Evidence Brief: Frailty

Contents

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

Date of publication: September 2025

Please acknowledge this work in any resulting paper or presentation as:
Evidence Brief: Frailty. Katie Nicholas and Katy Greenfield. (September 2025). UK: Workforce, Training and Education Knowledge Management Team

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Key publications – the big picture

Hospital at Home for frailty
British Geriatric Society, August 2025
This publication, co-produced with the UK Hospital at Home Society, highlights the evidence base, current situation and potential of Hospital at Home services for older people in the UK.

The Frailty Academy: A System Wide Education and Workforce Development Programme
Royal College of Physicians, August 2025
The Frailty Academy is a system-wide education and training initiative designed to equip the health and care workforce with the knowledge, skills, and confidence to deliver safe, person-centred care for people living with frailty (see Figure 1). Developed within Surrey Heartlands ICS, it offers a tiered framework of learning, from basic awareness to advanced clinical expertise. Over 6,000 staff have engaged with the programme, contributing to measurable improvements in patient safety and outcomes. The Academy has been recognised nationally as an exemplar model for education and training in frailty care and replication of its framework has the potential for scalable change across the NHS.

Fit for the future: 10 Year Health Plan for England (accessible version)
Department for Health and Social Care, July 2025
This is a plan to create a new model of care, fit for the future. It will be central to how we deliver on our health mission. We will take the NHS's founding principles - universal care, free at the point of delivery, based on need and funded through general taxation - and from those foundations, entirely reimagine how the NHS does care so patients have real choice and control over their health and care.

Identification and management of patients with frailty
BMA, Updated May 2025
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.

The case for more nurses and AHPs working in older people's healthcare
British Geriatrics Society, March 2025
Nurses and allied health professionals (AHPs) are essential to the provision of older people's healthcare, working across acute, community and primary care as part of multidisciplinary teams. Despite this, there is a lack of data about how many nurses and AHPs currently work with older people and how many are needed in order to provide care for the ageing population. This report is our first attempt to fill that gap.

Transforming the frailty pathway
NHS England, February 2025
The purpose of this paper is to provide an update on NHS England's plans to improve care for older people living with frailty by shifting care from hospital to community settings, delivered though a neighbourhood health service.

Be proactive - Delivering proactive care for older people with frailty
British Geriatrics Society, November 2024
In October 2024, the BGS published Be proactive: Evidence supporting proactive care for older people with frailty. This first publication provides evidence to help colleagues build business cases for proactive care in their locality. Our second publication, Be proactive: Delivering care for older people with frailty, acts as a roadmap to support the delivery of proactive care services for older people with moderate to severe frailty. With the NHS England guidance as an overarching framework, we propose

colleagues use both BGS documents to deliver evidence-based proactive care.

Be proactive: Evidence supporting proactive care for older people with frailty
British Geriatrics Society, October 2024
This document focuses on proactive care and support for those living at home with moderate or severe frailty. Whilst there should be a needs-based approach to identification and intervention, those with frailty will predominantly but not exclusively be older people. Care for people living in care homes is described through the Enhanced Health in Care Homes model in England and similar programmes in the rest of the UK.

Frailty: research shows how to improve care
National Institute for Health and Care Research, October 2024
This Collection brings together evidence from the NIHR and elsewhere to help commissioners and healthcare providers address the challenge. The evidence we present supports improvements in the quality of care for people with frailty in the community, and in hospital.

Supporting people living with frailty
NHS Providers, March 2024
This briefing highlights the benefits of supporting people with frailty in the community at every stage of the frailty care pathway, while considering the risks to be managed. It shares examples of good practice, and explores some of the barriers to further progress, looking at what can be done to address these and ensure people with frailty receive the right care at the right time in the right place.

FRAIL strategy
NHS England, February 2024
Following publication of the Delivery plan for the recovery of urgent and emergency care services and the commitment in the NHS Long Term Plan for an acute frailty service/same day emergency care service (AFS) to be in place across every hospital with a Type I emergency department (ED) for 70 hours a week, this FRAIL strategy supports wider healthcare systems to deliver and improve acute frailty services across England by setting out a practical approach. This will mean more older people living with frailty can be safely discharged on the same day they arrive, avoiding admission overnight.

State of Health and Care of Older People in England 2024
Age UK, September 2024
Our report finds older people are struggling due to insufficient access to high quality NHS treatment, as well as social care, and that the system is under-prepared for population ageing.

NHS Long Term Workforce Plan
NHS England, 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
NHS England, 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
British Geriatrics Society, 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
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

Through the visor: Reflecting on member experiences of the Covid-19 first wave
British Geriatrics Society, 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.

Geriatric Medicine: GIRFT Programme National Speciality Report
Getting it Right First Time, February 2021
Our deep dives, and data analysis to support them, identified significant unwarranted variation in the provision of geriatric medicine, care of people living with frailty and a significant opportunity for improvement. Our review has highlighted four core themes – effective use of data, leadership within the new structures, clinical quality improvement within hospital trusts and quality improvement at the interface with the community.

