ANNEX II to D7.1

A report on the assessment of the healthcare workforce education and training on *frailty* and *multimorbidity*

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INDEX

(Literature search strings available upon request)

Contributions:

Version	Date	Author (Unit)	Description
0.1	30.09.2016	Valeria Romano Maddalena Illario Alberto Borraccino	Table of content and document structure
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1. PROJECT BACKGROUND AND CONTEXT INFORMATION

The general objective of the SUNFRAIL project is to improve the identification, prevention and management of ***frailty*** in community-dwelling older adults within local and regional settings of EU countries. Due to the prevalence of multimorbidity in older adults, it is pivotal to design, test and implement innovative and transferable care models that can effectively and sustainably address complex needs, taking advantage of ICT tools.

In the framework of the consultation meeting for the Joint Action on Frailty, held in Rome on 30th March 2015, with the participation of EC experts, the problem of defining 'frailty' has also arisen. During the meeting, Mr Jorge Pinto Antunes (DG Sante) has brought about some specific concepts related to frailty. The following table shows a common background shared at EC level in the framework of the JA on Frailty, together with the representatives of Member States:

Ensuring an appropriate, trained and sustainable workforce is a major issue, due to the need to address multidimensional domains that influence health outcomes in older adults.

The British Geriatric Society (2014) recommends that professionals working with older adults must be aware of the importance of identifying whether the individual has a health status that could be considered a pre-frail condition, or is indeed presenting with frailty. This awareness should lead to an assessment for pre-frail and frail conditions in every encounter with health and social care professionals. (BGS, 2014).

Several scales are available for classifying frailty and are widely used (i.e. Rockwood scale, Fried scale, Tilburgh scale, Edmonton and others), but these scales for scoring frailty haven't brought to any intervention

to tackle the condition and are very little user-friendly, quite time-consuming and complicated (some contain 70 items) but, most of all, they all use different concepts of frailty and are not comparable.

The need identified was for a simple tool, for everyday use in primary care and community care settings (and not in acute care or hospital settings), to be administered not only by medical doctors and nurses but by other professionals as well, so that frailty could be identified at an early stage.

The Comprehensive Geriatric Assessment (CGA), a multidimensional, multidisciplinary diagnostic instrument, is designed to collect medical data, psychosocial and functional capabilities and limitations of older patients. It has been extensively studied (de Vos et al., 2012 its administration is long and time consuming thus unsuitable for screening of the growing numbers of older adults in the community or in primary care. Based on the need for simple, quick, easy to use, but reliable assessment tools (van Kan et al 2008) performed a systematic review of the screening tools for frailty. They concluded that there are several tools available like the Fried Criteria, the SPPB and the Frailty Index but that there is no consensus yet on the gold standard tool. A recent analysis (Pialoux et al.,2012), comparing various screening instruments for frailty concluded that only two instruments might be suitable but required further validation. Malnutrition as well as cognitive impairments (CI) are however often underdiagnosed using these instruments (Valcour et al., 2000) and in some cases malnutrition is not addressed at all.

According to the British Society of Geriatricians, a failure to provide healthcare staff with appropriate skills and training to meet the complexity of frail older people needs is one of the key factors contributing to the failure of the care of older people.

For these reasons, WP 7 will elaborate an innovative academic educational programme addressed to healthcare professionals, aimed at filling the existing gaps between the available standard training programmes in the partner countries and educational programmes aimed at meeting the needs of the increasing future ageing population. Specifically, the innovative programme would help in training healthcare staff with a strong focus in preventing, identifying and managing frailty and multimorbidity in the population. Multimorbidities are frequent in older adults, and impact quality of life, being associated with multiple symptoms, disabilities such as cognitive impairments, limited activities of daily living and reduced mobility hence are major public health issues (Boyd C et al. 2010). Furthermore, older adults are likely to be prescribed m therapies for multimorbidity. Polypharmacy is associated with increased mortality, incident disability, hospitalization, and emergency department visits in frail and prefrail older adults, but not in no frail adults. Polypharmacy should hence be monitored in these patient subgroups to optimize health outcomes (Beatriz B et al. 2017).

WP4 of Sunfrail has carried out a great work on literature review as a first step to the future design of an innovative model for frailty identification, prevention, care and management of multimorbidity. On this

concept, WP7 is built in order to create a correspondence of reciprocal needs and aims. Where WP4, with the first step of literature review, was seeking to find experiences about services designed for the detection, prevention and management of frailty and multimorbidity, WP7 was modelled on the framework of WP4 basic research questions, but specifically regarding the training and education of the health and social care workforce on the same concepts.

On the basis of WP4 findings, the project partners tried to define the concept of *FRAILTY* according to the experts' opinions and discussions. *Frailty* consists of a dynamic state affecting an individual who experiences losses in one or more domains of human functioning (Physical: nutrition (weight loss), mobility (slowness), physical activity, strength, endurance, balance, sensory functions; Psychological: cognition, mood, coping; Social: social relations, social support), which is caused by the influence of a range of variables and which increases the risk of adverse outcomes (Gobbens et al, 2010).

We need to be aware that the word 'frailty' is often misused, both in research and among professionals, considering concepts as 'disability' and/or multimorbidity as synonyms of frailty. It has therefore to be specified that frailty is rather a condition that makes even small factors and traumas (clinical or non-clinical) cause serious adverse effects on the overall condition and functioning (including health worsening and loss of autonomy). It is therefore relevant to state that frailty may be reversible with active interventions, to avoid its evolution over time towards disability and dependency.

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2. METHODOLOGY

The first step of WP7 consists, therefore, on a literature, documentation and first-hand experiences' overview regarding healthcare and social professionals and academic training programmes including the *frailty and multimorbidity* concepts. As little is known about professionals' knowledge of, their attitudes and practice in the assessment of frailty, an original qualitative study aimed to explore the awareness of key primary care professionals has as well been carried out in Piemonte, in order to acquire direct information. Ad-hoc questionnaires have been administered to project partners, so as to directly collect experiences of education and training programmes in their contexts and countries.

Literature search of training programmes already available has been driven by a more comprehensive evaluation approach in order to capture and identify innovative and effective experiences in the educational field, considering the multidimension of frailty.

The proposed approach is consistent with the previous successful experiences of the projects and models of multiple healthcare systems worldwide (De Almeida Mello et al., 2015; Landi et al. 2000).

This report is organised by professional roles' literature and material overview, as follows: medical training programmes; nursing programmes; pharmacy programmes; psychology programmes and social carers programmes. Documentation search and collection was carried out through the following steps:

1) Biomedical and professional databases literature search
2) EIP-AHA Action Groups' documentation collection and review
3) Sunfrail questionnaires about partners' healthcare services results
4) Direct questions to professionals
5) Original qualitative descriptive study (Focus groups)

As initially indicated in WP4 and previously suggested by Bousquet (CHU) and Nogues (CARSAT), the Sunfrail literature review adopts the methodological frame of the *scoping study* (Koskinen, 2015, Arksey, 2005, Levac, 2010). As a consequence, WP7 stages have been developed on the basis of the scoping studies steps, specifically adapting the methodology to the issue being studied and modifying inclusion/exclusion criteria accordingly:

1: Identifying the research question/s

2: Identifying relevant studies

3: Study selection

4: Charting the data, if feasible

5: Collating, summarizing, and reporting results

Inclusion criteria
○ The 'study' reports about training and education programmes/courses considering the concepts of frailty (or pre-frailty)/multimorbidity. ○ The final beneficiaries /target population on whom the programme focuses on are citizens aged 65 year or more. ○ The study (programme) focuses on community-dwelling people. ○ The programme/course involves the Identification, prevention and management of frailty and multimorbidity ○ The study includes a definition of the concepts of frailty and multimorbidity.
Exclusion criteria
○ The study regards programmes exclusively for the geriatrics specialty (medical, nursing and other healthcare professionals specializing in geriatrics and gerontology) ○ The study includes healthy active ageing only (without frailty). ○ The study /programme/course regards ADL disability and mobility-disability only (without frailty). ○ The study/course focuses on institutionalized people in nursing homes, residential homes, hospice. The study/course focuses on disability, healthy ageing only or on the end of life stage.

3. EDUCATION AND TRAINING IN MEDICINE / BIO MEDICAL SCIENTIFIC FIELD: MDs, GPs

Biomedical database literature search regarding the medical education field has brought about very little material concerning the concepts of *frailty* and *multimorbidity* in medical schools programmes. Specifically, the concept of *frailty* is commonly intended as referring to an acquired pathological status (population affected by at least one condition). Geriatric academic curricula, of course, extensively deal with akin concepts and do specialize in the care of the elderly, but those usually are very 'insitution/hospital/residential' oriented, whereas community dwelling citizens, older than 65 years, are apparently not specifically the final target of academic programmes, or only partially. This reflects the fact that prevention of a frailty status in the citizens hasn't been considered a priority by official academic medical programmes so far.

Ageing of the population in western societies and the rising costs of health and social care are refocusing

health policy on health promotion and disability prevention among older people. However, efforts to identify at-risk groups of older people and to alter the trajectory of avoidable problems associated with ageing by

early intervention or multidisciplinary case management have been largely unsuccessful. This failure arises from the dominance in primary care of a managerial perspective on health care for older people, and proposes instead the adoption of a clinical paradigm based on the concept of frailty (Lepeleire, 2009). On these basis, medical staff should be trained in order to effectively meet the needs arising from the present socio-demographic situation.

The medical profession has been challenged to engage more effectively with older adults. While medical professionals from most specialties will encounter older patients, shortcomings have been noted in undergraduate curricula worldwide with regard to content about older-adult health. The challenge for the medical profession is to inculcate undergraduate interest in aged care in the context of an increasing prevalence of older people suffering chronic illness and multiple comorbidities. Evidence suggests that management of acute illness associated with hospitalization dominate medical curricula. For example, a United Kingdom survey identified a lack of teaching time in medical undergraduate curricula related to ageing, where less than two weeks of a five-year degree addressed health care for older people (Annear, 2016).

By contrast, the teaching of Geriatrics is being more and more integrated in the final years of the degree in medicine and surgery. At the School of Medicine of Federico II University of Naples, the concept of preclinical (Fried's frailty) and clinical frailty (Rockwood's frailty) is being addressed jointly by lecturers and students. Consequently, the multidisciplinary interventions on frailty are being strengthened in terms of preventive and therapeutic actions targeting preclinical and clinical frailty, respectively. More importantly, the nursing degree involves the teaching of Comprehensive Geriatric Assessment, the Geriatric Services Network and the concept of "family nurses" who are representing the critical points of geriatric care delivery.

The available literature concerning the concepts of frailty and multimorbidity and their management mostly regards the geriatrics medical specialty. A more generic kind of publications deal with the medical staff needs about a better knowledge on adults' health of people aged 65 and older. Some physicians working in hospital wards reported a need for a deeper knowledge of geriatric care and geriatrics concepts.

A small sample study by Levine, (Levine et al., 2008) reports that a greater awareness and knowledge of geriatrics issues are vital for physicians in most specialties. Equally important is the need for close collaboration and communication across specialties.

The term ''interspecialty'' is used to describe a collaborative effort that is necessary for the care of older adults. Levine's work tells about a 2-day off-site chief resident immersion training addressed to investigating the needs of chief residents (CR) in the management and knowledge of adult care and geriatric issues. Objectives were to foster collaboration between disciplines in the management of complex older patients,

increase knowledge of geriatrics principles to incorporate into teaching, enhance leadership skills, and help CRs develop an achievable project for implementation in their CR year. Three cohorts totaling 47 trainees and 18 faculty mentors from 13 medical and surgical disciplines participated over 3 successive years.

Over all 3 years, medical disciplines represented by the trainees included internal medicine (n58), family medicine (n54), neurology (n55), psychiatry (n55), rehabilitation medicine (n53), anesthesiology (n56), cardiothoracic surgery (n52), otolaryngology (n56), ophthalmology (n53), general surgery (n51), urology (n52), and emergency medicine (n52).

The following table, reported in the Levine's study, illustrates the topics recognized by Chief Residents as needing more knowledge for improving their practice.

Topic covered formally	
Assessing decision-making in elderly patients	31
Conducting a preoperative assessment of an elderly patient	30
Conducting a functional assessment of older patients	31
Recognizing dementia	31
Managing dementia	31
Recognizing delirium	31
Managing delirium	31
Reviewing medications for evidence of polypharmacy	31
Assessing the adequacy of the patient's social support and living arrangements	30
Creating a postdischarge management plan	31
Understanding implications of different insurance coverage for older patients	31
Knowledge of long-term care services, including home care services	31
Recognizing the value of and facilitating the interdisciplinary, collaborative team process	31
Incorporating the principles of geriatric rehabilitation	31
Topic not covered formally	
Recognizing, evaluating, and treating urinary incontinence and voiding difficulties	29
Assessing and reducing risk for falls	31
Managing diabetes mellitus	30
Managing coronary artery disease	31
Taking into account cultural differences in making decisions regarding patient care plans	30

The article reports as well a proposal for implementing action plans in the medical practice, such as the details in the following table:

Specialty	Setting/Audience	Action Plan Project
Anesthesiology	Weekly conference/residents	"Understanding the Complexities of Managing the Elderly Patient in the Perioperative Setting"/To develop lecture and online resources with focus on managing elderly patients
Cardiothoracic surgery	Residents	To identify different surgical options available for lung cancer
Emergency medicine	Residents and attendings	"Pre-Op Assessment of the Geriatric Patient in the ED"/To educate ED staff to assess geriatric patients before operative repair of orthopedic injury
Family medicine	Community health center	To train residents and interns to review patients' healthcare proxies and end-of-life wishes
Internal medicine	Internal medicine intranet Web site/interns and residents	To incorporate evidence-based geriatrics bibliography into Web-based references for internal medicine trainees
Internal medicine	Intern conference/medical interns	"Dementia and Delirium"/To increase intern competence in the diagnosis and management of patients with these diagnoses
Internal medicine	Intern conference/interns and residents	"End-of-Life Care in Medically Complicated Elders"/To identify elderly people with end-of-life care needs. Choose appropriate means for symptom management. Combine cultural, medical, and social aspects into care plan
Neurology	Didactic lecture/neurology residents and medical students	"Gait Assessment and Fall Risk in Elderly Patients with Neurological Disease"/To understand different gait problems associated with neurological diseases, falls risk, and preventive measures
Ophthalmology	Residents and faculty	"Communication to Primary Care Providers Regarding Ophthalmic Disease"/To provide primary care physicians with regular updates and communication regarding their patients' visual and ophthalmic health
Otolaryngology	Otolaryngology grand rounds/residents in otolaryngology	"Prevention, Diagnosis and Management of Postoperative Delirium in ENT Patients"/To increase awareness in house staff about prevention and treatment of common postsurgical problems
Otolaryngology	Medicine and geriatrics departments grand rounds; Internal medicine Web-based journal/general internists, geriatricians	"Dysphagia: Cross-Disciplinary Diagnosis and Practical Management"/To produce and present a comprehensive talk with practical information on this topic for other disciplines
Psychiatry	Psychiatry grand rounds/attendings, residents, students	"Interdisciplinary and Community Resources for Caregivers of Patients with Dementia"/To inform psychiatry trainees and faculty about community-based resources for caregivers
Psychiatry	Ward rounds teaching/medical student psychiatry clerks and psychiatry residents	"Case-Based Approaches to Teaching Drug Interaction Concepts in the Elderly"/To minimize adverse drug interactions in psychiatric patients
Surgery	Anesthesia and surgical house staff	To improve recognition and treatment of delirium in postoperative and surgical intensive care unit patients
Urology	Urology residents and faculty	"Counseling Geriatric Patients on PSA and Prostate Cancer"/To increase

Several sources were screened in order to identify potentially-relevant studies. Within the available medical databases, Medline was chosen as the best source to be inspected in order to fulfil WP7 specific aims. The MEDLINE (Medical Literature Analysis and Retrieval System Online) is the richest bibliographic database of life sciences and biomedical information, includes bibliographic information, covering different scientific biomedical fields as medicine, nursing, pharmacy, dentistry, veterinary medicine, and health care. Medline offers the possibility of performing literature searches using textual and Medical Subject Headings (MeSH) possibilities for information retrieval, combining, if necessary Boolean expressions using MeSH terms, words in abstract and title of the article, author names, date of publication, etc.

