NHS

Evidence Brief: Frailty

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Produced by the Knowledge Management team Evidence Briefs offer an overview of the published reports, research, and evidence on a workforce-related topic.

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There may have been an update to this Evidence Brief - to check you are reading the most current version please see the links below:

- Complete Evidence Brief list – link for Workforce, Training and Education staff
- Complete Evidence Brief list – link for External staff

Key publications – the big picture

NHS Long Term Workforce Plan
Source: NHS England
Publication date: June 2023
The first comprehensive workforce plan for the NHS, putting staffing on a sustainable footing and improving patient care. It focuses on retaining existing talent and making the best use of new technology alongside the biggest recruitment drive in health service history.

Proactive care: providing care and support for people living at home with moderate or severe frailty
Source: NHS England
Publication date: December 2023
This guidance is for integrated care boards (ICBs) and provider organisations involved in the design and delivery of proactive care.
Proactive care is personalised and co-ordinated multi-professional support and interventions for people living with complex needs. Many systems are already delivering proactive care.
The specific aims of proactive care are to improve health outcomes and patient experience by:

1. delaying the onset of health deterioration where possible
2. maintaining independent living
3. reducing avoidable exacerbations of ill health, thereby reducing use of unplanned care.

Joining the dots: A blueprint for preventing and managing frailty in older people
Source: British Geriatrics Society
Publication date: March 2023
Older people use the NHS and social care services more than any other age group and as the population continues to age, the demand for such services will continue to grow. People are living for longer with more complex conditions in older age and often require specialist care from a range of professionals across the multidisciplinary team. At the same time, new organisations across the UK are taking on responsibility for commissioning health and social care services and it is essential that they get this right for older people. If services work for older people, the biggest user group for health and social care, they are more likely to work for everyone else.

Frailty Hub
Source: British Geriatrics Society
This page brings together articles, national guidelines and best practice relevant to frailty and is frequently reviewed and updated by the BGS Clinical Quality Committee and the Frailty in Urgent Care Settings Special Interest Group (SIG).

- Frailty Hub: Frailty and the NHS
- Frailty Hub: Education and Training resources

Identification and management of patients with frailty
Source: BMA
Publication date: 4th October 2022
Practices are required to identify and manage patients living with frailty, as part of routine consultations. This guidance sets out what practices should do to fulfil these requirements.

Through the visor: Reflecting on member experiences of the Covid-19 first wave
Author(s): Copeland and Greenbrook
Source: British Geriatrics Society
Publication date: March 2021
This report summarises the findings of a BGS member survey describing the experiences of working through the first wave of the COVID-19 pandemic. With respondents representing over twenty different professions working in acute, community

and primary care, it is believed to be the only survey capturing the full breadth of multidisciplinary health professionals' experiences caring for older people across the four nations. A follow-up report, Through the visor 2: Further learning from member experiences during COVID-19, is also now available.

Frailty and the NHS Long Term Plan
Source: AgeUK
Publication date: Updated July 2020
The NHS Long Term Plan outlines several important changes to the way the NHS should work to support patients and their carers. Improving care for older people living with frailty or multiple long-term conditions is one of its priorities.

Frailty: Ensuring the best outcomes for frail older people
Source: Royal College of Psychiatrists
Publication date: February 2020
Old age psychiatrists are trained to adopt a holistic approach, and practise within a biopsychosocial model (RCPsych, 2016); we focus on not only 'what is the matter' but more importantly 'what matters', to the people and families we serve, which is an approach advocated by patients and carer groups (Dementia Carer Voices, 2019). Within older adults mental health services we already have standards for patient and carer/family engagement and involvement (RCPsych, 2016). Whilst it is mainly older people that are frail, there are younger people with serious mental illness who are at risk of becoming frail and it is important that their needs are met in the same holistic way.

Reducing health inequalities for people living with frailty: a resource for commissioners, service providers and health, care and support staff
Authors: Garrett, Josie;Worrall, Sam and Sweeney, Sarah
Source: Friends, Families and Travellers
Publication Date: 2020
Abstract: This resource aims to share practical recommendations and examples of how commissioners, service providers and health, care and support staff can overcome barriers to health care for people at greater risk of frailty, including people experiencing deprivation, people who are homeless, people experiencing substance misuse, people with learning disabilities, LGBT people, people with mental health needs, people from Gypsy and Traveller communities, and vulnerable migrants. It offers insights on how services can work in collaborative, holistic and inclusive ways to reduce health inequalities for people living with frailty, and offer individuals the support needed to manage the condition in the long term.

Frailty Toolkit
Source: NHS RightCare
Publication date: June 2019
Increasing numbers of people are at risk of developing frailty. People living with frailty are experiencing unwarranted variationin their care. This toolkit will provide you with expert practical advice and guidance on how to commission and provide the best system wide care for people living with frailty.

Toolkit for general practice in supporting older people living with frailty
Source: NHS England
Publication date: April 2019
This document provides GPs, practice nurses and the wider primary care workforce with a suite of tools to support the case finding, assessment and case management of older people living with frailty.

Comprehensive Care: Older people living with frailty in hospitals
Source: National Institute for Health Research
Publication date: 2017

This review covers four key aspects of caring for older people living with frailty in hospital: Assessment; identifying and managing symptoms associated with frailty in hospital; discharge planning; and caring environments.
It features:

- 33 published studies
- 20 ongoing research projects
- Questions to ask about the care of older people with frailty in hospitals

Reducing harm from polypharmacy in older people
Source: Effectiveness Matters
Publication date: 2017
Polypharmacy is common among older people; it can increase the risk of adverse drug reactions and interactions, as well as reduce compliance and adherence.
Positive (but inconsistent) effects of deprescribing interventions have been observed.
Patient and practitioner decisions about stopping medications are influenced by social influences, expected consequences, and factors such as consultation length.

Helping People Thrive not Just Survive: A Framework for Frailty in Dorset
Source: NHS Dorset CCG
Publication date: March 2017
The Dorset Framework for Frailty has been developed by Dorset Clinical Commissioning Group (CCG) through multi-sectorial collaboration with health and social care providers, voluntary and third sector organisations, patients and their representatives. It is endorsed by the Dorset Frailty and End of Life Care Reference Group. The development of the framework is a response to the request for a common approach to the early recognition and identification of frailty as a long term condition, promoting early detection through case-finding, appropriate assessment, risk stratification; and backed up by planned and coordinated care and support.

Integrated care for older people with frailty
Source: British Geriatrics Society
Publication date: December 2016
The British Geriatrics Society and the Royal College of General Practitioners worked together to produce this report. An ageing society and the rising prevalence of frailty are game changers for the health and social care services, and our collaboration is designed to support GPs and geriatricians in responding to these significant new challenges.

Future of an ageing population
Source: Government Office for Science
Publication date: 2016
The UK population is ageing. In mid-2014, the average age exceeded 40 for the first time. By 2040, nearly one in seven people is projected to be aged over 75. These trends, partially mitigated by migration rates, will have a major effect on the UK. The Office for Budget Responsibility projects total public spending excluding interest payments to increase from 33.6% to 37.8% of GDP between 2019/20 and 2064/65 – equivalent to £79 billion in today's terms – due mainly to the ageing population.

Fit for Frailty Part 2: Developing, commissioning and managing services for people living with frailty in community settings
Source: British Geriatrics Society
Publication date: January 2015
The purpose of Fit for Frailty Part 2 is to provide advice and guidance on the development, commissioning and management of services for people living with frailty in community settings. The audience for this guidance comprises GPs, geriatricians, Health Service managers, Social Service managers and

Commissioners of Services. Fit for Frailty Part 2 is a companion report to an earlier BGS publication, Fit for Frailty Part 1 which provided advice and guidance on the care of older people living with frailty in community and outpatient settings (see below).

Fit for Frailty Part 1: Consensus best practice guidance for the care of older people living in community and outpatient settings
Source: British Geriatrics Society
Publication date: 2014
This guidance is intended to support health and social care professionals in the community, in outpatient clinics, in community hospitals and other intermediate care settings and in older people's own homes. Guidance for professionals encountering older people with frailty in acute hospitals has been published in the Silver Book1 and work to develop checklist to support the management of older people with frailty in acute hospital settings is ongoing.

Blog posts

Reducing health-related job loss among older workers
Author(s): Stephen Bevan
Source: Institute for Employment Studies
Publication date: 14th July 2023
Working age Britons with long-term health conditions have caused considerable head-scratching in the last two years. Why have so many chosen to leave the labour market early? The number of working age people who can't work because of long-term sickness has been increasing since before the pandemic. It rose from 2 million at the start of 2019 to 2.5 million as of early 2023. Since the pandemic started in early 2020, this number has increased by around 400,000, although the numbers have recently started to decline as the labour market 'cools' slightly.

Case Studies

A place to meet the needs of people living with frailty: Jean Bishop Integrate Care Centre
Source: NHS Employers
Publication date: June 2023
Discover how Hull and North Yorkshire ICB integrated health and care services to establish a centre for frailty.

Integrated working to address frailty needs: Bradford District and Craven Health and Care Partnership
Source: NHS Confederation
Publication date: 6th May 2022
Addressing frailty needs and improving outcomes through integrated working in Bradford District and Craven.

Case Studies
Source: Acute Frailty Network
Publication date: updated 2022
A suite of case studies from the Acute Frailty Network.

Case study: Providing rapid care to people in their own home rather than going to hospital, through a frailty virtual ward in Leeds
Source: NHS England
Publication date: March 2022
This case studies describes how the virtual ward in Leeds supports up to 40 patients per day and provides co-ordinated rapid care to people aged over 70 with moderate to severe frailty in their own homes.
Together, they have saved nearly 10,000 bed days since launching the pilot virtual ward in November 2019.

Integrated care for older people with frailty
Source: British Geriatrics Society

Publication date: December 2016
This report contains lots of case studies.
The British Geriatrics Society and the Royal College of General Practitioners worked together to produce this report. An ageing society and the rising prevalence of frailty are game changers for the health and social care services, and our collaboration is designed to support GPs and geriatricians in responding to these significant new challenges.

Supporting people living with frailty in Hull and East Riding
Source: NHS England
In Hull and East Riding, the team working as part of City Health Care Partnership CIC are at the beginning of their frailty ward journey.
Their aim is to implement a safe and effective virtual ward, enabling them to care for people in the place they call home. This requires integrating acute frailty emergency department teams, intermediate care, urgent care, specialist community frailty team and other providers, including Primary Care Networks.

Evaluating proactive care frailty clinics in Wolverhampton
Source: Arden & GEM CSU
Publication date: ?
Frailty is a condition that becomes more common as people get older, with implications for both the individual and the health and care system. To cope with rising demand, holistic and sustainable approaches to commissioning and providing care are needed.

Frailty Care
Source: Sussex Community NHS Foundation Trust
Publication date: December 2020
This innovation involved doctors, nurses and pharmacists working together to develop and test a new method of clinical care for frail inpatients in a community hospital in West Sussex. In addition to the standard medical and medicines management care, additional steps were designed and taken, and the effectiveness evaluated, within a Quality Improvement project.

Older people living with frailty 'virtual ward', West Dorset
Source: NHS
Publication date: January 2019
Hundreds of older people living with frailty are being monitored through a 'virtual ward' which helps keep them out of hospital. Doctors, nurses, social care staff, physios and others in West Dorset discuss patients who are put on a rolling 'virtual' list each week if thought to be at risk of hospital admission.

The Star for workforce redesign

More resources and tools are available by searching for Frailty in the Star

Statistics

You can find relevant statistics on the Health and Care Statistics Landscape under **"Health and Care"**

National Data Programme

Workforce, Training and Education staff can look at the National Data Warehouse (NDL) SharePoint site to find out more about datasets and Tableau products.

Published Peer Reviewed Research

Advanced Clinical Practitioners

The changing role of Advanced Clinical Practitioners working with older people during the COVID- 19 pandemic: A qualitative research study
Author: Morley, Dawn A., Kilgore, Cliff, Edwards, Mary, Collins, Pippa, Scammell, Janet Me, Fletcher, Kelsie and Board, Michele
Publication Date: 2022
Publication Details: International journal of nursing studies, 130, pp.104235. , England:
Abstract: BACKGROUND: COVID-19 was identified as a pandemic by the World Health Organisation (WHO) in December 2020. Advanced Clinical Practitioners (ACPs) in England working with older people with frailty, experienced their clinical role changing in response to the emergency health needs of this complex population group. In contrast to other countries, in England Advanced Clinical Practitioners are drawn from both nursing and allied health professions. Whilst much of the literature emphasises the importance of ensuring the sustainability of the Advanced Clinical Practitioners' role, the pandemic threw further light on its potential and challenges. However, an initial review of the literature highlighted a lack of research of Advanced Clinical Practitioners' capabilities working with uncertainty in disaster response situations., AIM: To capture the lived experience of how English Advanced Clinical Practitioners working with older people adapted their roles in response to the COVID-19 pandemic (October 2020-January 2021)., DESIGN, SETTING AND PARTICIPANTS: A qualitative research design was used. Following ethical approval, 23 Advanced Clinical Practitioner volunteer participants from across England with varied health professional backgrounds were recruited from Advanced Clinical Practitioners' professional and social media networks on Twitter using a snowballing technique., METHODS: Depending on preference or availability, 23 participants (nurses (18), physiotherapists (2), paramedics (2) and a pharmacist (1)) were interviewed singularly (n = 9) or as part of 3 focus groups (n = 14) using Zoom video communication. Audio recordings were transcribed and using qualitative data analysis software, NVivo 12 pro, coded for an essentialist thematic analysis of Advanced Clinical Practitioners' responses using an inductive approach. 27 codes were identified and collated into five themes. For the purposes of this paper, four themes are discussed: experiencing different work, developing attributes, negotiating barriers and changing future provision., FINDINGS: Advanced Clinical Practitioners successfully transferred their advanced practice skills into areas of clinical need during the pandemic. Their autonomous and generic, high level of expertise equipped them for management and leadership positions where speed of change, and the dissolution of traditional professional boundaries, were prioritised. Barriers to progress included a lack of knowledge of the Advanced Clinical Practitioner role and friction between Advanced Clinical Practitioners and physicians., DISCUSSION AND CONCLUSION: The study demonstrated the successful adaption of the Advanced Clinical Practitioner role to enable more creative, personalised and sustainable solutions in the care of older people living with frailty during the pandemic. The potential of Advanced Clinical Practitioner development is in a juxtaposition to the threat of pandemic services being dismantled once the emergency nature of care has passed. Healthcare organisations have a vital part to play in considering the enablers and barriers of Advanced Clinical Practitioner capability-based practice when responding to uncertainty. Copyright © 2022 Elsevier Ltd. All rights reserved.

Conference abstract: 61 Outcomes of an Advanced Nurse Practitioner-Led Pops Service in a District General Hospital
Abstract only*
Author(s): Irimia et al.
Source: Age and Ageing 50(Supplement 1)
Publication date: March 2021
Introduction: There is an increased need for geriatrician input to older adults outside of the medical wards. There is a lack of geriatricians to contribute to these services. An example includes the Proactive care of older people undergoing surgery (POPS) service where geriatricians perform comprehensive geriatric assessment (CGA) to identify comorbidities and geriatric syndromes which may lead to poor post-operative outcomes. Advanced nurse practitioners (ANP) are highly skilled staff members and are increasingly used to provide the POPS service. We wanted to review the outcomes of our Nurse Led POPS service. Methods: Patients aged over 70 admitted as an emergency to upper gastrointestinal and colorectal surgery were assessed by the POPS ANP using CGA. Assessments were completed on a proforma. Data was collected prospectively on a data collection form documenting new issues detected and interventions made. The results were analysed using an Excel spreadsheet. Results: 147 patients were reviewed by the ANP between November 2018 and March 2019. All patients were screened for frailty, cognitive impairment and delirium. 37.41% were clinically frail, 17.72% had cognitive impairment and 11.56% had delirium. New issues were identified in 90.47% of these patients; polypharmacy (80.27%), new catheter (53.74%), weight loss (46.94%), incontinence (36.05%), falls (29.25%) and pain (25.17%). Medical issues were also identified including electrolyte abnormalities (47% patients), acute kidney injury (22% patients), cardiac issues (8% patients) and respiratory problems (7% patients). Additional interventions included stopping medication (27.89%), starting new medication (20.41%), requesting further investigations (97.28%), referring to allied health professionals (95.24%) and advanced care planning (15.65%). Conclusions: A POPS ANP can effectively conduct CGA identifying new medical issues and geriatric syndromes missed by the surgical teams in an acute setting.

