ENGAGE project report 1

FRAILTY AND SOCIAL ISOLATION IN BASEL

Current practices in screening, prevention and management of frailty and social isolation in primary care

A survey report

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- SPITEX BASEL
- Spitex Allschwil Binningen Schönenbuch
- Spitex-Verband Baselland
- Universitäres Zentrum für Hausarztmedizin beider Basel
- Physioswiss Regionalverband beider Basel
- Verband der Psychologinnen und Psychologen beider Basel (PPB)
- Verband der Psychotherapeutinnen und Psychotherapeuten beider Basel (VPB)
- Schweizerischer Verband der Ernährungsberater/innen, beider Basel

CONTENT

ABOUT ENGAGE

The ENGAGE project responds to a growing concern in ageing societies: the complex and often silent challenges of frailty and social isolation among older adults. These issues affect many people in Basel-Stadt and Basel-Landschaft, often in ways that are not immediately visible. While research has shown that physical and social activities can support healthy ageing, these insights have not yet translated into everyday practice. Many older adults do not have access to, or are not able to take part in, programs that support physical and social wellbeing.

Our ambition is to develop locally grounded and sustainable support for older adults to be physical and socially active in ways that are meaningful to them. To do this, ENGAGE is working closely with older persons, healthcare professionals, and community organisations to explore what matters to people and what is feasible in practice. We aim to co-create supportive strategies, materials and tools that can be integrated into everyday community life and adapted over time. This way, we hope to contribute not only to better outcomes for individuals, but to a more connected and responsive system of care.

This report contains the first analysis of a survey with healthcare professionals in the Basel region. This information will be used to better understand current practices, challenges, and opportunities in identifying and supporting older adults, and to inform the development of practice-oriented support strategies.

SUMMARY

The ENGAGE survey collected responses from 80 healthcare professionals in Basel-Stadt and Basel-Landschaft to better understand how frailty and social isolation are identified and addressed.

The majority of respondents indicated they regularly encounter older adults affected by frailty and/or social isolation. Most reported using clinical judgment to assess these conditions, while only a minority used standardised tools such as the Clinical Frailty Scale or the Lubben Social Network Scale. Screening was most often described as sporadic, based on patient characteristics or professional impression, rather than applied systematically.

Commonly reported interventions included promoting physical activity, providing patient education, and individual care planning. Less frequently reported were referrals to structured programs, use of digital tools, or psychosocial interventions such as therapeutic support or social prescribing.

Formal training on frailty or social isolation was reported by only a small number of respondents, and fewer than half expressed satisfaction with the resources or conditions in which they carry out this work. Interprofessional collaboration was considered important by most participants, though levels of coordination and shared planning varied.

POLICY BRIEF

Key findings

- **Screening is inconsistent and tool use is limited**: Most professionals assess frailty and social isolation based on clinical judgment. Use of standardised tools is relatively low.
- **Formal training is lacking**: Only 17% of respondents reported formal education or training in frailty or social isolation assessment and intervention.
- **Interprofessional collaboration is valued but uneven**: While most professionals consider collaboration essential, actual coordination varies and is often informal.
- **Satisfaction with systemic support is mixed**: Fewer than half of respondents were satisfied with the system-level conditions supporting their work in this area.
- **Key interventions are present, but underutilised**: Professionals frequently promote physical activity and provide patient education, but fewer report referrals to structured programs or integration of psychosocial services. There is doubt whether patients will participate in community programs and whether such programs will be effective.

Implications for policy

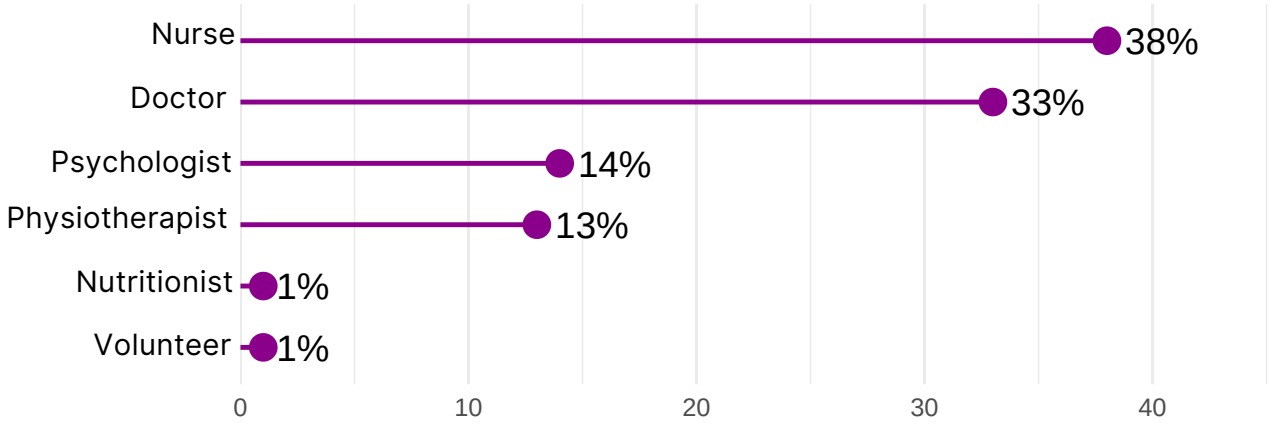
- **Strengthen infrastructure** for interprofessional collaboration, including the development and implementation of digital tools for communication and sharing of information.
- **Explore further reimbursement mechanisms** for preventive services, including frailty screening, psychosocial interventions, and collaborative treatment planning, to enable sustained early action across healthcare settings.
- **Develop and disseminate shared screening protocols** that are simple, validated, and integrated across different settings.
- **Support integrated care pathways** that link, screening, prevention, physical activity, and psychosocial support into routine practice.
- **Pilot local coordination models** to embed early detection and holistic interventions into municipal and cantonal health strategies.

SURVEY

Demographics

- Only healthcare professionals working in the ambulatory setting were included in the survey.559 people opened the survey link. 98 completed the demographic section and met the inclusion criteria. **80 healthcare professionals** fully completed the survey.
- Professional experience varied widely, with an average of 15 years, ranging between 0 and 41 years of experience.
- Participants worked in Basel-Landschaft (45,4%, n=64), Basel-Stadt (41.8%, n=59), and some worked in both regions (12.8%, n=18).

Which healthcare professionals participated?



- Around one third rate their knowledge about frailty as very high or high, and one third rated it as average.
- Self-rated knowledge for social isolation was lower. More than half rate their knowledge about social isolation as average.
- The majority worked in group practices (61.3%, n=49).
- Around half were employed in privately operated primary care settings.

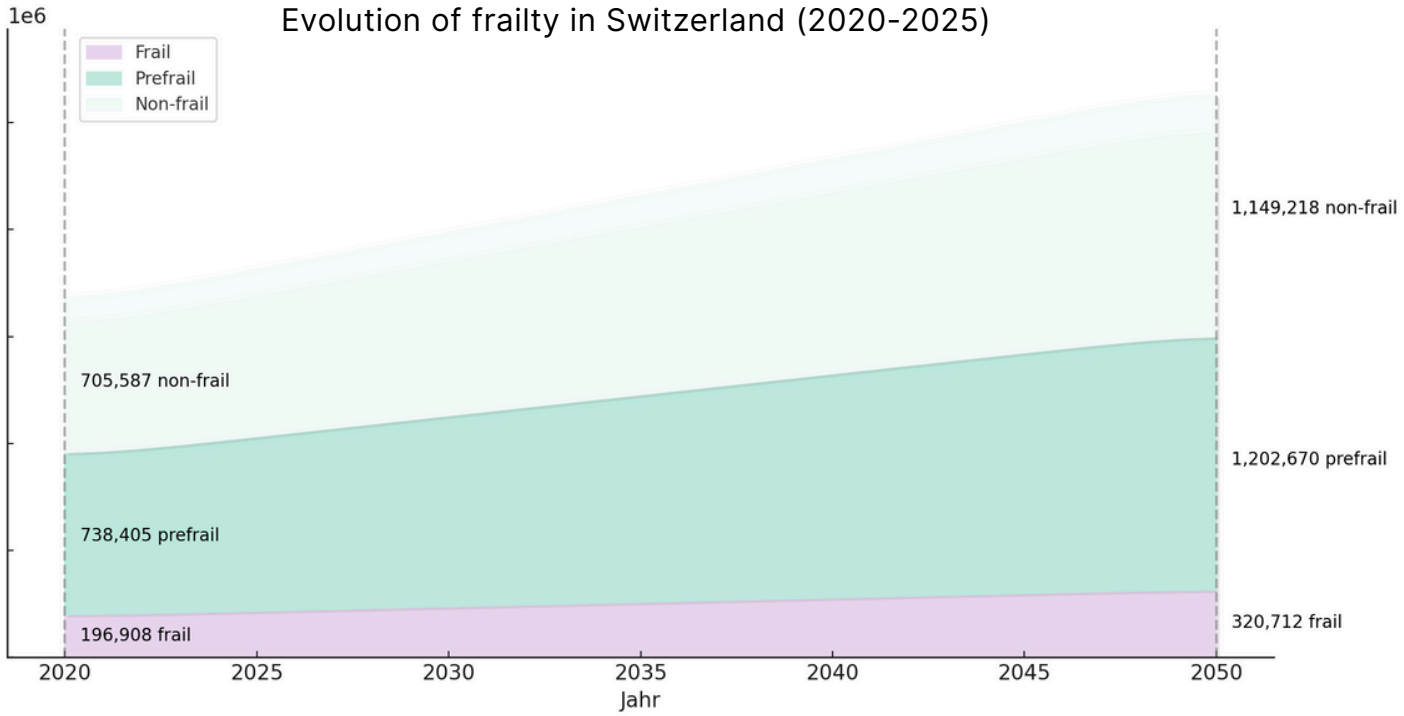
FRAILTY

Frailty is a multidimensional geriatric syndrome marked by a progressive loss of physiological reserves across multiple systems, which increases vulnerability to stressors such as acute illness or hospitalization.

