York Community Frailty Hub – York System Update

Prepared by: Community Services Senior Leadership Team, Nimbuscare

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Introduction

Since its establishment in November 2023, the Community Frailty Hub has brought together partners from the VCSE, City of York Council and York and Scarborough Teaching Hospital to form a coordinated, multidisciplinary "team of teams." Over the past two years, the Community Frailty Hub has played a key role in supporting people living with frailty to make informed choices about their care. The Hub delivers a crisis response, discharge support, and preventative interventions, all grounded in holistic, person-centred, and patient-led practice delivered within individuals' own homes and communities.

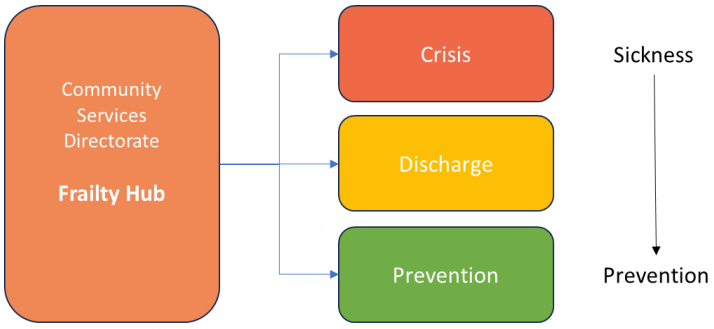
By integrating services and streamlining pathways, the Hub reduces the number of separate contacts required before individuals can access the support they need. This integrated model decreases inappropriate demand on health and social care services, reduces unnecessary hospital admissions, and strengthens support for people living with complex frailty.

Over the last 6 months, since the last system update, there has been several service developments including the Frailty Crisis Hub becoming a 24/7 service and the development of Integrated Neighbourhood Teams (INT) MDTs across the four York neighbourhoods. The Community Frailty Hub now leads eight MDT meetings; alongside daily Frailty INT MDT's the team are now hosting separate Palliative Care, Dementia and Discharge MDTs with representatives from numerous different partners.

Scope of Service

As mentioned above the service has three main delivery functions: 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. For more detail regarding the Community Frailty Hub functions please view the system update from July 2025 Link Here.

Figure 1: Community Frailty Hub Depiction

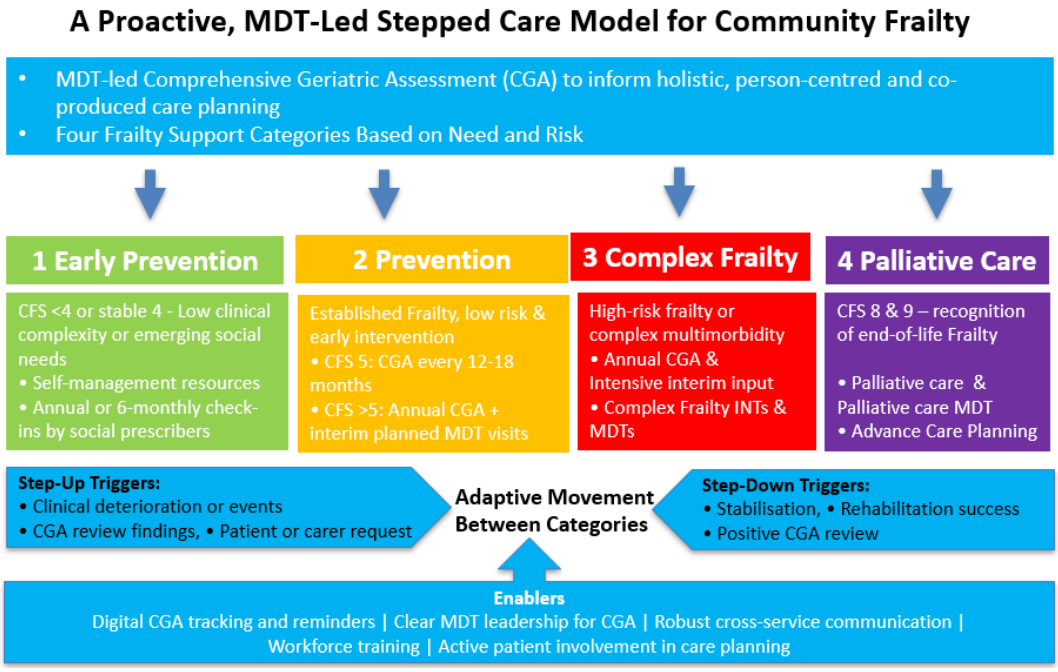


FRAILTY PREVENTION UPDATE

This service currently provides case management for over 3,000 frail people with complex needs, 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.

