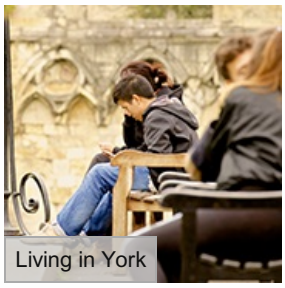
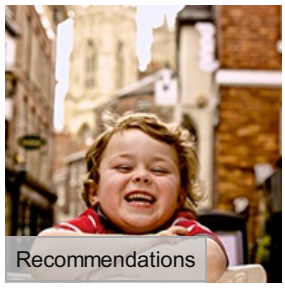




Frail Elderly Download this section

Why is this an issue?

There are several possible definitions of frailty but the common theme amongst all is that frailty is a collection of biomedical factors that reduce a person's physiological state (Lally & Chrome, 2007). The term frailty is not a diagnosis of a specific condition but rather it indicates a state of limited physical reserve (King's Fund, 2012a).

Society and services are organised around frailty as a state, often perceived as inevitable and irreversible, rather than a collection of modifiable health and social needs. As long as this mistake is made, then outcomes will continue to be limited (Age UK, 2014). The same Age UK report suggests that there is a distinct difference between what healthcare professionals would define as frail and the perception of frailty by the people that a healthcare professional would define as frail. In other words, people who are called 'frail' by healthcare professionals do not usually see themselves as 'frail'.

Age UK suggests that frailty should be used to describe something a person lives with, not what they are; frailty is not age and age is not frailty, although many of the issues associated with frailty are common to a wide range of the older adult age group.

Particular impacts of frailty can be seen at both personal and societal levels or a combination of both. In particular, the issues of relevance to older adults might include:

- Loneliness and isolation
- poverty (to include fuel and food poverty)
- housing, independent living, supported living arrangements, housing adaptations and independence
- hospital admissions, hospital discharges, social care support arrangements and the process of 're-ablement' following a

hospital stay
- Specific diseases or conditions which are most common in older adults or are the biggest causes of morbidity or have the most impact on quality of life for older adults
- end of life care and planning for death
- the impact of service provision for the ageing population within the UK

Draft National Institute of Clinical Excellence (NICE) guidance on disability, dementia and frailty in later life states that frailty exists where someone is at high risk of developing health problems including disability, having a fall or death. It can also require a dependency on others and the need for long-term care (Fried et al. 2004). These conditions will and often do require hospital based treatments.

However, if we view frailty as a collection of modifiable health and social care needs that can be changed, as suggested by Age UK, there are a range of improvements that can be considered to reduce frailty. As Age UK describe, these could mean:

"...the healthcare system treating frailty as something that can be addressed and improved; banks and other service industries ensuring that their systems meet the needs of all their customers, including those living with frailty; local authorities, planning authorities and the building industry working together to develop places that mean that people can stay independent for as long as possible." (Age UK, 2014, p45).

It should be noted that the perception of frailty between older people and professionals can differ and that just because an individual is over a certain age does not mean that they are necessarily frail. A King's Fund (2012) report into the care of frail older people with complex needs highlights that the majority of over 80 year olds say they are satisfied or very satisfied with their health and that certain cognitive functions improve with age.

The Age UK report 'Later Life in the UK' provides information about a range of quality of life indicators which show that:

- 11% of older people describe their quality of life as very poor, quite poor or neither good nor poor
- 24% of older people in the UK reported that their quality of life had got worse over the last year, whereas 9 per cent said it had improved
- However, 24% of people over 65 said they were very satisfied with their health, and 51% said they were fairly satisfied
- 37% are very satisfied and 55% fairly satisfied with their standard of living; this is higher than any other age group except 16-24 year-olds (at 40% and 45%)
- 28% are 'very satisfied' with their day-to-day activities; higher than any other age group except 16-24 year-olds (30%)
- 27% are 'very satisfied' with their ability to influence what happens in their lives; higher than any other age group except 16-24 year-olds (35%)
- 74% are either very or fairly satisfied with achieving their goals
- 82% said that in the last two weeks, they felt happy or contented either most days or every day; this was the highest for any age group
- 71% said that in the last two weeks, they never felt depressed; this was better than other age groups except 16-24 year olds (76%) and 45-54 year olds (74%)

The Age UK report draws on data from the Department for Environment, Food and Rural Affairs (2011) 'Survey of Public Attitudes and Behaviours towards the Environment' report which contained a number of questions about quality of life and life satisfaction. The full report can be found here.

