NHS
East of England
Community Health and Care
NHS Trust

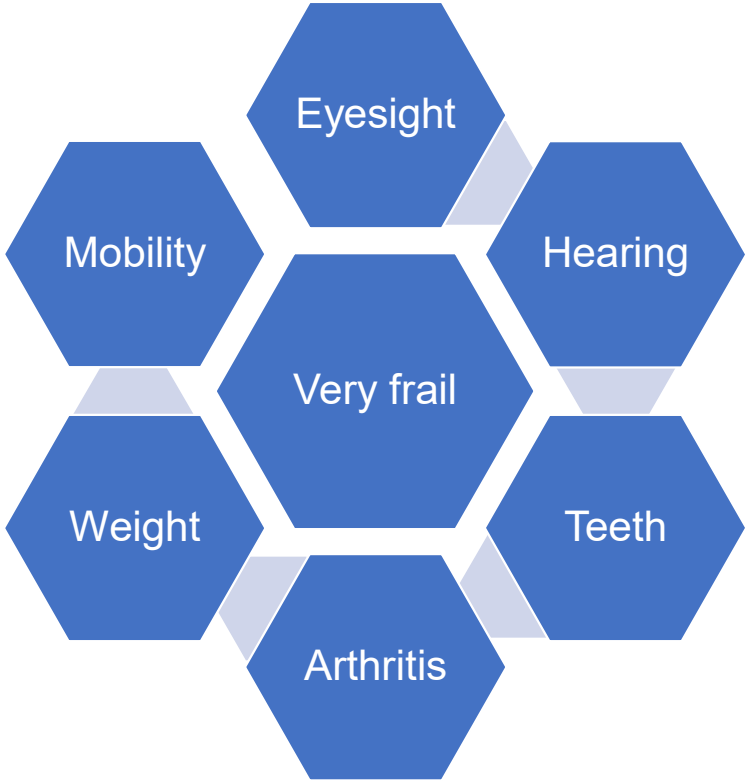
Frailty framework

Central East Integrated Care Board

16th July 2026

Delivering great health and care services in our local communities

Who are we talking about?



Who are we talking about?

Population divided by national published efi proportions

NHS
East of England
Community Health and Care
NHS Trust

CFS	CFS Label (2020)	NHS Category	Functional Characteristics
1	Very Fit	Fit	Robust, active, exercises regularly; no disease symptoms
2	Fit	Fit	No active disease; less fit than CFS 1; exercises occasionally
3	Managing Well	Fit	Medical problems well controlled; active beyond routine walking
4	Living with Very Mild Frailty	Mild Frailty	Not dependent; symptoms limit activities; often slowed or tired
5	Living with Mild Frailty	Mild Frailty	Needs help with high-order ADLs: finances, transport, heavy housework, medications
6	Living with Moderate Frailty	Moderate Frailty	Needs help with all outside activities and housekeeping; difficulty with stairs, bathing; possible minimal dressing assistance
7	Living with Severe Frailty	Severe Frailty	Completely dependent for personal care; stable; not at high risk of dying within 6 months
8	Living with Very Severe Frailty	Severe Frailty	Completely dependent; approaching end of life; would not recover from minor illness
9	Terminally Ill	Severe Frailty	Life expectancy under 6 months; not otherwise evidently frail

Delivering great health and care services in our local communities

LA area	Population 65+ (ONS)	Mild (33%)	Moderate (19%)	Severe (10%)
Hertfordshire	211,796	69,893	40,241	21,180
Cambridgeshire	125,472	41,406	23,840	12,547
Peterborough	31,703	10,462	6,024	3,170
Luton	26,363	8,700	5,009	2,636
Central Bedfordshire	56,858	18,763	10,803	5,686
Bedford Borough	33,389	11,018	6,344	3,339
Milton Keynes	43,497	14,354	8,264	4,350
	529,078	**174,596**	**100,525**	**52,908**

Source	Mild % (65+)	Moderate % (65+)	Severe % (65+)
eFI (original, 36 deficits)	33%	19%	10%
eFI2 (updated, 79 deficits)	30%	15%	3-5%
NHS contract assumptions	None	12%	3%

