Age friendly Salford

Salford
Integrated Care Partnership

Understanding Frailty

July 2025

Introduction

This short report is one in a series developed to showcase individual projects supported by Age Friendly Salford. While it contributes to the broader conversation around addressing frailty in Salford, it does not represent the full scope or outcomes of the wider Frailty Transformation Programme. Instead, it aims to capture specific learning and insights from a particular strand of work within the city's ongoing efforts to understand and respond to the impacts of frailty.

The work supports the development of a common understanding of frailty from the perspective of -

- **Individuals** who may be at risk of or are already considered frail
- **People who support people** who are frail both at home and in community settings
- **Clinical and non-clinical staff** who support frail individuals

Collectively we can all work together to:
Improve quality of life and independence, recognise that frailty is not an inevitable part of ageing and if found early find solutions which can reverse the impacts of being frail.

Summary

The Salford Frailty Programme aims to build a shared understanding of frailty and develop a collaborative, system-wide approach to its identification, management, and prevention.

Definition of Frailty

Frailty is a distinct condition related to the ageing process, characterised by a loss of physical and psychological reserves. It increases vulnerability to health and social changes, ***but is not an inevitable part of ageing and can be reversed with early intervention.***

Programme Overview

The programme brings together Clinical, local authority, public health, and voluntary sector partners. ***It focuses on coordination, education, and communication to support people living with or at risk of frailty.***

Education Framework

A frailty education framework was developed to suit different learning needs. It includes in-person and digital training, with Age Friendly Salford leading community-based sessions. ***Training has improved awareness and confidence among participants.***

Community Engagement

Community learning sessions have empowered older people and carers to recognise and manage frailty. ***Feedback highlights increased motivation, awareness, and proactive health behaviours.***

Outcomes

Key achievements include the adoption of the Clinical Frailty Scale (CFS), delivery of education sessions, and implementation of tests of change to improve service integration and person-centred care.

Next Steps

- Embed the Clinical Frailty Scale (CFS) across services
- Expand education delivery and accessibility
- Enhance communication and engagement
- Sustain and scale successful tests of change

What is frailty?

Frailty is a distinct condition related to the ageing process, but not an inevitable part of aging and can affect anyone of any age living with complex needs.

Frailty can develop when the body gradually loses its natural reserves (physical and psychological), making people vulnerable to sudden changes in their health and social needs, often triggered by small events such as a change in medication or a breakdown in carer support

The impacts of frailty

Around 10 per cent of people aged over 65 years are identified as frail, rising to between a quarter and a half of those aged over 85 years (British Geriatric Society).

Salford has a population of 270,800, of which approximately 35,000 residents are aged 65 years or older, constituting around 13% of the city's demographics.

Frailty can also have a profound impact on individuals, their families, and the healthcare system, with an increased risk of falls, hospitalisations, and reduced quality of life.

How can we measure if someone is frail?

There are a variety of tools used to measure frailty as set out in the table below. To ensure a consistent approach in Salford the Clinical Frailty Scale (CFS) has been adopted as the preferred tool.

