Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Healthy Ageing Strategy

2025-2028

Supporting Information

Our population

Table 1. The population context in Shropshire, Telford and Wrekin

	Shropshire	Telford & Wrekin
Total population (thousand)	324	186
Population age 65 and over (thousand)	84 in 2023 (117 by 2035) 26% (above national average of 18%*)	34 in 2023 (45 by 2035) 18% (same as the national average*)
Life expectancy at birth	80 for males 84 for females (above national average of 79 for males, 83 for females)	78 for males 82 for females (below national average of 79 for males, 83 for females)
Healthy life expectancy at birth	63 for males 67 for females (above the national average of 62 for males and 63 for females)	58 for males 60 for females (below national averages of 63 and 64)
Years of life lived in poor health	17 for males 17 for females	20 for males 22 for females
Gap in life expectancy at birth between the most and least deprived areas	5.5 years for males 3.5 years for females (below national average of 9.7 for males, 7.9 for females)	8.8 years for males 6.4 years for females (below national average of 9.7 for males, 7.9 for females)
Gap in healthy life expectancy between most and least deprived areas	4 years males 3 years females	12 years males 12 years females

Risk Factors

As a multi-factorial condition, frailty is associated with a wide range of correlates including[1]:

- Polypharmacy
- Deficits in vision and hearing
- Physical inactivity
- Poor balance and falls
- Smoking and excess alcohol consumption
- Impaired memory and cognition
- Social isolation
- Mood disorders
- Financial stress
- Poor nutrition

We have estimated the number of people aged over 65 in STW living with risk factors for frailty (Table 2), based on prevalence estimates from the scientific literature. These figures do not take into account local population characteristics which may differ from the samples used to estimate prevalence (for example ethnic mix, deprivation, rurality) and prevalence estimates are not available for the co-occurrence of risk factors, which increases frailty risk. As such these figures should be taken as an approximate illustration of the scale of the challenge, and its inexorable growth, and the important risk factors to target. For example, we estimate that there are around 47,000 over 65 year olds taking five or more medications, and that this will rise to 65,000 by 2035. Some other examples are 35,000 over 65s falling at least once a year, nearly 30,000 with hearing loss, 26,000 drinking more than the recommended amount of alcohol and 20,000 who are lonely some or all of the time.

Risk Stratification

The Electronic Frailty Index (eFI) is a validated method of using existing information from coding in primary care records to identify patients who are likely to be frail, and to estimate the level of frailty, based on a 'cumulative deficit model' which counts coding relating to 36 deficits including symptoms, signs, disease, disabilities and abnormal test values[2]. A greater number of these deficits means a higher eFI score and a prediction of more severe frailty. Higher eFI scores are linked with increased risk of mortality, emergency admission and care home admission at 1, 3 and 5 years, with risk increasing approximately linearly with increasing frailty: compared to fit over 65s, the hazard ratio for mortality, emergency admission or care home admission is approximately double for the mildly frail, triple for the moderately frail and quadruple for those with severe frailty[3].

Whilst eFI scores do not correlate strongly with clinically assessed frailty, clinical assessment is infeasible at the scale needed within available resources and priorities, and at a population level eFI is a good predictor of negative outcomes and therefore suitable for risk stratification. It is therefore recommended that eFI is used as the method for estimating the likely number of frail adults in our population, and as the basis for identifying eligible patients for proactive offers of care. However, due to the fact it provides a prediction of frailty status, and is validated for the over 65 cohort only (whereas frailty onset is commonly younger in population groups at highest risk, such as those living in deprivation), additional routes into care offers should also be established. These routes should include referrals from relevant professionals and the use of eligibility criteria that recognise the need to intervene earlier and more actively for those in CORE20+ groups. An estimation of the approximate number of older adults in eFI frailty categories in STW is shown in Figure 1.

