

A consultation on proposed multi-neighbourhood provider and single neighbourhood provider contracting models to support neighbourhood health services in England.

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About us

We're RCOT, the Royal College of Occupational Therapists. We've championed the profession and the people behind it for over 80 years; and today, we are thriving with over 35,000 members. Then and now, we're here to help achieve life-changing breakthroughs for our members, for the people they support and for society as a whole.

Our Response

Multi Neighbourhood Provider (MNP) Contracts

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?

RCOT supports the principle of using the NHS Standard Contract with an additional Neighbourhood Schedule because it offers a pragmatic route to implementing neighbourhood-based integrated care, reduces the need for entirely new contractual arrangements, and has the potential to support population-based commissioning focused on outcomes.

It would give ICBs significant flexibility, enabling services to be designed around specific community needs and encourage innovative multidisciplinary models that make best use of occupational therapists and other allied health professionals.

The success of this approach will depend on ensuring that the Neighbourhood Schedule explicitly supports multidisciplinary, person-centred care and gives equal prominence to rehabilitation, prevention and independent living outcomes. It should enable meaningful participation of allied health professionals (AHPs), social care and voluntary sector partners. The contract should include outcomes that reflect independence, participation and wellbeing, not solely healthcare utilisation measures. The risks if this approach is not taken is an ongoing over-reliance on medicalised approaches.

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

RCOT supports allowing local commissioners to determine the number of MNP contracts required within their area, rather than mandating a single MNP contract in all circumstances.

Neighbourhoods differ significantly in terms of population needs, geography, deprivation, rurality, provider maturity and existing partnership arrangements. Local flexibility is therefore important to

ensure contractual arrangements support effective integrated care and meet the needs of local communities.

RCOT believes the key consideration should not be the number of MNPs, but whether the contractual arrangement supports integrated, person-centred care, effective multidisciplinary working, and improved outcomes relating to health, wellbeing and participation. The model should also enable meaningful involvement of AHPs, social care partners and the voluntary sector in neighbourhood service delivery.

Occupational therapists work across health, social care, housing, education, employment and voluntary sector settings. For this reason, large-scale single-provider arrangements could unintentionally reduce the influence of local partnerships and community-based services.

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?

RCOT broadly supports the principle that primary medical care elements of neighbourhood services may be subcontracted by an MNP to Single Neighbourhood Providers (SNPs), as this has the potential to ensure services are delivered close to communities, maintain strong links with general practice, and support neighbourhood-level integration.

However, subcontracting arrangements should not result in primary medical care being viewed in isolation from the wider multidisciplinary services. Effective neighbourhood health depends on integration between general practice, occupational therapy, community nursing, rehabilitation services, mental health, social care, housing and voluntary sector partners. Contractual arrangements should actively incentivise collaboration across these professions and sectors rather than reinforcing organisational boundaries.

The model should also ensure that SNPs have access to the multidisciplinary expertise required to deliver preventative, proactive and personalised care. Occupational therapists play a key role in helping people manage long-term conditions, prevent hospital admissions, support timely discharge and remain connected to their communities.

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?

RCOT broadly agrees that the proposed MNP contracting model, together with its relationship with SNPs, has the potential to support more integrated commissioning arrangements by bringing services together around population needs and creating clearer accountability for neighbourhood outcomes.

However, integration will not be achieved through contractual arrangements alone. Successful implementation will depend on ensuring that SNPs, Integrated Neighbourhood Teams and wider

partners work collaboratively, with shared outcomes, effective information sharing and clear governance arrangements. RCOT would particularly emphasise the need for meaningful involvement of AHPs, social care, housing and voluntary sector organisations, whose contributions are essential to prevention, rehabilitation and supporting independence.

There is also a risk that complex subcontracting arrangements could create additional layers of bureaucracy or accountability challenges. The model should therefore include safeguards to ensure that integration is experienced by patients and communities, not just reflected in contractual structures.

Integrated Neighbourhood Team (INT) commissioning

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

Although RCOT is a national body, we favour Option 1 as the preferred starting point for most systems. This approach supports the coordination of Integrated Neighbourhood Teams across existing services and contracts without requiring large-scale contractual disruption or waiting for existing contracts to end.