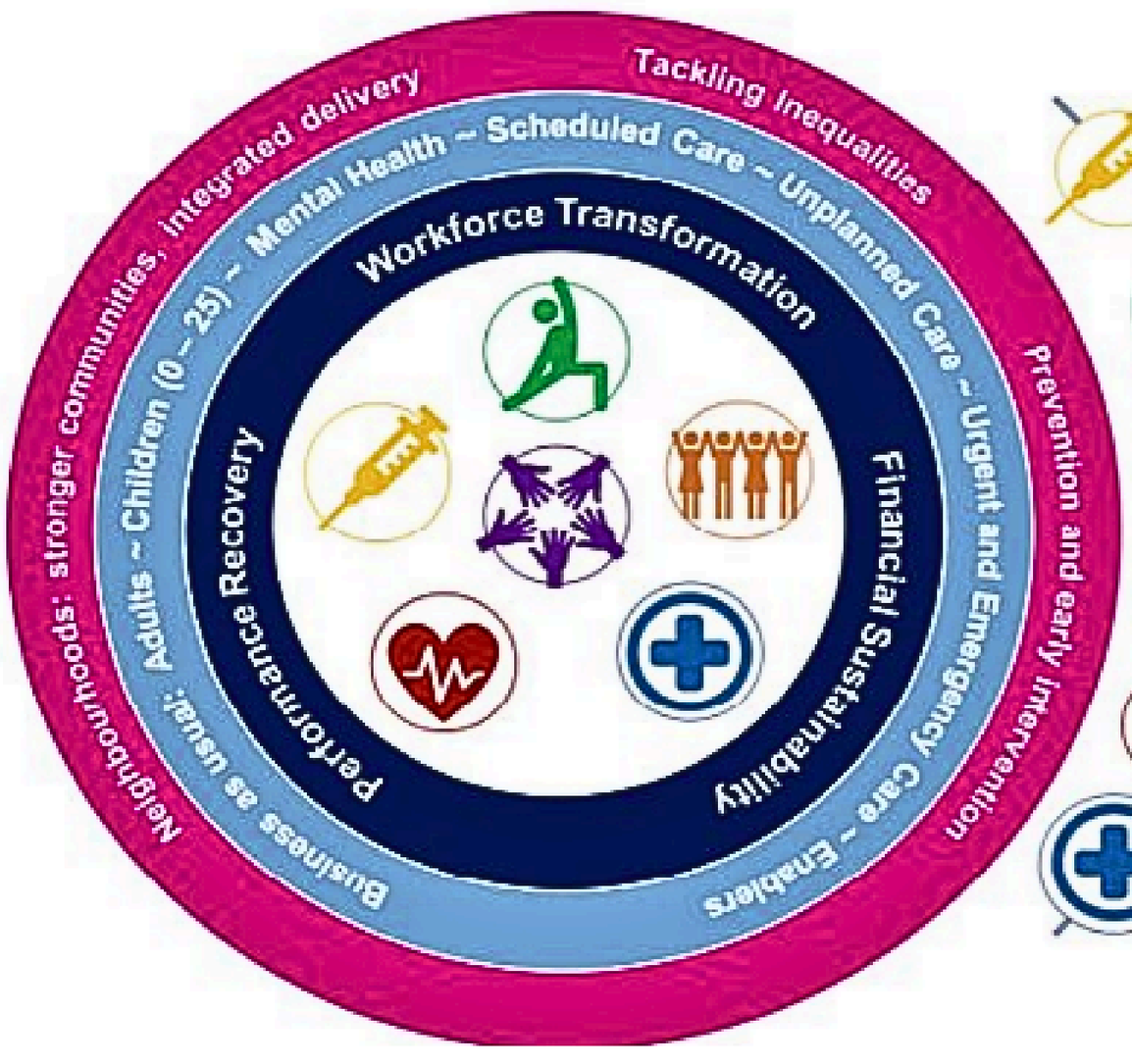
Model Name	Type	Key Features
Fried Phenotype	Phenotypic	Weight loss, exhaustion, grip strength, walking speed, physical activity
Frailty Index (FI)	Deficit Accumulation	Ratio of health deficits (physical, cognitive, psychological, social)
Clinical Frailty Scale (CFS)	**Judgment-Based**	**Visual scale from very fit to severely frail**
Edmonton Frail Scale (EFS)	Clinical Judgment-Based	Includes cognition, general health, functional independence, social support
Prisma-7	Clinical Judgment-Based	7-item questionnaire focusing on age, health, and activity

