Neighbourhood Health Teams: Foundations, and the First Service Offer for People Living with Frailty
Working Draft – Version 16

Service name	Neighbourhood Health Teams: foundations, and the first service offer for people living with frailty
Version and status	Working draft version 16, revised October 2026 following two Central East ICB Frailty Conferences and wider consultation with providers, primary care, local authorities, VCFSE partners, wider primary care professions, residents, carers and professional, quality, finance, workforce, digital and commissioning colleagues. The draft incorporates the resulting clinical, operational and commissioning feedback and is progressing through the required assurance and approval process.
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Population served	The 3.53 million people registered with general practice across Central East ICB, organised around 47 current neighbourhood planning footprints. The first commissioned cohort includes people at risk of frailty, including pre-frailty and social frailty, and people living with mild, moderate or severe frailty.
Service aim	A whole-population, evidence-based neighbourhood offer that supports prevention and early detection, reliable routine care, proportionate assessment and targeted intervention, enhanced coordination where needs are complex or fragmented, and urgent response, recovery and step-down—maintaining independence, preventing deterioration and crisis, reducing avoidable hospital use and health inequalities, and improving the experience of people and carers.
Delivered by and from	Existing local health, care and community services working as one connected neighbourhood partnership - in people's own homes, care homes, acute hospitals, community settings and through virtual arrangements.
Service commencement	Phased mobilisation from April 2027, subject to final approval, agreed contracting and governance arrangements, and each neighbourhood meeting the formal RAG go/no-go readiness gateway. Neighbourhoods may commence at different times according to readiness.
Next formal review	Following completion of the required clinical, quality, commissioning and governance review. The specification will continue to be reviewed through mobilisation, provider and partner testing, resident and carer involvement, and the agreed three-year evaluation cycle.

How to read this specification

This document has two parts. Part One is the Neighbourhood Health Team foundation: the common requirements that apply to every priority population Central East ICB commissions. Part Two is the first cohort module, setting out the offer for people living with frailty. Further cohort modules will be added over time without rewriting Part One.

A separate companion summary accompanies this specification. It covers mobilisation towards April 2027, local planning, programme risks, interdependencies and the neighbourhood planning footprints. That summary is not part of the commissioned specification.

Language used in this document

Term	Meaning
must / will	A requirement binding commissioned NHS providers and contract holders. Contributions from local authorities, VCFSE organisations and other non-NHS partners must be jointly agreed through lawful partnership, commissioning or Section 75 arrangements, remain subject to their statutory duties and available resources, and must not be treated as an unfunded mandatory contribution.
may	A genuine local choice. Providers and partners decide how, or whether, to apply it.
R1, R2 …	Numbered core requirements. These, together with the requirement tables in Part Two, are the essential content of this specification. Surrounding narrative is context and explanation, not requirement.

How this draft was developed

This draft has been developed through an iterative programme of engagement and review. It has been informed by the two Central East ICB Frailty Conferences held in July and September 2026; wider written and workshop feedback from NHS providers, primary care, community, acute and mental health services; local authorities and adult social care; VCFSE organisations and infrastructure partners; community pharmacy and other wider primary care professions; clinical and professional leads; Healthwatch; residents, carers and people with lived experience; and quality, safeguarding, digital, information-governance, finance, workforce, legal, commissioning and programme colleagues. It also draws on learning from neighbourhood and frailty programmes already operating across the Central East footprint, Our Way: Strategy to Delivery, the national Neighbourhood Health Framework and relevant frailty guidance.

Feedback has materially changed the specification. It has strengthened the whole-population model and five-layer care offer; clarified the British Geriatrics Society frailty definition, Rockwood Clinical Frailty Scale and proportionate use of Comprehensive Geriatric Assessment; distinguished routine evidence-based care from enhanced multidisciplinary coordination; and added clearer requirements for accountability, statutory boundaries, workforce and affordability, digital safety, urgent and discharge interfaces, carers, equality, community pharmacy, VCFSE participation, outcomes and readiness. Ongoing involvement will focus on testing operational deliverability, supporting implementation and maintaining a clear audit trail showing how feedback continues to inform the specification and its delivery.

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Part One — The Neighbourhood Health Team foundation

Part One applies to every priority population Central East ICB commissions through a Neighbourhood Health Team. It contains no cohort-specific requirements. The first cohort, frailty, is specified in Part Two.

1. Purpose and context

1.1 What Neighbourhood Health is

Neighbourhood Health organises health, care and community support around a defined population and place. It brings primary care, community health services, adult social care, mental health services, voluntary, community, faith and social enterprise (VCFSE) organisations, acute providers and wider local authority services together so that people experience joined-up, proactive and person-centred support.

A neighbourhood is a population connected by geography, community identity or shared need. General practice remains central through its registered population, although practice lists may cross neighbourhood boundaries. Local arrangements must therefore describe how practices connect with the relevant neighbourhoods and how people are supported where organisational and geographic boundaries do not align. Throughout this document, "general practice" means GP services specifically; "primary care" is used where the intended scope includes the wider primary care contractor professions, including community pharmacy, dentistry and optometry.

The 47 identified Central East neighbourhood footprints are the current planning geography. They do not imply a one-to-one relationship between a footprint, a Primary Care Network, a Neighbourhood Health Team (NHT) or any future contracting arrangement. A footprint may contain more than one person-facing NHT, typically serving 30,000 to 50,000 people where that supports continuity, trusted relationships and a manageable caseload, while some functions operate at a larger scale. Final configuration will be determined by local population need, existing relationships, provider proposals and future commissioning decisions.

The model delivers the three shifts set out in the NHS 10 Year Plan: hospital to community, analogue to digital, and treatment to prevention. It replaces fragmented movement between services with a connected local partnership accountable for a defined population and for the outcomes it achieves.

1.2 The case for change

Across Central East, people face rising long-term conditions, widening health inequalities, growing social care need, increasing urgent and emergency care demand, workforce pressure and marked variation in access. Services frequently work hard for the same people, but through separate referral routes, thresholds, records and operating arrangements. The result is fragmented support, needs recognised too late, and people and carers repeating their story across organisation after organisation and high costs to the system to deliver in such a fragmented and duplicative way.

Central East ICB serves 3.53 million GP-registered residents across Cambridgeshire and Peterborough, Bedfordshire, Luton and Milton Keynes, and Hertfordshire. Age profile, multimorbidity, deprivation, rurality, service use and access vary considerably between and within these areas. Local neighbourhood plans must therefore be built on locality-level data and community insight, not on a Central East average.

Neighbourhood Health is the mechanism for changing that. It uses shared intelligence to identify people whose needs are escalating, brings the right partners around them early, and coordinates a response built on what matters to the person. It is also the practical route to strengthening community assets and tackling the non-clinical determinants of health: housing, loneliness, debt, employment, digital exclusion and carer support.

1.3 Strategic alignment

Central East ICB will begin commissioning and mobilising the NHT foundation from April 2027. This is the starting point of a developmental programme expected to mature over a minimum of three years: not every element will be fully developed on day one. Improvement activity before and after mobilisation will strengthen delivery within the agreed core standard; it will not treat the model as a temporary test.

Our Way: Strategy to Delivery sets the expectation that Neighbourhood Health is how care is organised and delivered locally, not a time-limited programme or an additional layer of provision. Neighbourhood arrangements must therefore make care easier to reach, more joined up from a resident's point of view, and more local wherever possible. The model must reduce avoidable pressure across the whole system — including repeated or poorly coordinated contacts in general practice and community services, as well as

avoidable hospital use — by identifying need earlier and coordinating support around people with complex needs.

The model supports Better Care Fund objectives by reducing avoidable hospital demand, improving independence at home, strengthening discharge and narrowing the gap between a person becoming discharge-ready and returning to the most appropriate setting. It also supports place-based priorities on health inequalities, prevention, care homes, urgent and emergency care, reablement, end of life care and community resilience.

1.4 Design principles

Central East ICB has adopted eleven Neighbourhood Health design principles. They define the outcomes and behaviours the ICB will prioritise, the risks it is prepared to take, and the future state it is working towards with providers, local-authority partners and neighbourhood communities.

