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# Identifying acceptable components for home-based health promotion services for older people with mild frailty: A qualitative study

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## Abstract

Mild frailty is common in later life, increasing the risk of hospitalisation, loss of independence and premature death. Targeted health promotion services may reduce adverse outcomes and increase quality of life; however, effective, well-developed theory-based interventions are lacking. We aimed to explore perceptions of health promotion behaviours undertaken by older people with mild frailty, barriers and facilitators to engagement, and identify potential components for new home-based health promotion services. We carried out 17 semi-structured qualitative interviews and six focus groups with 53 stakeholders, including 14 mildly frail older people, 12 family carers, 19 community health and social care professionals, and 8 homecare workers, in one urban and one semi-rural area of England. Transcripts were thematically analysed. Older people with mild frailty reported engaging in a variety of lifestyle behaviours to promote health and well-being. Key barriers or facilitators to engaging in these included transport, knowledge of local services, social support and acceptance of personal limitations. Older people, carers and professionals agreed that any new service should address social networks and mobility and tailor other content to each individual. Services should aim to increase motivation through focussing on independence and facilitate older people to continue carrying out behaviours that improve their well-being, as well as provide information, motivation, psychological support and practical support. Stakeholders agreed services should be delivered over a sustained period by trained non-specialist workers. New services including these components are likely to be acceptable to older people with mild frailty.

KEYWORDS

health behaviours, health promotion, older people, older people's services, qualitative research

## 1 | INTRODUCTION

Frailty in later life is associated with greater risk of hospitalisation, functional decline, falls, worsening mobility and death (Clegg, Young, Iliffe, Rikkert, & Rockwood, 2013). However, mild (or pre- or early) frailty, where individuals are between robust and frail is more common and may be present in up to half of all older adults in high-income countries, depending on the definition used, compared to 11% who are frail (Collard, Boter, Schoevers, & Oude Voshaar, 2012).

Over time, this population is more likely to become robust or remain stable than those with frailty (Gill, Gahbauer, Allore, & Han, 2006), suggesting mild frailty could be an important opportunity for promoting health and delaying frailty. Indeed, targeting older people with a lower mortality risk is associated with greater effects on functional status (Stuck, Egger, Hammer, Minder, & Beck, 2002).

Targeting health promotion behaviours—i.e. actions with the potential to protect or enhance physical or mental health, or protect against declines (Steptoe, Gardner, & Wardle, 2010) offers a means of shielding against frailty and related detrimental outcomes. Within UK National Health Service (NHS) policy, there is a focus on targeted prevention and encouraging behaviours supporting health promotion (NHS England, Care Quality Commission, Health Education England, Monitor, Public Health England, Trust Development Authority (TDA), 2014). Additionally, far fewer older people are now receiving social care owing to reductions in public funding which is likely to lead to higher numbers of older people with unmet needs (Iparraguirre, 2017). Despite this, there is a paucity of policies focussing on preventing frailty in those already on a pathway to frailty (Drennan et al., under review), with a concurrent lack of services and interventions in this area.

Currently, the few interventions targeted at mild frailty focus mainly upon exercise to increase mobility, occasionally with changes in nutrition, or problem-solving therapy (Brown et al., 2000; Chan et al., 2012; Frost et al., 2017; Tieland et al., 2012), but neglect related issues such as social isolation, low mood, and sensory or cognitive impairment (Lang, Michel, & Zekry, 2009). Interventions which are multidimensional and home-based tend to target either broader or frailer populations, have had mixed success and can lack clarity as to their effective "active ingredients" (Behm et al., 2015; Li, Chen, Li, Wang, & Wu, 2010; Puts et al., 2017; Tappenden, Campbell, Rawdin, Wong, & Kalita, 2012). Stakeholder involvement in intervention development is recommended to maximise the acceptability, relevance and feasibility of frailty interventions (Gwyther et al., 2017) and can produce substantial changes (van Velsen et al., 2015).