Option 1 is more likely to preserve the contribution of a wide range of providers, including community services, social care, voluntary organisations and AHPs, while creating stronger incentives for collaboration around shared outcomes.

While Option 2 could eventually provide greater opportunities for pathway redesign, there is a risk that transferring multiple services to a lead provider could be complex, create disruption during transition, and reduce opportunities for smaller providers to contribute.

RCOT therefore supports a phased approach, with commissioners able to move towards Option 2 where there is evidence that local partnerships, governance arrangements and multidisciplinary working are sufficiently mature to support successful implementation.

6. Are there other options we should consider?

NHS England/DHSC should consider alliance- or partnership-based commissioning models for Integrated Neighbourhood Teams (INTs). Such approaches could bring together primary care, community services, social care, mental health, AHPs, voluntary organisations and housing partners under shared outcomes and governance arrangements.

RCOT would encourage greater use of outcomes-based commissioning focused on what matters to people and communities, including independence, participation in daily life, reducing health inequalities, preventing avoidable admissions, supporting timely discharge and enabling people to remain at home for longer. These outcomes are often achieved through coordinated multidisciplinary interventions rather than through any single service.

Commissioners should additionally consider models that formally embed AHPs, social care and

voluntary sector partners in neighbourhood leadership and decision-making, helping ensure that prevention, rehabilitation and independent living are integral to neighbourhood health services rather than secondary to medical care provision.

Commissioning Primary Care Networks and Single Neighbourhood Providers

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

Although RCOT believes all options should be available, we have concerns that introducing SNP/MNP contracting options alongside, or as an alternative to the PCN DES, could create unintended risks for the multidisciplinary workforce.

ARRS, which is embedded across almost all Primary Care Networks in England and is worth £1.5 billion annually, has been a significant enabler of occupational therapy in primary care, supporting their growth within PCNs and improving patient access to preventative, person-centred care.

Any move away from existing PCN DES arrangements must ensure that current ARRS-funded roles and future workforce investment are protected. We would welcome explicit safeguards to prevent the loss, dilution or fragmentation of established multidisciplinary teams during transition to SNP or MNP models.

An additional option to consider would be a model that retains national workforce funding mechanisms, including ARRS, irrespective of whether areas adopt PCN DES, SNP or MNP contracts. This would preserve successful multidisciplinary roles, support workforce planning and avoid unintended disincentives to employing occupational therapists and other allied health professionals in neighbourhood services.

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)?

RCOT agrees that practices should have the ability to opt into Single Neighbourhood Provider (SNP) arrangements where there is a clear case that this will improve integration, outcomes and patient experience.

However, we are concerned that the proposed approach, whereby PCNs and SNPs would not co-exist within the same geography, could create pressure for rapid transition and unintended disruption to established multidisciplinary teams. Occupational therapists and other AHPs have become increasingly embedded within primary care through PCN-based workforce models, particularly via ARRS.

Any move to SNP arrangements should therefore be supported by clear safeguards to protect workforce investment, employment stability and continuity of care. Practices should have confidence that successful multidisciplinary teams will not be lost or disadvantaged as a consequence of changing contractual models.

RCOT would support local flexibility, but only where transitions are phased, evidence-based and accompanied by explicit protections for existing workforce roles and funding streams, including those that have enabled the growth of occupational therapy within neighbourhood services.

9. Are there other options we should consider?

A further option would be to retain a nationally consistent mechanism for funding and supporting multidisciplinary neighbourhood teams, regardless of the contractual model adopted locally. This could allow neighbourhood providers to benefit from greater flexibility and integration while preserving successful workforce initiatives that have expanded access to AHPs, including occupational therapists.

We would also encourage consideration of a phased transition model, enabling areas to demonstrate workforce, patient and service benefits before fully replacing existing arrangements. This would reduce the risk of disruption to established teams and support organisational learning.

