North Cambridgeshire & Peterborough Care Partnership

# Frailty Best Practice Conference

16 July 2026

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***To support people to stay well, be independent and live happier and healthier lives, ensuring every person matters and every contact counts.***

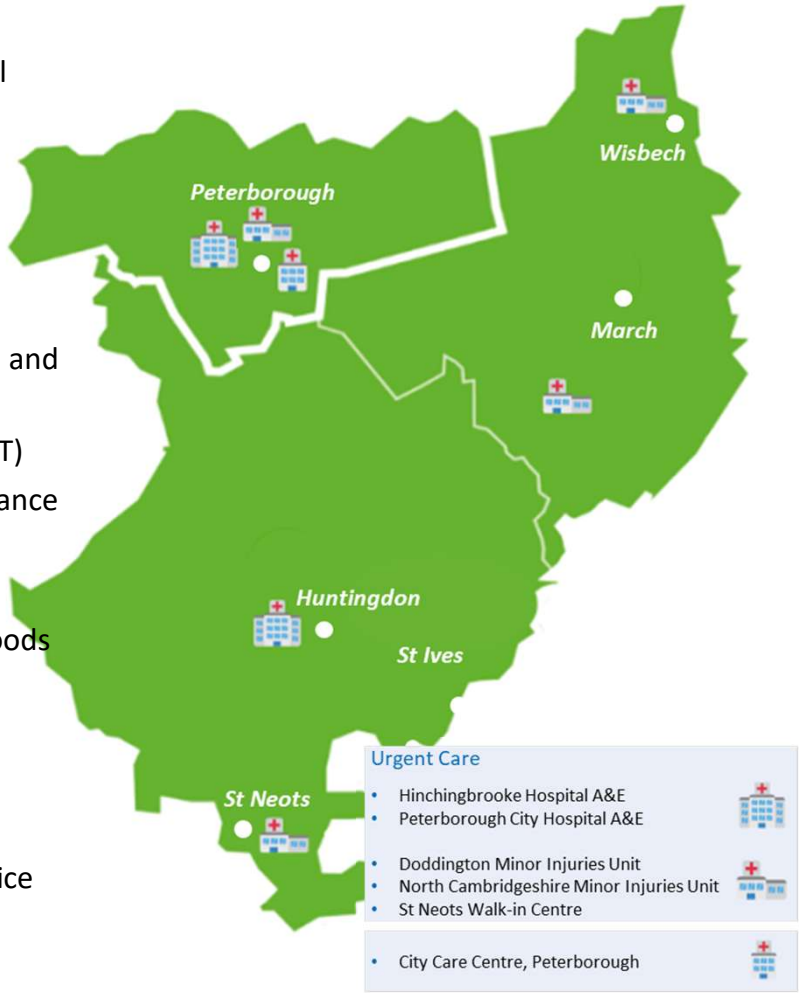
# NORTH CARE PARTNERSHIP

North Cambridgeshire & Peterborough Care Partnership

## WHO WE ARE

With a population of over 580,000, North Cambridgeshire and Peterborough Care Partnership is one of eight place-based partnerships within the Central East Integrated Care System. Our partnership comprises the following partners:

- **Two upper tier local authorities**: Cambridgeshire County Council, Peterborough City Council
- **Two District Councils:** Fenland, Huntingdonshire
- **Circa 2,000** local voluntary, community and faith organisations
- **One Health and Wellbeing Board**: Cambridgeshire and Peterborough Health and Wellbeing Board
- **One hospital provider**: North West Anglia NHS Foundation Trust (NWAngliaFT)
- **Two community providers**: Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and East of England Community Health and Care NHS Trust
- **One mental health provider**: Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- **Two ambulance trusts**: East of England Ambulance Service NHS Trust, East Midlands Ambulance Service
- **46 GP practices**
- **13 Primary Care Networks** (PCNs) that are co-terminus with our 13 Integrated Neighbourhoods
- **One C&P wide Local Medical Committee,** that represents, supports and advises GPs
- **One GP Federation**: Greater Peterborough Network (GPN)
- **Three Integrated Care Boards (ICB)**: Central East ICB, Norfolk and Suffolk ICB, Derbyshire, Lincolnshire and Nottinghamshire ICB
- **Healthwatch** Cambridgeshire and Peterborough providing an independent patient and service user voice for health and social care
- **Other partners** including parish councils, police, fire service and local businesses



