Classification: Official

NHS England

Proactive Community Frailty Service Standards

Minimum core to gold standards

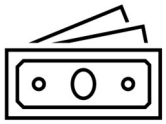
August 2024

Publication reference:

Challenges for people living with frailty in healthcare

Older adults are the biggest users of emergency services and health and social care generally

(British Geriatrics Society, 2023)

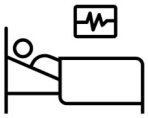


£5.8 billion annually spent on frailty inpatient activity

(Han et al., 2019)

“Moderate frailty population, people whose annual risk of urgent care utilisation, death and care home admission is 3 times that of an older person of the same age who is fit.”

(NHS RightCare, 2019)



50% of people living with frailty stay in hospital for over 21 days

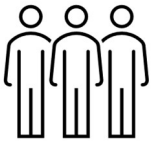
(GIRFT, 2023)

15% of discharged older people are back in hospital within 28 days

(BGS, 2023)

Elevated risk of hospital admissions for older people

(GIRFT, 2023)



“Around a third of older people with frailty experience functional decline during their stay“

(Hopper, 2021)

Health and functional status can quickly change direction for a person living with frailty. For example, a person can go from independent to dependence, fully mobile to reduced mobility, the occurrence of falls, delirium and from fully continent to problems with incontinence

(Clegg et al., 2013)

Solutions to the above problems uncovered by data

A community comprehensive geriatric assessment (CGA) can reduce hospital care days by 22%

(Nord et.al, 2021)

Relative risk score of hospital care episodes reduced by 17%

(Nord et.al, 2021)

Healthcare cost reduction by 17%

(Nord et.al, 2021)

Multiple studies looking at proactive community integrated care models showed a reduction in accessing acute services and care home admission and therefore a cost savings

(Béland & Hollander, 2011)

Proactive Community Frailty Service Standards

During the height of the pandemic years, the NHS responded to an unprecedented demand on healthcare services. As priorities now shift, the focus is on proactive care, particularly for the older population and those living with frailty. The aim is for all boroughs in London to offer a proactive community frailty service to help prevent hospitalisation and adverse events when possible, keeping people happy and healthy at home for as long as possible.

Current situation

The primary users of health and social care in the UK are older people. As the population in the United Kingdom increases in age, so do the number of people living with frailty and complex comorbidities (BGS, 2023; Soong et. al., 2015). Life expectancy for the first time is stagnating and is even declining in areas of higher deprivation. People are also experiencing poorer health in later years (Marmot et. al., 2020). It is estimated that around 10% of the population over 65 has some level of frailty, this figure increases exponentially with age (Clegg et. al., 2013). According to the Census 2021 data, the over 65 population in London is 1,043,400 (AgeUK London, 2021), it can be estimated that at least 104,340 people are living with frailty in London.

Frailty is a long-term health condition that describes a person's increased vulnerability to illness and adverse events. Due to a loss of reserves and resilience in the various body systems, recovery from these can be more complex and prolonged (Fried et. al., 2001; Mitnitski, Mogilner & Rockwood, 2001). This is often associated with age; however, it can occur in younger populations, is not inevitable, fluctuates and can be managed (Thompson et al., 2018). Specifically, there is an increased risk of developing frailty syndromes such as incontinence, declining function/mobility, exhaustion, falls, susceptibility to medication side effects, weight loss, pressure ulcers, cognitive impairment and delirium (Chen, Mao & Leng, 2014; Xue, 2011). More generally, people living with frailty are at higher risk for adverse events, hospitalisation, institutionalisation and death (Cesari et al., 2016). Preventing these events while focusing on quality of life and wellbeing must be prioritised (Whitty, 2023).

This report intends to encourage the following high-level aims:

1. Any clinician who sees a patient over 65 to complete the clinical frailty scale (CFS) and if clinically relevant, refer on for a holistic assessment by a community frailty service (or an acute frailty service if the patient is acutely unwell).
2. All London boroughs to offer a proactive community frailty service following the minimum core standard recommendations, offering a multidisciplinary holistic assessment such as the validated comprehensive geriatric assessment (CGA) for people living with frailty.

As part of this report, official NHS guidance such as the Long Term Plan (NHS, 2019), the Fuller Stocktake Report (Fuller, 2022) and the Proactive Care recommendations (NHS

England, 2023) were reviewed. This was supported by additional grey literature and current relevant evidence using academic databases such as PubMed, as well as Google Scholar. This review outlines recommendations for proactive community frailty services from minimum core to gold standard, ensuring strength based, personalised and holistic approach to all aspects of service delivery to address physical and mental health, well-being and social issues.

What is a community frailty service and why is it important?

The first step to managing frailty, is to identify it using an evidence-based tool such as the Clinical Frailty Scale (CFS). Once frailty is identified, if clinically relevant, a holistic person centred assessment such as the validated comprehensive geriatric assessment (CGA), should be commenced by a clinician with specialist training. It is important that a community frailty service exists to cover the proactive part of the frailty pathway, keeping people happy and healthy at home for longer (GIRFT, 2023; Department of Health & Social Care, 2023; Fuller, 2022; Adja et al., 2020; NHS, 2019; British Geriatrics Society, 2014).