Frailty and the NHS Long Term Plan
AgeUK, 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
Royal College of Psychiatrists, 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
Friends, Families and Travellers, October 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
NHS RightCare, 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
NHS England, 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
National Institute for Health Research, December 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
Effectiveness Matters, 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
NHS Dorset CCG, 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
British Geriatrics Society, 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
Government Office for Science, 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
British Geriatrics Society, 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
British Geriatrics Society, 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

Supporting older people across the frailty pathway
Royal College of Nursing, 3 July 2025
How can each of us in our individual roles support older people across the Frailty Pathway?

Workforce challenges in frailty Hospital at Home models and opportunities for trainees
Hospital at Home, 28 July 2023
I have been fortunate to work as a Specialist SAS Doctor in a Frailty Hospital at Home team for many years and have recently welcomed trainee Doctors into our team. Integrating them into our team of SAS Doctors, Advance Clinical Practitioners, Therapists, Nurses and Pharmacists allowed me the chance to

reflect on the challenges of adapting their current hospital-based training to this new model of care and the challenges and joys observed along the way.

Reducing health-related job loss among older workers
Institute for Employment Studies, 14 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

Co-developing an integrated, system-wide frailty strategy in Lincolnshire
NHS Arden and GEM CSU, no date
Nationally around 10% of people over 65 and 25-50% of those over 85, have a diagnosis of frailty. Approximately 5-10% of people attending Accident and Emergency Departments are older and living with frailty, leading to more than 4,000 admissions daily for falls, minor infections, medication side effects and other conditions related to frailty. However, frailty is not an inevitable part of ageing. If identified early, proactive and anticipatory care can minimise the risk of deterioration and associated loss of independence.

A place to meet the needs of people living with frailty: Jean Bishop Integrate Care Centre
NHS Employers, 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
NHS Confederation, May 2022
Addressing frailty needs and improving outcomes through integrated working in Bradford District and Craven.

Case study: Providing rapid care to people in their own home rather than going to hospital, through a frailty virtual ward in Leeds
NHS England, 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
British Geriatrics Society, 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
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
NHS Arden & GEM CSU, no 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
Sussex Community NHS Foundation Trust, 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 on 'virtual ward' keeps them well at home and out of hospital
NHS England, no date
The approach is being rolled out across Dorset and other areas of the country are running similar schemes to pinpoint elderly people and help support them better at home.

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

Frailty Focus: Empowering Rural Health With Advanced Nurse Practitioners: A Discussion Paper
Journal of Evaluation in Clinical Practice 31(3), 2025
Background: Frailty is a multidimensional condition with symptoms relating to falls, immobility, incontinence, impaired memory and medication side-effects. With increasing numbers of frailty, particularly in rural areas, healthcare systems are being challenged globally. Moreover, frailty may be more common in rural communities as a consequence of transportation issues, limited access to healthcare services and health promotion activities. Advanced Nurse Practitioners are ideally placed to

undertake comprehensive geriatric assessments and identify frailly syndromes. Aims: Explore the function of the Advanced Nurse Practitioner in managing people living with frailty in rural areas, drawing on a review of current guidelines, literature, and practice, considering public health agendas and evidence-based practice.

The impact of the district nurse advanced nurse practitioner role on the transformation of district nursing Abstract only*
British Journal of Community Nursing 30(2), 2025
This article examines the role of the district nurse advanced nurse practitioner and its contribution to the transformation of district nursing services. Primary care is under increasing pressure to bridge the gap between demand and resources, with national and local priorities focusing on frailty and unscheduled care. This article outlines the implementation of the district nurse advanced nurse practitioner role within NHS Greater Glasgow and Clyde and presents findings from a local evaluation. By exploring the impact across the four pillars of advanced practice - clinical practice, research and development, facilitation of learning and leadership - the early findings suggest that this innovative role has had a transformational impact on optimising primary care provision and reducing avoidable hospital admissions for patients on a district nursing caseload. Further research into this role is necessary to ensure that its contribution is comprehensively measured, strengthening the case for recognising this highly skilled role as a key player in NHS Scotland's primary and community health care systems.

Battling Frailty in Older Adults: The Critical Role of Advanced Practice Registered Nurses in Assessment, Management, and Prevention Abstract only*
Advances in Family Practice Nursing 7(1), 2025
Frailty is a geriatric syndrome and a global health concern for older adults. Although aging is a risk factor, frailty can occur in younger adults. There is no global definition of frailty. Although there are many validated screening tools, there is no gold standard for the assessment of frailty. The 5 criteria for frailty include weight loss, exhaustion, slowness, low activity level, and weakness. Frailty is complex and often overlaps with comorbidities. Frailty can be prevented. Nurses are leaders on the interdisciplinary team to assess, diagnose, manage, and prevent frailty in older adults.

Palliative Care for the Elderly With Heart Diseases in Tertiary Health care: A Concept Analysis
American Journal of Hospice and Palliative Medicine 41(9), 2024
Background: The increasing incidence of heart failure (HF) in the elderly leads to increased mortality, hospitalization, length of hospital stay, and health care costs. Older adults often face multiple drug treatments, comorbidities, frailty, and cognitive problems, which require early palliative care. However, these patients do not receive adequate palliative care.

