Frailty and frailty screening: a qualitative study to elicit perspectives of people living with HIV and their health care professionals

Levett, Thomas, St. Clair-Sullivan, Natalie, Simmons, Kiersten, Harding-Swale, Richard, Maddocks, Matthew, Roberts, Jonathan, Trotman, D, Yi, D, Vera-Rojas, Jaime and Bristowe, Katharine (2022) Frailty and frailty screening: a qualitative study to elicit perspectives of people living with HIV and their health care professionals. HIV Medicine. pp. 1-10. ISSN 1464-2662

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UK data from a long-running HIV real time sample study* shows that, from January to December 2021, Biktarvy was the number one naïve product prescribed by participating doctors.1*

The same study shows that, from January to December 2021, for participating doctors, Biktarvy was one of the top preferred switch options, and that 72% of patients prescribed Biktarvy were switched over from a non-TAF regimen.2†

Biktarvy is indicated for the treatment of adults infected with human immunodeficiency virus-1 (HIV-1) without present or past evidence of viral resistance to the integrase inhibitor class, emtricitabine or tenofovir.5,4

References:

This is a stock image and not a person living with HIV
ART, Anti-retroviral therapy; HIV, Human immunodeficiency virus; TAF, tenofovir alafenamide.
UK-BVY-0317 May 2022
Click here for Biktarvy prescribing information

Adverse events should be reported. For Great Britain and Northern Ireland, reporting forms and information can be found at www.mhra.gov.uk/yellowcard/ or via the Yellow Car app (download from the Apple App Store or Google Play Store). Adverse events should be reported to Gilead (safety_FC@gilead.com) or +44 (0) 1223 897500.
Frailty and frailty screening: A qualitative study to elicit perspectives of people living with HIV and their healthcare professionals

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Funding information
British HIV Association; National Institute for Health Research

Abstract

Objectives: People living with HIV are an ageing population with an increasing prevalence of frailty. Management of frailty requires assessment, communication and information sharing with patients. However, evidence regarding the meaning of frailty for this population, and the acceptability of frailty screening, is limited. This study aimed to explore the perceptions of older people living with HIV and HIV professionals towards frailty and routine screening for frailty.

Methods: Data collection consisted of in-depth individual qualitative interviews with older people living with HIV and focus groups with HIV professionals purposively sampled from outpatient HIV clinics in London and Brighton, UK. Verbatim pseudonymised transcripts were analysed using reflexive thematic analysis supported by NVivo.

Results: A total of 45 people living with HIV were interviewed, and 12 HIV professionals participated in two focus groups. Frailty was described as a series of losses around mobility, social inclusion, independence and mental acuity, which could happen at any age. Regarding language, for people living with HIV, explicitly using the word frail was acceptable during screening when approached sensitively and alongside provision of information and support to slow the progression of frailty. However, HIV professionals described concerns about using the word frail for fear of causing distress or offence.

Conclusion: Professionals described frailty in terms of functional deficits, whereas people living with HIV described a loss of personhood. Although there is a clear desire among people living with HIV to be informed of their frailty status, approaching conversations about frailty with understanding and compassion is vital. To gain the most from the screening, it is essential...
INTRODUCTION

The success of antiretroviral treatment means that HIV is now a long-term condition. Consequently, about 40% of people accessing HIV services in the UK are now aged 50 years and over [1]. Nonetheless, people living with HIV experience a disproportionate amount of comorbidities and earlier onset of geriatric syndromes (such as frailty and cognitive deterioration) and have three times as many chronic health conditions as does the general population [2].

People living with HIV with frailty report poorer quality of life and are at increased risk of negative health-related outcomes than those not living with HIV [3]. People living with HIV aged over 50 years also experience higher rates of pain than their peers without HIV [4], which negatively impacts upon employment rates, mental health, functional status and quality of life, resulting in increased healthcare resource usage. In UK health and social care settings, frailty screening is advocated from 65 years for the general population [5]. However, frailty in people living with HIV has been identified at younger ages than in the general population [2], meaning there is a risk of delayed identification of frailty and of identification of frailty at a more advanced stage, where some interventions may be less effective, resulting in greater health and social care costs [6].

Theories of frailty recognize its impact across physical, psychological and social domains [7, 8]. Similarly, theories of chronic illness recognize the impact of long-term conditions such as HIV on an individual [9]. However research to date has not considered the impact of living with both HIV and frailty concurrently.

