Bexley Wellbeing Partnership

Bexley Frailty Profile

Public Health Intelligence Team

Executive Summary

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- **Age is the single greatest risk factor for frailty, and Bexley has the 6th largest 50+ population in London: 89,006 people, or 40% of Bexley's total population.**
- **24,397 people or 27.4% of Bexley's age 50+ population are estimated to have mild, moderate, or severe frailty**
- **The Bexley picture corresponds with national evidence suggesting gender and deprivation are strong drivers of inequalities in frailty prevalence and outcomes, however local ethnicity data were not robust enough to draw conclusions:**
  - **Based on electronic Frailty Index scores in the age 65+ population, more females than males have moderate or severe frailty: 3,825 vs 2,634. Despite the larger underlying female population, this also constitutes a significantly higher prevalence: 16.5% (95%CI 16.1-17.0) vs 14.4% (13.9-14.9)**
  - **More than two thirds (69%) of emergency admissions for falls in people aged 65+ were for females. Again, despite the larger underlying female population, females are nevertheless over-represented. A similar, though less marked, pattern is evident in age 65+ unplanned admissions for ambulatory care sensitive conditions**
  - **Bexley's older population is less likely to live in its more deprived areas, meaning most emergency admissions for falls (65+) are for residents of less deprived areas. However, after adjusting for population size, those living in more deprived areas have a higher risk of emergency admission.**

Executive Summary

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- **Bexley's population is ageing, with the age 50+ population expected to grow by 26,500 people (+30%) by 2050**
- **Higher growth is expected in the higher age ranges, where frailty prevalence is higher**
- **If current estimates of frailty prevalence remain constant, we can expect 10,810 more frail people by 2050, increasing by 44% to 35,207**
- **NHS service use attributable to frailty across primary care and secondary care is estimated to be £43.2 million:**
  - **£21.6 million mild frailty**
  - **£14.6 million moderate frailty**
  - **£6.9 million severe frailty**
- **On the current trajectory, this would increase to £63.3 million by 2050:**
  - **£30.3 million mild frailty**
  - **£22.1 million moderate frailty**
  - **£10.9 million severe frailty**

a Evidence

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Frailty has been described as “the most problematic expression of population ageing” and highlights a growing concern.

-Clegg et al.

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Why is Frailty Important?

- **Frailty and Population Ageing:** Frailty is a growing concern as populations age and is linked to poorer health outcomes. Varying degrees of frailty are more common among older adults.
- **Delayed Care and Escalation:** Many older individuals with mild, moderate, or severe frailty tend to seek services only when they require acute care. This delayed presentation makes it more challenging to manage their care effectively.
- **Impact of Early Identification:** Early identification of frailty, combined with optimising care for individuals with multiple long-term conditions (multi-morbidity), can help reduce the likelihood of such escalation. It can also minimise the impact of these events, leading to better, faster recovery.
- **Hospitalisation Risks:** Frail individuals often experience prolonged hospital stays that can, worsen their condition and further increase their dependence. Frail patients are more likely to face delays in their transfer of care from hospital, and, in some cases, may spend their final days in hospital (Clegg et al).

“Frailty was introduced to explain why people of the same age have varying degrees of risk.”

-Kenneth Rockwood

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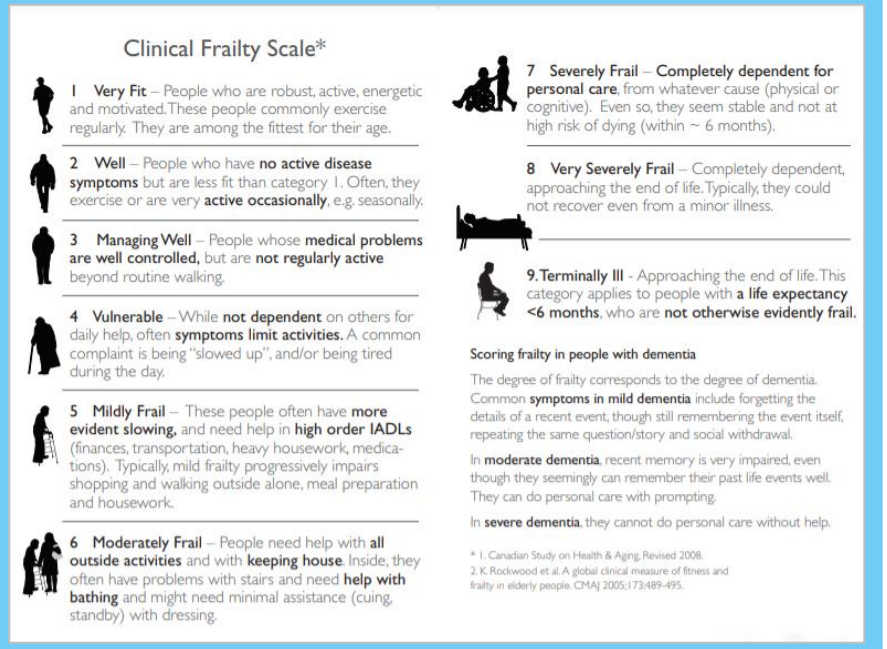
Defining Frailty

The concept of frailty is used to explain why a person may have disproportionate risk of adverse outcomes compared to someone else of the same age. For a frail person, “a small insult (e.g. infection, loss of partner) results in a striking and disproportionate change in health state” (Cambridge Institute of Public Health), and they are “at high risk of adverse outcomes such as falls, immobility, delirium, incontinence, side effects of medication – and admission to hospital or the need for long-term care.” (NHS England)

Whilst there is consensus that frailty is a state of increased risk, there is debate over the theoretical models offered to explain, define, and measure this state, which broadly fall into two camps:

The phenotypic model advanced by Fried defines frailty as a biological syndrome which can be isolated from associated conditions such as comorbidity and disability. This model theorises that reduction in resistance to stressors is due to a loss of physiologic reserve, and that the phenotypic components of this loss (shrinking, weakness, low energy, slowness, and low activity) interact to create a vicious cycle of frailty.

The accumulation of deficits model advanced by Rockwood proposes that “as people age, they accumulate health deficits, and that more deficits confer greater risk. Frailty results because not everyone of the same age has the same number of deficits.” In this model, there is no “essence” of frailty beyond the cumulative effect of all deficits, their composite risk. More recent work by Blodgett & Rockwood has shown that this model also successfully predicts excess risk in younger people aged 20+.



Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging. Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Measuring Frailty

Mirroring the two models of frailty are two approaches to measuring it:

Phenotypic: As it is not possible to directly observe or measure the loss of physiologic reserve theorised in the phenotypic model, the phenotypic components of the cycle of frailty are used as surrogates. There are numerous tools and scales available to clinical practice, variously using physical performance tests and/or questionnaires which frequently focus on strength, speed, activity and energy. For example, Fried's measure defines a person as frail if "three or more of the following criteria [are] present: unintentional weight loss (10 lbs in past year), self-reported exhaustion, weakness (grip strength), slow walking speed, and low physical activity".

Deficit index: Where phenotypic measurement focusses on a core set of deficits theorised to be most closely associated with a biological syndrome of frailty, the deficit index focuses on volume, measuring a higher number of deficits without hierarchy of importance. The only criteria for selecting deficits to measure is that they must be "acquired, age-associated, and associated with an adverse outcome and should not saturate too early." The index is calculated as the number of deficits observed divided by the number of deficits measured. The fraction derived is solely quantitative, the specific deficits observed do not affect the calculation.

Clinical frailty scale (pictured left): NHS England are clear that a frailty deficit index should not replace clinical judgment, because it is a "population risk stratification tool", in other words, it measures average risk across a group and to presume that any individual within the group typifies those characteristics is a case of the ecological fallacy. The clinical frailty scale is widely used in England based on a global clinical assessment.

The cycle of frailty (phenotypical decline) is a key concept, as it leads to worsening health and increased dependence, making recovery more difficult.

