National Audit Office

REPORT

Primary and community healthcare support for people living with frailty

Department of Health & Social Care and NHS England

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HC 1518

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Primary and community healthcare support for people living with frailty

Department of Health & Social Care and NHS England

Report by the Comptroller and Auditor General

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Gareth Davies
Comptroller and Auditor General
National Audit Office

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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[1] 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).

1 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.[2] 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).

2 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[3] 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.

Part One

The growing problem of frailty

1.1 This section of the report looks at what frailty is and how many people in England are affected. It sets out how frailty is affected by factors such as sex and socio-economic variations. It also examines the cost of frailty to the healthcare system.

What frailty is

1.2 Frailty is a clinically recognised medical syndrome related to the ageing process, in which multiple body systems gradually lose their in-built reserves. The Chief Medical Officer states that 'frailty' is used clinically to define the group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital or the need for long-term care. 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.

1.3 Frailty typically takes five to ten years to develop and there is often a slow decline of function. In England, clinicians often diagnose a person's level of frailty using a nine-point scale from 'very fit' to 'terminally ill', which includes the definitions of mild, moderate and severe frailty. Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework. People living with moderate frailty need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal help with dressing. People living with severe frailty tend to be completely dependent for personal care, but they seem stable and not at high risk of dying within six months. People living with very severe frailty will be approaching the end of life and often will not recover even from a mild illness. Older people with moderate or severe frailty often only come to the attention of healthcare professionals when in crisis; for example, they may go 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.

The extent of frailty

1.4 In 2025, there were approximately 11.2 million people aged 65 or older in England, although they will not all be living with frailty. There are several estimates of the number of people with frailty, which use different methods to assess frailty. There is also a national data set, the NHS England (NHSE) Core Contract GP data, which reports the numbers of people that GPs have diagnosed as living with frailty. However, this data set is limited, as it does not give any information on age, sex or socio-economic factors such as ethnicity or deprivation. Our analysis of the NHSE Core Contract GP data indicates that as at March 2025, approximately 1.06 million people aged 65 or over had been diagnosed as living with moderate frailty and 450,000 had been diagnosed as living with severe frailty.[4,5] This is likely to be an under-estimate as not all people aged 65 or over have been assessed for frailty.

1.5 There are sex and socio-economic variations in the incidence of frailty. Frailty is more common in women than in men (see **Figure 1**). Those from lower socio-economic groups are more likely to develop frailty and more likely to become frail earlier in life. Estimates from 2016-17 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 (see **Figure 2** on pages 16 and 17).

1.6 In his 2023 annual report, the Chief Medical Officer expressed concern about the increasing geographical concentration of older people in England, particularly in rural, semi-rural and coastal areas, stating, "if we choose, ostrich-like, to ignore the growing concentration of older adults and their inevitable healthcare needs in these geographical areas, we are not undertaking proper responsible planning and will have a far harder landing as the population in those areas inexorably age." This pattern is very likely replicated in people living with frailty.

1.7 The prevalence of frailty is very likely to increase as the population ages. Research based on data from 2006 to 2017 indicated that around half of people aged 85 or over were living with either severe or moderate frailty. The Office for National Statistics' population forecast, based on 2022 population estimates, showed that by 2045 there will be 73% more people in England aged 85 or over than in 2025 (**Figure 3** on page 18).

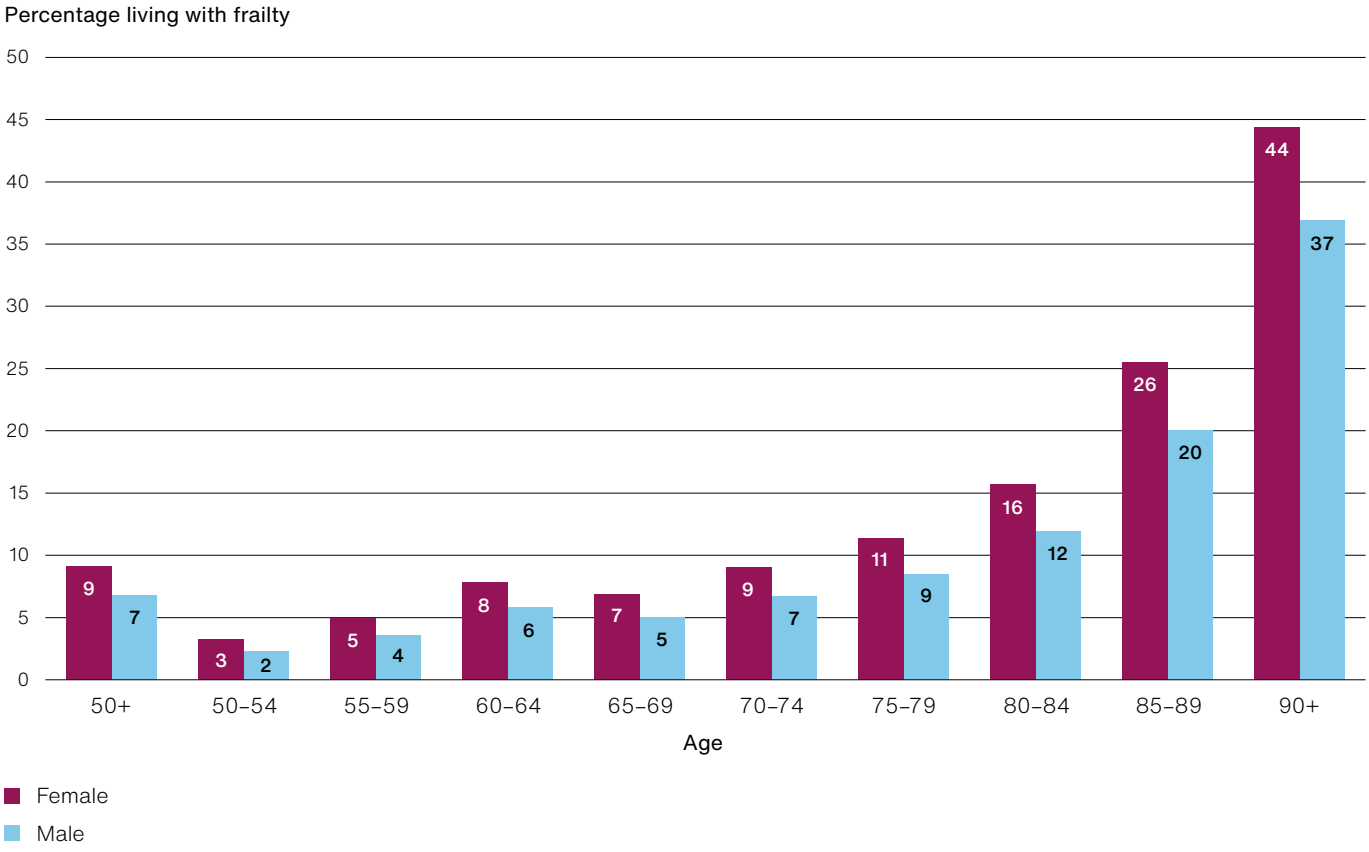
4 This is the cumulative total of all registered patients aged 65 or over whose latest frailty diagnosis between 1 April 2017 (when the frailty requirements were brought into the GP contract) and 31 March 2025 was either moderately or severely frail.

5 In the GP contract data, 'severe frailty' includes both people living with severe frailty and those living with very severe frailty.

Figure 1

Estimated percentage of people aged 50 or over living with frailty, by age and sex, England, 2017

Frailty is more prevalent amongst women and older people



Notes

1 Estimates are from the English Longitudinal Study of Ageing (ELSA), a representative sample of 18,000 adults aged 50 or older in England. These estimates are based upon wave 8 of the ELSA conducted in 2017.

2 The ELSA is conducted by an institutional collaboration including University College London, the Institute for Fiscal Studies, Manchester University, the National Centre for Social Research and the University of East Anglia and is funded by the National Institute on Ageing, the Department for Transport, the Department for Work & Pensions, the Economic and Social Research Council and the National Institute for Health and Care Research.

3 Frailty is assessed through the construction of a frailty index employing the variables in the ELSA. In a frailty index, the presence or absence of conditions (such as dementia), symptoms (such as hearing loss) and signs (such as tremors) are used to construct an index between zero and one to indicate whether an individual is likely to be living with frailty. Individuals with a frailty index score of greater than 0.36 were classified as living with frailty. Frailty indices have been shown to be associated with mortality, hospitalisations and nursing home admissions.

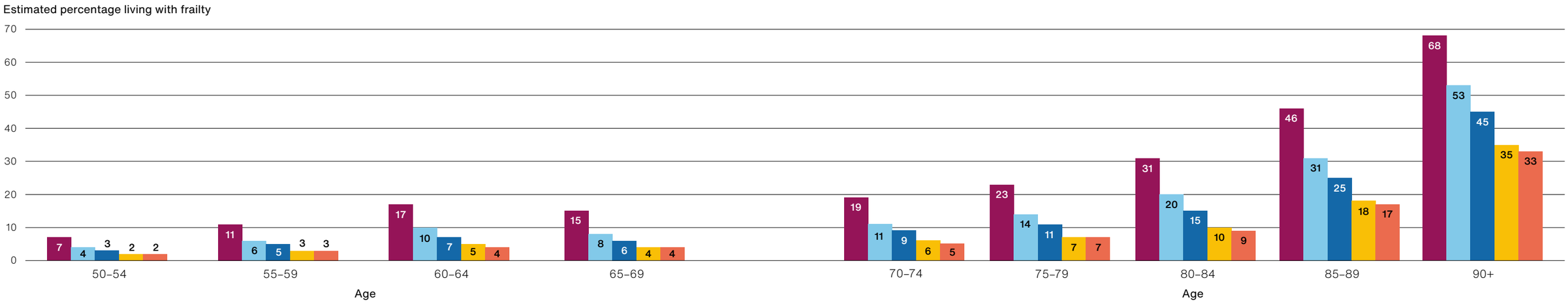
4 50+ refers to the average estimated percentage frail for all men and all women aged 50 or over.

