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Draft Australian National Subacute and Non-Acute Patient Classification Version 5.0 Submission on behalf of the Agency for Clinical Innovation (ACI) Frailty Taskforce

In response to the suggested inclusion of new clinical variables, the ACI Frailty Taskforce **does not** support the inclusion of frailty (or risk of frailty) as a measure of patient complexity.

The frailty risk score was developed using a population aged 75+ years who received care over a two year period in an acute setting in the UK. The tool is not a measure of frailty but the **risk** of frailty based on acute patients with frequent admissions. It is derived from ICD-10 codes post discharge made up of a mix of comorbidities and complications (for the article please refer to : https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30668-8/fulltext. The paper identified that the derived frailty score would be useful for research and health service planning as it is predictive at the group level, but the ability of the score to discriminate between individuals was low.

The ACI Frailty Taskforce acknowledges that frailty itself is an extremely useful variable to measure. However, in a clinical sense it is an important variable to measure at the **beginning** (not the end) of a patient episode, to aid in clinical care planning for the patient. A patient may be admitted to care with a degree of frailty which was not present on previous admissions and consequently, not present via use of the frailty risk tool. As a retrospective tool, the use of the frailty risk tool is of limited benefit to clinicians.

The ACI Frailty Taskforce recommends the use of a multi-domain frailty tool using routine data such as nutrition, physical function, cognition and medication use to capture the care needs of frail, older people. The use of the FRAIL scale or Rockwood Clinical Frailty Scale are more appropriate measures than the frailty risk score but capturing frailty on admission remains paramount.