



Homerton Healthcare
NHS Foundation Trust

Sustainable, Integrated and Coordinated Care for older people: How to make change real

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CMO Homerton Healthcare Foundation NHS Trust
London



A bit about me...



Practicing Clinician



Hospital Manager



Board Member



Leading through change and reaching the goal

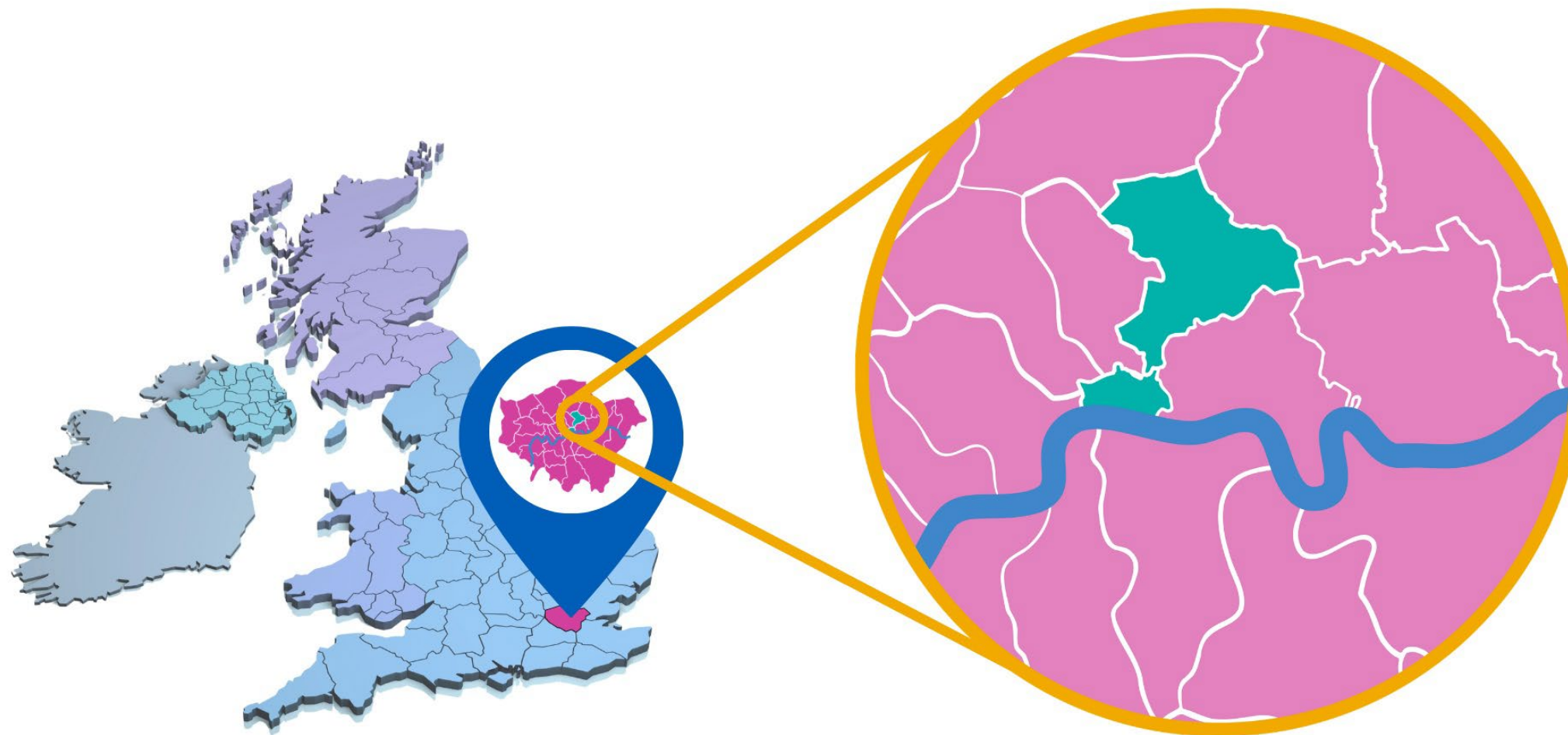
Experience across Primary, Secondary & Community Care



Homerton Healthcare: where we are



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Understanding Hackney: A System of Contrasts



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Inner-city London borough

High deprivation, health inequalities

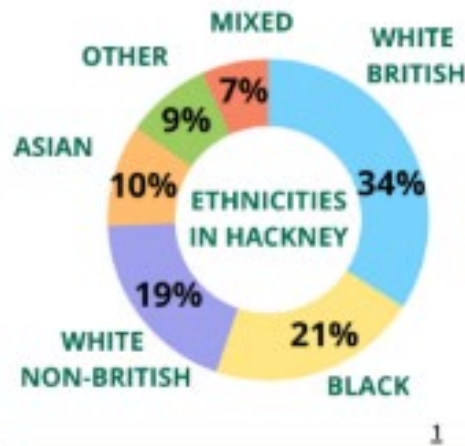
Diverse, multicultural population

High burden of chronic disease & frailty

Adjacent to the City of London (wealth contrast)