Source: National Audit Office analysis of D Sinclair et al., 'Frailty among older adults and its distribution in England', The Journal of Frailty and Ageing, Volume 11, Issue 2, April 2022, pages 163–168

Figure 2

Estimated percentage of women aged 50 or over living with frailty, by age and deprivation, England, 2017

Frailty is more prevalent in women who live in more deprived areas



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4 Quintile refers to one fifth (20%) of the population.

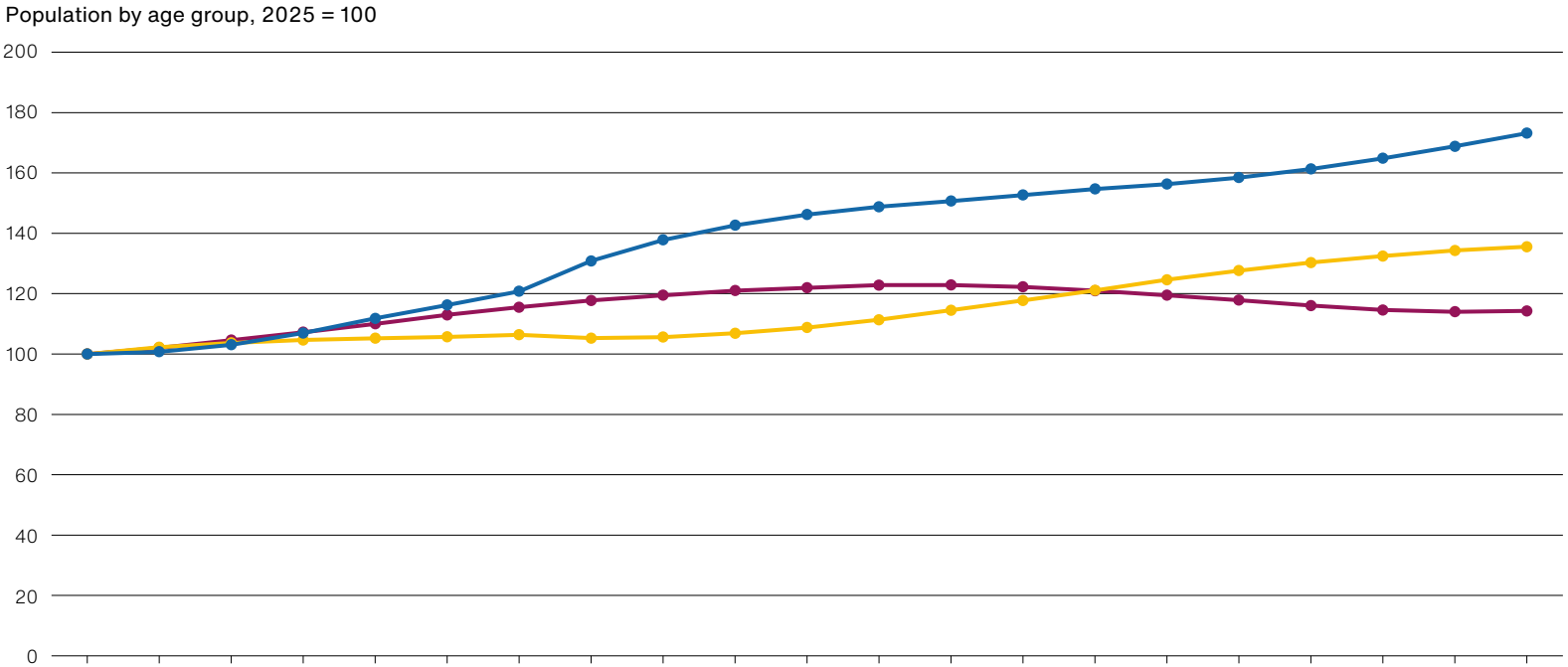
5 Deprivation data are from the Index of Multiple Deprivation (IMD). The IMD is conducted by the Ministry of Housing, Communities & Local Government and is the official measure of relative deprivation for small areas in England. It is based on seven different domains of deprivation: income, employment, education, health, crime, housing and environment.

Source: National Audit Office analysis of D Sinclair et al., 'Frailty among older adults and its distribution in England', The Journal of Frailty and Ageing, Volume 11, Issue 2, April 2022, pages 163–168

Figure 3

Population projections for people aged 65 or over in England, 2025 to 2045

It is projected that in 20 years there will be 73% more people aged 85 or over in England



	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045
65–74	100	102	105	107	110	113	116	118	119	121	122	123	123	122	121	119	118	116	115	114	114
75–84	100	102	104	105	105	106	106	105	106	107	109	111	114	118	121	125	128	130	132	134	136
85+	100	101	103	107	112	116	121	131	138	143	146	149	151	153	155	156	158	161	165	169	173

Note

1 The Office for National Statistics' population projections are based upon combining the latest mid-year population estimate with long run assumptions about life expectancy, fertility and migration, and are typically published every two years. The projections reported here were published in 2025 and are based upon mid-2022 population estimates.

Source: National Audit Office analysis of the Office for National Statistics data

1.8 Frailty can be slowed with the right prevention, care and support, and the British Geriatrics Society noted that frailty is not an inevitable part of ageing. The National Institute for Health and Care Research pointed to emerging evidence that suggested that the onset and severity of frailty could be delayed by preventative action including diet and physical activity. The Chief Medical Officer highlighted the importance of early identification, which could slow the progression of frailty and delay the loss of independence.

The impact of frailty

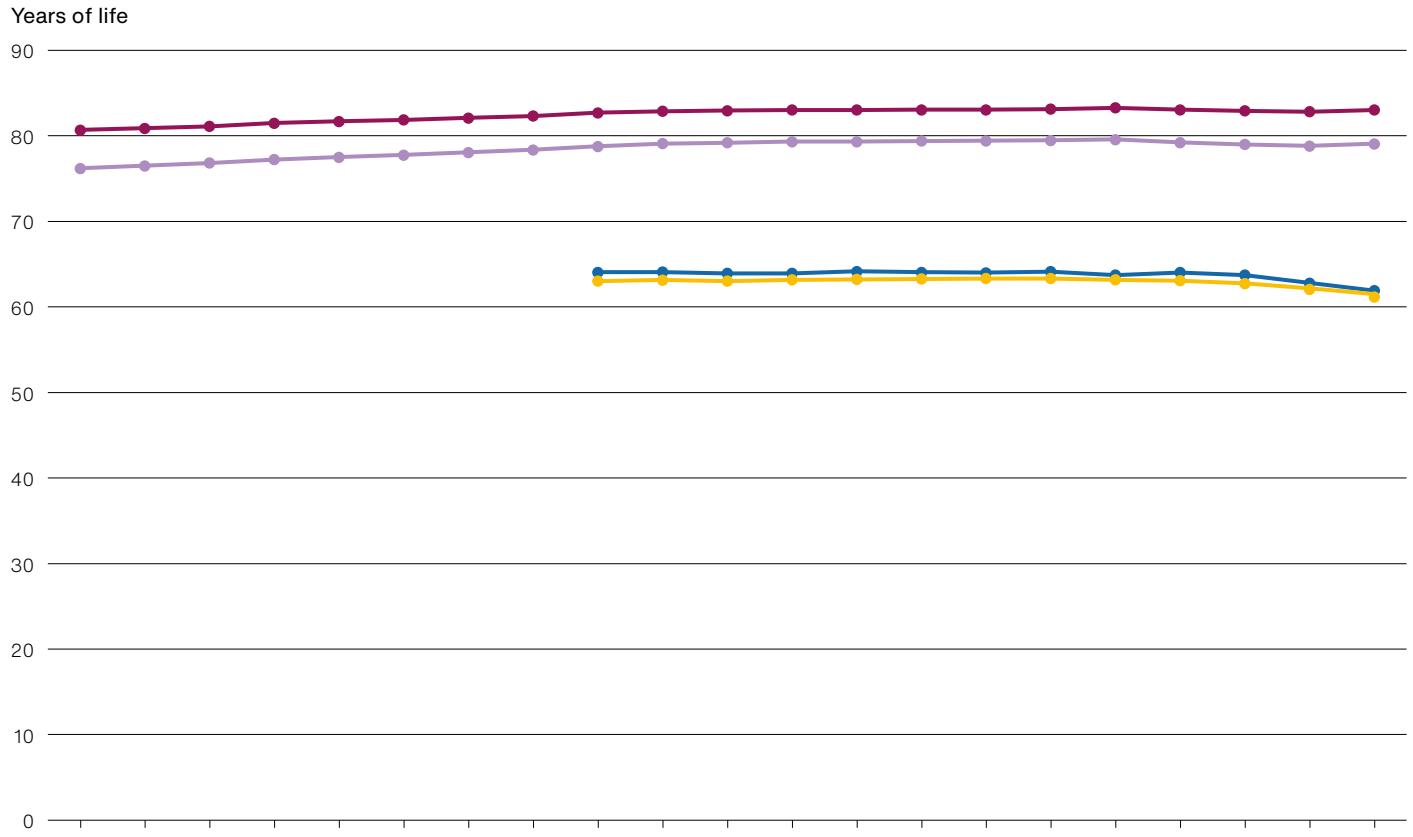
1.9 Frailty has a negative impact on people's health and therefore on the number of years people can expect to live in 'full health' (known as healthy life expectancy). However, it is difficult to quantify this impact as decreasing healthy life expectancy is also affected by lifestyle choices such as smoking and diet, wider social determinants of health and public health provision. The Office for National Statistics has reported that average healthy life expectancy has been decreasing and that people in more deprived areas will have lower healthy life expectancy than those in less deprived areas (see **Figure 4** on pages 20 and 21 and **Figure 5** on page 21).