A wide range of national policies and legislation are relevant to older people and frailty. This is a summary of some of the key information that is available.

- The National Service Framework: Older People (Department of Health, 2001) set out quality standards for health and social care services for older people.
- The 2012 Health and Social Care Act sets in place a legislative framework to modernise health and social care provision responding to the challenges of rising demand and treatment costs; the need for improvement; and the state of public finance (Health and Social Care Act, 2012). The new system is explained in this document: The-health-and-care-system-explained, March 2013
- The 2014 Care Act introduces major reforms to the legal framework for adult care and support in England (Care Act, 2014).
- The UK Advisory Forum on Ageing aims to improve the health and wellbeing of older people by giving older people a direct link to government.
- The National Institute for Health and Care Excellence (NICE) provides guidance, standards and sources of evidence including issues relevant to frailty. Their 'Pathways' tool provides a topic by topic guide (NICE pathways).
- The British Geriatrics Society is the professional body of specialists in the health care of older people in the UK.
- 'Fair Society, Healthy Lives', The Marmot Review was an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England (Marmot Review 2010).
- The Equality Act, 2010 brought together existing regulations that already gave protection against ageism and other forms of discrimination, and extended them. Age UK produce useful information which outlines the implications for older people (The Equality Act, Age UK).

A British Geriatrics Society (2014) guidance document called 'Fit for Frailty' identifies a range of recommendations that can be employed to help recognise and manage frailty in community and outpatient settings. The recommendations are summarised below and the full report can be accessed here.

- Older people should be assessed for the presence of frailty during all encounters with health and social care professionals. Gait speed, the timed-up-and-go test and the PRISMA questionnaire are recommended assessments

- Provide training in frailty recognition to all health and social care staff
- Do not offer routine population screening for frailty
- Look for a cause if an older person with frailty shows decline in their function
- Carry out a comprehensive review of medical, functional, psychological and social needs based on the principles of comprehensive geriatric assessment
- Ensure that reversible medical conditions are considered and addressed
- Consider referral to geriatric medicine where frailty is associated with significant complexity, diagnostic uncertainty or challenging symptom control
- Consider referral to old age psychiatry for those people with frailty and complex co-existing psychiatric problems, including challenging behaviour in dementia
- Conduct evidence-based medication reviews for older people with frailty (e.g. STOPP START criteria)
- Use clinical judgment and personalised goals when deciding how to apply disease-based clinical guidelines to the management of older people with frailty
- Generate a personalised shared care and support plan (CSP) outlining treatment goals, management plans and plans for urgent care. In some cases it may be appropriate to include an end of life care plan
- Where an older person has been identified as having frailty, establish systems to share health record information (including the CSP) between primary care, emergency services, secondary care and social services
    - Having the ability to share such information between health and social care providers, provides greater insight into the needs of our community. There is a shared vision both locally and nationally that the sharing of electronic records will be the way of the future.
- Develop local protocols and pathways of care for older people with frailty, taking into account the common acute presentations of falls, delirium and sudden immobility. Wherever the patient is managed, there must be adequate diagnostic facilities to determine the cause of the change in function. Ensure that the pathways build in a timely response to urgent need
- Recognise that many older people with frailty in crisis will manage better in the home environment but only with appropriate support systems