Frailty develops gradually through a combination of biological ageing, comorbidities, inactivity, and psychosocial factors. Evidence consistently identifies physical activity as the most effective strategy for frailty prevention, showing large effects on frailty status, mobility, and quality of life. Prevention is generally more effective than management, especially since 64% of prefrail individuals progress to frailty if left unsupported. Multicomponent interventions, particularly those that integrate physical activity, nutritional support, medication review, and psychosocial engagement, are recommended for a multidimensional management.

The epidemiological burden of frailty is enormous. Currently, the group of older persons in Switzerland who are prefrail or frail almost reaches 1 million. By 2050, this number is expected to increase by an additional half a million, stressing long-term care systems and healthcare financing. International evidence informs that becoming frail adds a yearly cost of around CHF 10.000, on average, because of long-term needs such as managing chronic conditions or fall-related injuries. Without additional investments in prevention, frailty will result in billions of additional costs for society in the coming years.

Evolution of frailty in Switzerland (2020-2025)



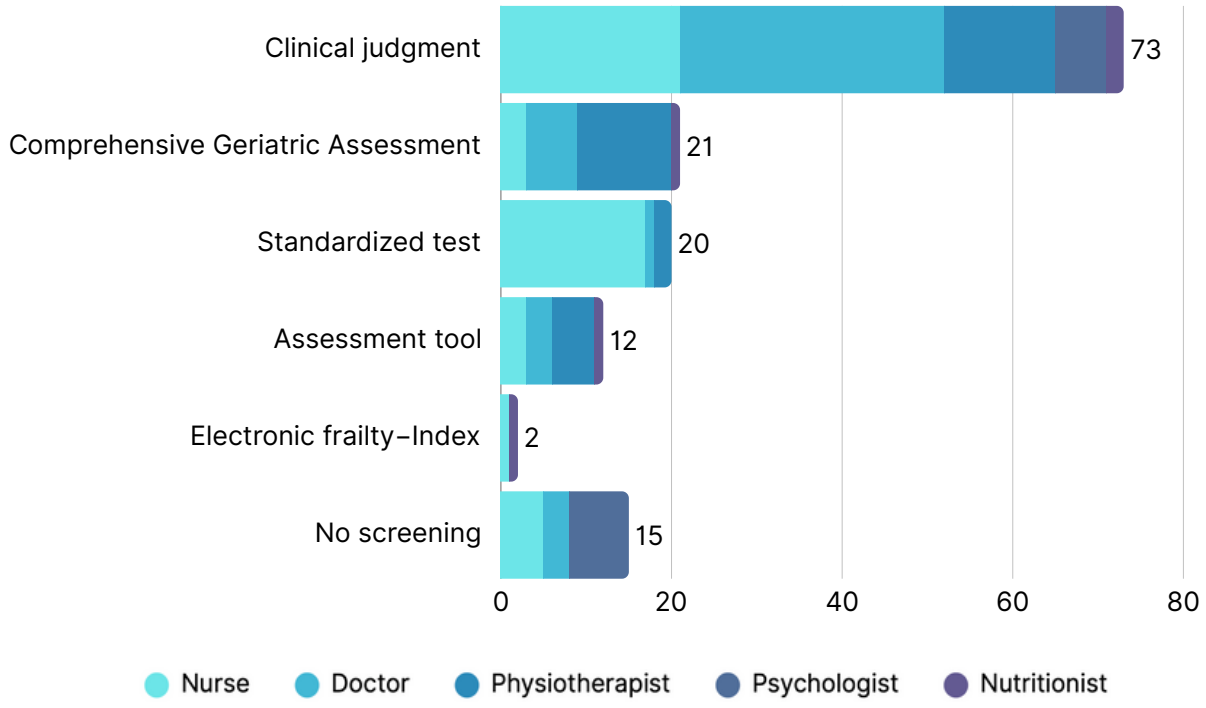
Note: This visualization was created by our team using official Swiss population data from opendata.swiss. The future trends are based on a prevalence model derived from meta-analysis data.

FRAILTY

Screening for frailty

- Most healthcare professionals encounter frail patients on a daily basis.
- The large majority screens for frailty in their practice.
- Screening is most often based on clinical judgement (75%, n = 73), rather than structured tools.
- This trend was consistent across professions, except among physiotherapists, where equal numbers used standardized test and clinical judgement.

How is frailty assessed in practice?



The use of **screening tools** is generally low, with

- InterRAI Frailty Screener (n = 3)
- Clinical Frailty Scale (n = 2)
- PRISMA-7 (n = 2)

The use of **standardised tests** is generally low, with

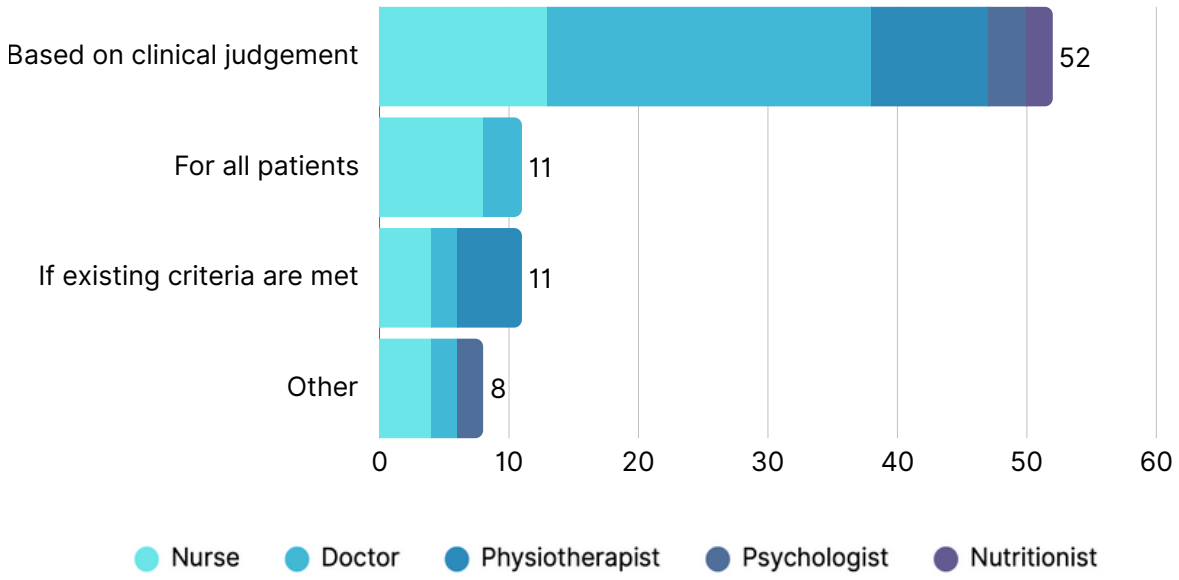
- Timed-Up-and-Go-Test (n = 16)
- Gait speed (n = 12)
- Grip strength (n = 5)

FRAILTY

Screening for frailty

- Frailty is most commonly assessed on a sporadic basis across all professional groups.
- When screening is based on defined criteria, it is typically initiated in response to factors such as the presence of a chronic disease (90 %, n = 9), multimorbidity (81 %, n = 9), a recent hospital stay (63 %, n = 7), acute health events (63 %, n = 7), or advanced age (55 %, n = 6), particularly when combined with a specific condition (63 %, n = 7).

When is frailty assessed?



