Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Healthy Ageing and Frailty Strategy

2025-2028

DRAFT v1.0

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

British Geriatric Society

'Frailty' is a term used in the medical literature and relevant national strategies and as such avoiding use of the term in this strategy potentially creates unhelpful confusion amongst our health and care workforce. However, it is important to acknowledge that amongst the wider community the term 'frailty' has negative connotations and risks reinforcing negative stereo types of ageing; many people even at the more severe end of the frailty continuum may not identify with the term and it is not recommended for public-facing materials. This strategy covers the full spectrum from frailty prevention (healthy ageing) to management of severe frailty.

Why We Need A Healthy Ageing And Frailty Strategy

Frailty is a loss of physical and mental resilience, leaving a person vulnerable to declining health and the inability to recover well from adverse events such as illness, injury or bereavement. Frailty is important because it compromises quality of life for the individual and increases the risk of death, disability, dementia, hospital admission, falls and the need for long-term care. It is a spectrum, from mild to severe, meaning that many people living with frailty remain independent and can live full lives with varying degrees of support. **The likelihood of frailty increases as we get older, but it is not inevitable, and at various stages along the spectrum it can be prevented, delayed, reversed and managed.** Conversely, frailty can occur at a younger age for those with an accumulation of health risks, and the risk of early frailty is higher among those living in deprivation, some ethnic minorities and those with chronic health conditions.

Frailty is a national priority because the number of people at risk of frailty is growing, and with it an increase in the need for health and care services. Years – or decades – spent in ill health mean personal suffering, strain on families, and use of health and social care services. Evidence shows that once established, the trajectory of frailty accelerates[1] and increasing frailty means increased care costs[2]: after adjusting for sociodemographic factors, annual healthcare costs doubled for people with mild frailty compared to 'fit' older adults, tripled for the moderately frail and quadrupled for the severely frail. The impact of increasing care costs is further compounded by the pattern we are seeing at a population level: the proportion of over 50s living with moderate frailty increased from 15% to 23% over an 11 year study period, and from 5% to 15% with severe frailty[2]. **Delaying the onset of frailty, and managing frailty well, to slow progression and reduce the need for unplanned care, are crucial for the long term financial and environmental sustainability of health and care services.**

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. **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.**

[1] Hollinghurst J, Fry R, Akbari A, et al. External validation of the electronic frailty index using the population of Wales within the Secure Anonymised Information Linkage Databank. *Age Ageing*. 2019;48(6):922-926

[2] Fogg C, England T, Zhu S, et al. Primary and secondary care service use and costs associated with frailty in an ageing population: longitudinal analysis of an English primary care cohort of adults aged 50 and over, 2006-2017. *Age Ageing*. 2024;53(2)

As an Integrated Care System, we have an urgent need to develop plans that reduce the impact of frailty on the quality of life of our population and on the demand for health and care services. This will be achieved through implementation of a strategy to delay the onset of frailty and deliver best-practice frailty management. The strategy encompasses our population aged over 65, and those over 50 who are at higher risk of early frailty.

How This Links To Other Local and National Work

Figures 1 and 2 show how this strategy to improve healthy ageing and frailty in STW fits with local and national priorities, and the relationship with other strategies that aim to prevent and support those with conditions related to frailty.

Links to STW Strategic Priorites	Links to National Policies and Initiatives
•STW Joint Forward Plan •STW Integrated Care Strategy •STW Neighbourhood Approach •Telford and Wrekin HWB Strategy •T&W Ageing Well Strategy •TWIPP Priorities •Shropshire HWBB priorities •Shropshire Plan •Shropshire Prevention Framework •ShIPP Priorities	•NHS Long Term Plan •NHS England Personalised care •Skills for Health Frailty Framework •Chief Medical Officer's Annual Report 2023: Health in an ageing society •Geriatric medicine - Getting It Right First Time •Be proactive: Proactive care for older people with frailty - British Geriatrics Society •NHS Proactive care: providing care and support for people living at home with moderate or severe frailty

Figure 1. Links between this strategy and other policies and initiatives

Figure 2. Links between this Strategy and other STW strategies

How Many People Are Affected?

Shropshire, Telford and Wrekin is currently home to around 118,000 over 65 year olds, which is expected to swell 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.

What We Will Do and How We Will Do It

This three-year system-wide strategy comprises five pillars that reflect the trajectory of frailty: educate, prevent, identify, manage and care. The ambitions relating to each pillar are set out in Figure 3, and our objectives are described in Text Box 1. 'SMART' objectives are specified in the accompanying Supporting Information document. The interventions to achieve the objectives are set out in Text Box 2 and the evidence base is described in Supporting Information.