Advanced practitioners working with older people in primary care and community settings: a survey of roles and use of technology
International Journal for Advancing Practice 2(4), 2024
Advanced practitioner (AP) roles are becoming increasingly common in primary care and community settings for supporting older people and those living with frailty. **Aims**: The aim of this study was to explore health and social work AP roles in primary care and community settings in the UK, and understand how they support older people and factors that may impact on APs use of technology in practice.

The changing role of Advanced Clinical Practitioners working with older people during the COVID- 19 pandemic: A qualitative research study
International Journal of Nursing Studies 130, 2022

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).

61 Outcomes of an Advanced Nurse Practitioner-Led Pops Service in a District General Hospital Conference abstract
Age and Ageing 50(Supplement 1), 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.

53 Advanced clinical practitioners and their role in delivering CGA to streamline the management of patients living with frailty
Age and Ageing 48(Supplement 1), 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.

An inter-professional advanced practice approach to Frailty @ the front door; optimising outcomes for patients with frailty through workforce re-design Conference abstract, outline only*
Physiotherapy 2015(Supplement 1), 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

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
Age and Ageing 50(4), July 2021
Background: Nursing homes for older adults have concentrated large numbers of severe cases and deaths for coronavirus disease 2019 (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
Age and Ageing 50(3), 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.

How Covid-19 will boost remote exercise-based treatment in Parkinson's disease: a narrative review
Npj Parkinson's Disease, 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.

The comprehensive Frailty Assessment at Forth Valley Royal Hospital (FVRH) Digitalised: for Covid-19 and beyond
Age and Ageing 50(Suppl 1), 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.

155 Establishing a community frailty unit during the Covid-19 pandemic
Age and Ageing 50(Suppl 1), 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.

Education and training

'Focus on Frailty': Co-Designing Digital Frailty Education with Healthcare Students
Journal of Multidisciplinary Healthcare 18, 2025

Introduction: Frailty is prevalent in hospitals and is associated with adverse events and poor health outcomes. In Australia, there is a need for co-designed, multidisciplinary, and contextually relevant frailty education to improve healthcare students' understanding and knowledge of frailty within the hospital setting.
Objective: This study aimed to i) explore healthcare students' understanding of frailty and their experiences with patients who are frail, and ii) seek healthcare students' design ideas for the content of a new digital frailty education course.

Bridging the Care Gap: Integrating Family Caregiver Partnerships into Healthcare Provider Education
Healthcare 13(15), 2025
Family caregivers are a vital yet often under-recognized part of the healthcare system. They provide essential emotional, physical, and logistical support to individuals with illness, disability, or frailty, and their contributions improve continuity of care and reduce system strain. However, many healthcare and social service providers are not equipped to meaningfully engage caregivers as partners. In Alberta, stakeholders validated the Caregiver-Centered Care Competency Framework and identified the need for a three-tiered education model-Foundational, Advanced, and Champion-to help providers recognize, include, and support family caregivers across care settings. This paper focuses on the development and early evaluation of the Advanced Caregiver-Centered Care Education modules, designed to enhance the knowledge and skills of providers with more experience working with family caregivers. The modules emphasize how partnering with caregivers benefits not only the person receiving care but also improves provider effectiveness and supports better system outcomes.

Frailty Focused Enhancements to Seniors' Hospital Care (FrESH): a Mixed Methods Study Reporting the Efficacy of Specialized Education for Front-line Staff
Canadian Geriatrics Journal 28(2), 2025
Background Acute care hospital stays often lead to increased frailty and functional decline in older adults. Interventions such as specialized education for nurses can improve health outcomes and decrease lengths of stay for these patients. This study aimed to identify the facilitators and barriers to providing care to older adults in acute care, and the efficacy of specialized education for front-line staff. Methods A specialized education program for front-line staff, Frailty Focused Enhancements to Seniors' Hospital Care (FrESH), was developed and delivered across five family medicine units in New Brunswick (NB).

Simulation based education in integrated older adult care - a new way of learning for a new way of working...24th International Conference on Integrated Care Poster abstract
International Journal of Integrated Care (IJIC), 2025
Background: The Integrated Care Programme for Older Persons in Ireland (ICPOP) aims to change the way health and social care for older persons is planned and delivered, with the aim of improving patient experience, quality and outcomes.1 A key component of ICPOP is the implementation of new ways of working across healthcare teams. Simulation based education (SBE) can help support the interprofessional educational needs of these newly established teams in a dedicated supported environment,2 and has the potential to promote change in healthcare delivery. Alongside this, SBE can also be utilised for system probing, where patient safety issues can be identified and remedied through system changes and training.

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

Journal of Emergency Nursing 50(1), 2024
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. 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.

'That's someone's grandma': Teaching person-centred care in a frailty context
The Clinical Teacher 21(1), 2024
BACKGROUND: The ability to provide person-centred care (PCC) is an essential skill for doctors and requires therapeutic empathy. We sought to evaluate a novel teaching approach to understand how medical students' personal reflections on an older person impact their views about PCC and frailty.