Frailty screening results are **communicated** to

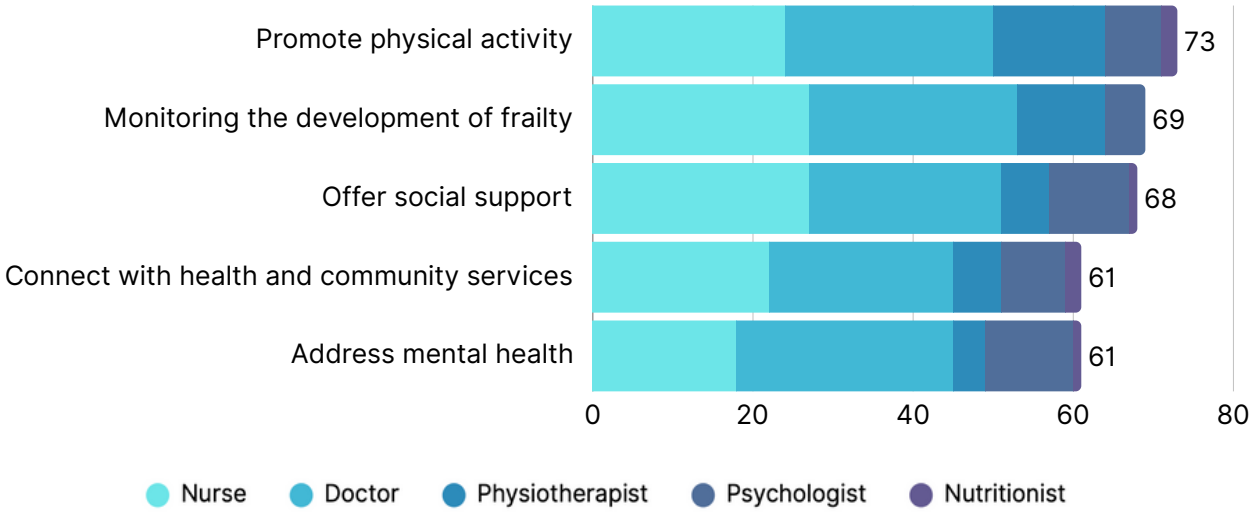
- Patients (72 %, n = 63)
- People close to the patient (52 %, n = 43)
- other healthcare professionals (46 %, n = 38)

FRAILTY

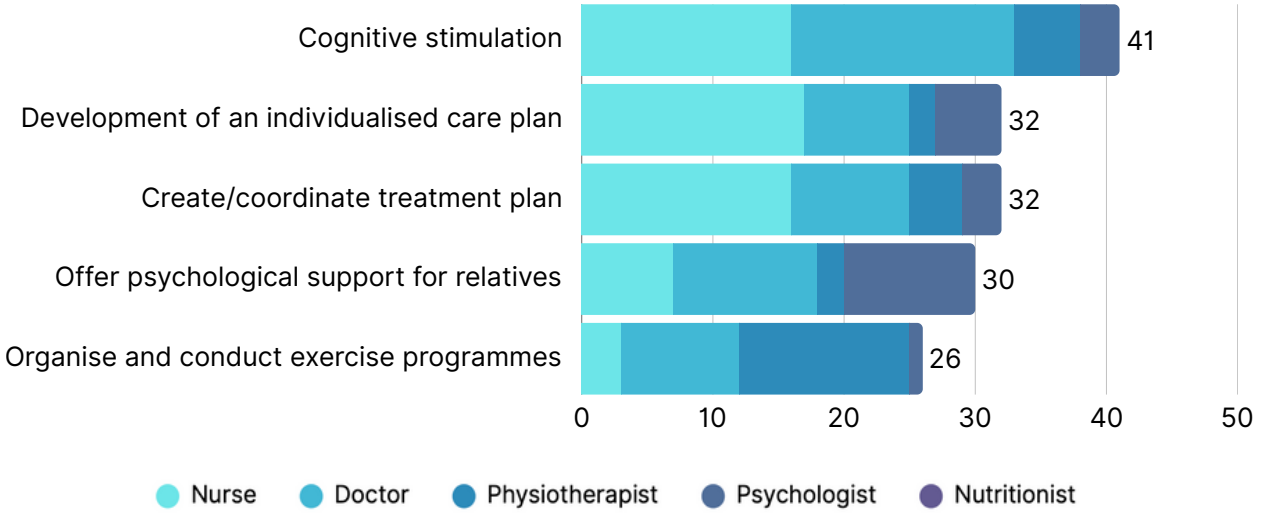
Guideline components implemented

- A diverse range of recommendations to prevent or treat frailty is currently being implemented.
- On average, a healthcare professional implements 8 guideline components in their practice.
- Healthcare professionals mostly follow-up on their interventions through exchange with relatives (86%, n = 84), discuss the patients' experiences on progression (74%, n = 72), and observation of psychosocial or functional results (65%, n = 64).

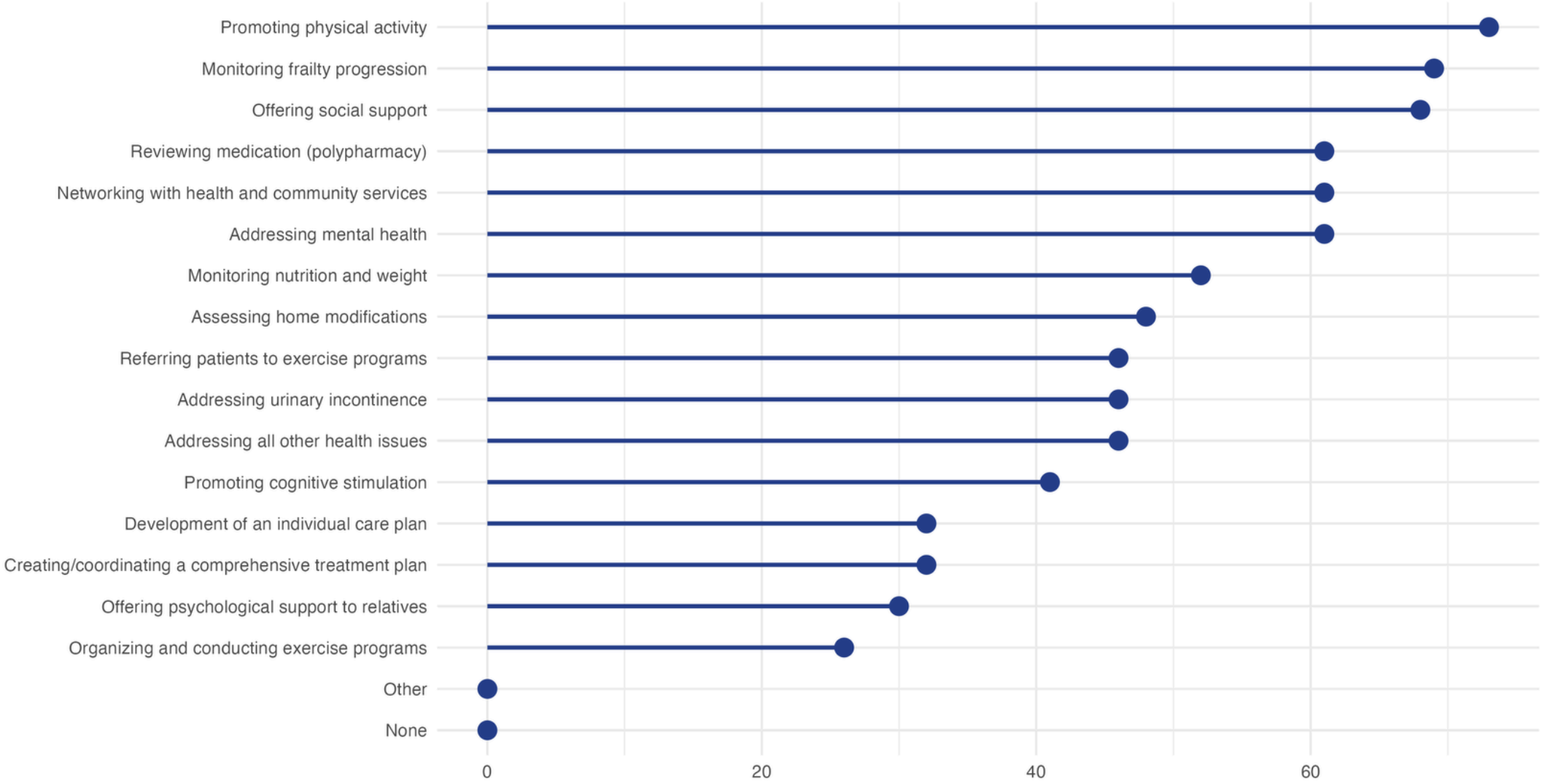
Five most implemented guideline components



Five least implemented guideline components



Currently implemented components of frailty guidelines

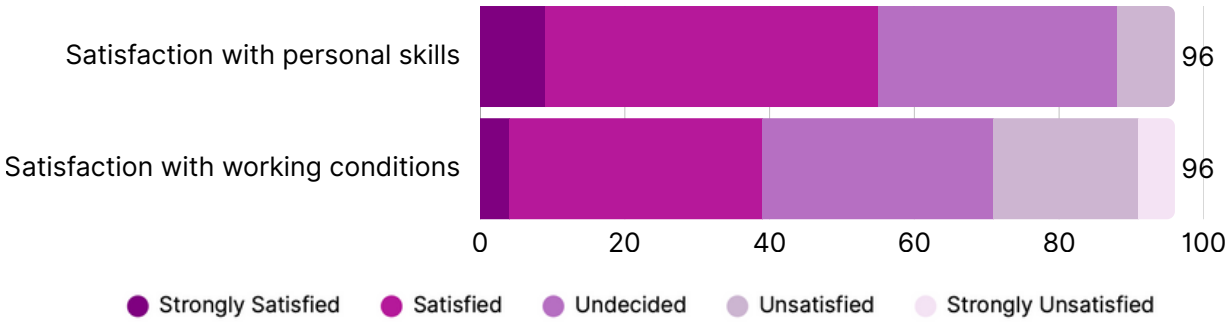


FRAILTY

Practice needs

- The majority of respondents expressed a desire for an evidence-based guideline (66 %, n = 40).
- Some healthcare professionals already base their practice on a guideline (8 %, n = 5).
- Participants reported high levels of satisfaction with their own skills to address frailty prevention and treatment.
- In contrast, satisfaction with the working conditions necessary to support frailty care was notably lower.
- The majority of respondents are undecided (49 %, n = 47) on whether their patients follow their prevention/treatment recommendations.