Numbers per PCN	
Mild	2,175
Moderate	1,252
Severe	659

Interventions

NHS East of England Community Health and Care NHS Trust

Interventions	Mild	Moderate	Severe
Comprehensive Geriatric Assessment	*	✓	✓
Multi-disciplinary interventions		✓	✓
Supervised Multicomponent Exercise	✓	✓	✓
Nutritional Support	✓	✓	✓
Medication Review and Optimisation	✓	✓	✓
Mental Health and Wellbeing	✓	✓	✓
Advance Care Planning		✓	✓
Carer Assessment and Support	✓	✓	✓
Hospital at home		✓	✓
Falls interventions	✓	✓	✓
Cognitive impairment and dementia interventions	✓	✓	✓
Care at end of life	✓	✓	✓
Enhanced care home support		✓	✓
Governance of integrated care	✓	✓	✓
Continence		✓	✓
Oral health	✓	✓	
Sensory impairment	✓	✓	
Sleep and fatigue	✓	✓	
Home health	✓		
Social isolation	✓	✓	

LA area	Mild (30%)	Moderate (15%)	Severe (3%)
Hertfordshire	63,539	31,769	6,354
Cambridgeshire	37,642	18,821	3,764
Peterborough	9,511	4,755	951
Luton	7,909	3,954	791
Central Bedfordshire	17,057	8,529	1,706
Bedford Borough	10,017	5,008	1,002
Milton Keynes	13,049	6,525	1,305
	158,723	**79,362**	**15,872**

"Frailty is not an inevitable consequence of ageing; it is a state of excess vulnerability that can be modified"

Delivering great health and care services in our local communities

NHS
East of England
Community Health and Care
NHS Trust

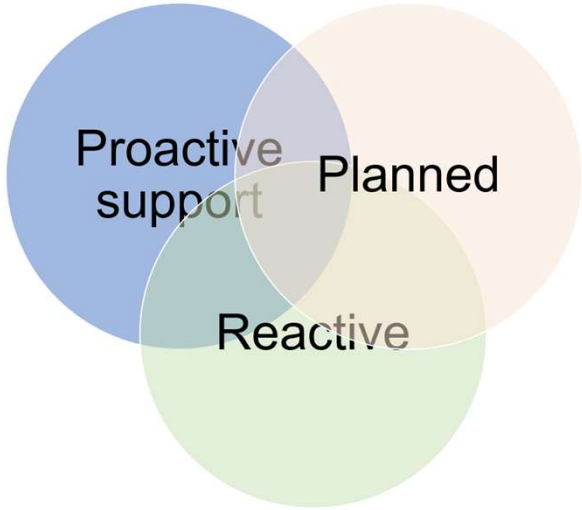
Indicative phasing and outcomes to be achieved

Year	GRACE Model (Counsell et al., JAGS 2009)	AGe-FIT Trial (Ekdahl et al., JAMDA 2016)	Proposed England Model (Projected)	Key Milestone
Year 1	Net investment: service establishment. Increased care intensity for highest-risk patients. No net system savings.	Emergency inpatient days higher in intervention arm initially as contacts increase identification of need.	**Net investment phase.** Hub establishment; workforce mobilisation; caseload build. No cost-effectiveness evaluation meaningful at this stage.	Service launch; caseload profiling
Year 2	Break-even approached for patients with 3–4 chronic conditions. A and E visits begin to reduce in high-risk sub-group.	Emergency inpatient days falling: 11.8 vs 16.5 (control) by 36 months. Total costs stabilising at 24 months.	**Target: break-even for CFS 7–9 cohort.** 15–20% reduction in unplanned admissions; nursing home admissions begin to reduce; care home AED transfers reduce 30–40%.	First performance review; system-level metric check
Year 3	Net cost savings confirmed for most complex sub-groups. QoL improvements sustained. Nursing home placement reduced.	Sustained emergency day reduction ($p<0.05$). Model cost-effective from system perspective.	**Target: system-wide net savings.** Bed-day reduction; 20% nursing home admission reduction (moderate frailty); frailty reversal in 30–40% of mild cohort. Commissioning contracts trigger performance-linked renewal.	Contract renewal decision; national evaluation data submission

