Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Borough of Telford and Wrekin

Health & Wellbeing Board

Thursday 18 September 2025

2.00 pm

Council Chamber, Third Floor,

Southwater One, Telford, TF3 4JG

Democratic Services:	**Lorna Gordon**	**01952 384978**
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Committee Members: **A J Burford (Co-Chair), S Whitehouse (Co-Chair), S P Burrell, K Middleton, S J Reynolds, K L Tomlinson, P Watling, J Britton, N Carr, S Fogell, S Froud, N Pay, E Hancox, F Mercer, H Onions, N Lee, C Parker and J Williams**

Agenda

Report.

6.0 Annual Public Health Report 2025 Towards a Smoke Free Future **To Follow**

To approve the Annual Public Health Report 2025: Towards a Smoke Free Future.

7.0 Early Language Support Project Update **Verbal Report**

To receive an update on the Early Language Support Project.

8.0 GP Access Update **27 - 50**

To receive an update from the ICS regarding the work that has been undertaken with GP surgeries to improve GP access.

9.0 STW Healthy Ageing/Frailty Strategy **51 - 168**

To review the Shropshire, Telford & Wrekin Healthy Ageing/Frailty Strategy 2025-2028.

HEALTH & WELLBEING BOARD

Minutes of a meeting of the Health & Wellbeing Board held on Thursday 26 June 2025 at 2.00 pm in Council Chamber, Third Floor, Southwater One, Telford, TF3 4JG

Present: Councillor A J Burford (Co-Chair), S Whitehouse (Co-Chair), Councillor S J Reynolds, N Pay, F Mercer, H Onions, C Parker and J Suckling

In Attendance: M Bennett (Better Care Fund Commissioning Lead), S Downes (Assurance and Integration Programme Manager and Telford and Wrekin Place Lead), K Griffin (Community Safety Partnership Manager), L Gordon (Member Support Officer), L Mills (Service Delivery Manager Health Improvement & Prevention) and H Potter (Insight Manager)

Apologies: Councillor K Middleton, Councillor K L Tomlinson, Councillor Watling, J Britton and S Froud

HWB10 Declarations of Interest

None.

HWB11 Minutes of the Previous Meeting

RESOLVED – that the minutes of the meeting held on 21 May 2025 be approved.

HWB12 Public Speaking

None.

HWB13 Terms of Reference 2025/2026

The Mayor & Member Support Officer presented the 2025/2026 municipal year Terms of Reference. Members were advised that at the Annual Council meeting in May 2025, delegated authority had been granted to each Committee to review their Terms of Reference. This delegation ensured the Board can maintain effective governance arrangements that reflected evolving system priorities and statutory responsibilities.

Members heard that as part of the review, the membership of the Board had been updated. The Mayor & Member Support Officer advised that these amendments had been made to strengthen representation and improve the Board's ability to meet quoracy requirements. The Board were informed all changes had been set out in red in Appendix A.

RESOLVED - that the Terms of Reference set out in Appendix A be agreed and reconfirmed for the 2025/2026 municipal year.

HWB14 Quarterly Strategy Progress Update

Members received the Quarterly Strategy Progress Report on the Health & Wellbeing Strategy, which was accompanied by a short presentation. The report provided an update against strategic priorities and was aligned with the wider performance framework. Members were advised that the report included case studies and highlighted both progress and ongoing challenges.

The Service Delivery Manager Health Improvement & Prevention summarised the report, noting strong developments in the last quarter, particularly in relation to underserved groups. Members heard that targeted work had been undertaken to address health inequalities, with new insights emerging from consultation activity. This included a focus on healthy weight, where data had identified higher obesity levels among specific population groups, such as individuals with learning difficulties.

Members were informed that grant funding had been secured to support new initiatives, including the Get Yourself Active project, a training and education programme involving social workers and national partners. The Board welcomed the progress made in co-production with voluntary sector organisations and local residents playing a key role in shaping services. The Live Well and Family Hubs were noted as examples of successful community engagement.

In relation to integration, Members were updated on improved neighbourhood-level working, supported by newly established steering groups. Collaborative efforts with Midlands Partnership Foundation Trust, SaTH and Shropshire Community Hospital Trust were highlighted as positive developments. The Board were advised that the area had been selected by Sport England as one of 53 sites participating in the Place Expansion Programme, a long-term initiative aimed at delivering strategic outcomes over a three to five year period.

Members heard that the resilience of the voluntary sector remained a concern, particularly in relation to long-term funding and capacity. While funding had been built into the Sport England bid, the need to maintain contracts and secure sustainable investment was emphasised. Integration and coordination across services was identified as a further challenge, especially in supporting individuals with multiple complex needs. Members were advised that scaling up preventative work would require additional resources and funding.

The Board noted that while the report celebrated progress and the shift towards care closer to home, there was a need to manage prioritisation and expectations in light of available data, resources and funding. Members were assured that data would continue to inform future work and that existing assets and resources available at local level would continue to be promoted and utilised in new ways. The Director of Public Health highlighted the strong collaborative work that took place between Shropshire Community Health Trust and the neighbourhood teams and suggested that the Board receive an update on the primary care healthy lifestyles offer at a future meeting.

Members noted increasing hospital admissions related to alcohol and drugs and asked about the future direction of integrated working. The Director for Public Health responded that ambitions were high, with strong engagement from Trust and Integrated Care Board (ICB) colleagues, citing the Telford & Wrekin Integrated Place Partnership (TWIPP) Accelerator Group as an example of collaborative leadership. The Board were advised that it was key that access to support for residents was seamless, regardless of the provider, and that funding resource grants could be a potential solution to this. The Chief Executive Officer for the Shropshire, Telford and Wrekin ICB noted that integration would vary depending on its impact on effectiveness and resident experience. He encouraged Members to view the 10-Year Plan as a mobiliser for existing work and stressed the importance of coordination and shared goals. He also raised the need for a broader conversation around financial sustainability and suggested TWIPP could support this. Members noted that grant funding was highly competitive, and resources were limited nationally. They acknowledged positive developments through TWIPP and the ICS, while recognising the scale of the challenge.

The Board noted the report and welcomed the progress made.

HWB15 Health & Wellbeing Strategy Performance Report

Members received a report from the Insight Manager providing an update on performance against the Health & Wellbeing Strategy priorities. The report was presented as part of the wider Joint Strategic Needs Assessment (JSNA**)** update and brought together key performance indicators in a single, consolidated format.

The Board were advised that the report would be developed further, with new data sources, such as GP activity being incorporated at future meetings. It was proposed that the performance report be presented to the Board on a six-monthly basis, allowing for more detailed discussion of updated measures.

Members were informed of several positive trends, including improvements in Year 6 healthy weight and early death rates among individuals with mental health conditions. A decline in self-harm among young people was also noted, alongside an increase in the percentage of cancers diagnosed early. These developments were seen as evidence that targeted work to address inequalities was having a positive impact on overall performance.

Members heard that healthy weight in the Early Years Foundation Stage (EYFS) and life expectancy remained areas of concern. It was noted that preventative work through TWIPP would be instrumental in addressing these issues.

The Board were advised that smoking prevalence in Telford remained significantly higher than national averages, with the area identified as an outlier. A deep dive into this issue was being undertaken through the Annual Public Health Report, which will be presented to the Board in September.

Additional indicators, including those related to opioid use and health checks via Clinical Practice Groups (CPGs), may be included in future reports as required.

During the discussion, Members emphasised the importance of early years support, particularly perinatal and postnatal care, as a key component of prevention. The Board queried the extent to which improvements could be achieved locally, noting that some issues required national-level action. The Director of Public Health acknowledged the complexity of shifting long-term outcomes. She highlighted the comprehensive nature of local plans, which included partnership working and data-driven approaches, but noted that broader cultural and national challenges also needed to be addressed. Regional and national perspectives were being explored to support this work.

RESOLVED – that:

a) **the current position regarding performance against strategy priorities be noted**
b) **the use of date to influence delivery of the Health & Wellbeing Strategy, targeting inequalities, and informing development of the Integrated Care Partnership Strategy and Joint Forward Plan be noted.**

HWB16 TWIPP Overview Update

Members received a presentation from the Assurance and Integration Programme Manager and Telford and Wrekin Place Lead providing an overview of the work and impact of the Telford & Wrekin Integrated Place Partnership (TWIPP). The presentation included a summary of current programmes, neighbourhood working, and future priorities.

Members were informed that TWIPP became a formal sub-committee of the Integrated Care Board (ICB) in September 2024, reflecting its strategic importance. The partnership brought together a wide range of organisations with a shared focus on improving outcomes, reducing inequalities, and enhancing prevention.

The Board heard that TWIPP had used local intelligence to refine its priorities, which now included supporting general practice, improving mental health and outcomes for children and young people and promoting healthy ageing. A wide range of programmes were being delivered under these themes.

Members were advised that TWIPP has adopted a flexible, person-centred approach to their neighbourhood working. The aim was to wrap the right services around individuals at the right time, supporting early diagnosis, self-care, and social prescribing. Each of the four neighbourhood areas had distinct needs, and the approach had been tailored accordingly.

The Live Well Hubs were highlighted as a key element of neighbourhood working. The hub in Madeley, operated by the Town Council, was cited as a

successful example of multi-agency collaboration, with a case study shared during the presentation. Members were informed that professional collaboration was a core component of the neighbourhood model, with regular joint working events attracting strong attendance and positive feedback. It was noted that over 100 professionals attended the most recent event in South East Telford.

In Newport and Central Telford, development of Neighbourhood MDTs was progressing, with TELDOC having operated a model since 2019. A new focus has been agreed for Malinslee, with an emphasis on mental health. Members heard that the Neighbourhood teams were working to better connect services and raise awareness of available support.

Members were updated on the Prevention Grants Programme, which has recently concluded. Funding has been awarded to support initiatives such as the expansion of Live Well Hubs, Calm Cafés and care navigators for autistic individuals and those with learning disabilities. The impact of these grants will be monitored through TWIPP, with updates to be brought to future Board meetings.

The Board were informed that a Health Conversation Campaign had also been introduced, building on the "Making Every Contact Count" approach. This included internal support for frontline workers and a public-facing campaign, with a vaccination focus launching in August. Members were also advised that the Sport England Place Expansion Opportunity would bring additional resources and strategic support to the area.

In relation to healthy ageing and frailty, Members heard that TWIPP was building on the successful Ageing Well consultation. Two key areas of focus were a one-stop advice shop for residents and for advice and resources to be consolidated for professional to access. It was expected that digital solutions and intelligence were to be used to support this work.

The Board welcomed the balanced distribution of prevention projects across neighbourhoods and priorities. Members emphasised the importance of placing Live Well Hubs where they are most needed and highlighted the importance of local authority leadership in areas such as housing and policing, and stressed the need for the Board and the ICS to support and challenge efforts to improve resident outcomes.

The Board noted the update and welcomed the progress made by TWIPP. Members acknowledged the importance of partnership working, neighbourhood-level delivery, and continued investment in prevention.

HWB17 Better Care Fund Update

Members received a presentation from the Better Care Fund Commissioning Lead, providing an update on the Better Care Fund (BCF) submission and outlining key changes to the programme for the current year. The presentation

included a summary of progress to date, national expectations, and future priorities.

The Board were reminded of the upcoming submission deadline and were asked to formally approve the BCF submission. Members were informed that the new national administration had introduced clearer requirements, with a simplified set of metrics and a strengthened governance assurance framework. A particular emphasis had been placed on improving hospital discharge arrangements and making better use of collective resources.

The Better Care Fund Commissioning Lead noted that there had been a strategic shift from sickness to prevention, with a growing focus on the use of digital technology. Members were informed of the introduction of Tech Tuesdays, showcasing innovations such as epilepsy sensors and other tools designed to improve the lives of people with complex conditions. There was a renewed focus on supporting independent living, with performance metrics centred on admission avoidance, hospital discharge, and long-term care.

The Board heard that national guidance now placed greater emphasis on length of hospital stay, with a clear expectation that patients were discharged as soon as they are clinically ready. Due to this, the effectiveness of the enablement offer was being reviewed, including the impact of additional funding for therapists received last year.

Members were advised that the end-of-year return had been completed, with a strong focus on integration. The submitted plan is expected to be approved, subject to conditions relating to performance metrics.

The Board were updated on work with community partners to promote independence, including the role of the Care Transfer Hub in reducing length of stay and improving discharge planning. A review of individual schemes had been undertaken to assess whether funding could be reallocated, though opportunities to do so remain limited.

Members noted their appreciation for the Better Care Fund Commissioning Lead for their ongoing management of the fund, with Members acknowledging the complexity of quarterly returns and the strategic alignment with broader system goals. The Board emphasised the importance of neighbourhood working and the challenges of reallocating resources, while supporting a place-based approach. The Better Care Fund Commissioning Lead noted improved integration, especially from hospitals, with a focus on reducing length of stay and enhancing discharge pathways. Members reflected on the increasingly collaborative nature of the process over recent years, and it was confirmed that NHS England had recognised this positive shift.

RESOLVED – that:

a) **the Better Care Fund Submission be approved**
b) **the Health & Wellbeing Board's support for the progress to date be noted**

c) that delegated authority to approve future submissions be granted to the co-chairs

HWB18 Housing Strategy Proposals Engagement

Members received an update from the Service Delivery Manager: Strategic Housing & Regeneration on the Draft Housing Strategy 2025–2030, which will replace the current strategy as it nears the end of its term. The update outlined key achievements of the previous strategy, including growth in the private rented sector and the success of the Better Homes for All programme, which has enabled inspections to ensure residents are living in safe and satisfactory conditions.

The Board were advised that the new strategy was being scoped by reviewing the current housing landscape and identifying changes since the adoption of the previous strategy. These included a growing population, particularly among older residents, a reduction in social housing availability and a decrease in full poverty levels. Members heard that these factors had significant implications for housing needs and priorities. The Service Delivery Manager: Strategic Housing & Regeneration advised that there were also national policy drivers such as delivery targets for new homes, affordable housing, homelessness prevention and the Renters Reform Bill, which also impacted the strategy.

Members heard that the proposed strategy prioritised ensuring that existing homes were of the highest possible quality and providing housing that supported vulnerable residents. The Service Delivery Manager: Strategic Housing & Regeneration noted that the proposed strategy also recognised that housing was a wider determinant of health.

The Board were informed that a successful consultation event had already taken place, with strong engagement from partners across health, social care, and community services. A key theme emerging from the consultation was the importance of aligning housing with health priorities.

During the discussion Members noted the significance of housing as a social determinant of health and praised the wide-ranging actions across sectors. The Board were advised that proposed strategy was due to be presented to Cabinet and encouraged broad resident engagement. Members supported the focus on vulnerable residents and commended the inclusive engagement process. Questions were raised about specialist accommodation and market shaping, to which the Director: Housing, Employment & Infrastructure responded that while progress had been made, especially in extra care, gaps did remain. She outlined ongoing efforts to improve dementia care, support for young people and care leavers, and collaboration with developers to meet diverse housing needs.

RESOLVED – that the Draft Housing Strategy 2025-2030 as set out in Appendix 1 be supported by the Health & Wellbeing Board.

HWB19 Community Safety Partnership Annual Report

Members received the Community Safety Partnership Annual Report, which provided an overview of progress made over the past 12 months and outlined future priorities. The presentation included key performance data, strategic developments, and partnership initiatives.

The Board were informed that overall crime levels in Telford & Wrekin had reduced significantly, with a notable 40% reduction in robbery and a 19% reduction in vehicle crime. These improvements reflected the effectiveness of collaborative working across agencies.

Members heard that the Community Safety Partnership's (CSP) new strategy was to be focused on reducing reoffending, preventing serious violence, tackling child sexual exploitation (CSE), reducing domestic abuse (DA) and addressing youth violence and driving offences.

The Chief Inspector provided the Board with an update against some key priority areas. Members heard that the annual report had been published and scrutinised, with input from a CSE Lived Experience Coordinator, and the Holly Project continued to inform learning and practice. The Chief Inspector also advised that a CSE Awareness Week was held to raise awareness and promote action. The Board were informed that the work around Domestic Abuse had focused on older people and individuals with learning disabilities. Partner agencies had received evidence-based strategies, and Clare's Law applications were being promoted. The funding has supported initiatives such as the Sanctuary Scheme (£1,500 allocation) and White Ribbon Days, which were well received. The CSP continued to promote Safer, Stronger Communities and had supported a range of community-led initiatives. Members were asked to note that whilst there had been a 21% increase in serious youth violence incidents, the evidence suggested that interventions were having a positive impact and partnership working with the Council and other agencies remained central to this effort. Ongoing efforts to improve road safety had included holding regular meetings to address Deaths and Serious Injuries, with a £10,000 Road Safety Fund being allocated to support a 12-month awareness campaign, including workshops for young drivers and passengers.

The Board emphasised the importance of police-resident feedback loops to build trust and noted the Ride-Along Scheme to enhance transparency and encouraged continued partnership working. Members raised concerns about rough sleeping, youth engagement and the need for direct incident reporting. The Chief Inspector acknowledged the enforcement challenges and stressed that there was ongoing work being undertaken with local businesses.

The Board noted the report and welcomed the progress made by the Community Safety Partnership. Members acknowledged the importance of continued collaboration, community engagement, and targeted interventions to improve safety and wellbeing across the borough.

HWB20 Chair's Update

The Chair advised that the next meeting of the Health & Wellbeing Board would be held on Thursday, 18 September 2025.

The meeting ended at 3.47 pm

Chairman: ----------

Date: Thursday 18 September 2025

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Telford & Wrekin Co-operative Council

Protect, care and invest to create a better borough

Health & Wellbeing Strategy 2023-2027

Delivery Progress Report

September 2025

Our vision - happier, healthier, fulfilled lives

Borough Vision 2023 ambition – inclusive, healthy, independent lives

Closing the Gap

- Our HWB Strategy highlights that tackling inequalities and closing the gap requires comprehensive action across our priority programmes, through a strong targeted, intelligence-led approach. Addressing wider determinants of health is crucial and the NHS has a particular focus on reducing health inequalities through its

- The gaps in health and wellbeing experience are most repeatedly seen in our most deprived communities, compared to the most affluent communities, the 20% most deprived communities, CORE20PLUS5 programme.

- Particular and specific inequalities are also faced by different groups of people, often referred to as inclusion groups and these are closely related to characteristics which are protected in the Equalities Act.

Closing the Gap – overview of inequalities focus across HWB Strategy

Healthy Weight	• Strategy engagement focus groups with at-risk groups including people with learning disabilities, mental health disorders, males, ages 55+, ethnic minority groups, people living within our most deprived communities • Key priority for Healthy Weight Strategy is to create opportunities to support groups facing inequalities including: children and adults with a learning disability, physical disability or long-term health condition, as well as those with a common mental health problem or serious mental illness. • Schools health & wellbeing programme selects schools to take part with the highest rates of excess weight and those in our most deprived communities	Integrated health and care	**Start for Life Family Hubs:** "core20" population, younger parents, black & minority ethnic group families **Primary Care:** All PCNs have nominated inequalities leads and specific health inequality related projects in place for 24/25. Health inequalities is one the prioritisation criteria the ICB Primary Care Team use to target practices requiring improvement support.
Alcohol, drugs & domestic abuse	**Alcohol & drugs :** Equality Impact Assessment completed alongside the Needs Assessment. Equality Action Plan to be integrated into annual strategy Action Plan, Ethnicity data now included in quarterly treatment monitoring data **Domestic Abuse:** focus on families with complex and multiple needs. The DA Forum assessing disproportionate impact of domestic abuse and lower service uptake rates among under-served groups, improving joint working with faith groups and BAME communities	Green & sustainable borough	Initiatives targeted towards under-represented groups - people from lower socio-economic groups, people from ethnically diverse communities and people with disabilities/additional needs.
Mental health & wellbeing	Children & Young People who: have SEND, looked after/care leavers, those who are NEET, and suffer multiple disadvantage and trauma adults who experience poor mental health alongside other vulnerabilities such as alcohol and drug use and housing needs	Economic opportunity	The Cost-of-living strategy is aimed at those residents in the Borough on the lowest incomes, be they working age or pensioners.
Prevent, detect & protect	People living in the most deprived 20% of communities in England – the core 20 are a key focus given the gaps in life expectancy the most deprived and most affluent communities. Cancer screening: narrowing the gap in uptake of screening programmes across GP practices, linked to deprivation Cancer Champions & Health Champions representative of diverse communities	Housing & homelessness	People affected by trauma and poor mental health Ongoing focus on homeless clients who present with complex and multiple needs.

T&W HWB Strategy highlights that tackling inequalities and closing the gap requires comprehensive action across our priority programmes, through a strong targeted, intelligence-led approach. The gaps in health and wellbeing experience are most repeatedly seen in our most deprived communities, compared to the most affluent communities, the 20% most deprived communities, CORE20PLUS5 programme. Particular and specific inequalities are also faced by different groups of people, often referred to as inclusion groups and these are closely related to characteristics which are protected in the Equalities Act.

Healthy Weight

Progress / Key Highlights

- **Action plan:** To enhance support for residents with learning disabilities and carers, involving Healthy Lifestyles, Adult Social Care, and NHS LD services. Staff training opportunities identified
- Schools Health & Wellbeing Programme to include **Eatwell training for staff in 2025/26**
- Early Years nutrition guidance supported with tailored checklists for settings and childminders
- Physical activity pilots launched for priority groups including: Move to Thrive (dementia), Breakfast Yoga (peri-/menopause), Wellbeing, Belonging and Moving for Serious Mental Health and illness.

Risks

- Nearly **40%** of children leave primary school overweight; adult overweight and obesity nearing **70%**
- Lack of Secondary schools with the **Schools Health & Wellbeing Programme**
- Challenges implementing 'Healthy Weight' Training to frontline staff, primarily due to competing organisational priorities (i.e. Options appraisal completion to deadline)

Performance Issues

- Healthy Families Programme supported 123 families in 2024/25
- This year's reduced engagement, combined with insight of challenges will inform future service development.
- Opportunities for group education sessions combined with physical activity are being explored.

Alcohol, drugs & Domestic abuse

Domestic Abuse & VAWG (Violence Against Women and Girls)

Progress / Key Highlights

- Significant increase in SPOC contacts:
  - 417 this quarter vs 306 last quarter.
- Specialist Support Service referrals stable:
  - 114 new referrals (vs 113).
- Open cases consistent: ~87 per month since April 2024.
- Children & Young People's Service referrals steady
  - 44 this quarter (vs 50).
- Average monthly caseloads remain around 31.

Risks

- No ring-fenced funding for VAWG prevention.
- Current programmes rely on mixed funding sources (DA Grant, Community Safety Partnership, PCC).
- Lack of central government funding limits programme expansion.

Drug & Alcohol Treatment

Progress / Key Highlights

- Recovery month range of activities including the launch of the Recovery Charter, with keynote by Dame Carol Black and pledges given by a wide range of partnership organisations

Risks

- PRH Alcohol Care Team disbanded, increasing pressure on Drug & Alcohol Liaison Team (DALT).
- DALT prioritising high-risk cases; limited capacity to see individuals before hospital discharge.
- Elevated overdose risk due to rising availability of synthetic opioids nationally.