Older people's views have been widely canvassed regarding self-care, health promotion and lived experiences of frailty (Birkeland & Natvig, 2009; Lloyd, Kendall, Starr, & Murray, 2016; Lommi, Matarese, Alvaro, Piredda, & De Marinis, 2014; Menichetti & Graffigna, 2016). However, to our knowledge, no study has focussed specifically on community-dwelling populations with mild frailty in the United Kingdom (UK), explored the acceptability of different health promotion behaviours or offered practical recommendations for designing new health promotion services. We therefore aimed to explore: (1) behaviours older people with mild frailty engage in to promote health and barriers/facilitators to engagement and (2) potential components for new home-based health promotion interventions to promote health and well-being in this group.

**What is known about this topic**

- The transitional state of mild frailty may be an opportunity to promote health and prevent decline before older people become frailer.
- Few health promotion services are currently targeted at this population.

**What this paper adds**

- Older people with mild frailty carry out a range of lifestyle behaviours to promote their health and well-being but these may be affected by factors such as health, social support and transport.
- New services should address socialising and mobility, as well as a personalised range of topics relevant to each individual, and provide information, motivation and practical and psychological support.
- New services should focus on independence and be delivered over a sustained time period by a non-specialist worker.

## 2 | METHODS

We carried out face-to-face, semi-structured qualitative interviews (Silverman, 2006) in participants' homes with community-dwelling adults aged ≥75 years who were judged to be "vulnerable" (not dependent on others, with symptoms of being 'slowed up' or tired that limited activities) or "mildly frail" (more evident slowing, with some assistance needed in instrumental activities of daily living, e.g. finances, heavy housework) on the Rockwood Clinical Frailty Scale (Rockwood et al., 2004). Older adults were recruited through one urban general practice, with a diverse ethnic population (84% White British, 8% Asian/Asian British and 4.5% Black African/Caribbean/British) where approximately one quarter of older people live in deprived households, and one semi-rural general practice, in an area with a majority White British population (97%) and low deprivation levels (Department for Communities and Local Government, 2015; Institute of Public Care, 2017). Almost half of all older people in both areas report being limited a little or a lot by long-term illness (Institute of Public Care, 2017). We sampled for maximum diversity with respect to age, gender, socioeconomic status and ethnicity.

People with a life expectancy of <6 months, housebound or with a dementia diagnosis were excluded. Carers were recruited through interviews with older people where possible; however, many

interviewees did not have paid care and their relatives provided general support not personal care. We therefore also recruited carers through snowball sampling at carers' groups at both sites. Carers were invited to participate in semi-structured interviews or focus groups at their choice. Focus groups were also carried out with community multidisciplinary frailty teams (with representation from primary care and social care) in each area and with urban homecare (domiciliary) workers. Focus groups with teams at their organisation were used as a pragmatic way to access multidisciplinary teams and to facilitate participation and discussion. We contacted the lead of relevant teams in each area and provided recruitment materials prior to the focus group. Consent was sought in person on the day of the focus group. Professionals who could not attend their team's focus group were invited to a second one to ensure a wide variety of experience was sampled.

Topic guides were developed from reviews of the existing literature and refined iteratively as the study progressed (see Table 1 for topic guide content). Interviews and focus groups lasted approximately 1 hr and were conducted by four research team members (AJ, AL, KK, KW) with experience of qualitative research and backgrounds in psychology, academic general practice and ageing research. Interviews and focus groups were conducted between December 2014 and July 2015. They were audio-recorded with consent (one older person declined but agreed for detailed interview notes to be taken), transcribed verbatim and brief field-notes were taken. We continued recruiting older adults and their carers until no new major themes emerged and the sample was sufficiently diverse.

We thematically analysed (Braun & Clarke, 2006) the data in NVivo 11 (QSR International Pty Ltd., 2015), led by RY. Transcripts were read independently by KK, AL, KW, RF and CA and each developed a thematic framework, which was amalgamated into a single initial coding framework through discussion. RY coded the transcripts according to the framework with minor revisions as needed. Themes and interpretations were discussed and agreed within the group.

This study was approved by the NHS Camden and King's Cross Research Ethics Committee (ref 14/LO/1698). All participants were provided with an information sheet explaining the study and were given the opportunity to ask questions prior to seeking consent. They were informed they could withdraw at any time, and capacity was assumed (as required by the Mental Capacity Act 2005) unless otherwise indicated. All participants provided informed consent to participate.