Table 2. Estimated number with frailty risk factors among the population aged over 65 in Shropshire and Telford & Wrekin

	Prevalence	Estimated number in 2023 (projected in 2035)*		
		STW ICS	Shropshire	Telford & Wrekin
Overweight	75% overweight or obese[4] 30% obesity	88,000 (121,000) overweight 35,000 (49,000) obese	63,000 (88,000) 25,000 (35,000)	25,000 (34,000) 10,000 (14,000)
Memory loss	40% age-associated memory impairment[5,6] 15% mild cognitive impairment[7]	47,000 (65,000) memory impairment 18,000 (24,000) mild cognitive impairment	34,000 (47,000) 13,000 (18,000)	13,000 (18,000) 5,000 (7,000)
Polypharmacy	31% aged 65-74; 50% aged 75+[8]	47,000 (65,000) taking 5 or more medications	34,000 (47,000)	13,000 (18,000)
Inactive	29% aged 65-74; 52% aged 75+[9]	47,000 (65,000) inactive	34,000 (47,000)	13,000 (18,000)
Falls	30%[10]	35,000 (49,000) falling annually	25,000 (35,000)	10,000 (14,000)
Depression	25%[11]	29,000 (40,000) depressed	21,000 (29,000)	8,000 (11,000)
Hearing loss	25% mild or worse hearing loss in the better ear[12]	29,000 (40,000) mild or worse hearing loss	21,000 (29,000)	8,000 (11,000)
Excess alcohol	Increasing risk drinkers 22% age 65-74; 15% age 75+[13] Higher risk drinkers 5% age 65-74; 2% aged 75+[14]	22,000 (30,000) increasing risk drinkers 4,000 (6,000) higher risk drinkers	16,000 (22,000) 3,000 (4,000)	6,000 (8,000) 1,000 (2,000)
Visual loss	14% 'low vision' (visual acuity <6/18 in better eye)[15]	17,000 (23,000) with low vision or worse	12,000 (16,000)	5,000 (7,000)
Loneliness	11% some of the time aged 65-74; 17% aged 75+ 3% always or often[16]	16,000 (23,000) lonely some of the time 4,000 (5,000) lonely always or often	12,000 (16,000) 3,000 (4,000)	5,000 (6,000) 1,000 (1,000)
Smoking	7.6%[17]	9,000 (12,000) smokers	6,000 (9,000)	3,000 (3,000)
Underweight	3%[18]	4,000 (5,000)	3,000 (4,000)	1,000 (1,000)

*rounded to the nearest thousand. Assumes constant prevalence and local prevalence is comparable to national evidence-based prevalence estimate

Denominators from Office for National Statistics 2023 mid-year population estimates and 2018-based projections

	STW ICS	Shropshire	Telford & Wrekin
Population over 65 in 2023 (2035)	117,890 (161,855)	84,358 (116,829)	33,532 (45,026)
Population 65-74 in 2023 (2035)	60,372 (82,692)	42,332 (58, 685)	18,040 (24,007)
Population 75 and over in 2023 (2035)	57,518 (79,163)	42,026 (58,144)	15,492 (21,019)

The estimates in Figure 1 are based on an assumption that 45% of over 65s are fit, 35% mildly frail, 15% moderately frail and 5% severely frail, in line with the original validation sample of over 900,000[2] adults and consistent with the frailty profile of a second external sample of over 450,000 adults[3]. However, longitudinal research found that an increasing proportion of people entered moderate and severe frailty categories over an 11 year study period, with concomitant decreases in the proportion with no frailty or mild frailty[19]. In the period 2006-2017 the proportion of the population in the severe frailty category increased from 5 to 15%, and those with moderate frailty increased from 15 to 23% of the 2.2 million patients studied. Figure 2 shows the modelled impact on healthcare costs of increasing frailty severity within the population, added to the projected population growth. Note that the cost figures themselves are limited in scope to primary and secondary healthcare (social care costs not included), and the unit cost data is from 2016-17. It is therefore included to illustrate the potential magnitude of risk from not intervening to delay the onset and progression of frailty, rather than for budgeting purposes. Details of the model assumptions are available on request.

