York Community Frailty Hub – System Update

Prepared by: Community Services Senior Leadership Team, Nimbuscare
Date: 18th July 2025

Community Frailty Hub Physiotherapist and Nurse visiting a patient

1.Introduction

The York Community Frailty Hub was established in November 2023 to address the fragmented support for older people in the community. The Hub is an integrated multidisciplinary initiative designed to proactively manage frailty within the community. This service provides frailty prevention, crisis response, and discharge support, aiming to reduce hospital admissions and improve the quality of life and health and social care outcomes for frail individuals in York. Everyone in the team was proud to see the **Community Frailty Hub outlined in the NHS 10year Plan as a Case Study**.

The York Community Frailty hub team is comprised of co-located frailty nurses, physiotherapists, occupational therapists, dieticians, social prescribers, social worker, health support workers, GPs with a special interest in frailty, GPs with a special interest in dementia, memory support advisors, dementia nurse, palliative care nurse, Age UK support workers, North Yorkshire Sport personal therapists, Carer's Centre support workers, care navigators and care co-ordinators.

Organisations providing staff for this integrated hub include:

Acute Trust Community Team - Community Response Therapist Triage Lead

Acute Trust – Dietician
Primary Care (Nimbuscare) - Frailty GPs, Therapists, Frailty Nurses, Generic Support Workers, Care Co-ordinators and Care Navigators
Local Authority - Social Worker
Voluntary Sector – York CVS -Social Prescribers, Age UK, Dementia Forward, North Yorkshire Sport, Carer's Centre
TEWV - Dementia Nurse
Hospice - Palliative Care Nurse

Governance arrangements are designed to be clear and collaborative. While Nimbuscare takes the lead in coordinating services within the hub, accountability for safe high-quality care remains with each individual employing organisation. To foster a shared culture of learning and improvement, Nimbuscare convenes a weekly, in-person Quality & Governance meeting. This forum brings together key representatives from all member organisations to openly share learning, reflect on events, and work collectively to enhance safety and quality across the system.

2.Scope of Services

As mentioned above the service has three main arms: frailty prevention, frailty crisis response, and discharge support. The hub also supports in the delivery of the Humber Virtual Frailty Ward for Scarborough, Whitby & Ryedale.

2a. Prevention

The Frailty Prevention service currently provides case management for over 3,000 of the most complex and vulnerable individuals, with the primary aim of supporting independence and promoting health through annual, community-based Comprehensive Geriatric Assessments (CGAs), as well as interim support where required from a proactive multidisciplinary frailty team.

These CGAs are conducted in patients' usual place of residence, excluding care homes at present. The service covers the York City Centre area, and eligibility is limited to individuals registered with one of the ten GP practices within the City of York.

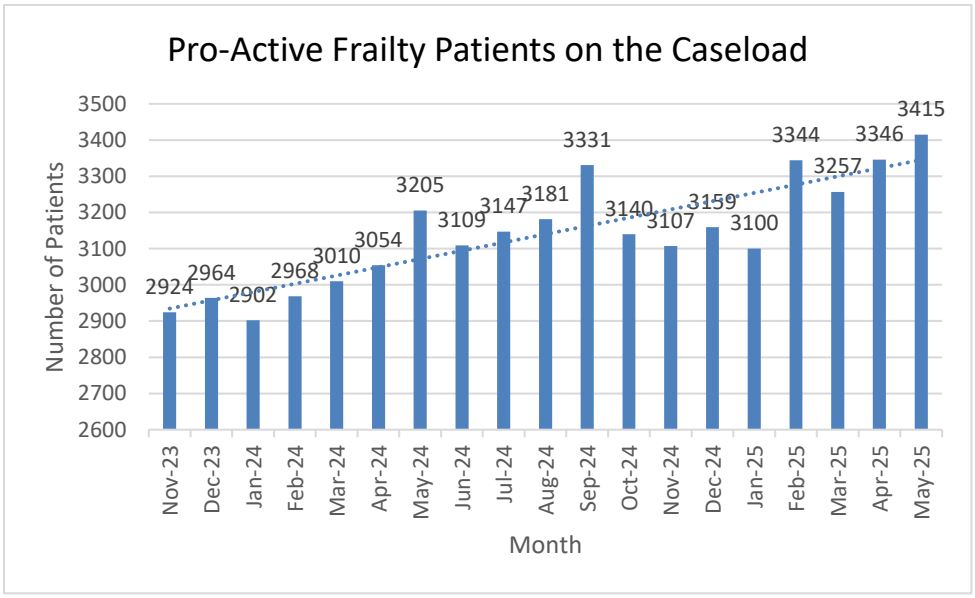
The CGA process is initiated by a Frailty Nurse and subsequently completed by key members of the multidisciplinary team, working collaboratively with the patient to develop a personalised care plan that reflects the individual's priorities and goals. All new referrals receive a CGA within four weeks of referral. Each person is assigned a named Frailty Nurse and has direct access to the Frailty Crisis Advice and Guidance (A&G) line as an alternative to contacting emergency services via 999.