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Risk Factors for Frailty

The RCGP cohort study, Whitehall II, and UK Key studies (RCGP, Whitehall II, UK Biobank) highlight the following key risk factors for frailty:

- **Socioeconomic Status:** Lower income and education levels are the primary drivers of frailty risk, particularly in older adults.
- **Gender & Ethnicity:** Post-menopausal women are at higher risk of osteoporosis and frailty, especially those from disadvantaged backgrounds, and ethnic minority groups, due to socio-economic factors and healthcare access barriers.
- **Long-term Conditions & Multimorbidity:** Long-term health conditions, especially when combined with low socioeconomic status, increase frailty risk.
- **Physical Inactivity & Poor Nutrition:** Sedentary lifestyles and poor nutrition are key contributors to frailty, particularly in disadvantaged groups.
- **Osteoporosis & Gender Differences:** Osteoporosis increases frailty risk through fractures and loss of mobility. Whilst estrogen loss for women after menopause increases bone fragility & heightening frailty risk, men tend to experience more severe outcomes due to later diagnosis and treatment.
- **Sarcopenia:** Loss of muscle mass and strength is a major contributor to frailty, leading to increased risk of falls, fractures, and disability.
- **Frailty Cycle:** Frailty often creates a self-perpetuating cycle of decline, increasing the risk of hospital admissions, functional decline, and mortality.

Frailty is not an inevitable consequence of ageing, and it is possible to prevent or delay its onset.

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Outcomes of Frailty

Frailty is not an inevitable part of aging, and it can be prevented, or its onset delayed by addressing modifiable risk factors, particularly in the management of long-term conditions. Frailty, if not managed, can lead to a cycle of decline that significantly impacts an individual's health and quality of life as outlined below:

- **Cycle of Decline:** Frailty often leads to a self-perpetuating cycle of functional decline. As physical and mental health deteriorate, individuals become increasingly dependent on others, which further reduces their ability to manage their health, increasing the risk of further frailty.
- **Increased Risk of Hospital Admission:** Frailty increases the likelihood of hospital admission due to falls, infections, or exacerbations of long-term conditions. Frail individuals often experience a reduced ability to recover, leading to longer hospital stays.
- **Readmission Risk:** Hospitalised frail patients are more likely to experience readmissions. This cycle of admission and readmission can contribute to further functional decline and higher healthcare costs.
- **Increased Mortality:** Frailty is strongly associated with higher mortality rates. Frail individuals are at greater risk of dying earlier than their non-frail counterparts, even when accounting for other health conditions.

Box 1. List of 36 deficits contained in the eFI.

Activity limitation	Memory and cognitive problems
Anaemia and haematinic deficiency	Mobility and transfer problems
Arthritis	Osteoporosis
Atrial fibrillation	Parkinsonism and tremor
Cerebrovascular disease	Peptic ulcer
Chronic kidney disease	Peripheral vascular disease
Diabetes	Polypharmacy
Dizziness	Requirement for care
Dyspnoea	Respiratory disease
Falls	Skin ulcer
Foot problems	Sleep disturbance
Fragility fracture	Social vulnerability
Hearing impairment	Thyroid disease
Heart failure	Urinary incontinence
Heart valve disease	Urinary system disease
Housebound	Visual impairment
Hypertension	Weight loss and anorexia
Hypotension/syncope	
Ischaemic heart disease	

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Analysing Frailty

Due to the variation in the way frailty is defined, measured, and recorded, this profile takes a pragmatic approach to analysing frailty data. Bexley Wellbeing Partnership does not have access to linked data for risk stratification and impactability modelling, therefore much of the analysis relies on triangulation and inferences drawn from national and/or academic evidence.

Prevalence: True underlying prevalence of frailty can only be estimated. Here we use a hybrid of two approaches. Estimated severe and moderate frailty prevalence is taken from the Electronic Frailty Index (eFI), a frailty index of 36 deficits, again drawn from EMIS GP systems. Due to perceived undercounting in eFI data, mild prevalence is derived as a synthetic estimate by applying age-specific prevalence rates from a large cohort study, to the age-specific population structure of Bexley residents.

Risk factors: Risk factors for frailty are inferred using demographic data from the Census, Office of National Statistics (ONS), Office of Health Improvement & Disparities (OHID), and socioeconomic indicators, but may not fully capture individual-level variations.

Outcomes: Hospital admissions for falls and Ambulatory Care Sensitive Conditions (ACSC), cannot be directly linked to frailty diagnoses in Bexley so are considered as proxy indicators due to their established association with frailty in the national evidence.

b Local risk factors

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Bexley: 50+ Population Insights

(Mid-2022 Estimates)

- Bexley ranks **6th in London** for both the 50+ and 65+ populations, with a large and growing older population, reflecting the broader trends seen in outer London boroughs

- The **50+ population** (approximately **89,006**) represents **40%** of Bexley's total population.

- The **50+ demographic** in Bexley is a key group for integrated health and social care services, as this age group often faces challenges related to long-term health conditions, frailty, and increasing care needs.

- Bexley's **65+ population** is approximately **41,477** people, representing **16.6%** of the borough's total population. Of the 65+ population in Bexley, around **56% are Female** and **44% are Male**.

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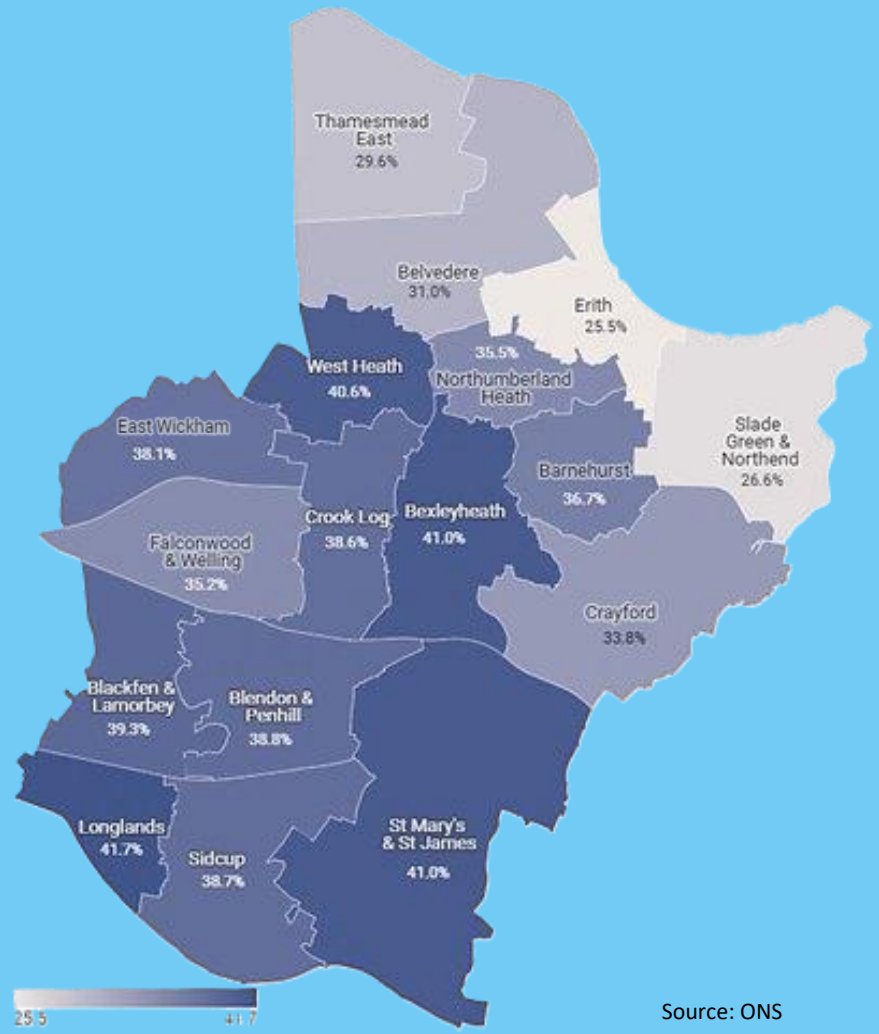
Mid-2022 population estimates – aged 50+

Proportion by ward of residence



Source: ONS

Bexley: Ethnicity Breakdown
(2021 Census)

