Cancer care in older people living with frailty:

An assessment and management toolkit

This toolkit is designed to support healthcare professionals in recognising, assessing, and appropriately managing frailty in older adults with cancer

This project is developed as a Collaborative Working Initiative between SIOG and Pfizer Limited.

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Pfizer

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INTERNATIONAL SOCIETY OF GERIATRIC ONCOLOGY

Disclaimers

This toolkit, developed as part of a collaborative working project between Pfizer Ltd and SIOG (International Society of Geriatric Oncology), is intended for educational purposes for UK healthcare professionals.

Pfizer provided funding for this project and SIOG commissioned and guided a third-party agency, Havas Gemini UK, to develop this toolkit.

All data and references provided are for informational purposes only.

Use of the toolkit should not replace individual clinical judgement, local policy or professional guidelines.

The information in this toolkit was reviewed for factual accuracy and compliance with the ABPI Code of Practice in May 2026. If you have any queries related to this toolkit please contact the UK National Representative via enquiry@siog.org

REF

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REF

Introduction to this toolkit

This toolkit is designed to support healthcare professionals in recognising, assessing, and appropriately managing frailty in older adults with cancer. This toolkit is intended to be used as a framework rather than as a directive for treatment. It includes information on general principles, rather than specific treatment information.

WHO	NHS healthcare professionals involved in the care of older adults with cancer, including oncologists, geriatricians, specialist nurses and allied health professionals, service managers, commissioners, and MDT members across all settings
WHAT	A practical, structured toolkit intended to support the identification and assessment of frailty in older people with cancer, guide clinical decision-making, and promote integration of frailty-informed approaches into care
WHY	Our population is ageing,[1] and frailty affects treatment tolerance, outcomes, and quality of life in older people with cancer.[2] Recognising and managing frailty appropriately supports equitable, effective care
WHEN	At key points in the cancer care pathway: referral, diagnosis, MDT planning, treatment initiation, and review

MDT: Multidisciplinary team.

REF

Why is this toolkit needed?

Our population is ageing, meaning more people will require frailty-informed cancer care.[1,2]

However, national clinical guidance on ageing and complexity within cancer care remains variable.

The ACCEND framework,[3]
A framework of core capabilities developed by Skills for Health and NHS England[4] outline broad workforce expectations and core frailty capabilities, but they are not cancer-specific, pathway-focused, or tailored to the nuanced needs of older adults

RCP/RCR guidance on implementing frailty assessment and management in oncology services offers pragmatic recommendations around screening, assessment processes and service design.[2] However, its focus is primarily at general and specialist system and service levels. It does not provide a structured competency framework or practical resources for all levels of the oncology workforce

This toolkit complements existing national frameworks by providing a geriatric oncology-specific, evidence-informed and pragmatic resource designed to support equitable, proactive and person-centred care for older adults with cancer.

Embedding frailty-responsive practice, recognising social and cognitive needs, and strengthening multidisciplinary collaboration, this toolkit aims to reduce inequity and ensure that older adults receive care that reflects their strengths, priorities and potential for living well with cancer.

ACCEND: Advancing Cancer Care Education and Training, RCP: Royal College of Physicians, RCR: Royal College of Radiologists.

How this toolkit has been developed



This toolkit is the output of a collaborative working project between Pfizer Ltd and SIOG



A broad spectrum of SIOG experts contributed to its development, including medical oncologists, surgeons, geriatricians and allied healthcare professionals



This toolkit is not definitive. Although input across the SIOG team has been provided, not all specialities could be represented

SIOG commissioned and guided a third party agency (Havas Gemini UK) to author this toolkit

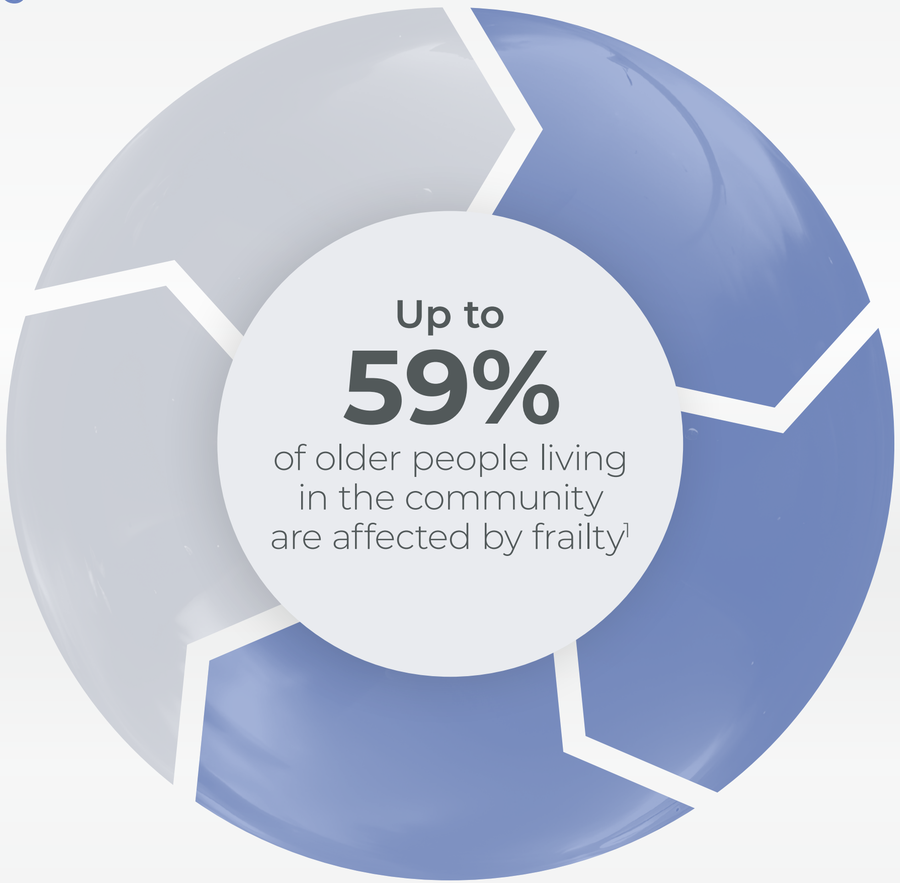
SIOG: International Society of Geriatric Oncology.

Increasing numbers of people are living with both cancer and frailty[1]



1 out of 3

cancer diagnoses are in people **>75 years old**[1]



By 2040:

×3

The number of people >65 years with a malignant cancer is expected to **treble**[2]

Adequate, holistic frailty assessment is essential to ensuring cancer care in older people is optimised

REF

One size does not fit all older people when it comes to cancer treatment decisions[1,2]



Robust/fit
older people with cancer

May **benefit** from intensive medical, surgical, and/or radiation therapies[2]



Frail
older people with cancer

May suffer **irreversible harm** from intensive medical, surgical, and/or radiation therapies[1,2]

Inadequate assessment of frailty

Undertreatment risk[1]

- Using a less intensive cancer treatment in a fit, robust older adult, and/or
- Not providing non-oncologic interventions in geriatric domains

Unnecessary adverse outcomes

Overtreatment risk[1]

- Cancer treatment that would not likely lead to symptom control in the person's remaining lifetime, or
- Intensive cancer treatment where there would be a greater net benefit from less intensive therapy

Irretrievably impaired quality of life

REF

A note on the language of frailty



Frailty:
"A medical syndrome with multiple causes and contributors that is characterised by diminished strength, endurance, and reduced physiologic function that increases an individual's vulnerability"[1]

While this toolkit refers to frailty in older adults with cancer, frailty can also affect many younger patients.[1]

FRAILTY IS A DISTINCTIVE HEALTH STATE RELATED TO THE AGEING PROCESS IN WHICH MULTIPLE BODY SYSTEMS GRADUALLY LOSE THEIR IN-BUILT RESERVES[2]

The medical and colloquial use of "frail" differ starkly from each other. In a medical context, frailty is considered a long-term condition which exists on a spectrum, with the potential to be reversed or improved. For the general public, however, frailty can mean weakness, hopelessness, and an inevitable loss of independence.[3]

This toolkit refers to frailty in its medical context throughout. Remaining mindful of the effect of language around frailty in general use is recommended as this mismatch in perceptions may affect care and outcomes.[2]

REF

This toolkit consists of four modules

Each module can be used alone or in combination with the others



Frailty overview

Key objectives

- Overview of what frailty is, who is affected by it, and its causes
- Information on the scale of the problem
- The case for change – why frailty assessment and management should be part of cancer care services



Assessment of frailty

Key objectives

- Understand why frailty assessment is important in cancer care
- Discuss who should be involved in frailty assessment
- Learn how frailty assessments should be undertaken, what tools are available, and their advantages and disadvantages
- Look at when frailty assessments should be done



Medical considerations

Key objectives

- Overview of the unique challenges of an older population undergoing medical management of cancer
- Why frailty matters in cancer treatment
- Treatment decision-making considerations in older people
- Radiotherapy considerations



Surgical considerations

Key objectives

- Overview of the unique challenges of an older population undergoing surgical management of cancer
- Why frailty matters in cancer surgery
- Treatment decision-making considerations in older people
- Future direction and best practice

REF

Targeted assessment, support, and management of frailty can lead to improved outcomes[1]

ASSESS

All HCPs involved in the care of older and frailer adults with cancer should:[1]

- Have the basic knowledge and skills to assess frailty and manage common frailty-related issues (or flag to someone who can) – and apply these skills in their routine practice
- Consider frailty alongside other assessments and patient values when making decisions about cancer investigation and treatment

SUPPORT

Consider frailty alongside shared decision-making, taking what really matters to patients and their families into account[1]

MANAGE

Recognise and optimise potentially reversible frailty-related issues such as polypharmacy, nutrition problems, and anaemia[1]

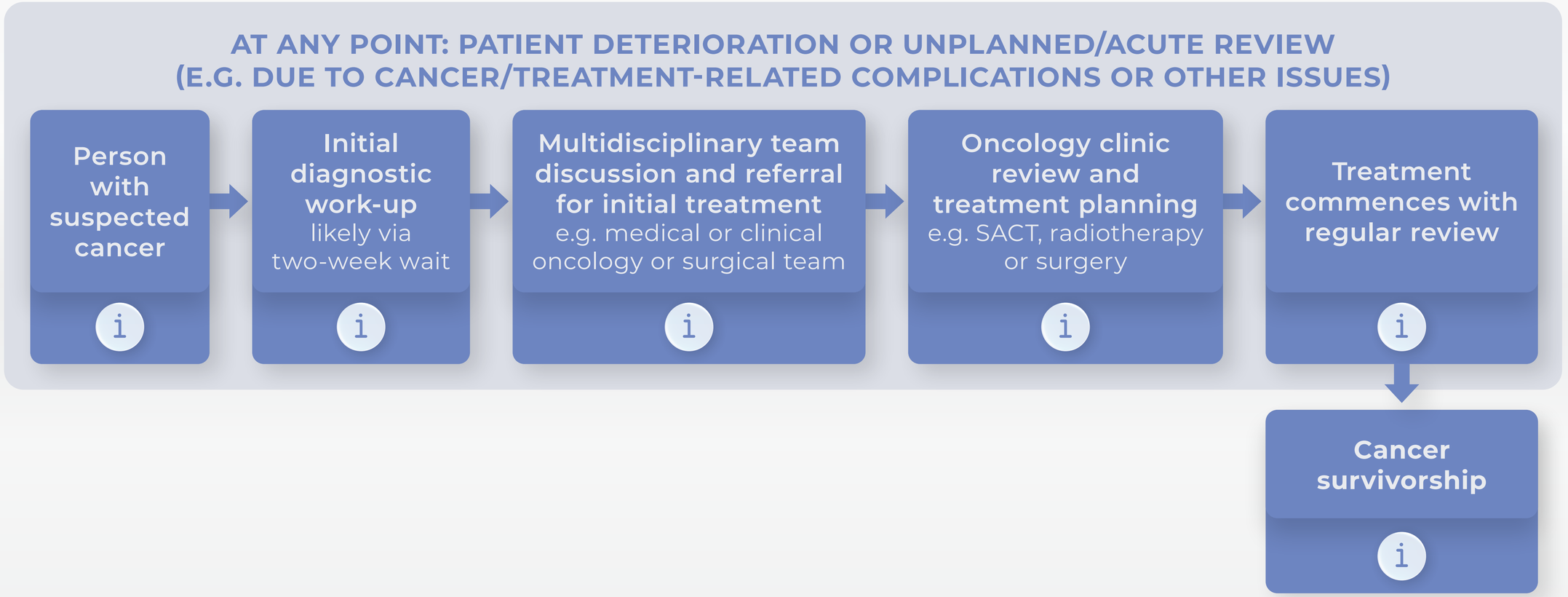
Optimising frailty may increase the range of therapeutic options for the older person as well as addressing other issues that may affect their quality of life[1]

HCP: Healthcare professional.

REF

Targeted assessment, support, and management of frailty can lead to improved outcomes[1]

Frailty assessments undertaken at each stage should inform further assessment, optimisation, and care goals[1]



Adapted from Royal College of Physicians. *et al.* Implementing frailty assessment and management in oncology services. 2023.
SACT: Systemic anti-cancer therapy.

Module 1:
FRAILTY OVERVIEW

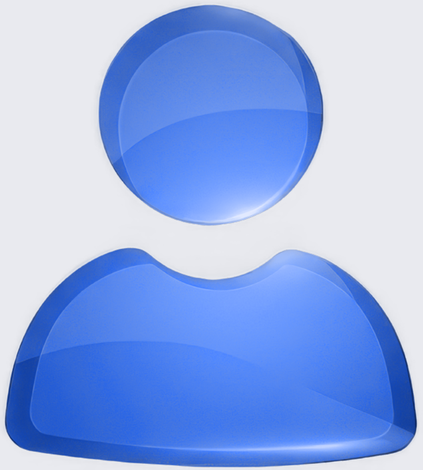
What is frailty?

The scale of the problem

The case for change

Current service assessment

Frailty is a life-limiting, preventable state of vulnerability related to ageing[1-3]



Older people with **frailty** often experience **five common syndromes:**[3]

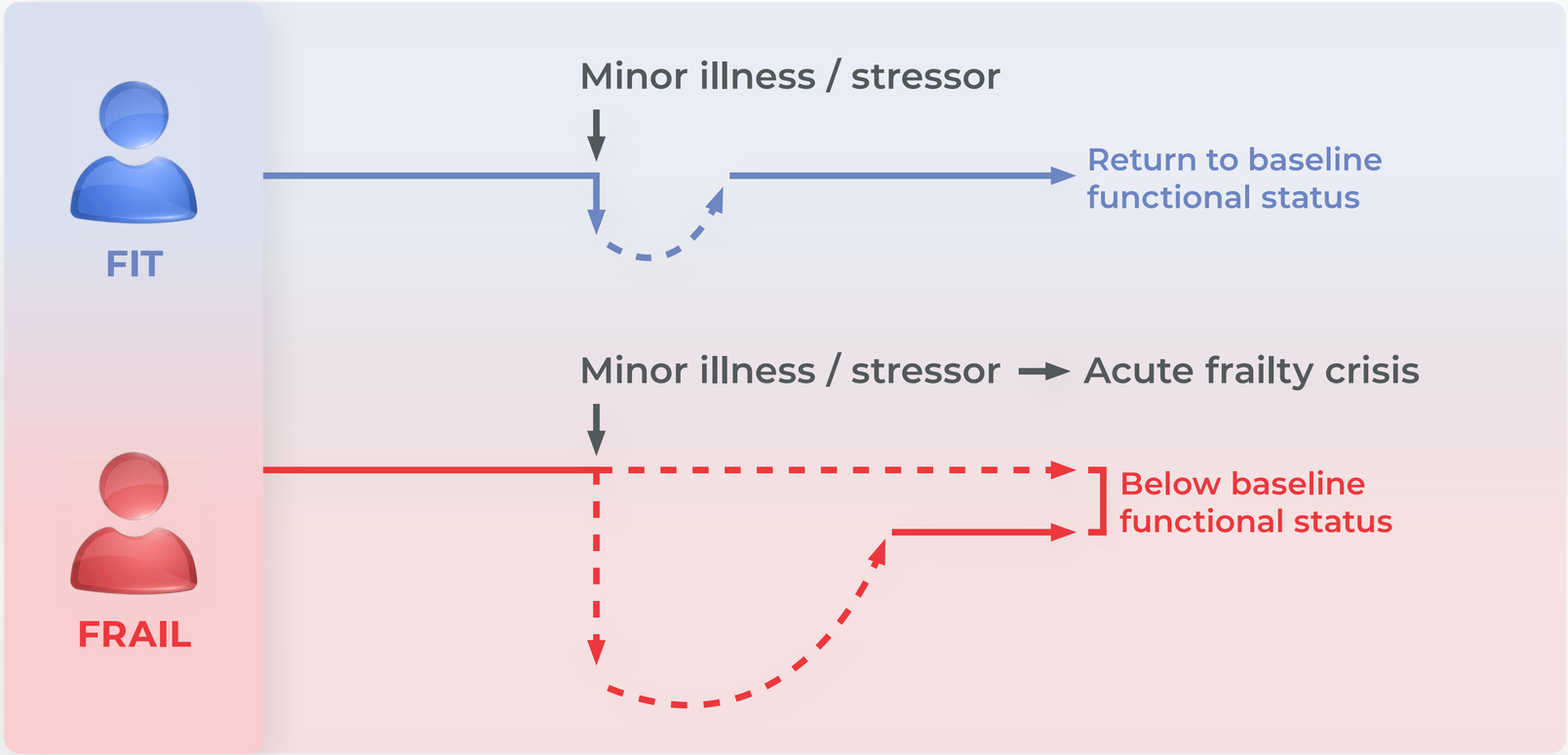
- **Delirium**
- **Immobility**
- **Falls**
- **Medication-related harm**
- **Incontinence**

People with severe frailty are **5x more likely to die** within a year than fit, robust older people[4]

REF

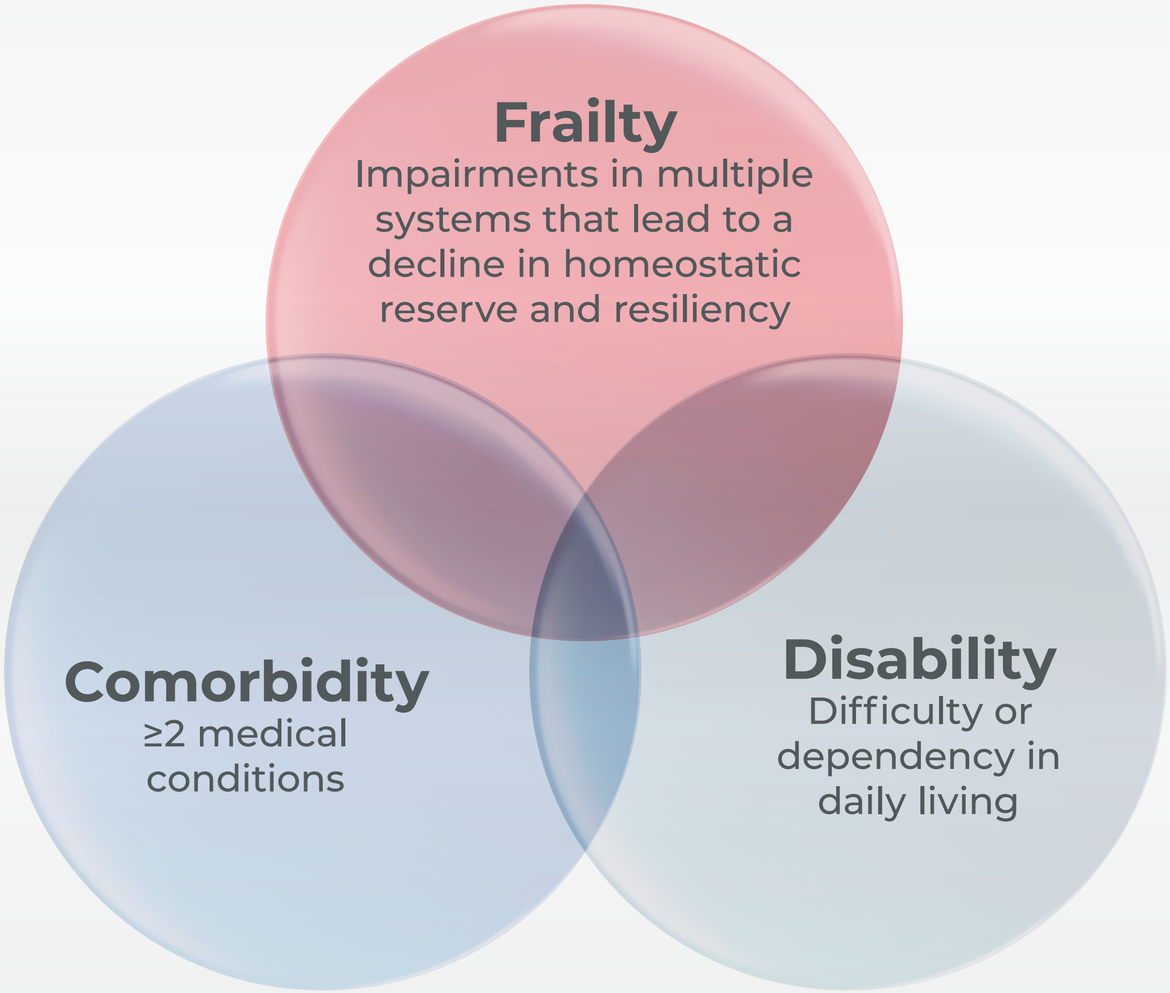
Frailty is characterised by reduced strength, endurance, and physical functioning[1]

It indicates a reduced ability to recover from minor illnesses or stressors compared with fit people[2]



Adapted from Clegg A. *et al. The Lancet*. 2013;381(9868):752-762.