The York Community Frailty Hub convenes a weekly multidisciplinary team meeting, which is accessible to all professionals involved in the care of individuals living with complex frailty, either

in person or remotely. This collaborative forum enables partners from across the health and social care system to come together to review and discuss complex cases from both clinical and social perspectives. Each case discussion results in the development of a personalised care plan, with clearly defined actions, that concentrate on priorities that matter to patients.

Weekly MDT Meeting at Nimbuscare offices

"This MDT has opened my eyes to the difference we can make to patients by working together. I don't feel alone anymore" District Nurse, York.



A 17% increase in patient case management numbers was achieved with no extra funding by working more collaboratively.

2b. Discharge Support

The Community Frailty Hub hosts two discharge services, which are currently in the process of being integrated. One of these services is the Discharge to Assess (D2A) team, which supports patients on Pathway 1 who have been identified as requiring a longer-term package of care. The team is notified of all relevant Pathway 1 patients deemed medically fit for discharge and facilitates their timely transition—either on the same day or the following day—by arranging short-term domiciliary care packages that include therapy and nursing support.

This service is designed to prevent medically fit individuals from remaining in hospital unnecessarily while awaiting a social work assessment, which has historically taken an average of nine days to complete. By facilitating earlier discharges, the service aims to enhance health and social care outcomes, promote independence, and reduce the risk of hospital-associated deconditioning.

In several instances, the level of care required has been successfully reduced, and some patients have ultimately not required any long-term social care support. Over the past six months, the initiative has saved a total of 1,008 bed days and reduced the average hospital length of stay for this patient cohort by eight days per individual.

Our other discharge service is the Enhanced Discharge Support Service EDSS – a service made up of Voluntary sector partners, Age UK, Carers Support, Social Prescribing and North Yorkshire Sport. This service provides support to expedite discharges when barriers are due to environmental and/or social circumstances as well as providing an integrated offer to support people following discharge from hospital, to prevent re-admission due to complex social situations. Outlined below are the number of referrals received as part of the EDSS service during Q1:

	April	May	June	Total
Social Prescribing (Discharge)	21	18	24	**63**
Age UK	36	48	43	**127**
Carers Centre	15	11	13	**39**
North Yorkshire Sport	3	3	2	**8**
TOTAL	**77**	**81**	**89**	**247**

**Please note, individuals may have been supported by more than one area of the service (e.g. if a person has been supported by both Age UK and a Social Prescriber this would be shown in both rows in the table above).*

2c. Frailty Crisis Response

The Frailty Crisis Response function of the Community Frailty Hub is a multi-agency, collaborative service designed to support frail individuals experiencing acute health or social crises in the community. The service operates through multidisciplinary case discussions, the provision of a dedicated Frailty Advice and Guidance (A&G) Line, and the coordination of timely, joined-up responses from relevant health, social care, and voluntary sector partners.

The core objective of the service is to provide urgent, clinically informed advice to those supporting frail and vulnerable patients, with the aim of avoiding unnecessary hospital admissions where appropriate and in the patient's best interest. The Frailty A&G Line offers a rapid-response alternative to 999 for clinicians and professionals working with this cohort.