New horizons in undergraduate geriatric medicine education
Age and Ageing 53(5), 2024
Current projections show that between 2000 and 2050, increasing proportions of older individuals will be cared for by a smaller number of healthcare workers, which will exacerbate the existing challenges faced by those who support this patient demographic. This review of a collection of Age and Ageing papers on the topic in the past 10 years explores (1) what best practice geriatrics education is and (2) how careers in geriatrics could be made more appealing to improve recruitment and retention.

Exploring the challenges of frailty in medical education
The Journal of Frailty and Aging 12, 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
Public Health 11, 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.

A systematic review of frailty education programs for healthcare professionals
Australasian Journal on Ageing 41(4), December 2022

Objectives: To identify and examine the reported effectiveness of education programs for health professionals on frailty.

Evaluating a frailty education program implemented through barbershops/ salons in Japan: a preliminary study Abstract only*
SN Social Science 2(55), 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

Conference Abstract: 134 A Quality Improvement Project – Physiotherapy caseload management on the older person's unit
Age and Ageing 50(Suppl 1), 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.

Perceptions, attitudes and training needs of primary healthcare professionals in identifying and managing frailty: a qualitative study
European Geriatric Medicine 12 (2), 2020
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.

Conference Abstract: Preparing the workforce for frailty, an education intervention for health professionals and community nurses in primary and community healthcare Abstract only*
Physiotherapy 105 (Supplement 1), 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.

Integrated care and whole system approaches

Co-developing and unlocking Integrated Proactive Neighbourhood Teams in Gloucestershire to improve care for people living with frailty...24th International Conference on Integrated Care, April 22-24, 2024, Belfast, Ireland Conference abstract
International Journal of Integrated Care (IJIC) , 2025
An ageing population means there's a growing demand and pressure on the system to remain sustainable. The Working as One transformation Programme endeavours "to deliver quality, integrated care for the people of Gloucestershire to support the best possible physical and mental health outcomes, enabling them to lead the most happy and healthy lifestyles". One improvement cycle of the Prevention workstream of Working as One is the development of Integrated Proactive Neighbourhoods; Integrated Neighbourhood Teams focussed on proactive frailty.

The IMPACT Hub...24th International Conference on Integrated Care, April 22-24, 2024, Belfast, Ireland Conference abstract
International Journal of Integrated Care (IJIC) , 2025
In alignment with 1 (Shared values and vision), 3 (people as partners in care), 4 (resilient communities new alliances), 5 (workforce capacity and capability) and 9 (transparency of progress, results and impact) of the nine pillars of integrated care The South Cotswold Primary Care Network impact hub is a Single point of access for professionals and services working with people with frailty and was designed to facilitate and improve communication between GP practices and professional teams, support the flow and navigation between services, build relationships with and between professionals, understand and access the available and most appropriate pathway to maximise system efficiency, follow up with individual patients on discharge that have been identified as at risk and needing further input with services and ultimately to be South Cotswolds Hub that can be used to explore what services are available locally and how to access them. To make this happen the FAS and HAT developed a process to simplify communications about a patient between these teams and the south Cotswold physio therapists through a phone call or email to the Hub.

Improving access to Urgent Community Response from emergency services through integrated working between community and ambulance Trusts in NW London...02-Jan-25 International Journal of Integrated Care (IJIC) TU INFO: 24th International Conference on Integrated Care, April 22-24, 2024, Belfast, Ireland Conference abstract
International Journal of Integrated Care (IJIC) 25, 2025
Aim: In October 2019 the Collaborative was awarded a small winter grant of £100k and chose to use this to establish a single shared referral route for emergency services (111 and 999 callers and London Ambulance Service staff). The aim was to simplify pathways, improve referrer experience and consistency of response and to support reduced demand on urgent and emergency care pathways and increase access to community based care.

Frailty Knowledge, Use of Screening Tools, and Educational Challenges in Emergency Departments in Ireland: A Multisite Survey
Journal of Emergency Nursing 50(1), 2024
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.

Case management for integrated care of older people with frailty in community settings
Cochrane Database of Systematic Reviews (5), 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.

A whole-of-health system approach to improving care of frail older persons Abstract only*
Australian Health Review 46(5), 2022
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.

Models of integrated care for older people with frailty: a horizon scanning review
BMJ Open 12(4), 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.

131 Developing an integrated comprehensive geriatric unit
Conference abstract
Age and Ageing 50(Supplement 1), 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.

Implementing SAFE™ care: Evaluating of a geriatric model of care for real-world practice Abstract only*
Geriatric Nursing 42(1), 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
European Geriatric Medicine 10, 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
Erasmus School of Health Policy & Management 19(13), 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.