# FRAILTY FOCUSSED INITIATIVES

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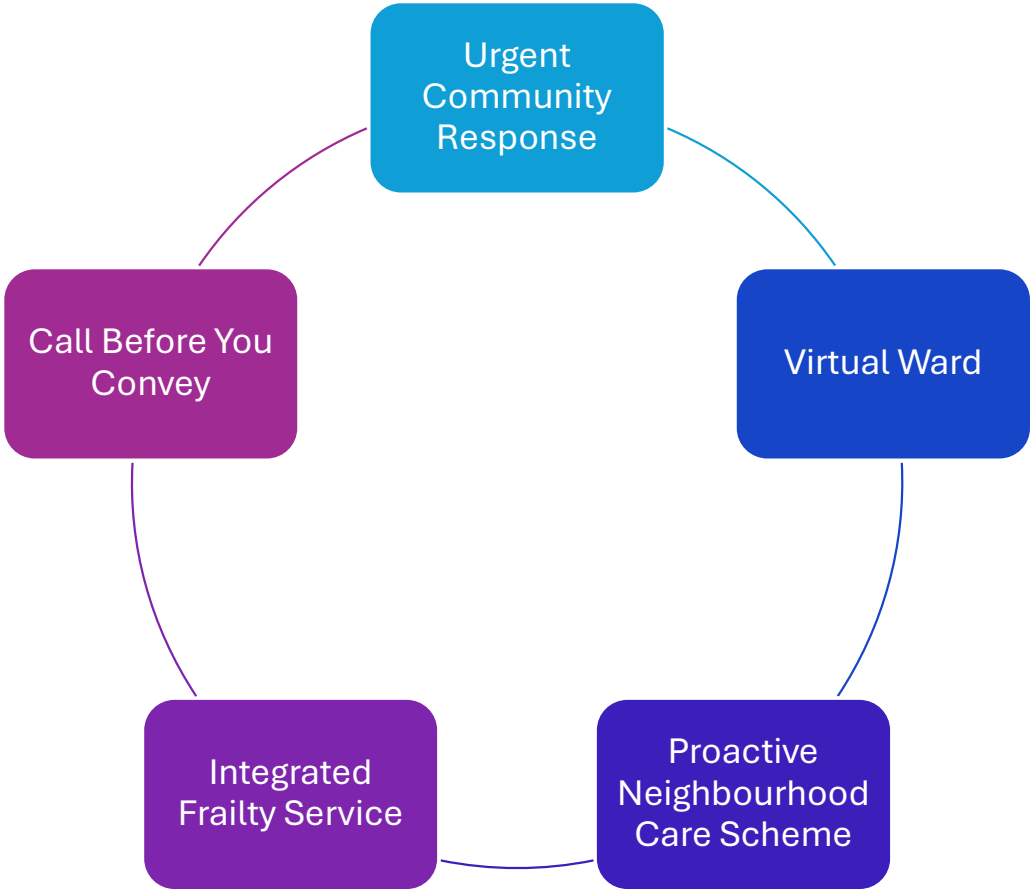
OVERVIEW OF DIFFERENT FRAILTY FOCUSSED INITIATIVES ACROSS NORTH CAMBRIDGESHIRE AND PETERBOROUGH



# The Problem @Peterborough City Hospital

Older adults with frailty were experiencing:

- Long hospital admissions
- Functional decline (deconditioning)
- Delayed specialist assessment
- Delayed discharge planning
- Avoidable admissions

**Aim**

Provide rapid assessment of frail older adults through a dedicated Frailty SDEC with the aim of reducing acute hospital conveyance and admissions.