Medline was screened through PUBMED, SCOPUS and WOS (Web of Science). Pubmed is a free search engine accessing primarily the MEDLINE database while Scopus and WOS are bibliographic databases, to be used under subscription, containing abstracts and citations for academic journal articles in the scientific medical field but also in the social sciences (including arts and humanities). Furthermore, both Scopus and the WOS allow search both forward and backward from a particular citation. Since MEDLINE, Scopus and WOS

complement each other, as neither resource is all-inclusive, several search strategies were tested (Burnham, J. F. (2006). Scopus database: a review. Biomedical digital libraries, 3(1), 1).

Study selection criteria

Inclusion and exclusion criteria, coherently with the research questions were decided to guide the screening process.

Inclusion criteria

To identify relevant studies, it was agreed on the set of criteria to be used during the title and abstract screening. In order to be selected the study had to:

• discuss, describe, assess, or evaluate an educational intervention or activity dealing with *frailty* or *multimorbidity*

• target professionals working in the biomedical scientific field, in particular MDs and GPs

• be addressed to the increase of either knowledge, awareness or competences in identifying, assessing or managing frailty or multimorbidity in healthy > 60 age subjects.

Exclusion criteria

Studies meeting the criteria indicated below were excluded:

• aimed at planning or promulgate advanced courses in geriatrics

• when targeted at frail or elderly subjects

• targeted at MDs or GPs but discussing interventions directed to non-healthy frail subjects

The screening process through title and abstract allowed the collection of a total of 226 papers among which 23 potential pertinent studies, between 2006 and 2015 were retrieved.

The selected papers were all retrieved and screened for pertinence. No papers fully met the inclusion criteria. Seven papers were selected because meeting at least one of the inclusion criteria.

• Five papers were intervention descriptions of initiatives, curricular and non-curricular courses aimed at increasing knowledge in geriatrics. All papers but one were flagged as ‘non pertinent’

• One manuscript was a commentary encouraging leaders of academic medicine, government, and business to debate the issues of education in gerontology issues. Paper was flagged as ‘non-pertinent’

• One manuscript was a short letter to the editor. Paper was flagged as ‘non-pertinent’

• One manuscript was a symposium report. Paper was flagged as ‘non-pertinent’

• Two papers were out of target, one was addressed to social workers and one was a written lesson for nurse staff. Papers were flagged as ‘non-pertinent’

• One manuscript was a qualitative study on the perception paramedics in US have on geriatrics issues. Paper was flagged as 'non-pertinent'

• Two reviews were selected because potentially useful: one was a survey over an 11-year period of intervention on geriatrics held in US and was flagged as 'non-pertinent', while the second review was also considered as 'non-pertinent'

• Six papers were reports of different interventions delivered to specific professionals, with intervention description, evaluation plan and results included. Three papers were considered partly pertinent and three were not pertinent

• three papers reported the evaluation of an intervention or of a specific tool employed for facilitating learning. One paper was considered not pertinent and two were included.

Selected papers assessed:

Alfarah, Z., Schünemann, H. J., & Akl, E. A. (2010). Educational games in geriatric medicine education: A systematic review. BMC geriatrics, 10(1), 1.

Manuscript Type: Review

Synthesis: The paper underpins that attitudes of nursing staff toward the elderly play a critical role in the quality of care provided in particular in long term care facilities. To involve professionals, it is suggested the use of Educational game since those represent a type of experiential learning where the learner, engaging in specific activities, increases his critical thinking and puts the results to work. The objective of the study was to systematically review the medical literature to assess the effect of geriatric educational games on the satisfaction, knowledge, beliefs, attitudes and behaviours of health care professionals (not only limited to nurses). The available evidence collected by the authors do not support the use of role playing interventions in geriatric education with the aim of improving the attitudes towards the elderly. These interventions require significant effort and time investment on the part of the educator and significant personnel resources.

Chiêm, J. C., Van Durme, T., Vandendorpe, F., Schmitz, O., Speybroeck, N., Cès, S., & Macq, J. (2014). Expert knowledge elicitation using computer simulation: the organization of frail elderly case management as an illustration. Journal of evaluation in clinical practice, 20(4), 534-543.

Manuscript Type: Descriptive (case management tools)

Synthesis: The paper is about a case management pilot project to decrease the risk of institutionalization of frail older people. A multicompetent intervention called *companion modelling*, already used to visualize and

understand the interactions between human and natural systems, wad employed. The agent-based model (ABM), used to assess the complex mechanisms underlying health care interventions, was tested defining a set of variables based on qualitative data extracted from 21 pilot case management projects. The model was used as a support for the elicitation of experts to articulate formally the description of the intervention and the problems encountered. The objective was to improve the understanding of case management as a complex intervention. The methodology employed provided a medium to articulate a proper formulation of complex dynamic interactions, its usefulness was on allowing scenarios to help to train care providers, case managers and other health care personnel by encouraging them to reflect on their own practice and better adapt to unexpected situations. The paper push on a further development of such tools to finer recommendations and issue better-informed decisions in the organization of frail elderly case management"

Ferguson, M. K., Thompson, K., Huisingh-Scheetz, M., Farnan, J., Hemmerich, J., Acevedo, J., & Small, S. (2015). The Impact of a Frailty Education Module on Surgical Resident Estimates of Lobectomy Risk. The Annals of thoracic surgery, 100(1), 235-241.

Manuscript Type: Intervention Evaluation (frailty module Assessment)

Synthesis: Paper discuss on whether frailty recognition and incorporation into surgical risk estimation can be taught to residents, or whether that ability only arises as a result of accumulated experience. The education module on frailty, that included a short course combined with reinforcing text and videos, significantly improved cardiothoracic residents' knowledge of frailty. Training in frailty may help educate residents in frailty recognition and surgical risk assessment.

Levine, S. A., Chao, S. H., Brett, B., Jackson, A. H., Burrows, A. B., Goldman, L. N., & Caruso, L. B. (2008). Chief resident immersion training in the care of older adults: an innovative interspecialty education and leadership intervention. Journal of the American Geriatrics Society, 56(6), 1140-1145.

Manuscript Type: report (intervention on Chief resident program)

Synthesis: Reynolds Foundation awarded in 2003 a 4-year grant to the Geriatrics Section at Boston University School of Medicine US to improve the care of older adults by increasing training in geriatrics in the many disciplines of medicine. As part of this project, the Chief Resident Immersion Training Program in the Care of Older Adults (CRIT) was conceived as an educational program. The authors state that CRs are an untapped resource for changing geriatrics practice and education, for increasing interspecialty communication and collaboration between providers of health care for frail and complex older patient. The figure is not common in European countries

Moran, W. P., Zapka, J., Iverson, P. J., Zhao, Y., Wiley, M. K., Pride, P., & Davis, K. S. (2012). Aging Q3: an initiative to improve internal medicine residents' geriatrics knowledge, skills, and clinical performance. Academic Medicine, 87(5), 635-642.

Manuscript Type: report (preliminary assessment of Q3 intervention resident program)

Synthesis: The paper deals with the intention to integrate geriatrics education into our existing general internal medicine services to improve residents' skills in assessing and managing the medical challenges of caring for geriatrics patients with a program named Aging Q3 (Quality Education, Quality Care, and Quality of Life) in south carolina US. In this paper authors reflect on the development and current state of the Aging Q3 program, share examples and data from the implementation process and the measured impact of the program and discuss lessons learned throughout the process. "

Pinheiro, S. O., & Heflin, M. T. (2008). The geriatrics excellence in teaching series: An integrated educational skills curriculum for faculty and fellows' development. Journal of the American Geriatrics Society, 56(4), 750-756.

Manuscript Type: report (mixed method assessment oGETS resident program for faculty members)

Synthesis: The paper describes a program the Geriatrics Excellence in Teaching Series (GETS) for faculties, its learning outcomes, content, teaching strategies, and assessment methods, and identifies lessons learned from the implementation and evaluation of the program. Authors conclude the GETS series participants have integrated effective teaching and learning processes into their educational routine even if several limitations were considered to rate the program as effective. Participants attested to the fact that open discourse with learners and peers in a nonthreatening and supportive environment enhanced their teaching and learning."

Rodriguez, E., Marquett, R., Hinton, L., McBride, M., & Gallagher-Thompson, D. (2010). The impact of education on care practices: an exploratory study of the influence of "action plans" on the behavior of health professionals. International Psychogeriatrics, 22(06), 897-908.

Manuscript Type: Evaluation (Action plan as a tool for effectiveness)

Synthesis: results indicate that while a commitment to change from learners might increase the likelihood of successful change, a crucial element to understand the likelihood of success is how realistic or difficult is to implement a specific plan of action. In other words, it is not only how committed someone could be to implement change, but how capable she/he is of envisioning a feasible path of action what predicts successful change "

No paper met the criteria in order to extract and discuss preliminary data results.

One important specific experience in this field was found at the University of Parma: the academic course in geriatrics already included a module about physiological frailty in the older subjects.

CONCLUSIONS on EDUCATION AND TRAINING IN MEDICINE / BIO MEDICAL SCIENTIFIC FIELD

To move the thinking of policy makers and providers away from a somewhat narrow focus on clinical health to be supportive of integrated service approaches will require important changes in the management and capacity building of human resources.

In particular, in the next future, health care staff has to be prepared to give people greater access to health information; support the development of higher levels of health literacy; promote improvements in people's lifestyles and support and, where appropriate, behaviour change; encourage people to play a greater role in the self management of their health. Subsequently, workforce development (in terms of knowledge, skills and competences) needs to underpin such approaches. It would therefore be necessary, for some EU countries, to a substantially 'rethink' of the divisions that have served to (a) compartmentalise e.g. primary, secondary health and social care services; and (b) create and often re-enforce particular professions or disciplines

Dubois et al (2006) in a context that embraced health protection and promotion affirmed that 'ensuring an appropriate, trained and sustainable workforce is clearly a major issue for European health policy now and in the future.

Consensus document on frailty identification and management achieved that any specific model of frailty when applied in a clinical setting was less important than the fact that whatever any validated principle is chosen, it is likely to be used by an appropriately skilled clinicians (Gordon, 2014). There is immediate work to be done in moving frailty medicine forward, since frailty is recognized to be reversible. Up to date the most evidence-based intervention for frailty is reported to be a Comprehensive Geriatric Assessment (GCA), defined as a 'multidimensional inter-disciplinary diagnostic process focused on determining a frail older person's medical, psychological and functional capability in order to develop a coordinated and integrated plan for treatment and long term follow up' (Stuck, 1993; Ellis, 2011). By that date an increased number of frailty screening tools have been developed and are used in clinical practice (Peters 2012) among which the CGA has been used as the criterion standard. As a consequence, getting CGA to the right patients, at the right time, should be considered the priority within the frailty framework. Unfortunately, a significant proportion of patients who might benefit from CGA do not currently receive it (BGS 2012) not only because of a lack in competences, but as frequently observed, because of an organizational problem (Robbins 2013), and because of the absence of a whole system approach. An approach that requires multidisciplinarity defined not just by involvement of multiple disciplines, but also by communication between them requiring coordination and iteration, responsibility and above all, the collation of all cumulative deficit in all

professional involved (Gordon 2014). The unanswered question, due to the lack of research on the field, is who should deliver this model of frailty. Adopting such a whole system approach requires that general practitioners and acute hospital specialists will understand the process, have sufficient skills, to conduct some aspects of frailty medicine, and actively integrate with other professionals involved, and such a perspective requires innovative comprehensive programmes to build those skills that will make these professionals competent frailty practitioners.

Unfortunately, as detailed here above, there is a substantial scarcity of experiences targeted at increasing professionals' knowledge and skills needed to tackle the issue of frailty in the elderly population, and even worse there is a complete lack of evidence on the financial, formative, educational and organizational structures needed to allow a whole system approach (Ellis 2014; Wyrko 2015).

To allow a progressive growth of the needed competences for the care of older adults, in order to identify and reverse frailty it is necessary to plan, deliver and test interprofessional model education, it is therefore necessary to adapt those models to the different scenarios. There is no 'one-size-fits-all model' for the care of older people, due to variance in services, both internal and external (for example ward set-up and social services provision). Thought needs to be given to how to correctly identify of those who are frail or at risk of becoming frail, and act early in order to prevent avoidable harm (Wyrko 2015). The challenge for the next future is to ensure that doctors in training spend a higher proportion of their time being educated and trained in interprofessional settings and involving the highest number of professionals at all levels; using high effective intervention both at medical school and in continuing education; and that all effective interventions are shared to become a reference model for any model of training.