1.10 As well as 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 (using data from 2003-04 to 2013-14). When people living 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. Analysis using data from 2006-17 found 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. The research also found that even people with mild frailty are twice as likely to be admitted to hospital than those who are not living with frailty, and their average hospital costs are nearly three times greater.

Figure 4

Average life expectancy and healthy life expectancy by sex in England, 2001 to 2023

Life expectancy has increased since 2001, but healthy life expectancy has been broadly flat since 2009 and has declined slightly since the COVID-19 pandemic in 2020



	2001 to 2003	2002 to 2004	2003 to 2005	2004 to 2006	2005 to 2007	2006 to 2008	2007 to 2009	2008 to 2010	2009 to 2011	2010 to 2012	2011 to 2013	2012 to 2014	2013 to 2015	2014 to 2016	2015 to 2017	2016 to 2018	2017 to 2019	2018 to 2020	2019 to 2021	2020 to 2022	2021 to 2023
Female life expectancy	81	81	81	81	82	82	82	82	83	83	83	83	83	83	83	83	83	83	83	83	83
Male life expectancy	76	76	77	77	78	78	78	78	79	79	79	79	79	79	79	79	80	79	79	79	79
Female healthy life expectancy									64	64	64	64	64	64	64	64	64	64	64	63	62
Male healthy life expectancy									63	63	63	63	63	63	63	63	63	63	63	62	62

Figure 4 *continued*

Average life expectancy and healthy life expectancy by sex in England, 2001 to 2023

Notes

1 Life expectancy projections are based upon the average mortality rates for different ages in a given three-year period and an assumed, constant reduction of mortality over time due to factors such as improvements in medicine. Healthy life expectancy adds a quality dimension to estimates of life expectancy by partitioning expected lifespan into time spent in different states of health.

2 Healthy life expectancy estimates the average years lived in 'very good' or 'good' health. This is derived from a subjective assessment of a person's health status ranging from 'very good' to 'very bad'. General health can be interpreted as measuring health-related well-being.

3 Self-reported health data are derived mostly from the Annual Population Survey (APS) and, in part, from the census. The APS is a continuous household survey conducted by the Office for National Statistics with a typical sample size of around 122,000 households (around 320,000 people). The APS data are weighted to reflect the size and composition of the general population, by using the most up-to date official population data.

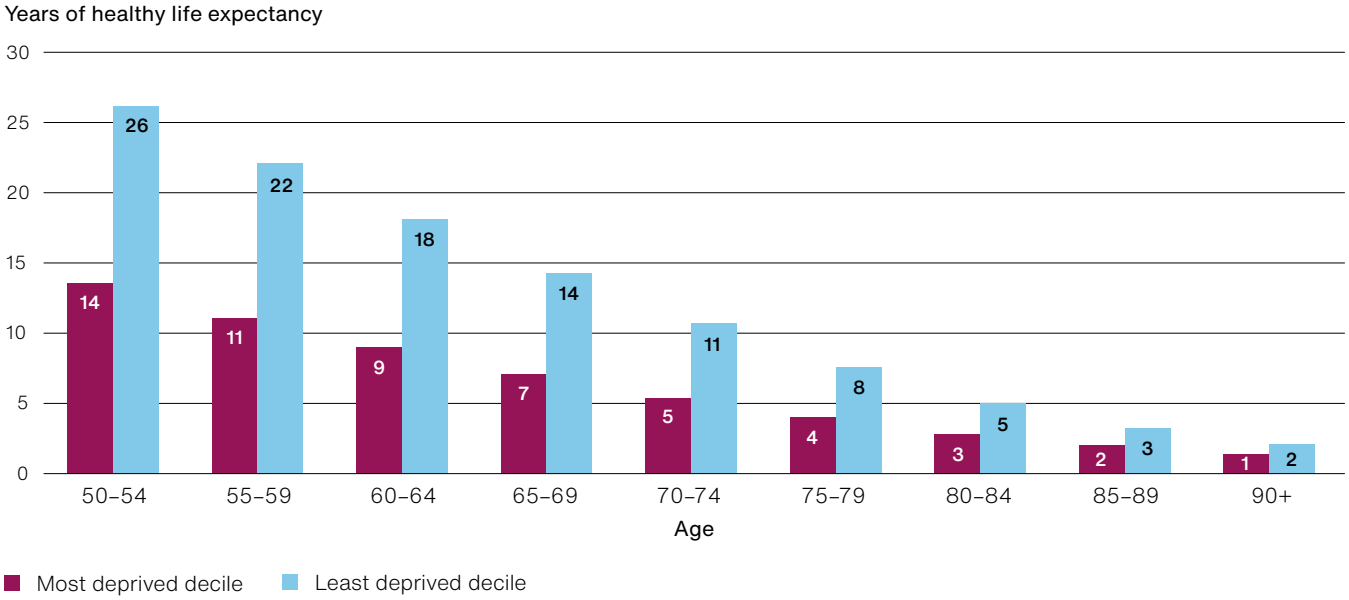
4 Healthy life expectancy data are only available from 2009–2011 onwards.

Source: National Audit Office analysis of the Office for National Statistics data

Figure 5

Years of healthy life expectancy for women aged 50 or over in England by age and deprivation, 2018 to 2020

Women aged 50 or over from the most deprived areas of England have around half the years of healthy life expectancy compared to those from the least deprived areas



Notes

1 Life expectancy projections are based upon the average mortality rates for different ages in a given three-year period and an assumed, constant reduction of mortality over time due to factors such as improvements in medicine. Healthy life expectancy adds a quality dimension to estimates of life expectancy by partitioning expected lifespan into time spent in different states of health.

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4 Decile refers to one tenth (10%) of the population.

5 Deprivation data are from the 2019 Index of Multiple Deprivation (IMD). The IMD is conducted by the Ministry of Housing, Communities & Local Government and is the official measure of relative deprivation for small areas in England. It is based on seven different domains of deprivation: income, employment, education, health, crime, housing and environment.

Source: National Audit Office analysis of the Office for National Statistics data

Part Two

The government's approach to frailty

2.1 This section of the report examines the government's strategic approach to frailty, including the establishment of an NHS England (NHSE) Frailty Project Board. It looks at the Department of Health & Social Care's (DHSC's) and NHSE's governance and management of Integrated Care Boards (ICBs).

Roles and responsibilities

2.2 In March 2025 the government announced it would abolish NHSE and change the responsibilities of ICBs, so some commissioning arrangements described in this report may change. As at August 2025, 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.

2.3 Through the national General Medical Services contract, 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.[6] NHSE publishes operational guidance to the NHS. ICBs commission primary care services (including GPs) and oversee local delivery, performance and management of the contract.

2.4 Local health and care services are organised as:

- ICBs, which are NHS organisations responsible for planning and commissioning health services for their local population;
- local primary care networks, which sit below ICBs and are formed of general practice 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;
- GPs, who are responsible for assessing who is at risk of frailty using a population-health approach to identify groups with the greatest need and for targeting care and support to help delay the onset or progression of frailty;

6 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.

- community health services, which are also part of the local NHS system and play an important role in day-to-day care for people living with frailty, such as specialist healthcare for specific problems or conditions, e.g. physiotherapy or podiatry; and
- local authorities, which are responsible for the oversight and delivery of adult social care to people living in their area, including commissioning care home places and domiciliary care for people who are eligible to receive care and support.

The government's strategic approach to frailty

2.5 There is a long-standing cross-party policy commitment to increase the numbers of years people can expect to live in 'full health' (known as healthy life expectancy) and to reduce inequalities. The previous government showed this commitment in the 2022 Levelling Up health mission which aimed to increase healthy life expectancy by 2035 and to reduce inequalities between areas by 2030. Most recently, the current government's 10 Year Health Plan, in 2025 signalled a move from a focus on ill health to prevention and pledged to increase healthy life expectancy for everyone. Frailty affects healthy life expectancy, ranging from slower recovery from health challenges to a greater risk of falls.

2.6 The NHS 2019 Long Term Plan identified several priorities to support people to age well, which included some frailty specific measures under the 'Ageing Well programme'. However, it did not include a strategic aim to support people with frailty. The Ageing Well programme in the 2019 Long Term Plan included urgent community response services (which aimed to stop people needing to be admitted into hospital), the Enhanced Health in Care Homes programme (for improving healthcare in care homes) and community teams (which aimed to provide more healthcare in communities).

2.7 The Long Term Plan set out indicative funding of £647 million from 2019-20 to 2023-24 to implement Ageing Well, to be distributed to ICBs as part of their general funding allocations. It also included a further £134 million to be allocated to targeted schemes over the same period (see **Figure 6** overleaf). NHSE told us that in 2022-23 NHSE reduced general funding allocated to ICBs to £77 million, switching £127 million to Virtual Wards instead; with the remainder deployed within core ICB allocations. This reallocation of funding away from Ageing Well continued in 2023-24.