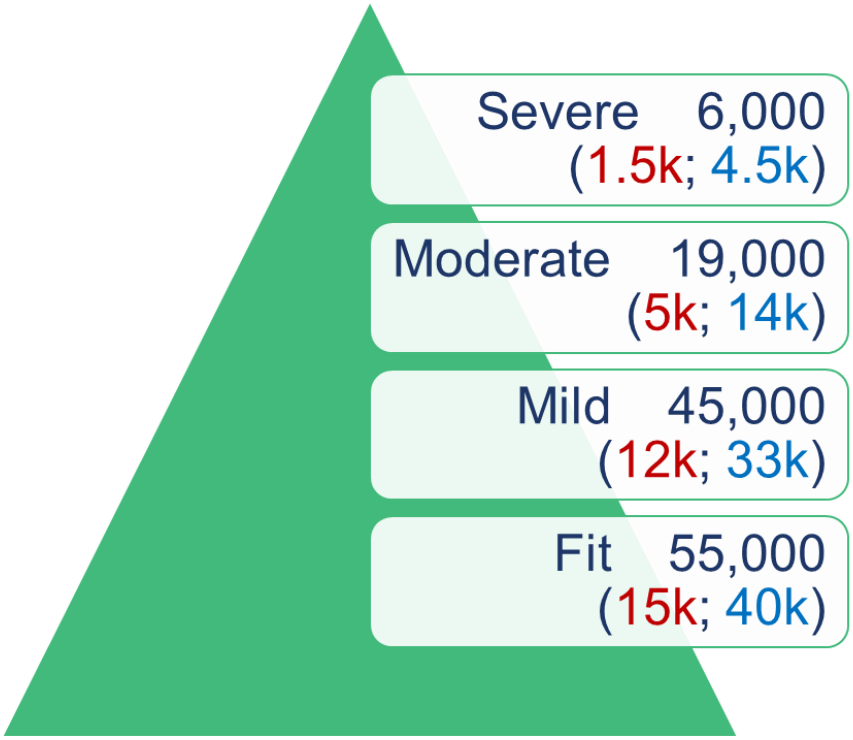


Figure 1. Estimated number of adults falling into eFI frailty categories in STW
Red = Telford and Wrekin residents; Blue = Shropshire residents

Frailty interventions

Studies of community-based interventions for reversing frailty progression found that **physical activity**, particularly **group exercise classes**, as well as **nutritional** and **cognitive** interventions were all effective, with a greater effect when offered in combination[20-27].