Performance

- 434 new treatment presentations (year to May 2025), above May 2022 baseline of 363
- **Adults in treatment:**835, compared to 820 at baseline
- 75% continue treatment post-prison release (vs 53% baseline, 57% national)
- 52% show positive progress (drug-free or sustained reduction), above national rate of 47%
- **Young people in treatment**:39 (vs 28 in May 2022)
- Naloxone issued to 81% of opiate-dependent individuals (above 80% national rate)

Mental Health & Wellbeing

Progress / Key Highlights

- Review of specialist mental health support framework underway; new provider engagement planned.
- TWIPP funding secured to expand ***Calm Cafés*** with dedicated support for 18–25 year olds; launch expected end of October.
- Strong partnership working evident across rehabilitation and inpatient care transformation programmes.

Risks

- **Mental Health Bill** progression presents system-wide implications.
  → A high-level briefing paper is being developed for senior social care officers. This sets recommendation for a system-wide readiness group, ideally led by the ICB.
- Safeguarding Board engaged with MH Act Lead from MPFT for further insight.

Performance

Positive outcomes in specialist supported accommodation

Increased physical activity engagement	**Reduced Isolation**	**Improved self-care**	**Community**

Protection, Prevent and Detect

Progress / Key Highlights

- **Community Blood Pressure:** Project funding secured until March 2026; strong engagement with TACT, Armed Forces Day, and homeless community via KIP
- **Community NHS Health Checks** (planning underway): via the 'Healthy Hearts' project, launching 3rd September in partnership with SET PCN
- **Community Falls classes:** Increases seen in attendance
- **Live Well Community Hubs:** In Wellington and Donnington set to launch in October
- Lingen Davies Sunflower Appeal launched to raise £5M for expanded cancer services at PRH; Cancer Champions supporting rollout of NHS Lung Cancer Screening in South East Telford
- **HPV/MMR Vaccination Uptake project:** Exploring extension of MoU to focus on MMR
- **Cancer Bus Tour** visiting key locations; 3 out of 5 days secured for Telford
- **Health Champions programme:** Growing, with volunteers trained in MECC and Feed the Birds
- Healthy Lifestyles Stop Smoking Advisors recruitment

Risks

- **HPV/MMR vaccine uptake project:** is time-limited; further investment required.
- **No risks for Cancer Champions:** Now fully funded by Lingen Davies following the end of NHS Core20 and WM Cancer Alliance funding.
- **Physical activity projects:** All funding-dependent; however these are either designed to be self-sustainability over the long-term with public interest, or alternative funding are being explored.

Integrated Health and Care: Neighbourhood Health

Progress / Key Highlights: TWIPP

- **Leadership transition:** Louise Mills appointed as Place Lead, ensuring continuity through existing relationships
- **Neighbourhood Health Implementation Programme:** Expression of Interest submitted to join national cohort of 42 areas; potential access to coaching and peer learning
- **Positive national recognition:** Dr Claire Fuller (NHSE) praised TWIPP's resident-focused partnership approach
- **Funding:** £333,000 prevention budget allocated for 2025/26; continuation of Community Blood Pressure Project secured until March 2026
- **Strategic alignment:** TWIPP's work supports Telford & Wrekin Vision 2032 for inclusive, healthy, independent lives
- **Expanded collaboration**: Now includes Telford College, DWP, and Shropshire Fire & Rescue
- **Neighbourhood progress:** MDTs active in TELDOC, Newport & Central, and South East Telford; Live Well Hubs expanding to Wellington and Donnington
- **Healthy Conversations Campaign** launched in August, aligned with flu/COVID clinics; runs until December

Progress / Key Highlights: Family Hubs

- Damson Family Hub launched at Donnington Community Hub and Silver Threads.
- Term-time drop-in sessions continue across communities, Monday to Friday.
- Parenting courses now open access via the website; 73 registrations to date.
- Government announced expansion of Best Start Family Hubs; awaiting final grant decisions.
- Renewed national focus on **75%** of children reaching a Good Level of Development by 2028.
- Telford & Wrekin currently at **67%,** with a target of **78%.**

Risks

- Potential reduction in future funding linked to Best Start Family Hub rollout.
- Venue identification still required for Newport and Wellington hubs.

Green & Sustainable Borough

Progress / Key Highlights

- **Green Flag Awards:** 8 sites recognised, including Telford Town Park (10th consecutive year) and Victoria Park (first-time award).
- **Wildflower Expansion:** Borough-wide shift to meadow-cut grass in selected areas to support pollinators and biodiversity. Autumn sowing planned across parks and nature reserves.
- **Water Quality Initiatives:** Blue-green algae detected in several pools due to prolonged warm weather. Council working with anglers and volunteers on reed planting to improve filtration and restore habitats
- **Nature Reserve Improvements:**

Beeches & Lodge Fields: New bench, pathway, and step upgrades.

Granville LNR: Path and natural play area completed.

Horsehay Pool: Floating reed rafts and updated fishing pegs installed.

Dawley Hamlets: Path and step improvements; signage/tree works underway.

- **Green Pledge Scheme:** Approved by Cabinet to encourage landowners, businesses, and community groups to collaborate in protecting and enhancing green spaces.
- **Play & Pitch Strategy:** Under consultation; developed using Sport England methodology to ensure adequate and inclusive pitch provision across the borough.
- **Local Nature Recovery Strategy (LNRS):** Regional collaboration with Shropshire Council to map and deliver nature recovery actions. Public consultation open; Telford & Wrekin supporting via comms and social media.
- **Tree Canopy Study:** Commissioned from Treeconomics to assess urban forest cover, species diversity, and environmental benefits including flood mitigation, carbon capture, and air pollution reduction.

Economic opportunity (1)

Progress / Key Highlights

- **Connect to Work:** Final agreement with DWP is nearly complete; launch set for September. Recruitment and referral preparations are underway to meet early targets.
- **Supported Internships:** DfE funding renewed and increased, allowing expansion from 10 to 30 places. Telford College will run two cohorts starting in September and January. Local employer interest is strong.
- **Learn Telford:** Successfully engaged minority communities, 45% of learners are from these groups, compared to the borough average of 12%.
- **Council Skills Strategy:** Published and available online; outlines key issues and actions across various themes.
- **Get Marches Working Plan:** Led by Shropshire Council, funded by DWP. Aims to raise employment rate to 80%. Broad consultation is ongoing; final plan due in late autumn.

Risks

- **Staff Recruitment:** Challenge in hiring enough qualified staff in time for the Supported Internship Pilot and Connect to Work. Recruitment is ongoing.
- **DWP Contract Delays:** Previous delays in contract agreement affected progress, but clarity has now been achieved and work is accelerating.

Performance Issues

- **Learn Telford:** Strong performance and impact.
- **Connect to Work & SI Pilot:** Too early for performance data; will be available once programs are operational.

Economic opportunity (2)

Progress / Key Highlights

- **Unlocking Potential in Telford and Wrekin: Good and Fair Employment** - collaborative, cross-sector group led by Ann Johnson: Telford Implementation Lead for Lloyds Bank Foundation
- Mission to create equitable employment pathways, helping all residents, particularly those with complex needs, to cultivate the confidence, resilience, and self-belief required for healthier working lives, rooted in Marmot Principles
- **Two active working groups meet monthly:**
  - **Work Readiness Group:** This group comprises public, private, and community organizations, including Landau, parts of the NHS, Enable, and Serco, focused on improving opportunities that support people, especially those with complex needs, into employment. The group's work specifically targets the cultivation of confidence and resilience.
  - **Telford Employer Group**: Working alongside the Telford Business Board, group includes major employers: NHS, Shropshire Fire Services, Telford College, CVS, Severn Hospice, Muller, Wrekin Housing Group, and Serco.
- **Current work being undertaken by the groups includes:**
  - Good and Fair Survey: An ongoing survey, open until October 4th, designed to understand the barriers residents face in securing good and fair employment.
  - Cross-Sector Collaboration: Developing opportunities for healthier workplaces and influencing work readiness and skills funding in the area, focus on building relationships between employers and those who provide services
  - Process Development: Influencing funding, commissioning, and strategies within the borough to ensure that those with complex needs and those facing institutional barriers can access or retain good and fair employment.
  - Theory of Change: being planned 12th November – to crystalise the changes in support and delivery for those with complex, intersectional and institutional discrimination in current provision, setting out clear actions for change informed by lived experience input, employers, service providers, good and fair work survey, earlier Re-imaging Recruitment events and influencing group work and pre-event appreciative inquiry review.

Housing & Loneliness

Progress / Key Highlights

- Homelessness data is unchanged, covering period from April until June 2025:
    - Advice Provided: 1137
    - Homelessness Duty Owed: 404
    - Number of people prevented from homelessness: 116
    - Number of people relieved from Homelessness: 206

Risks

More people with mobility or disability requiring specialist accommodation presenting as homeless.

Performance Issues: None

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Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

General Practice in Telford and Wrekin - access update

Health & Wellbeing Board

18th September 2025

(July 2025 data)

Executive Summary

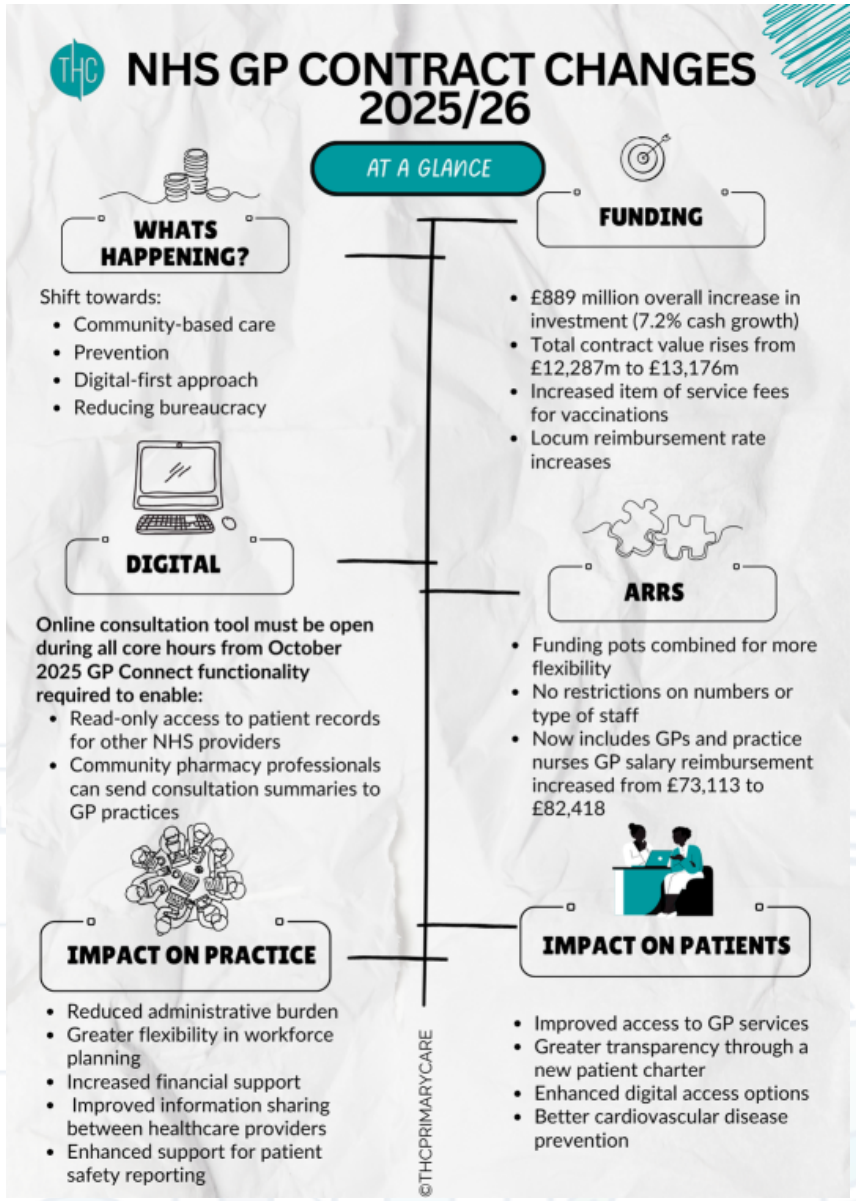
- Access is improving on key same/next-day measures, with targeted support for practices showing negative variation
- All practices are within PCNs; this underpins extended access (particularly for CMP patients) and neighbourhood delivery
- MGP roll-out is progressing care navigation, digital telephony, and “right care, first time” models are in place or going live across T&W
- QI visits and data-driven support are focused on the small number of practices below national comparators

Key headline metrics

- **% appointments delivered same/next day** - TW 58% vs ICB 53% vs England 51%
- **% seen within 14 days** - T&W 88% vs ICB 83% vs England 82%
- **% of GP led appointments** – TW 38% vs ICB 43% vs England 44%
- **GP Patient Survey (GPPS)** – year-on-year movement for ‘overall experience was good’ up from 66% to 72% in 2025

General Practice in Telford and Wrekin - Access update July 2025

General Practice Contract 2025-2026



NHS 10 Year Plan

National three shifts:

- Hospital to community
- Sickness to prevention
- Analogue (paper-based) to digital

The Goal

Deliver better care, utilise new technologies and medicines, and create a more sustainable health service that focuses on patient convenience and well-being.

General Practice Contract 2025/26

Three new contract requirements from 1st October 2025

- Online Consultation tools switched on for the duration of core hours
- You and Your General Practice must be on practice websites
- GP Connect Access Record (HTML and Structured) and Update Record must be enabled within GP Practice clinical systems

Practices are on track to deliver against these.

National context – Modern General Practice & 2025/26 priorities

Modern General Practice (MGP) model:

- *Care navigation & triage:* directing to the right clinician/service first time (including pharmacy, MSK, mental health, PCN roles).
- *Digital & telephony:* modern cloud telephony with call-back, real-time queuing, and demand insights; online requests triaged within safe timeframes.
- *Same-day urgent, timely routine:* urgent needs handled same/next day; routine within agreed windows; continuity for complex/CMP cohorts.
- *Data-driven improvement:* using GPAD/GP Connect/telephony dashboards to match capacity to demand.

2025/26 national priorities:

- Sustain/expand MGP, reduce unwarranted variation in access.
- Improve patient experience on access (GPPS questions), digital inclusion, and continuity for complex patients.
- Utilise Additional Roles (ARRS/PCN) to increase *non-GP* capacity where appropriate.
- Strengthen neighbourhood integration with community, urgent care, and pharmacy.

Telford and Wrekin 2025/26 Plan

Priorities for this year:

- **Access & experience:** same/next-day for urgent need; 14-day for routine; uplift GPPS access scores.
- **MGP implementation:** universal care navigation; full digital telephony with call-back; safe online triage flows.
- **Extended access at PCN level:** coordinated evening/weekend capacity with focus on **CMP** patients.
- **Workforce mix:** increased use of *other HCPs* (pharmacists, physios/First Contact Practitioners, PAs/ANPs/Paramedics) to free GP time for complex care.
- **Neighbourhood model:** primary care as the front-door in place-based teams (community, pharmacy, VCSE, mental health).
- **Support offers available to practices/PCNs:**
  - Access improvement coaching & demand/capacity modelling.
  - Digital telephony optimisation & care navigation training.
  - QI collaboratives; peer support; targeted data packs.
  - Pharmacy pathways (e.g., CPCS/Pharmacy First), MSK first contact, mental health practitioners.

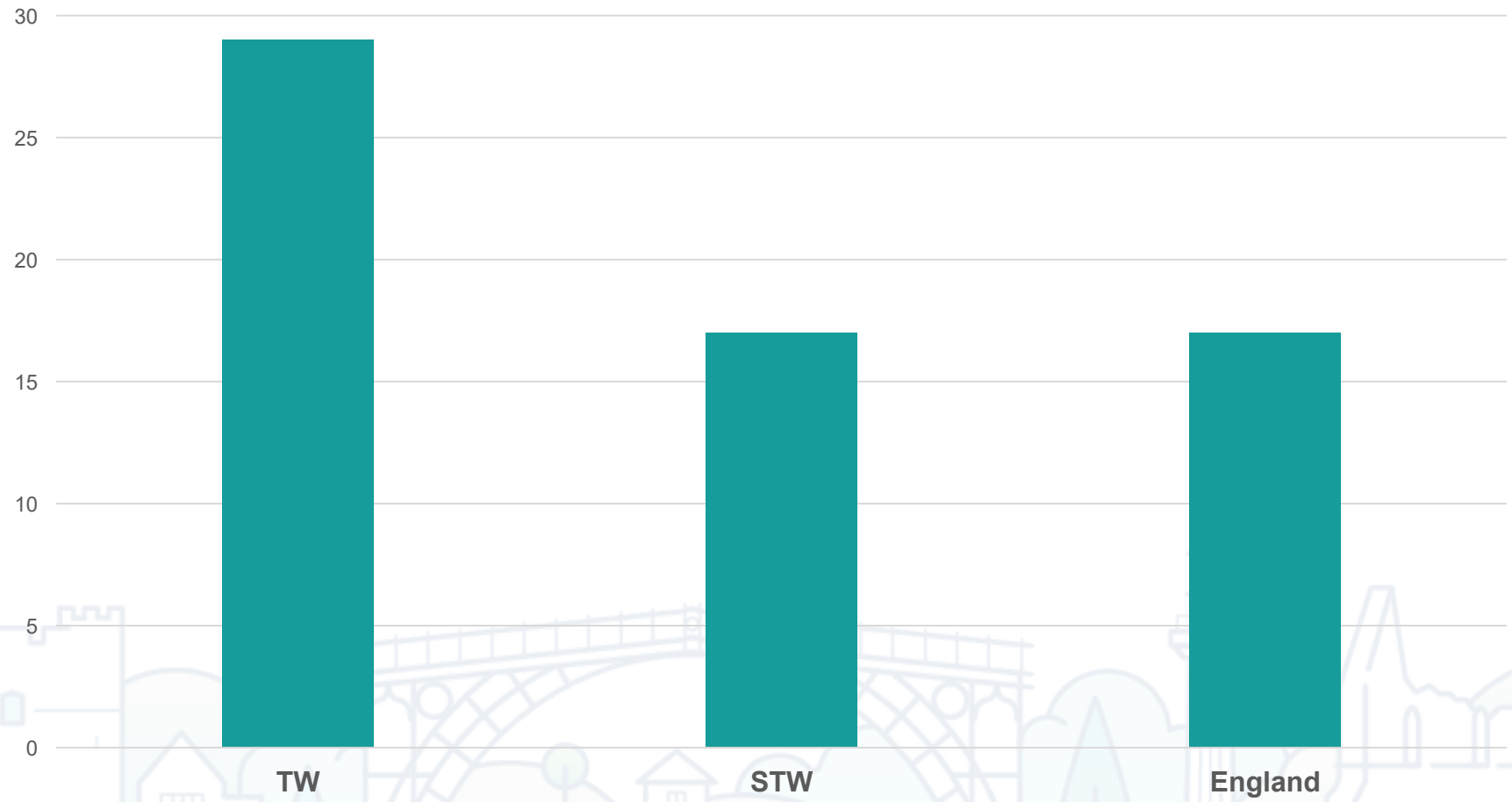
GP Dashboard and Local Metrics
Patient Access

Current performance – Access

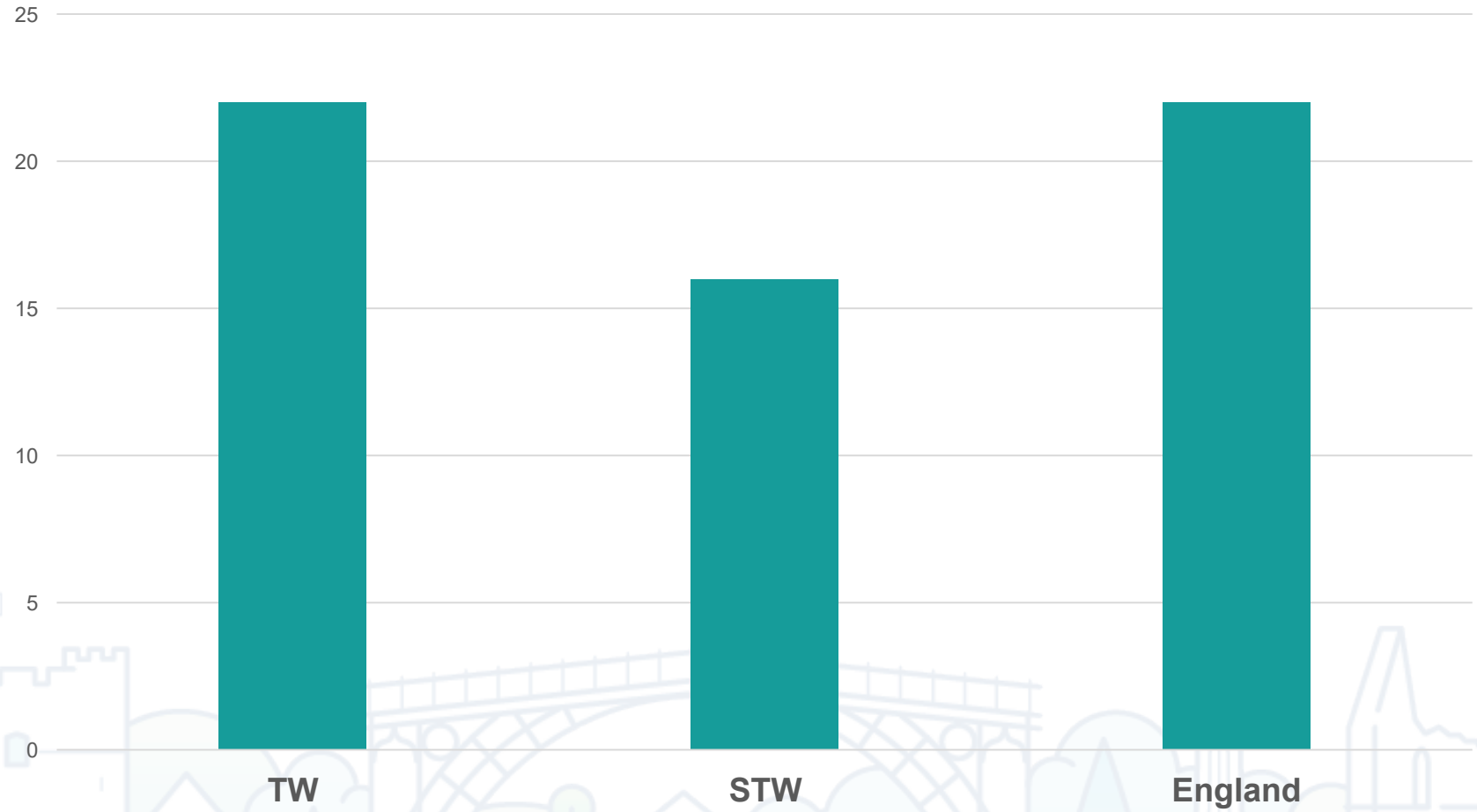
Same/Next-Day & 14-Day Access

- % appointments delivered same/next day - TW 58% vs ICB 53% vs England 51%
- % seen within 14 days - T&W 88% vs ICB 83% vs England 82%
- % of GP led appointments – TW 38% vs ICB 43% vs England 44%