Figure 6

Indicative funding allocated to the Ageing Well programme 2019-20 to 2024-25

NHS England's (NHSE's) reported allocations to the Ageing Well programme were less than originally intended

Financial year	Indicative funding allocations set out in the 2019 Long Term Plan			NHSE reported allocations as at July 2025	Difference
	Indicative general funding allocations to all integrated care boards (ICBs)	Indicative targeted funding allocations for specific schemes	Total indicative funding		
	(£mn)	(£mn)	(£mn)	(£mn)	(£mn)
2019-20	0	6	6	0	-6
2020-21	30	40	70	28	-42
2021-22	70	40	110	92	-18
2022-23	204	24	228	77	-151
2023-24	343	24	367	79	-288
2024-25	N/A	N/A	N/A	82	N/A

Notes

1 NHSE reports that the £92 million allocated in 2021-22 includes £18 million smaller funding pots targeted to urgent community response accelerator sites, 'System Leadership' and Enhanced Health in Care Homes.

2 NHSE told us that in 2022-23 NHSE cut the £204 million general funding allocated to ICBs to £77 million, switching the remainder to fund virtual wards instead with the remainder deployed within core ICB allocations.

3 We have not audited or validated these allocations.

4 The Long Term Plan Implementation Framework set out indicative funding from 2019-20 to 2023-24.

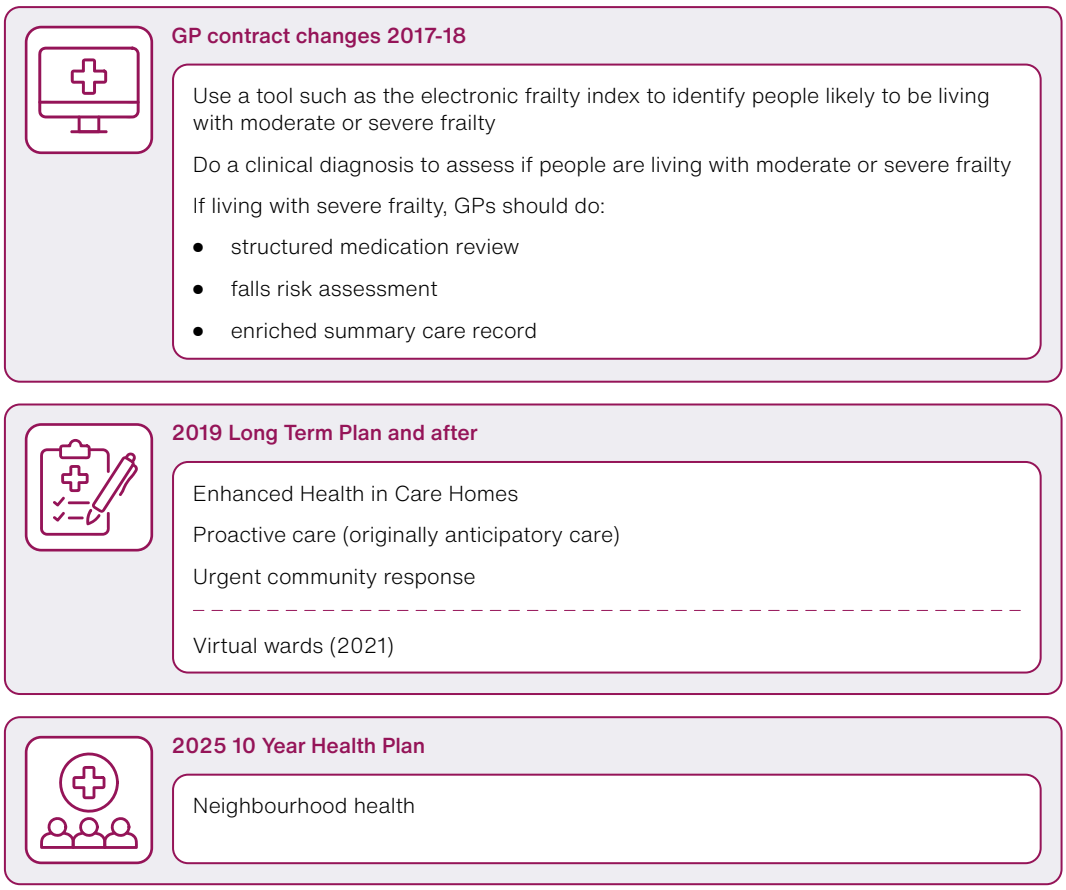
Source: National Audit Office analysis of NHS England (NHSE), Long Term Plan implementation framework (June 2019) tables 1, 2 and 3, and NHSE documents

2.8 Despite its recognition of the importance of frailty, NHSE has still not developed a cohesive approach with services that work together effectively to support people living with frailty, nor does it have a clear single joined-up strategy for dealing with frailty. It has set requirements for ICBs and GPs to provide health services that aim to assess and support people living with moderate and severe frailty (see **Figure 7**). These services are not always exclusive to frailty and aim to support people living with other health conditions. We examine local services in detail in Part Three. They include frailty assessments, healthcare for people in care homes (through the Enhanced Health in Care Homes programme) 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 services differently and they commission these services based on local need (see Part Three). As a result, there is no consistent national frailty provision.

Figure 7

The healthcare services and initiatives that assess and support people living with moderate or severe frailty

There are several services that aim to support people living with moderate or severe frailty



Notes

1 See Part Three for details of all these services and initiatives.

2 An enriched summary care record provides information additional to a standard summary care record.

3 Virtual wards were not included in the Long Term Plan. NHSE published guidance in 2021 and national funding was available from 2022-23.

Source: National Audit Office analysis of NHS England plans and guidance

2.9 In May 2024, NHSE set up a Frailty Project Board to direct the development of a frailty strategy. NHSE acknowledged that people living with frailty were using an increasing amount of healthcare resources and that a different approach was needed to manage this demand on the health system. It noted that there was a growing consensus that early intervention and shifting care to the community was the best way to meet this demand.

2.10 In 2024, NHSE recognised that local areas delivered and prioritised these various initiatives differently. NHSE also noted that these initiatives had been 'championed individually' with varying levels of investment and that a system-wide approach to frailty was needed. Some ICBs in areas we visited are trying to develop a systematic approach to frailty across the ICB to bring consistency. For example, the South West Region has created a 'frailty collaborative' to bring about a regional model. A year later than intended, in August 2025, the NHSE Board selected seven areas to pilot a system-wide approach to frailty that other areas could learn from. Progress was affected by external factors such as the change of government and subsequent policy decisions.

2.11 The 2025 10 Year Health Plan did not explicitly introduce any further developments on frailty although it set out the intention to develop several new service frameworks, with early priority given to frailty and dementia, which will be informed by phase one of the independent commission into adult social care, expected in 2026-27. There is no timetable for the framework's development although DHSC expects it to be published some time in 2026-27. The Medium Term Planning Framework for 2026-27 to 2028-29 is a positive step. It identified patients living with moderate or severe frailty as a priority for neighbourhood health and required ICBs to create a plan to more effectively manage their needs.

Governance and performance monitoring

2.12 NHSE considers that ICBs are responsible for managing and measuring performance of many of the services that aim to support people living with frailty. ICBs are responsible for providing community health services, which include urgent community response and virtual wards. GPs provide some services that are required through the national level GP contract (see Part Three for details on all these services).

2.13 There is limited national level data on these services, and what is available only measures some aspects of performance. This stops NHSE having a good national understanding of the quality of services provided and prevents ICBs benchmarking their performance with others. 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. Of the services discussed in Part Three, the exceptions are virtual wards and urgent community response services, which have quality-assured national data. National data on virtual wards include bed capacity and utilisation, as well as length of stay and discharge destination, but do not identify the benefits these services provide to people living with frailty.

2.14 GP contract data show the numbers of people who GPs assess for frailty and some of the follow-up services that they receive, such as falls risk assessments. 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.

2.15 NHSE has a statutory responsibility to oversee the overall delivery, performance and improvement of ICBs and providers. To help it do this, it has an agreed set of metrics against which it scores providers' performance (in the future this will expand to include ICBs whose metrics are not scored) and identifies any areas that need improvement. These metrics are set out in NHSE's new oversight framework, published in June 2025. The framework has six 'domains' of performance metrics:

- access to services;
- effectiveness and experience of care;
- patient safety;
- people and workforce;
- finance and productivity; and
- improving health and reducing inequality.

2.16 These metrics do not show the impact of frailty-related services on a person's quality of life or general health, although the 'improving health and reducing inequality' domain has a metric for the average years lived in healthy life. However, NHSE does not score any of the metrics in this domain and therefore performance against these measures does not impact organisations' overall scores. NHSE retains the power to intervene if there are material concerns regarding these services. NHSE has published some performance data for NHS Trusts, but data for ICBs will not be available until summer 2026.

2.17 ICBs measure the performance of their initiatives to support people with frailty often by focusing on the impact on the acute sector. Metrics include trends and changes in admissions to hospital, A&E attendances, ambulance call outs and calls to 999. These were the metrics that we typically saw in the areas we visited.

2.18 The British Geriatrics Society has noted the limits of current NHS metrics when trying to measure the impact of proactive care to identify and support people living with frailty. The aim of proactive care is to maintain independence in older individuals, which is difficult to measure in the short term and often requires long-term data over three to five years. Commonly used measures, such as hospital admissions and early hospital discharge, are less effective. The British Geriatrics Society argued that national guidance on how to measure the impact of proactive care would be beneficial, with clinical research evaluating the clinical utility of different approaches.

Part Three

Supporting people living with frailty

3.1 This section examines the support in non-hospital-based services for people living with moderate and severe frailty. It assesses how effectively GPs meet NHS England's (NHSE's) requirements to assess people for frailty and help those with severe frailty, including people in care homes. It also looks at the effectiveness of community health services and services that aim to prevent the need for people being admitted to hospital, such as virtual wards and urgent community response.