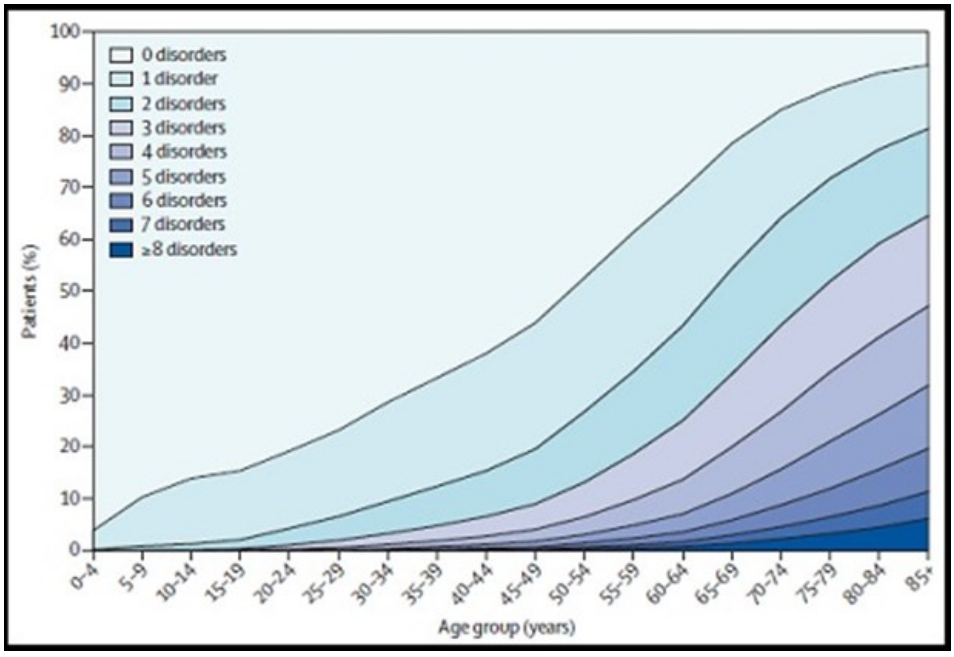
Barnett et al (2012) conducted a cross sectional study on 1.75 million people registered at 314 medical practices in Scotland as of March 2007. The purpose was to examine the distribution of multiple morbidity, and the interaction of physical and mental health disorders in relation to age and socioeconomic status. Multiple morbidity is a term which refers to a person having more than one health condition or disease, for example, diabetes and heart disease or arthritis, dementia and high blood pressure.

The key findings were:

- 42% of all patients had some (any) morbidities,
- 23% of all patients had more than one (i.e. were multi-morbid)
- Relative proportions of the population with multiple morbidities increase with age as might be expected,
- However, the largest absolute numbers of people with multiple morbidities were found in those aged under 65 years – this is due to the relative size of the populations under and over 65,
- Onset of multiple morbidity occurred 10-15 years earlier in those living in the most deprived areas compared with those in the most affluent areas,
- Socioeconomic deprivation was particularly associated with multiple morbidity that included mental health disorders, The prevalence of both physical and mental health disorders was:
    - 11% in most deprived areas,
    - 6% in least deprived areas,
- The presence of a mental health disorder increased with the number of physical morbidities:
    - 7% for five or more disorders,
    - 2% for one disorder.

Multiple morbidity becomes progressively more common with age. The figure below shows how morbidities accumulate with age. This places a particular challenge on health and social care services. The current system in York is not designed to cope with this level of complexity, in particular the complexity of managing mental health disorders.

Number of Chronic Disorders by Age



The most problematic expression of population ageing is the clinical condition of frailty. Frailty develops as a consequence of age-related decline in many physiological systems, which collectively results in vulnerability to sudden health status changes triggered by minor stressor events. Between a quarter and half of people older than 85 years are estimated to be frail, and these people have a substantially increased risk of falls, disability, long-term care, and death.

Better Care Fund

Current work is underway to strengthen shared care services under the Better Care Fund

The Fund (formerly the Integration Transformation Fund), was launched by the Government in June 2013 and is a single pooled budget to support services to work more closely together in the community at a local level.

