≥20). An index of social isolation (0–7), with higher scores meaning greater isolation, was generated at baseline and each follow-up from seven indicators, each worth 1 point: living alone, less than monthly face-to-face or telephone contact with children/family/friends, not being a member of any organisations, not working, not volunteering. The complete-case sample was restricted to those with IC and isolation scores at baseline and no missing data on covariates. Sequential growth curve models included the predictors age and sex, isolation, and then covariate blocks of socioeconomic factors, health behaviours, health; a fully-adjusted model included all predictors and covariates.

Results In the unconditional model, average IC score at baseline was 7.06, decreasing 0.23 units over each follow-up to 6.38 at the final wave. In a model including isolation, age, and sex, higher isolation was associated with lower baseline IC (beta=-0.23, 95% CI=-0.28 — -0.18) but not associated with the rate of change of IC. This effect remained after adjusting for socioeconomic factors, health behaviours and self-rated health.

Conclusion These results suggest social isolation has a detrimental effect on IC level, but not on the rate of decline over time. However, this initial complete-case analysis should be expanded with imputation of missing data and more complex modelling of IC trajectories. Nevertheless, the study highlights the potential of this novel IC model to monitor IC over time and explore factors detrimental to healthy ageing.

P35 PSYCHOLOGICAL FRAILTY AND SOCIAL FRAILTY IN OLDER ADULTS: A SCOPING REVIEW

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Background Frailty is increasingly being considered as multidimensional and can encompass physical, cognitive, psychological, and social frailty domains. However, while the physical and cognitive domains of frailty are established within the evidence base, there remains a lack of consensus over the psychological and social aspects of frailty. Therefore, the aims of this scoping review were to establish the extent of focus on psychological and social frailty within the frailty literature; how these domains are conceptualised/operationalised; and how they relate to physical and cognitive frailty.

Methods Using a focused search strategy to limit the scope to psychological and social frailty, one reviewer (MMcK) searched seven databases (CINAHL, EMBASE, MEDLINE, PubMED, Scopus, Web of Science, PsychINFO). Results were screened independently by two reviewers (MMcK, SC), without limits on date or geographic location of publication. Publications were considered eligible if they were focused on the specific domains of this review in community-dwelling individuals aged 50 years and over. Data was extracted using a piloted form and collated into descriptive and narrative synthesis.

Results Of 303 papers screened, 38 were included for full review. The majority of these were exclusively focused on social frailty (53%), whereas only 8% were focused on psychological frailty alone. The remaining 39% considered both domains along with other aspects of multidimensional frailty. Only one study per year was identified prior to 2014, with an exponential increase after this point highlighting the novelty of this area. Operationalisation of psychological frailty included the co-occurrence of physical frailty and low mood, depression, loneliness, and cognitive impairment. Social frailty was operationalised using a range of social concepts, including but not limited to loneliness, social support, participation, role, relationships, and networks. There was an interchangeability in definitions and measurements between frailty domains, with loneliness being utilised in measuring both psychological and social frailty, and in some cases cognitive frailty was conceptualised as psychological frailty. Both psychological and social frailty were consistently highly associated with adverse outcomes, including disability and mortality. However, the publications differed significantly on whether these associations were independent of or in addition to physical frailty.

Conclusion This review found that amongst the literature on psychological and social frailty there was little consensus on measurement, definitions, or the relationship between different frailty domains. What was evident, however, were the robust associations between negative outcomes and psychological and social frailty, which suggests that they should be afforded the same weight as the physical and cognitive frailty domains.

P36 IS IT GOOD, OR BAD, FOR HEALTH TO STOP WORKING AT OLDER AGES? EVIDENCE FROM THE HEALTH AND EMPLOYMENT AFTER FIFTY (HEAF) STUDY

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Aim Generally, good work is good for health but there are few objective data about the effect of permanent exit from work (either through normal retirement, or health-related job exit) on health at older ages. We aimed to explore if exit from the workforce is followed by a change in self-rated health, using longitudinal data from the Health and Employment After Fifty (HEAF) Study.

Methods A cohort of participants aged 50–64 years were recruited from 24 English general practices in 2013–14 and have been followed-up annually by postal questionnaire. At baseline, information was collected about demographic and employment circumstances, physical workload, psychosocial aspects of work and their general health. At each subsequent follow-up, participants self-rated their health and additionally reported whether they were still in paid employment or whether they had exited the workforce, and if so, whether the reason for exit was at least partly due to their health. We used logistic regression modelling to explore the effect of exit from the workforce on changes in self-rated health after adjustment for self-rated health at baseline, before and after controlling for demographic, employment, and socio-demographic factors.

Results HEAF recruited a total of 8,134 people aged 50–64 years at baseline, amongst whom 5,059 were in paid employment and were successfully followed-up. Of these, 3,617 were still working 5 years later, 947 exited work permanently not for health reasons, and 333 exited work permanently at least partly due to their health. Self-rated health remained the same for: 53% of those still in paid employment; 55% of those who exited the workforce not on health grounds; and 47% of those who exited due to their health. Self-rated health