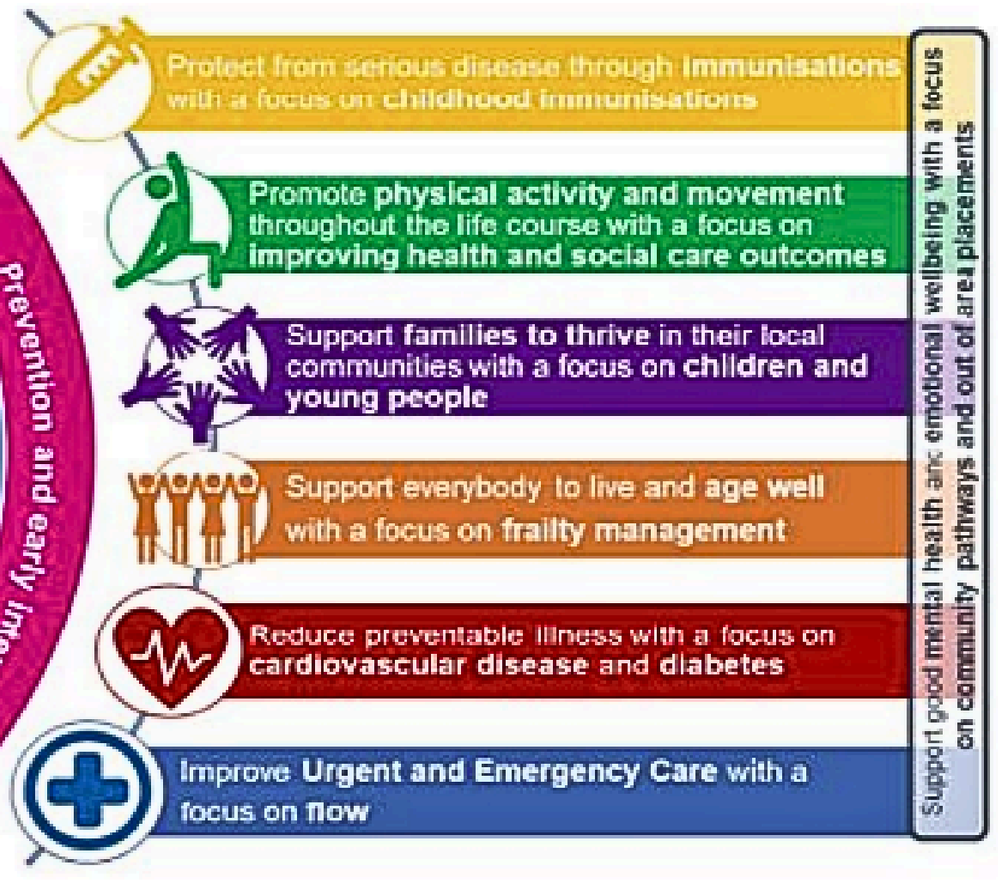
What is happening in Salford to support frailty?

Outcomes for ageing well:

Salford System Priorities 2024/2025

NHS
Salford Care Organisation
Northern Care Alliance
NHS Foundation Trust





People will live longer, and those years will be lived in good health (increasing healthy life expectance for all)

The gap in life expectance between the most and least deprived communities in the city will be reduced.

Following a review of the Salford Locality Plan in December 2024 the core priorities were defined for the period 2025 – 2023.

To enable Salford to work towards achieving these core outcomes seven system priorities have been identified. One of these priorities is to “support everybody to live and **age well** with a focus on **Frailty management”.**

Determining the precise number of frail individuals in Salford is challenging due to the lack of a standardised definition and comprehensive data collection systems. However, studies indicate that frailty prevalence increases with age, making the city's elderly population a priority group for assessment and intervention.

Salford Locality Frailty Programme

In late 2024 a system wide frailty programme was established bringing together representatives and from NHS, Local Authority, Public Health, and the Voluntary Sector. To support the programme of work a small grant was secured from Greater Manchester Transformation Funds to address the following three priorities:

- Programme Coordination
- Development and delivery of a frailty education programme
- Establish a model for Communication and Engagement of frailty

As set out in the report the programme has started to develop a consistent approach across all partners using:

The Clinical Frailty Score

The Clinical Frailty Scale (CFS) is a straightforward and accessible tool that can be used to quickly and simply assess patients living with frailty. A score from 1 (very fit) to 9 (terminally ill) is given based on the descriptions and pictographs of activity and functional status.

Standardised training

The London Clinical Network for Frailty and the British Geriatrics Society Frailty E Learning models provide learning from basic understanding through to clinical assessment. As can be seen later in the report the learning programme has been adapted to suit the participants and styles of learning, but the framework follows the models outlined.

The remainder of this report brings together the work done to date and insight into the outcomes as of June 2025.

Programme Coordination

The Frailty Partnership Transformation Working Group brings together partners from across a wide partnership of those working with individuals who are frail or at risk of becoming frail, whilst ensuring the voice of older people through strong links with the Age Friendly Salford programme. Through the transformational funding a part time Frailty Programme Co-ordinator been appointed employed by Inspiring Communities Together who are also the lead for the Age Friendly Salford programme.

The post holder works closely with the Salford Care Organisation Northern Care Alliance NHS Foundation Trust Progamme Management Office Team ensuring links between the partnership.

