Supporting people with frailty outside hospitals inquiry – evidence from the British Geriatrics Society (BGS)

1. BGS

1.1. The BGS is the membership organisation for all UK healthcare professionals engaged in the treatment and care of older people. We currently have over 5,600 multidisciplinary members including geriatricians, nurses, GPs, allied health professionals and pharmacists working in all care settings. BGS members are specialists in caring for older people at various stages of older age and they have extensive skills in how frailty should be prevented and managed in older people. We urge anyone involved in the development of frailty policies to engage with the expertise of the BGS and its members.

2. Defining frailty

2.1. There is a general lack of understanding by policy makers, commissioners, and those not specialising in older people's healthcare about frailty. Frailty is a medical condition, more common with increasing age, where people lose their in-built reserves and become increasingly vulnerable to illness and the consequences of illness. This vulnerability may be exposed by events such as an infection, change in medication or a more significant health event such as surgery. Frailty can be used to help identify people at highest risk of sudden deterioration in health and wellbeing, falls, confusion, hospital admission, disability, and the need for long-term care. Early identification of frailty, or the risk of frailty, enables steps to be taken to maintain health and wellbeing, reduce vulnerability to acute health issues and delay loss of independence.

2.2. Frailty requires accurate identification, assessment, diagnosis and severity grading. The Clinical Frailty Scale is a tool widely used by healthcare professionals to grade a person's level of frailty, from very fit to terminally ill. This should only be determined after assessment by a healthcare professional, such as through a Comprehensive Geriatric Assessment (CGA).

3. Prevalence of frailty

3.1. Frailty is common in older age. It is estimated that one in ten people over 65 years in the community live with frailty[1] and over half of people over 85 live with frailty.[2] The number of people in the UK over the age of 85 is set to double by 2047 to 3.3 million people,[3] which will result in an increasing prevalence of the condition. It is therefore vital that the whole healthcare system is equipped to support older people with frailty.

3.2. A person's level of frailty will determine how dependent they are on the health system. Those with mild frailty will need help with some everyday tasks and will need increasing clinical support to maintain independence, resulting in a 24% higher GP consultation rate compared to those with no frailty.[4] Those with

[1] https://doi.org/10.4415/ann_18_03_10
[2] https://doi.org/10.1016/s0140-6736(12)62167-9
[3] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2022based#changing-age-structure
[4] https://doi.org/10.1093/ageing/afz088

moderate frailty will need help with all outside activities, will have some personal care needs and will require significant assistance from healthcare professionals, resulting in a 41% higher GP consultation rate compared to those without frailty.[4] Those with severe frailty will have the most complex care needs and have the greatest dependency on the health system, resulting in 52% higher GP consultation rate and a three times higher hospital admission rate compared to those without frailty.[6] The majority of healthcare for those with frailty will have to happen in a person's home considering the support needed to independently travel to a healthcare facility. Severe frailty is a strong predictor of mortality and associated with five times higher one-year mortality rate compared to those with no frailty,[5] requiring significant healthcare needs, including palliative and end of life care.

3.3. Most older people – more than two thirds - will have multiple conditions, meaning frailty often exists alongside other health conditions, such as dementia.[6] Currently, UK health infrastructure is structured around single conditions which often does not allow for holistic person-centred care. This can be problematic for older people who may experience a sudden change from having no medical conditions to having several at the same time. The number of people living with multiple conditions will continue to increase so urgent action is needed to ensure the healthcare system is equipped to provide holistic care.

4. Frailty policy

4.1. Older people, many with frailty, are the biggest users of healthcare services. However, their needs are currently not being met. There is a huge disparity in frailty community services across the UK, with approaches varying within and across regions and providers. There is variation in all elements of frailty management, including identification, diagnosis, assessment, and interventions. Often, care is poorly integrated and not coordinated, leading to poor care outcomes.[7] There are pockets of best practice across the UK, which the BGS promotes,[8] but a joined-up national approach is needed to ensure equity in service provision across the UK.