Frailty is distinct from, but linked to, disability, comorbidities, and quality of life[1]

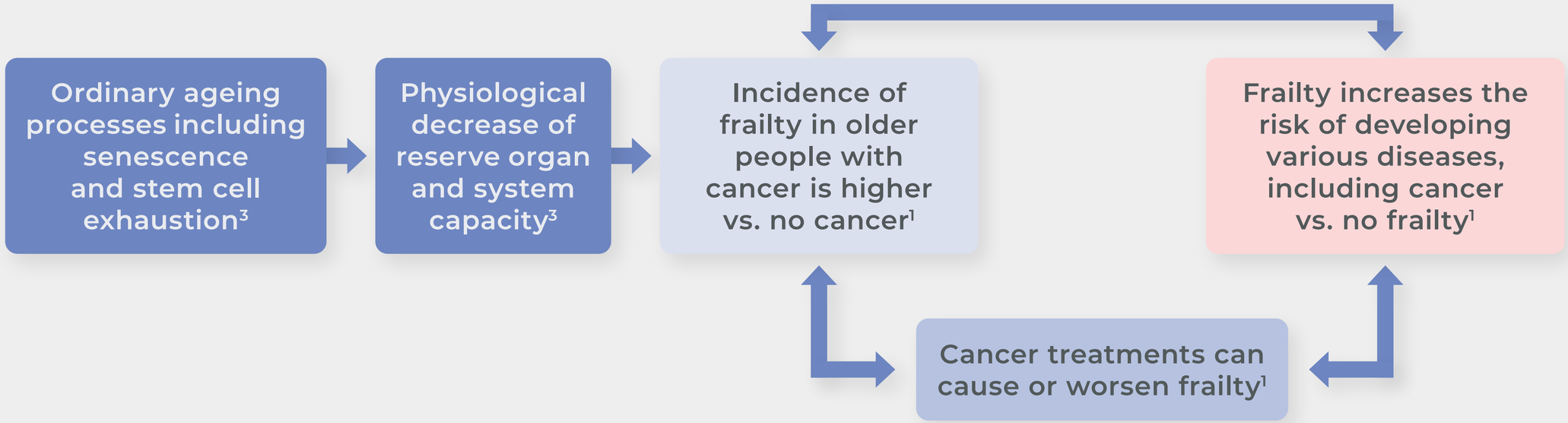


Multiple factors can contribute to frailty – including biological, psychological, and social factors.

A holistic, combined approach is needed to prevent and manage frailty, particularly in an oncology setting.[2]

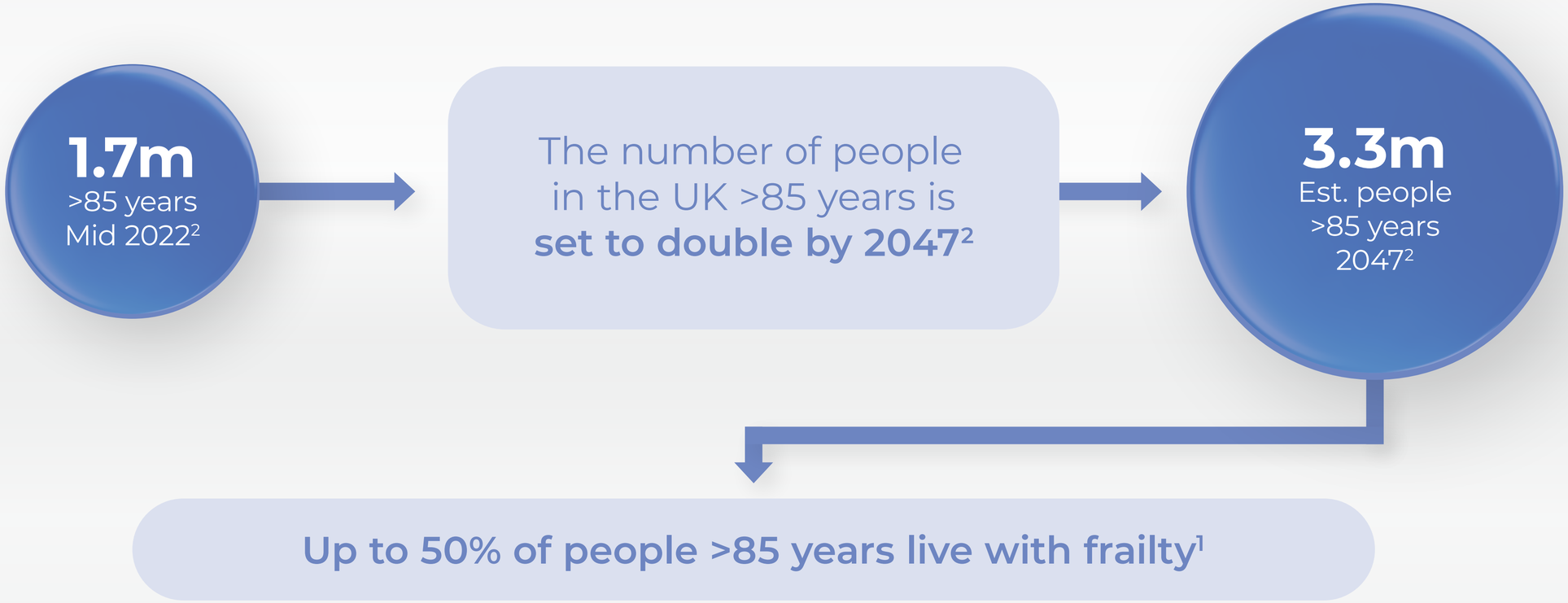
REF

Frailty results from the interaction of several biological, social, and lifestyle factors[1,2]



REF

>1 in 10 people over the age of 65 in the community live with frailty – and it is increasing as our population ages[1]



Age is the greatest risk factor for cancer:[1] Increasing numbers of people will be living with both cancer and frailty[2]



1 out of 3

cancer diagnoses are in people >75 years old[1]

By 2040:

×3

The number of people >65 years with a malignant cancer is expected to **treble**[2]

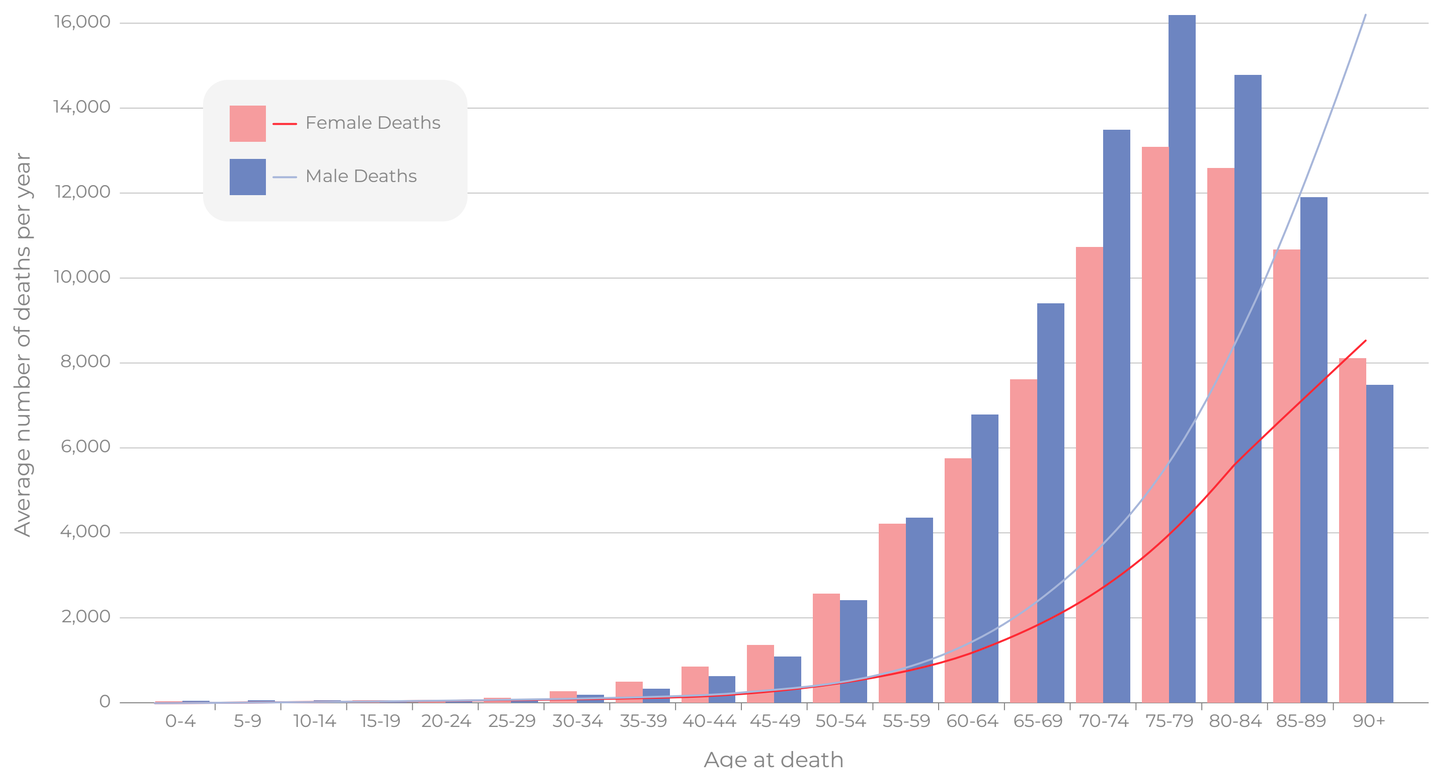
~1 in 4

people ≥65 years will be a **cancer survivor**[1]

REF

56% of cancer deaths are in people aged ≥75 years of age in the UK[1]

Average number of deaths per year
(All cancers combined), UK, 2021-2023[1]



56%

of all cancer deaths in the UK are in people ≥75[1]

90+ years

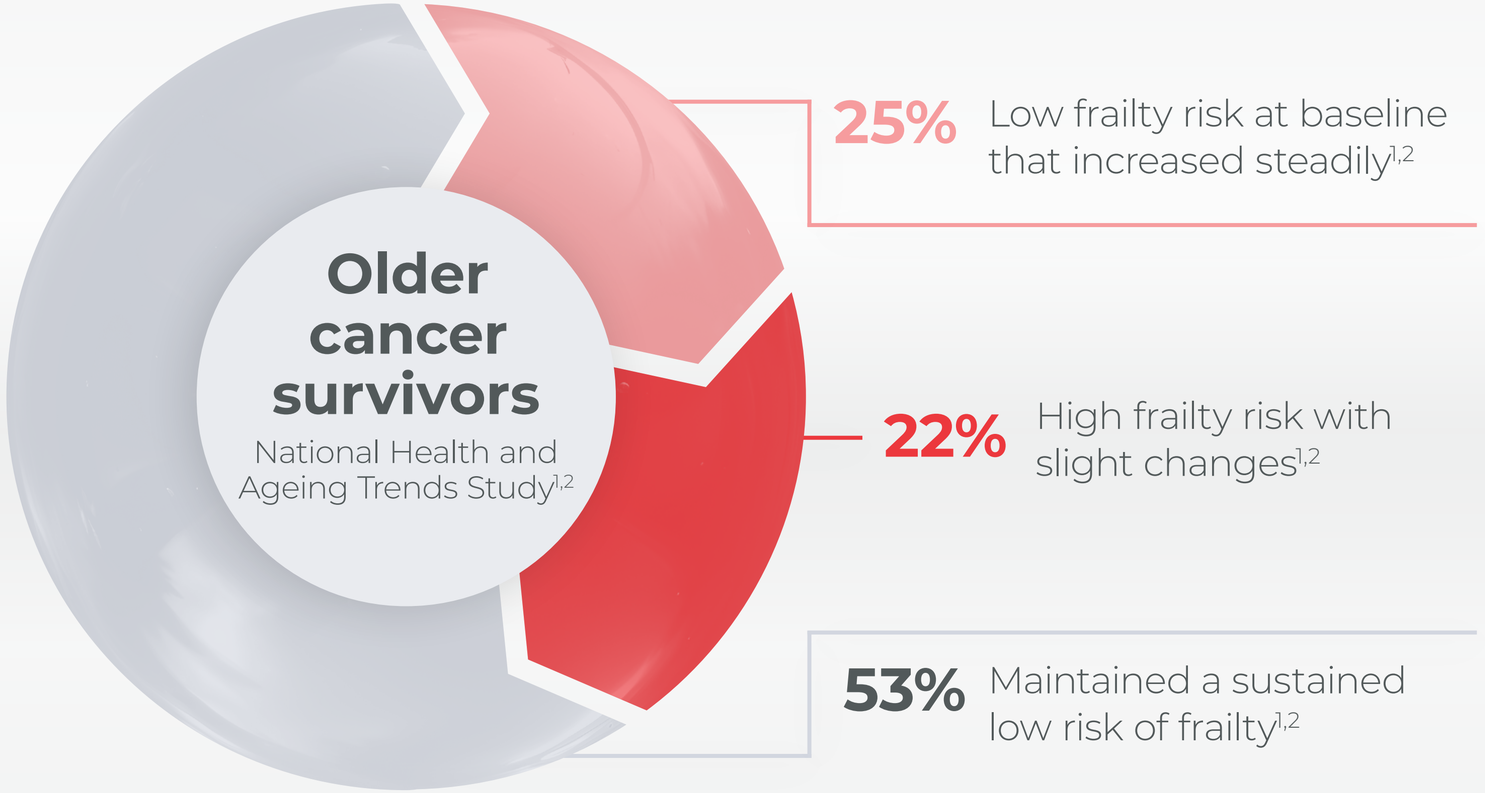
Peak mortality rate for cancer, 2021-2023, UK[1]

Around half of older people who survived cancer experienced worsening frailty[1,2]

in data from the National Health and Ageing Trend Study[1]

Predictors of high-risk frailty trajectories included:[1,2]

- Older age
- Female gender
- African American race
- Lower education and income
- Underweight or obesity
- Poor self-rated health
- Multiple chronic conditions
- Difficulties with activities of daily living
- Low cognitive function



A population-based longitudinal cohort study of community-dwelling older adults in the US. 1,763 older adults were diagnosed with cancer.[2]
Frailty was assessed by the Fried Frailty Phenotype. The group-based trajectory model was used to identify the trajectories of frailty. Multinomial logistic regression analyses were used to examine the socio-demographic and health-related predictors of different trajectories.

Too often, early signs of frailty are not recognised, resulting in missed opportunities for early intervention[1]

£5.8 billion

The **annual cost of frailty** to the NHS[1]

*"If we do not change the way we support older people to age well, we can anticipate a **dramatic increase in frailty-related disability** and dependency, **a negative impact on quality of life, morbidity and mortality,** further **escalation of acute and long-term health and care costs,** and an increase in the human and economic costs of **unpaid caregiving**."*

- British Geriatrics Society[1]

Older people with cancer are more likely to present as an emergency compared with younger people and less likely to have surgery, radiotherapy or chemotherapy than younger people[2]

Cancer treatment decisions risk over- or under-treatment if frailty isn't appropriately considered[1]



Robust/fit

older people with cancer

May **benefit** from intensive medical, surgical, and/or radiation therapies[2]

Consider inclusion in randomised controlled trials

UNDERTREATMENT RISK

Confidence to proceed with standard treatments[2]

Accurate frailty assessment

Prompt to consider tailored treatments[2]



Frail

older people with cancer

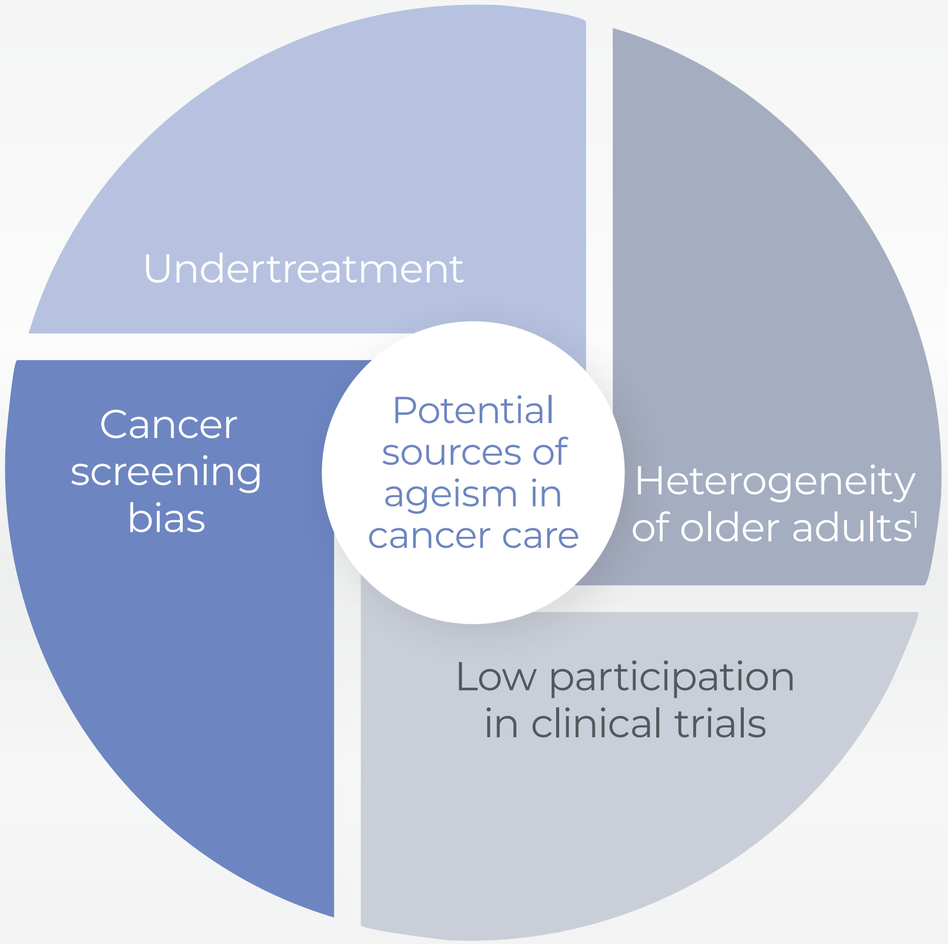
May suffer **irreversible harm** from intensive medical, surgical, and/or radiation therapies[1,2]

OVERTREATMENT RISK

Older people often experience inequitable cancer care[1]

Age alone can affect healthcare professionals' chemotherapy recommendations, meaning some older people face the possibility of undertreatment[1]

Can result in both undertreatment due to ageist stereotypes (leading to worse outcomes) and potential overscreening where it is continued despite guidelines suggesting cessation due to life expectancy/risks[1,3]



Older adults with cancer are a unique, heterogeneous population:[2]

- Multiple competing health and ageing-related conditions
- Distinct preferences that influence treatment decision-making and may affect cancer outcomes[2]

Collection of robust data for clinical decision-making for older adults is made considerably harder, because older adults are often under-represented in clinical trials[1]

REF

Many older people with cancer find healthcare fragmented and difficult to navigate[1]

Multimorbidity, polypharmacy, and complex needs can make navigation of care for older people with cancer difficult, impacting outcomes[1]

Booking
multiple appointments requires organisational work in line with different timeframes and systems

Attending
multiple appointments in multiple different locations, requiring time, travel and energy

Co-ordinating
follow-ups, monitoring, blood tests, and scans

Restricting
normal daily activities due to poor communication and lack of expected timeframes for at-home HCP visits

HCP: Healthcare professional.

The 10-year Health Plan for the NHS in England acknowledges that poor co-ordination of care for people living with frailty is associated with poor outcomes[1]

> *People living in care homes or who have frailty are **particularly likely to experience poor outcomes** when their care is poorly coordinated. They often end up in hospital **unnecessarily** and can **lose their independence** while there."*[1]
>
> - 10 Year Health Plan

Call before convey[1]

Tech-led services[1]

Modern Service Framework for frailty and dementia[1]

ICB: Integrated Care Board.

The UK's research funder community has committed to actively supporting the inclusion of older adults in research[1]

Joint statement signed by
>40 UK health funders[2]

A shared commitment to:

- **Actively support the inclusion of older adults in research**
- **Challenge unjustified exclusion, particularly where older adults have complex health conditions**
- **Ensure that research is designed with equity in mind and better reflects the diversity of the UK**

If we want tomorrow's treatments to work for everyone today, older people must be part of the research that creates them.

Through our 10 Year Health Plan, we're turbocharging research and clinical trials, including by the NIHR launching a UK-wide recruitment drive for participants to get involved in research.

Through our Plan for Change, we're tackling health inequalities head-on, making sure every medical breakthrough works for those who need it most and building an NHS that is truly fit for the future."

- Health Minister, Karin Smyth[2]

Assessing the impact of frailty

Questions for reflection

What is the scale of frailty in your area?

How will this number change in the coming years?

How well does your current service take the complexity of frailty into account?

Assessing the impact of frailty

Questions for reflection

Are any provisions in place to deal with the impact of frailty on families, caregivers, and wider communities?

How well does your service currently manage frailty? Are there any specific gaps you, your colleagues, or users of your service have identified?

How would you rate your current understanding and awareness of frailty?

Assessing the impact of frailty

Questions for reflection

Do you feel confident in the selection and use of frailty assessment tools?

How is a patient’s frailty status communicated with you and your colleagues?

Have you identified any gaps in frailty assessment, pathways, training, or communication?

Module 2:
ASSESSMENT OF FRAILTY

Why is the assessment of frailty important in cancer care?

Who should be involved in frailty assessment?

What tools should be used?

- Performance measures
- Initial frailty assessments
- Comprehensive Geriatric Assessment
- Specific domain tools

When should frailty assessment take place?

Gap analysis

Frailty status is a better predictor of treatment outcomes and adverse events in older people with cancer than age[1]

Assessing frailty is an essential step in addressing the care of an older person with cancer[2]

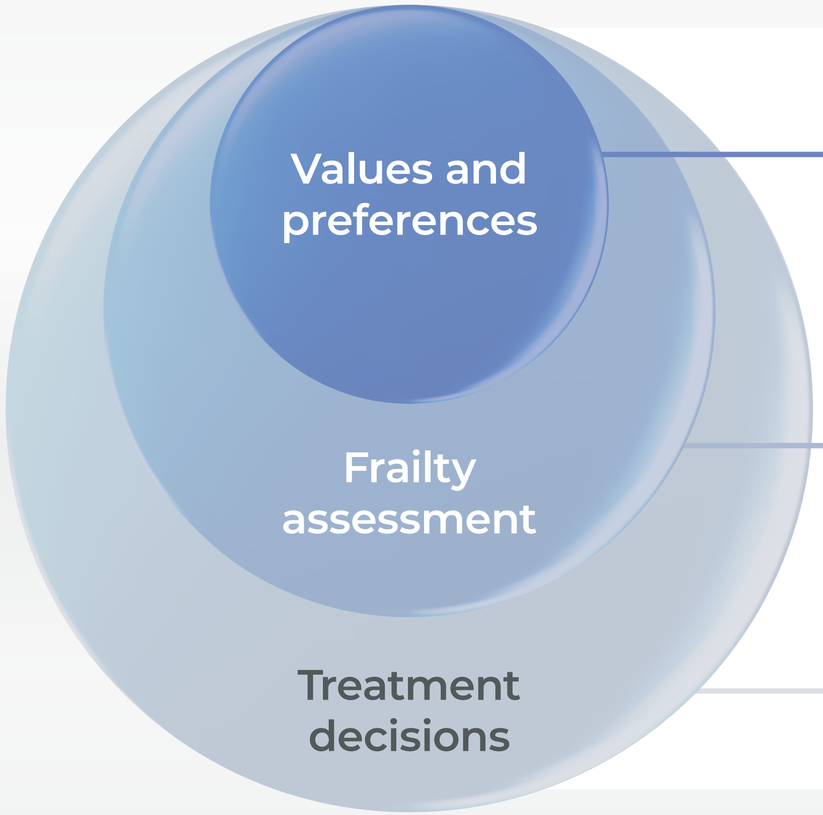
In a retrospective cohort study:[1]



*Defined as completing all planned baseline cycles of systemic therapy without significant dose modification.

