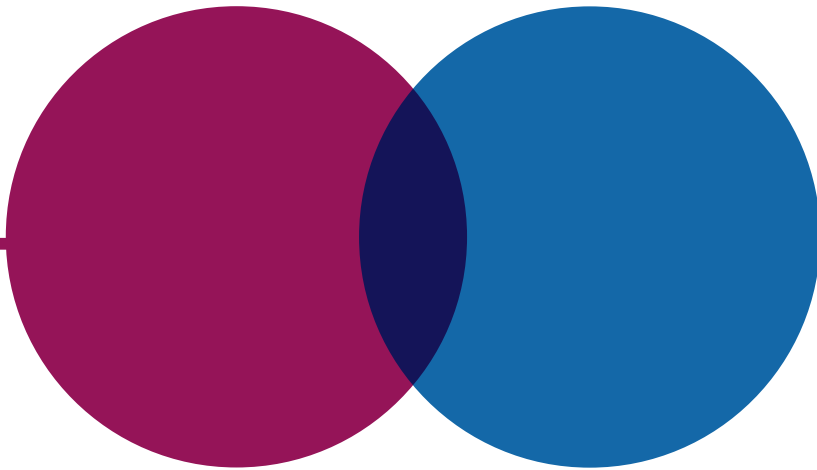




National Audit Office



REPORT

# Primary and community healthcare support for people living with frailty

Department of Health & Social Care  
and NHS England

---

SESSION 2024–2026  
5 DECEMBER 2025  
HC 1518

## Key facts

---

**1.51mn**

total number of people who GPs diagnosed as living with moderate or severe frailty as at March 2025

---

---

**£5.8bn**

estimated costs per year of frailty to the UK healthcare system (2019)

---

---

**Nearly  
6 times**

likelihood that people living with severe frailty will be admitted to hospital compared with those who are not living with frailty

---

- 1.9 million** number of patients who GPs assessed for frailty in 2024-25, 17% of all registered patients aged 65 or over
- 32** of 106 NHS local areas assessed less than 10% of registered patients aged 65 or over, in 2024-25
- 226,000** number of people who were diagnosed with severe frailty in 2024-25 (12% of those assessed for frailty in that year)
- 18%** of patients diagnosed with severe frailty in 2024-25 who had a falls risk assessment (against a requirement of 100%)
- 16%** of patients diagnosed with severe frailty in 2024-25 who had a medication review (against a requirement of 100%)
- 44%** residents of care homes who had a personalised care and support plan agreed or reviewed in 2024-25, down from 76% in 2022-23
- 100%** NHS local areas that met the standard that 70% of referrals to Urgent Community Response (which provide urgent care in people's homes) are responded to within two hours in 2024-25

## Summary

**1** Medical professionals use ‘frailty’ to identify the group of older people who have the highest risk of adverse outcomes such as disability, falls, hospital admission and the need for long-term care. The Chief Medical Officer considers that early identification of frailty can slow its progression and delay loss of independence. In addition to the negative impact on people’s health, frailty also results in costs to the healthcare system. In 2019, researchers estimated that frailty cost the UK healthcare system around £5.8 billion per year. There is a long-standing cross-party policy commitment to increase the number of years people can expect to live in ‘full health’ (known as healthy life expectancy) and to reduce inequalities.

**2** As at March 2025, GPs had diagnosed, in total, approximately 1.06 million people as living with moderate frailty and a further 450,000 as living with severe frailty. There is a strong link between ageing and frailty, and the prevalence of frailty will very likely increase as the population ages. The Office for National Statistics’ population forecasts show that by 2045 there will be 73% more people in England aged 85 and over than in 2025.

**3** The Department of Health & Social Care (DHSC) is responsible for setting and overseeing policy on improving health, including delaying and managing the onset of frailty and supporting people to age well. DHSC is also responsible for preventing poor health and tackling health disparities. Through the national General Medical Services contract, NHS England (NHSE) and DHSC set out the requirements for GP practices. The contract includes requirements for frailty identification and management, and GPs play a key role in diagnosing and supporting people with frailty. NHSE also publishes guidance to the NHS.

**4** At local level, Integrated Care Boards (ICBs) commission primary care services (including GPs) and oversee local delivery, performance and management of the contract. Local primary care networks sit below ICBs and are formed of general practices and other health and care organisations working together to provide integrated services to improve the health and wellbeing of their local population, including frailty interventions. NHS-funded community health services also support people living with frailty in the community. In March 2025, the government announced it would abolish NHS England and change the responsibilities of ICBs, so some commissioning arrangements described in this report may change.

**5** This report examines the effectiveness of the government's approach to identifying and managing frailty in non-hospital based services in England. We have therefore focused on how GPs<sup>1</sup> and NHS-funded community health services identify and support people living with or at risk of frailty before they reach the point of medical crisis or hospital admission.