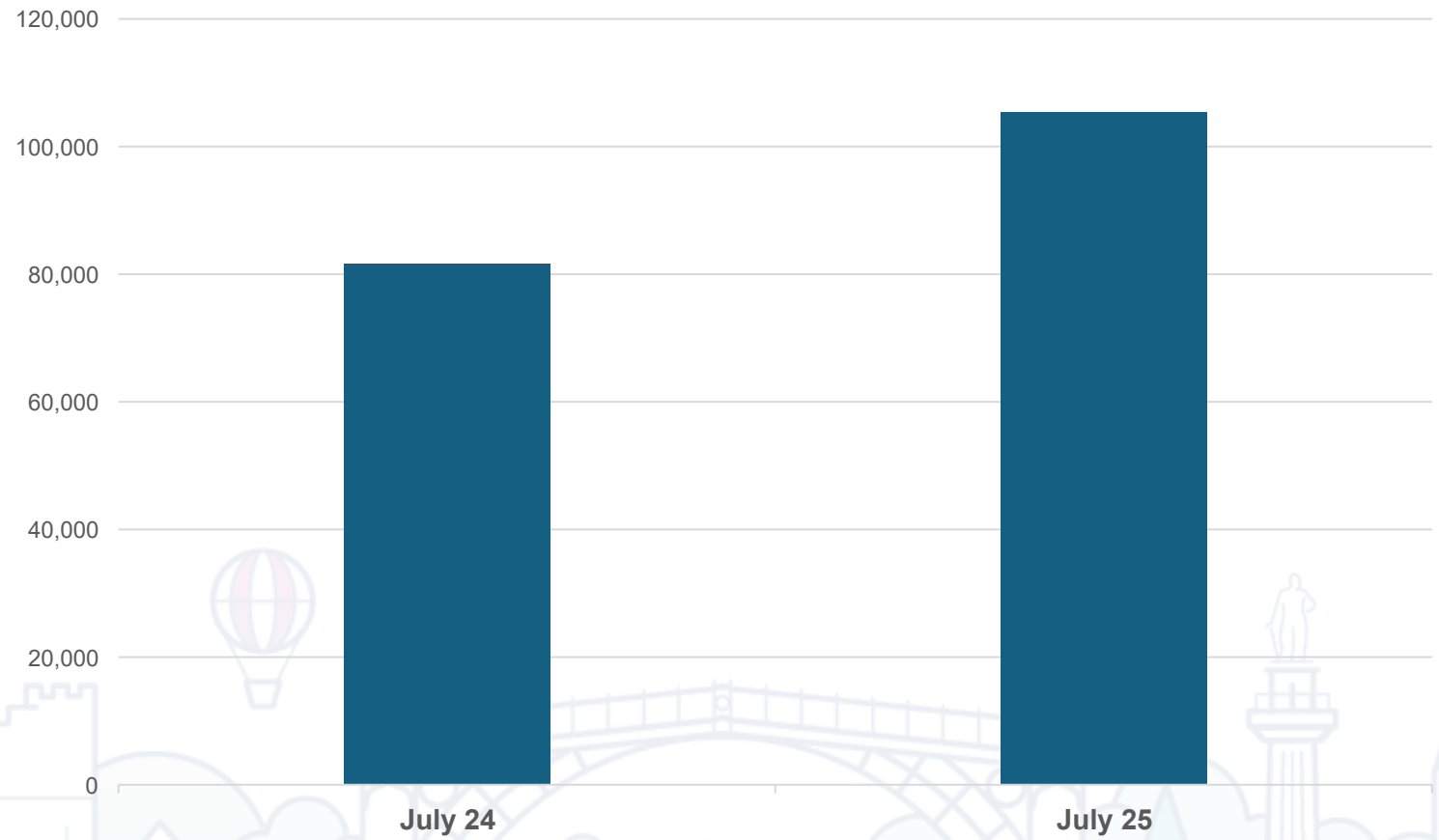
Percentage increase in total GP appointments (latest 24 month period)



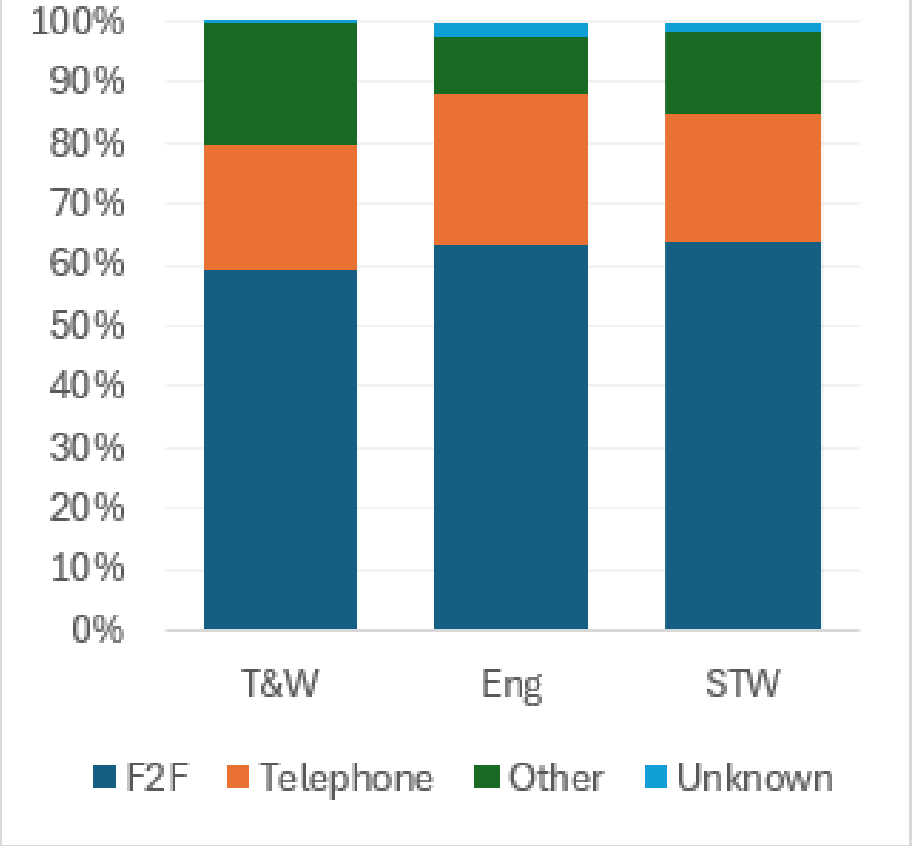
Percentage increase in appointments since the pandemic (to July 2025)



Total number of appointments in the latest month compared to same month in the previous year



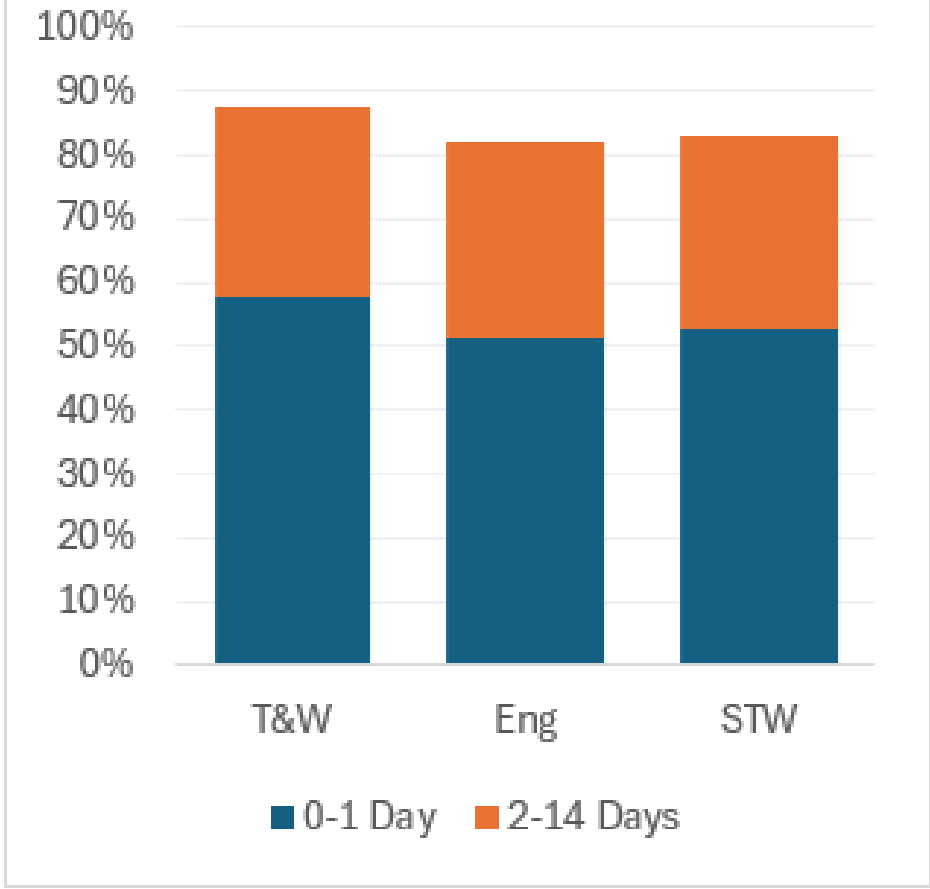
Appointment mode - latest month (July 2025)



	T&W	Eng	STW
F2F	59%	63%	64%
Telephone	20%	25%	21%
Other	20%	9%	13%
Unknown	0%	2%	2%

- General Practice appointments can take place by a number of different modes the main being Face to Face and Telephone appointments. Some others included Home Visits and Video Consultations
- Telford & Wrekin have a slightly lower percentage of F2F and Telephone appointments compared to England and Shropshire Telford and Wrekin as a whole

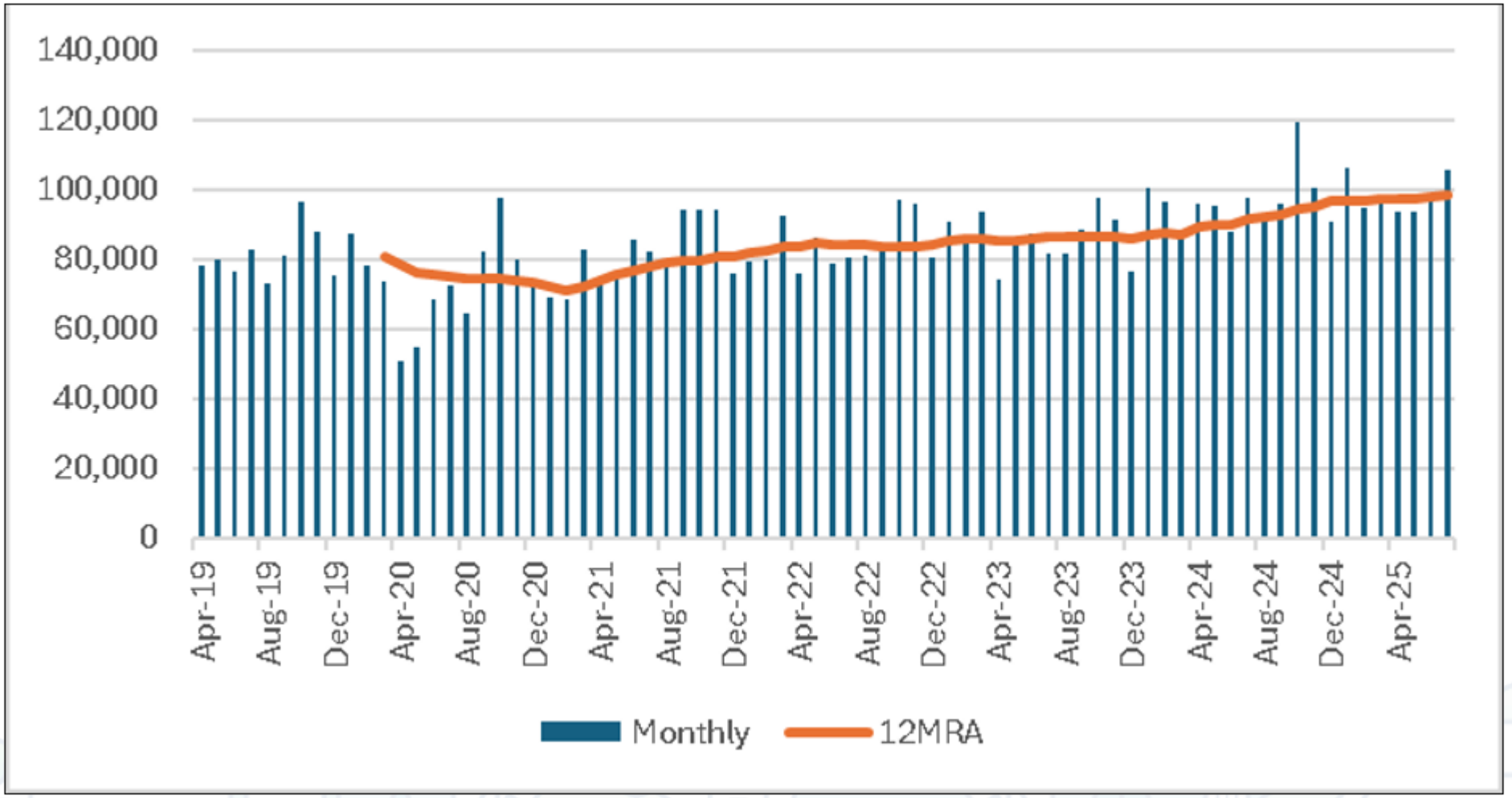
Appointment wait – latest month (July 2025)



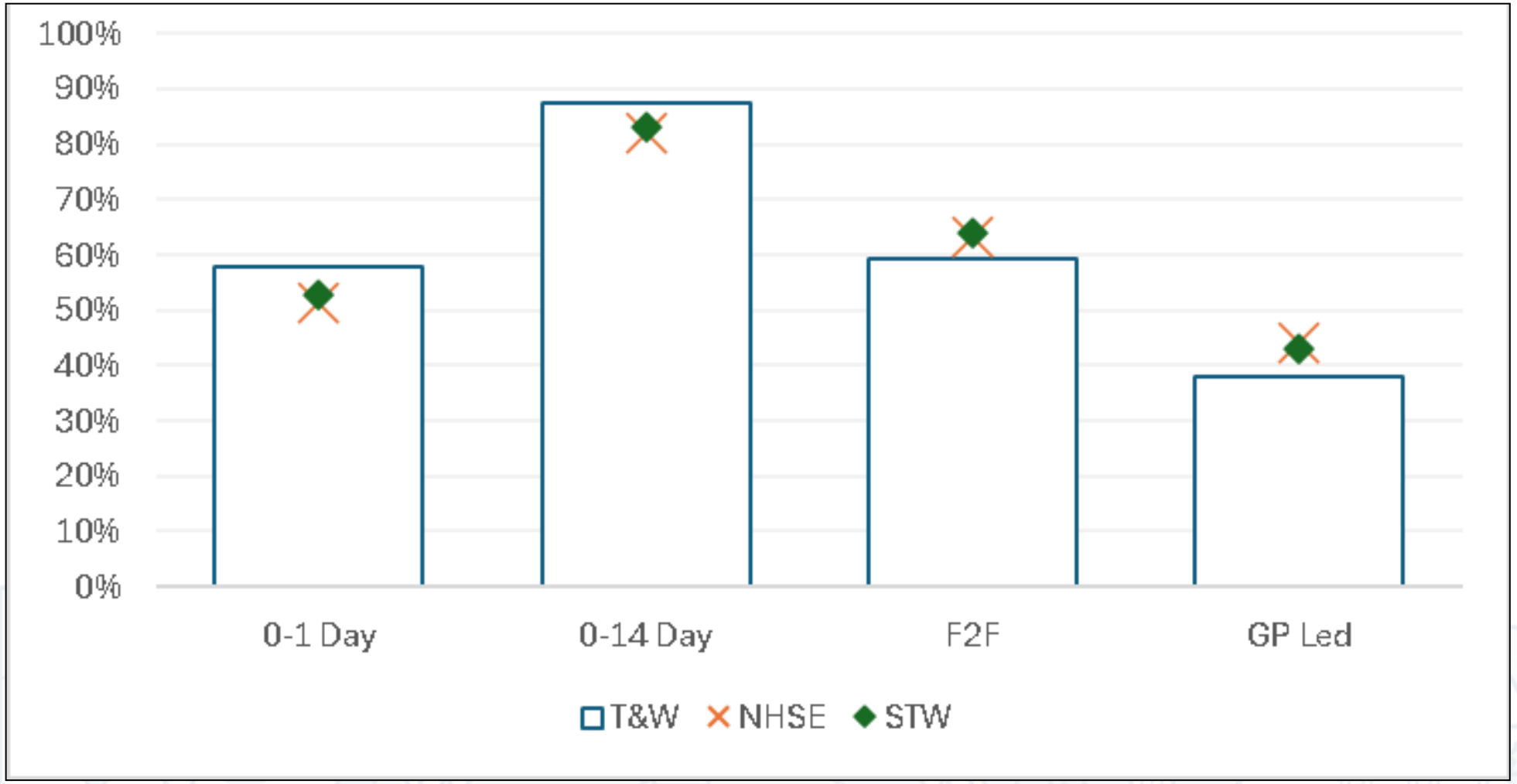
	T&W	Eng	STW
0-1 Day	58%	51%	53%
2-14 Days	30%	31%	30%
0-14 Days	**88%**	**82%**	**83%**

- The time patients spend between booking an appointment and being seen is represented in this chart.
- Telford & Wrekin practices report a higher percentage of their patients being seen within 14 days of booking their appointment than those who booked an appointment in England and in Shropshire, Telford and Wrekin as a whole.
- This was due to having a higher level of same/next day appointments than Eng and STW.

All appointments – monthly & 12 monthly rolling average



Ease of appointments for TW (all appointment categories) compared to STW and England – July 2025



General Practice Survey 2025 Feedback

GP Patient Survey – year-on-year (T&W practices only)

Variation

- Practices ≥ national benchmark (Overall experience ≥75%): **[1]**
- Practices < benchmark: **[6]** (a few ≥10pp below; under targeted support)
- Variation in phone/digital clustered by PCN, not simple rural vs urban split

Improvement vs 2024 ✅

- Overall experience (76% → 80%)
- Online access ease (59% → 63%)

Behind national ⚠

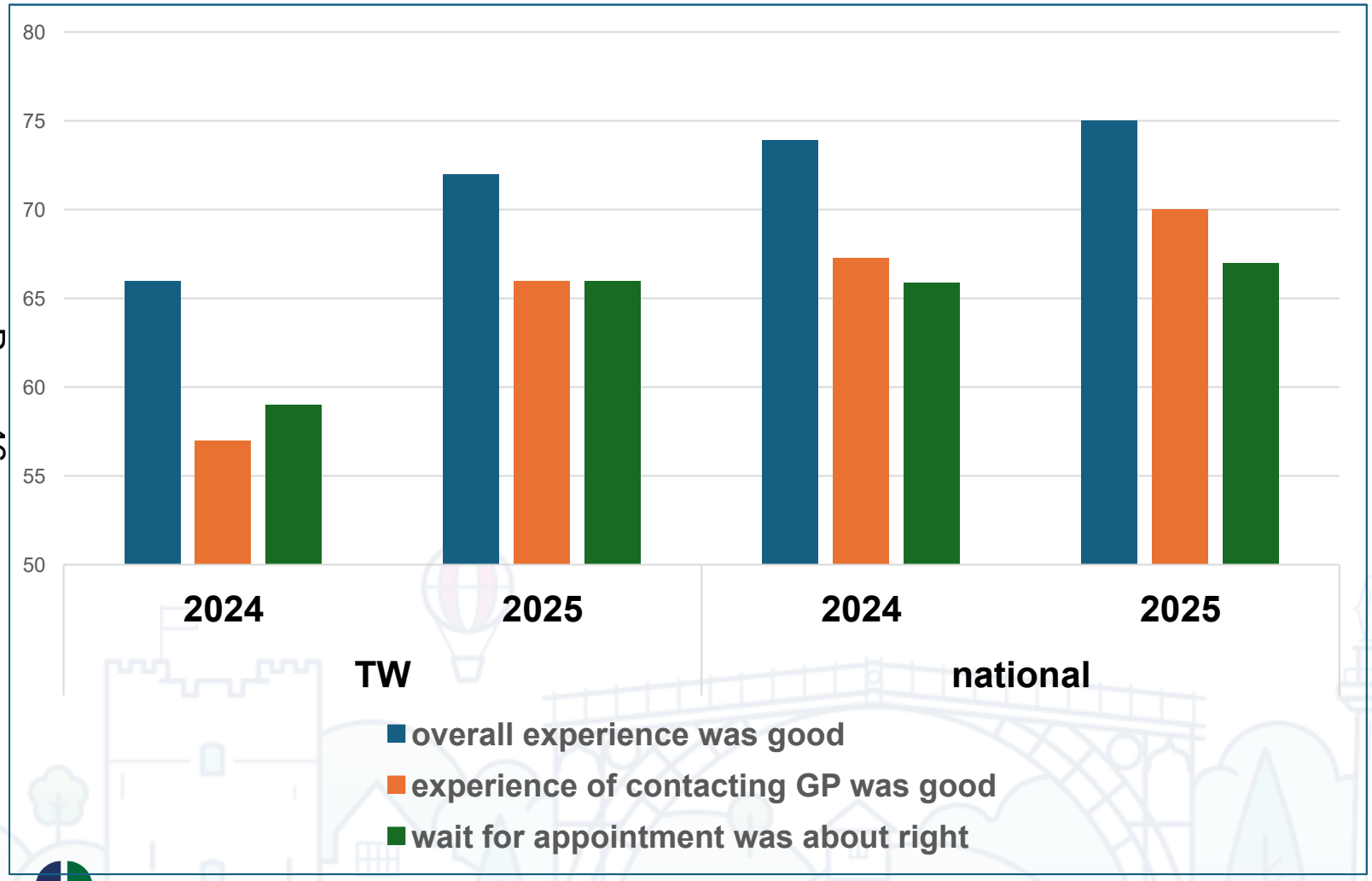
- Phone access (67% → 63%)
- Wait times (69% vs 72%)

GP Patient Survey 2025 STW ICB Summary

Headlines (ICB-level)

- Response rate: **37%** (5,827 / 15,821)
- Overall experience: **80% "Good"** (↑ from 76% in 2024; vs 75% national)
- Phone easy to get through: **63%** (↓ vs 2024; ~8pp below national 71%)
- Online access easy: **63%** (↑ from 59% in 2024; still below national 71%)
- Wait "about right": **69%** (vs 72% national)
- Clinician interaction rated "Good": **68%**

National GP Patient Survey results - summary



- Comparing 2025 results to 2024, TW practices have improved considerably on these three key metrics
- TW practices have moved much closer to the national averages for each metric in the last year

Practice Level Support (PLS) – Telford & Wrekin

Cohort:

- 8 practices identified across STW ICB
- **4 are in Telford & Wrekin**
- Selection based on access variation, GPPS results, assurance indicators

Timeline:

- Programme launch: **end of September 2025**
- Improvement cycles (8–12 weeks) through Q3/Q4

PLS Offer (core components):