Under pinning the Working Group two Task and Finish Groups have been established, details of the work delivered through these Working Groups is provide through this report

Aims of Working Groups

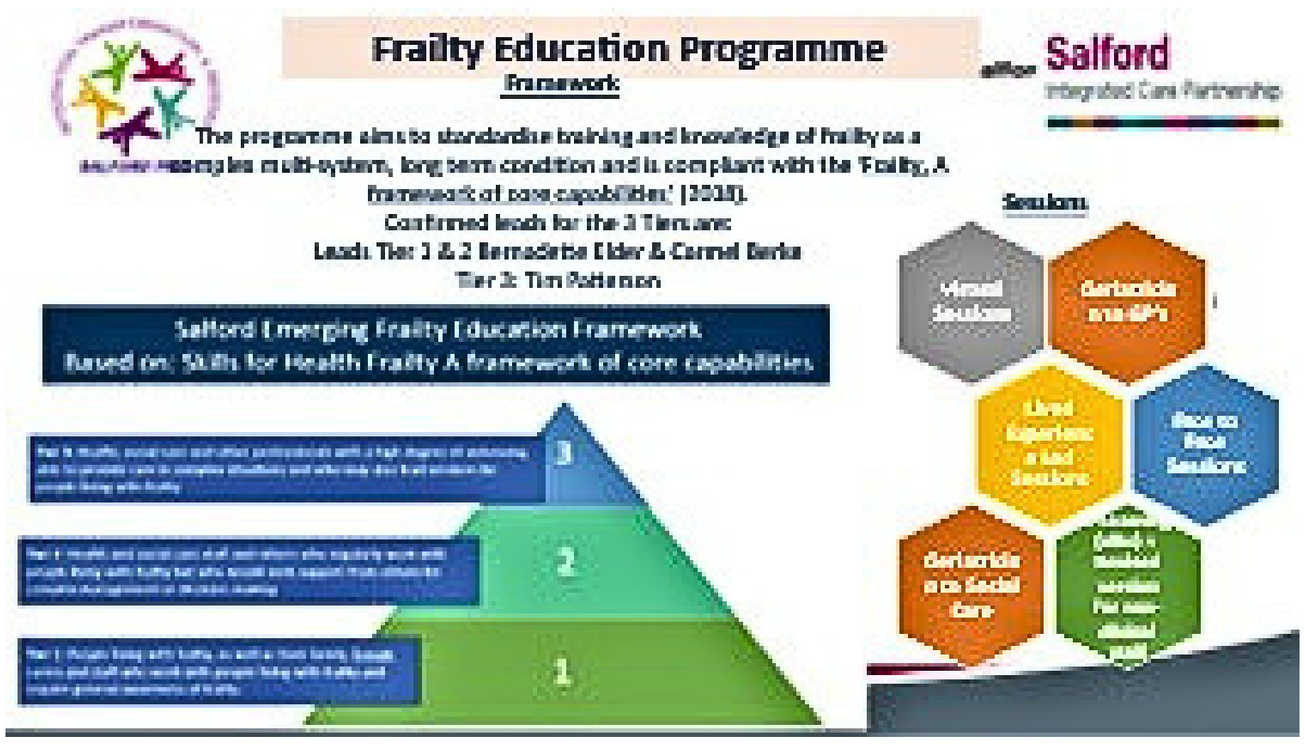
Education Task Group	Adult Social Care and Voluntary Sector (ASC / VSCE)
To enable members of acute, community, primary care, voluntary sector and other health and social care providers, to come together and design, develop and participate in a range of learning activities relevant to their role To support frailty identification and management, including Strength Based Approaches.	To improve collaborative working between ASC/VCSE To provide support in the community for those affected by frailty

Development and delivery of a frailty education programme

A key element of the frailty work is to ensure there is a consistent understanding of frailty across all elements of the programme. To drive the work a frailty education framework has been developed and a subgroup established to oversee the work.

The training aims to provide an understanding of what frailty is and what it looks like, to assist self-management, empower and support an assessment and provide early assistance reducing the likelihood of frailty.