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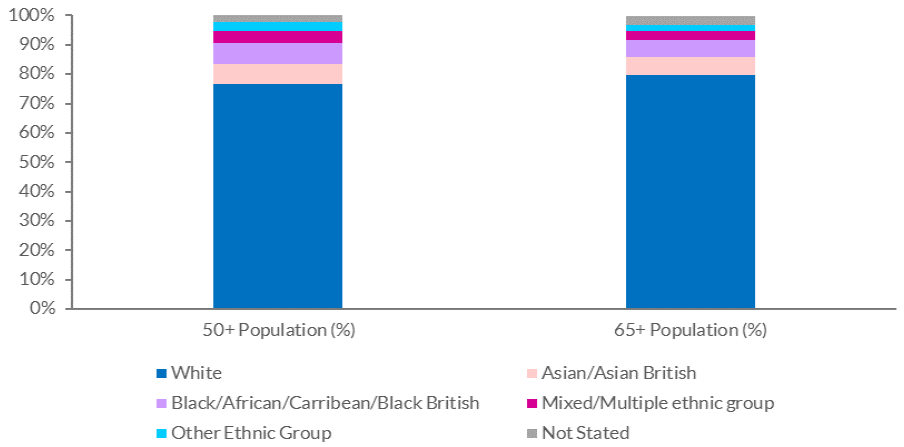
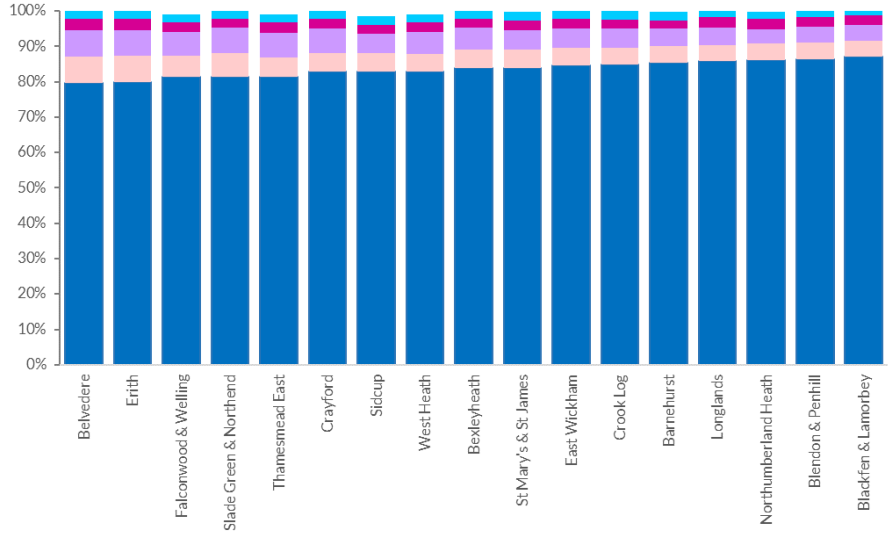
- The **65+ population** in Bexley is predominantly **White** (around **80%**), but there are notable proportions of people from **Asian** and **Black** ethnic backgrounds (around **6%** each).
- The **50+ population** shows a slightly more diverse ethnic composition, but people from White ethnic backgrounds still make up the largest proportion.
- The older population in Bexley is less diverse than the younger population, with the **50+ population** being **77% White** at the 2021 Census.
- This varies at ward level, with wards in the North of the borough tending to be more diverse, such as **Belvedere** and **Erith (**80% White), followed by **Slade Green & Northend,** and **Falconwood & Welling** (81%), and **Thamesmead East** (82%).



Ethnicity breakdown for 50+ population by ward



Bexley: Deprivation Insights
(Index of Multiple Deprivation - IMD)

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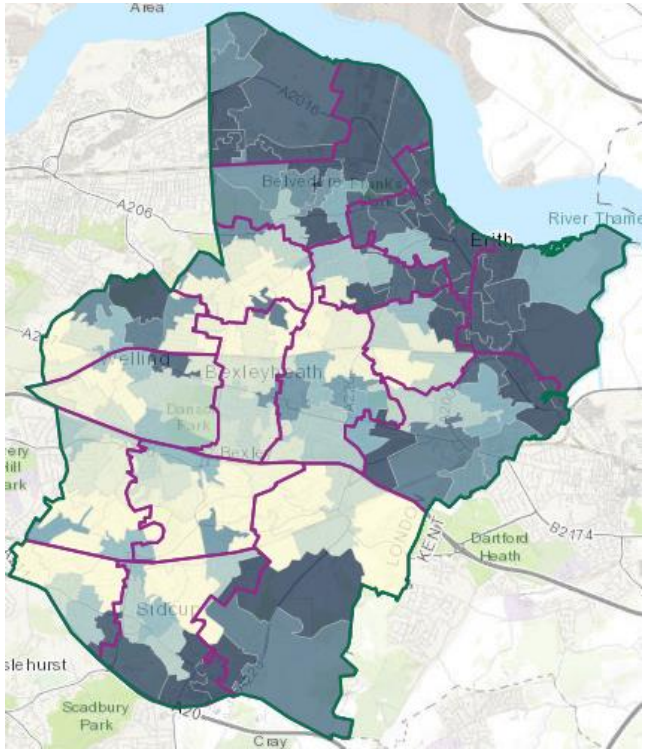
The **Index of Multiple Deprivation (IMD)** measures the relative deprivation in areas in England, using factors such as income, employment, education, housing, health, and crime. The IMD divides areas into five quintiles (IMD Quintile 1-5) based on their deprivation score.

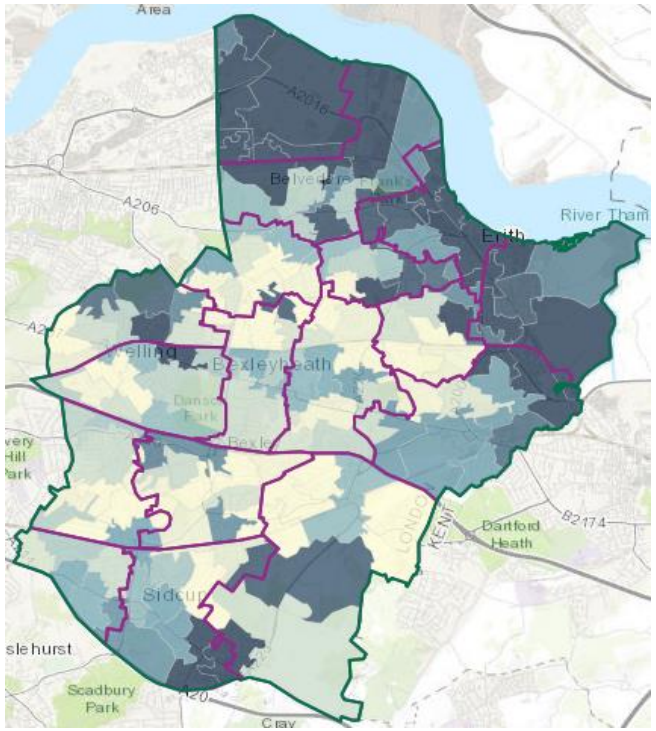
- There are no areas in Bexley that are in the most deprived 10% (nationally). There are however areas that are in the top/least deprived 10% of the country.
- There is a clear strip of deprivation across the North of the borough, and a patch at the south of the borough (and to a lesser extend two patches in the East (East Wickham ward) and the West.
- Income deprivation affecting older people tends to follow IMD for the most part – more older people in poverty in the North of the borough.

IMD Score - LSOA (2019)



Source: Bexley JSNA

Income Deprivation Affecting Older People Index (IDAOPI) – LSOA (2019)



Source: Bexley JSNA

Bexley: Frailty & Deprivation

(Index of Multiple Deprivation - IMD)

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- People living in deprived areas are **more likely** to experience frailty due to a combination of **poor nutrition**, **lack of physical activity**, **long-term health conditions**, and **limited access to healthcare**.
- Deprivation increases the chances of experiencing these challenges relating to the social determinants of health**,** such as **poor/unsafe housing**, **unemployment**, **lack of social support**, and **low income,** which also contribute to frailty.
- To reduce the impact of frailty, **targeted interventions** should consider higher levels of deprivation where people are most vulnerable/at higher risk.