Satisfaction to prevent or manage frailty in practice



This suggests that while professionals feel personally competent, structural or organisational factors may act as barriers to the successful prevention and management of frailty.

SOCIAL ISOLATION

Social isolation refers to the objective absence or infrequency of social interactions, such as having few people to talk to or low participation in group activities. It is distinct from loneliness, which is the subjective feeling of being alone. While related, social isolation and loneliness represent separate dimensions of social vulnerability and are measured using different tools. In older adults, particularly those living alone or with mobility limitations, isolation is a prevalent and under-recognized concern.

European and Swiss studies consistently report that 20–25% of community-dwelling older persons experience significant social isolation, with even higher rates among the oldest age groups. Social isolation is closely linked with health risks. It not only elevates the likelihood of chronic conditions but also predicts earlier mortality, functional decline, and institutionalisation. Importantly, a bidirectional relationship exists between isolation and frailty: socially isolated seniors have higher risk of becoming frail, and frailty itself may lead to further social withdrawal due to physical limitations or fatigue. This cyclical dynamic can accelerate the loss of autonomy and wellbeing. These pathways are supported by recent studies showing that socially isolated individuals are more likely to be inactive, undernourished, affected by depressive symptoms or elevated inflammatory markers.

Given its modifiable character, social isolation is increasingly recognised as a key target for prevention strategies. Community-based programmes, especially those that combine physical, social, and cognitive activities, have shown promise in reducing isolation and improving health outcomes. Examples include group exercise, leisure clubs, and volunteering schemes.

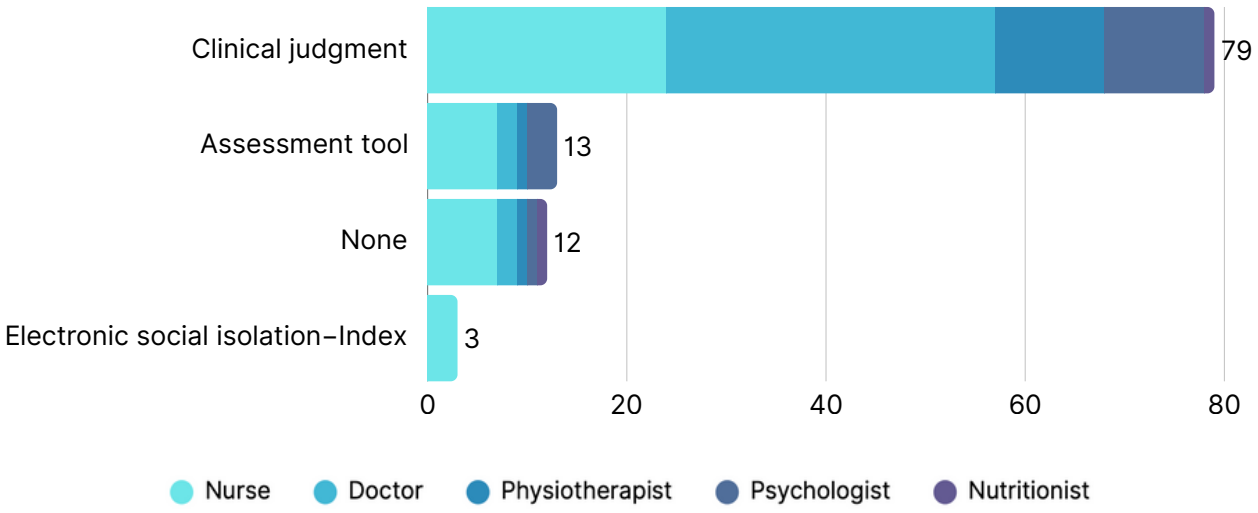
In line with the ENGAGE project’s focus on strengthening resilience in ageing, addressing social isolation is essential, not only to reduce psychosocial risk but also as part of an integrated approach to healthy ageing and frailty prevention.

SOCIAL ISOLATION

Screening for Social Isolation

- Most healthcare professionals (52 %, n = 48) encounter socially isolated patients a few times a week.
- Screening is strongly based on clinical judgement (88 %, n = 79), rather than structured tools.
- The trends were consistent across professions.

How is social isolation assessed in practice?



The use of **screening tools** is generally low, with

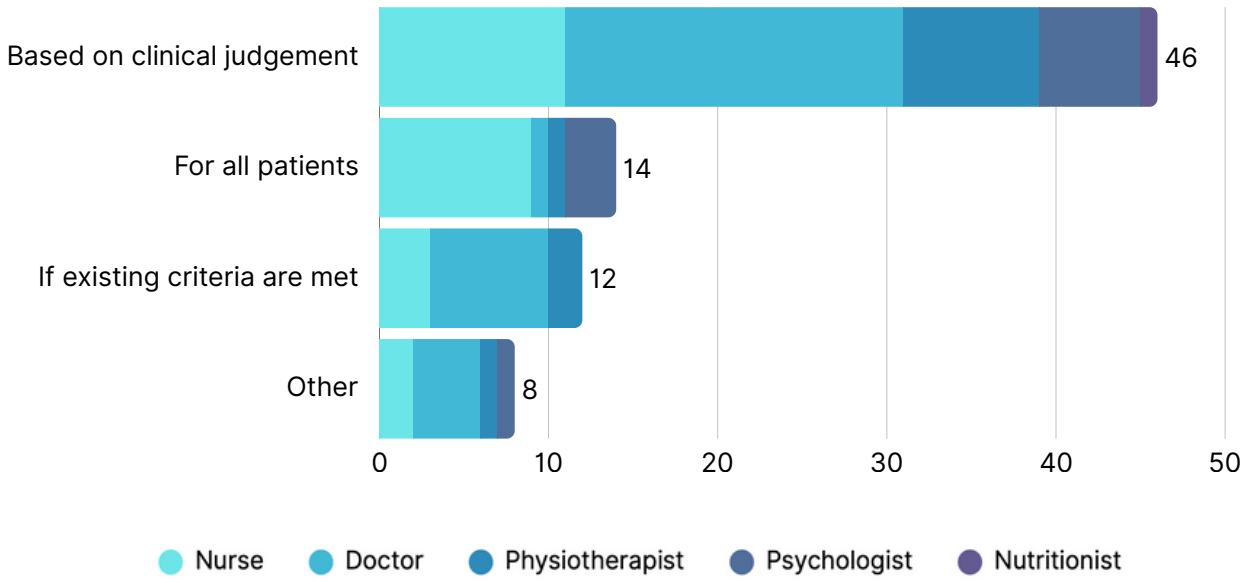
- Frequency of social contacts (n = 5)
- InterRAI (n = 5)
- Social Isolation Score (n = 1)

SOCIAL ISOLATION

Screening for Social Isolation

- Social Isolation is often assessed on a sporadic basis across all professional groups.
- When screening is based on defined criteria, it is typically initiated in response to factors such as living alone (n = 5), older age (n = 3) or mobility restrictions. (n = 2).

When is social isolation assessed?



Social isolation is **communicated** with

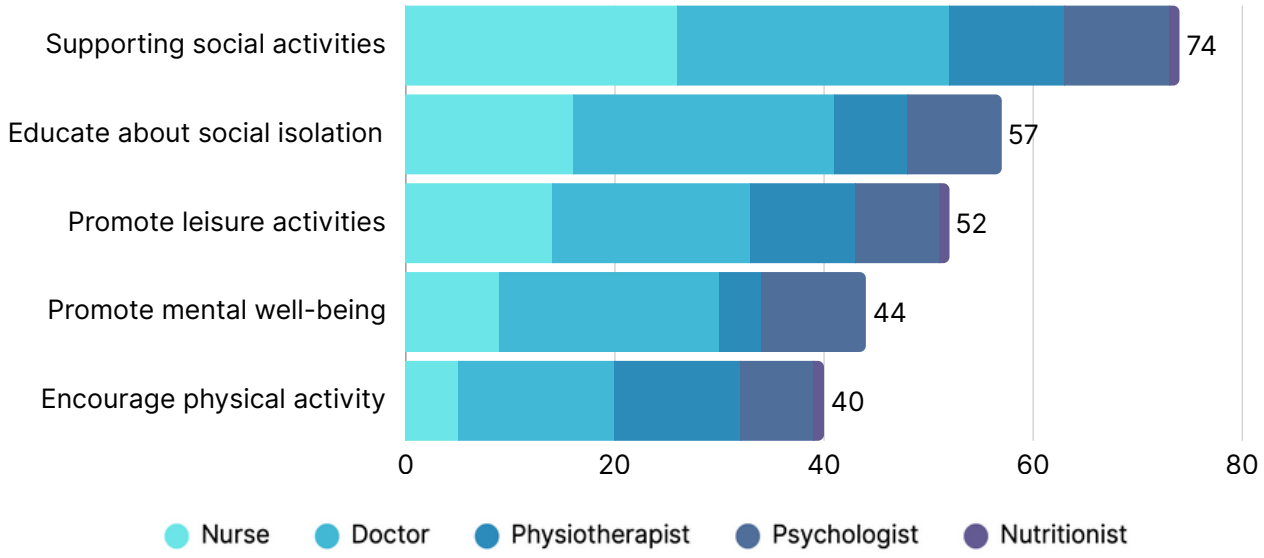
- Patients (n = 58)
- People close to the patient (n = 43)
- Other healthcare professionals (n = 25)