Current models of HIV care do not address the needs of people ageing with HIV, and 47% of healthcare and 62% of social care needs are not met [10]. Screening for frailty and a comprehensive geriatric assessment (CGA) can improve treatment decision making and outcomes (mortality and hospitalisations) in individuals without HIV [11]. Tools to identify patients at risk of frailty are increasingly used internationally [12] and have been integrated into UK primary care, and the 2019 European AIDS Clinical Society (EACS) guidance recommended frailty screening in older people living with HIV [13]. However, it is unknown whether screening for frailty, and the introduction of aspects of geriatric care, is acceptable, feasible and useful as part of HIV services, particularly for people living with HIV who are not chronologically considered an older person. If approaches to delivering screening for frailty are not designed in acceptable ways for people living with HIV, we risk considerably more frail morbidity. The aim of this study was to explore the perceptions of older people living with HIV and those of HIV professionals towards frailty and routine screening for frailty.

METHODS

Design

We conducted a qualitative research study underpinned by a critical realist paradigm [14]. Critical realism attempts to generate social-scientific knowledge that considers biological, psychological and social factors. This paradigm is particularly well suited to the present study - exploring the complexities of living with HIV and understanding frailty within this.

Research governance

Ethical approval was gained from West Midlands – Black Country Research Ethics Committee in the UK [20/WM/0110].

Setting

People living with HIV and HIV professionals were recruited from two outpatient HIV clinics in Brighton and London, UK. People living with HIV were provided with a participant information sheet and followed up by a member of the study team (NS) via their preferred means of communication. Professionals were recruited via direct contact. Written informed consent was obtained before any data collection.
Recruitment

People living with HIV aged 50 years and older were purposively sampled by age, gender, ethnicity and sexual orientation. People living with HIV aged under 50 years or lacking the capacity to consent were excluded. Participation in the study did not include screening for frailty; however, participants may have experienced frailty screening previously as part of their HIV annual health check. Professionals providing care for people living with HIV at participating sites were purposively sampled by profession: doctors, nurses, receptionists and administrative staff.

Data collection

Data collection was carried out via semi-structured individual interviews for people living with HIV and two focus groups for HIV professionals. Interviews were carried out by NS or DT (both trained by KB, an experienced qualitative methodologist), and all except one were conducted via telephone or video call. One interview was conducted in person in a private room at the interviewee’s usual place of HIV care. All participants with HIV were offered a £10 remuneration voucher. Two focus groups with mixed HIV professionals were facilitated by NS and KS or DT and conducted in a private room at the professional’s place of work.

The interview and focus group topics guides were informed by previous HIV research and theories of chronic illness and frailty [7, 9], including physical, psychological and social presentations of frailty [15]. The interview topic guide consisted of three main sections: (i) what frailty means to people living with HIV, (ii) the language used around frailty and (iii) frailty services and frailty screening previously as part of their HIV annual health check. Professionals providing care for people living with HIV at participating sites were purposively sampled by profession: doctors, nurses, receptionists and administrative staff.

thought of the tools, the people living with HIV were then asked how they may feel if they were asked to participate in them and the professionals were asked about their experiences of using these tools (see supplementary materials for further information relating to the topic guides). Two digital audio recorders were used during all interviews and focus groups. All participants were allocated a unique patient identifier, and data were transcribed verbatim and pseudonymised. Member checking was not conducted. All transcripts were entered into NVivo qualitative data analysis software for analysis and coding.

We estimated that approximately 40 people living with HIV would need to be interviewed to achieve sufficient information power [19]. This concept considers the study in terms of aims, specificity, theory, dialogue and analysis to inform the decision. As this study is exploratory in nature, focusing on an under-researched intersection (people living with HIV and frailty) but with a heterogeneous population, a large sample size was targeted to maximize the transferability of the findings.

Analysis

Interviews and focus groups were analysed using inductive thematic analysis in six phases: familiarization with data, generating initial codes, searching for themes, reviewing themes, defining themes and writing up findings. Analysis was iterative, moving throughout the phases as necessary to identify, analyse and report patterns in the data [20, 21]. Data collection and analysis were run concurrently to inform the development of the coding scheme and the decision to halt recruitment. Initial broader themes and contents were discussed by five members of the team (KB, NS, MM, JV, RH), and a reflexive dialogue was implemented throughout the initial open coding, axial coding and memo writing of the entire dataset (NS, KB) to identify subsequent themes and sub-themes, to develop key concepts and categories and to allow for comparison across participant groups. After the initial inductive coding, there was an additional phase of deductive coding applying theories around coping with chronic illness and illness identity [9, 22, 23], with the understanding that these theoretical frameworks may be rejected if they did not fit within the context of our participants’ experiences [24]. Initially, interviews and focus groups were analysed separately and initial codes generated in relation to the study objectives. As immersion continued, other codes were developed and incorporated. Axial codes were reviewed and refined to inductively generate themes, based on their perceived relationships. The resulting themes and sub-themes of both the interviews and the focus groups were then
reviewed concurrently to allow for a comparative analysis between the two groups to establish links or highlight differences in the emergent findings [25]. Findings are reported in line with the COREQ (consolidated criteria for reporting qualitative research) guidance on reporting qualitative research [26].