**6** This report sets out:

- the growing problem of frailty (Part One);
- the government's approach to frailty (Part Two);
- supporting people living with frailty (Part Three); and
- frailty and the new neighbourhood health service (Part Four).

## **Key findings**

The growing problem of frailty

**7 Frailty is a clinically recognised medical syndrome related to the ageing process, in which multiple body systems gradually lose their in-built reserves.**

People living with frailty typically walk slowly, get exhausted easily and struggle to get out of a chair or climb stairs, and are therefore likely to be housebound, or only able to leave their home with help. Frailty typically takes five to ten years to develop and there is often a slow decline of function. Older people with mild, moderate or severe frailty often come to the attention of healthcare professionals when in crisis (for example, going to A&E after a fall). The NHS recognises that, like most other long-term conditions, frailty can be effectively managed within primary care and other community-based services. Our analysis using GP contract data indicates that as at March 2025, in total, approximately 1.06 million people had been diagnosed as living with moderate frailty and a further 450,000 as living with severe frailty. This is likely to be an under-estimate, as not all people aged 65 or over have been assessed for frailty. The prevalence of frailty will very likely increase as the population ages (paragraphs 1.2, 1.3, 1.4 and 1.7 and Figure 3).

**8 There are sex and socio-economic variations in the incidence of frailty.**

Frailty is more common in women than in men. Those from lower socio-economic groups are more likely to develop frailty and more likely to become frail earlier in life. The data indicate that women aged 65 to 69 from the most deprived 20% of the population were almost four times more likely to be living with frailty compared to the least deprived 20% of the population. The Chief Medical Officer has also expressed concern about the increasing geographical concentration of older people in England, in rural, semi-rural and coastal areas. This pattern is very likely replicated in people living with frailty (paragraphs 1.5 and 1.6, and Figures 1 and 2).

<sup>1</sup> We use the term 'GPs' throughout the report as they are the contracting party, but their work may also be conducted within a wider general practice team.

**9 In addition to the harmful impact on people's health, frailty also results in costs to the healthcare system.** In 2019, researchers estimated that frailty cost the UK healthcare system around £5.8 billion per year. When people with frailty need an emergency admission to hospital, the cost of treating them is far higher than for people who do not live with frailty. Research indicates that people with severe frailty are nearly six times more likely to be admitted to hospital and have average hospital costs that are nearly nine times greater than those who are not living with frailty (paragraph 1.10).

The government's approach to frailty

**10 DHSC and NHSE do not yet have a single clear joined-up strategy for dealing with frailty, despite its increasing prevalence.** The NHS 2019 Long Term Plan identified several priorities to support people to age well, which included some frailty-specific measures. However, it did not include a strategic aim to support people with frailty. There are local services that aim to support people with frailty, including frailty assessments, healthcare to people in care homes (through the Enhanced Health in Care Homes programme (the programme)), the new model of care called 'neighbourhood health', and services to provide care in people's homes and avoid admitting them to hospital (such as urgent community response and virtual wards). Local areas deliver and prioritise these various initiatives differently. As a result, there is no consistent national frailty service. In May 2024, NHSE set up a Frailty Project Board to direct the development of a cross-organisational frailty strategy, but progress has been slow. For example, in August 2025, the NHSE Board selected seven sites to pilot a system-wide approach to frailty, a year later than intended. NHSE told us that progress was delayed by external factors such as the change of government and subsequent policy changes. The 2025 10 Year Health Plan (July 2025) set out the intention to develop several new service frameworks, with early priority given to frailty, but there is no timetable for the framework's development although DHSC expects it to be published some time in 2026-27 (paragraphs 2.6 to 2.11, and Figure 7).

**11 There is limited national level data on the outcomes of frailty-related services.** NHSE's performance measurements focus on the impact on and burden of illness on acute services and not on the impact on a person's quality of life, for example by measuring changes in healthy life expectancy. National data on virtual wards and urgent community response services have quality-assured national data but these data do not identify the benefits these services provide to people living with frailty. GP contract data show the numbers of people that GPs assess for frailty and some of the follow-up services that they receive. However, NHSE neither validates nor quality assures these data. NHSE mainly uses these data to support contractual payments and for management information, but not as a formal tool for assessing individual GP performance nor to identify national trends or local variations in performance (paragraphs 2.13 to 2.16).