There is a recognition that dependant on your role will determine the level of frailty understanding you will require and therefore three tiers of learning have been identified



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.
Tier 3 has been developed by the British Geriatrics Society and is funded by the BGS and NHS England

Tier one	Tier two (a&b)	Tier three
• People living with frailty • Family, friends and carers • staff who work with people living with frailty and require general awareness	• Health and Social care staff • Staff who regularly work with people living with frailty but who would seek support from others for complex management or decision making	• Health, Social Care and other staff with a high degree of autonomy, able to provide care in complex situations • May lead services for people living with frailty

There is also a recognition that for some E-learning (online) can provide individuals with time and space to complete their individual learning journey, however for others in person learning is their preferred method. The overarching framework for all learning has been established using the earlier mentioned recognised learning packages and adapting the style and tools for learning rather than developing different learning packages for both E-learning and in person learning

Tier one training – It was recognised during the initial engagement work with older people access information report that the preferred method of learning would be in person. This approach not only enables open conversation about frailty but also provides time and space to address any individual concerns raised. It was agreed that due to the track record **Age Friendly Salford** already has in delivery of health prevention training they would lead on the tier 1 (community learning element)

Delivery Team – Lead partner Inspiring Communities Together delivery in partnership with Age UK Salford and Salford CVS

Age Friendly Salford is a programme of work funded by Salford City Council to deliver a collaborative approach to working across agencies and with older people ensuring the best outcomes for older people. Supporting residents of Salford to live healthy and active lives, reducing the risk of poor health as we age.

What has been delivered - tier 1

The community learning sessions have offered an opportunity for conversations with older people, carers and frontline staff who support and engage with those affected by or with the potential to be affect by frailty. To date six frailty learning sessions in the community have been delivered with 60 individuals attending (37 Salford residents and 23 voluntary sector staff). Further sessions are planned for July onwards.

Older people who attend learning sessions told us:

- They felt empowered to make small, achievable positive changes to their own lives, such as being more mindful about good nutrition and hydration, moving more, staying connected to others and being more proactive when booking and/or attending medical appointments. Many talked about having more awareness of the importance of medication reviews.
- Others become reflective, thinking about where they are now, and comparing themselves to a time when they were more active, able, independent and healthy.
- Some people expressed an appreciation for the support their loved ones provide to enable them to maintain and improve their quality of life as they age.
- The majority of older attendees said the leaning would allow them to spot signs and changes in loved ones and neighbours and provide support and information to enable them to make simple changes with the purpose of reducing frailty.

Staff who have completed evaluation have reported an improvement in knowledge of frailty as a concept, with an increase in understanding from 3.54 to 4.58 average. Feedback also gave an insight to how the training will support them within their work, including a more competent detection of warning signs and a quicker response to risk as well as taking time for reflection - ‘thinking about the bigger picture and applying a holistic view.’ Some also stated this gave them a refreshed awareness and understanding of frailty.

> **I’m not as fit as I used to be and don’t know what I’d do without the support from my daughter. This training has made me realise that the friends I’ve made through Age Friendly Salford events and activities like this is so important to me, it keeps me going more than I realised**

> **This has made me more determined to keep going. Getting out and seeing these lovely people in this room is so important to me and I’m going to do all I can to keep going**

> **What I’ve heard this morning has made me think about how I can see changes in myself and my friends and think about the things I do to stay well.**

Tiers 2 and 3 training - Staff from social housing providers, public sector and voluntary and charitable organisations attended tier one community learning and provided feedback, giving insight to how this has increased their understand of frailty and how they would apply learning in their role.

Many stated an improved awareness of frailty and how this can impact people's day to day lives, impacting independence, leading to the need to additional support. Most said they would use this in their person lives to recognise signs in friends and family members.

Those supporting carers and people living with dementia, stated knowledge gained would offer an added perspective to spot the signs of frailty when visiting the people they support.

> **Before doing this training I wasn't aware that it's possible to move down the scale of frailty. It's strengthened the need for a quicker response to the completion and process of installing aids and adaptions in properties, which could reduce the likelihood of residents becoming or increasing their own level of frailty**

> **It will enable me to listen to carers, talking about people they work with and live with, with 'ears open' for frailty and for frailty within the carers (e.g., spousal carers).**

> **I feel more able to spot signs of frailty and more understanding of what to look out for.**

Establish a model for Communication and Engagement of frailty

To enable the development of a communication and engagement model for frailty across Salford we first need to understand what frailty means to:

- Individuals who may be considered frail
- Clinical teams who support individuals who may be frail
- Organisations who may provide neighbourhood activities which help reduce the impacts of frailty

In August 2024 we did a piece of work to explore how older people feel about the word frailty and what they understand it to mean Understanding Frailty.