NHS England/DHSC should consider introducing minimum workforce expectations within any SNP or MNP arrangements. This would help ensure that neighbourhood services continue to benefit from a broad multidisciplinary workforce, including occupational therapists.

Whatever model is adopted, clear protections for existing workforce funding, employment stability and continuity of care will be essential to ensure that contractual reform supports, rather than inadvertently undermines, the development of integrated neighbourhood services.

Procurement and overall feedback

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

The procurement processes must be proportionate to the scale and risk of the services being commissioned. Requirements relating to financial standing, governance, reporting and bidding should not inadvertently favour large organisations at the expense of community providers, social enterprises or voluntary sector partners.

Commissioners should use simplified procurement documentation wherever possible, provide clear evaluation criteria, and minimise duplication of information requests. Existing provider performance and established multidisciplinary partnerships should be recognised as evidence of capability.

Procurement processes should explicitly assess how bidders will support integrated neighbourhood teams, workforce development and access to AHP expertise, including occupational therapy. A transparent process that values collaboration, patient outcomes and community knowledge, rather than organisational size alone, will help create a more level playing field and support neighbourhood models that are both effective and locally responsive.

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

Smaller organisations may face barriers relating to procurement expertise, financial thresholds, governance requirements, legal costs, workforce capacity and the administrative burden associated with large-scale contracts.

Many GP-led organisations, social enterprises and voluntary sector providers have strong relationships with local communities but lack the infrastructure available to larger providers. Without appropriate safeguards, MNP procurement could unintentionally favour organisations with greater corporate capacity rather than those best placed to deliver neighbourhood care.

These barriers could be addressed through proportionate procurement requirements, standardised bid documentation, access to procurement and legal support, realistic financial thresholds and the encouragement of collaborative bids or alliance models. Commissioners should also ensure that evaluation criteria recognise experience of partnership working, multidisciplinary care and population health improvement, rather than focusing primarily on organisational scale.

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

RCOT believes that meaningful support from general practice should be a core requirement for any MNP proposal. Evidence should go beyond letters of support and demonstrate genuine engagement with practices across the neighbourhood population served.

Bidders should be required to show how GPs, primary care clinicians and multidisciplinary teams have contributed to the development of the proposal and how they will remain involved in governance, service design and decision-making.

Consideration should also be given to requiring evidence that a significant proportion of local practices support the proposed model, alongside confirmation that concerns raised by practices have been considered and addressed.

This approach would help ensure that neighbourhood services remain clinically informed, retain strong links with primary care, and are developed through partnership rather than imposed organisational change.

13. What additional support may commissioners require?

Commissioners may require additional support in workforce planning, organisational development, procurement design and change management to implement new neighbourhood contracting models successfully.

Guidance will be needed on protecting and sustaining multidisciplinary teams during transition, including roles funded through existing workforce initiatives. Commissioners should also receive

support to assess the likely impact of contracting decisions on workforce retention, integration and patient access.

Nationally developed implementation guidance, model documentation and examples of good practice would help reduce variation and support consistency across systems. Access to specialist expertise in AHPs, including occupational therapy, would also help commissioners design neighbourhood services that maximise prevention, independence and population health outcomes.

Clear national expectations regarding workforce protection and continuity of care would further support safe and effective implementation.

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

RCOT encourages NHS England/DHSC to consider how MNP and SNP contracts can maximise the contribution of the full multidisciplinary workforce, including occupational therapists. The guidance identifies opportunities to deliver services beyond those currently associated with PCNs, including care for people with long-term conditions, outpatient activity and leadership and transformation functions. Occupational therapists have an important role in all of these areas through prevention, self-management support, rehabilitation, frailty care, vocational rehabilitation and service redesign.

NHS England/DHSC should ensure that contract specifications, workforce expectations and outcome measures do not focus narrowly on medical and nursing models of care but explicitly support multidisciplinary leadership and delivery.

Finally, commissioners and providers should be encouraged to involve occupational therapists and other AHPs in the design, governance and transformation of neighbourhood services, ensuring local models make full use of the skills available across the workforce and support the shift towards prevention, independence and care closer to home.

Contact

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