South and West Herts
Health and Care
Partnership

Delivering Integrated Frailty Care in South and West Hertfordshire

16th July 2026

Working together
for a healthier future

South and West Hertfordshire Health and Care Partnership

South and West Herts Health and Care Partnership

South and West Hertfordshire (SWH) Health and Care Partnership (HCP)

West Hertfordshire Teaching Hospitals NHS Trust
Acute Hospital Provider

Central London Community Healthcare (CLCH) NHS Trust
Community Services (Adult)

Hertfordshire Community NHS Trust (HCT)
Community Services (Children)

Hertfordshire Partnership University NHS Foundation Trust (HPFT)
Mental Health Services

Central East ICB
Commissioner

Hertfordshire County Council
County Council

X5 Borough Councils
Three Rivers District Council; St Albans City & District Council; Watford Borough Council; Dacorum Borough Council; Hertsmere
Borough Council

VCFSE Alliance
Voluntary & Faith Sector

South and West Herts Health and Care Partnership

Operating Model – Through a Frailty Lens

SUPPORT CLOSE TO HOME
(pop. size: 5-20k – GP registered population)

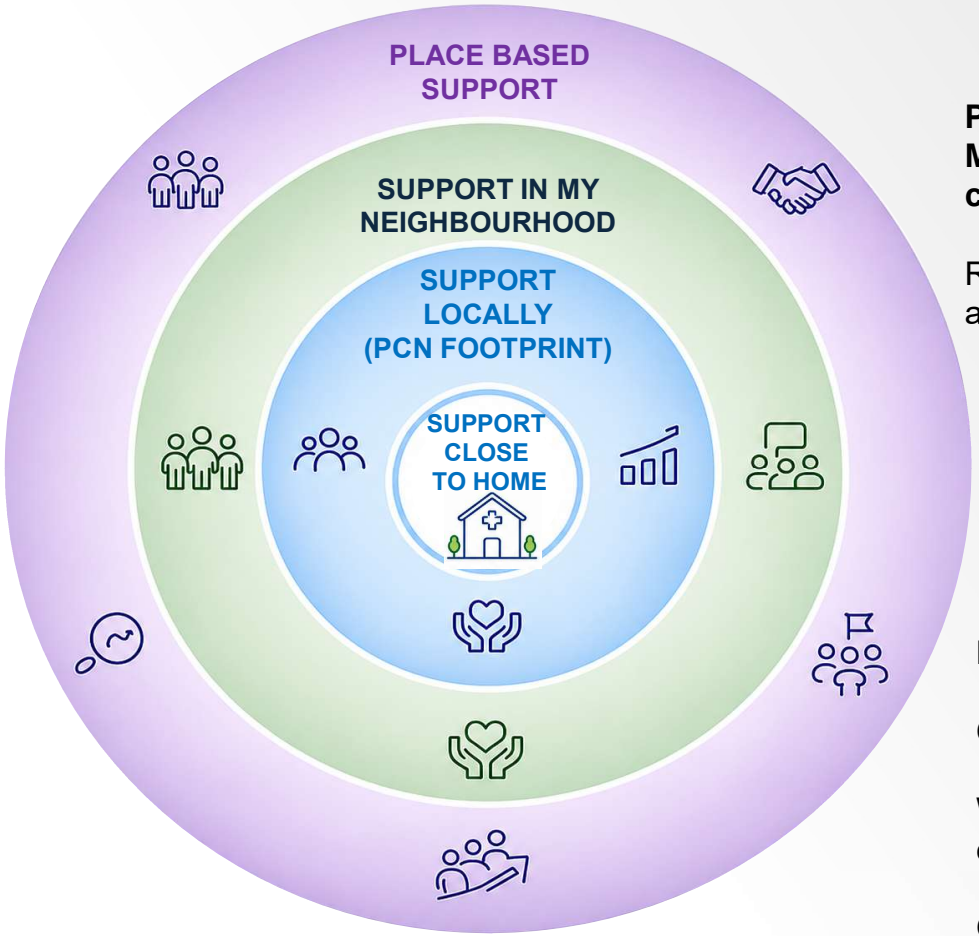
ECF focused interventions:

Polypharmacy/ Medication reviews
Targeted work on risk stratified lists of high-risk patients

SUPPORT LOCALLY
(pop. size: 20-50k)

Targeted work on advance care plans

Targeted work on risk stratified lists of high-risk patients



SUPPORT IN MY NEIGHBOURHOOD
(pop. size 100-250k)

Proactive care model (funded via Macmillan) to support high risk and super complex frail patients

Re-alignment of community services to a neighbourhood population

PLACE BASED SUPPORT
(pop. size 600k)