Local Care Network (LCN)	Bexley Wards	Deprivation Levels (IMD Quintile)	Areas of consideration
North Bexley	Barnehurst, Belvedere, Crayford, Erith, Northumberland Heath, Slade Green & Northend, Thamesmead East.	**Varied** – Mix of higher and lower levels of deprivation	**More deprived areas in Slade Green & Northend** and **Thamesmead East.**
Frognal	Blackfen & Lamorbey, Blendon & Penhill, Londlands, Sidcup, St Mary's & St James.	**Mixed** – Several areas in middle deprivation range	**More deprived areas in parts of St Mary's & St James**
Clocktower	Bexleyheath, Crook Log, East Wickham, Falconwood & Welling, West Heath.	**Low** – Several areas with lower levels of deprivation	**More deprived areas in parts of East Wickham**

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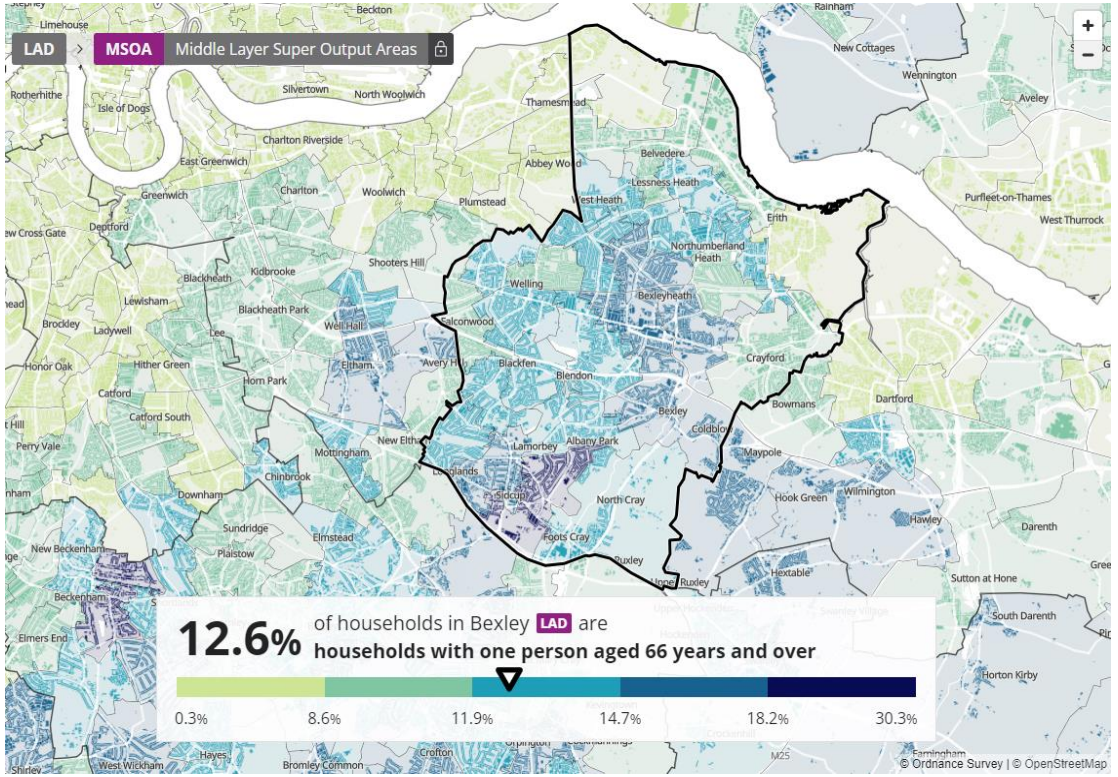
Frailty and Loneliness

Data source: 2021 Census

- Latest figures show **12.6%** of households in Bexley, are households with one person aged 66 and over living alone.



Source: ONS Census Maps

66+ Population Living Alone and Social Isolation

Data source: 2021 Census

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- Of the 66+ population in Bexley, **31%** live alone (compared to 30% nationally).

- This varies by LCN: In **North Bexley, 33%** of people aged 66+ live alone, compared **31%** in **Frognal** and **29%** in **Clocktower**.

Bexley wards with a higher proportion of 66+ living alone:

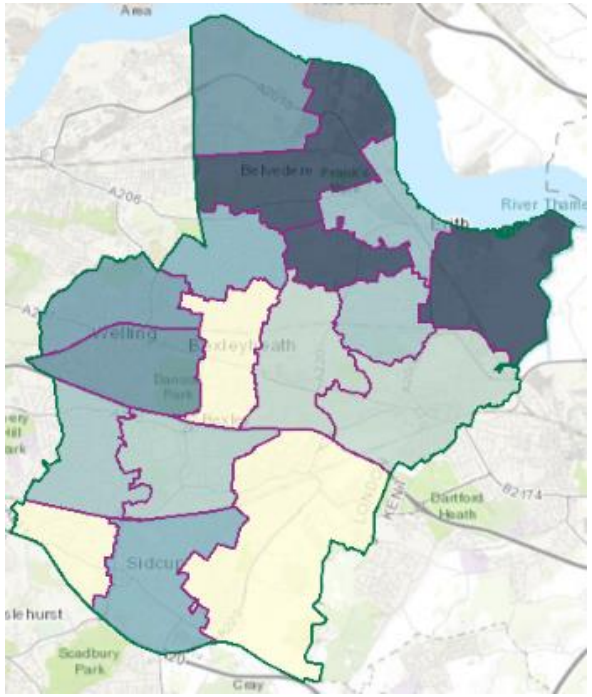
- **Slade Green & Northend:** 37.3% (more deprived)
- **Sidcup**: 37.1% (least deprived area)
- **Belvedere**: 35.6% (moderate deprivation, more diverse)
- **Crayford:** 34.8% (mixed deprivation)
- **Thamesmead East:** 34.0% (more deprived/ more diverse ethnic mix)

Fuel Poverty

Data Source: OHID / Department for Business, Energy and Industrial Strategy

- **Fuel Poverty (2022)**: 9.1% of households experience fuel poverty in Bexley, based on the "Low Income Low Energy Efficiency methodology.
- This varies by LCN: In **North Bexley,** this increases to **9.7%,** compared to **8.5%** in **Clocktower,** and **8.9%** in **Frognal**.
- Based on these modelled estimates, the highest rate of fuel poor households in the following wards:
  - Belvedere: 11.3%
  - Northumberland Heath: 10.7%
  - Slade Green & Northend: 10.0%

Percentage of households in fuel poverty - Low Income/Low energy Efficiency (LILEE) - Ward (2022)



Source: Bexley JSNA

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Prevalence

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Estimating Bexley's frail population

As described in the introduction on data availability, it is not possible to measure the true prevalence of frailty in Bexley.

Our estimates of prevalence are based on:

1) Electronic Frailty Index (eFI) scores from all registered patients at Bexley GPs, shown in pink in the table. Whilst these are direct observations, they can still only be said to be estimates because: (a) the eFI is a population level risk stratification tool, and (b) not all Bexley residents are registered with a Bexley GP, and vice versa.

2) Where eFI figures were found to undercount people in the milder and younger categories due to undercoding of deficits (variously between 26% and 94% lower than expected), synthetic estimates were created by applying research-based age-specific frailty estimates to Bexley's population structure, shown in green in the table.

In total, 24,397 people aged 50+ are estimated to be living with some degree of frailty in Bexley, more than 1 in 4 of the 50+ population (27.4%).

In all groups where eFI scores were used (shown in pink), prevalence was higher than expected, possibly reflecting Bexley's high number of care homes.