Up-scaling of an integrated care model for frail elderly patients
Conference abstract
International Journal of Integrated Care 16(A251), 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
Lancet Healthy Longevity 2, 2021
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

In the last 10 years, have our polytrauma patients become geriatric? The emergency trauma bay in the context of demographic change
European Journal of Trauma & Emergency Surgery 51(1), 2025
Purpose: One of the key challenges trauma centres are currently facing is the management of polytraumata in an ageing population. The aim of this study is to assess the extent to which demographic changes are reflected in the trauma bay population and the impact on geriatric polytrauma patient outcomes.
Conclusions: The ageing trauma bay population presents new challenges for medical staff, because polypharmacy, multiple comorbidities and frailty become more significant in an ageing population. Enhanced interdisciplinary management, particularly between trauma and geriatric specialists, may mitigate rising mortality rates. Geriatric trauma centres or at least more geriatric expertise might be required to improve the treatment and outcome in this changing population.

Evaluating an Innovative Model of Interdisciplinary and Interagency Primary Care for Homebound Seniors...24th International Conference on Integrated Care Conference Abstract
International Journal of Integrated Care (IJIC), 2025
Background: Expanding on evidence-based models for home-based primary care, the Eastern York Region North Durham Ontario Health Team (Canada) launched the Seniors Home Support program in June 2021 to improve access to primary care for homebound seniors. Success of this program is in its patient-centered design, which has fueled the integration of geriatric and palliative care within a primary care service for a seamless patient experience across the continuum of care. Frail homebound seniors face a myriad of challenges to accessing traditional office-based primary care due to cognitive, physical, or social factors. Frailty, coupled with trends in increasing lifespans and chronic diseases, puts homebound seniors among the highest users of acute medical services and highly vulnerable to receiving fragmented care across health care settings. The Seniors Home Support program is a sustainable model of care that improves health care delivery and the patient and caregiver experience through one integrated team of primary care providers, nursing, allied health, and paramedics working across health sectors.

Implementing a multidisciplinary approach for older adults with multiple sclerosis: Geriatric neurology in practice
Multiple Sclerosis and Related Disorders 92, 2025
BACKGROUND: Older adults with multiple sclerosis (MS) face unique challenges arising from age-related changes in MS pathophysiology and overlapping geriatric syndromes. There is a need for geriatrics-focused multidisciplinary care for the rapidly growing older MS population.

Improving Multidisciplinary Team Working to Support Integrated Care for People with Frailty Amidst the COVID-19 Pandemic
International Journal of Integrated Care 23(1), 2023
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.

100 Frailty Hot Clinics: Rapid Cga and Speciality Diagnostics reduces rates of hospitalisation and re-attendance Conference abstract
Age and Ageing 50 (Supplement 1), 2021
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.

Conference abstract: 60 Front door specialist frailty MDT working at MFT NHS Trust – The Therapy Team Poster Presentation
Conference abstract*
Age and Ageing 50 (Supplement 1), 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.

Wessex Acute Frailty Audit: applying quality improvement methodology to design and implement a regional frailty audit using a collaborative, multiprofessional approach
BMJ Open Quality 9, 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.

Culture trumps everything: The (un)expected trust about building a frailty team across the continuum for a vulnerable population
Conference abstract
International Journal of Integrated Care 19(374), 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.

New ways of working

Comprehensive Geriatric Assessment (CGA) and Optimisation Services in Older Kidney Patients: Results from the First UK-Wide Transplant Centre and Renal Unit Survey Study
Journal of Clinical Medicine 14(9), 2025
Background: Demand for renal replacement therapy (including dialysis, transplantation and supportive care) in patients over 60 is increasing. Concerns regarding poorer outcomes and decision-making in this cohort have been raised. Evidence suggests these relate to frailty, multimorbidity and cognitive impairment, all seen frequently in older age. Comprehensive Geriatric Assessment (CGA) is a multidisciplinary methodology proven to improve outcomes relating to this triad and could be transformative for older kidney patients. This national UK survey aims to describe (1) attitudes/beliefs of renal physicians and transplant surgeons in the UK toward the CGA for older potential kidney transplant recipients and those being considered for dialysis or supportive care; (2) provision of CGA services for these patients in the UK; (3) barriers and enablers to the provision of these CGA services in the UK.

Nurses

Clinical outcomes of nurse-coordinated interventions for frail older adults discharged from hospital: A systematic review and meta-analysis
Journal of Clinical Nursing 33(11), 2024
To determine the effects of nurse-coordinated interventions in improving readmissions, cumulative hospital stay, mortality, functional ability and quality of life for frail older adults discharged from hospital.

The role of the district nurse in screening and assessment for frailty
British Journal of Community Nursing 27(5), 2024
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
British Journal of Community Nursing 26(3), 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
British Journal of Nursing 30(10), 2021
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
British Journal of Nursing 28(13), 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*
British Journal of Community Nursing 22(9), 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.

Frailty: a term with many meanings and a growing priority for community nurses Abstract only*
British Journal of Community Nursing 21(8), 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 Abstract only*
Nursing Standard 26(3), 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

The value of the occupational therapy workforce in primary care: A rapid review Abstract only*
British Journal of Occupational Therapy, 2025
Introduction: Primary care is a growing area for allied health professionals, including occupational therapists, offering opportunities for early intervention and prevention alongside collaborative, holistic approaches to patient care. The aim of the rapid review was to explore the evidence regarding positioning occupational therapists in this setting.