Text Box 1. What We Will Do

1. Improve understanding about healthy ageing and frailty

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 who are pre-frail or mildly frail, compared to moderately or severely frail

Reduce disparities in the deprivation and ethnic profile of frail adults, both in the proportion who are frail and the median 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 holistic care plan recorded in their shared-care record

Reduce the proportion of moderately frail adults progressing to severe frailty

Reduce disparities in the deprivation and ethnic profile of frail adults, both in the proportion who are moderately frail and the median 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 disparities

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

Increase the proportion of severely frail adults with a 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

By the end of the 1st year of strategy implementation, infrastructure will be in place to support making population-level proactive care offers: digital infrastructure, Information Governance, mechanisms to identify eligible residents, outcomes frameworks, care pathways and workforce in place to enable the provision of safe and excellent care.

By the end of the 2nd year, proactive care pathways will be operational and evaluation underway; awareness and educational interventions will be delivered with a plan to scale-up to full coverage of target audiences. By the end of the 3rd year, evaluation will be published that describes the outcomes of all interventions to educate, prevent, identify, manage and care, including qualitative assessment of experiences of patients, carers and staff.

Text Box 2. How We Will Do It

Interventions to prevent and manage frailty

1. We will develop a comprehensive healthy ageing and frailty education and training programme for people in healthcare and other public-facing jobs, and raise awareness amongst the general public

2. Provide a universal prevention offer including a proactive invite to all pre-frail 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. For those identified as at risk of health inequalities also make a proactive offer of health coaching and clinical frailty assessment. Repeat the offer at 5 yearly intervals

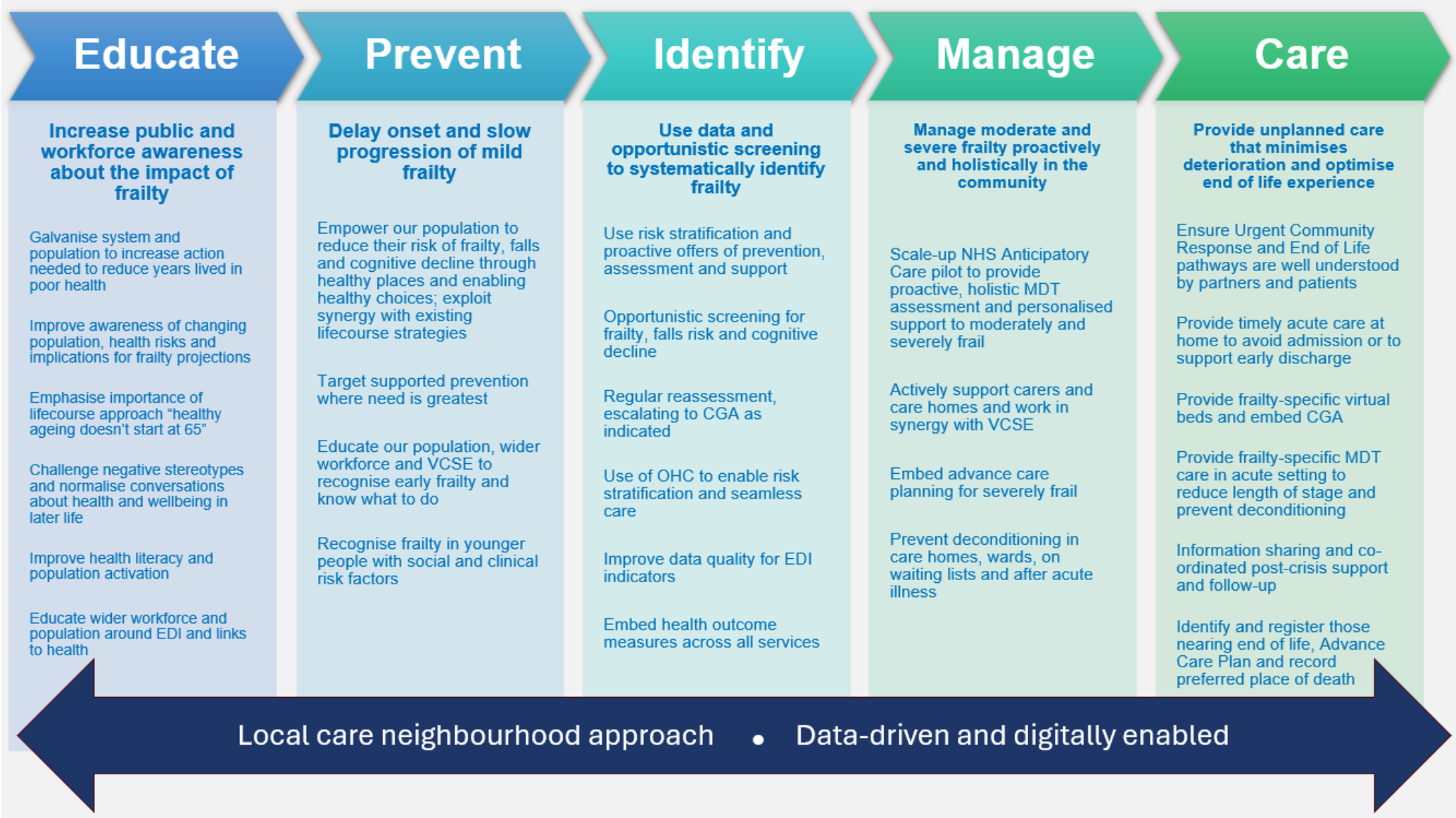
3. Make a proactive offer of clinical frailty assessment followed by a holistic care plan of community-based support to all those identified as being likely to have moderate frailty from medical records and referrals. Repeat the offer at 5 yearly intervals or sooner by referral or trigger event e.g. unplanned care episode; for those at risk of health inequality the offer should be made at a 3-yearly interval