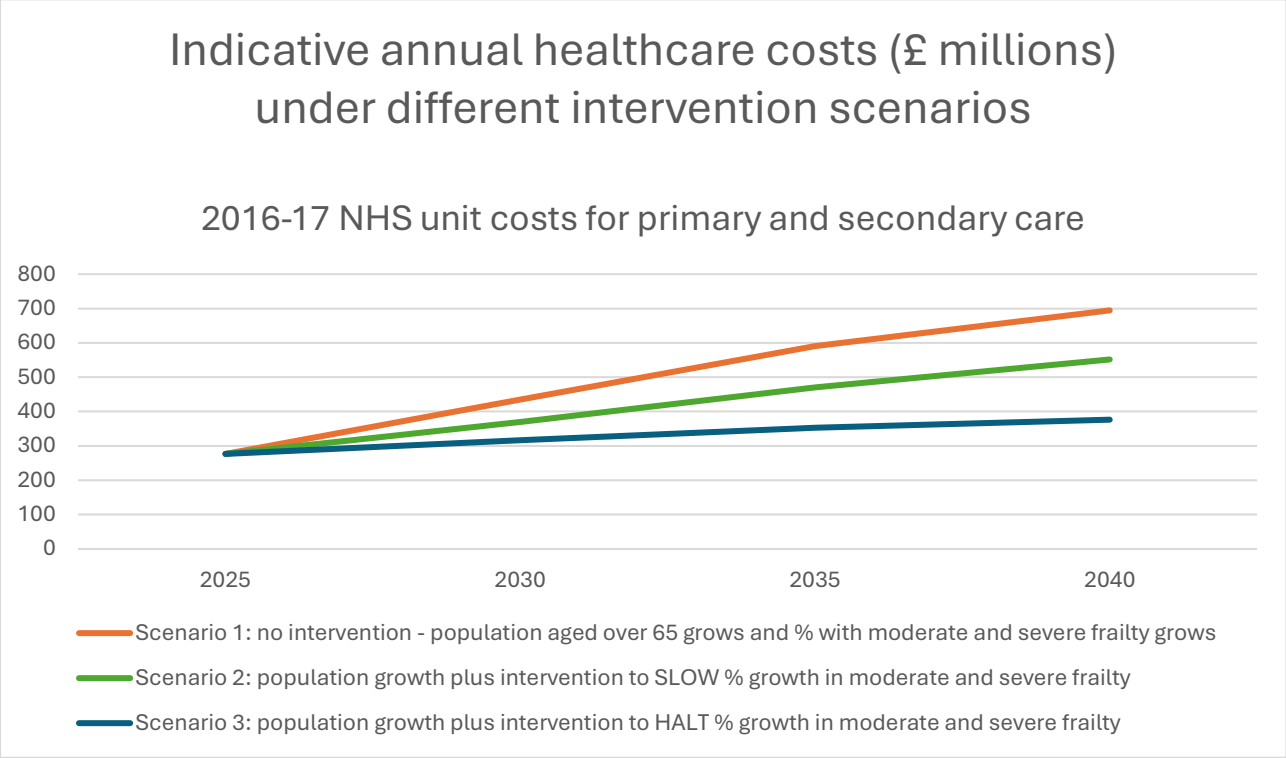


Figure 2 . Illustration of cost implications of different population frailty scenarios

Data from over 8,000 participants aged 50 and over from the English Longitudinal Study of Ageing (ELSA) was analysed over a 12 year follow-up period, to identify potential determinants of frailty and frailty progression[27]. Findings suggest there may be scope to reduce both frailty incidence and progression by **reducing obesity** and sedentary behaviour, increasing the intensity of **physical activity**, and improving success of **smoking cessation** tools. There is evidence that **multicomponent exercise programmes** combining strength, balance and aerobic training are most effective[25] and that intensity of physical activity is important: ELSA participants who reported vigorous activity at least once a week had significantly reduced frailty progression over a 10-year period but mild physical activity was insufficient to slow progression[26]. Analysis of ELSA data also revealed a dose-response relationship between progression of frailty over ten years and increasing frequency of **cultural engagement** (visits to the cinema, theatre and museums every few months or more frequently), after adjusting for confounders[28]. The authors conclude their findings are consistent with calls for multimodal, multifactor, community approaches to supporting health in older age. Interventions to support **mental, cognitive and emotional health** are considered to be particularly important as older adults may be less likely to engage with exercise and nutrition interventions if mental wellbeing is not also addressed[26], and a Japanese study of frailty progression among community-dwelling older adults found that lower levels of **health literacy** were a predictor of frailty progression over a 4-year follow-up period[29].

Frailty prevention

Interventions are needed to improve understanding of the range of risks and protective factors for healthy ageing amongst our middle-aged and older population, and to improve uptake of risk-reducing evidence-based interventions offered by health services, local authority and VCSE partners, in line with STW's local care neighbourhood approach (Figure 3).