Integrated service principles

NHS
East of England
Community Health and Care
NHS Trust

Principle	Description
Function over disease	Functional independence is the organising goal, not disease management.
Proactive identification over reactive referrals	Validated two-stage protocol - eFI2 or alternatives followed by clinical validation
Relationship over episode	Longitudinal, trusting relationships with a named team.
Multidisciplinary over single profession	Medical, nursing, therapy, pharmacy, social care, psychology and other non registered professional roles
Home as the default	The person's own home is the preferred setting for care including acute episodes.
Equity by design	Service intensity and resource allocation explicitly weighted to address the earlier and greater frailty burden in deprived communities and coastal/rural areas.
Whole-person, not single-domain	Physical frailty, cognitive impairment, depression, carer strain, social isolation, and end-of-life needs all in scope.
Parallel planning for recovery and deterioration	Both recovery and dying are possible outcomes; care planning works with both simultaneously.
Measurement as standard	Frailty scores, functional outcomes, PROMs, and carer wellbeing collected routinely and published in system wide dashboards for frailty.
Shared digital clinical record	A single, real-time clinical record accessible to all team members and partner organisations (primary care, acute hospitals, ambulance service, social care). Available, in real time, to the person and their carers
Risk and decision making	Primary analysis of risk is through the persons eyes – not professional or organisational perspectives



Delivering great health and care services in our local communities

International evidence of what makes integrated working real

NHS
East of England
Community Health and Care
NHS Trust

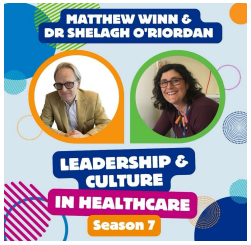
Scale and population reach through	Leadership	Organisational structure	Governance and accountability	Contract approach
•A standardised model with defined core components •Population stratification tools that work at scale •Central capability support that enables local implementation without each site reinventing infrastructure	•Managerial •Strategic •Clinical	A single entry point for the population served. • A named multidisciplinary team with defined roles •Financial risk sharing between partners	•Cross-organisational membership: •Real decision-making authority: •Named accountability: individual organisations	•Minimum 3-year contract term •Capitation as the gold standard •Trajectory-based performance metrics: •Outcomes-based commissioning

Lessons from outside healthcare:

1. A shared outcome framework is not optional infrastructure — it is the mechanism by which a multi-agency initiative holds together.
2. The backbone function must be explicitly funded. A programme director, data analyst, and relationship manager are not overheads — they are the structural precondition for the collaboration to function at scale.
3. Trust is built, not assumed. Any implementation plans must include structured relationship-building activities between NHS, social care, voluntary sector, and community organisations.
4. Mutually reinforcing activities require active coordination. A joint service must actively connect voluntary sector, social care, and community interventions to clinical care plans.
5. Population-level outcomes require a 5+ year horizon for systems change. The commissioning framework's 3-year cost trajectory is correct for clinical outcomes; systemic change in how health and social care organisations work together will take longer.

Delivering great health and care services in our local communities

How are you/we defining risk?



Shealgh O'Riordan, President of UK Hospital at Home Society

“Deconditioning isn’t caused by illness; it’s caused by hospitalisation. It just doesn’t happen at home.”

“What clinicians think is risky and what patients think is risky are often completely different things.”

"Many patients think going to hospital is incredibly risky — because they know what they might lose.”

“Just because we can do something doesn’t mean we should.”

“At home, the power dynamics are completely different — people have control over their decisions.”

Jugdeep Dhesi, President of the British Geriatrics Society

“Sometimes ‘doing nothing’ is the right thing. Supporting patients to make realistic choices about their care is essential, especially later in life.”

NHS
East of England
Community Health and Care
NHS Trust

Thank you