To respond to rising caseloads and increasing staffing pressures, a new structured approach to prevention and frailty caseload management is being introduced to risk stratify the patients on caseload to improve efficiency and offer a tailored anticipatory care response. This model supports earlier identification of need, ensuring a consistent and person-centred response, and strengthens multidisciplinary working across the system.

Figure 2: A new approach to caseload management



See Appendix 1 for a Case Study of a Therapy Led Prevention CGA.

Complex Frailty Integrated Neighbourhood Teams (INT) MDT's

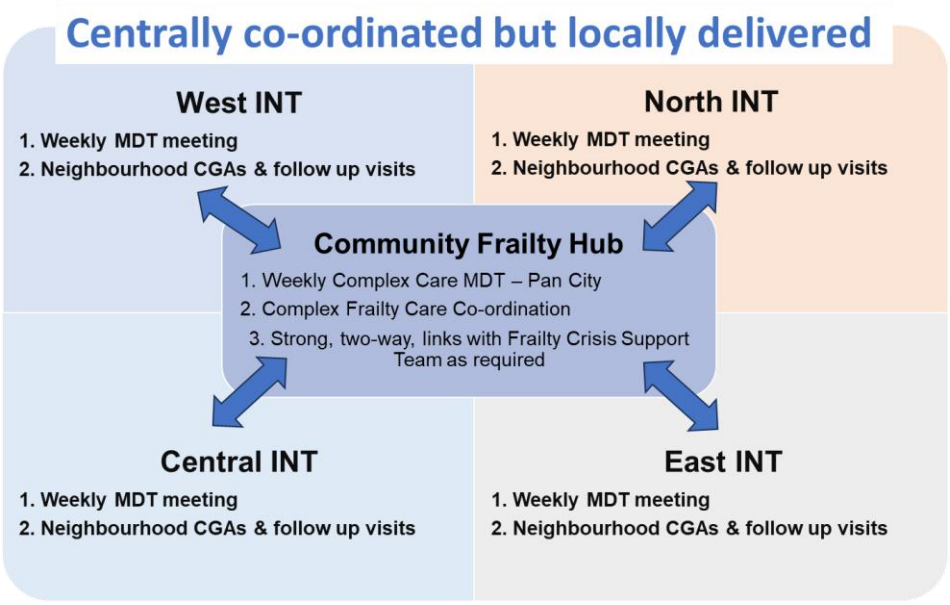
From September, as part of frailty prevention, we have worked with system partners to develop weekly Complex Frailty INT MDTs across the four city centre neighbourhoods.

The Complex Frailty INT MDT model brings together local health and care professionals to provide joined-up support for people living with complex frailty. These neighbourhood-based MDTs include staff from Primary Care, Community Nursing, the Community Frailty Hub, and Social Prescribing. The aim is to provide proactive, coordinated care for people where their complex frailty is not currently being well managed, and would benefit from close case management. **51** patients are currently being supported as part of the Complex Frailty Integrated Neighbourhood Team INTs.

Patients who are referred into this pathway receive a Comprehensive Geriatric Assessment (CGA) which is initiated by either a GP with a Special Interest in Frailty, a therapist or Social Prescriber. This ensures that complex conditions are well managed, medicines are reviewed safely, and any unnecessary treatments are reduced.

Once the CGA is completed, each patient is discussed within their local neighbourhood weekly MDT. The team works with each person to develop personalised care plans, identifying early unmet need and support people to stay well at home.

Figure 3: INT MDT Depiction



Lessons Learnt from 2-month review:

- This is a very responsive service (CGAs done within days of referral)
- GP assessments are thorough and effective deprescribing is evident

- Advanced Care Planning is taking place
- The care plan is patient led and what matters most to the patient is paramount
- Significant value is being added by the involvement of Social Prescribing and the voluntary sector – need to ensure clear documentation of this in patients health records

Figure 4: Percentage of patients with involvement of non-registered services in the first 3-months of the Complex Frailty INT MDTs

Central	91%
North	100%
East	62%
West	71%

For the next system update report, we will be able to provide outcome measures such as PAMS and SWEMWBS from the 3-month reviews that will be starting to take place for this cohort at the beginning of January. We will also be reviewing the unplanned activity within the system for patients within this caseload.

Feedback from a Partner GP Practice:

"It has been a pleasure to be involved in the start of complex frailty INTs for the North and West INTs. As PCN CD for a practice with patients in both these areas it has been eye opening to see the overlap in services who are providing support to the people we discuss. So many of them are well known to several agencies at the same time and this forum gives an opportunity to work together to avoid duplication and reinforce good practices suggested by other agencies.