Challenges → Opportunity for innovation

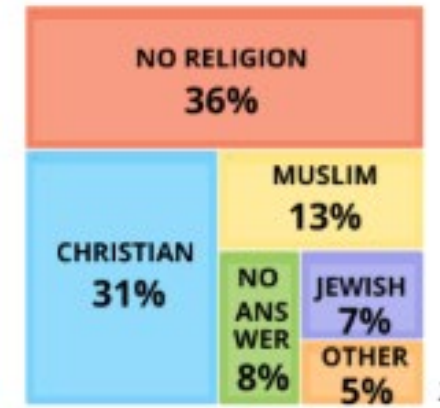
Population in Hackney



RICH ETHNIC AND CULTURAL MIX



RELIGION BREAKDOWN

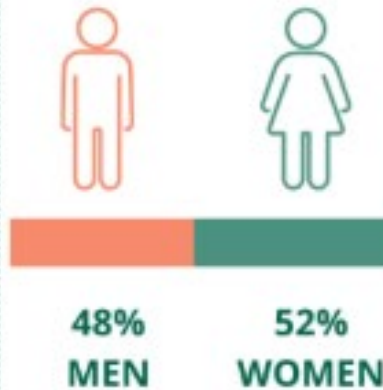


POPULATION IN HACKNEY

Hackney



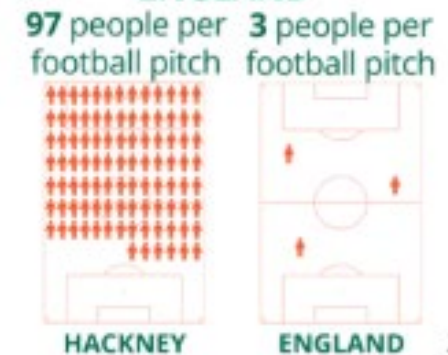
YOUNG POPULATION



6TH HIGHEST LGBTQ+ POPULATION IN ENGLAND

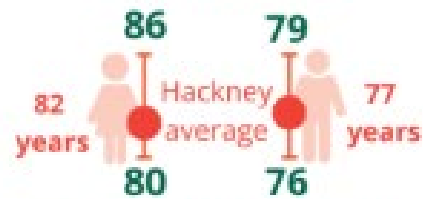


3RD MOST DENSELY POPULATED BOROUGH IN ENGLAND



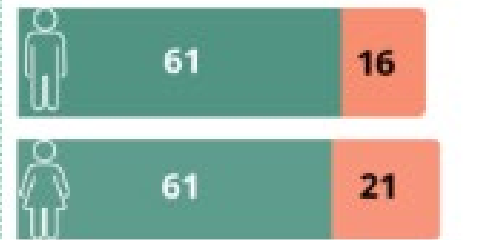
Health in Hackney

PEOPLE LIVE SHORTER LIVES COMPARED TO MANY OTHER LONDON BOROUGHS



LIFE EXPECTANCY ACROSS LONDON BOROUGHS VS HACKNEY ²

RESIDENTS SPEND ON AVERAGE AROUND A QUARTER OF THEIR LIVES IN POOR HEALTH



Years lived in good health (dark green) | Years lived in poor health (orange) ³



MANY MORE RESIDENTS ARE DIAGNOSED WITH DEPRESSION NOW THAN 10 YEARS AGO

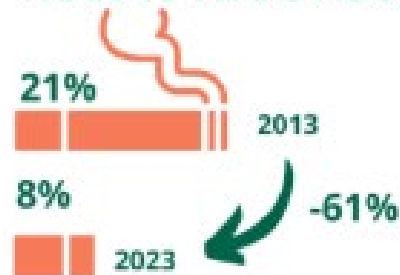


Hackney

HEALTH IN HACKNEY



SIGNIFICANTLY LESS RESIDENTS SMOKE NOW THAN 10 YEARS AGO



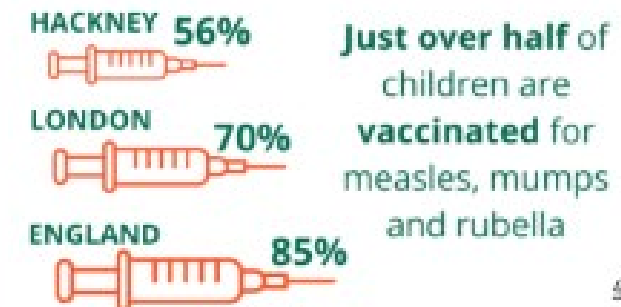
PROPORTION OF ADULTS WHO SMOKE ⁴

MANY RESIDENTS ARE ABOVE A HEALTHY WEIGHT



PROPORTION OF PEOPLE ABOVE HEALTHY WEIGHT ⁵

LOW VACCINATION RATES LEAVE RESIDENTS VULNERABLE TO INFECTIONS



⁶

Where we work



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We treat people at our big hospital site, and also look after people in the community and in their homes.



Homerton University Hospital



St Leonard's Hospital



Hackney Ark

Homerton Healthcare in numbers

3,800

members of staff



5,600

babies born



345

patients seen in A&E per day



17,000

ambulance handovers



357,000

outpatient appointments



25,000

operations performed



400

number of beds



79,000

patients admitted to hospital



73,500

hot meals made for patients



35 Community services in



11 sites

260,000

patients cared for at home



140

research activities per year



1,100

students



244

trainee doctors



54

apprenticeships



Three Parts + One System

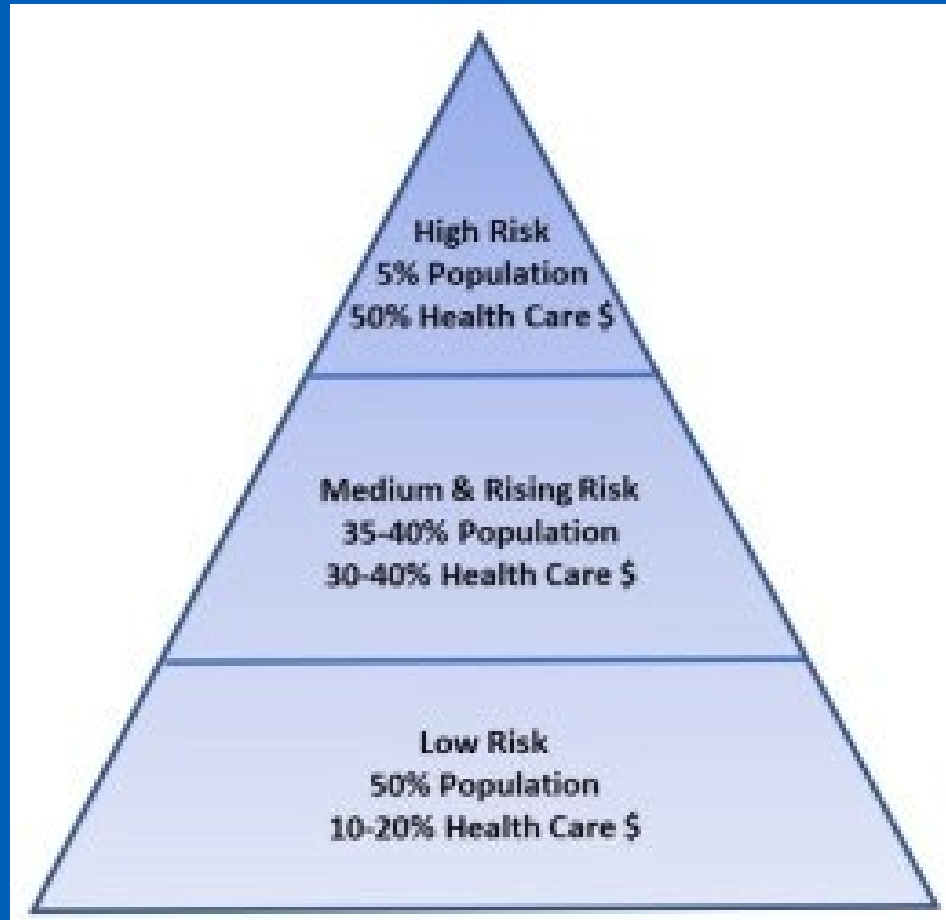
1. Secondary Care (Hospital)
2. Community Care
3. Primary Care
4. Summary: Integrated System