The role of GPs: assessment

3.2 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. GPs are paid to do this work, and provide other essential services and routine work, using the 'global sum' which is based on a weighted sum for each patient in that practice. NHSE has not set any standards or expectations for the numbers of people to be assessed. The contract states that practices should use tools such as the electronic frailty index (the index) to help identify people at risk of living with frailty. The index uses existing information within the electronic primary healthcare record to identify people who may be living with varying degrees of frailty. The index is not intended to be used as a diagnostic tool, but as a 'population risk stratification' tool.

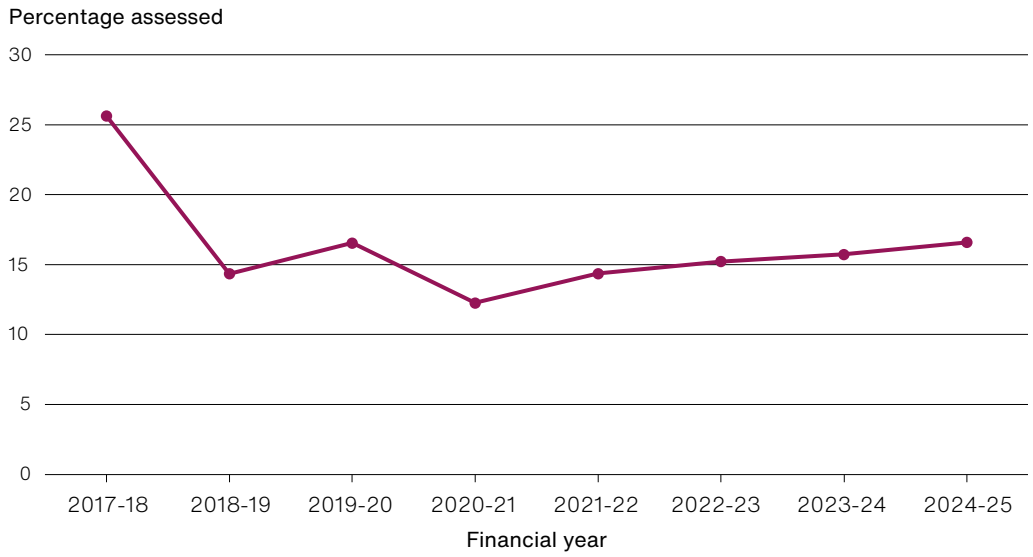
3.3 When the index identifies someone at risk of living with frailty, NHSE guidance is that GPs should use direct clinical assessment and judgment to confirm if that person has frailty. This assessment may happen opportunistically; for example, when a patient sees their GP about another condition, or as part of more systematic work in that area focusing on people living with frailty. Several of the areas we visited were doing this more systematic work on small patient groups. For example, in Clacton, in the Suffolk and North East Essex Integrated Care Board (ICB), the primary care network ran a pilot where they used population-level data to identify just under 100 people who had a high level of hospital admissions and GP appointments and were living with moderate or severe frailty. They offered targeted support to these people.

3.4 In 2024-25, GPs assessed 1.9 million people aged 65 or over for frailty. The trend in the proportion of their registered patients aged 65 or over that GPs assessed for frailty is below its peak of 26% in 2017-18, the year the requirement was introduced. It reduced to a low of 12% in 2020-21 during the COVID pandemic, and was 17% in 2024-25 (see **Figure 8**). As the data suggest that GPs are not assessing everyone aged 65 or over, neither NHSE nor the Department of Health & Social Care (DHSC) know accurately how many people are living with frailty and may need support.

Figure 8

Percentage of registered patients aged 65 or over that GPs have assessed for frailty by year, in England, 2017-18 to 2024-25

The percentage of GP patients assessed for frailty has increased slowly since the COVID-19 pandemic



	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Percentage of registered patients aged 65 or over assessed for frailty	26	14	17	12	14	15	16	17

Notes

1 The National Institute for Health and Care Excellence (NICE) guidance for frailty diagnosis in primary and community care settings is to consider using tools such as an informal assessment of gait speed; a formal assessment of gait speed; self-reported health status; or the PRISMA-7 questionnaire. The PRISMA-7 is a seven item yes/no questionnaire covering age, general health, activities and social support, with each answer receiving a score of one or zero. A score of three or more indicates an increased risk of frailty and the need for further clinical review.

2 NICE is an executive non-departmental body of the Department of Health & Social Care that provides a range of clinical guidance to the NHS in England and Wales.

Source: National Audit Office analysis of GP contract services data, NHS England

3.5 As at March 2025 GPs had diagnosed:

- 450,000 people with severe frailty (4% of registered patients aged 65 or over); and
- 1.06 million people with moderate frailty (9% of registered patients aged 65 or over).

3.6 There is significant and unexplained local variation in the proportion of patients who were assessed for frailty. This may be due to local capacity, local prioritisation or data issues. NHSE is aware of this variability but does not know the causes. In 2024-25, 32 of 106 local NHS areas[7] assessed less than 10% of their registered patients aged 65 or over (see **Figure 9** overleaf). However, nine of 106 local areas assessed 90% or more of this group of people.

The role of GPs: support for people living with severe frailty

3.7 Once a patient has been diagnosed with severe frailty, the GP contract requires GPs to do a clinical review, which includes:

- an annual medication review;
- a discussion on whether the patient has fallen in the past year (a falls risk assessment); 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) and activation of that record at the patient's request.
- GPs are contractually required to diagnose and manage frailty in patients aged 65 or over as part of the core contract paid under global sum, and are therefore not separately incentivised for this work. NHSE has not set any performance targets for providing this support, and it does not use the data available to monitor compliance.

3.8 Data from the GP core contract on the level of support given after a frailty diagnosis strongly suggest that GPs are failing to provide adequate levels of follow-up support.[8] In 2024-25, 226,000 patients were diagnosed with severe frailty (12% of those assessed for frailty in that year). Of those 226,000 patients:

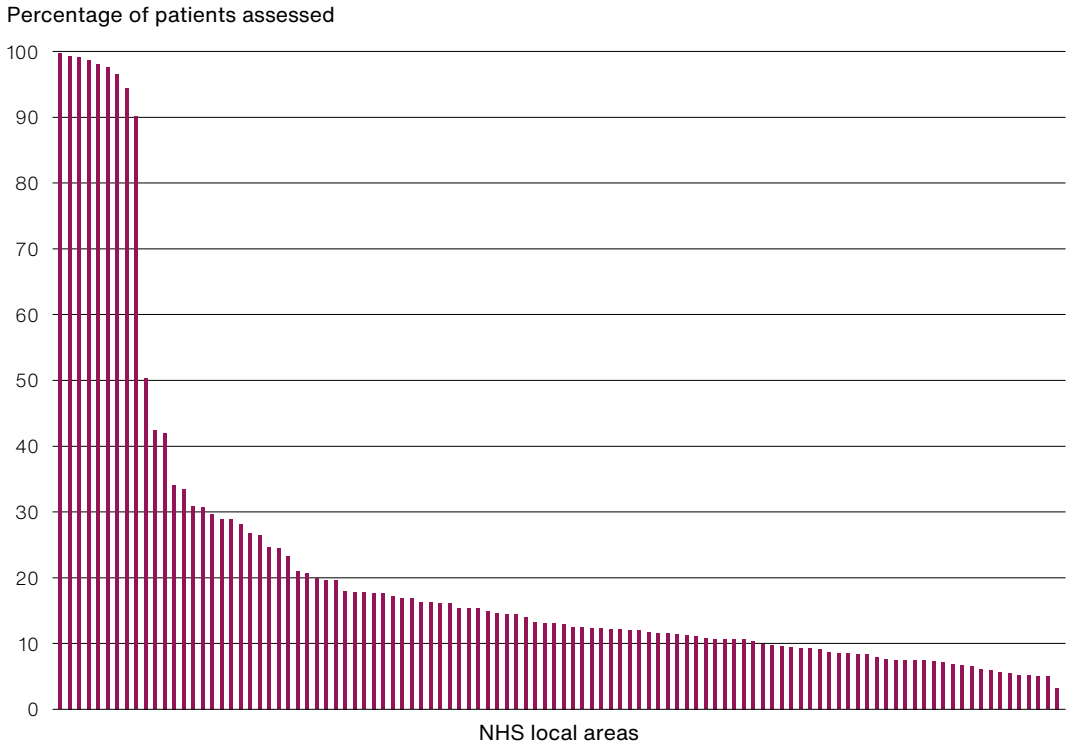
- 16% (37,000) had a medication review;
- 18% (41,000) had a falls risk assessment; and
- 29% (66,000) had given consent for an enriched summary care record (see **Figure 10** on page 33).

7 These local areas are known as Sub-ICBs which are areas which pre-2022 covered Clinical Commissioning Groups.
8 NHSE guidance requires general practice teams to record relevant activity using the appropriate 'SNOMED' codes. The data do not capture activity that is not recorded using the correct code.

Figure 9

Percentage of registered patients aged 65 or over assessed for frailty in 2024-25 by local area in England

There is significant and unexplained local variation in the percentage of patients assessed for frailty



Notes

1 NHS local areas refer to Sub-Integrated Care Boards which pre-2022 covered Clinical Commissioning Groups (CCGs). CCGs were created following the Health and Social Care Act in 2012 and were clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. CCGs were dissolved in July 2022 and their duties were taken on by the new, larger Integrated Care Boards.

2 The National Institute for Health and Care Excellence (NICE) guidance for frailty assessment in primary and community care settings is to consider using tools such as an informal assessment of gait speed; a formal assessment of gait speed; self-reported health status; or the PRISMA-7 questionnaire. The PRISMA-7 is a seven item yes/no questionnaire covering age, general health, activities and social support, with each answer receiving a score of one or zero. A score of three or more indicates an increased risk of frailty and the need for further clinical review.