What older people told us frailty meant to them - how it made them feel - what it looks like

The word frailty had different meanings to individuals. Frailty was something which was an issue faced as people age not experienced by younger people

- Some described frailty using words such as, limited, sad, dependent, incapable and undernourished, frailty was something they feared
- For others they were motivated to maintain health, be active, be mindful, eat well and be socially connected.

There was however consensus that frailty affected people experiencing poor physical and/or mental health and those with poor nutrition and/or hydration.

There was a recognition that frailty was closely linked to isolation and loneliness.

There was agreement that there was little understanding of frailty, and it was suggested that people used the word frail and frailty without fully understanding it as a concept.

Clinical teams and organisations who support individuals who may be frail to reduce the impacts of frailty

There are various support services on offer in Salford for people aged 65 years and over, which as part of the work have been mapped across the city. It is vital to ensure information is accessible to public and private sector organisations, as well as health and care services and people affected by or with the likelihood of being affected by frailty.

Test of Change

To understand how those who support people who may be at risk or considered frail are currently operating, a workshop brought together members from the SFWG to review the initial mapping of services and discuss current knowledge and use of the service provision on offer.

From the workshop, it was clear that there was limited awareness of what was available beyond individuals' own knowledge. However, there was a shared commitment to better understand how a more person-centred approach could be adopted across the system.

Through the ASC/VCSE working group, a number of tests of change have been developed to continue bridging the gaps identified.

Test	Aim/s	Outcomes
To support Adult Social Care (ASC) to develop community-based outreach and screening of early health prevention by offering face to face communication with Salford residents	Increased signposting and strengths-based working to enable quality of life in communities for longer Building resilience in older people and carers. Supporting ASC staff to improved knowledge of services providing support for people across Salford.	Reduction in non-emergency calls to ASC Increased use of services available in the community. Older people able to be more confident in looking after their own health and wellbeing
To develop an evidenced based model of work between District Nurses (DN) and VCSE which can be shared with the patient during and on discharge so they are more informed of services they can access to reduce loneliness, improve general health, wellbeing and movement.	Enable people affected by frailty to live well in their own home Building resilience in older people and carers Improved understanding for DN team, of service provision in Salford supporting people affected by frailty with a score of between 5 and 7	Reducing caseloads for DN. Reduction in the number of frail people attending emergency departments.
To increase signposting to non-statutory services from Occupational Therapy Team (OT) to enable people affected by frailty to live well in their own home for longer.	Enable people affected by frailty to live well in their own home Building resilience in older people and carers Improved understanding for OT team, of service provision in Salford supporting people affected by frailty with a score of between 5 and 7	On discharge from OT team, people are more informed of provision they can access to reduce loneliness and improve general health, wellbeing and movement in their own communities Older people able to be more confident in looking after their own health and wellbeing

Conclusion

The Salford Frailty Programme has made significant strides in establishing a shared understanding of frailty and building a collaborative, system-wide approach to its identification, management, and prevention. Through coordinated efforts across health, social care, and the voluntary sector, the programme has laid the foundation for a more resilient and informed community.

Key achievements include:

- The development and delivery of a frailty education framework.
- The adoption of the Clinical Frailty Scale (CFS) as a standardised assessment tool.
- The implementation of community-based learning sessions that have empowered individuals and professionals alike.
- The initiation of innovative tests of change to improve service integration and person-centred care.

Feedback from participants highlights **increased awareness**, confidence, and motivation to take proactive steps in managing frailty both personally and professionally. These early outcomes demonstrate the potential for long-term impact on quality of life, service efficiency, and health equity across Salford.

Next Steps

To build on the momentum and ensure sustainability, the following actions are recommended:

- **Embed the Clinical Frailty Scale (CFS) -** Continue to support teams across the system to adopt and consistently use the CFS as the standard tool for identifying and assessing frailty.
- **Expand and Education Delivery –** Continue to deliver the frailty education programme by expanding delivery methods (in-person and digital) and ensuring accessibility for all relevant stakeholders.
- **Enhance Communication and Engagement -** Finalise and implement a city-wide communication and engagement model that reflects the diverse perspectives of individuals, carers, and professionals, and promotes a shared understanding of frailty.
- **Sustain and Scale Tests of Change -** Evaluate the outcomes of current tests of change and explore opportunities to scale successful models across Salford to further reduce emergency interventions and improve community resilience.

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Age Friendly Salford is a programme of work contracted by Salford City Council.
Inspiring Communities Together are the lead partner working in partnership
with Age UK Salford and Salford CVS