The Hackney model

- One integrated provider (Acute + Community)
- Place-based leadership
- Strong GP networks
- Shared accountability across sectors
- Aligned incentives

Understanding the Whole System

Triangle of care



Triangle Model:

FNOF → Emergency Department

Falls → Community Care

Frailty & Multimorbidity → Care at Home

Key Insight:

ED attendance is only one visible part of a wider system failure or success

A Patient Story (Entry Point to the System)

- Elderly patient
- Falls → ED attendance
- Diagnosed with fractured neck of femur (FNOF)
- Complex needs: frailty, comorbidities

Frailty in the Emergency Department:

- 2023; ED 4800 attendances of patients aged over 65
- 49% CFS (Clinical Frailty Scale) 5 or more
- Higher CFS at younger ages

Principles of managing Frailty in the ED

- Rapid assessment
- Early frailty identification
- Multidisciplinary involvement
- Admission vs alternative pathways

Emergency Department Response in Practice

- Clinical Frailty Assessment (CFS) completed at first contact (assessment nurses) for all patients
- Frailty assessments for those identified:
 - Geriatrician review(Geriatrician at the Front door)
 - Frailty SDEC
 - PT, OT and nursing assessments in ED
- Admission vs alternative pathways:
 - Virtual Ward
 - Therapy at Home

Neck of femur fractures

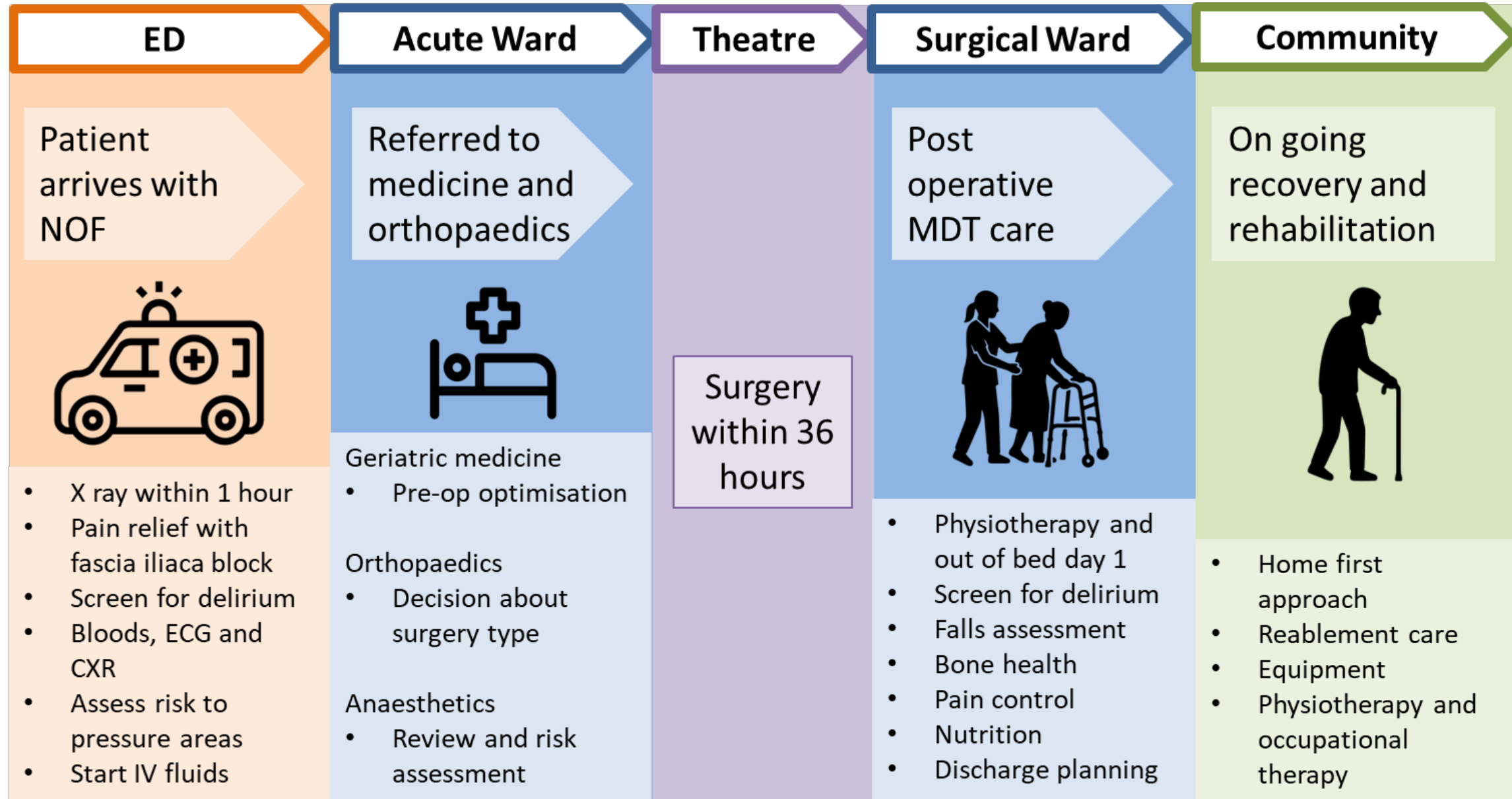
Most common reason for frail older adults to need emergency surgery

Looking after these patients costs approximately £2 billion nationally each year

Data about care is provided to the National Hip Fracture Database (NHFD), which sets national standards and key performance indicators



Our pathway



- Orthogeriatric care
- Emergency Department

The NHFD best practice criteria look at elements of care across the patient journey including:

- Time to surgery
- Delirium assessment
- Perioperative geriatrician review
- Early physiotherapy
- Nutrition, falls and bone health assessments