People living in deprived areas of London, especially those who also belong to a minoritised group, experience poorer health (Centre for Ageing Better, 2023). In general, living in an urban area of England is linked to higher levels of frailty (Sinclair et al., 2022), and people in the least deprived areas experience an average of 11 more good health years than those living in the most deprived areas (ONS, 2022). Evidence shows that only half of older adults living with frailty receive appropriate healthcare interventions (Steele et. al., 2008). A community frailty service mapping exercise completed by the NHS England London Frailty Clinical Network, shows that unwarranted variation exists across the capital. Seven boroughs do not have a proactive community frailty service, and those that do, have quite varied offers. This has identified a geographical health inequality that needs to be addressed.

Some evidence shows that frailty could be reversible in some cases (Gill et al., 2006), but only if identified promptly and the appropriate intervention occurs. Older people living with frailty are often complex and ideally community teams would offer a proactive, holistic, integrated, coordinated, multidisciplinary service that is flexible to each individual's needs (BGS, 2015). This type of service has the potential to support people to live more independent lives, improve wellbeing, while also reducing the demand for acute services, primary care appointments and social care. However, achieving this within the current NHS and social care resource crisis (financial and workforce) has been a challenge, and local areas have developed unique and creative ways to address the needs of this population. This has led to the variation in the services offered across the region. Variation in how a service is delivered may not in itself be a problem, as long as the service provided exists and meets the minimum criteria.

Evidence shows that community frailty care offered proactively, can prevent adverse events, reduce unnecessary hospitalisations and improve quality of life while ensuring cost savings on a bigger scale over the longer term (Murtagh et al., 2023; Thompson et al., 2022; Beswick et al., 2008). It is important these services are integrated with and work alongside acute frailty services, secondary specialist care, community services, social care, primary care and

care homes. This has the potential to relieve pressure from other overstretched areas such as Emergency Departments, primary care and inpatient wards (Fuller, 2022). In recent years, there has been more demand and therefore focus on acute frailty care. However, although there will always be a need for acute frailty services, it is important to also invest in services to prevent those adverse events causing people to use the acute services in the first place.

Frailty identification

All clinicians who make contact with a person 65 or older or someone who has multimorbidity (two or more conditions), especially if they are experiencing one of the common frailty syndromes, should be assessed for frailty using the Clinical Frailty Scale (CFS) or other validated assessment tool (Whitty, 2023; GIRFT, 2023; Subramaniam et al., 2022; Church et al., 2020; BGS, 2015). Age and poverty are two of the biggest risk factors for multimorbidity and frailty, and will appear earlier with higher levels of deprivation (Whitty, 2023; Thompson et al., 2018). This should be considered when deciding whether to assess for frailty as biological and chronological age do not always match. Around 70% of people living with frailty will also have multimorbidity (Vetrano et al., 2019). If a patient is acutely unwell, and if there is no recent baseline, use information from two weeks before the patient became unwell to calculate the frailty score (Charlton et al., 2022; NICE, 2016).

Due to the close relationship and overlap between frailty and dementia – all memory services should be assessing for frailty using the Clinical Frailty Scale (BGS, 2015; Kulmala et. al., 2013; Petermann-Rocha et al., 2020).

As GPs have regular contact with their patients and may know them best, they may be the best clinicians to identify frailty accurately (BGS, 2015). In addition, to improve data collection, coding frailty score and status in EMIS/SystmOne should be standardised (Sinclair et al., 2022; NHS England, 2018).

Proactive identification of frailty using data (the electronic frailty index, or internally generated EPR reports, frailty data quality is mixed), combined with a clinical review as part of a comprehensive geriatric assessment (CGA), when appropriate, may contribute to even more proactive frailty care. This may offer further opportunities for intervention and can support and encourage self-management (Mosello et al., 2016; NICE, 2016; BGS, 2015).

Once a person has been identified to have frailty, the following criteria should initiate action to start or refer for CGA:

1. Moderate to severe frailty, CFS 6 and above
    - Some areas may consider all people living with frailty, CFS 4 and above (this needs to be locally agreed)
2. No report of or evidence of a CGA in over a year
    - Or if they have had a recent CGA, but there has been a change in health or function (GIRFT, 2023)
3. If they are experiencing a change relating to any of the frailty syndromes

Frailty intervention

Research shows that earlier frailty intervention leads to better outcomes. Regardless of stage of frailty, older people have better outcomes with a comprehensive geriatric assessment (CGA) (Stuck and Iliffe, 2011).

The main constraint for community frailty service development is strongly linked to limited resources. To prevent people moving into the severely frail and most dependent state, it is recommended that services focus on preventing the deterioration of people with mild or moderate frailty to prevent and/or delay this deterioration (Hopper, 2021). People living with moderate frailty benefit most from personalised proactive interventions as this can reduce progression of frailty and preventable use of acute services (NHS RightCare, 2019).

Service recommendations

Compiling current evidence, guidance, recommendations and current practice, the following recommendations outline the high-level core minimum standards for proactive community frailty services.