Frailty virtual hospital

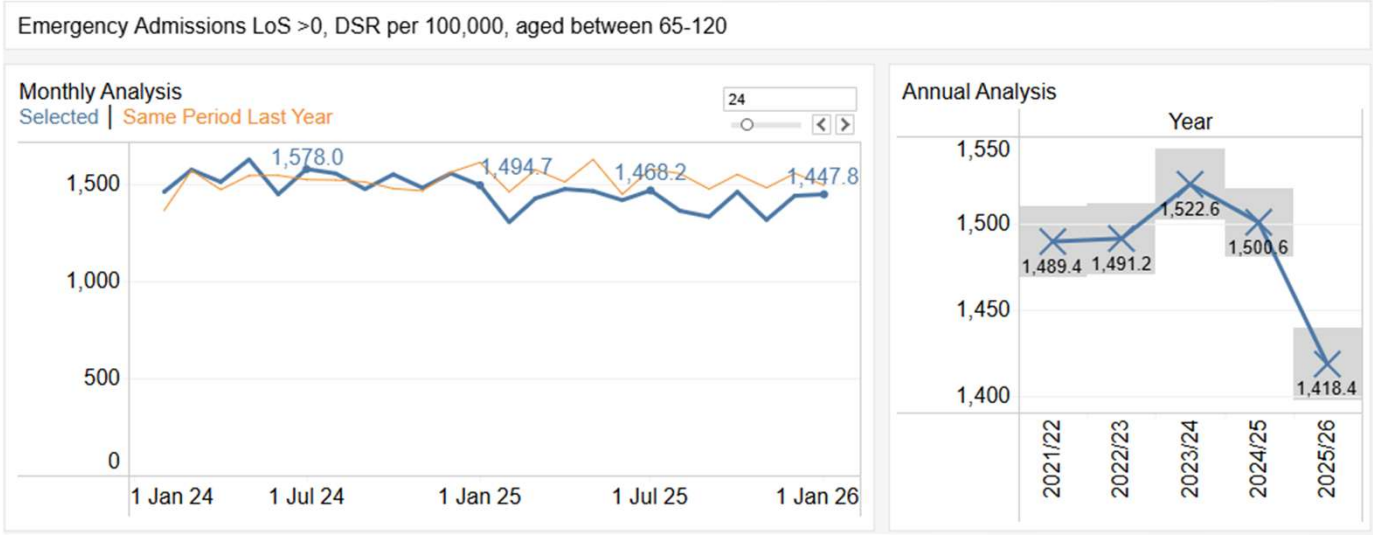
Care co-ordination at the 'front door'

Work with ACS to develop our transfer of care hub

Outreach model to care homes for Dementia patient (Alzheimer's Society funded)

HCP developing frailty offer over the past few years

Focus on key areas in SWH in 25/26 has achieved a reduction in non-elective admissions in over 65-year-olds.



South and West Herts Health and Care Partnership

NHS Central London Community Healthcare NHS Trust

NHS West Hertfordshire Hospitals NHS Trust

Integrated Frailty Care in West Hertfordshire Delivering Hospital at Home Through Partnership Working

Central East Frailty Conference

July 2026

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What

The service supports acutely unwell frail patients to receive hospital level care at home, who would otherwise require hospital admission. Interventions provided for up to 14 days.

Who

- Aged 65+
- Clinical frailty score of 4 or more
- Exacerbation of a frailty related condition