Name	Surgery on day of, or day after, admission	Number of cases submitted	Admitted to orthopaedic ward within 4 hours	4AT Test recorded on admission	Perioperative medical assessment	Physiotherapist assessment by the day after surgery	Mobilised out of bed by the day after surgery	Nutritional risk assessment
Homerton Hospital	76.6	114	10.8	96.5	98.2	96.4	77.5	100.0
North Middlesex Hospital	46.0	260	9.3	100.0	94.6	99.2	86.1	98.8
Whipps Cross Hospital	50.8	518	10.8	76.6	96.1	99.4	82.1	97.5
Whittington Hospital	84.4	169	17.4	97.6	98.2	98.8	78.4	99.4
Royal Free Hospital	46.5	171	1.2	89.5	91.8	84.7	58.8	90.1
University College Hospital	72.0	145	33.1	94.5	93.8	97.9	63.6	99.3
Queens Hospital Romford	58.6	583	7.4	88.0	66.4	98.6	94.7	94.3

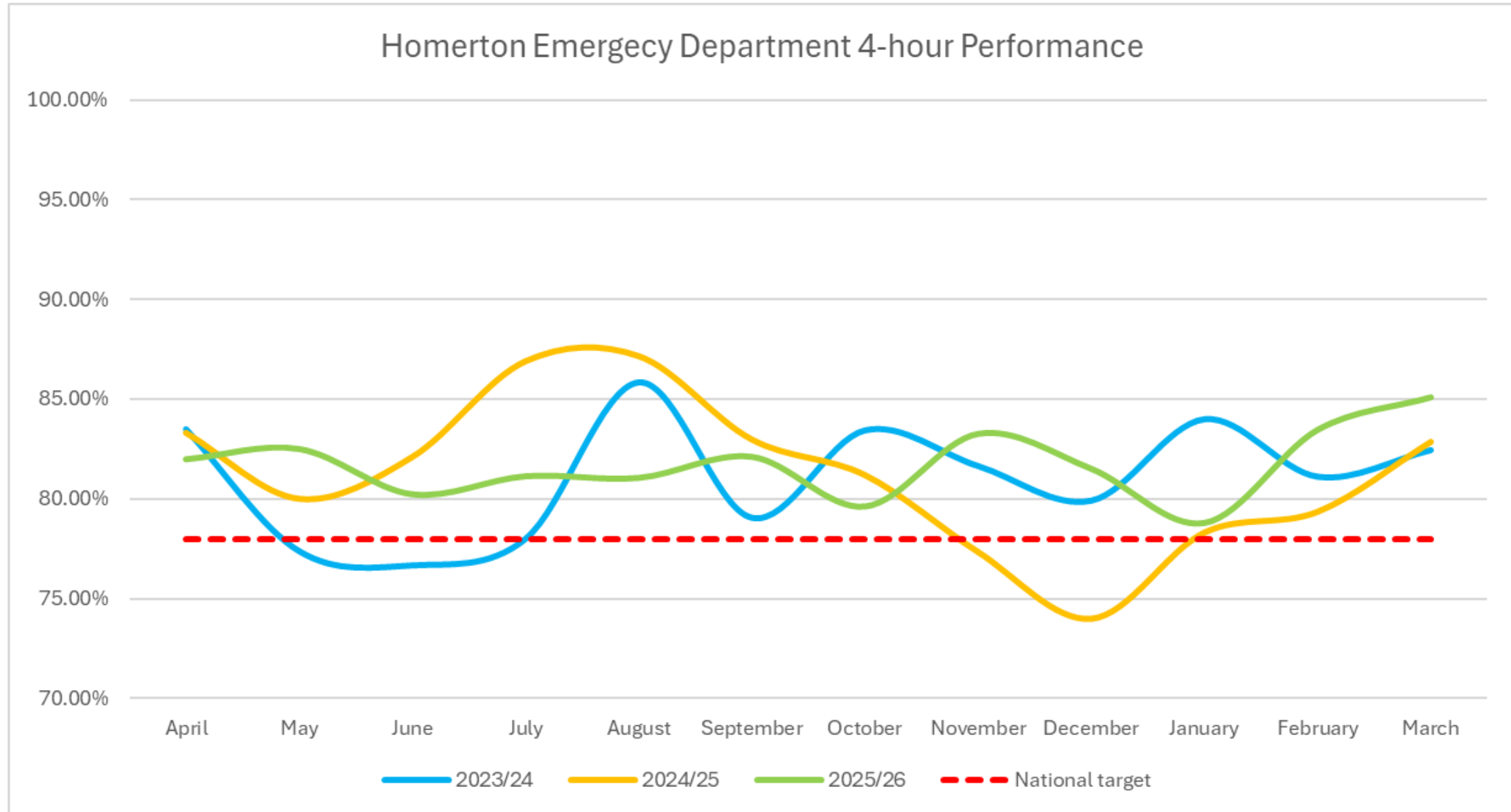
4-hour Standard

- The number of patients admitted, transferred or discharged from the emergency department within 4-hours.
- Introduced to the NHS in 2004 as a measure to combat crowding and Exit Block in EDs.
- Long waits are consistently associated with avoidable patient harms, and poor patient and staff experience.
- *National Standard is 78% of patients being admitted, transferred or discharged within 4 hours.*

Homerton's performance



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London ED performance



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	April	May	June	July	August	September	October	November	December	January	February	March
BHRUT	78.5%	79.2%	78.8%	79.9%	78.7%	79.0%	77.8%	70.7%	75.9%	75.4%	79.3%	78.3%
Barts	70.0%	70.2%	69.2%	73.4%	72.0%	71.9%	70.0%	69.1%	68.7%	71.1%	73.1%	75.9%
Chelsea & Westminster	81.8%	79.5%	80.4%	79.0%	76.8%	77.8%	77.8%	78.7%	78.3%	77.3%	78.4%	79.1%
Croydon	79.1%	77.5%	74.8%	74.6%	75.1%	75.2%	74.2%	74.8%	75.9%	73.5%	70.6%	79.4%
Epson & St Helier	73.9%	68.9%	65.4%	74.2%	75.9%	74.0%	73.5%	71.8%	70.8%	72.8%	74.1%	75.1%
Homerton	82.0%	82.5%	80.3%	81.1%	81.1%	82.1%	79.6%	83.3%	81.5%	78.8%	83.5%	85.1%
Imperial College	75.2%	75.5%	76.0%	77.2%	76.1%	75.0%	76.0%	77.7%	76.2%	75.5%	77.0%	80.1%
Kings College	73.1%	73.6%	71.6%	72.9%	74.0%	69.5%	73.1%	69.6%	70.0%	67.5%	68.5%	72.1%
Kingston & Richmond	76.2%	77.4%	77.4%	74.8%	74.9%	70.2%	72.9%	70.5%	71.8%	69.7%	72.9%	78.1%
Lewisham & Greenwich	65.5%	67.8%	68.5%	69.8%	67.8%	68.7%	76.1%	76.6%	75.6%	71.8%	74.3%	75.8%
London North West	76.7%	75.7%	78.2%	78.1%	75.7%	75.5%	72.6%	73.7%	72.7%	71.1%	75.1%	84.2%
Royal Free	73.9%	76.7%	77.9%	79.2%	78.9%	77.8%	77.6%	76.8%	76.8%	75.5%	77.0%	80.7%
St George's	83.7%	78.4%	80.1%	78.6%	78.3%	78.0%	79.0%	80.3%	81.3%	76.1%	75.5%	78.2%
The Hillingdon	74.8%	77.0%	78.6%	81.4%	81.8%	79.5%	76.8%	79.0%	75.2%	77.4%	81.2%	80.8%
UCLH	71.5%	70.1%	73.9%	74.6%	74.5%	69.4%	72.9%	70.4%	73.3%	69.1%	74.3%	80.9%
Whittington	70.3%	71.6%	73.2%	74.8%	71.2%	70.7%	69.8%	72.4%	69.1%	68.9%	73.0%	74.5%

