****

**Frailty and the Lincolnshire Frailty Pathway**

This document is for Adult Care and Community Wellbeing only.

02/12/2022 Version 2

Contents

[**KEY POINTS** 2](#_Toc124778871)

[**What is Frailty?** 2](#_Toc124778872)

[**Why is Frailty important?** 3](#_Toc124778873)

[**Lincolnshire Frailty Pathway** 3](#_Toc124778874)

[**Frailty Screening** 3](#_Toc124778875)

[**Frailty Assessment** 4](#_Toc124778876)

# **KEY POINTS**

* Frailty is a syndrome usually but not always associated with ageing, where a combination of factors limit resilience and the ability to recover from illness or trauma.
* People living with frailty benefit from an integrated approach to preventing deterioration and maintaining wellbeing.
* Needs assessments should screen for frailty and prompt a referral for a frailty assessment wherever frailty may be indicated.

# **What is Frailty?**

Frailty is not an illness, but a syndrome that combines the effects of natural ageing with the outcomes of multiple long-term conditions, a loss of fitness and reserves. Frailty is a loss of resilience that means people living with frailty do not bounce back quickly after a physical or mental illness, an accident or other stressful event.

In clinical terms, frailty is characterised by loss of biological reserves across multiple organ systems and increasing vulnerability to physiological decompensation after a stressor event.

People living with frailty are likely to have a number of different issues or problems, which, taken individually, might not be very serious but when added together have a large impact on their health, confidence and wellbeing.

Frailty occurs more often as people become older. Of people over 85, about one in four is living with frailty and increasingly it is suggested that frailty needs to be thought of as a long-term condition.

* The overall prevalence of frailty in people aged over 60 is 14% and it tends to be more common in women.
* 5% of people aged 60-69 have frailty. This rises to 65% in people aged over 90. In England there are 1.8 million people aged over 60 and 0.8 million people aged over 80 living with frailty.
* Frailty is linked with poor mobility, difficulty doing everyday activity, or simply ‘slowing down’.
* Frailty results in large increases in the health cost for care settings such as inpatient, outpatient and nursing homes.
* Frailty progresses with age. As the population of England ages, the prevalence and impact of frailty is likely to increase.

# **Why is Frailty important?**

Frailty is important as:

* recognising frailty allows the identification of people at risk with complex care needs;
* it permits sub-stratification by needs, not age;
* it crosses health and social care, so can drive integration;
* it is predictive: finding those who benefit from active and healthy ageing;
* it will guide and track commissioning, design and service delivery;
* it directs towards key outcomes: maintained functional ability and wellbeing;
* it provides opportunity to standardise care for people with similar needs.

# **Lincolnshire Frailty Pathway**

Lincolnshire is tackling frailty through the development of a coordinated, cross system approach.

All health and care professionals should be aware of frailty and identify where people would benefit from assessment and planning that minimises the impact of frailty on people’s wellbeing.

Click on the link to find out more information about the [Lincolnshire Frailty Pathway](https://www.lincolnshirecommunityhealthservices.nhs.uk/our-services/frailty-pathway), including resources and a practice toolkit.

# **Frailty Screening**

Promoting wellbeing involves actively seeking improvements in aspects of wellbeing set out

Lincolnshire Adult Care has adopted the PRISMA-7 Frailty Screening tool, embedded within its needs assessments to help practitioners identify when someone is experiencing frailty.

PRISMA-7 is an internationally recognised basic seven question screening tool to identify people likely to be categorised as frail and that would benefit from a full frailty assessment, undertaken by either the person’s primary care or neighbourhood working team.

Triggers are:

1. Are you older than 85 years?
2. Are you male?
3. In general, do you have any health problems that require you to limit your activities?
4. Do you need someone to help you regularly?
5. In general, do you have any health problems that require you to stay at home?
6. In case of need, can you count on someone close to you?
7. Do you regularly use a cane, a walker, or a wheelchair to move about?

A person hitting three or more of the seven triggers should be referred to their primary care team using the Lincolnshire Frailty Pathway Letter (available via Mosaic), to request that a full frailty assessment is undertaken.

# **Frailty Assessment**

Lincolnshire has adopted the Edmonton Frailty Assessment and Scale. Frailty assessments should be undertaken by primary care teams and increasingly as neighbourhood working develops, assessments and coordinated plans are being developed in a more integrated way.

More information on the Edmonton Frailty Assessment can be found on the [Lincolnshire Frailty Pathway website.](https://www.lincolnshirecommunityhealthservices.nhs.uk/our-services/frailty-pathway)

A copy of the Work Force Matters – Frailty briefing document can be requested via the Lead Professional Team; email – practice.development@lincolnshire.gov.uk.