FRAILTY NEEDS ASSESSMENT REFRESH

Final 27.11.24

Farah Kidy (RRE) MPFT

Introduction

This needs assessment was carried out between April and October 2024 to inform the update of Staffordshire and Stoke-on-Trent's Healthy Ageing and Frailty Strategy. The aim was to identify current and potential future needs

Definition and importance of frailty.

Frailty is a long-term condition in which "multiple body systems gradually lose their in-built reserves resulting in an increased risk of unpredictable deterioration following minor events." (British Geriatric Society, 2023). Advancing frailty is associated with many negative consequences including hospitalisation, falls, admissions for long-term care, impaired quality of life and loneliness. (Emiel O Hoogendijk, 2019)

Conceptually, frailty is multidimensional with physical and psychological components; it is an extreme consequence of the ageing process; and it is dynamic. However, frailty is not an inevitable part of ageing and is preventable and reversible up to a point. (Emiel O Hoogendijk, 2019)

As the population ages we are likely to see continued increases in the very oldest groups in our communities. Though it should be remembered that not all older people are frail and not all frail people are old. This needs assessment and associated strategy aims to prepare the ICB for preventing frailty, reducing inequalities and responding to health and care needs of older adults.

Identifying Frailty

For service planning and academic purposes, frailty is can be identified using electronic tools applied to primary care records. The most widely used of these is the electronic frailty index (eFI). eFI was developed using a cumulative deficit framework and routinely collected primary care data. It includes 36 measures some of which are diagnoses and others of which are functional. (Table 1) It was developed and validated to identify those aged 65 years or older who are at increased risk of mortality, hospitalisation and nursing home admission. (Clegg A, 2016) It is conceptually a screening rather than diagnostic tool. (Rockwood, May 2016)

Activity limitation	Memory and cognitive problems
Anaemia and haematinic deficiency	Mobility and transfer problems
Arthritis	Osteoporosis
Atrial fibrillation	Parkinsonism and tremor
Cerebrovascular disease	Peptic ulcer
Chronic kidney disease	Peripheral vascular disease
Diabetes	Polypharmacy
Dizziness	Requirement for care
Dyspnoea	Respiratory disease
Falls	Skin ulcer
Foot problems	Sleep disturbance
Fragility fracture	Social vulnerability
Hearing impairment	Thyroid disease
Heart failure	Urinary incontinence
Heart valve disease	Urinary system disease
Housebound	Visual impairment
Hypertension	Weight loss and anorexia
Hypotension/syncope	Ischaemic heart disease

Table 1 Showing conditions and states contributing the electronic frailty index

Screening and the prevalence of frailty.

Screening for frailty was introduced as part of the GP contract in 2017/18. eFI was one was of the recommended screening tools, but there was encouragement to use Gait Speed Test, PRISMA-7, Rockwood Score or Timed up and Go test to make the diagnosis. (NHS England, n.d.) At an ICB level, 10.6% of eligible patients are screened. At an ICB level more eligible patients are screened than most of our demographic peers (Figure 1). However, there is variability across the patch with 17.5% of eligible patients being screened in Stoke-on-Trent and only 4.8% being screened in Cannock Chase. (Figure 2) It should be noted that public-facing data around this activity are dated.

Getting robust estimates of the population with diagnosed rather than screened frailty is challenging. Based on diagnosis after screening in primary care, there were 4,081 patients identified with moderate frailty and 3,576 diagnosed with severe frailty in the period 2020/21 in SSOT (www.model.nhs.uk). For smaller scale geographies, data are reported as the proportion of patients aged 65 years or older with a diagnosis of moderate or severe frailty. Applying these data to population figures for 2024 and 2034 on a CCG footprint gives the estimates shown in *Table 2*. To account for the poor coverage, estimates have been generated for the prevalence of frailty should all those aged 65 years old be screened. This assumes that the distribution of frailty remains the same. (*Table 2*)

Using data from The English Longitudinal Study of Ageing and the Cognitive Function and ageing study, Sinclair et al (2020) modelled the prevalence of frailty and pre-frailty in Local Authority areas, in those aged 65 years and older. The criteria for frailty were taken from a number of different tools and so the data are not directly comparable to eFI-based estimates (David Sinclair, 2020) Data are reported as a percentage of the total population in the local authority area. Applying these rates to ONS Census 2021 data generates very different estimates of frailty. (*Table 3*)

These two data sets give very different estimates of the current and future burdens of frailty. This is due to the different definitions applied and the slightly different geography. Sinclair et al have used a larger number of variables than would fall into eFI moderate but a smaller number than would fall into eFI severe to define frailty. They have also weighted the parameters according to the functional deficit they may cause. Both data sources agree that there is a substantial burden across the ICB and that this will increase.

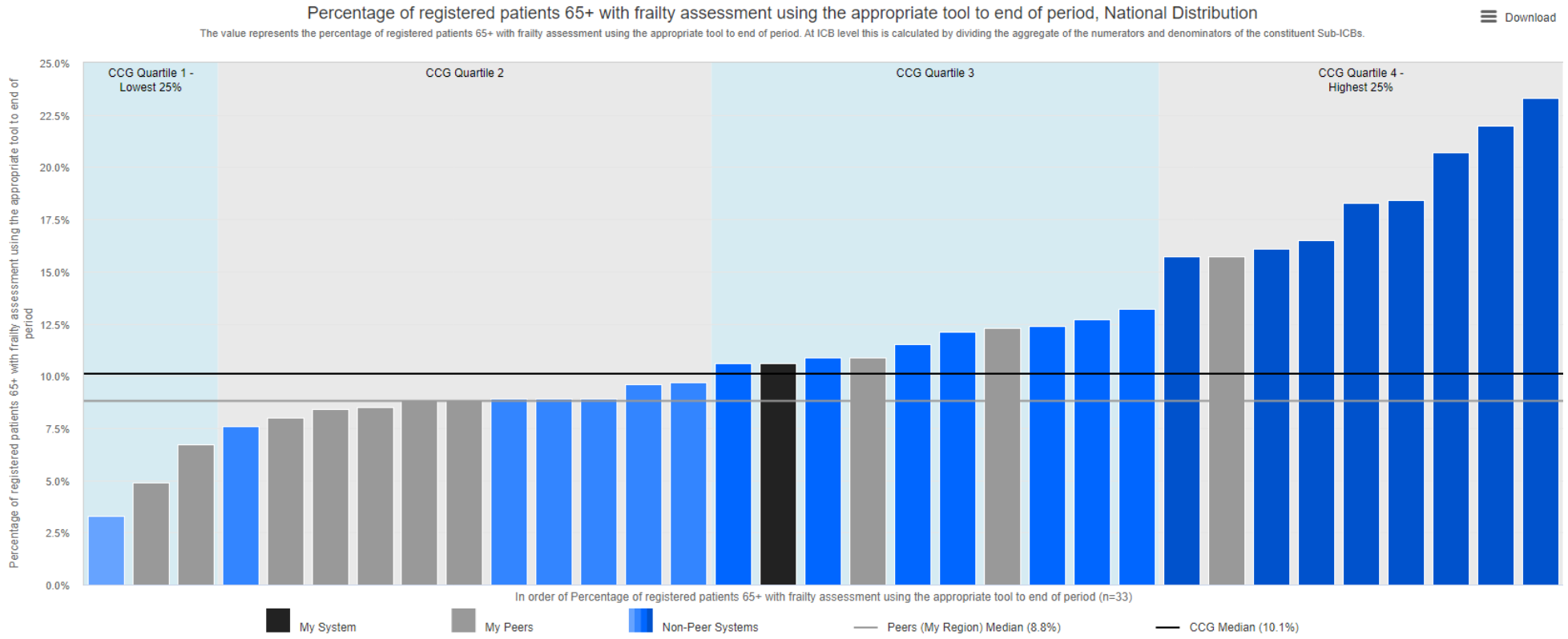


Figure 1 Showing the percentage of eligible patients who are assessed for frailty, by ICB. 2020/21. www.model.nhs.uk

Black bar = SSOT

Grey bars = demographic peers.

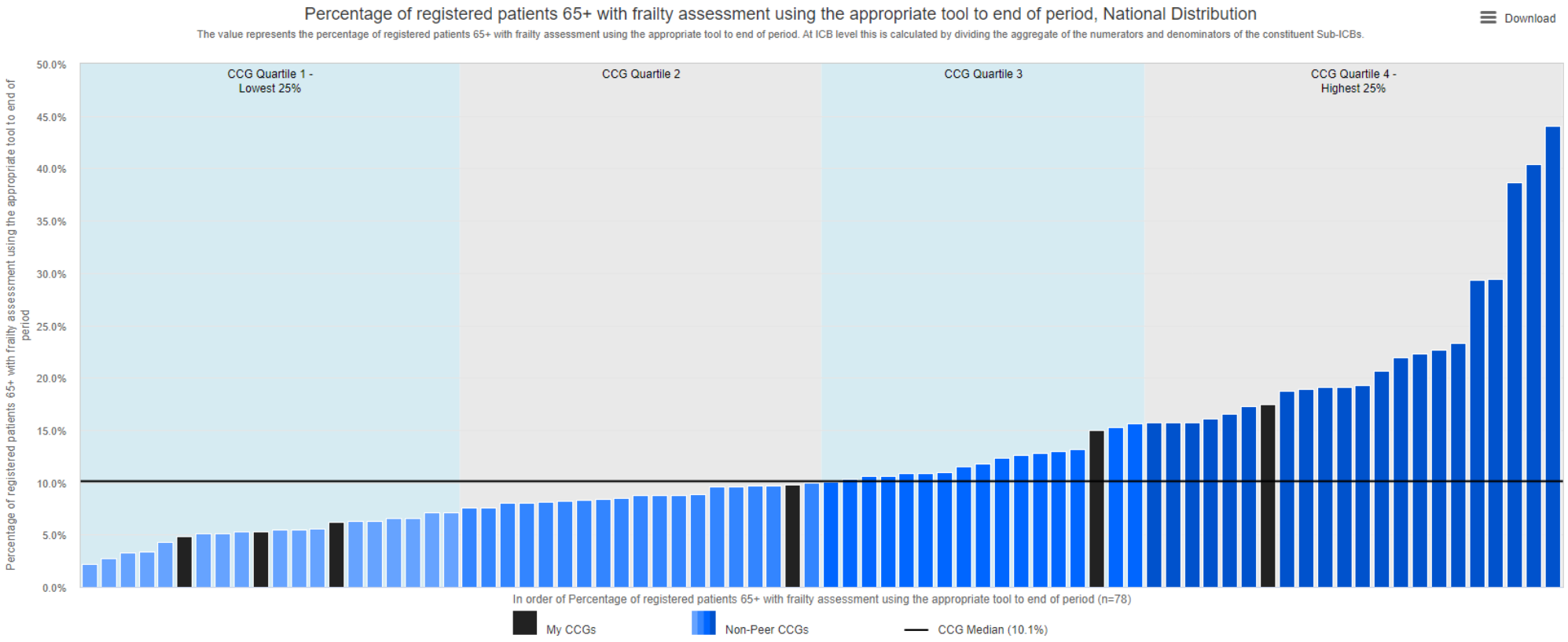


Figure 2 Showing the percentage of eligible patients who are assessed for frailty, by CCG. 2020/21. www.model.nhs.uk

Black bars are the CCGs in SSOT – from right to left – Stoke, North Staffordshire, East Staffordshire, Stafford and surrounds, South east Staffordshire and Cannock Chase

CCG area	pop 65+ 2024	pop 65+ 2034	coverage	Mod (%)	n - current, 2024	n- full, 2024	n - current, 2034	n-full 2034	Sev (%)	n - current -2024	n- full -2024	n - current 2034	full 2034	Total mod plus severe current 2024	Total mod plus severe full 2034
Stoke-on-Trent	49214	56933	17.5	4.1	2018	11530	2334	13339	4.1	2018	11530	2334	13339	23060	26677
Cannock Chase	29717	35953	4.8	0.3	89	1857	108	2247	0.3	89	1857	108	2247	3715	4494
North Staffordshire	52010	60180	15.0	3.0	1560	10402	1805	12036	1.6	832	5548	963	6419	15950	18455
Stafford and surrounds	39398	47359	6.2	1.2	473	7625	568	9166	0.7	276	4448	332	5347	12074	14513
East Staffordshire	27973	34465	9.8	1.2	336	3425	414	4220	0.6	168	1713	207	2110	5138	6330
South East Staffordshire and Seisdon peninsula	55061	63483	5.3	0.9	496	9350	571	10780	0.5	275	5194	317	5989	14544	16769
Total					**4971**	**44190**	**5801**	**51788**		**3658**	**30290**	**4261**	**35451**	**74,480**	**87,239**

Table 2 Showing estimated numbers of people with moderate and severe frailty. Calculated from frailty rates (www.model.nhs.uk) 2020/21 and population statistics from ONS. Numbers have been rounded. Pop = population, Mod = moderate, Sev = severe, n= number. Current = applying rates of completeness of frailty screening seen in "coverage". Full = assuming all eligible 65+ years adults are screened and frailty distribution does not change

Local Authority	pop 2024	pop 2034	Pre-frail (%)	n -2024	n-2034	Frail (%)	n -2024	n-2034	Total -2024	Total -2034
Stoke-on-Trent	260757	266893	3.1	8083	8274	1.5	3911	4003	11995	12277
Cannock Chase	104320	110030	3.1	3234	3411	1.2	1252	1320	4486	4731
East Staffordshire	123098	129031	3	3693	3871	1.1	1354	1419	5047	5290
Lichfield	106432	109651	2.6	2767	2851	0.8	851	877	3619	3728
Newcastle-under-Lyme	132994	138079	3.2	4256	4419	1.2	1596	1657	5852	6075
South Staffordshire	114126	117351	2.7	3081	3168	0.8	913	939	3994	4107
Stafford	142519	150817	2.8	3991	4223	1.1	1568	1659	5558	5882
Staffordshire Moorlands	99345	100302	2.7	2682	2708	0.8	795	802	3477	3511
Tamworth	76167	75785	2.9	2209	2198	1.1	838	834	3047	3031
Total				**33996**	**35122**		**13078**	**13511**	**47,074**	**48,633**

Table 3 Showing estimated numbers of people who are pre-frail or living with frailty, by Local Authority area. Calculated from frailty rates in Sinclair et al, and Census 2021 population statistics. Pop= population n= number. Numbers have been rounded

Local estimates

Applying eFI to ICB data curated by Graphnet allows a different estimate for frailty and how this will change. (Figure 3)

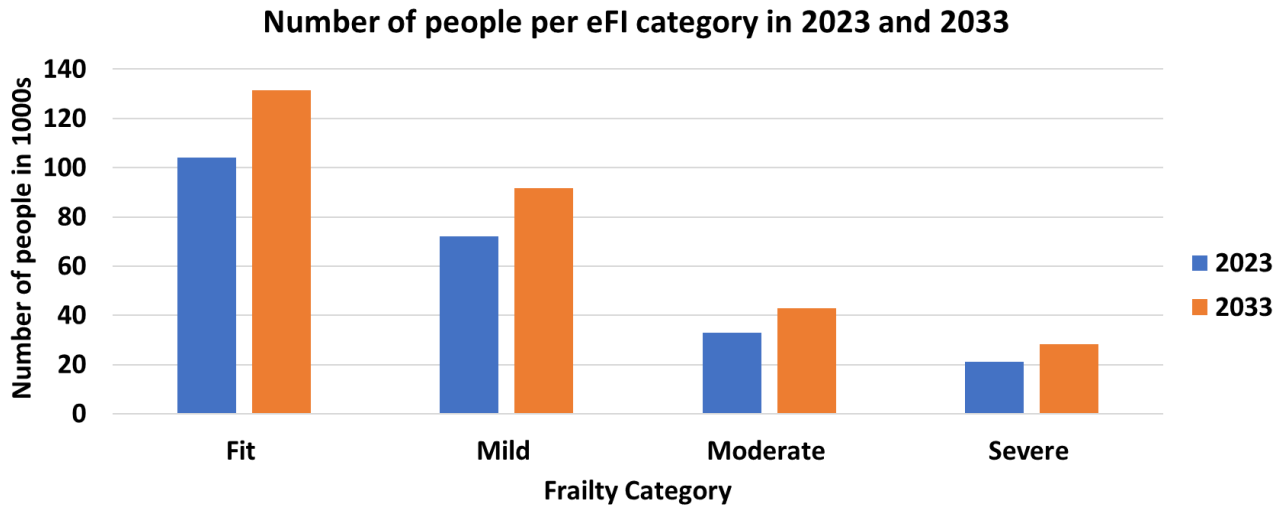


Figure 3 Showing current and future estimates of frailty using ICB data curated by Graphnet.

Costs of frailty.

Costs of frailty can be difficult to measure. Fogg et al, 2024, provide estimates of primary and secondary costs. These increase exponentially with increases in eFI category. (Figure 4) However the large number of people in the mild frailty category means that absolute costs are greatest for this group. (Fogg C, 2024) Some caution is needed in interpreting the results since the confidence intervals around estimates are large.