A retrospective cohort study in a major metropolitan outpatient oncology service. Participants were adults aged over 65 years with a solid malignancy who had been referred for consideration of systemic therapy, who had completed a baseline frailty assessment between January 2019 and July 2021.[1]

Each older person's needs must be at the centre of any frailty assessment to avoid age discrimination[1]



Older people with cancer may be less willing to sacrifice quality of life in exchange for quantity compared with younger people[2]

Discussing values and preferences can help determine treatment benefits, unacceptable harms, and net benefit/harms[2]

Supports the optimal care of older people with cancer by:[3]

- Helping to assess the appropriateness of diagnostic investigations
- Gauging the potential risks and benefits of cancer treatment and informing shared decision-making with patients
- Allowing identification and optimisation of frailty-related issues, which have potential to improve symptoms, quality of life and tolerance of cancer treatments

Should be personalised based on preferences, frailty status, cancer type, and stage[1]

As well as benefitting patients and their families, frailty-informed care can also potentially benefit healthcare teams and the wider NHS[1]

With frailty informed care, compared with nonfrailty informed care:



Patient/carer benefits[2]

Improved quality of life

Reduction in loneliness/isolation

Reduction in carer burden

Maintenance of independence



Healthcare team/system benefits[1,2]

Reduced hospital admissions/readmissions

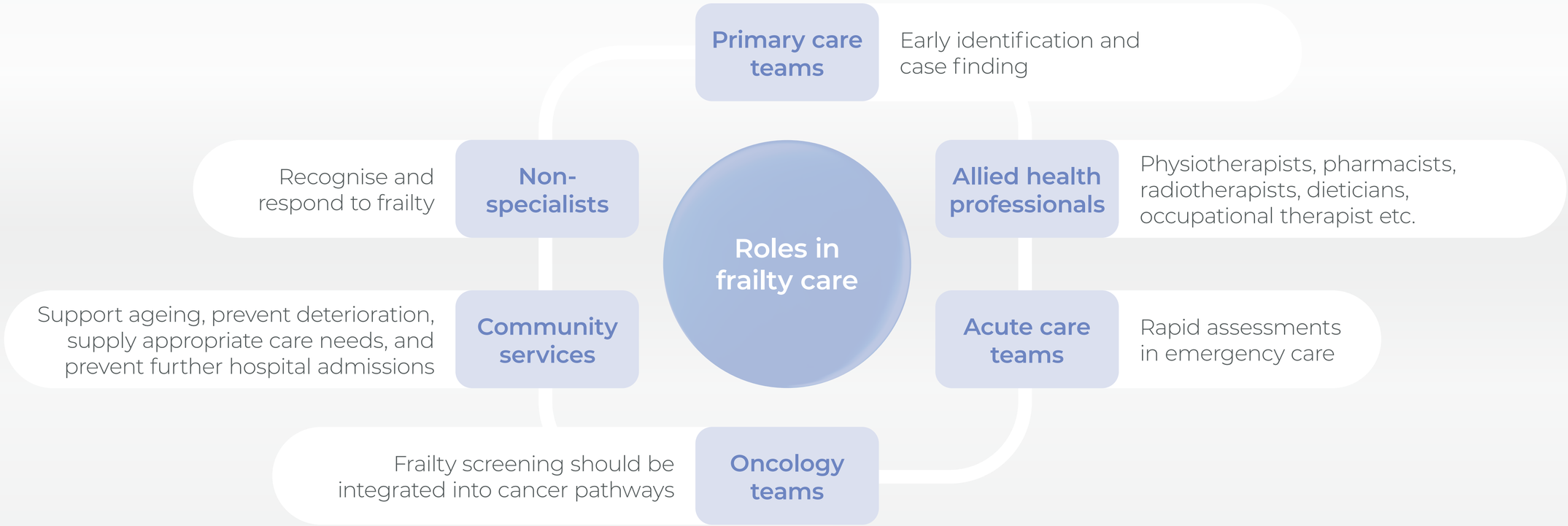
Cost and resource savings

Capacity benefits

Longitudinal studies show that increasing frailty heightens the risk of loneliness.[3] Social isolation is associated with more rapid progression of frailty compared to those who are not socially isolated, perpetuating a vicious cycle.[4]

Frailty assessments may be undertaken and recorded successfully by any appropriately trained member of the healthcare team[1]

Frailty is everyone's business, requiring a multidisciplinary approach across all healthcare settings[1]



The most appropriate person may vary both between individual units and at different points on the pathway.[1]
These roles are suggestions only.

Staff at all levels of cancer care should be involved in frailty assessments[1]

3 Specialist services

Assessment + optimisation with a dedicated oncogeriatric team + MDT[1]

WHO: Large centres with a dedicated MDT or service.[1]

WHAT: Comprehensive Geriatric Assessment, advanced supportive, rehabilitative and palliative approaches including advance care planning. Complex decision-making.

2 Targeted services

Routine assessment within existing cancer care pathways, with onward referral when necessary[1]

WHO: Small centres without a dedicated oncogeriatric service/new services in development.[1]

WHAT: Focussed assessment and intervention (covering domains of frailty). Prehabilitation and rehabilitation.

1 Universal services

Frailty informed day-to-day practice[1]

WHO: All individuals caring for older people with cancer.[1]

WHAT: Frailty screening, addressing what matters to each person, mobility, mentation, medication, staff training, and creating an accessible environment.

MDT: Multidisciplinary team.

Workforce competencies for tiered geriatric oncology care

Universal services - Tier 1[1,2]

Purpose

- Ensure every older adult receives equitable, age and frailty-aware care
- Recognise when additional support may be needed and escalate appropriately
- Reduce avoidable distress, confusion, safety risks and accessibility barriers
- Supporting individuals to age well

Core competencies

1. Awareness and early identification:
   - What is frailty
   - Frailty screening - benefits
2. Communication and engagement
3. Practical accessibility: walking aids, hearing aids, glasses
4. Creating a supportive environment
5. Ageing well: exercise, nutrition, social activities, smoking cessation, alcohol intake, and well-being
6. Professional boundaries and escalation:
   - Understanding delirium and cognitive decline
   - Understanding signs of deterioration

Workforce competencies for tiered geriatric oncology care

Targeted services - Tier 2[1,2]

Purpose

- Identify and respond to early or emerging frailty-related needs before they become crises
- Provide tailored, proactive interventions that optimise treatment tolerance, safety, function and wellbeing
- Ensure appropriate referral, communication and care coordination across oncology and wider services
- Reduce avoidable hospital admissions, treatment interruption and patient/carer distress

Core competencies

1. Frailty recognition (using validated screening tools)
2. Understanding of domains of frailty, and how they potentially influence one another:
   - Physical frailty including mobility, falls, nutrition, sarcopenia, fatigue, food insecurity
   - Social frailty including social isolation, social support, social activities, social belonging, financial income, social networks
   - Cognitive frailty including cognitive impairment, dementia, risk of delirium
   - Psychological frailty including mood and anxiety
3. Targeted profession-specific assessment such as mobility, ADLS, fatigue, psychological and social needs, medication safety, cognition, nutrition
4. Tailored interventions such as exercise, nutrition, social support, including referral onto community services - befriending, social prescribing, local groups
5. Communication and decision-making, including shared decision-making
6. Care coordination/navigations
7. Monitoring and escalating
8. Person-centred and strength-based practice (seeing the person – not just the cancer)

ADL: Activities of daily living.

Workforce competencies for tiered geriatric oncology care

Specialist services - Tier 3[1,2]

Purpose

- Identify and respond to early or emerging frailty-related needs before they become crises
- Provide tailored, proactive interventions that optimise treatment tolerance, safety, function and wellbeing
- Ensure appropriate referral, communication and care coordination across oncology and wider services
- Reduce avoidable hospital admissions, treatment interruption and patient/carer distress

Core competencies

1. Comprehensive Geriatric Assessment
2. Complex decision-making
3. Management of multimorbidity and polypharmacy
4. Capacity, communication and ethical practice – including safeguarding.
5. Multidisciplinary coordination and system leadership
6. Advanced supportive, rehabilitation and palliative approaches – includes advance care planning
7. Escalation, safety and risk management – rapid recognition and timely response when a patient deteriorates e.g. delirium and treatment toxicity

Allied health professionals, nurses and pharmacists play essential and complementary roles in recognising, assessing, and addressing frailty in older people with cancer[1]

AHPs work across settings



And have significant impact on people with cancer in many areas including[1]

- Quality of life
- Physical fitness and mobility
- Wellbeing and mental health
- Fatigue
- Communication
- Swallowing
- Nutrition
- Function
- Pain
- Incontinence

The importance of AHP roles in cancer care was outlined in the recent National Cancer Plan for England:[2]

The National Cancer Plan for England (2026)[2]

- Primary clinical drivers of the "Universal Prehab" Mandate
- Leading the shift towards community care
- Delivering personalised care plans
- Empowering through self-management
- Driving workforce productivity

AHP: Allied health professional.

Your current practice (1/7)

Questions for reflection for AHPs, pharmacists and nurses

Understanding and role clarity

0 = Not at all | 10 = Very

How confident are you in recognising early and established frailty in older people with cancer?

0 1 2 3 4 5 6 7 8 9 10

How clearly is your professional role understood within the MDT?

0 1 2 3 4 5 6 7 8 9 10

Do you feel that your assessments and recommendations are routinely valued and integrated into MDT discussions and treatment planning?

Yes No Notes:

AHP: Allied health professional, MDT: Multidisciplinary team.

Your current practice (2/7)

Questions for reflection for AHPs, pharmacists and nurses

Assessment and intervention

Which frailty-related domains do you routinely assess within your scope of practice?

E.g. Nurses: functional decline, cognition, symptom burden, treatment tolerance. Pharmacists: polypharmacy, potentially inappropriate medicines, adherence, treatment interactions. AHPs: mobility, nutrition, communication, activities of daily living, falls risk

Are validated tools available and embedded into routine practice to support your assessments?

How often do you identify potentially reversible frailty-related issues? Are you able to intervene or escalate concerns in a timely fashion?

AHP: Allied health professional, MDT: Multidisciplinary team.

Your current practice (3/7)

Questions for reflection for AHPs, pharmacists and nurses

Communication and continuity

How effectively are your findings communicated to the wider MDT and across care settings?

Are care plans reviewed and adapted as a person's frailty status or cancer treatment changes?

Do you feel empowered to advocate for treatment modification, supportive interventions, or referral when frailty impacts a person's safety, quality of life, or treatment tolerance?

AHP: Allied health professional, MDT: Multidisciplinary team.

Your current practice (4/7)

Questions for reflection for AHPs, pharmacists and nurses

Service and system factors

Does your service enable early involvement of nurses, pharmacists, and AHPs in the cancer pathway?
Including pre-treatment, treatment, and survivorship

Are there clear referral and escalation pathways for identified frailty-related concerns?

Are there any limitations on your ability to deliver proactive frailty-informed care?
E.g. lack of training, workforce, time constraints, digital systems

Are particular patient groups less likely to benefit from multidisciplinary frailty assessment and intervention?
E.g. those with cognitive impairment, sensory loss, language barriers, or social vulnerability

AHP: Allied health professional, MDT: Multidisciplinary team.

Your current practice (5/7)

Questions for reflection for AHPs, pharmacists and nurses

Action plan (Practice Level: Individual)

Based on your reflections in the previous questions, what actions could be taken on an individual, team, or system level?

Suggested action	Notes
Embed routine consideration of frailty into everyday clinical assessments and reviews	
Use professional expertise to identify and address modifiable frailty-related issues e.g. medicines optimisation, nutrition support, mobility and function, symptom management	
Contribute actively to shared decision-making by bringing a frailty-informed perspective to discussions with patients, families, and MDT colleagues	

AHP: Allied health professional, MDT: Multidisciplinary team.

Your current practice (6/7)

Questions for reflection for AHPs, pharmacists and nurses

Action plan (Practice Level: Team/service)

Based on your reflections in the previous questions, what actions could be taken on an individual, team, or system level?

Suggested action	Notes
Promote earlier and more consistent involvement of nurses, pharmacists, and AHPs in cancer pathways	
Support MDT processes that integrate functional, medicines, and supportive care assessments into treatment decisions	
Contribute to education and training initiatives to improve frailty awareness and skills across the workforce	

AHP: Allied health professional, MDT: Multidisciplinary team.

Your current practice (7/7)

Questions for reflection for AHPs, pharmacists and nurses

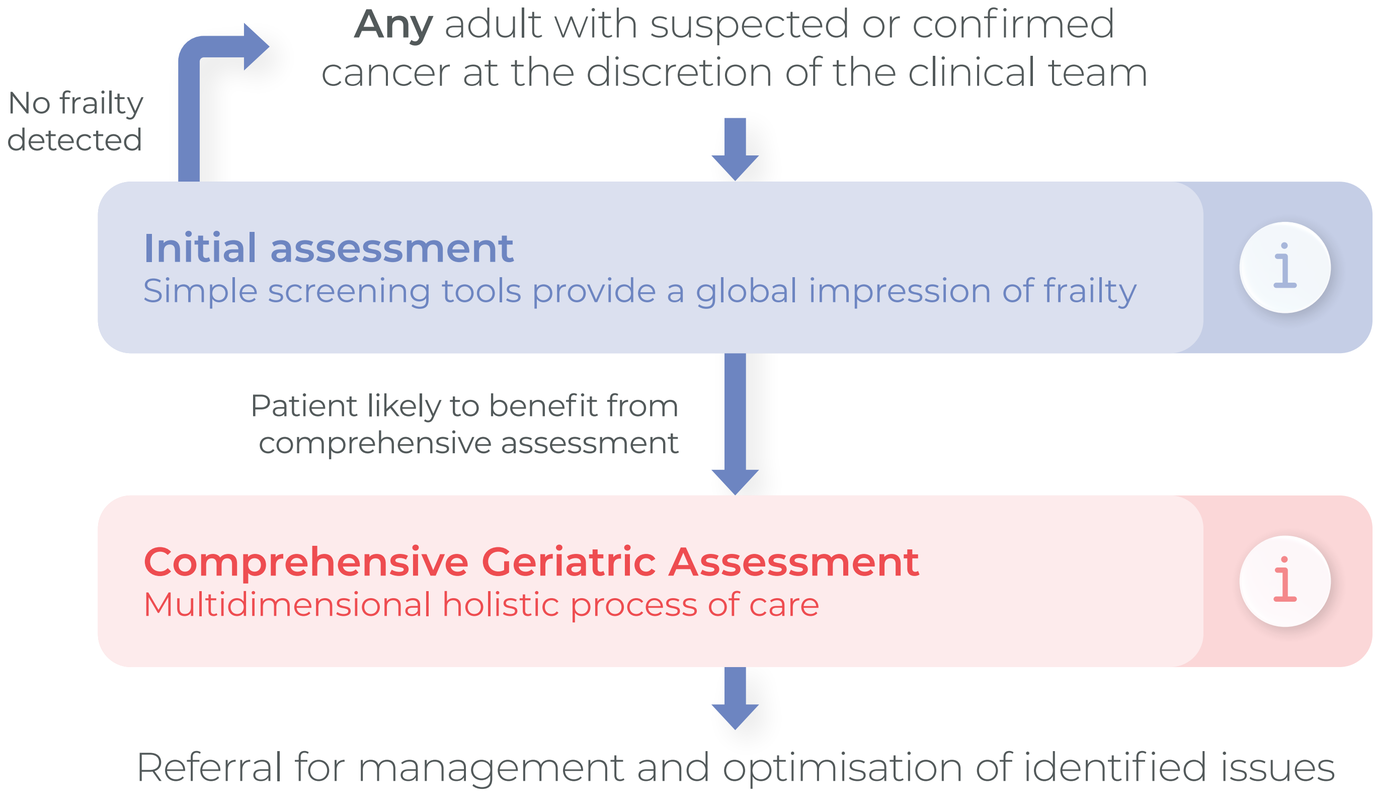
Action plan (Practice Level: System)

Based on your reflections in the previous questions, what actions could be taken on an individual, team, or system level?

Suggested action	Notes
Advocate for clear documentation and visibility of multidisciplinary frailty assessments within shared records	
Engage in service development, audit, or quality improvement initiatives focused on frailty-informed cancer care	
Support the development of advanced, specialist, or extended roles in geriatric oncology across nursing, pharmacy, and AHP professions	

AHP: Allied health professional, MDT: Multidisciplinary team.

A 2-step approach to frailty assessment is recommended in cancer care[1]



Selecting the right assessment tools is an important aspect of frailty recognition and assessment[1]

Performance measures

Assesses functional limitations but may miss several frailty domains[1]

Initial frailty assessment tools

Quick and simple to administer. Can determine who would benefit from comprehensive geriatric assessment[1]

Comprehensive Geriatric Assessment

Requires specialist training and can take several hours to administer[1]

Specific domain tools

Useful where specific issues have been identified

Risk stratification, particularly when clinical suspicion of frailty is low[2]

Individualised care planning and management

Reflection: Use of initial frailty assessment tools in your service (1/2)

Initial assessment tools

Which frailty assessment tools are currently used in your service? *Select all that apply*

- ☐ *Clinical frailty scale*
- ☐ *CRANE*
- ☐ *G8*
- ☐ *VES-13*
- ☐ *SAOP3*
- ☐ *Automated tools*

Who typically conducts the frailty assessments?

Select all that apply

- ☐ *Oncologist*
- ☐ *Allied Health Professional (e.g., physiotherapist, occupational therapist)*
- ☐ *Geriatrician*
- ☐ *Specialist Nurse*

Suitability of current tools

Do the current tools support shared decision-making and treatment planning?

- ☐ *Yes*
- ☐ *No*
- ☐ *Partially*

Have you identified any challenges or limitations with the current tools?

Please describe:

Reflection: Use of initial frailty assessment tools in your service (2/2)

Potential opportunities for change

Are there any additional frailty assessment tools you believe should be considered?

Could digital or automated tools improve frailty assessment in your setting?

- [ ] *Yes*
- [ ] *No*
- [ ] *Not sure*

What resources would be required to implement digital tools? *(if applicable)*

Frailty screening tool checklist

A tool to help select the appropriate tool for each assessment

Area of work:

Appointment length:

Approximate time available to administer tool:

Available MDT members:

What purpose are you testing for?

- ☐ *Frailty identification*
- ☐ *Determine need for CGA*
- ☐ *Guide rehabilitation intensity and goals*
- ☐ *Trigger MDT referral*
- ☐ *Identify areas, such as nutrition, cognition, mobility, that require follow up*
- ☐ *Support shared decision-making*

Which tools are available?

	Yes	*No*
Is the tool validated and reasonably accurate?	☐	☐
Is the tool simple to perform?	☐	☐
Does the tool confer greater benefits than the risks of undertaking the test?	☐	☐
Is there a treatment or intervention that can be offered as a result of using the tool which will affect outcomes?	☐	☐
Is the condition being screened for likely to be important to well-being?	☐	☐
Is there a frailty treatment plan in place if concerns are identified during screening?	☐	☐

Based on Burberry D. 2024. Available at: https://cpoc.org.uk/sites/cpoc/files/documents/2024-06/CPOC%20Leads%20event%202024%20-%20David%20Burberry.pdf. Access date: May 2026.

CGA: Comprehensive Geriatric Assessment, MDT: Multidisciplinary team.

The ECOG Performance Status Scale (ECOG-PS) is the primary tool for evaluating functional ability in oncology[1,2]

Its use in assessing frailty is limited[3]

ECOG-PS measures functional limitations, i.e. how a disease **impacts a person's daily living abilities.**[2]

It can be used to **guide treatment decisions** and as a prognostic indicator.[4]

Benefits	Disadvantages
• Simple[4] • Widely used in daily clinical practice[4] • Considered easy to remember by clinicians[4] • No significant variation[4]	• Subjective[1] • Particularly prone to bias in older people[1] • Limited ability to respond to changes in condition[1] • Limited ability to account for multimorbidity, frailty, and cognition[1] • Limited granularity[3]

ECOG Performance Status Scale[2]

0 — Fully active
Able to carry on all pre-disease performance without restriction

1 — Restricted in physically strenuous activity
But ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work

2 — Ambulatory
and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours

3 — Capable of only limited self-care
Confined to bed or chair more than 50% of waking hours

4 — Completely disabled
Cannot carry out any selfcare; totally confined to bed or chair

5 — Dead

ECOG-PS: Eastern Cooperative Oncology Group Performance Status Scale.

The Rockwood Clinical Frailty Scale can indicate prognosis and care requirements in older people with cancer[1]

CFS is a global frailty assessment tool that **assesses the person's illnesses, function and cognition** to generate a frailty score[2,3]

Benefits

- Simple[1]
- Predicts in-hospital mortality, nursing home placement, and length of hospital stay in older people[1]
- Easily incorporated into consultations[3]
- Widely adopted in the NHS[3]
- Category 9 may be contentious in oncology and palliative care[1]

Disadvantages

- Limited evidence for use in oncology[1]
- Mostly focuses on function, lacks assessment of cognitive function, mood and nutrition[3]
- May be subjective[3]



1. VERY FIT

People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.



2. FIT

People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g., seasonally.



3. MANAGING WELL

People whose **medical problems are well controlled**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.



4. LIVING WITH VERY MILD FRAILTY

While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up" and/or being tired during the day.



5. LIVING WITH MILD FRAILTY

People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living**.

CFS: Clinical Frailty Scale.