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	Estimated number frail		
Female	Mild	Moderate	Severe
50-64	2,197	214	26
65-74	2,679	481	70
75-84	3,180	1,303	318
85+	1,606	1,171	483
Male			
50-64	2,080	203	25
65-74	2,417	432	63
75-84	2,393	977	237
85+	918	659	267

Synthetic estimates based on academic research

Electronic Frailty Index scores

Estimated number of frail people resident in Bexley and attributable NHS costs per year (not including community health and social care service costs)

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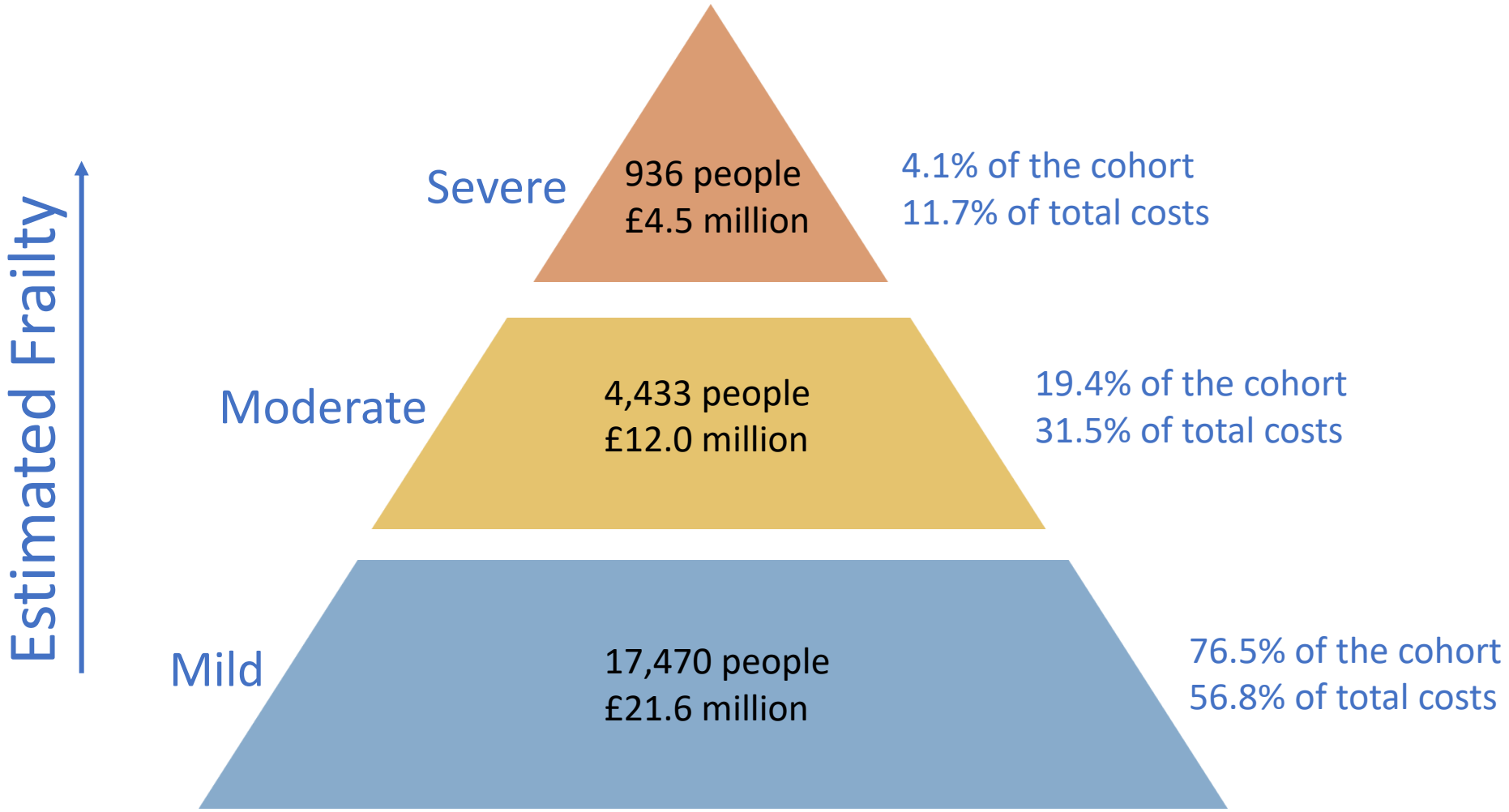
Multiplying the estimated number of people in each age and severity-specific frailty category by the average annual cost of age and severity-specific NHS service use from a very large recent study allows us to estimate the annual NHS costs associated with each segment of the cohort.

Subtracting the baseline NHS service use costs that can be expected for people of that age regardless of frailty allows us to calculate the estimated service use costs that can be attributed to frailty.



Number of people by Electronic Frailty Index category registered with a Bexley GP and attributable NHS costs per year (not including community health and social care service costs)

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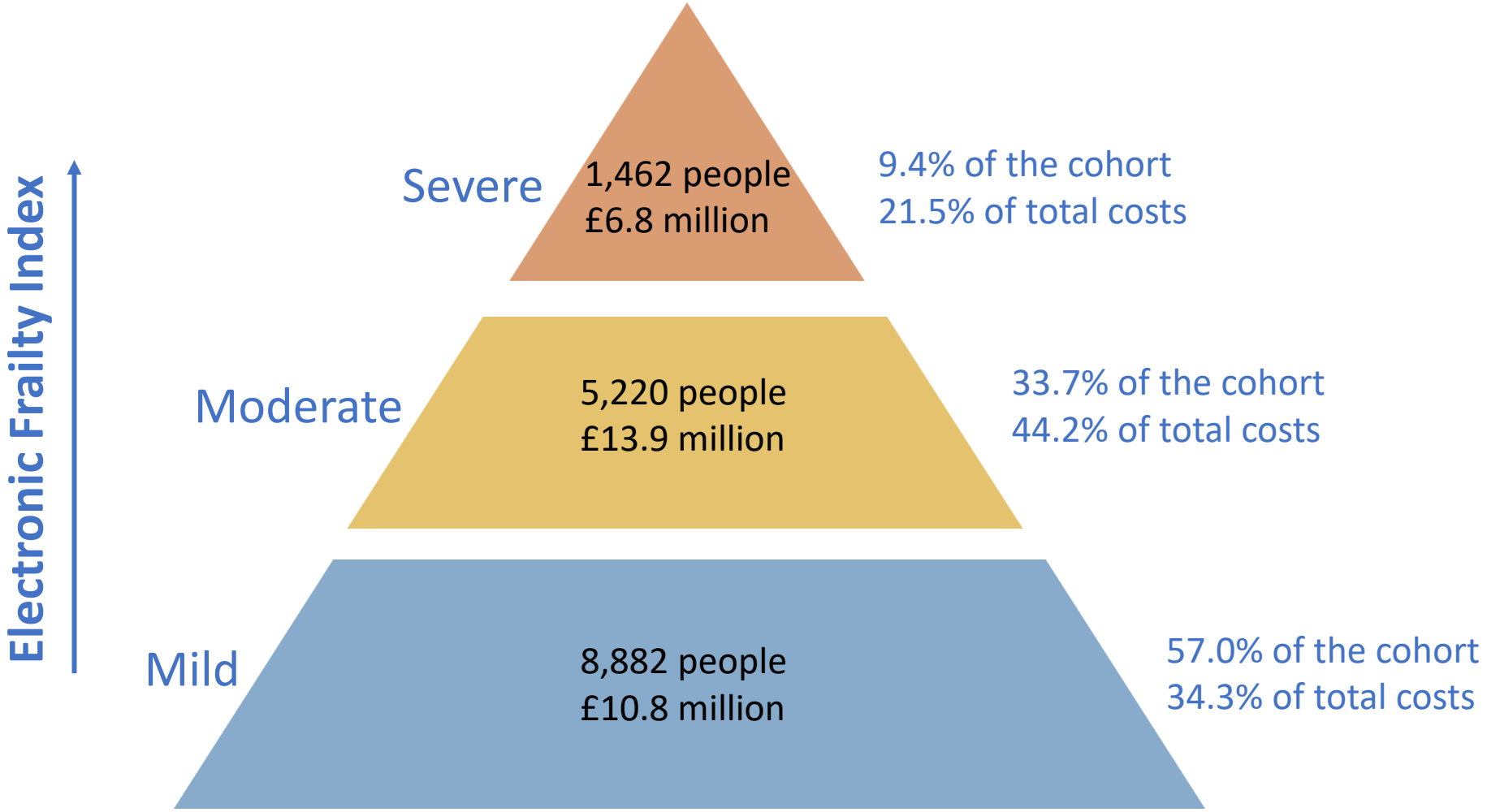
Using the eFI scores recorded for registered patients at Bexley GPs gives a different picture to that expected from the research-based estimates.

The number of people in the severe and moderate categories is higher in the GP data, possibly due to a high number of care homes in the borough.

The number of people in the mild category is lower than expected, which may be due to under-coding of eFI deficits in less frail patients.



