated into neighbourhood care.
- The NHT model is incomplete as it only focuses on clinical service delivery and does not include wider social care and public health reform. The 10-year plan states that NHTs will include social care providers and external specialist providers.

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

Max 1250 characters

- There are concerns regarding the risk of larger NHS organisations dominating future contracting arrangements. Smaller providers may be excluded due to eligibility criteria, (such as holding patient lists), and there is a risk that smaller providers and independent contractors may be crowded out by large trusts or provider collaboratives.
- Contracting, governance and reporting requirements must remain proportionate and should not unintentionally disadvantage independent contractors and smaller providers.
- 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
- Community pharmacies should be able to participate without every service requiring a complex chain of subcontracting.

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

Max 1250 characters

- Support from general practice is important, but this should not be the sole criteria for MNPs as other primary care providers should be involved within the contractual arrangements
- 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.
- 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.
- As neighbourhood models develop, medicines optimisation, deprescribing, prevention and the safe and effective use of medicines should not be seen solely as functions of general practice or hospital-led services. The expanding clinical role of pharmacists, including independent prescribing, provides an opportunity to make pharmacy expertise much more integral to neighbourhood care.
- National model documents are needed including the standard-form SNP subcontract, a model alliance agreement for multi MNP geographies, a model Neighbourhood schedule, plus an outcomes and metrics library aligned to population segmentation, data-sharing agreement templates and worked procurement examples.
- Commissioners also need capacity support for managing subcontract chains and alliance governance.

13. What additional support may commissioners require?

Max 1250 characters

- There is a need for dedicated funding to help providers establish governance arrangements, legal entities, digital capability, workforce development and contract management infrastructure including planning for growth.
- These new models will require workforce transfer, organisational development and change management support. Providers are effectively being asked to create entirely new delivery structures, and the practical support will be required to enable this to happen.
- Support should include 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 should be aware of national guidance, such as MO guidance for ICBs
- Commissioners might require more support and guidance on working with social care and public health
- Patient experience (safety, quality, access) has not been mentioned in the consultation document. More focus is needed on this and commissioners may require more support on how to best commission for improved patient experience.
- There needs to be a clear mechanism for collective community pharmacy voice and clinical leadership.
- There should be a formal mechanism for community pharmacy clinical and contractor representation in neighbourhood decision-making.

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

Max 1250 characters

- Neighbourhood health must address the wider determinants of health, including employment, housing, debt, safeguarding, education and mental wellbeing, not only clinical pathways.
- One of the key aspects of neighbourhood care is prevention, which includes education, social care, public health, mental health etc. These contracts do not seem to encourage partnership working outside of NHS providers.
- There must be parity across all four primary care disciplines, with access to integrated digital infrastructure and dedicated transition support for providers.
- Neighbourhood health should build on existing successful infrastructures, relationships and partnerships, rather than creating parallel structures that duplicate or destabilise mature arrangements that are already in place
- We believe that Neighbourhood health cannot achieve its stated objectives of prevention, access, demand reduction and tackling inequalities without fully utilising community pharmacy as an equal primary care partner and, where appropriate, a contract holder. The frameworks should explicitly recognise community pharmacy as part of the neighbourhood delivery model
- The contracts must consider and engage key stakeholders on their participation and ensure models of delivery dock into existing governance bringing in a wider range of healthcare.
- The pharmacy workforce must be included and integrated into Neighbourhood Health Team, sharing information and participating in MDT decision-making.
- Community pharmacy is a clinical workforce that must be embedded within neighbourhood health services. Community pharmacy contributes to the clinical workforce, provides accessibility to patients and the public with a high frequency of contact with patients. It has significant population reach, combined with medicines expertise as well as independence from the traditional hospital / GP infrastructure. Community pharmacy is an extraordinary neighbourhood asset.
- Commissioning should allow pharmacies to be paid for clinical outcomes, not just individual interventions.
- Where a pharmacy serves several neighbourhoods, there should be mechanisms for standardisation across the MNP footprint.

15. Are you responding as an individual or on behalf of your organisation?

- Individual
- **Organisation:** Royal College of Pharmacy