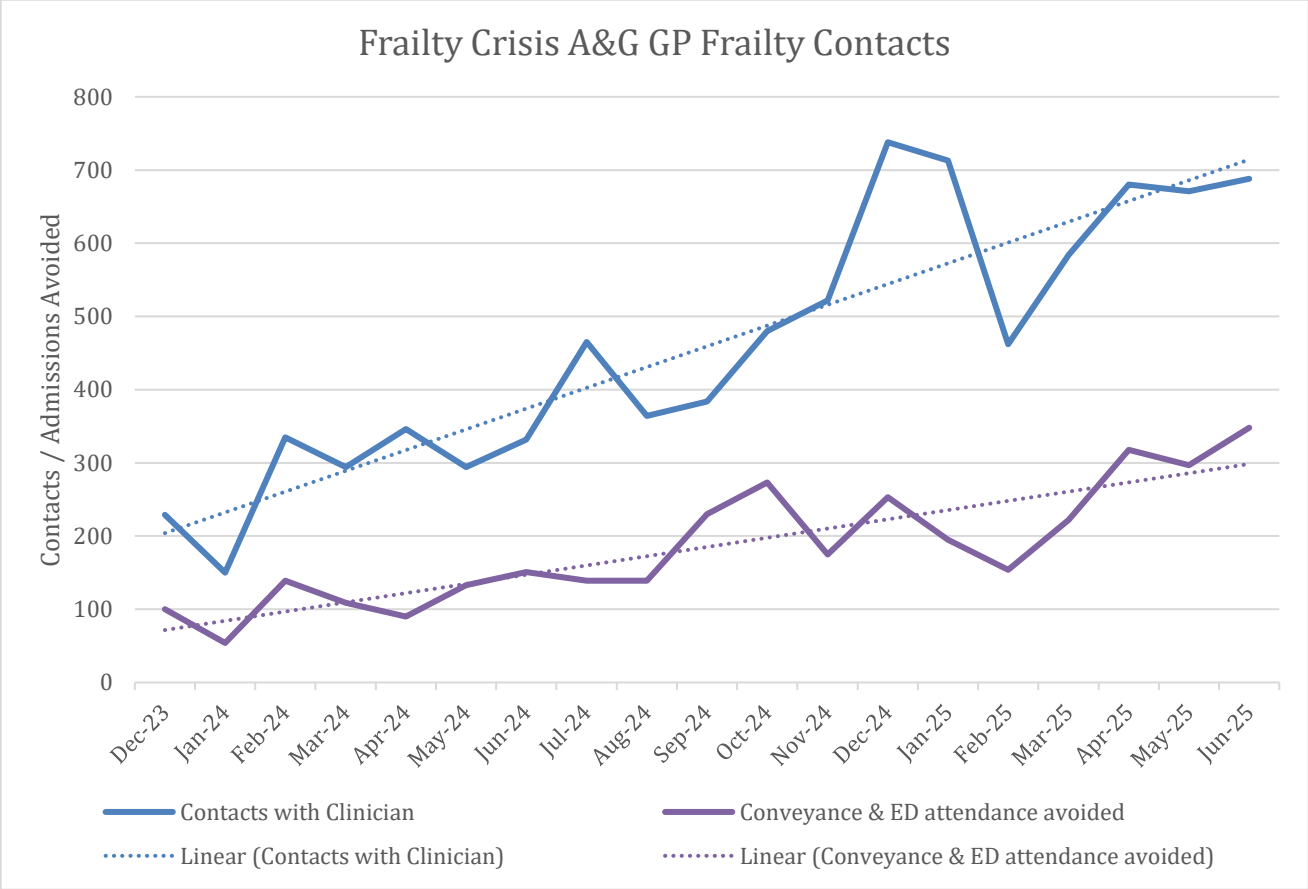
Crisis presentations to the Community Frailty Hub are primarily managed through the following mechanisms:

- Senior clinical input via the GP with Special Interest (GPwSI) in Frailty through the A&G Line
- Multidisciplinary team discussions to assess need and plan coordinated intervention
- Organisation and mobilisation of joined-up, multi-agency, community-based responses
- Ongoing oversight and case management for the duration of the crisis period, with seamless transition back to routine or anticipatory care once stabilised

The team has access to real-time capacity and resources across a wide range of services within the hub, enabling timely and effective interventions. These include:

- **Urgent Community Response (UCR):** A 2-hour paramedic/nurse-led medical response for frail individuals at imminent risk of hospital admission without prompt intervention
- **Community Response Team (CRT) – York and Scarborough Teaching Hospitals NHS Foundation Trust (YSFT):** A 2-hour therapy response for patients requiring urgent rehabilitation or functional support to avoid admission
- **Adult Social Care:** A dedicated Social Worker embedded within the Community Frailty Hub
- **Voluntary and Community Sector (VCSE):** Services including Social Prescribing Link Workers and dedicated Age UK support workers who conduct follow-up visits and welfare checks. These staff are trained to perform basic clinical observations and act on behalf of the hub following a crisis episode

This integrated model ensures that patients receive the right care, in the right place, at the right time—maximising opportunities to support individuals to remain safely in their usual place of residence during periods of crisis.



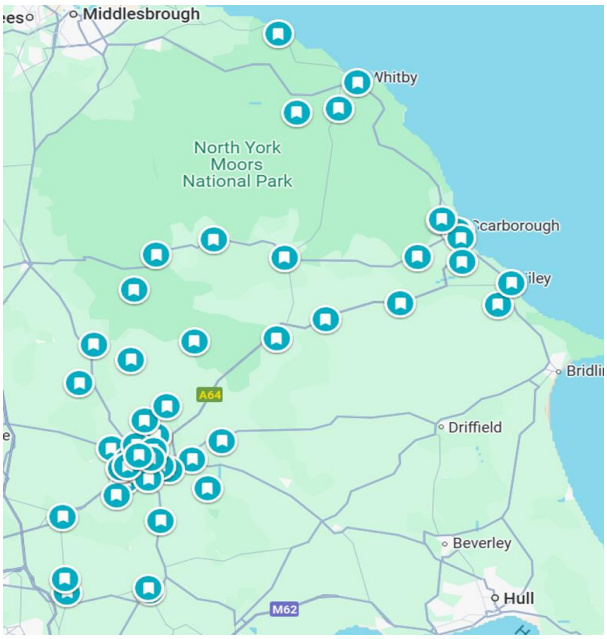
The graph above clearly illustrates the marked increase in overall activity within the Frailty Crisis Advice & Guidance (A&G) service since its launch in November 2023. By June 2025, activity levels had almost equalled those seen in December 2023 and were twice as high as in June 2024. This upward trend raises serious concerns that, should referral numbers continue to rise, it may become necessary to temporarily suspend new referrals on high-demand days in order to maintain service quality and safety.