This is an iterative process and having learned that as well as medical interventions such as deprescribing and effective care planning and navigation, there are key non medical interventions such as social prescribing, voluntary and social care input which are as or more likely to result in health benefits in the longer term. We are seeing impact at 3 monthly reviews but I anticipate even more benefit felt at 6 month and 9 month reviews. Thanks for the listening approach which is being taken to co-produce the INTs."

See Appendix 2 for a Case Study from the Complex Frailty INT.

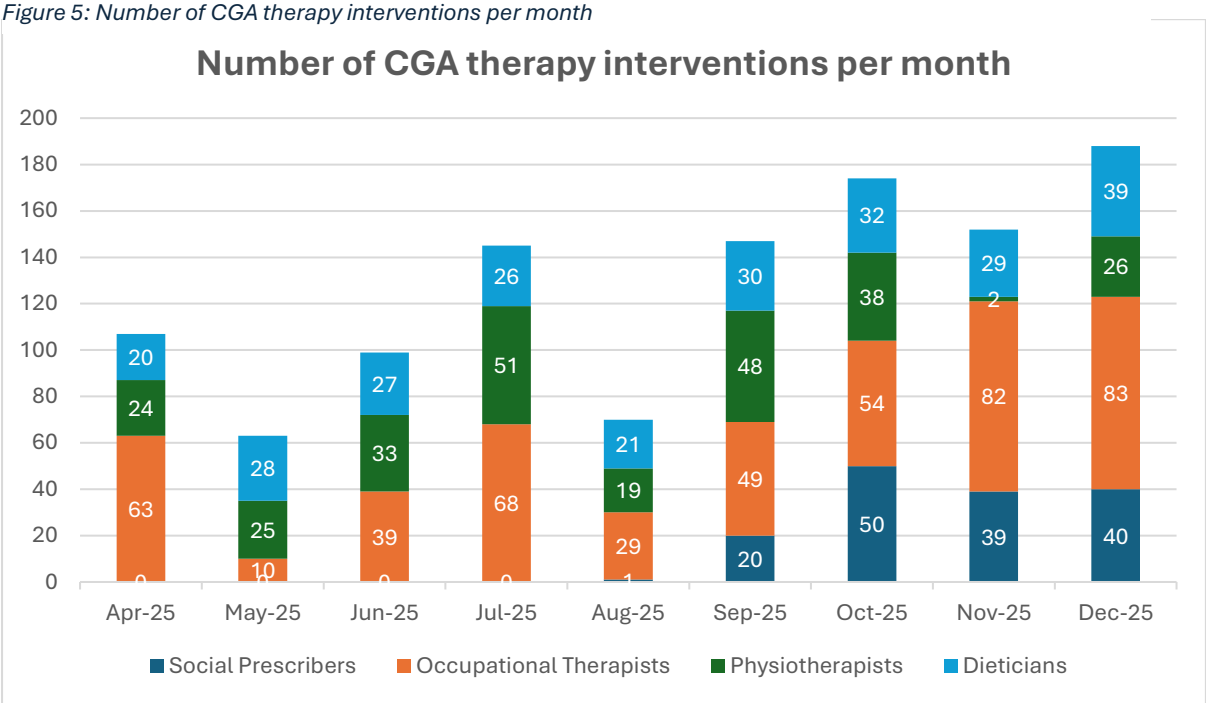
Frailty Prevention Assisted Technology

As part of the Complex Frailty INT service, a cohort of 20 patients, split across the four neighbourhoods, will be identified and supported with a MiiCare 'Monica' device. This is an AI-powered home hub and wellbeing virtual assistant that will prompt and coach a person based on 'learned' patterns of behaviour and insights.

The aims of the MiiCare Pilot are to:

- Enable independent living for longer and reduce symptoms of loneliness and isolation.
- Enhance overall well-being through routine reminders, for example medication, hydration and social interaction.
- Reduce pressure on caregivers and healthcare systems by providing objective data that supports a preventative approach and avoids patients reaching crisis.
- Optimise care packages by tailoring support to actual, data-driven needs.

Figure 5: Number of CGA therapy interventions per month



Outcome measures:

Dietitian: a mini nutritional assessment score is competed for all patients seen by the dietitian, this is a validated score suitable for those individuals over 65yrs. As well as considering weight loss, BMI and appetite, it also considers recent admissions/acute disease or psychological stress, mobility, and whether they have any neuropsychological problem such as dementia or depression. Most patients (89%) referred to the dietitian are either malnourished or at risk of malnutrition. Over the last 12 months **64% of patients have seen an improvement in their nutrition score after an intervention from the Community Frailty Hub dietitian.**

Social Prescribing: all patients that are supported through the Social Prescribing service complete the ONS4 wellbeing measure pre and post intervention, the outcome of these for quarter 3 are below:

- **Life Satisfaction - 75% of patients asked reported improved life satisfaction.**
- **Worthwhile - 100% of patients asked reported feeling more worthwhile**
- **Happiness - 75% of patients asked reported feeling happier**
- **Anxiety - 75% of patients reported feeling less anxious**

FRAILTY CRISIS UPDATE

From 1st December 2025 the Frailty Crisis Advice and Guidance line became a 24/7 service model. This service development is aligned to the pre-existing Nimbuscare OOH's service, which enabled us to upskill staff to cross cover between the two services. Through this service expansion you will see that contacts to the service continue to rise (see Figure 5) and conveyances to ED and admissions avoided are following the same trajectory. The total number of conveyances and ED admissions avoided in the last year is 5,204.