# The Cohort

- Aged >65 years with a frailty syndrome
- Clinical frailty score >4
- Medically stable (NEWS <4)
- Suitable for same day discharge

Service Launch – 10th November 2025

Evaluation – November 2025 – May 2026

Comparator – May 2025 – November 2025

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# The Intervention

Implemented a dedicated Frailty SDEC pathway:

- Early frailty triage
- CGA
- Daily MDT Review
- Therapy Input
- Medication Optimisation
- Community and Virtual Ward pathways
- Supporting a 'home first' approach

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# The Evidence

***Reduced LOS despite increased winter demand, with significantly low readmission rate***

| Measure | Result |
|---|---|
| Average LOS | **12.9 → 9.6 days (26% reduction)** |
| Discharges | **43% increase** |
| Bed days saved | **7,147** |
| Capacity released | **39 beds over 6 months** |
| 30-day readmission | **7.1%** |
| Virtual Ward discharges | **149 patients** |

NHS
North West Anglia
NHS Foundation Trust

# The Learning

## What worked:

- Dedicated frailty pathways work
- Early frailty focused MDT assessments improve outcomes
- Early therapy involvement is an  absolute necessity
- Use of Virtual Ward
- Discharge planning at the front door

## Challenges:

- Therapy capacity
- The right staffing model
- Collaborative/Aligned VS Fragmented community services work better
- Family expectations

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# What Next?

- Expand therapy service
- Strengthen community integration
- Evolving frailty pathways to match staffing and patient expectations
- Community Geriatrician role
- Focus on reducing readmissions
- Put the Geriatrician at home (PGH)

Frailty SDEC has improved patient flow, reduced hospital stay, released significant inpatient capacity and maintained safe outcomes for older adults.

# PROACTIVE NEIGHBOURHOOD CARE SCHEME

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## FRAILTY AND AT RISK GROUPS

- An ICB funded scheme, delivered through Place via PCN's.
- Funding provided to PCNs to proactively identify people living with frailty and other risk indicators and carry out a comprehensive review and personalised care and support plan.
- Building on end of life MDTs, PCNs required to develop MDT working with Integrated Neighbourhood partners.
- Aim is to support people to live independently at home, reduce falls and unplanned use of health and care services.
- Started in 2023, currently on the third iteration of the scheme
- Care plan targets are set, have always been exceeded , with 10,633 completed by end March 2026
- To ensure this work was measurable and consistent, PCN activity was reported using SNOMED codes, capturing both when a patient had a care plan in place, and when a patient had declined a care plan.
- PCN's use MYCaW® to monitor a patients wellbeing score, demonstrating the impact on the individual.

# EVOLUTION F0R 2026/27

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2026/27 scheme aligns with Government's Neighbourhood Health Framework 2026/27, whilst also incorporating best practice from **National Neighbourhood Health Implementation Programme (NNHIP)**, and supports requirements around population health management, risk stratification and multiagency proactive care in Integrated Neighbourhood Teams as outlined in the PCN Network Contract DES and in line with the CORE20PLUS5 approach.

The purpose of this scheme is to support improvements in:

- Emergency admissions rates for over 65s
- Patient reported outcome and experience measures (PROMs/PREMs)
- Social care demand (care home admissions and need for long term care)

*Funding allocations to PCNs based 25% non-elective admission (NEL) rates (2025); 25% deprivation (IMD) score (2025); and 50% PCN weighted list size (Jan 2026).*
*We need to deliver c4000 care plans across North Place.*

**Patient Cohort Criteria:**

Individuals at risk of deteriorating health or wellbeing that could lead to a rising risk of unplanned or escalating health and care needs in the near future in at least one of the following groups. This scheme focuses on reducing unplanned hospital admissions; therefore, previous recent admission to hospital should be considered as a prioritisation criterion for the cohort.