Conference abstract: 53 Advanced clinical practitioners and their role in delivering CGA to streamline the management of patients living with frailty
Author(s): Everett et al.
Source: Age and Ageing 48(Supplement 1)
Publication date: February 2019
Topic: Older people living with frailty are at risk of recurrent hospital admissions. CGA is associated with decreased morbidity and better cognition. As older people are susceptible to repeat assessments, frequent moves and treatment delays consequent to poorly integrated services, mechanisms to ensure personalised care plans remain responsive to patient’s needs after discharge are not always robust due to lack of clarity within the MDT of roles and responsibilities. Intervention: Two newly appointed Advanced Clinical Practitioners (ACP) identified older people with frailty admitted onto the acute medical unit from a defined geographical area. Documentation was on an inter-professional proforma containing elements of the CGA as well as the clinical frailty scale (CFS). Assessments were continued during admission and completed after discharge at the patient’s residence. Where appropriate, anticipatory care plans were written by the ACPs in conjunction with the patient. The ACPs remained custodians of the care plans and ensured they remained responsive to the patient’s needs over time. Data was collected on admission rate in the last year as well as post implementation of the CGA process. Improvement: Out of 242 patients screened, the ACPs identified 44 patients living with frailty (CFS ≥ 5) and conducted over 100 home visits between May 2017 and January 2018. Data was available for 30 patients. The mean admission rate pre CGA was 2.5 and mean hospital

length of stay (LOS) during these admissions was 10.09 days (n = 25). Advanced care plans were completed on 20 (67%) patients. Assessment, proactive care planning and follow up was associated with a mean readmission rate of 1.1 and mean LOS of 6.6 days during the readmission, a decrease of 4.3 days. Six patients died in the study period (CFS 6−8). The mean number of days between initial admission and death of 97.7 days (range 45−209). Discussion: Living with moderate to severe frailty is associated with recurrent admissions and higher LOS. We were unable to control for several confounding factors but personalised, proactive care planning and follow up appears to be associated with fewer readmissions and LOS. Investing in dedicated, skilled practitioner workforce who are able to assess and manage patients living with frailty in conjunction with the MDT is likely to lead to substantial cost savings for a trust.

Conference abstract: An inter-professional advanced practice approach to Frailty @ the front door; optimising outcomes for patients with frailty through workforce re-design
Author(s): Kellichan et al.
Source: Physiotherapy 2015(Supplement 1)
Publication date: January 2019
Purpose: To respond to the increasing number of frail older adults and the complexities of their presentation (Clegg et al, 2013), a diverse and advancing skill set is required (BGS, 2017). Service redesign was undertaken to transform the workforce to improve patient experience in patients presenting with frailty by providing alternative pathways to acute admission and supporting patients as close to home as possible, using a patient centred approach. The team promptly recognises deterioration of the older adult and ensures appropriate pathways are identified for patients who require acute hospital care.

Covid-19

Age and frailty are independently associated with increased Covid-19 mortality and increased care needs in survivors: results of an international multi-centre study
Author(s): Geriatric Medicine Research Collaborative
Source: Age and Ageing 50(3)
Publication date: May 2021
Introduction: Increased mortality has been demonstrated in older adults with coronavirus disease 2019 (COVID-19), but the effect of frailty has been unclear. Methods: This multi-centre cohort study involved patients aged 18 years and older hospitalised with COVID-19, using routinely collected data. We used Cox regression analysis to assess the impact of age, frailty and delirium on the risk of inpatient mortality, adjusting for sex, illness severity, inflammation and co-morbidities. We used ordinal logistic regression analysis to assess the impact of age, Clinical Frailty Scale (CFS) and delirium on risk of increased care requirements on discharge, adjusting for the same variables. Results: Data from 5,711 patients from 55 hospitals in 12 countries were included (median age 74, interquartile range [IQR] 54–83; 55.2% male). The risk of death increased independently with increasing age (>80 versus 18–49: hazard ratio [HR] 3.57, confidence interval [CI] 2.54–5.02), frailty (CFS 8 versus 1–3: HR 3.03, CI 2.29–4.00) inflammation, renal disease, cardiovascular disease and cancer, but not delirium. Age, frailty (CFS 7 versus 1–3: odds ratio 7.00, CI 5.27–9.32), delirium, dementia and mental health diagnoses were all associated with increased risk of higher care needs on discharge. The likelihood of adverse outcomes increased across all grades of CFS from 4 to 9. Conclusion: Age and frailty are independently associated with adverse outcomes in COVID-19. Risk of increased care needs was also increased in survivors of COVID-19 with frailty or older age.

[The demography and characteristics of SARS-Cov-2 seropositive residents and staff of nursing homes for older adults in the Community of Madrid: the SeroSOS study]
Author(s): Candel et al.
Source: Age and Ageing 50(4)
Publication date: July 2021
Background: Nursing homes for older adults have concentrated large numbers of severe cases and deaths for coronavirus disease 2019 (COVID-19). Methods: Point seroprevalence study of nursing homes to describe the demography and characteristic of severe acute respiratory syndrome by coronavirus 2 (SARS-CoV-2) immunoglobulin G (IgG)-positive residents and staff. Results: Clinical information and blood samples were available for 9,332 residents (mean age 86.7 ± 8.1 years, 76.4% women) and 10,614 staff (mean age 45.6 ± 11.5, 86.2% women). Up to 84.4% of residents had frailty, 84.9% co-morbidity and 69.3% cognitive impairment; 65.2% of workers were health-aides. COVID-19 seroprevalence was 55.4% (95% confidence interval (CI), 54.4–56.4) for older adults and 31.5% (30.6–32.4) for staff. In multivariable analysis, frailty of residents was related with seropositivity (odds ratio (OR): 1.19, P = 0.02). In the case of staff, age > 50 years (2.10, P < 0.001), obesity (1.19, P = 0.01), being a health-aide (1.94, P < 0.001), working in a center with high seroprevalence in residents (3.49, P < 0.001) and contact with external cases of COVID-19 (1.52, P < 0.001) were factors associated with seropositivity. Past symptoms of COVID-19 were good predictors of seropositivity for residents (5.41, P < 0.001) and staff (2.52, P < 0.001). Conclusions: Level of dependency influences risk of COVID-19 among residents. Individual and work factors, contacts outside the nursing home are associated with COVID-19 exposure in staff members. It is key to strengthen control measures to prevent the introduction of COVID-19 into care facilities from the community.

[How Covid-19 will boost remote exercise-based treatment in Parkinson's disease: a narrative review]
Author(s): Langer et al.
Source: Npj Parkinson's Disease 7:25
Publication date: 2021
The lack of physical exercise during the COVID-19 pandemic-related quarantine measures is challenging, especially for patients with Parkinson’s disease (PD). Without regular exercise not only patients, but also nursing staff and physicians soon noticed a deterioration of motor and non-motor symptoms. Reduced functional mobility, increased falls, increased frailty, and decreased quality of life were identified as consequences of increased sedentary behavior. This work overviews the current literature on problems of supplying conventional physiotherapy and the potential of telerehabilitation, allied health services, and patientinitiated exercise for PD patients during the COVID-19 period. We discuss recent studies on approaches that can improve remote provision of exercise to patients, including telerehabilitation, motivational tools, apps, exergaming, and virtual reality (VR) exercise. Additionally, we provide a case report about a 69-year-old PD patient who took part in a 12-week guided climbing course for PD patients prior to the pandemic and found a solution to continue her climbing training independently with an outdoor rope ladder. This case can serve as a best practice example for non-instructed, creative, and patient-initiated exercise in the domestic environment in difficult times, as are the current. Overall, many recent studies on telemedicine, telerehabilitation, and patientinitiated exercises have been published, giving rise to optimism that facilitating remote exercise can help PD patients maintain physical mobility and emotional well-being, even in phases such as the COVID-19 pandemic. The pandemic itself may even boost the need to establish comprehensive and easy-to-do telerehabilitation programs.

The comprehensive Frailty Assessment at Forth Valley Royal Hospital (FVRH) Digitalised: for Covid-19 and beyond Abstract only*
Author(s): Rodgerson and McNeil
Source: Age and Ageing 50(Suppl 1)
Publication date: March 2021
Introduction: Comprehensive Geriatric Assessment (CGA) improves outcomes for frail patients; at FVRH this is delivered by the Frailty Intervention Team (FIT) comprising of senior nurses, allied health professionals (AHPs) and doctors. Faced with COVID-19, we took the opportunity to digitalise CGA documentation to preserve these benefits for patients whilst facing greater acuity, staffing and time pressures. An electronic solution was adopted to reduce paper-usage in COVID-receiving areas. Prior to COVID-19, CGA was recorded within case-notes, presenting challenges when patients were readmitted out-of-hours as these were stored off-site and not accessible out-of-hours. Method: Trakcare is the patient-management system in many Scottish hospitals. The Electronic Patient Record (EPR) was used to record pro-forma against admissions which were accessible and updatable for any patient 24–7-365. Patients meeting the Healthcare Improvement Scotland (HIS) Frailty criteria were considered "frailty-positive", with an e-alert added-reappearing on any re-admission. Providing no HIS-exclusion criteria, an electronic-CGA (e-CGA) was recorded or updated. The pro-forma designed contained information not immediately available to clerking practitioners. This evolved following discussion amongst the FIT to include information such as escalation-status, medication-arrangements and baseline cognition. Results: Over 13 weeks, 116 EPRs were reviewed. During weeks 1–3 (n = 8, 12, 7 respectively), e-CGA completion averaged 31%. Following FIT collaboration, this rose to 82% (n = 9) by week 12. Qualitative feedback from the MDT indicated that FIT, downstream wards and night-staff felt that having access to previous escalation-plans made immediate-management easier to determine, and discussions with families more productive for patients. Conclusions: Development of the FVRH e-CGA is ongoing, with an electronic frailty-screening tool being implemented to improve frailty-identification on admission to ensure correct streaming of patients to the FIT. We have demonstrated a cost-neutral method for improving access to CGA for patients using existing IT systems whilst protecting staff time, preserving patient care during the COVID-19 pandemic.

155 Establishing a community frailty unit during the Covid-19 pandemic Abstract only*
Author(s): H Wilson
Source: Age and Ageing 50(Suppl 1) pp. i12-i42
Publication date: March 2021
Introduction: In response to the Covid19 pandemic a community Hospital was transformed in to a Community Frailty Unit (CFU). The aims were to meet the needs of patients living with frailty including medical instability and end of life care outside the acute setting, to improve patient flow and to improve integration of acute and community frailty services. Method: Existing community teams were integrated with an acute based multidisciplinary team including a frailty practitioner and pharmacist. Supported by programme managers they rapidly transformed (within 3 weeks) processes to align these with the acute site including paperwork, assessments, use of a flow board, board rounds and discharge to assess. Technology was used to organise transfers via the NHS Digital approved App Pando. Point of care testing and oxygen concentrators were put in place. Results: Median and mean length of stay (LOS) in the acute site reduced by 59% (14.5 to 6 days) and 56% (18 to 8 days) respectively. Median and mean LOS in the community site reduced by 38% (16 to 10 days) and 39% (18 to 11 days) respectively. Readmissions fell from 10% to 2%. 85% of staff rated the following better or much better: the capability of the service to manage every aspect of the patient's care; integration;

co-ordination of transfers. 83% of staff rated patient experience better or much better and 79% rated discharge co-ordination better or much better. At 85% bed occupancy at a cost of £67 k/bed/year this released 5,525 bed days and 16.9 beds with a return on investment of £1,132,300. Conclusion: It is possible to rapidly integrate community and acute services and to establish acute frailty unit care in a community setting. A CFU can lead to improved integration, patient flow, patient and staff experience at reduced system wide cost.

Education and training

Exploring the challenges of frailty in medical education
Author(s): Winter and Pearson
Source: The Journal of Frailty and Aging 12 pp. 134-148
Publication date: 2023
Frailty is common, and medical students and doctors across all specialties will look after patients with frailty. The General Medical Council requires UK medical schools to teach and assess on frailty, and national geriatric societies across the globe include frailty in their recommended undergraduate curricula. However, frailty in medical education is challenging; there is uncertainty around what frailty is in medical education, including how and when to teach it; controversies in mapping teaching and assessments to recommended curricula; patients with frailty can be challenging to include in teaching and assessments due to functional, sensory, and/or cognitive impairments; an individual with frailty is likely to present atypically, with less predictable recovery, introducing complexities into clinical reasoning that can be challenging for students; the term frailty is often negatively perceived, used colloquially and avoided in educational interactions. This commentary discusses these challenges around frailty in undergraduate medical education and serves to provoke discussion about why frailty is so challenging to teach and learn about, including recommendations for how frailty education could be improved.

Effects of an educational intervention on frailty status, physical activity, sleep patterns, and nutritional status of older adults with frailty or pre-frailty: the FRAGSALUD study
Author(s): Casals et al.
Source: Public Health 11
Publication date: 2023
Introduction: The prevalence of frailty is increasing worldwide, emphasizing the importance of prioritizing healthy ageing. To address this, cost-effective and minimally supervised interventions are being sought. This study aimed to assess the impact of an educational program on frailty status, physical function, physical activity, sleep patterns, and nutritional status in community-dwelling older adults with at least 1 Fried's frailty criteria. Methods: A 6-month multicentre randomized controlled trial was conducted from March 2022 to February 2023 in 14 health centres located in Cadiz and Malaga, Spain. The educational intervention consisted of 4 group sessions and 6 follow-up phone calls spread over 6 months. The program focused on educating participants about frailty and its impact on health, providing guidelines for physical activity, healthy dietary habits, cognitive training, psychological well-being and social activities. A total of 163 participants, divided into control (n = 80) and educational groups (n = 83) were assessed before and after the intervention. Results: The results showed a significant group-time interaction in the physical function evaluated with a large effect on Short Physical Performance Battery score (η2p = 0.179, −0.1 [−1.2–1.0] points for control group vs. 1.0 [0.0–3.0] points for educational group, p < 0.001), and an effect on the 4-meter gait test ((η2p = 0.122, 0.5 [0.1–0.0] s for control group vs. –0.4 [−0.5–−0.3] s for educational group, p < 0.001), and the 5-repetition sit-to-stand test (η2p = 0.136, 1.0 [0.0–1.2] s for control group vs. −4.3 [−7.0– −2.3] for educational group, p < 0.001). Additionally,

the use of accelerometers to assess physical activity, inactivity, and sleep patterns revealed a significant small effect in the number of awakenings at night (($\eta 2p = 0.040$, 1.1 [−0.5–3.4] awakenings for control group vs. 0.0 [−2.2–0.0] awakenings for educational group, $p = 0.009$). The findings also highlighted a significant medium effect regarding malnutrition risk, which was assessed using the Mini-Nutritional Assessment score ($\eta 2p = 0.088$, −0.7 [−2.3–1.5] points for control group vs. 1.5 [−0.5–3.0] points for educational group, $p < 0.001$). Discussion: Thus, the 6-month educational program effectively improved physical function, sleep patterns, and nutritional status compared to usual healthcare attendance in community-dwelling older adults with frailty or pre-frailty. These findings underscore the potential of minimally supervised interventions in promoting a healthy lifestyle in this vulnerable population.

A systematic review of frailty education programs for healthcare professionals

Author(s): Warren et al.
Source: Australasian Journal on Ageing 41(4)
Publication date: December 2022
Objectives: To identify and examine the reported effectiveness of education programs for health professionals on frailty. Methods: A systematic review was conducted of articles published up to June 2021, examining the evaluation of frailty training or education programs targeting health professionals/students. The participant demographics, program content and structure, effectiveness assessment methodology and outcomes, as well as participant feedback, were recorded with narrative synthesis of results. Results: There were nine programs that have evaluated training of health professionals in frailty. These programs varied with respect to intensity, duration, and delivery modality, and targeted a range of health professionals and students. The programs were well-received and found to be effective in increasing frailty knowledge and self-perceived competence in frailty assessment. Common features of successful programs included having multidisciplinary participants, delivering a clinically tailored program and using flexible teaching modalities. Of note, many programs assessed self-perceived efficacy rather than objective changes in patient outcomes. Conclusions: Despite increasing attention on frailty in clinical practice, this systematic review found that there continues to be limited reporting of frailty training programs.