Principle	What this means in practice
1. People before organisations	Care is organised around residents and neighbourhood populations, not organisational structures, contracts or institutional boundaries. Functional independence, quality of life and what matters to the person are the organising goals, rather than managing individual diseases in isolation. Neighbourhoods become the primary unit through which care is planned, coordinated and delivered.
2. Prevention before crisis	We invest upstream in prevention, early intervention and proactive care management to reduce avoidable deterioration, hospital use and dependency. We use population segmentation, risk information and clinical validation to find people before crisis, rather than waiting for a referral.
3. Start with need, not services	Population segmentation, risk stratification and population health intelligence identify who will benefit most. Service intensity and resource allocation address unequal need, poorer access and worse outcomes in deprived, rural and other underserved communities. Frailty is the first priority cohort; the same infrastructure will support future cohorts including children and young people, SEND, mental health, multiple long-term conditions and end of life care.
4. One person, one plan, one clinical accountability model	We reduce duplication through shared care plans, trusting clinical decisions once made, and moving towards a single accountable clinical model across organisations wherever possible. Relevant information and plans are visible in real time to authorised partners and, wherever possible, to the person and their carers. Longitudinal, trusting relationships replace disconnected episodes of care.
5. Health and social care working as one system	Health, social care and wider community support will work through coordinated pathways, shared planning and clearly defined responsibilities. Integration does not merge or transfer statutory duties, eligibility decisions, professional accountability or organisational liability. Adult social care, VCFSE organisations, community networks, housing, carers and prevention services are partners in delivery, subject to lawful agreements, agreed resources and their respective governance arrangements.
6. Neighbourhoods by default, hospitals by exception	Care is delivered as locally as possible, digitally where appropriate, at home wherever feasible, and in hospital only when necessary. The person's own home or usual place of residence is the preferred setting for planned and acute care wherever this is safe, appropriate and consistent with their wishes.
7. Accountability follows population	Decision-making, responsibility and resources are progressively aligned around defined populations, creating clear accountability for outcomes, experience, quality and value.
8. Outcomes over activity	We reward improvements in health, independence and experience rather than throughput or institutional performance. Need, function, outcomes,

Principle	What this means in practice
	experience, service use, inequalities and carer wellbeing are measured as standard and used for shared assurance and improvement.
9. One budget mindset	We act as stewards of the total public resource available to residents. The long-term ambition is population-based funding, whole-population budgets and year-of-cost accountability that support better outcomes and prevention.
10. Earn greater freedom through delivery	Every NHT delivers the agreed core functions, outcomes and accountability requirements; local partners may adapt staffing, workflow and additional support to local need and assets. Teams that demonstrate capability, maturity and delivery will be trusted with greater autonomy and financial accountability, evolving from service delivery to population outcomes and ultimately population-resource stewardship.
11. Evidence-based, proportionate and reliable care	Care will reflect the best available evidence, agreed Central East clinical standards and professional judgement. People with similar needs should be able to expect a consistent core standard wherever they live, while the intensity and method of delivery are adapted proportionately to individual circumstances, inequalities, preferences and local community assets. Local flexibility must not result in unjustified variation in access, quality, safety or outcomes.

2. Aim, outcomes and scope

2.1 Aim

To establish a connected neighbourhood arrangement across every Central East footprint that holds responsibility for a defined population and actively manages agreed priority cohorts through proactive, responsive and coordinated health, care and community support.

2.2 Intended outcomes

The service will deliver person-centred, coordinated care closer to home, supporting people to remain well, independent and connected to their communities for as long as possible, with timely escalation and recovery support when needs increase.

Outcome area	Expected change
Experience and continuity	Fewer avoidable transfers between services and repeat referrals; clearer communication; a named point of coordination where required; better continuity; and less repetition of information by people, carers and professionals.
Population health and independence	Earlier identification of need, stronger prevention, improved self-management, and support to maintain function, wellbeing and independence.
Integrated delivery	Primary care, community services, social care, mental health, VCFSE and acute partners working around shared cohorts, care plans and outcomes.
Urgent and emergency care	Reduced avoidable escalation, ambulance conveyance, emergency department attendance, admission, readmission and delayed discharge where safe alternatives exist, alongside fewer poorly coordinated repeat contacts in general practice and community services.
Health inequalities	More targeted action for people and communities at greatest risk of poor access, poorer outcomes or avoidable escalation, supported by monitoring and reporting across protected and inclusion characteristics.
Workforce and sustainability	More effective use of the existing workforce and assets, supported by clear role mapping, better multidisciplinary working, appropriate skill development and the ability to shift care from hospital to community over time.

Outcome area	Expected change
Strategic contribution	A demonstrable neighbourhood contribution to the Our Way objectives of improved access and continuity, reduced avoidable utilisation and better value from the resources available.

2.3 Scope

This specification sets the outcomes, core functions and minimum capabilities required of NHS-commissioned Neighbourhood Health arrangements, whatever their local configuration. Mandatory requirements bind commissioned NHS providers and contract holders only. Contributions from councils, VCFSE organisations and other non-NHS partners must be jointly agreed through lawful partnership, commissioning or Section 75 arrangements and remain subject to statutory duties, governance and available resources. The specification does not prescribe detailed workflow, meeting format, staffing structure, digital product, clinical pathway or provider configuration. Providers must demonstrate how their proposed model will achieve the required outcomes, connect effectively with specialist services and maintain statutory and professional responsibilities.

Local models must start from and build on existing general practice, Primary Care Network, community service and Place infrastructure. This specification does not assume that existing services will be replaced, or that clinical, coordination or administrative activity will transfer to general practice or any other partner without an agreed assessment of capacity, resource, contractual responsibility and impact.

This specification commissions a population-based model rather than an integrated case-management service alone. It covers prevention and early detection, supported self-care, reliable routine evidence-based care, proactive identification and targeted intervention, enhanced coordination where needs are complex or fragmented, and urgent response, recovery and step-down. Not every person identified with frailty will require an active NHT caseload, multidisciplinary discussion, named coordinator or CGA. Where one existing service can meet the person's needs safely and effectively, care should continue through that service without unnecessary referral or additional process.

What this specification does not do

It is not a detailed service-line specification, a complete clinical pathway, or a final contracting decision.

It does not predetermine the number or configuration of NHTs within a planning footprint, the relationship between Primary Care Networks and NHTs, whether a Single Neighbourhood Provider, Multi-Neighbourhood Provider or another contracting route will be used, or which organisation will undertake any future integrator role.

It does not direct local authorities, VCFSE organisations or other non-NHS partners in how to organise their services. Their contributions must be jointly agreed through lawful partnership, commissioning or Section 75 arrangements, remain subject to statutory duties and resources, and include explicit agreement on funding, capacity, governance and risk.

These matters will be addressed through the relevant commissioning, contracting and partnership processes.

3. Core requirements

This section is the essential content of Part One. Requirements R1 to R14 describe the minimum position expected from April 2027 and the direction of development over a minimum three-year period. Where delivery depends on phased infrastructure or locally agreed contracting arrangements, the provider must use an approved interim arrangement with a clear development plan.

3.1 Minimum operating requirements

Ref	Requirement	Evidence of readiness and delivery
R1	**Defined footprint and accountable population** Each NHT will operate within an agreed local footprint that relates clearly to one of the 47 planning footprints. A planning footprint may contain more than one person-facing NHT. Local plans must describe the relationship with Primary	Confirmed footprint and population profile; general practice links and cross-boundary arrangements; local inequality and asset profile.

Ref	Requirement	Evidence of readiness and delivery
	Care Networks, cross-boundary arrangements, care homes and priority communities.	
R2	**A connected partnership, not a new silo** The NHT will connect existing health, care and community capacity around a shared population. It must remove or simplify referral steps and enable direct professional working, rather than create an additional layer.	A description of how the NHT connects primary care, community services, adult social care, mental health, VCFSE and specialist services without duplication.
R3	**Health and social care integration** Commissioned NHS providers must demonstrate joined-up health and social care delivery through agreed pathways, shared care planning, joint decision-making and a coordinated response for people with complex needs. Local-authority participation must be agreed lawfully and must preserve Care Act 2014 duties, eligibility decisions, prevention and wellbeing duties, carers' rights, advocacy, safeguarding, market-shaping and local governance. NHS Continuing Healthcare and NHS-funded Nursing Care responsibilities remain distinct. The local operating model must include a duties and funding schedule, a dispute-resolution route and a named organisation responsible for maintaining support while eligibility or funding decisions are pending.	Agreed operating model, pathway maps, escalation arrangements and evidence of joint working.
R4	**Clear clinical, operational and organisational accountability** Each NHT will have clearly defined clinical and operational leadership and clear accountability for its active cohort. Before mobilisation, the local model must include a signed RACI covering clinical decisions, care coordination, outstanding actions, discharge and transfer, data control, incidents, safeguarding, contract performance, escalation and liability. It must name the accountable decision-maker for each function and describe coordination, enabling infrastructure, decision rights, partner responsibilities and escalation. The contract holder, accountable provider and location of any Integrator function will be agreed separately through the contracting and governance review.	Named accountable functions and people; proposed coordination and enabling arrangements; governance and escalation process; partner contributions; evidence of clinical and contractual accountability.
R5	**Population health management and differentiated response** Every NHT will use linked population-health information, community insight, service-use intelligence and clinical judgement to understand the needs, assets, inequalities, access and outcomes of its whole population; design universal, targeted and enhanced responses proportionate to need; identify people who may benefit from assessment or intervention; and select an active coordination cohort based on complexity, fragmentation, modifiable need and	Population profile; inequality and asset analysis; differentiated population offer; agreed identification and clinical-validation process; documented active-cohort criteria; baseline demand and capacity analysis.

Ref	Requirement	Evidence of readiness and delivery
	likely benefit. Risk scores and digital searches may support identification but must not, alone, determine diagnosis, intervention or inclusion in the active cohort.	
R6	**Proportionate active cohort management** The NHT will actively coordinate support for a defined cohort of people whose needs are complex, escalating, fragmented across services or otherwise likely to benefit from enhanced multidisciplinary coordination. Inclusion must not be based on frailty severity or a risk score alone. For each person in the active cohort, the NHT must record the reason for inclusion, outcomes sought, named coordinator, accountable clinical lead, professionals or organisations responsible for each action, review and escalation arrangements, and criteria for reduced coordination, active monitoring or step-down. People whose needs can be met safely and effectively through routine care or a single service must not be placed on an active NHT caseload solely because frailty has been identified.	Agreed digital process; active cohort audit; named accountability; evidence of action completion, review and safe step-down.
R7	**Integrated team working and caseload management** The NHT will operate as a connected team (team of teams concept) that holds and manages its active cohort through day-to-day professional coordination, direct communication, huddles and formal multidisciplinary review where this adds value. Meeting format and frequency may be determined locally, provided decisions are timely, ownership is clear and actions are completed. Teams should be developed to be high trust, referral threshold light and act in the best interests of the service user. Practitioners will be supported by strong leaders to enable everyone to work at the top of their professional license	NHT operating model; active cohort process; direct-access arrangements; decision and action log; evidence of timely review and escalation.
R8	**Named coordination, clinical accountability and personalised planning** Every person receiving enhanced multidisciplinary coordination will have a named coordinator responsible for maintaining the plan, supporting communication, tracking agreed actions and ensuring safe review, escalation and transition; a named accountable clinical lead appropriate to the person's needs and established care relationships, responsible for clinical oversight within an explicitly agreed scope; and clearly identified professionals or organisations responsible for each assessment, intervention, decision and follow-up action. The named accountable clinical lead does not assume professional, statutory, organisational or legal liability for care delivered, delayed or omitted by another professional or organisation.	Care plan audit; named lead recorded; evidence of person and carer involvement; plans visible to relevant partners.

