Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Healthy Ageing Strategy

2025-2028

"Not all older people are frail, and frailty is not an inevitable part of ageing."

British Geriatric Society

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The Severn Centre Walking Football

Introduction

The Healthy Ageing Strategy aims to create the basis for a cultural change in how we think about and respond to frailty and ageing across Shropshire, Telford and Wrekin. It supports a shift from hospital-based care to care in the community, involving local authorities, voluntary and community organisations, and primary and community health services. It aligns with England's 10-Year Health Plan and local ageing well strategies, all shaped by public engagement.

This strategy takes a public health approach and is built on public health data showing how our population is ageing, how many people may become frail, and how long they live in good or poor health.

Listening to residents and professionals was central to shaping the strategy.

Listening to our residents: How we shaped the Healthy Ageing Strategy

We undertook a consultation of residents and those working in the care of people as they age including health and social care, voluntary and community sector organisations in Shropshire, Telford and Wrekin. Residents and professionals shared valuable insights that have helped shape our approach and a summary of the findings is available on our website.

Our residents clearly told us that they understood the term frailty but preferred to call the strategy, and resulting services, something different that was more inclusive of those who are being prevented from developing frailty though to severe frailty. Some communities found the term particularly upsetting. Although frailty is a medical term which is defined by the British Geriatrics Association as a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves, and we need to use it describe some of the aims of this strategy, we have called the strategy *Healthy Ageing* and will use this terminology wherever practical.

A key message from the engagement was the importance of involving people who are considered frail or needing to age healthily, in decisions about their own care. We intend to plan for this, especially through the shift from hospital to community-based care and healthy ageing (prevention). This supports the view of 69% of residents who felt that frailty is a condition that can be prevented, delayed, or managed with the right care and support. While many associated frailty with reduced mobility, frequent falls, personal vulnerability, and difficulty with daily tasks, they also highlighted broader challenges:

- Limited access to services in rural areas
- Rising costs of non-NHS support services impacting household budgets
- Inconsistent service availability across the county.

When seeking support, residents said they typically turn to their primary care services or someone with lived experience of frailty. In some communities, faith groups play a key role in providing support. However, most participants who thought they should, did not believe they had received a clinical assessment for frailty.

Health priorities varied: those in poorer health focused on accessing healthcare services, while those in better health emphasised staying physically active.

We are deeply grateful to all residents, voluntary and community sector organisations and health and care professionals who contributed to this consultation. We will commit to updating progress on the strategy through our media channels to keep the public informed.

Why is it important to age well?

Ageing well is essential for maintaining a good quality of life. Without proactive support, residents face increased risks of poor health outcomes including disability, dementia, hospital admissions, falls, and the need for long-term care.

Frailty is not a fixed condition; it exists on a spectrum from mild to severe. Many people living with frailty remain independent and lead fulfilling lives with the right support. While the likelihood of frailty increases with age, it is not inevitable. At various stages, frailty can be prevented, delayed, reversed, or managed.

Frailty can also affect younger residents, particularly those with multiple health conditions. The risk of early frailty is higher among people living in deprivation, some ethnic minority groups, and those with long-term health issues.

Our residents have told us that avoiding emergency hospital visits is a priority for them. This aligns with the national NHS goal to support people in managing their health proactively and within their communities, reducing reliance on hospital-based care. This is a move known as the hospital-to-community shift.

Frailty is a national priority because the number of people at risk is growing. This increase brings greater demand for health and care services. Living for years—or even decades—in poor health leads to personal suffering, pressure on families, and strain on health and social care systems.

Evidence shows that once frailty becomes established, its progression can accelerate. As frailty increases, so do care needs and associated costs. That's why delaying its onset and managing it effectively is vital, not only for the wellbeing of our residents but also for the long-term sustainability of health and care services, both financially and environmentally.

How this links to other local and national work?

Figures 1 shows how this strategy will improve healthy ageing and frailty in STW fitting with local and national priorities, and the relationship with other strategies that aim to prevent and support those with conditions related to frailty.