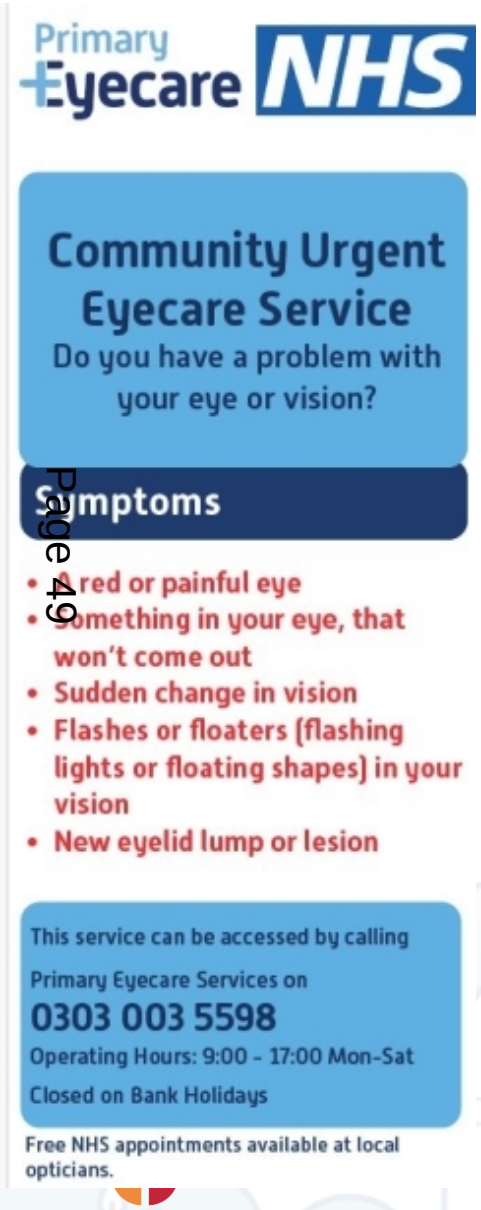
- 📊 **Data-driven diagnostics** – demand & capacity modelling, telephony analytics, appointment ledger review
- 🏥 **On-site QI support** – workflow mapping, care navigation, digital triage pathways
- ☎️ **Targeted interventions** – telephony optimisation, demand-management tools, access templates
- 🤝 **Peer support & best practice** – exemplar SOPs, staff training modules
- ✅ **Monitoring & assurance** – time-bound improvement plans, follow-up via Primary Care Quality Framework

Expected outcomes:

- Reduce variation in access (same/next-day, 14-day)
- Improve GPPS access scores
- Enhance patient experience of telephony/digital routes
- Build sustainable improvement capacity within practices

Other Sectors of Primary Care Supporting Improved Patient Access

Optometry First new community service



- Primary Eyecare services are the new provider from July 1st
- Phased mobilisation is underway and scheduled for all services to be operational by 31st January 2026
- CUES (community urgent eyecare service) is the main service to be offered
- Other services include;
  - Cataract referral filtering and post-op assessment
  - Glaucoma Enhanced Case Finding (ECF), Repeat Readings (RR) and low-risk monitoring
  - Medical Retina referral filtering and low risk monitoring
  - Integrated Paediatric eye care service

Pharmacy First

- This service enables patients to get certain prescription medications directly from a pharmacy, without a GP appointment
- It frees up GP appointments for patients who need them most and will give people quicker and more convenient access to safe and high quality healthcare
- This includes the supply of appropriate medicines for 7 common conditions including earache, sore throat, and urinary tract infections, aiming to address health issues before they get worse.
- Currently, NHS patients in England must visit their GP to access prescription only medication, meaning repeated GP visits and delays in treatment

1. Healthy Ageing Strategy 2025-2028

Meeting Name: Telford & Wrekin HWBB
Meeting Date: 18 September 2025
Report Presented by: Vanessa Whatley, Chief Nursing Officer
Report Approved by: Vanessa Whatley, Chief Nursing Officer
Report Prepared by: Lorna Watkins, Strategy Development Manager
Action Required: To support the Healthy Ageing Strategy

1) **Note the Healthy Ageing Strategy 2025-2028 fully aligns with both Health and Wellbeing Strategies and SHIPP and TWIPP priorities.**
2) **The Health and Wellbeing Board supports the Healthy Ageing Strategy Implementation.**

1.1. Purpose

The purpose of this report is to support a 3-year strategy Healthy Ageing Strategy for care of those who have or at risk of developing frailty as they age. The strategy's vision is to enable people in Shropshire, Telford and Wrekin to age well by living longer, healthier, and more independent lives though extending healthy life expectancy, reducing inequalities, and ensuring that all individuals, experience an improved quality of life as they age. This will be delivered though through proactive, personalised, and compassionate care in a strongly Place-led, neighbourhood model, in which we will support our communities to thrive at every stage of later life.

1.2. Executive Summary

1.2.1. The Healthy Ageing Strategy sets out a system-wide approach to support residents in Shropshire, Telford and Wrekin to age well. It focuses on prevention, early identification, and coordinated care for those at risk of or living with frailty. The strategy is aligned with national priorities including the NHS 10-Year plan and local strategies such as the JFP (Joint Forward Plan) and Ageing well initiatives. It is built on public health data and shaped by engagement with residents, professionals and community partners.

1.3. Recommendations

1.3.1. Note the Healthy Ageing Strategy 2025-2028 fully aligns with both Health and Wellbeing Strategies and SHIPP and TWIPP priorities.

1.3.2. The Health and Wellbeing Board supports the Healthy Ageing Strategy Implementation.

1.4. Conflicts of Interest

1.4.1. There are no conflicts of interest identified

1.5. Links to the System Board Assurance Framework (SBAF)

1.5.1. The Healthy Ageing Strategy supports the SBAF with the delivery of strategic objectives related to population health, reducing inequalities, and improving care outcome. The strategy addresses risks related to increasing

demand on health and care services due to an ageing population and contributed to mitigations through proactive care, community-based support and digital innovation.

1.6. Alignment to Integrated Care Board

1.6.1. The strategy is closely aligned with the Integrated Care Board's (ICB) strategic objectives to improve population health, reduce health inequalities, and deliver sustainable, high-quality services. It supports the transition from reactive to proactive care and from hospital-based to community-based models. Frailty was formally identified as a commissioning priority by the ICB in January 2025, and this strategy provides a framework for achieving the associated success criteria and outcomes. At a national level, frailty has been recognised as a key priority due to its significant impact on urgent and emergency care services, contributing to increased demand and system pressures.

The strategy directly supports several national priorities, including:

- Hospital to Community: Promoting care closer to home and reducing reliance on acute services.

- Analogue to Digital: Enabling digital transformation in care planning, assessment, and service delivery, while ensuring inclusivity for those less confident with digital tools.

1.7. Key Considerations

1.7.1. **Quality and Safety:** 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 resulting oin poor health outcomes and reliance on emergency services if proactive services are not in place.

1.7.2. **Financial Implications:** The trajectory of frailty accelerates and increasing frailty means increased care costs. After adjusting for sociodemographic factors, annual healthcare costs double for people with mild frailty compared to 'fit' older adults, tripled for the moderately frail and quadrupled for the severely frail. Preventing, slowing or proactively addressing frailty reduce these costs.

1.7.3. **Workforce Implications:** Includes training and education programmes for staff, promotes co-production and quality improvement.

1.7.4. **Risks and Mitigations:** Risks include inconsistent implementation and digital exclusion; mitigated through inclusive design and evaluation. The risk of not having a strategy to address frailty is likely to result in increased unplanned demand and lack of predication of health and care services required.

1.7.5. **Engagement:** Strategy shaped by extensive engagement with residents, VCSE Partners and professionals.

1.7.6. **Supporting Data and Analysis:** Based on public health data and local population projections; includes estimates of frailty prevalence. A public health approach has been taken using risk stratification to identify the impact of frailty on the population in both places. 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 due to the lack of active use of the data sources and clinical verification this is expected to have underestimated the numbers of those who mildly or moderately frail compared to national benchmarks.

1.7.7. **Legal, Regulatory, and Equality:** Integrated Impact Assessment has been completed; strategy addresses disparities by deprivation and ethnicity. This strategy will positively impact on the protected characteristic of age. It has a targeted neighbourhood approach to ensure inclusivity and appropriate organisation of services to support diverse communities in the STW system in order to reduce health inequalities.

1.8. Impact Assessments

1.8.1. **Has a Data Protection Impact Assessment been undertaken?** No

1.8.2. **Has an Integrated Impact Assessment been undertaken?** Yes

1.9. Attachments

1.9.1. Appendix A: Healthy Ageing Strategy 2025-2028
Appendix B: Integrated Impact Assessment
Appendix C: Public and Professional consultation summary
Appendix D: Supporting Information

2. Main Report

2.1. Introduction

The report seeks approval for a three-year strategy focused on the care and support of individuals who are living with, or at risk of developing, frailty as they age. The strategy sets out a vision for enabling people in Shropshire, Telford and Wrekin to age well—living longer, healthier, and more independent lives. This will be achieved by extending healthy life expectancy, reducing health inequalities, and enhancing quality of life through proactive, personalised, and compassionate care. The approach is rooted in a Place-based, neighbourhood model that empowers communities to thrive at every stage of later life.

The strategy aims to prevent frailty improve outcomes for people living with frailty by:

- Increasing healthy life expectancy
- Reducing health inequalities
- Enhancing the experience of patients and carers
- Slowing the growth in demand for health and care services

To achieve these aims, the strategy sets out the following objectives:

- Improve public and workforce understanding of frailty and awareness of available support services
- Delay the onset of frailty and reduce disparities in its development
- Slow the progression of frailty and address inequities in outcomes
- Enhance the quality of life for individuals with moderate to severe frailty
- Strengthen care coordination and planning for those with severe frailty through better use of digital tools
- Deliver services closer to home through a neighbourhood-based model
- Reduce unplanned care and emergency attendances related to frailty, thereby decreasing avoidable hospital admissions

2.2. Background

Shropshire, Telford and Wrekin has a growing population of older people, with significant numbers at risk of frailty. The strategy responds to this challenge with a public health approach and alignment to national and local strategies and priorities.

Frailty is a medical clinical term that refers to a reduction in physical and mental resilience, which increases an individual's vulnerability to adverse health outcomes such as illness, injury, or bereavement. This condition significantly impacts quality of life and is associated with a heightened risk of mortality, disability, dementia, hospitalisation, falls, and the need for long-term care.

It is important to recognise that frailty exists on a spectrum ranging from mild to severe. Many individuals living with frailty continue to lead independent and fulfilling lives, often with varying levels of support. While the likelihood of developing frailty increases with age, it is not an inevitable consequence of ageing. At different points along the spectrum, frailty can be prevented, delayed, reversed, or effectively managed.

Although commonly associated with older age, frailty can also develop earlier in life, particularly among individuals who experience an accumulation of health risks. This strategy primarily addresses age-related frailty, but it also incorporates a preventative focus aimed at younger populations. As the approach evolves, it will retain the flexibility to adapt to a broader range of needs.

Certain groups face a higher risk of early-onset frailty, including those living in socioeconomically deprived areas, some ethnic minority communities, and individuals with chronic health conditions. Given the growing number of people affected by frailty, it has become a national priority. Without a personalised and proactive approach, the increasing prevalence of frailty poses a significant risk of placing additional strain on urgent and emergency services, as well as on primary care.

2.3. Main Body of report

The Healthy Ageing Strategy is structured around five interdependent pillars—**Educate, Prevent, Identify, Manage, and Care**—which together form a

comprehensive framework for improving outcomes for people at risk of or living with frailty.

- **Educate:** Focuses on increasing awareness and understanding of frailty among the public, carers, and the health and care workforce. This includes promoting knowledge about prevention, early signs, and available support services, as well as embedding frailty education into professional development programmes.
- **Prevent:** Aims to delay the onset of frailty through targeted interventions, lifestyle support, and proactive outreach. This includes universal prevention offers, such as health education resources and signposting to community-based services, particularly for those aged 50+ who are at increased risk.
- **Identify:** Establishes consistent and reliable methods for identifying individuals at risk of frailty or those already experiencing it. This includes the use of validated assessment tools, shared care records, and population health data to support early detection and personalised care planning.
- **Manage:** Supports individuals with mild to moderate frailty through coordinated care pathways, digital tools, and proactive case management. It also focuses on reducing progression to severe frailty by ensuring timely interventions and equitable access to services.
- **Care:** Enhances support for people with severe frailty and their carers through comprehensive geriatric assessments, advance care planning, and improved end-of-life care. It prioritises dignity, choice, and continuity of care, with a strong emphasis on reducing unplanned hospital admissions and supporting care in preferred settings.

The strategy sets out clear objectives aligned to these pillars, including:

- Reducing the onset and progression of frailty
- Improving quality of life for individuals with frailty
- Reducing reliance on unplanned and acute care services
- Addressing inequalities in frailty outcomes across different communities

To support delivery, the strategy includes a three-year implementation plan with defined milestones for each year. These milestones cover workforce training, digital enablement, service redesign, and community engagement. Progress will be monitored through a robust evaluation framework, which includes both process and outcome measures, such as:

- Uptake of frailty assessments and care plans
- Reduction in emergency admissions related to frailty
- Improvements in patient-reported outcomes and experience
- Reduction in disparities by deprivation and ethnicity

Oversight will be provided by the Healthy Ageing Strategy Steering Group, which will ensure alignment with national guidance, local priorities, and system-wide transformation programmes.

2.4. Conclusion

The strategy provides a clear, evidence-based roadmap for improving outcomes for older residents and ensuring the sustainability of health and care services. It reflects the voices of our communities and the commitment of our system partners.

2.5. Recommendations

2.5.1 Note the Healthy Ageing Strategy 2025-2028 fully aligns with both Health and Wellbeing Strategies and SHIPP and TWIPP priorities.

2.5.2 The Health and Wellbeing Board supports the Healthy Ageing Strategy Implementation.

Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Healthy Ageing Strategy

2025-2028

DRAFT v4.0

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

British Geriatric Society

Contents

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.

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	• 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

• 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	

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.

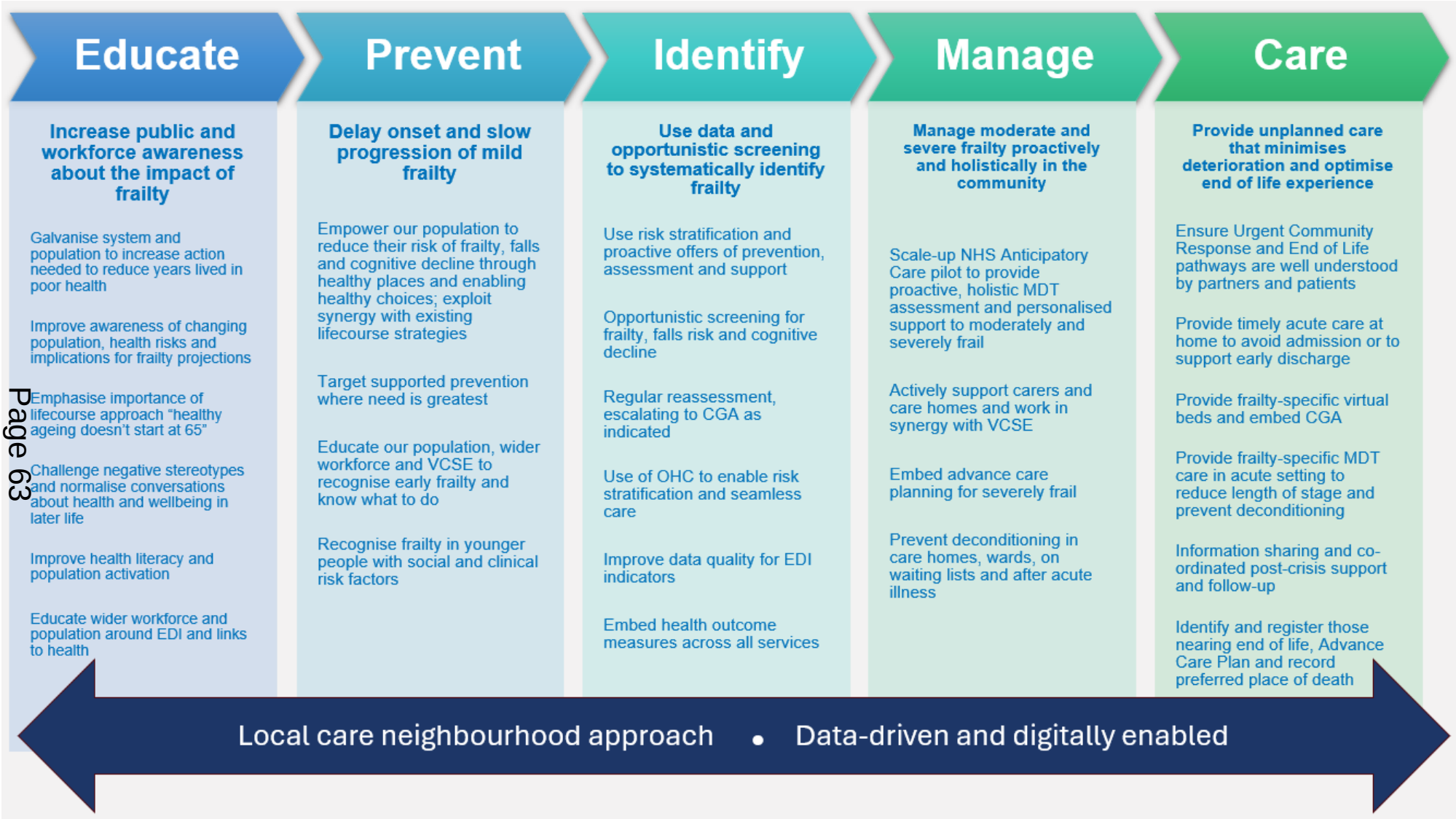
We recognise that healthy ageing must be inclusive of all communities, including neurodiverse residents and those from the LGBTQ+ community. Residents with learning disability and autism may experience barriers to accessing health and care services and may be at increased risk of early frailty due to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

References

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NICE; 2015: Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset: NICE guideline Reference number:NG16; Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset accessed 21st August 2015

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NHS
Shropshire, Telford and Wrekin

Integrated Impact Assessment

Description and purpose of an IIA

An Integrated Impact Assessment (IIA) is a mechanism which enables public sector organisations to consider the needs of different groups. An IIA helps to identify the potential positive and negative impacts of proposed changes to services on people who live in the area. It also lists a set of potential solutions that may help to address some of the areas identified as having a negative impact on a particular group or community

If it is identified that a programme or project may have an impact on a particular group or community, the legal duty to involve individuals, their carers, and representatives, will apply.

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Version history:			
Date	**Version**	**Author**	**Summary of changes / notes**
02/05/2025	1	Lorna Watkins	Draft
26/06/2025	1.2	Lorna Watkins	Revision and amendments from comments/feedback
12/08/2025	1.3	Lorna Watkins	Additional comments added from the feedback from Quality team.
15/08/2025	1.4	Lorna Watkins	Amendment to post engagement, disability under protected characteristics and adjustment to sexual orientation

Approval Log:		
Stakeholder	**Approved?**	**Date Approved**
ICB Quality Team	Yes	12/08/2025
ICB Health Inequalities	Yes	26/06/225
Equality and Involvement Committee	Yes	06/08/2025

Programme/Project Overview

Name of the policy/project / service development being reviewed	**Healthy Ageing Strategy**
Description of project, service, policy being reviewed	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.
Description of the proposed change	Improve understanding about healthy ageing and frailty. **Delay and level-up the onset of frailty.** Frailty is not inevitable: It can be delayed or prevented through modifiable factors like activity, nutrition, and social connection. Early onset risk factors: Frailty can appear before age 65, especially in deprived and minoritised populations. In STW, 22% of the population is over 65 (vs 18% nationally), indicating a higher baseline risk of frailty. **Slow down and level-up the progression of frailty.** National evidence shows that frailty progresses faster without intervention. Annual healthcare costs are twice as high for people with mild frailty compared to 'fit' older adults. it is suggested three times higher for those with moderate frailty, four times higher for those with severe frailty. This provides a strong economic rationale for early intervention to prevent progression along the frailty spectrum. (Clegg *et al.*, 2016) (*Fit for frailty*, no date) **Improve and level-up quality of life for people with moderate & severe frailty.** People with moderate/severe frailty often live with multiple long-term conditions and poor functional status. In STW, on average, people live 17–22 years of their life in poor health, with a 12-year gap in healthy life expectancy between most and least deprived. The goal is to narrow this gap by offering early identification and supportive care across all demographics. **Improve and level-up care for people with severe frailty and their carers**. Local data suggests: 6,000 people aged 65+ live with severe frailty. A smaller proportion receive a CGA (Comprehensive Geriatric Assessment), or have a documented ReSPECT plan, care coordinator, or preferred place of death. The strategy aims to standardise and scale up access to these high-quality interventions. **Reduce and level up need for unplanned care among those with frailty** Frailty increases hospital admissions, Falls, A&E attendances and emergency bed days.

	In STW it is estimated 19,000 older adults have moderate frailty, a group highly likely to drive avoidable unplanned care buy introducing early interventions we could reduce this pressure.
Who is this project, service, policy likely to have an impact on? Consider patients/service users, carers, staff, partner organisations, or the whole population	The strategy encompasses our population aged over 65, and those over 50 who are at higher risk of early frailty. 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. (*Population projections - Office for National Statistics*, no date)
Will the proposed change result in a change in demand for health and / or social care services? If yes, please provide details	Yes, the strategy will result in a change in demand for health and social care services. In the short term, demand may rise due to proactive outreach and assessments. Over time, if successful, the strategy aims to reduce the growth of demand, especially for unplanned and institutional care, by improving healthy ageing, delaying frailty, and managing it more effectively in the community.

Engagement and Involvement

The NHS and Local Authorities are required by law to make arrangements to involve individuals, their carers, and representatives, as set out in the Health and Care Act 2022. This includes the planning of the commissioning arrangements, in the development and consideration of proposals for changes that would have an impact on services and in decisions affecting the operation of services.

Involving people and communities in a meaningful way brings many benefits. It increases the legitimacy of decision making, builds the reputation of public bodies, and makes them more accountable and transparent. It is the right thing to do.

Has any engagement and involvement been undertaken in gathering evidence to develop your proposals?	Yes
If yes	
Describe what activity has been undertaken to involve patients the public and wider stakeholders?	Between May and June 2025, NHS Shropshire, Telford and Wrekin undertook a comprehensive and inclusive engagement programme to inform the development of its Healthy Ageing Strategy 2025–2028. This engagement was designed to ensure that the strategy reflects the lived experiences, needs, and aspirations of older adults, carers, professionals, volunteers, and community stakeholders across the region. **Purpose and Scope of Engagement** The engagement aimed to: • Raise awareness of frailty as a long-term condition that can be prevented, delayed, or better managed. • Understand the experiences of those living with or supporting someone with frailty. • Gather views on how care and support could be improved. • Inform the development of a proactive, person-centred strategy for healthy ageing. The strategy itself targets adults aged 65+, and those over 50 at increased risk of frailty, addressing the full spectrum from prevention to care. **Engagement Activities** A multi-method approach was adopted to ensure broad and representative participation: **Online Surveys**: - A public survey (526 responses) and a professional survey (79 responses) captured both quantitative and qualitative insights. - Questions explored understanding of frailty, experiences with services, barriers to access, and preferences for communication and support. **Targeted Face-to-Face Engagement**: - Conducted with 305 individuals across 33 community groups in Shropshire and Telford & Wrekin.