- Housebound
- On EOL/ Palliative Care Register
- Recent unplanned hospital admission for over 65s
- Moderate frailty (eFI 0.25-0.36 or Rockwood 6-7)
- Mild/mod frailty (eFI 0.13-0.24 or Rockwood 4-5) with at least 3 LTCs OR severe respiratory disease
- Complex health and care needs

# OVERVIEW OF PROCESS FOR PROACTIVE CARE

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## PROACTIVE CARE PLANNING FOR THOSE AT RISK






| 1. Cohort | 2. Review/ Booking | 3. Consent | 4. Personalised Care and Support Plan | 5. Case Conference | 6. Review/ Close |
|---|---|---|---|---|---|
| GP and Health and Care partner Data used to identify cohort | Check suitability of cohort and co-ordinate PCSP with annual review (where applicable) | One week prior to clinic care co-ordinator calls patient to introduce Wellbeing Check as part of annual review. Option to opt out. | Consultation with person and carer recorded in SystmOne/ EMIS and/or JOY | Where required Virtual Case conference organised with INT members identified in care plan. | Lead professional reviews with person and carer at 6-8 weeks |
| • Mod Frailty<br>• Housebound<br>• End of Life<br>• Recent/ Current Hospital Admission<br><br>✓ Add ***'Eligible for integrated care pathway" (XabrK) 936221000000104*** to all identified as eligible to signify **COHORT** | ✓ Book PCSP as part of LTC review (if req.)<br>✓ Schedule follow up review in 6-8 weeks at same time<br>• If patient not suitable for scheme Add ***"Proactive care needs assessment not appropriate" (YaH1z) 1239441000000103*** | ✓ Consent recorded<br>✓ If patient declines Intervention add ***"Care Planning Declined" (XaeDZ) 1025351000000104*** to signify **DECLINED** | PCSP to include:<br>✓ Rockwood Frailty<br>✓ Falls Assessment<br>✓ Activities of daily living<br>✓ Structured Medication Review (if req.)<br>✓ Respect (if req.)<br>✓ Mental Health/ Memory<br>✓ Carers assess (if req.)<br>✓ Crisisplan<br>✓ MYCaW® (1)<br>✓ National Patient Questionnaire<br>✓ Add ***"Integrated Care Plan" (Y27df) 325671000000104*** | ✓ Lead prof. Recorded in medical record<br>✓ Patient/ carer given contact details of lead professional<br>✓ Copy of Care Plan shared | • Update on goals/ plan<br>• What's working / not working<br>• What is agreed next step?<br>• Is further case conference required?<br>**Set date for next review or close**<br>✓ Update plan<br>✓ Referrals/ signposting<br>✓ MYCaW® (2)<br>✓ Patient Survey |

# SPECIFICATION DETAILS

## PROACTIVE PERSONALISED CARE PLANS

For each person identified, in a detailed consultation, using approaches such as a **"what matters to you"** conversation, offer and co-develop an effective proactive personalised care plan with the individual (building on existing care plans as appropriate). Local partners in the Integrated Neighbourhood should be included in the development of the care plans as indicated by the needs of the patient.

Proactive personalised care plans must include all four sections below:

1. **Universal prevention offer:** Ensure GP registration, vaccinations, NHS Health Check, annual LTC reviews, ReSPECT conversation and plan documented, and clinically indicated assessments (e.g. medication review*, memory, mental health, multifactorial falls risk assessment).
2. **Personalised care offer:** Tailored support based on individual needs and professional input, including clinical/mental health care, social needs (finance, housing, food), functional needs (mobility, continence, communication), access to work/training, exercise, social prescribing, and multi-agency support.
3. **Pre-emptive crisis management plan:** Co-produced escalation plan with clear actions for deterioration, covering urgent care navigation, medical/social care arrangements, and identification of a key contact person.
4. **Onward referral and ongoing support:** Identify and refer to partner organisations (e.g. local authority, VCSE), ensure coordination during or after planning, and evidence referrals (e.g. via JOY).

# SUCCESSES, CHALLENGES AND OUTCOMES

## SUCCESSES

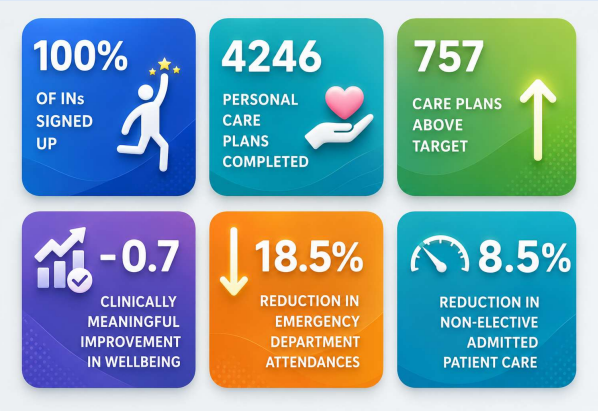
- PCN engagement- 100% sign up and signed data sharing agreements to allow linking of data
- Joined-up input across medical and non-medical teams- Care coordinator, falls, OT, social care and VCSE input being linked together
- Clearer ownership of actions and follow-up - Clarifies who is doing what - Reduces duplication and chasing
- Better support around discharge, falls, frailty and carer breakdown
- Safeguarding, housing and carer issues being surfaced in the same forum as clinical concerns
- Increased confidence that vulnerable patients are not falling through gaps