**TABLE 1** Topic guide content for each stakeholder group

| Group | Topics |
|---|---|
| Older people<br>*Interviews* | • A typical day and support required<br>• Health experiences, including appetite, energy, muscle strength, sleep<br>• Activities, socialising and health behaviours and barriers and facilitators to these<br>• Domains a new service could cover, with examples<br>• The type of person to deliver a new service and their skills<br>• The structure of a new service and the involvement of people providing support<br>• Feelings about a new service and what might encourage participation |
| Carers<br>*Interviews, focus groups* | • A typical day and health experiences for the person they support<br>• Their caring role<br>• Ways older people can maintain well-being and independence, barriers and facilitators and how friends and family might provide support<br>• Opinions of a new service and existing services<br>• Domains to cover, with examples<br>• The kind of person to deliver a new service<br>• The structure of a new service and the involvement of people providing support<br>• How people might be encouraged to take part |
| Community health and social care professionals<br>*Focus groups* | • Health needs of older people with mild frailty and what helps them to maintain health and independence<br>• Domains to cover in a new service<br>• Skills and training needed to deliver the service<br>• Structure and delivery of a new service<br>• Ways to encourage older people to participate<br>• Existing health promotion services, experiences of these and how these might fit with a new health promotion service |
| Homecare workers<br>*Focus groups* | • Experience of working with mildly frail older people<br>• What helps older people to stay as healthy as possible and barriers and facilitators to this<br>• Structure of a new service<br>• Person and skills to deliver the service<br>• Role of homecare workers in a new service<br>• How older people might be encouraged to take part |

**TABLE 2** Participant characteristics

| Older people with mild frailty ($n$ = 14) | | |
|---|---|---|
| Area | Urban | 9 |
| | Semi-rural | 5 |
| Gender | Male | 6 |
| | Female | 8 |
| Age group | 75–79 | 6 |
| | 80–84 | 2 |
| | 85–89 | 3 |
| | 90–94 | 3 |
| Ethnic group | White British | 11 |
| | Irish | 1 |
| | Other Asian | 1 |
| | Not reported | 1 |
| Living arrangements | Alone | 9 |
| | With someone else | 5 |
| Marital status | Single | 3 |
| | Married/cohabiting | 6 |
| | Divorced | 1 |
| | Widowed | 4 |
| Age completed education | Before 15 | 2 |
| | 15–16 | 4 |
| | 17–20 | 5 |
| | 21 or after | 3 |
| Pension | State | 13 |
| | Private | 3 |
| | Employer | 1 |
| Social security benefits | Pension credit | 5 |
| | Council tax benefits | 3 |
| Disability benefits | Attendance allowance | 3 |

## 3 | FINDINGS

We interviewed 14 older adults with mild frailty, 12 family carers and 27 community health and social care professionals (Tables 2 and 3). As noted, we recruited a diverse sample of older adults according to gender, age and socioeconomic status; however, there was limited ethnic diversity as the majority of people were White British. All older people were experiencing some frailty symptoms to be eligible for the study, although older people's health problems varied. Some were very limited in mobility due to their physical health, while others had reduced energy and were finding activities more difficult but could get out and about independently. Two carers were recruited through the older person with mild frailty interviewed; the remainder were recruited from local carers' groups. Most carers (n = 9) were female. We sampled a range of partner-carers, family carers and one paid carer of people with frailty and dementia across each area. Within our health and social care professional focus groups, we sampled a range of primary care (e.g. GPs, nurses) and social care (e.g. social workers, care services managers) professionals, as well as homecare workers.

The following four themes emerged: behaviours to promote health and well-being, barriers and facilitators to health promotion behaviours, content of a health promotion service for people with mild frailty, and delivery of a health promotion service for older people with mild frailty.