Minimum core standards

- ✓ Includes patients receiving proactive community frailty care (not limited to acute only)
- ✓ Holistic review such as the Comprehensive Geriatric Assessment (CGA)
- ✓ Core team is multidisciplinary (>3)
- ✓ As a minimum include those over 65 living with frailty; however, consider flexibility in age acceptance criteria depending on local needs
- ✓ Not limited to housebound or severe frailty
- ✓ Access to geriatrician, consultant, or senior frailty specialist
- ✓ Accept referrals from all health and social care providers
- ✓ Home visits as standard
- ✓ Clear and concise referral form
- ✓ Create a Universal Care Plan (UCP) to document Advance Care Planning discussions
- ✓ Output is a personalised care and support plan, using an accessible digital tool viewable by relevant health and social care professionals involved in the person's care, and when appropriate also accessible to the patient

Gold standards

In addition to the minimum core service standards, the gold standard list can be seen as potential improvement opportunities. The following recommendations outline the high-level gold standard components for proactive community frailty services.

- ✓ Work closely with all parts of the frailty pathway (community, acute, primary care, mental health, social care, ambulance services) to identify challenges and successes and always explore ways to improve integration, efficiency and patient care, finding ways to ensure patient records (including CGA details) are viewable across and between the pathway
- ✓ Multidisciplinary team to aim for: doctor (consultant, GPwSI), physician associate, advanced clinical practitioners, nurse specialist/practitioner/community matron, pharmacist, physiotherapist, occupational therapist, social worker, mental health professional, community navigator, dietician
- ✓ Capacity and demand corresponds to local population need and deprivation levels
- ✓ Develop local pathways for acutely unwell patients
- ✓ Offer patient self-referral if appropriate for locality and patient group
- ✓ Provide an advice line for referrers to ring to discuss referral and patient details
- ✓ Work with local communities to develop improved community offers for frail older people
- ✓ Agree a set of local outcome/process measures, monitor these while giving services time to develop and establish, acknowledging that it may take time to see improvement
    - Number/percentage of patients with a Clinical Frailty Scale (CFS) score coded in that month (should match number of CGAs)
    - The following are process measures, evidence already shows this has an impact:
        - Number of falls assessments done
        - Number of medication reviews done
        - Number of Advance Care Planning discussions done (and number of associated Universal Care Plans created)

Evidence for the recommendations

This section will explore supporting evidence for both minimum core and gold standard recommendations, promoting opportunities for quality improvement. Any changes should be implemented over time, ensuring resources are available to support any changes made. Priority should always be centred around holistic, person-centred care (Adja et al., 2020; Escourrou et al., 2017).

1. Minimum age criteria: a person 65 (or younger) living with frailty
    - Consider the ability to accept a patient under 65 who may have developed frailty at an earlier age (Walsh et al., 2023)
        - Common risk factors for early onset frailty are older age, deprivation, female, Asian ethnicity, learning disability, severe mental health, multiple comorbidities, homelessness, drug/alcohol misuse, smoking and urban locations (Walsh et al., 2023; Bai et al., 2023)
    - Clinical frailty scale (CFS) is validated for all ages and comprehensive geriatric assessment (CGA) is validated for those over 65
        - A CGA is a holistic assessment so will likely have benefits despite not being validated for the under 65s; however, if a condition specific holistic assessment validated for the relevant situation exists, consider using this (Rockwood and Theou, 2020; CGA Toolkit Plus, 2015)
2. Accept referrals from all professionals
    - Consider self-referral for previous patients who may require re-assessment (Clark et al., 2009)
3. Ensure the service referral form is clear and concise including reason for referral, specific concerns of referring clinician and consent to view patient records (François, 2011)
    - Consider offering an advice line to discuss referral and priority
4. Triage according to a holistic review of the patient's records (in a multidisciplinary setting) and referral reason
    - For example, falls, blackouts, social concerns, safeguarding, self-neglect, etc could be prioritised
5. The core team should be multidisciplinary with a minimum of three, mostly registered health and social care staff (Fuller, 2022; Hopper, 2021; CGA Toolkit Plus, 2015)
    - Understand the local population and ensure multidisciplinary team capacity can support this demand (NHS RightCare, 2019)
    - Recommended professionals for the multidisciplinary team are: doctor (consultant, GPwSI), physician associate, advanced clinical practitioners, nurse

specialist/practitioner/community matron, pharmacist, physiotherapist, occupational therapist, social worker, mental health professional, community navigator, dietician (Crocker et al., 2024; Hickson, Child & Collison, 2022; Brown et al., 2020; NICE 2015; Turner & Clegg, 2014)

- Other professionals, specialists, Sponsor GPs, Voluntary Community and Social Enterprise (VCSE) to be involved as necessary

6. Home visits should be offered as standard (Fuller, 2022; WHO, 2021; Hopper, 2021; Huss et al., 2008)
7. CGA completed at home reduces mortality, nursing home admission (Frese et al., 2012) and unnecessary hospital admissions (Di Pollina et al., 2017)
8. Ensure integration and joint working with other services and commissioners ensuring a whole pathway approach that can support patients along their journey (Fuller, 2022).
9. Relevant information collected from all patient contact must be sharable to other parts of the pathway (BGS, 2015; BGS, 2014)

Holistic assessment recommendations:

1. The comprehensive geriatric assessment (CGA) is the gold standard in frailty care as it is multidisciplinary, holistic, person centred and is a validated tool providing a structure for assessment, evaluation and care planning (WHO, 2021; BGS 2015; Stuck and Iliffe, 2011).
    - A CGA is time consuming, a minimum of 1.5 hours plus time for care planning and referrals is needed for assessment
    - Local agreement for resource will be needed, if resources are sparce those accepted may be limited to moderate-severe frailty (BGS, 2014; Turner & Clegg, 2014); however, all older people will likely benefit from a CGA (Stuck and Iliffe, 2011).
        - ➢ Systems may look to develop, test or research innovative ways of delivering CGA in order to maximise the population reach of the CGA interventions within workforce and financial constraints
2. Multimorbidity review with clinical assessment and management (NICE, 2016); improves early diagnosis, early intervention and quality treatment (Department of Health & Social Care, 2023; Whitty, 2023)
3. Support condition self-management and healthy lifestyle advice (Inzitari et al., 2018; Palmer et al., 2018; NICE, 2015)
4. Maintain independence as this will link to improved quality of life (Whitty, 2023)

5. The assessment is person centred and involves family and carers (with consent) when relevant (NICE, 2015; Hopper, 2021; WHO, 2021)
6. Assume people have capacity and support them to make informed decisions (Office of the Public Guardian, 2020)
7. Consider that a person living alone with no carer may be more complex and require additional resources (Mukamel et al., 2007)
8. Ensure assessment details are available to referrer and GP, and ideally accessible by any relevant healthcare professionals (BGS, 2015)
9. The following areas should be reviewed, based on the concept of the CGA (CGA Toolkit Plus, 2015):
    - Ask the person what matters to them and what their priorities are (Fuller 2022)
        - Social assessment
        - Physical health review including vital sign observations, physical assessment, auscultation, otoscope, weight, height
        - Review diet and fluid intake, with nutrition and dietary advice provided for people with undernutrition (Crocker et al., 2024; WHO, 2021)
        - Review function and activities of daily living
        - Review mobility and falls considering environment, strength and balance, cognition, aids and social factors
            - If falls or near misses are identified: bloods, ECG and lying-standing blood pressure should be done (Montero-Odasso et al., 2022)
            - Exercise recommended for older people with deteriorating physical capability, pelvic floor muscle training for older women experiencing urinary incontinence (World Health Organisation, 2021), intervention must be “adaptable and flexible” (Inzitar et al., 2018)
    - Review cognition using a validated tool
        - If someone already has a dementia diagnosis, this is not recommended as standard practice (BGS, 2014)
    - Review mood and mental health (WHO, 2021)
    - Dental assessment (Everaars et al., 2021)
    - Vision assessment (WHO, 2021)
    - Hearing assessment is important (WHO, 2021) to prevent dementia and improve quality of life and wellbeing (Wolff et al., 2023; Livingston et al., 2020)

- Home modifications, environment hazards (WHO, 2021)
- Medication assessment with regular reviews as needed - STOPP/START (Crocker, 2024; BGS, 2014)
- Advance care planning to be considered when appropriate (NHS Improving Quality, 2016)
    - Update details in Universal Care Plan (UCP)
- Full review of usual bloods (U&Es, FBC, LFTs, HbA1c, TSH, Vitamin D, B12/folate, bone profile, and any other tests identified during assessment)
    - If nothing has changed, recent bloods within a year can be reviewed

10. The assessment is completed in order to generate an intervention plan: a personalised care and support plan (including any escalation plans), decided on between the clinician, the patient and carers (if relevant) (Crocker, 2024; Palmer et al., 2018; NICE, 2016; NICE, 2015; BGS, 2014)
    - Interventions should be undertaken by the community frailty service when possible to relieve pressure on primary care
11. A named individual should be designated to coordinate care (GIRFT 2021)
12. It is best practice to share a copy of the care plan and discharge summary with the patient (BGS, 2014; NICE 2016)
13. For continuity of care and to avoid duplication, ensure assessment details and care plan are shared with and care handed over to the relevant health and social care professional responsible for usual care on discharge (GIRFT 2021; Palmer et al., 2018; BGS, 2015)
14. Develop local pathways for acutely unwell patients – particularly for falls, delirium and sudden immobility (BGS, 2014; NHS RightCare, 2019)

Workforce recommendations:

Workforce must be considered for a service to operate to its full potential. A focus on staff retention will contribute positively to continuity of care (Mukamel et al., 2007). The needs of the local population will need to be explored, and resources allocated appropriately to ensure good care within a manageable caseload (NHS RightCare, 2019).

1. Build multidisciplinary team as outlined above
2. Match multidisciplinary team capacity to the demand of the local population (NHS RightCare, 2019)

3. Consider the needs of local populations – including hard to reach groups (homeless, travellers, any other communities that tend not to present to health and social care but may benefit from intervention) (Threapleton et al., 2017; Dowrick et al., 2009)
4. Consider language and culture, patients may respond better to a person of similar cultural background - or a person with some knowledge or interest in their culture (Mukamel et al., 2007)
5. Geriatricians to offer some home visits to cultivate a deeper understanding of patient and staff needs and challenges (Mukamel et al., 2007)
6. All members of the team to complete frailty training: student nurses and junior doctors who rotate through a service are especially important (Hopper, 2021; Palmer et al., 2018; BGS, 2015)
    - ICBs to ensure relevant staff are trained in frailty (Voluntary Community and Social Enterprise (VCSE), social care, home care, care home workers, community services, etc.)
7. Ensure there are opportunities for staff career progression and learning (Hopper, 2021)
8. Consider research and quality improvement projects aligned with individual interests
9. Build a flexible workforce that can move to and from different environments, while also encouraging a welcoming atmosphere for newcomers (BGS, 2015)