The medical UCR provision is now provided by a combination of both Paramedics and Trainee Advanced Clinical Practitioners (ACPs). This shift has allowed for a more flexible approach to service delivery. Since making this change, we have seen a significant increase in the number of medical UCR contacts taking place each month, from around 125 in the summer of 2025 to over 200 in recent months.

The use of the Crisis Advice and Guidance line by the Yorkshire Ambulance Service across the region is also an area of improvement, as seen Figure 6, showing how the contacts to the line have been increasing from all areas of the Ambulance Service. This has been achieved by focussed communication with YAS colleagues, alongside the recent expansion of the Crisis A&G line as a 24/7 service which is available to support YAS colleagues to avoid unnecessary hospital admissions whenever required.

See Appendix 3 for a Case Study of the Frailty Crisis Service.

Figure 6: Contacts with Senior Frailty Clinicians and Conveyances & ED admissions avoided

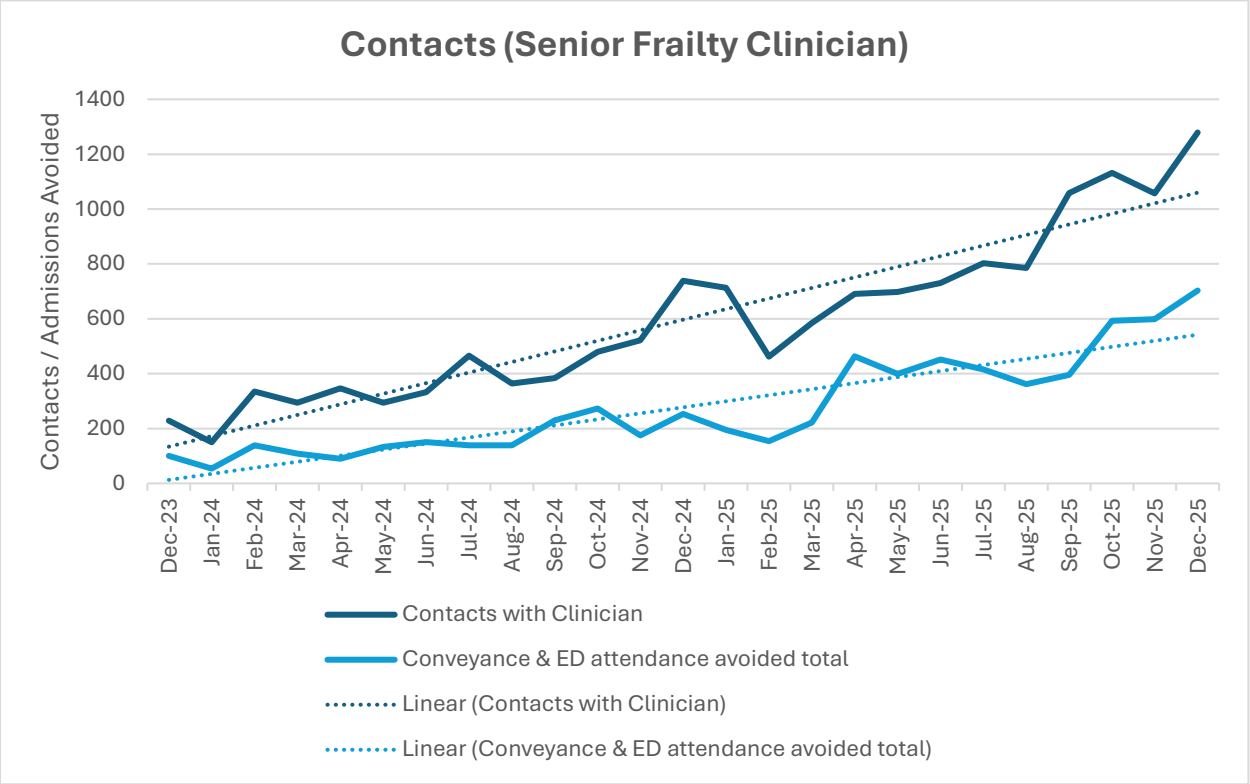
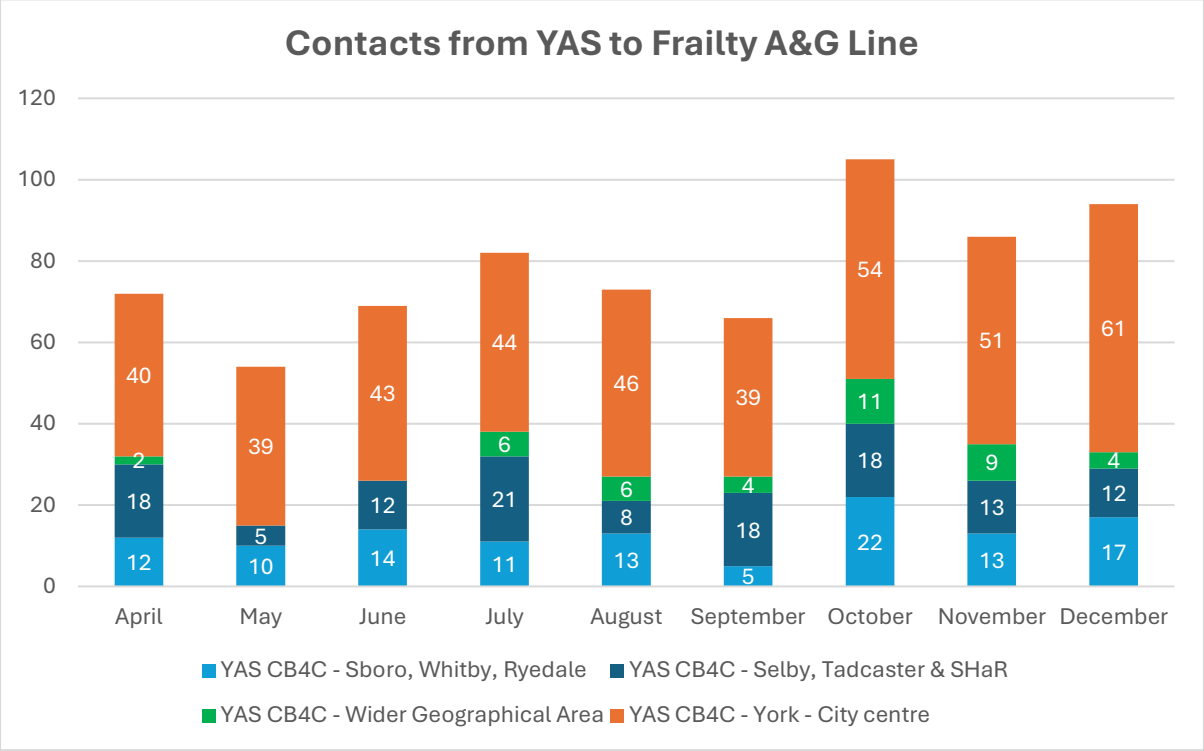