## CHALLENGES

- Information sharing of patient level data between system partners
- Maintaining flexibility for each PCN/IN to have an individualised approach within a programme delivered consistently across Place
- Analytics expertise and capacity a gap
- Outcome measures – not currently capturing system wide impact only secondary care
- Outcome measures -qualitative impact of care plan delivery and partner working

## OUTCOMES FOR 2025/26

- 4246 personal care plans completed
- 0.7 clinically meaningful improvement in well-being
- 18.5% reduction in emergency department attendances
- 8.5% reduction on non-elective admitted patent care



# WISBECH PRIMARY CARE NETWORK

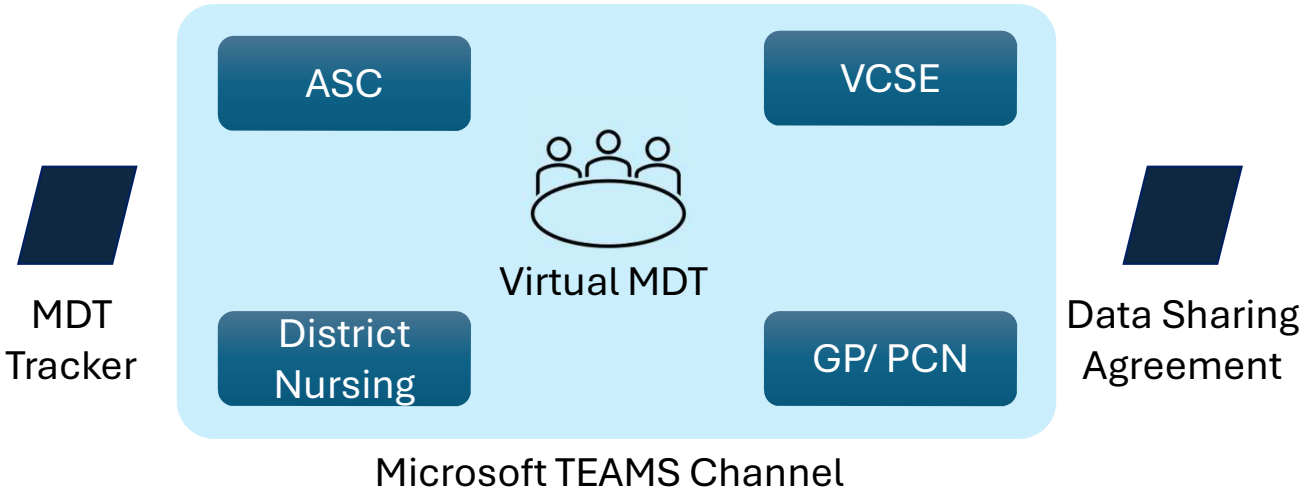
## DEVELOPING OUR INTEGRATED NEIGHBOURHOOD TEAM

- Wisbech a rural market town in Fenland, Cambridgeshire, bordering Norfolk and Lincolnshire
- Population of circa 50,000
- Some of the most deprived neighbourhoods in Cambridgeshire
- Older population - Around 22% of residents are aged 65 or over
- Diverse Eastern European community, particularly people from Poland, Lithuania
- Four GP Surgeries – work together at a Primary Care Network