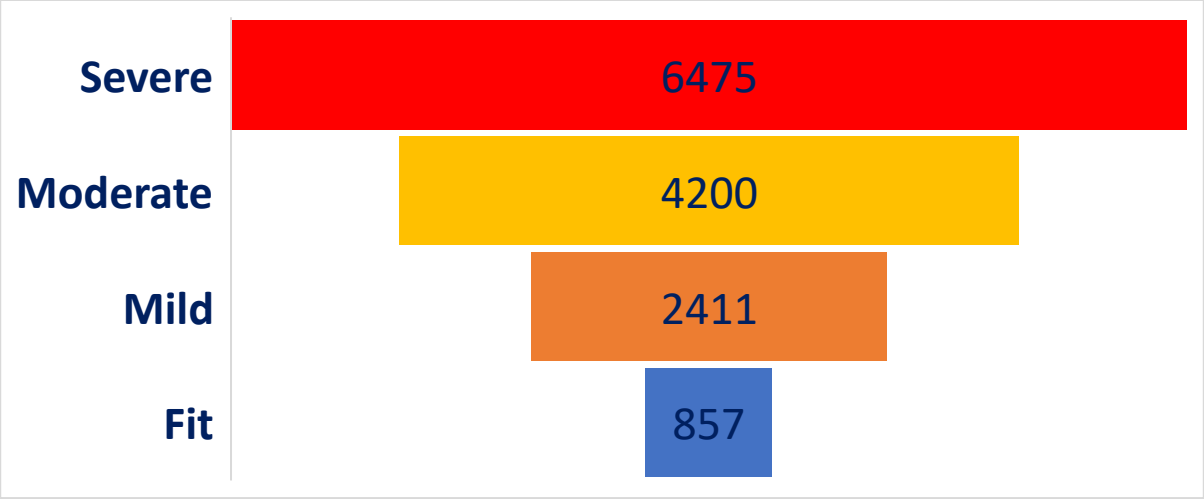


Figure 4 Showing mean cost in GBP per person per year according to eFI frailty category as reported in (Fogg C, 2024)

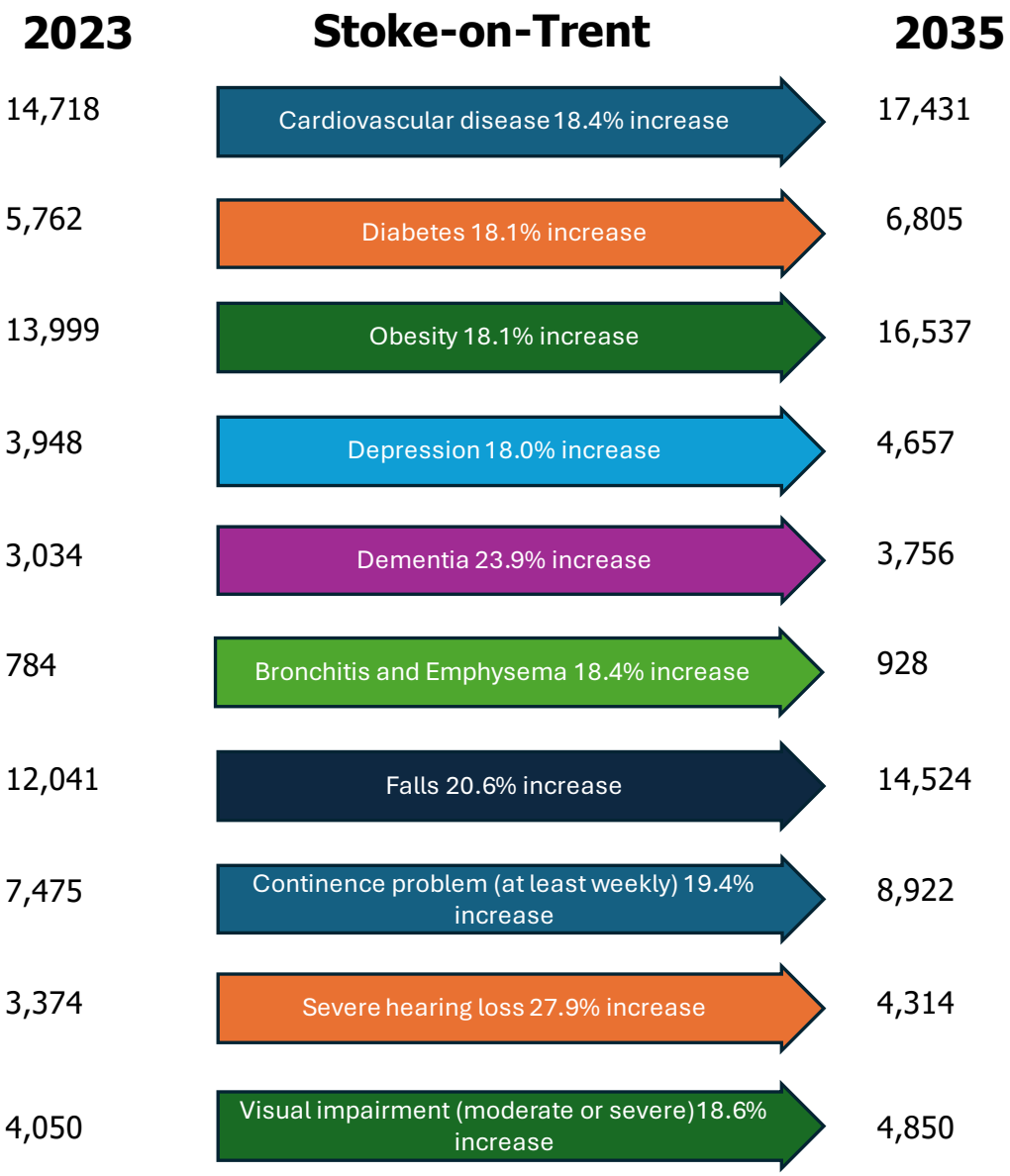
Prevalence of Multimorbidity

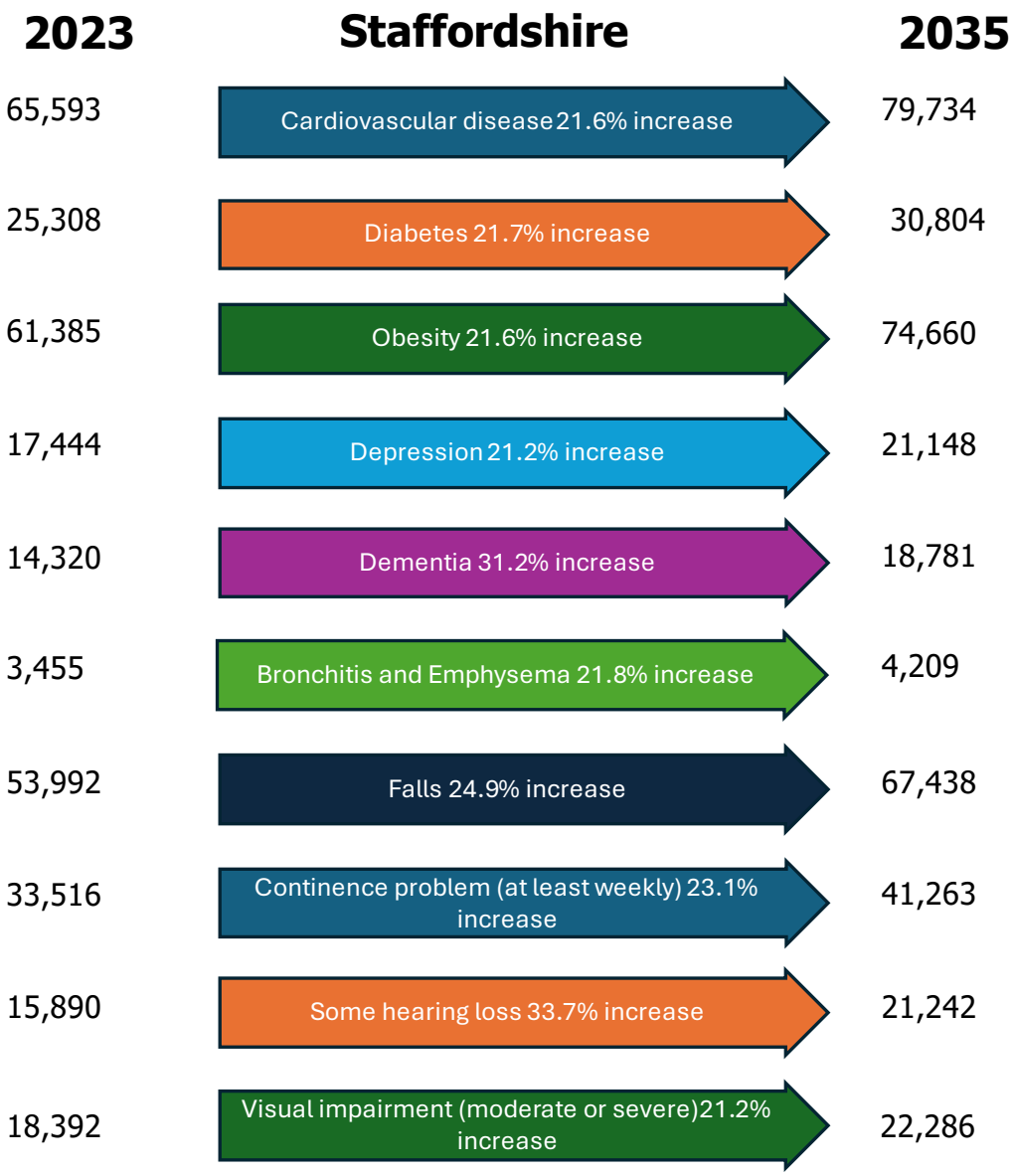
Estimates of multimorbidity in England return inconsistent results. In a study of over 60 million patients in England derived from secondary care usage data, 20.1% of those aged 60-69, 25% of those aged 70-79 and 21.5% of those aged 80 or older had two or more long-term conditions. Increasing deprivation and advancing age were strongly associated with the presence of multimorbidity. Females and those from of Asian ethnicity had a slightly increased risk (Valabhji J,

2024). Complex multimorbidity occurs up to 7 years earlier in those living in the most deprived centile compared to those living in the least deprived centile. (Head, 2021) Diseases cluster together with hypertension, pain and mood disorders often complicating other chronic illnesses. (NICE CKS, 2024)

We can expect between 1 in 5 and 1 in 4 of the older adults in the ICB will be living with multimorbidity. These rates are likely to be higher in more deprived areas. Many the most common conditions contributing to multimorbidity are likely to increase over the next decade. Increases are particularly large in dementia, falls, severe hearing loss and continence problems. Figure 5 Disease clusters offer an opportunity to identify and treat co-morbidities early. Many of the most common conditions contributing to multimorbidity are captured by the eFI, so the overlap between frailty and multimorbidity in our data will be large.

Figure 5 Showing projected changes in health conditions in adults aged 65 or older, in Stoke-on-Trent and Staffordshire.. Considers changes in demographics but not changes in disease epidemiology Data from www.poppi.org.uk Derived from ONS data. Crown copyright 2020


2023
Stoke-on-Trent
2035
14,718
Cardiovascular disease 18.4% increase
17,431
5,762
Diabetes 18.1% increase
6,805
13,999
Obesity 18.1% increase
16,537
3,948
Depression 18.0% increase
4,657
3,034
Dementia 23.9% increase
3,756
784
Bronchitis and Emphysema 18.4% increase
928
12,041
Falls 20.6% increase
14,524
7,475
Continence problem (at least weekly) 19.4% increase
8,922
3,374
Severe hearing loss 27.9% increase
4,314
4,050
Visual impairment (moderate or severe) 18.6% increase
4,850



Screening and diagnosis

NHS health checks can be viewed as an early tool for the identification of single or multiple morbidities. Attendance at NHS health checks has been shown to be associated with a long-term decrease in all-cause mortality and multi-organ disease if there is follow up after the initial diagnoses are made. (McCracken, 2024) From a healthy ageing perspective, this offers a route into early detection and management of risk factors.

The cumulative percentage of the eligible population aged 40-74 who received an NHS Health check between 2018/19 and 2022/23 is 6.2% in Staffordshire and 23.7% in Stoke-on-Trent. These are both significantly lower than the England rates. There has been a steady downward trajectory exceeding the decline in England since 2013 in Staffordshire. (Figure 6)

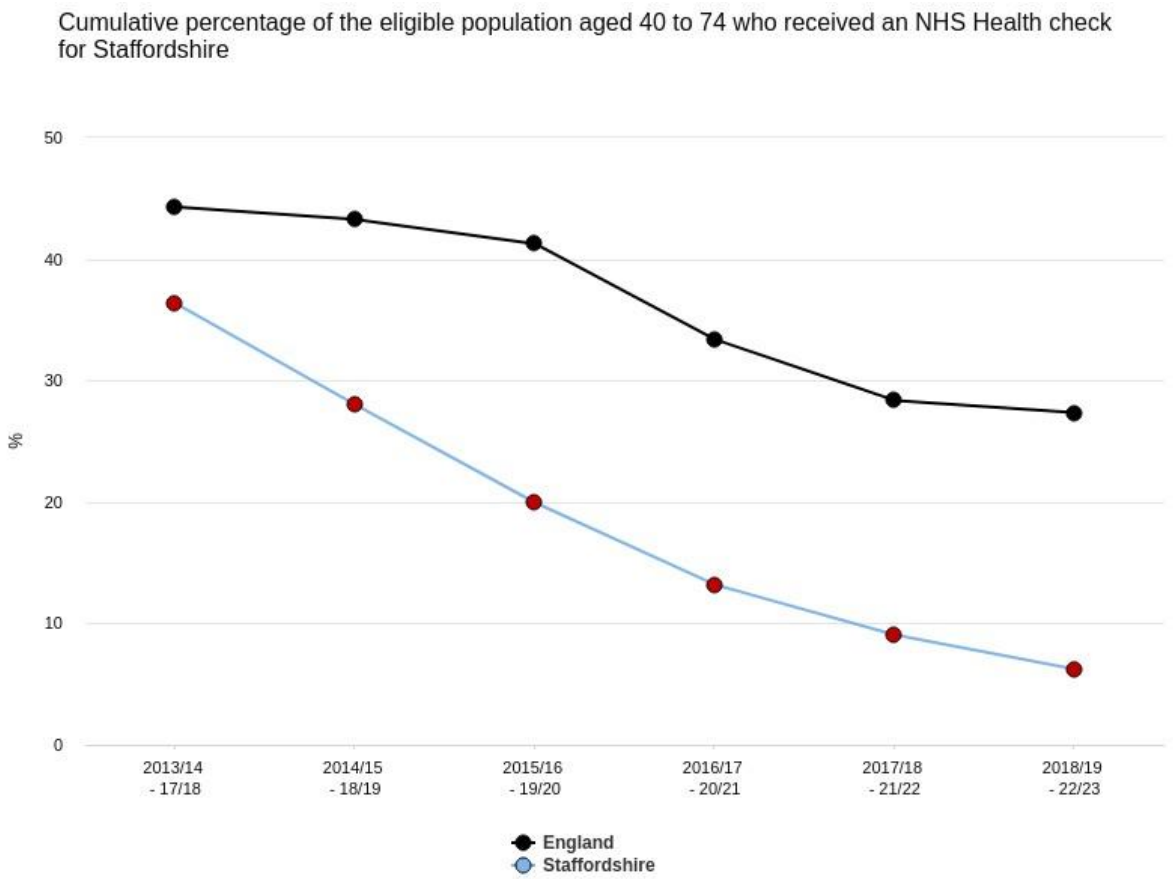


Figure 6 Showing trends in cumulative percentage of the eligible population aged 40-74 who received an NHS Health check in Staffordshire Source: OHID [Public health profiles - OHID (phe.org.uk)]

In Stoke-on-Trent, NHS Health Check coverage was significantly better than in England until the most recent data cycle. (Figure 7)

Whilst some of the steeper areas of the decline across the ICB are likely to be an effect of the pandemic, the general downward trend had begun before this.

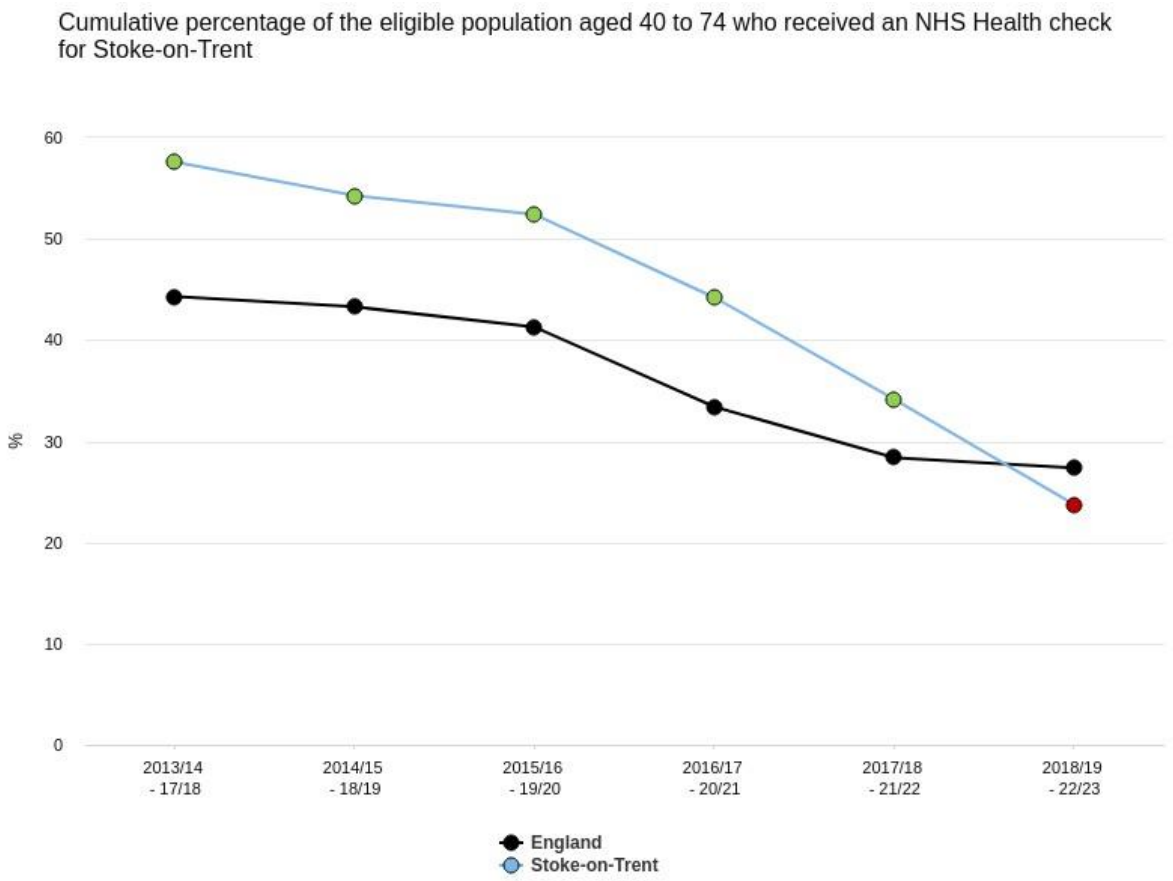


Figure 7 Showing trends in cumulative percentage of the eligible population aged 40-74 who received an NHS Health check in Stoke-on-Trent Source: OHID Public health profiles - OHID (phe.org.uk)

Take home messages

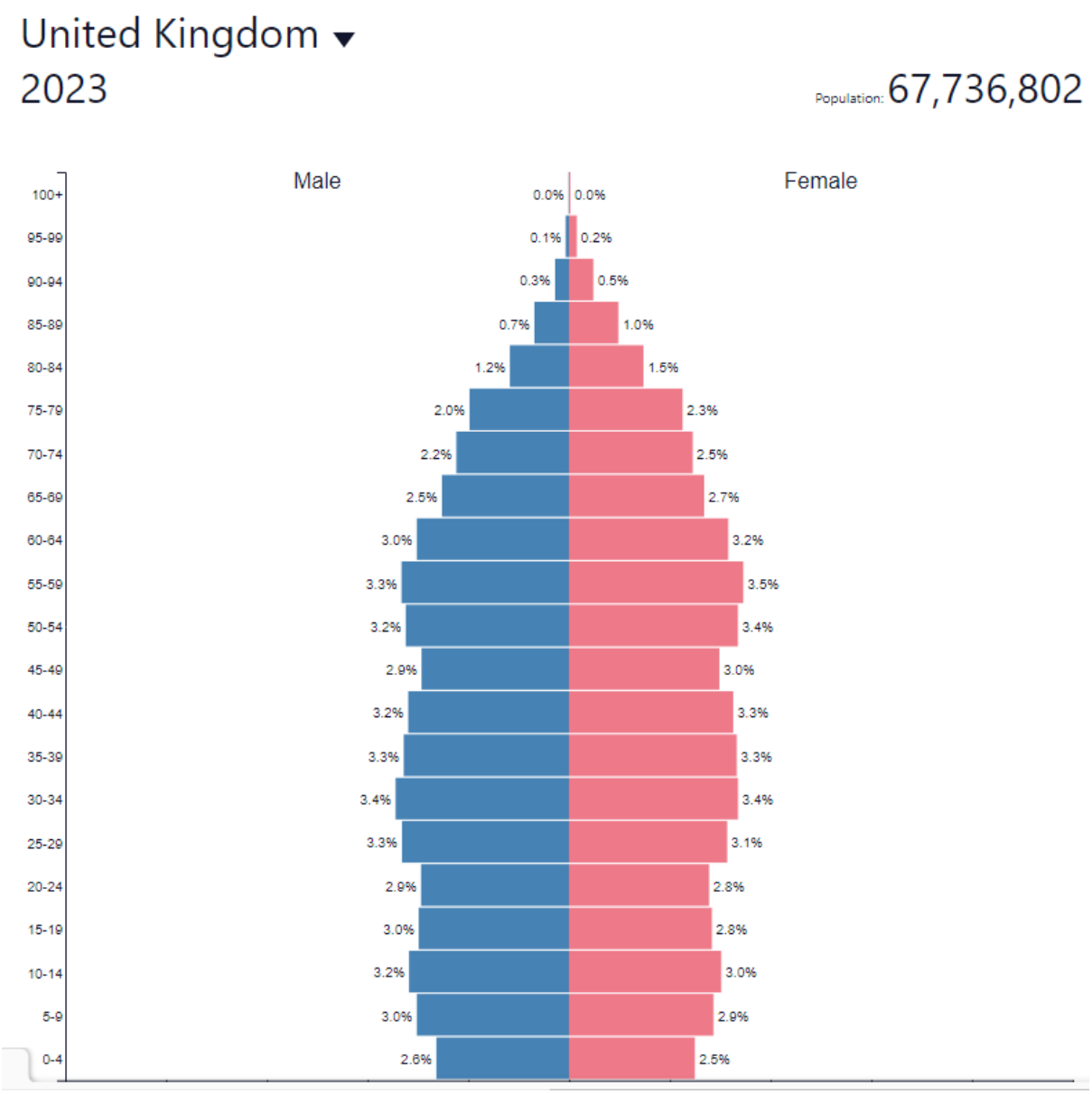
There are sufficient data from screening tools to estimate the burden of frailty. But this is not the same as a diagnosis. The error margin around screening needs to be taken into consideration when service planning. There are existing mechanisms to encourage screening for and diagnosis of frailty and morbidities in primary care, but uptake is poor.