Figure 7: Contacts from YAS to Frailty A&G Line



FRAILTY HUB DISCHARGE UPDATE

As part of the Discharge to Assess Bridging service (D2A) pathway, bridging packages of care are put in place to support people in need of support post discharge once deemed medically fit (rather than waiting for a social worker assessment as an inpatient). Continuous improvement of this service has taken place with an increase in therapy input, demonstrating a reduction in average length of hospital stay by 8 days per patient. We're building on the success of this model by integrating this service with another discharge service within the Community Frailty Hub, the Extra Discharge support Service (EDSS).

Our aim is to deliver a fully integrated Discharge Service through the amalgamation of the Enhanced Discharge Support Service (EDSS) and the Discharge to Assess Bridging Service (D2A), operating as a single, coordinated pathway within the Community Frailty Hub via the Hub's single point of access.

This integrated model will create a seamless, end-to-end discharge process that ensures patients with frailty and complex needs experience timely, safe transitions from hospital to home, supported by multidisciplinary clinical oversight, and voluntary sector provision.

Through integration, the service will:

- Provide one single point of access and coordination, streamlining communication between acute, community, and voluntary sector partners to improve efficiency and consistency.
- Enable holistic, multidisciplinary case management for all patients discharged through the service, combining clinical assessment, therapy input, and social support to address physical, emotional, and practical needs.
- Support discharge within 24 hours of referral, with home assessments on the day of discharge and a full Comprehensive Geriatric Assessment (CGA), if appropriate, within 24–48 hours.
- Deliver flexible, short-term packages of care (up to four times daily for up to four weeks), including support with personal care, medication, meal preparation, reconditioning, and reablement.
- Ensure rapid access to clinical expertise, including Frailty Crisis GP advice and guidance, therapy input, and social prescribing, to reduce delays and enhance patient outcomes.
- Utilise the strengths of voluntary sector partners—Age UK, Carers Support, North Yorkshire Sport, and Social Prescribers—to provide wraparound support that addresses social isolation, carer wellbeing, and access to community resources.