SOCIAL ISOLATION

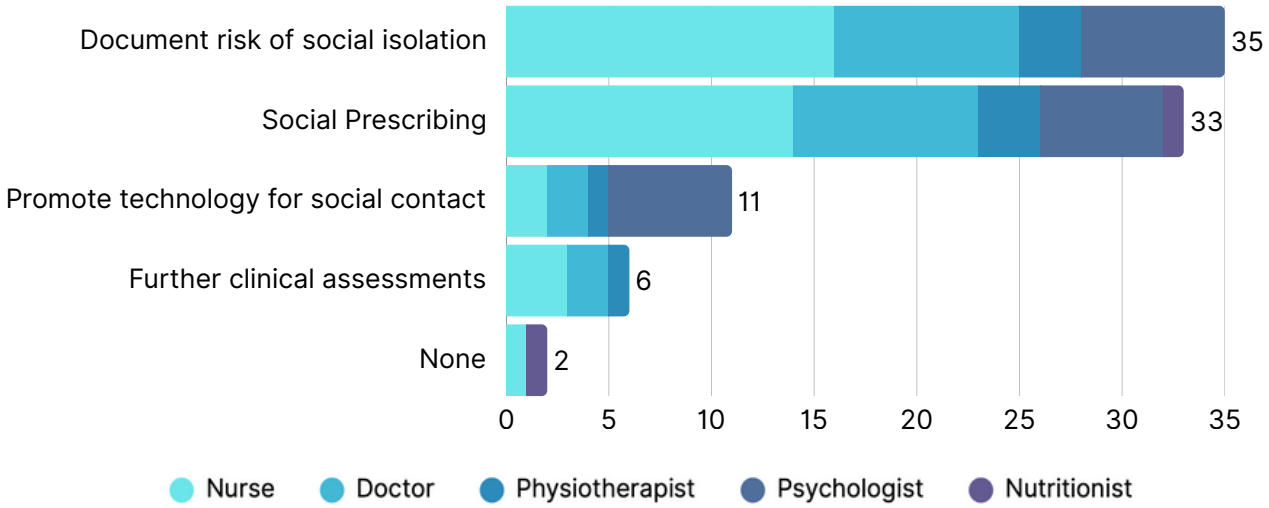
Guideline components implemented

- It is less common to implement interventions for social isolation than for frailty.
- In relative numbers, psychologist implement the most interventions.
- Almost half of respondents are undecided on whether their patients follow their intervention recommendations.
- To follow-up on the success of their recommendations healthcare professionals use patient experiences (8 1%, n = 73) or track participation (50 %, n = 45).

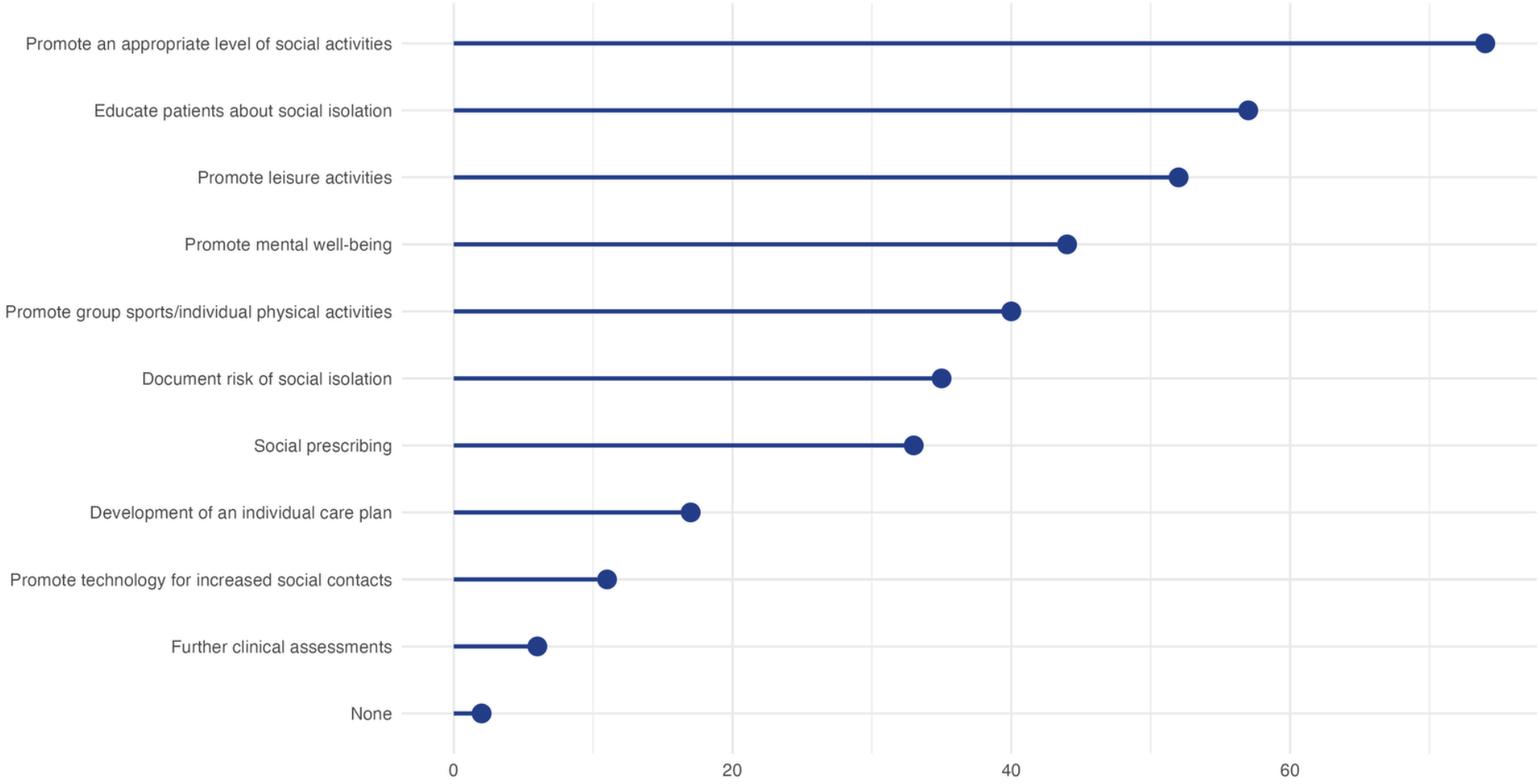
Five most implemented guideline components (absolute numbers)



Five least implemented guideline components (absolute numbers)



Currently implemented components of social isolation guidelines

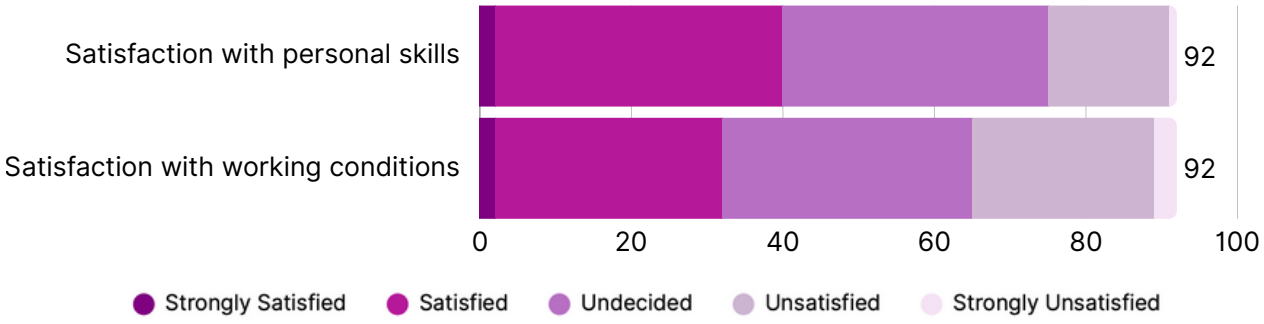


SOCIAL ISOLATION

Practice needs

- The majority of respondents expressed a desire for an evidence-based guideline (71 %, n = 41).
- A smaller number of particiapants is already using one (5 %, n = 3).
- Participants reported high levels of satisfaction with their own skills to address social isolation prevention and treatment.
- In contrast, satisfaction with the working conditions necessary to support social isolation care was notably lower.

Satisfaction to treat or prevent social isolation in practice



This suggests that while professionals feel personally competent, structural or organisational factors may act as barriers to the successful prevention and management of social isolation.

COLLABORATION

Many older adults live with a combination of medical, functional, and social challenges that evolve over time. Supporting them often requires input from different professionals, each bringing a distinct perspective. In practice, working together effectively across professions can make care more coherent, timely, and centred on what matters to the person.

Interprofessional collaboration is seen as a key part of integrated care, particularly in the context of frailty prevention. Frameworks such as the World Health Organization's Integrated Care for Older People (ICOPE) and Integrated People-Centred Health Services (IPCHS) emphasise the importance of coordinating services across settings and professions to support older adults in remaining healthy and independent for as long as possible.