Occupational therapists delivering patient and caregiver home safety education in a rehabilitation setting Conference abstract
Age and Ageing 48, 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. The Occupational Therapists (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.

163 Overcoming Frailty: Evaluating the role of an occupational therapist on a frail elderly team Conference abstract
Age and Ageing 46(Supplement 1), 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.

Pathways and interventions

Team based triage and pathway care delivery in an ICPOP Hub...24th International Conference on Integrated Care, April 22-

24, 2024, Belfast, Ireland Conference abstract
International Journal of Integrated Care (IJIC) 25, 2025
The aim of the Integrated Care Programme for Older Persons is to develop and implement integrated services and pathways for older people with complex health and social care needs, shifting the delivery of care away from acute hospitals towards community based, planned and coordinated care. In implementation we set about developing new pathways of care into the following; Rapid Access, Falls and Frailty, Cognitive and Movement Disorder. We developed rapid decision support mechanisms, single point of access to facilitate rapid acceptance and processing of referrals. It was evident that the administration team and processes have the potential to improve patient experience, reduce inequalities, promote better care - and contribute to better working environment for all staff.

Enabling public, patient and practitioner involvement in co-designing frailty pathways in the acute care setting
BMC Health Services Research 19(797), 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.

229 HomeFIRsT – Outcomes of a Frailty Intervention and Response Team in the Emergency Department of a Large Acute Teaching Hospital Conference abstract
Age and Ageing 47(Supplement 1), 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).

Paramedics

Prevalence and severity of frailty amongst middle-aged and older adults conveyed to hospital by ambulance between 2010 and 2017 in Wales
Age & Ageing 54(5), 2025
Background Ambulance services are commonly used by older adults. The scope of services continues to adapt in response to more non–life-threatening calls, often due to the acute consequences of chronic illness. Frailty increases with increasing age, but it is not known how common or severe it is within patients conveyed to hospital by ambulance.
Conclusions The high prevalence of frailty within adults aged ≥50 with emergency conveyances suggests upskilling ambulance crews with frailty training to enhance their assessment and decision making may improve patient outcomes. The high proportion of conveyances from residential homes indicates

scope for increasing integration of community services to provide more patient-centred care pathways.

Paramedic assessment of frailty: An exploratory study of perceptions of frailty assessment tools
Irish Journal of Paramedicine 3(1), 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.

Ambulance clinicians' perceptions, assessment and management of frailty: thematic analysis of focus groups
British Paramedic Journal 3(3), 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.

Physical fitness

Frailty and Physical Fitness in Elderly People: A Systematic Review and Meta-analysis Abstract only*
Sports medicine 51(1), 2021
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.

Physiotherapists

Physiotherapy Resource Allocation for Reducing Progression of Frailty in Acute Care: Getting It Right Requires Measuring It Right...American Congress of Rehabilitation Medicine (ACRM) 101st Annual Conference Research Poster, Abstract only*
Archives of Physical Medicine & Rehabilitation 106(4), 2025
To address the demands of an aging patient population, hospitals need to embark on service model redesign. Redesigns require robust metrics to guide decision making in staffing and skill mix. However, data quantifying the utilization of health discipline services such as physiotherapy (PT) in acute care is limited. The objective of this study is to explore changing trends in patient demographics and enhanced PT workload data to inform recommendations on resource adjustments needed to

meet the needs of older adults admitted to acute medicine inpatient units.

Conference abstract: 48 Specialist Physiotherapist leading in the frailty revolution in ambulatory emergency care at the John Radcliffe Hospital, Oxford
Age and Ageing 49(Supplement 1), 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

Prescribing

Achieving Royal Pharmaceutical Society competencies: a frailty nurse's perspective Abstract only*
Journal of Prescribing Practice 1(1), 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

Interprofessional collaboration on oral health for frail home-dwelling older people: a focus group study on needs and barriers experienced by general practitioners and community pharmacists
BMC Primary Care 26(1), December 2025
Background: Despite the increased risk of deteriorating oral health among older individuals, dental attendance often declines over time in frail home-dwelling older people (FHOP), resulting in a significant burden of untreated oral disease. Literature highlights the importance of interprofessional collaboration to address oral health problems in ageing societies, emphasising the potential roles of general practitioners (GPs) and pharmacists. However, there is currently limited evidence regarding (a) their engagement in oral health and (b) the perceived needs and barriers in contributing collectively to the oral health of FHOP. Therefore, this study aims to explore the needs and barriers perceived by GPs and pharmacists regarding interprofessional collaboration on oral health for FHOP.

How do primary care clinicians approach the management of frailty? A qualitative interview study
Age & Ageing 53(5), 2024

Background Around 15% of adults aged over 65 live with moderate or severe frailty. Contractual requirements for management of frailty are minimal and neither incentivised nor reinforced. Previous research has shown frailty identification in primary care is ad hoc and opportunistic, but there has been little focus on the challenges of frailty management, particularly within the context of recent introduction of primary care networks and an expanding allied health professional workforce. Aim Explore the views of primary care clinicians in England on the management of frailty.