Over the past year, the Frailty Crisis team has successfully prevented 2,743 patients from attending the Emergency Department (ED) or necessitating a 999 emergency call.

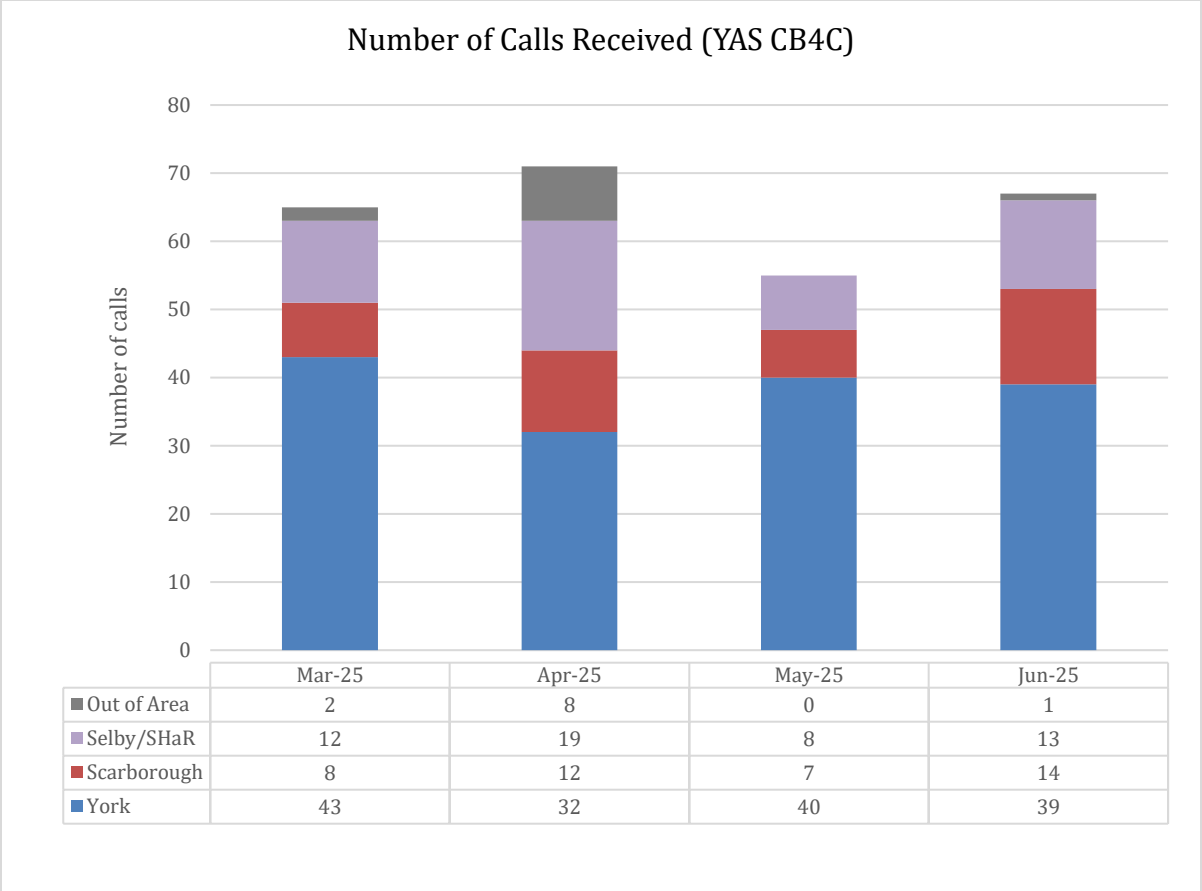
In addition to avoiding 999 activations, the crisis line plays a critical role in supporting paramedics with conveyance decisions. **In 84% of cases, the York Community Frailty Hub has enabled paramedics to avoid hospital transfers** by providing timely clinical advice after an ambulance has been dispatched. This has allowed patients to be safely supported within the community rather than being conveyed to hospital. An audit of these cases showed that 89% of patients who were kept at home remained in their usual place of residence two weeks following the avoided admission, indicating that the service is offering a safe and effective alternative to hospital-based care.