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Annual average* (per person)

17,470 mild | 5,438 moderate | 1,489 severe

Individual prescriptions	52.5	86.2	129.5
Primary care F2F appointments	9.9	11.9	12.7
A&E attendances	0.3	0.6	0.9
Unplanned admissions	0.2	0.4	0.7
Length of unplanned admission in days	6.7	10.2	14.3

(average only of those with admissions)

Primary care costs	£887	£1,334	£1,862
Unplanned admissions costs	£725	£1,652	£2,972

(average including those with no admissions)

*As per previous slides, these are modelled estimates derived from eFI scores, synthetic prevalence estimates, and research-based service use averages and costs

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17,470 mild | 5,438 moderate | 1,489 severe

Individual prescriptions (thousands)	916	469	193
Primary care F2F appointments (thousands)	173	65	19
A&E attendances (thousands)	5.8	3.2	1.4
Unplanned admissions (thousands)	3.9	2.4	1.1
Length of unplanned admission (thousands)	25.7	24.7	16.0

Primary care costs (millions)	£15.5	£7.3	£2.8
Unplanned admissions costs (millions)	£12.6	£9.0	£4.4

*As per previous slides, these are modelled estimates derived from eFI scores, synthetic prevalence estimates, and research-based service use averages and costs

	Projected number frail			Projected change		
Female	Mild	Moderate	Severe	Mild	Moderate	Severe
50-64	2,624	256	32	+427	+42	+5
65-74	3,734	670	97	+1,054	+189	+27
75-84	4,547	1,863	454	+1,367	+560	+137
85+	2,788	2,032	839	+1,182	+861	+356
Male						
50-64	2,324	226	28	+244	+24	+3
65-74	3,190	570	83	+773	+138	+20
75-84	3,637	1,485	360	+1,244	+508	+123
85+	1,678	1,204	487	+760	+545	+221

Synthetic estimates based on academic research

Electronic Frailty Index scores

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Future projections

If the estimated age and sex specific prevalence of frailty remains constant, and Bexley's population grows as projected by the most recent GLA projections, by 2050 there will be:

- **26,500 more people aged 50+, and a greater proportion of this age group will be 75+, up from 23.2% to 27.9%**
- **10,810 more frail people, increasing from the current estimate of 24,397 to 35,207, an increase of 44%**
- **£20.1 million more attributable cost, increasing from the current estimate of £43.2m to £63.3m, an increase of 47%**

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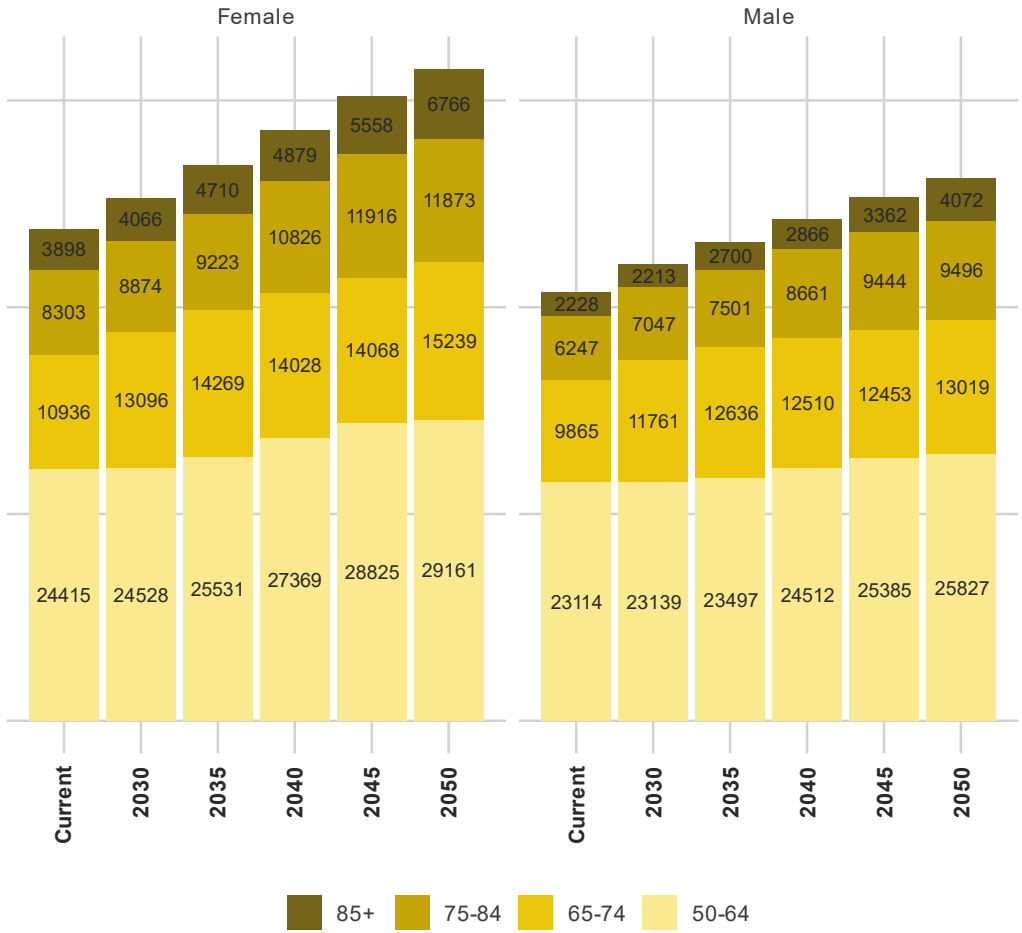
Projected future change in resident population by age and sex (count)

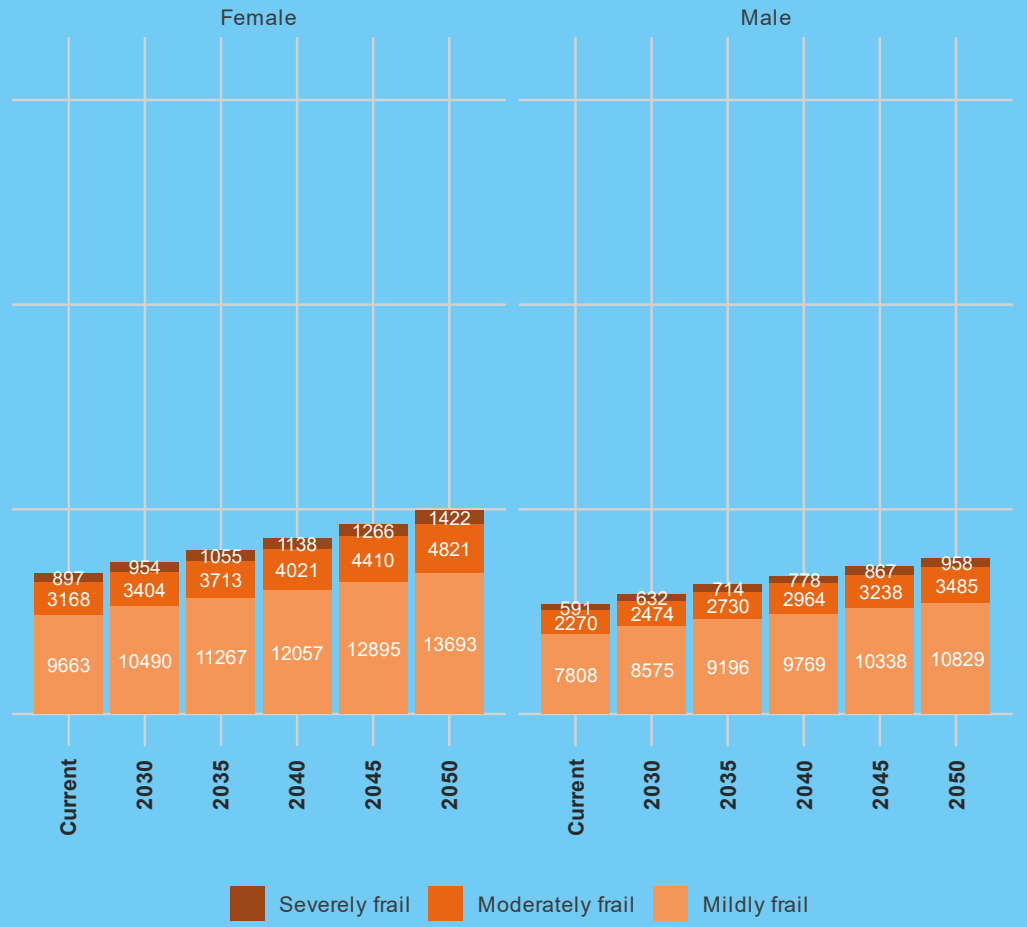
Bexley, Current-2050



Source: GLA 2022-based Demographic Projections, 2024

Projected future change in frail population by severity and sex (count)