4. Make a proactive offer of Comprehensive Geriatric Assessment, case co-ordination, Advance Care Plan and ReSPECT to all those identified as being likely to have severe frailty from medical records and referrals. Case coordinator to arrange review as needs evolve

5. Provide Frailty Assessment Unit at both acute sites 7 days a week, linking to community frailty management services and related pathways

Implementation of the strategy will be overseen by the Healthy Ageing and Frailty Strategy Steering Group, reporting to existing council and NHS committees and partnership Boards. A working group for each pillar will ensure delivery and report to the steering group.

Figure 3. The Five Pillars of our Healthy Ageing and Frailty Strategy



How We Will Monitor Progress

Progress towards achieving the objectives set out in Text Box 1 will be reviewed at the end of each year. At the end of the 3-year strategy implementation period success will be assessed, with particular focus on process outcomes to reflect the short timescale. 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 moderate and severe frailty, and reduced inequity in the experience of frailty. The working groups should report to the steering group on successes, challenges and learning, to inform a review of the Healthy Ageing and Frailty Strategy, including full business cases to support sustainable funding arrangements. The level of strategic ambition should be reviewed at this stage, and the evidence should be considered for extending the reach of proactive care models into targeted screening for common features and pre-cursors of frailty.

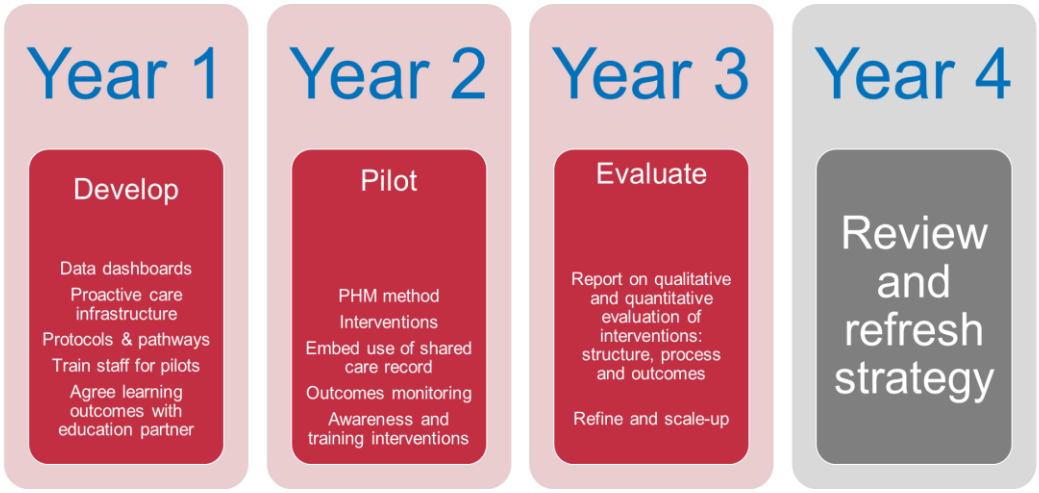


Figure 4. When We Will Reach Key Milestones

To support achievement of the strategy aims, it is recommended that a network of Healthy Ageing Champions are nominated, to bring this vital lens to other strategy development and implementation processes across the partner organisations of the ICS, and that relevant healthy ageing metrics are incorporated in all ICS outcomes frameworks to reinforce and share accountability for success.

Successful delivery of this strategy will

- Extend healthy life expectancy
- Reduce inequality
- Improve outcomes and experience of care for those with frailty
- Reduce growth in demand for health and care services