### 3.1 | Behaviours to promote health and well-being

Older people with mild frailty reported carrying out a wide range of purposeful or incidental health behaviours, including taking exercise, paying attention to diet, socialising, activities to enhance mood and memory, and creating occupational activities (e.g. daily shopping):

> *I try to do things that improve my memory. I'll watch quiz programmes on television, I'll do crosswords, I play bridge.*
> *(OP10, F, 79)*

> *I just go out every day to get my newspaper and buy a little food to eat, something like that.*
> *(OP2, M, 93)*

Some used assistive devices such as hearing aids, walking aids or devices for opening jars. Older adults also reported modifying activities around frailty symptoms (e.g. fatigue, weakness), for example pacing activities with regular breaks, arranging activities for times when their energy levels were higher or ceasing unpleasant activities (e.g. tiring or painful heavy housework, disliking cooking):

> *We try not to overdo things in the sense that we would try not to have a series of activities on the same day.*
> *(Carer 1, partner carer)*

Healthcare services were largely spoken of positively, though older adults varied in how frequently they accessed these. However, although professionals discussed a wide range of relevant local services (e.g. day centres, exercise classes), the majority of older people rarely discussed or accessed these. Several paid for private assistance, mainly cleaners, although these arrangements were not discussed by many professionals.

### 3.2 | Barriers and facilitators to health promotion behaviours

People with mild frailty, carers and professionals cited a diverse array of internal and external factors affecting health behaviours. Disabilities arising from physical health conditions (e.g. chronic obstructive pulmonary disease, arthritis) or frailty were reported as prominent barriers to undertaking more active behaviours such as

**TABLE 3** Carer and community health and social care professional characteristics

| ID | Area | *N* | Participants |
|---|---|---|---|
| Carers (*n* = 12) | | | |
| Carer 1 (interview) | Urban | 1 | Male partner carer of a female interviewee with frailty |
| Carer 2 (interview) | Urban | 1 | Female partner carer of a male person with dementia |
| Carer 3 (interview) | Urban | 1 | Female paid carer of a female interviewee with frailty |
| Carers focus group 1 | Urban | 3 | Partner and family carers for people with frailty and dementia (two female, one male) |
| Carers focus group 2 | Semi-rural | 6 | Partner and family carers for people with frailty and dementia (five female, one male) |
| Community health and social care professionals (*n* = 27) | | | |
| Community-based professionals focus group 1 | Urban | 8 | GPs, geriatricians, nurses, occupational therapists, care services manager |
| Community-based professionals focus group 2 | Semi-rural | 9 | Nurses, social workers, care co-ordinators, office managers of homecare services |
| Community-based professionals focus group 3 | Urban | 2 | Physiotherapists |
| Homecare workers focus group | Urban | 8 | Homecare workers from one urban organisation who provided daily to weekly support to older adults requiring help preparing meals, leaving the house or with personal care. |

exercise, hobbies and social activities, while a good memory was considered a vital part of ageing well by many people with mild frailty:

> *I don't think people want to come and see people who have no memory.*
>
> *(OP1, F, 93)*

A network of social support (including partners, adult children, grandchildren, friends and sometimes neighbours) and transport (journeys that could easily be made by foot, bus, taxi or car and a beneficial outdoor environment) were also spoken of positively by older people, as they provided support, freedom and opportunities to socialise and contribute (e.g. by volunteering):

> *Well, [husband] does every bloody thing! He does the shopping, he takes me to my hairdresser, hopefully! … thank heavens I have my partner.*
>
> *(OP6, F, 86)*

Knowledge of local services and the skills to access them (e.g. form-filling) were considered important by professionals, carers and some older adults:

> *We didn't have a "disabled badge" [for free car parking]. I mean, you probably have to jump through hoops to get one of them, I'm not even sure how you'd go about it.*
>
> *(Carers focus group 1)*

Regarding motivation, although all older people reported that they expected some level of physical, social and cognitive decline and tried to consciously accept this, many feared further decline and dependency; these fears were compounded by largely negative perceptions of social care services and risks of vulnerability to abuse. Behaviours associated with independence and a sense of self developed over a lifetime were therefore more likely to be undertaken than those associated with "being elderly," although this varied across individuals:

> *I do try and keep myself active and not be a person that's sitting in the armchair all the time, because I'm not that sort of person; I like to anticipate life.*
>
> *(OP14, F, 85)*

Most older people talked about positive mood as a facilitator to problem-solving and undertaking activities. Low mood and the effects of bereavement could be accommodated by carrying on regardless. However, several older people, carers and professionals felt that low mood was not a barrier to, but a result of, being unable to continue valued activities:

> *But [friend] gets very tearful, sometimes I go round and she gets really tearful; she says, "Remember what I was like!?" and I do.*
>
> *(OP10, F, 78)*

Other factors discussed by a smaller group of stakeholders included problems with finances (e.g. for transport, food) and the indoor environment (e.g. stairs, heating).