Bridgnorth Community Hosptial Wellbeing day

Figure 1

Links to Shropshire, Telford & Wrekin Strategic Priorities	Links to National Policies and Initiatives
• All Age Autism Strategy • Dementia Vision Pathway • Health and Care Pathways Development (Hospital Transformation Programme and Local Care) • Long Term Conditions Strategy • Musculoskeletal Transformation Programme • Shropshire HWBB Priorities • Shropshire Integrated Place Partnership Priorities • Shropshire Plan • Shropshire Preventions Framework • Shropshire, Telford & Wrekin Commissioning Priorities • Shropshire, Telford & Wrekin Joint Forward Plan • Shropshire, Telford & Wrekin Neighbourhood Approach • Telford & Wrekin Ageing Well Strategy • Telford & Wrekin Health Wellbeing Strategy • Telford & Wrekin Integrated place partnership Priorities • Telford & Wrekin Vision 2032 • Urgent Emergency Care Improvement Plan	• Be Proactive: Proactive care for older people with frailty – British Geriatrics Society • Chief Medical Officers Annual Report 2023: Health in an ageing society • Geriatric medicine – Getting it Right First Time • NHS 10year Plan • NHS England Personalised Care • NHS Neighbourhood Guidelines • NHS Proactive Care: Providing care and support for people living at home with moderate or severe frailty • Skills for Health Frailty Framework

How many people are affected?

Shropshire, Telford and Wrekin is currently home to around 118,000 over 65-year-olds, which is expected to increase to around 162,000 by 2035. We estimate there are around 45,000 people aged over 65 living with mild frailty, 19,000 moderately frail and 6,000 with severe frailty. More details about the local population and estimated numbers living with frailty, are provided in the accompanying Supporting Information.

In Shropshire, Telford and Wrekin we have a larger proportion of people aged over 65 than nationally (22% compared to 18% across England), along with significant numbers at risk of earlier onset frailty, such as people who live in deprivation and those from Pakistani and Bangladeshi communities. On average our residents live the final 17-22 years of life in poor health, and there is a gap of up to 12 years

between the healthy life expectancy of the most and least deprived. So, reducing the number of years lived in poor health, particularly for the most deprived who live the longest in poor health, is where the opportunity lies for improving quality of life for our residents whilst slowing the growth in health and care costs.

What will we do?

This strategy aims to address healthy ageing and co-ordinated healthcare support to those with frailty who are resident in our population aged over 65, and those over 50 who are at higher risk of early frailty as a priority. However, some of the aims of the strategy means that younger people and those with lower risk may benefit.

The Healthy Ageing Strategy is organised into five pillars that show how we will tackle healthy ageing. These are

- educate,
- prevent,
- identify,
- manage and
- care.

Through these pillars we will address the feedback from our residents including avoiding fragmented care, improving the recognition of frailty and looking at any gaps in services. Our health and care professionals told us that where digital can help it should be enabled but we also recognise that our residents told us not everybody is confident with accessing digital services for their healthcare needs so we will make adjustments for this.

