Central East Frailty Conference

What we heard and what happens next

10 September 2026

Thank you to everyone who joined us at Cranfield University for the second Central East Frailty Conference and contributed to discussions about the draft neighbourhood health specification, with a focus on frailty. Since the event, the team has reviewed the feedback shared through the workshops and the questions raised via Mentimeter (Menti). This report brings together what we heard and will inform the next iteration of the draft specification.

A clear message from the day: the draft specification provides a strong foundation, but successful delivery depends on making the model proportionate, practical and genuinely integrated. Neighbourhoods should build on existing services, relationships and community assets, with a consistent core offer and enough local flexibility to respond to their population.

What we heard from the day

- **Keep support proportionate** People with mild frailty need an accessible prevention and self-management offer, not automatic enrolment into an intensive clinical programme. For moderate and severe frailty, assessment and intervention should respond to individual need rather than category alone.
- **Target enhanced coordination where it adds value** Complexity, fragmented care, interacting needs, risk, carer instability and likely benefit should drive active neighbourhood support. A frailty score or urgent event should trigger review, not automatically determine the response.
- **Build on what already works** Delegates strongly supported using established neighbourhood partnerships, proactive care approaches, community pharmacy, social prescribing, mental health support, carer forums and local Voluntary, Community, Social, Faith and Enterprise (VCSFE) networks rather than creating new structures.
- **Work as one team, not just through meetings** Integrated working should mean direct day-to-day communication, shared plans, clear action ownership and rapid escalation. Formal multidisciplinary meetings should be used when complexity or interdependent decisions require them.
- **Invest in the conditions for delivery** Workforce capacity, sustainable VCSFE funding, shared information, joint development, role clarity and aligned commissioning are essential. Neighbourhood health is a cultural and operational change programme, not simply a new service description.

What delegates told us through Menti

5.3 / 10	Top expectation	5.7 / 10
Average readiness to deliver neighbourhood health	Clarity about expectations, delivery, funding and next steps	Average readiness at the end of the day

At the start of the day, 135 delegates rated their readiness to deliver neighbourhood health at an average of 5.3 out of 10. Clarity was by far the most common expectation, appearing 39 times, alongside networking, ideas, inspiration, understanding and funding. By the close, 52 respondents rated readiness at 5.7 out of 10. This modest improvement reinforces the need for continuing engagement and practical detail on delivery, accountability, funding, information sharing and the route to April 2027.

Examples shared on the day

- **Multi-agency community working** Examples from Cambridgeshire, Luton and Wisbech showed VCSFE partners participating in solution-finding forums, triage and early-response meetings alongside statutory services, supported by shared risk management and information-sharing arrangements.
- **Connecting staff to local support** Directories, social prescribing, community pharmacy, mental health community connectors and local carer forums were highlighted as practical assets that can help teams understand what is available and connect people to the right support.
- **Integrated capacity and proactive care** Participants described pooled or repurposed funding, VCSFE staff working within integrated teams, existing proactive care models and programmes such as WorkWell as approaches that could inform implementation and be adapted locally.

Themes from the workshop rooms

A proportionate offer across the frailty continuum

Delegates distinguished prevention and routine frailty management from enhanced Neighbourhood Health Team (NHT) coordination. Mild frailty should focus on exercise, nutrition, social connection and supported self-management. Moderate and severe frailty should share a reliable core offer, with fuller assessment and coordination added according to complexity and need.

Identification through data and local intelligence

Population segmentation, service-use information and risk tools can create a review pool, but electronic searches alone will miss people. Clinical judgement and intelligence from carers, reception teams, community nurses, pharmacists, social care and community organisations are needed to recognise deterioration, hidden need and people at risk of unequal access.

One coordinated response around the person

People and carers should know who is coordinating care, who owns each action and how to get help when needs change. A shared, understandable plan should follow the person across services, reduce repeated assessments and support direct professional communication rather than making the person navigate organisational boundaries.

VCSFE, carers and communities as equal partners

The sector brings trusted relationships, prevention, transport, nutrition, welfare advice, mental health support, volunteering and routes into communities. Delegates wanted VCSFE partners involved in collective triage, planning and delivery, with sustainable funding, safeguarding support and workable data-sharing arrangements rather than reliance on short-term grants or onward referral alone.

Outcomes that show whether life is better

Delegates favoured a small shared framework combining person and carer experience, independence and goal attainment, continuity, equitable access, service use and workforce sustainability. Activity reductions should not be treated as success if quality, experience, carer burden or unmet need worsen.

What this means for the developing specification

The emerging core offer will need to bring together:

- a clear distinction between prevention and supported self-care, routine frailty management, enhanced NHT coordination and crisis response;
- a lighter minimum offer for mild frailty and a common, proportionate core for established frailty;
- functional criteria for enhanced support based on complexity, fragmentation, risk, carer stability and likely benefit;
- proportionate, holistic assessment that reuses existing information and produces clear goals, actions and accountability;
- named coordination, shared plans, direct multi-agency working and explicit step-down and rapid re-entry arrangements;
- practical and funded roles for local authorities, carers, community partners and the VCSFE; and
- one small outcomes framework spanning model readiness, reliable care, experience, equity, impact, service use and workforce sustainability.

Next steps

The conference feedback will now be used to develop the next iteration of the Central East Neighbourhood Health Team frailty specification, which will be shared later in the year. Further work will define the core offer, measures, implementation requirements and the respective responsibilities of neighbourhood teams and supporting integrator functions.

We will continue to engage with residents and carers as the draft specification is developed, ensuring that their experiences and priorities inform the next iteration.

Co-development with providers, primary care, local authorities and VCSFE partners will continue through an online event later in the year.

Central East commissioning intentions are due to be published on **30 September 2026**. Data-sharing arrangements will be progressed through the DELPPHI rollout, and engagement will continue on the proposed primary care investment and variation to current commissioning arrangements.

Delivery is planned to begin from **1 April 2027**.

Delegates were invited to share further feedback through the post-event survey by **Friday 18 September 2026**. Feedback and questions remain welcome after that point and will continue to inform the specification and implementation work.

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.