Ref	Requirement	Evidence of readiness and delivery
	The personalised care and support plan must describe the person's goals, agreed actions, responsibilities, medicines and falls considerations where relevant, carer needs, contingency arrangements, review points and escalation routes.	
R9	**Step-up, step-down and recovery pathways** Each neighbourhood will have agreed operational routes into urgent community response, same-day primary care, ambulance and out-of-hours services, Home First, reablement, intermediate care, virtual wards and Hospital at Home, specialist advice, community nursing, therapy, adult social care and palliative and end of life care. Pathways must specify access points, operating hours, response times, acceptance criteria, responsibility during hand-off and after discharge, action ownership until completion, escalation where the receiving service lacks capacity, rejected-referral routes and feedback to the registered practice. The pathway must support admission avoidance, safe transfer of responsibility, recovery and the person's preferred place of care.	Local pathway map and standard operating procedures; named contacts; step-up and step-down criteria; evidence of discharge follow-up and actioned recommendations.
R10	**Residential and supported living settings are integral** Care homes, extra care housing, supported living and other residential settings must be included within neighbourhood population approaches and pathway development.	Care home engagement plan; care home participation in multidisciplinary working where needed; agreed links with palliative and end of life pathways.
R11	**Community assets and VCFSE partnership** NHT arrangements must provide funded VCFSE participation in design, delivery, governance and review, with a formal governance voice and representation through multiple local networks. Commissioned-provider and wider community-ecosystem roles must be distinguished. Contracting must be proportionate and accessible to small and specialist organisations and provide full-cost recovery, infrastructure support, MDT participation, community-intelligence and closed-loop feedback arrangements. No single organisation or individual may be treated as representing the whole sector.	Asset map; defined routes into relevant VCFSE networks and organisations; referral and feedback routes; examples of community-led and VCFSE-delivered support.
R12	**Data, outcomes and accountability** The NHT will use DELPPHI for agreed population health segmentation, cohort intelligence, caseload planning and reporting, alongside agreed outcome, process, citizen and professionals experience, equity and balancing measures. Contractual performance measures and local improvement measures must be clearly distinguished.	DELPPHI outputs, or documented interim population health arrangements; NHT dashboard; contract performance report; improvement log; resident, carer and staff feedback; Place and ICB assurance.

Ref	Requirement	Evidence of readiness and delivery
R13	**Five-layer care model applied locally** Each NHT must show how its offer delivers all five layers of the Central East care model for its population and each commissioned cohort. The high-impact interventions within an agreed cohort core offer are mandatory; providers may select additional interventions and adapt delivery to local need where the core standard and outcomes are maintained.	Local five-layer offer; evidence that core interventions are available and delivered; local rationale for additional or adapted provision.
R14	**Leadership and core membership** Every neighbourhood must have in place the leadership, membership and access to expertise set out in section 3.2. Roles may be delivered by different organisations or individuals, but each function must have clear accountability, protected contribution and authority to act.	Named or proposed leads for each function; terms of reference; agreed partner contributions; documented arrangements with adult social care and VCFSE partners.

3.2 Leadership, membership and access to expertise

An NHT is an ongoing way of organising and delivering care around a shared population. It is not a multidisciplinary team meeting, a separate referral destination or a prescribed workforce establishment. Multidisciplinary review is one mechanism within a wider population-based model and should be used only where it adds value.

The functions, disciplines and capabilities below must be available to every neighbourhood. They do not prescribe job titles, employers, professional composition or a single staffing structure. Functions may be delivered through existing, redesigned or newly commissioned roles where there is sufficient funded capacity, competence, authority, accountability and protected time. Each Place must demonstrate through its workforce and financial plan that the functions can be delivered safely and sustainably.

Function	Minimum Central East ICB requirement
Primary care clinical leadership	A named GP or primary care clinical lead provides clinical leadership for the NHT, supports cohort identification and appropriate clinical decision-making, and maintains continuity with general practice. The role provides leadership and oversight within its agreed scope; it does not transfer professional or organisational accountability for care delivered, delayed or omitted by another provider.
NHT operational leadership	A named NHT manager or facilitator coordinates the operating model, active cohort process, delivery plan, action tracking, operational escalation, partnership working and performance review.
Community health leadership	A named community health lead secures the core community and district nursing contribution and access to therapy, rehabilitation, reablement and community clinical assessment.
Care coordination	A named care coordination function holds the active cohort, maintains contact with people and carers, coordinates personalised plans, obtains consent where relevant, records decisions, tracks actions and ensures safe review, escalation and step-down.
Adult social care	Each NHT must establish and maintain agreed arrangements with the relevant social care service so that it participates as a core delivery partner. These must include named contacts and agreed routes for statutory expertise, advice, assessment and care-package pathways, safeguarding, equipment, referral, escalation, information sharing and joint working.
VCFSE partnership and community connection	A defined arrangement enables relevant VCFSE networks and organisations to participate in design, governance and delivery, including as commissioned providers where appropriate. No single person or organisation may be assumed to represent the whole sector.

Function	Minimum Central East ICB requirement
Social prescribing	Social prescribing capability connects people with practical, community and wellbeing support. Employment, hosting and delivery arrangements may vary locally. Social prescribing must not be treated as interchangeable with the wider VCFSE sector.
Pharmacy and medicines optimisation	Community pharmacy must be a funded clinical partner in governance and delivery. Arrangements must define prescribing interfaces, structured medication review, medicines optimisation, referral and post-discharge follow-up, shared-record access, workforce requirements and the commissioning and funding mechanism, including independent prescribing as it develops. Medicines optimisation must address adherence, high-risk medicines, polypharmacy, falls and bone-health risk, deprescribing where harmful and evidence-based long-term-condition optimisation where beneficial.
Mental health contribution	A core mental health contribution appropriate to the population and commissioned cohort must be available within the NHT, with specialist expertise accessed through the extended team.
Population health and data	A named population health and data function supports DELPPHI, population segmentation, risk stratification, high-utilisation analysis, clinical validation, baselines, health inequality analysis and reporting. The delivery arrangement for this support will be confirmed before approval.
Specialist and consultant advice	Reliable access to advice on complex clinical issues, supporting shared decision-making, building capability and linking the NHT with acute and specialist pathways.
Integrator arrangement	The Integrator arrangement must, as a minimum, coordinate provider contributions; maintain the operating model, active-cohort and case-management infrastructure; support shared data, action tracking and reporting; convene escalation and resolve operational barriers; assure workforce and partner readiness; and enable proportionate access for VCFSE and community partners. Its geography, delegated authority, resources, accountability, relationship with Health and Care Partnerships, Places, providers and local authorities, and conflict-of-interest controls must be approved before mobilisation. These functions are separate from the choice of host organisation and from any future lead-provider or Multi-Neighbourhood Provider contract.

Every neighbourhood must also have reliable access to the extended expertise its commissioned cohorts require, and to wider partners including acute providers, ambulance services, public health, district councils, benefits and debt advice, employment support, digital inclusion, education and safeguarding. The provider or integrator must ensure these interfaces are reliable and that specialist advice becomes coordinated action. Cohort-specific expertise requirements sit in the relevant cohort module.

3.3 The five-layer care model

The Central East five-layer care model is the common framework for population planning, commissioning, delivery and assurance. Every commissioned cohort must be supported across all five layers. Movement between layers will reflect changing need and likely benefit; it must not depend solely on a diagnosis, frailty score or service threshold.

Care model layer	Required neighbourhood delivery response
1. Prevention, screening and early detection	Use population-health intelligence, community insight, systematic searches, self and carer referral and opportunistic contact to identify emerging need, reduce risk and connect people to prevention. This includes physical activity, strength and balance where appropriate, nutrition and hydration, medicines safety, oral and sensory health, smoking cessation, social connection and action on housing, poverty, transport, caring pressure and digital exclusion.

Care model layer	Required neighbourhood delivery response
2. Supported self-care and routine evidence-based management	Provide accessible information, coaching, digital and non-digital support, social prescribing, community connection and reliable management of existing health conditions. Routine care should be delivered through the person's existing services wherever this can meet need safely and effectively, without unnecessary transfer into an active NHT caseload.
3. Proactive identification and targeted intervention	Use clinical and community intelligence to identify people at risk of deterioration, missed care, loss of independence, repeated urgent-care use or carer breakdown. Provide timely, targeted assessment and intervention to address modifiable need before crisis occurs.
4. Enhanced coordination for complex or fragmented needs	Provide proportionate multidisciplinary assessment, named coordination, clinical oversight, personalised planning and action follow-through where needs are complex, escalating or fragmented across services. Formal multidisciplinary review should be used only where it adds value.
5. Urgent response, recovery and step-down	Coordinate same-day assessment, urgent community response, admission avoidance, Hospital at Home, discharge, rehabilitation, reablement, recovery and follow-up. Support may be intensified or reduced as circumstances change, with rapid re-entry where deterioration or carer breakdown occurs.