3 NICE is an executive non-departmental body of the Department of Health & Social Care which provides a range of clinical guidance to the NHS in England and Wales.

Source: National Audit Office analysis of GP contract services data, NHS England

Figure 10

Numbers of patients diagnosed with severe frailty who received specified support in England, 2024-25

A small proportion of the 226,000 patients diagnosed with severe frailty in 2024-25 are getting the support NHS England (NHSE) has specified

Notes

1 Figures rounded to the nearest thousand.

2 Structured medication reviews are an evidence based and comprehensive review of a patient's medication to improve quality of care and reduce risk of harm from medication.

3 A comprehensive falls risk assessment may include assessing for home hazards, visual impairment and drug treatments. Interventions commonly offered by specialist falls services include strength and balance training, home hazard assessment and intervention, vision assessment and referral and medication review.

4 A standard summary care record includes patient information such as current medication, allergies and details of previous bad reactions to medicines. If a patient consents, an "enriched" summary care record can be constructed containing additional information such as significant medical history, reason for medication, anticipatory care information (such as information about the management of long-term conditions), end of life care information and immunisations.

Source: National Audit Office analysis of GP contract services data, NHS England

3.9 The National Institute for Health and Care Excellence (NICE) has guidelines related to frailty. These 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 who had a fall, have also received a falls risk assessment and management, as per the guidelines. However, the data indicate that some local areas (70%) are not following NICE guidelines as the number of people who had a falls risk assessment is less than the number of people who had a fall. If local areas were following these guidelines, we would expect to see that the number of falls risk assessments would roughly match the number of people who have had falls (see **Figure 11**). NHSE does not understand what is causing this local variation.

The role of GPs: support for people in care homes

3.10 NHSE set up the Enhanced Health in Care Homes programme (the programme) to ensure stronger links between primary care networks and their local care homes to provide people in care homes with the same healthcare they would get at home. The programme originated with pilots in the New Care Models (Vanguards) programme (2015), and the 2019 Long Term Plan announced that it would be rolled out across England. To provide services in the programme, NHSE pays GPs an amount weighted by the number of care home beds for which they are responsible. In addition, NHSE also paid GPs for specific activities under the programme such as a structured medication review and having a care plan agreed or reviewed, but these payments ended in 2023-24. The programme requires that:

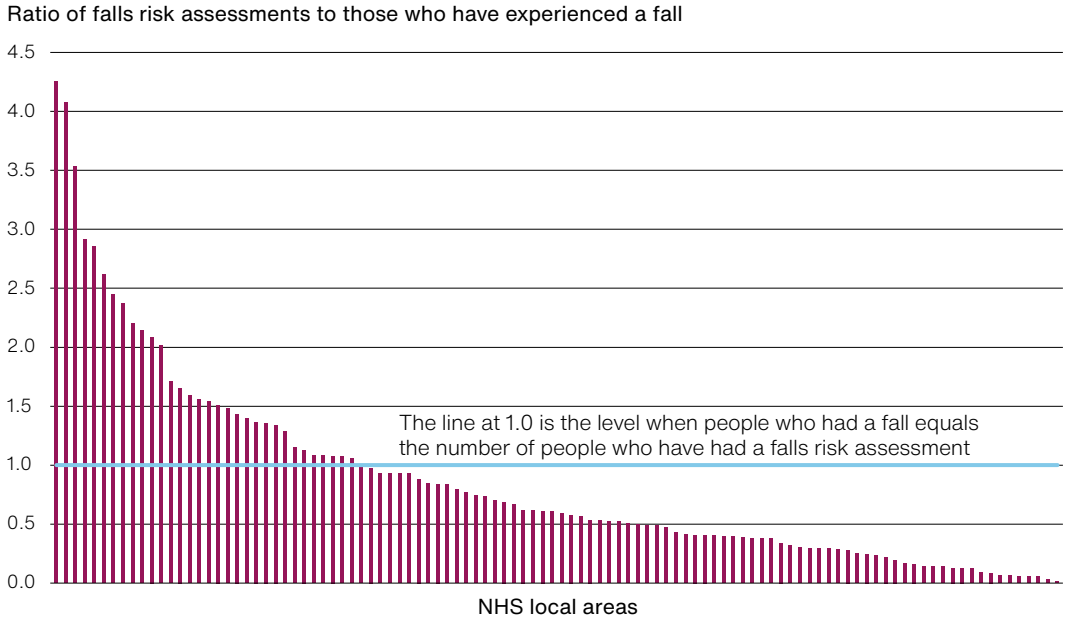
- all care homes should be aligned with a primary care network (which are groups of GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas) and have a named clinical lead;
- a clinical lead will coordinate multi-disciplinary team meetings and actions including a weekly care home round; and
- all care home residents, within seven days of admission or readmission must:
    - have participated in a comprehensive personalised assessment of need undertaken by the multi-disciplinary team;
    - have participated in the development of their personal care and support plan (care plan) with the multi-disciplinary team; and
    - have been prioritised as people who would benefit from a structured medication review.

3.11 External stakeholders, such as the British Geriatrics Society and the National Care Association were generally positive about the programme in establishing a good framework and its potential for reducing hospitalisations of care home residents through advanced care planning and medication reviews. However, these stakeholders noted that implementation varies locally. The lack of data interoperability between the NHS' and care homes' IT systems creates problems.

Figure 11

Ratio of the number of people diagnosed with severe frailty who had a falls risk assessment to the number of people diagnosed with severe frailty who had a fall (in England in 2024-25)

Some areas in England are following NICE guidelines for people with severe frailty who have had a fall, but most are not



Notes

1 The National Institute for Health and Care Excellence (NICE) is an executive non-departmental body of the Department of Health & Social Care that provides a range of clinical guidance to the NHS in England and Wales.

2 NICE 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. A comprehensive falls risk assessment may include assessing for home hazards, visual impairment and drug treatments. Interventions commonly offered by specialist falls services include strength and balance training, home hazard assessment and intervention, vision assessment and referral and medication review.

3 NHS local areas refer to Sub-Integrated Care Boards which pre-2022 covered Clinical Commissioning Groups (CCGs). CCGs were created following the Health and Social Care Act in 2012 and were clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. CCGs were dissolved in July 2022 and their duties were taken on by the new, larger Integrated Care Boards.

Source: National Audit Office analysis of GP contract services data, NHS England

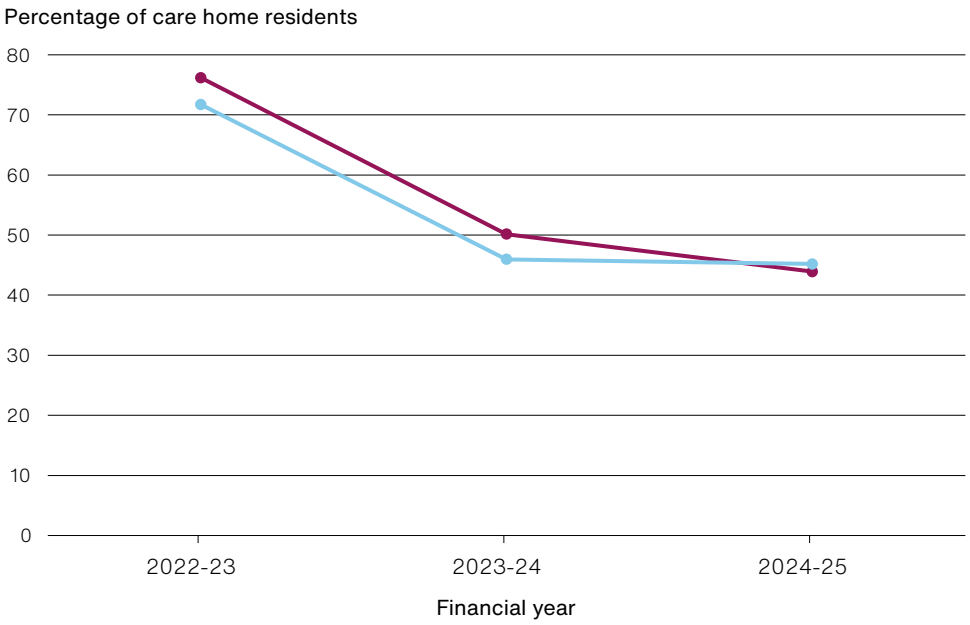
3.12 Although the programme is operated through NHSE's primary care network contract (Directed Enhanced Services), NHSE does not have central oversight of the programme and does not know whether the programme is achieving its aims. NHSE's plans to evaluate the programme were put on hold during COVID, and NHSE told us that it does not intend to evaluate the programme at a national level.

3.13 Evidence indicates that levels of support provided by GPs and primary care networks under the programme may be deteriorating in some important aspects of care and are falling short of some requirements. For example, the percentage of residents who had a personalised care plan agreed or reviewed has fallen sharply, from 76% in 2022-23 to 44% in 2024-25 (see **Figure 12**). This fall occurred when payments ceased for these activities, but GPs may still be providing this support and not recording that they are doing so. There is also significant local variation in care plans (see **Figure 13**).

Figure 12

The percentage of care home residents who get specified support, 2022-23 to 2024-25

The level of support provided under the Enhanced Health in Care Homes programme is deteriorating in some important aspects of care



	2022-23	2023-24	2024-25
Personalised care and support plan	76	50	44
Structured medication review	72	46	45

Notes

1 The Enhanced Health in Care Homes (EHCH) programme is a framework to guide the commissioning of and delivery arrangements for health and social care in collaboration with care homes. It puts contractual requirements on Primary Care Networks (PCNs) to ensure that every care home: is aligned to a PCN, has a named clinical lead, has a weekly home round and has established protocols for information sharing, shared care planning, use of shared care records and clear clinical governance.