*Clinical reasoning used where a patient may fall out of the criteria

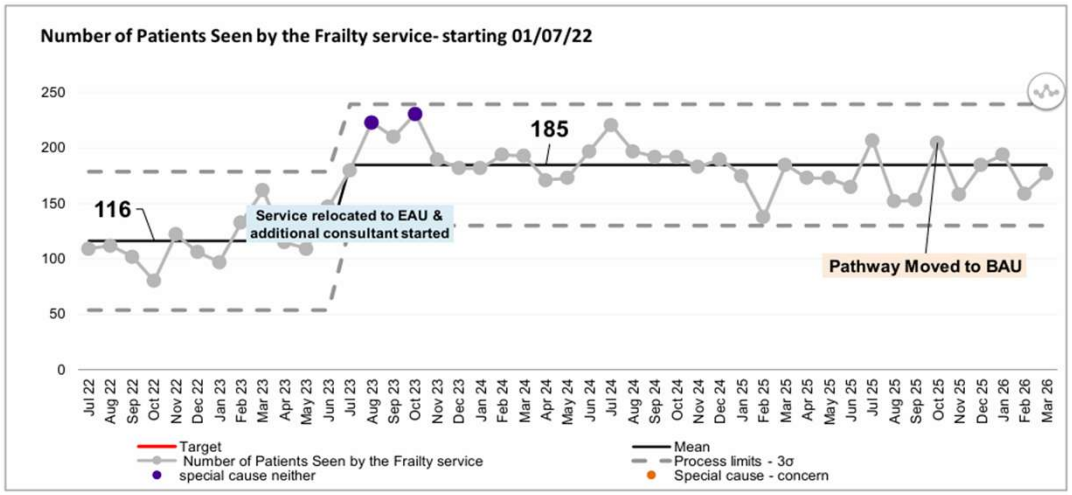
How

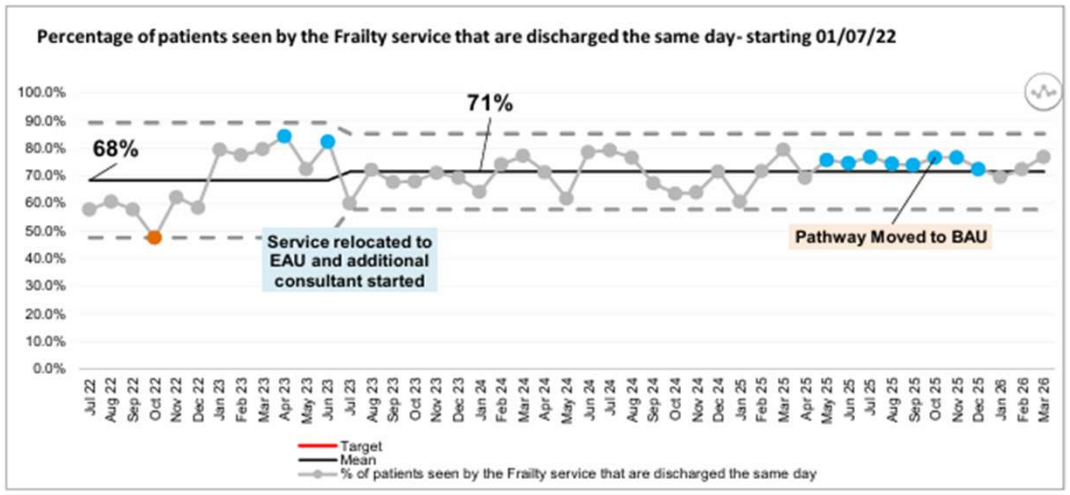
- Early Supported Discharged: Acute hospital provider
- Admission avoidance: Emergency Departments and Urgent Community Response Care Coordination Centre

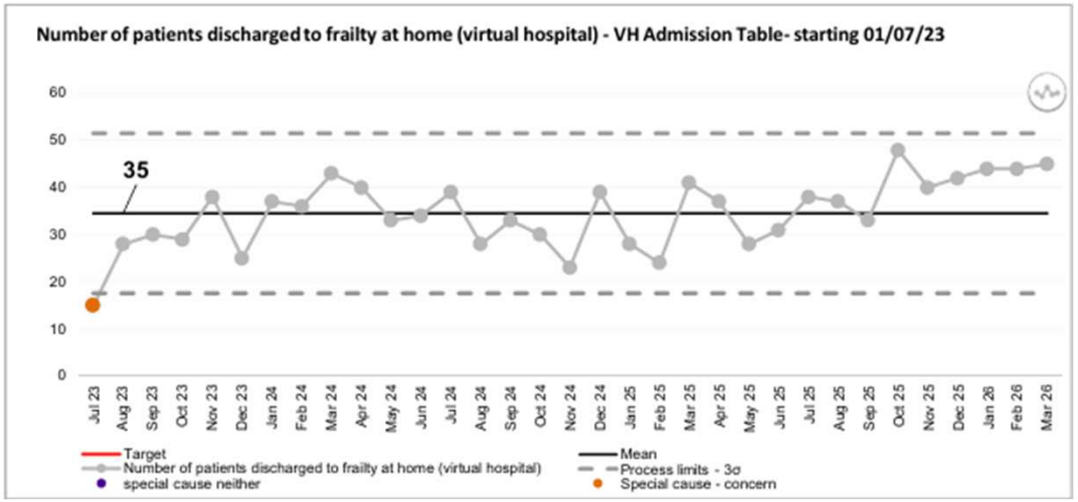
Frailty Hospital at Home journey

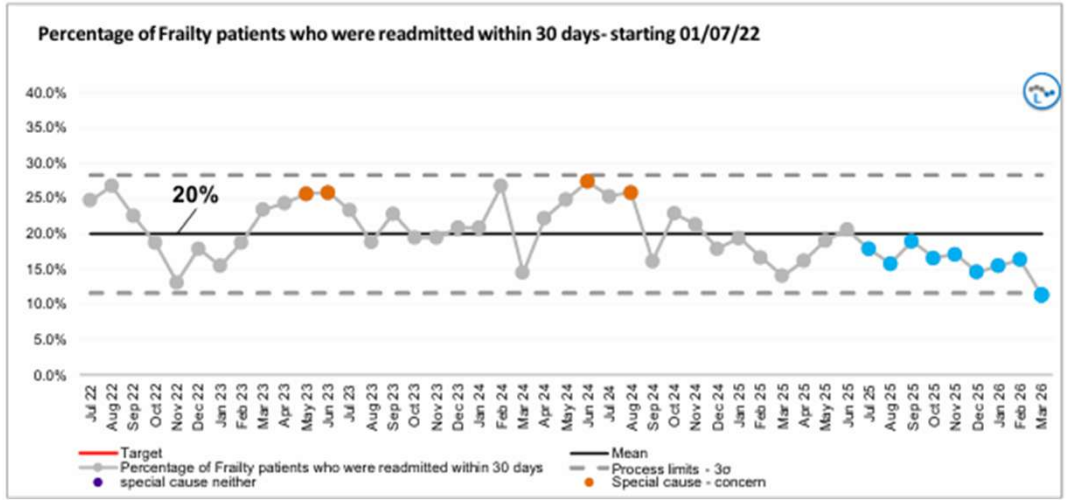
	Enters VW from WGH acute ward or ED	Enters VW from home or Out of area hospital
Onboarding to VH	Reviewed and consented by Acute Frailty VH Medic or AP for clinical suitability for H@H	Reviewed and consented by Nurse Consultant or H@H AP for clinical suitability for H@H
VH stay	**Community H@H** Will have on average **5 visits** to complete physical assessments/reviews, administer IV medications, take bloods or investigations. Patients will have on average **3 remote consultations** Access to day admission to acute setting for additional interventions/imaging as required Average stay in H@H for **7 days** (a day more for step down)	
Offboarding from VH	87% of patients will remain at home at the end of H@H Almost all patients will have ongoing care from a community/voluntary service on discharge 13% will have a decline that requires re/admission to hospital	