- Reduce duplication by aligning workforce capacity, care planning, and assessment processes under one shared governance and reporting framework.
- Deliver measurable system benefits, including reductions in hospital-acquired infections, length of stay (LOS), and readmissions, alongside improved patient satisfaction and continuity of care.

A recent audit of patients supported during quarter 3 shows the % of patients with reduced care needs post discharge.

October – 74%

November – 57%

December – 43%

See Appendix 4 for a Community Frailty Hub Discharge Case Study

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COLLABORATIVE WORKING

The Community Frailty Hub subcontracts six partner organisations to deliver holistic, patient-centred care to frail patients in York. These partners are York CVS, York Carer's Centre, Age UK York, North Yorkshire Sport, the provision of an adult social care worker from City of York Council and York and Scarborough Teaching Hospital's UCR Community Response Team Triage Service. There are two further services, TEWV and Dementia Forward, who are hosted as part of the Community Frailty Hub but are contracted via the ICB to deliver their services.

Each of the six partner organisations attend a monthly collaborative governance meeting where KPI data is discussed, along with being a space for individuals to share learning events and ask for any support or feedback as required. A six-month survey was shared with the attendees of this meeting, to gain insights on collaborative working, communication, staff experiences and integration as well as asking for any challenges or improvements to be identified.

A summary of feedback received is below:

Feedback is highly positive and constructive. Partners value the Community Frailty Hub as a genuinely collaborative, supportive and effective model that delivers tangible benefits for patients and staff alike. Continued focus on communication, clarity of process and time for reflection will help the Hub mature and maintain its strong foundations.

See Appendix 5 for VCSE Case Studies as part of the Community Frailty Hub

As part of the SLAs signed by the partner organisations, five out of the six have KPIs which are reported to Nimbuscare on a monthly basis. Samples of this data is available below.

Figure 8: Carer's Centre KPI

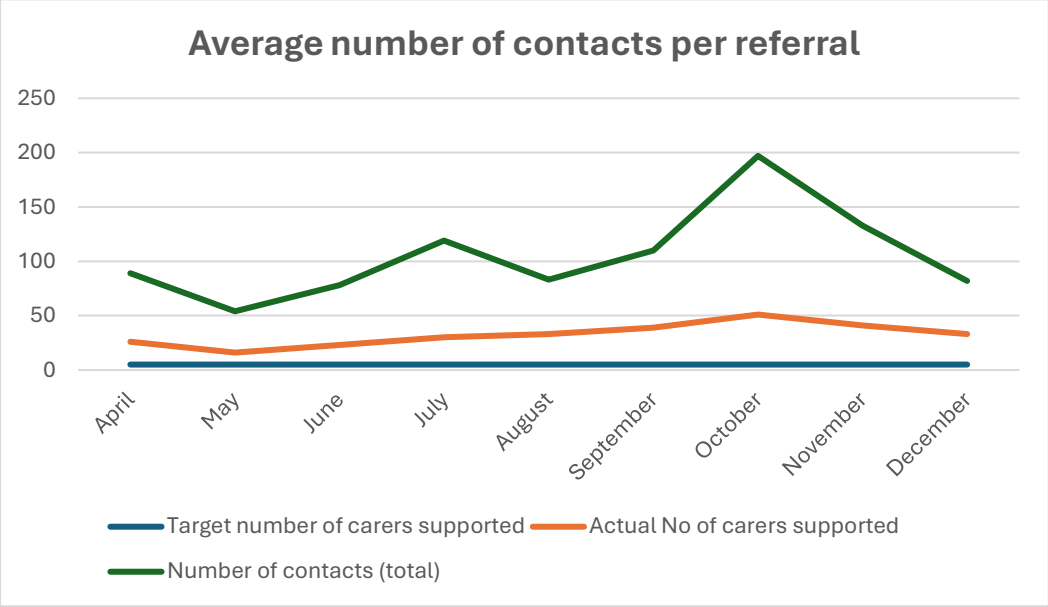
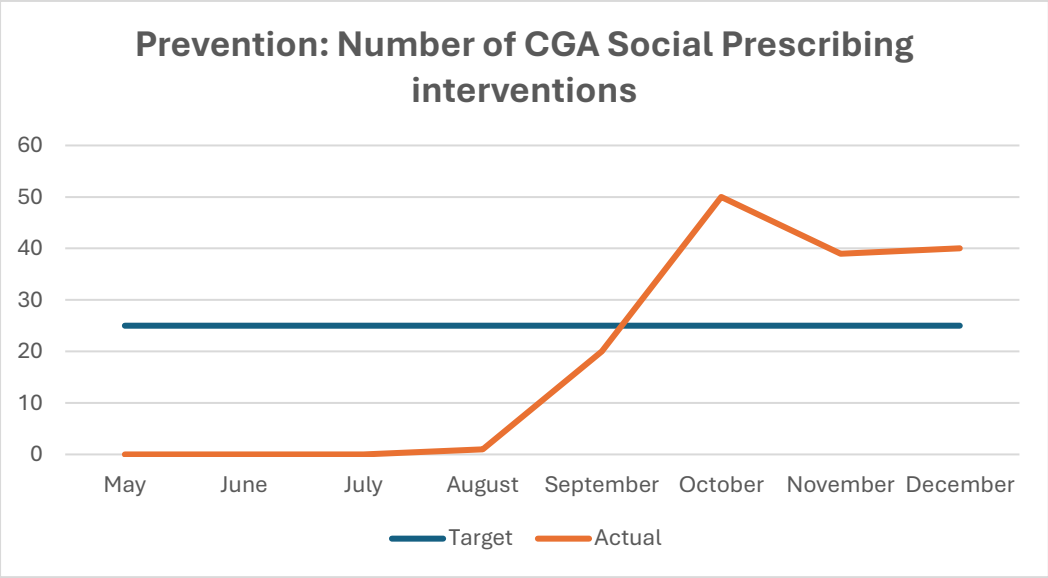


