

The 10 Year Plan, the Medium Term Planning Framework and Neighbourhood Health Framework identify people living with frailty as a priority cohort and call for a shift of care from hospitals into community-based health services. The Best Practice Guide for NHS Frailty Pathways provides clear actions to begin that shift.

Understanding need and resource planning

ICBs must build a linked data picture of frailty demand, combining primary care, secondary care and community services data as a minimum.

- Tools such as the Electronic Frailty Index and hospital frailty risk score should be used to support accurate identification of the frailty population
- Data should model the impact of shifting care from emergency departments (EDs) to community
- Systems should monitor functional decline, utilisation and cost per 1,000 people living with frailty
- Financial arrangements across the system should be aligned to support the shift of resource from hospital to community

Identification, assessment and care planning

The guide targets people with a clinical frailty score (CFS) of 5 or above. Current spend is concentrated on those scoring 6 or more, indicating a gap in earlier intervention.

- Frailty status recorded in electronic patient records and maintained as a live register, co-ordinated by the neighbourhood multidisciplinary team (MDT).
- Comprehensive Geriatric Assessments (CGAs) used routinely, incorporating falls assessment, medication reviews, fragility fracture assessments and advance care plans (ACPs) where appropriate
- Care planning should focus on strengths and goals rather than limitation or withdrawal of services
- Strong organisational leadership across GP, community and acute settings is essential to drive consistent identification and assessment

Digital records and care plan visibility

CGAs and ACPs must be held digitally and accessible in real time across all relevant providers, with patients only needing to share their story once.

- All professionals should have access to up-to-date assessments, care and support plans and medication details
- CGA should be initiated within one hour of acute admission for people with frailty (CFS 5+)
- Shared records require robust governance, including medication safety and deprescribing protocols

Community-based care

ICBs and local authorities must jointly develop neighbourhood-level frailty plans with executive-level commitment to shift resources from hospital to community.

- Neighbourhood MDTs, comprising GPs, community nurses, frailty practitioners, allied health professionals, pharmacists, social workers and voluntary, community, faith and social enterprise (VCSFE) partners, meet regularly to deliver care, with specialist input on demand
- Expanded urgent community response services and virtual ward capacity, with integrated pathways linking care homes and intermediate care to avoid unnecessary ambulance conveyance
- GP-led rounds, medication reviews and advance care planning as standard for all care home residents
- Investment in expanding community health services and the primary care workforce to meet demand
- Place-based collaborative leadership across health and social care is needed to sustain neighbourhood-level delivery

Frailty-attuned hospital care

Providers must deliver at least 70 hours per week of acute frailty or same day emergency care services, with CGA and CFS scoring at the front door and Home First capacity for same-shift discharge.

- Tier 2 and tier 3 frailty-skilled coverage across EDs and assessment units
- Full CGA bundle for all people with frailty attending ED
- Clear handover to community services for all unavoidable admissions

Workforce and capability

Multi-agency training aligned to the Skills for Health Core Capabilities Framework (tiers 1 to 3), with tier 3 specialists accessible seven days a week for at least 10 hours a day.

- Workforce mapping to identify gaps, with staffing numbers set against local demand
- Expansion of tier 2 practitioners and new clinical roles with structured progression
- A well-supported, frailty-attuned workforce, with strong collaboration across health, social care and VCSFE partners