However, collaboration can be challenging. Time pressures, limited communication structures, and differing responsibilities or documentation systems can make coordinated working difficult, even when there is strong motivation to collaborate. These are not individual shortcomings, but common system-level issues across many care settings in Switzerland and the world.

At the same time, many professionals already engage in informal coordination and know the value of trusted local relationships. Where collaborative practices are well supported, through shared tools, clear referral pathways, or regular opportunities to meet, teams report greater confidence in working together and better outcomes for patients.

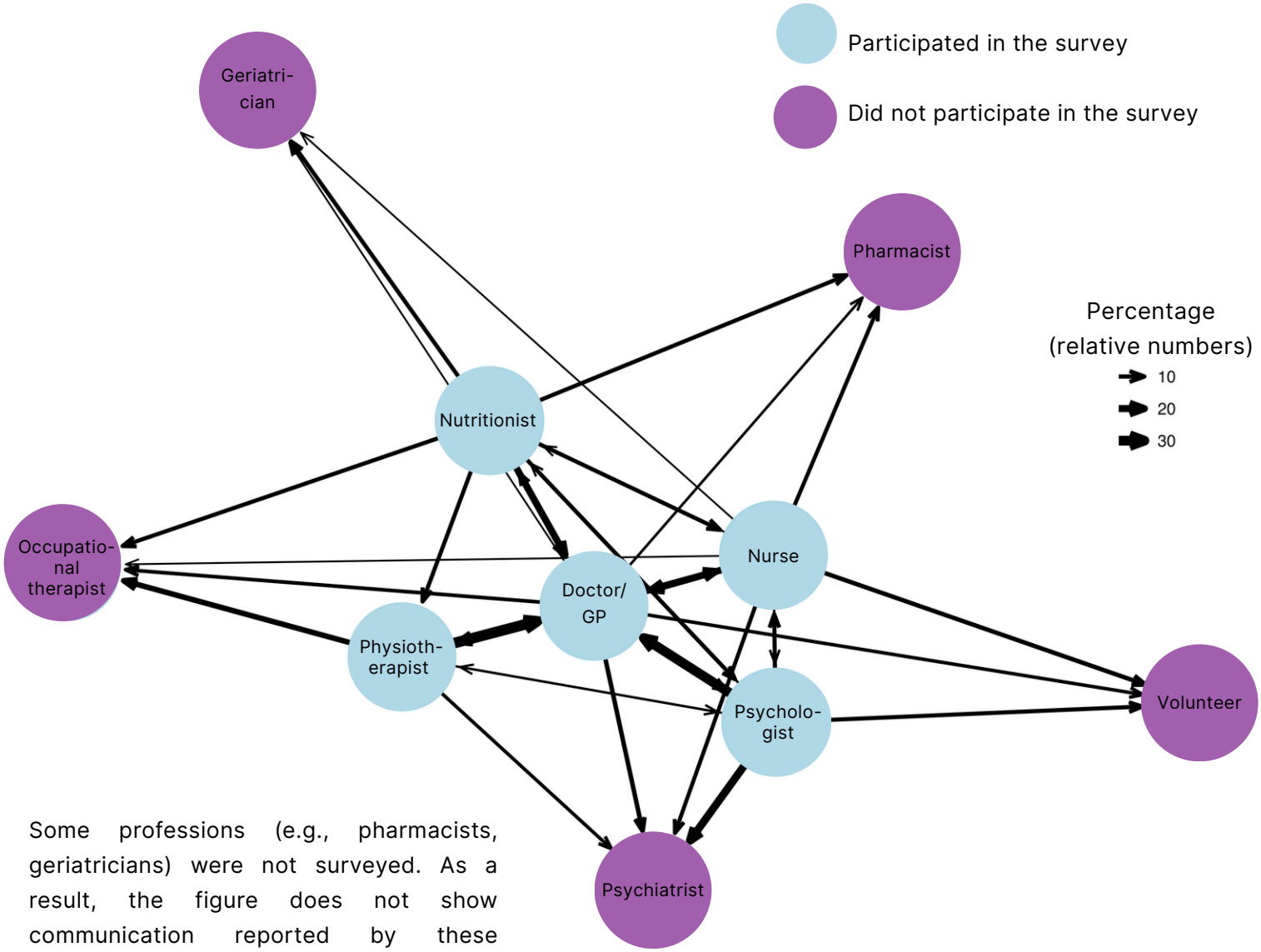
Collaboration is not always easy, but it remains an important part of care that many professionals value. As care needs grow more complex, the ability to connect around shared patients in small, feasible ways may help make prevention more timely, care more consistent, and ageing in place more achievable.

COLLABORATION

Communication patterns

- Nurses and doctors communicate with the most diverse group of healthcare professionals.
- Across professions the most frequent communication partners are nurses, general practitioners, physiotherapists.

Figure: the arrows show the direction of communication (see important note below). The thicker the line, the more frequent the contact.



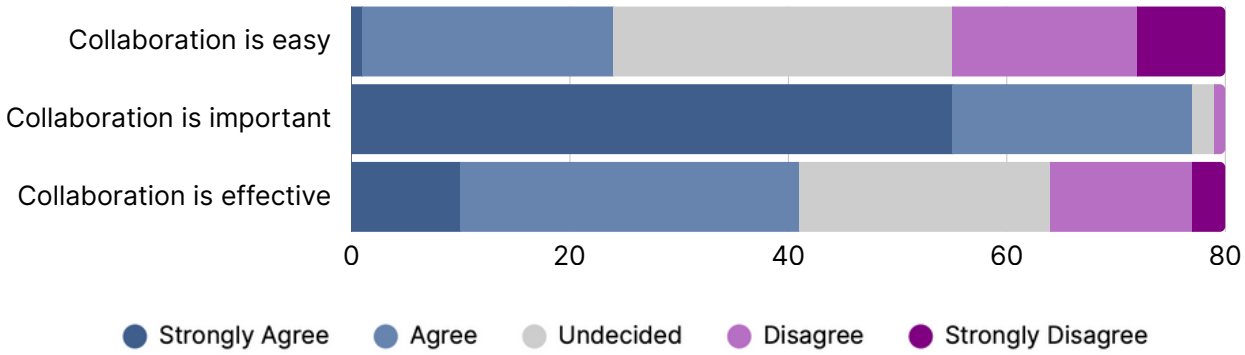
Some professions (e.g., pharmacists, geriatricians) were not surveyed. As a result, the figure does not show communication reported by these professions, only communication to them . This may give the impression of one-way communication patterns, which is a limitation of the survey design.

COLLABORATION

Communication patterns

- The communication frequency is very diverse amongst partipants.
  - More than half communicates once per month or less with a colleague
  - Around one fifth communicates on a weekly basis.
- The three most frequently reported reasons for communication between healthcare professionals are:
  - Coordination of patient care implementation (45%, n = 40)
  - Joint development of patient care plans (38%, n = 34)
  - Communication about shared care plans (29%, n = 26)

Perceptions regarding interprofessional collaboration



- Professionals more frequently reported initiating collaboration themselves rather than being approached by others, suggesting a perceived lack of reciprocity in collaborative efforts.
- While participants viewed interprofessional collaboration as very important, they were less likely to agree that it is easy or effective.
- This suggests that, despite recognising its value, healthcare professionals encounter barriers that hinder successful collaboration.

ACTIVITY PROGRAMS

Community-based activity programs are gaining recognition as a promising approach to support healthy ageing. These programs, which include walking groups, movement classes, gardening, and group-based social activities, offer older adults an opportunity to remain physically active, socially connected, and meaningfully engaged in their communities. Over the past decade, research has shown that participation in such programs can have a measurable impact on both frailty and social isolation.

Frailty is not solely a medical condition but a dynamic state influenced by physical, psychological, and social factors. Community activity programs help address these in combination. They contribute to improved mobility, balance, and strength, while also encouraging regular routines and social interaction. Importantly, the evidence suggests that programs which are consistent, group-based, and tailored to the participant's functional level tend to be the most effective. The social aspect of these programs is often just as critical as the physical one. Shared activity fosters a sense of belonging and mutual encouragement, which in turn supports sustained participation and psychological well-being.

Community programs can help mitigate isolation by creating safe, welcoming spaces where older adults can interact with peers. They offer opportunities not only for connection but for rebuilding confidence, particularly after illness, loss, or life transitions. In some cases, participation in these programs has been shown to restore a sense of purpose and identity.