Figure 9: CVS KPI



NEXT STEPS

- Integrated Neighbourhood Team development, auditing all home visiting taking place across York and exploring the opportunities that neighbourhood home visiting service will offer for integrated care.

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

- Participating in research into the various arms of the Frailty Service in conjunction with York St John University. Outcomes of this will be included in the next System Report.

- Continuing with the plans to establish the Community Frailty Hub as a Training Centre. We are currently hosting our second rotation of GP Trainees and FY2s and the hub will be hosting paramedic, therapy and nursing students.

- Piloting a 12-month deprescribing project across Primary Care, improving and standardising our Frailty coding across the city and focussing on deprescribing in frail patients across all of Primary Care with a varietyof high risk medication in Frailty.

- Setting up of Direct to Administer remote prescribing service across York System to improve efficiency for Community Teams and accelerate the administration of urgent end of life medications.

- Complex Frailty INT MDTs to enter Phase 2 in January 2026, with the inclusion of additional system partners (Community Therapists and LACs).

- Creation of Dementia Pathways to support the diagnosing of patients with simple dementia within the Community Frailty Hub – pilot for Community diagnosing underway.

- Discharge MDT with clinical oversite and representation from the voluntary and community sector to help prevent re-admissions when possible.

- Palliative Care MDT – to be hosted by the Community Frailty Hub in partnership with the Specialist Palliative Care team and St Leonard's Hospice

- Enhanced Care of Older People (EnCOP) Competency Framework to be delivered through workshops to all the work force within The Community Frailty Hub, including subcontracted partners.

The Next System Update Report is due July 2026.

Appendix 1 – Therapy Led Prevention CGA Case Study

Following a fall, an older adult living alone was identified as being at increased risk of loss of independence and future hospital admission. Although previously managing personal care independently, the fall led to reduced confidence in mobility and concerns about safe function at home. Early referral to the Frailty Prevention Therapy Team enabled a therapy-led CGA to be completed in the community, supporting timely intervention and prevention of further deterioration.

The assessment identified several modifiable risks, including postural hypotension, unsafe equipment use, difficulty with bed transfers, and inconsistent use of a lifeline alarm. Through a coordinated, therapy-led approach, practical and targeted interventions were implemented, including provision of specialist equipment to support bed mobility, a seated strength programme, safer outdoor mobility aids, and improved independent living solutions. Concerns regarding blood pressure were escalated to the Community Frailty Hub team, with Age UK York monitoring put in place to avoid unnecessary escalation to acute services.

As a result, the patient regained confidence in indoor and outdoor mobility, maintained independence in daily living, and the need for formal care support was reduced. This case demonstrates how early, therapy-led CGA can enable safe discharge, prevent re-admission, and support sustainable independence through integrated community working.

Appendix 2 - Complex Frailty INT Case Study

An older adult was referred by their GP to the Complex Frailty INT MDT due to increasing frailty and reliance on a family carer. The case was discussed at the neighbourhood MDT meeting, enabling a timely and holistic assessment.

A home-based Comprehensive Geriatric Assessment (CGA) was completed by a GPwER Frailty, involving the patient and her son. MDT discussions identified priorities including optimising pain management, improving breathlessness, rationalising medication, and supporting the patient's wish to remain at home and avoid hospital admission.