The Geriatric-8 (G8) questionnaire identifies older people with cancer likely to benefit from a full geriatric assessment[1]

The G8 tool is an easily accessible geriatric screening tool which covers **nutritional status, weight loss, body mass index, motor skills, psychological status, number of medications, self-perception of health, and age**[2]

Benefits	Disadvantages
• Simple and quick to complete[2] • Available as self-report option[1] • Useful across diverse cancer types[2] • Assesses frailty domains beyond functioning[1]	• Inconsistent evidence of ability to predict cancer outcomes[2] • Use is limited to screening

G8 Scale[1]



CGA: Comprehensive Geriatric Assessment, G8: Geriatric-8.

The Senior Adult Oncology Programme 3 (SAOP3) tool is a validated multi-domain assessment which detects vulnerabilities requiring specific referrals[1]

SAOP3 is a comprehensive, validated, mostly self-reported tool which identifies **people who require a full CGA**[1,2]

Benefits	Disadvantages
• Assesses frailty domains beyond functioning[1] • Directs referrals to individual professions[1] • Simple and quick to complete[1] • Useful for busy oncology clinic settings[1] • Incorporates clinician-assessed cognition[1] • Validated in oncology[2]	• Not designed to predict prognosis[2] • Requires access to a dedicated geriatric oncology team for assessment[2]

Domains assessed include:

- Activities of daily living
- Cognition
- Nutrition
- Psychosocial aspects
- Quality of life

Outputs indicate which healthcare professional referral is required, including:

- Outpatient physical therapy
- Physiotherapy
- Occupational therapy
- Outpatient nutrition
- Behavioural medicine
- Social work
- Speech and language pathologist
- Neurology
- Pharmacy
- Patient financial services

CGA: Comprehensive Geriatric Assessment, SAOP3: Senior Adult Oncology Programme 3.

The Comprehensive Risk Assessment and Needs Evaluation (CRANE) tool is a multi-domain assessment which highlights issues requiring action[1]

CRANE allows people to self-assess their **physical health, social wellbeing, psychological, practical, and environmental needs**[1]

Benefits

- Self-reported[1]
- Developed by the Geriatric Oncology Liaison Development service at Guys and St Thomas' NHS FT
- Can be used to assess urgency in waiting lists[2]
- Often used in conjunction with CFS

Disadvantages

- Not formally validated yet[1]

CFS: Clinical Frailty Scale, CRANE: Comprehensive Risk Assessment and Needs Evaluation.

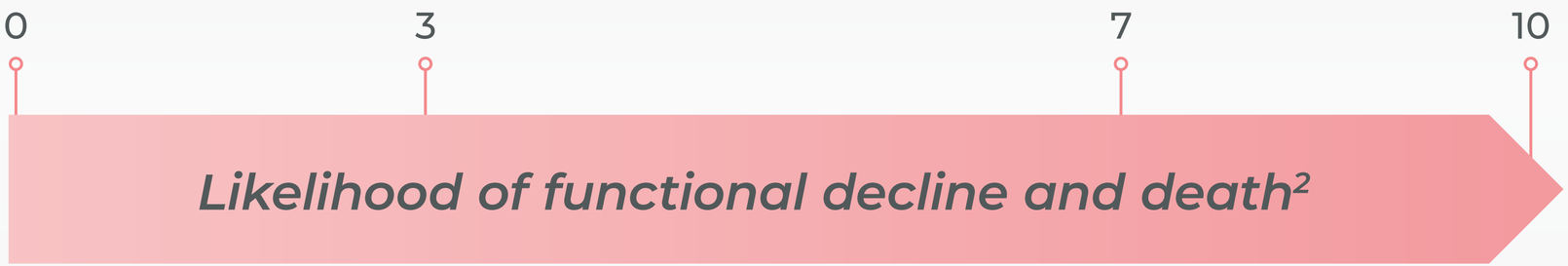
The Vulnerable Elders Survey-13 (VES-13) screens people for frailty and vulnerability[1,2]

VES-13 is a screening tool for vulnerability in older adults that assesses **age, self-rated health, physical function, and functional limitations** to identify those at increased risk of health deterioration[1,2]

Benefits	Disadvantages
• Can be completed prior to an appointment[1] • Extensively validated in cancer settings[1] • Simple[3]	• Some people require support to complete the tool[1] • Not designed specifically for oncology settings

A score of 3 or more indicates a vulnerable individual[3]

A score of 7 or more is associated with high risk of functional decline and death, as well as lower likelihood of completing radiotherapy treatment[2]



VES-13: Vulnerable Elders Survey-13.

A Comprehensive Geriatric Assessment is the gold standard for optimising frailty in older adults[1]

CGA is a multi-step process of care:[2]

1. A multidimensional holistic assessment of an older person which considers health and wellbeing
2. Formulation of a plan to address issues which are of concern to the older person (and their family and carers when relevant). Interventions are then arranged in support of the plan
3. Progress is reviewed and the original plan reassessed at appropriate intervals with the interventions reconsidered accordingly

Assessment + **Management**

A CGA includes both **assessment and management** of issues across several domains[1]



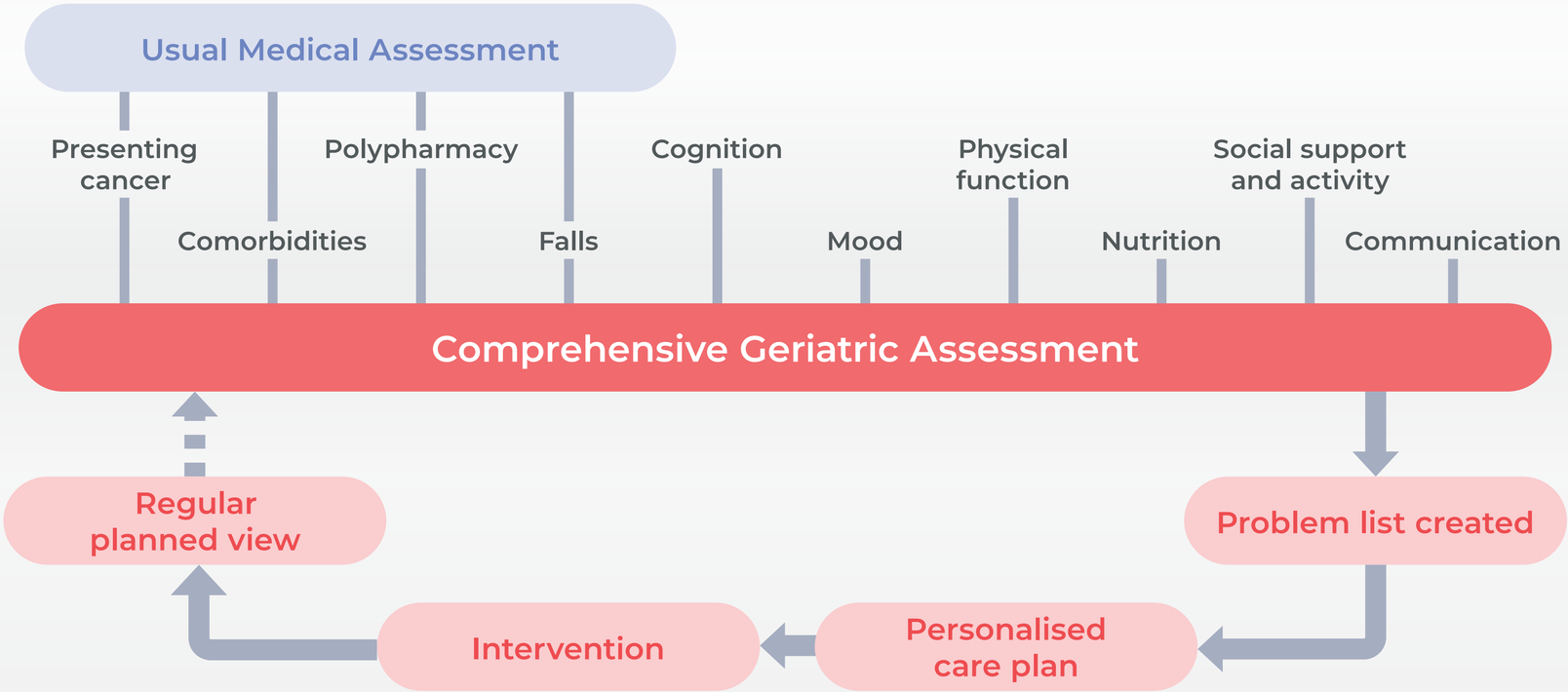
Generally performed by **specialist geriatric teams**[1]

GPs or other HCPs may co-ordinate the assessment[2]

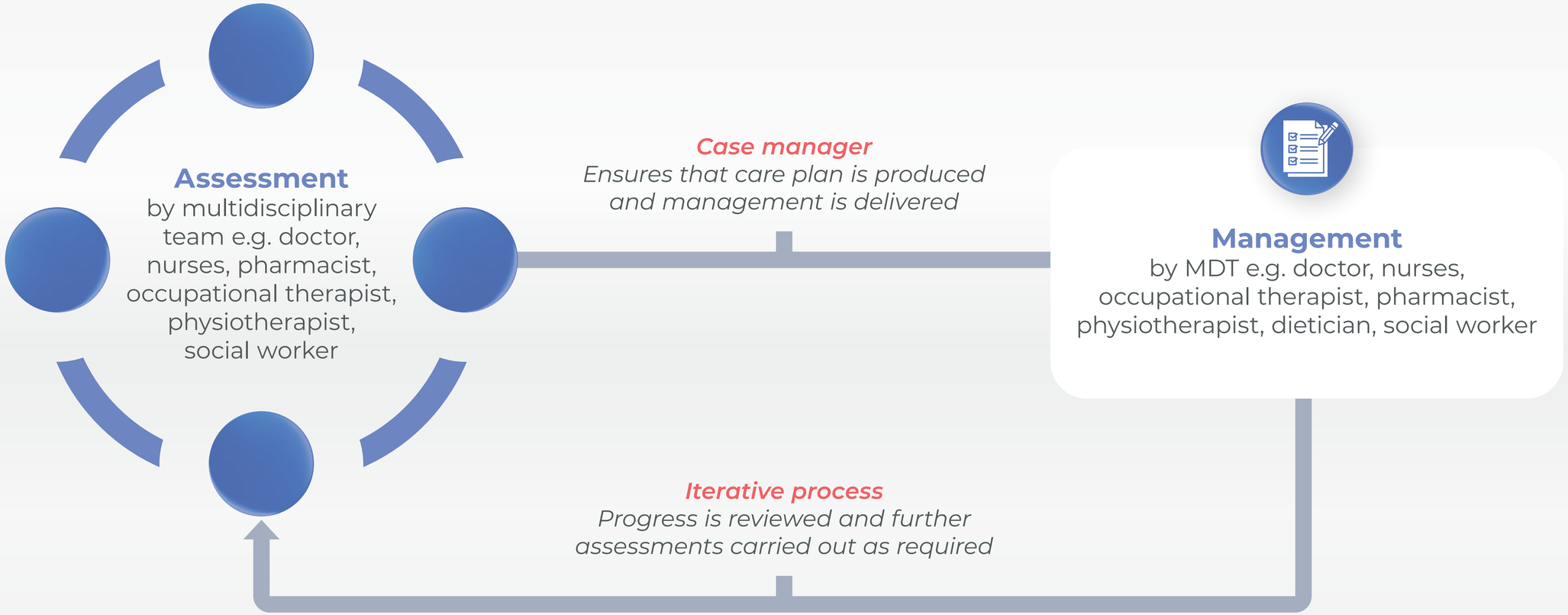
CGA: Comprehensive Geriatric Assessment, GP: General practitioner, HCP: Healthcare professional.

A Comprehensive Geriatric Assessment includes wider domains than a usual medical assessment[1-3]

Identification and optimisation of frailty-related issues should be a core element of holistic oncological care. Changes that can be made to optimise reversible frailty-related issues include reviewing medicines, improving nutrition and managing anaemia.[1]



CGA is an iterative, multidisciplinary process used to manage frail or vulnerable older people*[1]



CGA: Comprehensive Geriatric Assessment, MDT: Multidisciplinary team.

*While frailty is defined as a distinct medical syndrome, 'vulnerability' recognises the wider determinants that may affect cancer treatment tolerance and outcomes, such as functional, cognitive and social factors.

Assessment of capacity should be a routine part of frailty care and part of a CGA[1]

Assessment of mental capacity

Advance care planning

Previous wishes and feelings may be established by:

- An Advance Statement (legally binding)
- The views of a legal proxy with powers appropriate to the decision in question (legally binding)
- Verbal statements made by the person before capacity was lost

Avoiding assumptions

Just because a person is ill, advanced in years or has frailty, it does not automatically follow that they lack capacity. Capacity is assumed to be present until shown otherwise.[1]

Deprivation of liberty safeguards

People who lack capacity should only be deprived of their liberty when it is in their best interest, and in the least restrictive way possible.[1]

Capacity testing

Two stages:[1]

- The person cannot make a decision due to 'a condition of mind or brain.' In older people this is most often dementia or delirium
- The person cannot understand, retain, weigh up, or communicate information relevant to the decision in question

Both parts of the test must be satisfied to state that capacity is lacking.

Powers of attorney

A person with capacity (the donor) may appoint another person (the attorney) to make decisions on their behalf when they lose capacity.[1]

Relevant legislation

England & Wales:
The Mental Capacity Act 2005

Scotland:
Adults with Incapacity (Scotland) Act 2000

Northern Ireland:
Mental Capacity Act[1,2]

CGA: Comprehensive Geriatric Assessment.

Advance care planning has the potential to prevent people receiving care and interventions that may be of low value[1]

Advance care planning seeks to help individuals articulate their preferences and priorities for care in the face of an uncertain future[1]

Current approaches to advance care planning require some predictability in disease trajectory. This is complicated by the presence of frailty, where any plans must necessarily be adaptable to future changes in circumstance[1]

Recognising this uncertainty, and understanding what matters to each person, is key to advance care planning discussions

Universal principles for advance care planning[2]

- The person is central to developing and agreeing their advance care plan including deciding who else should be involved in the process
- The person has personalised conversations about their future care focused on what matters to them and their needs
- The person agrees the outcomes of their advance care planning conversation through a shared decision-making process in partnership with relevant professionals
- The person has a shareable advance care plan which records what matters to them, and their preferences and decisions about future care and treatment
- The person has the opportunity, and is encouraged, to review and revise their advance care plan
- Anyone involved in advance care planning is able to speak up if they feel that these universal principles are not being followed

REF

CGA pathway self-assessment (1/2)

Are CGAs currently used within your service?

- [ ] *Yes*
- [ ] *No*

When are CGAs typically initiated in your service?

- [ ] *Diagnosis*
- [ ] *During treatment*
- [ ] *Pre-treatment*
- [ ] *Post-treatment*

Is there a designated lead or team responsible for CGA delivery?

- [ ] *Yes*
- [ ] *No*

Which professionals are involved in CGA delivery?

Select all that apply

- [ ] *Geriatrician*
- [ ] *Physiotherapist*
- [ ] *Oncology nurse*
- [ ] *Occupational therapist*
- [ ] *Pharmacist*
- [ ] *Social worker*

Are CGA findings used to inform cancer treatment decisions?

- [ ] *Yes*
- [ ] *No*
- [ ] *Some of the time*

Is there a process for MDT discussion of CGA results?

- [ ] *Yes*
- [ ] *No*
- [ ] *Some of the time*

Are CGA outcomes documented in a shared electronic record?

- [ ] *Yes*
- [ ] *No*
- [ ] *Some of the time*

Is there a mechanism for follow-up or reassessment post-treatment?

- [ ] *Yes*
- [ ] *No*
- [ ] *Some of the time*

CGA: Comprehensive Geriatric Assessment, MDT: Multidisciplinary team.

CGA pathway self-assessment (2/2)

Do staff involved in CGA receive specific training in geriatric oncology?

☐ *Yes* ☐ *No* ☐ *Some of the time*

Are there sufficient resources (time, staff, tools) to deliver CGA effectively?

☐ *Yes* ☐ *No* ☐ *Some of the time*

Do any barriers exist to delivering CGA in your service?

Identified priority areas for improvement

What aspects of CGA delivery work well in your service?

Do any areas need improvement?

Are there patient groups who may be underserved by current CGA processes?

☐ *Yes* ☐ *No*

What support or resources would help improve CGA delivery?

CGA: Comprehensive Geriatric Assessment, MDT: Multidisciplinary team.

Activities of Daily Living (ADL) scales assess independent living skills to identify functioning[1]

ADLs can be classified into basic skills required to manage basic physical needs or instrumental ADLs, which include more complex activities related to independent living.[2] Objective rating scales are available for the assessment of both.[1,3]

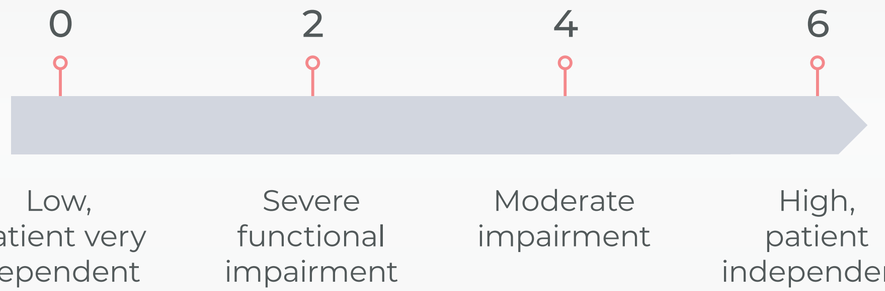
Benefits

- Easy to administer[1]
- Choice of instruments for basic or complex activities of daily living[1]
- Suitable for community or hospital settings[1]
- Creates a common language for practitioners to describe function[3]

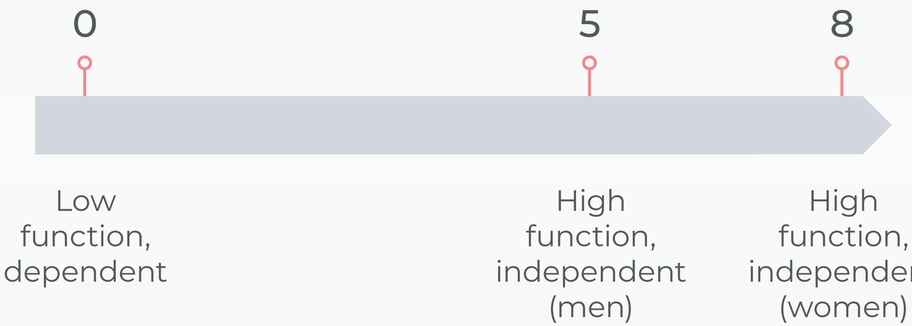
Disadvantages

- Relies on self-reporting[1]
- Prone to under or overestimation[1]
- Not sensitive to small, incremental changes in function[1]
- Assumes traditional gender roles and requires adjustment according to gender[1]
- Culturally biased[4]

Katz Index of Independence in Activities of Daily Living:[3]



Lawton Instrumental Activities of Daily Living scale:[1]



ADL: Activities of Daily Living.

The Charlson Comorbidity Index predicts risk of death within 1 year of hospitalisation in people with specific comorbid conditions[1]

The Charlson Comorbidity Index is a weighted score which considers the number and seriousness of comorbid conditions to better understand cancer outcomes.[1]

Benefits

- Predictor of hospital mortality
- Also effective at predicting post-operative complications, prolonged ICU stay, and extended hospital stays
- Validated
- Simple to administer

Disadvantages

- Limited to specific conditions

Included comorbid conditions:

- Myocardial infarction
- Congestive heart failure
- Peripheral vascular disease
- Cerebrovascular disease
- Dementia
- Mild-to-moderate or severe chronic lung disease
- Rheumatologic disease
- Peptic ulcer disease
- Liver disease
- Diabetes mellitus with or without chronic complications
- Hemiplegia
- Renal disease
- Metastatic or non-metastatic malignancy
- Leukaemia
- Lymphoma
- AIDS

Results categories:[2]

0 points	1-2 points	3-4 points	≥5 points
No comorbidities	Mild	Moderate	Severe

AIDS: Acquired Immune Deficiency Syndrome, ICU: Intensive care unit.

Screening Tool of Older Persons' Prescriptions (STOPP) and Screening Tool to Alert to Right Treatment (START) criteria facilitate medication review in older people with multiple diseases[1]

STOPP/START was explicitly designed for use in clinical settings with input from various healthcare and geriatric specialists, enabling a person-centred approach when reviewing and prescribing medicines.[1]

Benefits	Disadvantages
• Applies to most clinical settings • May be quick to administer	• Requires some prescribing or medicines expertise

Within each included physiological system, there are 80 STOPP and 34 START criteria accompanied by a short explanation:

STOPP Medication to consider *stopping* in people over 65

START Medication to consider *starting* in people over 65

INFO NICE guidelines or other supporting/useful information

START: Screening Tool to Alert to Right Treatment, STOPP: Screening Tool of Older Persons' Prescriptions.