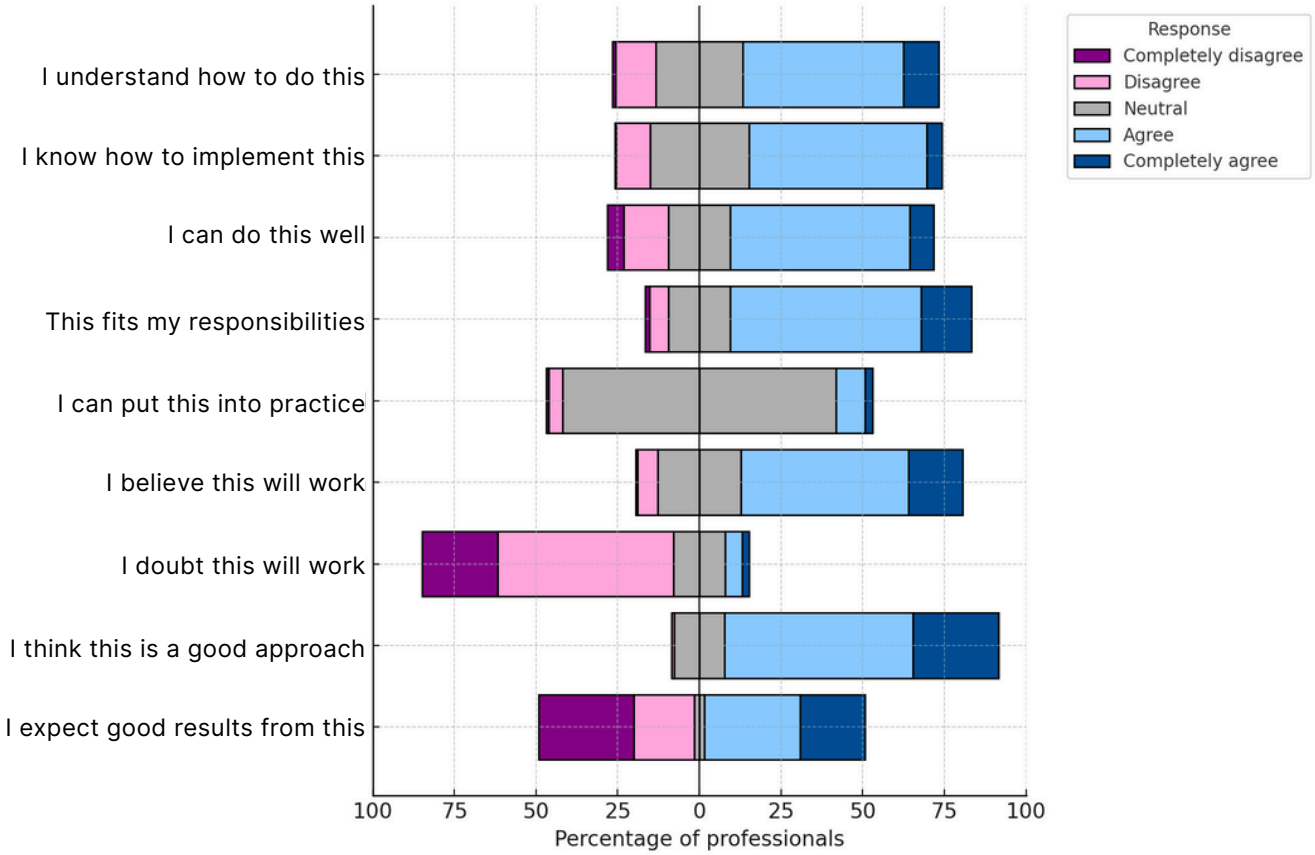
Despite these benefits, several barriers remain. Many older adults face challenges in accessing programs due to limited transportation, cost, or lack of information. Others may be hesitant to join without a trusted recommendation. Healthcare professionals are well-placed to support participation. Structural coordination between health services and community programs is still limited in many regions. When implemented with attention to local context, accessibility, and participant needs, community activity programs represent a low-cost, sustainable strategy to promote resilience in old age.

ACTIVITY PROGRAMS

Engaging older persons in activity programs

- Almost all participants were aware of local activities or community programs for older persons.
- In general, healthcare professionals have the knowledge and skills to promote activity programs, and see it as part of their job, showing a positive attitude. This is confirmed by a large percentage disagreeing to pessimistic views.
- The behavioral control item indicates that professionals are largely neutral on whether they can effectively influence patients' motivation to participate.
- The outcome expectation item indicates a clear lack of consensus on weather local activity program's will be an effective option for their patients.

The **figure** shows responses from healthcare professionals on factors influencing their promotion of activities programs for older persons. The statements are organized using the **Theoretical Domains Framework (TDF)**, which identifies key behavioural drivers such as knowledge, skills, and attitudes. Agreement with each factor is shown in blue (right), disagreement in purple (left), and neutral responses (grey) are centered.

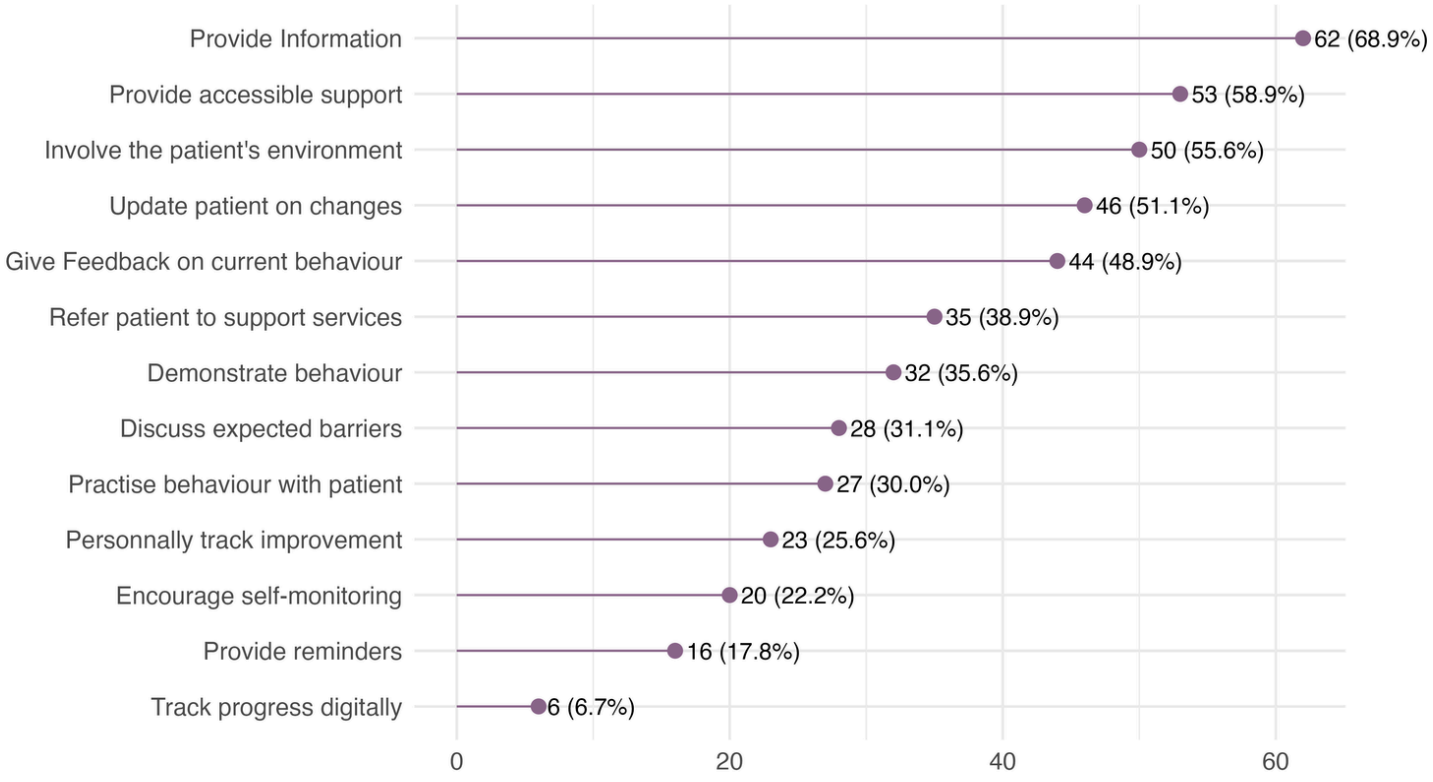


ACTIVITY PROGRAMS

Supportive strategies

- Almost all participants to some extent include supportive strategies to promote activities (physical or social) in older persons.
- Most respondents reported using educational and motivational strategies, such as providing information, encouraging patients, and involving their social environment.
- Feedback on adherence and regular follow-up conversations are also commonly used, suggesting a strong emphasis on continued support and personal engagement.
- Techniques that promote self-reflection and long-term behaviour change, such as goal setting or analyzing patient behaviour, were less frequently used, pointing to a potential training or resource gap.

Figure: participants were asked to indicate what strategies they use to support older persons being active and participating in physical and or social activities.