The Frailty Advice and Guidance (A&G) Line was initially established to support services within the City of York. However, its remit has recently been expanded to encompass a broader geographical area aligned with the York and Scarborough Teaching Hospitals NHS Foundation Trust footprint. This includes support for Yorkshire Ambulance Service (YAS) paramedics and the 2-hour Urgent Community Response (UCR) across all localities served by the Trust, including Pocklington.

(See below heat map illustrating activity across the expanded geography over the past three months, mapping activity to the Acute Trust geography)

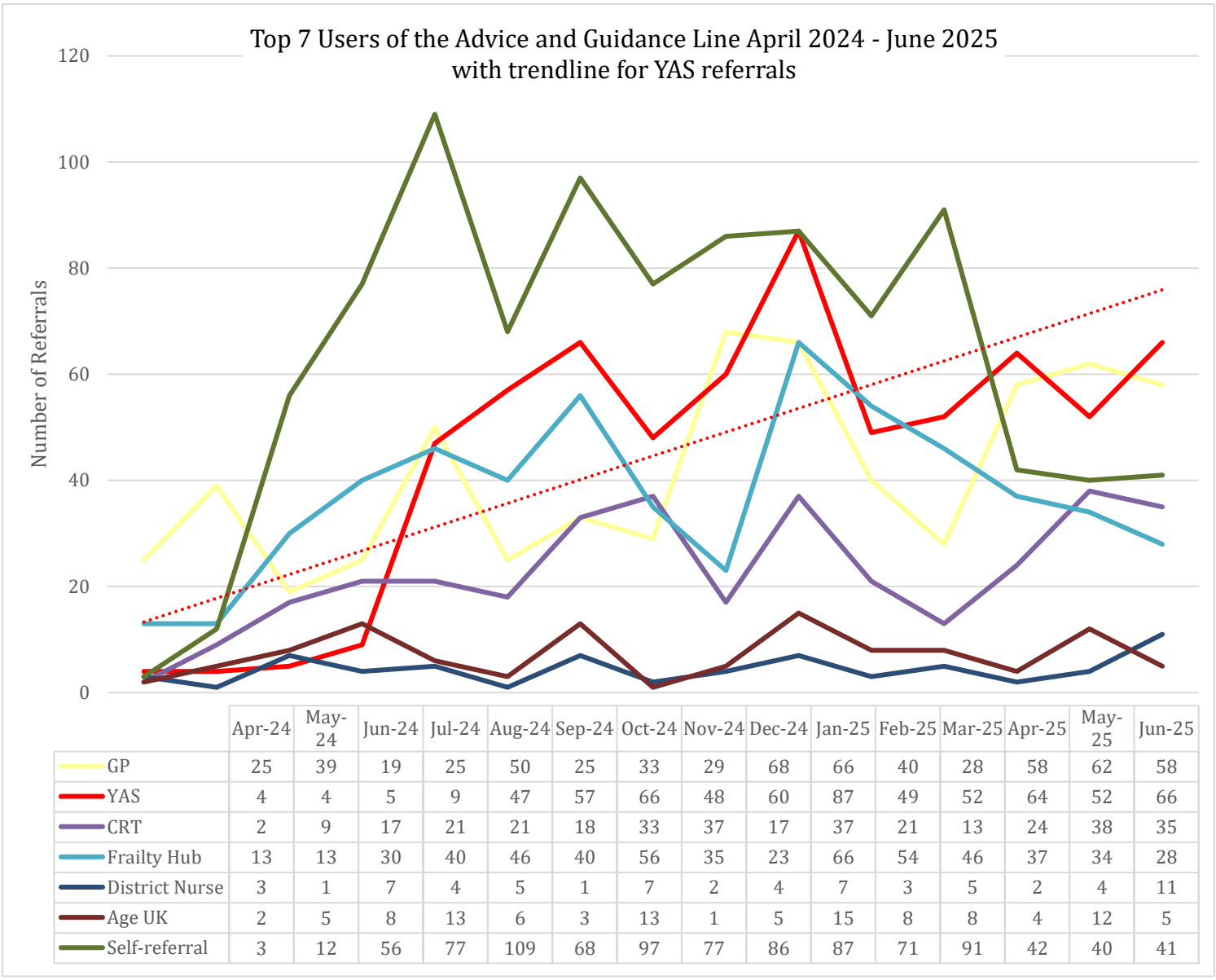


Heat map of source of YAS Call Before Convey calls in last 3 months



	Mar-25	Apr-25	May-25	Jun-25
Out of Area	2	8	0	1
Selby/SHaR	12	19	8	13
Scarborough	8	12	7	14
York	43	32	40	39