The Anticholinergic Cognitive Burden scale assesses the cumulative burden of anticholinergic medicines[1]

The scale considers each person's cumulative risk by adding up each of the medicines being taken, including those prescribed for purposes other than anticholinergic properties.[1,2]

Benefits	Disadvantages
• Validated[1] • Aids medicines reviews[1] • Compiled using literature review, in vitro data, and consensus agreement[3]	• Lack of standardisation[3] • Requires ongoing updating[3]

The Anticholinergic Cognitive Burden scale scores each medicine as:[3]

- **0** — *No* anticholinergic activity
- **1** — *Low* anticholinergic activity
- **2** — *Moderate* anticholinergic activity
- **3** — *High* anticholinergic activity

A SCORE OF ≥3
IS SIGNIFICANT
+ risks are thought to increase further with higher scores[2]

REF

The Timed Up & Go test is widely used to measure a person's functional mobility, including fall risk[1]

Measures dynamic balance and functional mobility in older adults.[2] The person is timed getting up from a chair without using their arms, walking 3 metres, turning around, returning to the chair, and sitting down.[3]

Benefits

- Simple to administer[2]
- Takes only a short time to perform[2]
- Walking aids can be used during the test[1]

Disadvantages

- High test-retest user error risks[2]
- Turning assessed only in the person's preferred direction[2]

For people aged between 65 and 99:[3]



+ Clinical judgement:

In addition to the time taken, also consider other factors, such as the age of the person, the type of footwear, the use of a walking aid, and the general health of the person

REF

Mini-Cog® screens for cognitive impairment in older adults[1]

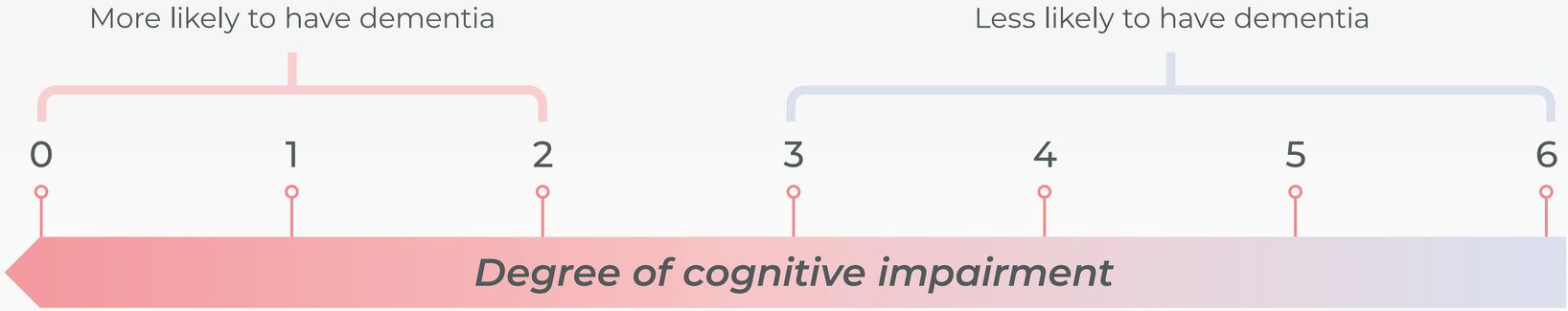
Measures a person's ability to recall three words and accurately draw a clock from memory.[1]

Benefits

- Highly user friendly[1]
- Quick to administer[1]
- Healthcare provider administered[1]

Disadvantages

- Not a diagnostic test for dementia or any cause of cognitive impairment[1]

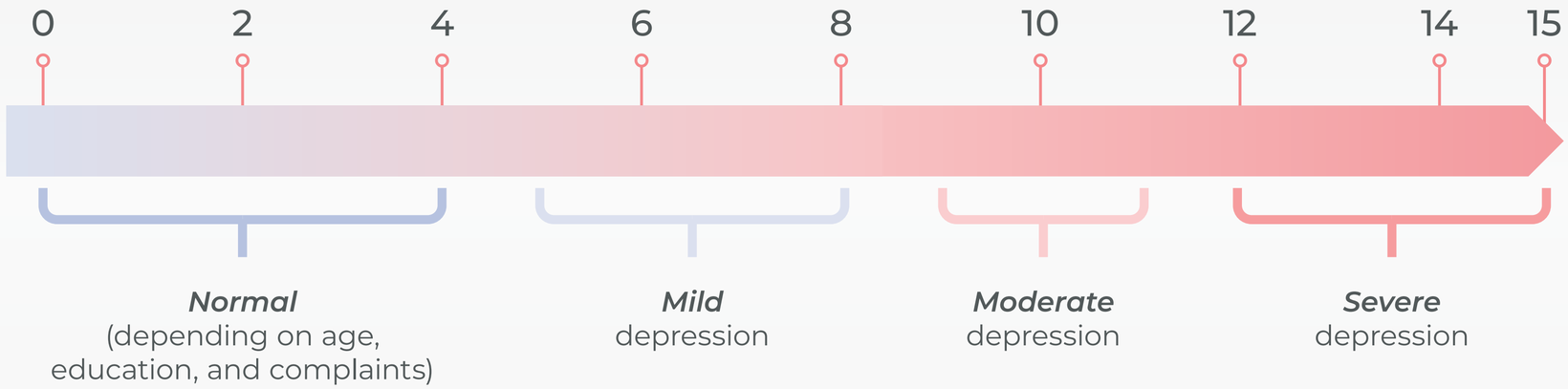


The Geriatric Depression Scale (GDS) screens for depressive symptoms in older adults[1]

The GDS is a multidimensional, multidisciplinary diagnostic and therapeutic activity that helps identify people at risk of/with depression.[1]

Benefits	Disadvantages
• Validated and extensively used in older population[2] • Available in long- and short-form varieties[2] • Reliable[2] • Simple to administer[2]	• Does not assess suicidality[2] • Not a substitute for a diagnostic interview[2]

Short-form (15) version:[2]



GDS: Geriatric Depression Scale.

The Medical Outcomes Study (MOS) Social Support Survey measures the availability of support to people with chronic illness across several domains[1]

The MOS Social Support Survey was originally developed for use in the Medical Outcomes Study. It consists of four subscales and one overall summary index.[1]

Benefits

- Simple to administer[1,2]
- Validated[2]
- Available in multiple languages and suitable for various cultures[2]

Disadvantages

- May be inconsistent across different populations

Comprises of:[1]

- Emotional/informational support
- Tangible support
- Affectionate support
- Positive social interactions

+
Summary score

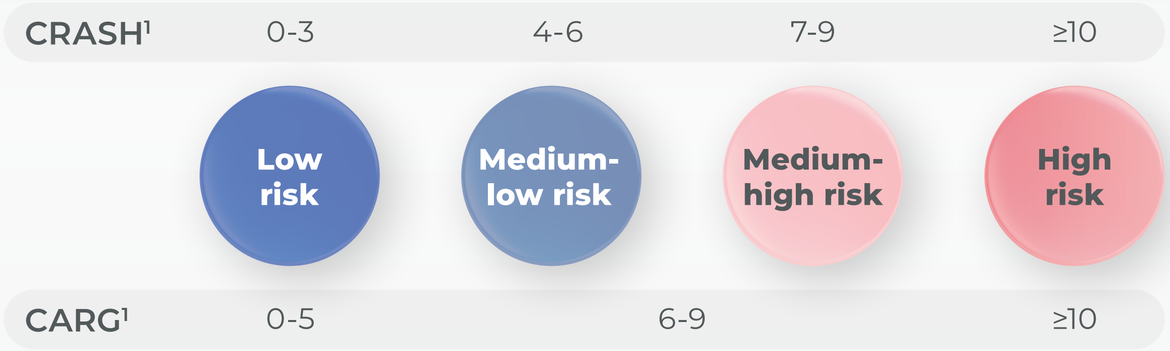
MOS: Medical Outcomes Study.

The Cancer Aging Research Group (CARG) and Chemotherapy Risk Assessment Scale for High-Age Patients (CRASH) scores help to predict the risks of chemotherapy toxicity in geriatric oncology[1]

CARG score was established from a study of 500 people aged ≥65 years.

CRASH was developed as an evaluation tool for predicting adverse reactions to chemotherapy in older people with cancer.[1]

Benefits	Disadvantages
• Easy to use[1] • Validated (CARG)[1] • Useful to guide decision-making[1]	• CARG is less comprehensive than CRASH[1] • CRASH can be time-consuming • Inconsistent validation[1] • Not validated for use in immunotherapy and targeted treatments[1]



CARG: Cancer Aging Research Group, CRASH: Chemotherapy Risk Assessment Scale for High-Age Patients.

The SARC-F symptom score predicts people with sarcopenia who are at risk of poor functional outcomes[1]

SARC-F assesses strength, ambulation, rising from a chair, stair climbing, and a history of falls to identify potentially sarcopenic people, or those at risk of developing sarcopenia.[1,2]

Benefits

- Requires little training to administer[2]
- Predicts physical performance and muscle strength[2]
- High sensitivity when combined with MRSA 7[2]
- Quick and easy to use

Disadvantages

- Subjective[2]
- Not specific to muscle mass or muscle strength[2]

Components:[2]



Each component can be given a score of 0, 1, or 2.[2]

A score of

>4

= predictive of sarcopenia and poor outcomes[1]

MRSA 7: Mini Sarcopenia Risk Assessment, SARC-F: Strength, Assistance in walking, Rise from a chair, Climb stairs, Falls.

The 4AT assessment tool allows for early and rapid recognition of delirium[1]

4AT measures 4 items and was designed specifically for rapid and sensitive initial assessment of cognitive impairment and delirium in routine clinical use.[2,4]

Benefits

- Quick to administer (~3 mins)[2]
- No special training required[2]
- High sensitivity and specificity[2]
- Accessible for people unable to provide verbal responses[2]
- Validated in various settings[2,3]

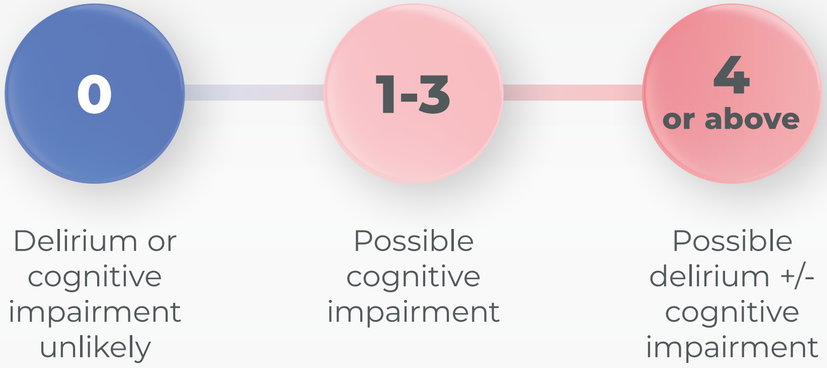
Disadvantages

- May provoke strong emotional reactions in people with dementia or confusion[2]

The 4AT has 4 items, each of which begins with an 'A':[2]

- **A** Alertness
- **A** AMT4: Abbreviated Mental Test -4
- **A** Attention test: Months of the year backwards
- **A** Acute change or fluctuating course

Scoring:[3]



4AT: 4 'A's test.

Frailty assessment should start early in the cancer pathway and be regularly repeated at the beginning of care episodes[1,2]

Every step along the cancer diagnosis and treatment pathway is an opportunity for frailty assessment

Patient with suspected cancer	Initial diagnostic work-up	Multidisciplinary team discussion and referral for initial treatment	Oncology clinic review and treatment planning	Treatment commences with regular review
	likely via two-week wait	e.g. medical or clinical oncology or surgical team	e.g. SACT, radiotherapy or surgery	
	i	i	i	i

i **At any point: patient deterioration or unplanned/acute review**
(e.g. due to cancer/treatment-related complications or other issues)

Frailty assessments undertaken at each stage should inform further assessment, optimisation and goals of care – for example:

Fit/pre-frail: e.g. CFS 1–3 or G8 ‘normal’	Mild frailty: e.g. CFS 4–5, G8 ‘abnormal’	Moderate–severe frailty: e.g. CFS 6+
Care as usual but address reversible issues: sarcopenia (‘prehabilitation’) and nutrition	Actively seek out and manage frailty-related issues e.g. falls, cognitive impairment, continence, polypharmacy Consider specialist geriatric/oncogeriatric input	Think about care versus cure, and advance care planning Consider specialist geriatric/oncogeriatric and/or palliative care input

Table adapted from the Specialised Clinical Frailty Network toolkit. Frailty assessment tool and thresholds for further assessment/referral should be tailored to each setting.
CFS: Clinical Frailty Score, G8: Geriatric-8.

A gap analysis can help identify the differences between current frailty assessments for older people with cancer and the desired future state



A gap analysis is a key step when improving patient services as it helps identify discrepancies between current performance and desired outcomes. It enables healthcare providers to pinpoint specific areas where services fall short, such as missed opportunities for frailty assessment or management



By understanding these gaps, healthcare teams can develop targeted strategies to enhance service quality, improve efficiency, and better meet patient needs. This proactive approach helps in setting measurable goals, allocating resources effectively, and prioritising changes that have the greatest impact on patient care



Ultimately, a gap analysis fosters continuous improvement and ensures that patients receive the best possible service

Gap assessment tool (1/8)

Objective

What are the key goals for frailty assessment in your service or organisation?

Current service overview

When are frailty screening tools or frailty-related factors being assessed across your current pathway?

What staff groups currently undertake frailty assessments, or assess frailty-related factors?

Are all staff currently undertaking frailty assessments appropriately trained?

How are frailty assessments currently documented?

Gap assessment tool (2/8)

Desired state

What does “gold standard” frailty identification and assessment look like in your service or organisation?

What should happen at each step in your pathway to achieve the gold standard?

Do any additional assessments need to be added into the pathway? How should they be documented?

If an assessment identifies that a person requires care escalation or referral, what would the ideal pathway look like?

Gap assessment tool (3/8)

Desired state

What additional resources will be needed to ensure frailty assessments are undertaken at every step of the pathway?

Tip: consider resources such as sites, training, equipment, available rooms etc

How will success in the gold standard pathway be assessed?

Which stakeholders need to be involved?

Gap assessment tool (4/8)

Gap identification

Are there points in your current pathway in which frailty is not being consistently assessed?

How often is frailty screening not available at the time of MDT discussions?

Are CGA appointments readily available without extensive waiting times?

What reasons do you think cause frailty assessments to be missed? E.g. time pressures, lack of staff, training gaps, IT issues, lack of equipment?

CGA: Comprehensive Geriatric Assessment, IT: Information Technology, MDT: Multidisciplinary team.

Gap assessment tool (5/8)

Gap identification

Are there any other gaps that you can identify in:

Resources e.g. training, equipment, staff:

Processes e.g. gaps in the pathway, potential bottlenecks:

Data:

Stakeholder engagement:

Gap assessment tool (6/8)

Objectives

Define your short, medium, and long-term objectives. Prioritise each objective according to urgency and impact:

	Short-term objectives (0-6 months) e.g. process fixes, training etc	Medium-term objectives (6-18 months) e.g. pathway redesign	Long-term objectives (18+ months) e.g. digital integration or workforce planning
High priority: Essential for patient safety or required for MDT decision-making			
Medium priority: Important but not time-critical			
Low priority: Desirable but resource-dependent			

Gap assessment tool (7/8)

Action planning

Objective	Action	Responsible person/team	Key stakeholders	Timeline	Risks and mitigation	Measure of success

Gap assessment tool (8/8)

Communication and dissemination

For each objective or action, consider the following:

Who needs to know? E.g. oncology teams, surgical teams, MDT co-ordinators etc

How should information be shared? E.g. email updates, MDT briefings, training sessions, quick reference guides

Who is responsible for ensuring effective communication?

Module 3:
MEDICAL CONSIDERATIONS

Unique challenges in older people with cancer

Why frailty matters in cancer treatment decisions

Treatment decision-making in older people with cancer

- Supportive pre-treatment modifications
- Altered treatment goals
- Dose modification
- Schedule changes
- Regime modifications

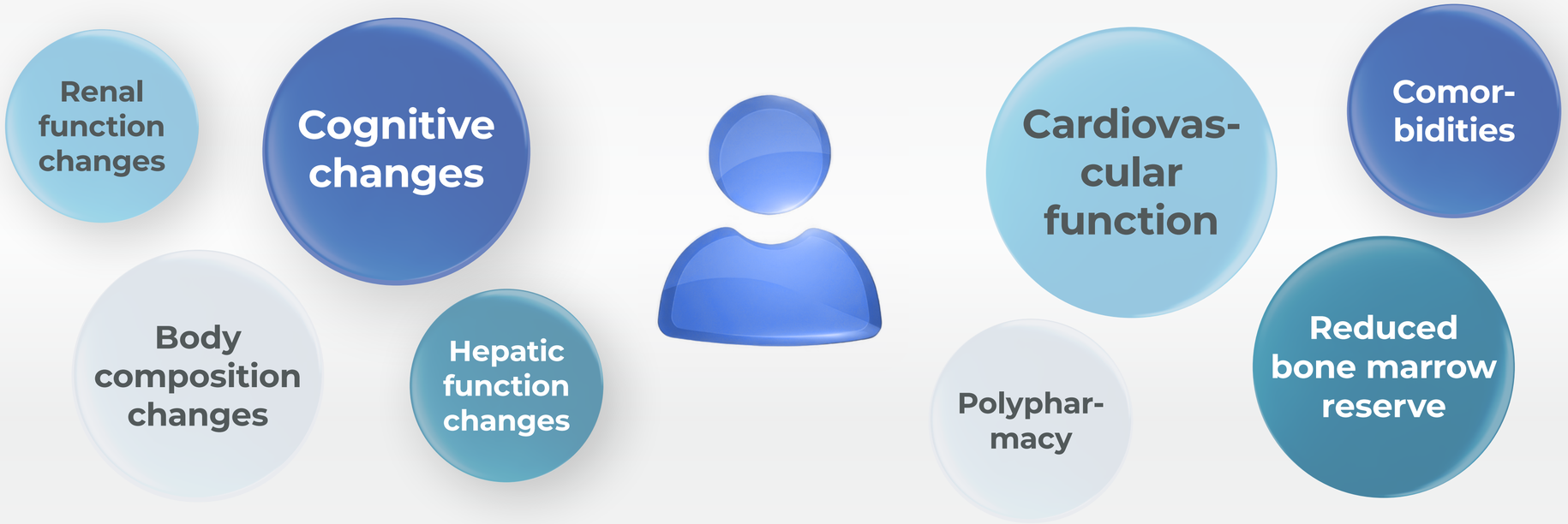
Radiotherapy considerations

Beyond treatment: Adopting a whole person approach

Reflections and actions

Frailty status

Challenges affecting older people with cancer[1,2]



Understanding and addressing the unique medical challenges of cancer in older people is increasingly important as the population ages[1]

Older adults are under-represented in clinical trials

Despite accounting for most of cancer diagnoses and deaths[1]



Although

1 out of 3

cancer diagnoses are in people **>75 years old**[2]

only

1%

of oncological trials registered with clinicaltrials.gov **were older-patient specific** between 2000 and 2019[3]

Reasons for under-representation include:[1]

- Sociodemographic characteristics and living conditions (e.g. social isolation, being single, divorced or widowed, not having children and the absence of close family members)
- Healthcare professional perceptions of insufficient informal support or high homecare requirements

REF

Cancer treatment decisions risk over- or under-treatment if frailty isn't appropriately considered[1]



Robust/fit
older people with cancer

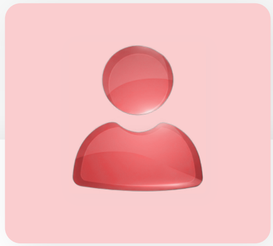
May **benefit** from intensive medical, surgical, and/or radiation therapies[2]

UNDERTREATMENT RISK

Confidence to proceed with standard treatments[2]

Accurate frailty assessment

Prompt to consider tailored treatments[2]



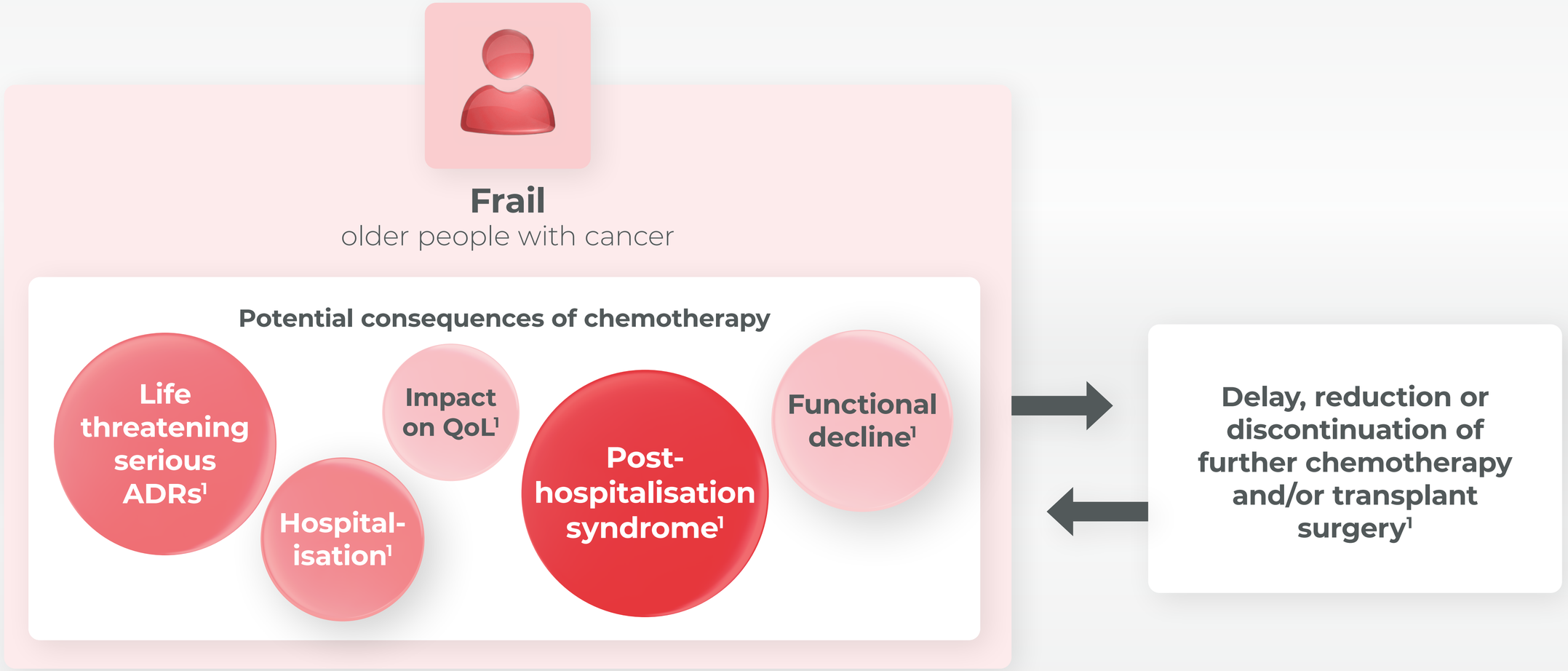
Frail
older people with cancer

May suffer **irreversible harm** from intensive medical, surgical, and/or radiation therapies[1,2]

OVERTREATMENT RISK

REF

The consequences of chemotherapy overtreatment or toxicity in frail older people can be wide-ranging[1]



QoL: Quality of life, ADR: Adverse drug reaction.

Holistically managing frailty may help to improve cancer treatment outcomes[1]

Comprehensive frailty assessment[1,2]

- Appropriate cancer treatment
- Management of functional impairment
- Management of comorbidities
- Review and minimisations of polypharmacy
- Fall risk mitigation
- Nutritional impairment management
- Cognitive impairment management
- Mood/mental health status management
- Social support solutions

Improved treatment outcomes and QoL vs. standard care[1]

People whose frailty has been optimised may benefit from an expanded range of therapeutic options, minimised risk of AEs, and a higher likelihood of completing treatment courses.