	- Included older adults, carers, people with long-term conditions, and those from digitally excluded, rural, and ethnically diverse communities. **Stakeholder Listening Event**: - Attended by 42 professionals from health, social care, and VCSE sectors. - Provided feedback on the strategy's vision, priorities, and areas for improvement. **Community Outreach**: - Engagement at local events such as the 'See Hear' event in Shrewsbury, Lawley coffee mornings, and Bridgnorth Community Hospital open day. - Distribution of leaflets, posters, and comms toolkits to VCSE partners and Patient Participation Groups. **Midpoint Review**: - Conducted to identify gaps in engagement and adjust outreach strategies. - Led to increased engagement with underrepresented groups, including Muslim, Hindu, and Sikh communities, and those who had received formal frailty assessments.
How will you/have you used the insight that you have gathered to inform your proposals?	The feedback from over 950 participants, including older adults, carers, professionals, and community stakeholders, directly influenced the structure and content of the strategy. The five strategic pillars—Educate, Prevent, Identify, Manage, and Care—were refined to reflect the themes and priorities raised during engagement. Key examples of how insight has shaped proposals include: **Person-Centred Care and Involvement**: - With 99.5% of respondents emphasising the importance of being involved in care decisions, the strategy commits to co-production and shared decision-making as core principles. - Proposals include the development of care coordination roles and a single point of contact to support continuity and personalised care. **Equity of Access**: - Feedback highlighted significant disparities in service access due to geography, digital exclusion, and transport barriers. - As a result, the strategy includes targeted interventions for rural and deprived communities, and a commitment to equity—not just equality—in service provision. **Digital Inclusion and Communication**: - Insight revealed that digital confidence declines with age, and many prefer printed materials and trusted community sources.

	- The strategy proposes a dual approach to communication—digital and non-digital—and investment in digital literacy support for older adults. **Early Identification and Prevention**: - Professionals and the public identified gaps in early identification and preventative services. - The strategy includes the rollout of consistent frailty assessment tools, proactive care pathways, and universal prevention offers for adults aged 50+. **Support for Carers and Social Connection**: - Carers expressed a need for greater support, and many respondents highlighted the role of social groups in maintaining wellbeing. - Proposals include enhanced support for unpaid carers, expansion of community-based services, and investment in peer-led initiatives. **Cultural Sensitivity and Diverse Needs**: - Targeted outreach to underrepresented groups informed proposals for culturally appropriate services and communication. - The strategy includes actions to build trust with diverse communities and ensure services are inclusive and responsive.
How will the outcomes (i.e. how the information collected has influenced decisions) be reported back to those that have been involved?	The findings from the public and professional engagement have been compiled into a comprehensive report, which will be used to inform the final Healthy Ageing and Frailty Strategy. This report will be made available through the NHS STW website and shared directly with stakeholders, including voluntary and community sector organisations, Patient Participation Groups, and professional networks. In addition to formal publication, tailored communications will be developed to ensure accessibility for different audiences. This includes summaries in plain English, printed materials for digitally excluded groups, and updates via community groups and local events. The communications and engagement team will also work with trusted community leaders to cascade key messages and ensure feedback reaches those who may not access digital platforms. By closing the feedback loop, NHS STW aims to demonstrate how public and stakeholder insight has shaped decisions, build trust in the strategy's implementation, and lay the groundwork for continued collaboration and co-production.
How has/will the proposals for this programme or project be shaped by co-production activity?	Co-production has been a central principle in the development of the Healthy Ageing and Frailty Strategy 2025–2028. From the outset, NHS Shropshire, Telford and

	Wrekin committed to designing the strategy in partnership with those who have lived experience of frailty, their careers, and the professionals and volunteers who support them. The engagement programme was designed not simply to consult, but to co-produce. This was achieved through a multi-layered approach that actively involved stakeholders in shaping the strategy's direction, priorities, and delivery model. Public and professional surveys, targeted face-to-face engagement, and a stakeholder listening event provided rich qualitative and quantitative insight. These activities were structured to allow participants to reflect on their experiences, identify gaps in current provision, and propose solutions. The feedback was not only collected—it was analysed, interpreted, and directly embedded into the strategy's design. For example, the strategy's emphasis on person-centred care, equity of access, and proactive prevention reflects the priorities voiced by participants. The inclusion of culturally sensitive outreach, support for unpaid carers, and non-digital communication options are direct responses to community feedback. Professionals also shaped proposals around care coordination, digital tools, and workforce development. The co-production approach was iterative. A midpoint review allowed the team to identify underrepresented voices and adjust outreach, accordingly, ensuring that the final strategy is inclusive and representative of the diverse communities across Shropshire, Telford and Wrekin.
Please provide a brief outline of your approach and objectives for any additional patient and public involvement	The approach to additional patient and public involvement will be rooted in the principles of co-production, inclusivity, and transparency. It will focus on ensuring that the strategy remains responsive to evolving needs and continues to reflect the lived experiences of those it serves. Key objectives include: **Sustained Engagement**: Establishing regular opportunities for feedback through community forums, patient panels, and targeted outreach, particularly with groups identified as underrepresented in the initial engagement (e.g. ethnic minority communities, digitally excluded individuals, and unpaid carers). **Collaborative Evaluation**: Involving patients and the public in evaluating the impact of new services and interventions,

	including participation in pilot reviews, service redesign workshops, and outcome assessments. **Accessible Communication**: Ensuring that updates, progress reports, and opportunities for involvement are communicated in formats that are accessible and culturally appropriate, using both digital and non-digital channels. **Localised Co-Design**: Working with neighbourhoods and Primary Care Networks to co-design place-based solutions that reflect local priorities, particularly in rural and deprived areas. This ongoing involvement will be coordinated by the Communications and Engagement Team, in partnership with VCSE organisations, community leaders, and health and care professionals. It will ensure that the strategy remains dynamic, inclusive, and shaped by those with the greatest insight into what ageing well truly means.
If no	
How will you involve stakeholders/citizens in gathering evidence and developing your plans?	
How has/will the proposals for this programme or project be shaped by co-production activity?	

Evidence: What evidence/ information are you using to inform this assessment

What are the key sources of data, indicators, research and other sources of evidence you are using to inform the assessment and determine impact?

• Consider nationally available data such as health profiles, RightCare data, Hospital Episode Statistics (HES) data, national / international research

• Consider local data such as JSNA data, contract performance data, pilot activity evaluations, qualitative data from local research / focus groups, or other robust sources of evidence

Protected Characteristic Groups	The Healthy Ageing and Frailty Strategy aims to ensure equitable access and positive impacts across various protected characteristic groups, in line with the Equality Act 2010. The Healthy Ageing and Frailty Strategy aims to ensure equitable access and positive impacts across various protected characteristic groups, in line with the Equality Act 2010. The strategy specifically addresses the following characteristics: **Age:** The strategy is designed for people aged 65+ and those over 50 at risk of early frailty. It recognises that frailty is more common with age but not inevitable and aims to delay onset and improve quality of life through proactive care and support. **Race/Ethnicity:** The strategy identifies higher risk of early frailty among some ethnic minority groups, particularly Black, Pakistani and Bangladeshi communities in Shropshire, Telford and Wrekin. It includes targeted outreach, culturally appropriate interventions, and aims to reduce disparities in frailty onset and care outcomes. **Disability:** Frailty often overlaps with physical and cognitive impairments. Including learning disabilities and autism. The strategy promotes personalised care planning, holistic assessments, and community-based support to improve independence and reduce unplanned care for people with disabilities. **Gender:** While not explicitly differentiated in the strategy, gender differences in frailty prevalence and care needs are acknowledged in national evidence. The strategy's commitment to personalised care ensures gender-sensitive approaches are embedded in assessments and planning. **Carers**: Carers are explicitly included in the strategy's objectives, particularly in the pillar focused on improving care for people with severe frailty. It promotes support for carers through care coordination, advance care planning, and involvement in decision-making. **Deprivation:** The strategy highlights that people living in deprivation are at higher risk of early frailty and poorer outcomes. It uses population health data to target interventions in deprived areas and reduce the 12-year gap

	in healthy life expectancy. **Digital Exclusion and Literacy:** The strategy acknowledges barriers to digital access and health literacy. It includes both digital and face-to-face engagement options, and works with VCSE partners to reach excluded groups and ensure equitable access to information and services.
Economically deprived/socially excluded groups and communities and carers	Efforts will be made to ensure equitable access to services, particularly for socially excluded groups and those in economically deprived areas. The strategy targets areas of high deprivation, using eligibility edibility data from CSU per GP and then targeting the GPS in core 20 areas via Shape.
Welsh Residents / Welsh Language Speakers	This Strategy is primarily focused on the Shropshire, Telford, and Wrekin area, and does not specifically target Welsh-speaking populations. However, bilingual or translation services will be made available if required to support any Welsh- speaking patients.
Staff	Data collected from staff surveys, feedback mechanisms, and performance evaluations. Information will be used to monitor staffing capacity.
Quality of care/treatment (Patient / Staff experience)	Data will be collected through patient satisfaction surveys and staff feedback. Quality of care will be measured using clinical outcomes (e.g., Clinical frailty assessment scores, co-produced holistic care plans in shared-care records, qualitative assessments of experience, hospital admissions) Regular audits and feedback loops will be implemented to ensure continuous improvement. The strategy aims to enhance healthy ageing and support those with a frailty diagnosis to aid an improved quality of life and staff experience.
Climate change	Although the Healthy ageing and frailty strategy does not directly address climate change, it is committed to adopting sustainable practices, such as reducing unnecessary hospital admissions and promoting local community-based care to minimise patient travel. Integration of digital tools will also reduce the carbon footprint associated with in-person consultations. Digital tools for self-- management will also help reduce the need for travel, contributing to lower carbon emissions. Digital access is a key enabler but also a potential barrier. The strategy mitigates this by offering both digital and face-to-face engagement, Partnering with VCSEs to reach digitally excluded groups, Providing translated and accessible materials, monitoring uptake by demographic to ensure equity.

Assessment of the impact of the service change / project / policy

Taking into account the evidence gathered assess whether the service/project / policy has a positive, negative or no impact on people who live or work in the area.

- Positive impact means promoting equal opportunities, reducing inequalities, improving access, improving health and wellbeing or improving relations between equality groups

- Negative impact means that people living or working in the area or a group(s) could be disproportionately disadvantaged, discriminated against indirectly or directly, reduce access, increase inequality or there may be a negative effect on relations between equality groups

- No impact means that no effect is expected on people living or working in the area or equality groups

	Please indicate "Positive Impact, Negative Impact, No Impact or Don't know"
Will the proposal have a direct impact on health, mental health and wellbeing?	Positive Impact
Will the proposal affect an individual's ability to improve their own health and wellbeing?	Positive Impact
Will your work affect Health Inequalities?	Positive Impact The Healthy Ageing and Frailty Strategy is designed to reduce health inequalities by targeting groups at higher risk of early frailty and poorer outcomes. These include individuals living in areas of high deprivation, ethnic minority communities (particularly Pakistani and Bangladeshi populations), and those with limited access to healthcare or digital services. The strategy uses population health data to identify and proactively support these groups through tailored interventions, including health coaching, culturally appropriate communication, and community outreach. It also addresses barriers such as digital exclusion and low health literacy by offering both online and face-to-face engagement options. By focusing resources where they are needed most and embedding equity into every stage of the care pathway, the strategy aims to narrow the gap in healthy life expectancy and improve outcomes for underserved populations.
Will the proposal affect an individuals ability to travel and/or access services?	Positive Impact
Will your proposal have an impact on Climate change?	Positive Impact The Healthy Ageing and Frailty Strategy is expected to have a positive impact on climate change, and this impact can be measured and

	aligned with the ICS Green Plan. By shifting care from hospital to community and home-based settings, the strategy reduces the need for patient and staff travel, thereby lowering associated carbon emissions. The increased use of digital tools for self-management and virtual consultations further supports a low-carbon care model. These changes can be quantified through metrics such as reductions in unplanned hospital admissions, uptake of digital consultations, and estimated CO_2e savings from avoided travel and hospital stays. These indicators will be monitored and reported annually, enabling a clear read-across into the system's sustainability goals and supporting the delivery of a greener, more efficient health and care system

Please use the box below to provide reasons for any answers above where you have answered 'Negative Impact', 'No Impact' or 'Don't know'.

Consider:

What are the causes of these impacts?

Will the impacts be difficult to remedy or have an irreversible impact?

Will the impacts be short, medium or long term?

Are the impacts likely to generate public concern?

What are the unintended consequences of your work?

Do outcomes vary across groups and who might benefit most and least?

Will the proposal have any impact on people (or groups of people) with protected characteristics / vulnerable groups or staff?

Age	Positive Impact	The strategy targets people aged 65+ and those over 50 at risk of early frailty. In STW, 22% of the population is aged 65+, compared to 18% nationally. Frailty

		increases with age but is not inevitable and can be delayed or reversed.
Disability	Positive Impact	Frailty often coexists with physical and cognitive impairments. The strategy promotes holistic assessments and personalised care to support independence and reduce hospitalisation. Around 6,000 people in STW are estimated to have severe frailty.
Gender Reassignment	No Impact	The strategy does not include specific actions related to gender reassignment. No differential impact is anticipated.
Marriage and civil partnership	No Impact	The strategy does not address marital or partnership status. No differential impact is expected.
Pregnancy and maternity	No Impact	The strategy focuses on older adults and does not directly affect pregnancy or maternity.
Race	Positive Impact	The strategy identifies higher frailty risk among Pakistani and Bangladeshi communities in STW. These groups are targeted for proactive care offers and culturally appropriate outreach to reduce disparities in frailty onset and outcomes.
Religion or belief	No Impact	The strategy does not address religion or belief directly. However, culturally sensitive care may indirectly support religious needs.
Gender	Positive Impact	While not explicitly differentiated, the strategy's personalised care approach ensures gender-sensitive planning and

		delivery. National data shows gender differences in frailty prevalence, which the strategy accommodates through tailored care.
Sexual Orientation	Positive Impact	The Ageing Well and Frailty Strategy is committed to promoting inclusive, person-centred care that recognises and respects the diverse identities of older people, including those within the LGBTQ+ community. By addressing the unique health and social care needs of older LGBTQ+ individuals—particularly those living in rural areas or in same-sex relationships—the strategy aims to reduce inequalities, improve access to culturally competent services, and foster environments where everyone feels safe, valued, and supported as they age.
Carers	Positive Impact	Carers are supported through coordinated care planning, involvement in decision-making, and recognition of their role in managing severe frailty. The strategy includes case coordination and advance care planning for those with severe frailty.
Economically deprived communities	Positive Impact	The strategy targets areas of high deprivation. In STW, there is a gap of up to 12 years in healthy life expectancy between the most and least deprived. Proactive care offers are tailored to reduce this disparity.
Socially Excluded Groups	Positive Impact	The strategy includes outreach via VCSE partners, addresses digital exclusion, and offers flexible access options. It also includes

		health coaching and repeat offers for those at risk of health inequality.
Welsh Residents / Welsh Language Speakers	Positive Impact	While focused on STW, translation and bilingual support will be provided where needed to ensure equitable access for Welsh-speaking residents.
Staff	Positive Impact	The strategy includes workforce development, training in frailty care, and support for staff wellbeing. It aims to build capacity and improve job satisfaction through education and role clarity across the system.

Please use the box below to provide reasons for any answers above where you have answered 'Negative Impact', 'No Impact' or 'Don't know'.

Consider:

What are the causes of these impacts?

Will the impacts be difficult to remedy or have an irreversible impact?

Will the impacts be short, medium or long term?

Are the impacts likely to generate public concern?

What are the unintended consequences of your work?

Do outcomes vary across groups and who might benefit most and least?

The Healthy Ageing and Frailty Strategy primarily focuses on improving the quality of life and care for older adults and individuals experiencing frailty. As such, it does not directly address issues related to gender reassignment, marriage and civil partnership, religion, sexual orientation, or pregnancy and maternity. These aspects are not expected to be impacted by the strategy because the interventions and objectives are centred around age-related health concerns and frailty management. Therefore, there are no anticipated changes or effects on these protected characteristic groups.

Quality Impact Assessment

Complete this section (indicated with blue shading) if this programme or project is required to complete a Quality Impact Assessment for NHS Shropshire, Telford and Wrekin?

Duty of Quality	
To what extent would successful implementation of this programme impact positively or negatively on any of the following: **compliance with the NHS Constitutional access targets** **partnerships with other services** **safeguarding children or adults** **the duty to promote equality**	Positive Impact
Comments/Risks	**Compliance with the NHS Constitutional access targets:** Potential to indirectly reduce pressure on urgent and emergency services by preventing complications and admissions. **Partnerships with other services:** Enhances coordination across primary care, community services. Aligns with ICB priorities for integrated care. **Safeguarding children or adults:** While not a primary safeguarding service, the structured review process introduces more regular contact with patients, increasing the opportunity to spot red flags. **The duty to promote equality:** The Healthy Ageing and Frailty strategy aims to reduce local variation and ensuring consistent care for patients regardless of where they live. It also creates opportunities to identify and respond to the needs of patients with complex or additional needs.
Mitigations/Actions	**Partnerships with other services:** Clear mobilisation and communication plan to define provider vs. existing service roles. Involve community nursing leads during mobilisation phase. Shared vision and alignment with other strategies and engagement with services revising pathways.

Patient Experience	
To what extent would successful implementation of this programme impact positively or negatively on any of the following: **patient choice** **personalised & compassionate care** **waiting times for appointments** **patient outcomes** **number of complaints**	Positive Impact

Comments/Risks	**Patient Choice:** The strategy promotes co-produced holistic care plans, giving patients more involvement in decisions about their care. Patients will have greater say in where, how, and by whom they are cared for—especially those with moderate or severe frailty. Risk that proactive offers may feel standardised or "paternalistic" rather than empowering **Personalised & Compassionate Care:** Care will be more person-centred, with increased empathy and responsiveness to individual needs and contexts. It prioritises case coordination, recognising the complexity of living with frailty. It also targets health inequalities, which supports equity and dignity in care delivery. Risk that Inconsistent delivery across providers; risk of "tick-box" care planning. **Waiting Times for appointments:** Over time, as the population health improves and unplanned care use drops, the pressure on reactive services may ease, potentially reducing demand for urgent appointments and improving access. Initial pressures could strain appointment systems, but strategic success may rebalance demand toward prevention, improving access long term. Risk that Short-term increase in assessment and planning workload may create bottlenecks **Patient Outcomes :** There will likely be measurable improvements in physical, mental, and emotional health outcomes among older adults. Interventions will focus on earlier identification and prevention, which are known to yield better long-term outcomes. Good frailty management reduces hospitalisation, death, and disability. Outcomes depend on follow-through; risk of assessments without timely interventions **Number of complaints:** By increasing patient satisfaction and perceived quality of care, it is likely to reduce the number of complaints, especially those related to fragmented or insensitive care. The strategy directly addresses these areas with better communication through care planning, dedicated care co-ordinators along with public and workforce education. However if expectations rise but service gaps remain, complaints may initially increase
Mitigations/Actions	**Patient Choice:** Train staff in shared decision-making and communication. Ensure care plans are co-produced with patients and carers. Use culturally appropriate materials for diverse communities

	Personalised and Compassionate Care: Provide standardised training in holistic assessments and compassionate care. Implement peer reviews and quality audits of care plans. Involve patients and carers in feedback loops. **Waiting times for appointments:** Phase rollout geographically or by risk tier. Introduce additional staff capacity (frailty nurse practitioners, coordinators). Use digital assessments where appropriate to triage. Secure ring-fenced time for frailty assessments in primary care. **Patient Outcomes:** Ensure clear referral pathways from assessment to intervention. Build feedback loops into care plans for monitoring progress. Invest in community services that support nutrition, mobility, mental health. **Number of complaints**: Communicate the strategy transparently to the public with realistic timelines. Use complaints data as learning tools and build in rapid response systems. Promote a culture of continuous improvement and feedback collection.

Patient Safety	
To what extent would successful implementation of this programme impact positively or negatively on any of the following: **systems to safeguard patients to prevent harm** **systems for ensuring that the risk of healthcare acquired infections is reduced** **workforce capability, skills and capacity** **number of incidents reported**	Positive Impact
Comments/Risks	**Systems to safeguard patients to prevent harm:** The strategy emphasises early identification of frailty, case coordination, and proactive care planning, which reduces the risk of neglect, missed deterioration, and inappropriate interventions. **Systems for ensuring that the risk of healthcare acquired:** Community-based care and reduced hospital admissions will likely reduce risk of HCAIs. However, expansion of frailty services at acute sites could introduce new exposure risks if infection prevention controls are not aligned. **Workforce capability, skills and capacity:** Significant upskilling of staff and additional capacity for assessments,

	planning and coordination. There is a risk of overburdening existing teams if resources are not expanded. Patient skills and ability also risk from digital, understanding and even will to support and engage. **Number of incidents reported:** Early stages may see increased incident reporting as new care pathways are embedded, and staff learn to flag risks. Over time, better care coordination and proactive management should reduce actual incidents.
Mitigations/Actions	**Systems to safeguard patients to prevent harm:** Embed safeguarding checks into CGA and frailty assessments. Train staff on recognising safeguarding risks in older adults. Ensure case coordinators are equipped to act as safeguarding advocates. Integrate with existing safeguarding referral pathways. **Systems for ensuring the risk of healthcare-acquired infections (HCAIs) is reduced:** Ensure frailty units at acute sites follow strict IPC protocols. Incorporate infection prevention training in all frailty staff training. Prioritise virtual and home-based assessments where appropriate. Monitor infection rates specifically for patients in frailty pathways. **Workforce capability, skills and capacity:** Develop and deliver a targeted frailty education and training programme (as already proposed). Recruit dedicated frailty practitioners and coordinators. Use phased roll-out to balance workload. Enable task sharing across multidisciplinary teams including VCSE partners and building to support patient access and support for digital competence and availability or funding. **Number of incidents reported:** Encourage a learning culture where reporting is seen as positive. Include incident reporting themes in frailty working group reviews. Use data to identify patterns and refine care pathways. Reinforce use of datix/reporting systems in community and primary care settings.

Clinical Effectiveness	
To what extent would successful implementation of this programme impact positively or negatively on any of the following: **clinical leadership** **delivery of evidence based practice** **clinical engagement of staff and patients**	Positive Impact

consistent delivery of high quality standards **improved patient outcomes**	
Comments/Risks	**Clinical leadership:** The strategy depends on system-wide implementation and multidisciplinary collaboration, which encourages strong clinical leadership across care settings. It provides an opportunity to empower clinicians as strategy champions and leads of workstreams. A clear vision and achievable goals will enable a shared purpose. **Delivery of evidence-based practice:** The strategy is built around national guidelines and evidence (e.g. CGA, ReSPECT, frailty scores), supporting standardised and evidence-led care pathways. **Clinical engagement of staff and patients:** Shared decision-making, holistic care plans and patient/carer involvement—all of which improve engagement. Staff engagement is likely to rise if they see a clearer framework for proactive, meaningful care. **Consistent delivery of high-quality standards:** The strategy aims to standardise care but success depends on workforce capacity, digital systems, and equitable delivery across sites. Variability in implementation could undermine consistency. **Improved patient outcomes:** Central goal of the strategy is to delay, reduce and manage frailty to improve quality of life, reduce admissions, and increase independence—key patient outcome metrics.
Mitigations/Actions	**Clinical leadership:** Appoint frailty clinical leads in each organisation and service area. Create a clinical leadership forum under the Steering Group. Offer leadership development and protected time for clinical leads. Involve clinicians in co-designing care models and evaluation metrics. Review and redesign of pathways, commissioning services for prevention. **Delivery of evidence-based practice:** Embed NICE-aligned tools (e.g. frailty assessment instruments) in care pathways. Train staff in evidence-based frailty management and preventative approaches. Use audits and quality improvement to check adherence to best practice. Review and update interventions based on latest research and local data. **Clinical engagement of staff and patients:** Involve staff and patients in design and testing of care pathways. Recognise and reward staff who contribute to improvement efforts.