**TABLE 4** Perceptions about potential health and well-being domains to address in a new home-based health promotion service

| Domain | Level of support | Quotes |
|---|---|---|
| Mobility and exercise | Widespread support across the majority of people with mild frailty, some carers and all professionals for advice regarding low-level exercises to maintain mobility, prevent deterioration and potentially help with arthritis symptoms. Professionals emphasised tailoring the exercise type to the person's preference and increasing motivation. | *"quite general exercise that doesn't need a physio, but with the idea of trying to prevent falls and in future prevent deterioration" (Community-based professionals focus group 3)* |
| Socialising | Considered an essential component by the majority of people with mild frailty, carers and professionals, with variation in preferred levels of socialising. Suggested interventions ranged from encouraging an active role in family or volunteering to home visits or regular contact by friends or befrienders. | *"there are people, many people who are extremely lonely and desperate for somebody to come in so they can talk and talk and talk, and (slight laugh) then there are others who would just like occasional, so they feel like they haven't lost total contact with the outside world." (OP5, M, 91)* |
| Finances and paperwork | Positive support across some older people and professionals for general advice in future planning and completing application forms, but not identified as an issue by carers. Professionals highlighted that this may be a sensitive matter due to its relation to lifetime habits and fears of debt. | *"Just a little bit of advice, you know, because some of these forms are … you think, what are they on about!?" (OP10, F, 78)* |
| Computing skills | General positive support across a few semi-rural older adults and professionals, but not discussed by carers and some people with mild frailty. Professionals advocated using computers, iPads and mobile phones to facilitate access to problem-solving advice and improve the future uptake of telehealth interventions. | *"I would like to go to classes to learn the Internet; I don't think I've got the brain to do it anymore. I think I'm past it!" (OP12, F, 79)* |
| Mood | Mixed support across people with mild frailty and carers, although most were unclear what sort of service could be offered to improve mood. Mood was not raised as an issue by professionals. | *"I'd be willing to speak to someone [about low mood], yes … I don't know what they would suggest." (OP9, F, 83)*<br><br>*"Now that is awful, to me that is, it's terrible … I can just imagine it; somebody coming round to cheer you up" (OP4, M, 79)* |
| Memory | Some people considered this an important component, but overall there were mixed opinions across older people and carers. Most were unclear what could be offered. One professional focus group suggested low-level practical strategies (e.g. buying a diary), while carers thought reassurance, explanation and memory exercises could be helpful. | *"It's very kind that you offer that, but I don't need that, no, no." (OP9, F, 83)*<br><br>*"That's an idea; now that sort of thing appeals to me" (OP4, M, 79)* |
| Environmental adjustments | Carers and professionals considered this an important domain for some people (e.g. alterations to baths or stairs, falls prevention, ensuring adequate heating) but highlighted potential challenges around attachment to family homes and finances. Few people with mild frailty talked about this and did not feel it was a high priority. | *"certain people's properties, maybe council or private, will get to a stage where then that environment is not designed for the person's needs … I think that could possibly be looked at again in the early stages, before it's too late." (Carers focus group 1)* |
| Nutrition | Most people with mild frailty felt that nutritional advice would not be a necessary component of a new service. They connected low energy to ageing rather than diet and so felt this was not something that could or needed to be addressed. Carers had mixed views, while professionals considered it necessary but sensitive and recommended only addressing it after rapport had been built. | *"I don't know what they can say to me. My wife cooks and gets fruit every day and we've always got food in the cupboard." (OP8, M, 79)* |
| Medicines management | Most people thought medicines advice was unnecessary as they felt comfortable with their medicines and could easily seek appropriate support (e.g. GP or pharmacist). Carers felt this would be helpful for themselves. Professionals also considered medicines under a GP or pharmacist remit and recommended signposting if there were problems. | *"I think [medicines] is something between the doctor and the patient" (OP14, F, 85)* |
| Other topics | Personal hygiene, carer education and free time for carers were also suggested by carers and homecare workers | |