Frailty Services at West Herts









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Frailty Hospital at Home Outcomes and impact

Patient experience reflects high levels of satisfaction with the model of partnership delivery	This service was outstanding! It gave me reassurance that I would continue to be cared for at home. Having someone check in daily was wonderful!	
	Very polite, courteous, very thorough assessment, knowledgeable. An amazing service!	
	Removed the dread of going into hospital. Roll this team out further, the best of the NHS!	
	I would recommend Frailty H@H to my family and friends	**100%**
Performance outcomes evidence a clinical and cost-effective partnership	Occupancy target of >80% met 6 months in last year 80% admission avoidance 20% ESD	
	30-day readmission rate is **similar** to matched patients who were admitted to Hospital. VH patients have a **25% reduction** in readmission at 90 days than matched patients.	
	H@H Care costs around **£182 per bed day**, considerably less than inpatient care (£569) >>> £5million cost savings since go live in 2023 if equivalent care was delivered as an inpatient.	

Acuity tier on entry in line with Virtual Wards in East of England region	**CLCH Acuity Tier on VH admission**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
	S&WH Frailty H@H	**0%**	**0%**	**53%**	**47%**
	Average East of England region	**17%**	**49%**	**24%**	**10%**

NEWS2 scores on entry in line Virtual Wards in East of England region	**NEWS2 score on VH Admission**	**NEWS2 0 – 2**	**NEWS2 3 - 4**	**NEWS2 5 or more**
	S&WH Frailty H@H	**40%**	**40%**	**20%**
	Average in East of England region	**79%**	**17%**	**4%**

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CLCH
Central London Community Healthcare NHS Trust
NHS
West Hertfordshire Teaching Hospitals NHS Trust
General Practice
(Primary Care Networks)
Hertfordshire County Council
Informal Carers
Family Carers
FRAILTY
HOSPITAL AT HOME
PARTNERSHIP
Wrapping Care Around the Person
Voluntary Services
(Voluntary & Third Sector)
Together
Collaborative
Compassionate
Connected
CLCH NHS Trust • West Hertfordshire Teaching Hospitals NHS Trust • Hertfordshire County Council
General Practice • Voluntary Services • Informal Carers

Future Development & Take-Home Messages

Next steps

- Expansion of Hospital at Home capacity
- Seven-day service
- Enhanced integrated pathways

Three take-home messages

✓ Comprehensive Geriatric Assessment should begin at the front door.

✓ Hospital at Home delivers high-quality acute level care while reducing unnecessary admissions.

✓ Success depends on genuine partnership across all providers

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South and West Herts Proactive Care Programme

Central East Frailty Conference

July 2026

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Aim and Objectives of the Proactive Care Programme

The aim of the programme is to **develop and implement a proof of concept for a pro active, data driven, person-centred care model for "high risk" older people with frailty, that once tested and proven can be rolled out across the wider system.**

Specifically focussed on improving health and care services for the moderate and severely frail older population, seeking to:

1. *Reduce preventable interventions; ED attendances, admissions diagnostics, prescribing and elective care*
2. *Delay the onset of health deterioration where possible*
3. *Maintain independent living*
4. *Reduce avoidable exacerbations of ill health, thereby reducing use of unplanned care.*

What makes it different from existing services?

- ✓ Unapologetically solely focused on a specific high-risk cohort requiring a very different, highly personalised, proactive, holistic and intensive model of care
- ✓ Does not rely on referral
- ✓ Holistic, comprehensive wrap-around care from wide range of services and support, especially including the third sector, peer support and carer support
- ✓ Strong links with specialist care