	Develop clear communication and engagement plans for public and workforce. Provide feedback to staff on impact of their work on patient outcomes. **Consistent delivery of high-quality standards:** Develop and roll out standard operating procedures (SOPs) and shared documentation templates. Use digital shared care records to support continuity. Establish quality assurance mechanisms, including peer reviews and benchmarking. Provide training and support to ensure consistent interpretation of frailty assessments. **Improved patient outcomes:** Monitor outcome indicators such as unplanned admissions, frailty progression, QoL. Ensure care plans include personalised goals and follow-up. Address inequality by targeting at-risk groups with enhanced offers. Build an evaluation framework into every pillar to track outcome impact. A clear vision and buy in across the system and pathway re-design to reduce risk.

Health Inequalities	
To what extent would successful implementation of this programme impact positively or negatively on any of the following: **prevention of ill health** **promotion of self-care** **equality of access to services for vulnerable groups** **ability to engage/ inform vulnerable groups** **impact on/support partners to reduce inequalities**	Positive Impact
Comments/Risks	**Prevention of ill health:** The strategy places significant emphasis on prevention by offering a universal and proactive approach to identifying early frailty, particularly in underserved populations. It recognises that the causes of ill health and frailty are often rooted in structural inequalities, including, deprivation, long-term exposure to environmental risks (e.g. poor housing, low income) and barriers to accessing preventive healthcare and lifestyle support. In Shropshire, Telford and Wrekin (STW), residents in the most deprived communities experience up to 12 fewer years of healthy life expectancy compared to the least deprived — highlighting the need for prevention models tailored to those most at risk. **Promotion of self-care:** Supported self-management of frailty risk factors and access to resources (e.g. online health

	education, signposting to services). This enhances autonomy. While the strategy supports self-care through digital tools, education, and signposting, it also recognises barriers to activation and motivation faced by many target populations. These include low health literacy and limited understanding of frailty as a manageable condition, Language and cultural barriers, particularly in Pakistani and Bangladeshi communities, Digital exclusion among older adults, especially those living alone, in rural areas, or on low incomes and aims to reduced confidence, mental health challenges, and low sense of agency among people with multiple disadvantages. To be effective, self-care promotion must be relational, not transactional — combining digital offers with face-to-face, localised support (e.g. health coaches, community navigators) and co-produced materials suited to different literacy levels and cultures. **Equality of access to services for vulnerable groups:** The strategy explicitly aims to reduce inequality by offering earlier and more frequent frailty interventions to those in deprived areas, providing targeted outreach for minoritised ethnic communities and carers by using PHM (population health management) tools to identify and invite those at higher risk. However, historical underutilisation of services by vulnerable groups stems not only from service gaps, but from institutional mistrust, especially in groups who feel services are not responsive to their needs, transport, language, and accessibility barriers and a lack of sustained relationships with care providers. Services must be co-designed with those affected and delivered in familiar, trusted spaces. **Ability to engage/ inform vulnerable groups:** Success depends on delivery methods. The strategy supports engagement through health coaching and outreach, but reaching marginalised communities will require active, localised effort. **Impact on/support partners to reduce inequalities:** Aligns with ICS goals to tackle health inequalities. It promotes joint working between health, social care, and voluntary sectors, potentially amplifying the effect of collective efforts to reduce inequity.
Mitigations/Actions	**Prevention of ill health:** A universal prevention offer will proactively invite adults aged 50+ who are pre-frail or mildly frail to access online and in-person health education and support. Targeted support will prioritise the 16,000–20,000 older adults in the lowest two deprivation quintiles in STW (based on 2021 ONS deprivation data and PHM

	segmentation). Offers will include face-to-face access points and be delivered in collaboration with VCSE organisations already embedded in deprived communities. Built into the "Prevent" pillar of the strategy and resourced through Core20PLUS5 and prevention budgets. Responsible teams: Public Health Leads, PCNs, VCSE delivery partners. Monitoring: Quarterly PHM analysis of uptake and prevention activity, disaggregated by deprivation and ethnicity. Governance: Frailty Strategy Steering Group and ICB Health Inequalities Committee. **Promotion of self-care:** A tiered model of self-care support will include digital resources, paper-based guidance and one-to-one health coaching for those with low digital access or health literacy. The strategy addresses activation barriers (e.g. low confidence, cognitive impairment, cultural beliefs) by embedding motivational interviewing into staff training. Estimated reach: 30,000–40,000 adults aged 50+ over 3 years will be eligible for self-care support offers (based on frailty risk stratification). Responsible teams are Education & Workforce subgroup, digital, community providers, VCSE health coaches. Monitoring and annual review of uptake and PROMs; tracked by digital inclusion, age, and socioeconomic status. Governance will be in the form of Strategy Working Groups, health care models, training, local authority committees. **Equality of access to services for vulnerable groups:** Services will be co-designed and flexibly delivered, with language translation and visual-based communication, Home-based assessments and telephone options for housebound or rurally isolated residents, community-based assessments via faith centres, pharmacies, and VCSE venues. It is estimated 10,000–12,000 individuals across Core20PLUS5 groups in STW will be prioritised for outreach (based on ICB Core20 data). Contracts with providers will include clear KPIs for reaching under-served populations. Responsible teams will be Place-based commissioning leads, provider organisations, PCNs. Monitoring will be in the form of dashboards reviewed quarterly for service use by deprivation, ethnicity, and access method (digital vs in-person). **Ability to engage/ inform vulnerable groups:** Partner with local leaders and VCSE organisations to co-design and deliver engagement. Use trusted settings (faith centres, libraries, food banks) for outreach. Allocate dedicated funding and capacity for engagement with vulnerable groups.

	Impact on/support partners to reduce inequalities: Involve partners in all pillars of delivery and strategy oversight. Share data and insights across sectors to target resources effectively. Co-develop outcome metrics that reflect social determinants of health and inequality reduction. VCSE will help deliver frailty education and outreach, they will act as health coaches or navigators alongside being able to inform co-production to deliver the five pillars (Educate, Prevent, Identify, Manage, Care).

Productivity and Innovation	
To what extent would successful implementation of this programme impact positively or negatively on any of the following: **the best setting to deliver best clinical and cost effective care** **elimination of any resource inefficiencies** **low carbon pathway** **improved care pathway** **focusing resources where they are needed most**	Positive Impact
Comments/Risks	**The best setting to deliver best clinical and cost-effective care:** The strategy shifts focus from reactive hospital-based care to proactive, community-based, and home-based interventions—the most cost-effective and person-centred settings for frailty. **Elimination of any resource inefficiencies:** Addresses inefficiencies by targeting high-risk groups early and avoiding crisis-driven admissions. However, new infrastructure and services may temporarily increase costs during rollout. **Low carbon pathway:** Community and digital-first care reduces travel and avoids high-carbon hospital admissions. However, full benefit depends on wider system alignment (e.g. estate, digital tools). **Improved care pathway**: Creates a standardised, tiered care model from prevention through to complex care, reducing fragmentation and variability. It includes assessment, planning, and escalation mechanisms. **Focusing resources where they are needed most:** Directly targets those at greatest risk—older adults, those living in deprivation, and ethnic minority populations—maximising the impact of limited resources.

Mitigations/Actions	**The best setting to deliver best clinical and cost-effective care**: Build and strengthen community care infrastructure (e.g. community frailty teams). Ensure shared-care records support coordination across settings. Train staff in delivering care in non-acute environments. Monitor outcomes and costs to demonstrate value. **Elimination of any resource inefficiencies**: Use population health data to prioritise high-impact groups. Phase implementation to match capacity and evaluate impact early. Apply LEAN principles in pathway design to avoid duplication. Monitor resource use and cost-effectiveness metrics. **Low carbon pathway:** Prioritise remote consultations and local delivery of care where safe. Monitor and report on carbon impact of care settings. Engage ICS estates and sustainability leads to align care pathways with Net Zero NHS goals. **Improved care pathway:** - Fully implement the five-pillar model (educate, prevent, identify, manage, care). Develop clear referral criteria, pathway diagrams, and SOPs. Evaluate and iterate the pathway using patient and staff feedback. **Focusing resources where they are needed most:** Use risk stratification and local data to identify priority groups. Embed health equity lens in all decision-making. Align resources with levels of frailty, social risk, and care gaps. Monitor uptake and adapt based on access and outcomes data.

Workforce	
To what extent would successful implementation of this programme impact positively or negatively on any of the following: **staffing levels** **skill mix** **competencies of staff** **sickness** **retention** **turnover**	Positive Impact
Comments/Risks	**Staffing levels:** The need for proactive assessments, care planning, case coordination and 7-day frailty unit operation will require increased staffing capacity, which may initially strain services. There is also a risk on capacity and demand

	as we move to preventions and align pathways and contracts. **Skill mix:** Encourages the use of multi-disciplinary teams (MDTs) and task-sharing, enabling more efficient deployment of skills across sectors. **Competencies of staff:** Elevate workforce competencies in frailty prevention, identification, and management. However, a significant education and upskilling effort is required. **Sickness:** New demands may lead to initial stress or burnout without proper support. Long term, improved morale and proactive working may reduce sickness. **Retention:** Offers meaningful work and development opportunities which can improve job satisfaction. But risks of burnout or poor rollout could harm retention. **Turnover:** If workload grows without support, turnover may increase. But if the strategy is well-managed, with training and support, staff stability could improve.
Mitigations/Actions	**Staffing levels:** Conduct workforce capacity modelling aligned to strategy goals. Secure short-term investment for new roles (e.g. frailty nurses, care coordinators). Use phased implementation to spread demand. Collaborate with VCSE partners to extend capacity. **Skill mix:** Map required roles (e.g. GPs, therapists, nurses, social workers, link workers). Introduce new or blended roles (e.g. frailty practitioners, community paramedics). Encourage inter-professional training and flexible workforce models. **Competencies of staff:** Implement the strategy's education and training pillar at scale. Develop competency frameworks for frailty roles. Offer accredited training pathways in frailty care and CGA. Monitor competency uptake and refresh regularly. **Sickness:** Monitor workloads and provide wellbeing support for frontline staff. Use rotas and caseload planning tools to avoid overload. Build resilience training and peer support into staff development. Include workforce health metrics in the strategy's evaluation. **Retention:** Provide clear career progression routes within frailty pathways. Celebrate success and showcase impact of staff contributions. Offer mentoring, supervision, and

	wellbeing resources. Build recognition into organisational culture (e.g. frailty champions). **Turnover:** Monitor turnover rates across services involved. Act early on staff feedback and stress signals. Foster team-based approaches and sense of mission around healthy ageing. Ensure induction and onboarding reflect new frailty responsibilities.

Resource Impact	
To what extent would successful implementation of this programme impact positively or negatively on any of the following: **Estates** **IT resource** **Equipment** **Other agencies e.g. Social care/safeguarding/ voluntary sector**	Positive Impact
Comments/Risks	**Estates:** Community-based care and 7-day frailty units will require suitable estate space, especially at acute and community sites. However, reducing hospital admissions may relieve overall estate pressures over time. **IT resource:** Success depends on digital infrastructure—including shared care records, population health management, and digital frailty alerts. Existing systems may need upgrades and integration. **Equipment:** New roles (e.g. mobile assessment teams) and proactive care offers may require basic diagnostic tools and mobile devices, but equipment needs are not extensive. **Other agencies e.g. Social care/safeguarding/ voluntary sector:** Relies on integration with social care, safeguarding, and the voluntary/community sector to deliver coordinated,

	equitable, person-centred care. These partners will face increased demand for coordination and delivery.
Mitigations/Actions	**Estates:** Audit estate capacity and identify needs for frailty hubs or reconfiguration. Repurpose underutilised community spaces for assessments and interventions. Align with ICS estate strategies for co-location of services. Engage estates teams early to plan for access, safety, and environment. **IT resource:** Invest in interoperable IT systems to support multi-agency working. Develop shared dashboards and real-time data for monitoring frailty. Ensure data governance frameworks are in place. Provide digital training and support to workforce. **Equipment:** Map out and standardise required equipment for community and frailty teams. Bulk-purchase mobile devices for assessments and digital access. Ensure funding covers maintenance and replacement cycles. Conduct regular inventory audits for efficiency. **Other agencies e.g. Social care/safeguarding/ voluntary sector:** Formalise joint governance through multi-agency working groups. Co-develop care pathways and shared protocols. Fund or support VCSE partners to deliver self-management and outreach. Embed joint training across sectors, including safeguarding awareness.

Monitoring

Effective monitoring will help identify any adverse or positive impact arising from the service / policy change, as well as help with future planning and service development.

What monitoring processes will you implement to assess the ongoing impact of the changes on patients and the public after it has been completed?

Effective monitoring will be critical to ensuring that the implementation of the STW Healthy Ageing and Frailty Strategy supports equity, prevents unintended negative consequences, and informs future service planning and development. The following monitoring processes will be implemented:

1. Outcome and Process Monitoring
   - Track quantitative indicators such as:
     - Frailty levels by severity
     - Uptake of assessments, care plans, and community services
     - Hospital admissions and emergency care usage
   - Disaggregate data by age, ethnicity, deprivation level, and gender to identify and address inequalities.

2. Patient and Public Feedback

- Conduct regular patient experience surveys and focus groups, especially involving:
  - Older adults from deprived communities
  - Ethnic minority groups
  - People with limited digital access
- Monitor complaints and compliments to identify service gaps or equity concerns.

3. Multi-Agency Reviews
- Carry out joint reviews of complex cases across health, social care, and voluntary sectors to ensure:
  - Equitable care coordination
  - Early identification of safeguarding or access issues

4. Workforce Monitoring
- Assess staff training uptake on frailty, personalised care, and cultural competence.
- Monitor workforce wellbeing, retention, and capacity to identify pressures that may impact equitable care delivery.
- Monitoring capacity and demand with current services until streamlined and new pathways are in place.
- Monitoring of partner and provider feedback to include incident reporting.

5. Public-Facing Evaluation
- Publish a plain-language annual report highlighting:
  - Impact on health inequalities
  - Progress in addressing access and outcome disparities
  - Actions taken in response to public feedback

These processes will ensure that positive outcomes are measured equitably, and any adverse effects on vulnerable or underserved groups are identified early and addressed. Monitoring will inform the continuous development of services to support inclusion, fairness, and better patient outcomes for all.

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Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Healthy Ageing: Engagement Report

NHS Shropshire, Telford and Wrekin

Communications and Engagement Team

July 2025

Introduction & engagement approach

Background and context

NHS Shropshire, Telford and Wrekin has developed a draft Healthy Ageing and Frailty Strategy 2025–2028 aimed at supporting people to age well, prevent or manage frailty earlier, and reduce health inequalities.

Scope of the Strategy:

- Covers adults aged 65+, and those over 50 at increased risk of frailty.
- Addresses the full frailty spectrum: prevention, early identification, management, and care.
- Based on five key pillars: Educate – Prevent – Identify – Manage – Care.

- The strategy is in response to growing local need and national priorities around ageing well and managing frailty.
- STW has a higher-than-average population aged 65+, and significant inequalities in healthy life expectancy, especially linked to deprivation and ethnicity.
- There is an urgent need to delay the onset of frailty, improve quality of life for people living with frailty, and reduce unplanned hospital admissions.

Engagement overview

- NHS Shropshire, Telford and Wrekin undertook public and professional engagement to gather the experiences and views of local people, or their families, who live with symptoms of frailty, as well as both professionals and volunteers.
- Feedback from the engagement will shape future services and ensure we meet the diverse needs of the local population.
- The engagement builds on previous feedback and ensure the voices of people over 50 with long term conditions, people living with frailty, their family and carers, volunteers and professionals guide how future frailty prevention and frailty services will be planned and delivered in the future.
- A comprehensive communications and engagement plan was developed to gather views from older adults, carers, professionals, volunteers and stakeholders across our communities.
- The aims of the engagement activity was to:
    - Raise awareness of frailty as a long-term condition that through approaches to Healthy Ageing can be prevented, delayed, and better managed, particularly in its early stages.
    - Explain the current model of frailty care and the vision for healthy ageing through a more proactive, person-centred approach to supporting people living with or at risk of frailty.
    - Understand people's experiences of living with or supporting someone with frailty in Shropshire, Telford and Wrekin.
    - Gather views on how care and support could be improved, including opportunities for more integrated, community-based and preventative models of care.
    - Use feedback to inform the development and delivery of a bold and ambitious Healthy Ageing and Frailty Strategy for the next three years.

Methodology

The NHS STW communications and engagement team undertook a period of extensive engagement over a six-week period from 20 May 2025 to 30 June 2025, to understand the views of our target audience:

- Older people living with frailty or at risk of developing frailty (particularly those aged over 65, and over 50 in higher-risk groups).
- Carers, families, and unpaid supporters of people with frailty.

Our approach included the following:

- **Online public and professional surveys providing opportunity for quantitative and qualitative feedback.**
- **Targeted engagement** including one to one interviews with service users and professionals from key frailty services such as the Care Transfer Hub, and wards at the acute hospital where there are a high prevalence of frail people
- **Targeted community outreach t**o ensure that we heard the voices from those harder to reach / digitally excluded groups we conducted community engagement with targeted groups, organisations and community leaders.
- **Stakeholder listening event** with professionals, the VCSE community and wider stakeholders to share the strategy and gather views.
- **A Mid-point Review** was conducted at 3 weeks to identify which demographics and geographical locations we had reached and to identify any gaps, target audiences or groups we still needed to engage with.

Public survey questions*

- How well do you understand frailty?
- What kinds of support do you think help people age well and stay independent for longer?
- If you or someone close to you experienced symptoms of frailty, who would you contact first?
- How would you rate your involvement in decisions about frailty care or support?
- Have you or the person you care for ever experienced a health or care crisis (not just hospitalisation)? What happened, and what do you think could have helped prevent it?
- How confident are you that frailty is a condition that can be prevented, delayed, or managed?
- What do you think would help people live a happier, healthier and longer life as they age?
- How well do you feel services work together when caring for older frail people (e.g. health, social care, voluntary services)?
- What would make care and support for people with frailty better in your view?
- Do you think current services for older or frail people are fair and accessible for everyone – no matter their background (e.g. ethnicity, disability, income, where they live)?
- What challenges do you, or someone you support, face in staying independent and well?
- How important do you think it is for frail people to be involved in decisions about their own care?
- What matters most to you (or the person you care for) when it comes to staying independent and well in later life?
- How would you prefer to receive information about ageing well and support for frailty?
- How confident are you using digital tools to manage health (e.g. apps, video appointments, online forms)?
- Is there anything else you'd like us to consider as we develop the Healthy Ageing and Frailty Strategy?

**Full survey questions in the appendix*

In-person Targeted Engagement Questions (public)

- What do you understand by the term frailty, and do you identify as frail?
- Have you or someone you care for ever received support related to frailty? *(Probing questions: what organisation and what help received? What worked well?)*
- What would make care and support for people with frailty better in your view?
- How should information and support about ageing well and frailty be communicated to ensure accessibility for all?
- Is there anything else you'd like us to consider as we develop ways to support people with frailty to age well?

Professional Survey Questions*

- What is your connection to frailty?
- How well do you understand the term frailty? How well do you think the term frailty is understood?
- Have you ever used the frailty assessment scale?
- What do you see as the main gaps in service provision for people living with mild to moderate frailty?
- In what way would the healthy ageing and frailty strategy address your concerns?
- Do you think there are any pillars missing from the strategy?
- For each of the pillars can you share any strengths, weaknesses or opportunities for improvement under each heading?
- How do you see digital tools (such as smartphones, apps, websites, assistive TEC (Technology Enabled Care) or online platforms) supporting people living with or at risk of frailty?
- Do you have any experience of using any digital tools to identify people with frailty?

**Full survey questions in the appendix*

Promotion and distribution

- NHS STW web page was launched: [Healthy Ageing and Frailty - NHS Shropshire, Telford and Wrekin]
- The survey links were shared widely through a stakeholder briefing, a press release to local media, newsletters and social media channels by NHS STW and ICS partners.
- A comms toolkit was distributed to partner organisations (including VCSE) and stakeholders across the health and social care system including the press release, newsletter/website copy, poster/leaflet and social media copy/assets.
- Information and the request to join groups went to our full VSCE distribution list and all Patient Participation Groups.
- Leaflets and information was given out at engagement events and in addition at events including ‘See Hear’ event in Shrewsbury. Lawley coffee morning, Telford Patient First, Shropshire Patient Group, Shropshire Support refugees, Community Connectors Shropshire and Telford, Bridgnorth Community Hospital open day.

Targeted engagement & midpoint review

Targeted engagement was conducted across Shropshire, Telford, and Wrekin to ensure that the voices of people living with frailty and those aged 50+ with long term conditions with protected characteristics were heard.

Frailty Midpoint Review

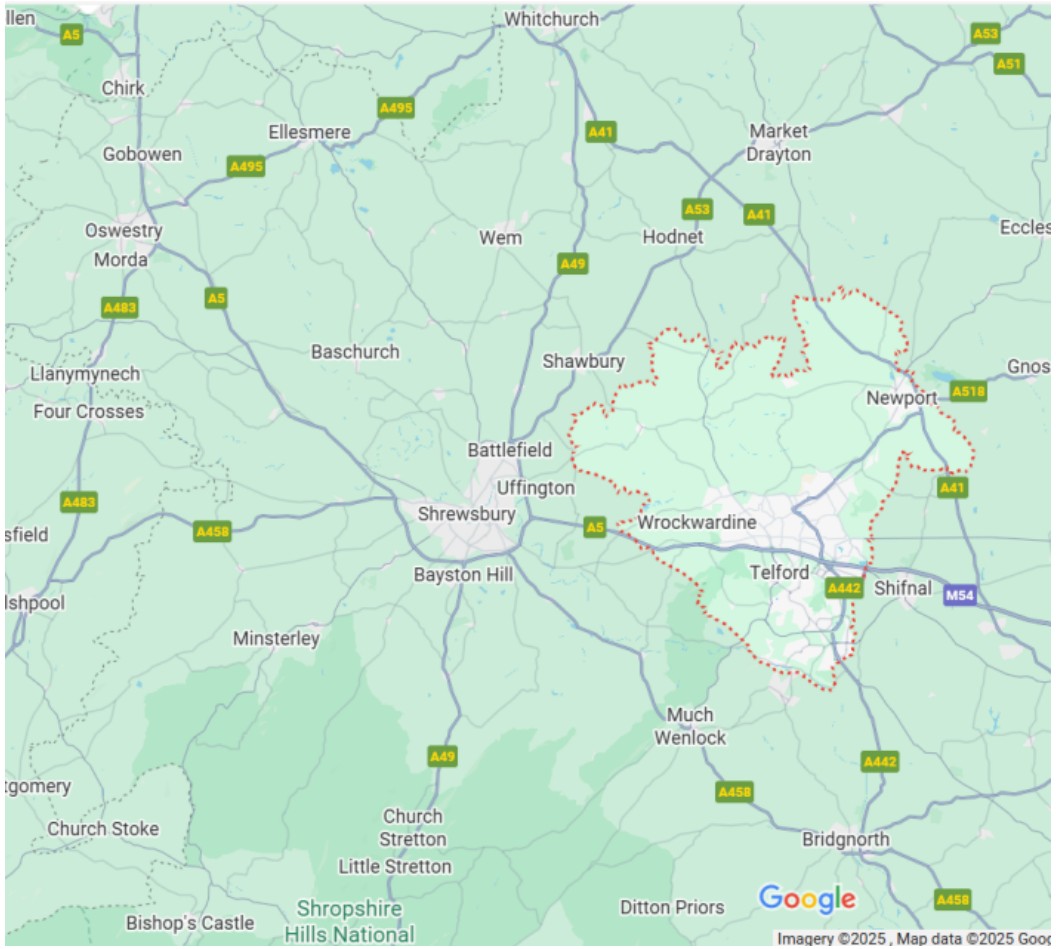
- To address the findings from the Frailty Midpoint Review, we increased engagement with underrepresented groups by developing targeted outreach strategies for Muslim, Hindu, and Sikh communities, and enhanced efforts to gather responses from a broader range of ethnic minority groups.
  We also targeted those individuals who had had a formal frailty assessments by visiting wards at the acute hospital and the care transfer hub.
  While continuing our efforts in Telford, we also increased engagement in Shropshire to balance response rates.
- Leveraging the good response rate from disability groups helped us gather more detailed insights and feedback.
- We ensured the needs and perspectives of the 65-75 age group were well-represented and considered additional strategies to engage younger respondents over 50. Finally, we assessed the effectiveness of current communication channels and adjusted them as needed to improve reach and inclusivity.