3.4 Core functions and levels of working

Neighbourhood Health operates at three connected levels. At population level, data and local insight build a shared view of need, inequalities, demand and assets. At cohort level, partners come together around priority groups with shared plans, pathways and common outcomes. At individual level, personalised assessment, care coordination and action produce one plan that is understood, acted upon and reviewed with the person and their carers.

Every neighbourhood will deliver the following core functions. They may be delivered by different people and organisations locally, but each function must be clear, accessible and accountable.

Function	Minimum expectation
Understand	Use shared data, local intelligence and community insight to understand the population, assets, inequalities and service variation.
Identify	Use proactive case finding and responsive identification to recognise people and cohorts at risk of escalating need.
Coordinate	Hold and manage the active cohort through direct integrated working, with clear clinical oversight, named coordination, action ownership and follow-up. Use huddles or formal multidisciplinary review where they add value.
Plan	Develop proportionate personalised care and support plans that reflect clinical needs, function, personal goals, carer capacity and the wider determinants of health.
Respond	Provide or coordinate timely support when a person deteriorates, including links to primary care, urgent community response, virtual wards, Hospital at Home, reablement, adult social care and specialist advice.
Recover and sustain	Support discharge, rehabilitation, reablement, self-management, community connection and review to prevent avoidable re-escalation.
Learn	Use outcome data, patient and carer feedback, case review and staff insight to improve delivery and reduce variation.

4. Service delivery requirements

4.1 Population health management and proactive identification

Each NHT will apply population health management through four connected activities: **understanding the whole population**, using linked data, service intelligence, community insight and professional knowledge to understand need, inequalities, assets, access, service use, outcomes, cost and unwarranted variation;

designing differentiated responses, planning universal, targeted and enhanced support proportionate to population need; **identifying people for assessment or intervention**, combining digital searches, risk information, professional judgement, self and carer referral, community intelligence, opportunistic contact and significant events; and **selecting the active coordination cohort**, identifying people whose complexity, fragmentation, modifiable needs and likely benefit justify enhanced multidisciplinary coordination.

Frailty severity, high service use or a risk score may contribute to decisions but must not determine them alone. Population health management must support reliable routine care and prevention as well as active cohort management. It must not create a separate list, duplicate existing registers or result in automatic referral to a multidisciplinary meeting.

4.2 Assessment, care planning and named coordination

People receiving a coordinated NHT response will have an assessment proportionate to their needs. Existing valid information must be reused before further assessment is undertaken. Assessment must consider clinical needs, function, medicines, mental health, housing, social connection, safeguarding, carer capacity and what matters to the person. Cohort-specific clinical requirements are set out in the relevant module.

Assessment must identify whether the person is a carer, has an unpaid carer or nominated supporter, lives alone or lacks an effective informal support network. It must include systematic carer identification, information, involvement, assessment and resilience support; recognise young, young-adult and hidden carers; and allow a nominated person or lawful representative where appropriate, including where capacity fluctuates. Personalised plans must include contingency arrangements and a clear escalation trigger where carer strain or breakdown risks crisis.

The outcome will be a personalised care and support plan understood by the person and, where appropriate, their family or carer. The plan must set out agreed goals, actions, responsible professionals, review arrangements and escalation routes. It must minimise duplication and must be visible to relevant professionals through locally agreed shared record arrangements.

Where a person has complex or escalating needs, the neighbourhood will assign a named coordinator or lead professional. This role may be held by a care coordinator, community practitioner, GP, social worker or other appropriate professional. Its purpose is to ensure actions are followed through, people do not fall between services, and the person and carer know who to contact.

4.3 Integrated team working

Each neighbourhood will have an integrated NHT arrangement that enables professionals to work together routinely around the active cohort, rather than relying on referral into a meeting. Core partners must use direct professional communication, shared decision-making and clear action ownership. Huddles and formal multidisciplinary meetings may be used where they add value, but urgent decisions must never wait for the next scheduled meeting.

The NHT will review its cohort, coordinate personalised action, identify the most appropriate professional or service to lead each intervention, and set proportionate review points. It must also identify recurrent barriers, gaps in provision and opportunities to improve pathways or use community assets differently.

4.4 Proactive, responsive and recovery support

Mode of support	What the neighbourhood arrangement will provide
Proactive support	Case finding, welfare contact where indicated, anticipatory care, prevention, self-management support, social prescribing, strength and balance, medication review, care home reviews and community connection.
Responsive support	Rapid multi-agency assessment and coordination when there is a change in need, rising risk, carer concern, frequent attendance or an opportunity to prevent a crisis.
Urgent step-up	Clear links to same-day primary care, urgent community response, virtual wards and Hospital at Home, intermediate care, diagnostics, specialist advice, adult social care and other relevant urgent pathways.
Discharge and recovery	Early planning from hospital or community beds, review of discharge recommendations, home-based assessment where needed, reablement, equipment, social care, welfare follow-up and prevention of readmission.

Mode of support	What the neighbourhood arrangement will provide
Sustained support	Ongoing coordination for people with complex needs where episodic support alone is insufficient, including review of goals, carer needs and service involvement.

4.5 Identification, access, transition and step-down

Neighbourhood Health will operate a no-wrong-door approach and will not depend on a single professional referral or clinical dataset. People may self-refer or be identified and referred by carers, general practice, community and acute services, care homes, adult social care, mental health services, ambulance and urgent care, hospices, community pharmacy, dentistry, optometry, housing, VCFSE organisations and other trusted community partners. The local model must describe how community intelligence is received, acted on, recorded and combined with population-health analytics, and how closed-loop feedback is returned. Residents and carers must be told who to contact, who is coordinating support, how the shared plan is used, what happens when needs change and how to raise a concern without being passed between organisations.

The response must be proportionate. Where one service can address the need safely and effectively, the NHT must facilitate direct action rather than require unnecessary referral, case discussion or duplicated assessment.

A referral or agreed action is not complete when it has been sent. Responsibility must remain clear until it has been received, appropriately progressed and the next step is understood. Discharge must be treated as a transfer of coordinated responsibility: the receiving arrangement must confirm that essential medication, equipment, care, follow-up and escalation routes are in place.

When enhanced coordination is no longer required, the named coordinator must ensure that outstanding actions are complete, the plan is updated, responsibilities are understood and the person and carer know how to seek further support. The person may move to routine care, targeted support, an active monitoring or watchlist arrangement, or full step-down from NHT coordination. A person must be able to return rapidly to enhanced coordination following deterioration, hospital admission, a significant change in circumstances or carer breakdown. Stability or completion of one intervention does not, by itself, require closure.

4.6 Community assets, VCFSE partnership and community trust

Neighbourhood Health will build on the strengths, relationships and assets within local communities. NHTs must use a 'what matters to you' and strengths-based approach, and each Place must maintain a community-asset baseline developed with local authorities, residents and relevant VCFSE networks and organisations. The VCFSE sector is diverse: smaller and specialist organisations may need proportionate infrastructure, funding or practical support to participate. Involvement must be secured through suitable networks and multiple routes, and must never rely on one organisation or individual speaking for the whole sector.

Each neighbourhood will actively involve residents, carers and community organisations throughout design, mobilisation, delivery and review, and must demonstrate how that insight has influenced local priorities, access arrangements, delivery and improvement. NHTs must be visible, understood and trusted in the communities they serve. Each neighbourhood must:

- explain its offer and access routes in clear, accessible language;
- provide both digital and non-digital information;
- work through trusted community organisations and local networks to reach different groups; and
- gather feedback and demonstrate how it has influenced delivery.

This is about making the neighbourhood offer understood and trusted locally. It does not require any area to create a new public-facing brand or standalone service.

5. Enablers and standards

5.1 Workforce and capability

Neighbourhood Health requires workforce contributions from across partner organisations, not the creation of a wholly separate team. Each core partner must identify the capacity, role, leadership and decision-making authority it contributes. Staff must have protected time for integrated working, clear operational processes and support to work across organisational boundaries. A multi-agency workforce means staff from different health, care, local authority and VCFSE organisations working to shared outcomes and agreed processes; it does not require a common employer, job title or contractual arrangement.

The accountable provider or Integrator, supported by Central East ICB and partner organisations, must ensure the workforce has the capability and funded capacity to deliver this specification. Before contract award, each Place must quantify cohort volumes, intervention demand, caseloads, workforce by discipline, leadership, coordination and administration time, vacancies, training, estates, digital costs, transitional funding and a three-year funding envelope. This includes induction to the neighbourhood model and development in person-centred care, population health management, care coordination, safeguarding, mental health, medicines safety, advance care planning, physical activity and behaviour-change conversations, oral health, cohort-specific clinical skills and use of community assets, with reliable access to specialist advice.

Each local plan must include a practical workforce map showing who currently does what and when, the skills and capacity available, and where shortages, turnover, duplication or unclear roles affect delivery. Teams must consider safe role redesign and multi-skilling within professional competence and governance, supported by appropriate development.