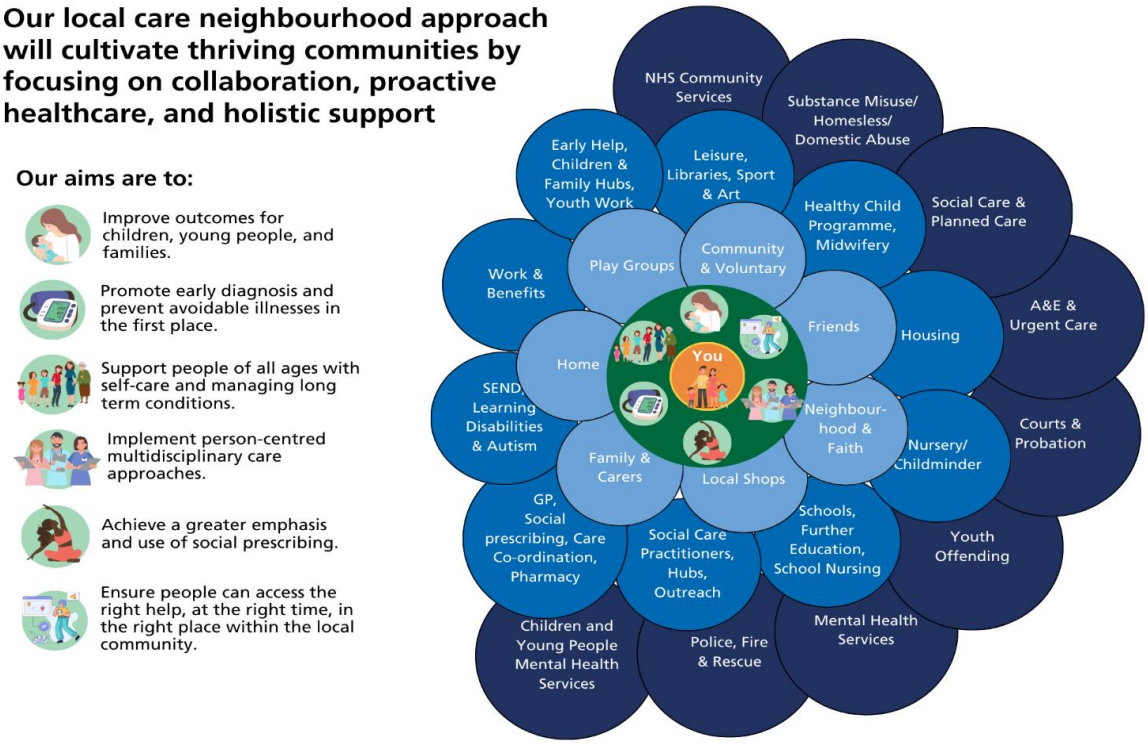


Figure 3. STW Local Care Neighbourhood Approach

The principle of proportionate universalism means that intervention should be offered to all residents with a more intensive offer of support for those at risk of health inequality. To delay the onset and slow the progression of early frailty, a digital health education resource to support self-guided risk management is recommended as a universal offer, due to the large number in this cohort, with additional support from health coaches to increase uptake of interventions[30-32] among CORE20+ residents who are at risk of early frailty, prolonged disability and premature mortality.

Digital inclusion

The risk of excluding members of the cohort who are less likely to access digital offers must be acknowledged and mitigated. Rates of engagement with the internet have increased steadily since data

collection began in 2013[33]: by 2020, 85% of those aged 65-74 had used the internet in the past 3 months, and 55% of those aged 75 and over. Rates have increased most markedly among older adults, and it is reasonable to assume they will continue to increase as more digitally-skilled cohorts age. However, in 2020, 11% of 65-74 year olds had never used the internet and 38% of those aged 75 and over. Rates of internet use are 10% lower among disabled people aged 65-74 compared to non-disabled people, and 15% lower over the age of 75. Among Bangladeshi adults of any age, a further 10% have never used the internet compared to the general adult population, and the disparity for older Bangladeshi adults may plausibly be greater than this. At age 65-74, rates of internet usage are 2% lower among women than men, widening to a 10% gap over age 75. People in socially and economically deprived communities are also more likely to be digitally excluded[34].

The pattern of digital exclusion to a large extent mirrors the pattern of health inequalities in older age. This reinforces the need to augment the offer to CORE20+ groups with health coaching in addition to initiatives that support digital inclusion. Without concerted and appropriately tailored efforts to reach groups most at risk of poor health in older age, a solely digital approach may compound the health gap. However, a population approach to digital self-management could make an important contribution for a large number of digitally engaged older people. With the ageing of cohorts who are already digitally engaged, it is anticipated that rates of digital exclusion will continue to fall, although we must continue to recognise and monitor the uneven pattern of digital exclusion and inequalities in frailty

Frailty management

For the smaller cohort of those with moderate frailty, a community-based workforce should provide frailty assessment using a validated clinical tool as part of a holistic assessment of need, co-produce care plans with patients supported by a multi-disciplinary team, make referrals, and enable access to relevant statutory and VCSE offers. As frailty progresses, Comprehensive Geriatric Assessment (CGA) is recommended as the backbone of a case-management approach to ensuring the needs of those with severe frailty, whether living in the community or in a care setting, are recognised and managed. CGA is a structured tool to assess medical, psychological and functional capability in order to develop a co-ordinated and holistic care plan. Evidence suggests that CGA can reduce the risk of unplanned hospital admission for those living with frailty in the community, as well as improving medication, patient functioning, and quality of care[35,36]. In acute services, use of CGA by a dedicated multi-disciplinary team for the assessment and management of patients with frailty, can reduce admissions, length of stay and improve outcomes[37-39]. Figure 4 summarises the key components of high quality frailty care in community and hospital settings[40].

