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Table 1. Self-declared reasons for HCPs to identify frailty.

Response category	Responses (n) *	Example quotes
Tailoring treatment or discharge plans to better meet patients' needs	51	*"Helps to direct appropriate services/treatment"* *"I think it allows me to begin to plan in my mind what interventions and discharge planning may be needed from an early stage of the admission."*
Allows for taking action such as referrals or putting measures in place for prevention and/or support	29	*"Useful if its part of a pathway, something can be done about what you have identified"* *"We must identify if a person is living with frailty in order to do something about it. Either attempt to reverse where they are on the frailty trajectory. Name it, stage it as we would for cancer in order to work with that person, establishing what matters most to them for the duration of their life."*
Providing holistic care through assessing a wide range of needs	26	*"To ensure appropriate holistic assessment takes place, and an MDT approach"* *"Supports the wider needs of our patient, promotes a holistic assessment."*
Identifying and addressing risks, such as falls or deconditioning	18	*"It assists in looking at potential risk and trying to reduce and support the minimisation of risk"* *"To optimise patient centred rehab & for safety"*
Prognosis and future planning	16	*"Establishing goals for quality of life and meaningful medical input and ceiling of escalation"* *"Prognostication, education, treatment consideration"*
Improve patient outcomes, such as improving quality of life or reducing readmission	12	*"to help direct holistic treatment approach to give patient's and the NHS resources the best outcome"*

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Doesn't (always) lead to change	8	*"From a therapists point of view we do not treat frail people any differently to any other older person. We are simply doing so for the sake of government targets"*
Measuring frailty is important for assessing prevalence and change	6	*"In clinical assessments we use clinical frailty score. It give an instant picture of ability and need. It is also objective and can change from assessment to discharge indicating response to therapy."*
Not as important as other assessments	4	*"having a frailty score is not as important as a thorough assessment of patient's overall condition and history"*
Other comments (n=13) (e.g. don't know enough, hidden meanings)		
No response (n=24)		

*Some respondents provided responses fitting in multiple categories

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Table 2. Reported tools used by HCPs to assess frailty.

Tool	Practitioners using tool (n=137 total responses)	PT (n=63)	Nurse (n=22)	OT (n=20)	Doctor (n=19)
Comprehensive Geriatric Assessment	76 (55%)	36 (57%)	10 (45%)	12 (60%)	10 (53%)
Clinical frailty scale	53 (39%)	21 (33%)	8 (36%)	6 (30%)	14 (74%)
Gait speed test	38 (28%)	18 (29%)	3 (14%)	3 (15%)	6 (32%)
Electronic Frailty Index	21 (15%)	9 (14%)	1 (5%)	2 (10%)	8 (42%)
Fried phenotype	16 (12%)	8 (13%)	0 (0%)	2 (10%)	4 (21%)
PRISMA-7	16 (12%)	6 (10%)	4 (18%)	0 (0%)	1 (5%)
Timed Up and Go	4				
Balance tests (Berg, Tinetti or TUSS)	3				
No tool	9				
Other (n=2): “experience”, FRAIL scale					
Other tools used by one respondent only: trauma-specific Frailty Index, FAME, FRAT, SARC-F, HIS Think Frailty, Kradle care planning e-application, and range of movement with 180° turning Edmonton frailty scale, St Louis Rapid Geriatric Assessment, “goal oriented”					

FAME: Falls Management Exercise, FRAT: Falls Risk Assessment Tool, HIS: Healthcare Improvement Scotland; OT: Occupational Therapist, PT: Physiotherapist, SARC-F: Sarcopenia screening tool, TUSS: Timed unsupported steady stand.

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Table 3. Ways in which HCPs adapt care according to an individual's frailty score.

Response category	n	Quotes
Specialise care according to where a person is in the frailty trajectory, with preventative approaches in early stages and palliative approaches in later stages	21	*"Mild - sign post, advise, prevention. moderate, recognise to prevent admissions, speed up discharges, severe - advanced care planning etc"* *"The level of frailty will dictate the type of input provided, the location and who delivers it, the intensity and the goals agreed with the patient."*
Consider frailty-specific factors that may affect care, including mobility (and effect on physiotherapy), nutrition, medication, delirium, dementia and/or falls risk	17	*"may be the difference between advising transfers only or a few steps with a w/aid as risk increased in the frailer patient of fractures/more serious injury etc"* *"If identifying someone as frail, I would have a lower threshold for dose reduction of chemotherapy in the event of toxicities"*
Inform care plan interventions (e.g., choice of treatment, deciding whether to treat)	15	*"it forms part of the discussion to identify appropriate route of investigation and management"* *"You can always do something when patients are in hospital but whether should or should not is important"*
Initiate advanced care planning discussions for those diagnosed with more severe frailty	13	*"Advanced planning discussions, it helps me decide whether we are actively treating or moving towards comfort management"* *"Consider ACP/AMBER discussions"*
Prompt further assessments, mainly comprehensive geriatric assessment	13	*"CGA is completed"* *"refer patient for CGA with a focus on medication review, cognitive assessment and other assessments and referrals as relevant to patient"*

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Understand the potential trajectory of the patient and so be able to set better goals	11	*"Thinking about how they may cope with treatment and what their trajectory may be"* *"Everything from goals to planned treatment to daily care"*
Inform the level of multidisciplinary team involvement in care planning	10	*"Full MDT approach"* *"Greater MDT working"*
Identify care needs and social or community support, particularly with greater frailty	10	*"yes gives an indication as to what care needs / advice / help required going forward and enhancing future life plans."*
Guide communication with and referrals to other professionals (e.g., GP involvement, discussions with medical doctor and/or referral to frailty nurse, medication review)	8	*"liaise with frailty nurse and make adequate care plan for patient"*
Contribute to a wider, patient-centred assessment and align to individual goals and priorities, but not guide plans specifically	7	*"Depends on presentation and assessment outcome. Frailty is only part of the holistic assessment."*
Provide realistic expectations of outcomes	6	*"Importance of realistic goal and patient centred care planning especially when discharging from acute hospital"*
A basis for discussion with the patient about frailty and their priorities	6	*"Ensuring the individual is aware they are living with frailty, what that could mean to them and where they are on the frailty trajectory."*
Changing the focus of the care plan (e.g., to avoid hospital admission, to minimise frailty risks)	3	*"Be pragmatic with the approach; avoid unnecessary hospital admission and use comprehensive plan to support this"*
Other	6	e.g. equipment assessments, as a baseline

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Table 4. Pathways of additional support for the management of frailty.

Pathway	**n**
Specialist teams or services ● Including: falls (4), fragility fracture (1), continence (1), complex discharge (1), medicines management (1), sleep clinic (1), diabetes specialist (1), specialist teams (2), Parkinson's disease team (1)	22
Community services ● Mainly specific community teams, reablement, community matrons and one day hospitals.	21
Approach tailored to the individual's specific needs	14
Allied health professionals (mainly physiotherapists, dietitians, occupational therapists and pharmacists)	14
Social services	11
Third sector services	10
Dedicated frailty team	6
Other related teams (e.g., older person's rapid assessment unit)	6
Social prescribing or care navigation services	5
General practitioner referral	1
Intermediate care	1
Palliative care	1
Unclear or no pathway	3