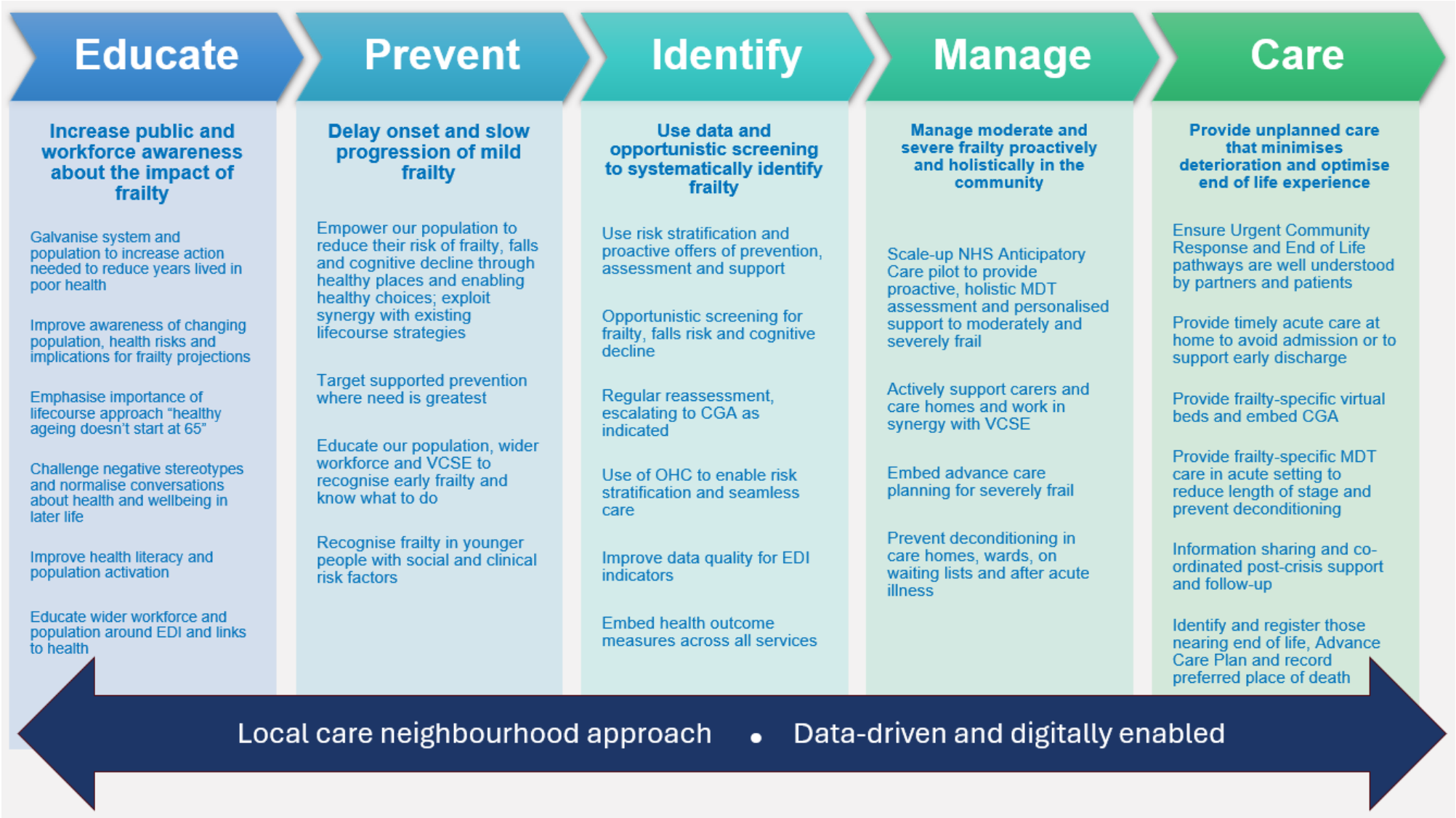
We recognise that healthy ageing must be inclusive of all communities, including neurodiverse residents and those from the LGBTQ+ community. Residents with learning disability and autism may experience barriers to accessing health and care services and may be at increased risk of early frailty due to co-occurring physical and mental health conditions.

Similarly, older LGBTQ+ residents may face unique challenges such as social isolation, historical discrimination, and reduced access to culturally competent care.

Our strategy will ensure that services are designed and delivered in ways that are sensitive to these needs, drawing on the All-Age Autism Strategy and working with community partners to promote equity, dignity, and personalised support for all. This includes ensuring assessments and care plans reflect individual identity, lived experience, and preferences, and that staff are trained to provide inclusive care.

The ambitions relating to each of these pillars are set out in the illustration below.

The Five Pillars of our Healthy Ageing Strategy



Our objectives are described in the box below.

1. Improve understanding about healthy ageing

Increase public and workforce understanding of the impact of frailty and how to prevent, delay, identify and manage it.

2. Delay and level-up the onset of frailty

Increase the proportion of residents **who** are at risk of frailty or mildly frail, compared to moderately or severely frail

Reduce the variation in the deprivation and ethnic profile of frail adults, both in the proportion who are frail and the average age of frailty onset.

3. Slow down and level-up the progression of frailty

Increase the proportion of moderately frail adults with a frailty assessment score and co-produced care plan recorded in a shared-care record enabling improved access to information.

Reduce the proportion of moderately frail adults progressing to severe frailty

Reduce variation in the deprivation and ethnic profile of frail adults, both in the proportion who are moderately frail and the average age of moderate and severe frailty onset; reduce disparities in the recording of a clinical frailty assessment score and care plan

4. Improve and level-up quality of life for people with moderate & severe frailty

Increase the quality of life of those with moderate or severe frailty and reduce variation

5. Improve and level-up care for people with severe frailty and their carers

Increase the proportion of severely frail adults with a comprehensive geriatric assessment tool (CGA) , care plan, case co-ordinator, advance care plan, ReSPECT plan, preferred place of death recorded, and death occurring in their preferred setting.

Reduce ethnic and deprivation disparities in the above

6. Reduce and level up need for unplanned care among those with frailty

Reduce the number of people living with frailty requiring unplanned care

Reduce the proportion of people living with frailty admitted to hospital for unplanned care

Reduce disparities by deprivation and ethnicity in unplanned care among those with frailty

How will we know we are making progress?