2 A personalised care and support plan is a series of facilitated conversations in which the patient, or those who know them well, actively participates to explore the management of their health and well-being within the scope of their whole life and family situation.

3 Structured medication reviews are an evidence based and comprehensive review of a patient's medication to improve quality of care and reduce risk of harm from medication.

4 Within seven working days of admission or re-admission, the EHCH framework requires every person living in a care home to have participated in the development of their personalised care and support plan and should be identified and prioritised as people who would benefit from a structured medication review.

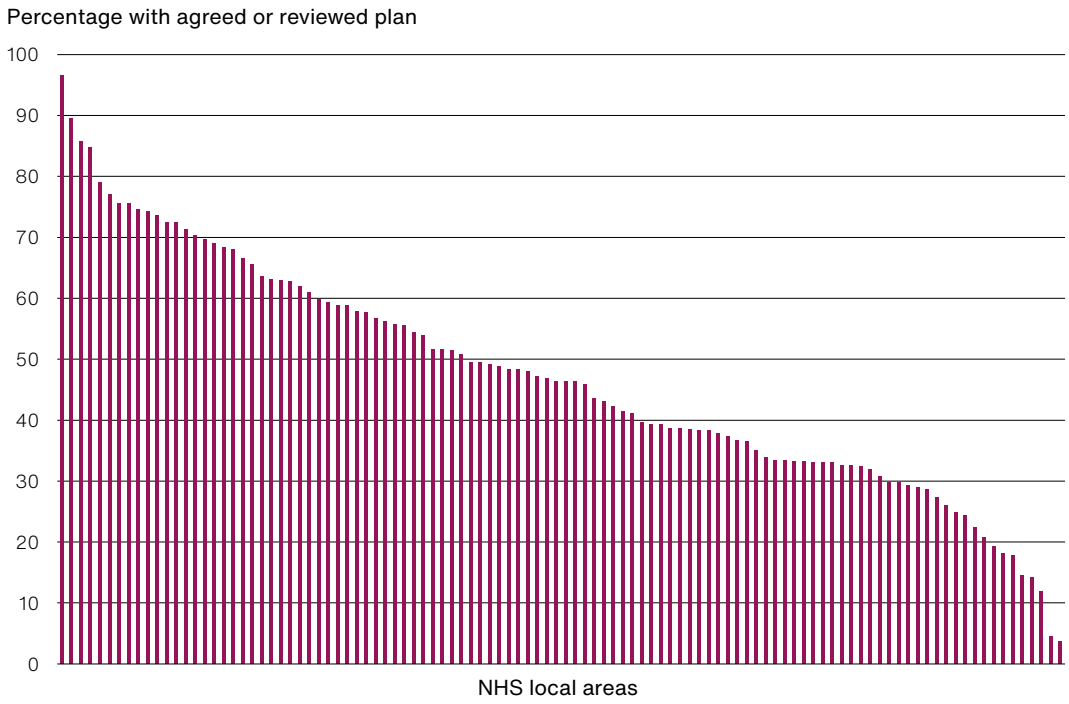
5 The data for structured medication reviews only include permanent care home residents. The data for personalised care and support plans also include temporary care home residents.

Source: National Audit Office analysis of Network Contract Directed Enhanced Services, NHS England

Figure 13

Percentage of care home residents with a personalised care and support plan agreed or reviewed, by local NHS area, 2024-25

There is significant and unexplained local variation in the proportion of care home residents with a personalised care and support plan agreed or reviewed



Notes

1 A personalised care and support plan is a series of facilitated conversations in which the patient, or those who know them well, actively participates to explore the management of their health and well-being within the scope of their whole life and family situation. Within seven working days of admission or re-admission, the Enhanced Health in Care Homes framework requires that Primary Care Networks ensure that every person living in a care home to have participated in the development of their personalised care and support plan.

2 NHS local areas refer to Sub-Integrated Care Boards which pre-2022 covered Clinical Commissioning Groups (CCGs). CCGs were created following the Health and Social Care Act in 2012 and were clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. CCGs were dissolved in July 2022 and their duties were taken on by the new, larger Integrated Care Boards.

Source: National Audit Office analysis of Network Contract Directed Enhanced Services, NHS England

Community health services

3.14 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. They are often used by children, older people, people living with frailty (or with chronic or multiple conditions), or people near the end of their lives. Services that are relevant to frailty are wide-ranging and include urgent community response, district nursing, and falls prevention services. For people living with frailty, these services offer important support to help them live independently for longer and at home rather than in hospital. While community health services are different to and funded separately from primary care and GPs, they should work closely together.

3.15 There are no specific data on the extent to which people living with frailty use community health services, but older people tend to use these services more. For example, in May 2025, NHSE recorded 5.2 million care contacts (i.e. a person's interactions or appointments with healthcare services) that month for people aged 65 or over with community health services. For people of all ages that month there were 8.5 million care contacts with community health services.

3.16 It is very difficult to generate robust or comprehensive information on how much is spent on providing community health services to people living with frailty, owing to the way community health service activity is reported and costs allocated. The funding and commissioning of community health services is complex, but it is mainly through ICBs who commission most adult community health services. In 2023-24, ICBs reported that they allocated £12.3 billion of annual NHS funding to community health services overall. This does not include community health services funded by local authorities or those funded by charitable donations.

3.17 NHSE has given community health services a lower priority than acute services, and NHSE and external stakeholders recognise that funding and targets have led to prioritising acute services. Several of the areas we visited also noted this bias and the existence of structural barriers to moving the focus from acute to community health services, such as funding streams and resource allocation.

Improving community health services

3.18 The Fuller Stocktake on how to integrate primary care highlighted the importance of community health services and the key role they play in providing integrated care for people.[9] NHSE has highlighted the importance of community health services to its aim to deliver care closer to people's homes. However, ICBs commission, deliver and categorise community health services differently, in accordance with local need. As a result, there is no standard 'offer' for community services locally, risking inconsistent and variable service delivery across England. NHSE recognises that a lack of standardisation could make it difficult to identify unwarranted variation and inequalities. As a result, in January 2025, NHSE published new guidance that provided standard definitions and categorisation of the different types of community services. This guidance was for ICBs and their partners to support their understanding of the levels of demand and capacity, to inform planning with providers and to ensure the best use of funding to meet local needs and priorities. NHSE has not specified a timeline by which ICBs should implement this guidance. NHSE is also working to improve the quality of community health services data.

Workforce

3.19 District nurses play an important role in delivering community health services for older people but there has been a marked decline in their numbers. In March 2025 half of all unique care contacts (i.e. a person's interaction or appointment with healthcare services) for people aged 65 or over in the community were with district nursing services. In May 2025, the Nuffield Trust estimated that, between 2009 and 2024 the number of staff recorded in NHS district nurse roles fell by 43%, from 7,643 to 4,322 (full-time equivalent). There has been an increase in other community-based roles but data do not allow us to assess how much these roles focus on supporting people with frailty.

3.20 In 2024, in its report on the geriatrician workforce, the British Geriatrics Society called for the recruitment of more healthcare professionals into the specialty of geriatric medicine, to make up what it estimated to be a 1,800 shortfall (by 2030) in geriatrician posts and to retain and support existing staff. It did not specify whether the shortfalls were greater in acute or primary care or community health services. Several of the areas we visited (as well as the external stakeholders we interviewed) also pointed out the need and support for more geriatric skills and capacity in the community. In the South West Region, NHSE clinical leads for frailty are coordinating training programmes that aim to improve the understanding of frailty across all sectors of healthcare and for citizens, as well as to give clinicians the skills to support those living with frailty.

9 Fuller stocktake report, 'Next steps for integrating primary care', May 2022, *Fuller report*.

Urgent community response

3.21 The aim of urgent community response services is to provide urgent care to people in their homes that helps to avoid hospital admissions and enable people to live independently for longer. These people include those living with frailty.

3.22 NHSE requires all ICBs to provide, as a minimum, an urgent community response service from 8am to 8pm, seven days a week, with a standard of providing urgent care within two hours of referral for 70% of referrals. NAO analysis of urgent community response data for 2024-25 shows that, across ICBs, between 70% and 98% of all people referred to and accepted into the service (data do not specify the person's condition) were seen within two hours of referral, equalling or exceeding the threshold of 70%, with all ICBs meeting the threshold. NHSE told us that the most recent estimate available of the total cost of urgent community response referrals (based on 2023-24 reference costs) was £235 million.

3.23 Experience of urgent community response services in the places we visited had been generally positive. An NHSE-commissioned national evaluation of urgent community response services found staff and patients positive about how these services treat people quickly. Overall findings were inconclusive on their impact on A&E attendances or emergency admissions in the nine sites that were part of the evaluation, as the sites showed mixed effects on attendances and admissions to A&E. NHSE is planning an analysis of urgent community response which is due to report early in 2026.

Virtual wards

3.24 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. Sometimes known as 'hospital at home', 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. Virtual wards are used to treat a variety of conditions, including providing care to people living with frailty. NHSE performance data indicated that people with care needs associated with frailty accounted for 46% of people in virtual wards in March 2025.