5.2 Digital, information sharing and records

Safe coordination requires timely access to relevant information. Central East ICB will provide DELPPHI for the agreed population health, segmentation and planning functions. The accountable provider or integrator will be responsible for ensuring that case-management and shared care-planning arrangements support the active cohort, action tracking and relevant information access. All arrangements must comply with UK GDPR, the Data Protection Act, the Caldicott Principles, the Common Law Duty of Confidentiality and local information-sharing agreements.

Before active cohort management begins, each neighbourhood must meet a minimum digital and information-governance standard: approved data-sharing agreements and data protection impact assessments; defined controller and processor roles; role-based access; interoperable shared records and care plans; referral and action tracking; audit trails; incident response; patient transparency; data-quality controls; safeguards for sensitive mental-health information; and accessible non-digital routes. Any fallback must be time limited, clinically safe, explicitly risk assessed and supported by a funded route to the intended solution. Active cohort management must not commence where these criteria are not met.

This specification sets the capabilities digital arrangements must provide — information sharing, shared care planning, referral and action tracking, coordination, reporting, information governance and interoperability. Any product or contracting decision will follow clinical, digital, information-governance, primary care and commissioning review.

Digital tools must enable rather than complicate collaborative working. Neighbourhoods must make increasing use of them for proactive identification of need, remote monitoring, risk stratification, early intervention, shared care planning and population health management. Digital access, including the NHS App as it develops, must reduce friction, but must never replace telephone or other routes for people who prefer or need them. People and carers must be able to understand their plan and, wherever possible, access information relevant to their own care.

5.3 Quality, safety and safeguarding

Neighbourhood working does not dilute any organisation’s duty to identify, record, refer and escalate safeguarding concerns. Each organisation remains responsible for its own clinical governance, professional accountability, safeguarding duties and incident management. Local arrangements must specify referral routes, the lead agency, communication with residents and families, escalation, dispute resolution and action ownership across organisational boundaries, including where concerns relate to self-neglect, domestic or financial abuse, carer strain or housing risk.

Each NHT must maintain documented clinical governance arrangements for its active cohort, identifying named clinical leadership, decision rights, professional accountability, risk ownership, escalation routes, incident reporting and clinical audit. The detailed model may reflect local provider arrangements, but must be explicit and capable of assurance.

The model must operate in line with the Mental Capacity Act and must involve people in decisions about their care as far as possible. Frailty, cognitive impairment or mental health need must never be assumed to mean that a person lacks capacity. Adult safeguarding, self-neglect, carer strain, domestic abuse, financial abuse and housing-related risks must be considered as part of whole-person assessment and planning.

Continuous improvement is a core service function, not a substitute for a defined service model or contractual assurance. Each NHT must use timely data, case review, staff and resident insight and proportionate improvement methods to strengthen the reliability of its core processes, explaining and addressing variation without redefining the mandatory core offer.

5.4 Equality, inclusion and health inequalities

Neighbourhood Health will use data, local knowledge and community insight to identify and reduce inequity in access, experience and outcomes, recognising the impact of deprivation, rurality, ethnicity, language, disability, digital exclusion, housing, transport, social isolation, caring responsibilities and the earlier onset of ill health in some communities. Outcomes must be routinely reviewed across protected characteristics and inclusion groups, and neighbourhoods must identify and act on unwarranted variation.

Local delivery plans must include formal equality, rural, transport, estates-accessibility and digital-inclusion tests. They must provide accessible non-digital routes; identify and act on communication needs, including hearing or visual impairment, cognitive or acquired brain injury, language, interpretation and reasonable adjustments; and comply with the Accessible Information Standard. Targeted outreach must reach people experiencing homelessness, deprivation, isolation, unstable housing and other underserved circumstances. Access and outcomes must be monitored by relevant demographic and inclusion characteristics, with corrective action where inequity is identified.

Local plans must include practical action to reach people who are less likely to access support through traditional routes, undertaken with public health, adult social care, housing, VCFSE partners and the communities most affected. Resident and community insight is a core input to design, delivery and assurance, not a separate engagement activity. Throughout 2026/27, Central East ICB and local partners will undertake in-depth involvement with residents, carers, community organisations and people with lived experience to test accessibility, outcomes and the practical operation of the model.

5.5 Estates and infrastructure

Partners must make best use of existing NHS, primary care, local authority, VCFSE and community estate before seeking additional capacity. Local plans must consider shared clinical and administrative space, accessibility, service location, digital delivery, utilisation, duplication and opportunities to share benefits and risks. Any costs, savings or resource transfers must be transparent and agreed through the relevant commissioning, business case and partnership arrangements. This specification does not impose an unfunded contribution on participating organisations.

6. Governance, commissioning and performance

6.1 Governance and accountability

Neighbourhood Health requires partnership, clinical and contractual accountability to be explicit. Each NHT must demonstrate agreed clinical governance arrangements that enable full cross-organisational working, led by the Neighbourhood Clinical Lead. Each organisation and professional remains responsible for its statutory duties, clinical decisions, professional practice, safeguarding and regulated activity. The NHT holds collective responsibility for coordination, agreed actions and follow-through for the active cohort. This does not create shared legal or clinical liability for care delivered by another organisation. The final contract holder, provider accountability and location of any coordinating or integrator function will be agreed through the Central East ICB contracting and governance review, which will also confirm the relationship between the Neighbourhood Delivery Committee, Place and Health and Wellbeing Board arrangements, provider governance, quality assurance and existing statutory responsibilities.

Level	Responsibility and assurance requirement
Central East ICB / commissioner	Sets strategic commissioning direction, the common service standard and the outcome framework. Holds contractual accountability unless delegated through an agreed arrangement. Enables population health planning and receives assurance on quality, equity, delivery and value.
Place Partnership / Health and Wellbeing Board	Provides place-level partnership accountability, aligns local assets and plans with population needs and local authority priorities, oversees local plans and population outcomes, and escalates barriers or commissioning requirements.
Adult social care	Contributes statutory expertise, prevention, assessment, review, reablement, Home First, discharge and wider care-market insight, supporting integrated neighbourhood delivery and population outcomes.
Contract holder / integrator	Holds the agreed contractual delivery responsibility, provides enabling infrastructure and case-management arrangements, coordinates provider contributions, aligns workforce and operational plans, maintains professional governance and assures delivery against this specification.

Level	Responsibility and assurance requirement
Neighbourhood Health Team	Holds and actively manages the defined cohort, operates the local model, maintains clinical and operational accountability, coordinates local pathways and partner action, and uses data and feedback to improve delivery.
Partner organisations	Retain statutory, professional and employment responsibilities while delivering their agreed contribution to the NHT, the shared cohort and the agreed outcomes.
Residents and carers	Shape priorities, co-design solutions, provide feedback on experience and help interpret whether the model is making a meaningful difference.
VCFSE networks, partners and providers	Contribute community insight, design and delivery expertise; connect the NHT with local networks; participate in governance where appropriate; and fulfil provider responsibilities where commissioned.

6.2 Commissioning and financial arrangements

Commissioning and financial arrangements will build on existing contracts, services, workforce and local assets where these support the future model. Baseline mapping will identify current investment, capacity, variation, duplication and gaps. The purpose is to align resources and accountability around neighbourhood populations and outcomes, not to add a parallel layer.

From April 2027, NHT arrangements will be commissioned through the most appropriate locally agreed mechanism. Because the national consultation on Single and Multi-Neighbourhood Provider models closes on 10 September 2026, this specification is contract-model neutral: it defines the service, outcomes and accountability required, while the contracting process determines who holds the contract. Contracts will be outcome-led and must support shared responsibility across primary care, community, mental health, VCFSE and local authority partners. Where neighbourhood functions overlap with legacy arrangements, commissioning must simplify, redesign, align or decommission duplication rather than add fragmentation.

The ICB intends to commission neighbourhood arrangements at Place level, aligned to unitary authority geographies. Neighbourhoods within each Place must work as a coherent whole, with clear relationships, consistent interfaces and shared accountability for the Place population, though not necessarily the same delivery arrangements; some services will operate at multi-neighbourhood or ICB scale. Places must identify commissioning and decommissioning requirements, opportunities for VCFSE delivery and the changes needed to remove duplication.

Commissioning intentions for 2027/28 must signal the changes required: population health management, proactive cohort identification, care coordination, shared caseload management, direct professional working and clear accountability for follow-through. Detailed delivery arrangements may develop locally, but required outcomes and responsibilities must be explicit in relevant contracts. The longer-term direction is towards provider collaboratives or lead-provider arrangements able to coordinate the neighbourhood offer coherently for each Place, with fewer fragmented contracts and clearer leadership from primary care, GP collaboratives and other providers.

The NHT foundation and each cohort offer will be commissioned and evaluated over a minimum three-year horizon. Year one will focus on mobilisation, workforce and relationship development, establishing the active cohort and delivering the core offer reliably. Outcomes, utilisation and value will then be assessed against an agreed trajectory across the full period, not through a year-one cost-reduction test. Existing March 2029 measures are interim milestones within that longer period.

No transfer of activity, caseload, coordination responsibility, clinical workload, demand or financial risk between organisations is assumed through this specification. Every proposed shift across primary care, community, acute, mental health, social care, local government or VCFSE partners must have an agreed resource-flow and risk-sharing schedule and a net-burden assessment covering workforce, capacity, finance, contractual responsibility, dependencies, risks and expected benefits. No shift may begin until accountable organisations have signed off that capacity and funding follow the activity.