Potential Factors Influencing Adoption of a Primary Care Pathway to Prevent Functional Decline in Older Adults
Canadian Geriatrics Journal 26(2), 2023
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. 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.

'Frailty as an adjective rather than a diagnosis'-identification of frailty in primary care: a qualitative interview study
Age and Ageing 52(6), 2023
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.

Rapid evidence review to understand effective frailty care pathways and their components in primary and community care
International Journal of Health Governance 27(1), 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.

The dynamics of frailty development and progression in older adults in primary care in England (2006-2017): a retrospective cohort profile
BMC Geriatrics 22(30), 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.

Creation of a New Frailty Scale in Primary Care: the Zulfiqar Frailty Scale (ZFS)
Medicines 8(19), 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. 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*
Maturitas 145,March 2021
Objectives: To assess the validity and acceptability of the online FRAIL scale in identifying frailty in community settings. 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.

75 This is (Probably) Not the frailty solution you are looking for: Utilisation of a novel stand-alone community-based ambulatory care unit Conference abstract
Age and Ageing 50(Supplement 1), 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.

How can identifying and grading frailty support older people in acute and community settings? Abstract only*
Nursing and Older People, 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*
Primary Health Care 30(6), 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
British Journal of General Practice 69(678), 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.

Think local, act personal: Lessons from an integrated primary care initiative for frail, older people Conference abstract
International Journal of Integrated Care 19(408), 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.

Implementing change in primary care practice: lessons from a mixed-methods evaluation of a frailty initiative
British Journal of General Practice Open, 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.

Frail older people with multi-morbidities in primary care: a new integrated care clinical pharmacy service Abstract only*
International Journal of Clinical Pharmacy 40, 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.

Frailty assessment in primary health care and its association with unplanned secondary care use: a rapid review
BJGP Open 2(1), 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.

Radiotherapy staff

Clinical Judgement, Treatment Decisions and Frailty Management in Older Cancer Patients: A Qualitative Study Exploring the Experiences of Radiation Therapy Staff
Journal of Medical Radiation Sciences, 2025
INTRODUCTION: Treatment of older cancer patients can be complex due to frailty that comes with age, and the benefits of radiation therapy for frail older patients are unclear. Radiation therapy staff play a crucial role in identifying and monitoring frailty and tailoring treatment. Research on radiation therapy in frail older patients is limited, and frailty assessments are not widely used in routine care. Understanding staff experiences with clinical judgement and frailty assessment is important for effective treatment. This study explored the radiation therapy staff's experiences of clinical judgement, treatment decision-making, and managing frail older cancer patients.

Fostering Frailty-based Care for Older Adults with Cancer: A Unique Role of Advanced Practice Radiation Therapist (APRT) in Geriatric Oncology...Leading the way: Radiography Advanced Practice (LTWRAP) International Conference Conference abstract
Radiography 31, 2025
With Singapore's ageing population, cancer incidence among older adults is rising rapidly. Many of these patients present with frailty, comorbidities, and reduced treatment tolerance, requiring more individualised care. This initiative explores the role of Advanced Practice Radiation Therapists (APRTs) in enhancing geriatric radiation therapy services. It examines how role expansion can support complex care needs and contribute to more personalised, safe, and effective cancer treatment for older adults.

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
Age and Ageing 50(1), 2021
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

Improving comprehensive geriatric assessments with the clinical frailty scale: a focus group study
BMC Geriatrics 25(1), December 2025
Background: The purpose of this study is to exploratively evaluate the geriatric team's views on the implementation of the Comprehensive Geriatric Assessment (CGA) and Clinical Frailty Scale (CFS) on frail older people with acute orthopaedic disorders who are cared for in two geriatric care wards in the southwest of Sweden.

Implementation processes and staff experience of an integrated acute frailty home treatment service Abstract only*
Journal of Integrated Care 33(2), 2025
Purpose: Frailty increases the risk of adverse outcomes such as falls and disability and has a major impact on health and care services. Admission to hospital confers significant risks, including deconditioning, delirium and hospital-acquired infection. In the UK, there has been a significant shift towards acute care at home using integrated "hospital at home" (HaH) services as the delivery model. The purpose of this study was to explore the

implementation processes and staff experiences of a frailty home treatment service (FHTS) in England.

Healthcare workers' experience of screening older adults in emergency care settings: a qualitative descriptive study using the Theoretical Domains Framework
BMC Geriatrics 24(1), 2024
Background: In emergency care settings, screening for disease or risk factors for poor health outcomes among older adults can identify those in need of specialist and early intervention. The aim of this study was to identify barriers and facilitators to implementing older person-centred screening in emergency care settings in the Mid-West of Ireland.