Risk factors for frailty, deterioration and inequality

Both modifiable and non-modifiable risk factors are included.

Age and life expectancy

Age is a key driver for frailty. Over the next 30 years the population of the United Kingdom will continue to age with the proportion of those aged 80 or older approximately doubling (males: 2.3% to 4.7%, females: 3.2% to 5.9%). (Figure 8)


United Kingdom
2023
Population: 67,736,802
Male
Female
100+
95-99
90-94
85-89
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4
0.0% 0.0%
0.1% 0.2%
0.3% 0.5%
0.7% 1.0%
1.2% 1.5%
2.0% 2.3%
2.2% 2.5%
2.5% 2.7%
3.0% 3.2%
3.3% 3.5%
3.2% 3.4%
2.9% 3.0%
3.2% 3.3%
3.3% 3.3%
3.4% 3.4%
3.3% 3.1%
2.9% 2.8%
3.0% 2.8%
3.2% 3.0%
3.0% 2.9%
2.6% 2.5%

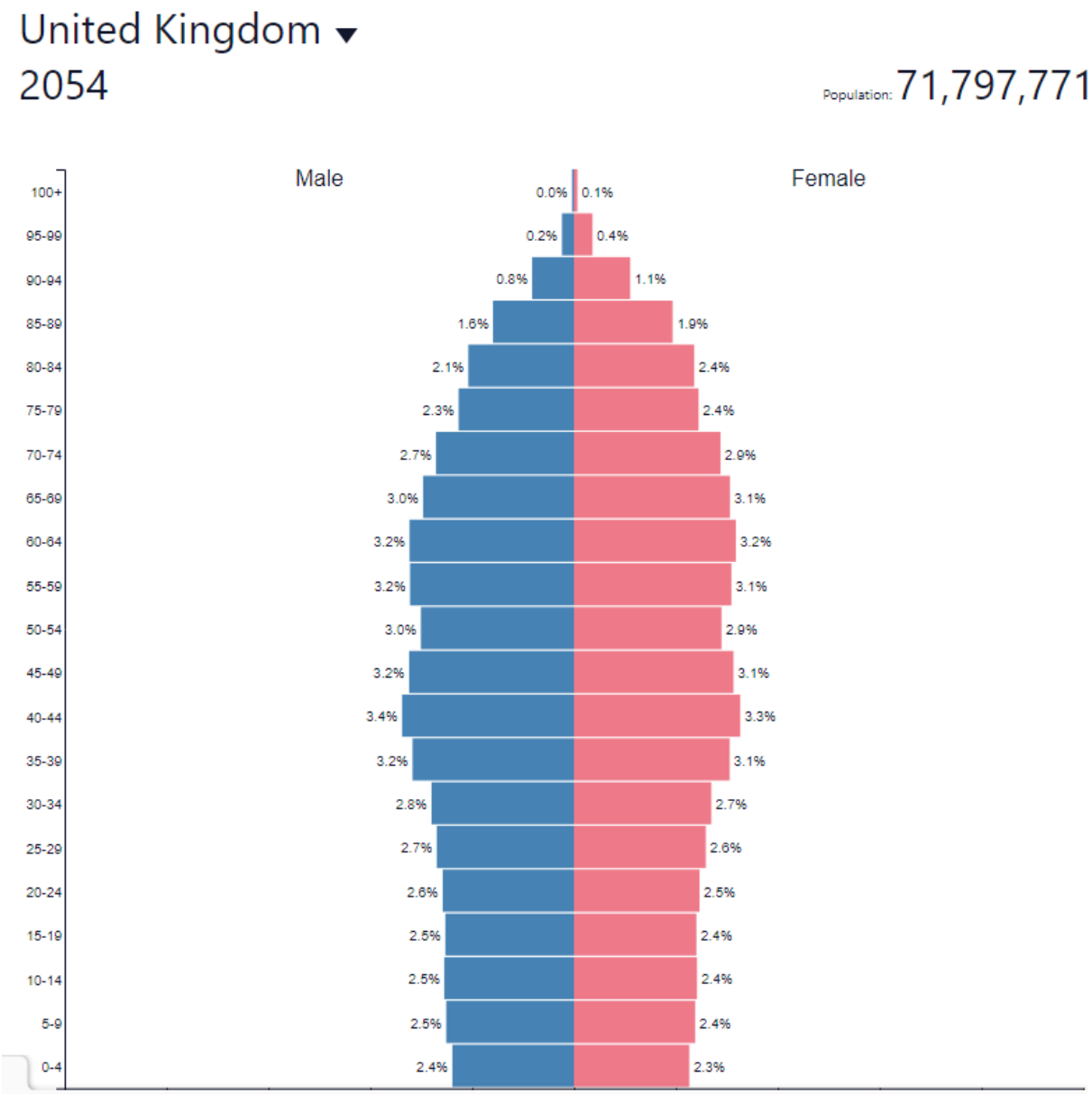


Figure 8 Showing population pyramids for the United Kingdom

From https://www.populationpyramid.net/ - last accessed April 2024

Data from Census 2021 are available for a limited number of variables at time of writing. Figure 9 and Table 4 show that there is variation in the proportion of the population in different age bands across Staffordshire and Stoke-on-Trent. There are a higher proportion of older people in Lichfield, Staffordshire Moorlands and South Staffordshire. Whilst in Stoke-on-Trent and Tamworth, there are higher proportions of the future older population.

		40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+	total
Stoke-on-Trent	n	15100	15251	16615	16160	14241	12196	11792	8560	5858	3434	1818	121023
	%	6.0%	6.0%	6.6%	6.4%	5.6%	4.8%	4.7%	3.4%	2.3%	1.4%	0.7%	
Stafford	n	7802	8510	10087	9926	8804	7842	8297	6573	4395	2405	1443	76085
	%	5.8%	6.4%	7.6%	7.4%	6.6%	5.9%	6.2%	4.9%	3.3%	1.8%	1.1%	
Staffordshire Moorlands	n	4849	5998	7706	7583	6776	6282	6956	5201	3483	1907	1053	57794
	%	5.1%	6.3%	8.1%	8.0%	7.1%	6.6%	7.3%	5.5%	3.7%	2.0%	1.1%	
South Staffordshire	n	5633	6611	8267	8708	7815	6794	7289	5934	4031	2279	1107	64468
	%	5.2%	6.2%	7.7%	8.1%	7.3%	6.3%	6.8%	5.5%	3.8%	2.1%	1.0%	
Tamworth	n	4590	5062	5673	5101	4605	4288	4203	2957	1811	998	495	39784
	%	5.9%	6.5%	7.3%	6.6%	6.0%	5.5%	5.4%	3.8%	2.3%	1.3%	0.6%	
Newcastle under Lyme	n	6750	7430	8729	8704	7830	6786	7235	5281	3727	2282	1178	65932
	%	5.6%	6.1%	7.2%	7.2%	6.5%	5.6%	6.0%	4.4%	3.1%	1.9%	1.0%	
Lichfield	n	5950	6783	7940	7773	6627	6096	6856	5731	3595	1896	969	60217
	%	5.7%	6.5%	7.6%	7.5%	6.4%	5.9%	6.6%	5.5%	3.5%	1.8%	0.9%	
East Staffordshire	n	7345	7671	8809	8567	7454	6111	6171	4659	3086	1827	1016	62714
	%	6.1%	6.3%	7.3%	7.1%	6.2%	5.1%	5.1%	3.9%	2.6%	1.5%	0.8%	
Cannock Chase	n	5529	6320	7694	7408	6023	5271	5291	3946	2601	1385	762	52229
	%	5.6%	6.4%	7.8%	7.5%	6.1%	5.3%	5.4%	4.0%	2.6%	1.4%	0.8%	
West Midlands	n	346439	358524	399959	387298	333203	289466	290042	222135	154229	92077	51218	2924589
	%	6.0%	6.2%	7.0%	6.7%	5.8%	5.0%	5.0%	3.9%	2.7%	1.6%	0.9%	
England and Wales	n	3629086	3669538	3998930	3941142	3392156	2906736	2941409	2138156	1490930	907272	514313	29529668
	%	6.3%	6.4%	6.9%	6.8%	5.9%	5.0%	5.1%	3.7%	2.6%	1.6%	0.9%	

Table 4 Showing the population in structure in Staffordshire and Stoke-on-Trent.

Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.3.0. Based on 2021 Census data

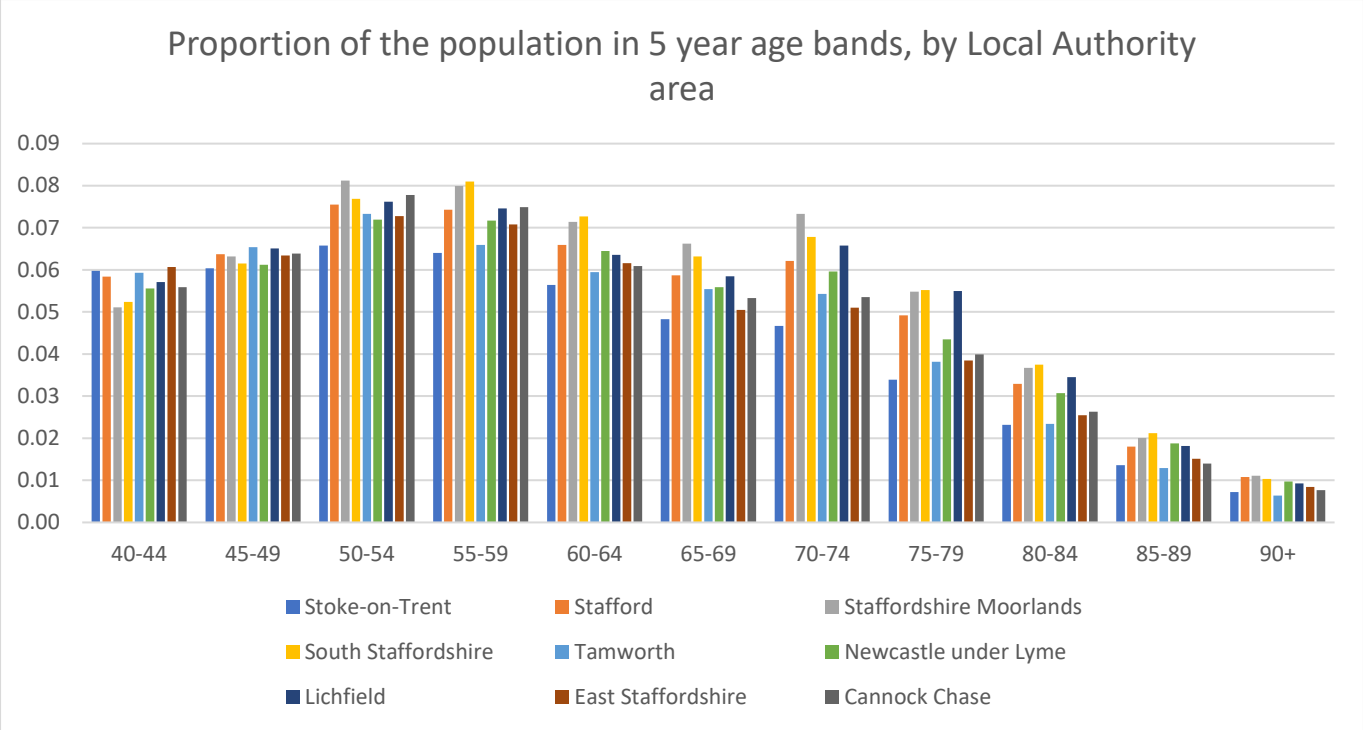


Figure 9 Showing the proportion of the population in 5 year age bands, by Local Authority area

Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.3.0. Based on 2021 Census data

Population projects are based on 2018 data and show that the proportion of the population aged 65 years and older will continue to increase in the area, albeit less quickly than in England as a whole. (Table 5) The rate of change is varied across the ICB footprint with Cannock Chase, East Staffordshire and Stafford showing the greatest projected increases. Lichfield, Staffordshire Moorlands and Stoke-on-Trent show the smallest increases. (Table 6)

Age 65+	2023	2028	% change 2023-28	2033	%change 2023-33
Staffordshire	203,591	221,420	8.76%	240,968	18.36%
Stoke-on-Trent	46,094	49,561	7.52%	53,275	15.58%
Staffordshire & Stoke-on-Trent	249,685	270,982	8.53%	294,244	17.85%
West Midlands	1,165,113	1,268,800	8.90%	1,387,085	19.05%
England	11,041,499	12,175,728	10.27%	13,408,469	21.44%

Table 5 Showing population projections, 65 years or older, for the ICB area

Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.3.0. Based on 2018 national population projections

Age 65+	2023	2028	% change 2023-28	2033	%change 2023-33
Cannock Chase	20,636	22,791	10.4%	25,387	23.0%
East Staffordshire	24,919	27,830	11.7%	31,050	24.6%
Lichfield	26,201	27,797	6.1%	29,663	13.2%
Newcastle-under-Lyme	28,033	30,227	7.8%	32,488	15.9%
South Staffordshire	29,239	31,752	8.6%	34,382	17.6%
Stafford	32,889	36,157	9.9%	39,837	21.1%
Staffordshire Moorlands	25,889	27,771	7.3%	29,881	15.4%
Tamworth	15,784	17,095	8.3%	18,281	15.8%
Staffordshire	203,591	221,420	8.8%	240,968	18.4%
Stoke-on-Trent	46,094	49,561	7.5%	53,275	15.6%
Staffordshire & Stoke-on-Trent	249,685	270,982	8.5%	294,244	17.8%
West Midlands	1,165,113	1,268,800	8.9%	1,387,085	19.1%
England	11,041,499	12,175,728	10.3%	13,408,469	21.4%

Table 6 Showing population projections, 65 years or older, for the ICB area by sub-geography

Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.3.0. Based on 2018 national population projections

However, focussing in on the oldest age groups shows a different distribution. In Staffordshire, the projected increase in this age group is approximately 10% greater than in England and approximately 12% greater than in the West Midlands. (Table 7) And looking at sub-geographies, projected increases in Tamworth and Lichfield are greater than other areas. (Table 8)

Age 85+	2023	2028	% change 2023-28	2033	%change 2023-33
Staffordshire	25,832	30,331	17.42%	38,784	50.14%
Stoke-on-Trent	5,187	5,673	9.37%	7,026	35.45%
Staffordshire & Stoke-on-Trent	31,019	36,004	16.07%	45,809	47.68%
West Midlands	159,077	178,090	11.95%	219,784	38.16%
England	1,511,088	1,675,779	10.90%	2,122,470	40.46%

Table 7 Showing population projections, 85 years or older, for the ICB area

Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.3.0. Based on 2018 national population projections

Age 85+	2023	2028	% change 2023-28	2033	%change 2023-33
Cannock Chase	2,549	2,976	16.7%	3,784	48.5%
East Staffordshire	3,210	3,716	15.8%	4,786	49.1%
Lichfield	3,390	4,166	22.9%	5,340	57.5%
Newcastle-under-Lyme	3,911	4,333	10.8%	5,480	40.1%
South Staffordshire	3,846	4,535	17.9%	5,590	45.3%
Stafford	4,268	5,129	20.2%	6,547	53.4%
Staffordshire Moorlands	3,034	3,508	15.6%	4,634	52.7%
Tamworth	1,623	1,967	21.2%	2,623	61.6%
Staffordshire	25,832	30,331	17.4%	38,784	50.1%
Stoke-on-Trent	5,187	5,673	9.4%	7,026	35.4%
Staffordshire & Stoke-on-Trent	31,019	36,004	16.1%	45,809	47.7%
West Midlands	159,077	178,090	12.0%	219,784	38.2%
England	1,511,088	1,675,779	10.9%	2,122,470	40.5%

Table 8 Showing population projections, 85 years or older, for the ICB area by sub-geography

Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.3.0. Based on 2018 national population projections

Life expectancy in general and healthy life expectancy in particular offer a different perspective on the ageing process.