Evaluating a frailty education program implemented through barbershops/ salons in Japan: a preliminary study

Author(s): Makabe et al.
Source: SN Social Science 2(55)
Publication date: 2022
Although frailty has detrimental physical and psychological effects on elderly people, it is potentially reversible. In this study, we aim to evaluate the effectiveness of a pilot frailty education program implemented through barbershops/salons in Japan. In January 2018, we selected five barbershops/salons in Japan where customers were educated on frailty, which was classified as “normal,” “prefrail,” and “frail.” We developed a web-based assessment tool to reduce the workload for barbers/stylists. Participants included 45 customers (82% women), with a median (interquartile range) age of 53.0 (47.5–57.5) years, and a mean ± SD BMI of 22.3 ± 2.7. Frailty scores indicated that 35% of participants were normal, 58% were prefrail, and 7% were frail. Frailty status scores reflected no significant differences after the intervention. Customers classified as frail were advised to visit the regional comprehensive support center for further professional frailty assessment. Participants, especially those aged over 65 years, found the web-based assessment difficult to use. In conclusion, a frailty education program implemented through barbershops/salons is possible because barbers/stylists can provide information on and assessment of frailty. Females and highly educated customers are more likely to be interested

in participating. Nevertheless, a simple intervention is essential to expand the program nationwide.

[Conference Abstract: 134 A Quality Improvement Project – Physiotherapy caseload management on the older person's unit]

Abstract only*

Author(s): Snape et al.

Source: Age and Ageing 50(Suppl 1)

Publication date: March 2021

Introduction: Complex health issues, co-morbidities and the number of patients living with frailty are critical concerns associated with the ageing population (Kojima et al, 2019). In this wider context, there is an emphasis on targeting resources efficaciously within the NHS. A consequence of capacity constraints, inpatient physiotherapy teams across the OPU at a large urban teaching hospital, prioritise their patient caseload, but lack evidence-based guidance on dosage and frequency of physiotherapy intervention, to inform the process. The aim of the quality improvement project was to design and deliver a staff education and training package to facilitate implementation of a newly-developed, evidence-based prioritisation resource. Method: Plan-Do-Study-Act cycles and the Com-B model to influence behaviour changes were employed between October 2019 and March 2020. Stakeholders were engaged throughout the design process. Training to all 11 physiotherapists consisted of familiarisation with the resource through content discussion and "mock-use" training sessions to ensure intra/inter-rater-reliabilty. Physiotherapist staff knowledge and confidence of prioritisation was evaluated by questionnaire. Accuracy of use of the prioritisation tool was determined by comparison of staff prioritisation decision with expert opinion. Results: From the 11 questionnaire responses, pre to post intervention physiotherapy knowledge of the prioritisation categories increased (43% to 100%), physiotherapist rated confidence using the prioritisation tool increased (mean score, 6.9 to 8.2/10) and accuracy of prioritisation of patients improved (mean 42.1% to 92.3%). Conclusion: The education and training package developed to support implementation of the prioritisation tool resulted in improved staff knowledge and confidence of patient prioritisation and increased the accuracy of OPU physiotherapy targeting. This project has highlighted the importance of staff training in resource allocation to ensure that decisions regarding which patients receive physiotherapy intervention are efficacious. This has increased relevance in a department with a large number of rotational staff.

[Perceptions, attitudes and training needs of primary healthcare professionals in identifying and managing frailty: a qualitative study]

Author: Avgerinou, Christina, Kotsani, Marina, Gavana, Magda, Andreou, Martha, Papageorgiou, Dimitra-Iosifina, Roka, Violeta, Symintiridou, Despoina, Manolaki, Chrysanthi, Soulis, George and Smyrnakis, Emmanouil

Publication Date: 2021

Publication Details: European geriatric medicine, 12, (2) pp.321-332. , Switzerland:

Abstract: PURPOSE: Although frailty can be delayed or prevented by appropriate interventions, these are often not available in countries lacking formal education and infrastructure in geriatrics. The aim of this study was to: (a) explore ideas, perceptions and attitudes of primary health care (PHC) professionals towards frailty in a country where geriatrics is not recognised as a specialty; (b) explore PHC professionals' training needs in frailty; and (c) define components of a frailty educational programme in PHC., METHODS: Qualitative design, using two focus groups with PHC professionals conducted in Thessaloniki, Greece. Focus groups were audio recorded and transcribed. Data were analysed with thematic analysis., RESULTS: In total 31 PHC professionals (mean age: 46 years; gender distribution: 27 females, 4 males) participated in the

study (physicians n = 17; nurses n = 12; health visitors n = 2). Four main themes were identified: (1) Perceptions and understanding of frailty; (2) Facilitators and barriers to frailty identification and management; (3) Motivation to participate in a frailty training programme; (4) Education and training. The main barriers for the identification and management of frailty were associated with the healthcare system, including duration of appointments, a focus on prescribing, and problems with staffing of allied health professionals, but also a lack of education. Training opportunities were scarce and entirely based on personal incentive. Professionals were receptive to training either face-to-face or online. A focus on learning practical skills was key., CONCLUSION: Education and training of professionals and interdisciplinary collaboration are essential and much needed for the delivery of person-centred care for people with frailty living in the community.

Conference Abstract: Preparing the workforce for frailty, an education intervention for health professionals and community nurses in primary and community healthcare Abstract only*
Author(s): McKelvie et al.
Source: Physiotherapy 105 (Supplement 1)
Publication date: January 2019
Purpose: The Comprehensive Geriatric Assessment (CGA) is a multidisciplinary assessment that identifies the medical, psychosocial, and functional needs of older people. This service evaluation considers the impact of training allied health professionals (AHPs) and community nurses to undertake a CGA assessment in primary and community settings.

Preparing the workforce for frailty, an education intervention for allied health professionals and community nurses in primary and community healthcare Abstract only*
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Integrated care and whole system approaches

Case management for integrated care of older people with frailty in community settings
Author(s): Sadler et al.
Source: Cochrane Database of Systematic Reviews 2023(5)
Publication date: 2023
Ageing populations globally have contributed to increasing numbers of people living with frailty, which has significant implications for use of health and care services and costs. The British Geriatrics Society defines frailty as "a distinctive health state related to the ageing process in which multiple body systems gradually lose their inbuilt reserves". This leads to an increased susceptibility to adverse outcomes, such as reduced physical function, poorer quality of life, hospital admissions, and mortality. Case management interventions delivered in community settings are led by a health or social care professional, supported by a multidisciplinary team, and focus on the planning, provision, and co-ordination of care to meet the needs of the individual. Case management is one model of integrated care that has gained traction with policymakers to improve outcomes for populations at high risk of decline in health and well-being. These populations include older people living with frailty, who commonly have complex healthcare and social care needs but can experience poorly co-ordinated care due to fragmented care systems.

[Frailty Knowledge, Use of Screening Tools, and Educational Challenges in Emergency Departments in Ireland: A Multisite Survey]

Author: Moloney, E., O'Donovan, M. R., Sezgin, D., McGrath, K., Timmons, S. and O'Caoimh, R.

Publication Date: 2023
Publication Details: Journal of Emergency Nursing, , United States: Elsevier Inc.

Abstract: Background: Recognizing frailty and providing evidenced-based management in busy emergency departments is challenging. Understanding the knowledge and educational needs of ED staff is important to design training that might improve patient outcomes. Objective(s): This study aimed to explore frailty knowledge of ED staff, use of frailty screening instruments in Irish emergency departments, and educational challenges in the emergency department. Method(s): A multisite survey of ED staff (different specialties) was conducted between April and September 2021. An anonymous online survey was distributed via email. Free-text sections were analyzed using content analysis. Result(s): In total, 168 staff (nursing, medical and allied health) participated, representing 9 of 26 Irish emergency departments (35%). Most respondents were nurses (n = 78, 46%). Less than half of respondents had received frailty identification training (n = 81, 48%). One-fifth of emergency doctors and nurses (20%) were unsure how to define frailty. Major barriers to ED frailty screening were resource deficits, insufficient diagnostic pathways from the emergency departments, and lack of education on suitable instruments. Conclusion(s): Most of the ED staff surveyed relied on clinical judgment rather than formal training in frailty identification. A high proportion reported poor knowledge and low confidence in recognizing frailty. Dedicated staff with frailty management expertise, bespoke education initiatives, and clearly defined frailty screening pathways may help address the issues identified. Copyright © 2023 Emergency Nurses Association

[A whole-of-health system approach to improving care of frail older persons] Full text available with NHS OpenAthens account*

Item Type: Journal Article

Authors: Whiting, Elizabeth;Scott, Ian A.;Hines, Laureen;Ward, Tamara;Burkett, Ellen;Cranitch, Erin;Mudge, Alison;Reymond, Elizabeth;Taylor, Andrea and Hubbard, Ruth E.

Publication Date: 2022
Journal: Australian Health Review 46(5), pp. 629-634

Abstract: The population is aging, with frailty emerging as a significant risk factor for poor outcomes for older people who become acutely ill. We describe the development and implementation of the Frail Older Persons' Collaborative Program, which aims to optimise the care of frail older adults across healthcare systems in Queensland. Priority areas were identified at a co-design workshop involving key stakeholders, including consumers, multidisciplinary clinicians, senior Queensland Health staff and representatives from community providers and residential aged care facilities. Locally developed, evidence-based interventions were selected by workshop participants for each priority area: a Residential Aged Care Facility acute care Support Service (RaSS); improved early identification and management of frail older persons presenting to hospital emergency departments (GEDI); optimisation of inpatient care (Eat Walk Engage); and enhancement of advance care planning. These interventions have been implemented across metropolitan and regional areas, and their impact is currently being evaluated through process measures and system-level outcomes. In this narrative paper, we conceptualise the healthcare organisation as a complex adaptive system to explain some of the difficulties in achieving change within a diverse and dynamic healthcare environment. The Frail Older Persons' Collaborative Program demonstrates that translating research into practice and effecting change can occur rapidly and at scale if clinician commitment, high-level leadership, and adequate resources are forthcoming. What is known about the

topic? Providing frailty-focused care can improve outcomes, particularly by avoiding unnecessary admissions to hospital and reducing hospital-acquired complications, such as delirium and functional decline. Several evidence-based interventions exist that apply to specific points in the trajectory of older frail patients from hospital presentation to discharge and beyond, but these are not generally well integrated across the entire patient journey. What does this paper add? This paper describes a whole-of-healthcare system approach to improving care and outcomes for frail older people in Queensland. Rather than developing new care initiatives, the approach was taken to invest in pre-existing evidence-based interventions developed and validated in Queensland clinical settings and scale them across the state over 3 years. What are the implications for practitioners? This state-wide scale-up of evidence-based interventions has profiled how the healthcare system can be redesigned to implement models that better support vulnerable older people.

Models of integrated care for older people with frailty: a horizon scanning review
Author(s): Kjelsnes et al.
Source: BMJ Open 12(4)
Publication date: 2022
Objectives Frailty, a multifaceted geriatric condition, is an emerging global health problem. Integrated care models designed to meet the complex needs of the older people with frailty are required. Early identification of innovative models may inform policymakers and other stakeholders of service delivery alternatives they can introduce and locally adapt so as to tackle system fragmentation and lack of coordination. This study used horizon scanning methodologies to systematically search for, prioritise and assess new integrated care models for older people with frailty and investigated experts' views on barriers and facilitators to the adoption of horizon scanning in health services research. Methods A four-step horizon scanning review was performed. Frailty-specific integrated care models and interventions were identified through a review of published literature supplemented with grey literature searches. Results were filtered and prioritised according to preset criteria. An expert panel focus group session assessed the prioritised models and interventions on innovativeness, impact and potential for implementation. The experts further evaluated horizon scanning for its perceived fruitfulness in aiding decision-making. Results Nine integrated care models and interventions at system level (n=5) and community level (n=4) were summarised and assessed by the expert panel (n=7). Test scores were highest for the Walcheren integrated care model (system-based model) and EuFrailSafe (community-based intervention). The participants stated that horizon scanning as a decision-making tool could aid in assessing knowledge gaps, criticising the status quo and developing new insights. Barriers to adoption of horizon scanning on individual, organisational and wider institutional level were also identified. Conclusion Study findings demonstrated that horizon scanning is a potentially valuable tool in the search for innovative service delivery models. Further studies should evaluate how horizon scanning can be institutionalised and effectively used for serving this purpose.

Conference abstract: 131 Developing an integrated comprehensive geriatric unit
Author(s): Emery et al.
Source: Age and Ageing 50(Supplement 1)
Publication date: March 2021
Introduction: Surrey Downs Health and Care (SDHC) is an innovative partnership consisting of the acute trust, community provider, three local GP federations and local authority. Together they deliver integrated health and care services for the Surrey Downs population. In April 2019, SDHC formally took over the management of an acute escalation ward at Epsom General

Hospital. The aim was to redesign the model of care to offer a more integrated approach towards the management of patients with frailty. Method: A change in leadership with interface frailty consultants developing an integrated multidisciplinary team (MDT) with reassignment of community staff. All members of the MDT had an equal voice and this helped develop the one team ethos. There were many developments along the way, but key changes included the agreement that a patients' time is the most valuable currency and that we should be changing conversations from "what is the matter with you?" to "what matters most to you?" Results: 1. A 100% increase in average daily discharges 2. An increase to 70% being discharged to their own home, versus 20% previously 3. A reduction from an average length of stay of 40 days to 13 days compared to the same time last year 4. Reduced 30-day readmissions at 15% versus previous average of 25%. Conclusion: By blurring boundaries between the acute and community, allowed a frictionless pathway for patients. This has led to improvement in patient care and outcomes for the patient and system as a whole.

Implementing SAFE™ care: Evaluating of a geriatric model of care for real-world practice Abstract only*
Author(s): Peig et al.
Source: Geriatric Nursing 42(1)
Publication date: January-February 2021
Systems Addressing Frail Elders (SAFETM) Care is a geriatric model of care that identifies high-risk hospitalized older adults, and provides targeted interprofessional interventions for risk factors associated with frailty. This post, mixed methods study sought to evaluate SAFETM Care implementation retrospectively at one public academic medical center and describe practical "real-world" considerations for implementation using the Consolidated Framework for Implementation Research (CFIR). In addition to barriers and facilitators, hidden characteristics to consider for implementation include initiating conditions, skills and experiences of implementers, interpersonal challenges, unique facilitators and barriers, surprising conditions, and threats to and requirements for sustainability. Implementation of SAFETM Care demonstrated effective adoption and implementation, but faced multiple threats that led to failed sustainability. The public sharing of these successes and failures will help implementers understand and make progress in adapting such important geriatric programs and quality improvement initiatives.

The Acute Frailty Network: experiences from a whole-systems quality improvement collaborative for acutely ill older patients in the English NHS
Author(s): van Oppen et al.
Source: European Geriatric Medicine 10 pp. 559-565
Publication date: 2019
Older people form a growing proportion and volume of those accessing urgent care, much of which is provided by non-specialists in geriatric medicine. Non-specific presentations, multiple comorbidities and functional decline make assessment and management of this cohort challenging. In this article we describe the approach and methods of the Acute Frailty Network (AFN), a national quality improvement collaborative designed to support acute hospitals in England to deliver evidence-based care for older people with frailty. We report on 3 years' experience of whole-systems quality improvement through the network. Using local case studies, we illustrate initiatives through which AFN hospitals improved services and outcomes for older people with frailty and urgent care needs. We describe returns on investment and sustainability of implementation, and reflect on future directions for the AFN.

Facing frailty: exploring effectiveness of integrated care for frail older people
Author(s): Looman

Source: Erasmus School of Health Policy & Management 19(13)
Publication date: 2019
This thesis aimed to explore the (cost-)effectiveness of preventive, integrated care for community-dwelling frail older people. The first part of this thesis focused on the effectiveness and cost-effectiveness of a specific preventive integrated care intervention, the Walcheren Integrated Care Model (WICM). The second part of this thesis critically reflected on the concepts and methodologies used to explore the (cost-)effectiveness of integrated care for frail older people. This second part included a systematic review and an exploration of the effectiveness of integrated care for six profiles of frail older people.