AE: Adverse events, QoL: Quality of life.

Current service analysis

How is frailty status communicated to the medical oncology team?

How does frailty status currently influence choice between standard-dose and reduced-dose chemotherapy regimens?

Are any additional supportive care measures implemented because of frailty assessment results?

Current service analysis

What strategies are currently in use to minimise treatment related toxicity?

Are frailty findings routinely communicated to patients and their caregivers?

The benefits of assessing and managing frailty within cancer care have been demonstrated through several randomised controlled trials[1]

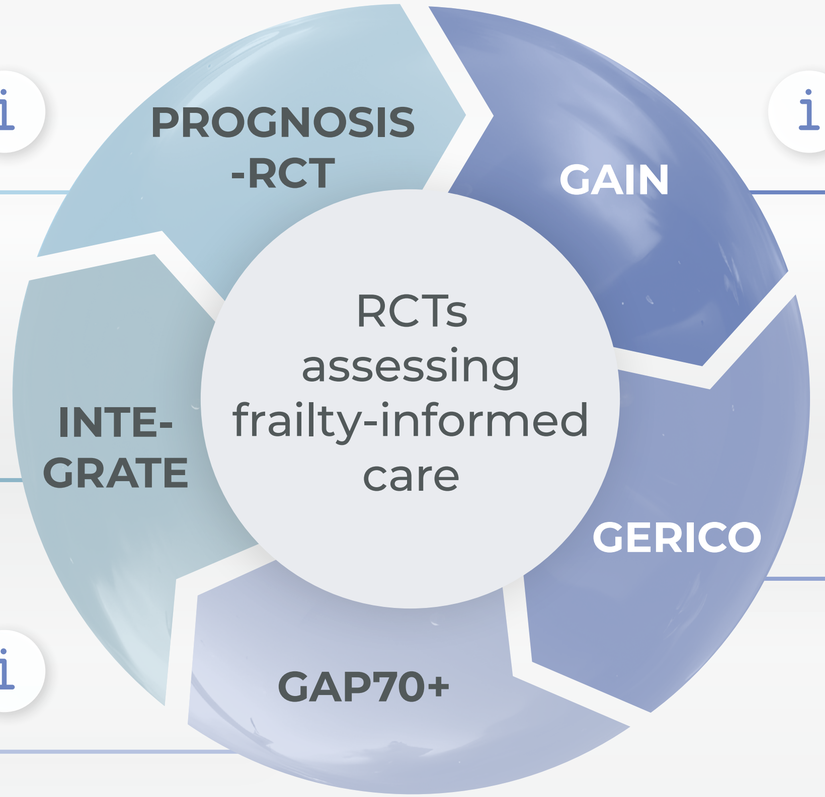
Tendency towards improved physical performance was seen in the least frail[1,6]

~10% lower grade 3+ toxicity with frailty-informed care vs. standard care (absolute risk)[1,2]

Better health-related quality of life with frailty-informed care vs. standard care[1,5]

17% more chemotherapy completions with frailty-informed care vs. standard care (absolute risk)[1,3]

26% lower risk of grade 3-5 toxic effects with frailty-informed care vs. standard care[1,4]

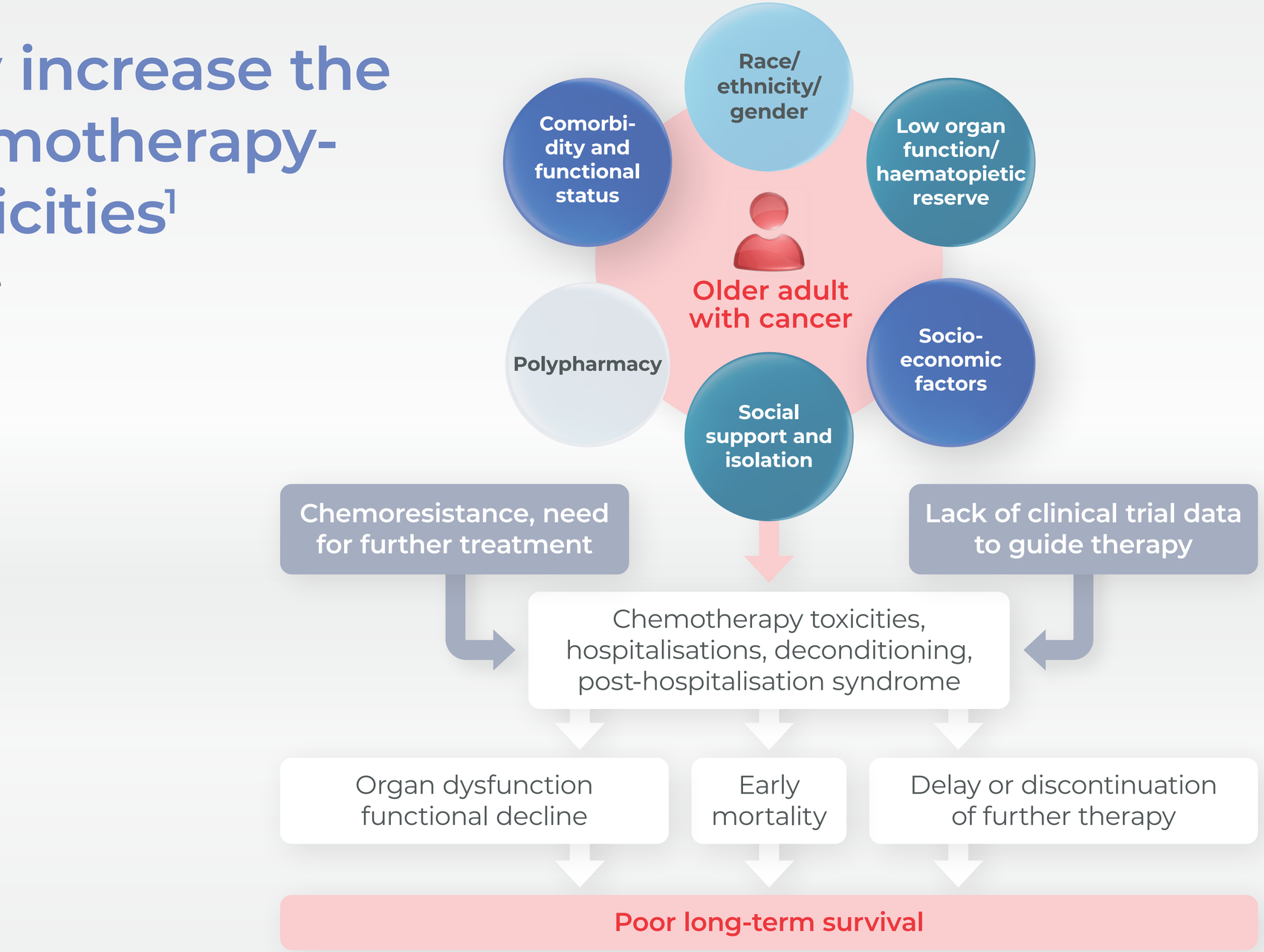


Frailty-informed care was defined as Comprehensive Geriatric Assessment and appropriate interventions. Interventions varied in each trial.

GAIN: Geriatric Assessment–driven Intervention, GAP70+: Evaluation of geriatric assessment and management on the toxic effects of cancer treatment, GERICO: Effect of geriatric intervention in frail older patients receiving chemotherapy for colorectal cancer, INTEGRATE: Integrated Geriatric Assessment and Treatment Effectiveness, PROGNOSIS-RCT: Effects of comprehensive geriatric assessment-guided interventions on physical performance and quality of life in older patients with advanced cancer: A randomized controlled trial, RCT: Randomised controlled trial.

Frailty may increase the risk of chemotherapy-related toxicities[1]

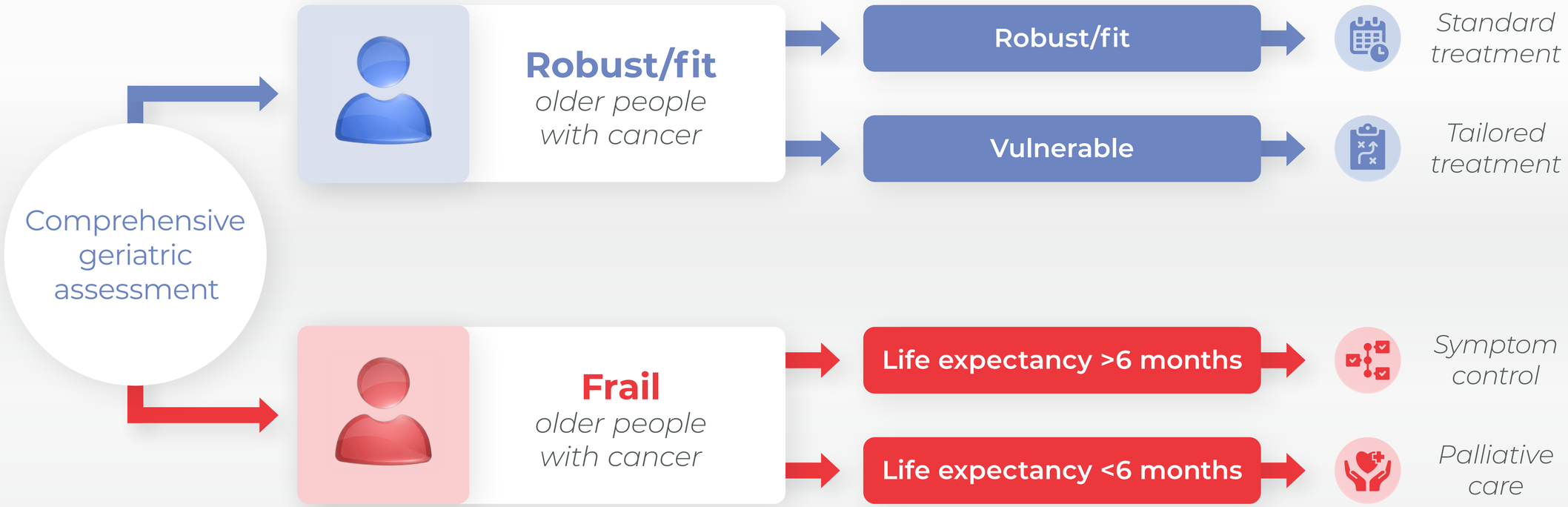
vs. robust, fit people



Adapted from Bhatt VR. *Future Oncology.* 2019;**15**(22):2557-2560.

The outcomes of a comprehensive frailty assessment should contribute to choosing the type of cancer treatment for each person[1]

Suggested algorithm for personalised treatment for older adults with cancer:[2]



Adapted from O'Donovan *et al. Technical Innovations & Patient Support in Radiation Oncology.* 2020;**16**:30-382.

Frailty status can inform treatment decision-making and allow a person-centred process of care[1]

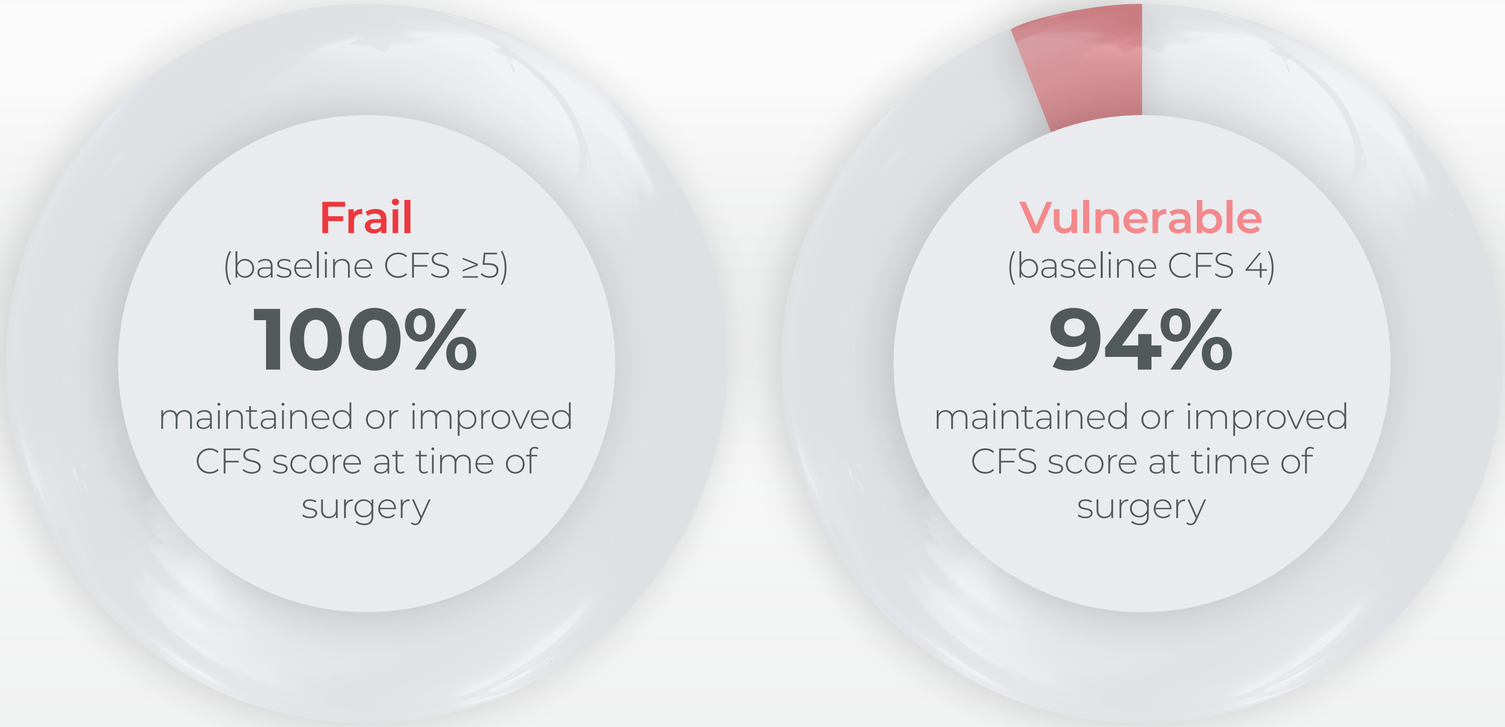
Tailored treatment options for personalised frailty-informed cancer care

- Supportive pre-treatment interventions
- Altered treatment goals
- Dose modification
- Schedule changes
- Regimen modification

Frail older people with cancer were optimised for treatment through a multimodal, specialist prehabilitation service[1]

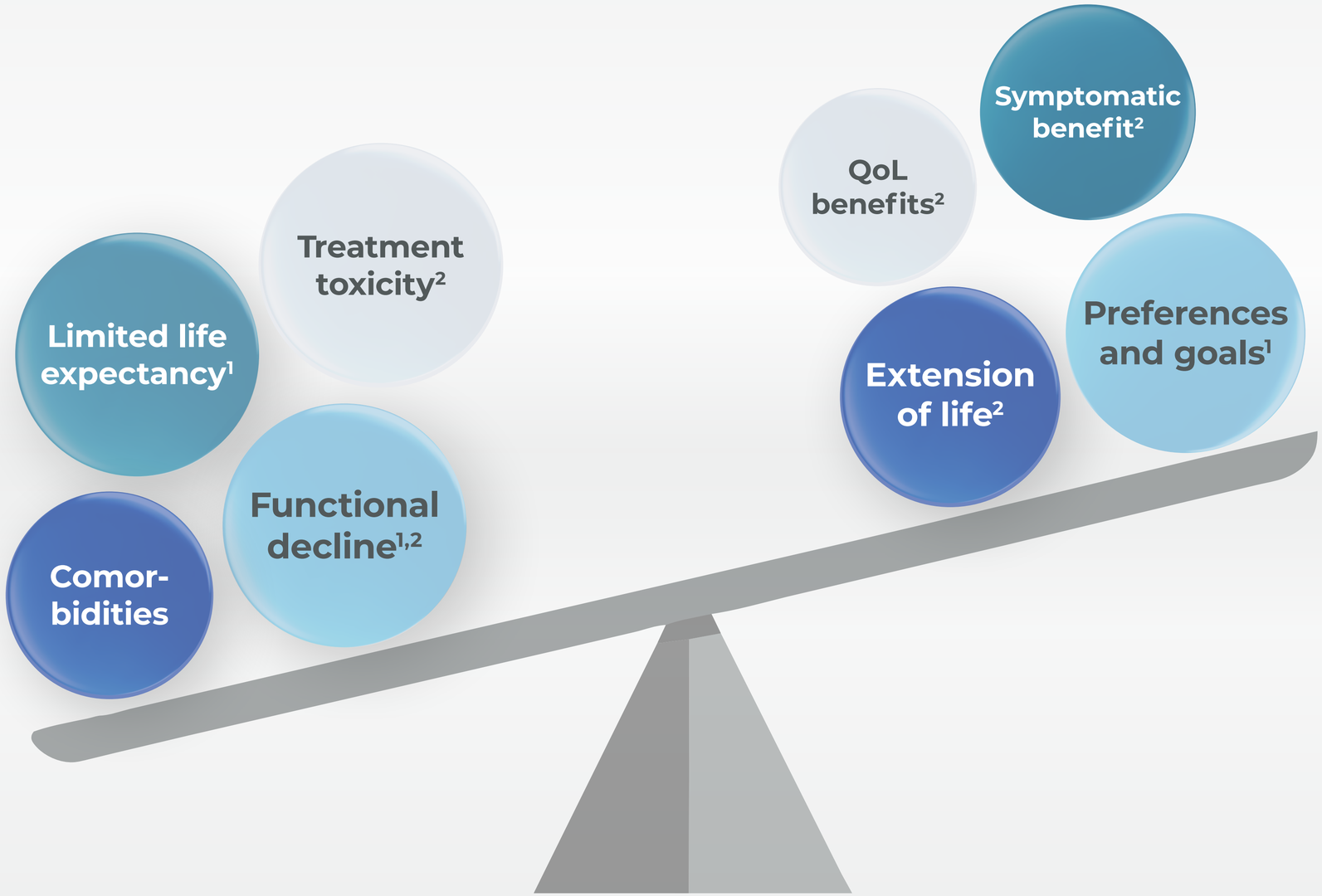
In Liverpool University Hospitals NHS Foundation Trust, older people (N=436) on a cancer surgical pathway were referred to a multi-disciplinary prehabilitation clinic:[1]

Participants received individualised exercise, wellbeing, and nutrition plans, and support.



CFS: Clinical Frailty Scale.

Cancer treatment decisions in older adults living with frailty can be a complex balance[1,2]



QoL: Quality of life.

Older people may value a range of outcomes beyond the extension of life[1]

Older people with cancer may be less willing to sacrifice quality of life in exchange for quantity compared with younger people[2]



Each person's values and preferences can help determine:[2]

- Desired treatment benefits
- Unacceptable harms
- Whether a given treatment constitutes a net benefit or net harm

REF

Primary treatment modification resulted in improved tolerability without compromising treatment efficacy[1]

Secondary analysis of the UK-based GAP70+ study

GAP70+ study (N=609)
Aged 70+ with incurable solid tumours or lymphoma and at least one impaired geriatric assessment domain

Primary treatment modification **46.1%** (n=281/609)[1]

71.9% Primary dose reduction

11.7% Schedule change

vs. standard of care:

14% improved treatment tolerability
Grade 3-5 toxic effects, RR: 0.86 (95% CI: 0.77 to 0.96)[1]

Other cancer types
RR: 0.82 (95% CI: 0.67 to 0.96)

Gastrointestinal cancer
RR: 0.82 (95% CI: 0.70 to 0.96)

14% lower risk of functional decline
RR: 0.80 (95% CI: 0.67 to 0.95)[1]

CI: Confidence intervals, GAP70+: Evaluation of geriatric assessment and management on the toxic effects of cancer treatment, RR: Relative risk.

BSH AML guidelines advise reducing chemotherapy intensity in frail older people[1]

Recommendations include:

- All patients should be evaluated for their ability to tolerate intensive chemotherapy – this should be on the basis of geriatric assessment with emphasis on premorbid performance status, physical function and comorbidities. In general, a score of >10 on Edmonton frailty scale, >3 on HCT- CI and >2 on ECOG PS would be at a higher risk for treatment related morbidity and mortality with intensive chemotherapy
- Where possible, assess organ function/comorbidities with specialists and tests (e.g. echocardiography, lung function tests) to aid treatment decisions. Develop the use of a geriatric assessment tool in your local setting
- Those considered ‘fit’ should be additionally evaluated for the most appropriate treatment according to the biological diagnostic features of the AML

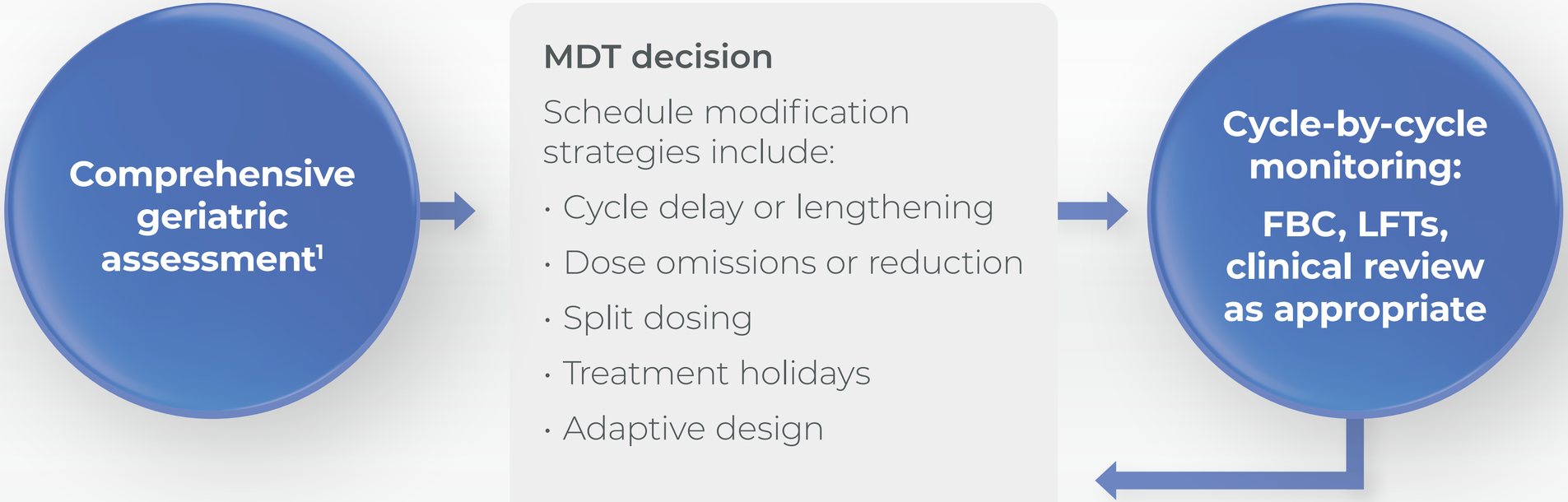
Less intensive therapy:

- The new standard therapy for older AML patients considered unfit for intensive chemotherapy is venetoclax and azacitidine
- Venetoclax combined with low-dose cytarabine is an alternative combination for those patients with the nucleophosmin 1 gene mutation

AML: Acute myeloid leukaemia, BSH: British Society for Haematology, ECOG-PS: Eastern Cooperative Oncology Group Performance Status, HCT-CI: Hematopoietic Cell Transplantation-specific Comorbidity Index.

