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.