**Out of Area includes Pocklington, Easingwold, Hull, Boroughbridge, Market Weighton*



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
GP	25	39	19	25	50	25	33	29	68	66	40	28	58	62	58
YAS	4	4	5	9	47	57	66	48	60	87	49	52	64	52	66
CRT	2	9	17	21	21	18	33	37	17	37	21	13	24	38	35
Frailty Hub	13	13	30	40	46	40	56	35	23	66	54	46	37	34	28
District Nurse	3	1	7	4	5	1	7	2	4	7	3	5	2	4	11
Age UK	2	5	8	13	6	3	13	1	5	15	8	8	4	12	5
Self-referral	3	12	56	77	109	68	97	77	86	87	71	91	42	40	41

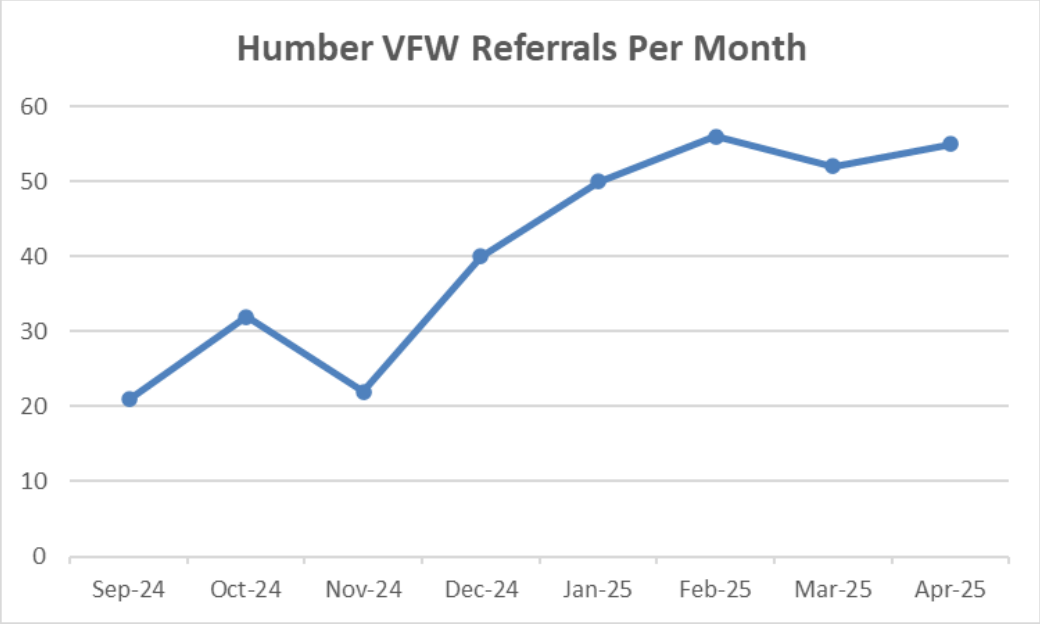
The data above illustrates the increasing utilisation of the Frailty Advice and Guidance (A&G) Line by Yorkshire Ambulance Service (YAS). In June 2024, YAS was among the lowest sources of referral; however, following the introduction of the "Call Before Convey" service in August 2024—which directly connects on-site YAS clinicians to the Frailty A&G Crisis Line—there has been a marked and sustained increase in calls from YAS to prevent conveyance of patients. Since the implementation of this service, YAS has consistently ranked among the highest users of the Frailty Crisis A&G line, alongside Primary Care.

2d. Supporting the Humber Virtual Frailty Ward

Humber Community Trust and Nimbuscare have collaboratively funded the appointment of a third General Practitioner to the Frailty Crisis Advice and Guidance (A&G) Line, with the post commencing in December 2024 and continuing through to the end of July 2025. This strategic enhancement was put in place to support the geographic expansion of the "Call Before Convey" initiative, provide remote clinical oversight for the Humber Virtual Frailty Ward, and enable the acceptance of clinician-to-clinician referrals from across the system.

This additional GP resource has been pivotal to the success of the Humber Virtual Frailty Ward, facilitating the delivery of seven-day GPwER Frailty clinical oversight and allowing patient admissions to be managed over weekends.

The graph below demonstrates a significant increase in activity within the Humber Virtual Frailty Ward following the introduction of the third GP in December 2024. Feedback from staff has indicated that the service is operating as a clinically safe and effective Virtual Frailty Ward. Notably, the referral pattern has shifted from predominantly step-down cases to an increasing proportion of step-up admissions, reflecting the ward's evolving role in proactive crisis intervention.



NHS England (NHSE) has invited the team to present their transformation journey in establishing a successful Virtual Frailty Ward model. In parallel, North Yorkshire (NY) Commissioners are actively exploring options to support the continued delivery of this critical GP role.