*Performance highlighted in green is where Homerton was the highest performing trust in London

Hospital as System Leader

- Not just treatment centre
- Coordinates across system
- Sets clinical standards
- Drives pathway redesign
- Works beyond hospital walls

Patient Story – fall at home

- Same patient profile
- Fall occurs at home
- No immediate ED attendance

Community Care Model



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- Rapid response teams
- Integrated Community Services
- Virtual wards
- Rehabilitation at home
- Close links to hospital specialists
- Shared records and communication

- **Rapid response teams**
- Integrated Community Services
- Virtual wards
- Rehabilitation at home
- Close links to hospital specialists
- Shared records and communication

- Paramedic + Community Team Intervention
- Rapid response team
- Assessment at home
- Immediate care provided
- Avoid ED conveyance where safe

Community Care Model



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Integrated Independence Team

Admission Avoidance

Rapid Response

Emergency Dept
Short stay ward

- 2hr UCR – therapists
- 8am-8pm 7 days

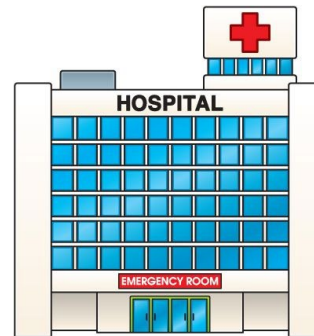
ParaDoc

- 2 hr UCR – Doctors (GPs) and paramedics
- 8am – midnight 7 days
- Home Visits

Frailty Virtual Ward

- Geriatrician, Nurses, therapist, pharmacist
- Hospital at Home
- Up to 14 days

Hospital



Frailty Virtual Ward

- In-reach to wards
- Aim to reduce LOS

Post Discharge

Rapid Response

- Post d/c HV's
- Ensure managing & prevent re-admission

ParaDoc

- Urgent GP / paramedic review at home - safety netting

Frailty Virtual Ward

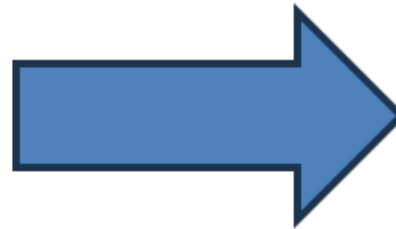
- Post d/c management of frail patients

Rehabilitation at Home

- Intensive MDT rehab up to 6 weeks

Admission Avoidance

- Two Urgent Community Response (UCR) teams (Therapy, GP/Paramedic) covering 8am – Midnight seven days a week
- Frailty Virtual Ward (Nurse/Geriatrician led)
- Rapid Care (urgent care support)
- Proactive Care



Facilitating Rapid Discharge from Hospital

- Rapid Response therapy team (ED, Acute Care Unit, SDEC)
- Frailty Virtual Ward (Nurse/Geriatrician led)
- Discharge to Assess (Therapy led)
- Rapid Care (urgent care support)

Post Discharge follow up, Rehab and preventing re-admission

- Rehab at Home (Intermediate Care Rehab up to 6 weeks)
- Frailty Virtual Ward (Nurse/Geriatrician led)
- Discharge to Assess (Therapy led)
- Rapid Response Therapy Team (Therapy led)
- Two Urgent Community Response teams (Therapy, GP/Paramedic)