### 3.3 | Content of a health promotion service for people with mild frailty

Opinions about which domains to cover varied across stakeholders (Table 4), though socialising and mobility were seen as the primary domains to address. All stakeholders agreed that a new home-based health promotion intervention would need to be tailored to the individual's situation and preferences:

> *Everyone is different aren't they? Every old person is different and got different needs.*
>
> *(OP8, M, 79)*

Carer and health professional focus groups and some older adults (though most found it difficult to comment on this) recommended addressing these domains through providing information (e.g. about local services), psychological support (e.g. listening, building rapport) and practical support (e.g. falls prevention planning, recommending exercises):

> *What people don't get is you don't get information about the services … there's an awful lot of services being provided, but the joining up is very bad.*
>
> *(OP13, M, 75)*

> *Well, I think mainly to talk over your problems really. I mean, I know that sounds silly, but … it puts your mind at ease and that's OK.*
>
> *(OP12, F, 79)*

Motivating people to change behaviour was viewed as an important component, through ensuring changes were relevant to each individual, encouraging choice across a range of options and providing support over time:

> *Somebody that would perhaps, not in a patronising or a challenging way, but may be able to persuade and encourage people to change behaviours or change health beliefs into a kind of channel whereby it's more purposeful or useful to their health.*
>
> *(Community-based professionals focus group 2)*

Signposting was recommended by professionals when a higher level of support was needed and available locally (e.g. a pharmacist for medication advice, Citizen's Advice Bureau for financial advice), although one professional focus group advised a clear boundary between existing services and what a new service might offer. Carer and family involvement in a health promotion service was viewed positively by carers and a few older adults, though professionals cautioned that this could occasionally be a barrier to developing rapport and trust with the older person.

### 3.4 | Delivery of a health promotion service for older people with mild frailty

A home-based service was largely acceptable to older people, and a few older people and professionals felt it could give greater insight into issues such as falls risk, the home environment and nutrition. Many older people, carers and professionals felt that appointment frequency and duration should be individually tailored in order to achieve meaningful change, though there were some patterns. Carers and professionals favoured approximately 1-2 hr per appointment, between one and eight times per month over at least 3 months; older adults largely agreed with a proposed 30 min per week over 6 weeks. Continuity of worker and ongoing support over a sustained period of time were deemed the most important factors by carers, professionals and some older adults, who felt this facilitated building rapport and trust, encouraged change and enabled discussion of sensitive topics:

> *I would say at least a couple of months … a lot of people take a long while to learn to trust and to get to know people.*
>
> *(OP11, F, 79)*

People with mild frailty mostly preferred a mature person with life experience who they thought could more easily understand their concerns, though some favoured a "lively" young person. Communication skills (e.g. empathy, compassion) were considered paramount, and professional qualifications, though favoured by carers, were seen by most older people and professionals as unnecessary or potentially detrimental (e.g. appearing too extreme for their current issues, encouraging dependency). Professionals felt that such a health promotion worker could be successful providing they had general health knowledge, adequate support from local clinicians and a good knowledge of local services:

> *I don't think you need O levels or A levels [English secondary school qualifications] or anything like that to do that, as long as you've got the people skills.*
>
> *(OP10, F, 79)*

One potentially problematic area acknowledged by professionals was identifying and encouraging older people with mild frailty to access a new health promotion service, a view reflected by older people's mixed interest in accessing a hypothetical new service. Although seeking private help for specific needs (e.g. a cleaner) was acceptable to most people, a new health service to address current challenges was not always seen as appropriate. Many feared this may lead to them becoming more dependent:

> *At the moment, I don't need any help … you know, because it would stop me from coping, which would just make me worse, I think.*
>
> *(OP7, F, 88)*

Professionals felt that this largely stemmed from denial or feeling that difficulties with shopping or socialising were not matters that could be addressed by healthcare services. Suggested ways of overcoming this negative perception by older people and professionals included advertising in local non-health settings (e.g. local newspapers, shops), using word of mouth and communicating a positive focus on maintaining health and independence rather than frailty or decline:

> *Sell it to people in a way that at the end of it, you will feel better for what you've achieved and not how bad you are.*
> *(OP13, M, 75)*

## 4 | DISCUSSION

Older people with mild frailty carry out a variety of lifestyle behaviours to promote health and well-being, and health, social support and transport are important facilitators for engaging in these. Stakeholders have a consensus view that new services for mild frailty should be personalised and focus on maintaining independence. In addition to addressing topics of socialising and mobility, it should cover a broad range of domains and facilitate individuals to carry out activities and behaviours that could improve their well-being through providing information and signposting, emotional and practical support, and boosting motivation. Stakeholders prefer a non-specialist trained worker to provide this low-level support, ideally over a sustained period of time.

Frail and robust older adults across a range of countries report a range of health promotion priorities, behaviour and activities (e.g. shopping, gardening, crosswords) and internal processes (e.g. accepting decline and interdependency) to maintain positive well-being (Birkeland & Natvig, 2009; Boggatz & Meinhart, 2016; D'Avanzo et al., 2017; Holm & Severinsson, 2013; Lloyd et al., 2016; Lommi et al., 2014; Menichetti & Graffigna, 2016; Nicholson, Meyer, Flatley, Holman, & Lowton, 2012; Warmoth et al., 2016). Our study showed that people with mild frailty, whose needs have not previously been explored, engage in similar health promotion activities and have similar motivational barriers. However, we also highlighted a wider range of external factors affecting health behaviours (such as knowledge, transport and social capital), which new services could have a potential role in addressing.

In contrast to previous interventions targeted at mild frailty, which have mainly focussed upon group exercise for mobility (Frost et al., 2017; Puts et al., 2017), our qualitative study suggests that stakeholders value personalised interventions addressing a broad range of domains. Inclusion of personalised planning and tailored goal setting within self-management interventions for older people has been associated with a greater impact upon activities of daily living (van het Bolscher-Niehuis, den Ouden, de Vocht, & Francke, 2016), while one qualitative meta-synthesis emphasised the need to focus interventions upon building on older people's own resources and context (D'Avanzo et al., 2017). Increasing motivation may be an important component and services may benefit from explicit content focussed on behaviour change to initiate or capitalise on health behaviours already undertaken by mildly frail older adults.

Previous qualitative studies of experiences of preventative home visit (health promotion) services for people aged 80+ or with long-term conditions suggest that they are valued for providing an accessible contact and psychosocial support through good communication skills (Behm, Ivanoff, & Zidén, 2013; Williams, Smith, Chapman, & Oliver, 2011). This aligns with our findings, which further suggest that health promotion services are more likely to be acceptable if delivered by a non-specialist support worker rather than a clinician. Delivering interventions for older people over a sustained time period is supported by one meta-analysis which found that multiple follow-up appointments are more effective than a single visit for preventing nursing home admissions and functional decline (Stuck et al., 2002).

Within the UK's current climate of austerity, the NHS emphasises partnerships with the voluntary or third sector in providing supportive services (NHS England, Care Quality Commission, Health Education England, Monitor, Public Health England, Trust Development Authority (TDA), 2014), e.g. in some areas Age UK is commissioned to provide Care Navigation services (advice and signposting for different subjects) to older people. Currently, there is an absence of policies directed at groups on a pathway to becoming frail, which may reduce support for frailty prevention services compared to those with a specific policy agenda (Drennan et al., under review). However, frailty prevention services fit within the existing NHS focus on targeted prevention and encouraging healthy behaviours (NHS England, Care Quality Commission, Health Education England, Monitor, Public Health England, Trust Development Authority (TDA), 2014) and our present study shows that these kind of services would be feasible and acceptable to older people.