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4. EDUCATION AND TRAINING IN NURSING

The educational training in Nursing follows in Europe the Directive on the Mutual Recognition of Professional Qualifications. This document sets the basic education requirements for five sectors of health professionals (doctors, dentists, pharmacists, nurses and midwives) to allow them to work in other EU countries based on their qualifications (De Raeve 2014). The average of programmes is similar in all considered countries, even if not all of them are academic nursing degrees (CCNURCA 2013, Lahtinen et al 2013).

The present overview of the literature on academic education and training in several countries shows that caring for frail older adults is indeed quite a new concept for the health and social systems and few papers have been found fully respecting the inclusion criteria. Interestingly, most researches addressed the issue of how to attract and retain nursing students in the field of older people care, an issue that appears to be extremely relevant due to stereotypes associated with elderly and ageism. In fact, one of the main findings is the lack of trained professionals with appropriate skills for the care of older people (Ryan 2013, Bardach and Rowles 2012, Alsenany 2009) and this could affect the early detection of frailty.

According to Bardach & Rowles (2012) traditional curricula at undergraduate level do not equip health professionals with the required knowledge for taking care of older people. Even if, facing the epidemiological transition, nursing is shifting its focus from a traditional institution-oriented paradigm to nursing practice in patients' homes, the academic world is slow to respond.

In many European countries, Geriatric/Gerontological Nursing or Older People Care are offered at Post Graduate Diploma (PGD) or at Master levels. In Italy, for instance, Geriatric Nursing has been acknowledged as Advanced Nursing Practise in 2006 by the law 43/06. PGDs in Geriatric Nursing have been launched in some universities since 1995, (counting in the year 2002/2007 for the 3,5% of the PGD offer for nurses), following the Guidelines of the Italian Federation of Registered Nurses (IPASVI). Unfortunately, this offer has not been successful, because only an average of 6% of Nurses who have undertaken a PGD program have chosen Geriatric Nursing in the years 2002/2007 (IPASVI 2007). The reasons can be found in the lack of official recognition granted to Geriatric Nurses, the cost of courses, the lack of attractiveness to work with older people. (Shin 2015, Koh 2012, Kydd et all 2014). Consequently, at present only few universities are still offering the programme.

In the last decade, the PGDs in Family and Community Nursing addressing the generalist/specialist training of primary care nurses has been introduced in Austria, Italy, Spain, Switzerland and UK, but even if the programmes included geriatric modules, a specific approach towards the frail condition was still not clearly addressed.

A core module on Frailty will be introduced in the current edition (2016-17) of the PGD on demand for the Alpine Space Project Co.N.S.E.N.So (COmmunty Nurses for Elderly in a chaNging SOciety) by the University of

Turin. The learning core module will be delivered in the 4 partner countries (Austria, France, Italy end Slovenia) during the project.

The University of Lincoln (UK) launched in 2015 a new MSc Specialist Practice for Health and Social care of Frail Older Adults. The programme will be a mixture of learning through university attendance; individual tutorials; work-based supervision, peer support and networking groups using a virtual learning environment discussion forum; support and assessment of independent study.

The longitudinal study of Brown at al (2008), aimed at understanding the influence of students' learning experiences on shaping their predispositions to work with older adults, suggested that students do not necessarily enter nurse training with negative predispositions. They maintain that such negative views could develop during their training as a result of clinical placements in 'impoverished' environments of care in which they witness poor standards of care and negative attitudes towards older people. However, if they experienced 'enriched' environments they are far more likely to view gerontological nursing in a favourable light (Brown, 2008).

Alsenany (2008) explored this topic among Saudi Arabia Nursing students and found out that living with older adults, as it is still happening in the Saudi families, enhance the positive attitude towards the elderly, but a that the number of nurses interested in working with older people has decreased significantly and that nursing students have, in general, relatively poor knowledge of the physical and behavioural aspects of ageing. This is consistent with research showing that attitudes of students are subject to change based upon learning environments, such as Potter et al (2013) and Wallace et al (2006), describing the influence of specific knowledge on evolving values, attitudes, and actions. Ferrario et al (2007) found negative attitudes toward older adults in surveying four colleges of nursing. Consequently, successful aging as an organizing framework, developed faculty as aging specialists, and required coursework and clinical experiences with healthy and frail older adults, have been introduced to enhance the curriculum.

Similarly, the studies of Vertejee (2015), Anderson et al (2005), Lee et al (2015), Heise et al (2012) reinforced that in order to develop a positive attitude and to avoid ageism, innovative education methods and occasion of contact with older through proper placements in the community are pivotal. The utilisation of simulation is as well considered key elements to enhance the students' experience (Smith and Barry, 2012).

Kirkpatrick and Brown (2004) describe a geriatric nursing course that employs Narrative Pedagogy through stories and a service-learning project. A premise of the course is that stories, in film and literature, are analysed in depth through critical and reflective thinking, expanding the repertoire of the student's lived experiences and helping students to engage with older persons in a therapeutic relationship. Gallagher and Carey (2012) conducted a qualitative research on how student interest in gerontological nursing increased after students interviews with older adults who were not acutely ill on their past life experience. Similarly, Clark (2015) gave a conceptual framework for using narrative in the professions of medicine, nursing, and social work describing the implications for patient-centered practice and interprofessional teamwork.

Indeed, many studies reinforced the vision on Advanced Practice Nursing as LeCount (2004) and Goldberg et al (2015) that defined a set of competencies for ANPs working with older people with frailty in UK, through a Delphi study with a national panel of clinical experts and lay representatives.

However, Deschodt et al (2009), after a cross-sectional mail survey of 17 baccalaureate nursing education programmes in Belgium, performed in 2007 and aimed at to identify the coverage of Gerontological care in baccalaureate nursing education programmes, recommend that because a minority of nursing students choose the gerontology specialist option, gerontology content in basic nursing curricula should be increased and a minimum standard curriculum and specific competencies for care of older people should be formulated for all baccalaureate nursing education programmes.

The School of Nursing at the University of Missouri has set up a practice called Senior Care, a home care agency that specializes in the care of frail older adults. Because undergraduate students typically value hands-on technical skills and are slow to recognize the importance of other skill sets needed to manage frail older adults, several clinical exercises to engage students in comprehensive assessment and planning for their clients have been planned. Students examine issues of poly pharmacy and older adults, as well as environmental, psychosocial, physiological, and health-related behaviours of their assigned clients (Marek et al 2004).

Outside the academic world, initiatives could be found in the Continual Medical Education (CME) or CPD offer for professionals but it is not possible to map all of them for a proper evaluation (Anderson et all 2014, Oeseburg et all 2013). A paper from Gustafsson et al (2014) found out that for community nurses is difficult to update their knowledge and work with Evidence Based Nursing (EBN). The findings revealed that the nurses perceived that when nursing frail older people EBN is a desired intention/mission, but they feel a lack of practical supporting structures to apply evidence and a lack of confidence in their own capacity to apply evidence. Moreover, they hold a belief that “it will work anyway”.

Pearson P. et al (2014) report on a National Career Framework for nurses caring for older people with complex needs in England developed in UK building on the British geriatric Society “Fit for frailty “(2014) paper and on a Delphi survey agreement among Local Education and Training Board experts.

According with Ryan at al (2013) to deliver integrated health care for seniors, and especially for frail seniors, a team approach and effective collaboration among primary, community, emergency and hospital services is pivotal. To reach these outcomes professionals must be trained in three broad areas of competencies geriatrics, interprofessional practice, and inter-organizational collaboration (GiiC).

Significant gaps in workforce preparation are evident in these areas as assessed in the work of Hawkins “Gerontological Training Needs Assessment” (2014). Witt et al (2014) in analysing the necessary competencies in primary health care for attending to older adults identified twenty eight competencies by

consensus that were classified into twelve domains for professional health practice and education when caring for frail older adult in primary health care.

Montagnini et al (2014) consider Interdisciplinary Team Training (IDT) essential component of ensuring quality geriatric care delivery, requiring coordination of many medical, psychosocial, and therapeutic interventions. Fitzgerald and Regenstreif (2007) developed the curriculum for interdisciplinary team working inside the PACE rural area. The Programs of All-inclusive Care for the Elderly (PACE) since 1983, offers a comprehensive, community-based long-term care option to frail older adults aimed to help them to live as independently as possible, in their own homes and communities. The curriculum learning approach combines didactic and experiential learning modules. The didactic modules provide students with a background in interdisciplinary geriatric care and the PACE program. The experiential modules are designed to provide students with the opportunity to work as part of an interdisciplinary team with a home and community based frail elder population.

CONCLUSIONS on EDUCATION AND TRAINING IN NURSING

The search is not exhaustive. There is a considerable amount of descriptive and experiential information and some pieces of research could have been lost because not indexed by biomedical databases. The studies retrieved have not been critically assessed for their quality, but included to obtain an overview of the issues under interest of WP7.

Nurses are indeed the largest workforce dealing with older people, but few nurses are interested in advancing their knowledge to work with older adults. Ageist stereotypes could affect health care delivery if preventive interventions are considered ineffective or treatable conditions are dismissed as being a normal part of ageing (European Patient Forum (EPF), 2013) and should be considered. In fact, the European Patient Forum (2013) recognises that to ensure high quality of care is pivotal to understand how older people are perceived by healthcare staff as well as by health researchers.

Innovative teaching methods using simulation, narrative at direct contact with healthy ageing people appear to enhance curricula. Interprofessional education is a key element to foster the development of skills in primary care teams in the care of older adults. Frailty in older people is not yet recognised as a field of education and training in the nursing education.

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House of Commons - Health Committee: Written evidence from the British GeriatricsSociety http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/6/6vw03.htm

5. EDUCATION AND TRAINING IN PHARMACY

The research on last ten years' literature from different databases (SCOPUS, PUBMED, CINHAL, GOOGLE SCHOLAR UK, SCIFINDER) concerning evidence of the existence in EU of teaching and training programmes for pharmacist regarding frailty or frail elderly gave very limited results. One of the most reliable experiences regarding services related to the management of frailty is represented by the Programs of All-Inclusive Care for the Elderly (PACE) based in the US. The PACE provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. An interdisciplinary team of health professionals provides PACE participants with coordinated care. For most participants, the comprehensive service package enables them to remain in the community rather than receive care in a nursing home. PACE is a program under Medicare, and states can elect to provide PACE services to Medicaid beneficiaries as an optional Medicaid benefit. Only the PACE programs reports on the successful training to pharmacists aimed at involving them in the activities of interdisciplinary teams engaged in many services to frail old people, like medication dispensing and distribution, drug utilization reviews, and so on. Papers reporting on information/education services conducted by pharmacists involving frail elderly patients do not refer as well to experiences in the EU, but rather to Australian, New Zealand or Far East countries.

A second search was conducted including in the research keywords the term (multi)morbidity and (co)morbidity, considering that the term "frail" could be too specific and could make us miss relevant papers. Results obtained were much more encouraging, giving evidence that many experiences on training and education of pharmacists to activities like medication review and simplification, prevention of inappropriate prescribing and so on, do already exist in EU countries. Either clinical pharmacists working in hospital settings, or community pharmacists are actually involved in the activities of multidisciplinary teams and receive therefore education regarding specifically drug use for type2-diabetes, GI protection, dementia, COPD and asthma, post-traumatic stress disease, erectile dysfunction, etc. in polymedicated old patients. All these experiences underline that inclusion of pharmacists represents an added value to improve quality in the use of medicines in +65-population, together with the importance of support from computerized systems and of prevision of financial reimbursement to community pharmacists.

A more structured education programme to pharmacist participating in an interdisciplinary course could therefore start from a basis of previous experiences and consolidate isolated results so far obtained.

The literature search brought to a few interesting results.

The PACE program: Home-based long-term care defined that when pharmacists are integral members of an IDT (interdisciplinary team) in various settings, they can provide valuable services in the context of a *PACE* program. In addition to providing medication reviews, pharmacists can work in conjunction with the IDT to enhance patients' compliance, provide education to participants and other health care professionals, and

monitor drug therapy for optimal outcomes and potential adverse events (Bouwmeester C, et al., 2012). The article by Vouri, S.M. and Tiemeier, A. , titled *The ins and outs of pharmacy services at a program of all-inclusive care for the elderly,* concentrates again onto PACE programs: PACE programs offer a multitude of opportunities for pharmacists who specialize in geriatrics, including medication reviews, medication therapy management, therapeutic drug monitoring, fall prevention, quality assurance initiatives, chronic disease management, anticoagulation services, drug information resources, education and inservice programs, medication dispensing and distribution, drug utilization reviews, infection control, and many other services. Senior care pharmacists are uniquely qualified to promote their services to PACE programs and provide quality care to both the interdisciplinary team and participants of the program. (Vouri, S.M., Tiemeier, A., 2012).

The study by Rojas-Fernandez et al., states some specific tasks that a clinical pharmacist can perform in his role: assessment of (1) appropriateness of the drugs on the basis of frailty, (2) drugs that can impair cognition, (3) medication adherence and management skills, and (4) control of vascular risk factors. Pharmacists provide education about medication and disease and conduct home visits to ensure adequate transitions in care (Rojas-Fernandez et al., 2014). An important additional role that a pharmacist can have in the frailty prevention context is falls prevention. Pharmacists can support the identification of those patients at risk of falling and to assist them to minimise their risk and to develop a fall care plan (Truter I., 2011). The work by Hunter KA et al., *Pharmaceutical Care for Home-Dwelling Elderly Persons: A Determination of Need and Program Description* describes the testing of a medication, health and functional status assessment used by a pharmacist with older adults living in the community and how the results of this assessment were used to support the inclusion of a pharmacist on the multidisciplinary team (Hunter KA et al, 1996).

A search of the web regarding the education of pharmacists has also been performed. The results highlighted some experiences, such as the course *Continuing pharmacy education through distance learning-Management of elderly patient: from evaluation to intervention,* held by the Italian cooperative 'CePoss', providing distance learning courses for social and health care professionals. The course provides further education on the cognitive issues in old people either community-dwelling or institutionalized. Other local courses also deal with informing and educating health professionals on aspects of medical malpractice, often underestimated, on the proper use of drugs and the importance of taking care with empathy, science and energy against ageism behaviour. The sensitivity and competence of informed and motivated operators will contribute to help the many frail and sick elderly: they will be more careful in picking symptoms and signs of the "diseases caused by drugs".