At age 65, the life expectancy for females is approximately 2 years longer than for males. However, there is little difference between disability-free or healthy life expectancy between the sexes. Therefore, females are spending longer living with a disability or in poor health. (Table 9)

Life expectancy in Stoke-on-Trent is lower than that in Staffordshire or England. And more years are spent living with a disability or in poor health. (Table 9)

	Sex	Age	Time period	England	Staffordshire	Stoke-on-Trent
Life expectancy at 65	Male	65	2020 - 22	18.4	18.4	17
Life expectancy at 65	Female	65	2020 - 22	20.9	21	19.2
Disability-free life expectancy at 65	Male	65	2018 - 20	9.8	9.9	7.1
Disability-free life expectancy at 65	Female	65	2018 - 20	9.9	9	7
*Time spent living with a disability	Male	65	2018 - 20	8.6	8.5	9.9
*Time spent living with a disability	Female	65	2018 - 20	11	12	12.2
Healthy life expectancy at 65	Male	65	2018 – 20	10.5	11.6	7.1
Healthy life expectancy at 65	Female	65	2018 – 20	11.3	11	7.2
*Time spent living in poor health	Male	65	2018 – 20	7.9	6.8	9.9
*Time spent living in poor health	Female	65	2018 – 20	9.6	10	12

Table 9 Showing selected measures of life expectancy. www.fingertips.phe.org.uk

**= calculated from the rows above*

Source: Productive Healthy Ageing Profile, Finger Tips

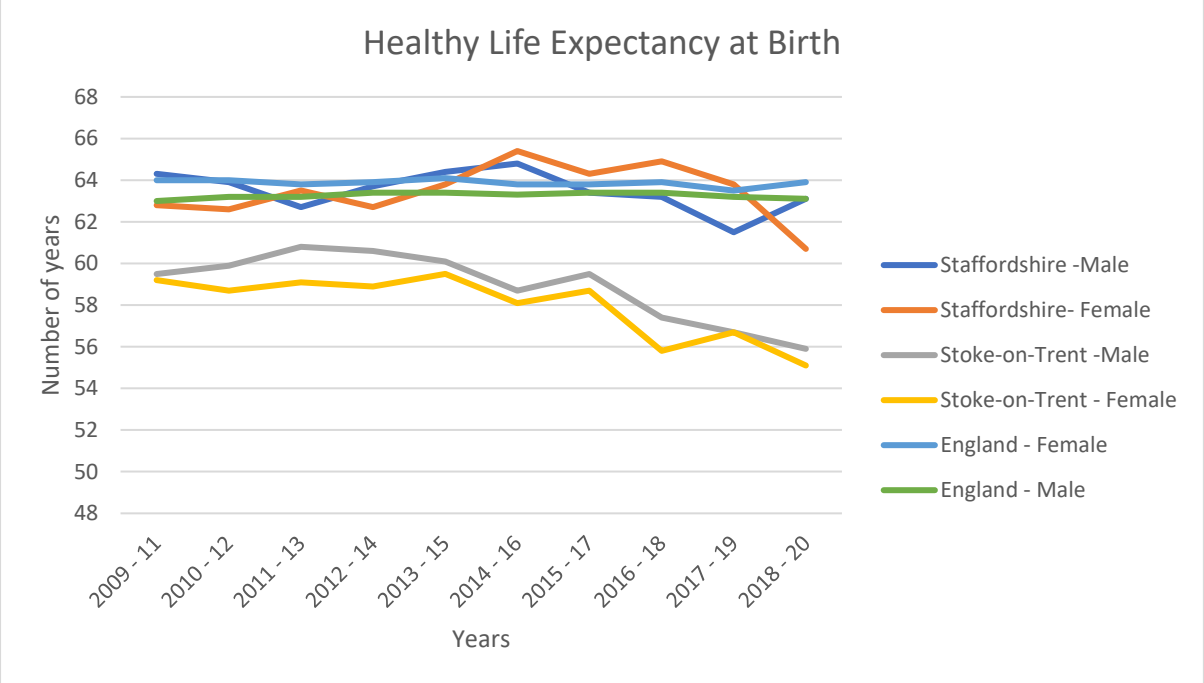


Figure 10 Showing trends in health life expectancy at birth

Source: Productive Healthy Ageing Profile, Finger Tips

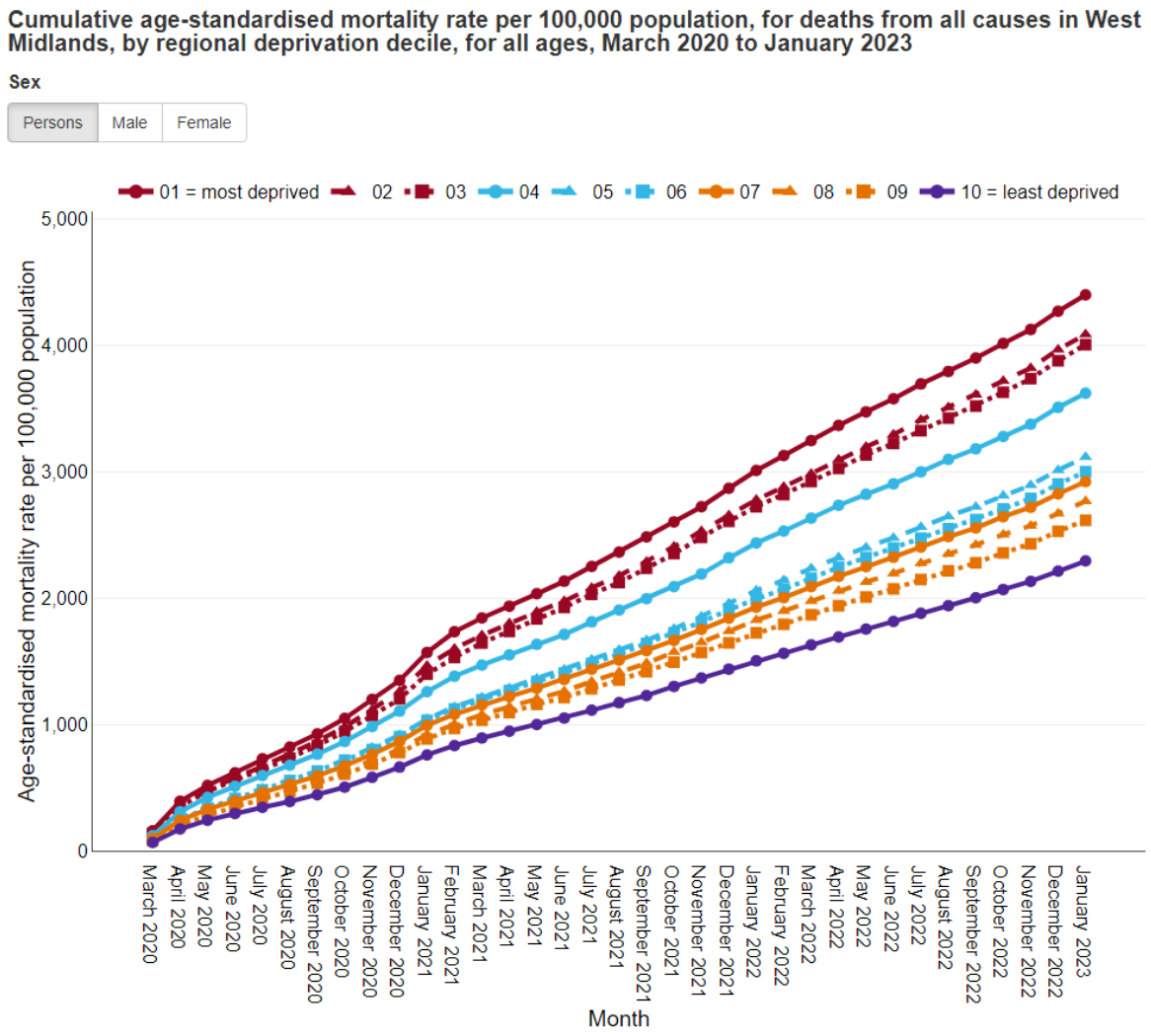
After a period of stability, healthy life expectancy across SSoT started to decrease in 2013-2015. The rate of decrease in more marked in Stoke-on-Trent than in Staffordshire. Nevertheless, in all areas, a child born in 2020 can expect to have a shorter healthy life expectancy than a child born in 2009.

Take home messages

The population of older adults in the ICB area will continue to increase over the next ten years. This increase will be most dramatic in those aged 85 years or older. There is uneven distribution of older and oldest adults across the ICB area. This has implications for planning services, but also for housing, transport and leisure facilities.

Deprivation

The links between deprivation and poor health outcomes is well established. Both absolute and relative deprivation are important. Cumulatively in the West Midlands, there are over two thousand more deaths in the most deprived compared to the least deprived decile. (Figure 11)



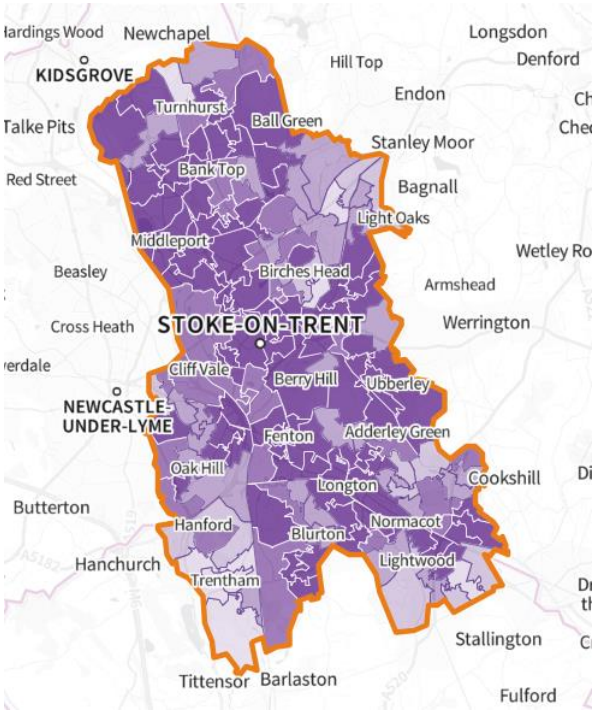
Source: CHIME - COVID-19 Health Inequalities (phe.gov.uk)

Figure 11 Showing cumulative age-standardised mortality rates in the West Midlands, by deprivation decile.

ONS data show that inequality has been slowly increasing in the UK since the 1980s. (Figure 12) This combination of increasing deprivation and increasing inequality make health gains even more challenging to achieve.

Figure 12 Showing changes in income inequality in the UK

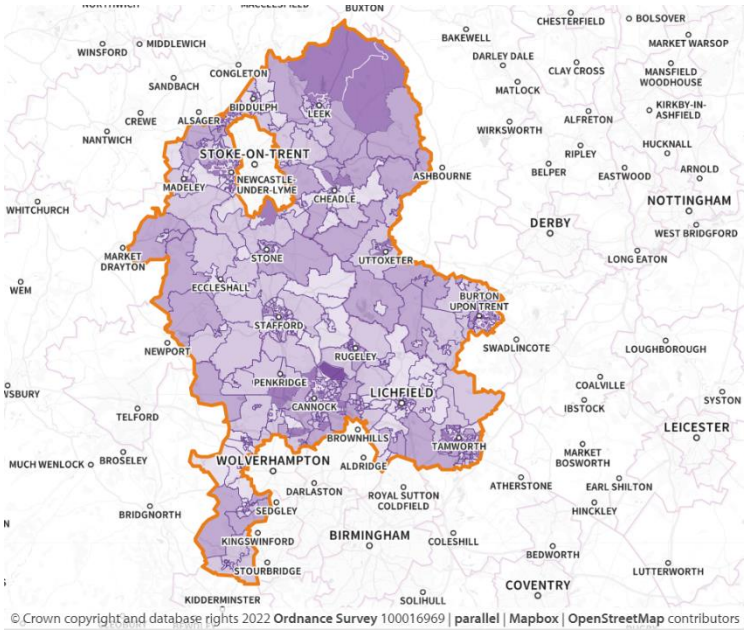
Stoke-on-Trent



Stoke-on-Trent as a whole falls into the most deprived category of UTLAs and over half of the small areas within Stoke are in the most deprived fifth of areas nationally. The England-wide Index of Multiple Deprivation distribution spans 0.54 to 92.73 with a mean value of 21.67. The average score for Stoke-on-Trent is 34.5, the highest is 66.24. However, there are also a small number of areas in the fifth least deprived areas nationally, largely in the south of the geography. The lowest deprivation score in Stoke-on-Trent is 5.64 (Figure 13).

Figure 13 - Deprivation in Stoke-on-Trent Darker colour indicates higher deprivation

Staffordshire

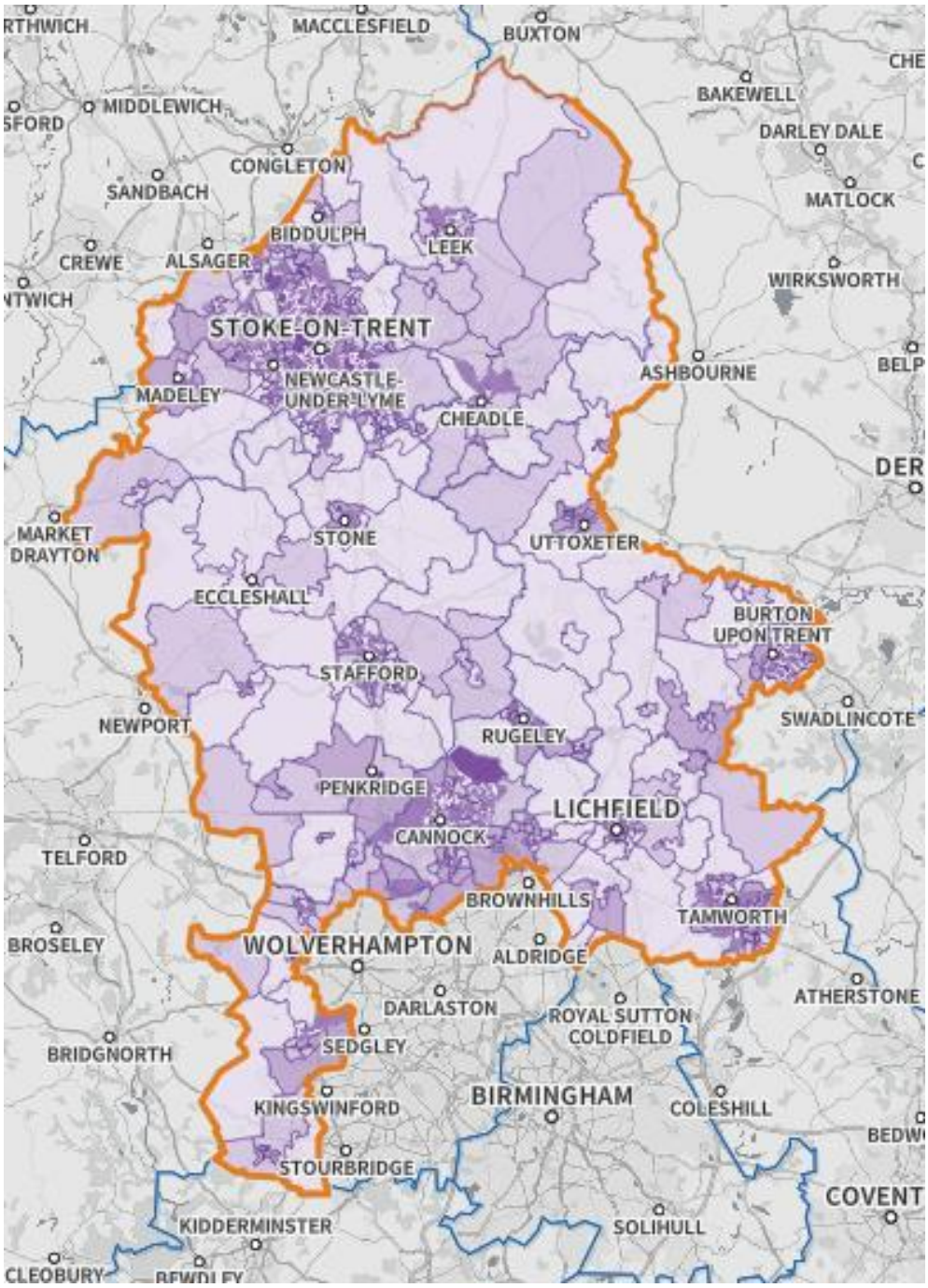


Staffordshire is a very diverse local authority with regard to deprivation, with a lower extreme IMD score of 1.58 in an area of Stafford and a higher extreme of 61.66 in an area of Tamworth. The average score for the county is 16.57, lower than the overall England average of 21.67. Areas of highest deprivation are generally centred around the towns of Burton-on-Trent, Newcastle-under-Lyme, Tamworth and Cannock (Figure 14).

Figure 14 - Deprivation in Staffordshire. Darker colour indicates higher deprivation

.

Focussing on older adults, the Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of those aged 60 or over who experience income deprivation. Although this focusses on a single parameter of deprivation, it has the advantage of being age specific. (Figure 15)



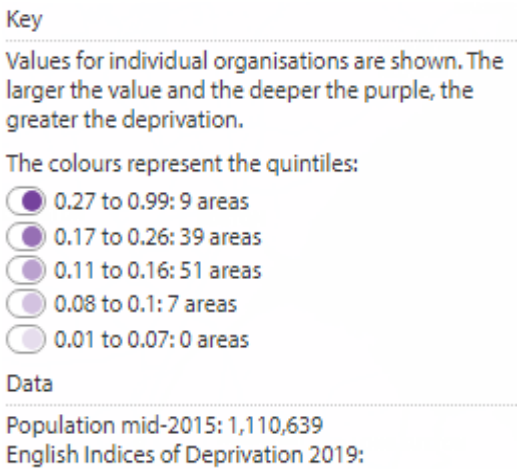


Figure 15 Showing Income Deprivation Affecting Older People Index

Shape atlas - https://app.shapeatlas.net/ - last accessed April 2024

The geographical distribution of deprivation in older adults does not absolutely mirror that of deprivation in the population in general. When planning services, a granular approach is needed to ensure that deprivation is appropriately identified.

Fuel poverty

NICE quality standards include addressing excess winter deaths due to cold homes. A household is defined as being in fuel poverty if it needs to spend 10% or more of its income on energy to maintain a satisfactory heating regime. Fuel poverty in both Stoke-on-Trent and Staffordshire is significantly higher than the England average of 13.1%; levels of fuel poverty in Stoke-on-Trent being some of the highest in England (Table 10).

Indicator	Stoke	Stafford shire	England
Fuel poverty (low income, low energy efficiency methodology) 2021	22.9%	15.8%	13.1% (range 5.2% to 23.2%)

Table 10 - Fuel poverty, Stoke-on-Trent and Staffordshire - Source: OHID: Public health profiles - OHID (phe.org.uk)

Changes in frailty with deprivation.

Within the ICB, moderate and severe frailty are seen more often in the most deprived quintiles.

Take home messages

Deprivation is associated with earlier onset of multimorbidity and increased frequency of moderate and severe frailty. There are some differences in the distribution of deprivation in older adults compared to the general population. Data below show that several other risk factors (smoking, alcohol and loneliness) are also greater in areas of higher deprivation. Frailty should be sought out in deprived areas in both older and younger adults.