Conference abstract: Up-scaling of an integrated care model for frail elderly patients
Author(s): Merino et al.
Source: International Journal of Integrated Care 16(A251)
Publication date: December 2016
Introduction: Population aging and the increased number of chronic diseases push the healthcare systems to design and implement new strategies to improve the quality of services. These strategies require investment in ICT tools, promotion of patient empowerment in the management of their disease and a better integration of health and social care services. CareWell project focuses on the delivery of integrated healthcare to frail elderly patients who have complex health and social care needs, are at high risk of hospital or care home admission and require a range of high-level interventions due to their frailty and multiple chronic diseases. Carewell aims at deploying services supported by ICT which enhance the coordination and communication of healthcare professionals, improves patient´s remote follow up and boosts patient (and caregiver) empowerment. The aim of the project is the identification of the impact of implementing an integrated care model for frail elderly patients, according to quality of care, efficiency and both patients´ and professionals´ satisfaction.

Loneliness, social isolation, and frailty

The longitudinal relationship between loneliness, social isolation, and frailty in older adults in England: a prospective analysis
Author: Davies, Katie and al, Et
Publication Date: 2021
Publication Details: Lancet Healthy Longevity, 14 Jan 2021, pp.8. , European: Journal article.
Abstract: Examines the relationship between loneliness, social isolation and frailty in elderly people in England, drawing on analysis of a national longitudinal dataset. Outlines the background to the study, indicating that an estimated 10% of people aged 65 and over are frail and that loneliness and social isolation are linked to increased mortality and poorer functional capacity, and describes the methodology. Presents the findings indicating that: respondents with higher levels of loneliness, and those with higher levels of social isolation, had higher frailty scores; increasing age was associated with an increased frailty score; and medium to high levels of loneliness and/or social isolation increased the risk of developing frailty. Discusses the implications of the findings, highlighting the importance of understanding the mechanisms by which loneliness and social isolation increase the risk of developing frailty in providing opportunities to attenuate this risk.

Multidisciplinary teams and working

Improving Multidisciplinary Team Working to Support Integrated Care for People with Frailty Amidst the COVID-19 Pandemic
Author: Barber, S., Otis, M., Greenfield, G., Razzaq, N., Solanki, D., Norton, J., Richardson, S. and Hayhoe, B. W. J.
Publication Date: 2023

Publication Details: International Journal of Integrated Care, 23, (1) pp.23. , Netherlands: Ubiquity Press.
Abstract: Multidisciplinary team (MDT) working is essential to optimise and integrate services for people who are frail. MDTs require collaboration. Many health and social care professionals have not received formal training in collaborative working. This study investigated MDT training designed to help participants deliver integrated care for frail individuals during the Covid-19 pandemic. Researchers utilised a semi-structured analytical framework to support observations of the training sessions and analyse the results of two surveys designed to assess the training process and its impact on participants knowledge and skills. 115 participants from 5 Primary Care Networks in London attended the training. Trainers utilised a video of a patient pathway, encouraged discussion of it, and demonstrated the use of evidence-based tools for patient needs assessment and care planning. Participants were encouraged to critique the patient pathway, reflect on their own experiences of planning and providing patient care. 38% of participants completed a pre-training survey, 47% a post-training survey. Significant improvement in knowledge and skills were reported including understanding roles in contributing to MDT working, confidence to speak in MDT meetings, using a range of evidence-based clinical tools for comprehensive assessment and care planning. Greater levels of autonomy, resilience, and support for MDT working were reported. Training proved effective; it could be scaled up and adopted to other settings. Copyright © 2023 The Author(s).

Conference abstract: 100 Frailty Hot Clinics: Rapid Cga and Speciality Diagnostics reduces rates of hospitalisation and re-attendance
Author(s): Lim et al.
Source: Age and Ageing 50(Supplement 1)
Publication date: March 2021

Introduction: Acute hospitalisation is associated with an increased risk of progressive frailty, morbidity and subsequent institutionalisation. North Middlesex University Hospital is an Acute District General Hospital with over 550 attendances to A&E per day. Comprehensive Geriatric Assessment (CGA) is the gold standard approach for a holistic multi-disciplinary assessment (MDT) of frail patients. A rapid access daily hot clinic service for frail patients opened using quality improvement (QI) methodology to deliver rapid CGA focusing on admission avoidance and early supported discharge. Method: 4 PDSA cycles were conducted. A process map identifying key moments in patient care was derived from time studies of the first 10 patients' journeys. Patients were triaged through the Geriatrician "hotphone" for acute admissions into the Hot Clinic. Dedicated clinic and waiting rooms were placed on the acute frailty unit (Amber) staffed by a dedicated Consultant Geriatrician and Health Care Support Worker working with the Frailty Ward Clerk, Frailty Specialist Nurse, Therapies, specialities in-reach and same-day diagnostics. A shared clerking proforma and subsequent CGA Discharge Summary were completed and emailed to the referrer the same day. Qualitative and Quantitative feedback was gained from referrers, patients and relatives through a structured questionnaire. Metrics were gathered including rate of admissions, re-attendance and use of enhanced community services.Results: From the first 48 Hot Clinic patients, there was a low 30-day re-attendance rate (17%—for unrelated reasons), low 30-day re-admission rates (4%) and low Did Not Attend rate (6%) for new referrals and high satisfaction scores for recommending the service (9-10/10) from patients, relatives and referrers. Conclusions: Early rapid MDT can reduce re-attendances and re-admissions to hospital in frail patients. A streamlined patient journey can be delivered by frailty-trained staff and in a suitable environment. QI Methodology enables a structured measurable approach to development of the Acute Frailty Pathway.

[Conference abstract: 60 Front door specialist frailty MDT working at MFT NHS Trust – The Therapy Team Poster Presentation]
Author(s): Tuner et al.
Source: Age and Ageing 50 (Supplement 1)
Publication date: March 2021
Introduction: The therapy team consists of physiotherapists, Occupational therapists and therapy technicians working generically to deliver a comprehensive therapy assessment to patients presenting in our Emergency Department, Clinical Decisions Unit and Medical Admissions Unit between the hours of 08:00–18:00 7 days a week. The therapists provide the hospitals frailty service in ED and MAU with early therapy assessment and intervention, supporting the provision of a Comprehensive Geriatric Assessment. The aims of our service are to provide early therapy assessment of our most vulnerable patients to avoid unnecessary hospital admissions and reduce readmission rates, and for those requiring hospital care to provide early mobilisation and discharge planning to reduce length of stay and complications associated with hospital admission. We provide the therapy component of the CGA as part of the specialist frailty MDT service and act as an interface with local community health and social services. Method: A full review of our frailty MDT service was undertaken and a re-allocation of our resources and staff was piloted in July 2019. During this pilot our therapy staff presence was re-distributed allowing greater patient numbers to be assessed promptly on their arrival to ED. This adjustment supported the Frailty MDT actions of:

- Further developing and redefining the Frailty nurse role basing them in ED and triage
- Close working relationships in ED between ED and frailty teams
- Education of ED staff in using the Clinical Frailty Score
- Releasing consultant geriatrician time, enabling them to be based in ED throughout the day
- Linking with community services

Results: Data collection showed total referrals to therapy increased from 67 (June 2019) to 160 (July 2019). In July same day discharges were at 43%; discharges ≥72 hours 24%; 7 day readmission at 9%; 28 day readmissions at 11% and 38% were referred to community services. Conclusion: These changes enabled us to provide a full MDT frailty service to frail older people presenting at our ED in a timely manner and to a larger number of suitable patients.

[Wessex Acute Frailty Audit: applying quality improvement methodology to design and implement a regional frailty audit using a collaborative, multiprofessional approach]
Author(s): Lewis et al.
Source: BMJ Open Quality 9
Publication date: 2020
Introduction An acute hospital stay increases the risk of negative outcomes for those living with frailty. This paper describes the application of quality improvement methodology to design and implement a regional audit to gain an understanding of care provision. Methods Small scale tests of change (Plan–Do–Study– Act cycles) were used to design the audit structure and questions. Data collectors met face to face with 2–3 multiprofessional clinicians on 58 wards in 10 hospitals across the region, using an electronic tool to gather data. Outcomes were analysed manually in Excel by extracting from the electronic audit tool. Results 58 wards across 10 hospitals participated in the audit, which identified three key themes: lack of awareness and frailty training outside medicine for older people specialties, and significant variability of both frailty identification and comprehensive geriatric assessment. Conclusion Combining quality improvement methodology with a collaborative, regional approach to design and implementation of a frailty audit creates a reliable tool ensuring all stakeholders are considering improvement from the outset. The results have

facilitated an agreed regional approach on how best to use local resources to improve and standardise frailty care provision. By highlighting areas of good practice and significant gaps in frailty identification, personalised care planning and hospital wide provision of frailty training, this region of the UK will now be able to drive up standards of care.

Conference abstract: Culture trumps everything: The (un)expected trust about building a frailty team across the continuum for a vulnerable population
Author(s): Nicholson et al.
Source: International Journal of Integrated Care 19(374)
Publication date: August 2019
Introduction: Hospital Emergency Departments (EDs) experience high presentation rates from older adults residing in Aged Care Facilities (ACFs), yet few intervention studies have addressed the specific care needs of this vulnerable, high-risk population. This paper presents Mater Aged Care in an Emergency (MACIAE), a service dedicated to supporting aged care facility residents, their families, facility carers and GPs, with the goal of providing a seamless care transition in order to ensure the highest and safest standard of care with the upmost compassion and dignity. The program was designed with patients and families/ carers, ACFs, local general practices, Primary Health Networks, ambulance services, hospital providers and researchers. Methods: The study was implemented 2013-2016. All older adults presenting from ACFs to the ED of Mater Hospital Brisbane, Australia were included. The evaluation was a pre/post design using retrospective baseline data from hospital records, and prospectively collected post-implementation data. The objectives were to determine whether this intervention significantly impacted on patient outcomes and organisational outcomes. Ethics approval for the study was obtained through the Mater Research Ethics Committee. Results: This study demonstrates the significant improvements can be achieved by a specific aged care service working across the continuum. Participants (n=1130) were from over 200 ACFs. Intervention resulted in 30% drop ward admissions; reduced LOS from 6.5 to 4.0 days (national average 8.0 days); reduced 28-day representation rates from 17.8% to 4.6%; 88% of patients commenced on an End of Life pathway were able to be transferred to their environment of preference; and, there were over 300 Advanced Care Plans implemented. Satisfaction from acute, primary care and ACF providers was very high. A cost-benefit analysis demonstrated a 10:1 outcome. Discussion: This study demonstrates significant improvements were achieved by integration of an acute frail older person service into an ED, which works with families, primary health and social care to implement strategies to meet the needs of this population. Lessons learnt: Key to implementing and sustaining this model of integrating care are leadership; culture – it makes or breaks it; time – it takes longer than you think; data - speaks louder than words; and, passion - to keep you going through the tough times. Limitations: The present study involved a pre-post implementation study design, therefore we cannot speculate whether or not our results were entirely due to the MACIAE service implementation. Future studies should consider implementation of a Randomised Controlled Trial. We also note that this study was implemented in only one hospital. Suggestions for future research: In January 2018, the Older Person Centred Care Team formed, merging three existing teams, focused on managing frail and older patients and families/carers across the continuum. Current research is focused on rapid assessment of frailty, embedding a case management approach to support care closer to home and involving patients/ families/ carers in decisions about a model that meets their future needs.

Nurses

[The role of the district nurse in screening and assessment for frailty]
Author: Horner, Ruth Louise
Publication Date: 2022
Publication Details: British journal of community nursing, 27, (5) pp.226-230. , England:
Abstract: An ageing population is leading to greater demands on healthcare services; investments are being made to allow complex care to be given in patient's homes by community care staff, as highlighted in the NHS Long Term Plan (2019). Frailty is often identified in secondary care when acute crisis is hit; frailty does not suddenly occur and will happen over time. This article aims to explore community screening, the assessment processes of frailty and the role the district nurse has. It also addresses how working collaboratively with the wider multidisciplinary team to earlier identify service users with frailty can assist in improving patient outcomes by empowering and supporting service users to remain at home. Recognising continual improvement to service users' care and changes in practice should be considered and disseminated. based upon best available evidence.

[Perceptions, practices and educational needs of community nurses to manage frailty]
Author(s): Martin et al.
Source: British Journal of Community Nursing 26(3)
Publication date: March 2021
Early intervention on frailty can help prevent or delay functional decline and onset of dependency. Community nurses encounter patients with frailty routinely and have opportunities to influence frailty trajectories for individuals and their carers. This study aimed to understand nurses' perceptions of frailty in a community setting and their needs for education on its assessment and management. Using an exploratory qualitative design we conducted focus groups in one Health Board in Scotland. Thematic content analysis of data was facilitated by NVivo© software. A total of 18 nurses described the meaning of frailty as vulnerability, loss and complex comorbidity and identified processes of caring for people with frailty. They identified existing educational needs necessary to support their current efforts to build capability through existing adversities. Our study indicates that current practice is largely reactive, influenced by professional judgement and intuition, with little systematic frailty-specific screening and assessment.

[North Tyneside initiative to introduce a new nursing role in care homes]
Item Type: Journal Article
Authors: Craig, Lynn
Publication Date: 2021
Journal: British Journal of Nursing 30(10), pp. 588-590
Abstract: The author of the article describes plans to appoint advanced care practitioners to improve care for residents and support nurses by offering professional development opportunities and enabling career progression. It mentions that according to the British Geriatric Society (BGS) (2016), 75-80% of carehome residents have cognitive impairment, and many also have multiple long-term conditions, functional dependency and frailty.

[The role of the registered nurse in supporting frailty in care homes]
Author(s): Lynn Craig
Source: British Journal of Nursing 28(13)
Publication date: 2019
People in nursing and residential homes are more likely to suffer frailty. Registered nurses are a crucial component of the care delivery service and can offer support to patients who have

complex care needs and comorbidities and are at risk of unplanned admissions to secondary care. This article explores frailty and the role of the nurse in assessing for frailty. Three aspects of patient care-nutrition status, polypharmacy and exercise and cognitive function-are discussed as areas where nurses can target their interventions in order to support those considered as frail, aiming to reduce the impact of frailty and negative health outcomes.

What are community nurses experiences of assessing frailty and assisting in planning subsequent interventions? Abstract only*
Author(s): Hannah Britton
Source: British Journal of Community Nursing 2;22(9) pp. 440-445
Publication date: September 2017
With an ageing population and increasing focus on community care, this study aimed to explore the experiences of community nurses in assessing frailty and planning interventions around frailty. Six community nurses were recruited for face-to-face semi-structured interviews as part of this qualitative study which was underpinned by a competence framework (Royal College of Nursing, 2009). Thematic analysis was used and frailty was identified as an emerging topic within practice. Participants discussed several aspects associated with frailty; however, some uncertainty around the concept of frailty and its definition was noted, particularly for staff who had received limited frailty training. Participants had a growing awareness of frailty in practice, but challenges-including time constraints and staffing within some roles, a perception of limited services to support older people, and for some a lack of confidence and training-presented barriers to frailty assessment. The Rockwood frailty scale was used by participants within practice, but evidence suggested it was felt to lack validity within the community setting.

Frailty: a term with many meanings and a growing priority for community nurses Abstract only*
Author(s): Sophie Louise Wallington
Source: British Journal of Community Nursing 2;21(8) pp. 385-9
Publication date: 2016
The question of exactly what frailty is and what that may mean for patients is extremely complex. This is a very conceptual problem requiring a broad and long-term solution. It is not a disease or a condition that can be treated in isolation. Frailty is a collection of contributing factors that culminate in an individual being susceptible to poorer outcomes following health-care interventions and minor illness. The solution to such a complex problem lies in engaging and empowering staff to understand and champion frailty. Once better understood, it will be possible to educate and enable this workforce to recognise the signs of frailty, poor prognosis and patients requiring more specialised palliative care. Informing staff working within a health-care economy of this issue must be the first step in a shift towards managing patients with frailty more appropriately, and streaming their care towards the correct care pathways sooner. This article discusses what frailty is, what it may mean for patients, and attempts to expand on why the construct of frailty is a prevalent issue for community nurses. The link between frailty and mortality is discussed and how targeted appropriate advanced care planning may be used to address this demographic challenge.