As regards multimorbidity, pharmacists can face the important issue of Drug Related Morbidity (DRM). O'Connor, M.N. et al. reports about Inappropriate prescribing detection tools or criteria most frequently cited in the literature are described and their role in preventing inappropriate prescribing and other related health care outcomes are examined, also prescriber adequate training of health personnel (prescribers) in geriatric

pharmacotherapy is desirable, possibly following interactive approaches with direct feedback, more effective than lectures and dissemination of written material (O'Connor, M.N.; Gallagher, P.; Omahony, D., 2012). Another paper relates to the experience of the management of risk of PDRM in the setting of Portuguese community pharmacies. Pharmacists' opinion is that coaching provided on-site is a pivotal element to support the intervention components. It is more efficient than other alternatives, such as follow-up phone calls and interim workshops. Pharmacists pointed out additional benefits for coaching, such as keeping motivation and aiding the learning process by conferring with a colleague (Pereira, Guerreiro; Martins, A.P.; Cantrill, J.A., 2012). The same authors, starting from the assertion that preventable drug-related morbidity (PDRM) is a problem of unacceptable magnitude, report on a pilot intervention to manage the risk of PDRM in the setting of Portuguese community pharmacy. PDRM are identified by the use of validated PDRM indicators. Pharmacist training is provided, as well as on-site coaching. Inter-professional relationship improvement is a fundamental issue. A retrospective review of Home Medicines Review cases performed on 224 community-dwelling older people (65 years or older) reports that medication management in older people is complex and challenging. A suitably trained pharmacist, with full access to the patient medical record and supporting resources, can help to improve the appropriate use of medicines in this population at-risk (Castelino, Ronald L.; Bajorek, Beata V.; Chen, Timothy F.,2011).

Various authors participating in the European Innovation Partnership on Active and Healthy Ageing, Action Group B3, studied on the Mechanisms of the Development of Allergy, WP 10; Global Alliance against Chronic Respiratory Diseases. The AIRWAYS-ICP project is presented, aimed at proposing and implementing on a EU scale new strategies for the management of Chronic Respiratory Diseases, starting from collection of best practices in EU countries and studying models to overcome existing barriers. A multi-sectoral approach is mandatory, including pharmacists in the healthcare professionals. An educational approach to all stakeholders is foreseen (2015).

Continuing education in Italy is focussed on nutrition and communication with elderly citizens.

Patients' education is also very important in this field. The present literature overview also considered works about pharmacists involved in patients' empowerment and their knowledge in drug use in polytherapy (for details on literature search and selection, please make a request for Appendix I).

In **EIPonAHA AG1**, the "State of the Play" publication for 2015 included some EU "Good practises" regarding adherence programs for frail elderly. These programs develop in most cases IT tools to support either health care professionals (HCP, and among them pharmacists) in lifelong education (see **Table 2**, N. 1-5) or frail elderly through mobile devices to keep them in contact with HCP (see **Table 2**, N. 6-11) and to receive counselling to therapy.

Table 2

N.	Organisation	Committent	Country
1	CURIAMO - Centro Universitario Ricerca iinterdipartimentale Attività Motoria	Healthy active personalised performances on youthful walking for ageing liberating knowledge	Italy
2	DSTF Department of Drug Science and Technology, University of Turin	QUELYPHARM - Qualificationog polypharmacy geriatric with optimisation of the use of drugs and diagnostic tests	Italy
3	Scottish Government, Health and Social Care Alliance Scotland	ALISS. Local Information System for Scotland	Scotland
4	University of Porto, AgeUP-Adhere	Fostering Prescription and dadherence actions of regional level - Collaborative digital platforms between healthcare professionals or between HCP and patiens	Portugal
5	Muy Ilustre Colegio de Farmacéuticos de Valencia (MICOF)	Pharmaceutical Home Care project	Spain
6	General Pharmaceutical Council of Spain (Consejo General de Colegios Oficiales de Farmacéuticos de España)	ADHIERTE Programme - electronic devices and alerting systems fot patients	Spain
7	Medical University Warsaw, Medspire sp .zo.o.	Compliance 3D for asthma patients	Poland
8	Catalan Health Service (CatSalut)	Health Education Programme targeting the Elderly on the Correct Use of Medicines (PESGG) - Training programmes and interventions for HCP on adherence management	Catalonia
9	Consejera de Sanidad y Politica Social, Region Murcia	Active and Healthy Ageing Coalition - Lifestyle interventions to improve quality of life and management of disease	Spain
10	AIFA Consortium	Improving Adherence and Concordance to long-term therapies in older patients at regional level	Italy
11	Univesity of Florence, International Osteoporosis Foundation (IOF), European Society for Clinical and Economic Aspects of Osteoarthritis (ESCEO), Fondazione e Medicina (ORTOMED), Region od Tuscany	MONitorinf of prescripion and improving Adherence to anti-Osteoporotic treatments (MONADOS)	Italy

6. EDUCATION AND TRAINING IN PSYCHOLOGY

This literature overview pays particular attention at two main lines. The first BOTTOM UP search, has regarded existing curricula, syllabus and education within academic and non-academic/training models and programmes for professional psychological profiles in the field of ageing frailty and multimorbidity, both at national and international level. The second line, TOP DOWN, focused on searching the web for scientific contributions supporting academic careers and training programmes and models for health and social care staff in psychology.

For the first line, BOTTOM UP, in addition to personal knowledge, the main source of information was the internet, mainly through Google as search engine. Internet provided information about the goals and the acquired competencies at the end of the training programs in geriatrics and gerontology, and little information about the theoretical approach. We wanted to focus on how the training of these professional profiles is developed at national and international level, so it has been necessary to use English and Italian key-words (i.e. university, geriatrics, gerontology) during the search. The first search results allowed us to improve a specific vocabulary that helped us in finding more specific results (i.e. university [and] curriculum [and] psychogeriatric [and] psychogerontology).

For the second line, TOP DOWN, the procedure was quite similar to the first proceeding with a search of online material. In fact, as for the theoretical contents, the search was based mainly on the Psychinfo database, without excluding PubMed and CINAHL, although search on these databases provided results almost zero. Specific keywords, such as Frailty [and] Psychosocial; Frail [and] Psychosocial Frailty [and] Psychosocial; Frail [and] Education [and] Psychological Curriculum, were used but led to poor results. This limitation has led to query alternative and more inclusive sources, such as Google Scholar, always using specific keywords. Even this process has led to poor outcomes. It is likely that the scientific community contributes to the diffusion of theoretical contributions in support of academic and / or training programs through more generic sources or ‘jargon-free’ forms of communication, with a reduced configuration of specialized and scientific information.

Line 2 TOP DOWN, namely the search for scientific papers in support of the contents of academic-educational/training curricula (relating to the line 1 BOTTOM UP) that contributes to the definition of professional profiles with psychological skills in the ageing and frailty field: a summary, from psycnet apa and other sources, is reported of the most significant articles among those that emerged from the search carried out.

Qualls, S. H., Segal, D. L., Benight, C. C., & Kenny, M. P. (2005). Geropsychology training in a specialist geropsychology doctoral program.*Gerontology & Geriatrics Education*, *25*(4), 21-40.

http://www.tandfonline.com/doi/abs/10.1300/J021v25n04_03

The first PhD specialty program in Geropsychology that was launched in 2004 at CU-Colorado Springs is described. Consistent with a scientist-practitioner model, the curriculum sequence builds systematically from basic to complex knowledge and skills across the domains of scientific psychology, research methodology, general clinical, geropsychology science, and clinical geropsychology. Practicum experiences also build skills in core clinical competencies needed by geropsychologists, including assessment, psychotherapy, neuropsychological evaluations, caregiver consultation and counseling, health psychology, and outreach/prevention. Research mentoring prepares students with the skills needed to conduct independent research useful to the clinical practice of geropsychology. Challenges faced in the process of developing the program include the development of a training clinic, balancing specialty and generalized training, building a specialty culture while maintaining faculty integration, attracting faculty and students during a start-up phase, and defining an identity within the field. The mental health services center that was launched to meet training needs while addressing a services niche in the community contributes substantially to the essence of this program, and is described in some detail. Future opportunities and challenges include program funding, heavy demands of specialty training on top of generalist training, maintaining consistency between expectations of clinical and non-clinical faculty, providing interdisciplinary experience, and expansion of practicum opportunities.

Knight, B. G., Karel, M. J., Hinrichsen, G. A., Qualls, S. H., & Duffy, M. (2009). Pikes Peak model for training in professional geropsychology. *American Psychologist*,*64*(3), 205.

http://psycnet.apa.org/journals/amp/64/3/205/

The ageing of the population will increase demand for psychological services for older adults, which challenges the profession of psychology to provide those services. In response to that challenge, professional geropsychology has been developing over the past few decades to meet current and prepare for anticipated future demand. The development of a range of training opportunities is important to enable psychologists to work effectively with older adults. This article describes the Pikes Peak model for training in professional geropsychology. The model is an aspirational, competencies-based approach to training professional geropsychologists that allows for entry points at multiple levels of professional development.

Karel, M. J., Knight, B. G., Duffy, M., Hinrichsen, G. A., & Zeiss, A. M. (2010). Attitude, knowledge, and skill competencies for practice in professional geropsychology: Implications for training and building a geropsychology workforce. *Training and Education in Professional Psychology*, *4*(2), 75.

http://psycnet.apa.org/journals/tep/4/2/75/

Professional geropsychology is a growing area of practice and training. To meet the mental health needs of an ageing population, increasing numbers of psychologists need to develop competence to work with older adults, their families, and related care systems. The Pikes Peak model for geropsychology training (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009) delineates attitude, knowledge, and skill competencies for professional geropsychology practice and makes recommendations for training. In this paper, we define and illustrate the Pikes Peak geropsychology practice competencies through a case example. In the case, an older man with complex needs seeks care through a generalist psychologist in an outpatient setting. The attitudes, knowledge, and skills that the psychologist needs to consider, and implications for training, are reviewed. Training recommendations and resources are provided, with a focus on the training needs of psychologists who wish to expand their practices to include older adults.

Qualls, S. H., Scogin, F., Zweig, R., & Whitbourne, S. K. (2010). Predoctoral training models in professional geropsychology. *Training and Education in Professional Psychology*, *4*(2), 85.

http://psycnet.apa.org/journals/tep/4/2/85

Although small in number, current predoctoral programs in professional geropsychology offer models and training strategies that can guide future program development. Training opportunities exist within generalist programs as well as in geropsychology tracks within broader programs. This article explores the variety of ways by which predoctoral programs can facilitate development of foundational attitudes, knowledge, and skills that comprise the competencies in geropsychology. New programs can benefit from the guidance and ideas offered about how to accomplish professional geropsychology training within a variety of structures.

Hinrichsen, G. A., Zeiss, A. M., Karel, M. J., & Molinari, V. A. (2010). Competency-based geropsychology training in doctoral internships and postdoctoral fellowships. *Training and Education in Professional Psychology*,*4*(2), 91.

http://psycnet.apa.org/journals/tep/4/2/91/

Opportunities for geropsychology training in doctoral internships and postdoctoral fellowships have slowly grown over the years. There will be a need for more geropsychology training programs as the U.S. population ages concurrent with increased demand for mental health services from older adults. This article provides recommendations for competency-based geropsychology training that derive from the Pikes Peak Modelfor Training in Professional Geropsychology. We believe the recommendations provide useful guidance to existing internships and postdoctoral fellowships that offer geropsychology training, as well as to those who would like to establish programs.

Karel, M. J., Gatz, M., & Smyer, M. A. (2012). Ageing and mental health in the decade ahead: what psychologists need to know. *American Psychologist*,*67*(3), 184.

http://psycnet.apa.org/journals/amp/67/3/184/

Until relatively recently, most psychologists have had limited professional involvement with older adults. With the baby boomers starting to turn 65 years old in 2011, sheer numbers of older adults will continue to increase. About 1 in 5 older adults has a mental disorder, such as dementia. Their needs for mental and behavioral health services are not now adequately met, and the decade ahead will require an approximate doubling of the current level of psychologists' time with older adults. Public policy in the coming decade will face tensions between cost containment and facilitation of integrated models of care. Most older adults who access mental health services do so in primary care settings, where interdisciplinary, collaborative models of care have been found to be quite effective. To meet the needs of the ageing population, psychologists need to increase awareness of competencies for geropsychology practice and knowledge regarding dementia diagnosis, screening, and services. Opportunities for psychological practice are anticipated to grow in primary care, dementia and family care giving services, decision-making-capacity evaluation, and end-of-life care. Ageing is an aspect of diversity that can be integrated into psychology education across levels of training. Policy advocacy for geropsychology clinical services, education, and research remains critical. Psychologists have much to offer an ageing society.

Holtzer, R., Zweig, R. A., & Siegel, L. J. (2012). Learning from the past and planning for the future: The challenges of and solutions for integrating ageing into doctoral psychology training. *Training and education in professional psychology*, *6*(3), 142.

http://psycnet.apa.org/journals/tep/6/3/142/

The long forecast “elder boom” has begun. Beginning in 2011, 10,000 members of the “baby boom” generation began turning 65 each day. This demographic shift in our society mandates that predoctoral programs in clinical psychology incorporate ageing as an integral component of their core and elective training. While fully supporting the concept of broad and general training for predoctoral professional psychology programs, the authors maintain that the infusion of ageing into doctoral psychology training curricula has been inadequate. In this article the authors provide an overview of geropsychology training models and discuss the challenges involved in incorporating ageing into the curriculum of predoctoral training in clinical psychology. Potential solutions and examples for accelerating infusion of ageing knowledge base are discussed in the context of different geropsychology training models. The authors conclude that providing services to this rapidly growing segment of the population presents both an employment

opportunity to broaden the reach of psychologists' profession, as well as an ethical responsibility to train future professionals who will practice within their area of knowledge and expertise.

With regard to the line 1 BOTTOM UP, as can be seen from point 3, the overview of academic-educational/training curricula in psychology on ageing about frailty and multimorbidity is rich and complex, although multifaceted and not very characterized only on the frailty among the different levels of education: undergraduate, postgraduate, third-level (masters, PhD and post-doc fellowship), as well as on LLL (lifelong learning).

