Evaluation of the Bath & North East Somerset Community Wellbeing Hub Pilot Multi-Disciplinary Team Frailty Service

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Funder: This report was funded by the Community Wellbeing Hub via the Better Care Fund

This report was supported using OpenAI's ChatGPT. OpenAI (2025). ChatGPT (Version 4.0). All findings, interpretations, and conclusions remain those of the authors.

Contents

Executive Summary

Funder

This report was commissioned by the Community Wellbeing Hub and funded by the Better Care Fund programme to evaluate the impact of the Multi-Disciplinary Team (MDT)[1] Frailty Service for clients and to understand how effective collaborative working has been across multi sector agencies.

Background

The NHS England Five Year Forward View, British Geriatric Society 'Fit for Frailty' publication, and published frailty pathways recommend a move from a reactive to a proactive approach to frailty management, and from a medical to a multi-professional/ integrated model approach. Care should be person centred, with the client/ resident at the centre of decision making in the community. This report describes the inception, delivery and impact of a 21-month pilot community-based, multi-disciplinary frailty service informed by this evidence-base and designed to meet the needs of people living within Bath and Northeast Somerset (BANES). The pilot was initially designed to include referrals from primary care, proactive case finding from clinical systems and direct referrals from voluntary services. This was quickly streamlined to a defined group of voluntary services utilising the Community Wellbeing Hub and RIVIAM digital as core enablers for referrals and multidisciplinary working.

Evaluation Methods

This service evaluation report describes the 8-week set-up phase (June-September 2023) and integrates Frailty MDT client clinical data (n=157), professional e-survey feedback data (n=13) from the organisations/agencies represented in the MDT, and client and carer qualitative interview data (n=6) for the period September 2023 to March 2025. The Frailty MDT pilot project has demonstrated measurable improvements in client outcomes, service efficiency, and collaboration with health and social care partners. By adopting a proactive approach to person-centred care through multi-agency, the Frailty MDT has made significant impacts on the wellbeing of frail and elderly individuals across the BANES region.

The Frailty MDT's focus on early intervention and partnership working has demonstrably reduced duplication of effort and helped prevent costly hospital and care home admissions. With modest investment, the Frailty MDT pilot project exemplifies effective multidisciplinary collaboration, delivering impactful, person-centred care and aligning with NHS strategic priorities.

Frailty MDT Service Key Statistics and Impact

- Integrated working across primary, secondary, and voluntary health and social care organisations led to 157 client referrals to the Frailty MDT
- A proactive comprehensive holistic MDT completed for 141 clients
- Home visits and comprehensive geriatric assessment (CGA) for 125 clients completed by the Advanced Nurse Practitioner, Dorothy House Hospice Care, and Health Coaches
- Early identification of pre-frailty (Rockwood measure 4) for 20 clients with outcomes to slow or stop progress into frailty implemented
- Advanced care planning discussions with 64 clients involving crisis plans, ReSPECT, Health and Welfare Lasting Power of Attorney (LPA)

The Frailty MDT has delivered meaningful impact by doing two things exceptionally well. First, it enabled **proactive, cross-organisational working**, identifying unmet need early and coordinating care across health, social care, and voluntary sectors. This reduced hospital admissions and supported people to stay well at home:

"The Frailty MDT is a great way of enhancing communication between professionals, reducing duplication and establishing the best way forward to support service users. It puts the service user at the centre." (Alzheimer's Society)

Second, it provided **holistic, comprehensive client assessments** that included social, financial, and housing issues, therefore offering truly person-centred care, and addressing factors that are known to influence current and future health outcomes:

"We were seen, not just listened to. It was very practical." (Client)

To preserve the Frailty MDT's impact, these two elements should continue in any future service. They represent the core value of the service and align directly with NHS priorities. Commissioners are encouraged to invest in these features as essential foundations for effective, integrated frailty care.

Impact of Stopping MDT Frailty Service

If the Frailty MDT were to stop, the coordination and quality of care for vulnerable individuals would likely decline. Clients may face delayed identification of needs, fragmented care, and an increased risk of emergency hospital admissions due to the loss of proactive, preventative input. Carers would experience fewer emotional and practical support options, heightening stress and isolation. Health and social care professionals, including GPs and nurses, would need to absorb the MDT's workload, leading to reactive rather than preventative care. System-wide, the loss of early intervention may increase costs through more frequent Emergency Department use and hospital stays. The frailty service expertise of the Advanced Nurse Practitioner and cross-sector collaboration links e.g., with organisations such as Age UK, BEMSCA, and the Alzheimer's Society, may weaken. Ultimately, clients and carers who rely on the MDT's consistent, joined-up support may feel lost and fail to access alternative support.

Executive Summary *Cont.*

MDT Frailty Service Future Vision

As demand for integrated, person-centred care continues to grow, the frailty MDT presents a compelling model for future service delivery — one that bridges system priorities with what matters most to clients. To preserve and extend the MDT's positive impact, the vision for the future should focus on embedding and scaling the two elements that offer the greatest value.

At the system level, proactive, cross-organisational working must remain a core feature. This includes early identification of unmet need and coordinated planning from the point of referral onwards. The MDT model has shown that when professionals from across health, social care, and the voluntary sector work in partnership, they can prevent crises, reduce hospital admissions, and deliver timely interventions that support people to live well at home. Maintaining this proactive, joined-up approach is essential to ensuring limited resources are used effectively and client journeys are smoother and more consistent.

At the client level, the holistic, comprehensive assessment approach must continue to be prioritised. The MDT creates space to explore a client's medical, emotional, social, financial, and housing needs in an integrated way, enabling interventions that are both clinically appropriate and personally meaningful. This depth of assessment, coupled with coordinated action, is what distinguishes the service from standard pathways.

These two elements, system-wide collaboration from the outset and holistic client care, must be retained and resourced. They are not simply features of the MDT model of care; they are its foundation.

We recommend the MDT Frailty Service, and its long-term evaluation sits within the HCRG Care Group community services 'Transformation Programme' to include an Executive Lead, funding, and goals which match national and local priorities in line with the Ten Year Health Plan for England (2025-2035)[2].

Pilot Background Proposal 2023

MDT Frailty Service Future Vision

The Five Year Forward View (NHS England[3]), Fit for frailty[4] (BGS) and frailty pathways outlined a move from reactive to a proactive approach to the management of frailty, and from a medical model to a multi-professional/ integrated model with the client/ resident at the centre of decision-making in the community as far as possible. The NHS 10-year plan[5] , and most recently the primary care Primary Care Network specifications[6], detail how care models should include multi-disciplinary team working, proactive and person-centred care. The Chief Medical Officer's report[7] makes the case that illness with ageing is not inevitable with work around prevention; quality of ageing is as important as longevity, and to focus where the needs are greatest.

Positive outcomes of integrated working, anticipatory care and comprehensive geriatric assessment (CGA) could include identifying new diagnoses; person-centred multi-professional review of medicines and care; shared learning and decision making; referrals avoided; increased advanced planning /ReSPECT discussions. CGA has been shown to reduce hospital and care home admissions, reduce mortality and improve satisfaction[8].

Aim: To identify increases in community frailty and prevent the need for urgent and emergency care, leading to potential admission to an acute setting/ Care Home

A Frailty MDT anticipatory care service was planned to meet the above aim and to run as a pilot for 12 months, using the first 8 weeks of the pilot to identify snagging and revise any processes. The MDT would provide proactive assessments and provision of support, care or aids for those with frailty, who were identified as:

- At highest risk of decline and/or hospital admission,
- Complex health concerns,
- Self-neglect concerns,
- Safeguarding concerns or high use of emergency / primary care services,
- People who may not approach, engage with, or meet a referral threshold to existing health and social care agencies.

Objectives:

- Early identification of an increase in frailty, enabling implementation of preventative care and support.
- Early identification of people at risk of self-neglect and/or safeguarding concerns.
- Highly skilled assessment of frailty using evidence-based interventions.
- Engagement with the client / family / carer for shared decision-making outcomes.
- Discuss and document advanced planning decisions and client-centred wishes.
- Provide personalised holistic care plans.
- Knowledge and skills transfer among attendees of MDT.

Inclusion Criteria:

- Clinical Frailty Scale > 5
- Aged 65+
- BANES resident registered with a BANES GP
- Not under current/active pathway
- In need of proactive support and likely to benefit from MDT discussion

Exclusion Criteria:

- Care home resident
- Current acute illness or uncontrolled condition
- Recent discharge from hospital
- No consent to shared records

Proposed Service model

(see Appendix 1 proposed client pathway and, appendix 2 final client pathway)

- To deliver one Frailty MDT per week with four or more clients discussed at each MDT, after which all remaining identified care and support requirements would be referred to the appropriate team. No clients were to remain under the care of the Frailty MDT, this was proposed as a 'review and refer service'. Referrals were to be made from the Community Wellbeing Hub and voluntary services who recognise those clients who may need additional support, and to include people who may not approach, engage with, or meet a referral threshold to existing health and social care agencies.
- A second arm of the service was to proactively seek for referrals using the Integrated Care Record Population Insights Tool (ICR) to identify those with a recognised need or early frailty.
- Client pathway, documentation and administration processes to be developed, tested and finalised within the first 8 weeks of the pilot and refined over the remaining 12 months.