4.2. National policy approaches to frailty from NHS England and the Department of Health and Social Care have been disjointed, with little progress made on the commitments made in the 2019 Long Term Plan, and there is no overall frailty strategy. Recent initiatives by NHS England are welcome, such as the NHS England Frailty Project Board. However, only a relatively small number of sites have been selected to pilot a system-wide approach through the Frailty Improvement Collaborative, meaning many areas will continue to fall behind in service provision. The BGS has resources, expertise, and examples of how frailty should be managed in older people and this should be rolled out across the UK in every part of the healthcare system, including acute, community, primary, neighbourhood, care homes, and specialist care.

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[5] https://doi.org/10.1093/ageing/afw039

[6] https://cks.nice.org.uk/topics/multimorbidity/background-information/prevalence/

[7] https://doi.org/10.1093/ageing/afaf174

[8] https://www.bgs.org.uk/IntegratedSystems

4.3. The BGS recommends a national frailty strategy is developed, outlining standardised expectations for frailty care across the UK and informed by the Frailty and Dementia Modern Service Framework for England. This in turn should inform local frailty strategies, which every system should be required to develop and operationalise through neighbourhood teams alongside integrated acute frailty pathways with local hospitals. Strategies should include approaches to population health management, proactive care, and equity of access to Comprehensive Geriatric Assessment (CGA) and subsequent care and be supported by a digital and workforce strategy. It is important that systems are also required to measure their performance through key performance indicators, and that this is reported on nationally to determine the quality of frailty services across the UK.

4.4. Systems should be required to evaluate their performance against previous government initiatives, such as Urgent Community Response, Enhanced Health in Care Homes, Hospital at Home, and proactive care. Each system should be required to benchmark itself to identify gaps in provision. An agreed set of metrics to monitor progress is essential.

4.5. In 2023, the BGS published *Joining the dots: A blueprint for preventing and managing frailty in older people.*[9] This document sets out how to achieve age-attuned frailty care across health and social care settings. It outlines seven system touchpoints that should be included when planning and commissioning health and social care for older people, alongside 12 recommendations. This document should inform national frailty policy and serve as a guide in the implementation of the NHS England Ten Year plan. The BGS recommends the Public Accounts Committee considers the recommendations outlined in this document.

5. Comprehensive Geriatric Assessment (CGA)

5.1. CGA is a term used to describe a structured multidisciplinary assessment to identify an older person's needs. It is an evidence-based approach considered to be the gold standard method to prevent and manage frailty syndromes, incorporating an assessment of physical, psychological, functional, social, and environmental factors. This includes accurate diagnosis and shared decision-making around interventions, such as exercise, nutrition management, and medicine management. The results are used to develop an individualised holistic care plan. When done well, CGA leads to better outcomes for older people including falls prevention, improved bone health and fracture reduction, reduction in inappropriate polypharmacy, and delirium management. It is important that all healthcare professionals who interface with older people have an awareness and understanding of the clinical interventions and benefits of CGA. The BGS's CGA Hub provides an overview of the concept and process of CGA aimed at healthcare professionals.[10]

5.2. Variation in frailty management often stems from the lack of a standardised approach to CGA. Policy guidance on CGA is weak, resulting in inadequate implementation and duplication. If implemented well, CGA provides a

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[9] https://www.bgs.org.uk/joining-the-dots-a-blueprint-for-preventing-and-managing-frailty-in-older-people-0

[10] https://www.bgs.org.uk/CGA#whatiscga

framework for addressing all frailty-related syndromes across all healthcare settings and avoids duplication of assessments. For example, assessments and interventions for falls and delirium are often similar and implementing CGA appropriately should minimise the duplication of pathways and services.

5.3. To address variation, policy and contractual frameworks must explicitly explain CGA components. For example, where GP activity related to frailty is incentivised in contracts, this should be framed as addressing elements of CGA, such as falls, care planning, and structured medication reviews. Similarly, policies such as the Enhanced Health in Care Homes framework outlines mechanisms for embedding CGA within care home settings, and this should be articulated more clearly. The BGS recommends strategies to expand CGA provision at scale through relevant policy, strategy, workforce development and investment.