In particular, usually, the training and academic-educational offer relating to the professions in the fields of ageing and frailty is aimed to integrating among medical aspects / cognitive and their rehabilitation. So it is in psychology too, where training move to the field of educational sciences, the neuro-cognitive rehabilitation and physical and psychological ageing contrast. Analyzing especially the educational institutions of the Anglo-Saxon countries, it was possible to see a clear persistence of an approach largely biomedical, but with a growing push toward the psychological and social issues. The growth in the number of elderly in the population has led to the emergence of inalienable societal challenges, both at the organizational level and at the human level. There is increasing attention to the training of social workers who can provide psychological support to the elderly and to help them not to get excluded from society, through the strengthening of their own resources. In psychology, the predominant profession in the field of ageing and frailty is that of the geropsychologist. The academic-educational/training activity of this profession is based on the integration in particular between developmental neuropsychology and a psychosocial approach. First, we need to fill the gap between the theoretical production and the actual inclusion at the level of academic-educational/training programs. It is also necessary to develop a defined and socially recognized professional identity. This trend on line 2 TOP DOWN seems to recall a need for increased presence of professionals with psychological skills to understand the complexity of the phenomena of ageing and frailty. Essentially, it also recalls the need of a better definition of frailty. There is, in fact, the urgent need to reach consensus among the several definitions of frailty already existing. Sharing the conceptual model of frailty (physical VS multidimensional approach) could be the first necessary step toward the achievement of a shared definition of frailty. In this regard, our current studies adopted the following definition of frailty: "Dynamic state affecting an individual who experiences losses in one or more domain functioning, which caused by the influence of a range of variables and which increase the risk of adverse outcomes" (Gobbens et al., 2010). There is also an urgent need to reach consensus to define a screening tool for the identification of frailty. Currently, there is a wide variety of tools for evaluating frailty in older adults that, for simplicity, could be grouped into two categories: a single domain evaluation, typically the physical dimension, and a multidimensional evaluation, based on physical, psychological, and social dimensions. The presence of many frailty instruments makes it impossible to compare data from different studies.

According to us, meanings and measures for frailty screening should: 1) look at the "whole person" functioning; 2) be multidimensional, detecting variables in the physical, psychological, and social domains, 3) evaluate severity of frailty and classify subjects in different level of frailty (e.g., frail, pre-frail, and robust); 4) collect and combine self-report and performance-based measures.

A multidimensional definition of frailty impacts on health care and social management level; these refer to some needs, for example: screening programs at national level in order to early identify subjects at risk for frailty; interventions in community-dwelling older adults to increase the awareness on the theme of frailty, risk factors for frailty and preventive actions. The impact of this multidimensional definition also concerns issues for research and training of various professional profiles dealing with frailty: detection of the pre-frailty condition, developing a cut-off score for pre-frailty for the most common frailty instruments; implementation of innovative and low cost interventions (e.g., multi-tasking programmes) for preventing frailty, and testing their effectiveness; study of frailty in a longitudinal way in order to evaluate the impact of frailty on negative outcomes and the relationships of cause-effect among variables. Finally, the impact of multidimensional definition of frailty affects preventive interventions. According to these topics, interventions to prevent frailty are urgently needed.

7. SOCIAL WORK EFFECTIVENESS AND EDUCATION

An attempt has been done to extensively search scientific literature databases for social workers' education regarding frailty and multimorbidity. The results from research articles were very poor.

A wider and less specific search has then been carried out through the web and through professionals working in the field. It seems no specific publications have been issued regarding the education of social workers related to the concepts of frailty and multimorbidity, but some first-hand experiences mention the work of social carers with older people. A reference publication, produced by Brian Kerr, Jean Gordon, Charlotte MacDonald and Kirsten Stalker, for the Scottish Executive by the Social Work Research Centre of the University of Stirling, was found through a web search: 'Effective social work with older people', published in 2005. Although not explicitly referring to the concepts of frailty and multimorbidity, the report refers to the social work aimed at protecting and caring for the elderly population in Scotland. The report is aimed at analysing the needs and preferences of the elderly population regarding social work professionals providing for social care and the outcomes of social care services. That is not a report specifically regarding social workers' training and education but it provides with useful elements that could be transferred to educational programmes. Particular attention was then paid to the academic programmes of social work at Torino University, because of local immediate availability of information. The academic programmes for the training of social workers at the University of Torino do not specifically include subjects related to older people's care but rather still refer to 'disadvantaged and vulnerable' groups in the population, considering mainly children

and vulnerable people in general. For this reason, after a thorough reading of the academic programmes and subjects, a deeper investigation of these specific programmes at Torino University was avoided.

The 'Effective social work with older people' review was part of the 21st Century Review of Social Work, for which the Scottish Executive asked the Social Work Research Centre at the University of Stirling to review the evidence base for effective social work with older people. The objectives were: to identify effective and desirable outcomes for older people, including outcomes desired and defined by older people themselves; to identify the distinctive skills required by social workers in order to achieve desirable and effective outcomes and to draw out and discuss the implications for future policy and practice in the field. The paper looks at effective social work with older people with a range of needs and conditions and considers desirable outcomes in a variety of domains and settings. The report particularly highlights the preferences of older people as service users.

Older people may not always identify or distinguish the contribution of particular professionals; rather, they may form a view about the overall quality of services received. Older people value services which can support them in all aspects of their lives, as required, not just with personal care and relationships. Low level preventative help, like housework and gardening, enhances quality of life and helps maintain independence. However, these tasks do not require qualified social workers.

A five-year research and development programme conducted at York University examined outcomes of social care for older people, disabled people and carers. It identified three types of desirable outcome – maintaining current quality of life, facilitating positive change and impacts of the service process. The second of these may be most pertinent to effective social work with older people. 'Change' outcomes to aim for include improvements to physical functioning, confidence, skills and morale. The social and policy context for social work with older people should also be considered. As regards Scotland, for instance, a substantial number of older people live in poverty or face financial hardship. Where possible, effective social work with older people will involve income maximisation, combined with a sensitive approach to discussing financial matters.

Another relevant issue is 'anti-ageism': the evidence shows that older people routinely face discrimination, for example, through stereotyping and denial of opportunities available to other adults. Anti-ageism is an essential part of effective social work, along with consideration of issues of gender, race, disability and sexual orientation. Recent policy initiatives in Scotland emphasise the importance of joint working and a 'Joint Future', notably through the single shared assessment first developed for older people. The Scottish Executive has not issued a framework specific to working with older people, as it has for other service user groups, but integrated services and teams have developed nationally. The Interim Report of the 21st Century Social Work Review notes that social workers in integrated teams have varied experiences of their effectiveness and that clarity of roles and responsibilities, coupled with good support, are essential.

Old age is not in itself a problem, pathology or indication of need. Older people should not be seen as a homogeneous group with a single set of needs. Significant demographic changes affecting projected numbers

of older people must be considered when planning effective future deployment of social workers. The number of people of pensionable age in Scotland is set to rise significantly while the number of people in the age groups most likely to care for older people is decreasing. A lot of these research data could be transferrable to the demographic situation of most European countries, therefore, even if the review particularly considers the Scottish context, many issues could be considered as common and relevant ones across Europe.

There is little research evidence about the impact of mental health problems, other than dementia, on older people. Depression is the most prevalent condition, often linked to loss or poor physical health. However, depression often goes undiagnosed and untreated. The majority of older people aged up to 85 do not report long term illness or impairment. However, certain conditions are associated with old age and can seriously affect people's ability to carry out daily living activities. Social workers may not be best placed to provide assessment and care management in every case but where major loss and change are involved, their particular skill mix will be most appropriate. One in six carers is an older person, many of whom provide a very high level of weekly care. They may have to deal with disabling conditions of their own as well as the demands of supporting another person. Where breakdown or deterioration occurs, perhaps bringing relationship stress, grief and loss, social workers have much to offer in terms of assessment, care planning and counselling.

Standard social work texts contain less information about working with older people than about some other service user groups. At the same time, there are arguments against categorising older people as a separate group, as if different from other adults. Effective social work with older people draws on distinctive aspects of the social work role – sensitive communication, moving at the individual's pace, starting where the client is, supporting the person through crisis, challenging poor practice, engaging with the individual's biography and promoting strengths and resilience. Few studies have evaluated the effectiveness of monitoring and review or the relative outcomes of different approaches to these tasks. There are indications that insufficient attention is sometimes paid to monitoring and review.

Social work tasks include building trust and support, assessing risk and vulnerability, and providing information about and opportunities to discuss different options. Social workers have a number of specific legislative duties relevant to working with older people. In fulfilling these duties, for example in the role of mental health officer or when conducting assessments prior to 'significant intervention' in relation to 'incapable' adults, social workers must, again, balance individual rights with the need to protect and promote the welfare of people in need. In addition, careful mediation between the competing wishes of the older person and family relatives, or between family relatives themselves, may be required. Old age may be marked by experiences of loss, change and transition. Social workers need a good understanding of the significance and impact of life course transitions and the ability to see the older person in the context of his or her life history.

Older people do not require social work support simply because of their age. They will have largely the same range of needs for social work as any other adults. They are most 5 likely to seek social work help or develop needs arising from a combination of conditions and circumstances, often involving loss and change. Social work with older people cannot be considered effective unless older people themselves are satisfied with it. Service users want to be listened to and respected as individuals. Social care with older people is more effective when its intended outcomes are identified at an early stage – during assessment – and built into care planning. Older people must be closely involved in the process, with outcomes based on their wishes and priorities as far as possible. Older people like services which support them in various aspects of their lives, not just personal care and relationship needs. Low level preventive services are valued. Social workers bring a unique mix of skills and expertise to situations of complexity, uncertainty and conflict. These include a 'whole system' view, engaging with the older person's biography, supporting individuals and families through crises associated with loss or transition, helping to ameliorate the practical impact of change and challenging poor practice. 39 Social workers must work creatively with risk. They need finely tuned skills to achieve the 'right' balance between promoting self determination and independence for the older person while, at the same time, ensuring that vulnerable individuals have adequate protection. There is much scope for a positive, proactive approach to social work with older people, for example through income maximisation, promoting individual strengths and capacity, and helping people rebuild confidence and networks following loss or change.

Recent moves towards joint working within a multi-disciplinary setting, and the introduction of single shared assessment, make it imperative for social workers to be clear and confident about their distinctive role. The debate among service planners regarding the appropriate degree and nature of specialism for social workers with older people is little reflected in the literature. However, research and practice experience leads us to conclude that social workers with older people require a strong foundation of core, generic social work skills and values, on which specialist knowledge and skills can build.

The review considers different outcomes in a variety of domains, including promotion and maintenance of independence, assessing and managing risk, assessing and managing vulnerability, personal care and work with families, as well as outcomes in the range of settings in which older people live, for example, care homes, with family, and at home alone.

Methodologically, the research team who wrote the review under consideration combines extensive experience in research in community care for older people with significant practice and management experience of services for older people.

While there is a considerable amount of research and publications about the needs of older people, the impact of demographic change and social policy developments, rather less work has been conducted on

evaluation of 'what works' and what is valued by older people themselves, still less on the effectiveness of what social workers do. Consequently, the findings and conclusions of the work presented here were discussed in a consultation exercise with a number of very experienced and skilled social workers.

A key factor in determining the quality of social care services for older people is the extent to which older people themselves are satisfied with both the assessment of their needs and the services provided. Services which provide high quality care according to economic or clinical criteria are far from ideal if, as a result of that care, the user is unhappy or dissatisfied. A review of the literature on older people's satisfaction with services in Britain and North America (Bauld at al 2000) concluded that "*older people's responses to satisfaction questions are affected by a range of*
complex and interrelated factors. Disentangling the effects of user and carer characteristics from expressed opinions poses considerable challenges for
those hoping to use satisfaction surveys to gauge service quality."

The authors list nine factors or characteristics which they anticipate will influence responses or make interpretation difficult. These include:

- fear of dependency or reprisal
- reluctance to criticise individual workers
- entitlement (users with limited resources receive services as an entitlement; this naturally may reduce their willingness to criticise or comment on quality)
- expectations (Older service users are often characterised as having low expectations of services, which may affect satisfaction ratings. Expectations often centre around interaction issues - the manner in which services are provided rather than the nature of the services or quality of care)
  - lack of knowledge
  - physical and mental health (including cognitive impairment)
  - life satisfaction.
- As part of the wide consultation process for the 21 st Century Review of Social Work, a panel of users and carers was invited to describe its dreams and aspirations for how services should be provided in the future.

  They offered the following ideas:
  - people should be valued as individuals: it is important to be an integrated part of society
  - need to understand where social workers are coming from, and vice versa
  - need to be aware that carers need someone to talk to too
  - freedom from fear and being able to share and contribute in a valued way
  - choice and control through direct payments

• services should be about choice and control as consumers

• engaged listening - social worker's skill of listening important - when practiced, much more effective-life changing

• development of a skill set, centred round issues (the manner in which services are provided) rather than the nature of the services or quality of care.

• need for whole person assessments - not simply about 'ticking boxes'

(Extract from a Minute of a users and carers' panel meeting, part of the 21st Century Review of Social Work, provided by Review staff)

Of particular relevance to Kerr's review, group members emphasised that caring for an older person:

• must be individual, recognising both service users' unique needs, and the other support available to them

• changes over time, with needs often increasing

• must deal with the whole person – not separate 'nursing', 'social' and 'domestic' tasks

• requires sensitivity and flexibility – and involves a relationship

• should attend to dignity, pride and quality of life, not just maintaining life and hygiene (Jones et al., 2001:61).

Group participants in this work for the Care Development Group thought that assessment should:

• be prompt when help was needed

• take account of individual needs, circumstances, and preferences

• use information from a range of sources e.g. GP, District Nurse

• be multidisciplinary and undertaken only once, not lots of times by different people

• be reviewed regularly

• listen to the service user's view – but also not always be totally determined by this because the service user's perceptions can be at odds with what is happening

• take account of and value the family carer's contribution, recognising that carer support can prevent greater needs arising (Jones et al, 2001: 66).

The report continues describing social care local reforms in Scotland and the economic status of the elderly Scottish population, we have therefore avoided to consider those details, although it would be important to report that the brief summary of the financial disadvantage - and in many cases, poverty – faced by older people is relevant to Kerr's essay for two reasons. First, to reiterate the conclusion of other work done for the 21st Century Review Group, social work has a distinctive role amongst the poor and socially excluded sections of our society. Secondly, it highlights '*the important area of income maximisation, often triggered by social work assessment'*: effective social work with older people will ensure that income is maximised through assistance with benefit claims and other financial advice. the social worker's sensitivity in

approaching the subject of financial assessment will be important, particularly if the older person prefers not to disclose, or refuses to accept the services they need because of fears about being able to meet the charge. The introduction of single shared assessment was an important initiative designed to streamline needs assessment, reducing duplication by enabling health and housing staff to play a much greater role in the process. For health staff (district nurses, community based CPNs and so on), working within a culture where health care is always 'free at the point of delivery', the expectation that this will include discussions about charging and involvement in financial assessments, has been a real difficulty and may have slowed the implementation significantly. This is also where the role of social workers becomes very important.