3. Risks & Suggestions of focus

1. Frailty Crisis A&G at high risk of becoming overwhelmed in the coming months given past growth rate. There is an opportunity to grow this arm of the service and provide care home support as well, especially as we now are progressing the 24/7 arm of the Frailty Crisis A&G line

2. Despite the support from Humber and North Yorkshire Commissioners regarding the expansion of the Call before Convey into Scarborough, Whitby & Ryedale, the funding for this post is not guaranteed and outcome from discussions with the ICB Exec team are still awaited.

3. More Therapy support needed in Community (as per Trust Community Services Gap Analysis paper) to prevent further admissions

4. Next Steps for the Community Frailty Hub

- Supporting Integrated Community Services provision within Neighbourhoods and pan-geography working

- Supporting in the provision of a single, 24/7, care co-ordination and point of access for patients that require a community-based response.

- Integrated Neighbourhood Team development (supporting the development of Primary Care Visiting Teams and Frailty MDTs based within neighbourhoods)

- Extending the Frailty Crisis A&G line into a 24/7 service in a phased approach by training and integrating with OOHs GPs (first phase going live in September 2025)

- Building dementia diagnostic capability within the team (from September 2025)

- Creating strong links between ED and the Community Frailty Hub to bring frail patients home at the front door

- Introducing AI technology and complex case management for our High Intensity Users with Frailty

- Participating in national dementia and social frailty research

- Establishing the hub as a Frailty Training Hub (from August 2025)

5. Summary

The York Community Frailty Hub is delivering impactful, coordinated, and cost-effective care for some of York's most vulnerable citizens and is being recognised nationally as an example of excellent integrated delivery of Community Care. Continued investment in this model promises further efficiencies, reduced hospital admissions, better outcomes, and an enhanced community care experience. This integrated service is evolving at pace and finding efficiencies whenever possible. Please see appendices below with patient case studies as examples of the integrated care provided within the Community Frailty Hub.

APPENDIX 1

Prevention Case Study: Supporting Complex Needs Through the Community Frailty Hub

Community Frailty Hub Team working in Nimbuscare offices

Background

Patient living with her husband, was referred to the Community Frailty Hub following a fall and several medical follow up's and a subsequent intentional overdose 2 weeks later, which raised significant safeguarding and mental health concerns. Historically independent and socially active, her functional ability rapidly declined after the fall and a confirmed fracture. Her situation was further complicated by emerging cognitive decline, relational strain with her spouse, and escalating social isolation.

Comprehensive Geriatric Assessment – Key Findings

The Community Frailty Prevention Team conducted a Comprehensive Geriatric Assessment (CGA). Key clinical and social issues identified included:

- Low mood and emotional distress
- Impaired mobility and increased falls risk
- Social isolation and carer strain
- Nutritional decline and reduced appetite
- Reduced engagement in previously enjoyed social activities
- Emerging cognitive decline and safeguarding concerns

Preventative Interventions and Collaborative Actions

In line with the patient's wishes to remain at home, the Community Frailty Prevention Team coordinated a comprehensive and multidisciplinary response:

- Medication review (including deprescribing)
- Regula BP monitoring via carers with frailty GP oversight
- Engagement with Community Mental Health Team
- Carer support for personal care and nutrition support
- Support from the frailty MDT including Occupational Therapy, Dietitian, and Social Prescriber
- Exploration of social and financial support via Age UK
- Advance care planning including ReSPECT form completed with patient and family
- Referral for driving safety assessment

Outcome and Impact

This lady remains at home, supported by a personalised care plan and a multi-agency safety net. The following outcomes were achieved through the prevention service:

Area	Impact
Mental Health	Supported through CMHT input, addressing emotional wellbeing and family safeguarding concerns.
Falls Risk	Postural hypotension is being monitored, medication adjusted, and OT referral underway to improve safety.
Nutrition	Nutritional needs identified and support from the teams dietitian.
Social Isolation	Addressed through referral to the teams Social Prescriber and exploration of respite options.
Autonomy & Planning	Advance care planning completed with clear preferences documented, enhancing patient control over future care.
Family Support	Improved confidence among family members in ability to manage care at home, with clear escalation plans in place.
Crisis Avoidance	Avoided readmission and reduced risk of acute deterioration through proactive, integrated community care.

Conclusion

This case illustrates the crucial role of community-based, preventative services in supporting older adults with complex health and social care needs. Through timely, person-centred assessment and coordinated multi-disciplinary intervention, the Community Frailty Hub has enabled the patient to avoid hospital re-admission, improve her quality of life, and remain safely in her home environment.

APPENDIX 2

Discharge Case Study (EDSS)

The team supported a patient's discharge from hospital back to his flat, there were some delays expected due to safety concerns about his home situation, the involvement of the EDSS team meant the patient's discharge could be expedited. Due to requiring assistance to navigate the stairs, he was identified as being at higher risk in the event of a fire. A Social Prescriber became involved to provide essential support aimed at improving his safety and independence.