The MDT was proposed to comprise:

- Frailty Advanced Nurse Practitioner (0.4 FTE)

The following to meet once per week for 2.5 hrs, either online or face to face.

- GP
- Dietitian
- Pharmacist
- Social Worker
- Administrator

Finance from ICB

£15,000 for 12 months to cover Primary care staff costs. Frailty Advanced Nurse Practitioner salary already covered by BSW ICB.

Progress to date

The service was launched in June 2023.

Service delivery refinements

During the first 8 weeks of the pilot the following aspects of the above service model were considered and refined:

- Established links and support with the Community Wellbeing Hub which provided access to voluntary services and premises for the Frailty Team, including the lead. This also enabled ability to gain consent to share information across the system.

Pilot Background Proposal 2023

- Project team and membership of weekly MDT agreed. The breadth and complexity of client need, and variety of operating models across the system meant that a far broader MDT membership was required than originally thought, which would utilise the skills, expertise, data systems and networks of Community partners.

  Final MDT comprises:

  - West of England Rural Network (WERN) Village Agents
  - Age UK
  - Carers Centre
  - Stroke Association
  - Health Coaches (HCRG)
  - Alzheimer's Society
  - Bath Ethnic Minority Senior Citizens Association (BEMSCA)
  - Dorothy House Hospice Care
  - Community Wellbeing Hub
  - Frailty Advanced Nurse Practitioner (0.4 FTE)

- Developed and agreed the pathway for Frailty review/MDT and the assessment document.
- Introduced the Rockwood frailty score (Appendix 3) to be conducted at first assessment and 'What Matters for you', to ensure care was personalised.
- Documentation agreed e.g. frailty MDT referral form (Appendix 4), introduction letter, frailty MDT assessment paperwork (see Appendix 5), outcomes letter template.
- Established a data management system e.g. coordination of referrals via RIVIAM, which worked well via the 'Ageing Well Pod'.
- Proactive universal signposting/ information.

Challenges/Revisions from original plan

- Including Primary Care staff input into the weekly MDTs proved to be challenging and was not achieved. Challenges cited included funding (despite some funding being available), backfill, and releasing staff. The costs provided to support this resource were therefore not used.
- Proactively seeking referrals via the ICR Population Insights Tool was not possible. Extensive efforts were taken to work with GP practices and partners to access the relevant data but there was no Data Protection Impact Assessment (DPIA) for proactive/ case finding within GP records. The volume of work required to conduct a DPIA assessment was not practical.
- Operating as a 'review and refer' service was quickly found to not be the appropriate model to meet clients' needs. The MDT quickly agreed that clients needed to stay under their care for as long as required to meet their needs, and/ or ensure recommended next steps were in progress. Most clients needed to remain under the Frailty service for a period, albeit a relatively limited time. A two-week follow-up after the MDT was implemented. The purpose of this follow-up appointment with the ANP was:
  - to ensure the client had received, understood and agreed/or required amendments to, the letter from the Frailty ANP, which described the outcome and recommendations from the MDT discussion.
  - to promote shared decision making with the client by providing them time to discuss the contents of the letter with family members and/or their GP before they met again with the ANP;
  - to enable the ANP to check that recommended actions (e.g. referrals) were in progress, or re-activating referrals (client or system hadn't done).
- It was planned that one of the evaluations would include the Personal Wellbeing Office for National Statistics 4[9] measure recorded at first contact with clients and then 4-8 weeks after work finished. However, due to resource and time constraints it was not possible to follow-up with clients at the 4–8-week interval.

Key outcomes during the pilot included:

- Establishment of the Community Wellbeing Hub weekly MDT and mutual benefits and efficiencies of integrated working.
- Able to tailor care to clients' needs and help to meet the requirements of the equality agenda.
- Significant advantages of assessing clients in their homes and using a multi-agency approach.
- Improved completion of ReSPECT forms for clients seen within the new service.
- Shared learning about the benefits of the Integrated Care Board (ICB) Integrated Care Record.
- Identifying knowledge gaps and supporting new training opportunities. Formal teaching delivered to Community Wellbeing Hub, voluntary organisations, Community MDT and other partners.
- The health and social care benefits to clients of health, social care and voluntary services working as a single team. This was a novel and innovative approach, which is not currently replicated anywhere else in the ICB system.

The Community Wellbeing Hub and its members are central to delivering the Frailty MDT enabling cross-organisation communication, providing physical meeting spaces, and access to RIVIVAM. This supports integrated working across BANES.

Check out the Frailty MDT in action: https://vimeo.com/946904680?share=copy

In partnership with

Evaluation Methods

1. Client clinical data

Between June 2023 and the end of March 2025, 157 clients were referred to the Frailty MDT. The average holding time for a client in the 'Ageing Well Pod'/Frailty MDT was 3-4 weeks from first assessment to complete discharge usually recorded as a 'needs met' entry on RIVIAM. The average number of clients discussed in the weekly MDT meetings was 15-20 clients. As of 31st March 2025, there were 21 clients still held by the 'Ageing Well Pod'.

The ANP and research team designed an excel spreadsheet to record key client clinical data including Rockwood clinical frailty scores, clinical outcomes (e.g., advanced care plan complete, medication stop recommendation), clinical advice topics discussed (e.g., infection control, mobility/falls), and social advice topics discussed (e.g., finance, carer support). The ANP manually input clinical data into the spreadsheet at regular intervals over the data collection period. The ANP and research team reviewed the clinical data spreadsheet at two time periods (December 2024 and April 2025) to ensure consistency in recording, level of detail and accuracy, missing values, and manual errors. The Frailty MDT clinical data (n=157) were then summarised to provide an overview of the key findings from the dataset.

2. Frailty MDT professionals impact e-survey data

Qualitative data were collected via an electronic survey (e-survey) completed anonymously by 13 clinical and non-clinical professionals involved in the Frailty MDT. Participants who responded to the survey were from the following organisations/agencies Bath Ethnic Minority Senior Citizens Association (BEMSCA) n=1; West of England Rural Network n=3; The Carers Centre n=1; HCRG Care Group n=1; Alzheimer's Society n=2; Age UK Bath & North East Somerset n=2; Dorothy House Hospice Care n=2; NHS Royal United Hospital n=1.

The e-survey included open-ended questions exploring individual roles within the MDT, organisation/agency contribution to MDT meetings, examples of MDT client support, client contact methods, and MDT strengths, weaknesses, and opportunities for improvement (see Appendix 6). The e-survey aimed to:

- Generate insights to help understand the benefits, challenges, and impact of the Frailty MDT from MDT professionals.
- Inform the qualitative interviews with MDT clients and carers.

The e-survey launched at a Frailty MDT meeting on 29th January 2025 and data were again collected over a 36-day period from January to March 2025. Participation was voluntary and three reminder emails were sent to Frailty MDT members. The average time to complete the e-survey was 14 minutes.

Thematic analysis was used to analyse responses. All submissions were read in full, and an inductive coding process was applied to identify recurring phrases and patterns. These were refined into core themes through an iterative process, with particular attention to common viewpoints and significant reflections across roles. For example, initial codes such as "working together," "no duplication," and "joined-up care" were grouped to form the core theme of Enhanced Communication and Collaboration. This theme was then validated by reviewing it against other responses to ensure consistency and depth.

ChatGPT was used to assist with summarising and structuring the thematic insights, while all coding and interpretation was conducted and verified by the research team to ensure accuracy and context. The findings were then mapped against relevant national strategies including the NHS Long Term Plan[4], the FRAIL Strategy[10], and NICE Guidelines on Multimorbidity and Frailty (NG56)[11] to assess alignment and inform recommendations.

3. Client and carer qualitative interview data

To complement the MDT professional perspectives from the e-survey findings, a series of one-to-one qualitative interviews (n=6) were conducted with clients and carers who had accessed the frailty MDT (see table 1).

The ANP used a purposive sampling to approach potential clients and invite them to participate in an interview with the Lead Research Nurse. If clients indicated they would like to be involved, the Lead Research Nurse contacted participants via telephone to explain the purpose of the research and to arrange a convenient date and time for the interview. Participants were given at least 24 hours to consider participating and consent was obtained the day prior to interview.

Interviews were conducted in April 2025 mostly at the client's home (n=5) and one conducted via telephone. The aim was to understand the Frailty MDT client lived experience. Interview topics included: types of clinical and social support received from the Frailty MDT, whether they felt the Frailty MDT had had a positive/negative impact on their lives, how clients were accessing clinical and social care support prior to being referred to the frailty MDT, and how clients might access clinical and social care support if the Frailty MDT had not been involved (see Appendix 7).

Interviews lasting approximately 30 minutes each were audio recorded and transcribed verbatim using Microsoft Teams embedded software. Anonymised transcripts were analysed using manual thematic analysis to form key codes which were then compared to the e-survey codes.

