SHROPSHIRE HEALTH AND WELLBEING BOARD
Report

Meeting Date	**18/09/2025**					
Title of report	**Healthy Ageing Strategy**					
This report is for (You will have been advised which applies)	Discussion and agreement of recommendations	x	Approval of recommendations (With discussion by exception)		Information only (No recommendations)	
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Which Joint Health & Wellbeing Strategy priorities does this report address? Please tick all that apply				
	Children & Young People		Joined up working	x
	Mental Health	x	Improving Population Health	x
	Healthy Weight & Physical Activity	x	Working with and building strong and vibrant communities	x
	Workforce	x	Reduce inequalities (see below)	x

What inequalities does this report address?

- Inequalities in health outcomes: People in deprived areas, certain ethnic minority communities, and those with chronic conditions face higher risks of early-onset frailty.
- Inequalities in access to services: Risks of inconsistent implementation and digital exclusion are recognised, with mitigations planned through inclusive service design.
- Disparities by deprivation and ethnicity: The Integrated Impact Assessment identifies these gaps and sets out targeted neighbourhood approaches to ensure inclusivity and equitable service delivery.
- Age-related inequalities: The strategy focuses on the protected characteristic of age, aiming to reduce inequities in healthy life expectancy and quality of life as people get older.

Report content

1. Executive Summary

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.

2. Recommendations

- Note the Healthy Ageing Strategy 2025-2028 fully aligns with both Health and Wellbeing Strategies and ShIPP and TWIPP priorities.
- The Health and Wellbeing Board supports the Healthy Ageing Strategy Implementation

3. Report

Introduction

The report seeks support 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

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.

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.

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.

Risk assessment and opportunities appraisal (*NB This will include the following: Risk Management, Human Rights, Equalities,*	An Integrated Impact Assessment has been completed and approved by the Equality Involvement Committee, Health Inequalities and quality team. The Integrated Impact assessment can be sent on request.

Community, Environmental consequences and other Consultation)		
Financial implications (*Any financial implications of note)*	None at this stage however as the Health Ageing Strategy develops, where there is opportunity to draw on external money to support change for aspects of the strategy, we will be proactive in this. Improvements will be tested using quality improvement methodology and where investment is required business cases will be developed and put through usual channels and priority assessments. Overall, this is a cultural change to how we proactively care for older people.	
Climate Change Appraisal as applicable	N/A	
Where else has the paper been presented?	System Partnership Boards	Telford & Wrekin Integrated Place Partnership Board To be presented Shropshire Integrated Place Partnership Board – 16/10/2025
	Voluntary Sector	CP meeting with Chief Officer Group (COG) 25/09 to discuss how best to share with VCSE Partners however key VCSE partners sit on both Place groups and boards.
	Other	System Place Accelerator groups Strategy and Prevention committee Equality and Involvement committee System Strategy & Development Group Quality and performance Committee – 25/09/2025
List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) Engagement Report and Integrated Impact Assessment can be provided on request.		
Cabinet Member (Portfolio Holder) or your organisational lead e.g., Exec lead or Non-Exec/Clinical Lead Vanessa Whatley – Chief Nursing Officer, NHS STW		
Appendices *A*ppendix A – STW Healthy Ageing Strategy Final DRAFT for approval Appendix B - Supporting Information for STW Healthy Ageing Strategy		