Sex

Females experience more frailty than males across all ages, but usually live longer. (Gordon EH, 2017) (Park C, 2021) This pattern is also seen in the ICB.

Ethnicity

The impact of ethnicity and deprivation on health outcomes can be difficult to tease apart. At this time, a relatively small proportion of older adults in the ICB come from an ethnic minority group. The population of Stoke-on-Trent is more diverse that of Staffordshire. In both areas, the majority of people from an ethnic minority group come from Asian backgrounds. (Fig 3)

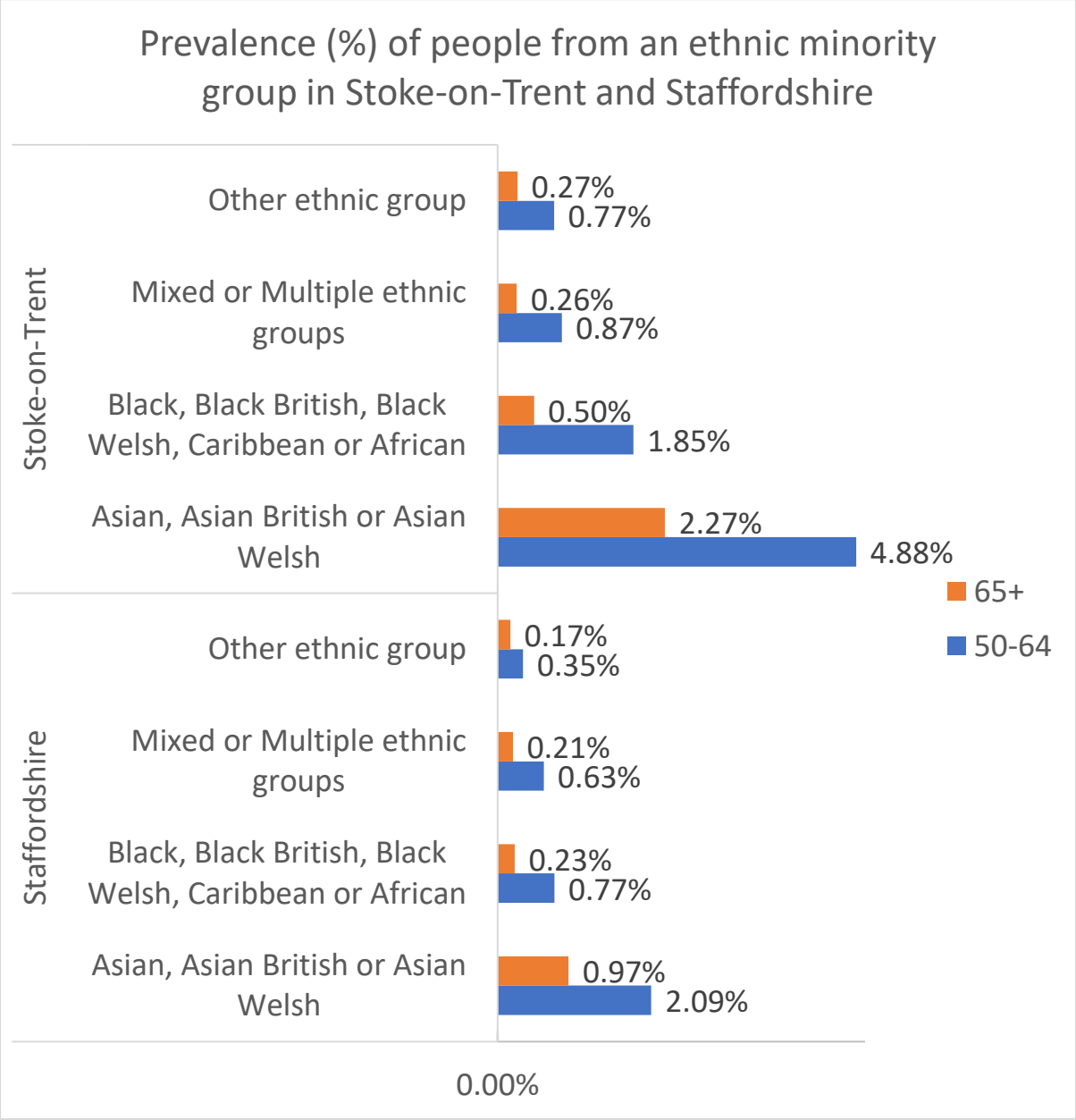


Figure 16 Showing the prevalence (%) of older adults from an ethnic minority group

Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.3.0. Based on census 2021 data - https://www.ons.gov.uk/filters/39d42bfe-311d-4bfd-822a-d6bdcd49c2d8/dimensions#get-data

Take home messages

As the next generation of older adults start to become frail, there will be increases in the proportions of all ethnic minority groups across the ICB area. The largest increases in frailty will be seen in Asian, Asian British populations. This may result in increased frailty compared to predictions

based on current demographic profiles. Language and cultural sensitivities should be built into services. Targeted case finding may be needed.

Lifestyle

In both Stoke-on-Trent and other parts of Staffordshire, smoking prevalence has been steadily decreasing from 2015 to 2022, with Stafford (2.9%) having the lowest levels of smoking prevalence in England. (Table 11)

Levels of physical activity are lower and levels of obesity higher than the England averages. Fruit and vegetable intake is significantly lower in both Staffordshire and Stok-on-Trent compared to England, with Stoke-on-Trent having the lowest level of intake in the country. (Table 11) However, these data are not available stratified by age.

Data about admissions where alcohol intake plays a role are available for older adults. The number of admissions in Staffordshire and Stoke-on-Trent are both significantly greater than those in England. Stoke-on-Trent has the highest alcohol-related admission rates in those aged 65 years or older in the country. (Table 11)

Lifestyle indicators	Age	Time period	England	Staffordshire	Stoke-on-Trent
Smoking Prevalence in adults (18+) - current smokers (APS)	18+ yrs	2022	12.7%	9.3% ↓	16.3% ↓
Percentage of physically active adults	19+ yrs	2022/23	64%	67.9% ↑	62.1% ↑
Percentage of adults (aged 18+) classified as overweight or obese	18+ yrs	2022/23	63.8%	68.2% ↑	73.8% ↑
Admission episodes for alcohol-related conditions (Narrow) - Over 65s per 100,000	65+ yrs	2022/23	810	1131 →	1370 →
Proportion of the adults meeting the recommended '5-a-day' fruit and vegetable consumption (new method)	16+ yrs	2022/23	31%	29.3%	22.2%

Table 11 Showing selected lifestyle factors Source: OHID [Public health profiles - OHID (phe.org.uk)]

Healthy lifestyle behaviours (diet, exercise, no smoking, limited alcohol and healthy BMI) from age 50 protect against frailty as long they are sustained. The greatest reduction is risk is seen from being a non-smoker – Hazard Ratio 0.56 (95% confidence interval [CI] 0.44–0.71; $p < 0.001$). But each additional healthy behaviour also results in a decrease in the hazard ratio. Although the decrease in risk is greatest if behaviours are established by age 50, there is still benefit to adopting new healthy behaviours in later mid-life. (Andres Gil-Salcedo, 2020) Removal of a healthy behaviour in old age accelerates the progression of frailty. This is particularly noticeable if there is sleep disruption or a lack of exercise. (Markus J Haapanen, 2024)

Changes in frailty with lifestyle

Leading an active life, establishing a good sleeping pattern, eating a broad range of fruit and vegetables, maintaining a healthy weight, smoking cessation and alcohol avoidance carry a myriad of health and wellbeing benefits. The available life course studies highlight the importance of early prevention and long-term maintenance of healthy lifestyles measures. The high levels of admissions

with alcohol-related episodes suggests that measures to help limit alcohol intake should be prioritised.

Vaccination coverage

In Stoke-on-Trent the influenza vaccine coverage for people over 65 is similar to the mean for England, meets national targets (as set out in the Annual flu letter) and is improving. However, vaccination coverage at-risk populations are below the England average and does not meet targets. The rate of 'at risk' people being vaccinated is improving. Pneumococcal vaccine coverage exceeds national figures. (Table 12)

In Staffordshire the influenza vaccine coverage is above the England average, meets targets and is improving. Vaccine coverage for 'at risk' individuals exceeds the England average and is improving, though still falls slightly short of the targets. Pneumococcal vaccine coverage exceeds national figures. (Table 12)

Vaccination programme indicators	Age	Time period	Target	England	Staffordshire	Stoke-on-Trent
Population vaccination coverage - Flu (aged 65+)	65+ yrs	2022/23	>75%	79.9%	82%	79.5%
Population vaccination coverage: Flu (at risk individuals)	All ages	2022/23	>55%	49.1%	53.2%	48.2%
Population vaccination coverage - PPV	65+ yrs	2022/23	>75%	71.8%	72.5%	76.4%
Population vaccination coverage - Shingles vaccination coverage (71 years old)	71	2022/23	>75%	48.3%	48.6%	53%

Table 12 Showing vaccination coverage. Source: OHID Public health profiles - OHID (phe.org.uk)

Screening

Cancer screening coverage continues to mirror national trends and is decreasing for cervical cancer and breast cancer but increasing for bowel cancer. Coverage is significantly better than national rates in Staffordshire, and significantly worse in Stoke-on-Trent. (Table 13)

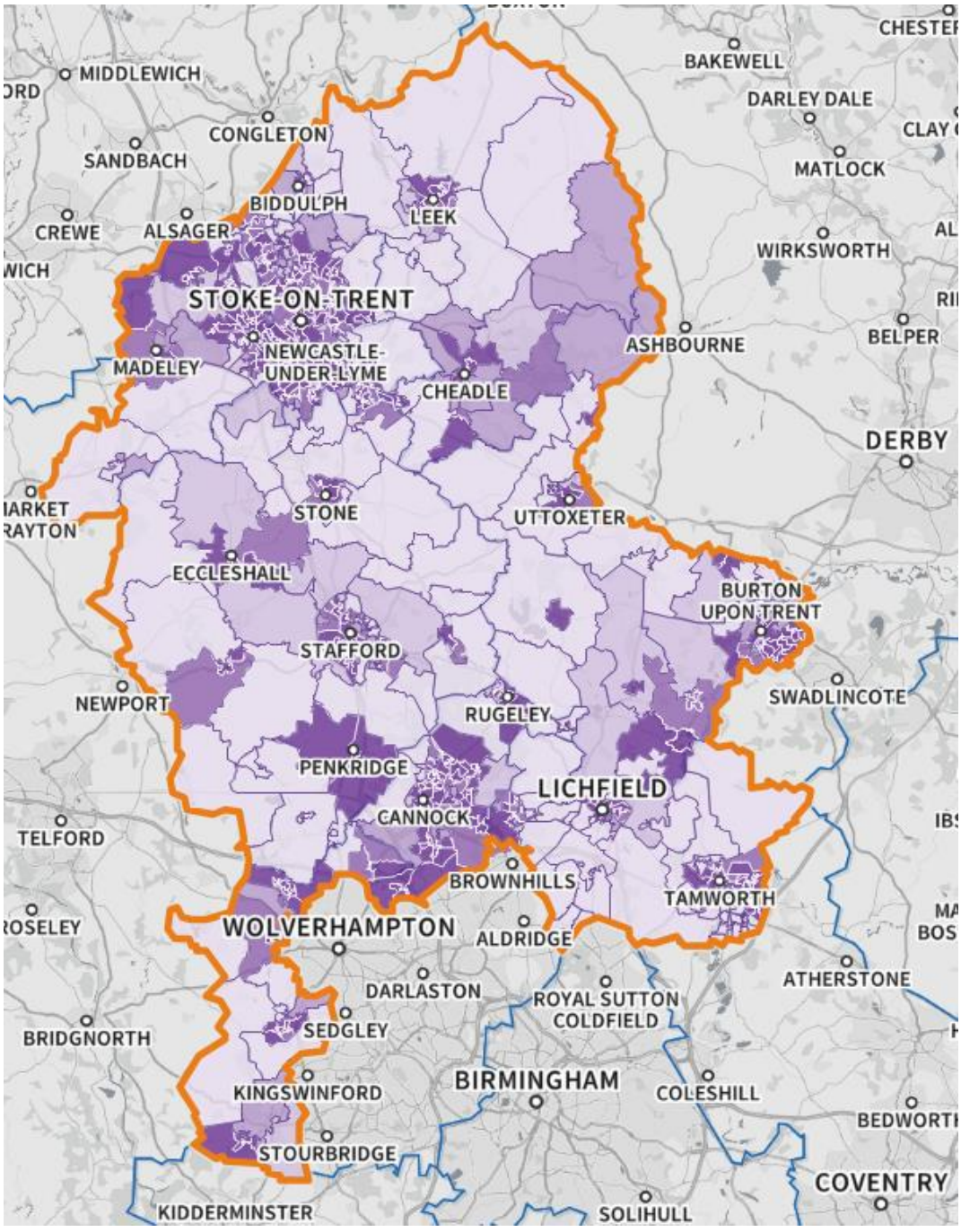
Screening/early intervention	Sex	Age	Time period	England	Staffordshire	Stoke-on-Trent
Cancer screening coverage - breast cancer	Female	53-70 yrs	2023	66.2%	71.5	64.5%
Cancer screening coverage - cervical cancer (aged 50 to 64 years old)	Female	50-64 yrs	2023	74.4	75.6%	72.9%

Cancer screening coverage - bowel cancer	Persons	60-74 yrs	2023	72%	73.9%	67.8%

Table 13 Showing cancer screening coverage Source: OHID Public health profiles - OHID (phe.org.uk)

Access

Ease of access is determined by many factors including travel time. As a rule of thumb, a journey longer than 15 minutes can act as a barrier to accessing services. 65.95% of households can access GPs within 15mins by public transport or walking. Travel times are longer in rural areas. Figure 17 below describes GP accessibility.



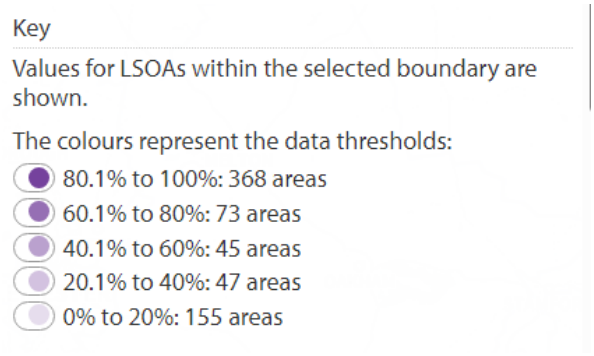


Figure 17 - Percentage of households who can reach a GP in 15 minutes travel time or less -taken from the OHID SHAPE Place tool (SHAPE Place (shapeatlas.net))

Since community-based services can be delivered from a variety of settings, understanding which settings are most readily available is also part of ensuring equitable access. Even within the relatively urbanised city of Stoke, there are areas where either GP surgeries or pharmacies (rather than both) are most readily accessible (Figure 18).

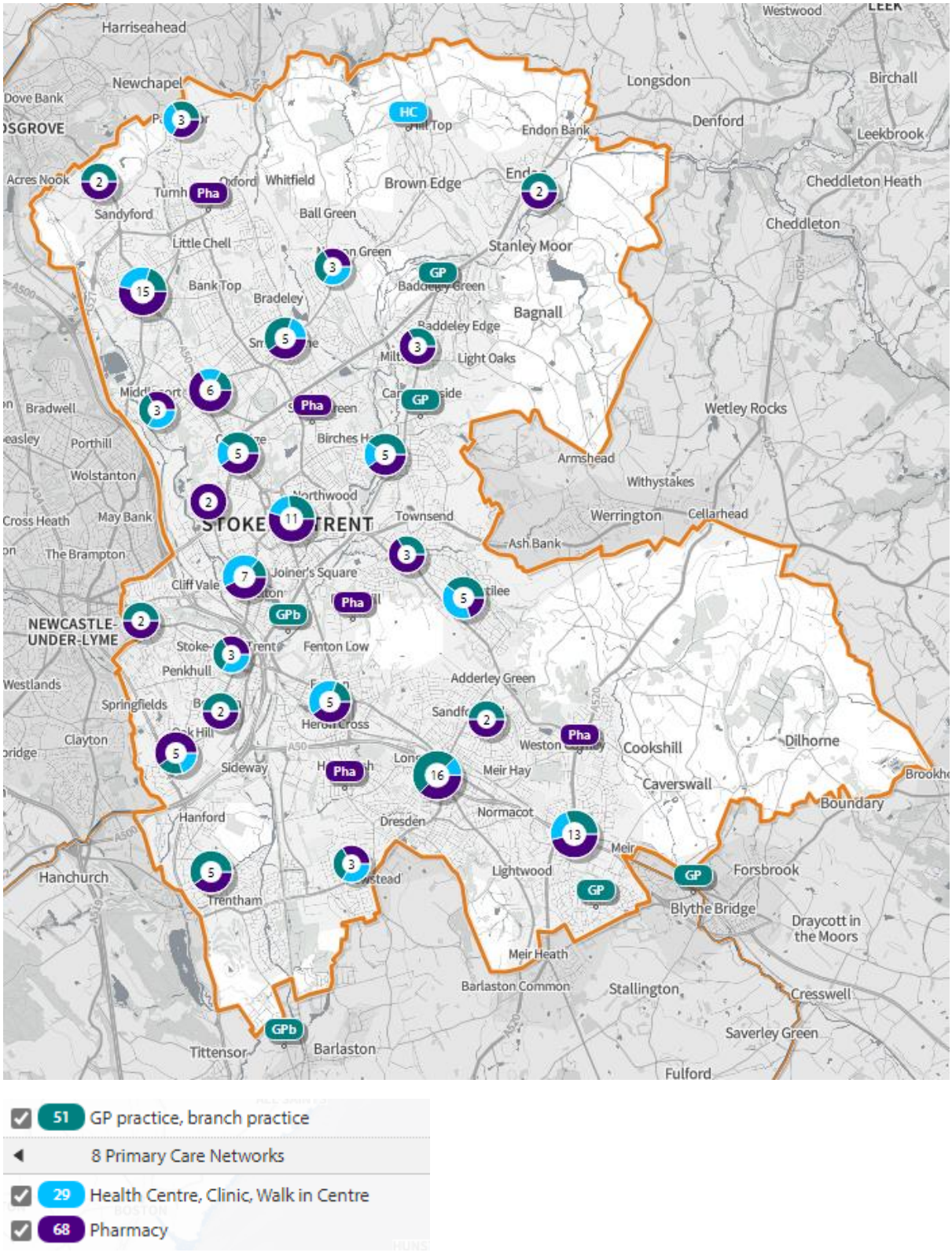


Figure 18 - Distribution of GPs, Health Centres and Pharmacies, Stoke-on-Trent - taken from the OHID SHAPE Place tool (SHAPE Place (shapeatlas.net)

Loneliness

Loneliness and social isolation contribute as much as physical inactivity to the development of frailty. (Davies, 2021) National data show that more women report loneliness than men. And that older men report less loneliness than their younger counterparts. (Figure 19) Since these data are self-reported, there may be a degree of social bias in men not reporting loneliness. So, they are likely to underestimate the problem.