Outcome measurement/service evaluation recommendations:

Collecting data for people living with frailty is challenging and complex. System coding could be improved, and figures such as admission, conveyance, length of stay, readmission and more are impacted by a number of factors. Research has shown that patients seen by well established services, often have better outcomes. This may mean that it will take some time to see improvement in the data (Mukamel et al., 2007). Depending on local options for data collection, some ideas to help measure outcomes are:

1. Waiting time to be seen (BGS, 2015) – consider first visit within two weeks
2. Number of incoming referrals, referral source and number of discharges
3. Admission avoidance (BGS, 2015) – can the clinician confirm and code that the intervention prevented an admission?
4. Collect outcomes/actions that the assessment generated
    - Some examples might be: referrals, patient contacts, interventions, tools, assessments, etc
5. Collect process measures that the assessment generated

    - Some examples might be: medication reviews/changes, falls assessments, advance care planning (evidence supports these so we know they prevent adverse events)
6. Patient self-reported outcomes, quality of life and experience measures to evaluate services (BGS, 2015)
    - Self-Reported Quality of Life (e.g. EQ3D)
    - Patient Activation Measures
    - Patient and carer experience of health and social care services
    - Patient safety and avoidance of harms such as falls, pressure sores, adverse drug reactions, deterioration in mobility
    - Place of death being as preferred
    - Self-reported loneliness (e.g. de Jong-Gierveld loneliness scale)
    - Self-reported pain (e.g. geriatric pain measure short form)
    - Self-reported functional measures
7. Local health services data – bed days, outpatient visits, ambulance callouts, primary care consultations, patient safety (BGS, 2015)
8. Audits of the AUA DES (Avoiding Unplanned Admissions Direct Enhanced Service) modified to include frailty and unmet patient needs (BGS, 2015)
    - Waiting time to be seen for CGA after an index event or recognition of frailty
    - Delay in hospital awaiting an assessment, which could have been completed at home had an appropriate patient pathway been in place

When considering outcome measures and evaluation data, it is important to consider that many factors can influence this information. Data showing unplanned admissions and health and social care costs will take time to reflect a service or organisational change (BGS, 2015; Vestjens et al., 2019). Investment decisions should be committed to for the long term in order to see the real impact of these changes (Oliver, 2014). Evidence shows that these services are effective in improving outcomes for people living with frailty, time and patience is required before the impact will be seen in the figures.

Conclusion

All London boroughs should aim to have a service that can fulfil the minimum core standards recommended for proactive community frailty. The more detailed gold standards can provide a framework for quality improvement if resources allow. This will support people living with frailty and prevent avoidable admissions and adverse events, keeping more people happy and healthy at home for longer.

References

Adja, K.Y.C., Lenzi, J., Sezgin, D., O'Caoimh, R., Morini, M., Damiani, G., Buja, A. & Fantini, M.P. (2020). The importance of taking a patient-centered, community-based approach to preventing and managing frailty: a public health perspective. *Frontiers in public health*, 8, p.599170.

AgeUK London (2024). *Facts and Figures*. Available at: https://www.ageuk.org.uk/london/about-us/media-centre/facts-and-figures/#:~:text=There%20are%202.5%20million%20people,figures%20from%20the%202021%20Census [Accessed 07 May 2024]

Bai, G., Wang, Y., Mak, J. K., Ericsson, M., Hägg, S., & Jylhävä, J. (2023). Is Frailty Different in Younger Adults Compared to Old? Prevalence, Characteristics, and Risk Factors of Early-Life and Late-Life Frailty in Samples from Sweden and UK. *Gerontology*, *69*(12), 1385-1393.

Béland, F., & Hollander, M. J. (2011). Integrated models of care delivery for the frail elderly: international perspectives. *Gaceta Sanitaria*, 25, 138-146.

Beswick, A. D., Gooberman-Hill, R., Smith, A., Wylde, V., & Ebrahim, S. (2010). Maintaining independence in older people. *Reviews in Clinical Gerontology*, 20(2), 128-153.

Beswick, A. D., Rees, K., Dieppe, P., Ayis, S., Gooberman-Hill, R., Horwood, J., & Ebrahim, S. (2008). Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *The Lancet*, 371(9614), 725-735.

British Geriatrics Society. (2014). *Fit for Frailty*. Available at: https://www.bgs.org.uk/resources/resource-series/fit-for-frailty [Accessed 07 May 2024]

British Geriatrics Society (2014). *Fit for Frailty Part 1: Consensus best practice guidance for the care of older people living in community and outpatient settings*. Available at: https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-23/fff_full.pdf [Accessed 08 May 2024]

British Geriatrics Society. (2015). *Fit for Frailty Part 2: Developing, commissioning and managing services for pe \ople living with frailty in community settings*. Available at: https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-23/fff2_full.pdf [Accessed 08 May 2024]

British Geriatrics Society. (2023). *Joining the dots: A blueprint for preventing and managing frailty in older people.* Available at: https://www.bgs.org.uk/Blueprint [Accessed 07 May 2024]

Brown, F., Fry, G., Cawood, A., & Stratton, R. (2020). Economic impact of implementing malnutrition screening and nutritional management in older adults in general practice. *The Journal of nutrition, health and aging.* 24(3), 305-311.