Frailty and its significance in older people's nursing Full text available with NHS OpenAthens account*
Author(s): Heath et al.
Source: Nursing Standard 26(3)
Publication date: 2011
The term frail is commonly used to describe older people, but reports on the care of older adults in hospital highlight that the clinical implications of frailty are not understood fully by all

nurses. Frailty can be an indicator of older people's health status and healthcare needs. An understanding of frailty and its mechanisms will help nurses to determine care priorities, particularly the urgency for anticipatory, proactive, preventive and compensatory care to prevent unnecessary mortality and morbidity. This article discusses the significance of frailty in older people's nursing. It highlights the responsibility of registered nurses to recognise deterioration in health as a result of frailty and to implement appropriate interventions.

Occupational Therapists

Conference abstract: Occupational therapists delivering patient and caregiver home safety education in a rehabilitation setting
Author(s): Webster et al.
Source: Age and Ageing 48
Publication date: 2019
Background: The patient profile in a 160-bed rehabilitation hospital is evolving with increasing numbers of older adults admitted with falls and frailty. In 2018 a snapshot audit revealed over 60% of patients obtained scores indicative of cognitive impairment. Traditional falls prevention education delivered in a group format relies on attendees having an adequate level of sensory registration and cognitive abilities to comprehend and recall information given. Te Occupational Terapists (OTs) proposed greater benefits from caregiver inclusion in such education to enhance understanding for both patients and caregivers on falls prevention and home environment modifications to facilitate safer home discharges. Method(s): A mixed-methods design was used. Quantitative data was gathered using a pre and post education 10-point Likert scale to assess attendees' perceived knowledge in four domains: Falls risk factors Modifiable environmental factors Managing falls Accessing support/information to reduce risk of falls Qualitative data was gathered through written feedback. Referrals were generated by OTs. Evening sessions facilitated increased caregiver attendance. OTs delivered a 45 minute PowerPoint presentation, demonstrated adaptive equipment and engaged in discussion with attendees. Information packs were provided to caregivers including a Home Safety Assessment Tool to aid with home environment modification. Result(s): Data from April 2018-2019 was analysed using Microsoft Excel. 21 groups were facilitated with 385 attendees overall. Average percentage increase in knowledge in each of the four domains was 30%. Overall knowledge increased by 32%. Conclusion(s): Increased knowledge of modifiable falls risk factors and supporting persons at risk of falls in the home was demonstrated. OTs reported reduced caregiver concerns regarding home environment modification. Home assessments completed after group attendance found caregivers had implemented recommendations made in the presentation. Further data could be collected to measure the degree of environmental modification completed prior to OT home assessments. Additional qualitative data is required to fully assess benefits to both patients and caregivers.

Conference abstract: 163 Overcoming Frailty: Evaluating the role of an occupational therapist on a frail elderly team
Author(s): Niamh Muldoon
Source: Age and Ageing 46(Supplement 1)
Publication date: September 2017
Background: Occupational Therapists can significantly reduce hospital admissions and ensure timely, appropriate and safe discharges home in older adults with frailty (COT, 2016). A Frail Elderly Team was established in an acute hospital in January 2016 to effectively meet the needs of older people with complex needs. The Occupational Therapist, as part of the interdisciplinary team, places an immediate focus on the person’s meaningful occupations, enabling participation in daily activities and maximising quality of life. Methods: A quantitative study was conducted in order to evaluate the efficacy of the

Occupational Therapy role on the Frail Elderly Team. Data was collected on all patients referred to the Occupational Therapist from January to December 2016. A review of assessment outcomes, treatment methods, discharge recommendations and day hospital input was carried out using Microsoft Excel. A detailed analysis of the data collected was completed to evaluate the role of the Occupational Therapist. Results: The Occupational Therapist received 487 referrals between January and December 2016. Following assessment, 24% of patients were discharged home from the Emergency Department. Of those admitted, 48% continued to be reviewed by the Frail Elderly Team Occupational Therapist until their discharge home. Cognitive screens were administered with 383 patients; assessments of personal and domestic activities of daily living were completed with 308 patients and 40 patients were issued with adaptive equipment. A new interdisciplinary clinic in the day hospital generated 47 referrals for Occupational Therapy. Further input from the Community Occupational Therapist was indicated for 113 patients. Conclusions: The role of the Occupational Therapist has been evaluated, demonstrating a commitment to effectively meeting the needs of older people with frailty and promoting independent living.

Pathways and interventions

Enabling public, patient and practitioner involvement in co-designing frailty pathways in the acute care setting
Author(s): O'Donnell et al.
Source: BMC Health Services Research 19:797
Publication date: 2019
Background: Although not an inevitable part of ageing, frailty is an increasingly common condition in older people. Frail older patients are particularly vulnerable to the adverse effects of hospitalisation, including deconditioning, immobility and loss of independence (Chong et al, J Am Med Dir Assoc 18:638.e7–638.e11, 2017). The 'Systematic Approach to improving care for Frail older patients' (SAFE) study co-designed, with public and patient representatives, quality improvement initiatives aimed at enhancing the delivery of care to frail older patients within an acute hospital setting. This paper describes quality improvement initiatives which resulted from a co-design process aiming to improve service delivery in the acute setting for frail older people. These improvement initiatives were aligned to five priority areas identified by patients and public representatives. Methods: The co-design work was supported by four pillars of effective and meaningful public and patient representative (PPR) involvement in health research (Bombard et al, Implement Sci 13:98, 2018; Black et al, J Health Serv Res Policy 23:158–67, 2018). These pillars were: research environment and receptive contexts; expectations and role clarity; support for participation and inclusive representation and; commitment to the value of co-learning involving institutional leadership. Results: Five priority areas were identified by the co-design team for targeted quality improvement initiatives: Collaboration along the integrated care continuum; continence care; improved mobility; access to food and hydration and improved patient information. These priority areas and the responding quality improvement initiatives are discussed in relation to patient-centred outcomes for enhanced care delivery for frail older people in an acute hospital setting. Conclusions: The co-design approach to quality improvement places patient-centred outcomes such as dignity, identity, respectful communication as well as independence as key drivers for implementation. Enhanced inter-personal communication was consistently emphasised by the co-design team and much of the quality improvement initiatives target more effective, respectful and clear communication between healthcare personnel and patients. Measurement and evaluation of these patient-centred outcomes, while challenging, should be prioritised in the implementation of quality improvement initiatives. Adequate resourcing and administrative commitment

pose the greatest challenges to the sustainability of the interventions developed along the SAFE pathways. The inclusion of organisational leadership in the co-design and implementation teams is a critical factor in the success of interventions targeting service delivery and quality improvement.

229 HomeFIRsT – Outcomes of a Frailty Intervention and Response Team in the Emergency Department of a Large Acute Teaching Hospital
Author(s): O Shaughnessy et al.
Source: Age and Ageing 47(Supplement 1)
Publication date: September 2018
Background: Emergency Department (ED) attendance, for an older person is often associated with elevated risks of deleterious outcomes due to a reduction in physiological reserves. A holistic model of care, delivered by interdisciplinary teams embedding geriatric competencies into their service has been recommended (Conroy & Turpin, 2016). Home FIRsT (Frailty Intervention & Response Team), comprising a candidate Advanced Nurse Practitioner, Clinical Specialist Occupational Therapist, Clinical Specialist Physiotherapist and Medical Social Worker was introduced to the ED of large acute hospital in May 2017. Objectives include avoidance of unnecessary admissions among older patients (≥70years, Manchester triage category 3–5). Methods: Quality Improvement methodology underpinned the development of care pathways. Tests of change were performed using Plan-Do-Study-Act cycles. The team developed a common assessment form using shared interdisciplinary competencies. Patient demographics and outcomes are collected for the purposes of prospective auditing; Microsoft excel is used for data collection and analysis. Results: In the first nine months of service delivery, 1980 ED attendances were recorded. 802 were male (41%) and 1,178 female (59%) with a mean age of 80 years (range 63–104). 60% (n = 1,203) were discharged home from the ED; 21% (n = 257) had onward referral to Medicine for Older Persons ambulatory care services. Compared to the same nine month period the previous year there were approximately 230 fewer admissions among similar patients corresponding to a bed day saving of 4,500 days. In relation to ED re-attendances, 10% of those discharged had an unscheduled admission within a month (hospital re-admission rate for similar patients was 13% over the same period). Conclusion: Home FIRsT enabled comprehensive geriatric assessment to begin in the ED and prevented approximately 1 admission a day without raising re-admissions. The bed day saving equates to about €4.5 million, which highlights the efficacy and cost effectiveness of this service.

Paramedics

Paramedic assessment of frailty: An exploratory study of perceptions of frailty assessment tools
Author(s): Harris et al.
Source: Irish Journal of Paramedicine 3(1)
Publication date: 2018
Introduction: Frailty is recognised as a significant variable in the health of older adults. Early identification by paramedics of those at risk of frailty may assist in timely entry to an appropriate clinical care pathway. Early referral to such pathways has been shown to improve patient outcomes and quality of life, as well as deliver economic benefits. To date, little research has been completed regarding assessment of frailty by paramedic professionals using validated assessment tools. The objective of this study was to determine paramedicine students' perceptions of screening tools to facilitate assessment and knowledge of frailty of older adults. The Edmonton Frail Scale (EFS) and the Groningen Frailty Index (GFI) were determined suitable for this purpose. Methods: The research adopted a mixed methods approach using a survey tool developed to gather both qualitative and quantitative data from students at the completion

of a structured aged care clinical placement. Thematic analysis of the qualitative data identified key features of the tools, while a Likert-type scale was used to measure perspectives about the suitability of the tools for use in paramedic practice. Results: Thirty-seven paramedicine students were invited to participate in the study. Thirteen were able to use both tools to conduct frailty assessments and submitted survey responses. Student perspectives indicated both the EFS and GFI are potentially suitable for paramedicine and as clinical learning tools regarding geriatric assessments. Median time to administer the tools was eight minutes for the EFS and ten minutes for the GFI. Conclusion: Paramedicine students support a frailty assessment tool to assist clinical decision making regarding older adults. Further appraisal of validated frailty assessment tools by operational paramedics in a pre-hospital environment is warranted to determine absolute utility for Australian paramedics.

Ambulance clinicians' perceptions, assessment and management of frailty: thematic analysis of focus groups
Author(s): Green et al.
Source: British Paramedic Journal 3(3) pp. 23-33
Publication date: 2019
Introduction: More than half of all patients attended by the South Western Ambulance Service NHS Foundation Trust are over the age of 65. In 2017, 62% of older patients who were the subject of a frailty assessment were believed to have at least mild frailty (1/5 of all patients). Frailty is an increasingly relevant concept/diagnosis and ambulance services are well positioned to identify frailty and influence the ‘care pathways’ through which patients are directed (thereby influencing health outcomes). Throughout the South Western Ambulance Service NHS Foundation Trust, a mandatory training session regarding frailty was delivered to clinical personnel in 2017 and frailty assessment tools are available on the electronic Patient Clinical Record. Aim: To explore and gain insight into the current knowledge, practice and attitudes of ambulance clinicians regarding frailty and patients with frailty. Methods: Two focus groups of ambulance clinicians (n = 8; n = 9) recruited from across the South Western Ambulance Service NHS Foundation Trust were held in October 2017. Focus group discussions were analysed thematically. Results: Knowledge of conceptual models of frailty, appropriate assessment of patients with frailty and appropriate care pathways varied substantially among focus group participants. Completion of the ‘Rockwood’ Clinical Frailty Scale for relevant patients has become routine. However, conflicting opinions were expressed regarding the context and purpose of this. The Timed-Up-and-Go mobility assessment tool is also on the electronic Patient Clinical Record, but difficulties regarding its completion were expressed. Patient management strategies ranged from treatment options which the ambulance service can provide, to referrals to primary/community care which can support the management of patients in their homes, and options to refer patients directly to hospital units or specialists with the aim of facilitating appropriate assessment, treatment and discharge. Perceptions of limited availability and geographical variability regarding these referral pathways was a major feature of the discussions, raising questions regarding awareness, capacity, inter-professional relationships and patient choice. Conclusion: Knowledge, practice and attitudes of ambulance staff, with regard to frailty, varied widely. This reflected the emerging nature of the condition, both academically and clinically, within the ambulance profession and the wider healthcare system.

Physical fitness

Frailty and Physical Fitness in Elderly People: A Systematic Review and Meta-analysis Full text available with NHS OpenAthens account*
Author: Navarrete-Villanueva, David, Gomez-Cabello, Alba,

Marin-Puyalto, Jorge, Moreno, Luis Alberto, Vicente-Rodriguez, German and Casajus, Jose Antonio
Publication Date: 2021
Publication Details: Sports medicine (Auckland, N.Z.), 51, (1) pp.143-160. , New Zealand:
Abstract: BACKGROUND: Frailty is an age-related condition that implies a vulnerability status affecting quality of life and independence of the elderly. Physical fitness is closely related to frailty, as some of its components are used for the detection of this condition., OBJECTIVES: This systematic review and meta-analysis was conducted to investigate the magnitude of the associations between frailty and different physical fitness components and to analyse if several health-related factors can act as mediators in the relationship between physical fitness and frailty., METHODS: A systematic search was conducted of PubMed, SPORTDiscus, and Web of Science, covering the period from the respective start date of each database to March 2020, published in English, Spanish or Portuguese. Two investigators evaluated 1649 studies against the inclusion criteria (cohort and cross-sectional studies in humans aged >= 60 years that measured physical fitness with validated tests and frailty according to the Fried Frailty Phenotype or the Rockwood Frailty Index). The quality assessment tool for observational cross-sectional studies was used to assess the quality of the studies., RESULTS: Twenty studies including 13,527 participants met the inclusion criteria. A significant relationship was found between frailty and each physical fitness component. Usual walking speed was the physical fitness variable most strongly associated with frailty status, followed by aerobic capacity, maximum walking speed, lower body strength and grip strength. Potential mediators such as age, sex, body mass index or institutionalization status did not account for the heterogeneity between studies following a meta-regression., CONCLUSIONS: Taken together, these findings suggest a clear association between physical fitness components and frailty syndrome in elderly people, with usual walking speed being the most strongly associated fitness test. These results may help to design useful strategies, to attenuate or prevent frailty in elders., SYSTEMATIC REVIEW REGISTRATION: PROSPERO registration no. CRD42020149604 (date of registration: 03/12/2019).

Physiotherapists

Conference abstract: 48 Specialist Physiotherapist leading in the frailty revolution in ambulatory emergency care at the John Radcliffe Hospital, Oxford
Author(s): B Greensitt
Source: Age and Ageing 49(Supplement 1)
Publication date: February 2020
Background: The Ambulatory Assessment Unit (AAU) at the John Radcliffe Hospital aims to provide excellent care for complex patients with varying range of medical presentations. It sees over 50% of the acute take in operational hours, with over 40% of AAU patients over the age of 70. Staff feedback consistently identified a suboptimal service provided to the frail group within this patient cohort. A dedicated physiotherapist specialising in older people living with frailty joined the team in October 2018 to address this.
Aims

1. Early identification of patients with frailty attending the unit
2. Improve staff understanding of frailty to enhance patient care
3. Assess patients to either enable a patient to return home safely or support ambulatory pathway
4. Refer to community services that can support the patient and enable them to live well after hospital attendance
5. Review the impact of the specialist physiotherapist’s role

Methods

1. Introduction of frailty identification as per frailty team guidance
2. Frailty questionnaire to ascertain baseline understanding and learning needs to develop staff training
3. Assess patients using a Comprehensive Geriatric Assessment
4. Raise staff and patient awareness of community support services available within the community
5. Data collection to review interventions taken, bed days saved and re-attendance rates

Results

- 129 new patients were seen in a 4-month period.
- 85% returned home the same day; 64% had their ambulatory pathway supported with therapy intervention and 21% had an acute admission avoided directly due to therapy. 15% were admitted to an acute bed for safety
- 60% of patients were referred to community services and 50% were signposted to a range of community and support services
- The re-admission rates for therapy related reasons within 7 days and 30 days were 0% and 4% respectively. 38 bed days were saved with a calculated cost saving of £15,162

Future service delivery and conclusions: There is ongoing work to obtain patient experience data for those who had their admission avoided directly due to therapy intervention. A training programme on frailty for all members of the MDT is to be developed. A dedicated therapy service in an ambulatory setting has a role in ensuring that patients' needs are met in the most appropriate place and enhances their quality of life after hospital attendance.