York's Plan proposes a transformation of the local health and social care system, focusing on three main elements:

- The development of local care hubs of health and social care staff who will rapidly assess and diagnose issues and needs to enable people to remain at home or return there at the earliest opportunity
- Shared Care Records, so people only have to provide their details and case history once
- Single Point of Contact – a health or social care-lead who takes responsibility for the individual as they move between services.

The vision is to create a health and social care system with residents at the centre with support around them. It's hoped the proposals will see a more responsive service, with increased cross-organisational working, a more innovative use of pooled budgets and increased partnership working, leading to improved outcomes for residents and more cost effective services

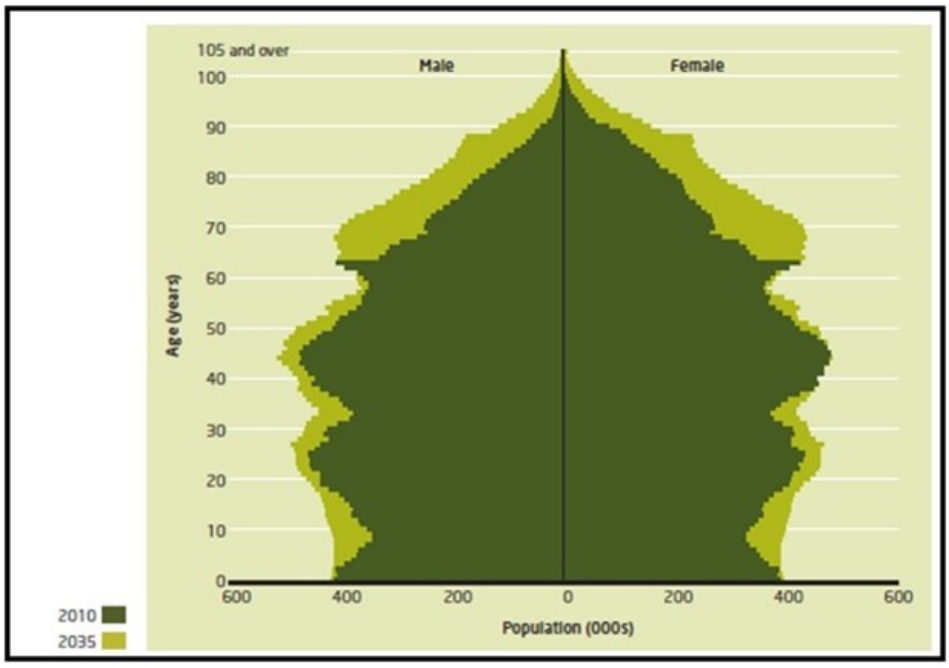
Final detailed plans will be submitted to NHS England. If approved, York's plans will be tested throughout 2014-2015, with delivery starting in 2015-2016 (City of York Council, 2014).

The Collaborative Transformation Board oversees the work related to the Better Care Fund proposals. At the time of writing this content, the final approved plan is not available but information on the progress of this work can be found here.

What is the national picture?

Our population is ageing. Demographic information about the population in York can be found here.

Nationally, the proportion of our population who are aged 65 or over is increasing. The chart below shows the 2010 actual population age profile of England and the predicted population profile of England in 2035.



Source: Kings Fund (2012b): Transforming the Delivery of Health and Social Care

This shows that the number of people aged 65 or over will continue to increase and make up a larger proportion of our national population. The old-age dependency ratio is defined as the number of people of pension age and over for every 1,000 people of working age. It is predicted to increase from 300 in 2006 to 375 in 2021 and 492 in 2051. If the planned changes in pension age are accounted for, the ratio is expected to be 358 in 2041 and 342 in 2051 – still higher than it currently is (King's Fund, 2012b).