Table 1: Client and Carer Interview Participants

Participant number	Age *(years)*	Gender	Frailty Score	Ethnic Group	Postcode
1	77	Male	n/a carer	White British	BA1
2	90	Male	6	White British	BS40
3	90	Female	7	White British	BS40
4	89	Female	6	Afro-Caribbean	BA1
5	93	Male	7	Afro-Caribbean	BA1
6	80	Female	n/a carer	White British	BA2

Evaluation Results

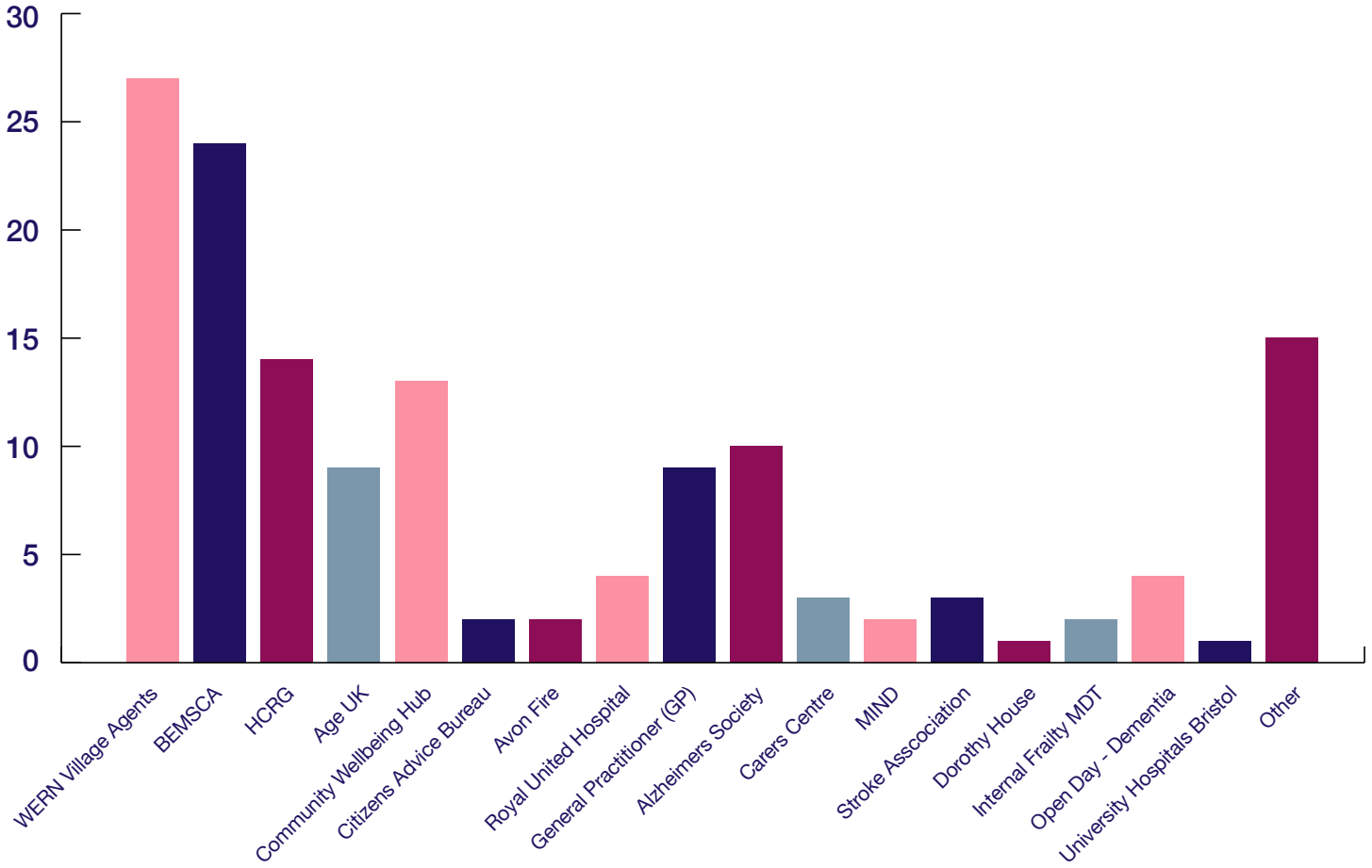


Figure 1: Organisations referring clients to Fraililty MDT

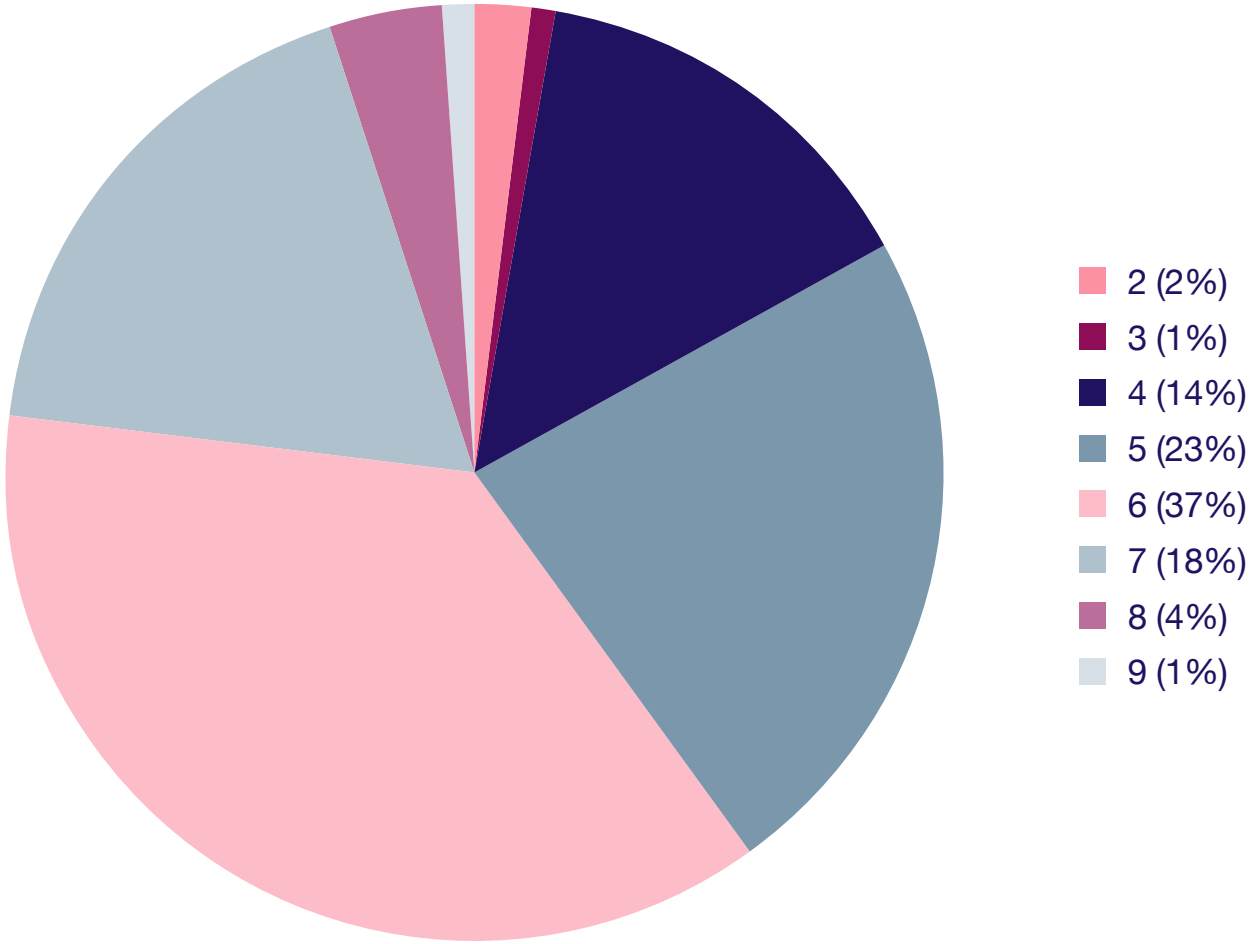


Figure 2: Client Rockwood Clinical Frailty Scale Scores (n=100)

Client outcomes from MDT clinic*

Table 2: Client outcomes from MDT Clinic.

Outcome	Frequency
New Advance Care Plan completed e.g. ReSPECT/LPA/written crisis plan	64
Medication start recommendation	35
Medication stop recommendation	65
End of life care	1
Decline referral	8

Referrals to primary care & community

Table 3: Fraility MDT with Referrals to primary care & community

Service/Organisation	Number of clients (n=92)
GP letter	125
GP MDT attended	40
RUH (clinical advice & referral)	23
ReMIND UK	10
Primary Care Mental Health	10
Reablement	6
Community Nurse/SALT	18
Continence Service	7
Virtual ward/ HCRG Urgent Community Response	6
Social Work	7
Community Matron	5
Dorothy House	4
Health Coaches	1

*There was also a total anticholinergic burden reduction.