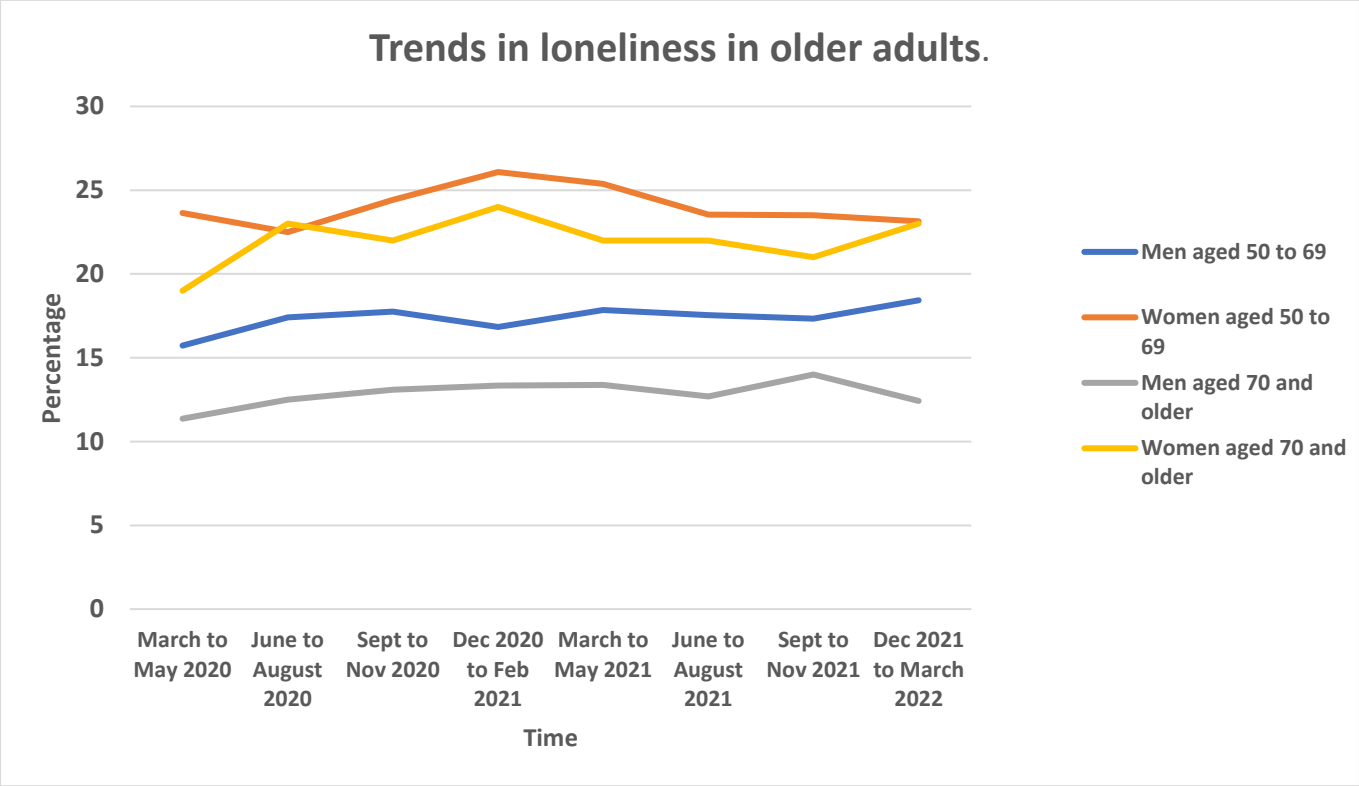
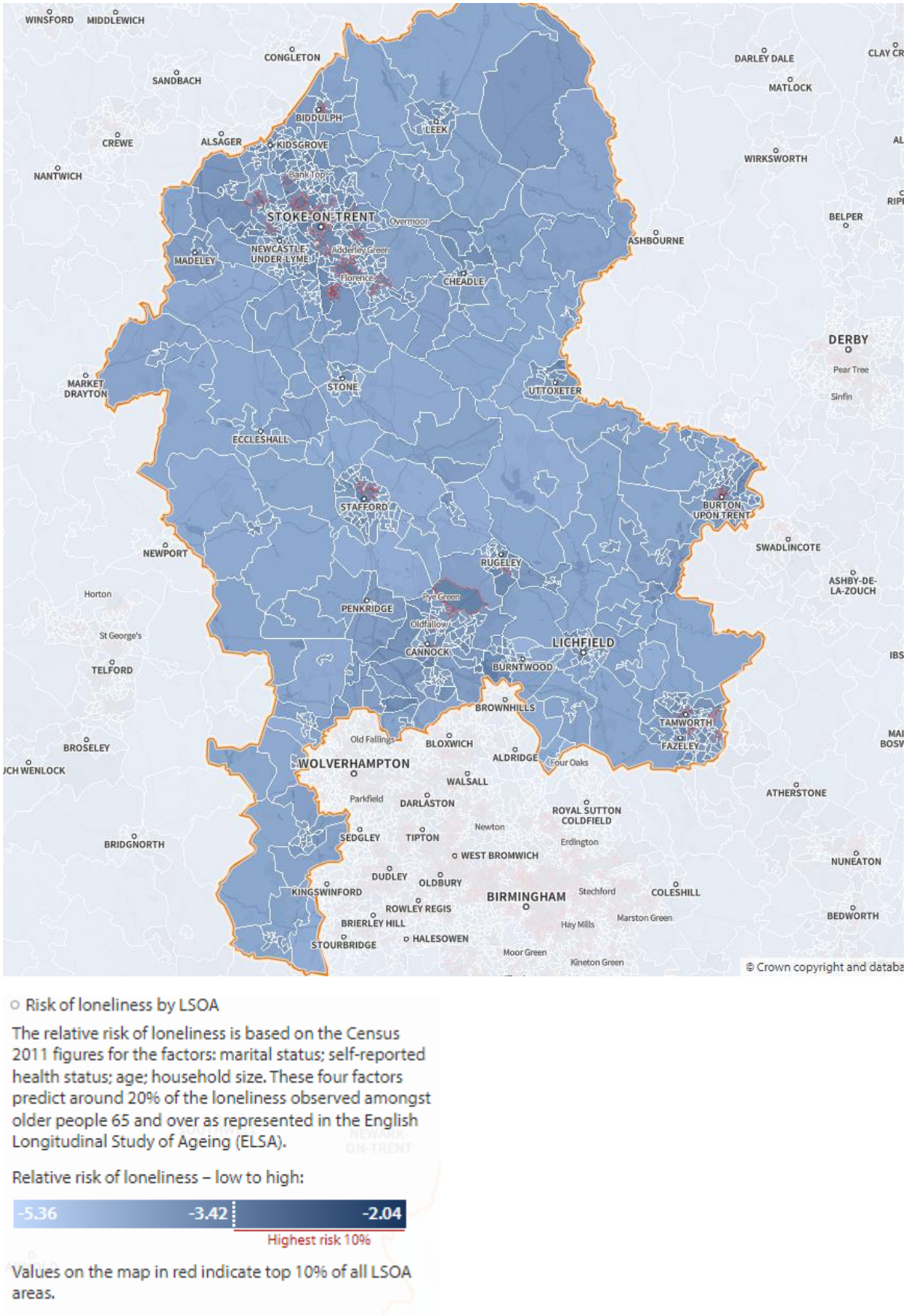


Figure 19 Showing trends in self-reported loneliness in older adults in England. source https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/adhocs/14409trendsinpersonalwellbeingandlonelinessbyageandsex

Geographically the risk of loneliness is highest in areas of higher deprivation. (Figure 20) Across the ICB, 12.6% of households are occupied by one person aged 65 years or older. (NHS England, Model Health System, 2024) Deaths coded as unattended or ill-defined have been shown to be a good proxy measure for deaths where bodies are found in a state of decomposition. On a background of decreasing deaths from all causes in 1990s and 2000s, there were sharp increases in deaths where bodies were found in state of decomposition. Males were affected more than females. (Hiam L, 2024) The authors suggest that isolation and breakdown of social structures are contributing causes.

Current services for loneliness are varied. However, there are commissioned services to provide day care and help at home. These capture many of the most isolated in the community. (personal communication – Carl Bennett).



○ Risk of loneliness by LSOA

The relative risk of loneliness is based on the Census 2011 figures for the factors: marital status; self-reported health status; age; household size. These four factors predict around 20% of the loneliness observed amongst older people 65 and over as represented in the English Longitudinal Study of Ageing (ELSA).

Relative risk of loneliness – low to high:

-5.36 -3.42 -2.04

Highest risk 10%

Values on the map in red indicate top 10% of all LSOA areas.

Figure 20 Showing relative risk of loneliness by lower super output area. Source: https://app.shapeatlas.net/

Polypharmacy

Definitions of polypharmacy vary. Most research uses a numerical approach and the cut-off for high use may be as low as five or as high as ten unique prescription items. (Pazan, 2021) The British Geriatric Society and others recommend considering the types of drugs as well as the number. Classes of drugs highlighted for particular attention include:

- Antimuscarinics.
- Long-acting benzodiazepines and some sulphonylureas, other sedatives and hypnotics.
- Opiates
- Non-steroidal anti-inflammatory drugs (Turner, 2014)

There is likely a bidirectional causal relationship between polypharmacy and frailty as well as other negative consequences such as falls and confusion. And there is emphasis placed on identifying and addressing *inappropriate* polypharmacy rather than applying a numerical definition. (Turner, 2014) (Pazan, 2021)

SSOT is third highest compared to peers for prescription of ten or more unique items to those aged 75 years or older (Figure 21) and highest compared to peers for those aged 85 years or older (Figure 22).

Although these data do not stratify by how appropriate or otherwise the prescriptions are, there is scope for improvement to bring levels of polypharmacy in line with demographic peers.

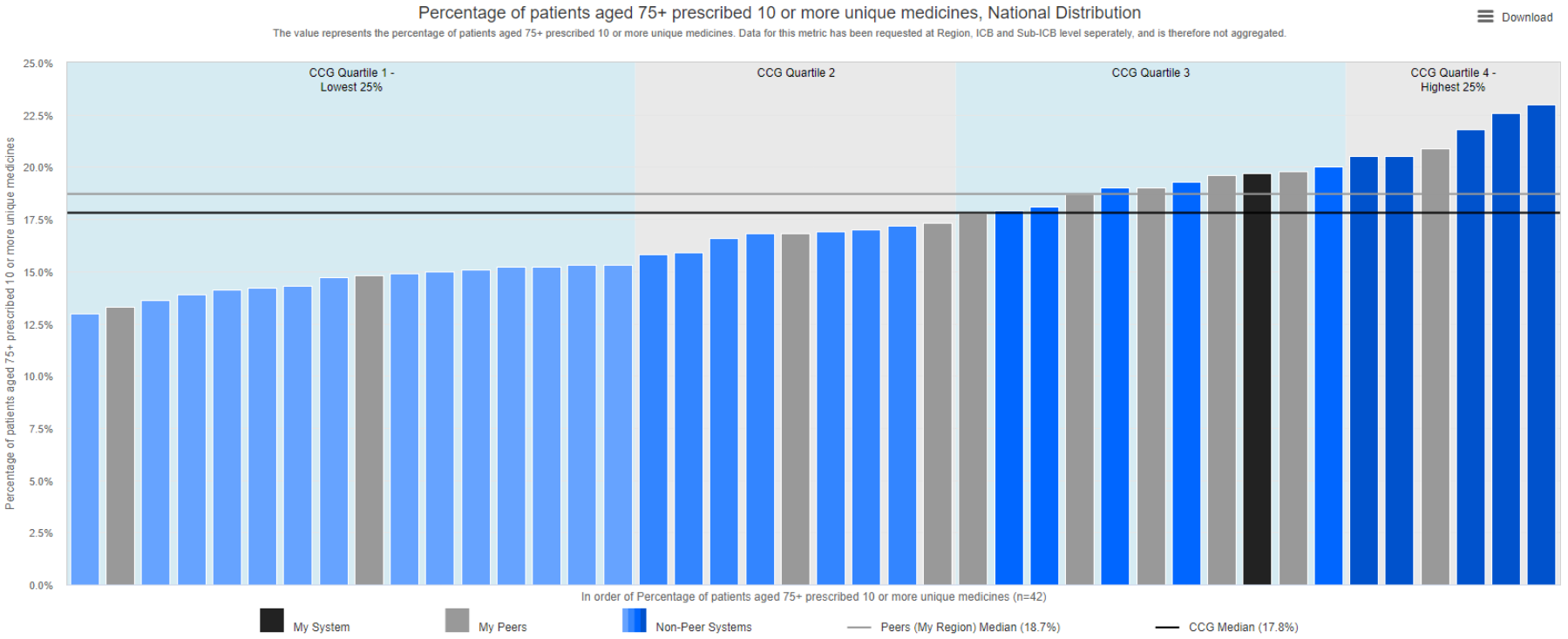


Figure 21 Showing the percentage of patients aged 75 years or older being prescribed 10 or more unique medications. www.model.nhs.uk

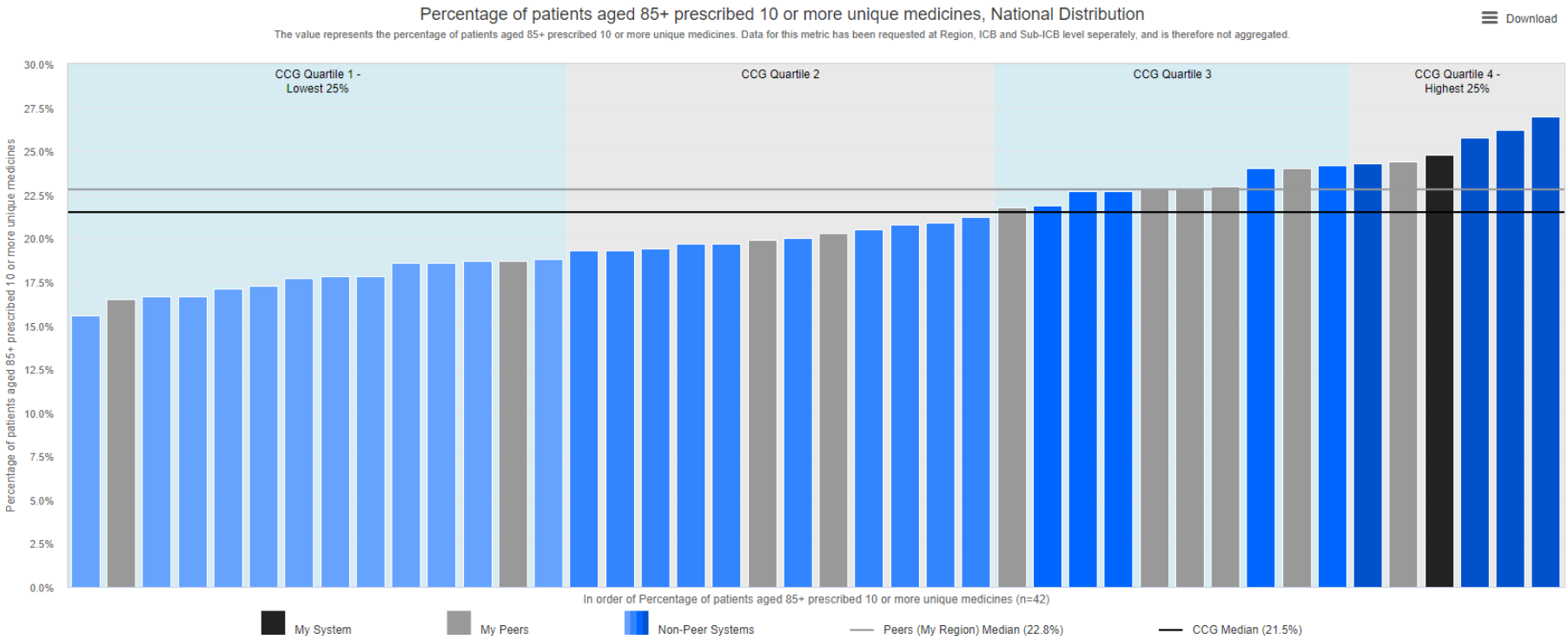


Figure 22 Showing the percentage of patients aged 85 years or older being prescribed 10 or more unique medications. www.model.nhs.uk

Sensory compromise

Hearing loss is associated with isolation, mood disorders, falls, increased mortality and worsening cognitive function. Early assessment and use of aids may improve outcomes. (Völter, 2020)

Self-reported difficulties with hearing are captured in the GP Patient Survey administered to adults aged 16 years or older. 7.4% of SSOT residents reported hearing difficulties or deafness in 2023. This is the 7th highest rate by CCB in the country and is higher than the rate in England of 6.0%. (UKHSA Fingertips Public Health Profiles., n.d.)

Self-reported blindness or partial sight affects 1.5% of the adult population in the ICB. This is similar to national figures. (UKHSA Fingertips Public Health Profiles., n.d.) In 2022/23, the crude rate of adults aged between 65 and 74 years and registered blind or partially sighted with the Local Authority in Stoke-on-Trent was 479 per 100,000. The rates in this area are decreasing and are amongst the lowest when compared to nearest statistical neighbours. In those aged 75 year or older, the rate increases to 2039 per 100, 000 (approx. 430 people). (UKHSA Fingertips Public Health Profiles., n.d.)

In 2022/23, the crude rate of adults aged between 65 and 74 years and registered blind or partially sighted with the Local Authority in Staffordshire was 467 per 100,000. There has been little change over time and the rates are amongst the highest when compared to nearest statistical neighbours. In those aged 75 year or older, the rate increases to 2438 per 100, 000 (approx. 2380 people). (UKHSA Fingertips Public Health Profiles., n.d.)

Since these are crude rates, comparing between areas is open to bias. However, we can conclude that the blindness and partial sight increase substantially with age. For both hearing loss and sigh loss, proactive testing should be encouraged.

Use of health and social care services

Social care use

Pubic facing social care use data are available by age rather than frailty status. Personal budgets and direct payments to those in receipt of financial support improve well-being and can improve outcomes. (UKHSA Fingertips Public Health Profiles., n.d.) In both Stoke-on-Trent (Figure 23) and Staffordshire (Figure 24), the proportion of those aged 65 years or older receiving self-directed support is significantly below the England rates and is decreasing.

However, the proportion of those aged 65 years or older and in receipt of support who feel in control of their lives is significantly higher than England in Stoke-on-Trent (Figure 25Figure 26) and is similar to England in Staffordshire (Figure 26).