Prescribing

Achieving Royal Pharmaceutical Society competencies: a frailty nurse's perspective Abstract only*
Author(s): Joanne Banks
Source: Journal of Prescribing Practice 1(1)
Publication date: January 2019
Frailty is related to the ageing process and describes how a person's inbuilt reserve struggles to withstand major changes in health, such as infection, a change to medication or a new environment. The British Geriatric Society (2014) approximate that around 10% of people over the age of 65 years have frailty rising to between a quarter to a half of those aged over 85 years. Patients who are deemed frail are often at risk of adverse outcomes; therefore, it is important to seek out these individuals and care for them appropriately. This includes carrying out regular medication reviews and deprescribing where necessary. This article will discuss prescribing for frail patients using the Royal Pharmaceutical Society's Competency Framework for all Prescribers.

Primary Care and Community

Potential Factors Influencing Adoption of a Primary Care Pathway to Prevent Functional Decline in Older Adults
Author: Fanaki, C., Fortin, J., Sirois, M. -J, Kroger, E., Elliott, J., Stolee, P., Gregg, S., Sims-Gould, J. and Giguere, A.
Publication Date: 2023
Publication Details: Canadian Geriatrics Journal, 26, (2) pp.227-234. , Canada: Canadian Geriatrics Society.
Abstract: Introduction To help recognize and care for community-dwelling older adults living with frailty, we plan to implement a primary care pathway consisting of frailty screening, shared decision-making to select a preventive intervention, and facilitated referral to community-based services. In this study, we

examined the potential factors influencing adoption of this pathway. Methods In this qualitative, descriptive study, we conducted semistructured interviews and focus groups with patients aged 70 years and older, health professionals (HPs), and managers from four primary care practices in the province of Quebec, representatives of community-based services and geriatric clinics located near the practices. Two researchers conducted an inductive/deductive thematic analysis, by first drawing on the Consolidated Framework for Implementation Research and then adding emergent subthemes. Results We recruited 28 patients, 29 HPs, and 8 managers from four primary care practices, 16 representatives from community-based services, and 10 representatives from geriatric clinics. Participants identified several factors that could influence adoption of the pathway: the availability of electronic and printed versions of the decision aids; the complexity of including a screening form in the electronic health record; public policies that limit the capacity of community-based services; HPs' positive attitudes toward shared decision-making and their work overload; and lack of funding. Conclusions These findings will inform the implementation of the care pathway, so that it meets the needs of key stakeholders and can be scaled up. Copyright © 2023 Author(s).

'Frailty as an adjective rather than a diagnosis'-identification of frailty in primary care: a qualitative interview study
Author: Seeley, A., Glogowska, M. and Hayward, G.
Publication Date: 2023
Publication Details: Age and Ageing, 52, (6) pp.afad095. , United Kingdom: Oxford University Press.
Abstract: Introduction: In 2017, NHS England introduced proactive identification of frailty into the General Practitioners (GP) contract. There is currently little information as to how this policy has been operationalised by front-line clinicians, their working understanding of frailty and impact of recognition on patient care. We aimed to explore the conceptualisation and identification of frailty by multidisciplinary primary care clinicians in England. Method(s): Qualitative semi-structured interviews were conducted with primary care staff across England including GPs, physician associates, nurse practitioners, paramedics and pharmacists. Thematic analysis was facilitated through NVivo (Version 12). Result(s): Totally, 31 clinicians participated. Frailty was seen as difficult to define, with uncertainty about its value as a medical diagnosis. Clinicians conceptualised frailty differently, dependant on job-role, experience and training. Identification of frailty was most commonly informal and opportunistic, through pattern recognition of a frailty phenotype. Some practices had embedded population screening and structured reviews. Visual assessment and continuity of care were important factors in recognition. Most clinicians were familiar with the electronic frailty index, but described poor accuracy and uncertainty as to how to interpret and use this tool. There were different perspectives amongst professional groups as to whether frailty should be more routinely identified, with concerns of capacity and feasibility in the current climate of primary care workload. Conclusion(s): Concepts of frailty in primary care differ. Identification is predominantly ad hoc and opportunistic. A more cohesive approach to frailty, relevant to primary care, together with better diagnostic tools and resource allocation, may encourage wider recognition. Copyright © The Author(s) 2023. Published by Oxford University Press on behalf of the British Geriatrics Society. All rights reserved.

Rapid evidence review to understand effective frailty care pathways and their components in primary and community care
Author(s): Thoman et al.
Source: International Journal of Health Governance 27(1) pp. 54-75
Publication date: 2022

Purpose –Different pathways of frailty care to prevent or delay progression of frailty and enable people to live well with frailty are emerging in primary and community care in the UK. The purpose of the study is to understand effective frailty care pathways and their components to inform future service development and pathway evaluation in primary- and community-care services. Design/methodology/approach – A rapid evidence review was conducted: 11 research publications met the inclusion criteria and were analysed using narrative thematic synthesis. Findings – There is strong evidence that resistance-based exercise, self-management support, community geriatric services and hospital at home (HAH) improve patient health and function. In general, evaluation and comparison of frailty care pathways, components and pathway operations is challenging due to weaknesses, inconsistencies and differences in evaluation, but it is essential to include consideration of process, determinant and implementation of pathways in evaluations. Originality/value – To achieve meaningful evaluations and facilitate comparisons of frailty pathways, a standardised evaluation toolkit that incorporates evaluation of how pathways are operated is required for evaluating the impact of frailty pathways of care.

The dynamics of frailty development and progression in older adults in primary care in England (2006-2017): a retrospective cohort profile
Author(s): Fogg et al.
Source: BMC Geriatrics 22(30)
Publication date: 2022
Background: Frailty is a common condition in older adults and has a major impact on patient outcomes and service use. Information on the prevalence in middle-aged adults and the patterns of progression of frailty at an individual and population level is scarce. To address this, a cohort was defined from a large primary care database in England to describe the epidemiology of frailty and understand the dynamics of frailty within individuals and across the population. This article describes the structure of the dataset, cohort characteristics and planned analyses. Methods: Retrospective cohort study using electronic health records. Participants were aged ≥50 years registered in practices contributing to the Oxford Royal College of General Practitioners Research and Surveillance Centre between 2006 to 2017. Data include GP practice details, patient sociodemographic and clinical characteristics, twice-yearly electronic Frailty Index (eFI), deaths, medication use and primary and secondary care health service use. Participants in each cohort year by age group, GP and patient characteristics at cohort entry are described. Results: The cohort includes 2,177,656 patients, contributing 15,552,946 person-years, registered at 419 primary care practices in England. The mean age was 61 years, 52.1% of the cohort was female, and 77.6% lived in urban environments. Frailty increased with age, affecting 10% of adults aged 50–64 and 43.7% of adults aged ≥65. The prevalence of long-term conditions and specific frailty deficits increased with age, as did the eFI and the severity of frailty categories. Conclusion: A comprehensive understanding of frailty dynamics will inform predictions of current and future care needs to facilitate timely planning of appropriate interventions, service configurations and workforce requirements. Analysis of this large, nationally representative cohort including participants aged ≥50 will capture earlier transitions to frailty and enable a detailed understanding of progression and impact. These results will inform novel simulation models which predict future health and service needs of older people living with frailty.

Creation of a New Frailty Scale in Primary Care: the Zulfiqar Frailty Scale (ZFS)
Author(s): Abrar-Ahmad Zulfiqar
Source: Medicines 8(19)
Publication date: 2021

Introduction: Very few frailty scales are used by general practitioners as they are time consuming and cumbersome. We designed a new scale for the rapid detection of frailty. Methods: We developed a frailty screening tool for use in primary care, referred to as the Zulfiqar Frailty Scale (ZFS). This scale was tested in a general practitioner's office for six months in Plancoët, France. Only patients over 75 years of age with Activities of Daily Living (ADL) ≥4 were included. The objective of this research was to validate the scale, evaluate its performance, and compare this screening tool with other scales such as the Fried Scale, the Gerontopole Frailty Screening Tool (GFST), the modified Short Emergency Geriatric Assessment (mSEGA) Grid A, and the Comprehensive Geriatric Assessment (CGA). Results: A total of 102 patients were included, with a mean age of 82.65 ± 4.79; 55 were women and 47 were men. The percentage of frail subjects was 63.7% in our scale, 67.7% in the mSEGA grid A, 75.5% in the GFST, and 60.8% for the Fried criteria. After a comprehensive geriatric assessment, frailty syndrome was found in 57 patients (55.9%). In general, both scales showed solid performance, and differences between them in the sample were minimal. As the CGA showed a prevalence of frailty of 55.9%, a similar prevalence threshold for the ZFS (i.e., 64% at the threshold ≥3 could be assessed). The completion time for our scale was less than two minutes, and staff required no training beforehand. Its sensitivity was 83.9%, and its specificity was 67.5%. Its positive predictive value was 80%, and its negative predictive value was 73%. The Pearson correlations between the geriatric scores were all strong and roughly equivalent to each other. Conclusions: Our frailty screening scale is simple, relevant, and rapid (taking less than two minutes).

Assessment of the validity and acceptability of the online FRAIL scale in identifying frailty among older people in community settings Abstract only*
Author(s): Yu et al.
Source: Maturitas 145 pp. 18-23
Publication date: March 2021
Objectives: To assess the validity and acceptability of the online FRAIL scale in identifying frailty in community settings. Methods: Frailty was assessed using the online version of the FRAIL scale (a simple frailty questionnaire). Validity of the scale was examined in a sample of 1882 persons aged 60 years or older (inlcuding a pilot sample of 65 persons for assessing the face validity) recruited from 24 elderly centres in Hong Kong. Convergent validity was estimated using correlation coefficients between scores on the FRAIL, SARC-F (a simple questionnaire for assessing sarcopenia) and AMIC (Abbreviated Memory Inventory for the Chinese). Predictive validity was examined by logistic regression using IADL (Instrumental Activities of Daily Living) limitations and hospitalization as outcomes. Acceptability of the scale was assessed from the perspective of a sub-sample of 205 older persons and 33 centre staff. Results: Following minor revisions, all participants were able to understand and answer the online FRAIL scale. The FRAIL scale correlated with SARC-F ($r = 0.627$, $p < 0.001$) and AMIC ($r = 0.302$, $p < 0.001$). Being pre-frail and frail were associated with incident IADL limitations (OR = 1.58, 95 %CI = 1.11−2.25 and OR = 3.01, 95 %CI = 1.87−4.84, respectively) and incident hospitalization (OR = 1.38, 95 %CI = 1.03−1.85 and OR = 2.79, 95 %CI = 1.89−4.12, respectively) at year 2, after controlling for age, sex, marital status, and educational level. 77.8 % of participants agreed that the scale would enable them to understand their health status. However, only 35.0 % accepted a digital approach for conducting health assessment or accessing assessment results. 90.9 % of centre staff agreed that the scale could be used to identify their members who are potential candidates for frailty intervention. Conclusions: The online FRAIL scale is valid for use in community elderly centres in identifying frailty. Further effort is required to improve the acceptability of the online FRAIL scale among older persons.

Conference abstract: 75 This is (Probably) Not the frailty solution you are looking for: Utilisation of a novel stand-alone community-based ambulatory care unit Abstract only*
Author(s): Dykes and Jones
Source: Age and Ageing 50(Supplement 1)
Publication date: March 2021
Introduction/Aim: Our organisation wished to expand its “Care Closer To Home” capability, especially for older and/or frail patients. Our novel Ambulatory Care Unit (ACU) in a community hospital, staffed by GPs & nurses, opened a year ago. The ACU has some Point of Care (POCT) diagnostics, access to plain-film radiography and OT/physio. During the planning of the unit,” acute frailty” was anticipated to be core business. We wished to determine whether this turned out to be the case. Method: Interrogation of the ACU patient log (spreadsheet collated from Data Collection Forms) Dec 2018-Nov 2019.
Results

- Of the 587 patients seen in the ACU, 277 (47%) were 370 years old (mean 64.5, median 69).
- 58/587 patients saw a physiotherapist during their ACU visit(s), 51/587 an OT, and 21/587 were referred to community services (half by the ACU therapists).
- Clinical Frailty Scale (Rockwood) was recorded in only 357/587, but of these, 105 (29%) had a CFS of 5–8.
- 35/105 (33.3%) had seen our physio, 26/105 (25%) OT, nine (8.6%) were referred to community services, and nine were admitted as too unwell to manage on an ambulatory basis.

Conclusion/Discussion: Recording of CFS by ACU staff was poor, limiting the validity of our results. Nevertheless, it is obvious that most patients seen in our ACU are not frail, and do not require therapies input. Those that are frail, however, have an acceptable conversion-to-admission rate of 8.6%, comfortably below the national target (20%). Barriers to greater utilisation of our service for frail patients may include lack of urgent but non-emergency transport options for the less mobile, lack of access to certain commonly-used tests (e.g. CT, troponin) and referrer anticipation of difficulty discharging the frail patient in crisis without a new or boosted care package and/or access to respite beds. These aspects of service planning need to be addressed if the potential utility of community-based units like ours for frail patients is to be maximised.

How can identifying and grading frailty support older people in acute and community settings? Abstract only*
Author(s): Lucy Lewis
Source: Nursing and Older People
Publication date: August 2020
Identifying frailty is essential to support older people living with complex health and social care needs. This article discusses how a Florence Nightingale Foundation travel scholar used her scholarship to explore best practice in identifying frailty in acute and community settings in Scotland with the aim of developing services for people living with frailty locally and regionally in England. As the move to integrated care services develops in England, valuable insights from Scotland will assist in the proactive design of bespoke services around the needs of individuals in the community and, when acutely unwell, in the hospital setting.

Creating a complex needs team for people with frailty Abstract only*
Author(s): Jennifer Trueland
Source: Primary Health Care 30(6)
Publication date: 2020
Michele Pulman reveals how she combines the skills of a frailty nurse and a GP to provide holistic care in the community. In her new role as a complex care and frailty nurse in general practice, Michele Pulman (pictured) is bringing together the skills and

experience she has built up over years working in the community.

Delaying and reversing frailty: a systematic review of primary care interventions
Author(s): Travers et al.
Source: British Journal of General Practice 69(678)
Publication date: 2019
Background Recommendations for routine frailty screening in general practice are increasing as frailty prevalence grows. In England, frailty identification became a contractual requirement in 2017. However, there is little guidance on the most effective and practical interventions once frailty has been identified. Aim To assess the comparative effectiveness and ease of implementation of frailty interventions in primary care. Design and setting A systematic review of frailty interventions in primary care. Method Scientific databases were searched from inception to May 2017 for randomised controlled trials or cohort studies with control groups on primary care frailty interventions. Screening methods, interventions, and outcomes were analysed in included studies. Effectiveness was scored in terms of change of frailty status or frailty indicators and ease of implementation in terms of human resources, marginal costs, and time requirements. Results A total of 925 studies satisfied search criteria and 46 were included. There were 15 690 participants (median study size was 160 participants). Studies reflected a broad heterogeneity. There were 17 different frailty screening methods. Of the frailty interventions, 23 involved physical activity and other interventions involved health education, nutrition supplementation, home visits, hormone supplementation, and counselling. A significant improvement of frailty status was demonstrated in 71% (n = 10) of studies and of frailty indicators in 69% (n=22) of studies where measured. Interventions with both muscle strength training and protein supplementation were consistently placed highest for effectiveness and ease of implementation. Conclusion A combination of muscle strength training and protein supplementation was the most effective intervention to delay or reverse frailty and the easiest to implement in primary care. A map of interventions was created that can be used to inform choices for managing frailty.