**RESULTS**

**Participants**

A total of 57 participants were recruited; 45 people living with HIV were interviewed, and two focus group discussions were conducted with 12 HIV professionals (see Table 1).

**Findings**

The findings are presented in the order in which they were explored within the topic guide; however, the sub-themes presented were developed from the data. Overall,
TABLE 3 How do we talk about frailty

<table>
<thead>
<tr>
<th>Subtheme</th>
<th>Illustrative quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>It’s a sensitive discussion</td>
<td>(6) “I think it’s much better to turn it around and to talk about ageing well” (FGD 2, HIV professional 1)</td>
</tr>
<tr>
<td></td>
<td>(7) “Because age is something that you never recover from, it’s like on your way out, is not it, being on your way out?” (P20)</td>
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<td></td>
<td>(8) “So, yeah, I’m still here, still going on and never expected to see 55, never expected to see 30, so yeah, every day is a bonus.” (P26)</td>
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<td></td>
<td>(9) “That’s how I would want it, not to come in straight away, sit down, and go ‘Yeah, you have got frailty.’ You know, that’s just too cold, and that’s how my HIV results was ...” (P40)</td>
</tr>
<tr>
<td>Using the word “frail”</td>
<td>(10) “Maybe the label should come in later ... I mean it’s dishonest to hide it completely, is not it? ... But in the sensitivity, I think it’s not dishonest to delay is it ... but if for anybody’s own wellbeing about a subject, it can be beneficial just to hold back on the labels.” (P9)</td>
</tr>
<tr>
<td></td>
<td>(11) “I really hate the word! So, what I do not ever say to people ‘frailty’ ... I never say ‘Oh, I’m going to do the Frail Scale’, because it just sounds so horrible.” (FGD2, HIV professional 5)</td>
</tr>
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</table>

Frailty, what does it mean

It’s a series of losses

Frailty was described as a series of losses. Both people living with HIV and professionals recognized the loss of function and mental acuity associated with frailty (Figure 1). For example, when discussing mobility, both groups described reduced mobility as a loss; however, the impact of the loss was contextualized socially for people living with HIV and clinically for the professionals. People living with HIV described it in terms of personal losses, loss of independence and an inability to do things they once could, such as engage in exercise, meet up with friends or drive. Losses were not described in isolation but were interrelated, impacting upon one another if not addressed. For example, a loss of mobility means they cannot meet up with friends, resulting in a lack of socialization that was detrimental to their mental wellbeing but also continued inactivity, which led to subsequent deconditioning and a further decrease in mobility. This was particularly troublesome as they felt the resulting outcome would be a further loss of independence and consequently isolation (quote 1). Conversely, although professionals also discussed frailty and reduced mobility as a loss, the loss was described as a loss of function as opposed to the personal losses people living with HIV described and was contextualized in terms of greater care needs, such as increased health and social care utilization.

Loss of function was described both physically and mentally, with the terms frailty and vulnerability used interchangeably. Participants also described the possibility that a loss of physical or mental function could lead to frailty; however, this was felt to be particularly true in relation to poor mental health. Professionals discussed how a person could become more vulnerable if they experienced poor mental health, as it might mean they could not do the things they needed to do to support their physical health, and therefore become frail. This belief was also echoed among people living with HIV (quote 2).

It depends on your age

The conceptualisation of frailty was not singular. Rather, participants across both groups discussed how frailty can happen at any age and therefore appeared to hold two different definitions of frailty, one related to age and the other to health. Several people living with HIV felt that, although they did not consider themselves frail, they had experienced frailty when they were younger, and this was centred around the time of their diagnosis, before the commencement of antiretroviral therapy or a decline in physical or mental wellbeing (quote 3).