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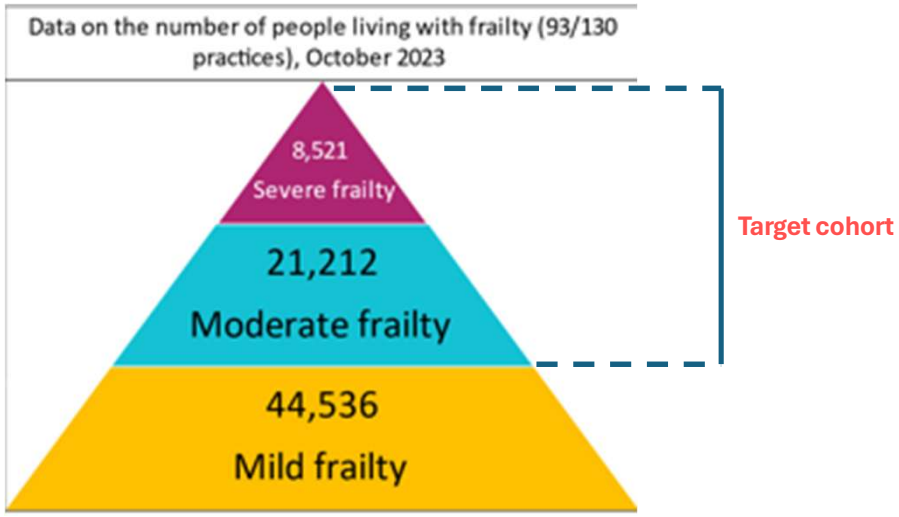
Target Cohort for the Proactive Care Programme

Data from 92 practices (out of 130) in HWE ICS show that there are over 74,000 people living with frailty. This suggests that there are more than 100,000 people across the entire ICS who are living with frailty.

The majority of people are living with mild frailty (60%) and approximately 11% of people with frailty have severe frailty.

High number of people aged over 65 with LTC who have not had a frailty status recorded.



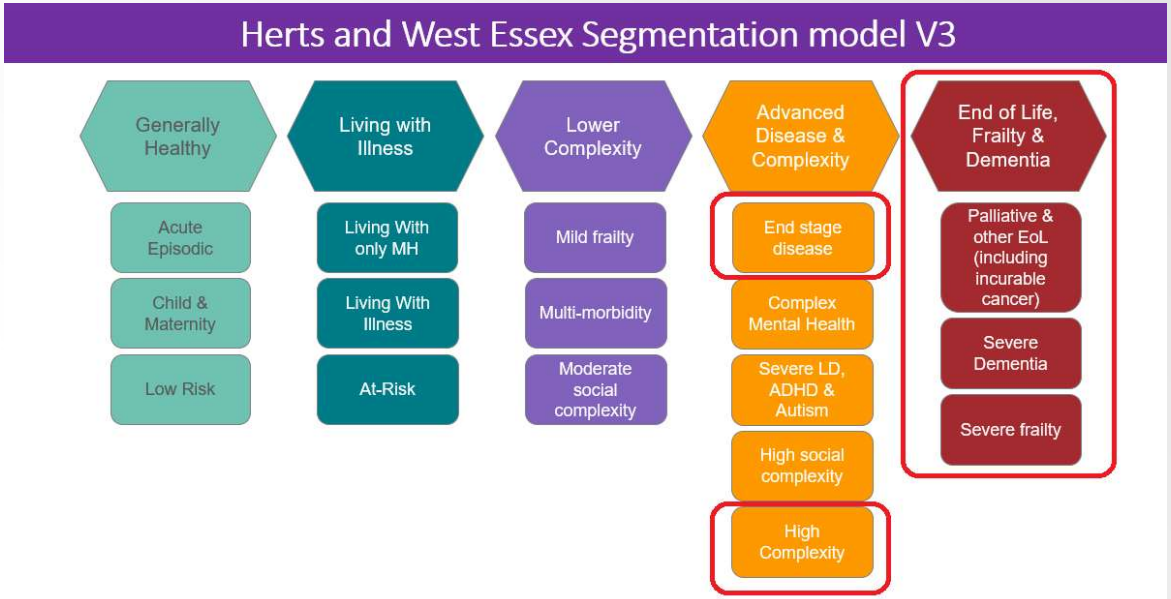
The high-risk cohort of patients in Dacorum make up approximately 4% of the total population but account for 32% of the Emergency Admission Costs in FY22/23 and 25% of the bed days – 10,397.

Methodology

Proactive, data driven, preventative and holistic model of care where patients are identified through data and analytics.

Cohort selection

- Searches reviewed, Frailty and Dementia cohort.
- Had 2 or more emergency admissions in the last 6 months or a 10 days or more length of stay in hospital.
- Have an end stage disease or are high complexity **or** fall into the 'End of Life, Frailty & Dementia' Segments of the Hertfordshire and West Essex Segmentation Model.
- These include EFI deficits for social vulnerability, housebound etc.
- Additional criteria:
  - ~~65 years and over~~
  - Moderate/Severe Frailty
  - Not specifically EOL but patients on register will be flagged.
- Balance segmentation and clinical judgement
- A continuous improvement approach will be undertaken to increase the accuracy of the searches through applying learning from the initial identified cohorts and their appropriateness to receive an intervention.



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Clinical / Operational Model

Onboarding	Assessment	MDT Care	De-escalation
Cohort identification (segmentation and risk stratification)	Comprehensive holistic assessment (CGA)	Care co-ordination and navigation via daily MDT mtgs with reg spec input	Back to care routine , medication review completed, care plan in place once appropriate and agreed
Clinical validation of cohort	Care and support planning	Urgent Community Response “in-hours” function	Considerations for EOL, patient disengagement, maximised care and patient benefit.
Home visits and Care programme offer	Multidisciplinary care plan delivery	Medicines Management, Health coaching / Social Prescribing	
Enrolment		Use of community assets (Vol sector)	
		Holistic review and care plan update. Determination of no of reviews and discharge.	