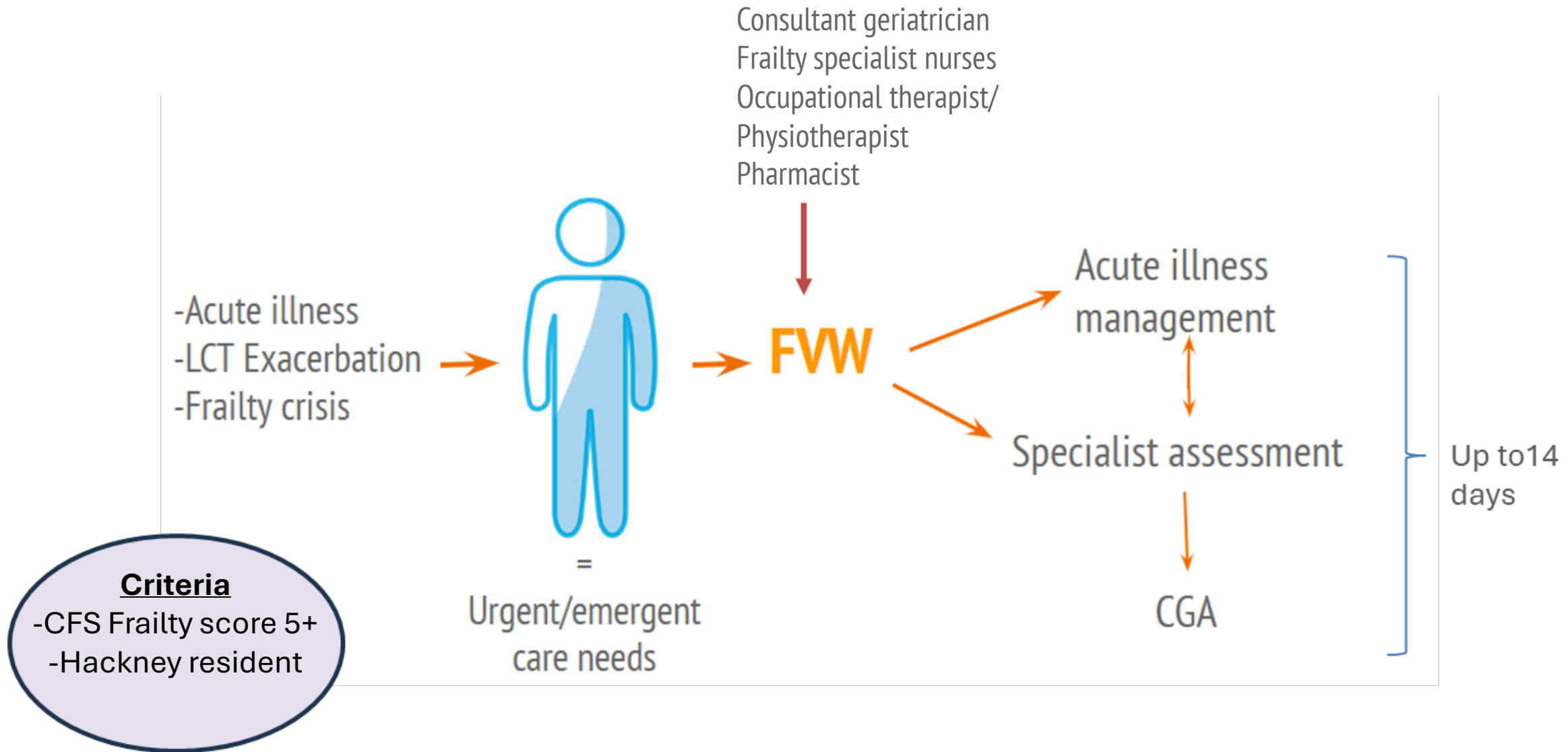
Community Care Model



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- Rapid response teams
- Integrated Community Services
- **Virtual wards**
- Rehabilitation at home
- Close links to hospital specialists
- Shared records and communication

Frailty Virtual Ward



How Admission Avoidance Works in Practice

12pm

- 80 year old frail female fall on floor - no serious injury
- Found on floor by carer who calls ParaDoc (instead of Ambulance service)

1pm

- ParaDoc (GP/paramedic) arrive within 2hrs
- Assess patient medically then assist up from floor (Raizer chair)
- Complete further assessments and arranges any urgent tests/medications

4pm

- Fall – refer to Rapid Response – arrive within 2hrs
- Physiotherapist/Occupational Therapist for completes full falls assessment, intervention, mobility aid, equipment, advice

Next Day

- Frailty – if required (e.g. delirium) referral to Frailty Virtual Ward to review/monitor at home for up to 14 days to ensure recovery and prevent admission to hospital

IIT

Admission Avoidance

- % UCR referrals seen within 2 hours: 93%
- % UCR referrals admission avoidance: 90%

Facilitating Rapid Discharge

- % referrals seen within 1 hour in ED: 96%
- % referrals discharged home from ED: 80%

Post Discharge follow up, Rehab and preventing re-admission

- % Rehab/D2A patients seen with 72 hours: 93%
- % readmissions 30 day: 8-14%

Paradoc

- Urgent Community Response

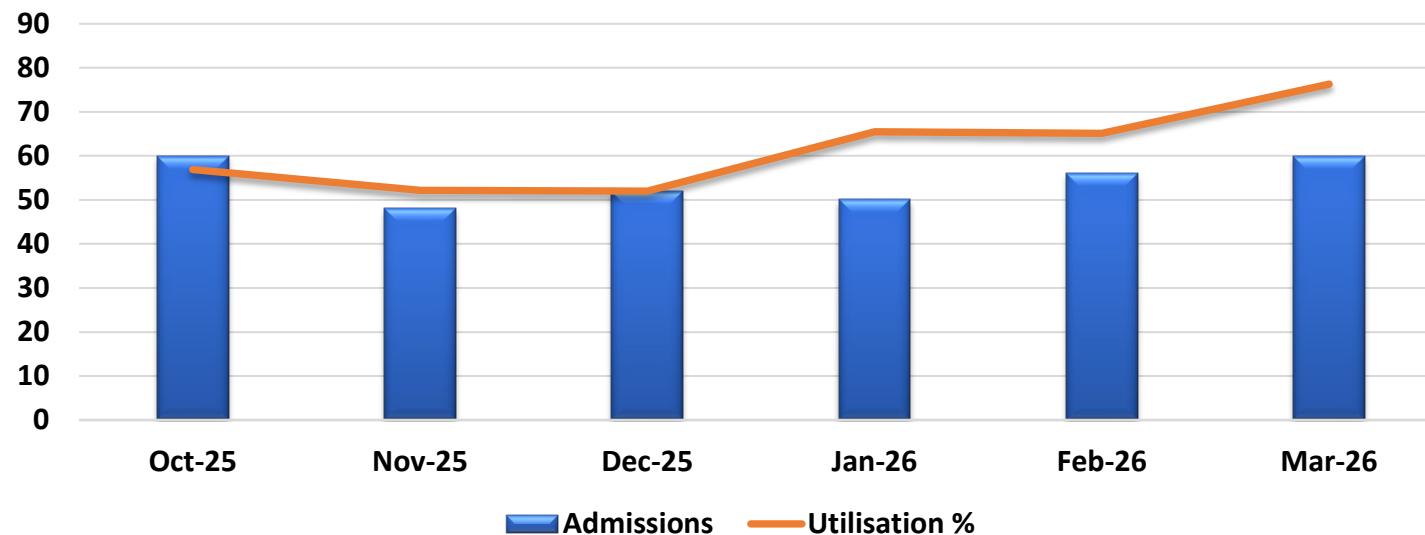
- Ave 170 UCR referrals accepted per month
- 95% of UCR referrals seen within 2 hrs of referral (national target is 70%)
- 91% of UCR referrals avoid admission to hospital
- Initial analysis shows that only 8% attend ED within the 7 days following a ParaDoc assessment (i.e. 92% don't attend ED in the following 7 days)

Frailty Virtual Ward



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FRAILTY VIRTUAL WARD	Number of admissions	Bed Capacity	Average occupancy	Average utilisation (%)	Ave LoS (days)	Location at Discharge from FVW (Usual Place of Residence)
Oct-25	60	26	14	56.9	7.8	93%
Nov-25	48	26	13	52.2	7.9	94%
Dec-25	52	26	13	52.0	7.9	94%
Jan-26	50	26	17	65.5	9.6	98%
Feb-26	56	26	16	65.1	8.4	96%
Mar-26	60	26	19	76.3	10.2	86%
Apr-26						



