NHS
Central East
Integrated Care Board

Welcome to the
Central East Frailty Best Practice Conference

16 July 2026

Agenda for the day

10:00	Welcome and scene setting
10:05	Central East approach to frailty
10:25	National frailty framework proposal
10:45	Q&A
11:00	**Break**
11:20	Workshops – Session One
12:10	Workshops – Session Two
13:00	**Lunch**
13:40	Workshops – Session Three
14:30	Sharing best practice and what happens next
15:00	Event closes

Your hosts for today…

Maria Wogan

Exec Director for Neighbourhood` Health and Partnerships: Bedfordshire, Luton & Milton Keynes (BLMK)

Ed Knowles

Director for Neighbourhood Health and Partnerships: Hertfordshire

Pam Green

Director for Neighbourhood Health and Partnerships: Cambridgeshire & Peterborough

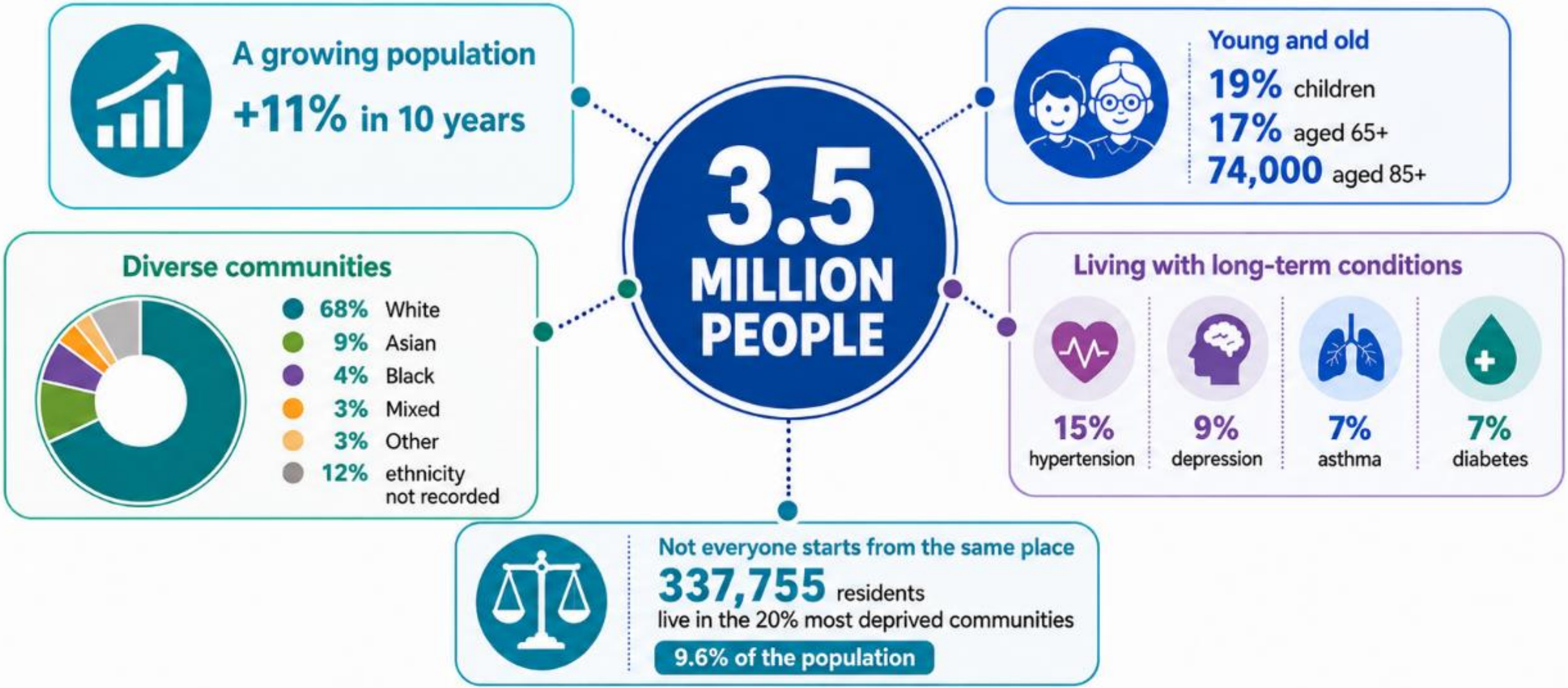
Welcome and Scene Setting

- Our Way – Strategy to Delivery
- One shared ambition – Neighbourhood Health Teams
- Frailty first
- National reform accelerating
- Learning from pioneers
- From design to delivery