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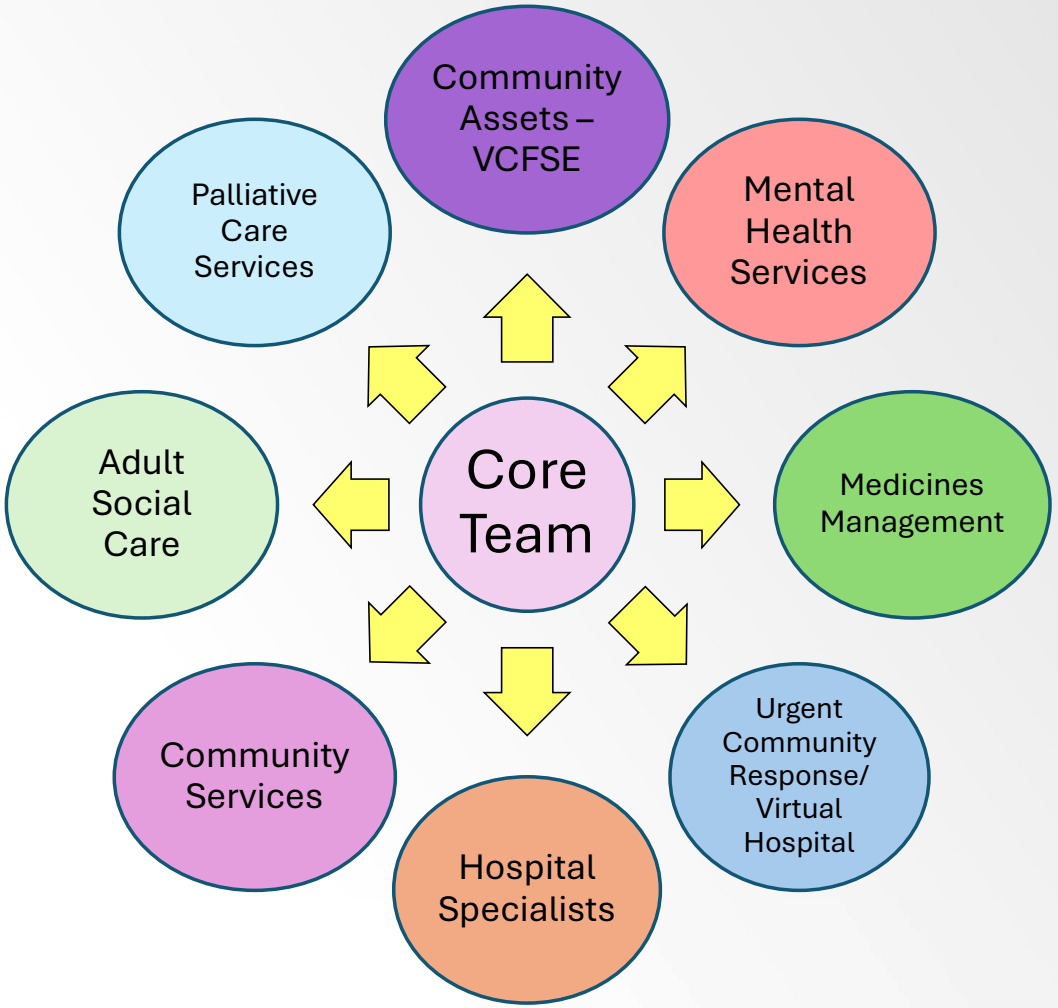
Team Structure

Role
GP
Pharmacist
Clinical Operational Lead
Neighbourhood Case Managers
Neighbourhood Case Coordinators
Programme Manager
Data Analyst



Case Study: Stabilising health needs and preventing carer breakdown

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SITUATION

- **Mr M (patient)**: 82yo male who lives with his wife Mrs. M (no children). Has Dementia Lewy Bodies & recently diagnosed Parkinson's; osteoarthritis, gastric ulcer, fractured shoulder, hypertension and other conditions.
- **Mrs M (registered carer)**: Has high BP and type 2 diabetes; noticed rise in BM over past few months and suspects that it is related to carer stress, but GP told her that she is not due for a diabetic review. She is told to check her BP at the GP but cannot leave Mr M alone. She needed reassurance and advice about managing Mr M's appointments & changing medicines.

ACTION

- Examination revealed significant oedema which can affect mobility and risk of falls – team **provided diuretics to offload fluids**.
- **Started ACP discussions** - Mr M does not want to be admitted to the hospital.
- Team returned to **monitor Mr M's renal function** and deliver a pressure relieving cushion for his sacrum.
- **Supported Mrs M to navigate Mr M's diagnosis of Parkinson's** and changing medications. Looked at options for respite and for carers for Mrs M.
- **Team provided BP machine for Mrs M**, dropped her readings to the GP, and emailed them to ask to review her diabetes.