Other important policy aims for the Scottish Executive are social justice and equity, therefore issues like anti-ageism and discrimination are taken into consideration.

"Anti-ageism' is a dimension of social justice and community care services have a particular role to play in increasing the number of older people who enjoy active and independent lives" (MacDonald 2004). Hughes and Mtejuka, quoted by Thompson (1997), define ageism as *"the social process through which negative images of and attitudes towards older people, based solely on the characteristics of old age itself, result in discrimination".*

He identifies one manifestation of institutional ageism as the 'tendency for social work with older people to be seen as routine and uninteresting, more suited to unqualified workers and social work assistants than to qualified social workers'.

Thompson (2001:12) goes on to identify a number of implications for social work assessment. Quoting Marshall (1989) and Fennel (1988), he first argues that assessment should address not only simple notions of need and service availability, but also wider issues which form part of a comprehensive assessment. The second relates directly to ageism and can be divided into two parts. Assessment should include consideration of the impact of ageism on older people's lives, including low self-esteem, feelings of being a nuisance and so on. On the other hand, care must be taken to ensure that ageist assumptions are not influencing assessment. As with racism and sexism,

if we are not actively 'swimming against the tide of cultural and institutional ageism we shall be carried along with it [...]'.

Dominelli (2004) also notes the complexity of the impact of social dimensions such as gender, race, disability, mental health and sexual orientation, in work with older people. She writes:

"the negative image of the older person as dependant and in need of care portrays an ageist construction that treats every older person the same by ignoring the specific needs of older individuals and the contribution that older people as a group have made and continue to make to society" (Dominelli, 2004:137).

Thompson's book was first published in 1993 and it may be argued that effective social work practice has, or should by now have incorporated these ideas and concepts. However, a Joseph Rowntree Foundation

publication (2004) about the priorities which older people themselves defined as important for 'living well in later life', gives pause for thought. The older people involved in these projects did not commonly refer specifically to 'ageism' but the projects reported 'strong' evidence of its existence in the spheres of poverty and a denial of opportunities.

SOCIAL WORK WITHIN INTEGRATED SERVICES

For at least the last ten years, government policy throughout the UK has urged social services, social work, health and housing staff to work together more effectively, as a major strategy for improving community care services. In Scotland, the theme was articulated as part of the 'modernising government' agenda in *Modernising Community Care - An Action Plan* (Scottish Office 1998).

A Joint Future Group was set up to explore these aims further, leading to 'A Joint Future – The Report of the Joint Future Group' published in December 2000. The Scottish Executive accepted the group's recommendations for:

- single shared assessments
- shared information (across health, housing, and social service agencies)
- financial and service management frameworks; and
- joint resourcing and management of services.

The enthusiasm for 'joined up' services is not universally shared, however.

Dalley (2000) goes onto identify three sets of factors affecting the attitudes of all the professionals involved, which severely inhibit the improvements hoped for. These include:

- professional ideology; the shared belief systems which are created and maintained through the development and consolidation of common knowledge bases, along with training processes to which entry is guarded and circumscribed
- the power of cultural allegiance, often associated with particular organisations and their ways of doing things, based on assumption, stereotype and long term unquestioned custom and practice
- force of circumstance, the conditions under which professionals just have to get on with the work, and do their best in trying situations.

Of particular relevance to this essay is a suspicion, harboured by some social workers with older people, that single shared assessment and related integrated service delivery arrangements represent an indifference to and dilution of their particular skills and competence. Having had exclusive responsibility for comprehensive assessments since the introduction of community care, suddenly other professional groups -including housing staff – were expected to share this responsibility, after the briefest of induction and training. Research about multidisciplinary joint work has identified a number of underlying difficultness, reflected in

the fact that social workers in multi-disciplinary teams have varying experience of their effectiveness. There is a need for such teams to be well supported and clear about their goals, and for social workers' roles and responsibilities to be well understood by all team members.

The majority of older people up to the age of 85 do not report having long-term illness or disability. Nevertheless, certain types of physical illness are strongly associated with old age. These include arthritis, and other muscular-skeletal conditions, heart and circulatory diseases and eye complaints (MacDonald 2004).

Many older people will be referred for the first time to social services as a result of

- a fall, or similar accident, resulting in a fracture and hospital admission
- stroke, heart attack or similar sudden onset, leading to admission for treatment or medical assessment
- the advance of a debilitating and disabling condition, such as arthritis, or Parkinson's, to the point where ability to maintain an independent lifestyle without significant support is seriously impaired
- similarly, deterioration and increase in sensory impairment

The most common reason for social work referral is a decrease in the older person's capacity to carry out the activities of daily living. In some situations, treatment, including surgery, may well restore physical capacity, although significant rehabilitation, convalescence and 'intermediate care' may be required before that person's confidence and capacity are sufficiently restored to enable a return to a reasonable quality of life in their own home. Working in partnership with housing and health authorities, social services are able to support rehabilitation with equipment, adaptations, home support and care services. The process of assessment (to ensure that the services to be provided are tailored to meet individual needs) and of care management (to ensure that services remain in place so long as they are needed) is an essential part of supporting the older person.

Projected demographic changes indicate an increased demand for community care for older people in future. Therefore, it is important to be clear about the social work role in community care – as opposed to the role of social care or social services – to ensure the most effective deployment of a scarce resource. The range of difficulties, vulnerabilities and needs of any adult service user group may continue into old age and can be exacerbated by, or combine differently in, old age. Alternatively, many people are referred for social work support for the first time following the onset of physical illness or frailty in old age.

The present reporting of Kerr's work is obviously limited to the year of publication of it, therefore the social workers' skills are not updated with recent developments of frailty and vulnerability syndromes, and one of that work's conclusions is that social workers' skills should be targeted at people with complex or/and rapidly changing needs, rather than having preventive objectives.

Talking about roles, tasks and skills for effective social work with older people, Kerr's review starts by looking at interpretations of the social work role within some standard social work texts, before going on to look at direct work with older people; it will examine the work required in situations where vulnerable older adults may need protection. Finally, social work in health and group care settings is discussed.

To provide a framework, Kerr's work takes a brief look at some standard texts, written for social workers and students, which address the role of the social worker with older people. Strikingly less has been written on this topic compared with the number of publications about social work with other service user groups, such as children and families. At the same time, there are arguments against categorising older people separately from other adults (Midwinter 1990), and, older people do not form a homogenous group with a single set of needs. Nevertheless, there appear to be some distinctive, if overlapping, aspects to the social work role with older people.

Marshall's text, *Social work with old people* (1990) is one of the few dedicated to this field. She suggests that the social work role lies in:

• communication, including sensitive listening and awareness of non-verbal communication
• taking time to assess needs, starting where the older person is
• supporting people with managing crises that arise through loss and change, e.g. bereavement, changing physical and mental health
• supporting people whose lives are constrained by illness and disability
• practical help
• generating and organising resources
• Working with other professionals
• Helping the helpers, including carers and colleagues
• Combating ageism.

In *Quality Work with Older People*, Mary Winner (1992) provides a similar list, adding 'ability to work in an ethnically sensitive way, and combat individual and institutional racism towards older people' and 'capacity to work effectively as a member of a multidisciplinary team, consult with a member of another discipline, and represent the interests of an older person in the multidisciplinary context'. In a different section she writes:

"It is possible that the complexity of some social work with older people is sometimes not fully understood. The work can require fine judgements regarding:

• *acceptable risk taking*
• *the limits of self determination;*
• *family or carers conflicts;*
• *exploitation;*

• *abuse, and*
• *challenging poor practices" (Winner 1992*

Fourteen years later, these themes are still very much to the fore in a text written to support social work students with the new Degree in Social Work (Crawford and Walker, 2004). Community care reforms have resulted in an emphasis on the care management role, but not to the exclusion of engaging with individual service users to try to develop an understanding of their lives and needs. Crawford and Walker focus on the importance of:

• effective communication
• core tasks of assessment, planning, intervention, and review
• understanding of individual experiences and the importance of biography
• empowering and anti-discriminatory practice
• identifying and working with vulnerability and abuse
• partnership working with older people, carers and agencies.

The importance of anti-ageist practice, and the need to promote the strengths and resilience of older people are also strongly emphasised by recent writers for a social work audience (Thompson 2002, Phillipson 2002).
One of the most important features of the NHS and Community Care Act 1990 was the introduction of the right to community care assessment. The intention was to ensure that any services or assistance offered to someone in need were tailor-made to those needs, because they were based on a comprehensive assessment. Services were to be 'needs led', not 'service driven'.
As community care services developed and as skills and understanding of the need for, and importance of, eligibility criteria developed, assessment developed a secondary and perhaps implicit function of creating the basis for prioritisation of allocation of resources or services - in short, a rationing device. Assessments are carried out by social workers primarily to establish the individual needs of older people before creating a package of care services designed to meet those individual needs.
Social work texts emphasise the importance of holistic assessment practice which takes account of a wide range of factors and steers away from routine matching of services to needs (e.g. Thompson 2001). Richards (2000), drawing on case materials in an ethnographic study of assessment of older people's needs, suggests that where older people's perceptions are not given due weight, the risks of unwelcome or inappropriate interventions increase.
The introduction of single shared assessment was intended to 'broaden the range of assessors to include professionals from health and housing and where relevant, other agencies and groups' (Scottish Executive, 2001). More recent guidance has distinguished between care management and care co-ordination and states that care management is 'a complex activity that should be carried out by professionally qualified staff,

suitably trained, who have appropriate skills, competencies, and experience' (Scottish Executive, 2004: 9). The majority of staff undertaking care management are professionally qualified social workers in local authorities and, whilst it is anticipated that there will be an increase in the participation of other key health and social care professionals, social workers are likely to continue to play the major care management role (Scottish Executive, 2004).

Although there is an increasing emphasis on the importance of effective joint working, we have uncovered surprisingly little research into the assessment approaches of different professions in community settings. However, a qualitative study carried out in Scotland in 1998 explored assessments of 18 frail older people, undertaken by social workers and district nurses (Worth, 2002). An ethnographic approach was taken to analysing the process, involving interviews with practitioners and observation of assessment practice. Similarities and differences of approach between district nurses and social workers were explored. It appeared that social workers and district nurses had different, but complementary, areas of expertise which brought together the components of a holistic needs assessment. The two groups covered similar areas of enquiry in their assessments apart from the financial assessments which only social workers were required to carry out. As might be expected, social workers tended to put greater emphasis on social, and nurses on health needs.

As regards momnitoring and reviewing, Kerr's review reports from the literature that : 'Monitoring and reviewing are essential parts of care management if services are to respond to changing needs and resources are to be used to best effect' (Scottish Executive, 2005:11). Assessing the impact of the 1993 community care reforms, Warburton and McCracken (1999) suggest that social service departments did not pay sufficient attention to monitoring and reviewing care of older people. Often social workers are unable to maintain an active involvement in individual care management once needs are assessed and services provided. As the reports of the Care Commission show, good standards of care are not always achieved. The social worker is needed to empower the older person and their relatives to raise any concerns or to advocate on behalf of an older person where the standard of care is inadequate, where it is not centred on the individual and when there is concern about neglect or even abuse. Then, along with the resident and family, the social worker should regularly review the implementation of the care plan, ensuring that it is updated to meet changing needs.

The Community Care and Health (Scotland) Act 2002 (s.8-11) introduced the entitlement for 'substantial and regular' adult carers to have an assessment of their ability to care ('carer's assessment'), independent of any assessment of the person they support. Given the numbers of older people who are also acting as carers, already noted, this development is very relevant

Pickard (2004) has undertaken a comprehensive review of the effectiveness of services for carers in the U.K. She supports her evidence of the efficacy of social work intervention with data from a study of community

care for 419 older people and 238 care givers in 10 local authorities in England and Wales (Davies and Fernandez 2000). This research suggested that counselling and therapeutic

social work activity was effective in reducing stress on carers. The study also found that social work and counselling were highly cost-effective in reducing subjective carer 'burden' compared to other interventions. However, social work intervention was not effective in delaying moves to long term residential care and only a small proportion of carers (18%) were found to have access to a qualified social worker.

It is vital for effective social work with older people that the demands of care management are not allowed to prevent social workers from engaging meaningfully with older people and developing a good understanding of their lives, needs and wishes. There is a risk of assessment becoming bureaucratic, being used primarily to ration services rather taking a holistic, user-centred approach. Care management should not be seen as an alternative to counselling and casework, where these are needed. It is important for social workers to take a positive and proactive approach to working with older people, for example, through anti-discriminatory work, by promoting individual strengths and resilience, and by helping rebuild confidence, self-esteem and social networks following experiences of loss or change.

A key task in social work with older people is to weigh up the promotion of independence, self determination and individual rights against the need to provide sensitive protection to vulnerable adults facing risk. Achieving what is often a fine balance between these competing demands will involve building trust and support, careful assessment, opportunities to discuss different options, protection planning, monitoring and review.

There is evidence about the effectiveness of social work in a range of settings, including health care, group care, care homes and in work with families and carers.

Moreover, research and development work has found that social care is more effective when its intended outcomes are identified at an early stage - when carrying out assessment and care planning. Older people must be closely involved in this process, with outcomes based on their wishes and priorities as far as possible. Rather than accepting maintenance of the status quo as a desired outcome, wherever possible effective social work will aim to bring about positive change, such as improved physical and emotional well being.

Other work published by the 21 st Century Review has described the context of social work. In this paper, our brief look at context is limited to issues significant to work with older people, notably ageism and poverty – poverty of income, of quality of life and indeed of expectations about services. These issues have long been highlighted in the education and training of social workers, promoting the holistic approach to the whole person in their environment which older people say they value.