Professionals also described a frailty that was not related to age or diagnosis, shaped by their experiences with people living with HIV who were frail because of their life circumstances, such as experiencing homelessness and substance use. Here, the discussion around mental ‘fragility’ arose again, with professionals unsure whether being mentally frail constituted being frail. Professionals who treated a greater cohort of younger frail people living with HIV felt it important to clarify whether mental fragility is part of being frail (quote 4).

Age-related frailty for people living with HIV held a clear description that manifested itself physically as an elderly, hunched-over person, perhaps with a mobility aid, and descriptions of them as pre-grave, on a one-
TABLE 4  Screening and frailty services within HIV care

<table>
<thead>
<tr>
<th>Theme</th>
<th>Illustrative quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and frailty services within HIV care</td>
<td>(12) “I would think of a frail person with HIV would benefit from having like a home visit or something like that, with somebody who understands HIV, because it’s surprising how many people in the medical profession do not ... so people do need to understand the HIV, and the issues that can develop from it, and from the drugs of course, as well.” (P15)</td>
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<td></td>
<td>(13) “I do think my experience in the last three or 4 years that maybe there is a male and female difference ... To be female, HIV, ageing and going through, you know, this madness that can be created, and I'm not ... I know that not all women have this madness through the change that can happen in women, but I did feel at one point I thought I cannot go on.” (P40)</td>
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<td></td>
<td>(14) “If you had the resources, and I mean are there frailty specialists ... you know, could you refer people onto other healthcare professionals that could be of help to them? ... If my consultant was concerned ... there were issues that I, you know would it be appropriate to say ‘Well, would you like to see the frailty practitioner?’ ... and then he or she could make an assessment, could provide ... do whatever they could.” (P21)</td>
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<td></td>
<td>(15) “Yeah, of course I’d want it communicated. You know, if there was something which could be done about it, and I’m certain that there is.” (P24)</td>
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<td></td>
<td>(16) “do not know how I would take it, if somebody said ‘Oh, you are frail’ because nobody wants to be frail, do they?” (P9)</td>
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<td></td>
<td>(17) “If I was straight and married I’d probably have young grandchildren at this time, but if you do not have that straight background, therefore it’s difficult to see yourself ... I think ‘Oh my God! Am I really that age?’ right, and you think about slowing down now, and of course, I am, the body’s actually telling myself to slow down ... unless you have had a previous life as being, you know, married with children ... So, it’s difficult to put ... when you are gay, it’s difficult to put yourself in the age category.” (P2)</td>
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<td>(18) “I think the trigger has to be really, if the patient has indicated signs of frailty, for example, has talked about maybe living alone, or not engaging socially, or something like this, if they have raised alarms.” (P24)</td>
</tr>
<tr>
<td></td>
<td>(19) “Looking on statistically, you know, maybe a woman pre-menopausal.” (P37)</td>
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<td></td>
<td>(20) “I can think of younger heterosexuals, particularly males living with HIV, but you know, women as well, but where the availability of support is much less. So, even if we identify need, it’s harder ... and much less acceptable, but also much less available.” (FGD1, HIV professional 6)</td>
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<td></td>
<td>(21) “Then you know, with whatever results that comes from that, there’s further discussion.” (P37)</td>
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<td></td>
<td>(22) “I think you might find that some people would struggle. You might get some people saying ‘I do not know how to do a grip strength, I’m not going to do that. How the hell am I meant to be able to do that. I cannot do a grip strength, I cannot do a timed walking.’ So, I think you could get some clinician push back as well with the Fried one.” (FGD 1, HIV professional 2)</td>
</tr>
</tbody>
</table>

way street, fading away and being dependant on others (quote 5).

How do we talk about frailty

It’s a sensitive discussion

The language used when discussing frailty was considered of great importance as it was felt that discussions of frailty may cause offence. This was attributed to the negative connotations associated with the word frail and that “it’s a point in life nobody wants to reach”. Although the importance of sensitive, kind and reassuring language was recognized universally, this was interpreted differently by the participant groups. Professionals talked about the importance of using language to empower the patient, focussing on “ageing well” (quote 6). This contrasted with people living with HIV, who described how “nobody actually wants to get old” (quote 7). They placed the focus on “living well” rather than “ageing well”, which has particular resonance for people living with HIV, some of whom never expected to get old (quote 8). Professionals felt that frailty discussions should take place in an informal way, such as asking how patients are managing at home or whether they need support. However, for people living with HIV, reflecting on their experiences of receiving their HIV diagnosis, easing into frailty conversations sensitively was of the utmost importance. For some, this meant initially delaying the frailty label and allowing them time to settle into the
appointment. Opening a conversation about how they are doing, and their symptoms and what they mean, might allow the patient to realize themselves that they may be becoming frail, rather than being presented immediately with the facts (quote 9).