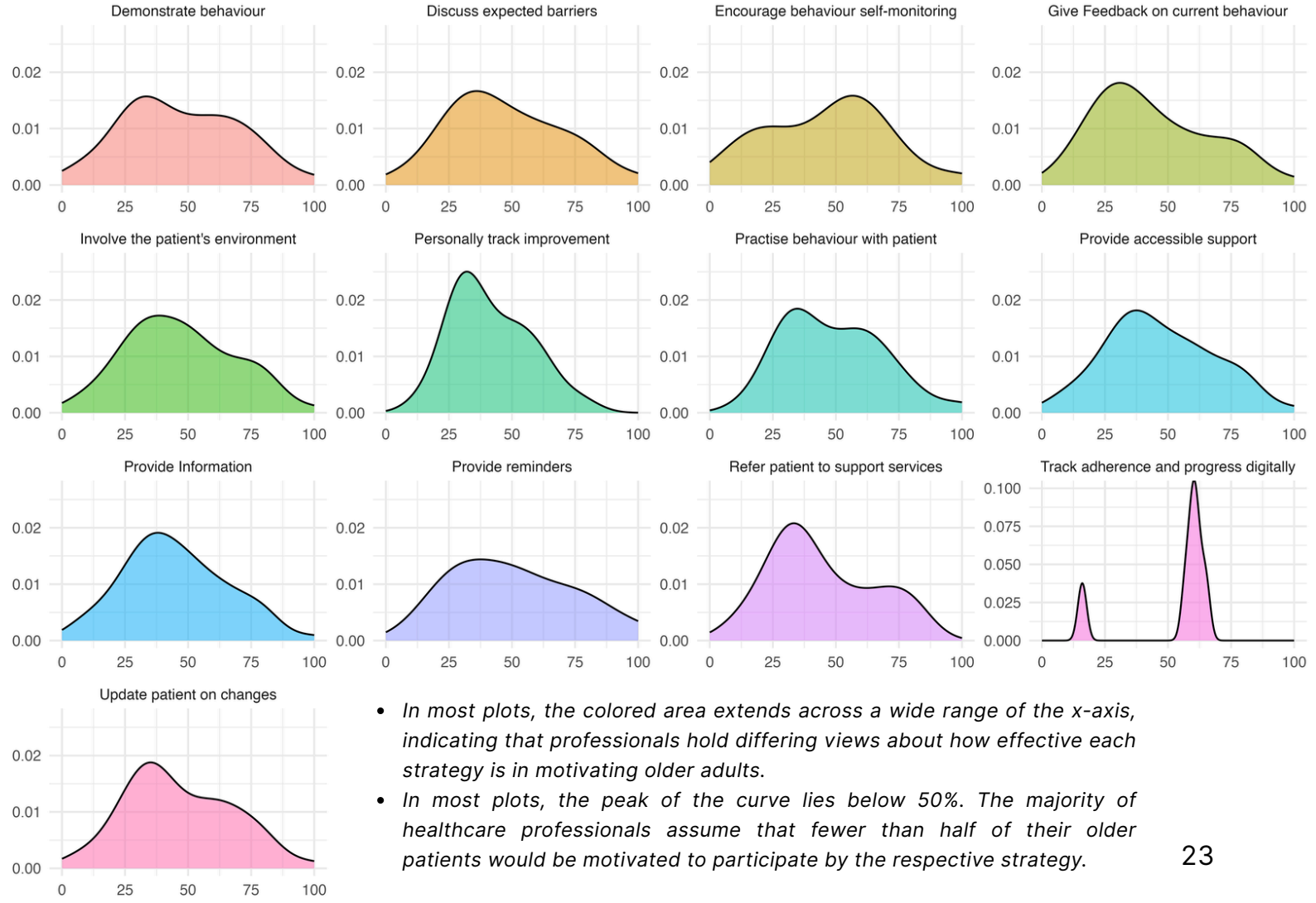


ACTIVITY PROGRAMS

Motivating older persons to participate

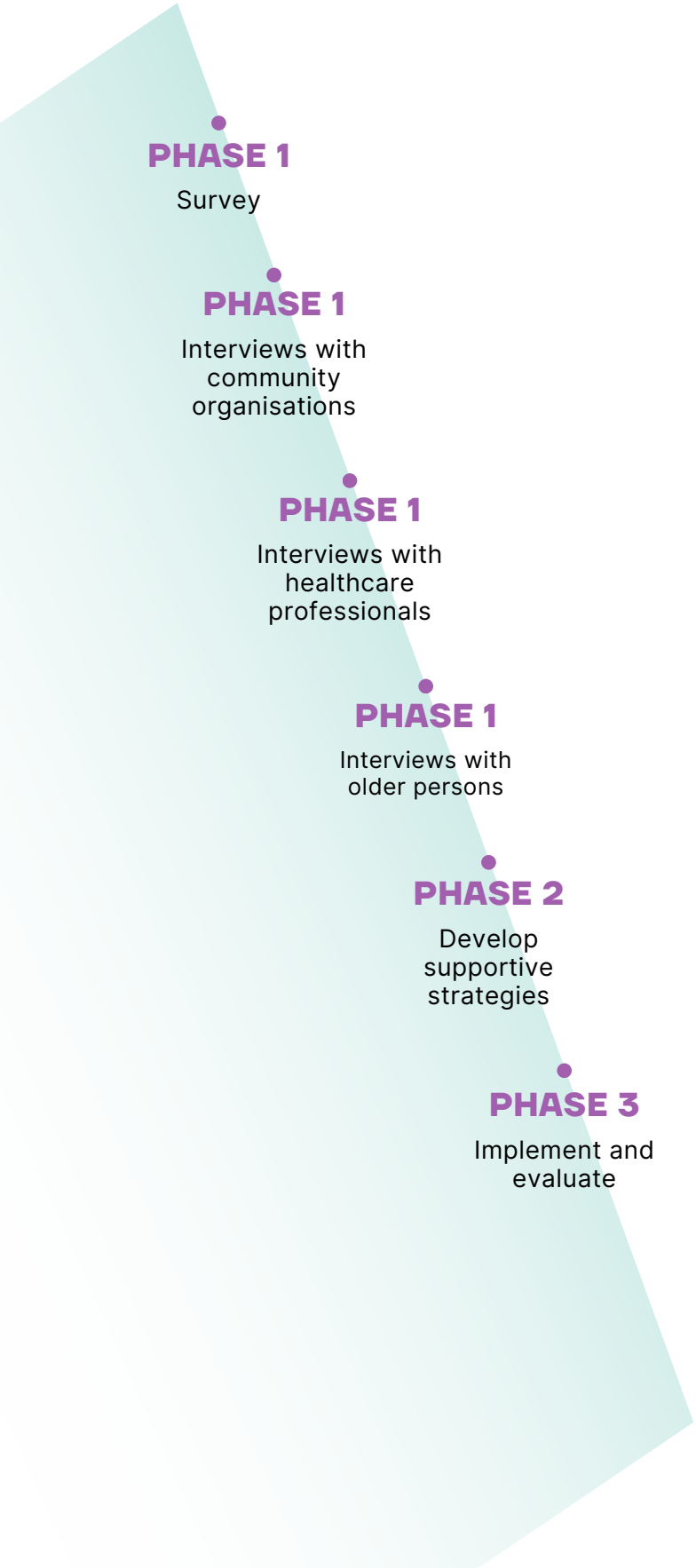
- Healthcare professionals varied widely in how they perceive older persons to be motivated to participate in activity programs.
- On average, professionals estimate 44% of older adults as motivated to participate in such programs, with estimates ranging between 24% and 64%.

This **figure** shows how healthcare professionals perceive the effectiveness of various support strategies in motivating older adults to participate in an activity program. The x-axis indicates the expected percentage of motivated patients who would participate in a program (0–100%). The peaks of the curve correspond to the most frequently reported estimates. For instance, a peak at 60% indicates that many respondents expect the respective intervention to motivate approximately 60% of patients. Wider curves mean opinions vary more; narrower curves suggest stronger consensus. Strategies with peaks farther to the right are generally viewed as more effective.



- *In most plots, the colored area extends across a wide range of the x-axis, indicating that professionals hold differing views about how effective each strategy is in motivating older adults.*
- *In most plots, the peak of the curve lies below 50%. The majority of healthcare professionals assume that fewer than half of their older patients would be motivated to participate by the respective strategy.*

NEXT STEPS



Phase 1: After completing the initial survey, the ENGAGE project will carry out a series of interviews with community organisations, healthcare professionals, and older persons. These conversations will help the team better understand how frailty and social isolation are perceived, experienced, and addressed from different perspectives. The aim is to uncover needs, barriers, enablers, and existing resources that can inform the development of supportive solutions.

Phase 2: The ENGAGE team will work collaboratively with stakeholders to design supportive strategies. These may include ways to strengthen existing services, adapt or create new activities, or improve connections between sectors. The process will be grounded in co-creation to ensure relevance for older persons and the practice field.

Phase 3: In the final phase, ENGAGE will put the developed strategies into action and assess how they work in practice. This will involve implementing the initiatives in selected settings and evaluating their feasibility, acceptability, and impact. The findings will guide adjustments and help determine how the approach can be scaled or adapted to other communities.

RESOURCES

Frailty

- Hoogendijk E O et al. Frailty: implications for clinical practice and public health. The Lancet 2019, Volume 394, Issue 10206, 1365 - 1375.
- O'Caoimh R et al. Prevalence of frailty in 62 countries across the world: a systematic review and meta-analysis of population-level studies. Age and Ageing 2021, Volume 50, Issue 1, 96–104.
- Mehta P et al. A Systematic Review of Clinical Practice Guidelines for Identification and Management of Frailty. J Nutr Health Aging 2021, Volume 25, Issue 3, 382 - 391.
- Racey M et al. Effectiveness of physical activity interventions in older adults with frailty or prefrailty: a systematic review and meta-analysis. CMAJ Open 2021, Volume 9, Issue 3: E728 - E743.

Social isolation

- Hoang PM et al. Embracing connection: A review on first-ever clinical guidelines on social isolation and loneliness in older adults. Geriatrics 2024, Volume 9, 117.
- Tong F et al. Systematic review of efficacy of interventions for social isolation of older adults. Frontiers in psychology 2021, Volume 12, 554145.
- A toolkit on how to implement social prescribing. Manila: World Health Organization Regional Office for the Western Pacific; 2022. Licence: CC BY-NC-SA 3.0 IGO.

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