Tibbs (2001) argues that some older people 'have special needs which require specialist expertise'. She goes on to describe 'problems' that might occur without specialist knowledge such as *"difficulty in making the initial contact with the person, achieving the balance*

between the person's right to autonomy, and their need for help, and their need for emotional support throughout the process." Tibbs' argument may be best understood as a plea for specialist knowledge and expertise to be built onto the core skills and knowledge of the generic social worker. Work with older people, whatever their presenting problem, requires these tasks to be completed, as in work with other service user groups.

8. INFORMATION COLLECTED BY ACTION EIP-AHA GROUPS

In the framework of the EIP-AHA works, the Action Groups and the Reference Sites Network have developed a *synergy topic* regarding '**Masters of AHA educating seniors, health and social carers and entrepreneurs**'. The working group is composed by: N Goswami, A Nizinska, R Roller-Wirnsberger, P Eklund, J Malva, C Jeandel, H Blain, M Nogues.

Although the concept of *active and healthy ageing* does not correspond to the concept of frailty detection and management - but can have some overlapping elements - the courses considered in the synergy work are a valuable example to be included in the present report.

The work has been developed as follows.

Rationale: Integrated, interdisciplinary and inter-professional education for all stakeholders is needed to tackle the interrelated syndrome of frailty, malnutrition, falls, chronic diseases, and their social consequences.

General objectives: Development of an innovative, dynamic and sustainable care system for AHA by capacity building through senior/patient centred, multidisciplinary and inter-professional educational programmes aimed at patients, patient caregivers (both formal and informal), health and social carers, administrators and entrepreneurs.

Specific objectives:

1- Multi-professional education to improve the links between all stakeholders through better understanding of the knowledge and competencies of each stakeholder.

2- Master of Gerontology and Geriatrics: To develop dynamic and sustainable care systems that will encompass inter-disciplinary, inter-professional education (IPE) and learning (IPL) including RRI business models.

3- Best evidence holistic perspective to bring together research, practice, policies and market by courses in medical, nursing, pharmacy, social, behavioural, psychological, economic physiological, management service aspects related to prevention and management of ageing and using the innovation loop of planning up-scaling strategies.

4- To promote AHA as well as the empowerment of self-care and (care) independency, by placing the older person at the centre of care.

Contribution to the Scaling Up Strategy of the EIP on AHA: The program will be started at the Medical University of Graz, Austria by a well-defined Master of Gerontology and Geriatrics in English. The course teachers and participants will be from different institutions in Europe. This programme will be a pilot for other European programmes. The multi- professional approach will be developed in collaboration with the *European Interdisciplinary Council on Aging* (EICA) gathering professionals from all disciplines interested in AHA also implementing knowledge transfer to political, economic and lay stakeholders in the field. Some examples of education programmes carried out in other regions are given in Table 4.

Table 4: Examples of Masters of Gerontology and Geriatrics in Europe

Austria	Graz Medical University		Master of Gerontology and Geriatrics	English
Austria	Medical Doctors' Association Austria	http://www.aerztekammer.at/veranstaltungen	Postgraduate Training Course for Medical Doctors in Geriatric Medicine	German
Belgium	European Academy of Aging (EAMA)	http://eama.eu	Leadership programme for academic geriatricians	English
France	Languedoc Roussillon (15-17)	http://reseau-ideli-2015.strikingly.com	***Trans Innov Longévité***: Trans-disciplinary, multisectoral, private-public partnership to train and coach on frailty, ageing and independent living	French
Portugal	Ageing@Coimbra	http://www.ed.uc.pt/educ/curso?id=96	Distance Learning Course for Care Providers and the general public	Portuguese
UK	British Geriatric Society	http://www.bgs.org	Spring Postgraduate training course geriatric medicine Edinburgh Scotland	English
UK	University of	http://www.oxford.edu.	Onsite training courses	English

To ensure efficient running of the programme, a scientific advisory committee has been put in place to elaborate a landscape of educational events that will be retrieved from the homepage of the Medical University of Graz/Austria. Experts on the committee will set up quality standards for live as well as long distance educational events in the field of AHA (e-learning). Experts will be chosen by the committee for their educational, clinical and/or research expertise in the field of AHA. The committee will be composed of members from all stakeholders involved in AHA across Europe. The committee will work closely with the members of the RRI framework to ensure evidence based multi-professional education and to deliver educational research results per se.

Expected Outcomes / Contribution to MAFEIP

1- Impact on QOL of seniors

2- Ensure health promotion, literacy, engagement and empowerment of senior citizens in aspects related to adopting interventions and life styles that promote active and health aging (e.g. acceptance of evidence-based interventions, behavioral changes towards AHA).
3- Impact on Sustainability of Health and Care Systems
4- Impact on Economic, Growth and Jobs

The EIP-AHA has then developed a collection of *good practices* in Action Group A3.

The need of shaping a new module for screening, treatment and monitoring of frailty and functional decline as well as a more suitable training offer for healthcare professionals on frailty topics has been proposed by different group members of the A3 action group of EIPonAHA (2013). The Action Plan of the A3 action group on "Prevention and early diagnosis of frailty and functional decline, both physical and cognitive, in older people" of the European Innovative Partnership on Active and Healthy Ageing (EIPonAHA) and the collection of good practices realised in 2013 , registered a number of projects and initiatives concluded or still ongoing. A list of possible experiences to be explored for the relevant synergies with the SUNFRAIL objectives (EIPonAHA 2013) is included herewith:

D	EIPonAHA SELECTION FROM THE GOOD PRACTICEs COLLECTION 2013					
	TITLE	Country Organisation		TOPIC	PAGE	DESCRIPTION
1	Transforming care for Frail older people	UK Department of Health Social Service and Public Safety (DHSSPS NI)		FRAILTY IN GENERAL	84	The PRISSM project will produce e-Learning tools and modules on prevention of frailty and functional decline that are tailored for to train health professionals on caring for frailty patients.
2	Frailty Programme in the Community (FPC)	PORTUGAL UNIFAI and Municipality of Guimarães	2014	FRAILTY IN GENERAL	49	A training programme for health professionals (nurses, physiotherapists, psychologists, nutritionists) - A training programme for young volunteers to work with professionals and older people; - A booklet with guidelines for older people self-care; - Organization of support networks for frail people (including older people, caregivers, health professionals and young volunteers)
3	Frailty detection in the outpatient clinic	SPAIN SERMAS Hospital Universitario de Getafe		FRAILTY IN GENERAL	69	1. Create a database about frailty, frailty risk factors and its consequences. 2. Training courses for primary care and other specialists on frailty detection and interventions using clinical data and technical resources.

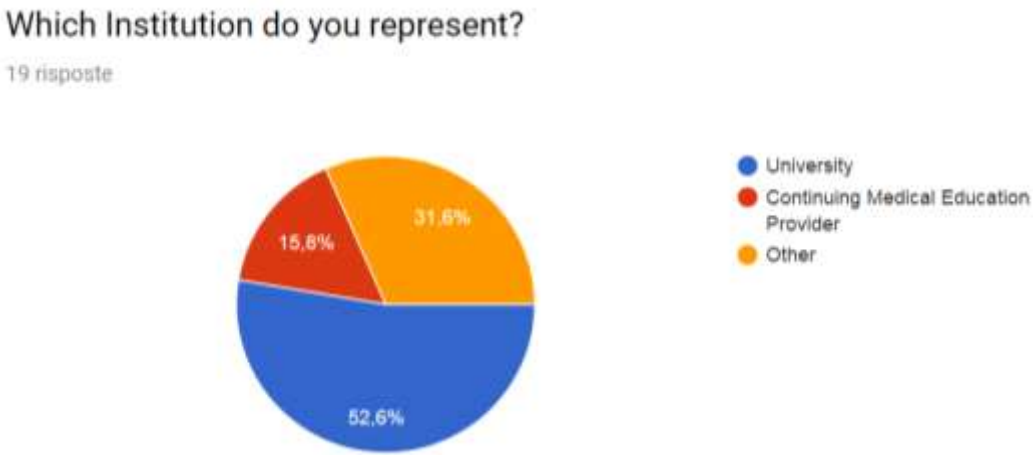
						3. Develop a lab to assess with specific techniques, the functional ability in the elderly (gait, balance, cognitive impairment, body composition, etc) 4. Protocols and guidelines to assess frailty and disability.
4	Old town, new elders Social and health frailty of older residents in Genoa	ITALY Di.S.For, Department of Educational Sciences, University of Genoa, Italy		FRAILTY IN GENERAL	27	Enhances employment and job creation with specific regard to training of students involved in social assistant university degree. Observing and describing elderly people condition in Genoa from the health and socioeconomic perspectives.

QUESTIONNAIRES on SOCIAL AND HEALTHCARE SERVICES

The literature search results obtained by the search were not satisfying. WP7 members have therefore decided to collect some more useful information by using other Sunfrail tools, such as questionnaires (in the workplan).

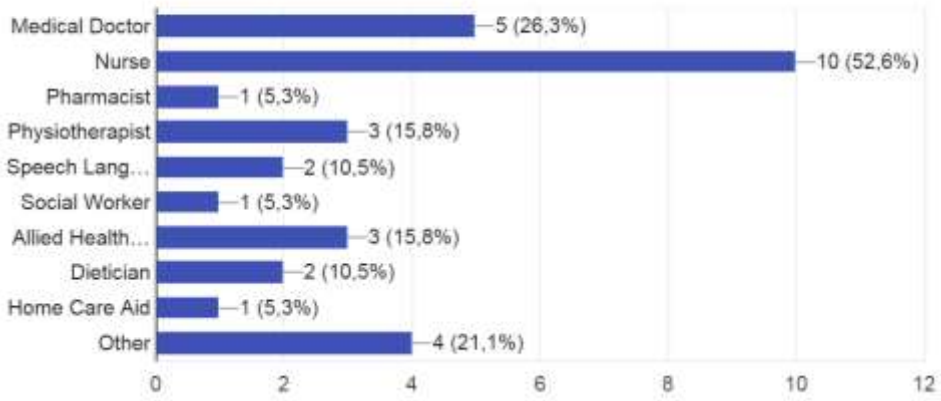
The Sunfrail project provided the partners with questionnaires to be filled in and delivered, in order to elaborate data, information and useful details on the participating partner regions' health and social services.

In this regard, it would be interesting and more profitable to ask directly the training programs designers about the theoretical structure on which their teaching is based and, for this reason, WP7 also provided partners and stakeholders of the EIP-AHA with questionnaires regarding such an overview. Project partners already provided completed questionnaires, but an on-line survey was submitted to EIP-AHA Action Groups. Only 19 participants replied to the survey. The results are illustrated as follows:



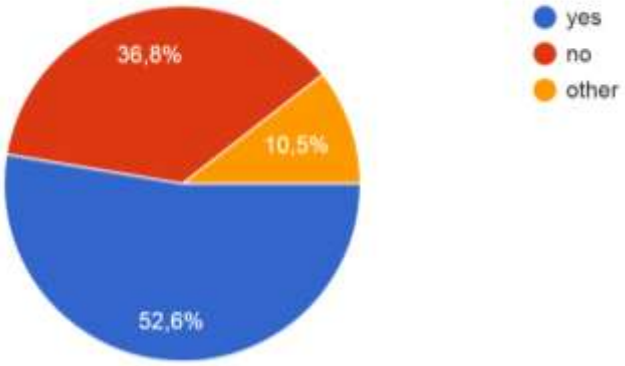
Which professionals attend your education and training programmes

19 risposte



1. TRAINING TARGETS 1.1 Are there training targets set to improve the health and social care professionals' skills in health promotion for active and healthy ageing ?

19 risposte



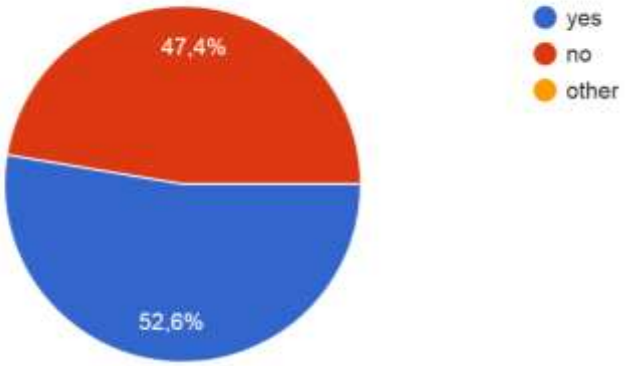
1.1a If "yes" or "other" in Q1.1, please specify

8 risposte

We are searching for increasing good practices objective capabilites
national standards that have to be addressed
holistic approaches, multidomain interventions (social, medical, architectural, psychological, ...)
2nd year of the course called Nursing in chronicity and disability. Al 2° anno di corso è presente un Insegnamento che si chiama Infermieristica nella cronicità e disabilità
In Northern Ireland it is not the role of University to identify training targets. For post-graduate/registration training needs - these are identified within Health and Social Care (HSC) Trusts and commissioned by Department of Health (DoH).
Although the training for the Specialist Trainees in Geriatrics does not include the above, the curriculum does include specific grids for Chronic disease management, Disability and Rehabilitation.
The starting point of the training is to strengthen the sustainability of the client and his social environment. In addition, the nurse interventions of the training shall, wherever possible, aimed at strengthening the self management of the client.
NID pervention program, Healthy Food and Fisical Activity program, Palliative Care promotion project

1.2 Are there training targets set to improve the capacity of health professionals in detecting and/or managing frailty in the older adults (≥65) population?

19 risposte



1.2 b If "yes" or "other", please specify

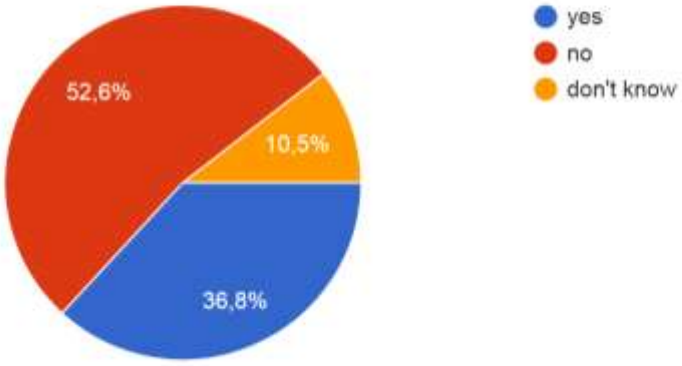
14 risposte

-
same as 1.1
I have read about CME courses devoted to pharmacists in my country regarding frail elderly mangement
Multidimensional assessment tools, Plural-parametric evaluation: comprehensive geriatric assessment (CGA); personalized care and support plan
The teaching quoted above includes several modules: Geriatrics, Oncology, Neurology and Nursing L'insegnamento sopra citato comprende diversi moduli: Geriatria, Oncologia, Neurologia e Infermieristica

Management of FRailty and ist prevention in older adults (Learning objective in undergraduate Clinical Learning Objectives Catalogue)
Not role of University to set targets
No specific targets for this within HSC Clinical Education Centre
The current training curriculum has specific requirements which are essential in managing Frailty. These include Comprehensive Geriatric Assessment (CGA), Management of Acute and chronic illness, Disability, Multi-disciplinary working, Nutrition, Homeostasis and Tissue viability. Trainees also have enhanced exposure to management of patients in sub-acute and community settings through recently introduced 'Acute Care at Home' (ACAH) and 'Enhanced Care at Home services' (ECAH). The British Geriatrics Society (BGS) has also provided guidance on the recognition and management of older patients with frailty in community and outpatient settings through 'Fit for Frailty' tool.
nn
A part of the training is focused on the identification and management of frailty. See my email I have sent you some days ago.

