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
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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.