These efforts were also informed and aligned with the advice and guidance given from the Health Ageing and Frailty Steering Committee.

Face to Face Engagement
Groups and sites visited

16 groups in Shropshire, including:

- Pontesbury Carers
- Highley Walking Football
- Mayfair CoCo
- Oswestry Carers
- Shrewsbury Hospice
- Bridgnorth Age UK
- Coppice Falls prevention
- Crowmoor Falls prevention (multiple groups)
- Harlescott Falls prevention
- Royal Shrewsbury Hospital:
  - Care Transfer Hub
  - Ward 36
  - Ward 18
- Age UK Albrighton friendship
- Bridgnorth Community Hospital
- North Shropshire Dementia Friendly Churches



17 groups in Telford, including:

- Madeley Walking Group
- Telford Hospice
- Telford diverse community
- Madeley Friendly Faces
- Admaston Health walk
- Shire Homes Wellington
- TAARC Community Garden
- Age UK Hollingswood
- Age UK Newport
- Lawley Community Coffee
- Fit4All Woodside
- Age UK Turnpike
- Age UK Newport
- Fit4All Frizes
- Fit4All Apley Court
- Fit4All Lowe Court
- Fit4All Heywood Lonsdale

Engagement Response Overview

Total number of respondents

We have had a good response to the survey with a total of over 954 respondents.

This is broken down as:

- Public (service users, cares and family members):
  - **Public Online survey:** 526 respondents
  - **Targeted face to face engagement:** 305 respondents
  - **Paper Survey**: 4 respondents
- Professional (health and care professionals and volunteers):
  - **Professional online survey:** 79 respondents
  - **Stakeholder listening event:** 42 respondents

Online Public Survey - Summary

Online Public Survey Respondent Breakdown (Demographics)

In total, 526 people responded to the online public survey. This is broken down as follows:

Age:

Majority (75%) aged 65+, with 4% aged 85+. Only 3% of respondents aged under 50

Demographics:

- Significant majority of respondents were White British (93%), with a further 2% from other White backgrounds, and a small number of responses from other ethnic backgrounds.
- 5% (27) of respondents identified as members of the LGBTQ+ community, whilst 2 responses came from individuals who identify as transgender.
- 57% told us they were not disabled, with most of the remaining respondents telling us they face challenges with mobility, and long-term health conditions.

Postcodes:

- 304 responses were received from residents of Telford and Wrekin, 201 from Shropshire, and 14 from people whose home address is out of area (but may have a connection to the area).

Key Headlines from the Online Public Survey

- **Involvement in Care Decisions**: 99.5% of respondents told us that it is important that frail people are involved in decisions about their care
- **Perception of Frailty:** 69% feel that frailty is a condition that can be prevented, delayed or managed. People associate the word frailty with losing mobility, frequently falling, personal vulnerability, and a reduced ability to complete daily physical tasks.
- **Impact of Support:** When people receive support for frailty from a local health and care organisation, they overwhelmingly feel that it made a difference to their condition (93% responding 'Yes' or 'Somewhat')

Accessibility: Only 6% of respondents told us that current services for older or frail people are fair and accessible for everyone.

  - Respondents told us that poor access to services is a real challenge in rural areas, the increasing cost of non-NHS support services is a challenge to household budgets, and there is a repeated perception of a 'postcode lottery' existing across the area

- **First Point of Contact:** For over half of respondents, they would contact their GP first if they or someone close to them experienced symptoms of frailty. Few others would access other parts of the health and care system, with most respondents choosing to consult family/friends, or wait until experiencing a crisis.
- **Clinical Assessment:** 96% of respondents didn't not believe they had clinically been assessed for frailty.

Respondent Profiling

2. Which of the following best describes your experience of frailty? (select all that apply)

	Answer Choices	Response Percent	Response Total
1	I feel I may be living with frailty (mild, moderate, or severe)	31.67%	159
2	I have a long-term condition (such as dementia or a heart condition) that affects my health, mobility or independence	26.89%	135
3	I care for or support someone living with frailty	26.10%	131
4	Prefer not to say	7.57%	38
5	Other (please specify):	20.92%	105

3. How would you describe your current health or resilience?

	Answer Choices	Response Percent	Response Total
1	I'm very fit and active	29.29%	152
2	I'm well, but not regularly active	16.38%	85
3	I have some health limits but can manage most things	37.57%	195
4	I find it harder to get around, I sometimes need help to walk with walking aids or someone to help me to get out of my home.	15.80%	82
5	I'm quite dependent on others for daily tasks	5.78%	30
6	I'm completely dependent on others for daily tasks and getting out of my home	1.35%	7
7	Not sure/prefer not to say	0.96%	5
		answered	519
		skipped	7

Clinical Approaches to Frailty

4. Have you ever been told you've been assessed for frailty?

	Answer Choices	Response Percent	Response Total
1	Yes	3.27%	17
2	No	93.08%	484
3	Not sure	3.65%	19
		answered	520
		skipped	6

5. Do you have a care plan for frailty or long-term health needs?

	Answer Choices	Response Percent	Response Total
1	Yes	1.75%	9
2	No	96.31%	496
3	Not sure	2.33%	12
		answered	515
		skipped	11

A significant majority of our respondents are not on a formal pathway for frailty or have ever received an assessment. Equally, most do not have a care plan in place which covers frailty.

This pattern was identified at the mid-point review but has persisted despite increased targeted engagement to enhance.

Current Health

3. How would you describe your current health or resilience?				
Answer Choices			**Response Percent**	**Response Total**
1	I'm very fit and active		29.29%	152
2	I'm well, but not regularly active		16.38%	85
3	I have some health limits but can manage most things		37.57%	195
4	I find it harder to get around, I sometimes need help to walk with walking aids or someone to help me to get out of my home.		15.80%	82
5	I'm quite dependent on others for daily tasks		5.78%	30
6	I'm completely dependent on others for daily tasks and getting out of my home		1.35%	7
7	Not sure/prefer not to say		0.96%	5
			answered	519
			skipped	7

Around 55% of respondents acknowledge they have some personal level of limits to their health, which for many can make daily tasks and jobs challenging.

The term “Frailty”

7. How well do you understand the term “frailty”?			
Answer Choices		**Response Percent**	**Response Total**
1	Very well	30.25%	157
2	Somewhat	52.22%	271
3	I've heard of it but don't really understand it	15.61%	81
4	I've never heard of it before	1.93%	10
		answered	519
		skipped	7

When looking at the 91 respondents who indicated a lack of knowledge, their suggested definitions showed similar patterns to those who felt more confident in defining them.

How well do you understand the term "frailty"?	What is your age?						
		85 and over	Aged 75-84	Aged 65-74	Aged 50-64	Under 50	Prefer not to say
	Very well	10 45.5%	42 31.1%	69 29.6%	32 28.1%	3 23.1%	0 0.0%
	Somewhat	10 45.5%	74 54.8%	121 51.9%	56 49.1%	9 69.2%	1 50.0%
	I've heard of it but don't really understand it	2 9.1%	18 13.3%	38 16.3%	22 19.3%	1 7.7%	1 50.0%
	I've never heard of it before	0 0.0%	1 0.7%	5 2.1%	4 3.5%	0 0.0%	0 0.0%

The older a respondent, the more likely they are to fully understand the phrase “frailty”, with almost twice as many understanding at 85+ compared with those under 50.

What kinds of support do you think help people age well and stay independent for longer?

9. What kinds of support do you think help people age well and stay independent for longer? (Select up to 3)

	Answer Choices	Response Percent	Response Total
1	Advice on healthy lifestyles (diet, exercise, sleep)	30.71%	160
2	Support for managing long-term health conditions	68.71%	358
3	Opportunities for social connection and friendships	45.11%	235
4	Information and advice about ageing well	28.02%	146
5	Access to local community activities	24.95%	130
6	Home adaptations or equipment	46.07%	240
7	Support for carers and families	23.42%	122
8	Help with finances or housing	8.45%	44
9	Other (please specify):	9.21%	48
		answered	521
		skipped	5

Respondents prioritised proactive management of long-term conditions, and opportunities for social connection and friendships.

This was also reflected in many of the conversations that took place through the targeted engagement.

Participants highly valued being with their peers in a structured environment supporting their mobility (e.g. Fit 4 All).

Support for Frailty

11. Have you (or someone you care for) ever received support related to frailty?

	Answer Choices	Response Percent	Response Total
1	Yes	29.75%	155
2	No	70.25%	366
		answered	521
		skipped	5

13. Did the support or intervention make a difference?

	Answer Choices	Response Percent	Response Total
1	Yes	55.13%	86
2	Somewhat	34.62%	54
3	No	6.41%	10
4	Not applicable	3.85%	6
		answered	156
		skipped	370

Around 30% of respondents have personal experience in dealing with frailty.

However, of those who do, around **90%** felt that the support they had been offered by local organisations made a difference.

Support for Frailty cont/...

When focusing on those who told us support made a difference, respondents emphasised the importance of enabling the patient to **stay in their own homes** for longer and the **support offered for family and loved ones**.

Multiple responses highlight the value of the **support received at the end-of-life phase.** They appreciated how **external support helped in signposting** and coordinating services, alleviating worries for elderly or vulnerable people individuals.

"My husband is 92 and has Alzheimer's. Thanks to the help we have had he is able to lead a fuller life. He goes into the Beacon Day Centre at Mayfair three times a week using Ring and Ride, which gives him a feeling of independence. Whilst he is there he has a happy and relaxed time playing games or just sitting reading the newspaper with lots of fun and laughter. He feels recognised and valued as a person and has gained much of his previous self confidence, which he lost as he lost his memory."

What do you think would help people live a happier, healthier and longer life as they age?

When considering what respondents felt would help people live a happier, healthier and longer life as they age, whilst most prioritised different factors in a consistent way across cohorts, there were differences when viewed against a respondent's current health/resilience.

- **Poorer health:** Respondent's with poorer health prioritised **better access** to local health services and receiving **clearer information** about frailty (likely due to age and poor eyesight).
- **Better health:** Those with better health, likely in the earlier stages of frailty, placed far greater priority on **support with staying physically active.**

18. What do you think would help people live a happier, healthier and longer life as they age? (Select up to 3)

	Answer Choices	Response Percent	Response Total
1	Better access to local health services	62.07%	324
2	More local services like a frailty clinic near home or advice clinics that link with your GP.	55.75%	291
3	Support with staying physically active	56.51%	295
4	Help with nutrition and hydration	15.90%	83
5	Support for carers and families	25.29%	132
6	Clearer information about frailty	14.18%	74
7	Social connection and loneliness support	41.76%	218
8	Other (please specify):	6.70%	35
		answered	522
		skipped	4

What do you think would help people live a happier, healthier and longer life as they age? (Select up to ...	How would you describe your current health or resilience?							
		I'm very fit and active	I'm well, but not regularly active	I have some health limits but can manage most things	I find it harder to get around, I sometimes need help to walk with walking aids or someone to help me to get out of my home.	I'm quite dependent on others for daily tasks	I'm completely dependent on others for daily tasks and getting out of my home	Not sure/prefer not to say
	Better access to local health services	86 20.0%	45 18.7%	138 26.1%	47 20.5%	23 26.4%	5 23.8%	5 45.5%
	More local services like a frailty clinic near hom	74 17.2%	49 20.3%	113 21.4%	52 22.7%	19 21.8%	4 19.0%	0 0.0%
	Support with staying physically active	104 24.2%	45 18.7%	108 20.4%	41 17.9%	12 13.8%	1 4.8%	3 27.3%
	Help with nutrition and hydration	37 8.6%	9 3.7%	23 4.3%	9 3.9%	5 5.7%	3 14.3%	0 0.0%
	Support for carers and families	36 8.4%	28 11.6%	44 8.3%	22 9.6%	9 10.3%	2 9.5%	1 9.1%
	Clearer information about frailty	16 3.7%	12 5.0%	22 4.2%	20 8.7%	8 9.2%	3 14.3%	0 0.0%
	Social connection and loneliness support	65 15.2%	47 19.5%	70 13.2%	35 15.3%	7 8.0%	3 14.3%	2 18.2%
	Other (please specify):	11 2.6%	6 2.5%	11 2.1%	3 1.3%	4 4.6%	0 0.0%	0 0.0%

System Performance

Local services so that travel is at a minimum. More home visits rather than attending clinics. More resources for OT and Physiotherapy locally. More day centres.

More and better understanding and trust of services that voluntary organisations can provide along with funding and an easier contracting route for voluntary sector services to deliver home from hospital & preventative services.

Seeing the same GP, having the same carers and social support so that they are familiar with and to the frail person

Better joined up services. Better listening skills by NHS. Faster diagnosis. Less reliance on long term opiates and other drugs which result from delays

19. How well do you feel services work together when caring for older frail people (e.g. health, social care, voluntary services)?

	Answer Choices	Response Percent	Response Total
1	Very well	1.72%	9
2	Quite well	13.22%	69
3	Not very well	38.70%	202
4	Not at all well	24.71%	129
5	Don't know	21.65%	113
		answered	522
		skipped	4

The majority of respondent's (64%) felt that services don't work very well together caring for older frail people.

In the long term better preventative support in those areas of frailty that it is suited to (e.g. falls prevention). In the short-term ensuring a level of social contact with others in a similar situation. Mutual support is a motivating factor for improved mental health and for continued physical activity.

Improved up to date GP records. People cannot get appointments and therefore struggle on because there is no follow up or joined up information, and they do not get diagnosed with a condition by their GP surgery so nothing is on their record

As a society we don't treat older people well. We leave them alone with numerous medications but little preventative care or support. A healthy society starts young and carries on through different ages. People are living longer not because we are healthier but have medication to prolong life but without the care or quality for a good older age.

What matters most to you (or the person you care for) when it comes to staying independent and well in later life

Key themes which emerge from this question include:

Financial Concerns

- Financial Challenges brought on by the cost of funding private care
- Paying for mobility sessions and activities to help slow down the onset of frailty
- Perceived inequity between those who must privately fund care, and those who receive state support

Travel and Access

- Rurality, and poor public transport links
- Centralisation of services in larger towns

Social Interaction

- Maintaining active social links, and reducing a feeling of isolation
- Notably relevant for those without children, many have concerns around who will be there when they age

Access to GP Appointments

- Being able to access their GP promptly and reliably, and have confidence that the doctor they see will understand their conditions and medical history

Financial challenges to buy the equipment and services I need to be independent. I do receive Attendance Allowance which is a great help, but it doesn't cover the full cost.

Access to pain management and physio services in a reasonable timescale. Current experience of Shropshire pain management has been if they can't intervene, ie ablation, they are not interested in teaching management techniques.

A lot of people over 70 are single and live on their own, the social side is as important as the physical wellbeing side.

Speed of referrals and being seen to discuss ways forward. Waiting for months and years can worsen a condition considerably

I couldn't have children, so I will have no one to help me as I get older and I have a degenerative disease which will only get worse, so at some point I will need to move to sheltered accommodation. However, unless you are on benefits, which I'm not, there are very few opportunities to move to suitable accommodation.

I'm already quite active but need to travel to most activities by car. Socialising is very important but some activities cannot provide this and there is a cost involved. Groups like the U3A, WI etc aim to bring people together but the Integrated Health opportunities need to be better advertised.

Digital Tools

Considering the average age of respondents**, the survey shows a high level of confidence compared to others.** 79% of respondents are either ‘very’ or ‘somewhat’ confident, with only 9% choosing the bottom two options.

However, **confidence levels vary significantly by age.** For those aged under 50, 67% tell us they are very confident, however for those aged 75+, this drops to below 32%.

Within the free text comments, there is a **high degree of general hesitancy towards technology replacing human interaction**, particularly from the older age groups. Equally respondents reference **poor broadband reliability in rural areas, the lack of a single system for all records and appointments, and unclear access to reliable information.**

26. How confident are you using digital tools to manage health (e.g. apps, video appointments, online forms)?

Answer Choices		Response Percent	Response Total
1	Very confident	42.88%	223
2	Somewhat confident	35.77%	186
3	Not very confident	12.50%	65
4	Not confident at all	5.77%	30
5	I do not use digital tools	3.08%	16
		answered	520
		skipped	6

How confident are you using digital tools to manage health (e.g. apps, video appointments, online forms)?	What is your age?						
		85 and over	Aged 75-84	Aged 65-74	Aged 50-64	Under 50	Prefer not to say
	Very confident	2 9.5%	44 32.1%	109 46.8%	58 50.4%	8 66.7%	1 50.0%
	Somewhat confident	5 23.8%	52 38.0%	85 36.5%	40 34.8%	4 33.3%	1 50.0%
	Not very confident	10 47.6%	24 17.5%	21 9.0%	10 8.7%	0 0.0%	0 0.0%
	Not confident at all	1 4.8%	12 8.8%	12 5.2%	5 4.3%	0 0.0%	0 0.0%
	I do not use digital tools	3 14.3%	5 3.6%	6 2.6%	2 1.7%	0 0.0%	0 0.0%

Targeted Engagement - Summary

Targeted Face to Face Engagement Respondent Breakdown (Demographics)

Total shared experiences: 305

- Age ranges 50 to 90+, with the majority in their 70s or 80s.
- The gender ratio is approximately 3 females to 1 male (no one identified as transgender)

Postcodes for locations of engagement

- Telford and Wrekin: 17
- Shropshire: 16 (including WV postcodes inside our border)

(Some groups had a mix of Shropshire, Telford, and Wrekin residents; 1 person was from Wales)

Demographics:

- **Ethnicity:** White British 287, Asian 2, Afro-Caribbean (Jamaican) 14, Romanian 1.

Group characteristics

- Carers, long-term health conditions, old age, frailty (as defined by the strategy), digitally excluded, rural, urban, diverse community, and economically deprived backgrounds.

Key Headlines from Face-to-Face Engagement

Question 1: What do you understand by the term frailty, and do you identify as frail?

- People associate the word frailty with losing mobility (particularly associated with falls), old age, personal vulnerability, physical or mental frailty, and a reduced ability to complete daily physical tasks. It was seen as a negative word and, for some in the Jamaican community, particularly offensive. The majority of people did not see themselves as frail, as they could still do things for themselves and maintained a positive mindset of '***keeping going***.' Where people accepted, they were frail, it was because of specific conversations with health professionals or falls.

'I've been told I am too frail for surgery if they find I have bowel cancer. So, I must be frail, but at 87, what can you expect? I can still do things for myself and walk here to this group and the Albrighton surgery, so I'm not too frail yet but I have come to terms with my health.'

- Several younger people felt they had periods of being frail during treatment, a flare-up or hospital admission, but in general didn't consider themselves frail.
- Healthy Ageing was not seen as the absence of health-related issues but rather continuing to be involved in community life and retaining independence. It should be noted that these comments came from the more physically able.

Key Headlines from Face-to-Face Engagement

Question 2: Have you or someone you care for ever received support related to frailty?

- Most individuals were not able to identify specific frailty services but described experiences with general practice, hospital outpatient/inpatient/emergency department services, falls clinics/falls prevention classes, exercise/social groups, carer (paid and unpaid), and provision of equipment.
- **General Practice** – positive comments focused on the care and treatment when seeing a healthcare professional. Some practices were named as excellent. Negative comments were around the difficulty in making an appointment, continuity of care, and transport to appointments, particularly for more urban practices. The majority of people aged 78 and above were not able to use online booking services or the NHS App. They relied heavily on younger family members to make appointments for them or to phone the surgery themselves and reported considerable delays in receiving treatment.
- **Acute Hospitals –** positive comments were focused on the care and treatment received as outpatients. Negative comments were generally about ambulance wait times, emergency departments, and some inpatient care for older people and those with dementia, lack of respect for older people, and transport issues. START support on the Rehabilitation ward was named as excellent (Shropshire Community Trust).
- **Community groups** were considered very positive in maintaining levels of fitness and social connection. Negative comments were around difficulties getting to groups for non-drivers and those with poor mobility. Falls prevention classes were seen as effective. Hospice care and support groups were reported as excellent. The Black and Asian community members reported generally seeking help from within their community, family, or faith group.
- **Areas of concern** –negative experiences had prevented some from seeking help, either because of a fear of hospital admission or difficulty making an appointment. Those without younger family/friends, digitally excluded, from diverse communities, with poor health literacy, and without transport were worst affected.

Key Headlines from Face-to-Face Engagement

Question 3: What would make care and support for people with frailty better in your view?

Answers to this question were diverse depending on an individual's experience, background, and location.

Common themes were:

- Physical access – availability of transport to appointments, including GP and community groups
- Access to book appointments –simplified, person-based, not online
- Timely help
- Simplify forms and information
- Attitude of staff – respect for older people and knowledge of frailty
- Home visits –general practice professionals doing home visits for housebound
- Carers - increased provision in rural areas
- Taking responsibility for oneself and planning ahead
- Annual in-person checks for all older people
- Supported living and care homes having visits from GPs, and other health professionals regularly
- Advocates and health professionals from diverse communities
- Care plans and one person to co-ordinate care and a single point of access for all health needs

Key Headlines from Face-to-Face Engagement

Question 4: How should information and support about ageing well and frailty be communicated to ensure accessibility for all?

Very few people we spoke to were confident online. Most people's preferred communication by:

- Written format via local newsletters/magazines, leaflets and posters
- From known trusted sources such as community groups, health and social care professionals, libraries, friends/ family, and peer groups.
- Those who were online often used Facebook, Email and Googled topics.
- Work with diverse communities 'grassroots' initiatives to combine health information with community events.
- Radio and black radio stations
- Information in lots of different formats, including braille, spoken, large print and written

Key Headlines from Face-to-Face Engagement

Question 5: Is there anything else you would like to consider?

- Access to health and care services was the most frequent additional issue to consider – this related to difficulty using online access and physical barriers to access such as distance and transport (for example general practice and acute hospitals).
- Social connection was repeated often as something important to consider. This includes family connections and social networks in community.
- The relationship of confidence and motivation with frailty came up at various times
- A number of people gave feedback about the health and wellbeing needs of unpaid family carers
- Other feedback included the benefit of exercise, timing of services, frailty amongst working age population and differing cultural attitudes to ageing

**Many people used this question as an opportunity to emphasise points that had been raised already*

Key Headlines from Paper Survey

- From the 150 paper surveys distributed, only 4 responses were received.
- The questions on the paper survey were the same as those used in the Face-to-Face Engagement.
- As a result, the themes identified from the paper survey responses aligned with those from the face-to-face engagement and have therefore been included with the Face-to-Face qualitative analysis.