# WISBECH EARLY RESPONSE TEAM (WERT)

## WHAT IS IT?

- X2 Weekly Virtual MDT meeting to discuss people identified as at risk of deterioration/ hospital admission
- Trialled approach as part of NNHIP pilot – new approach started 1 June 2026
- Linked to Proactive Neighbourhood Care Scheme, though broader reach
- Attended by GP Practice staff (Four Practices in Wisbech and make up the PCN – circa 50,000 pts)
- Adult Social Care and District Nursing reps
- Voluntary Sector Network Alliance reps (honorary contract arrangement with the PCN)



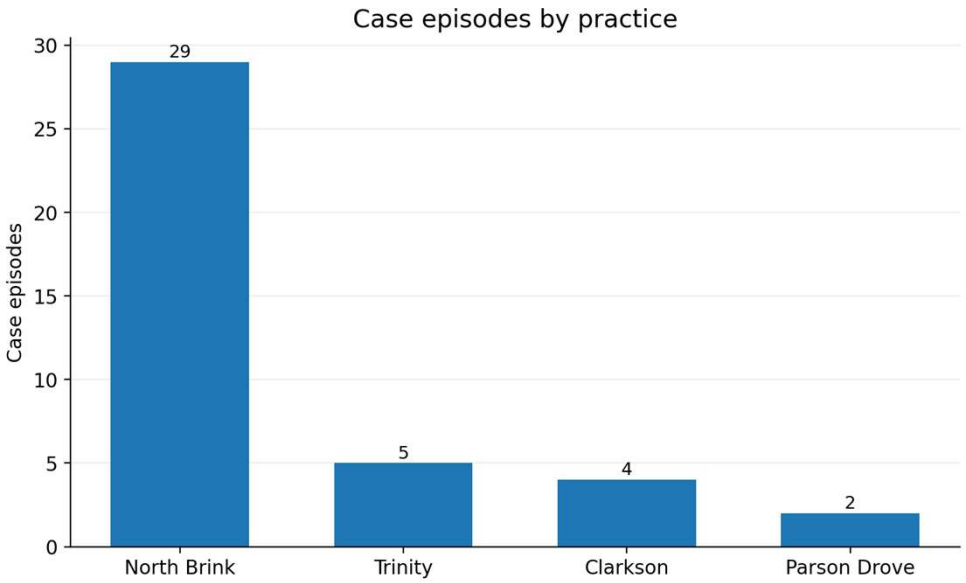
# HOW DOES IT WORK?

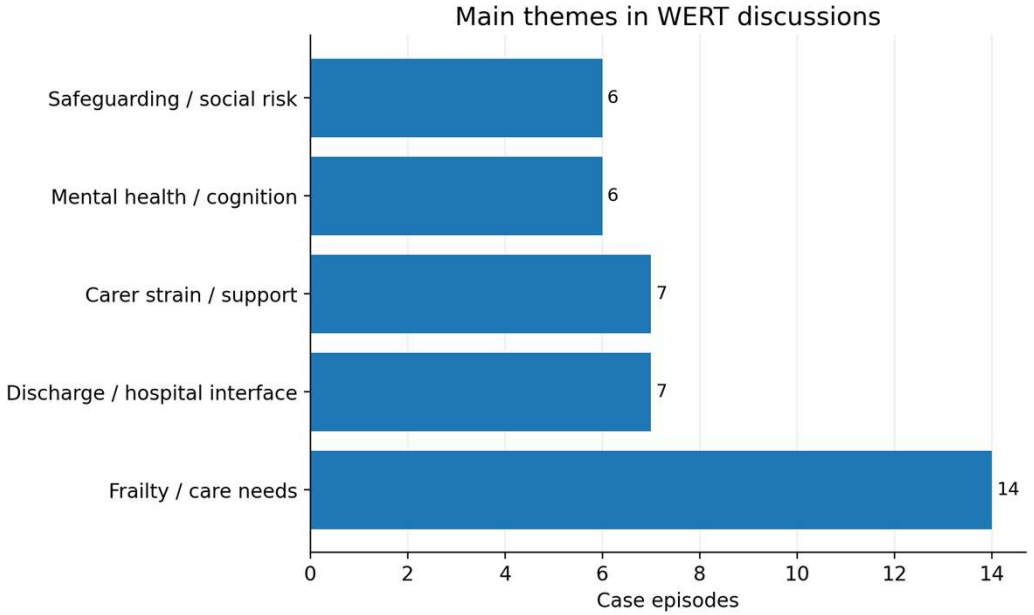
- PCN Hosts the MDT Meeting / TEAMS Channel
- Care Co-ordinator administers the meeting
- Partners add people of concern to the MDT list for discussion (deadline 2pm the day before the meeting)
- Partners review list and add brief notes to tracker
- MDT discussion on person and carer/ family and actions agreed/ documented
- Date for review agreed at meeting – added to future MDT agenda