Referrals to Voluntary services

Table 4: Frailty MDT referrals to Voluntary services

Voluntary service	Frequency
Age UK	47
Carers Centre	28
Curo	8
WeCare	17
Avon Fire Safety	15
Reconnecting Twerton	3
WERN Village Agents	4
Hearing & Vision	10
Stroke Association	2
Citizen Advice Bureau	3
Alzheimer's Society	3
MIND	6
Podiatry	4
Speech & Language Therapy	1
Admiral Nurse Dorothy House (Dementia UK)	2
Herbert's Protocol (Avon Fire & Police)	2
Other	22

Probable new diagnosis

Table 5: Probable new diagnosis

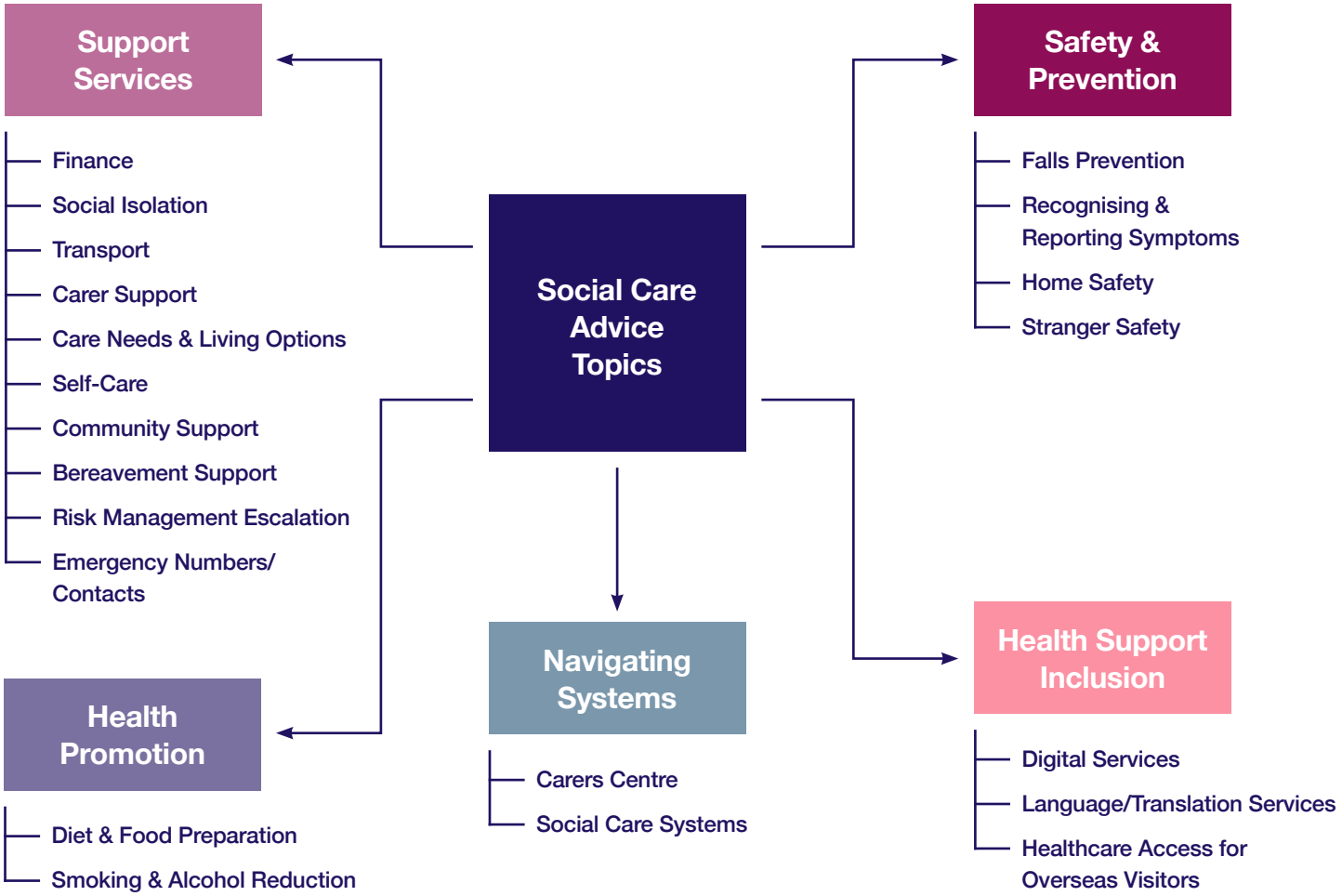
New diagnosis	Frequency
Cognitive Impairment/ Dementia	23
Skin/Pressure Ulcer	5
Lymphoedema	1
Postural hypotension	14
Weight Loss	22
Mental Health	10
Atrial Fibrillation	3
Hypoglycaemia	1
Constipation	11
Incontinence	3
Infection	9
Falls	20
Medication side-effects	8
Other	11

Clinical and Social topics advice shared with client

Table 6: Clinical and Social topics advice shared with client

Clinical Advice provided	Number of clients (n=92)
Speech/Swallow	19
UTI	8
Delirium	22
Memory/Capacity	29
Wound care	3
Driving / Transport	5
Continence	33
Medications side-effects	78
Nutrition	25
BP/postural hypertension	21
Post falls/ falls advice	39
Skin integrity	9
Emergency planning	21
Infection	4
Rehabilitation	7
Safeguarding	3
Hearing/Vision	8
Other	4

Figure 3: Social Care Advice Topics Overview



Key Findings: Frailty MDT Impact Professionals E-Survey

The themes listed below emerged as the MDT's key strengths, highlighting the Team's commitment to improved communication, personalised care, carer support, and the dedication of its staff.

1. Enhanced Communication and Collaboration:

The Frailty MDT has fostered improved communication between agencies, reducing duplication and ensuring that clients received coordinated and person-centred care. The MDT approach enabled valuable knowledge-sharing, ensuring that all aspects of a client's needs were considered.

2. Holistic and Person-Centred Care:

Clinical and non-clinical staff consistently emphasised the MDT's commitment to viewing clients as individuals rather than as a set of medical needs. Comprehensive referral discussions ensured crucial details were not overlooked, and personalised care plans were developed to support wellbeing at home and prevent hospital admissions.

3. Support for Carers and Families:

The MDT provided essential guidance and emotional support to unpaid carers, ensuring their needs were acknowledged alongside those of the cared-for individual. Clinical and non-clinical staff worked to empower carers by linking them with additional support services (e.g., Attendance Allowance, Blue Badges) and practical resources (e.g. shopping support service).

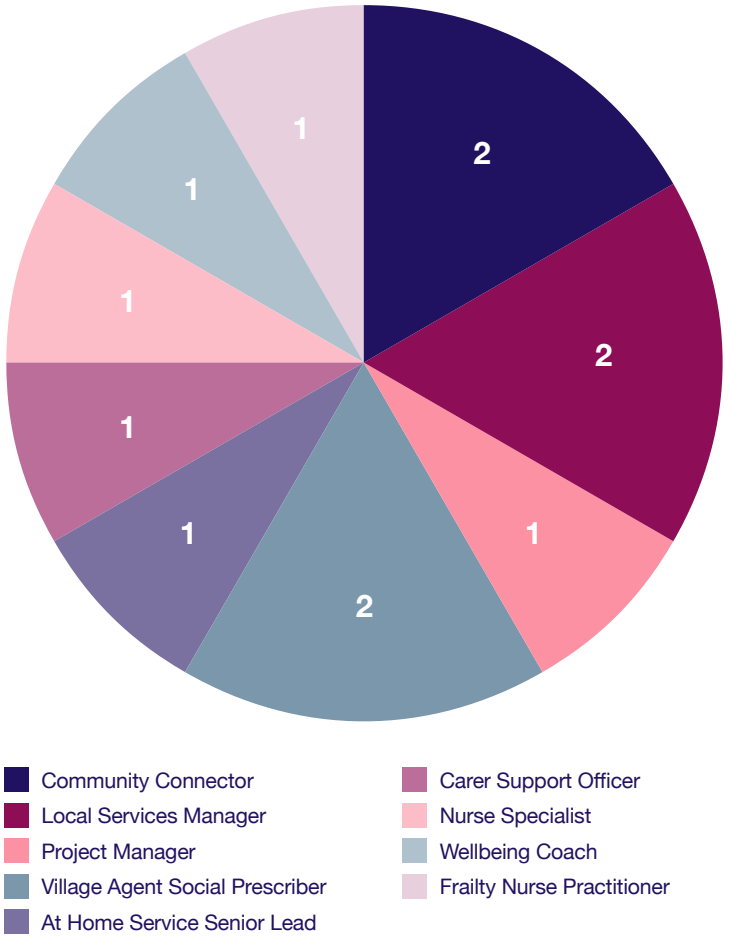
4. Commitment and Dedication of Staff:

The MDT's success was underpinned by the dedication of professionals who contributed their expertise above and beyond their primary roles. Clinical and non-clinical staff regularly provided support without additional funding, demonstrating their commitment to improving client outcomes.

Frailty MDT Organisations, Roles, and Contributions

The participants' survey responses emphasised how different roles ranging from medical professionals to community support workers collaborated to ensure clients received comprehensive, tailored care (see figure 4).

Figure 4: Frailty MDT Roles and Contributions



Key Findings: Frailty MDT Impact Professionals E-Survey

Responses to "What Your Role Brings to the Frailty MDT" emphasised the skills, expertise, and practical contributions that each role offered. This included clinical assessments, emotional support, and providing information to improve client outcomes.

1. Community and Cultural Support

BEMSCA (Bath Ethnic Minority Senior Citizen Association):

- Supports BAME communities, ensuring cultural needs are met.
- Provides insights into clients who may not otherwise engage with services.
- Ensures representation and advocacy for ethnic minority elders.

2. Medical and Clinical Support

Frailty Nurse/Practitioner:

- Provides clinical assessment, hospital prevention strategies, and direct care.
- Plays a key role in clinical decision-making within the MDT.

Nursing/Palliative Specialists:

- Advises on complex care needs, symptom management, and end-of-life care.

3. Dementia and Cognitive Support

Alzheimer's Society & Dementia Advisers:

- Supports individuals with dementia, and their carers.
- Ensures updates and advice are shared with the MDT for ongoing care planning.