6. Preventing frailty and slowing progression

6.1. Frailty is not an inevitable part of ageing. It can be prevented and its progress slowed. Regular exercise, particularly strength and balance training, and good nutrition can prevent the onset of frailty developing in older age.[11] Likewise, loneliness and social isolation can contribute to frailty risk.[12] The BGS's *Healthier for longer: how healthcare professionals can support older people*,[13] outlines how healthcare professionals can support older people to remain healthy and independent into older age, especially benefitting older people with mild frailty.

7. Proactive care

7.1. Proactive care aims to reduce or delay negative health outcomes through identifying and targeting those at risk of frailty and tailoring health interventions to support them to live well for longer. It aims to delay the onset of health deterioration, maintain independent living, and reduce avoidable periods of ill health, thereby reducing unplanned care.[14] The *BGS's Be proactive: Proactive care for older people with frailty* resources outline the evidence base, delivery recommendation, and examples of best practice for proactive care.[15]

7.2. Proactive care involves identifying those within the population who may be at risk of developing frailty. This can be done is a variety of ways, such as analysing admission, discharge and caseload data; and using algorithms to identify people on databases. The Electronic Frailty Index (eFI) is a tool that uses data from a person's electronic health record to identify and grade the severity of frailty. The tool is highly influential and is used nationally across the NHS, with the newest edition (eFI2) currently being implemented following release in April 2025.[16] Once risk of moderate or severe frailty has been

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[11] https://doi.org/10.4061/2011/569194
[12] https://doi.org/10.1016/s2666-7568(20)30038-6
[13]: https://www.bgs.org.uk/resources/healthier-for-longer-how-healthcare-professionals-can-support-older-people
[14] https://www.england.nhs.uk/long-read/proactive-care-providing-care-and-support-for-people-living-at-home-with-moderate-or-severe-frailty/
[15] https://www.bgs.org.uk/be-proactive-proactive-care-for-older-people-with-frailty
[16] https://doi.org/10.1093/ageing/afaf077

identified, a holistic assessment using evidence-based CGA should take place followed by a personalised care and support plan, which may include an Advance Care Plan.

7.3. The BGS recommends that policy makers and commissioners should prioritise national funding and contractual arrangements to ensure that proactive care is available to all older people with frailty living in the community. This should be a fundamental component of new integrated neighbourhood teams. The Jean Bishop Integrated Care Centre in Hull is an example of a successful model of proactive care.

8. Community healthcare provision

8.1. Many older people with frailty syndromes prefer to receive healthcare at home or in community settings, rather than in a hospital. Urgent Community Response (UCR) refers to immediate crisis intervention, such as for falls and infections. It is important that local services provide high quality UCR, which is integrated with Hospital at Home and rehabilitation services. This will reduce the risk of deconditioning, delirium, and hospital-related infections whilst supporting the individual to remain independent and reducing hospital admissions.

8.2. Hospital at Home, sometimes referred to as virtual wards, is an alternative to acute hospital care for people who are sick enough to be in hospital. This can be as an alternative to admission or early supported discharge. Safe and effective care for people with frailty can be provided through Hospital at Home with similar outcomes than care in hospitals, and at a lower cost. In 2025, the BGS co-produced *Hospital at Home for frailty: Current situation and future potential.*[17] This outlines our recommendations to government to roll out Hospital at Home services, and to streamline community care delivery by combining UCR, ambulance and Hospital at Home services. It remains to be seen how these pathways will integrate with emerging neighbourhood teams, but the BGS recommends an integrated approach to crisis care delivery for older people, and this should be standardised across all community-based teams, founded on CGA as a clinical model of care.

8.3. Effective care for people with frailty after a crisis requires early mobilisation and rehabilitation. Rehabilitation must be available to all older people leaving hospital regardless of the setting they have been discharged to. Without rehabilitation, older people being discharged from hospitals experience further deterioration. BGS's *Reablement, Rehabilitation, Recovery: Everyone's business* outlines the evidence base behind rehabilitation for older people, highlights examples of best practice, and outlines policy recommendations.[18]

9. Frailty care in care homes

9.1. Around 300,000 people aged 65 and over live in a care home in England and Wales, accounting for 82.1% of all care home residents.[19] Most older people living in care home will have frailty, high care needs, and are in the last two