- There are over 22.7 million people aged 50 years and over, over a third of the total UK population
- There are now nearly 14.7 million people in the UK aged 60 and above
- There are now more people in the UK aged 60 and above than there are under 18
- For the first time in history, there are 11 million people aged 65 or over in the UK
- There are more pensioners than there are children under 16
- In 2010, approximately 640,000 people in the UK turned 65; in 2012, the figure was about 800,000. The number turning 65 is projected to decrease gradually over the next 5 years to around 650,000 in 2017 3 million people are aged 80 or over
- 3 million people are aged 80 or over
- The number of centenarians living in the UK has risen by 73% over the last decade to 13,350 in 2012

Source: Age UK Later Life in the UK (2014)

NHS England produce an evidence pack aimed at highlighting areas for improvement within GP services. The full pack can be accessed here. Much of the information provided in this pack is of particular interest to older adults and the key points are summarised below (all of the data refers to England):

- 53% of people report that they have a long term health condition. Across all Clinical Commissioning Groups, this varies between 42% - 64%
- 12% of patients with a long term condition feel that they do not receive enough support. Across all Clinical Commissioning Groups, this varies between 7% - 23%
- 19% of patients experience moderate, severe or extreme pain and discomfort. Across all Clinical Commissioning Groups, this varies between 11% to 32%
- 5 in every 1,000 people are in a nursing home. Across all Clinical Commissioning Groups, this varies between 0.6 to 16.5 people per 1,000
- 51 in every 1,000 people claim disability living allowance. Across all Clinical Commissioning Groups, this varies between 25.1 to 112.2 people per 1,000
- The prevalence of long term conditions is both increasing and under reported
- The number of GP appointments has been increasing year on year. In particular the number of GP appointments used by older adults has increased significantly
- 87% of people describe their overall experience of GP surgeries as good. Across all Clinical Commissioning Groups, this varies between 74% to 93%
- 70% of people describe their overall experience of GP out of hour's services as good. Across all Clinical Commissioning Groups, this varies between 55% to 85%
- Emergency admissions for conditions that should not usually require hospital admissions are increasing
- Emergency pressures are increasing. There are an increasing number of A&E attendances in A&E units that are classed as 'Type 2' (a consultant led single speciality unit e.g. ophthalmology or dental units) and 'Type 3' (any other type of A&E unit / minor injury unit / walk in centre that is not a 24 hour dedicated consultant led A&E unit). An increasing number of A&E attendances turn into hospital admissions.

What does this look like in York?

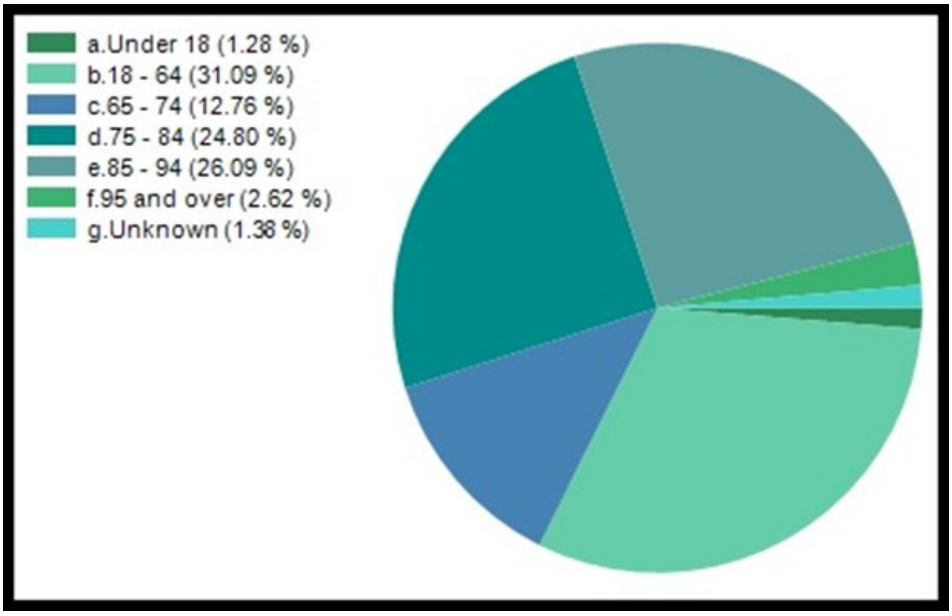
The Public Health England 'Older People's Atlas' resource provides data against a range of measures for York. The full resource can be accessed here. Information from this resource is detailed in the sub-headings of this section.