Today's objectives – creating the conditions

- ***Showcase Excellence*** – highlighting the best frailty models from our neighbourhoods and places
- ***Demonstrate Impact*** – sharing evidence of improved outcomes and reduced utilisation of hospital care
- ***Connect and Collaborate*** – bringing together leaders from across health, care and community services
- ***Learn, Improve, Codify and Scale*** – understanding what works to inform a commissioning specification
- ***Driven by one question: what best serves our population? -*** transforming care for people living with frailty and their families and carers – delivering better experiences, better outcomes and greater independence

The people we serve



A diverse population

Scaling Neighbourhood Health in Central East: A Frailty-First Approach

Our Way in Action: Driving Improvement Through Priority Programmes

Care Delivery Model

- Prevention & Screening
- Self Care
- Early Intervention
- Complex Care
- Crisis

Managed Care Delivery

- **Data sharing** — Enable timely safe access to information across organisations and settings
- **Population segmentation & stratification** — Define population groups and identify those most likely to benefit from tailored interventions
- **Proactive outreach** — Shift from reactive care to planned anticipatory care and engagement
- **AI enabled triage** — Direct people to the right care at the right time reducing unnecessary demand
- **Care Co-ordination** — Coordinate care seamlessly across services to ensure timely, integrated support for individuals

Priority Starter Programmes

- **B1. Prevention and screening for cancer** — Increase uptake consistently and timeliness of cancer prevention screening and early detection
- **B2. Self care for MSK** — Roll out the use of AI self care technology for MSK pathways to increase attendance at work
- **B3. Utilisation risk management in cardiology** — Reduce avoidable utilisation and escalation by identifying people at risk earlier and intervening proactively
- **B4. Care coordination for advanced illness** — Provide coordinated person-centred care for people with advanced illness through managed care approach
- **B5. Acute care pathway for mental illness** — Improve outcomes and experience for people with severe mental illness by ensuring rapid access to the right care first time

Commissioning Provider Collab Models

- **C1. Dermatology pathway** — Recommission dermatology services using an already designed pathway to simplify access and reduce unnecessary demand
- **C2. Diabetes pathway** — Recommissioning the diabetes pathway using existing proven specification developed in one place scaling it system wide
- **C3. Neurodiversity** — Commence the product development cycle.
- **C4. NHTs** — Commence the product development cycle for neighbourhood health teams and delivery services

Our aim is to establish a Neighbourhood Health Team in every neighbourhood, applying a **Quality Improvement (QI)** approach, prioritising **people with frailty** as the initial cohort to test and refine the model during 2026/27, to commission Neighbourhood Health Teams from April 2027.

Scaling Neighbourhood Health in Central East: A Frailty-First Approach

Three Footprints, eight Places, 47 Neighbourhoods, 79 PCNs & 267 GP Practices

North C&P	No. of Neighbourhoods, PCNs & Practices	13 NbHs, 13 PCNs & 46 GP Practices
Cambs South	No. of Neighbourhoods, PCNs & Practices	8 NbHs, 9 PCNs & 38 GP Practices
Bedford	No. of Neighbourhoods, PCNs & Practices	4 NbHs, 4 PCNs & 13 GP Practices
Milton Keynes	No. of Neighbourhoods, PCNs & Practices	4 NbHs, 9 PCNs & 28 GP Practices
Central Beds	No. of Neighbourhoods, PCNs & Practices	4 NbHs, 9 PCNs & 24 GP Practices
Luton	No. of Neighbourhoods, PCNs & Practices	4 NbHs, 6 PCNs & 23 GP Practices
East & North Herts	No. of Neighbourhoods, PCNs & Practices	6 NbHs, 12 PCNs & 47 GP Practices
South & West Herts	No. of Neighbourhoods, PCNs & Practices	4 NbHs, 17 PCNs & 48 GP Practices