Centre for Ageing Better (2023). *State of Ageing 2023*. Available at: https://ageing-better.org.uk/summary-state-ageing-2023-4 [Accessed 07 May 2024]

Cesari, M., Prince, M., Thiyagarajan, J.A., De Carvalho, I.A., Bernabei, R., Chan, P., Gutierrez-Robledo, L.M., Michel, J.P., Morley, J.E., Ong, P. & Manas, L.R. (2016). Frailty: an emerging public health priority. *Journal of the American Medical Directors Association*, 17(3), pp.188-192.

CGA Toolkit Plus (2015). *Comprehensive Geriatric Assessment*. Available at: https://www.cgakit.com/ [Accessed 10 May 2024]

Charlton, K., Sinclair, D. R., Hanratty, B., Burrow, E., & Stow, D. (2022). Measuring frailty and its association with key outcomes in the ambulance setting: a cross sectional observational study. *BMC geriatrics*, 22(1), 935.

Chen, X., Mao, G., & Leng, S. X. (2014). Frailty syndrome: an overview. *Clinical interventions in aging*, *9*, 433–441.

Church, S., Rogers, E., Rockwood, K., & Theou, O. (2020). A scoping review of the Clinical Frailty Scale. *BMC geriatrics*, 20(1), 393.

Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour research and therapy*, 47(11), 910-920.

Clegg, A., Young, J., Iliffe, S., Rikkert, M.O., & Rockwood, K. (2013). Frailty in elderly people. Lancet, 381 868:752-762.

Crocker, T.F., Ensor, J., Lam, N., Jordão, M., Bajpai, R., Bond, M., Forster, A., Riley, R.D., Andre, D., Brundle, C. & Ellwood, A. (2024). Community based complex interventions to sustain independence in older people: systematic review and network meta-analysis. *BMJ*, 384.

Department of Health & Social Care (2023). *Major conditions strategy: case for change and our strategic framework*. Available at: https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2 [Accessed 06 June 2024]

de Stampa, M., Vedel, I., Buyck, J. F., Lapointe, L., Bergman, H., Beland, F., & Ankri, J. (2014). Impact on hospital admissions of an integrated primary care model for very frail elderly patients. *Archives of gerontology and geriatrics*, 58(3), 350-355.

Di Pollina, L., Guessous, I., Petoud, V., Combescure, C., Buchs, B., Schaller, P., Kossovsky, M. & Gaspoz, J.M. (2017). Integrated care at home reduces unnecessary hospitalizations of community-dwelling frail older adults: a prospective controlled trial. *BMC geriatrics*, 17, pp.1-10.

Dowrick, C., Gask, L., Edwards, S., Aseem, S., Bower, P., Burroughs, H., Catlin, A., Chew-Graham, C., Clarke, P., Gabbay, M. & Gowers, S. (2009). Researching the mental health needs of hard-to-reach groups: managing multiple sources of evidence. *BMC Health Services Research*, 9, pp.1-12.

Escourrou, E., Cesari, M., Chicoulaa, B., Fougère, B., Vellas, B., Andrieu, S., & Oustric, S. (2017). How older persons perceive the loss of independence: the need of a holistic approach to frailty. J Frailty Aging, 6(2), 107-112.

Everaars, B., Jerković-Ćosić, K., Bleijenberg, N., De Wit, N. J., & Van Der Heijden, G. J. M. G. (2021). Exploring associations between oral health and frailty in community-dwelling older people. *The Journal of frailty & aging*, *10*, 56-62.

François, J. (2011). Tool to assess the quality of consultation and referral request letters in family medicine. *Canadian Family Physician*, 57(5), 574-575.

Frese, T., Deutsch, T., Keyser, M., & Sandholzer, H. (2012). In-home preventive comprehensive geriatric assessment (CGA) reduces mortality—a randomized controlled trial. *Archives of gerontology and geriatrics*, 55(3), 639-644.

Fried, L. P., Tangen, C. M., Walston, J., Newman, A. B., Hirsch, C., Gottdiener,J., Seeman, T., Tracy, R., Kop, W.J., Burke, G. & McBurnie, M.A. (2001). Frailty in older adults: evidence for a phenotype. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, 56(3), M146-M157.

Fuller C. (2022). Next steps for integrating primary care: Fuller stocktake report. *NHS England*. Available at: http://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/ [Accessed 10 May 2024].

Gill, T.M., Gahbauer, E.A., Allore, H.G. & Han L. (2006). Transitions between frailty states among community-living older persons. *Arch Intern Med*;166:418–23.

GIRFT – Getting it Right the First Time (2023). *Six Steps to Better Care for Older People in Acute Hospitals*. Available at: https://gettingitrightfirsttime.co.uk/wp-content/uploads/2023/07/GIRFT-BGS-Six-Steps-to-Better-Care-for-Older-People-FINAL-V2-July-2023.pdf [Accessed 10 May 2024]

Han, L., Clegg, A., Doran, T., & Fraser, L. (2019). The impact of frailty on healthcare resource use: a longitudinal analysis using the Clinical Practice Research Datalink in England. *Age and ageing*, 48(5), 665-671.

Hickson, M., Child, J., & Collinson, A. (2022). Impact of a dietitian in general practice: care of the frail and malnourished. *Journal of Human Nutrition and Dietetics*, *35*(1), 145-153.

