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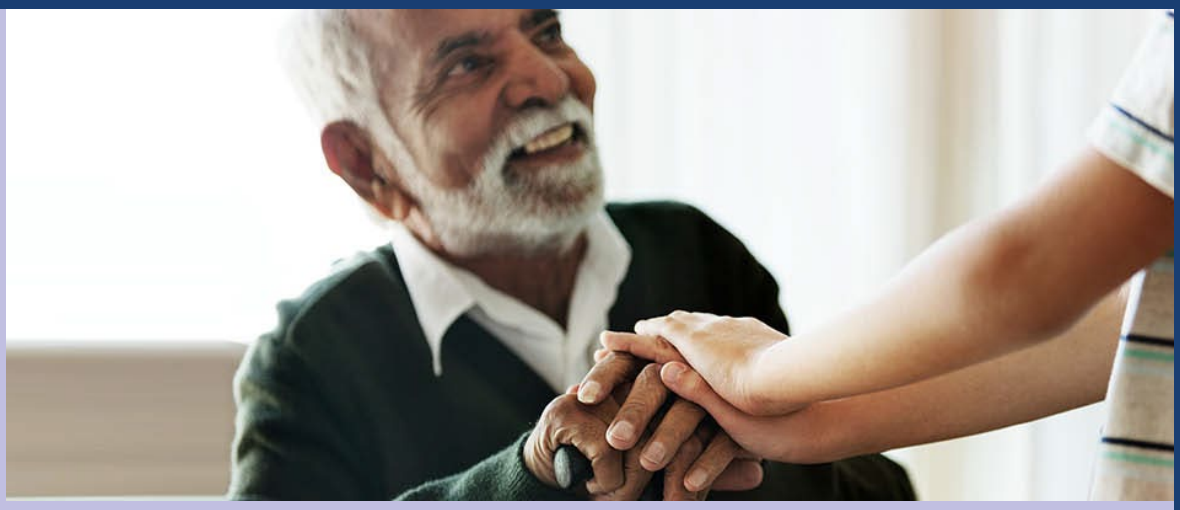

Using individual and neighbourhood profiles and trends to understand frailty with nationally representative population data

Part 2: Frailty and receipt for care in England

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Executive Summary

June 2021

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The problem

The geographical distribution of frailty, as demonstrated by our previous report, showed substantial differences between different parts of the country. This is important, because people living with frailty are likely to benefit from social support. This report addresses the key question of how differences in the distribution of frailty relate to the need for formal care.

What did we do?

We took the geographical differences in frailty and examined how these relate to the geographical patterns of (local authority funded) care receipt in the same areas, using an independent data source.

Key findings

Our analysis indicates the following key results:

- 0.7 million people aged 65 and older in England were estimated to be frail in 2018, with another 1.6 million pre-frail, but only 0.5 million adults in the same age group received formal care.
- There is a variation between areas of the number of prefrail and frail adults aged 65 and older in local authorities and the number of long-term care recipients in the same age group.
- 124 local authorities (82.1%) have a greater number of persons with frailty over the age of 65 than care recipients within the same age range. It is likely that frail people require some care, suggesting there is a formal care deficit present in much of the country. It is unclear how much of this discrepancy in care needs is made up for by unpaid and privately paid care.

Overall, there is evidence of a gap between the prevalence of frailty and the provision of adult social care in most local authorities. The gap is not uniform, and some areas show substantially lower levels of care receipt for their geographical area, compared to what would be expected based on frailty prevalence estimate.

Caveat:

This is a geographical analysis, so individuals are not matched to individual care receipt. The prevalence of frailty is an estimate, and may differ from the true level. Care receipt is only measured by formal care provided by local authority funding; it does not account for informal or unpaid care by friends and family, nor privately funded formal care.

Conclusion

In some areas of England, the receipt of local authority funded care is lower than would be expected from estimates of the prevalence of frailty. As the population ages, the need for care is likely to increase. This study raises the possibility that current provision of local authority funded care may not be adequate to meet existing needs.

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