Scaling Neighbourhood Health in Central East: A Frailty-First Approach

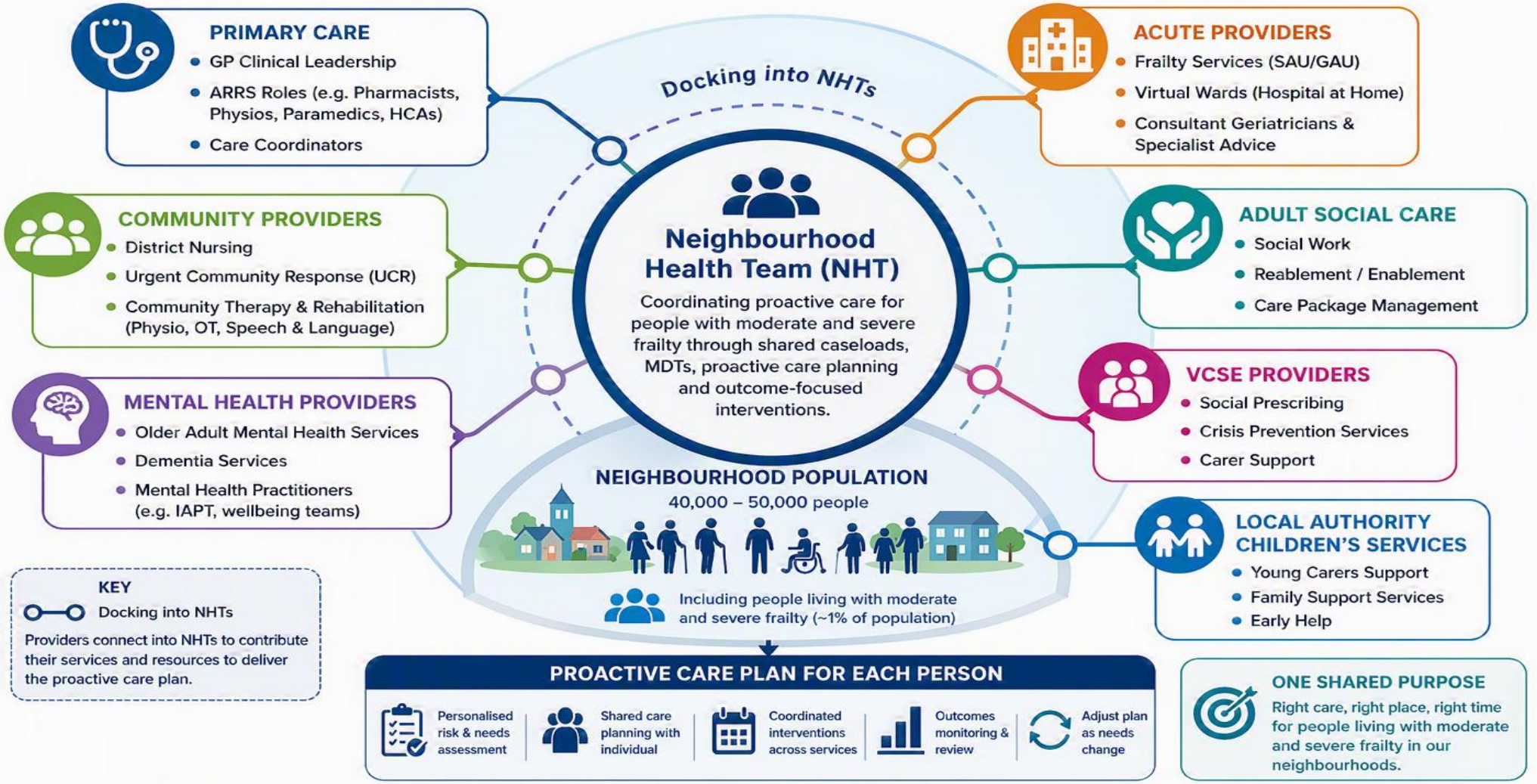
- **10% of the population** – 350,000-390,000 residents living with severe and moderate frailty.
- **Over 40% of NHS spend -** £218m per annum. Excluding people with mild frailty and does not include primary care, community services, prescribing or social care costs
- The challenge is growing rapidly. **By 2047 the population aged 65–84 is projected to increase by 28%,** while those aged **85+ will increase by almost 90%**
- Without change, demand will keep rising. **Moderate frailty is projected to grow by 51% and severe frailty by 55% over the next two decades**