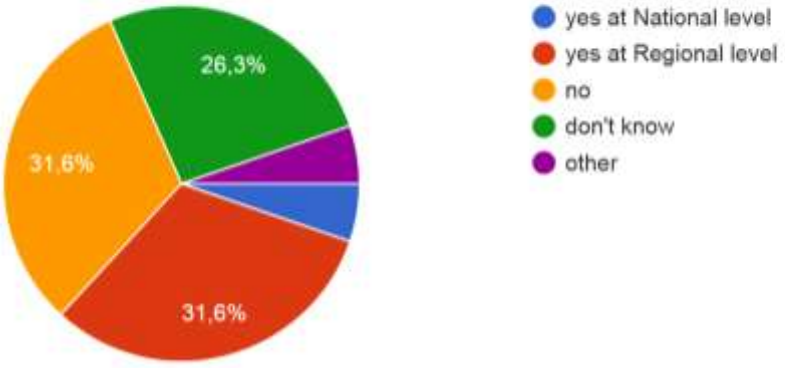
1.3 Are there training targets clearly addressing the difference between frailty, multimorbidity and disability?

19 risposte



2.TRAINING NEEDS 2.1 Are you aware of any surveys which collect health and social care professionals' training needs on periodic basis in your context?

19 risposte



2.1.b If yes in Q2.1a, please provide a short description

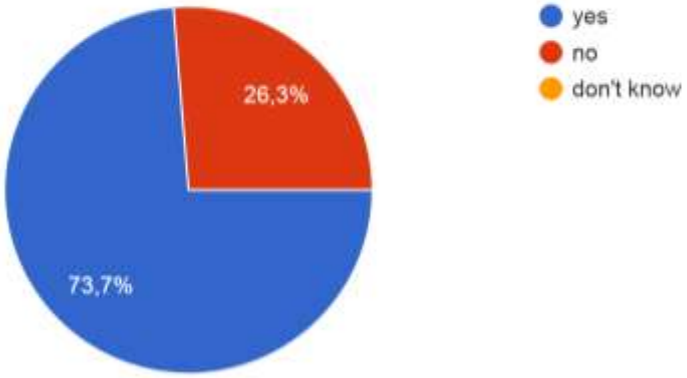
Frailty may not be specifically mentioned but a number of programmes (uniprofessional and multiprofessional) are requested which enable professionals to support patients and their carers in terms of their mobility, rehabilitation and reablement. These programmes would address issues such as mobility, rehabilitation, reablement, Safeguarding, dementia tissue viability, seating and posture, Falls Stroke , chronic disease management, Long term conditions in a range of settings.

The National Training Survey held annually provides a platform for the trainees to highlight any training requirements perceived by them. Trainees also have representation in the SAC and BGS training committees.
The SAC itself is in the process of developing a specific curriculum competency requirement in 'Frailty' –this work is already in an advanced phase.
At the regional level, individual Health Trusts are already developing services addressing the needs of Frail people in both hospital and community settings e.g. Frailty wards, ACAH and ECAH services.

The health board of scotland

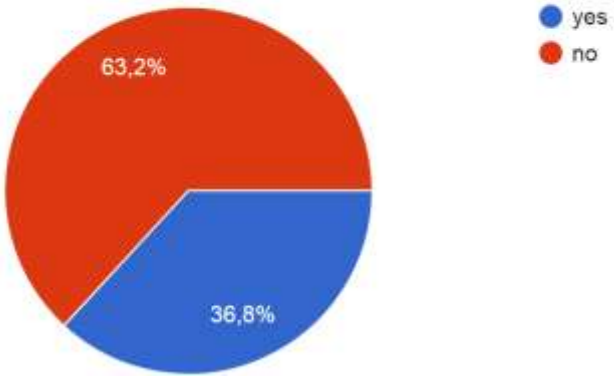
3. TRAINING OFFER 3.1 Does the training you provide include programmes addressing frailty identification and management?

19 risposte



3.2 Do you have any training good practice in the care of older people and/or frailty prevention and management to share?

19 risposte



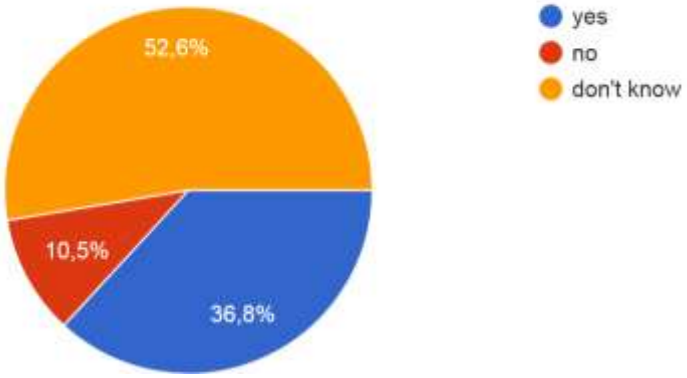
3.2a If yes, please give a short description

6 risposte

We are compiling specific behaviours as good practices in the mealtime
The environmental domain of frailty is included through architectural classes and visits ; Plural-parametric evaluation: comprehensive geriatric assessment (CGA); personalized care and support plan.
3 Day Leadership programme for care home staff - to instill the skills, knowledge and confidence needed for leaders in this sector to take proactive steps in inspiring and leading their teams towards better standards of care and reduce avoidable hospital admissions.
All the above domains are part of CGA which is incorporated in the Fit for Frailty tool.
MSc in Gerontology
In my opinion the Training (1-year) HBO-VGG (nurse Gerontology and Geriatrics)is a good training. I am also involved in a short training 'frail elderly' meant for physiotherapists.

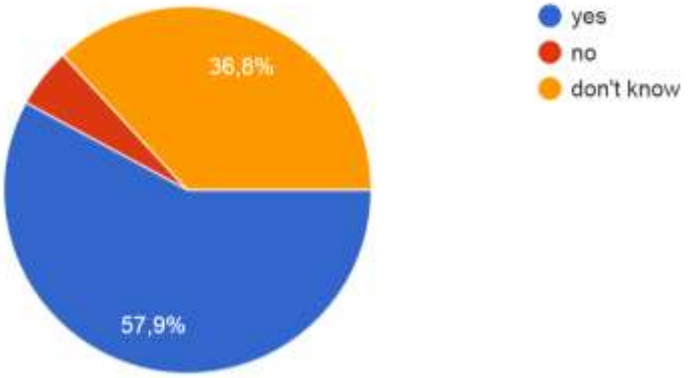
3.3. Are General Practitioners involved in training courses focusing on the management and prevention of frailty in older adults?

19 risposte



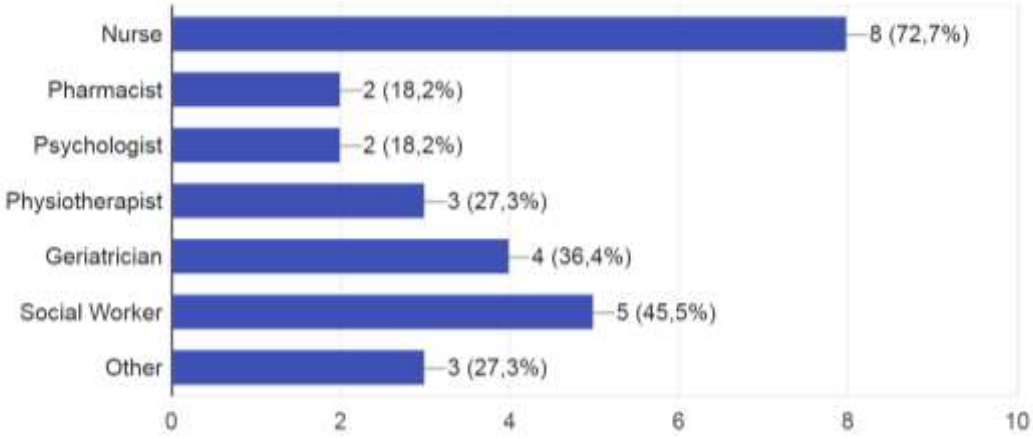
3.4 As far as you know, are there other health / social care professionals involved in training activities in the community setting?

19 risposte



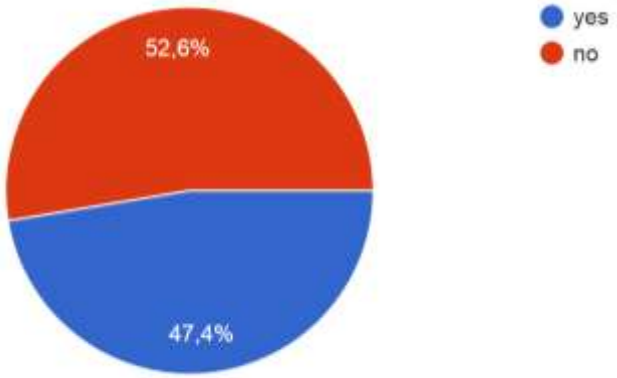
3.4a If "yes" in the previuos question, which professionals are involved?

11 risposte



3.5 Do you offer multidisciplinary and interprofessional training for health and social care professionals addressing the care of older people?

19 risposte



3.5 a If "yes" in the previous question, please give a short description of your programmes

8 risposte

Training programs in manage of behaviour problems in Dementia, Assessment and Quality of Life
all undergraduate nurses and AHP students engage in shared learning
2 Masters and 14 University diploma (DU) in the fields of gerontology, geronto-psychiatry, cardio-geriatry, infectiology in older people, social & health management, frailty, integrated care pathways, nutrition for the elderly, therapeutic and drugs, case manager.
The multidisciplinary and interprofessional education is guaranteed that the Teaching includes modules where teachers are different professionals (geriatrician, oncologist, neurologist, nurse)

Short one day training programmes related to the management of patients with multiple morbidities

Interactive workshop to facilitate collaborative working - Fundamentals For Living Well. This one day workshop was commissioned to support a local Clinical Commissioning Group's 'Care Homes Scheme'. The input from participants throughout the course of the day was utilised by the CCG to support the development of meaningful outcomes in keeping with the ethos of the 'Care Homes Scheme' for people 'living as well as you can in your usual residence'

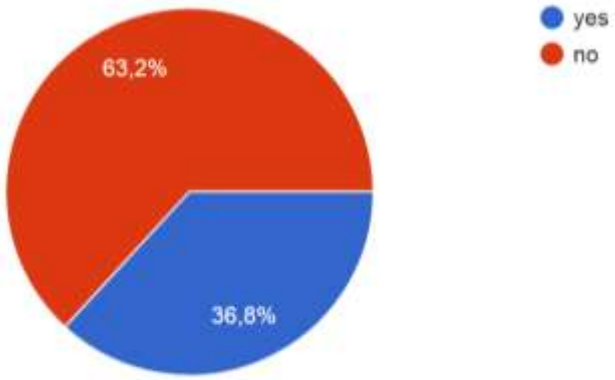
The above model of training is best suited to address the increasing service need of managing Frailty. At present this model is driven by individual specialities like Geriatrics but a regionally integrated approach involving all relevant specialities including Primary care will need developed.

1. Specific competency requirement in the Training curriculum.
2. Supervised Training and standardized assessments for Trainees.
3. Standardized approach in the implementation of CGA
4. Specific section for Frailty in development for the training curriculum.

Msc In Gerontology

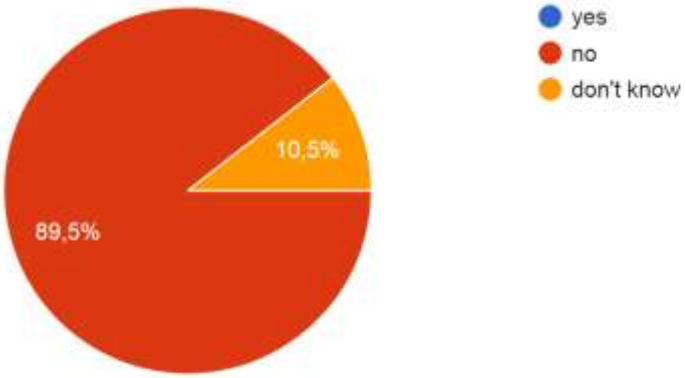
4.1 Does your institution provide training on e-health and telemedicine tools?

19 risposte



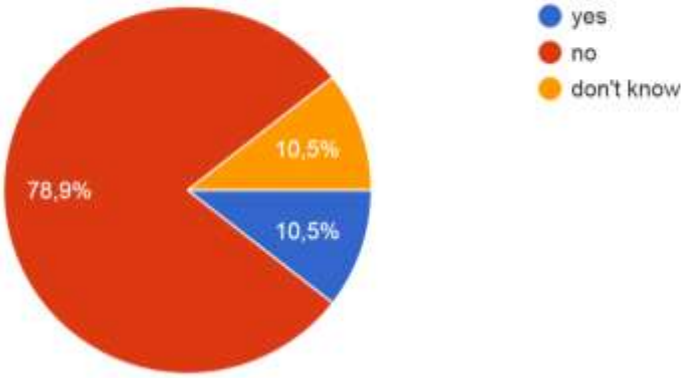
4.2 Do you provide e-health and ICT literacy programmes involving citizens aged +65 and/or their informal carers?

19 risposte



6 Do you offer courses/programmes/information about frailty detection and management, addressed to citizens over 65 and/or their carers?

19 risposte



(The first three respondents to the survey were from: UK, Spain, Italy, Croatia.)