Schedule modifications may be an option to reduce toxicity without compromising efficacy in frail people[1,2]

Treatment decisions should be personalised based on treatment choice and patient needs



MDT: Multidisciplinary team, FBC: full-blood count, LFT: liver function test.

Treatment regimen choice can help to minimise disruption to quality of life[1,2]

Standardised frailty tools should guide treatment choice

Simplification or reduction of treatment intensity, balancing efficacy and tolerability.

Potential strategies include:

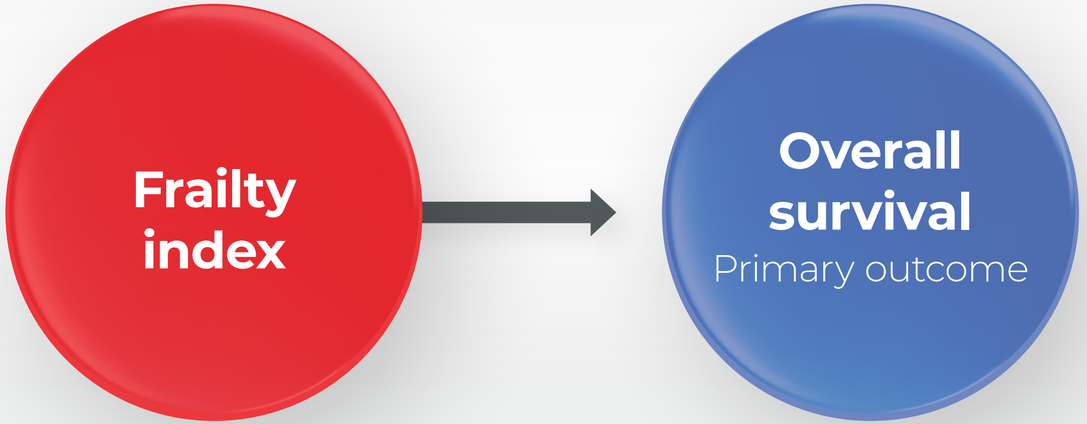
- Simplified regimens
- Monotherapy or oral agents
- Adaptive design

Monitoring of toxicity and quality of life

REF

There is a lack of evidence assessing the effects of radiotherapy in older people living with frailty[1]

In people who received radiotherapy with or without chemotherapy, frailty (assessed using the 40-item Frailty Index as part of a CGA) was associated with overall survival[2]



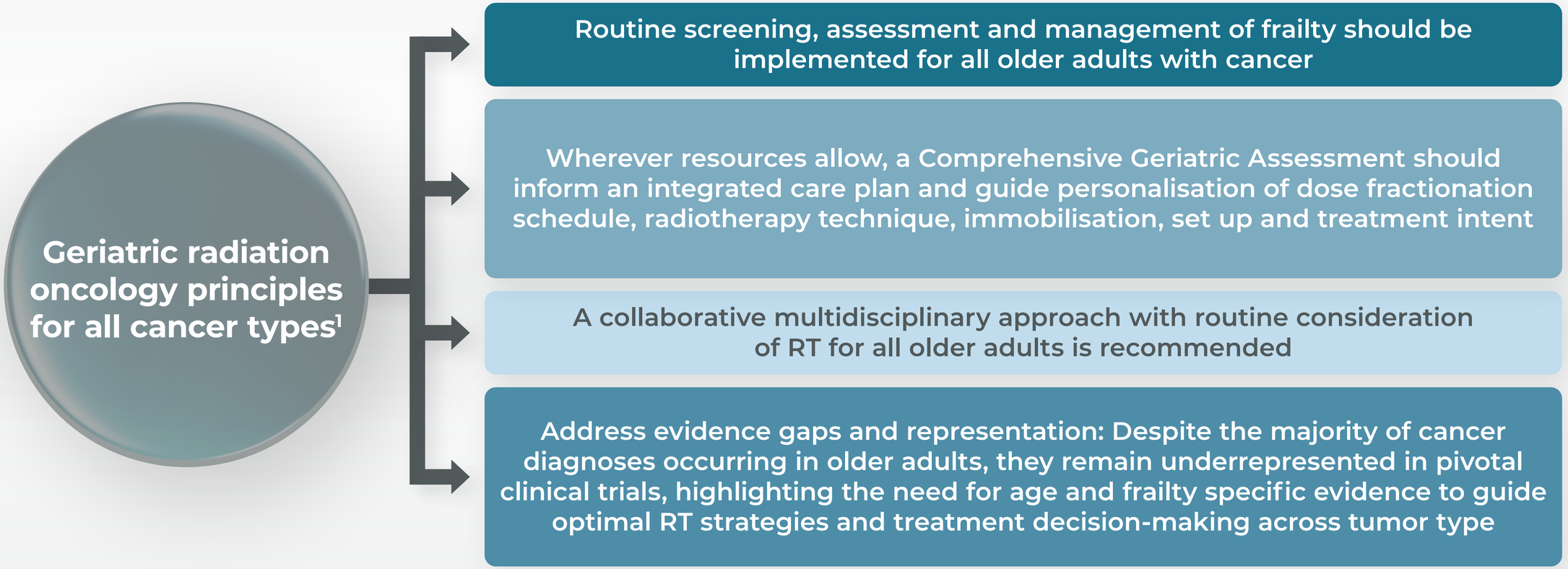
(Median follow-up: 819 days, HR: 1.478, 95% CI: 1.182–1.848, *P*<0.001) Grade ≥3 toxicities were observed in 38% of patients, but frailty was not significantly associated with toxicity.[1]

Additional research is needed to determine the role that frailty should play in radiotherapy treatment decisions and the impact of frailty on radiotherapy cancer control and toxicity outcomes[1]

A prospective cohort of 117 people aged ≥65 years with newly diagnosed HNSCC enrolled between 2017 and 2022.[2]

CGA: Comprehensive Geriatric Assessment, HR: Hazard ratio, HNSCC: Head and Neck Squamous Cell Carcinoma, CI: Confidence intervals.

The integration of geriatric medicine principles into radiation oncology ensures a holistic baseline assessment of older adults to avoid over- or undertreatment, appropriately guide interventions, and optimise cancer outcomes and quality of life[1]



Principles for individual cancer types can be found at in Morris, L. *et al. Journal of Geriatric Oncology* 2026;**17**:102839
RT: Radiation therapy.

Older people with cancer and frailty often face needs that extend far beyond clinical management. Equitable, person-centred care considers all needs, not just medical care in isolation[1]

While some of these factors are not specific to frailty, they can compound barriers to care for a frail older person with cancer:



Frail
older person with cancer

Transport & practical barriers

Transport difficulties can limit attendance at appointments and increase treatment burden.

Consider:

- Whether care can be brought closer to home
- Whether the person could access any local transport support schemes

Social isolation

Frailty and cancer can reduce social participation and increase dependence.

Consider:

- What the person's support network looks like
- Whether they have any caring burdens
- Social prescribing, befriending services, community groups, and carers' support organisations

Hospital visits

Repeated hospital visits can be impractical, tiring and burdensome.

Consider:

- Whether care can be brought closer to home
- Whether appointments can be consolidated

Survivorship

Frailty can fluctuate. The end of medical treatment should not be considered the end of the older person's care journey.

Consider:

- Ongoing assessment
- Pathways for rehabilitation, nutrition support, fatigue management, and psychological support
- Long-term proactive care rather than acute, crisis-driven care

Information accessibility

Older, frail people may find it particularly difficult to take in complex medical information.

Consider:

- Alternative formats
- Limiting use of jargon
- Accessibility needs such as sensory impairments, cognitive issues, or limited digital literacy
- Multiple touchpoints to reinforce information

Financial wellbeing

Cancer and frailty can both cause financial strain on the person and their family or caregivers.

Consider:

- Signposting to financial advice, benefits assessments, employment support etc.
- Incorporating financial risk into holistic MDT discussions

MDT: Multidisciplinary team.

Your current practice (1/9)

Questions for reflection for medical oncologists

Understanding and role clarity

0 = Not at all | 10 = Very

How confident are you in recognising early and established frailty in older people with cancer?

0 1 2 3 4 5 6 7 8 9 10

How confident are you in interpreting frailty assessment findings (e.g., CFS, G8, VES-13, initial screening tools) and integrating them into treatment planning?

0 1 2 3 4 5 6 7 8 9 10

How effectively do you feel your current assessment of frailty across various domains is?

Treatment tolerance/SACT toxicity risk	*Very effective*	*Effective*	*Room for improvement*
Comorbidities and polypharmacy	*Very effective*	*Effective*	*Room for improvement*
Renal/hepatic reserve	*Very effective*	*Effective*	*Room for improvement*
Nutritional or functional decline	*Very effective*	*Effective*	*Room for improvement*
Cognitive vulnerability	*Very effective*	*Effective*	*Room for improvement*

Your current practice (2/9)

Questions for reflection for medical oncologists

Role and MDT integration

0 = Not at all | 10 = Very

How clearly is the role of medical oncology understood within the MDT regarding frailty-informed cancer treatment decisions?

0 1 2 3 4 5 6 7 8 9 10

Do you feel that frailty assessments undertaken by colleagues (AHPs, nurses, pharmacists, geriatricians) are routinely valued and directly influence your treatment planning?

☐ *Yes* ☐ *No*

Which validated tools do you routinely use or rely upon?

☐ *CFS* ☐ *G8* ☐ *VES-13* ☐ *SAOP3* ☐ *CGA*

Are there any gaps you have identified?

Are frailty assessment results available in a timely fashion to influence your treatment decisions?

Examples: Dose modification, regimen simplification, schedule changes, treatment holidays

AHP: Allied health professional, MDT: Multidisciplinary team, SACT: Systemic anti-cancer therapy.

Your current practice (3/9)

Questions for reflection for medical oncologists

Treatment planning, communication and continuity

How often does frailty status influence your chemotherapy or systemic therapy recommendations?

Examples: Dose modification, regimen simplification, schedule changes, treatment holidays

Are there clear, streamlined referral or escalation pathways when frailty is identified?

Examples: To geriatric medicine, AHPs, nutrition, palliative care

Have you identified any limitations which impact your ability to deliver frailty-informed care?

Examples: Limited access to CGA, lack of time/clinic capacity, incomplete assessment data, digital system barriers, or workforce gaps

Your current practice (4/9)

Questions for reflection for medical oncologists

Treatment planning, communication and continuity

How effectively are frailty findings communicated across the MDT and across care settings?

Examples: Surgical teams, community services, primary care

Do treatment plans receive ongoing adjustment as frailty status evolves during treatment?

Examples: Cycle-by-cycle reviews, toxicity monitoring, functional changes.

Do you feel empowered to initiate discussions about treatment modification, supportive interventions, or de-escalation when frailty is likely to impact safety, tolerability, or quality of life?

MDT: Multidisciplinary team.

Your current practice (5/9)

Questions for reflection for medical oncologists

Communication and continuity

How effectively are your findings communicated to the wider MDT and across care settings?

Are care plans reviewed and adapted as a person’s frailty status or cancer treatment changes?

Do you feel empowered to advocate for treatment modification, supportive interventions, or referral when frailty impacts a person’s safety, quality of life, or treatment tolerance?

MDT: Multidisciplinary team.

Your current practice (6/9)

Questions for reflection for medical oncologists

Service and system factors

Does your service enable early involvement of medical oncologists in the cancer pathway?

Including pre-treatment, treatment, and survivorship

Are there any limitations on your ability to deliver proactive frailty-informed care?

E.g. lack of training, workforce, time constraints, digital systems

Are there clear referral and escalation pathways for identified frailty-related concerns?

Are particular patient groups less likely to benefit from multidisciplinary frailty assessment and intervention?

E.g. those with cognitive impairment, sensory loss, language barriers, or social vulnerability

Your current practice (7/9)

Questions for reflection for medical oncologists

Action plan (Practice Level: Individual)

Based on your reflections in the previous questions, what actions could be taken on an individual level?

Suggested action	Notes
Routinely incorporate frailty screening into pre-treatment oncology assessments (including before SACT discussions).	
Use oncological expertise to evaluate how frailty affects toxicity risk, regimen choice, and likelihood of treatment completion.	
Actively integrate frailty findings into shared decision-making conversations with patients and caregivers.	

SACT: Systemic anti-cancer therapy.

Your current practice (8/9)

Questions for reflection for medical oncologists

Action plan (Practice Level: Team/service level)

Based on your reflections in the previous questions, what actions could be taken on a team level?

Suggested action	Notes
Promote earlier access to geriatric assessment, prehabilitation, pharmacy review, and AHP involvement for patients being considered for systemic therapy.	
Work with MDT colleagues to ensure frailty findings (CGA, screening tools) are consistently available before MDT/treatment decisions.	
Support development of streamlined pathways for frailty-triggered referrals (nutrition, falls, cognition, polypharmacy review).	

AHP: Allied health professional, CGA: Comprehensive Geriatric Assessment, MDT: Multidisciplinary team.

Your current practice (9/9)

Questions for reflection for medical oncologists

Action plan (Practice Level: System level)

Based on your reflections in the previous questions, what actions could be taken on a system level?

Suggested action	Notes
Advocate for clear documentation and visibility of frailty assessments within oncology EPR systems and MDT summaries.	
Participate in QI, audit, and service development initiatives to improve frailty-informed oncology care.	
Support development of enhanced geriatric-oncology models (e.g., embedded geriatrician in oncology clinics, joint MDTs).	

EPR: Electronic patient record, MDT: Multidisciplinary team, QI: Quality improvement.

Module 4:
SURGICAL CONSIDERATIONS

Unique challenges in older people with cancer

Why frailty matters in cancer surgery decisions

Surgical decision-making in older people with cancer

- Prehabilitation
- Procedure selection
- Anaesthetic considerations
- Rehabilitation
- Palliative care

Current best practice and innovations

Reflections and actions

Frailty status

Challenges affecting older people with cancer[2]



Understanding and addressing the unique surgical challenges of cancer in older people is increasingly important as the population ages[1,2]

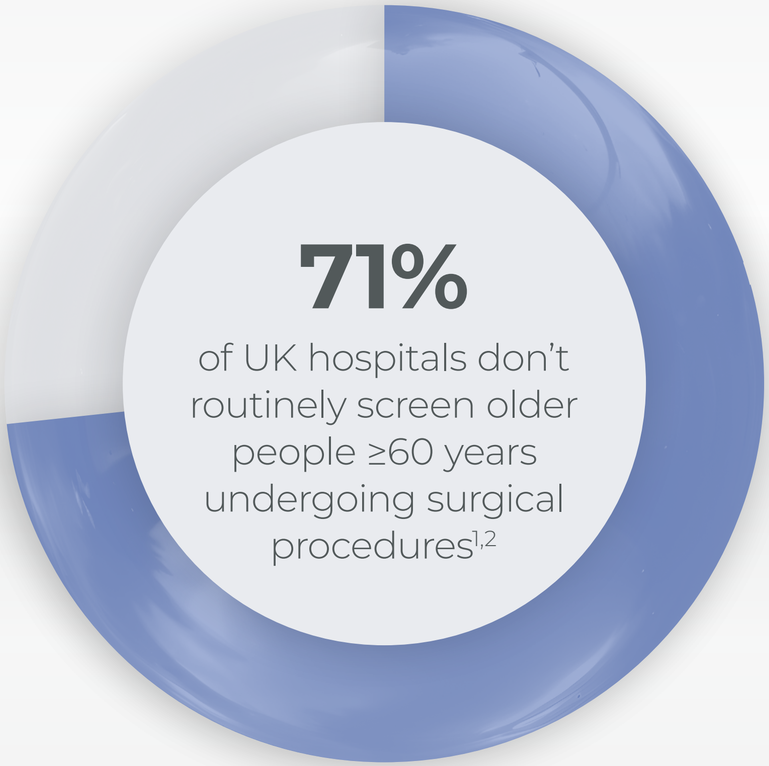
REF

There is a gap in routine frailty screening of people undergoing surgery[1]



1 out of 5

surgical patients **over 60** are living with frailty in the UK (19.6%)[1]



REF

Cancer treatment decisions risk over- or under-treatment if frailty isn't appropriately considered[1]



Robust/fit

older people with cancer

May **benefit** from intensive medical, surgical, and/or radiation therapies[2]

UNDERTREATMENT RISK

Confidence to proceed with standard treatments[2]

Accurate frailty assessment

Prompt to consider tailored treatments[2]



Frail

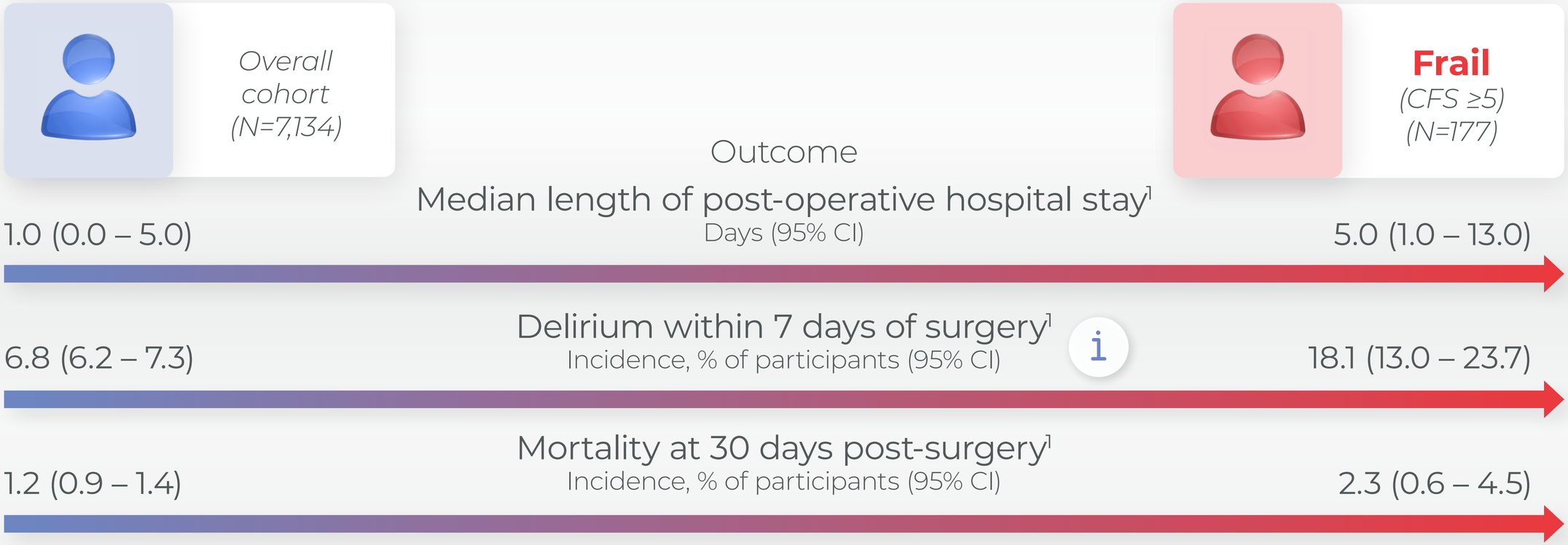
older people with cancer

May suffer **irreversible harm** from intensive medical, surgical, and/or radiation therapies[1,2]

OVERTREATMENT RISK

Older people living with frailty are at high risk of poor outcomes after surgery[1]

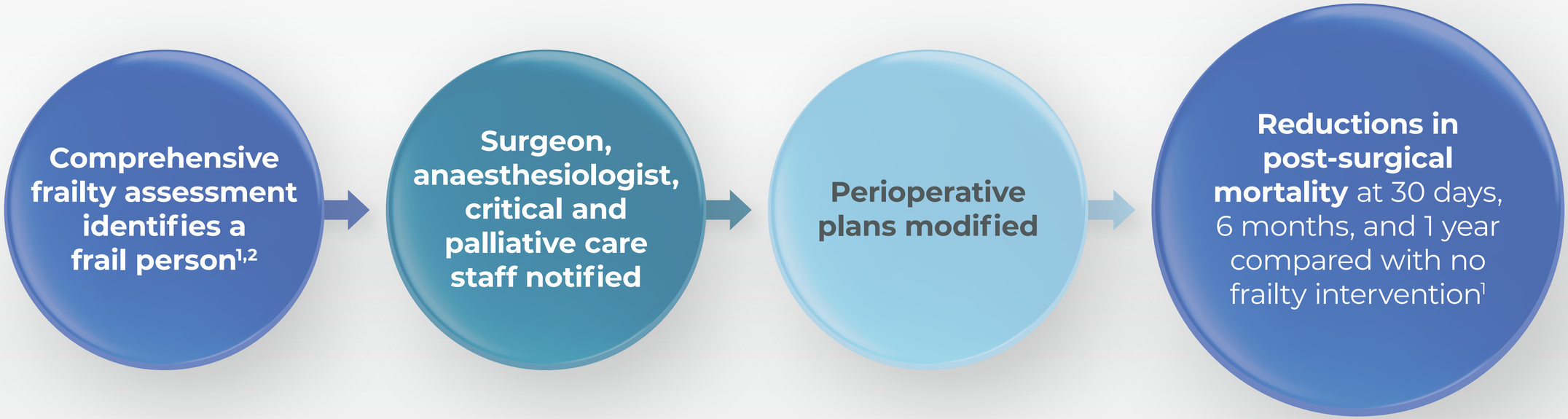
In SNAP3, a large prospective study of the impact of frailty and multimorbidity on postoperative outcomes in elective and emergency surgical patients aged 60 years in the UK:[1]



A prospective observational cohort study over 5 days in 2022 aiming to recruit all UK patients aged 60 yr undergoing surgery (excluding minor procedures). Data included patient characteristics, clinical variables, Clinical Frailty Scale (CFS), multimorbidity (two or more comorbidities), length of stay (LOS), postoperative delirium, morbidity, and mortality. Quantile regression and mixed effects logistic regression were used to analyse relationships.