[17] https://www.bgs.org.uk/HospitalAtHomeFrailty
[18] https://www.bgs.org.uk/reablement-rehabilitation-recovery-everyone%E2%80%99s-business-0
[19]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/olderpeoplelivingincarehomesin2021andchangessince2011/2023-10-09

years of life. Therefore, it is vital care homes are equipped to provide frailty-attuned care focused on CGA and have access to specialist expertise in dementia and end of life care. The national Enhanced Healthcare in Care Homes programme promised improved healthcare provision in care homes but much of what was promised has not materialised. BGS's *Ambitions for Change: Improving healthcare in care homes* outlines 11 recommendations for local and nation decision-makers to consider improving health care for those living in care homes.[20]

10. End of life care

10.1. Older people with severe frailty face a great degree of diagnostic and prognostic uncertainty, unpredictability and escalating care needs which do not fit into traditional models of palliative care as they reach the later stage of life. Their needs are significantly different to those dying of a single condition and they will have varying trajectories of decline. The current palliative and end of life care model in the UK does not serve older people with frailty, meaning many do not receive the end of life care that they need. The BGS has published some key messages on end of life care outlining some key facts and statistics about the majority of those dying each year – older people.[21] Around 70% of those dying each year are older people, most with multiple conditions including frailty, resulting in a mismatch between service provision and population needs.

10.2. Urgent action is needed to ensure that the community and primary care workforce is equipped with the skills needed to identify and care for older people with frailty at the end of life, alongside specialist care. This will support the provision of person-centred care focussed on managing uncertainty and helping to plan for deterioration through Advance Care Planning. When done well, CGA should offer Advance Care Planning and capture preferences towards treatment. Investment is needed to ensure care teams can provide continuity of care to those with frailty dying in the community, acting as their key point of contact, and supporting them to die in their preferred place of death. It is expected that the number of deaths in care homes will increase significantly over the next 25 years, and support will be needed for this function as the hospices of the future. The development of the Palliative and End of Life Care Modern Service Framework for England is an important opportunity to address these issues.

11. Workforce

11.1. To ensure the UK is equipped to support the ageing population, it is vital that policy makers prioritise investing appropriately in the health and social care workforce. This will include training the next generation of frailty experts and embedding frailty principles within the wider community and primary care workforce. Those specialising in older people's healthcare have the skills and capabilities to provide expert frailty care to older people in the community but there are not enough of them to support the UK's increasingly ageing population. The BGS has long advocated for more geriatricians, nurses, GPs with specialist interest in Frailty, Advanced Clinical Practitioners in Frailty, and

[20] https://www.bgs.org.uk/ambitions-for-change-improving-healthcare-in-care-homes
[21] https://www.bgs.org.uk/bgs-key-messages-end-of-life-care

allied health professionals working in older people's healthcare, alongside an expansion in training numbers, and national recruitment drives to support this.[22] [23] Every system should know the need for and plan for an expansion of tier 3 trained frailty experts to manage multidisciplinary teams. This plan should be mapped against system population needs and demographic shifts.

11.2. There is huge variation across UK community and primary care teams in frailty core capabilities, and little data available at a local system level to determine which areas are falling behind. The BGS has the educational resources available to skill up the workforce, in particular a Tier 3 level online course on frailty *(Frailty – identification and interventions),* which has been accessed by 14,500 learners since 2023.[24] This elearning module is available free of charge to all health and social care professionals (currently funded by NHS England until June 2026) and, at a minimum, the BGS recommends that the module is a mandated requirement for all healthcare professionals caring for older people in primary and community care. Additionally, we recommend every system should have a training plan aligned to the frailty core capabilities and mapped against the population need.

If you would like to discuss any aspect of our submission or invite one of our expert members to give oral evidence, please contact our Policy Co-ordinator, Lucy Aldridge, to make arrangements (l.aldridge@bgs.org.uk).

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GP with Extended Role in Frailty

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[22] https://www.bgs.org.uk/the-case-for-more-geriatricians-strengthening-the-workforce-to-care-for-an-ageing-population
[23] https://www.bgs.org.uk/moreNAHPs
[24] https://www.bgs.org.uk/frailtyelearning