Bexley, Current-2050



Source: GLA 2022-based Demographic Projections, 2024

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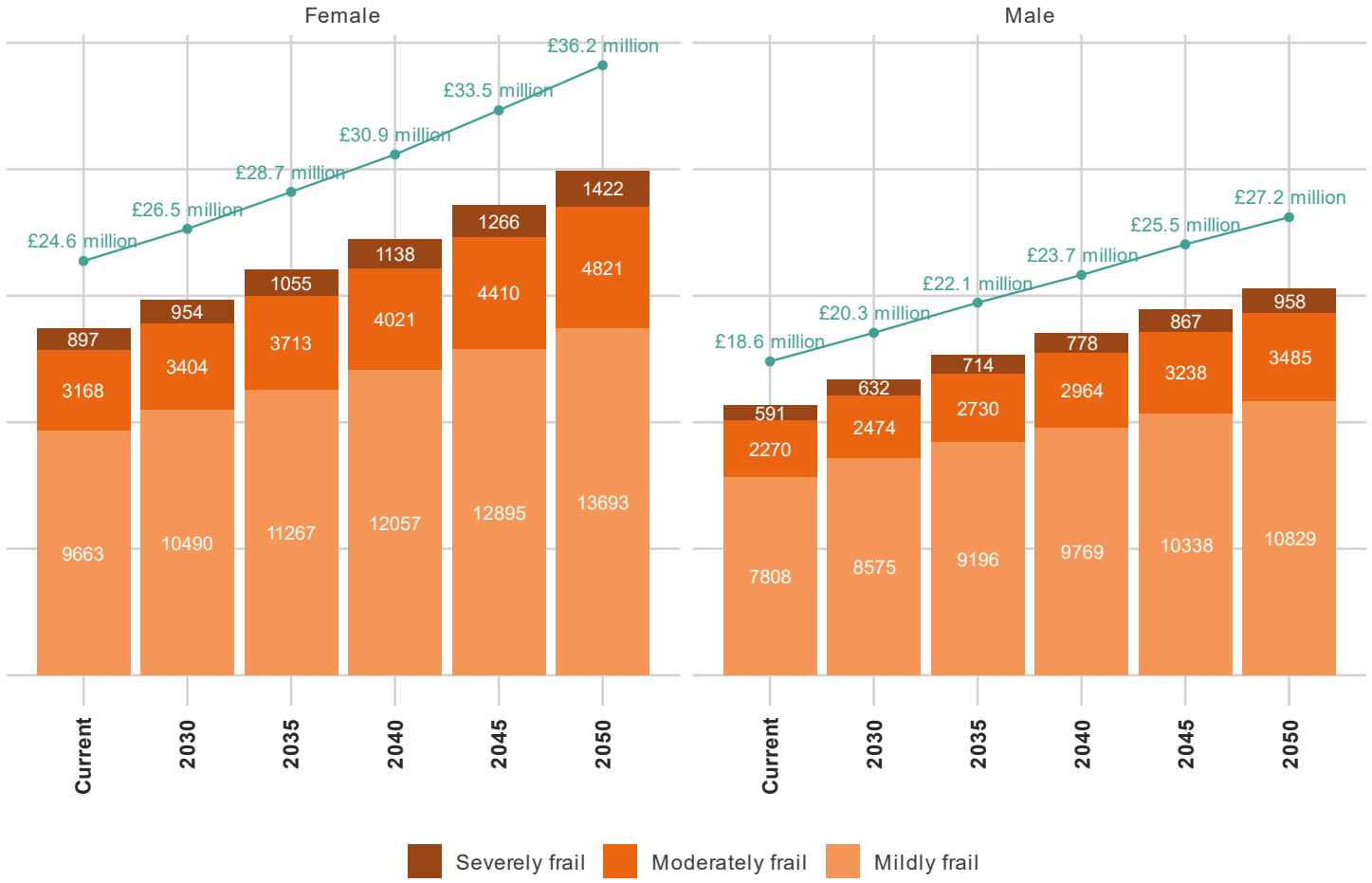
Projected future change in frail population by severity and sex (count) with estimated attributable NHS costs per year

Bexley, Current-2050



Source: GLA 2022-based Demographic Projections, 2024

d Proxy outcomes

Bexley Wellbeing Partnership

Emergency Hospital Admissions due to Falls in People aged 65 and over

Data Source: OHID/NHS England-HES data

Bexley Wellbeing Partnership

- **2023/24**: 848 hospital fall-related injuries in those **aged 65+** (based on unpublished data). 860 falls in 2022/23 with a rate of 1,944 falls per 100,000 in Bexley, compared to 1,933 in England.

- **Gender Profile**: **69%** of people aged 65+ with emergency hospital admissions due to falls were **female -** also in line with national findings

- **Trend**: Over-representation of falls injuries in females, more so in the **65-69** (72%) and **80+** (71%) age groups, compared to Bexley's 65+ female population of 56%.

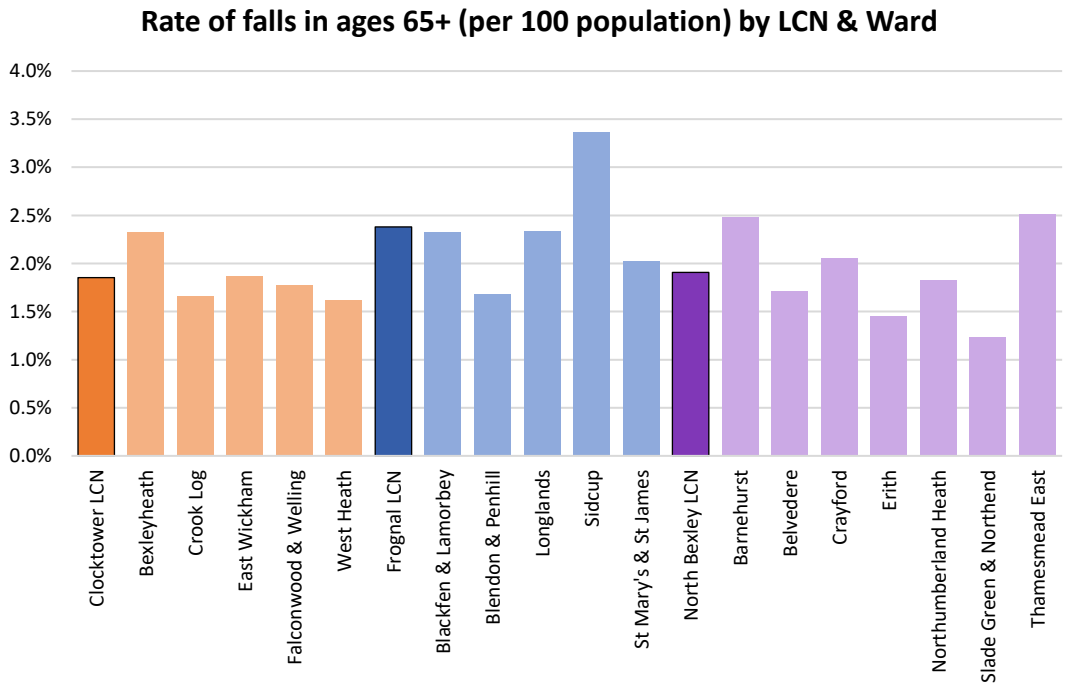
- **Ethnicity**: 77.4% of emergency admissions due to falls injuries were from White ethnic backgrounds (this includes White British & White Irish) compared to 2.0% Asian, 0.4% Mixed ethnicities, 1.8% were of other ethnic backgrounds. ***Data completeness:*** *for 18.5% of people admitted for falls injuries in 2023/24, ethnicity was either not known or not stated*.

Emergency Hospital Admissions due to Falls in People aged 65 and over

Data Source: NHS England – HES data

Bexley Wellbeing Partnership

- **Numbers by LCN:** 328 people with emergency admissions due to falls lived in Frognal, compared to 281 in Clocktower, and 239 in North Bexley.
- **Rate of falls per 65+ population:** in the 65+ population, a higher rate of falls occurred in more the deprived parts of Sidcup, Thamesmead East, and Barnhurst (as shown below).