## Supporting people with frailty

The role of GPs

**12 The proportion of patients aged 65 or over that GPs assess for frailty has increased since the COVID pandemic, to 17% in 2024-25, but is well below 26% in 2017-18, the year the requirement was introduced.** Since 2017-18, the GP contract requires GPs to identify any registered patient aged 65 years or over who is living with moderate or severe frailty. NHSE has not set any standards or expectations for the numbers of people to be assessed. In 2024-25, GPs assessed 1.9 million people aged 65 or over for frailty. The proportion of registered patients aged 65 or over that GPs assessed for frailty peaked at 26% in its first year of 2017-18. It reduced to a low of 12% in 2020-21 during the COVID pandemic and was 17% in 2024-25. As the data suggest that GPs are not assessing everyone aged 65 or over, neither NHSE nor DHSC know accurately how many people with frailty may need support (paragraphs 3.2 and 3.4, and Figure 8).

**13 GPs are not providing the required support and follow-up for people diagnosed as living with severe frailty.** Once a patient has been diagnosed with severe frailty, the GP contract requires GPs to undertake a clinical review, which includes an annual medication review, a discussion on whether the patient has fallen in the past year and a discussion on the benefits of an enriched summary care record (which provides information additional to a standard summary care record, such as significant medical history). GPs are failing to provide the required levels of follow-up support. In 2024-25, 226,000 patients were diagnosed with severe frailty.<sup>2</sup> Of those, only:

- 16% (37,000) had a medication review;
- 18% (41,000) had a falls risk assessment; and
- 29% (66,000) had given consent for an enriched summary care record.

GPs are contractually required to identify and manage frailty in patients aged 65 or over as part of the core contract, paid as part of their routine work (known as the global sum), and are therefore not separately incentivised for this work. NHSE has not set any performance targets for the provision of this support, and it does not use the data available to monitor compliance (paragraphs 3.7 and 3.8, and Figure 10).

<sup>2</sup> NHSE guidance requires general practice teams to record relevant activity using the appropriate 'SNOMED' codes. As a result, the data do not capture activity that is not recorded using the correct code.

**14 There is significant and unexplained local variation across and within ICBs in the proportion of people being assessed for frailty and the support that they receive.** In 2024-25, 32 of 106 NHS local areas<sup>3</sup> assessed less than 10% of their registered patients aged 65 or over and nine areas assessed over 90%. There is also wide local variation in the support provided to people diagnosed with severe frailty. The National Institute for Health and Care Excellence's (NICE's) guidelines specify that any patient living with frailty who has fallen in the past year should be offered a comprehensive falls risk assessment and comprehensive falls management. The data that are available do not enable us to track whether individuals diagnosed with severe frailty and who have had a fall, have also received a falls risk assessment and management, as per the guidelines. However, it is clear that some local areas are not following NICE guidelines, as the number of people who have had a falls risk assessment is less than the number of people who have had a fall. In 2024-25, 30% of local NHS areas followed NICE guidelines. However, 70% of local NHS areas did not follow NICE guidelines. NHSE does not understand what is causing the local variation in both assessment and support (paragraphs 3.6 and 3.9, and Figures 9 and 11).

**15 Support that GPs provide under the Enhanced Health in Care Homes programme (the programme) is deteriorating in some important aspects of care.** The programme was set up to ensure stronger links between primary care networks and their local care homes, to provide people in care homes with the same support they would get at home. However, the support that GPs and primary care networks provide is falling short of some requirements. For example, the percentage of residents who had a personalised care and support plan agreed or reviewed has fallen sharply, from 76% in 2022-23 to 44% in 2024-25. There is also significant local variation. NHSE does not have central oversight of the programme and does not know whether the programme is achieving its aims. It has no plans to evaluate the programme at national level (paragraphs 3.10 to 3.13, and Figures 12 and 13).

3 These local areas are known as Sub-ICBs which are areas which pre-2022 covered Clinical Commissioning Groups.

## The role of community health services

**16 Community health services are important to supporting people living with frailty, but NHSE has given them a lower priority than acute care.** Community health services cover a broad range of services delivered in the community to support people from birth to death. They tend to be delivered in people's homes but are also delivered in care homes, community hospitals, clinics and schools. Services that are relevant to frailty are wide-ranging and include urgent community response, district nursing, and fall prevention services. There has been a marked decline in the numbers of district nurses, who play an important role in delivering community health services for older people. In March 2025, half of all unique 'care contacts' (a person's interactions or appointments with healthcare services) for people aged 65 or over in the community were with district nursing services. Between 2009 and 2024 the number of full-time equivalent staff recorded in NHS district nurse roles fell by 43%. NHSE and external stakeholders recognise that funding and targets have led to prioritising acute services over community health services. Several of the areas we visited also noted this bias and the existence of structural barriers to moving priorities from acute to community services, such as funding streams and resource allocation (paragraphs 3.14, 3.15 and 3.19).