## WHY THIS MATTERS

- It gives practices and partners a consistent route for escalation.
- It makes social, functional and clinical concerns visible in one forum.
- It allows review, follow-up and closure rather than one-off discussion.

# WHERE CASES ARE COMING FROM AND WHAT THEY ARE ABOUT – 1st MONTH




**INTERPRETATION**

The current case mix is mainly frailty, care needs, discharge issues, carer strain, mental health/cognition and wider social risk.

*Provisional where noted; based on currently uploaded WERT notes through 24 June 2026.*

# ILLUSTRATIVE CASE EXAMPLES

### 1. FRAILTY, FALLS AND NO LOCAL FAMILY SUPPORT

Older couple repeated falls and growing support needs.

WERT discussion with care coordinators, falls input, Caring Together, future planning and practical safety measures.

Benefit: one forum brought together family support, falls risk and future care planning rather than each issue being handled separately.

### 2. UNSAFE DISCHARGE / COMPLEX HOME SITUATION

Person discharged from hospital with major concerns around safety at home.

WERT coordinated home visits, equipment delivery, safeguarding concerns, continuing care actions and feedback to the acute trust re inappropriate discharge.

Benefit: the discharge problem became a shared system issue and learning opportunity.

### 3. SELF-NEGLECT AND WIDER SOCIAL RISK

Person with deterioration noticed by neighbours, poor home conditions and concern around cognition and self-neglect.

WERT discussed and coordinated a response re mental health, social care, fire safety and follow-up.

Benefit: risks that are often split across agencies became visible together, with a more joined-up response.

*Illustrative examples drawn from uploaded WERT notes; phrased here in anonymised form for presentation use.*

# BENEFITS, CHALLENGES AND KEY LEARNING

The MDT meetings are already building shared understanding across practices, CPFT, social care and voluntary sector partners.

### BENEFITS

- Earlier escalation / intervention before crisis worsens
- Joined-up input across medical and non-medical teams- Care coordinator, falls, OT, social care and VCSE input being linked together
- Clearer ownership of actions and follow-up - Clarifies who is doing what - Reduces duplication and chasing
- Better support around discharge, falls, frailty and carer breakdown
- Safeguarding, housing and carer issues being surfaced in the same forum as clinical concerns
- Increased confidence that vulnerable patients are not falling through gaps

### CHALLENGES

- Time pressures – prioritising prep for and attendance at meeting
- Reduced from x3 MDTs a week to x2
- Data feeds – Hospital Discharge data, District Nursing Caseload data
- IT access for non NHS.net partners is complicated
- Complexity of people's situations – not always accepting of support
- Measuring impact – use of services, staff survey introduced – does this feel like a good use of time?

### LEARNING

- Identifying the cohort that is already in contact with multiple services
- One shared MDT list that partners can edit works well – avoids multiple versions and time consolidating info
- Information Governance makes practitioners nervous about sharing – Data Sharing Agreement enables open conversations
- Bringing diff. roles together allows teams of teams to learn from each other
- Case discussions make clear the inefficiencies and mis-communication of the current fragmented model

*Provisional where noted; based on currently uploaded WERT notes through 24 June 2026.*

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# Where Next?

- Develop **Integrated Frailty Service** – expand capacity/ scope
- Shift of services **out of hospital** and into communities
- Introduce a **comprehensive geriatric assessment** tool used across health and care partnership
- Continuation/ expansion of **Proactive Neighbourhood care scheme** – additional at-risk cohorts
- Embedding **MDT working**
- Development of PHM tools – **DELPHI roll out**
- Investment in **voluntary sector provision**

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# QUESTIONS