Hopper, A. (2021). Geriatric Medicine GIRFT Programme National Specialty Report. *GIRFT*. Available at: https://gettingitrightfirsttime.co.uk/wp-content/uploads/2021/09/Geriatric-Medicine-Sept21h.pdf [Accessed 10 May 2024]

Huss, A., Stuck, A., Rubenstein, L. Z., Egger, M., & Clough-Gorr, K. M. (2008). Multidimensional preventive home visit programs for community-dwelling older adults: a systematic review and meta-analysis of randomized controlled trials. *Journals of gerontology. Series A-biological sciences and medical sciences*, 63(3), 298-307.

Inzitari, M., Pérez, L.M., Enfedaque, M.B., Soto, L., Díaz, F., Gual, N., Martín, E., Orfila, F., Mulero, P., Ruiz, R. & Cesari, M. (2018). Integrated primary and geriatric care for frail older adults in the community: implementation of a complex intervention into real life. *European journal of internal medicine*, 56, pp.57-63.

Kulmala, J., Nykänen, I., Mänty, M., & Hartikainen, S. (2013). Association between frailty and dementia: a population-based study. *Gerontology*, 60(1), 16-21.

Livingston, G., Huntley, J., Sommerlad, A., Ames, D., Ballard, C., Banerjee, S., & Mukadam, N (2020). Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. *The Lancet*. 396(10248), 413-446.

Marmot, M., Allen, J., Boyce, T., Goldblatt, P., & Morrison, J.. (2020). Health Equity in England: The Marmot Review 10 Years On. *Institute of Health Equity.* Available at: https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on [Accessed 10 May 2024]

Mitnitski, A. B., Mogilner, A. J., & Rockwood, K. (2001). Accumulation of deficits as a proxy measure of aging. *The Scientific World Journal*, 1, 323-336.

Montero-Odasso, M., Van Der Velde, N., Martin, F.C., Petrovic, M., Tan, M.P., Ryg, J., Aguilar-Navarro, S., Alexander, N.B., Becker, C., Blain, H. & Bourke, R. (2022). World guidelines for falls prevention and management for older adults: a global initiative. *Age and Ageing*, 51(9).

Mukamel, D. B., Peterson, D. R., Temkin-Greender, H., Delavan, R., Gross, D., Kunitz, S. J., & Williams, T. F. (2007). Program characteristics and enrollees' outcomes in the Program of All-inclusive Care for the Elderly (PACE). *The Milbank Quarterly*, 85(3), 499-531.

Murtagh, F.E., Okoeki, M., Ukoha-Kalu, B.O., Khamis, A., Clark, J., Boland, J.W., Pask, S., Nwulu, U., Elliott-Button, H., Folwell, A. & Harman, D. (2023). A non-randomised controlled study to assess the effectiveness of a new proactive multidisciplinary care intervention for older people living with frailty. *BMC geriatrics*, 23(1), p.6.

NHS (2019). *The NHS long term plan*. Available at: https://www.longtermplan.nhs.uk/ [Accessed 07 May 2024]

NHS England (2023). P*roactive care: providing care and support for people living at home with moderate or severe frailty*. Available at: https://www.england.nhs.uk/long-read/proactive-care-providing-care-and-support-for-people-living-at-home-with-moderate-or-severe-frailty/ [Accessed 07 May 2024]

NHS England (2018). *SNOMED codes and descriptions*. Available at: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2019%2F07%2Fqsr-sfl-2019-20-codes-list.xlsm&wdOrigin=BROWSELINK [Accessed 02 August 2024]

NHS Improving Quality (2016). *Planning for your future care: A guide*. Available at: https://goldstandardsframework.org.uk/cd-content/uploads/files/ACP/Planning-for-your-future-care_patient-leaflet.pdf [Accessed 13 June 2024]

NHS RightCare (2019). *Frailty Toolkit: Optimising a frailty system*. Available at: https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/07/frailty-toolkit-june-2019-v1.pdf [Accessed 10 May 2024]

National Institute for Health and Care Excellence (2015). *Older people with social care needs and multiple long-term conditions*. Available at: https://www.nice.org.uk/guidance/ng22/resources/older-people-with-social-care-needs-and-multiple-longterm-conditions-pdf-1837328537797 [Accessed 28 May 2024]

National Institute for Health and Care Excellence (2016). Multimorbidity: clinical assessment and management. *NICE Guidelines*. Available at: https://www.nice.org.uk/guidance/ng56/resources/multimorbidity-clinical-assessment-and-management-pdf-1837516654789 [Accessed 10 May 2024}

Office for National Statistics (2021). *Census 2021*. Available at: multimorhttps://www.ons.gov.uk/census [Accessed 07 May 2024]

Office for National Statistics (ONS) (2022). *Health state life expectancies by national deprivation deciles, England: 2018 to 2020*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2018to2020 [Accessed 11 June 2024]

Office of the Public Guardian (2020). *Mental Capacity Act Code of Practice*. Available at: https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice [Accessed 14 June 2024]

Oliver, D. (2014). Preventing hospital admission: we need evidence based policy rather than “policy based evidence”. *BMJ*, 349.

Palmer, K., Marengoni, A., Forjaz, M.J., Jureviciene, E., Laatikainen, T., Mammarella, F., Muth, C., Navickas, R., Prados-Torres, A., Rijken, M.; et al. (2018). Multimorbidity care model: Recommendations from the consensus meeting of the Joint Action on Chronic

Diseases and Promoting Healthy Ageing across the Life Cycle (JA-CHRODIS). *Health Policy*, 122(1), 4-11.