**17 Urgent community response services are meeting targets.** The aim of urgent community response teams is to provide urgent care to people in their homes, which helps to avoid hospital admissions and enables people to live independently for longer. In 2024-25, between 70% and 98% of all people referred to and accepted into the service were seen within two hours of referral, equalling or exceeding the threshold of 70%. All ICBs met or exceeded the threshold. An NHSE-commissioned national evaluation of urgent community response services found staff and patients were positive about the services, but was inconclusive on the impact they had had on A&E attendances or emergency admissions (paragraphs 3.21 to 3.23).

**18 ICBs are not meeting the target to use 80% of virtual ward capacity.** A virtual ward is an acute clinical service with staff, equipment, technologies, medication and skills usually provided in hospitals delivered to selected people in their usual place of residence, including care homes. It is a substitute for acute inpatient hospital care. Virtual ward models vary - some use remote technology to monitor a patient's condition along with in-person visits, while others follow a more traditional form of care with regular in-person visits. NHSE measures their use by looking at the proportion of patients cared for in virtual wards against the available virtual ward capacity. It requires ICBs to ensure usage of virtual wards is consistently above 80%, but rates from April 2024 to March 2025 averaged 74%. Several of the areas we visited had mixed views on virtual wards. Some areas noted that virtual wards helped to reduce pressure on hospital beds and that patients liked the service. However, some areas were concerned that older patients may be discouraged by the technology in virtual wards (paragraphs 3.24 to 3.26).

## Frailty and neighbourhood health

### **19 The 2025 10 Year Health Plan set out the government's commitment to a neighbourhood health service but lacked detail on, and funding for, implementation.**

The 2025 10 Year Health Plan set out several initiatives specifically for frailty, including developing a modern service framework for frailty and dementia in 2026-27; and deepening the involvement of social care professionals in rehabilitation, recovery and frailty prevention. However, the Plan did not contain any detail on implementation or funding to help ICBs move to a neighbourhood health service. More recent planning guidance from NHSE mentions frailty as a priority for neighbourhood health services and asks for growth in community health services (paragraphs 4.6 and 4.7).

## **Conclusion**

**20** Early diagnosis of frailty, along with the right support, can slow its progression and delay loss of independence, enabling older people to live longer and healthier lives. Despite DHSC's and NHSE's recognition of the importance of earlier identification and care, there are clear failings in how GPs assess and support people living with frailty, with worrying unexplained variation in practice across England. The absence of a joined-up strategy for addressing frailty is compounded by NHSE's lack of action on unexplained variation and obscured by limited and unchecked data. While NHSE and DHSC have put in place some positive initiatives that aim to help people living with frailty, these are fragmented and lack holistic evaluation to demonstrate their combined impact.

**21** The scale and impact of our ageing population will only grow in the future. Without effective support and earlier interventions in the community, the NHS risks encountering people living with frailty only when it is too late and independence cannot be recovered. The NHS needs a greater focus on slowing frailty and maintaining independence for the sake of individuals as well as measuring the impact on hospitals. With the 10 Year Health Plan and the shift to prevention, we can now see the possibility of fundamental change in how healthcare is delivered, with neighbourhood health services and an increasing focus on bringing together the different elements of healthcare. However, if this shift is to gain traction and bring about real improvements, NHSE and DHSC need also to introduce structural changes, including accountability and performance management responsibilities, clear service standards, meaningful budgets and financial incentives and better use of technology.

## Recommendations

**22** These recommendations will apply to DHSC or NHSE as set out in each recommendation. We expect these recommendations to transfer to the new organisational structure that will result from the abolition of NHSE.

- a** GPs are not providing the level of support that people living with frailty need. To improve this, NHSE should set clear and consistent requirements for GPs to assess and support people living with frailty, including the proportion and frequency of assessments and the minimum acceptable care to be provided.
- b** NHSE needs to put in place systematic follow-up for unexplained variations in performance against requirements it has set in the GP contract.
- c** NHSE should set out a timetable for its work to standardise community health services and details on how community health services will align with and support the move to neighbourhood health services.
- d** NHSE should assess the added value of collating and quality assuring consistent data from general practices on the numbers of frailty assessments conducted and the support provided as a result.
- e** NHSE needs to establish a direct measure of how well the NHS maintains the independence of the population rather than relying on measures that focus on the perceived burden on the NHS and on hospitals, in particular.
- f** There are many piecemeal initiatives for frailty but no real understanding of the impact they make on people's health. DHSC should commission a systematic evaluation to demonstrate whether its patchwork of frailty initiatives is working together to provide an effective and holistic approach to supporting people living with frailty. This should include urgent community response, the Enhanced Health in Care Homes programme, virtual wards, community health services and neighbourhood health.
- g** To help bring about integration, DHSC and NHSE should create more effective mechanisms to enable service level funding to flow from acute care to community health services.