Figure 4a. Frailty: research shows how to improve frailty care in the community (NIHR)[35]

Figure 4b. Frailty: research shows how to improve frailty care in hospital (NIHR)[35]

SMART Objectives

1. Delay and level-up the onset of frailty

a. Increase % of >65s in eFI fit or mild over 10 yr period; years 1-5 slow reduction in % who are fit/mild

b. Reduce disparities in % of cohort and median cohort age by deprivation and ethnicity

2. Slow and level-up progression to severe frailty

a. Increase % moderately frail with i) frailty assessment score recorded in shared-care record, ii) co-produced holistic care plan in shared-care record

b. Reduce % of >65s progressing to eFI severe over 10 yr period; years 1-5 slow increase in % eFI severe

c. Reduce disparities by deprivation and ethnicity in objectives 2a-b; Reduce median age of moderate frailty by deprivation and ethnicity

3. Improve and level-up quality of life for people living with moderate frailty

a. Increase moderate frailty cohort median quality of life score after implementing holistic care plans

b. Reduce disparities by deprivation and ethnicity in median QoL scores among moderately frail

4. Improve and level-up quality of life for people living with severe frailty and their carers

a. Increase % severely frail with i) CGA, ii) holistic care plan and iii) case co-ordinator

b. Increase cohort median quality of life score after CGA and implementing co-produced holistic care plans

c. Increase carer and patient median satisfaction scores among the severe frailty cohort

d. Reduce disparities by deprivation and ethnicity in objectives 4a-c; Reduce median age of severe frailty by deprivation and ethnicity

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

a. Reduce number of people living with frailty i) requiring unplanned care for all causes, ii) requiring unplanned care as a result of a fall, iii) attending A&E for all causes, iv) admitted for unplanned care

b. Reduce % of unplanned care episodes leading to admission among those with frailty; reduce % of falls resulting in admission for frail patients