OUTCOME

- **After 3 weeks**: oedema resolving well, mobility improving, chest clear, renal function improving, and Mr M happy with comfortable cushion.
- **Mr and Mrs M feeling supported and less stressed** having the PAC team to contact when advice is needed. Mrs M feedback says she is delighted to have the team involved.
- **Plan for Mr M**: Mrs M to monitor his weight and BP and alert team of any changes. PAC team to monitor fluid overload, arrange ECHO, facilitate referral to physio, review case in monthly MDT, and continue ACP conversations.

LEARNING

- Patient's health *stabilised* but **patient and carer need ongoing support** and monitoring.
- **PAC team identified oedema** which was not picked up previously; provided treatment, reducing risk of falls.
- **Carer needs to be well to avoid patient hospitalisation**. However, **carer also needs medical and social support**, including respite. She gets 2 hours a week but some weeks this does not go ahead.
- **PAC team providing support to the carer – how is this activity captured**

Case Study: Proactive Assessment and review Improved Mood and Mobility inHousebound Patient with Complex History

South and West Herts Health and Care Partnership

SITUATION

- **56 F**, housebound, informally cared for by husband.
- **Past medical history**: chronic pain, HF, OA, depression
- **Patient's main concerns:** mobility and mood
- **Patient's goals:** QOL and independence (e.g showering)

1. **Blood tests** indicated Vitamin D and B12 deficiencies
2. **Chronic pain** impacting ADLs
3. **Physiotherapy** assessment concluded multiple equipment/adaptations required
4. **Mental health** and mood left unsupported; traumatic past experiences = struggles with new people/environments

ACTION

1. Loading doses of **Vitamin D and B12** completed
2. Patient referred to **Pain Clinic**
3. ACS referral for **home adaptations**, and **equipment** through HES
4. Referrals for HPFT **Talking Therapy** and Mind **Online Groups**

OUTCOME

1. Bloods now in **normal range**; pt to continue maintenance doses of Vitamin D OTC
2. Pain levels **improving** and Pain Management plan for steroid injections
3. Mobility **improved**; exercising daily; greater independence and less exertion
4. On waitlist for 1:1 Therapy; "attending" groups weekly; **"feeling so much better"**

LEARNING

- Small adjustments can lead to huge improvements in mood, mobility, and motivation

"I can use my perching stool to sit with my husband while he cooks dinner – he feels like my husband again and not my carer."

- **Overall:** Self-management improved with patient demonstrating awareness around own health and taking active steps to continue improving

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NHS Central London Community Healthcare NHS Trust