Scaling Neighbourhood Health in Central East: A Frailty-First Approach

- Neighbourhood Health Teams serve populations of around **30–50,000 people**
- **Primary Care** provides the clinical leadership at neighbourhood level
- Health, care, community and VCSE professionals together as **one team**
- Initial focus is people living with **frailty** – creating the 'base plate' to build on
- Population health data and **risk stratification** drive identification of people most at risk – rolling out Delpphi in 26/27
- Both **proactive prevention with rapid reactive support** when needs escalate
- **Shared caseloads** replace traditional referral-based ways of working wherever possible
- Success measured by **improved outcomes**, experience and reduced service utilisation

Mobilising Existing Services Around Neighbourhood Populations

Providers wrap around neighbourhoods and dock into NHTs to deliver proactive, person-centred care



The NHT does not replace existing services; it coordinates, aligns and mobilises them around the needs of people living with frailty.

Commissioning approach

Tight – Loose - Tight

- Strategic commissioning **specification –** population need and best practice
- Commissioning for **outcomes – e.g:**
    - Improved patient-reported outcomes and experience
    - Improved continuity and coordination of care
    - Reduction in non-elective admissions for frailty cohorts
    - Reduced emergency department attendance
    - Increased uptake of anticipatory care planning
    - Reduced falls and medication-related harm
    - Increased proportion of care delivered in community settings
    - Improved support for carers and unpaid carers
- Measuring **impact** - DELPPHI

Commissioning approach

Funding options

- **Re-design / re-purpose** existing resources
- **Reform** the Better Care Fund
- **Review** existing funding mechanisms – e.g. Primary Care Network Directed Enhanced Service – local variation

Contracting delivery models

- Lead Provider
- Provider Collaborative
- Alliance Contract
- Place Based Partnership model
- Others?

Break time

Workshops start at 11:20

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Workshops: Session One

Room	Title
Lecture Room One	East Cambridgeshire Integrated Neighbourhood and Ely Primary Care Networks (PCNs)
Lecture Room Two	Health and Independent Living Support (HILS)
Lecture Room Three	Cambridge University Hospitals NHS Foundation Trust
Lecture Room Four	Carers in Bedfordshire and Carers in Hertfordshire

Workshops: Session Two

Room	Title
Lecture Room One	Hospice perspective
Lecture Room Two	Chiltern Hills PCN and The Bridge PCN
Lecture Room Three	Bedfordshire Hospitals NHS Foundation Trust (BHFT)
Lecture Room Four	Manor View Practice
Lecture Room Six	East London NHS Foundation Trust (ELFT) and Bedfordshire Rural Communities Charity

Lunch time

Workshops restart at 13:40

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Workshops: Session Three

Room	Title
Lecture Room One	Central London Community Healthcare Trust and West Hertfordshire Teaching Hospital
Lecture Room Two	Hatters Heath PCH and East of England Community Health and Care NHS Trust
Lecture Room Three	Hertfordshire Community NHS Trust (HCT)
Lecture Room Four	North West Anglia NHS Foundation Trust (NWAFT) – North Place Team

Thank you

to everyone who has shared their insights today and led workshops

Sharing
Best practice

And what happens next…

What happens next?

- ***Event write up*** – we have been capturing the key insights and ideas shared today and will turn that into a post event report that we will share with you all
- ***Development of specification*** – will begin, based on what we've heard today and the data we've gathered
- ***September session*** – we will meet again in September to keep this conversation going and check in on where we have got to with the specification. Sign up link will be sent after the conference and along with even more best practice examples

Thank you

For attending, sharing your ideas and thoughts, and for being part of the journey

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