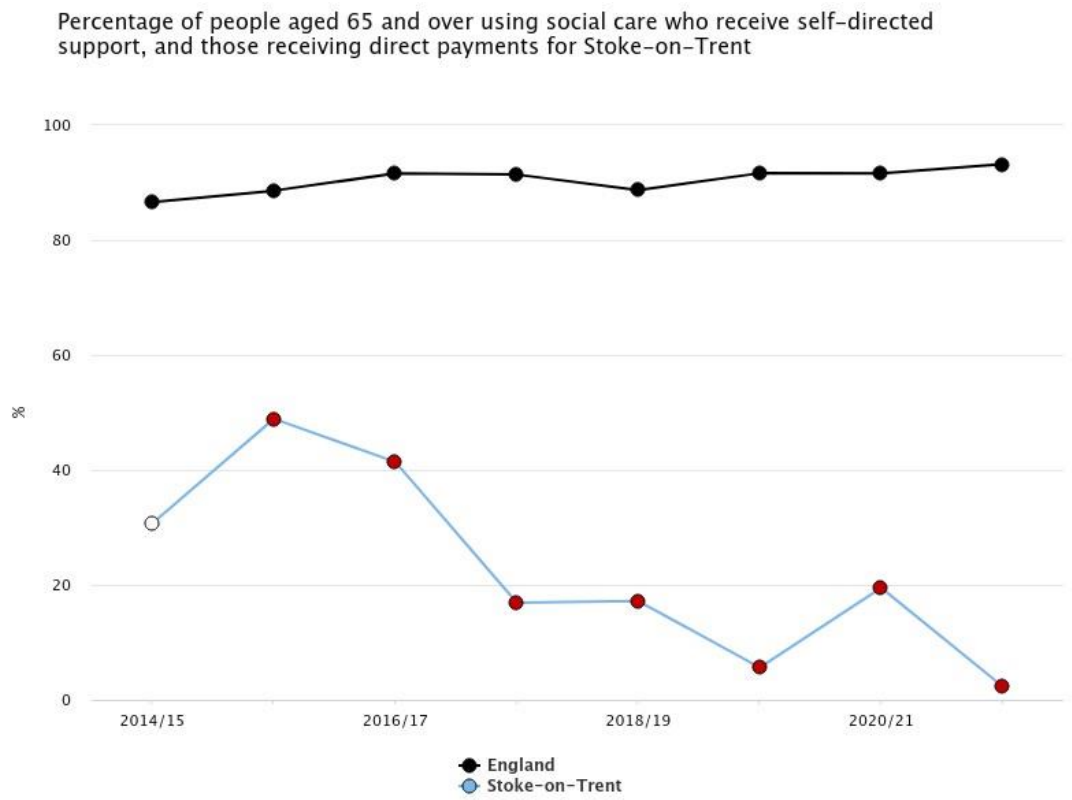


Figure 23 Showing trends in the percentage of people aged over 65 who receive self-directed support or direct payments in Stoke-on-Trent. Fingertips Healthy Ageing Profile

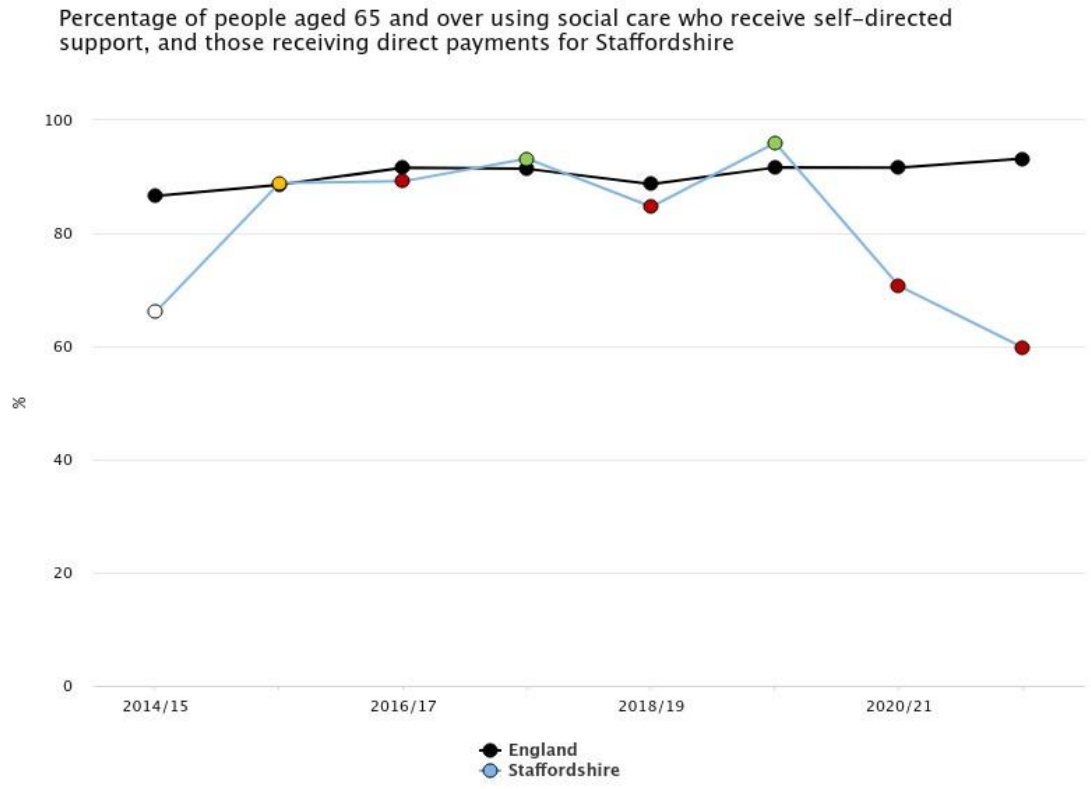


Figure 24 Showing trends in the percentage of people aged over 65 who receive self-directed support or direct payments in Staffordshire. Fingertips Healthy Ageing Profile

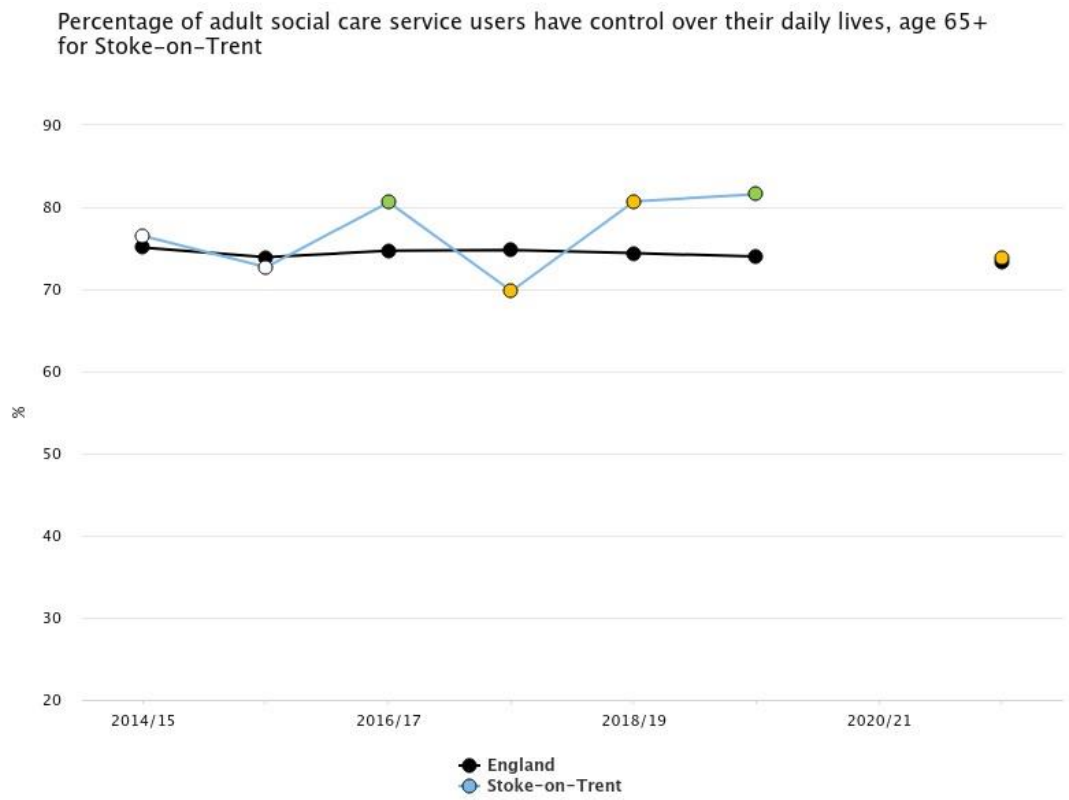


Figure 25 Showing trends in the percentage of people aged over 65 who feel in control of their lives in Stoke-on-Trent. Fingertips Healthy Ageing Profile

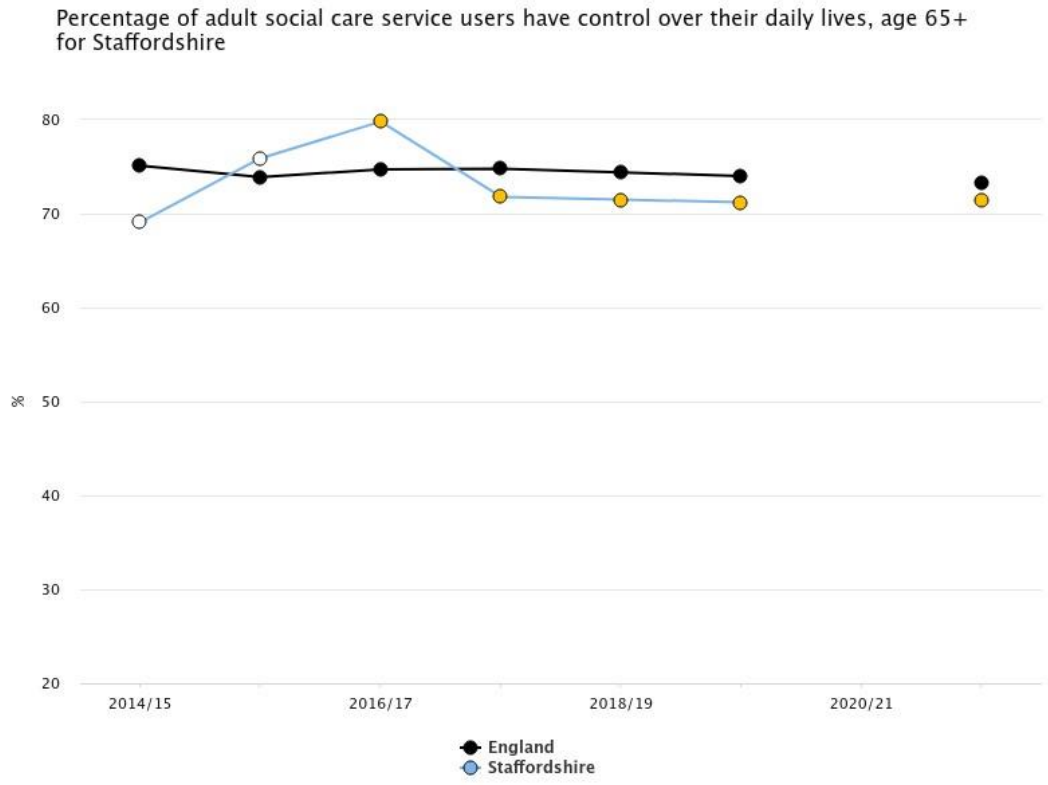


Figure 26 Showing trends in the percentage of people aged over 65 who feel in control of their lives in Staffordshire. Fingertips Healthy Ageing Profile

Community Care Use

MPFT provide a wide range of community care services over much of the SSOT ICB footprint. Analyses are undergoing to understand patterns of usage and the associated expenses. Data and figures in this section are provided by Dominic Ellington (Operational Manager & Associate Chief Clinical Informatics Officer) at MPFT.

Across all services, 10% of service users make up 67% of activity. And the top 1% of users make up 28% of activity. (Figure 27)

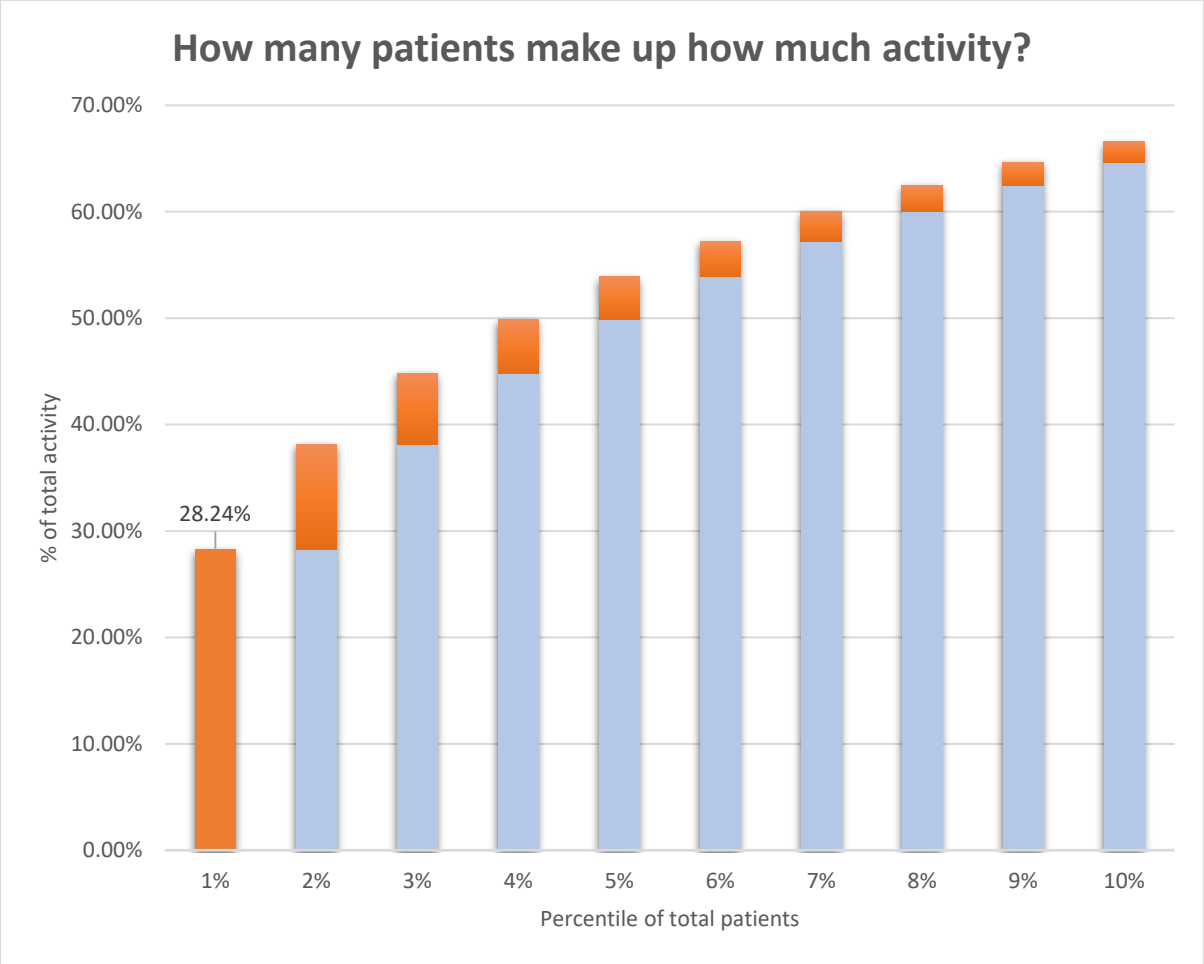
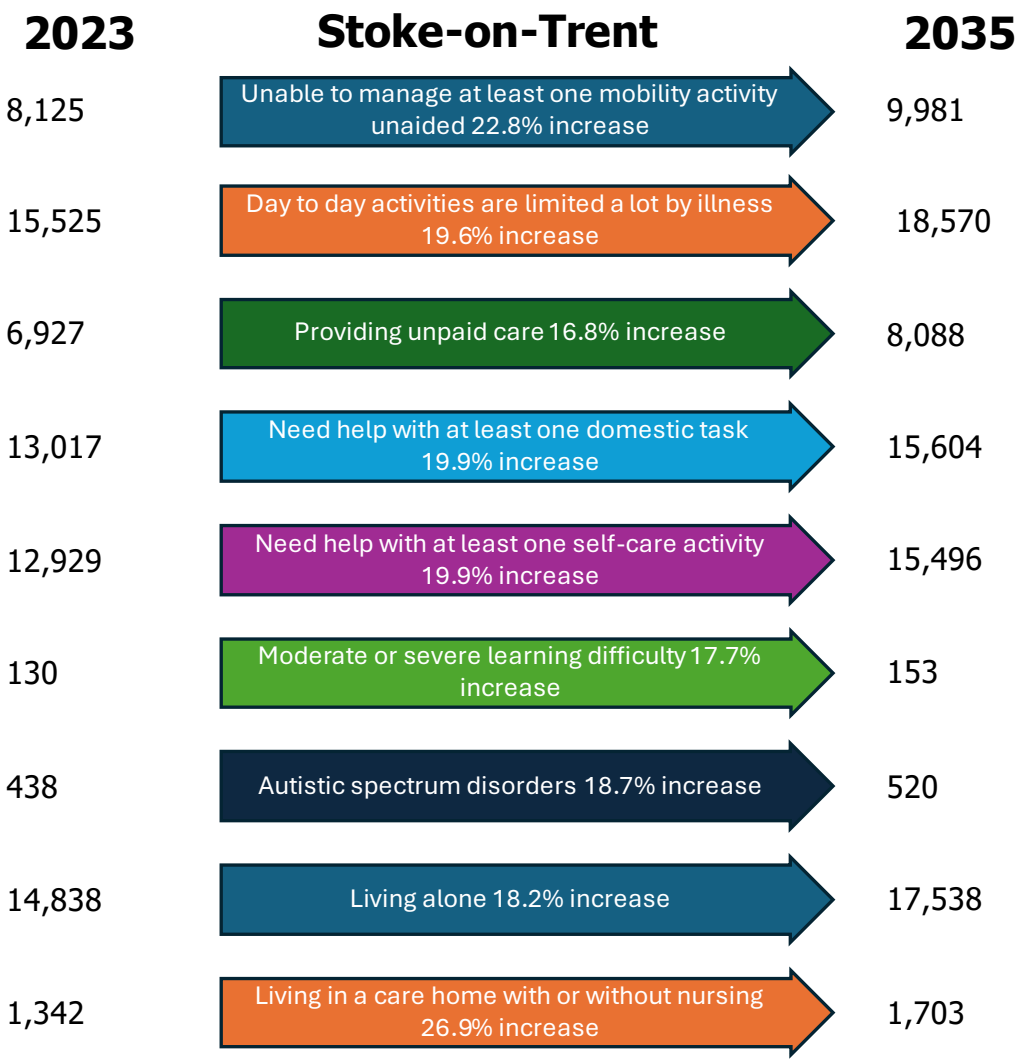


Figure 27 Showing the intensity of service use by percentile of total patients.