By the end of the 1st year of the strategy

- We will develop ways to reliably identify those at risk, or with, frailty and establish baselines for improvement.

- We will try different approaches to test ways of changing the way we organise and join up services to support healthy ageing, this includes co-production and our workforce using a quality improvement methodology. We will evaluate these projects to make sure we use our resources well and meet the needs of our residents with good results using measurements and the experience of those who use the services.

- We will look at the opportunities that digital services can offer to our workforce and our residents and how we might use these, especially to plan care. We will be aware that not all residents are confident with digital tools and plan for this too.

- We will develop our data sharing arrangements, and how we measure improvement to lay the foundations for the strategy. This will include developing a set of impact metrics to ensure we meet our aims and objectives and provide a solid evaluation of the changes.

- We will understand the population needs at Place and neighbourhood levels which will help us plan for the different needs of our residents.

- We will develop an education and training programme for our system involving our education and lived experience experts.

By the end of the 2nd year,

- We will be using assessment tools to assess those residents who are at risk or living with frailty consistently.

- We will be using proactive care pathways which are being evaluated to ensure they are effective.

- We will co-ordinating the care of our residents.

- We will have increased awareness and educational interventions to support the workforce.

- We will understand some of the improvements identified in year 1 and how to scale them up.

- We will have interventions in place at neighbourhood level aimed at our rural communities and those communities where there is deprivation, or where there a need to level up health services for those at risk or with frailty.

- We will have implemented relevant digital tools.

- Provide a universal prevention offer including a proactive invitation to those at risk of frailty and mildly frail adults over 50 to access an online health education resource; signpost to local statutory and VCSE offers for supported self-management of frailty risk factors.

By the end of the 3rd year,

- We will continue the work of year 1 and 2 to continue to drive improvement in services and outcomes of our population.
- We will have evaluated our progress and be able to describe the outcomes of the interventions to educate, prevent, identify, manage and care for those at risk of or living with frailty. This will be including the experiences of residents, their carers, and the workforce.

Implementation of the strategy will be overseen by the Healthy Ageing Strategy Steering Group with strong links with our local authorities, voluntary and community partners, NHS Trusts and primary care. The Steering group will ensure strategy remains dynamic and updated in line with any significant change to national guidance.

How will we monitor progress?

Progress towards achieving the objectives and meeting our milestones will be reviewed at the end of each year. At the end of the 3-year strategy implementation period progress will be assessed, with particular focus on outcomes. Process outcomes are indications of progress towards achieving longer term shifts in overriding objectives such as the median age of frailty onset, reduced proportion of the cohort progressing to m and impact on those with moderate and severe frailty, and reduced inequity in the experience of frailty. Successes, challenges and learning will inform a further review of the Healthy Ageing Strategy, to support sustainable funding arrangements.

Successful delivery of this strategy will

- Put in place the steps needed to extend healthy life expectancy
- Reduce inequalities
- Improve outcomes and experience of care for those with frailty as we test new ways of working
- Reduce growth in demand for health and care services

Conclusion

This Healthy Ageing Strategy sets out our commitment to supporting coordinated healthcare and promoting healthy ageing for residents across Shropshire, Telford and Wrekin. Our focus is on those aged 65 and over, as well as residents over 50 who are at higher risk of early frailty.

The strategy outlines our system-wide approach, including clear objectives and milestones aimed at improving the lives of people experiencing deteriorating health in older age. Our goal is to help residents extend the number of years they spend in good health, maintaining independence and wellbeing for as long as possible.

In addition to improving outcomes for Shropshire, Telford & Wrekin residents, this strategy supports the efficient and effective use of health and care resources, aligning with the NHS 10-Year Plan and the national shift from hospital-based to community-based care, and from analogue to digital services.

To support the development of this strategy, we have drawn on a wide range of public health data and insights. Supplementary documents are available on our website and by request, including:

- Healthy Ageing Strategy: Supplementary Information
- Healthy Ageing Strategy: Results of Public and Professional Consultation
- Healthy Ageing Strategy: Equality Impact Assessment

We would like to extend our sincere thanks to the residents, voluntary and community sector partners, and health and social care professionals who contributed to this strategy. We are also grateful for the continued support of the Healthy Ageing Strategy Steering Group, who will lead the coordination and delivery of this important work.

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