Conference abstract: Think local, act personal: Lessons from an integrated primary care initiative for frail, older people
Author(s): MacInnes et al.
Source: International Journal of Integrated Care 19(408)
Publication date: August 2019
Introduction: An increasing number of older people living at home with complex needs challenges health and social care systems. SUSTAIN or 'Sustainable Tailored Integrated Care for Older People in Europe' is a 4-year project which aims to support and monitor improvements to established integrated care initiatives for older people living at home with multiple health and social care needs. A primary care medical centre in the South East of England was selected as one of 14 case sites delivering integrated care for this population. The 'Over 75 Service' is led by senior practice nurses and delivered by a team of general practitioners, community nurses, social care workers, voluntary sector staff, health trainers and care navigators. This paper presents an evaluation of the implementation of this service and explores explanations for success. A Patient Participation Group (PPG) gave feedback on the service and the evaluation.
Methods: SUSTAIN uses a multiple embedded case study design (Yin, 2013) and an implementation science approach. Data was collected from multiple sources including interviews and focus groups with Over 75 Service managers and professionals (n=7), steering group minutes (n=9) and field notes, staff hours date. Data was analysed thematically. Results and Discussion: A key decision, made early on in the design of the service, was to use the Dalhousie frailty screening tool which enabled a shared vision and understanding of frailty.

Collaboration and multidisciplinary teamworking was facilitated by effective multidisciplinary team meetings, which provided a vehicle for establishing personal contacts, sharing information, promoting understanding of individual roles and responsibilities and increasing knowledge of available services. There was a culture of inclusiveness with all agencies valued equally for their contribution. Positive interpersonal relationships were key to the success of the service and direct, personal contact was highly valued. Organisational structures supported the development of close working relationships and collaboration as one individual from each organisation was assigned to the Over 75 Service. The practice matrons were a single point of contact for service users and staff and were able to share information and provide advice and support to the team. Specific challenges were short-term funding contracts, increasing demand and a lack of capacity to deliver some services. There were also challenges around data protection, access to data and unwieldy IT systems hindering information sharing. Conclusions: A highly localised organisational structure, positive interprofessional personal relationships and a shared vision were important ingredients facilitating successful implementation of the Over 75 Service. Lessons Learnt: Relational continuity is an important enabler of integrated care initiatives for older people with complex needs in a primary care setting. However, delivery is dependent on the availability of adequate resources. Limitations: Although results are context-specific, lessons can be learnt about what works in terms of delivering integrated care for frail, older people in this setting. Suggestions for further research: Further research is needed on the scale and spread of integrated care initiatives in primary care.

Implementing change in primary care practice: lessons from a mixed-methods evaluation of a frailty initiative
Author(s): Bryce et al.
Source: British Journal of General Practice Open
Publication date: 2018
Background The NHS is facing increasing needs from an aging population, which is acutely visible in the emerging problem of frailty. There is growing evidence describing new models of care for people living with frailty, but a lack of evidence on successful implementation of these complex interventions at the practice level. Aim This study aimed to determine what factors enable or prevent implementation of a whole-system, complex intervention for managing frailty (the PACT initiative) in the UK primary care setting. Design & setting A mixed-methods evaluation study undertaken within a large clinical commissioning group (CCG). Design and analysis was informed by normalisation process theory (NPT).Method Data collection from six sites included: observation of delivery, interviews with staff, and an online survey. NPT-informed analysis sought to identify enablers and barriers to implementation of change. Results Seven themes were identified. PACT was valued by professionals and patients but a lack of clarity on its aims was identified as a barrier to implementation. Successful implementation relied on champions pushing the work forward, and dealing with unanticipated resistance. Contracts focused on delivery of service outcomes, but these were sometimes at odds with professional priorities. Implementation followed evidence-informed rather than evidence-based practice, requiring redesign of the intervention and potentially created a new body of knowledge on managing frailty. Conclusion Successful implementation of complex interventions in primary care need inbuilt capacity for flexibility and adaptability, requiring expertise as well as evidence. Professionals need to be supported to translate innovative practice into practice-based evidence.

Frail older people with multi-morbidities in primary care: a new integrated care clinical pharmacy service Abstract only*
Author(s): Oboh et al.
Source: International Journal of Clinical Pharmacy 40 pp. 41-47

Publication date: 2018
Background: Older people confined to their own homes due to frailty, multiple longterm conditions and/or complex needs, are known to be at risk of medicines-related problems. Whilst a health and social care team approach to supporting these patients is advocated, there is limited evidence regarding how pharmacists can best contribute. Objective: To describe a new specialist pharmacy service (called the integrated care clinical pharmacist) in terms of how it works, what it achieves and its policy implications. Setting: Patients' own homes in Lambeth, London, UK. Method: Community matrons identified patients who were experiencing medicines related problems. These were referred to the integrated care clinical pharmacist who undertook a full medication review and recorded activities, which were independently analysed anonymously. Main outcome measure: Medicines-related problems and the associated interventions. Result 143 patients were referred to the service over a 15-month period. A total of 376 medicines-related problems were identified: 28 (7%) supply issues, 107 (29%) compliance issues, 241 (64%) clinical issues. A diverse range of interventions were instigated by the pharmacist, requiring the coordination of community pharmacists, primary and secondary health and social care professionals. Conclusion: This project demonstrated that including an integrated care clinical pharmacy service as part of the health and social care team that visits frail, older people in their own homes has benefits. The service operated as part of a wider inter-professional community team. The service also supported current health policy priorities in medicines optimization by identifying and addressing a wide range of medicines related problems for this vulnerable patient group.

Frailty assessment in primary health care and its association with unplanned secondary care use: a rapid review
Author(s): Davies et al.
Source: BJGP Open 2(1)
Publication date: 2018
Background: The growing frail, older population is increasing pressure on hospital services. This is directing the attention of clinical commissioning groups towards more comprehensive approaches to managing frailty in the primary healthcare environment. Aim: To review the literature on whether assessment of frailty in primary health care leads to a reduction in unplanned secondary care use. Design & setting: A rapid review involving a systematic search of Medline and Medline In-Process. Method: Relevant data were extracted following the iterative screening of titles, abstracts, and full texts to identify studies in the primary or community healthcare setting which assessed the effect of frailty on unplanned secondary care use between January 2005–June 2016. Results: The review included 11 primary studies: nine observational studies; one randomised controlled trial (RCT); and one non-randomised controlled trial (nRCT). Eight out of nine observational studies reported a positive association between frailty and secondary care utilisation. The RCT and nRCT reported conflicting findings. Conclusion: Older people identified as frail in a primary healthcare setting were more likely to be admitted to hospital. Based on the limited and equivocal trial evidence, it is not possible to draw firm conclusions regarding appropriate tools for the identification and management of frail older people at risk of hospital admission.

Recruitment and Retention

Attracting, recruiting and retaining nurses and care workers working in care homes: the need for a nuanced understanding informed by evidence and theory
Author: Devi, Reena, Goodman, Claire, Dalkin, Sonia, Bate, Angela, Wright, Judy, Jones, Liz and Spilsbury, Karen
Publication Date: 2021
Publication Details: Age and Ageing, 50, (1) pp.65-67. , England:
Abstract: The care home sector relies on nurses and care workers to deliver care to residents living with frailty and complex needs. However, attracting, recruiting and retaining staff is one of the biggest challenges facing this sector. There is evidence available that describes factors that influence staff decisions to join and/or remain in the care home workforce, for example, individual rewards (such as feeling valued at work or training opportunities), relationships with colleagues and residents, supportive management or working arrangements (including flexible hours). However, it is less clear how different strategies are informed by evidence to improve recruitment and retention. Care homes are heterogeneous in terms of their size, staffing levels and mix, staff age groups, geographical location and working conditions. What matters to different members of the care home workforce will vary across nurses and care workers of different ages and levels of qualification or experience. Recognising this diversity is key: understanding how to attract, recruit and retain staff needs to discriminate and offer solutions that address this diversity. This important area of practice does not lend itself to a 'one-approach-fits-all' solution. This commentary provides a brief overview of known workforce challenges for the care home sector and argues for studies that use empirical evidence to test different theories of what might work for different staff, how and why, and in different circumstances. Copyright © Crown copyright 2020.

Staff views, perceptions, and experiences

Talking about frailty: health professional perspectives and an ideological dilemma
Author: Cluley, V., Martin, G. and Radnor, Z.
Publication Date: 2022
Publication Details: Ageing and Society, 42, (1) pp.19. , European: Journal article.
Abstract: Presents the findings of a qualitative study that explored how health professionals perceive frailty, drawing on 40 interviews with healthcare professionals working in an emergency department in the English Midlands. Notes that there is little research on how emergency department health professionals make sense of frailty, despite growing demands on this area of healthcare to address frailty effectively. Reports that there is no universally agreed definition of frailty as used in clinical settings. Provides an overview of stakeholder perceptions of frailty in the existing literature. Sets out key findings, which include that: frailty was predominantly considered to be a clinical issue with a medical basis; participants also talked about their personal perceptions of frailty; staff were generally uncertain as to whether frailty represented the most appropriate term to use when addressing older people with multiple morbidities.

The benefits and challenges of embedding specialist palliative care teams within homeless hostels to enhance support and learning: Perspectives from palliative care teams and hostel staff
Author(s): Armstrong et al.
Source: Palliative Medicine 35(6) pp. 1202-1214
Publication date: 2021
Background: People residing in UK homeless hostels experience extremely high rates of multi-morbidity, frailty and age-related conditions at a young age. However, they seldom receive palliative care with the burden of support falling to hostel staff.
Aim: To evaluate a model embedding palliative specialists,

trained as 'homelessness champions', into hostels for two half-days a month to provide support to staff and residents and facilitate a multidisciplinary approach to care. Design: An exploratory qualitative design. Setting/participants: Four homeless hostels in London, UK, including nine hostel managers/support staff and seven palliative care specialists (five nurses and two social workers). Results: Benefits to introducing the model included: developing partnership working between hostel staff and palliative care specialists, developing a holistic palliative ethos within the hostels and improving how hostel staff seek support and connect with local external services. Challenges to implementation included limited time and resources, and barriers related to primary care. Conclusion: This is the first evaluation of embedding palliative care specialists within homeless hostels. Inequity in health and social care access was highlighted with evidence of benefit of this additional support for both hostel staff and residents. Considering COVID-19, future research should explore remote ways of working including providing in-reach support to homelessness services from a range of services and organisations.

Community care staff attitudes towards delivering a falls prevention exercise intervention to community care clients
Author(s): Burton et al.
Source: Health & Social Care in the Community 29(2)
Publication date: July 2020
Millions of older people world-wide receive community care services in their home to assist them to live independently. These services often include personal care, domestic assistance and social support which are delivered by non-university trained staff, and are frequently long term. Older people receiving community care services fall 50% more often than individuals of similar age not receiving services. Yet, few ongoing community care services include exercise programs to reduce falls in this population. We conducted an earlier study to examine the feasibility of community care staff delivering a falls prevention program. A critical finding was that while some of the assessment and support staff responsible for service delivery delivered the falls prevention exercise program to one or two clients, others delivered to none. Therefore, the aim of this qualitative sub-study was to understand reasons for this variation. Semi-structured interviews were conducted with 25 participating support staff and assessors from 10 community care organisations. Staff who had successfully delivered the intervention to their clients perceived themselves as capable and that it would benefit their clients. Older clients who were positive, motivated and wanted to improve were perceived to be more likely to participate. Staff who had worked at their organisation for at least 5 years were also more likely to deliver the program compared to those that had only worked up to 2 years. Staff that did not deliver the intervention to anyone were more risk averse, did not feel confident enough to deliver the program and perceived their clients as not suitable due to age and frailty. Experienced staff who are confident and have positive ageing attitudes are most likely to deliver falls prevention programs in a home care organisation.

Preventing frailty in older people: an exploration of primary care professionals' experiences
Author(s): Obbia et al.
Source: International Journal of Older People Nursing 15(2)
Publication date: December 2019
Background: An increasing number of the ageing population worldwide is at risk of becoming frail and incapacitated. This has the potential to impact not only on the well-being of individuals but also on the sustainability of healthcare systems. Objective: The aim of this study was to explore the views and experiences of frailty from the perspective of primary care professionals, including nurses, who work directly with older people within the community. Methods: A qualitative approach with a descriptive

phenomenological methodology was used, which focused on exploration of primary care professionals' current experiences of early detection and prevention of the onset of frailty. Four multi-professional focus groups were held with a total of thirty-three primary care professionals who worked with older people as part of their daily role. Participants included district nurses, general practitioners, home care workers, physiotherapists and social workers. Results: Professional views encompassed typical patterns of ageing, loneliness, presence of comorbidity, disability and end of life, with social conditions prevalent in most frailty they encountered. Three main themes emerged: the psychosocial nature of frailty, late detection of frailty and barriers to the feasibility of prevention. Physical frailty was considered a constituent part of ageing, which recognised the presence of a skills gap related to the detection of the early signs of frailty. Present health and social care systems are not designed to prevent frailty, and the competencies required by health and social care professionals are not usually included as part of their training curricula. This may hinder opportunities to intervene to prevent associated decline in ability of older adults. Conclusions: To enhance the early assessment of frailty and the planning of preventive multi-factorial interventions in primary care and community settings, training and effective detection strategies should be incorporated into the role and daily care activities of primary care professionals. Implications for practice: Using a multidimensional assessment instrument can help primary care professionals to identify older people who are frail or may become frail. In order to be able to carry out this properly strong inter-professional collaboration is needed. In addition, interventions aimed at preventing frailty or adverse outcomes of frailty should be tailor-made and thus should meet the needs and wishes of an older person.

Frailty: an in-depth qualitative study exploring the views of community care staff
Author(s): Coker et al.
Source: BMC Geriatrics 19:47
Publication date: 2019
Background: Frailty is seen across various health and social care settings. However, little is known about how healthcare professionals, particularly those who provide care for older adults living in the community view frailty. There is also a dearth of information about the extent to which a shared understanding of frailty exists across the various disciplines of care. Such an understanding is crucial across care professionals as it ensures consistent assessment of frailty and facilitates interdisciplinary working/collaboration which is a key component in the management of frailty. This study aimed to explore: (i) how community care staff from various specialties viewed frailty; (ii) whether they had a shared understanding; and (iii) how they assessed frailty in everyday practice. Methods: Semi-structured interviews were conducted with a purposive sample of 22 community care staff from seven specialties, namely: healthcare assistants, therapy assistants, psychiatric nurses, general nurses, occupational therapists, physiotherapists and social workers, recruited from four neighbourhood teams across Cambridgeshire, England. Interviews were analysed thematically. Results: There was a shared narrative among participants that frailty is an umbrella term that encompasses interacting physical, mental health and psychological, social, environmental, and economic factors. However, various specialities emphasised the role of specific facets of the frailty umbrella. The assessment and management of frailty was said to require a holistic approach facilitated by interdisciplinary working. Participants voiced a need for interdisciplinary training on frailty, and frailty tools that facilitate peer-learning, a shared understanding of frailty, and consistent assessment of frailty within and across specialities. Conclusions: These findings

underscore the need to: (i) move beyond biomedical descriptions of frailty; (ii) further explore the interacting nature of the various components of the frailty umbrella, particularly the role of modifiable factors such as psychological and socioeconomic resilience; (iii) care for frail older adults using holistic, interdisciplinary approaches; and (iv) promote interdisciplinary training around frailty and frailty tools to facilitate a shared understanding and consistent assessment of frailty within and across specialities.