6.3 Measuring progress, performance and learning

Central East ICB will use one proportionate measurement and value framework for NHTs. The contractual set will be small and explicitly defined, with published definitions, baselines, trajectories and attribution rules. It will include independence and function, quality of life, confidence, physical activity, social connection, carer experience, equity, continuity, completed actions and staff and workload balancing measures alongside safety

and avoidable utilisation. Wider measures will support learning rather than process compliance. NHS, local-authority and VCFSE partners will use common cost definitions, baselines, time horizons and avoided-activity assumptions; year one will not be judged solely on cashable savings.

6.3.1 National outcome requirements

The following requirements are drawn from the Neighbourhood Health Framework published in March 2026. Cohort-specific national targets are set out in the relevant cohort module.

National area	Headline requirement
Complex needs	95% of people with complex needs have an agreed care plan by 2027.
General practice access	90% of clinically urgent patients seen on the same day by March 2027.
Planned care	Contribute to diversion of at least 25% through single-point-of-access and multidisciplinary models in at least 10 high-volume specialties, and a 10% reduction in secondary care follow-ups by March 2027.
Urgent and emergency care	Reduce avoidable emergency department attendance, non-elective admission and Category 3 and 4 ambulance conveyance among priority cohorts, while increasing appropriate use of community alternatives.
End of life care	Increase identification of people approaching end of life by 10%, and reduce non-elective admissions and bed days for this cohort by 10%, by March 2029.
Patient and staff experience	Implement the national patient-reported and neighbourhood staff-experience measures as they are confirmed, supported by locally agreed interim measures.

6.3.2 Central East operational and improvement measures

Every neighbourhood will report against the six domains below. The framework holds a common Central East core while allowing each Place to add local measures reflecting its population, priorities and delivery model. All measures must be reported by neighbourhood and priority cohort and, where data allows, broken down by age, sex, ethnicity, deprivation, rurality and other relevant inclusion characteristics.

Domain	Core measures	How it will be used
1. Foundations and maturity	Defined footprint and cohort; physical, community and people-based asset and service map; named leadership and core membership; agreed governance; data-sharing arrangements; referral, escalation and case-management standard operating procedures; team charter and shared tools.	Baseline within the first 90 days of active delivery, then six-monthly self-assessment and peer review.
2. Person, carer and community experience	What-matters goals and goal achievement; patient-reported experience and outcome measures; carer feedback; continuity; repetition of information; accessibility and navigation; awareness of the local offer; community trust; and evidence that feedback has changed delivery. Locally co-produced questions must test whether people know who coordinates their care and how to contact them, understand what happens next, avoid repeating their story, see agreed actions completed, can access support in a way that works for them, and feel carers are listened to. MYCaW may be adopted locally.	Quarterly review, with lived-experience insight used to define and test improvement actions. Results considered alongside case-based review.
3. Pathway reliability and care coordination	Active cohort; named coordinator or lead professional; personalised plan; action completion; timely first contact; planned reviews; escalation plan; record visibility; continuity; and reduced avoidable referrals, transfers between services and duplicated paperwork.	Monthly operational dashboard. Core processes must move towards reliable delivery for at least 95% of eligible people.

Domain	Core measures	How it will be used
4. Workforce and partnership	Core attendance and contribution; staff experience; collaboration and integration; protected time; training; unresolved operational barriers; and cross-organisation escalation.	Quarterly pulse review and action plan at NHT and Place level.
5. System utilisation and value	Outpatient activity; emergency department attendance; ambulance conveyance; non-elective spells; inpatient bed days; general practice and PCN appointments; repeat and community contacts; experience of access; and continuity of care, for the defined cohort.	Monthly trend review against a baseline and rolling comparison. Utilisation must be interpreted alongside complexity, continuity and experience: the aim is reduced avoidable use, not indiscriminate reduction in contact.
6. Equity and reach	Who is identified, supported and benefiting; variation in access, experience and outcomes for priority communities; unmet need; digital exclusion; and gaps in local provision.	Quarterly review to target outreach and prevent the model reinforcing existing inequalities.

Each Place will report the agreed measures by neighbourhood and priority cohort to the Health and Wellbeing Board and the Neighbourhood Delivery Committee, with formal Place-level reporting at least quarterly. Where a measure cannot initially be produced at neighbourhood level, the Place must identify the data gap, the responsible owner and a resolution timetable.

6.3.3 How measures will be interpreted

The first year of commissioned delivery will focus on establishing the cohort consistently, embedding the operating model, improving process reliability and creating a credible baseline. An initial increase in proactive contacts, care planning or community activity is expected and must not be read as poor performance. Equally, integrated working may reduce formal referrals, transfers and repeat contacts, because partners can act together without transferring responsibility; lower referral activity must not automatically be treated as under-delivery. Activity must always be interpreted alongside outcomes, experience, continuity and completed actions.

National targets apply where specified. Central East and local trajectories will be agreed once baselines, definitions and data quality are understood. Contractual measures will be limited to a clear, proportionate set of outcomes and reliability requirements; wider measures will be used to understand variation and support improvement, rather than to apply blanket financial penalties.

Each NHT will maintain a proportionate improvement log recording the issue addressed, the measure followed, the action taken, the result, the learning and any decision to adapt or spread the change. Frontline professionals, residents, carers and delivery partners will help refine practical pathways, templates and documentation, within governance that provides safe boundaries for timely improvement. Where there is meaningful variation in local delivery, or where an intervention has a limited implementation evidence base, Central East ICB and Places will undertake proportionate evaluation at agreed interim points.

Part Two — First commissioned cohort: people living with frailty

Part Two applies in addition to Part One. It sets out the requirements specific to people living with mild, moderate or severe frailty. Later cohort modules will be added without altering Part One.

7. Frailty commissioning requirements

7.1 Why frailty is the first priority cohort

Frailty is the first cohort commissioned through the NHT foundation because national and local evidence shows substantial opportunity to maintain independence, prevent deterioration, improve experience and reduce avoidable hospital use. Delivery and learning here will establish the case and the infrastructure for a broader out-of-hospital offer for other cohorts.

Working Central East estimates indicate approximately 164,516 people living with mild frailty, 40,715 with moderate frailty and 20,603 with severe frailty. These figures provide the current planning baseline and must be interpreted alongside locality-level variation, data quality and inequalities.

7.2 Cohort and identification

The Central East offer includes people at risk of frailty, including pre-frailty and social frailty, as well as people living with mild, moderate and severe frailty. Prevention must address declining mobility, isolation, bereavement, loss of confidence, nutrition, housing, poverty, caring pressure and digital exclusion, with interventions intended to prevent or delay progression. There is no automatic age threshold: assessment and support must reflect need, clinical judgement and reasonable adjustments. The type and intensity of support, assessment and coordination will increase or reduce as circumstances change.

Identification will begin with DELPPHI segmentation of existing primary care data, which is a mandatory requirement of this specification, followed by agreed risk-stratification information, high-utilisation intelligence, local knowledge and clinical judgement. It must also draw on relevant community, mental health, social care, care home, discharge, urgent care and carer information, reusing valid assessments wherever possible.

Frailty is defined using the British Geriatrics Society definition: “Frailty: a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves.” Possible frailty may be identified through direct clinical contact, systematic general-practice searches, DELPPHI, the electronic Frailty Index, service-use information, local and community intelligence, carer information or a triggering event such as a fall, hospital admission, delirium, functional decline or carer breakdown. The **Rockwood Clinical Frailty Scale** is the agreed clinical tool for confirming and recording frailty severity. It must be completed by an appropriately trained professional using clinical judgement and information about the person’s usual level of function before the current illness or deterioration. It must not be derived automatically from an electronic score, applied solely from the person’s current acute presentation or used as the sole basis for access, eligibility, treatment limitation or resource allocation. The CFS score, assessment date and relevant clinical context must be recorded using the agreed Central East coding standard. Where the CFS is not validated or clinically appropriate for a particular person or population, an agreed alternative approach and reasonable adjustments must be used, supported by relevant specialist advice.

Frailty identification, CGA and active NHT coordination are distinct decisions: **identification** recognises possible frailty through data, clinical contact, community intelligence or a triggering event; **clinical confirmation and severity** require an appropriately trained professional to apply the Rockwood Clinical Frailty Scale, informed by the person’s usual baseline function; **assessment and planning** use CGA proportionately where the person’s needs and likely benefit indicate that a multidimensional and multidisciplinary assessment is required; and **coordination** provides enhanced NHT support only where complexity, fragmentation, escalating need or risk and likely benefit justify it. A person may have confirmed frailty and receive high-quality routine care, prevention or a single-service intervention without requiring CGA or admission to an active NHT cohort.

Clinical identification and coding may use the term frailty, but communication with people must use language they find understandable and acceptable. Teams must avoid imposing a label that may discourage engagement, explaining support instead in terms of maintaining independence, function, wellbeing and what matters to the person.

For people with mild frailty, the commissioned response will normally emphasise proportionate prevention and supported self-care delivered through connected health, local authority, community and VCFSE provision, focusing on what matters to the person, on strengths and assets, and on supervised activity, nutrition and social connection — with a clear route to more coordinated support whenever needs justify it. A formal

personalised care and support plan and named coordinator will be provided where the person's needs require a coordinated NHT response, rather than automatically for everyone identified with mild frailty.

Local plans must describe how population insight and opportunistic contact will identify emerging, mild, moderate and severe frailty — including potential frailty among carers — and connect people to the appropriate level of support.

7.3 The Central East core frailty offer

The following offer sets out the consistent frailty interventions every neighbourhood must provide or coordinate when clinically appropriate. 'Core' identifies the minimum service expectation for the relevant stage. It does not mean every person receives every intervention, or that the NHT directly employs every service. Interventions must be discussed with the person and offered according to clinical need and informed choice.