4. Carer and Family Support

Carers' Support Role:

- Provides emotional support, advice, and guidance for unpaid carers.
- Ensures the needs of both carers and those they care for are represented in MDT discussions.

5. Community Navigation and Practical Support

Village Agents and Wellbeing Coaches:

- Offers local insights, identifies vulnerable individuals, and makes referrals.
- Supports clients in their homes, identifying risks and needs.

6. Age UK Representative

Age UK MDT Representative:

- Shares relevant information about Age UK services.
- Provides advice on welfare benefits (e.g., Attendance Allowance, Blue Badges), housing, and social connection opportunities.

Responses to "How Your Role Fits Within the Frailty MDT" focus more on the integration of roles within the MDT, highlighting referral pathways, information sharing, and ensuring client needs are effectively represented in discussions.

- The Frailty Nurse (ANP) anchors the medical and clinical decision-making, supported by specialists in dementia care, palliative care, and carers' support.
- The Village Agents and Wellbeing Coaches provide on-the-ground insights, identifying and referring those in need of intervention.
- Age UK, Alzheimer's Society, and BEMSCA ensure clients receive holistic support that includes emotional, social, and practical assistance.

Methods for MDT to contact Clients

The primary contact methods for the MDT to contact clients were telephone followed by use of digital contact methods including video calling and email communications (see figure 5). In person visits to clients' homes were used by three respondents who described these visits as a valuable source of contextual information.

Benefits of Visting Clients in their Own Homes

- **Enhanced Understanding of Client Needs**
  Home visits enabled professionals to gain a clearer picture of a client's day-to-day living conditions, enabling them to identify risks such as trip hazards, poor nutrition, or medication issues. Observing how clients managed tasks like making a cup of tea or moving around their home provided valuable insights that are often missed in clinical settings. This deeper understanding helped professionals to tailor support to individual needs.
- **Improved Communication and Trust**
  Professionals reported that clients are generally more comfortable and willing to engage when visited in their own homes. This relaxed environment encouraged open discussions about their concerns, preferences, and future care. For those who may struggle with phone conversations, have hearing difficulties, or are wary of accessing health and social care digital services, face-to-face visits built rapport and trust.
- **Personalised and Effective Support**
  Visiting clients at home allowed professionals to provide immediate practical support. This included for example, reviewing medications, assessing the suitability of equipment, or identifying small changes that could significantly improve safety and independence. This personalised approach ensured care plans were more effective and better aligned with the client's real-life circumstances.

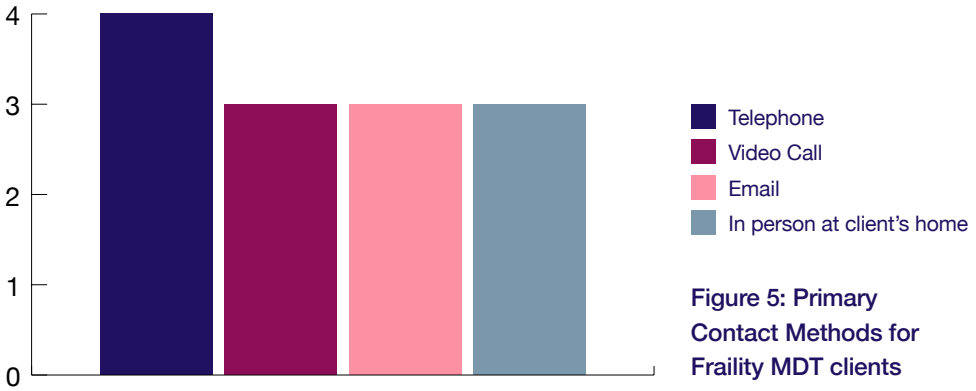


Figure 5: Primary Contact Methods for Frailty MDT clients

Impact Quotes

These e-survey quotes reflect the dedication and impact of multidisciplinary teamwork, holistic support, and commitment to improving the wellbeing of clients and carers.

Communication and Collaboration

"The Frailty MDT is a great way of enhancing communication between professionals, reducing duplication and establishing the best way forward to support service users. It puts the service user at the centre." (Alzheimer's Society)

"By bringing clients we know to the MDT, we have their background story, knowledge of informal support, risks that have been identified and longer-term aspirations – might be housing options, care preferences, and ReSPECT wishes." (WERN)

Holistic and Person-Centred Care

"I am especially proud of how in-detail the referrals are discussed, making sure not to miss anything, and seeing the person as a whole person and not just a number. Everyone in the MDT sees the importance of a person-centred approach." (HCRG Care Group)

Support for Carers and Families

"The family/friend is often impacted by their caring role and the needs of the cared for client. My role is to discuss this within the MDT and offer guidance and potential support and advice to the carer." (The Carers Centre)

Dedicated and Compassionate Staff

"The MDT members offer their time, knowledge, and skills every week without additional funding or support, in addition to their usual roles in order to support clients and families." (Royal United Hospital)

"The Frailty Advanced Nurse Practitioner role is centred around support of people with frailty including clinical, development, education and research (the four pillars of advanced practice)." (Royal United Hospital)

Key Findings: Client and Carer Interview Data

Client and Carer conversations offered rich, personal insights into how the frailty MDT is experienced at the individual level and further reinforced the key themes identified in earlier survey analysis: holistic and person-centred care, enhanced communication, and proactive support.

Holistic Assessment and Timely Support

Participants described the MDT's approach as comprehensive and timely, delivering care that addressed both medical needs and wider social concerns. One carer (Participant 1), supporting his wife living with dementia, spoke of how difficult it had been to access meaningful support until the frailty service became involved:

"Suddenly the ANP appeared. He looks at things from a slightly different angle — forward planning. I'm now aware of Continuing Health Care (CHC) funding in case of emergency."

"ANP helped us think of what we need, at the right time."

This support extended to practical information and emotional support. The Alzheimer's Society had already offered some help, but the carer noted that the ANP helped him select the most useful booklets from what he called an "overwhelming" range of information. The result was clarity and confidence in managing the next steps.

Reaching Isolated, Complex Cases

Participants 2 and 3, a 90-year-old couple living in a remote rural area, reflected on their experience of care after the husband had recently been advised not to drive. The wife, a wheelchair user following a stroke, requires a hoist and daily assistance. Though they had longstanding links with Village Agents and the Curo Rural Independent Living Service due to their adult son's complex needs, they described struggling to contact their GP. The ANP's involvement was pivotal in linking them to their GP and reviewing their multiple needs — including falls history, fluid retention, and pain.

"We were seen, not just listened to. It was very practical."

Cultural Competency and Community Trust

Participants 4 and 5 were referred to the service via BEMSCA, illustrating the service's reach into ethnic minority communities. Language, trust, and cultural understanding are critical in these contexts. The participants spoke warmly of the way support was delivered:

"When the ANP first came, it was a joy!"

"ANP's just in time – every time."

"I've had help with my tablets for pain. The ANP advocates for us – he gets it done."

Alleviating Isolation and Emotional Overload

Participant 6, a rural carer for her partner with dementia, described being overwhelmed by a large box of information containing 16 different documents:

"I didn't know whether to laugh or cry… everywhere I went, there was all this signposting. But you never actually got to somebody who said, 'I'll come and visit you.'"

She met the frailty team during a carers event at her GP surgery and described the relief she felt when a visit was offered:

"When the ANP said, 'I'll come and see you,' it was just wonderful. The ANP wrote a very comprehensive report. At last, I felt there was somebody putting all the bits of the jigsaw together. He is worth his absolute weight in gold, really."

These insights illustrate the essential role the frailty MDT plays in navigating complex care systems and delivering joined-up, person-centred care to those who are often overlooked by standard service pathways.

Success Story: Supporting a Frail Elderly Couple with Emergency Planning and Emotional Support

Background: A husband and wife, both elderly and living in their own home, were referred to the Frailty MDT. The husband had physical health needs, and the wife had a diagnosis of dementia. Despite these challenges, they were managing well at home but lacked a clear contingency plan should their circumstances suddenly change.

Holistic Assessment and Timely Support

Intervention:

- A Carer Support Officer conducted a home visit to assess their situation and develop an emergency plan.
- During the visit, the couple received emotional support and information about available wellbeing activities to help maintain social connections and improve their quality of life.
- The emergency plan outlined steps to be followed if one of them became unwell, ensuring that appropriate support services could step in as needed. This plan was also shared with relevant professionals to ensure continuity of care.