3.25 NHSE measures ICBs' use of virtual wards by looking at the proportion of patients cared for in virtual wards against capacity. It requires ICBs to ensure that usage of virtual wards is consistently above 80% of capacity. However, ICBs have not met this target and the rates of use from April 2024 to March 2025 averaged 74%. Several areas we visited had mixed views on virtual wards. Some noted that virtual wards helped to reduce pressure on hospital beds and that patients liked the service. Some areas we visited also noted the benefits of technology such as remote monitoring of patients in their own homes. However, they acknowledged that technology can be problematic, as some older, frail patients can be discouraged if they find it difficult to use technology.

3.26 Small-scale studies of virtual wards at ICB level reported generally positive results in reducing admissions and improved staff and patient experience. A NICE review assessed the cost-effectiveness of virtual wards compared to hospital care. It found that virtual wards and hospital at home models of care were usually reported as cost saving, but that studies may have over-estimated these savings. As a result, it concluded that using virtual wards and hospital at home models of care appeared to be cost-effective, but there was some uncertainty around the costs and benefits. NHSE has commissioned a large-scale evaluation of virtual wards in England which will report in 2026.

Part Four

Frailty and the new neighbourhood health service

4.1 This section of the report looks at the government's plans to establish neighbourhood health services as set out in the 2025 10 Year Health Plan. We will examine how this development could affect support for people living with frailty and how it differs from current ways of providing support.

Neighbourhood health

4.2 In July 2024, the NHS England (NHSE) Board noted a growing consensus that changing health and care needs can be met through prevention, early intervention, more targeted care and moving care into the community. It also recognised that over the past decade or so, only limited progress had been made on NHSE's aim to shift more activity from acute settings into the community. The Board concluded that it needed to adopt a different approach to support the population living with frailty to manage the demand and improve patient experience and outcomes.

4.3 Throughout 2025, NHSE and the government have clearly signalled a move to what they call a 'neighbourhood health service'. NHSE describes neighbourhood health as the alternative to the current system which it considers to be "hospital-centric, detached from communities and organises its care into multiple, fragmented siloes". It set out that neighbourhood health would "bring care into local communities, convene professionals into patient-centred teams and end fragmentation". The aim of neighbourhood health is to create healthier communities and help people to live healthy, active and independent lives.

Moving to neighbourhood health services

4.4 In January 2025, NHSE published guidelines for Integrated Care Boards (ICBs), local authorities and health and care providers to help local areas progress towards neighbourhood health, in advance of the 10 Year Health Plan published later that year. The guidelines set out six components of neighbourhood health. They stated that the focus for 2025-26 was adults, children and young people with complex health and social care needs who require help and support from multiple organisations and services. This included adults living with moderate or severe frailty.

4.5 The guidelines acknowledged that some places had already made progress towards providing an integrated approach to local delivery. We saw examples of this progress in several areas we visited.

- **Suffolk and North East Essex ICB**

  has developed a strategic approach to frailty that highlights the importance of integrated working. To support this approach with clinical leadership, it uses Integrated Neighbourhood Teams to coordinate care for people living with frailty across health, social care, voluntary organisations and primary care to deliver frailty assessments, crisis response and shared care planning. Its community services include strength and balance programmes and community-based support sessions tailored for people with a history of falls, low confidence or social isolation. These community services are partly funded by NHSE (Ageing Well funding), ICB funding, local authorities and voluntary and third sector groups.

- **Northamptonshire ICB**

  has 'Ageing Well' teams who coordinate and bring together healthcare professionals to support people living with frailty. These teams take referrals from several sources including GPs, carers, families and hospitals. The ICB has established memorandums of understanding with each primary care network with specified service requirements to help deliver its 'Ageing Well' programme. These requirements include a clinical lead and weekly multi-disciplinary meetings with members from a range of health, social care and voluntary sector professions.

4.6 The 2025 10 Year Health Plan set out the government's commitment to the neighbourhood health service. The Plan had several initiatives that related to frailty. These included:

- the development of a modern service framework for frailty and dementia in 2026-27;
- the development of new 'tech-led' services for people, such as those living with frailty, to help maintain their independence at home;
- to deepen the involvement of social care professionals in rehabilitation, recovery and frailty prevention;
- to avoid unnecessary transfers to hospital by having 'care come to them'; and
- to set a new standard that, by 2027, 95% of people with complex needs will have an agreed care plan.

4.7 The 2025 10 Year Health Plan did not contain any detail on implementation or funding to help ICBs move to a neighbourhood health service. It stated an intention to create new funding flows to enable savings from better care to lead to investment in community health service. This included proposed 'year of care payments' (where funding is based on providing care to a patient for one year) which NHSE intends to develop through 'test and learn' approaches in some pilot areas in 2026-27. NHSE has provided £10 million to support the rollout of the neighbourhood health service. The Medium Term Planning Framework for 2026-27 to 2028-29 mentions frailty as a priority for neighbourhood health services and asks for growth in community health services.

Challenges to establishing integrated care

4.8 During the last two decades, there have been several attempts to bring about more integrated services and move care away from hospitals and into the community. These include Integrated Care Pilots (2008), integrated care and support pioneers (2013) and the Vanguards (or New Care Models, 2015). These attempts have had varying levels of success, but none have achieved a systemic shift. The 2019 Long Term Plan promised to boost 'out-of-hospital' care and dissolve the historic divide between primary and community health services.

4.9 Some of the areas we visited noted several challenges to integrating health services including data interoperability, lack of clear metrics, constraints on funding flows and workforce capacity and capability. Their experiences and reflections included the following:

- **Data:** some had access to data from GP practices and other clinical sources with which they analysed frailty across their local population. However, they needed to put in place data sharing agreements with individual GPs to access these data. Others noted limited interoperability between data systems; for example, a lack of join up with and access between GPs, care homes, hospitals, community and social care.
- **Metrics:** there is a need for more standardised metrics for care; for example, there are no metrics to show how preventative healthcare impacts the need for social care, or whether people are being effectively cared for in their homes.
- **Funding:** there was a mixed picture on funding. Some local areas had used a range of funding sources to pay for their frailty services, including internal ICB funding, from NHSE or their local authority. Others noted a lack of funding, which meant they had to use funding from existing budgets. They noted the importance of being able to move money from the acute sector into community services.
- **Workforce:** there was a lack of general frailty skills and understanding across staff as well as shortages of specific specialisms such as geriatricians.

4.10 Some of the areas we visited reported benefits to integrated working, including closer working with social care, with good information sharing leading to quicker responses and appropriate escalation of problems.

Appendix One

Our audit approach

Our scope

1 This report examines the effectiveness of the government's approach to identifying and managing frailty in England. We have focused on how general practice and community services identify and support people living with or at risk of frailty. As such, this report does not look at support in secondary settings such as hospitals. In England, clinicians often assess a person's level of frailty using a nine point scale from 'very fit' to 'terminally ill' and includes the definitions of mildly, moderately and severely frail. In this report we focus on people living with moderate or severe frailty.

2 The report examines how effectively the government is tackling the challenges of growing numbers of people living with frailty including:

- whether the government has a clear strategy for managing and slowing the onset or progression of frailty in people;
- how effectively primary care detects people at risk of, or living with frailty; and
- how effectively primary care and community health services support people living with frailty.

Our evidence base

3 In examining these issues, we drew on a wide range of evidence sources including departmental documents, interviews with officials and stakeholders, case study interviews and data analysis. Our fieldwork was conducted from April to July 2025.

Document review

4 We reviewed approximately 150 documents including departmental documents, relevant stakeholders and clinical and academic research papers.

Departmental documents included:

- Frailty Project Board papers;
- operational planning guidance;
- strategic documents, including the 2019 Long Term Plan and 2025 10 Year Health Plan;
- guidance and good practice for Integrated Care Boards (ICBs) and GPs; and
- evaluation reports.

Interviews

5 We conducted interviews with relevant stakeholder groups and organisations during scoping and fieldwork to inform our findings and conclusions:

- government bodies: officials from NHS England (NHSE) and the Department of Health & Social Care (DHSC) responsible for overseeing or managing the strategy, commissioning, delivery or evaluation of frailty, and ageing policy and interventions in order to understand the current issues, challenges and future plans for supporting people living with frailty;
- health think tanks and charities: such as Age UK and the Kings Fund to understand perspectives from outside the healthcare service, including those of patients; and
- sector bodies: the Royal College of Physicians, the Chartered Society of Physiotherapists, the British Geriatrics Society and the National Care Association.

Case studies

6 We conducted five case study visits to ICBs to provide local insight into how initiatives to identify and support people living with or at risk of frailty are working on the ground. For each area, we explored the levels of frailty and the impact of factors such as deprivation. We examined initiatives including virtual wards, urgent community response services, the provision of community services and the integration of services across primary and community care, and their interaction with social services. We spoke with ICB clinical leads, GPs, social workers, care coordinators and other healthcare professionals such as physiotherapists.

7 Our case study selection criteria focused on local authorities with high rates of frailty, but differed in terms of geographical spread, rurality, and the frailty-related socio-demographics of the local population, particularly deprivation. We also considered information from scoping interviews about areas that were working in innovative ways with local partners in delivering support.

8 Our case studies were: Suffolk and North East Essex, North West London, South West London, Northamptonshire, and Cheshire and Merseyside. We also had a discussion with clinical frailty leads in the South West Region.

Data analysis

9 We analysed several datasets including:

- Directed Enhanced Services (for GPs' support to care homes to demonstrate performance with Enhanced Health in Care Homes);
- trends in workforce numbers, particularly for geriatricians;
- activity in community care sector for trends in activity relating to frailty, such as falls support;
- 'sit rep' statistics for virtual wards and urgent community response services to show ICB-level performance against nationally set targets; and
- GP contract data for numbers of people who are assessed as severely or moderately frail. While NHSE collates and publishes this information, it does not validate or check it for accuracy or reliability.

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