Frailty Virtual Ward: source of referral



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FRAILTY VIRTUAL WARD	Hospital Inpatient Ward	A&E	SDEC	GP	UCR (ParaDoc and IIT)	Other
Oct-25	33%	15%	0%	32%	12%	2%
Nov-25	48%	23%	2%	17%	4%	2%
Dec-25	35%	15%	2%	29%	12%	7%
Jan-26	34%	10%	4%	34%	2%	0%
Feb-26	38%	21%	4%	21%	9%	7%
Mar-26	35%	23%	2%	30%	4%	6%

Our teams



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Secondary care specialist input

- Older adults focused outpatient unit
- Comprehensive geriatric assessment by a multidisciplinary team
- Falls pathway – syncope and unexplained falls
- Integrated vestibular assessment and treatment
- Fall prevention exercise in City & Hackney
- Excellent patient feedback:

"It's the first time my problems have been properly understood and addressed."



Why This Matters

- Reduced ED attendances
- Reduced admissions
- Better patient experience
- Maintained independence
- Cost-effective care

Primary Care: The Foundation



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Role of Primary Care

- First point of contact
- Long-term condition management
- Prevention and early intervention
- Continuity of care



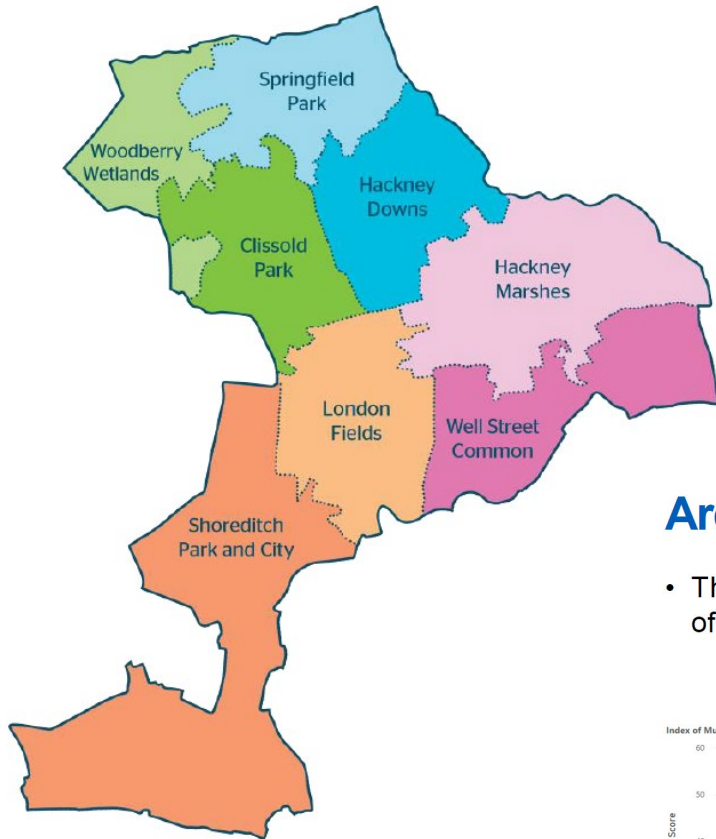
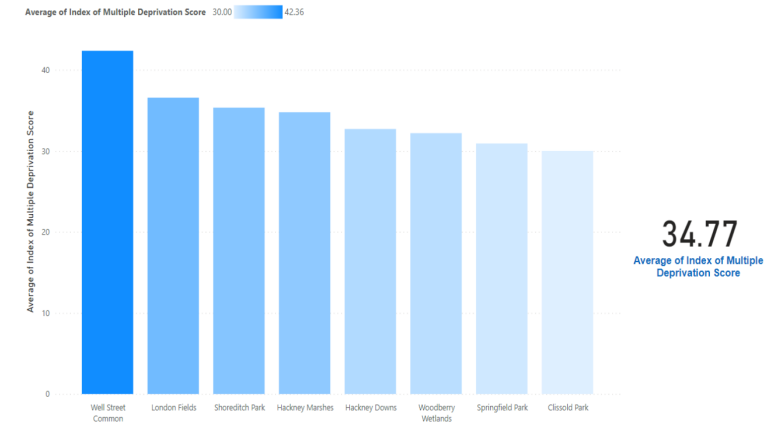
Key Elements

- Education & training
- Collective responsibility
- Place-based collaboration
- Clinical leadership within GP networks

PCNs & Deprivation

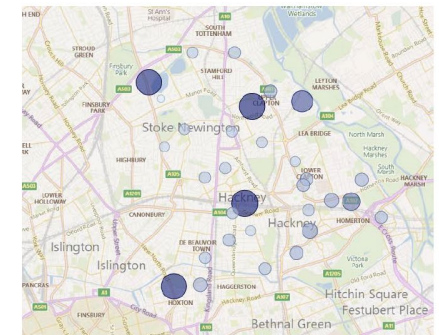
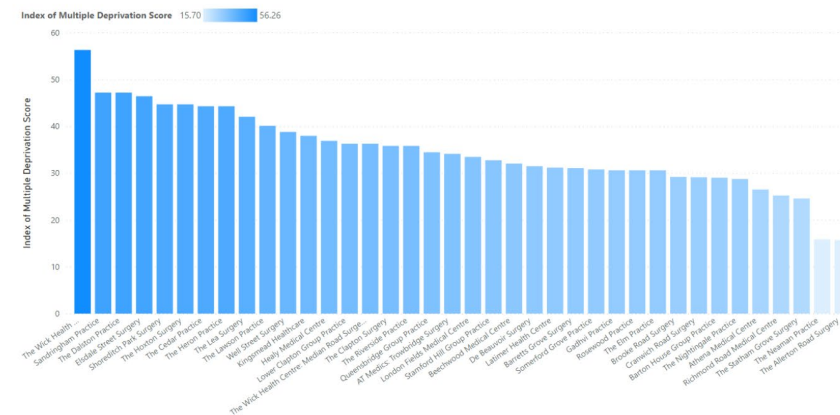
Area Context-Index of Multiple Deprivation

- The average index of multiple deprivation score for City & Hackney primary care practice locations is 34.77. Well Street Common have practices within the highest areas of deprivation



Area Context-Index of Multiple Deprivation

- The practice within an area of highest level of deprivation is The Wick Health Centre within the ward of Hackney Wick.