Ambulance clinicians' perceptions, assessment and management of frailty: thematic analysis of focus groups
Author(s): Green et al.
Source: British Paramedic Journal 3(3)
Publication date: December 2018
Introduction: More than half of all patients attended by the South Western Ambulance Service NHS Foundation Trust are over the age of 65. In 2017, 62% of older patients who were the subject of a frailty assessment were believed to have at least mild frailty (1/5 of all patients). Frailty is an increasingly relevant concept/diagnosis and ambulance services are well positioned to identify frailty and influence the 'care pathways' through which patients are directed (thereby influencing health outcomes). Throughout the South Western Ambulance Service NHS Foundation Trust, a mandatory training session regarding frailty was delivered to clinical personnel in 2017 and frailty assessment tools are available on the electronic Patient Clinical Record. Aim: To explore and gain insight into the current knowledge, practice and attitudes of ambulance clinicians regarding frailty and patients with frailty. Methods: Two focus groups of ambulance clinicians (n = 8; n = 9) recruited from across the South Western Ambulance Service NHS Foundation Trust were held in October 2017. Focus group discussions were analysed thematically. Results: Knowledge of conceptual models of frailty, appropriate assessment of patients with frailty and appropriate care pathways varied substantially among focus group participants. Completion of the 'Rockwood' Clinical Frailty Scale for relevant patients has become routine. However, conflicting opinions were expressed regarding the context and purpose of this. The Timed-Up-and-Go mobility assessment tool is also on the electronic Patient Clinical Record, but difficulties regarding its completion were expressed. Patient management strategies ranged from treatment options which the ambulance service can provide, to referrals to primary/community care which can support the management of patients in their homes, and options to refer patients directly to hospital units or specialists with the aim of facilitating appropriate assessment, treatment and discharge. Perceptions of limited availability and geographical variability regarding these referral pathways was a major feature of the discussions, raising questions regarding awareness, capacity, inter-professional relationships and patient choice. Conclusion: Knowledge, practice and attitudes of ambulance staff, with regard to frailty, varied widely. This reflected the emerging nature of the condition, both academically and clinically, within the ambulance profession and the wider healthcare system.

Exploring frailty: Community physical and occupational therapists' perspectives Abstract only*
Author(s): Roland et al.
Source: Physical & Occupational Therapy in Geriatrics 29(4)
Publication date: 2011
Frailty is prevalent among community-dwelling older adults. Community physical and occupational therapists provide at-home care to older adults, yet little is known about their ability to identify frailty, specifically the early development (pre-frailty). Objectives: To explore therapists' perspectives on frailty, and develop a definition of how they view and manage frailty in their practice. Eleven therapists (17.3 ± 12.0 years of experience) completed repertory grid-guided interviews. Principal

component analysis identified relationships in data and highlighted themes, and constant comparative analysis built upon emerging themes. Therapists recognized frailty as self-imposed isolation due to reduced motivation, lack of safe judgment, and declining physical fitness resulting in functional dependence. Therapists' image of frailty included deterioration of physical, mental, and social capacities, leading to an inability to thrive. Therapists recognized that the underlying comorbidities contributed to the unique expression of frailty within individual clients. Therapists' distinct perspectives of frailty add to current proposed definitions by establishing early identifiers to enable an effective and useable definition of "what is frail?"

Technology

Augmented reality glasses as a new tele-rehabilitation tool for home use: patients' perception and expectations Abstract only*
Author: Cerdan de Las Heras, J., Tulppo, M., Kiviniemi, A. M., Hilberg, O., Lokke, A., Ekholm, S., Catalan-Matamoros, D. and Bendstrup, E.
Publication Date: 2022
Publication Details: Disability and rehabilitation.Assistive technology, 17, (4) pp.480-486. , England:
Abstract: MATERIALS AND METHODS: A qualitative approach was employed to track perspectives from a range of patients with chronic lung and/or heart diseases. COPD, IPF and MI outpatients from Denmark and Finland were invited to participate. Data were collected through focus group and semi-structured in-depth interviews. Qualitative analysis was performed using standard thematic analytical approaches. A topic guide was used to explore experiences and perceptions of the ARG telerehabilitation device among participants., RESULTS: Thirteen patients (4 MI, 2 IPF and 7 COPD), 3 women and 10 men aged 56 to 75 years (mean age 63.3 years) were allocated into one focus group (9 patients) and 4 interviews (4 patients). Twelve patients reported the added value of ARG and suggested constructive changes such as the adjustable screen/brightness, robust head fixation for exercise performance, easy to navigate interface and supported feedback based on exercise performance., CONCLUSION: Patients with chronic heart or lung diseases described the added value in an ARG telerehabilitation programme. Improvements for a future version of the ARG were suggested. IMPLICATIONS FOR REHABILITATION Patients with chronic pulmonary and heart diseases have difficulties to change behaviour to a more active and healthy lifestyle, offers from the health sector to participate in rehabilitation programmes at the hospital are feasible and improves quality of life and exercise capacity. Not all the patients are capable of participating in such rehabilitation programmes due to frailty and long distance to the hospital. Telerehabilitation seems to be a potential treatment to cope with the needs expressed above. Patient involvement in the development of a telerehabilitation solution to empower chronic pulmonary and heart patients to train, ensures a positive contribution to the design of the expected augmented reality software and hardware envisioned solution for telerehabilitation. The development of a user-centered telerehabilitation platform responding to the preferences of patients with chronic disease will remove barriers that limit use and compliance and improve empowerment in future research projects.

Virtual Wards

Virtual wards: a rapid evidence synthesis and implications for the care of older people
Author: Norman, Gill, Bennett, Paula and Vardy, Emma R. L. C.
Publication Date: 2023
Publication Details: Age and Ageing, 52, (1) , England:
Abstract: BACKGROUND: Virtual wards are being rapidly developed within the National Health Service in the UK, and

frailty is one of the first clinical pathways. Virtual wards for older people and existing hospital at home services are closely related., METHODS: In March 2022, we searched Medline, CINAHL, the Cochrane Database of Systematic Reviews and medRxiv for evidence syntheses which addressed clinical-effectiveness, cost-effectiveness, barriers and facilitators, or staff, patient or carer experience for virtual wards, hospital at home or remote monitoring alternatives to inpatient care., RESULTS: We included 28 evidence syntheses mostly relating to hospital at home. There is low to moderate certainty evidence that clinical outcomes including mortality (example pooled RR 0.77, 95% CI 0.60-0.99) were probably equivalent or better for hospital at home. Subsequent residential care admissions are probably reduced (example pooled RR 0.35, 95% CI 0.22-0.57). Cost-effectiveness evidence demonstrated methodological issues which mean the results are uncertain. Evidence is lacking on cost implications for patients and carers. Barriers and facilitators operate at multiple levels (organisational, clinical and patient). Patient satisfaction may be improved by hospital at home relative to inpatient care. Evidence for carer experience is limited., CONCLUSIONS: There is substantial evidence for the clinical effectiveness of hospital at home but less evidence for virtual wards. Guidance for virtual wards is lacking on key aspects including team characteristics, outcome selection and data protection. We recommend that research and evaluation is integrated into development of virtual ward models. The issue of carer strain is particularly relevant. Copyright © The Author(s) 2023. Published by Oxford University Press on behalf of the British Geriatrics Society. All rights reserved. For permissions, please email: journals.permissions@oup.com.

Workforce Planning

Community frailty team workforce development – a personal reflection Abstract only*
Author(s): Corbett and Lewis
Source: Journal of Integrated Care 29(4)
Publication date: September 2021
Purpose: This paper represents a personal view of a newly appointed consultant practitioner trainee in frailty. This role was created as a result of a rapid workforce review of a Frailty Support Team (FST) in response to the COVID-19 pandemic. Design/methodology/approach: The FST traditionally worked alongside other community services. A "One Team" approach was developed whereby prior silos of community nursing, therapy and frailty teams became a single, locality based and mutually supportive integrated community service. This significantly increased capacity for an urgent community response for older people with complex needs and improved clinical management and coordination of care. As a workforce review identified the need for skills development, new roles for trainee advanced frailty practitioners (AFPs) and a consultant practitioner trainee in frailty were established. Findings: Staff experience of the "One Team" model was positive. The changes were thought to encourage closer and more efficient working between primary care and a range of community health services. The improved communication between professionals enabled more personalised care at home, reducing pressure on emergency hospital services. A rapid review of the workforce model has enabled the enhanced team capacity to cover a wider geographical area and improved recruitment and retention of staff by introducing a new pathway for career progression within the expanding specialism of frailty. Originality/value: The challenge of COVID-19 has prompted rapid service redesign to create an enhanced "One Team in the community." The innovative workforce model looks beyond traditional roles, values

the experience and capabilities of staff and develops the skills and confidence required to provide a more integrated and person-centred specialist community pathway for people living with frailty.

[Workforce planning for community-based palliative care specialist teams using operations research]
Author(s): Taghawi et al.
Source: Journal of Pain and Symptom Management 61(5)
Publication date: May 2021
Context: Many countries have aging populations. Thus, the need for palliative care will increase. However, the methods to estimate optimal staffing for specialist palliative care teams are rudimentary as yet. Objectives: To develop a population-need workforce planning model for community-based palliative care specialist teams and to apply the model to forecast the staff needed to care for all patients with terminal illness, organ failure, and frailty during the next 20 years, with and without the expansion of primary palliative care. Methods: We used operations research (linear programming) to model the problem. We used the framework of the Canadian Society of Palliative Care Physicians and the Nova Scotia palliative care strategy to apply the model. Results: To meet the palliative care needs for persons dying across Nova Scotia in 2019, the model generated an estimate of 70.8 nurses, 23.6 physicians, and 11.9 social workers, a total of 106.3 staff. Thereby, the model indicated that a 64% increase in specialist palliative care staff was needed immediately, and a further 13.1% increase would be needed during the next 20 years. Trained primary palliative care providers currently meet 3.7% of need, and with their expansion are expected to meet 20.3% by 2038. Conclusion: Historical, current, and projected data can be used with operations research to forecast staffing levels for specialist palliative care teams under various scenarios. The forecast can be updated as new data emerge, applied to other populations, and used to test alternative delivery models.

[The association between physician staff numbers and mortality in English hospitals]
Author(s): Harvey and Trudgill
Source: EClinicalMedicine 32
Publication date: 2021
Background Physician medical specialties place specific demands on medical staff. Often patients have multiple co-morbidities, frailty is common, and mortality rates are higher than other specialties such as surgery. The key intervention for patients admitted under physician subspecialties is the care provided on the ward. The current evidence base to inform staffing in physician medical specialty wards is limited. The aim of this analysis is to investigate the association between medical staffing levels within physician medical specialties and mortality. Methods This study is a cross-sectional analysis of national data, which is aggregated at provider level. Medical beds per senior, middle grade and junior physicians employed in physician medical specialties were calculated from national employment records for acute hospitals in England, in 2017. Outcome measures included unadjusted mortality rate and Summary Hospital-level Mortality Indicator (SHMI) in physician medical specialties. Both Raw mortality and SHMI include deaths during admission or within 30 days following discharge. Linear regression models were constructed for each medical staffing grade for unadjusted mortality, SHMI and SHMI adjusted for local provider factors. Findings The mean number of medical beds per senior, middle grade and junior physicians were 7.3(SD 2.5), 19.7(11.5), 10.1(3.1) respectively. Lower bed numbers per medical staff grade were associated with lower than expected mortality by SHMI; senior(Coefficient 0.012(95%CI:0.005-0.018),p = 0.001), middle grade(0.002(0.0002-0.005),p = 0.032) and junior(0.008(0.002-0.015),p = 0.014). Hospital providers were more likely to achieve a better than expected mortality

(SHMI<1) if beds per physician were lower than; 5.3, 14.6 and 9.0 for senior, middle grade and junior doctors respectively. Interpretation Acute hospital providers with fewer beds per medical staff of all grades are associated with lower than expected mortality. Funding No external funding is associated with this analysis.

The use of acuity and frailty measures for district nursing workforce plans Abstract only*
Author(s): David and Saunders
Source: British Journal of Community Nursing 23(2)
Publication date: January 2018
This article discusses the use of Quest acuity and frailty measures for community nursing interventions to quantify and qualify the contributions of district nursing teams. It describes the use of a suite of acuity and frailty tools tested in 8 UK community service trusts over the past 5years. In addition, a competency assessment tool was used to gauge both capacity and capability of individual nurses. The consistency of the results obtained from the Quest audits offer significant evidence and potential for realigning community nursing services to offer improvements in efficiency and cost-effectiveness. The National Quality Board (NQB) improvement resource for the district nursing services (NQB, 2017) recommends a robust method for classifying patient acuity/frailty/dependency. It is contended the Quest tools and their usage articulated here offer a suitable methodology.

eLearning

Frailty
Source: NHS England
This elearning programme aims to standardise training and knowledge of frailty as a complex multi-system, long term condition. This education programme is compliant with the 'Frailty, A framework of core capabilities' (2018). There are different tiers, depending on the level of skills and knowledge. Tiers 1, 2a and 2b have been developed by the London Clinical Network for Frailty in collaboration with Imperial College Healthcare NHS Trust and Wessex Academic Health Science and have been funded through Health Education England's Urgent and Emergency Care Workforce Collaborative for London.

Competency Frameworks

Advanced Clinical Practice in Older People Curriculum Framework
Source: Health Education England
Publication date: April 2022
The health and care systems are evolving rapidly to deliver innovative models of care that meet the increasing and changing needs of individuals, families, and communities. In recent years, not only has the education and training of traditional professional and clinical groups adapted to account for the shifting requirements of employers, patients, and the public, but new specialist roles have emerged, including that of advanced clinical practitioners (ACPs).

[Developing a competency framework for early career nurses undertaking post-registration education in care for older people]
Author: Hayes, N. and Naughton, C.
Publication Date: 2022
Publication Details: Nursing Older People, 34, (3) , United Kingdom: RCN Publishing Company Ltd.
Abstract: Background Within gerontological nursing as a postgraduate nursing specialty, there is a lack of consensus regarding the standardised competencies and education development required, particularly in the UK. Aim To develop and evaluate a competency framework for early career nurses undertaking post-registration education in a UK university in care for older people living with frailty. Method The competency framework was developed as part of a broader gerontological education-career pathway intervention to improve competence and retention among early career nurses. A four-step process was used to develop the framework guided by a consensus building approach. A mixed-methods approach to the evaluation was adopted, with an online survey, one-to-one interviews and focus group interviews with students and organisational stakeholders. Findings A total of 33 students completed the competency framework as part of an academic module, 30 of whom took part in the evaluation. There was consensus among interviewees that the competencies confirmed 'what they knew already' and identified areas they needed to develop. Survey respondents reported that the competency framework was a useful part of the education-career pathway. Conclusion The competency framework was acceptable to students and feasible to complete. It also enabled students to appreciate the unique knowledge and skills that underpin gerontological nursing and to evidence their expertise using a structured approach. Copyright © RCN Publishing Company Limited 2022.

[Older People's Mental Health Competency Framework]
Source: Health Education England
Publication date: 2020
The diverse audience for this Framework includes people from social care, physical and mental health services, community and voluntary sectors, and the independent sector, particularly when they are providing NHS care. It is intended to be concise in its outlook, to provide support and guidance to individuals and teams who come into contact with older people but may not be aware of, or consider themselves capable of, supporting an older person with mental health needs. In that respect, it is intended to increase awareness of OPMH needs across a wide range of specialties and professions. This Framework provides essential competencies, namely, the knowledge, skills and behaviours expected for the delivery of effective support, care and services for older people with mental health needs. Additionally, it supports the increasing integration of services and their respective workforces, with respect to improved communication, shared goals and the opportunity for joint education and training.

[Advanced Clinical Practice: Frailty Specific Competencies]
Author(s): Ian Setchfield
Source: East Kent Hospitals University NHS Foundation Trust
Publication date: August 2019
This document works in tandem with the Core competencies for Advanced Clinical Practitioners (ACP's). ACP's should aim to complete the core competency document prior to commencing these specific competencies. This will ensure that basic competencies are achieved and as such do not require re-assessment. However if an assessor or practitioner identifies learning needs in any of the core areas they should be addressed prior to continuing with this part.

Frailty: a framework of core capabilities
Source: Skills for Health
Publication date: August 2018
Health Education England and NHS England commissioned the development of this core capabilities framework to improve the effectiveness and capability of services for people living with frailty. Frailty is a long term condition related to the ageing process in which multiple body systems gradually lose their in-built reserves. It is now widely recognised as a state of reduced resilience and increased vulnerability, which results in some older people becoming more vulnerable to relatively minor changes in their circumstances which can lead to a deterioration in their health and/or ability to live independently. It is estimated that around 50% of people over the age of 65 are living with some degree of frailty and some who experience frailty earlier in life1 . People living with frailty are less able to adapt to stress factors such as acute illness, injury or changes in their environment, personal or social circumstances, and such changes are more likely to result in adverse health outcomes and loss of independence.

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