Demographics:

- 3 female, 1 male
- 2 White British 2 no answer provided
- Ages 61, 81, 81, 85
- 3 Shropshire SY2,3,7, 1 Telford TF7

Professional Survey Online - Summary

Online Professional Survey Respondent Breakdown (Demographics)

In total, 79 professionals responded to the online professional survey. This breaks down as follows:

Organisation	Number of Responses
Community Care Organisation	16
VCSE Organisation	11
Shropshire Community Health NHS Trust	9
MPUFT	8
Shropshire Council	7
GP Practice	5
Telford & Wrekin Council	4
Age UK	3
The Robert Jones and Agnes Hunt Orthopaedic Hospital	2
Keele University	1
NHS Shropshire, Telford and Wrekin	1
Severn Valley Railway	1
The Shrewsbury and Telford Hospital NHS Trust	1
VISS Sign Language Interpreting Service (Shropshire) Ltd.	1

Postcode Area	Number of Responses
Telford (including Wolverhampton)	26
Shropshire	39
Out of Area	6

Key Headlines

Total Responses: 79. Largely split between local professionals working in health or social care (55%) and local VCSE professionals or volunteers (34%).

Understanding of 'Frailty':

- 97% of local professionals have a strong understanding of the term ‘very well’ or ‘somewhat’.
- The general public often misunderstand the term, associating it with negative connotations, and is not something that can be influenced. Many responses reference a sentiment that frailty is an inevitable part of aging and directly associated with old age.

Frailty Assessment:

- 28% of respondents had used a frailty assessment scale previously.
- Around two thirds of these respondents had received formal training.

Opportunities for Improvement:

- Early identification of frailty is challenging as a result of perceived under-investment and a lack of resource in the community.
- Improved training for staff and increased awareness of frailty and local support services are needed for those working with mild to moderate frailty patients.

Digital Tools:

- Digital tools are valuable but should compliment, not replace, the personal care.
- Implementation should be inclusive, considering those with who lack digital skills, do not speak English as a primary language, or are BSL speakers

What do you see as the main gaps in service provision for people living with mild to moderate frailty?

Key Themes include:

Lack of Early Identification & Prevention

- Recognition of frailty and symptoms of within primary and community care can be poor, which prohibits the early identification and intervention.
- Frailty is still largely associated with old age, leading to reduced awareness within younger adults.

Insufficient Preventative Services

- Many services and groups are located in larger towns, leading to inequality for those living in rural areas.
- Community based falls prevention services are felt to be under-resourced, and an overall sentiment that services are reactive, rather than proactive.

Fragmented and Complex Service Navigation

- Services are disconnected, and there is a lack of overall care coordination.
- Patients lack a single point of contact, which leads to a lack of continuity of care and disconnected services.

Workforce & Resource Shortages

- There is an overall feeling that there is a disconnect between ambitions for care, and the reality of what is deliverable within the existing and proposed financial envelope.
- The county has a shortage of professional health and care staff, which prohibits staff delivering care to the best of their ability.

Barriers to Accessing Services

- Poor public transport networks across the rural areas of the county are a significant barrier
- There is a risk that those who are not IT literate face exclusion from being able to easily access services.

Mental Health and Dementia Support Gaps

- Mental health conditions within older people are not well understood, and support is under-resourced.

Social Isolation & Community Disconnection

- Particularly within rural communities, there are limited opportunities for social interaction amongst the older and potentially frail age groups, which leads to isolation and loneliness.

Key Quotes

I think people assume that frailty is just weakness as we age and to be expected in our latter years as part of normal ageing, rather than the resilience to bounce back from minor ill health to extend living life as healthy as possible.

I am part of a service that focuses on frailty between mild to moderate levels so I would like to believe that I understand frailty well in all health-related contexts. The general public might have less understanding and refer to a frailty as either a single condition (e.g. dementia) or it is inevitable in the journey of an individual's life.

Supported living for people who may have mild to moderate frailty are often stretched for resources. The spaces can be taken by people who may be more severly frail instead, in places that are not suitable for them. This has a domino effect - those with mild frailty may be overlooked.

One significant gap is the underinvestment in community-based falls prevention programmes. There is a clear need for these services to be delivered by appropriately trained specialist instructors with a thorough understanding of frailty. At present, some exercise sessions are marketed as suitable for older adults but are not tailored to the specific needs of those living with frailty, posing a risk of harm rather than benefit.

It is the overall holistic approach on a national scale that is lacking. So much of our resources are understandably being put towards the acute and reactionary nature of healthcare including A&E departments etc. However, if a wide variety of health professionals were pooled together to form hubs that cover their patches across the country like our service then I would like to think frailty as a condition would be better managed.

At present there is a reliance on family, neighbours and voluntary services to provide support. As our population ages demand is increasing and the resource to support is not there. It is key to engage with individuals at stage 3 who may not be presenting at their GP or other health professional before they become vulnerable.

It is good to see an increased focus on prevention and education - the reality of the proposals within current and future funding is debatable

This strategy would ensure that individuals presenting as 'frail' would primarily be addressed as people, not numbers or just problems. Patients are more likely to get on board with our recommendations and advice if they feel like they are being listened to. If our patients are on board with this, it will reduce the dependency on other specialist teams in the community and reduce the pressure on acute trusts and A&E departments.

Listening Event Feedback (Professional) – 11 July

Vision for the future

We asked: Considering the vision for the future ...

What don't you like?

- Negative word – Frailty
- Mental health isn't visible and need an outcome for it
- Too focused on the older adult
- Target age – Is 50yrs old too high or too young?
- Cost of preventative interventions/funding for public

What do you like about it?

- Talks about inequalities
- Neighborhood /place-based aspect
- Public and workforce understanding (The education piece)
- General feel is that it all sounds positive
- Universal offer being 50+ and not an older starting age
- Importance of education
- System approach
- Care co-ordination – Single point of access
- Early intervention
- Patient engagement development

What would you change?

- Addition of reversal of sever/med frailty to lower or less
  - How does it refer to it being person centered / holistic approach with joined up services. (This includes digital aspects across services)
  - Does it need objectives around how services interact and ensure patients are accessing appropriate services at the correct time
  - Educate – Make it fun
  - Peer support with real examples and real people
  - More focus on prevention, 50-70 age chart
  - IG to be resolved to allow services to work together
  - Education on triggers, i.e losing work, retirement, bereavement, becoming a carer, having an injury/operation
  - Individuals' acceptance of frailty
  - Who does the education and how?
  - More assertive outreach to underserved communities
  - Digital tools / Shared care record

The Future - 2028

People are living and aging well, and those who experience frailty are still able to live with safety, dignity and autonomy. What did we do to get there?

Universal access and equity in services

- A consistent directory of services available in both digital and hard copy.
- Every practice and area having access to the same level of service provision.
- Self-referral options and timely access to the right interventions.
- Tackling inequalities through **equity of access**, not just equality

Impact :

A fairer system where no one is left behind due to geography, age, or digital exclusion.

Integrated, person-centred care systems

- One point of contact for individuals.
- Seamless transitions (e.g., hospital to home).
- Shared care records and digital connectivity.
- A single referral system staffed by professionals trained in both health and social care.

- **Impact**

People experience smoother, more coordinated care journeys, reducing stress and improving outcomes.

Prevention First and community-based approaches

- Community health hubs and peer support groups.
- Affordable or free access to preventative services.
- Public health campaigns promoting healthy lifestyles.
- Use of wearable tech and AI to monitor and support wellbeing.

- **Impact**

Empowered individuals to take control of their health and reduced the burden on acute services.

Education and culture change

- Awareness of frailty and ageing as a normal part of life.
- Health coaching and lifestyle education from a young age.
- Changing perceptions and language around ageing and frailty.
- Building trust with diverse communities and cultural leaders.

- **Impact**

A more informed and compassionate society, where ageing is seen as positively and support is proactive.

Sustainable investment and co-production

- 5–10 year funding models to allow services to grow and innovate.
- Co-production with people with lived experience.
- Strong partnerships across voluntary, community, and statutory sectors.
- A shared charter or pledge to drive accountability and continuous improvement.

- **Impact**

Stability, innovation, and trust in the system, ensuring it could evolve with community needs.

Summary

Key themes /areas to review / change within the strategy

Theme	Key Findings
Understanding of Frailty	Many public respondents associate frailty with old age, falls, and vulnerability. Most face-to-face participants did not identify as frail, even when they met clinical criteria. Professionals noted that the term is misunderstood and often seen as inevitable or negative.
Access and Equity	Survey respondents highlighted poor access in rural areas, digital exclusion, and a postcode lottery in service provision. Face-to-face participants cited transport and digital barriers. Listening event attendees stressed the need for equity, not just equality, in access.
Involvement in Care	99.5% of survey respondents said it's important for frail people to be involved in care decisions. However, many reported not being assessed for frailty or having a care plan. Face-to-face feedback showed people often rely on family or wait until crisis to seek help.
Service Gaps	Professionals identified lack of early identification, under-resourced preventative services, and fragmented care. Public feedback echoed this, with many unaware of frailty services and reporting poor coordination and lack of a single point of contact.
Carer and Social Support	Both surveys and engagement sessions highlighted the importance of social connection and the role of unpaid carers. Many carers feel unsupported. Social groups were praised for maintaining wellbeing, but access was limited for non-drivers or isolated individuals.
Digital Tools and Communication	Survey showed digital confidence declines with age (only 32% of 75+ very confident). Face-to-face participants preferred printed materials and trusted sources like community groups. Listening event feedback stressed digital tools must not replace human interaction.
Professional Insights	Professionals called for better training, more community resources, and inclusive digital solutions. They noted that frailty is often not recognised early enough and that services are reactive rather than proactive.

We will

Year 1

- We will develop ways to reliably identify those at risk, or with, frailty.
- We will try different approaches to test ways of changing the way we organise and join up services to support healthy aging, this includes co-production and our workforce. We will evaluate these projects to make sure we use our resources well and meet the needs of our residents with good results.
- 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 Information Governance, and how we measure improvement to lay the foundations for the strategy. This will include developing a set of achievement to ensure we meet our aims and objectives.
- 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.

Year 2

- 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.

Year 3

- 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.

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Thank you

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Appendix

Key Links

Full survey questions

- Public Survey Questions
- Professional Survey Questions

Other strategies that are relevant to this piece of work:

- Draft Healthy Ageing and Frailty Strategy for 2025 to 2028
- Telford & Wrekin Council, Ageing Well Partnership Board. Co-produced by residents, Age UK, NHS, Healthwatch, and other partners, following an engagement survey (July–Sept 2022) with >2,800 responses the 2023–33 *Ageing Well Strategy*
- *JSNA data*
  - Telford & Wrekin Council | Joint Strategic Needs Assessment (JSNA) population headlines
  - JSNA - Joint Strategic Needs Assessment | Shropshire Council
- Shropshire, Telford and Wrekin's Joint Forward Plan
- 10 Year Health Plan for England: fit for the future - GOV.UK

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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
- Impaired memory and cognition
- Social isolation

- Physical inactivity
- Poor balance and falls
- Smoking and excess alcohol consumption
- 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.

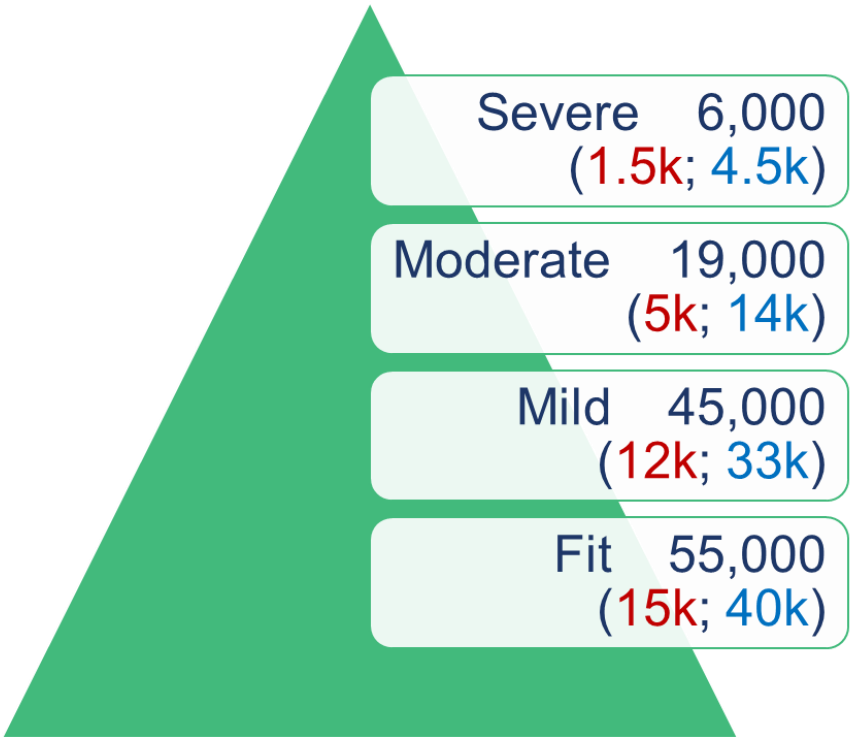


Figure 1. Estimated number of adults falling into eFI frailty categories in STW
Red = Telford and Wrekin residents; Blue = Shropshire residents

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].

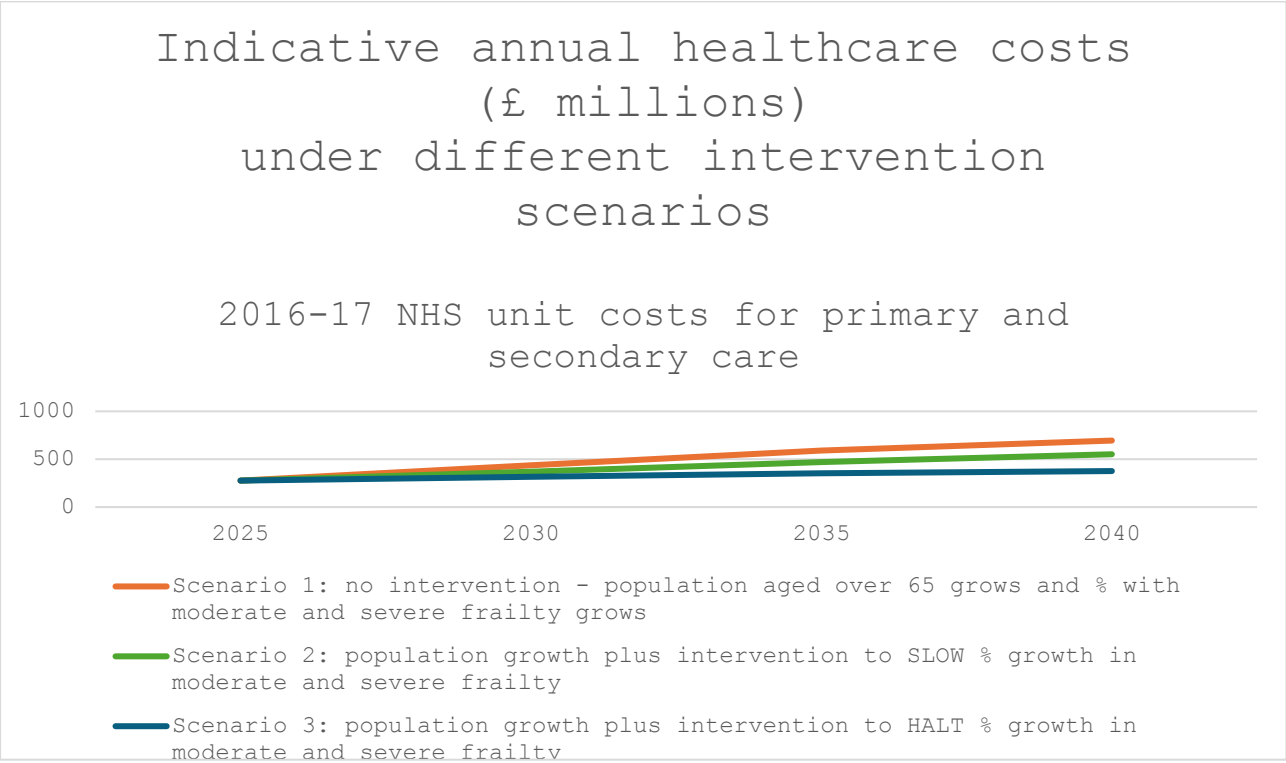


Figure 2 . Illustration of cost implications of different population frailty scenarios

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).

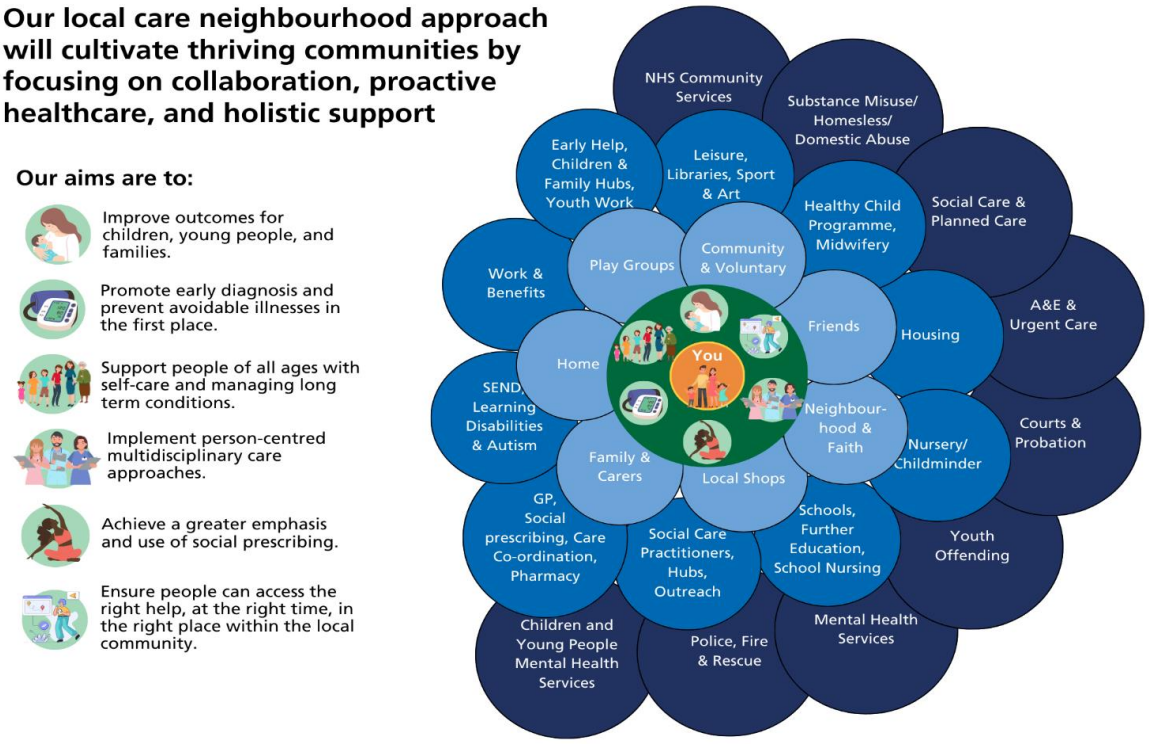


Figure 3. STW Local Care Neighbourhood Approach

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

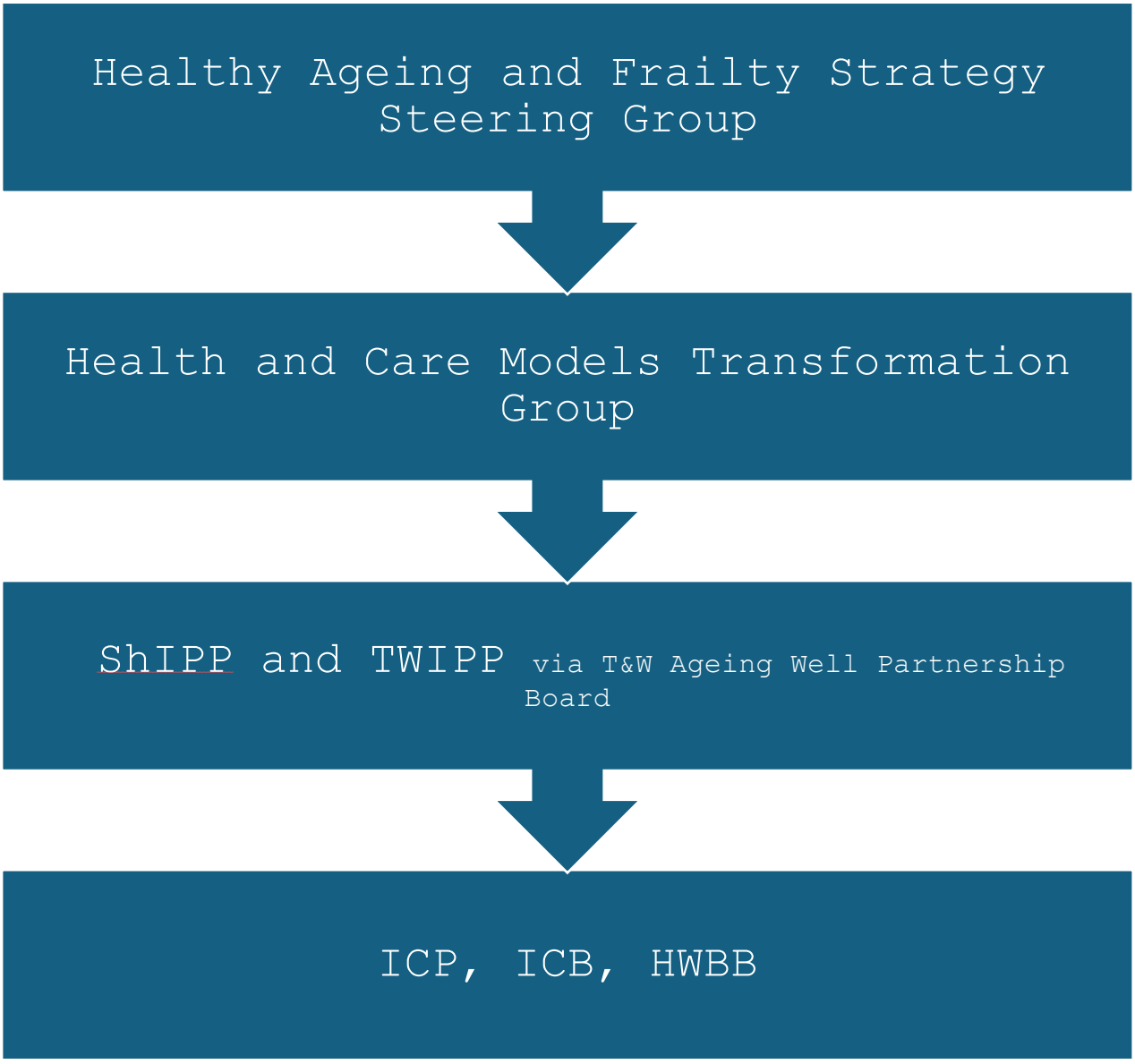
6. Support at end of life and level up end of life care

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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2. Clegg A, Bates C, Young J, et al. Development and validation of an electronic frailty index using routine primary care electronic health record data [published correction appears in Age Ageing. 2018;47(2):319]. *Age Ageing*. 2016;45(3):353-360. doi:10.1093/ageing/afw039

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