Parker, S.G., McCue, P., Phelps, K., McCleod, A., Arora, S., Nockels, K., Kennedy, S., Roberts, H. & Conroy, S. (2018). What is comprehensive geriatric assessment (CGA)? An umbrella review. *Age and ageing*, 47(1), pp.149-155.

Petermann-Rocha, F., Lyall, D.M., Gray, S.R., Esteban-Cornejo, I., Quinn, T.J., Ho, F.K., Pell, J.P. & Celis-Morales, C. (2020). Associations between physical frailty and dementia incidence: a prospective study from UK Biobank. *The Lancet Healthy Longevity*, 1(2), e58-e68.

Rockwood, K. & Theou, O. (2020). Using the Clinical Frailty Scale in Allocating Scarce Health Care Resources. *Canadian Geriatrics Journal*, 23(3), 254-259.

Sinclair, D. R., Maharani, A., Chandola, T., Bower, P., Hanratty, B., Nazroo, J., O'Neill, T.W., Tampubolon, G., Todd, C., Wittenberg, R. & Matthews, F.E. (2022). Frailty among older adults and its distribution in England. *The Journal of Frailty & Aging*, 1-6.

Soong, J., Poots, A. J., Scott, S., Donald, K., Woodcock, T., Lovett, D., & Bell, D. (2015). Quantifying the prevalence of frailty in English hospitals. *BMJ open*, 5(10), e008456.

Steel, N., Bachmann, M., Maisey, S., Shekelle, P., Breeze, E., Marmot, M., & Melzer, D. (2008). Self reported receipt of care consistent with 32 quality indicators: national population survey of adults aged 50 or more in England. *Bmj*, 337.

Stuck, A.E. & Iliffe, S. (2011). Comprehensive geriatric assessment for older adults. *BMJ*. Oct 27;343:d6799.

Subramaniam, A., Ueno, R., Tiruvoipati, R., Srikanth, V., Bailey, M., & Pilcher, D. (2022). Comparison of the predictive ability of clinical frailty scale and hospital frailty risk score to determine long-term survival in critically ill patients: a multicentre retrospective cohort study. *Critical care* (London, England), 26(1), 121.

Thompson, J., Cook, G., Masterman, C., Parkinson, M., & Bainbridge, L. (2022). Rapid evidence review to understand effective frailty care pathways and their components in primary and community care. *International Journal of Health Governance*, 27(1), 54-75.

Thompson, M. Q., Theou, O., Adams, R. J., Tucker, G. R., & Visvanathan, R. (2018). Frailty state transitions and associated factors in South Australian older adults. Geriatrics & gerontology international, 18(11), 1549-1555.

Threapleton, D.E., Chung, R.Y., Wong, S.Y., Wong, E., Chau, P., Woo, J., Chung, V.C. & Yeoh, E.K. (2017). Integrated care for older populations and its implementation facilitators and barriers: A rapid scoping review. *International Journal for Quality in Health Care*, 29(3), pp.327-334.

Turner, G., & Clegg, A. (2014). Best practice guidelines for the management of frailty: a British Geriatrics Society, Age UK and Royal College of General Practitioners report. *Age and ageing*, 43(6), 744-747.

Vestjens, L., Cramm, J. M., Birnie, E., & Nieboer, A. P. (2019). Cost-effectiveness of a proactive, integrated primary care approach for community-dwelling frail older persons. *Cost Effectiveness and Resource Allocation*, 17, 1-15.

Vetrano, D.L., Palmer, K., Marengoni, A., Marzetti, E., Lattanzio, F., Roller-Wirnsberger, R., Lopez Samaniego, L., Rodríguez-Mañas, L., Bernabei, R., Onder, G. & Joint Action ADVANTAGE WP4 Group (2019). Frailty and multimorbidity: a systematic review and meta-analysis. The *Journals of Gerontology: Series A.* 74(5), 659-666.

Walsh, B., Fogg, C., Harris, S., Roderick, P., de Lusignan, S., England, T., Clegg, A., Brailsford, S. & Fraser, S.D. (2023). Frailty transitions and prevalence in an ageing population: longitudinal analysis of primary care data from an open cohort of adults aged 50 and over in England, 2006–2017. *Age and Ageing*, 52(5), p.afa058.

Whitty, C.J.M. (2023). *Chief medical officer's annual report 2023: Health in an ageing society*. Available at: https://assets.publishing.service.gov.uk/media/65562ff2d03a8d000d07faa6/chief-medical-officers-annual-report-2023-web-accessible.pdf [Accessed 11 June 2024]

Wolff, A., Houmøller, S.S., Tsai, L.T., Hougaard, D.D., Gaihede, M., Hammershøi, D. & Schmidt, J.H. (2023). The effect of hearing aid treatment on health-related quality of life in older adults with hearing loss. *International Journal of Audiology*, pp.1-10.

World Health Organisation (2021). *WHO Integrated Care for Older People (ICOPE) Implementation Framework: Guidance for Systems and Services*. Available at: www.who.int/ageing/publications/icope-framework/en/ [Accessed 06 January 2021].

Xue, Q. L. (2011). The frailty syndrome: definition and natural history. *Clinics in geriatric medicine*, 27(1), 1-15.