Outcome:

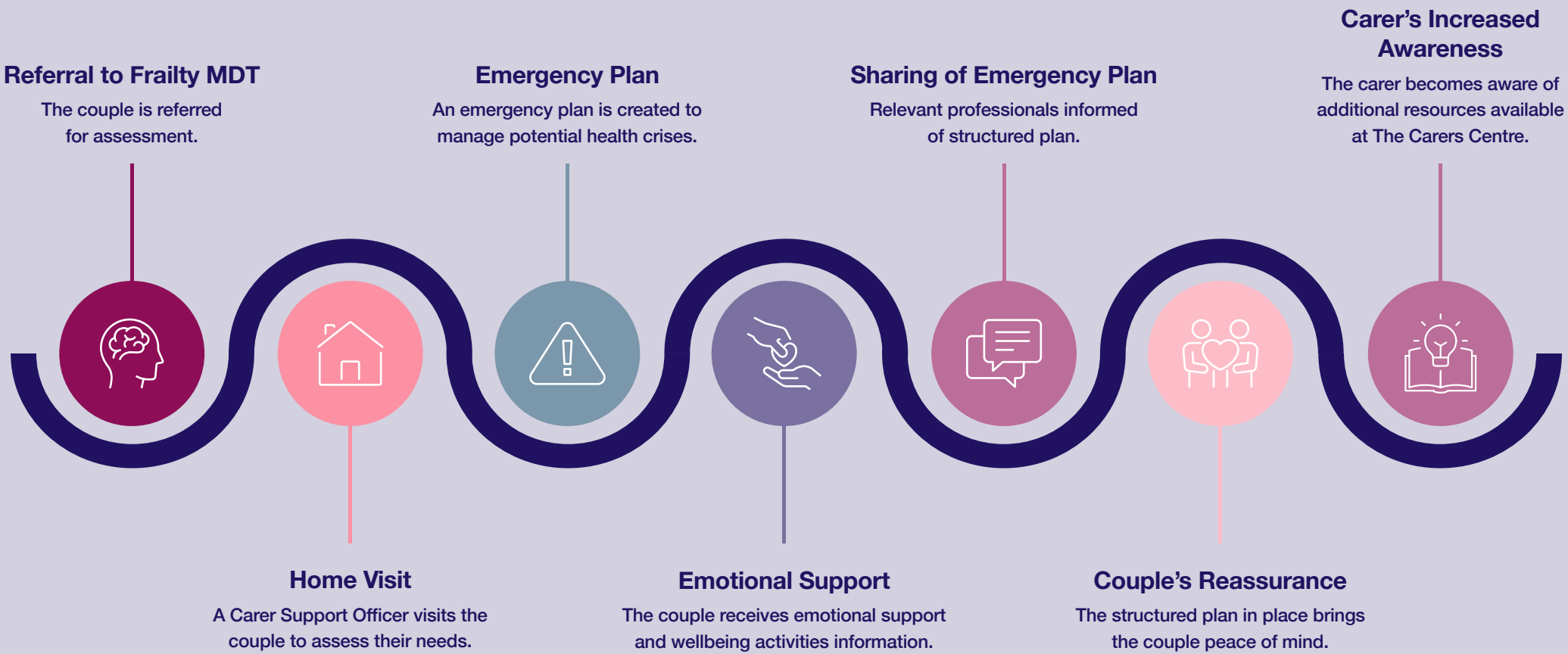
- The couple expressed reassurance knowing that there was a structured plan in place, giving them peace of mind about future emergencies.
- The carer (husband) felt more supported and aware of additional resources available to him through The Carers Centre.

Impact: This intervention demonstrates the value of proactive planning in preventing hospital admissions and improving client emotional wellbeing. The combination of practical support, emotional reassurance, and partnership working with community services ensured the couple felt secure and better prepared for unforeseen circumstances.

Key Learning: This case highlights the importance of:

- Early identification of vulnerable individuals who may benefit from Frailty MDT input.
- The role of emotional support alongside practical interventions to empower families and carers.
- Collaborative working between the Frailty MDT and community services to provide holistic care.

Figure 6: Example of Frailty MDT Client and Carer Pathway



What would happen if the Frailty MDT stopped?

Based on the data, the Frailty MDT's absence would likely result in reduced care coordination, higher rates of emergency care, and increased stress for both clients and healthcare professionals. Several potential consequences could arise including:

Impact on Clients and Families

- Delayed Identification of Needs: Vulnerable individuals, particularly those identified through voluntary sector involvement or community referrals, may go unnoticed.
- Reduced Person-Centred Care: Without the coordinated MDT approach, client care may become fragmented, increasing the risk of unmet social, emotional, and medical needs.
- Increased Hospital Admissions: The MDT's proactive home visits and early intervention strategies suggest it plays a vital role in preventing avoidable admissions. Without this, more clients may reach crisis points before receiving care.
- Emotional Support Gaps: Carers and families may experience reduced support, particularly in managing emergency plans, applying for financial aid, or accessing emotional support.

Impact on Health and Social Care Services

- Increased Pressure on Primary Care: GPs, community nurses, and social workers may struggle to fill the gap, leading to longer waiting times and fewer proactive interventions.
- Reduced Cross-Agency Collaboration: The MDT format encourages knowledge sharing and coordinated care plans. Without it, professionals may face challenges in information sharing and care coordination.
- Missed Opportunities for Preventative Care: The MDT's proactive identification of frailty risks and provision of wellbeing services may diminish, resulting in a reactive rather than preventative care model.

Impact on System Efficiency and Value for Money

- Increased Costs: Without the MDT's early interventions, clients may present at Emergency Departments in crisis more frequently, driving up costs for emergency care and hospital stays.
- Loss of Specialist Knowledge: The Advanced Care Practitioner's expertise in frailty care may be difficult to replicate in standard primary care settings.

Wider Social Impact

- Loss of Community Partnerships: The MDT successfully integrates support from groups such as Age UK, BEMSCA, and Alzheimer's Society. Without the MDT, these links may weaken.
- Reduced Confidence in Support Services: Vulnerable people and their families who have relied on the Frailty MDT service for reassurance and continuity may feel isolated, uncertain, and fail to access alternative support.

Frailty MDT Alignment with NHS Strategies and Guidelines

The Frailty MDT aligns with several key objectives in the NHS England's Long-Term Plan (2019)[4] and the FRAIL Strategy[9] by:

- Reducing hospital admissions through early intervention and proactive or anticipatory care.
- Improving integration by linking primary care, social services, and voluntary sector organisations.
- Enhancing patient (client and carer) outcomes by identifying unmet needs in the community.
- Providing holistic, person-centred care that aligns with national ambitions for personalised care pathways.

Below we highlight how the Frailty MDT connects to key elements of the NHS Long Term Plan4, the FRAIL strategy9, and NICE Guidelines on Multimorbidity and Frailty (NG56)10:

1. Effective Teamwork and Collaboration

The NHS Long Term Plan promotes integrated care systems (ICSs) to break down barriers between health and social care, improving multidisciplinary teamwork and enhancing partnerships across services. The established Frailty MDT model reflects this approach, with professionals from various sectors — including GPs, community services, and social care — working together to deliver improved client outcomes through shared expertise.

2. Person-Centred, Holistic Care

Both the NHS Long Term Plan and Multimorbidity and Frailty (NG56) Guidelines emphasise personalised care that addresses patients' broader social, emotional, and environmental needs. The Frailty MDT aligns with this by adopting a holistic approach where clients are seen as a 'whole person', not just medical cases. This focus on person-centred care mirrors the NHS Ageing Well agenda, which promotes proactive support for older adults, anticipatory care, and frailty services.

3. Enhanced Communication and Information Sharing

The NHS Long Term Plan highlights digital transformation to improve communication between services, supporting smoother referral processes and reducing duplication. The use of MDT meetings ensures information is effectively shared, enabling faster decision-making and enhanced coordination of care.

4. Proactive and Preventative Care

NICE guidelines on frailty management stress proactive, coordinated care for those with complex health needs. The MDT's focus on early identification, home visits, and environmental assessments directly aligns with NICE's recommendation for comprehensive frailty assessment. The MDT's proactive identification of vulnerable individuals further reflects the preventative care principles set out by NICE and the NHS Ageing Well initiative.

Frailty MDT Opportunities for Improvement

Several challenges and opportunities for improvement have emerged from the e-survey responses and are summarised below:

1. Access and Engagement Challenges

- Time Constraints: Multiple respondents mentioned that finding time to attend MDT meetings can be challenging, especially for busy professionals in primary care and social services.
- Limited Reach: While the organisations/agencies effectively engage with some vulnerable groups, there's potential to expand the reach of the service, particularly to those who are socially isolated or unaware of available support.
- Increase Home Visit Capacity: Where possible, prioritise home visits for clients who are isolated, have complex needs, or struggle with phone communication.
- Digital Access Barriers: Some participants noted difficulties using the confidential email system, which may slow communication or create frustration.

2. Operational Limitations

- Administrative Systems: The MDT's current system (RIVIAM) for tracking referrals, actions, and outcomes is described as inadequate, limiting the ability to measure progress effectively.
- Temporary Funding: Concerns about the MDT's reliance on short-term funding were raised, creating uncertainty about long-term sustainability.
- Resource Gaps: Some respondents mentioned challenges with contacting clients, particularly those who are hard to reach or disengaged from services.
- Flexible Contact Methods: While home visits offer benefits, a mixed approach combining face-to-face visits with phone check-ins may optimize time and resources.

3. Service Coordination Issues

- MDT Efficiency: While valued, MDT meetings may become inefficient if the client list expands significantly without additional resources. Some suggested using MDTs primarily as a triage stage to improve focus.
- Gaps in Communication Tools: A stronger reliance on RIVIAM (the MDT's communication and referral platform) was suggested to improve efficiency and reduce duplication.

4. Workforce and Capacity

- Staffing Pressures: The need for dedicated staff time to fulfil MDT actions and develop the service was highlighted, suggesting current roles may be overstretched.
- Training Needs: An identified ongoing need was ensuring all MDT members are confident using systems like RIVIAM and understand MDT processes. Equip staff with observational skills to make the most of home visits, identifying environmental risks and understanding subtle behavioural cues.

System and Client-Level Impact of the Frailty MDT

The Frailty MDT has delivered significant **system-level** and **client-level** impact through its proactive, integrated model of care.