*Using the word “frail”*

Although people living with HIV felt that initially delaying the use of the word frail may be beneficial, they described how it is necessary to use the word to ensure they understand what they are being told (quote 10). However, professionals described hesitancy about using the word frail: some felt it should be used selectively, whereas others felt that what you meant could be quite easily conveyed without being explicit (quote 11).

**Screening and frailty services within HIV care**

When people living with HIV discussed frailty services, they described the complexity of living with HIV and frailty, such as seeking care from healthcare professionals who understood HIV (quote 12); for some female participants, their gender added another layer (quote 13). Therefore, people living with HIV expressed a preference for frailty screening and services to be within HIV care or to start there, with referrals to other services when necessary (quote 14). Although people living with HIV were willing to be screened for frailty and informed of their frailty diagnosis, participants made it clear that this should be in conjunction with advice and information on how they can be proactive in slowing the progression of frailty and what services were available to them (quote 15). Some people living with HIV acknowledged that they may respond negatively to receiving the information (quote 16), and others felt that being screened for frailty would help them to recognize where they are on the frailty continuum and to mentally prepare. This was felt to be important, as some will not recognize frailty in themselves or may not have the same age-related life experiences (such as becoming a grandparent) and therefore may miss indicators of ageing and frailty (quote 17).

People living with HIV felt that screening should be triggered by the presentation of frailty indicators or that they could be more closely monitored from ages 50 plus (quote 18). Women living with HIV felt that screening when they were perimenopausal may be beneficial, given the risks of decreased bone density (quote 19). Professionals’ views on when to screen aligned with the view of frailty indicators being present; however, some expressed concerns around identifying frailty in younger patients and the lack of services to manage it (quote 20).

People living with HIV generally felt the screening tools presented were acceptable and that they would be willing to participate in them. The tools were frequently described as “a bit generic”; however, participants acknowledged that they were a good starting point that could lead to further discussions and input (quote 21). Although professionals acknowledged that the screening tools were a starting point, overall they had more negative views of them, with some feeling they were not relevant to their cohort or took too long to complete (quote 22).

**DISCUSSION**

Frailty can be present at any age and is conceptualized by both people living with HIV and HIV professionals in our study as a series of losses. People living with HIV and professionals differed in their beliefs around using the word frail but agreed that the language used when discussing frailty was of great importance. People living with HIV were willing to be screened for frailty and to receive frailty care as part of HIV services, but professionals felt that this may present some challenges.
Frailty was understood in two different ways, one associated with age and another with poor health, irrespective of age, in keeping with other studies [27]. Professionals recognized psychosocial issues, e.g. isolation, loneliness and depression as being closely interlinked to frailty. However, they were unclear about whether mental fragility was a cause, component or consequence of frailty. This has clinical implications for frailty assessment and diagnosis in this group [28]. The omission of psychosocial domains in frailty assessment tools has been criticized [29]. Screening for physical frailty alone may not be sufficient to identify issues affecting those ageing with HIV. Using a more holistic approach with physical, psychological and social domains such as the CGA fits with patients’ and professionals’ understanding of frailty and can be used to provide further assessment and interventions to those identified as frail.

Consistent with the findings of this study, previous research shows that older people often hold a negative view of the term frailty [30]. Negative health perceptions are an identified risk factor for frailty [31], and how an individual perceives their health can impact on health-seeking behaviour and illness progression [32]. Some people living with HIV described elements of frailty within themselves but did not currently identify as frail, perhaps related to the negative perceptions of ageing [33]. Archibald et al. [34] recently emphasized the relationship between frailty perceptions and the construction of self-identity, with studies showing frailty is ideologically positioned as a “failed identity” rather than an “aging well” narrative of success and independence [35]. How people view and experience their illness is also associated with quality of life, adherence and healthcare-seeking behaviour, which is pertinent as frailty is potentially reversible [36]. This is important for healthcare professionals to consider so they may encourage development of a patient’s positive self-identity, within psychological ownership [37].

The findings of this study shed new light on using the word ‘frail’ and, interestingly, were not entirely in line with a larger body of evidence calling for the term to be eliminated when patient facing [38]. Although some professionals felt that eliminating the use of the word frail may be beneficial, this was not supported by people living with HIV, who felt that the use of the word was essential to ensure truthfulness and portray clearly what they were being told. However, what is clear from this and other studies [39] is that how the information is presented is vital and that language should move away from negative narratives and representations of ageing to positive, reassuring language focused on living well.