NHS West Hertfordshire Hospitals NHS Trust

South West Herts

Care Coordination Centre

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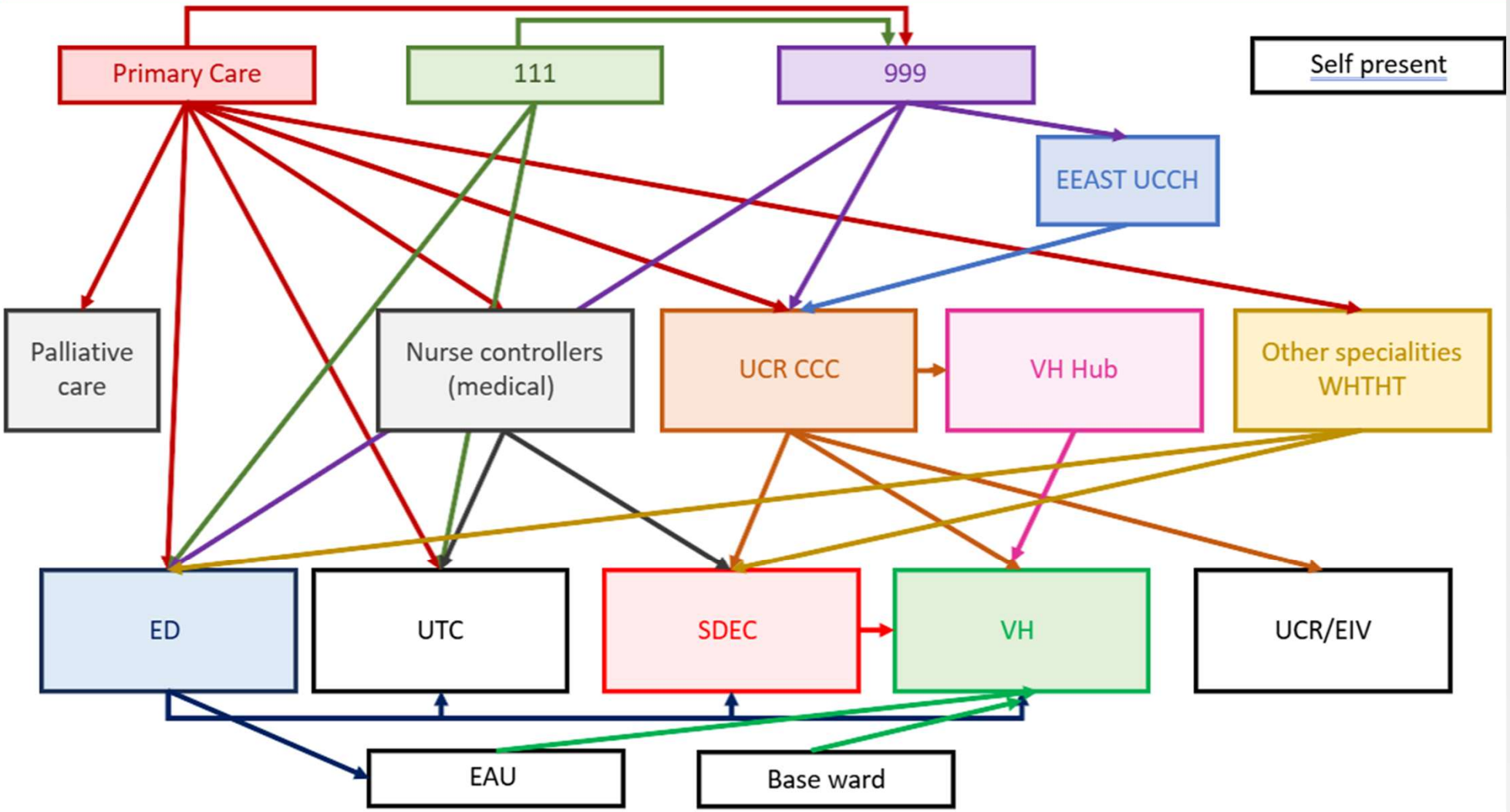
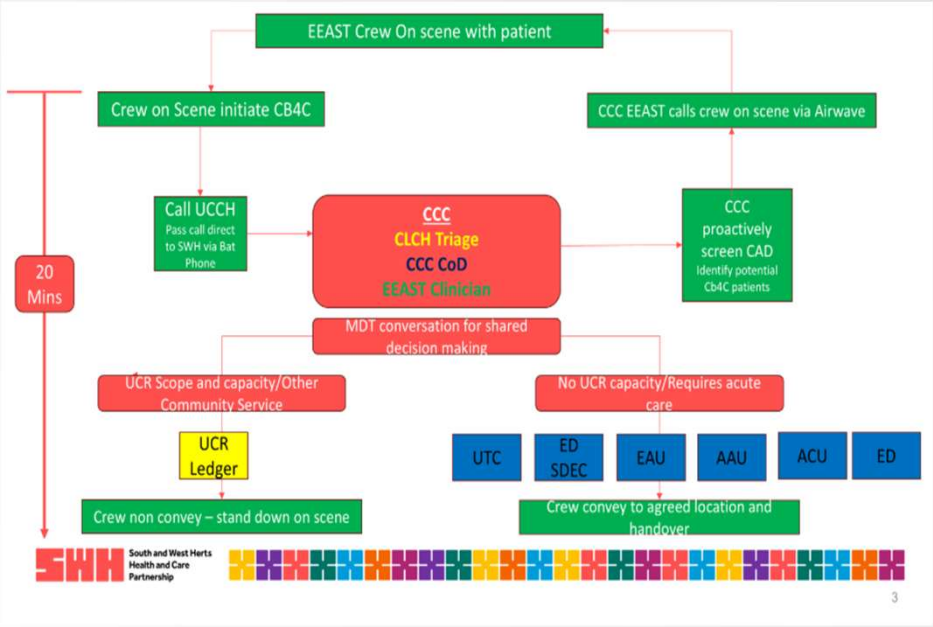
The Problem


Primary Care
111
999
Self present
EEAST UCCH
Palliative care
Nurse controllers (medical)
UCR CCC
VH Hub
Other specialities WHTHT
ED
UTC
SDEC
VH
UCR/EIV
EAU
Base ward

Care Coordination Centre Trial

Operating Model:

- Trial operating hours – Monday to Friday 09:00-17:00
- EEAST paramedic/CLCH triage clinician/ED consultant – MDT – Physically co-located at Watford ED
- Access to EEAST CAD/EPR, CLCH EPR, West Herts EPR
- Operates a push and pull model –
  - **PUSH** – Crews on scene can call into the CCC and engage in an MDT discussion.
  - **PULL** - EEAST clinician in CCC will proactively scan ongoing call list to identify patients that may benefit from a conversation with the CCC MDT. CCC will proactively call crew on scene and invite them to a shared decision-making conversation
- MDT will engage in a real-time, shared decision-making conversation with crew on scene.
- CCC have a series of options open to support patients and crew (including, but not limited to):
  - Advice and guidance to support safe non-conveyance
  - Direct booking onto UCR ledger for 2 hour response
  - Direct booking into other community service
  - Direct booking into dedicated EAU space
  - Direct referral into ED SDEC



Outcomes (Dec 25 - Apr 26):

- 2574 total contacts - 61% 75+. 86% over 50
- Daily average 25 contacts a day
- 68% generated by proactive call out – This demonstrates the effectiveness of this model
- 32% ED conveyance rate
- 54% conveyed to acute site – of which 40% conveyed to location other than ED
- 46% non conveyance

Next steps:

- Substantiate model
- Move to 12/7 model
- Route primary care referrals through CCC
- Full health economic evaluation with support of DHSC/NHSE