Currently, a number of similar models of broader health promotion services exist, which substantially overlap in content:

- Lifestyle advisor: education, training, support and/or counselling to improve health, delivered by health professionals or laypeople, and typically targeted at individuals or peer groups (Carr et al., 2011).
- Care navigation: link workers who identify relevant services and signpost people to these, with the aim of integrating care and facilitating referrals across different services (Health Education England, 2016)
- Health trainers: community-based non-professional workers delivering health behaviour change support across all ages (Department of Health, 2004)
- Self-management support: educational and supportive intervention by healthcare staff to increase patient skills to manage a condition (van het Bolscher-Niehuis et al., 2016)
- Health coaching: patient-centred behaviour change interventions delivered by health professionals (Oliveira, Sherrington, Amorim, Dario, & Tiedemann, 2017)
- Preventative home visits services: outreach services to promote health and independence in home-dwelling older people. These can include a wide range of interventions varying in scope and content

(Tøien, Bjørk, & Fagerström, 2015).

The content and delivery suggested by stakeholders in our study do not currently fit precisely within the remit of these existing models, although there may be some overlap, such as signposting and psychosocial support (Manderson, McMurray, Piraino, & Stolee, 2012; Tøien et al., 2015). These services are typically broad—few focus on the specific needs of people with mild frailty and encourage changes in health behaviours over a sustained time period, a key feature suggested by stakeholders. However, as specific professional skills were considered inappropriate for low-level support in health promotion in mild frailty (providing staff were adequately trained and supported), a non-professional role such as a "lifestyle advisor" or "health trainer" role may be the most suitable for service providers. Studies suggest that this type of role is generally acceptable, effective and cost-effective for chronic disease management, smoking and changing health behaviours and acceptable to the public and health professionals (Carr et al., 2011; Gardner, Cane, Rumsey, & Michie, 2012).

A recognised advantage to this kind of model is the potential ability to reach marginalised communities and create improved links for accessing health and social care (Carr et al., 2011). Given the higher rates of multimorbidity in more socioeconomically deprived areas (Barnett et al., 2012) and poorer self-rated health in black and minority ethnic groups (Evandrou, Falkingham, Feng, & Vlachantoni, 2016), this may represent an important opportunity to promote health. Although it was difficult to include people with a variety of ethnicities in this study despite our attempts to sample widely, engaging older minority ethnic groups in health promotion research is recognised as a challenge (Liljas et al., 2017). However, 5 out of 14 of our older people received pension credits (indicating low income) and only three received private pensions, indicating that our attempts to sample across a range of socioeconomic status were successful, and suggesting that home-based health promotion services may be acceptable to more deprived populations.

Strengths of our qualitative study include the wide range of key stakeholders relevant to new mild frailty services that were consulted. We captured a variety of health experiences across urban and semi-rural locations and sampled older adults varied according to age, gender and socioeconomic status. The analysis involved a wide range of team members with diverse experiences. We have outlined a number of practical recommendations for new services.

However, our study has a number of limitations. Due to our recruitment methods, we could not document characteristics of non-responders. Despite our attempts to sample widely and in areas with a more diverse population, our sample had limited ethnic diversity and so tailoring services to different cultural needs received limited discussion. Previous work suggests services may receive better uptake if providing information in a range of languages (Manthorpe et al., 2009). Member checking was not used as these findings led into further stakeholder discussion panels to design a new service. The discussion around service domains and characteristics was limited by some older people's difficulties in discussing a hypothetical new service. The professionals we recruited were working with frailer people and so could only draw upon more limited professional experience of a mildly frail population, though they had high consensus and provided insights into the fit between new and existing frailty services.

## 5 | CONCLUSION

In the views of stakeholders, health promotion services for older people with mild frailty have the potential to address currently unmet needs and appear to be acceptable to stakeholders. They should be tailored to individuals and encourage behaviour change, with a particular focus on socialising, exercises to improve mobility and maintaining independence. Desirable components of a health promotion services were information with signposting to relevant local services, encouragement and low-level practical and emotional support provided over a sustained time period by a skilled communicator. This role may be similar to that of a UK "health trainer" or "lifestyle advisor," but would need to be tailored to the specific needs of those with mild frailty. Future research needs to address those key components identified by older people as important and explore carer involvement and tailoring to different cultural needs. Rigorous evaluations of new initiatives for mild frailty are needed to provide additional data on the content, feasibility and acceptability of such interventions and their active components in practice.

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### CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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