CFS: Clinical Frailty Score, CI: Confidence interval.

Frailty status can be used to potentially improve and change practice in surgery[1]



In an assessment of 9,153 patients who underwent surgery and participated in a preoperative Frailty Screening Initiative.[1,2]

30-day mortality: 3.8% vs. 12.2%

6-month mortality: 7.7% vs. 23.9%

1-year mortality: 11.7% vs. 34.5%

All $P<0.001$[1,2]

Current service analysis (1/2)

Reflective questions

Are frailty assessments currently implemented by the surgical team?

How is frailty status communicated to the surgical team?

How does frailty status currently influence intensity or choice of surgery?

Current service analysis (2/2)

Reflective questions

Are any additional supportive care measures implemented because of frailty assessment results?

What strategies are currently in use to reduce adverse surgical outcomes in frail adults?

Are frailty findings or additional measures required routinely communicated to other healthcare professionals, patients, caregivers, or families?

All people aged ≥65 years, and younger people at risk of frailty, referred for elective or emergency surgery should have frailty status documented at referral, preoperative assessment and admission[1]

While frailty assessment is not yet routine in all settings, incremental progress toward this approach can still deliver meaningful benefits for patients and services. A perioperative frailty MDT should deliver:[1]

- **Preoperative assessment and optimisation of frailty, cognitive disorders and multimorbidity**
- **Treatment escalation and advance care planning**
- **Effective communication with patients and carers throughout the perioperative pathway**
- **Prognostication and shared decision-making**
- **Rehabilitation, goal setting and discharge planning with onward referral to community services**
- **Assessment and management of postoperative medical complications, hospital acquired deconditioning, postoperative cognitive disorders**

Streamlined care working with other disciplines and specialties.

MDT: Multidisciplinary team.

Current service: Surgical frailty assessment tools (1/2)

Reflective questions

Which frailty instruments are currently used in your service?

Are these tools validated in cancer surgery settings?

Are these tools recommended in guidelines?

Current service: Surgical frailty assessment tools (2/2)

Reflective questions

Are staff suitably trained to use frailty assessment tools?

Have you identified any current gaps in frailty assessment tools?

Assessment tools should be guided by individual patient needs[1]

Specific frailty tools that may be useful in a surgical setting include:

Information on general frailty tools is available in Module 2: Assessment

ASA Physical status classification
Measures overall physical status[2]

P-POSSUM Score
Predicts morbidity and mortality risk[3]

Nutritional Risk Screening (NRS-2002)
Evaluates nutritional status[4]

Frailty assessments should involve the multidisciplinary team.

ASA: American Society of Anaesthetists, P-POSSUM: Portsmouth Physiological and Operative Severity Score for the enUmeration of Mortality and morbidity.

ASA Physical status classification categorises perioperative health status and surgical risk[1]

ASA classification is based on overall physical status[1]

Benefits	Disadvantages
• Simple to use[1] • High predictive accuracy for post-operative outcomes[1]	• High interrater variability especially when assessed by anaesthesiologist[1]

ASA1	ASA2	ASA3	ASA4	ASA5	ASA6
Healthy	Mild systemic disease	Severe but not life-threatening systemic disease	Severe systemic disease that is constantly life threatening	Comatose, not expected to survive without an operation	Brain-dead, organs being procured for transplant

ASA: American Society of Anaesthetists.

P-POSSUM Score predicts postoperative morbidity and mortality[1]

Scoring is based on physiological and operative data[1]

Benefits

- Comprehensive: Incorporates 18 variables[2]
- Provides quantitative prediction of morbidity and mortality[2]
- Useful for audit and benchmarking surgical outcomes

Disadvantages

- Requires detailed data collection (blood tests, operative details)
- Time-consuming

Included variables:[2]

Physiological score

- Age
- Cardiac signs
- Respiratory signs
- Systolic blood pressure
- Pulse
- Glasgow coma score
- Urea nitrogen
- Sodium
- Potassium
- Haemoglobin
- White cell count
- Electrocardiogram

Operative score

- Operative magnitude
- No. of operations within 30 days
- Blood loss per operation (mL)
- Peritoneal contamination
- Presence of malignancy
- Timing of operation

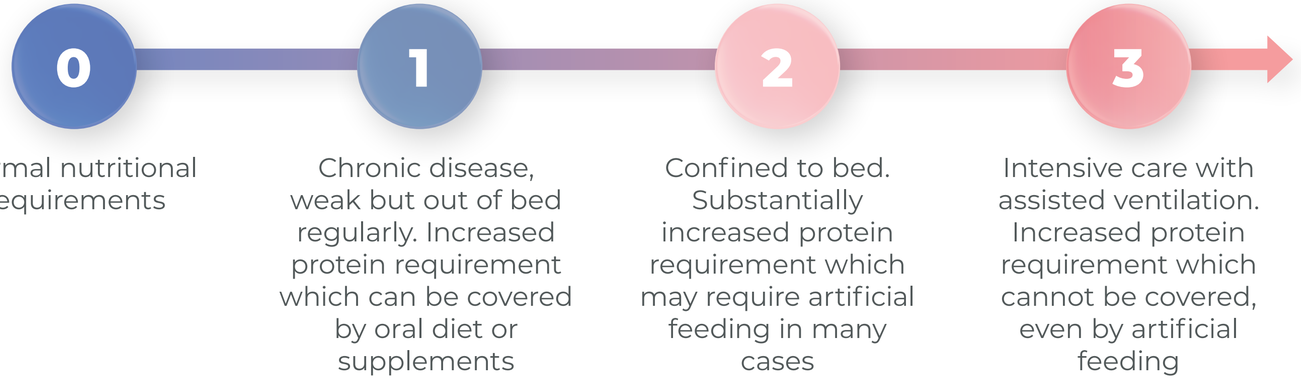
P-POSSUM: Portsmouth Physiological and Operative Severity Score for the enUmeration of Mortality and morbidity.

NRS-2002 estimates how nutritional status affects clinical outcomes[1]

Score determines whether nutritional support is required pre or post surgery[1]

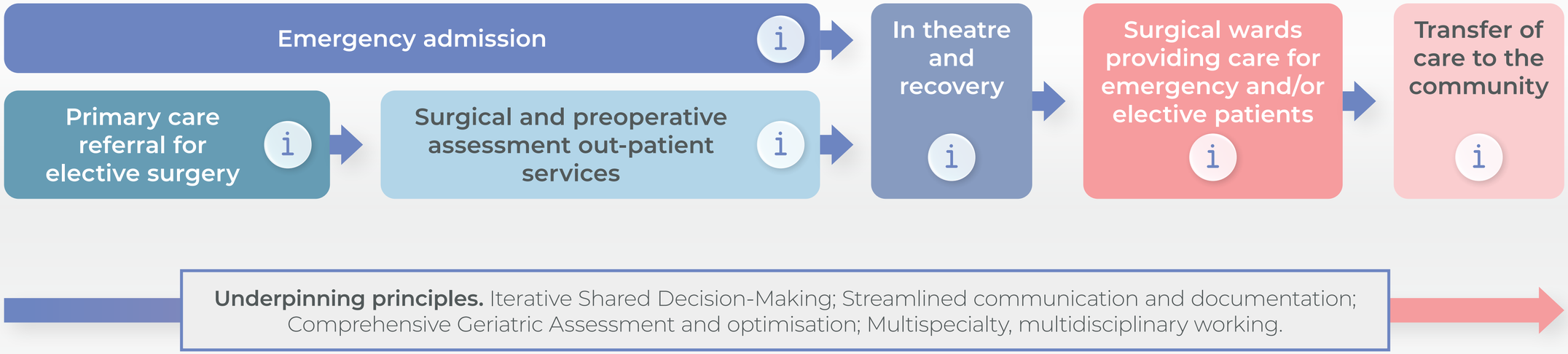
Benefits	Disadvantages
• Rapid and simple screening process • Linked to action; results are tied to specific care protocols • Factors in age, which is highly relevant for frail older people	• Moderate reliability • Limited individualisation

Initial screening to assess BMI, unintentional weight loss, illness, and reduced dietary intake



BMI: Body Mass Index, NRS: Nutritional Risk Screening.

Frailty status can help to anticipate care pre, peri, and post-operative requirements[1]



Adapted from Centre for Perioperative Care. et al. 2021. Available at: https://www.bgs.org.uk/sites/default/files/content/attachment/2021-09-28/Guideline%20for%20Perioperative%20Care%20for%20People%20Living%20with%20Frailty%20Undergoing%20Elective%20and%20Emergency%20Surgery.pdf. Access date: May 2026.

ACD: Advance Choice Document, ADRT: Advance Decision to Refuse Treatment, CFS: Clinical Frailty Score, DNAR: Do Not Attempt Resuscitation, eFI: electronic Frailty Index, GP: General practitioner, LPA, Lasting Power of Attorney, SDM: Shared Decision-Making.

Frailty status can inform treatment decision-making and allow a person-centred process of care[1]

Tailored treatment options for personalised frailty-informed cancer care[1,2]

- Supportive pre-treatment interventions
- Altered treatment goals
- Dose modification
- Schedule changes
- Regimen modification

Prehabilitation may improve a frail patient's physiologic reserve and outcomes after surgery compared with no prehabilitation[1]

Referral to prehabilitation programmes should be considered for people in whom physiological/functional status issues are identified[2]

Prehabilitation consists of 4 stages:[3]

1 Screening

Screening identifies any problems a patient might have. It should be done as soon as possible, often during the diagnostic process.

Aspects considered during screening include:

- Weight
- Nutrition
- Alcohol intake
- Physical activity
- Mental health/cognitive function
- Comorbidities
- Medication

Questionnaires such as the Holistic Needs Assessment may be used.

2 Assessment

Referral to specific prehab teams in either hospital or community settings.

Prehab teams may include:

- Exercise specialists
- Physiotherapists
- Occupational therapists
- Dietitians
- Nurses
- Pharmacists
- Other NHS staff

Tests may include a 6-minute walk test, nutritional assessment etc.

3 Intervention

May be a combination of:

- Universal interventions, e.g., information on diet, physical activity, and mental health
- Targeted interventions, e.g., referral to a dietician or exercise class
- Specialist interventions, e.g., hospital-based physiotherapy, nasogastric feeding, or referral to a psychologist or psychiatrist as appropriate

4 Monitoring

Monitoring progress helps the prehab team understand how the activities have been helping and if they need to change anything.

How much monitoring is needed depends on the type of intervention provided.

REF

Surgical procedure selection should take frailty status into account[1]

To plan the perioperative period, surgical and preoperative assessment teams should:[1]



Consider day surgery or admission on the day of surgery

- Promote day surgery or admission on the day of surgery for people living with frailty wherever possible, using the same principles as those used when considering patients without frailty



Use Enhanced Recovery programmes

- Ensure use of Enhanced Recovery programmes that include interventions for frailty

Anaesthesia in frail older people should consider impaired tolerance of psychoactive medications[1]

Minimise sedation

e.g. the use of ice packs on abdominal wounds to reduce the need for opioid

Goals of anaesthesia for frail people[1]

Optimise regional and non-opioid anaesthetics

e.g. regional vs. general anaesthesia where appropriate

Communication of frailty status to the whole multidisciplinary team, including anaesthesiologist, is essential[1]

The goal of rehabilitation is to improve outcomes and reduce disability[1]

Hospital staff should carry out:

A. Pre-discharge planning
- Undertake CGA[2]

B. Medication safety
- Medicines reconciliation[3]

C. Handover communication
- Referral to relevant services and follow up plans[2]

Transfer of care Checklist:

- ✔ *Patient medically fit with a rehabilitation plan*
- ✔ *Medicines reconciled and patients counselled*
- ✔ *Patient and carer understands rehabilitation plan*
- ✔ *GP discharge summary sent*

Community staff should ensure:

- Awareness of treatment escalation and advance care plan[2]
- Every consultation is a teachable moment to **make every contact count**. Promote lifestyle modification with proven benefits[2]

A 'one team' approach across all care settings is necessary to deliver high quality rehabilitation[1]

CGA: Comprehensive Geriatric Assessment, GP: General practitioner.

Frailty assessments may help identify people who would benefit most from early palliative care involvement, particularly people with cancer who are undergoing surgery[1]

Frailty screening initiative

Palliative care consultations
56 per year after frailty screening initiative vs.
32 per year before the initiative[1]



Frailty screening may prevent unnecessary operations in people who might not benefit from surgery, may be too high-risk, or for whom surgery is not a goal[1]

Current best practices and innovations in frailty practice

Case study 1: Virtual Frailty Ward in Leeds[1]

What it is

This virtual ward in Leeds supports up to 37 patients per day and provides co-ordinated, rapid care to people aged >65 with moderate to severe frailty in their own homes

How does it work?

Access: Single point accepts referrals from GPs, ambulances, hospitals, community services

Assessment: Community matron home visit within 2 hours + consultant decision

Care: Daily interventions (meds, fluids, monitoring, MDT reviews)

Why it's innovative

- Integrates hospital clinicians, community nursing, social care and third-sector partners into a single co-ordinated pathway with rapid referral/response
- Uses a mixed delivery model: In-person home visits combined with remote monitoring and huddles (virtual ward rounds)

Benefits

As of March 2023, they have saved over 21,500 bed days since launching the pilot virtual ward in November 2019

GP: General practitioner, MDT: Multidisciplinary team.

Current best practices and innovations in frailty practice

Case study 2: Prehab at Liverpool University Hospitals[1]

What it is

An allied professional-led prehabilitation service established in 2017 which aims to transform waiting time into preparation time. It treats around 1,000 people, and includes physiotherapists, dieticians, occupational therapists, assistant practitioners, and therapy assistants.[1]

How does it work?

People on cancer surgical pathways are eligible for referral from hepatopancreaticobiliary, colorectal, lung, urology, upper gastrointestinal, and complex gynaecological specialities. Patients undergo multi-modal assessment and personalised interventions. Ongoing support is provided via one to one or group-based follow up until surgery.[2]

Why it's innovative

- The service has helped people who would have been deemed unfit for surgery to optimise health and be accepted for major surgery. From initially being in one hospital for 2 cancer specialities, it has expanded to cover 3 sites and 8 cancer specialities.[1,2]

Benefits

Over a 12-month period, 477 people aged >65 were referred to the prehab service.[2]

- 436 underwent baseline frailty assessment. Of these, 380 went on to have surgery with an average period of 40 days between initial prehab assessment and their elective admission
- 50 scored ≥5 on the Clinical Frailty Scale, 105 fell within the vulnerable category and 163 were managing well at baseline
- 100% of people with a frailty score of ≥5 either improved or maintained their score
- 94% of people with a frailty score of 4 either improved or maintained their score

REF

Current best practices and innovations in frailty practice

Case study 3: Shared decision-making (SDM) in peri-operative care of older people at NHS Lothian[1]

What it is

An integrated, enhanced SDM process, specifically tailored for people who are frail and have been referred for elective urological or colorectal surgery.[1]

How does it work?

Meaningful discussions are structured around the BRAN questions – considering the Benefits, Risks, Alternatives, and the option of doing Nothing – to support people to make an informed choice about their care options.[1]

Why it's innovative

- SDM is a critical component in delivering truly personalised care, ensuring that people are actively involved in decisions about their treatment.[1]

Benefits

The SDM process within the peri-operative care of older people clinic was highly regarded by the people cared for and has demonstrated significant value in both patient outcomes and health and care system efficiency:

- 100% (n=22/22) of participants reported that the POPS team had made "a lot" or "every" effort to help them understand their health issues and to actively listen to what mattered most to them[1]
- 86% (n=19) felt that the team had made "a lot" or "every" effort to incorporate their priorities into the decision-making process[1]
- Between April and July 2023, SDM led to a 30% reduction in the number of people opting for surgery, with 9 out of 30 individuals deciding against the procedure after engaging in informed discussions about their options[1]
- Between January to August 2024, 42 planned procedures did not go ahead as a result of meaningful SDM discussions, saving the trust around £300,000 in costs[1]

SDM: Shared decision-making.

Current best practices and innovations in frailty practice

Case study 4: The Greater Manchester One-stop Lung Cancer Clinic[1]

What it is

A ‘one-stop’ clinic model, allowing patients to consult all relevant specialists in a single visit and make treatment decisions on the same day.[1]

How does it work?

People with resectable early-stage lung cancer attend:[1]

- A comprehensive nurse-led assessment on arrival to screen for frailty, cognition, nutrition, alcohol/tobacco use, medical history and preferences, including a video-recorded 30-sec sit-to-stand test
- A centralised clinic at the thoracic surgical centre with a thoracic surgeon, anaesthetist, oncologist, onco-geriatrician and respiratory physician, supported by exercise specialists, tobacco dependency advisers, and cancer nurse specialists
- Consultations with all necessary clinicians, with a dedicated nurse advocate for each person
- On-the-day consent and planning, with surgery candidates receiving pre-op tests and surgery dates, and radiotherapy patients scheduled for planning scans
- The MDT meets pre-clinic to review referral information, test results and treatment options.[1]

Why it’s innovative

- People with resectable early-stage lung cancer in the Greater Manchester area had experienced delays which threatened the area’s cancer performance. To address this, GM Cancer established a multidisciplinary taskforce, including patient representatives, to design, implement and evaluate the ‘GM One Stop Lung Cancer Clinic’.[1]

Benefits

- Reduced the time from referral to treatment decision, with a median saving of 16 days and elimination of long waits[1]
- Significantly reduced 12-month mortality (12.8% to 3.5%)[1]
- Reduced length of stay for people who opt for surgery[1]
- Approximately 160 fewer appointments among 114 post-implementation patients[1]

GM: Greater Manchester, MDT: Multidisciplinary team.

Your current practice (1/8)

Questions for reflection for surgical teams

Understanding and role clarity

0 = Not at all | 10 = Very

How confident are you in recognising early and established frailty in older people undergoing cancer surgery?

0 1 2 3 4 5 6 7 8 9 10

How confident are you in interpreting frailty assessment findings (e.g., CFS, G8, VES-13, initial screening tools) when planning surgical work-up?

0 1 2 3 4 5 6 7 8 9 10

Your current practice (2/8)

Questions for reflection for surgical teams

Role and MDT integration

0 = Not at all | 10 = Very

How clearly is your surgical role understood within the MDT when balancing frailty status with operative risk?

0 1 2 3 4 5 6 7 8 9 10

Do you feel that frailty assessments undertaken by colleagues (AHPs, nurses, pharmacists, geriatricians) are routinely valued and integrated into surgical decision-making?

☐ *Yes* ☐ *No*

AHPs: Allied health professionals, MDT: Multidisciplinary team.

Your current practice (3/8)

Questions for reflection for surgical teams

Frailty-related surgical domains

Which frailty-related domains do you routinely assess within your scope of practice?

Examples: Operative risk profile (functional status, cardiopulmonary reserve, sarcopenia, nutritional compromise), postoperative delirium risk, falls history/mobility issues, social support and ability to recover independently. Polypharmacy and comorbidity burden.

Which validated tools do you routinely use or rely upon?

- ☐ *CFS*
- ☐ *NRS-2002*
- ☐ *ASA class*
- ☐ *P-POSSUM*
- ☐ *Gait speed*
- ☐ *4AT*

Are there any gaps you have identified?

How often do you identify potentially modifiable frailty-related issues preoperatively (nutrition, mobility, polypharmacy, cognition), and are you able to intervene or escalate in a timely manner?

Your current practice (4/8)

Questions for reflection for surgical teams

Communication, pathway, and system factors

Are there clear, streamlined referral or escalation pathways when frailty-related concerns arise pre-surgery?

Examples: Referral to prehabilitation, anaesthetic optimisation, dietetics, or physiotherapy

Have you identified any limitations which impact your ability to deliver frailty-informed surgical care?

Examples: Limited time in preoperative assessment, lack of prehabilitation access, inconsistent CGA access, digital system gaps, workforce issues

How effectively are frailty findings communicated across the perioperative pathway?

Examples: Surgery, anaesthetics, oncology, community teams

Your current practice (5/8)

Questions for reflection for surgical teams

Communication, pathway, and system factors

Are surgical plans reviewed and modified when a person’s frailty status changes prior to surgery?

Examples: Change in ASA, worsening mobility, new delirium risk

Do you feel empowered to advocate for altered surgical approaches when frailty assessments suggest an increased risk?

Examples: Less intensive surgery, non-operative management, prehabilitation

Are particular patient groups less likely to benefit from multidisciplinary frailty assessment and intervention?

E.g. those with cognitive impairment, sensory loss, language barriers, or social vulnerability

Your current practice (6/8)

Questions for reflection for surgical teams

Action plan (Practice Level: Individual)

Based on your reflections in the previous questions, what actions could be taken on an individual level?

Suggested action	Notes
Incorporate frailty assessment routinely into preoperative surgical evaluation (including before consent).	
Use surgical expertise to identify and address modifiable risks (nutrition, mobility, polypharmacy, anaesthetic risks) that influence postoperative outcomes.	
Ensure frailty findings are central to shared decision-making, helping patients understand risks, benefits, and alternatives.	

Your current practice (7/8)

Questions for reflection for AHPs, pharmacists and nurses

Action plan (Practice Level: Team/service level)

Based on your reflections in the previous questions, what actions could be taken on a team level?

Suggested action	Notes
Promote earlier, consistent involvement of geriatricians, anaesthetists, physiotherapists, dietitians, and other AHPs in surgical pathways.	
Ensure perioperative MDT processes integrate frailty findings into surgical decision-making and operative planning.	
Contribute to team training initiatives on frailty-informed surgical care (delirium prevention, postoperative rehabilitation, consent with cognitive vulnerability).	
Support consistent use of validated surgical frailty tools (e.g., P-POSSUM, NRS-2002, CFS).	

Your current practice (8/8)

Questions for reflection for AHPs, pharmacists and nurses

Action plan (Practice Level: System level)

Based on your reflections in the previous questions, what actions could be taken on a system level?

Suggested action	Notes
Advocate for clear documentation of frailty assessments within preoperative and perioperative EPR systems	
Engage in quality improvement projects focusing on reducing postoperative complications and LOS in older frail surgical patients.	
Support development of specialist perioperative frailty or surgical prehabilitation services.	

EPR: Electronic patient record, LOS: length of stay.