Stage	Main purpose	Central East core offer
Mild	Prevent or delay progression and maintain independence.	Supervised multicomponent exercise; nutritional support; and action to address social isolation.
Moderate	Identify reversible problems, maintain function and prevent deterioration or crisis.	Proportionate Comprehensive Geriatric Assessment; coordinated multidisciplinary intervention; supervised multicomponent exercise; medicines review and optimisation; carer assessment and support where indicated; and consideration of social care assessment requirements. Care coordination to reduce fragmentation of experience and healthcare utilisation, including consolidation of outpatient activity around individual need rather than clinical specialty.
Severe	Coordinate complex and anticipatory care around the person's priorities.	Proportionate Comprehensive Geriatric Assessment; advance care planning; carer assessment and support; and coordinated care at the end of life. Care coordination to reduce fragmentation of experience and healthcare utilisation, including consolidation of outpatient activity around individual need rather than clinical specialty.

Comprehensive Geriatric Assessment is a multidimensional and multidisciplinary assessment and care-planning process, not a frailty severity score. It should be applied proportionately to need and likely benefit. A **proportionate CGA-informed review** may be completed in stages, draw on existing valid assessments and involve only the domains and professionals relevant to the person's needs. A **fuller multidisciplinary CGA** will normally be required where the person has moderate or severe frailty with interacting or unresolved needs, repeated deterioration, diagnostic uncertainty, significant functional decline, complex medicines, cognitive or mental-health needs, carer breakdown, recurrent hospital use or fragmented involvement from several services. CGA must lead to a coordinated personalised plan with agreed outcomes, action owners, clinical oversight, review arrangements and escalation or contingency plans. It must not become a repeated checklist or duplicate assessments already completed by other services.

Providers may decide how the core offer is organised locally, but must demonstrate timely access, clinical appropriateness and delivery of the agreed outcomes. Not all services supporting this population are NHS-commissioned, which is why delivery requires effective partnership working with the relevant local authority for the Place. The full intervention framework, including the wider locally selectable offer, is at Appendix B.

7.4 Standard operating pathway for frailty

The following sequence describes the minimum responsibilities and results required. It does not require every person to be discussed in a formal multidisciplinary meeting.

Stage	Required operating practice
1. Identify, confirm and record	Identify possible frailty using DELPPHI, systematic general-practice searches, available electronic frailty information, service-use intelligence, community and carer insight, significant events and clinical judgement. An appropriately trained professional must confirm and record frailty severity using the Rockwood Clinical Frailty Scale, based on the person's usual baseline function. The CFS must not be

Stage	Required operating practice
	automatically generated from an electronic score or applied solely during an acute presentation. Use agreed alternatives and reasonable adjustments where the CFS is not validated or clinically appropriate.
2. Make contact and agree involvement	Agree the most appropriate professional to contact the person, explain the coordinated neighbourhood approach, and obtain agreement to information sharing and coordination where required.
3. Complete proportionate CGA where indicated	Review and reuse existing information first. Where the person's needs and likely benefit indicate, undertake a proportionate CGA-informed review or fuller multidisciplinary CGA covering relevant domains, including physical health and function; mobility, falls and valued physical activity; cognition, delirium and mental health; medicines; nutrition and hydration; oral health; vision and hearing; continence; pain, sleep and fatigue; housing, poverty and environmental risk; social connection and community participation; carer capacity and resilience; social-care assessment or review requirements; advance and anticipatory care planning; and the person's own goals and priorities. The depth, sequence, lead professional and contributors must reflect the person's needs. CGA must result in coordinated action rather than assessment alone.
4. Plan and allocate	Agree a personalised plan, clinical oversight, named lead or coordinator, actions, responsible professionals, escalation arrangements and review point. Use direct integrated working, a huddle or formal review according to need.
5. Deliver and respond	Coordinate proactive intervention, connect the person with community support, and use existing urgent, specialist and recovery pathways when needs escalate.
6. Monitor and adjust	Review needs, outcomes and completed actions. People at any frailty stage who require active NHT coordination remain on the active caseload while that need continues, with the intensity and mix of interventions increasing or reducing as circumstances change. Stability or completion of one intervention does not, by itself, close the frailty caseload record.

Frailty planning must recognise that recovery, stability, deterioration and dying may all be possible, and must prepare for these possibilities at the same time.

7.5 Frailty-specific expertise and team requirements

In addition to the leadership and membership required by section 3.2, every NHT delivering the frailty offer must have reliable access to: geriatric and frailty advice, including geriatrician or consultant input; older people's mental health and dementia expertise; care home and frailty practitioners; falls, continence, therapy and rehabilitation services; urgent community response, Home First, reablement and intermediate care; virtual ward or Hospital at Home; hospice and specialist palliative care, contributing as clinical, community and commissioned delivery partners; and housing, carers services and wider local authority services.

Workforce development for this cohort must include frailty-specific capability alongside the general requirements at section 5.1.

7.6 Care homes, mental health and end of life care

Care home residents are part of the neighbourhood frailty population and must be connected to proactive identification, regular clinical input, medicines optimisation, falls prevention, anticipatory planning, staff support and timely escalation. The model must align with Enhanced Health in Care Homes and local care home pathways.

Mental health, learning disability, autism, neurodiversity and dementia must be designed into the neighbourhood architecture rather than added later. Dementia must be distinguished from frailty, while recognising overlap. Assessment and planning must cover mild cognitive impairment, depression, anxiety, severe mental illness, delirium, young-onset and rarer dementia, capacity, carer strain and the effect of mental health and cognition on function and engagement. Validated alternatives and reasonable adjustments must be used where standard frailty tools are unsuitable. An aligned route for future MHLDN cohort specifications must define early intervention, specialist interfaces and dementia-friendly practice.

For all care home residents and other people with frailty approaching the end of life, the NHT must support early identification, personalised advance care planning, locally agreed advance and emergency care planning discussions and documentation — including ReSPECT or PACT where applicable — carer support, and coordinated access to hospice, specialist palliative and end of life care. This offer must link directly with the developing advanced illness specification, which will address the wider all-age population.

7.7 Frailty outcomes and measures

Frailty measures sit within the common framework at section 6.3. The national headline requirement for this cohort is to reduce non-elective admissions and bed days of one day or more by 10% by March 2029, compared with the 2025/26 baseline, for people with frailty, care home residents and housebound people.

The final contractual set will be small and evidence-based, with wider measures used for assurance and improvement. It will cover:

1. identification and reach across the mild, moderate and severe frailty populations, including inequalities;
2. annual review status, personalised care planning and delivery of the agreed core interventions;
3. continuity of care, named coordination, action completion and people's experience of joined-up services;
4. emergency attendance, ambulance conveyance, admission and readmission, preventable and ambulatory care-sensitive admissions, bed days and outpatient use for the defined cohort;
5. function, independence, falls, carer experience and what-matters outcomes, with MYCaW considered as a possible local measure;
6. balancing measures, workforce impact, data quality and provider sustainability.

Measures must distinguish leading measures — consistent recording of frailty status, completion of annual reviews, and delivery of proportionate CGA, advance care planning, medicines optimisation and the other core interventions — from longer-term outcome measures, where change may take several years to become visible.

Central East ICB will also explore the Care Intensity and Fragmentation Index (CIFI) as a developmental measure of continuity and coordination, considering the number of services involved in a person's care, transfers between services, duration of involvement and the proportion of care that is reactive. CIFI must be tested and validated through DELPPHI before use for cohort identification, contractual performance or assurance, and must be interpreted alongside frailty status, emergency care risk, gaps in care, demographic information and clinical judgement. Definitions, baselines, trajectories and data capture requirements will be agreed through the measures work and clinical review.

7.8 Alignment of frailty pathways and contracts

From April 2027, Central East will commission neighbourhood health teams and other providers supporting people with frailty to work in an integrated way and deliver in accordance with this specification, with investment and incentives to support the transformation in ways of working required. This demands a significantly more mature partnership approach, trusted relationships, and data and resource sharing from all providers.

Frailty-related provision across general practice, secondary care, acute frailty, community health services, community nursing, therapy and rehabilitation, outpatient services, urgent community response, Hospital at Home, virtual ward, care homes, mental health services, palliative and end of life care, adult social care and VCFSE provision will be commissioned to align with the NHT foundation and the Central East frailty offer. Commissioning and contracting arrangements will progressively set out the contributions, interfaces, access routes, accountability, information sharing, measures and resource implications required.

This does not require all activity to move into one team or contract. It requires existing and future contracts to enable coordinated delivery and remove avoidable gaps, barriers and duplication — including reduced unnecessary outpatient activity and the integration of appropriate acute frailty capability into community pathways, aligned with urgent care, Hospital at Home, advanced illness and other linked specifications.

Appendices

Appendix A — Readiness checklist and local delivery plan requirements

A1. Readiness position required before service commencement

Appendix A1 is the formal signed RAG go/no-go gateway for each neighbourhood. Launch is prohibited where safety, accountability, workforce, funding, information governance, partner readiness or an essential pathway is rated Red. Amber items require a named owner, funded mitigation and deadline approved by the launch decision forum. Differentiated phasing is permitted so that only neighbourhoods meeting the gateway proceed. The gateway record must identify the accountable executive, evidence reviewed, approval forum, decision and conditions.