This study provides new insight into frailty screening within HIV services. EACS guidance is that people living with HIV aged 50 years and over should be screened for frailty using a rapid frailty instrument [3]. Although people living with HIV reported being willing to be screened for frailty, as long as information on services available to them to address their frailty issues was provided, discussions with professionals demonstrated that this was not always happening. This was attributed to time restrictions, relevance of tools and healthcare professionals assessing for frailty informally. However, although professionals have some reservations around these tools, people living with HIV generally found them to be acceptable if a little generic. As few studies have looked at using screening tools in busy HIV settings, taking into account professionals’ reservations of them and EACS guidelines, this study highlights the need for further research on the best screening tools for HIV settings [40].

People living with HIV expressed a preference to access frailty services either within HIV care or to be referred via HIV services, as they felt HIV professionals would understand frailty better within the context of HIV. However, HIV professionals reported feeling that they were perhaps not best placed to provide frailty care, as they are not experts in geriatric care. These results reflect those of Siegler et al. [41], that healthcare providers do not feel comfortable caring for issues that they do not usually treat, with a recent study also showing that 46% of geriatricians were not comfortable providing care to people living with HIV [42]. How to maximize healthy ageing in people living with HIV remains unclear [43], but dedicated ageing services for people living with HIV and the use of the CGA within a dual consultation of an elderly medicine and HIV physician is gaining traction [44].

**STRENGTHS AND LIMITATIONS**

Purposive sampling across two sites produced a diverse sample of people living with HIV; however, participants’ frailty status was unknown. We felt it was beneficial to not exclude individuals based on frailty status so as to get a broader understanding of what frailty means to people living with HIV, particularly as screening was being considered. However, future research could benefit from focussing on the experiences of people living with HIV living with frailty specifically. This study was strengthened by the use of triangulation [45], gaining views from people living with HIV and a diverse group of professionals using both interviews and focus groups to explore issues that influence the decisions of HIV professionals and the experiences of people living with HIV, their service users. This yielded important differences in perspectives related to use of the term frailty and conceptualisations of the term. The
data collection and analysis was led by an individual with a background in physiotherapy, which may have impacted the analytical lens applied, increasing focus on early identification and multidisciplinary team working; to mitigate this, others were involved in the analysis.

CONCLUSION

There can be physical, psychological, and social presentations of frailty in people living with HIV. This study provides new understanding around the language used when discussing frailty, with people living with HIV being clear that it is important to use the word frailty within clinical settings. HIV professionals should prioritize positive and reassuring language focused on living well, while maximizing engagement into care. For people living with HIV to gain the most from frailty screening, it is essential that information regarding frailty status is shared in conjunction with a clear plan of the next steps in their care. Alongside this, services should prioritize the social and psychological aspects of frailty, going beyond just the physical domains. Identification is only the starting point to then look at contributors for an individual management plan; however, how to do this in practice is unknown. Therefore, future research should focus on other holistic approaches, such as the CGA, within HIV services as the next step to look across the domains of frailty for people ageing with HIV.

AUTHOR CONTRIBUTIONS

Kiersten Simmons, Katherine Bristowe, Jaime H. Vera, M. Maddocks, Richard Harding-Swale, Deokhee Yi, Thomas Levett and Natalie St Clair-Sullivan contributed to the design of the study. Natalie St Clair-Sullivan and D. Trotman conducted the interviews and Natalie St Clair-Sullivan analysed the data under guidance from Katherine Bristowe, with input from Jaime H. Vera, M. Maddocks and Richard Harding-Swale. Natalie St Clair-Sullivan drafted the first version of the manuscript. All authors contributed to the interpretation of the data and revising the manuscript and gave final approval of the manuscript.

ACKNOWLEDGEMENTS

The research team acknowledges the support of the National Institute for Health Research Clinical Research Network (NIHR CRN). The authors thank the participants who contributed their time and experience to this study and all the patient and public representatives who contributed to the study design and materials. They also thank Professor Stephen Bremner for their work within the study team.

FUNDING INFORMATION

This study was funded by the British HIV Association and The NIHR Research for Patient Benefit programme. MM is funded by a NIHR Career Development Fellowship (CDF-2017-10-009) and NIHR Applied Research Collaboration South London (NIHR ARC South London) at King’s College Hospital NHS Foundation Trust. The views expressed in this article are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

CONFLICT OF INTEREST

None of the authors have any competing interests to declare.

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