Hospital-Based Health Professionals' Perceptions of Frailty in Older People
Gerontologist 64(7), 2024
Background and Objectives There is a high prevalence of frailty amongst older patients in hospital settings. Frailty guidelines exist but implementation to date has been challenging. Understanding health professional attitudes, knowledge, and beliefs about frailty is critical in understanding barriers and enablers to guideline implementation, and the aim of this study was to understand these in rehabilitation multidisciplinary teams in hospital settings.

Talking about frailty: health professional perspectives and an ideological dilemma
Ageing and Society 42(1), 2022
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
Palliative Medicine 35(6), 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.

Community care staff attitudes towards delivering a falls prevention exercise intervention to community care clients
Health & Social Care in the Community 29(2), 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.

Preventing frailty in older people: an exploration of primary care professionals' experiences Abstract only*
International Journal of Older People Nursing 15(2), 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.

Frailty: an in-depth qualitative study exploring the views of community care staff
BMC Geriatrics 19(47), 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.

Ambulance clinicians' perceptions, assessment and management of frailty: thematic analysis of focus groups
British Paramedic Journal 3(3), 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.

Exploring frailty: Community physical and occupational therapists' perspectives Abstract only*
Physical & Occupational Therapy in Geriatrics 29(4), 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.

Technology

Virtual Goals of Care Consultation for Advanced Frailty: a Qualitative Implementation Study Providing Insights from the Pandemic
Canadian Geriatrics Journal 28(1), 2025
Background During the COVID-19 pandemic, long-term care (LTC) facilities faced challenges in establishing appropriate goals of care (GoC) for residents during health crises. To address this, a virtual specialist consultation program was implemented to align care interventions with residents' frailty and expected outcomes.

Augmented reality glasses as a new tele-rehabilitation tool for home use: patients' perception and expectations Abstract only*
Disability and Rehabilitation: Assistive Technology 17(4), 2025
Explore perceptions, expectations and challenges following a telerehabilitation programme using augmented reality glasses (ARG) in patients with idiopathic pulmonary fibrosis (IPF), chronic obstructive pulmonary disease (COPD) or recently diagnosed myocardial infarction (MI).

Virtual Wards

Palliative virtual wards: a cross-sectional UK survey
BMJ Supportive & Palliative Care, 2025
OBJECTIVE: Various providers have piloted palliative virtual wards in the past 4 years. This survey provides the first aggregated data from across the UK.

Why is implementing remote monitoring in virtual wards (Hospital at Home) for people living with frailty so hard? Qualitative interview study
Age and Ageing, 2025
There is relatively low uptake of remote monitoring on frailty virtual wards (Hospital at Home) compared to virtual wards caring for people with other medical conditions. However, reasons for low uptake are poorly understood.
Objectives: To explore the views and experiences of frailty virtual wards stakeholders involved in implementing remote monitoring.

Virtual wards: a rapid evidence synthesis and implications for the care of older people
Age and Ageing 52 (1), 2023
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.

Workforce Planning

Prevalence of Frailty in European Emergency Departments (FEED): an international flash mob study
European Geriatric Medicine 15(2), 2024
Introduction: Current emergency care systems are not optimized to respond to multiple and complex problems associated with frailty. Services may require reconfiguration to effectively deliver comprehensive frailty care, yet its prevalence and variation are poorly understood. This study primarily determined the prevalence of frailty among older people attending emergency care.

Proactive care for frailty
British Journal of Hospital Medicine 19(1), 2024
Many providers aspire to scale up proactive care that prevents escalation of health and care needs, delays onset of disability, and reduces demand for emergency department attendance or admission to hospital or care home. NHS England offers guidance on personalised and coordinated multi-professional

support and interventions for people with moderate or severe frailty. This article reflects on the growing international evidence for an integrated proactive approach for older people with frailty and why investing in high-quality, joined-up care for older people across the whole system improves outcomes for people, reduces demand for services, increases system resilience, and delivers economic and societal benefits. Facing up to frailty requires creative whole system workforce planning and development that will be challenging to deliver in the current financial and recruitment context yet all the more worthwhile as scaling up proactive care has the potential to be a game changer.

Community frailty team workforce development – a personal reflection Abstract only*
Journal of Integrated Care 29(4), 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.

Workforce planning for community-based palliative care specialist teams using operations research
Journal of Pain and Symptom Management 61(5), 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.

The association between physician staff numbers and mortality in English hospitals
EClinicalMedicine 32, 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.

The use of acuity and frailty measures for district nursing workforce plans Abstract only*
British Journal of Community Nursing 23(2), 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
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

How to develop and maintain a frailty role
Royal College of General Practitioners, August 2023
Including what qualifications and capabilities you could consider as well as how to maintain those skills and capabilities.

Advanced Clinical Practice in Older People Curriculum Framework
Health Education England, 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
Older People 34(3), 2022
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.

Frailty framework
Skills for Health and NHS, 2021
The framework will be applicable to health, social care and other employers, employees, people living with frailty, carers, the community, the public and also to educational organisations which train students who will subsequently be employed in the workforce. The framework aims to describe core capabilities.

Older People's Mental Health Competency Framework
Health Education England, 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
East Kent Hospitals University NHS Foundation Trust, 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.