# Central East Frailty Conference

## What we heard and what happens next

**16 July 2026**

Thank you to everyone who joined us for the Central East Frailty Conference. The day brought together colleagues from primary, community and acute care, social care, local authorities, hospices and voluntary and community organisations. We heard about services already making a difference and used the workshops and Menti to consider what a future frailty offer should look like.

> **A clear message from the day:** we are not starting from scratch. Strong practice already exists across Central East, but it is not always joined up, consistently available or supported by sustainable funding. The task is to connect and build on what works, rather than design another model from the beginning.

## What we heard from the day

- **Start earlier.** Delegates wanted more focus on mild and moderate frailty, prevention and people who are under the radar. Exercise, nutrition, loneliness, housing and carer wellbeing all matter alongside clinical risk.
- **See the whole person.** Function, independence and what matters to the individual should sit at the centre. Comprehensive Geriatric Assessment, the 5Ms, medication review and advance care planning were recurring themes.
- **Join up proactive and urgent care.** Examples included proactive MDTs, care-home support, group clinics, Hospital at Home, frailty SDEC, virtual wards, rapid advice and follow-up after discharge. These need to operate as one pathway, not separate services.
- **Make home the default where it is safe.** Timely therapy, specialist outreach, coordinated community services and clear escalation routes can help people remain at home and avoid the deterioration that can follow an unnecessary admission.
- **Fund the work around the clinical model.** Named coordination, shared information, management support, workforce development and meaningful VCSE involvement are essential infrastructure, not optional extras.

## What delegates told us through Menti

| 6.2 / 10 | Top opportunity | Top barriers |
|---|---|---|
| Average readiness to deliver neighbourhood health | Collaboration, integration and shared learning | Funding and time, followed by capacity and organisational boundaries |

More than 100 delegates contributed ideas about the opportunities, and 82 people made 157 suggestions about what should appear in a commissioning specification. Funding was the most frequently cited barrier (20 mentions), followed by time (13). Capacity, organisational boundaries, leadership and shared records also featured strongly. The specification responses were consistent: recognise social care, carers and the voluntary sector; provide clear care coordination; involve frailty clinicians; support the workforce; improve digital information sharing; and measure outcomes that matter rather than creating another tick-box process.

## Examples shared on the day

- **Proactive and personalised support.** Wellness Hubs, group clinics, proactive care-home reviews, Better Health Bus outreach and 'What matters to you' conversations showed different ways of finding people earlier and organising support around them.
- **Rapid support closer to home.** Hospital at Home, frailty SDEC, the Silver Phone, virtual wards, urgent community response, discharge huddles and Welcome Home contact within 48 hours showed how coordinated advice and follow-up can avoid admission and support recovery.
- **Prevention and independence.** Home-based exercise, HILS support, social prescribing and GaitSmart were practical examples. The GaitSmart workshop reported 388 assessments, with 75% showing improved gait speed.

## Themes from the workshop rooms

### Earlier identification and equity by design.

Risk stratification is useful, but needs clinical and community validation. A population approach must include rural and deprived communities, self-funders, people not visible in GP data, people with learning disabilities and those who do not readily engage with services.

### One team around the person.

Delegates repeatedly described the need for continuity, a named team or coordinator, shared decision-making and specialist input into neighbourhood teams. Clear clinical responsibility and risk-sharing are needed, but organisational boundaries should not determine the person's experience.

### Carers, social care and the VCSE as core partners.

Unpaid carers were described as an often invisible workforce who may have significant needs of their own. They should be identified earlier, involved in planning and supported as care moves closer to home. One workshop reported a 72% increase in carer identification over one month following a GP pathway, digital flagging and targeted messaging, while recognising that outreach needs to suit the people concerned. Social care and VCSE organisations need to be involved in design and delivery, with realistic funding and infrastructure.

### Shared information and practical access.

Teams need to know what support already exists, be able to share the care plan and avoid repeated referrals and assessments. Access to social care information, a care plan visible across services and an agreed place to record CGA and 5Ms findings were repeatedly raised. Mobile and community-based approaches can help reach people who are housebound, isolated or unable to travel.

### A consistent core, delivered locally.

There was support for one Central East direction rather than three separate frailty models. The core functions, standards and outcomes should be consistent, while neighbourhoods retain flexibility over workforce, partners and how services are organised for their geography and population.

## What this means for the developing specification

The emerging core offer will need to bring together:

- proactive identification with clinical validation and a clear focus on prevention;
- holistic assessment, personalised goals and support for function and independence;
- named coordination, regular multi-agency working and specialist outreach;
- a shared care plan, medication review and timely ACP/ReSPECT conversations;
- connected proactive, urgent, at-home and post-discharge pathways;
- carers, social care and VCSE partners built into the model; and
- common measures covering experience, function, equity, quality and use of services.

## Next steps

The conference feedback will now be used to strengthen the draft Central East frailty specification. The next phase will test the proposed core offer, areas for local flexibility, measures, quality assurance and implementation requirements with providers, ICB colleagues, social care, the VCSE and people with lived experience.

The next Central East Frailty Conference will take place on **Thursday 10 September 2026**.

Further information and conference materials are available here: **Frailty Conference 2026 | NHS Central East ICB**

For questions or to contribute to the ongoing frailty and neighbourhood work, please contact **Faith Haslam, Head of Neighbourhood Model Development, at faith.haslam2@nhs.net**

*Thank you to all presenters, facilitators and delegates for sharing your experience, challenge and ideas.*