A shared care plan was implemented through a coordinated MDT approach. Social Prescribing supported decluttering, access to community activities, and practical help at home. Adult Social Care completed a needs assessment to enhance support, while voluntary sector partners provided befriending, household assistance, and carers'

support, including financial advice and emergency planning. Clear escalation pathways were agreed, reducing inappropriate use of urgent care.

Education was provided to the patient and her son to increase confidence in managing at home, and the Community Frailty Hub Crisis contact was shared as an alternative to hospital attendance. Ongoing MDT review, including GP follow-up, ensured symptom control and sustained care at home, demonstrating the value of integrated MDT working in supporting patients and carers and preventing unnecessary escalation.

Appendix 3 – Frailty Crisis Case Study

The Frailty Crisis A&G line was contacted about a frail, older gentleman by his wife who had noted that he was becoming more confused and unwell. To avoid an ambulance being sent, the GPwER Frailty arranged for a medical Urgent Community Response visit to take place within 2hrs. The crisis team suspected that he was retaining urine (as suggested by the findings from his recent bladder scans).

The GPwER Frailty became the central coordinator for the case, requesting point of care blood tests and bladder scanning to be undertaken the same day. Through the Community Frailty Hub, the GPwER supported the medical Urgent Community Response (UCR) clinicians with decision making and specialist medication advice, interpreted scan findings and brought together urology specialists and the Community Nursing team to agree an appropriate plan.

The Community Frailty Hub, District Nurses and urology worked in partnership to plan catheter management on SAU and avoid an acute admission. Following catheter insertion, follow up was arranged by the Community Frailty Hub and his confusion settled. A jointly agreed multi-agency plan was put in place to ensure ongoing support in Community.

Appendix 4 - Case Study from Integrated Discharge Support

Following an acute hospital admission, a patient was discharged home via the Discharge to Assess (D2A) pathway with a once-daily care package. A CGA was completed in the patient's home which enabled early identification of needs beyond the immediate reason for admission, supporting a safe and timely discharge. Following this, a referral to Occupational Therapy was made.

While the initial focus was mobility and COPD management, the CGA identified significant emotional and functional challenges linked to recent bereavement. Anxiety had led to reduced confidence, avoiding going upstairs in the home, and deterioration in activities of daily living, placing the discharge at risk of breakdown without further support. A referral was made to Social Prescribing.

Through co-ordinated working across the Frailty Prevention Therapy Team, primary care and social prescribing, the patient received emotional support, graded functional interventions and practical home-based solutions. Primary care was engaged to consider treatment options for untreated anxiety, while social prescribing support addressed environmental barriers, social isolation and access to bereavement services.

As a result, the patient regained confidence to use her home fully, re-engaged with daily routines, and developed coping strategies to manage anxiety independently. This integrated D2A approach prevented escalation back into acute services, supported sustainable independence, and demonstrated how holistic, community-based interventions strengthen discharge outcomes and system flow.

Appendix 5 – VCSE Case Studies

CVS Social Prescribing Case Study

During a hospital admission for planned knee replacement, staff noticed signs of self-neglect in the patient's husband. This triggered a social prescribing referral, which uncovered severe hoarding, lack of basic utilities, and financial hardship. The social prescriber coordinated a complex multi-agency response: deep cleaning, plumbing repairs, securing heating and hot water, applying for charitable grants, replacing essential household items, and linking the couple to debt advice and income-maximisation support. Continued follow-up ensured the couple could safely manage at home after discharge.

This case highlights:

- Multi-agency coordination across health, social care, charities, energy support schemes and community partners to stabilise a vulnerable environment for a frail household.
- Proactive safeguarding and early intervention, triggered by acute hospital staff and followed through by community-based social prescribing.
- A whole-system view of frailty—addressing environmental risks, poverty, and neglect that directly affect health outcomes.
- Facilitating safe discharge and preventing readmission through city-wide collaboration.

Carer's Centre Case Study

A carer supporting his wife with dementia was referred by hospital staff due to signs of carer strain following her recent admission for infection. A home visit provided tailored advice on legal planning, benefits, care options, Blue Badge access, and dementia-specific support. The worker also liaised with the couple's son to ensure unified family support. The intervention improved financial security, increased understanding of future care needs, and reduced the risk of carer breakdown.

This case demonstrates:

- Early identification of carer strain at hospital front-door services, followed by coordinated community carer support.
- Strengthened links between hospital wards, carer support services, dementia organisations, and local authority systems, improving continuity of care.
- Preventative, asset-based working, enabling carers to sustain their role longer and reducing crisis presentations.
- Embedding carer support as a core component of frailty management city-wide.