c. Reduce disparities by deprivation and ethnicity in objectives 5a-b

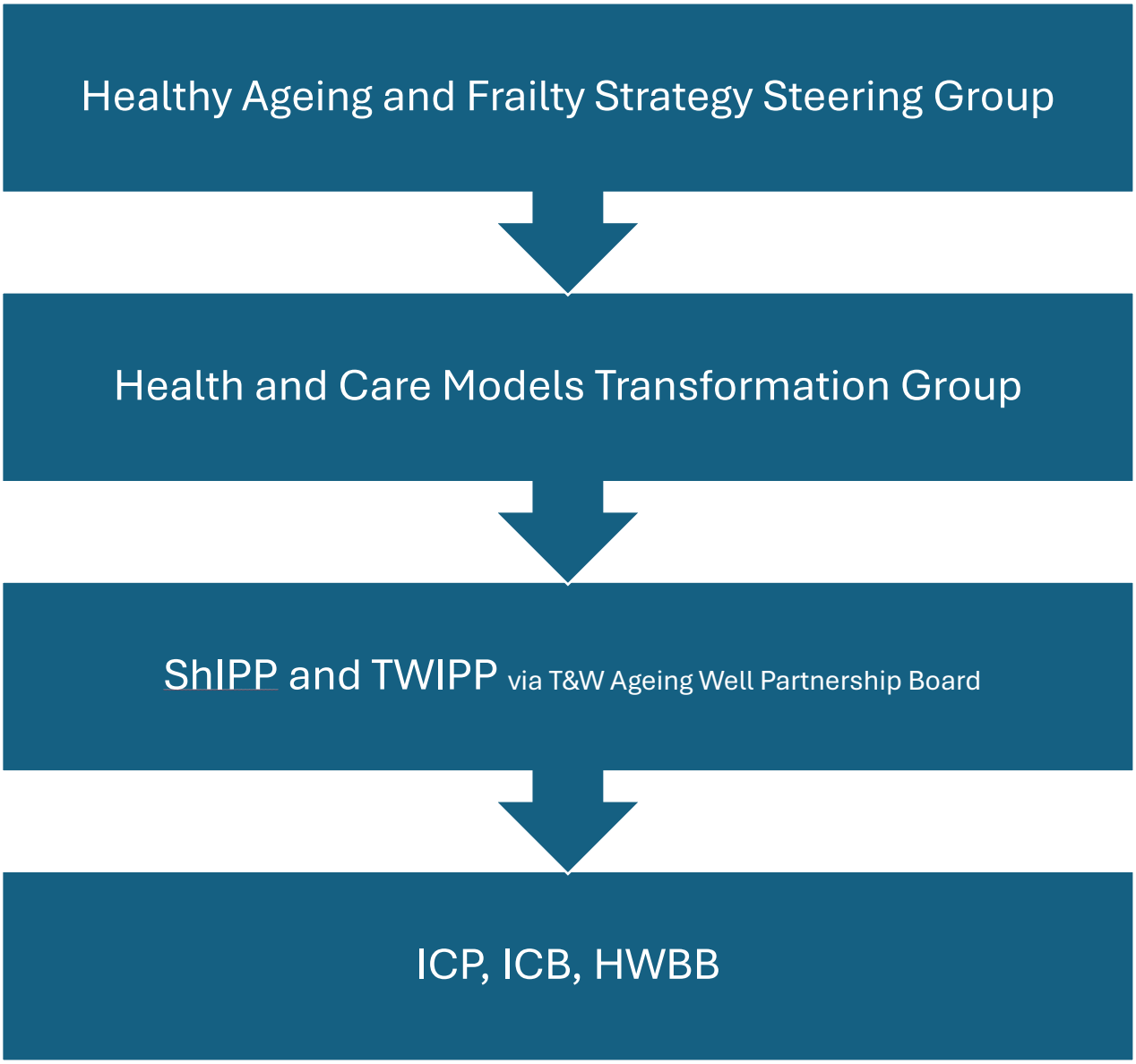
6. Support at end of life and level up end of life care

a. Increase % of severely frail with i) advance care plan, ii) ReSPECT plan, iii) preferred place of death recorded, iv) death in preferred setting

b. Reduce disparities by deprivation and ethnicity in objective 6a

Governance

Implementation of the strategy will be overseen by the Healthy Ageing Strategy Steering Group, reporting to the Local Care Transformation and HTP Models of Care Group, and from there into ShIPP and TWIPP. A working group for each pillar will report to the steering group.



Links to national policies and strategies

NHS Long Term Plan

NHS England » Personalised care

Skills for health Frailty-framework.pdf

Chief Medical Officer's annual report 2023: health in an ageing society - GOV.UK

Geriatric medicine - Getting It Right First Time - GIRFT

Be proactive: Proactive care for older people with frailty | British Geriatrics Society

NHS England » Proactive care: providing care and support for people living at home with moderate or severe frailty

Links to local policies and strategies

- Joint Forward Plan
- 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
- Long Term Conditions Strategy
- Palliative and End of Life Care Strategy
- Falls Strategy

Abbreviations

ACP	Advance Care Plan
CGA	Comprehensive Geriatric Assessment
eFI	Electronic Frailty Assessment
FAU	Frailty Assessment Unit
HWBB	Health and Well-Being Board
ICB	Integrated Care Board
ICS	Integrated Care System
MDT	Multi-Disciplinary Team
OHC	One Health and Care record (synonymous with SCR)
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
SCR	Shard Care Record or Summary Care Record
ShIPP	Shropshire Integrated Place Partnership
SMART	Specific, measurable, achievable, relevant and timely (objectives)
STW	Shropshire, Telford and Wrekin
TWIPP	Telford and Wrekin Integrated Place Partnership
VCSE	Voluntary, Community and Social Enterprise

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