This included helping him apply for a ground-floor independent living flat, arranging a fire safety review with the local fire service, and referring him for a falls pendant alarm. The Social Prescriber also referred the patient to North Yorkshire Sport, who delivered six tailored sessions focusing on balance and strength. These sessions significantly improved the patient's breathing control, reduced breathlessness, and increased both stamina and balance.

As a result, the patient is now able to get down the stairs independently and can walk to his local shop. He has since been allocated a ground-floor independent living flat close to his family. The Social Prescriber will continue to support him as he transitions into his new home and connects with his local community.

Discharge Case Study (D2A Bridging Pathway)

An 80-year-old lady was admitted to hospital with acute confusion. She was found to be in atrial fibrillation (AF), which was stabilised with medication. During her hospital stay, she experienced episodes of delirium at night, which resolved before discharge.

The ambulance crew raised safeguarding concerns regarding social frailty, her ability to cope at home, and ongoing confusion.

The Discharge Co-ordinator, alongside the patient's allocated Social Worker, visited her on the ward. A capacity assessment was completed, and the patient was found to have capacity. She expressed a strong desire to return home but felt anxious after a 10-day hospital stay. The patient stated she had been independent prior to admission. A full assessment was completed, and it was agreed that an initial care package of three visits per day would be put in place to assist with meals, medications, and personal care. The plan was to review and reduce these visits as she settled back at home and if no further safeguarding concerns arose. The discharge was arranged in collaboration with ward staff for the following day.

The patient was visited within an hour of returning home. A comprehensive assessment of her home environment and mobility was carried out. Old food was removed from the fridge, and fresh food was purchased. All outdated medications were removed to prevent confusion with

the new blister pack. The patient settled well back into her home environment, and the care package began as planned.

Referrals were made to Age UK for support with full shopping, as the patient had previously enjoyed visiting shopping centres. A referral to a Social Prescriber was also made to help reintroduce this activity. During the ward assessment, some ‘furniture walking’ was noted. At home, she managed well using a trolley; therefore, a referral was made to our therapy team for a four-wheeled walking frame for longer periods of mobilisation.

A nurse visit was arranged, and a Comprehensive Geriatric Assessment (CGA) was completed within 48 hours of discharge. No further referrals were required. The patient was added to our caseload for regular reviews and was made aware that she could contact our Community Frailty Hub for any interim support.

Upon discharge, the patient required significant encouragement and prompting to re-establish a routine, including eating meals on time, maintaining personal hygiene, and taking medication. Over the following 10 days, her care needs reduced from three visits per day to two, and then to once daily. It became evident that she was returning to her baseline, managing her own care, cleaning, and shopping independently.

A joint visit with the Discharge Co-ordinator and community Social Worker confirmed that the patient was coping well, and Adult Social Care assessed that no further input was required. Daily calls were arranged over the weekend (when services are reduced), and she was formally discharged from care the following Monday. Her bus pass was renewed to promote independence and reduce social isolation. The Social Prescriber was informed of the discharge plan.

The patient remains on our caseload for life, with a planned six-month review and annual CGA. She now has our contact details, and our partners in the voluntary sector continue to offer support should she need it in the future.

APPENDIX 3

Crisis: Supporting Complex Needs Through York Community Frailty Hub

86-year-old gentleman living with multiple co-morbidities and frailty, case managed by the prevention team in the Community Frailty Hub, recent decline following a hospital admission.

Daughter called the frailty crisis A&G line following a fall, they had picked him up but he "didn't seem quite right".

Concerns from the Hub GPwER Frailty regarding possible new confusion, 2-hour UCR paramedic response organised. The paramedic called back to the A&G for support from the senior clinician, it was found that he had a blood pressure that dropped on standing. His medication was reviewed by the Frailty GP and step up care support from the Frailty Hub arranged for three times a day with lying/standing blood pressure checks, with lunchtime support to be put in place by Age UK and follow up telephone appointment with Frailty GP and daughter scheduled for the following day.

However, a further fall the following day led to a YAS call out. As per the YAS Call Before Convey pathway, the patient was then re-referred to the community frailty hub for discussion, working diagnosis of recurrent falls due to poor mobility which had declined since recent hospital admission and deconditioning made. MDT discussion between the Frailty GP and CRT triage lead (sitting next to each other) led to a decision to send out a UCR therapist to assess for suitability to admit this gentleman to one of the four beds available at Fulford Nursing Home.

Patient was seen within 2 hours by a CRT therapist and deemed appropriate for Fulford Nursing Home. He was subsequently discharged home 8 days later with twice daily CRT visits and no further documented evidence of falls in the following weeks. Monitoring of his blood pressure showed that this drop in blood pressure had settled. He remains under the Community Frailty Hub caseload with the daughter and patient aware how to escalate again in the future rather than calling 999.