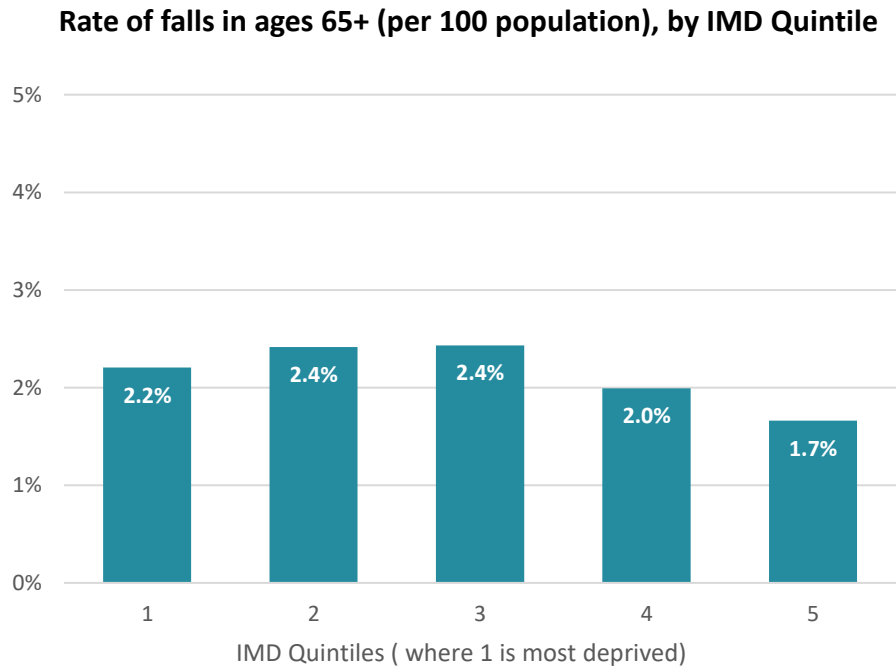
Deprivation and Falls in Bexley

Data Source: NHS England – HES Data

Bexley Wellbeing Partnership

- **Number of Falls**: 396 people with falls injuries lived in IMD Quintile 1-3, and 454 people lived in less deprived areas (IMD Quintile 4-5). With overall numbers, this would be expected, given more older people live in less deprived parts of the borough.

- **Rate of Falls:** Of the 65+ population living in IMD 1-3, a higher rate (average of 2.4%) of falls occurred in more deprived areas, compared to an average of 1.8% in IMD 4-5/least deprived.

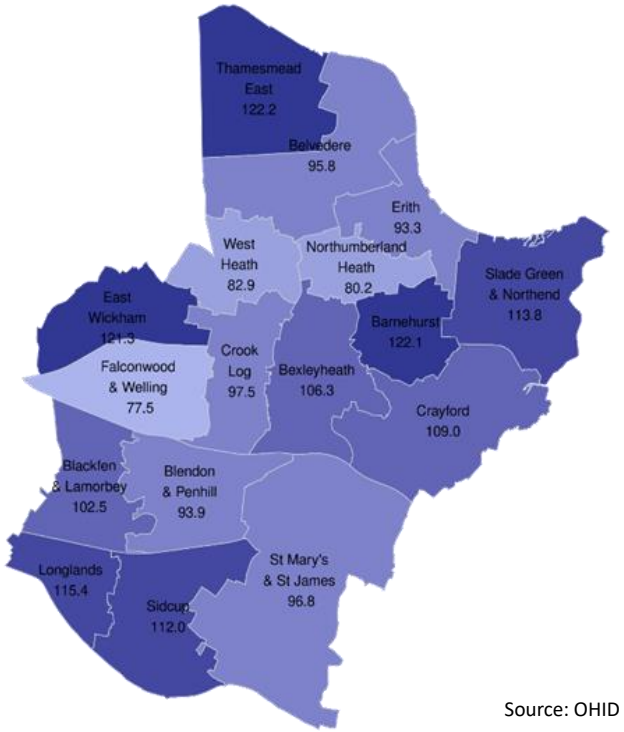


Emergency Hospital Admissions for Hip Fractures in people aged 65 and over

Data Source: OHID

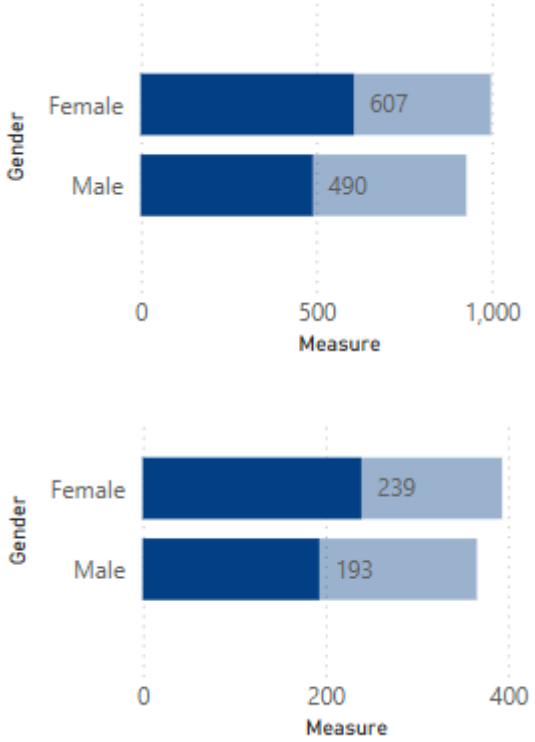
- For 2016/17-2021/22, the standardised admission ratio for hip fracture admissions for people aged 65+ in Bexley was 102.4 per 100, similar compared to 100.0 in England, but the **highest** rate in the London region.
- At ward-level, the pattern of hip fracture partially follows patterns of deprivation in the Borough, but not entirely.
- In 2022/23, there were 260 hip fracture admissions (rate of 587 per 100,000 aged 65+, significantly worse and **third highest** in the region).
- Over two-thirds (190) of these fractures, occurred in people aged **80 and over**: (rate of 1,584 per 100,000).

Emergency admissions for hip fractures ages 65+
Standardised admission ratio by ward of residence
2016/17 – 2020/21



Source: OHID

Unplanned admissions for ambulatory care sensitive conditions in ages 65+ by gender: number (top), rate per 1,000 (bottom)



- Unplanned admissions for ambulatory care sensitive conditions (ACSC) are potentially avoidable, because the conditions are in principle manageable in the community.

- An unplanned ACSC admission may therefore indicate a raised risk of hospitalisation due to the disproportionality that typifies the state of frailty.

- In 2024/25 there were 24% more age 65+ admissions for females than males, and despite the larger underlying population for females, this also represents a 4.3 percentage point higher rate of admission.

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LCN Scorecard

Bexley Wellbeing Partnership

Legend

Higher than England
Significantly higher than England
Lower than England
Significantly lower than England
Same as England

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	England Benchmark	Bexley	Clocktower	Frognal	North Bexley
	2021 Census	2021 Census	2021 Census	2021 Census	2021 Census
Percentage of the total resident population who are 50 to 64 years of age	▲ 19.4	▲ 19.3	▲ 20.0	▲ 19.7	▲ 18.3
Percentage of the total resident population who are 65 and over	▼ 18.4	▲ 16.6	▲ 18.7	▲ 19.9	▲ 12.6
Percentage of the total resident population aged 85 and over	▼ 2.4	▼ 2.4	▼ 2.8	▼ 3.2	▼ 1.5
Older people living alone, % of people aged 66 and over who are living alone	▼ 29.9	▼ 30.6	▼ 28.5	▼ 30.9	▼ 33.0
	Latest	Latest	Latest	Latest	Latest
Older people in poverty: Income deprivation affecting older people Index (IDAOPI)	14.2	10.9	8.6	8.8	15.9
Modelled estimates: proportion of households in fuel poverty based on LILEE (%)	▶ 13.1	▼ 9.1	▲ 8.5	▼ 8.9	▼ 9.7

Recent trend

▲ Increasing (change from previous Census)
▶ No change
▼ Decreasing (change from previous Census)

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