At the system level, the MDT has facilitated closer cross-organisational collaboration, enabling earlier identification of unmet client needs and streamlining access to appropriate support. Voluntary sector partners such as BEMSCA, the Carers' Centre, and local community navigators play a vital role in this process. Their expertise ensures that socially isolated individuals, those with emerging frailty, and carers with limited support are recognised earlier and connected with services they may not have otherwise accessed. This proactive, preventative approach reduces pressure on primary and secondary care while delivering more timely, person-centred interventions.

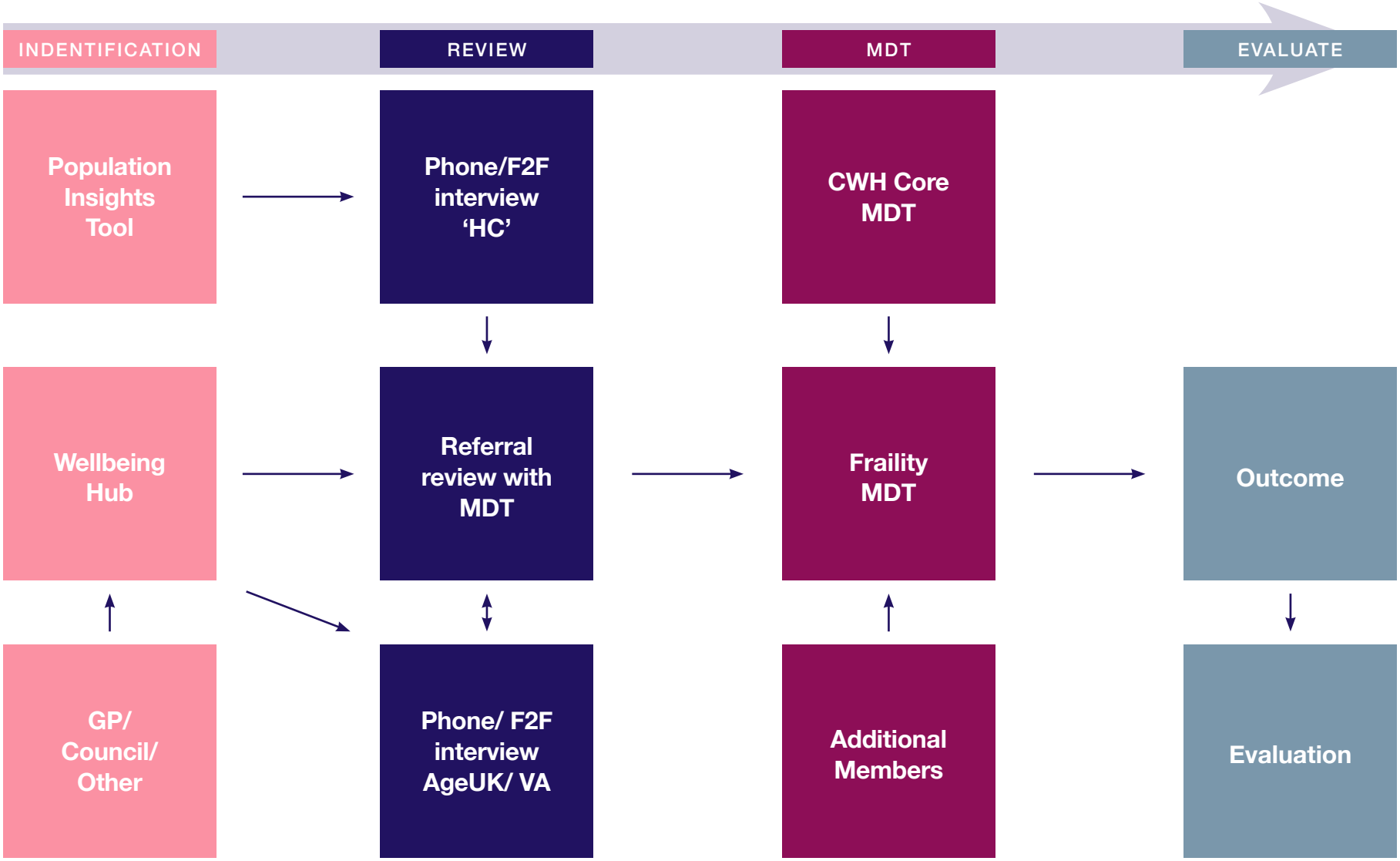
A compelling recent example of system-level impact involved a consultant from the RUH Geriatric Unit contacting the ANP for advice on referring a patient for community support. The ANP signposted the consultant to a new referral app, developed by Age UK and the Community Wellbeing Hub, which enables direct referrals to statutory and voluntary services. The app links to a dashboard that tracks referrals, priorities, and follow-ups, both during inpatient stays and after discharge. The consultant was pleased with the streamlined process and shared it with their team. Previously, patients were expected to self-refer post-discharge, often facing significant barriers. This example demonstrates the MDT's role in enabling proactive cross-organisational working and timely access to community support.

At the client level, the MDT's holistic approach ensures individuals are not only medically assessed but also supported in the broader context of their lives. The comprehensive assessment model captures a full picture of a person's needs — from medication management to social isolation, from housing insecurity to financial pressures. Many clients have received practical support such as assistance with applying for Attendance Allowance, Blue Badges, or help accessing safer, more suitable housing. This joined-up model of care would not have been achievable through traditional single-service interventions.

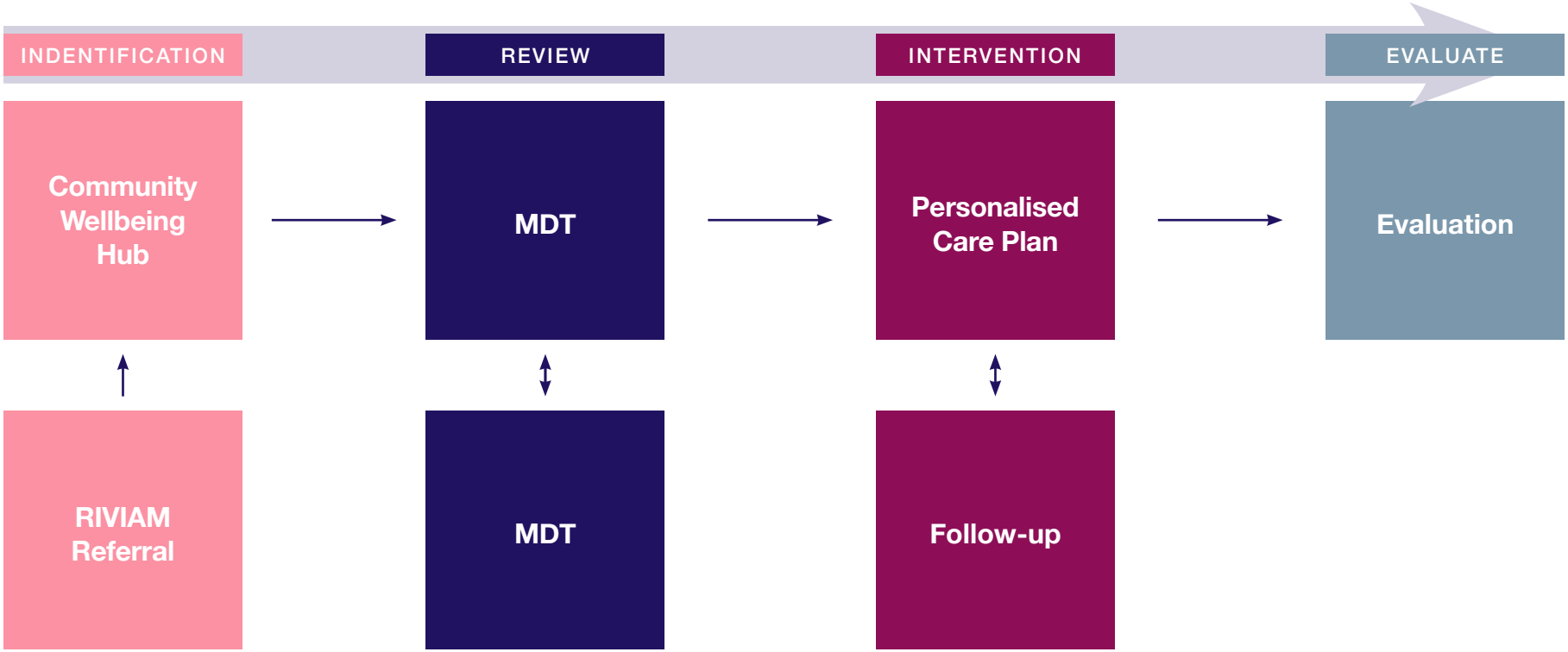
The MDT has created new opportunities for clients to engage in advanced care planning conversations in a timely and supportive setting. These discussions often missed or delayed, in conventional care pathways are approached sensitively, with the involvement of relevant professionals who understand the client's circumstances. As a result, clients are empowered to make informed choices about their future care preferences, reducing anxiety and avoiding unnecessary hospital admissions or interventions that do not align with their wishes.

In one case, a client who had multiple comorbidities and fluctuating capacity was supported through the MDT to complete an anticipatory care plan, ensuring their carers were linked to respite support, and receive financial advice — all within a single coordinated episode of care. This example illustrates the transformative nature of the MDT model, where integrated systems deliver personalised outcomes.