Readiness area	Required timing	Required position
Specification and contracting	Before contract award or variation	Approved service specification; defined contracting route; accountable provider or integrator; agreed financial and performance framework.
Neighbourhood foundations	Before service commencement	Confirmed footprint and accountable population; agreed geography and relationship with Place, PCN and multi-neighbourhood arrangements; shared purpose and team charter; core NHT membership and named clinical and operational leadership; asset and workforce mapping; partner contributions and governance.
Priority cohort readiness	Before active delivery	Agreed criteria and layered identification method; DELPPHI or interim population health process; active cohort and case-management arrangements for each commissioned cohort.
Operational readiness	From April 2027	Integrated day-to-day working and direct-access arrangements; named care coordination and personalised planning; documented interfaces with primary care, Pathways 1, 2 and 3, urgent community response, reablement, Home First, virtual ward or Hospital at Home, care homes and specialist advice; defined VCFSE and community routes with a current asset map; the relevant cohort core offer; and reporting arrangements.
Data, assurance and improvement	From service commencement	DELPPHI or agreed interim arrangements; national headline measures; contractual performance requirements; local baseline and dashboard; feedback mechanism; improvement log; and a clear reporting route to Place and the Neighbourhood Delivery Committee with a risk log and escalation process.

A2. Required content of a neighbourhood operational delivery plan

Each Place, working through Health and Wellbeing Board arrangements, will produce and maintain one locally owned Place Neighbourhood Health Plan as its Place-level implementation plan. Each neighbourhood or proposed NHT will maintain a concise operational delivery plan showing how it implements the Place plan and this specification. It must demonstrate local adaptation but must not omit the agreed core requirements.

Plans must include practical pathway maps showing who does what and when, direct access and escalation arrangements, and the contribution and capacity expected from each service. Where terms such as intermediate care, reablement or community rehabilitation describe different local arrangements, the plan must define the service, function and interface rather than rely on the label. Central East ICB baseline mapping will be provided to Places once validated; local plans must build on it rather than duplicate completed work.

Plan element	Minimum content required
Neighbourhood and population	Agreed footprint, population size and profile, general practice links including where lists cross boundaries, inequalities and relevant health and care data.
Assets and current offer	A service-and-contract map covering physical estate, community spaces, existing teams and pathways, VCFSE assets, workforce, care homes, primary care, urgent care, diagnostics and digital tools. Include a stop/start/change schedule; duplication and net-burden tests; benefits and disbenefits; equality impact; partner-capacity sign-off; sustainability of temporary funding; and local exemplars to protect, strengthen or spread.
Leadership and governance	Named clinical and operational leadership, core NHT membership, participating organisations and agreed contributions, terms of reference, integrator accountability, reporting route to Place and the Health and Wellbeing Board, and risk and issue escalation.
Priority cohort and pathway	Agreed cohort criteria; layered identification using DELPPHI, risk stratification, utilisation intelligence and clinical judgement; validation and coding; active cohort management; personalised coordination; urgent escalation and discharge interfaces.
Operating model	How the team holds and manages the active cohort through day-to-day coordination, direct access, huddles or formal review; decision rights; action tracking; review and escalation.
Urgent, recovery and discharge pathways	Operational links with urgent community response, Home First, reablement, intermediate care, virtual wards and Hospital at Home, social care, care homes and end of life care.
Workforce and capability	Contributions from each partner; role and skill mapping; capacity, shortage and turnover risks; multi-agency induction and development; and opportunities for safe role redesign.
Resident partnership and VCFSE role	How residents and carers will shape design and review; how VCFSE networks and organisations will contribute as strategic, community and delivery partners, including where commissioned; the local asset map and feedback process.
Data and measures	DELPPHI or agreed interim arrangements; baseline measures; NHT dashboard; national headline measures; contractual performance requirements; equity analysis; local improvement measures and reporting cycle.
Implementation milestones	Key actions, owners, dates and dependencies, aligned to the Central East ICB Enabling Action Plan.
Resources and sustainability	Recurrent resources; non-recurrent enabling funding with source, value, purpose, duration and restrictions; sustainability when temporary funding ends.
Risks and commissioning implications	Top risks and mitigations; dependencies on related programmes; known gaps, duplication, potential resource shifts, primary care contractual implications, service redesign needs and information for future commissioning.

Appendix B — Frailty intervention framework

This appendix applies only to the frailty offer and must not be read as part of the NHT foundation. It distinguishes the priority interventions forming the consistent Central East core offer from the wider evidence-supported interventions that may be selected according to individual and local need.

Cells marked CORE are requirements the service must make available and offer when clinically appropriate; they are not mandatory treatments for every individual. A tick identifies interventions that must be available and used where appropriate, with local flexibility in delivery. A blank cell does not prevent an intervention being offered where clinical judgement indicates benefit.

Intervention	Mild	Moderate	Severe
Comprehensive Geriatric Assessment		CORE	CORE
Coordinated multidisciplinary intervention		CORE	✓
Supervised multicomponent exercise	CORE	CORE	✓
Nutritional support	CORE	✓	✓
Medication review and optimisation	✓	CORE	✓
Social isolation	CORE	✓	
Advance care planning		✓	CORE
Carer assessment and support	✓	✓	CORE
Care at end of life	✓	✓	CORE
Mental health and wellbeing	✓	✓	✓
Falls interventions	✓	✓	✓
Cognitive impairment and dementia interventions	✓	✓	✓
Governance of integrated care	✓	✓	✓
Hospital at Home		✓	✓
Enhanced care home support		✓	✓
Continence		✓	✓
Oral health	✓	✓	
Sensory impairment	✓	✓	
Sleep and fatigue	✓	✓	
Home health	✓		

Appendix C — Working definitions

These definitions will be reviewed with clinical, commissioning, provider and local authority colleagues before approval.

Term	Working definition
Accountable population	The people for whom an NHT holds agreed population-level and cohort responsibilities within a defined footprint.
Active cohort	People requiring enhanced NHT coordination because their needs are complex, escalating or fragmented, or because there is a clear modifiable risk and likely benefit from coordinated multidisciplinary action. Inclusion is not determined solely by a frailty diagnosis, Rockwood Clinical Frailty Scale score, electronic risk score or level of service use. People may move between active coordination, active monitoring, targeted support and routine care as their circumstances change.
Comprehensive Geriatric Assessment (CGA)	A multidimensional and multidisciplinary assessment and care-planning process used to understand and respond to the health, functional, psychological, social, environmental and carer needs of a person living with frailty or complex needs. CGA is applied proportionately according to need and likely benefit and results in a coordinated personalised plan with clear action owners, clinical oversight, review and contingency arrangements. CGA is not a frailty identification or severity-scoring tool.

Term	Working definition
Rockwood Clinical Frailty Scale	The agreed clinical tool for confirming and recording frailty severity. It describes a person's overall level of fitness or frailty using clinical judgement and information about their usual baseline function before any current acute illness or deterioration. It must be completed by an appropriately trained professional and must not be automatically inferred from the electronic Frailty Index, used in isolation, or treated as the sole basis for access, treatment limitation, eligibility or resource allocation. An agreed alternative must be used where the scale is not validated or clinically appropriate.
Electronic Frailty Index	A population case-finding and risk-stratification method derived from coded information in general-practice records. It may be used with DELPPHI and other intelligence to identify people who may benefit from clinical review. It does not, by itself, confirm frailty, determine a Rockwood Clinical Frailty Scale score or establish eligibility for CGA or enhanced NHT coordination.
DELPPHI	The required Central East population health and planning capability supporting segmentation, cohort intelligence and neighbourhood planning. Distinct from any clinical frailty identification tool.
FReDA	A clinical frailty identification approach that may support case finding or implementation where approved through the Central East clinical process. It does not replace professional clinical confirmation using the Rockwood Clinical Frailty Scale and must not duplicate DELPPHI, general-practice searches or existing assessment processes.
Named coordinator	The single named professional who coordinates a person's plan, tracks actions, is the contact point for the person and carer, and ensures safe transfer or step-down. Replaces 'named lead professional' and 'care coordinator'.
Neighbourhood	A defined population and geography within which services work together around shared needs and outcomes. Not necessarily synonymous with a a PCN.
Neighbourhood Health Team (NHT)	A connected partnership of existing health, care and community teams responsible for a defined population and actively managing agreed cohorts.
Place	The unitary authority area used for partnership planning and commissioning. Arrangements will adapt as local government reform is implemented.
Population health management (PHM)	Use of linked data, local insight and clinical knowledge to understand need, identify inequalities and target support.
Integrator	A potential future organisation or agreed arrangement coordinating provider contributions, enabling infrastructure, case management and delivery. Multi-Neighbourhood Provider (MNP) contract models are the options under national consultation; this draft has not assumed a contract model. A specification for an integrator function will be developed as a next step.
VCFSE	Voluntary, community, faith and social enterprise organisations, including those contributing as strategic partners, community connectors or commissioned providers.

Appendix D — Key references

- Department of Health and Social Care and NHS England (2026) Neighbourhood Health Framework, 17 March 2026.
- NHS England (2026) Best Practice Guide for NHS Frailty Pathways, 14 May 2026.
- NHS England (2025) Neighbourhood Health Guidelines 2025/26.
- Central East ICB (2026) Draft Strategic Commissioning Report: Frailty and End of Life. Working draft.
- Hertfordshire and West Essex ICS (2026) Enhanced Commissioning Framework 2026/27. Draft.

- Winn, M. (2026) Central East ICB Frailty Conference presentation, July 2026, and Evidence Base for Integrated Frailty Services, version 11, 3 June 2026. Supporting technical evidence, to be issued alongside future consultation materials.