**Living Well with Frailty and Chronic Kidney Disease (CKD): Is this possible?**

The short answer to this question is of course yes. However it is based on many assumptions. Firstly, we know and can easily identify those patients with CKD who are frail. Secondly, we understand what frailty is and why it’s important and thirdly what can we do in practice to make a difference. Well all of this cannot be discussed or answered here the purpose therefore is just to raise probably more questions than answers but to provide ‘food for thought’.

Although there is not one universal agreed definition of frailty most agree it is a complex multidimensional decline in dependence and functional ability. There has been some great improvements in the general population to improve the care and outcomes of frail older people in our hospitals and communities. It is now one of the key priorities for NHS England. This has naturally led to examining how we use the principles and evidence identified in the general population to patients who are cared for in specialist areas of medicine such as renal.

For those who work in renal medicine there is no surprises to this, over recent years publications and understanding of frailty in CKD have increased but evidence of the how and what actually makes a difference is sparse. A recent systematic review identified a need for further research evaluating the role of a geriatric assessment in the advanced CKD population (1). This was further supported by the European Renal Best Practice Working Group emphasising the need ‘to identify those who would benefit from more in-depth geriatric assessment and rehabilitation’ and recommending further research in this area (2). A recent successful BRS grant has brought together a group of multi-professional clinicians and academics to examine priorities in this area for research.

There are probably some key priorities for the renal community to consider, building more evidence, in particular using principles of frailty identification and the use of a comprehensive geriatric assessment (CGA), understanding the patient and carer voice within this but also education and training. We have to plan ahead and be prepared to change; this may include specific roles and training in geriatric medicine. Renal services have always been outstanding in the MDT ways of working and needs to continue this by shifting resources and bringing in different processes that are evidence based which should improve the outcomes and quality of life for our older frail patients.

**Dr Helen Hurst, Consultant Nurse**

The University of Manchester, Manchester Academic Health Science Centre, Manchester University NHS Trust, Manchester, United Kingdom