Appendix 1 Proposed Client Pathway



Appendix 2 Final Client Pathway



Appendix 3 Rockwood Clinical Frailty Scale

Clinical Frailty Scale *

1. Very Fit

People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. Well

People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally

3. Managing Well

People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. Vulnerable

While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.

5. Mildly Frail

These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately Frail

People 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 assistance (queuing, standby) with dressing.

7. Severely Frail

Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. Very Severely Frail

Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill

Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, through still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

*1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

Appendix 4 Frailty MDT Referral Form

A frailty review is intended to support an older person who is frail or declining through early assessment and intervention. We can also offer support, advice and help to the teams and people that care for them.

There may be an initial discussion with a frailty nurse practitioner, frailty assessment with your client/ family, a home visit, or view at a Frailty MDT.

All must apply:

- ☐ 65yrs or older
- ☐ BaNES GP (if GP is outside the area, please submit referral to team for consideration)
- ☐ BaNES resident
- ☐ Consents to discussion among teams
- ☐ Consents to share health records (Consent may be from the client / LPA or Following Best Interests discussion)

Conditional Requirements:

Frailty Indicators - please tick any that apply:

- ☐ Rockwood score (Clinical Frailty Scale) between 4 and 6 (if known) You can use the Frailty APP to calculate the Rockwood score. Top tips for use of the Rockwood Clinical Frailty Scale.
- ☐ Weight Loss (Unintentional)
- ☐ Falls
- ☐ Incontinence (Change in continence)
- ☐ Mobility decreasing, Slowing down
- ☐ Cognitive Impairment (Increasingly forgetful, changes in personality, changes in behaviours - unrelated to a known mental health disorder)
- ☐ Delirium
- ☐ Weakness/ Lethargy/ Exhaustion
- ☐ Appetite Loss
- ☐ PolyPharmacy (More than 4 medicines/ More than 10 medicines)
- ☐ Multiple Morbitities/ Poorly controlled Long Term Condition/s (Such as hypertension, diabetes, heart disease, respiratory conditions etc.
- ☐ Sarcopaenia

General Indicators: please tick any that apply

- ☐ Progressive decline in health
- ☐ Increasing functional care or support required
- ☐ Frequent GP/ outpatient attendances without resolution
- ☐ Possibility of unplanned admission
- ☐ No advanced plan in place and in decline (Such as ReSPECT discussions/ TEP/ known wishes)
- ☐ Other, please specify:

If you think your client may benefit from a frailty review, please complete the details below and return by email to n.aplin@nhs.net

Name of client	
Address	
Contact Details	
Date of Birth and/or NHS number	
Reason for referral/ What would you like from the referral:	
Referres Name	
Your Role/ Organisation	
Your current/ previous input	
Your Email and Phone	
Patient at Home - identify any issues or risks that are considered helpful about the patient at home	
Home visit - identify any issues or risk to assist health professionals to make a safe home visit.	

Appendix 5 Frailty MDT Assessment

Date Completed	
Name of person completing assessment	
Role	
Organisation	
Follow up required date	

About the person

Name		GP surgery	
DOB		Do you have a known allergy?	
Tel No.		Emergency contact	
Address		Relationship	
		Serving or former military service including National Service	

Consent	Yes	No
Do you consent to information being shared with relevant organisations? Is there specific information you do not wish to be shared?		

Carers	
Does the Person have: a main Carer / Key Support	Is the Person: a Carer / Responsible for someone else?
Main carer name:	Contact / Relationship:

Does the Main Carer / Key Support require support to be able to help manage the person's wellbeing	Yes	No
Clinical/Care professional contacts:		
Are you a Carer if so do you have an emergency care plan?		

Financial management	
Lasting Power of Attorney / Advance directive?	Financial: Health and Welfare:
Benefits (attendance / carers allowance)?	

Relevant background information	
What matters to me:	
Who is important to me:	
Strengths and abilities:	
Things that are challenging:	

Frailty Syndrome / Area of Concern tick all that applies								
Weight Loss	Mobility	Delirium	Exhaustion	Multiple Morbidities			Incontinence	Lethargy
Falls	Cognitive Impairment		Weakness	Appetite Loss	Sarcopaenia		PolyPharmacy	Other

Cognition	Yes	No	Maybe	Comments
Any memory concerns				
Dementia diagnosis 6CIT if concerns*				
Link to *6CIT (Cognitive impairment) 1) What year is it? 2) What month is it? 3) What time is it (within one hour)? 4) Count backwards from 20 to 1 5) Say the months of the year in reverse 6) Repeat the address/phrase				

Falls	Yes	No	Maybe	Comments
Have you fallen in the last 12 months				
Cause? Balance / dizziness / giving way / slip, trip / fear How did you feel before the fall? Observation of falls risk: Vision				

Hearing	
Feet / Footwear Vital Signs T, P, BP, O2, Resp, L+S BP* Link to vital signs NEWS2 score*	

Mobility/ Functional Assessment	Yes	No	Maybe	Comments
Concerns?				
Mobility aids				
Stand from seated				
Get out of bed				
Get on/off toilet				
Access bath/shower				
Get up from the floor				
Can you manage the stairs?				
Equipment provided (please provide details)				
Undertake personal tasks				
Undertake domestic tasks				
Any concerns about your medicines?				
Do you take them as prescribed?				
Do you have a dosette box?				
Have you had a medication review?				
Bladder continence?				
Bowel continence?				
Continence management				
Nutrition	**Yes**	**No**	**Maybe**	**Comments**
Weight Loss				
Appetite				
Difficulties (digestive, swallowing, teeth, cutlery)				
Abilities (functional, resilience - what you can do)				
Skin	**Yes**	**No**	**Maybe**	**Comments**
Concerns				
Details - please provide				
Wellbeing				
Concerns?	Loneliness Fears and worries Low energy and tiredness Poor sleep Other			
If concerns GDS 4* Link to Geriatric Depression Screen - 4 point 1) Are you basically satisfied with your life? 2) Do you feel that your life is empty 3) Are you afraid that something bad is going to happen to you? 4) Do you feel happy most of the time?				

	Yes	No	Maybe	Comments
Do you exercise?				
Bothersome scale: 0 - 5	0 1 2 4 5			
What bothers you?				
Pain scale: 0 - 5	0 1 2 4 5			
Describe/Location of pain Worsening or relieving factors				
Are you able to access local facilities, hobbies, interests, church?				
Lifestyle and Environment	**Yes**	**No**	**Maybe**	**Comments**
Do you feel safe at home?				
Would you like to have a fire safety check?				
Communication needs				
Transport				
Open Front Door Independently				
Key Safe in Use				
Safe Home Maintained				
Special Sleeping Requirements				
Person is Housebound				
Pets in the Home				
Community Alarm				
Advance/Emergency Planning				
Is there a ReSPECT form / written wishes / Documentation (e.g. ReSPECT / written wishes)				
Who to contact / who can make decisions for you if you are unable?				
Preferences				
Priorities				
Further information or discussion?				
Personal Wellbeing Score ONS 4* (LINK to score) Feelings on aspects of a person's life				
Life Satisfaction - Overall, how satisfied are you with your life nowadays?	0-10			
Worthwhile - Overall, to what extend do you feel that the things you do in your life are worthwhile?	0-10			
Happiness - Overall, how happy did you feel yesterday?	0-10			
Anxiety - Overall, how anxious did you feel yesterday?	0-10			

Appendix 6 E-survey Questions

a) Which organisation do you work for?

b) What is your job title?

c) Can you describe how your role fits within the Frailty MDT?

d) Can you tell us what your role and organisation brings to the Frailty MDT?

e) Can you give an example of where your input/organisation has supported people on the Frailty MDT Register?

f) What are you especially proud of, when you think of the Frailty MDT?

g) What is your main way of contacting those on the Frailty MDT?

h) If you see people in their homes, can you identify any benefits from visiting their homes over other contact methods?

i) Thinking about the Frailty MDT, what do you think works well?

j) Thinking about the Frailty MDT, what do you think works less well?

k) If you were to suggest any changes to the current service provision, what would they be?

l) If the Frailty MDT was to stop, what would the impact be? Who would it impact most?

m) Is there anything else you would like to tell us?

Appendix 7 Client and Carer Interview Questions

a) Who referred you to the Frailty MDT?

b) Can you tell me a little about your visit?

c) What were the benefits of the service?

d) Did you find the home visit from Nic [ANP] helpful?

e) If you hadn't received input from the Frailty service, how else would you have received the support you have mentioned?

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Useful resources

- Free frailty e-learning for healthcare: https://www.e-lfh.org.uk/programmes/frailty/
- Frailty Hub, articles, national guidelines and best practice relevant to frailty: https://www.bgs.org.uk/resources/resource-series/frailty-hub
- Suzy Lamplugh Personal safety tools free app - https://www.suzylamplugh.org/hollie-guard

Report prepared by Dorothy House research team.

Phone

Switchboard: 01225 722 988
Clinical 24hr Advice Line: 0345 0130 555

Email

Frailty service enquires: Nic Aplin, Community Frailty Advanced Level Nurse Practitioner - n.aplin@nhs.net.
Clinical support or discussion around assessment, interventions or care of people living with frailty.

Online

dorothyhouse.org.uk

Post

Winsley, Bradford on Avon, Wiltshire, BA15 2LE

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