In terms of population profile, York has a very similar proportion of people aged 65 or over compared to regional or national rates. 17% of the population of York are aged over 65.

In terms of projected population figures, York's population in 2020 and 2035 is predicted to have a slightly higher percentage of people aged over 65 and over 85 than both regional and national projections. In 2020, 3.1% of York's population is predicted to be made up of people aged 85 or over compared to 2.8% of the English population and 2.7% of the Yorkshire & Humber region population.

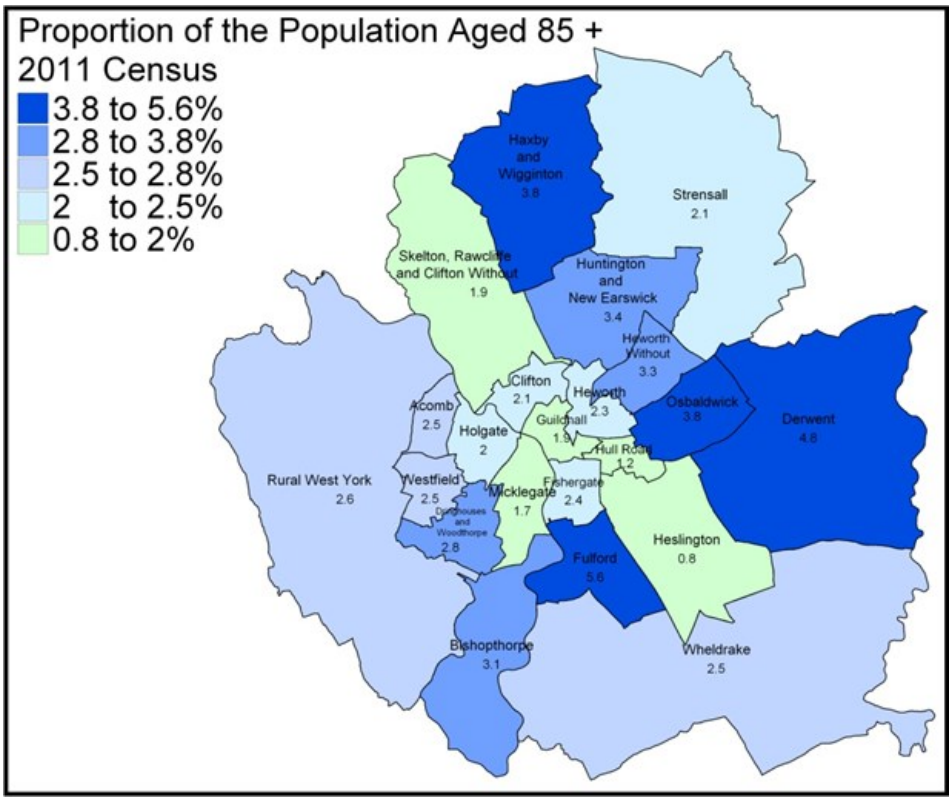
The proportion of adult social service customers aged 85 or over taken from the snapshot below in August 2014 is just under 29%. This is the age group most likely to be experiencing frailty. Overall, a 66% majority of adult social services customers are older people aged 65 years or over.

Proportion of Adult Social Service Customers by age band as at August 2014



Source: Frameworki, City of York Council's adult social care electronic record system.

The 2011 census shows that a number of outer lying wards in York have higher proportions of the very old (people aged over 85 years old), including Fulford, Derwent and Haxby and Wiggington:



Defining frailty to capture a range of needs including the impact of reducing physical capacity, means that it is useful to begin to identify what factors can modify health and social care needs.

Appropriate housing, supportive neighbourhoods and economic advantage, can help older people to remain healthy and well. York's Fairness Commission reported that two fifths of York's population live in places that are in the best 20% in the country (The York Fairness Commission, 2012) and York fairs well on measures of neighbourhood satisfaction with 92% of residents surveyed being satisfied or very satisfied about living in York (Big Survey, 2012).