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Primary – Secondary Care Interface Work in City and Hackney

City and Hackney Place Based Partnership



Interface domains/priorities

Quality and safety benefits

Improvements in patient & workforce experience

Primary/Secondary Care Interface

Increased efficiencies

Improved communication

Primary-Secondary Care Interface

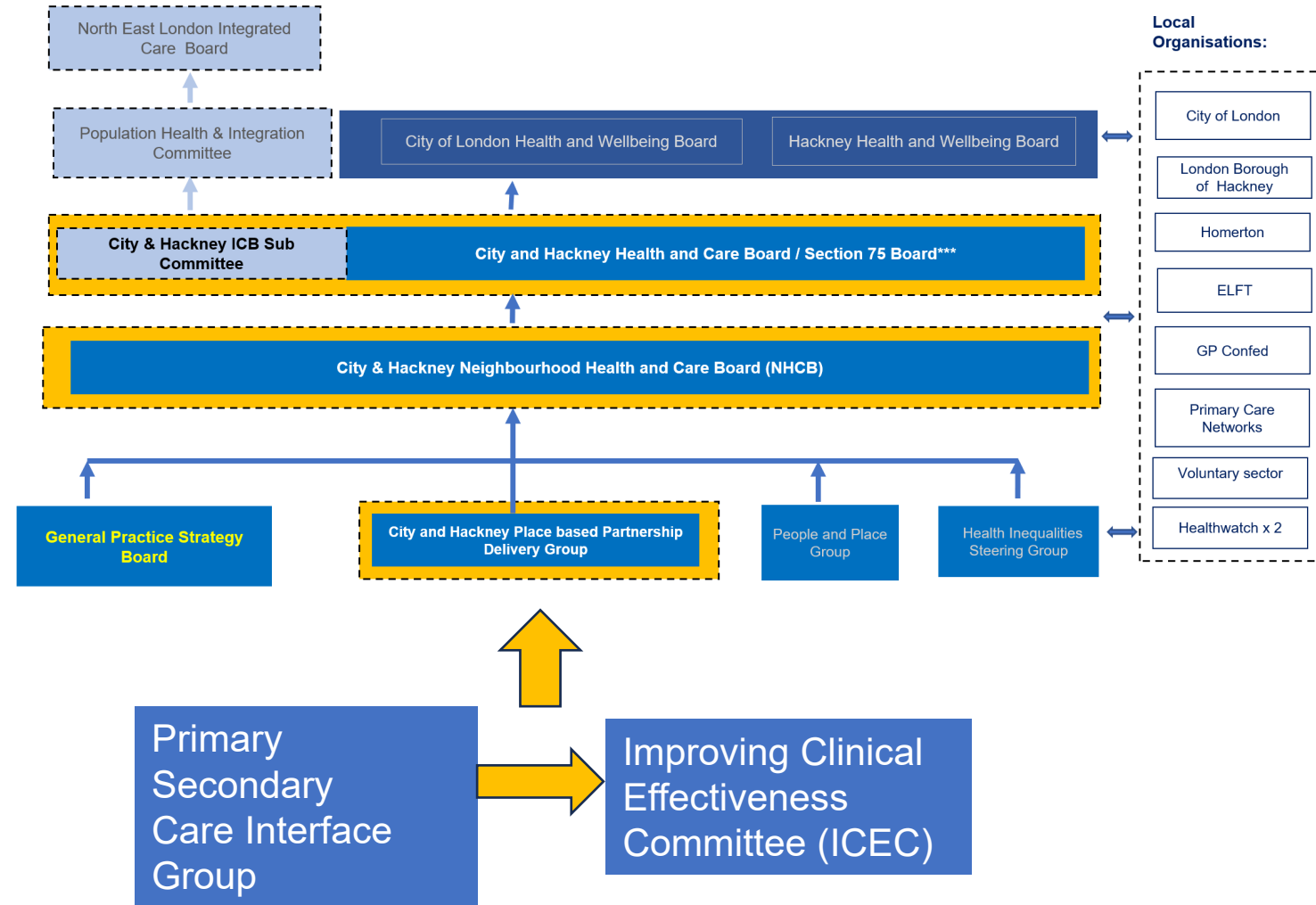


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NHS England Self-Assessment

City and Hackney Place Based Partnership (PbP) – Key Governance Meetings





Consultant-to-Consultant Referral Policy



Primary care referral audits



Primary/Secondary Care Workshop –engagement workshops attended by clinicians and practitioners working across primary and secondary care



Quality feedback and reporting



Pathway redesign



Co-ordination of communications to primary care

- Shared Pathway Development
- Clear referral thresholds
- Defined roles across system
- Evidence-based protocols
- Continuous review and improvement

- Urgent Advisory Services
- Rapid access to specialist advice
- Phone/email/virtual consultation
- Avoid unnecessary referrals
- Builds GP confidence

System Integration



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Clinical
Pathways



Relationships &
Communication



Quality



Fostering
our unique
ecosystem



Population
Health
Approach

Voluntary sector and Digital connectivity across the systems

Supporting

Supporting safe care at home

- Falls sensors, mats, and personal alarms
- Linked to central hubs and urgent community response teams
- Enables rapid support when incidents occur

Looking

Looking ahead

- Wearables and remote monitoring offer further potential
- Requires continued focus and accelerated development

Connecting

Connecting care through shared information

- Digital systems still not fully integrated
- OneLondon and eLPR improving information sharing
- Enables clinicians to access key patient information across settings

Strengthening

Strengthening support beyond clinical services

- Partnerships with the voluntary sector (e.g. Age UK)
- Strong links with neighbourhood teams
- “Home Settlement” support to help people recover safely after discharge

System Goal

- Right care, right place, right time
- Alternatives to ED embedded across system
- Primary + Community + Secondary aligned

Summary: Integrated System Impact



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What Integration Achieves

- Improved ED performance
- Stronger primary care
- Better clinical pathways
- Frailty Virtual Wards (VWS)
- Integrated Intermediate Care Teams (IIT)
- Better patient outcomes

Key Takeaways:

- Integration is hard—but essential
- Requires trust, leadership, and time
- Must be clinically led
- Sustainable when aligned across system

Next Steps:

- Integrated Neighbourhood Teams
- Deeper collaboration
- Data-driven improvement