However, The Fairness Commission highlighted that 7% of York's population live in areas that are in the 20% most deprived in England and noted that a rapidly ageing populationis bringing challenges, particularly on health, social care and housing options. There is a challenge involved in responding to frailty and identifying factors that are protective. That is, the things a person can do to protect against developing frailty or preventing its worsening such as exercising or eating well.

For frail older people a relatively small change in health or a minor adverse incident can result in significant deterioration (British Geriatric Society, 2014). From a medical viewpoint 'frailty syndromes' are identified when a fall or sudden change occurs and should raise awareness of the likelihood of frailty being evident (British Geriatric Association, 2014).

The nature of the response to a sudden change or adverse incident can have a protective impact, and alternative responses to hospital admission are viewed as necessary which can be achieved through new capacity and resilience in primary, community and social care services as well as the voluntary and housing sectors.

There are a range of other 'lifestyle' factors such as diet and exercise that can contribute to the ongoing health and wellbeing or management of long-term conditions in older adults. A range of information about 'lifestyles' can be found here.

There are a number of risk factors associated with a person becoming 'frail elderly'. National Institute for Clinical Excellence (NICE) is currently exploring the evidence around the prevention of frailty in later life by looking at preventative approaches which could be taken by people aged 40 – 65. This is expected to be released in February 2015.

References

1 Age Uk (2014). Housing in Later Life
Age Uk (2014). Housing in Later Life

2 Age UK (2014) Later Life in the UK
Later Life in the UK

3 Barnet, K. Et al (2012) Epidemiology of multimorbidity and implications for health care, research and medical education: a cross-sectional study
Epidemiology of multimorbidity and implications for health care, research and medical education: a cross-sectional study

4 British Heart Foundation (2012) Interpreting the UK Physical Activity Guidelines for Older Adults
Interpreting the UK Physical Activity Guidelines for Older Adults

5 Centreforum (2014) Ageing Alone - Loneliness and the 'Oldest Old'
Centreforum (2014) Ageing Alone

6 Citizen Advice Bureau (2013) Access Denied
Access Denied

7 Department of Health (2001) The Wanless Report: Securing Good Health for the Whole Population
The Wanless Report: Securing Good Health for the Whole Population

8 Department for Environment, Food and Rural Affairs (2011) Survey of Public Attitudes and Behaviours Towards the Environment
Survey of Public Attitudes and Behaviours Towards the Environment

9 Fujitsu (2011) Online government services and the offline older generation
Online government services and the offline older generation

10 Joseph Rowntree Foundation (2013) Living With Loneliness
Living With Loneliness

11 Joseph Rowntree Foundation (2012) Let's Talk About Loneliness
Let's Talk About Loneliness

12 Kings Fund (2006) Expenditure on Social Care for Older People to 2026
Expenditure on Social Care for Older People to 2026

13 Kings Fund (2012) Transforming the Delivery of Health and Social Care The case for Fundamental Change
Transforming the Delivery of Health and Social Care The case for Fundamental Change

14 King's Fund (2012) The care of frail older people with complex needs: time for a revolution
The care of frail older people with complex needs: time for a revolution

15 Lally, F., Chrome, P. (2007) Understanding Frailty
Understanding Frailty

16 National Institute for Health & Care Excellence (2013) CG161 Falls: Assessment and Prevention of Falls in Older People
CG161 Falls: Assessment and Prevention of Falls in Older People

17 Office for National Statistics (2012) Pension Trends Chapter 2: Population Change
Pension Trends Chapter 2: Population Change

In this section

Military Personnel, Their Dependents and Veterans
People Affected by Domestic Abuse
Parents
Student Community
Young Offenders
Young People Not in Education, Employment or Training

This page was last updated on 17 April 2015
This page will be reviewed by 17 April 2016

e: healthandwellbeing@york.gov.uk

Download PDF