There are overlaps in the services being accessed suggesting that there may be opportunities to streamline care contacts. Although baseline data do not include linkage to frailty status, a deep dive exercise on patients with complex needs revealed most score 7 or more on the Rockwood Clinical Frailty Scale.

Conditions which contribute to both increased community and social care need are likely to increase over the next decade. (Figure 28)

High community service use may be appropriate to an individual's need, however there is scope to streamline and improve processes. Frailty is likely to feature, particularly in the cohort of longer-term and more complex patients. Linked data would made investigation and analysis easier.


2023
Stoke-on-Trent
2035
8,125
Unable to manage at least one mobility activity unaided 22.8% increase
9,981
15,525
Day to day activities are limited a lot by illness 19.6% increase
18,570
6,927
Providing unpaid care 16.8% increase
8,088
13,017
Need help with at least one domestic task 19.9% increase
15,604
12,929
Need help with at least one self-care activity 19.9% increase
15,496
130
Moderate or severe learning difficulty 17.7% increase
153
438
Autistic spectrum disorders 18.7% increase
520
14,838
Living alone 18.2% increase
17,538
1,342
Living in a care home with or without nursing 26.9% increase
1,703

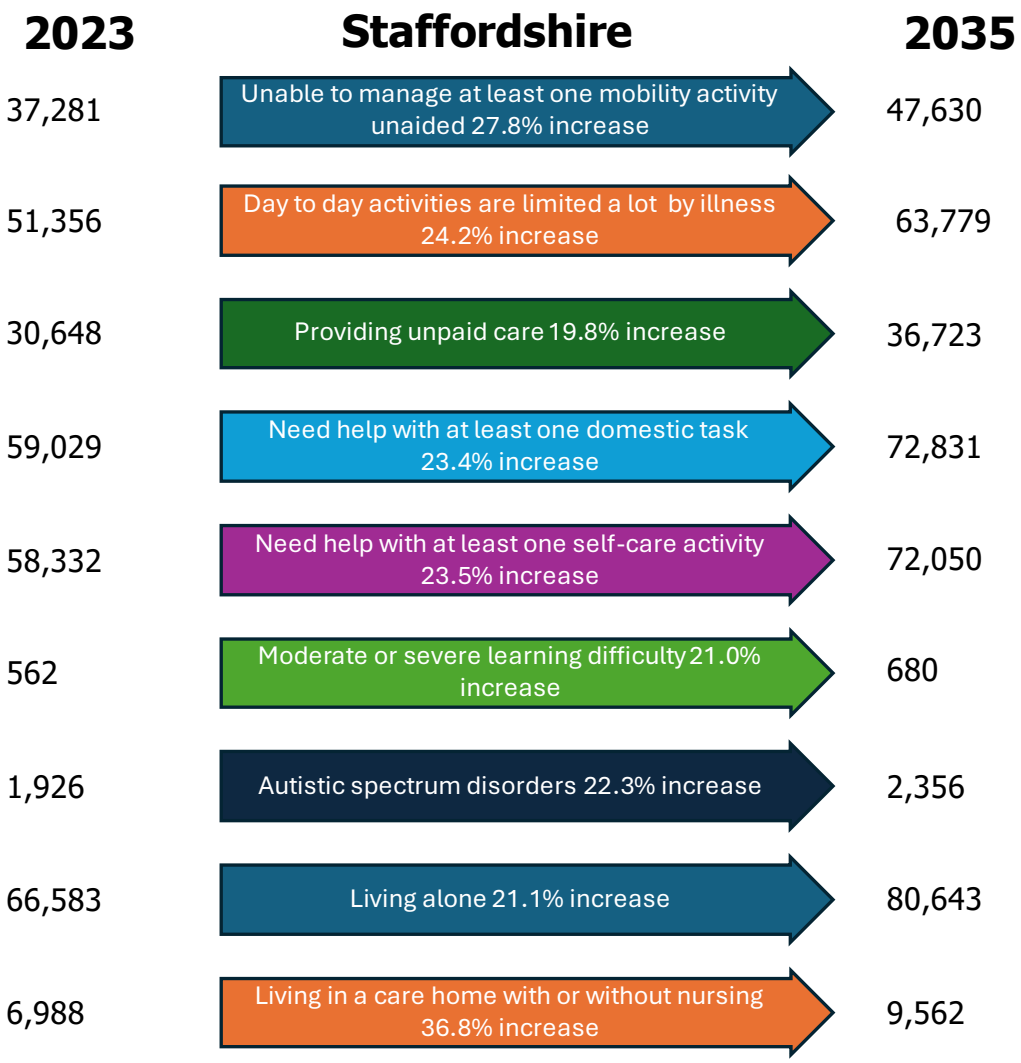


Figure 28 Showing projected changes in conditions impacting on community or social care need in adults aged 65 or older, in Stoke-on-Trent and Staffordshire. Considers changes in demographics but not changes in disease epidemiology. Data from www.poppi.org.uk Derived from ONS data. Crown copyright 2020

Primary care use.

As with community, the workload distribution is skewed in primary care. Database studies suggest that 10% of patients using approx. 40% of all primary care appointments in the UK. Further, this number has increased from 27 appointments per year (2000) to 60 appointments per year (2019). (Kontopantelis E, 2021)

Characteristics of those with higher primary care use vary across the age groups. In older adults, presence and severity of physical illness contributes to increased use. The impact of isolation, education, deprivation is mixed. (Welzel, 2017)

In the oldest adults (>85), chronic disease, decreasing functioning and financial worries increase primary care use. However, depression, decreased primary care use. (Buczak-Stec, 2020)

Examining use of primary care services across eFI categories between 2006 and 2017 in the Royal College of GPs Database, Fogg et al (2024) showed that all type of primary care contact increased

with frailty and with age. For example, the mean number of face to face appoints per year was 4.9 (SD 6.9) in the fit category, 9.9 (10.9) in mild, 12.2 (13.7) in moderate and 13.2 (15.8) in severe. (Fogg C, 2024) Although they included participants from aged 50 and older rather than 65 and older, these data are likely to be similar in SSOT.

Secondary care use

All guidelines for the care of frail adults suggest minimising disruptions to daily routines and enabling care at home where possible. Longer lengths of inpatient stay are associated with increases the risk of deterioration, leading to increasing immobility, declining function and reduced life span. (Hopper, 2021)

A benchmark of 30.9% is suggested as the minimum fraction of those aged over 75 who are discharged within 2 days. SSOT performs well compared to peers achieving 26.8% in quarter 4 of 22/23. (Figure 29) At the other of the scale, SSOT also has the lowest rate of admissions of 21 days or longer (12.4% vs benchmark 13.6%). (Figure 30) Unfortunately, SSOT also has the highest readmission rates in the country (25.4%), above peers and the benchmark of 16.2%. (Figure 31) As a corollary, SSOT also has some of the highest rates of multiple admissions in older frail patients (15.1% vs benchmark of 8.1%). (Figure 32)

In terms of discharges, 3.9% of patients aged 65 years or older are offered rehabilitation/ reablement on discharge from hospital. SSOT is in the top quartile for referrals compared to peers and non-peer ICBS. 73.7% are discharged to their usual place of residence (benchmark – 76.9%).

More in-depth information is available for adults aged 75 years and older who attend accident and emergency. In 2022/23, 41,255 adults aged 75 years or older, resident in the ICB were seen in A+E. In 2023/24 this had number increased to 43,349. Of these, 4316 (10.5%) in 2022/23 and 5103 (11.8%) in 2023/24 were care home residents. The ten most common reasons for admission overall are shown in Table 14. Cardiorespiratory causes and injuries cause most attendances where a code is recorded. In Table 15, the ten most common reasons for attendances are shown for care home residents. Head injuries and delirium are relatively more common.

Reason for presentation	2022/23	2023/24
Not recorded	5608	5794
Chest pain	2869	3081
Difficulty breathing	2825	2871
Hospital admission, emergency, direct	1951	2867
Dyspnoea	2325	2475
Injury of lower extremity	2284	2419
Injury of head	1896	1857
Injury of upper extremity	1870	1837
Abdominal pain	1530	1614
Pain in lower limb	1371	1227

Table 14 Showing the number of attendances to A+E by the ten most commonly occurring admission codes. Data from ICB intelligence services.

Reason for presentation	2022/23	2023/24
Not recorded	728	873
Difficulty breathing	391	494

Hospital admission, emergency, direct	295	483
Dyspnoea	333	385
Injury of head	300	344
Chest pain	199	262
Injury of lower extremity	220	245
Clouded consciousness	106	130
Injury of upper extremity	133	121
Abdominal pain	91	119

Table 15 Showing the number of attendances to A+E by the ten most commonly occurring admission codes, where patients are residents of care homes. Data from ICB intelligence services.

In 2022/23 the total number of bed days occupied by residents of the ICB aged 75 years or older was 28,267. By 2023/24 this had increased to 34,980. Respiratory disease account for 1 in 5 (20%) of bed days.

Diagnosis	Number of bed days
Influenza and pneumonia	4409
Other forms of heart disease	2797
Other diseases of urinary system	2548
Renal failure	1691
Chronic lower respiratory diseases	1684
Complications of surgical and medical care, not elsewhere classified	1237
Other bacterial diseases	1170
Diseases of oesophagus, stomach and duodenum	1127
Other diseases of intestines	1071
Other acute lower respiratory infections	1066

Table 16 Showing the number of bed days by diagnosis in 2023/24. Data from ICB intelligence services

For those aged 75 years and older, the number of readmissions in 2022/23 was 3358, (393, 11.7% care home residents). In 2023/24 the number of readmissions was 4452 (701, 15.7% care home residents). Diagnoses for admissions in all admissions is shown in Table 17 and for care home residents in Table 18.

Diagnosis	2023/24
Influenza and pneumonia	392
Other forms of heart disease	291
Other diseases of urinary system	245
Chronic lower respiratory diseases	245
Complications of surgical and medical care, not elsewhere classified	224
Other diseases of intestines	151
Symptoms and signs involving the circulatory and respiratory systems	144
Other acute lower respiratory infections	143
Renal failure	142
Symptoms and signs involving the nervous and musculoskeletal systems	140

Table 17 Showing the ten most common diagnoses for readmissions. Data from ICB intelligence services

Diagnosis	2023/24
Influenza and pneumonia	96
Other diseases of urinary system	42
Injuries to the head	40
Other acute lower respiratory infections	36
Chronic lower respiratory diseases	36
Lung diseases due to external agents	35
Other bacterial diseases	29
Symptoms and signs involving the circulatory and respiratory systems	24
Other forms of heart disease	23
Renal failure	22

Table 18 Showing the ten most common diagnoses for readmissions, care home residents. Data from ICB intelligence services

Data about use of hospital at home, virtual wards, outpatient use and supported discharge services are not in the public domain.

How demographics and service demands are predicted to change.

In an important report, the Health Foundation and the REAL Centre undertook analyses to understand the health and social care burden of the ageing population in England.

With regards to social care, they showed that need for support grows slowly until age 85 after which it increases sharply. However, the proportion of people needing care has deceased. Between 2006 and 2018, the proportion of those aged 80-84 with no limitations to activities of daily living increased from 68% to 75%. Over time, the needs of those seeking social care have become more complex. With regards to health care however, the proportion of those living with two or more long term conditions has increased. Particularly in the over 75s. (The Health Foundation, 2021)

The implication for SSOT is that both medical and social care complexity are likely to increase as the population aged over 75 years continues to grow. Numbers needing health care support in younger old age are likely to increase, whilst those needing social care are likely to decrease. How these changes impact on service delivery models will depend on both relative and absolute numbers of patients in the system.

Take home messages.

Patients with frailty contribute to workload at social care, community, primary and secondary care levels. Their needs are likely to increase in volume and complexity over time.

Admissions and readmissions are dominated by respiratory disease and injuries. Pathways to enable care at home need to be explored.

Further work is needed to understand how care can be streamlined across the system to improve patient outcomes and efficiency of care. Work is also needed to explore the pathways of patients with multiple admissions with consideration of pre- and post-hospital care. Although SSOT appears to be performing well in terms of reablement and rehabilitation after admissions, the data are not presented in relation to extent of frailty. For those with complex disease, it is unclear what mechanisms are being used to co-ordinate care between different providers. We cannot assume

that those who are not seeking care, particularly amongst the oldest in our communities, are not in need of care.

Both absolute and relative costs need to be taken into consideration when building the case for change of service models.

Predictive modelling will need to take a more nuanced approach capture the different needs of individuals based on medical vs social care needs.

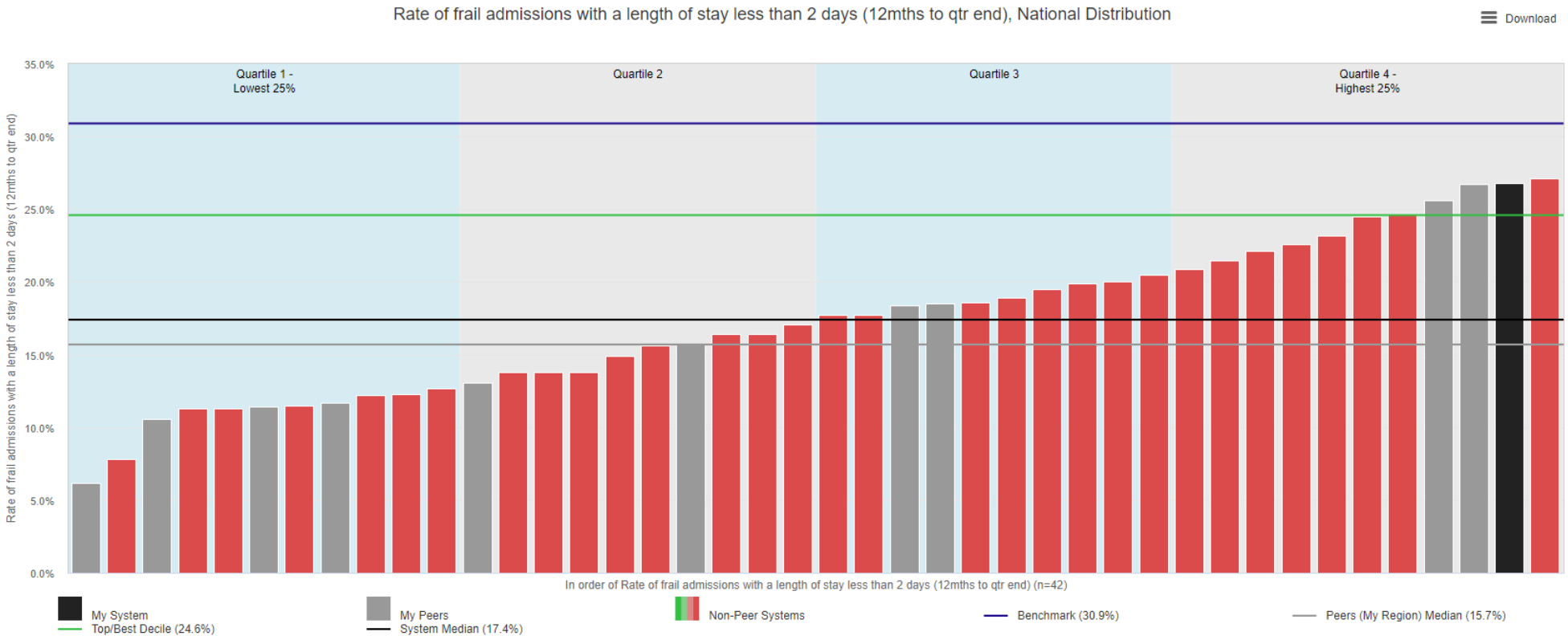


Figure 29 Showing the rate of admission, less than two days, for patients with frailty aged 75 years or older, by ICB. Quarter 4 22/23 www.model.nhs.uk

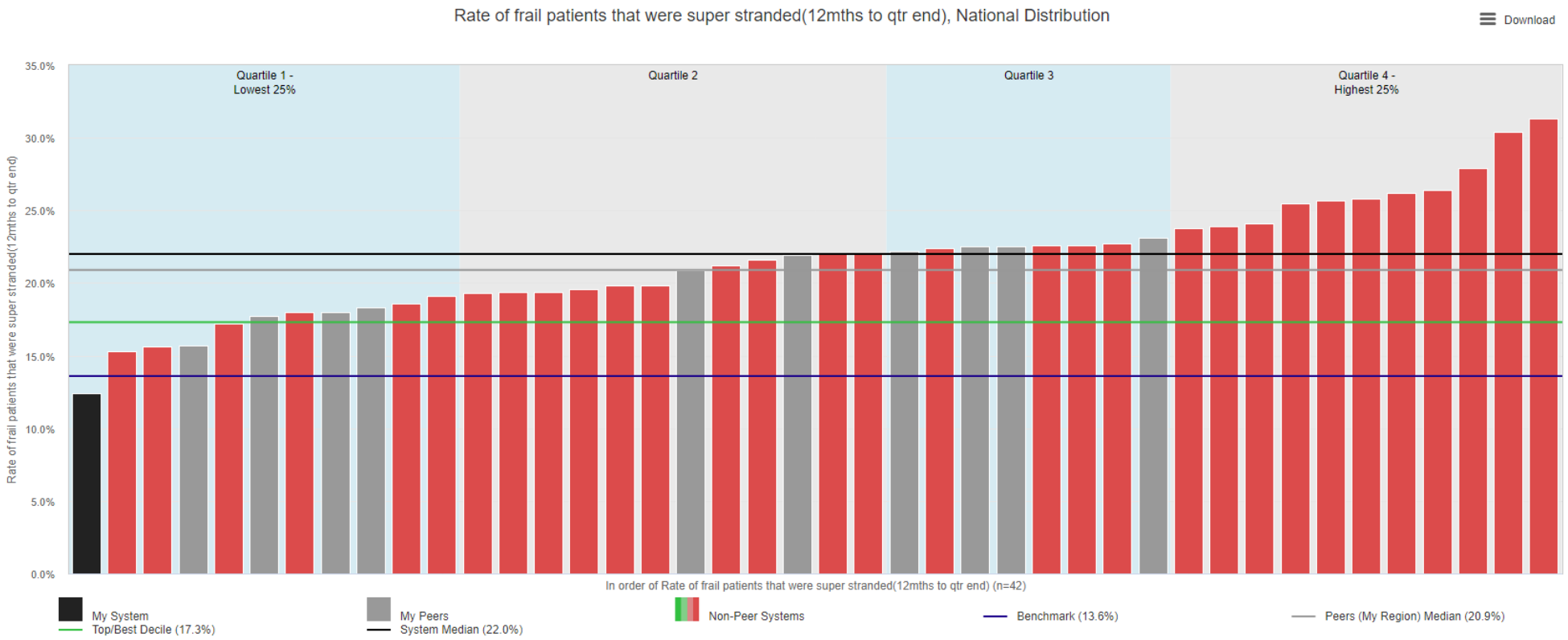


Figure 30 Showing the rates of frail patients who had admissions of 21 days or more, by ICB. Quarter 4 22/23 www.model.nhs.uk

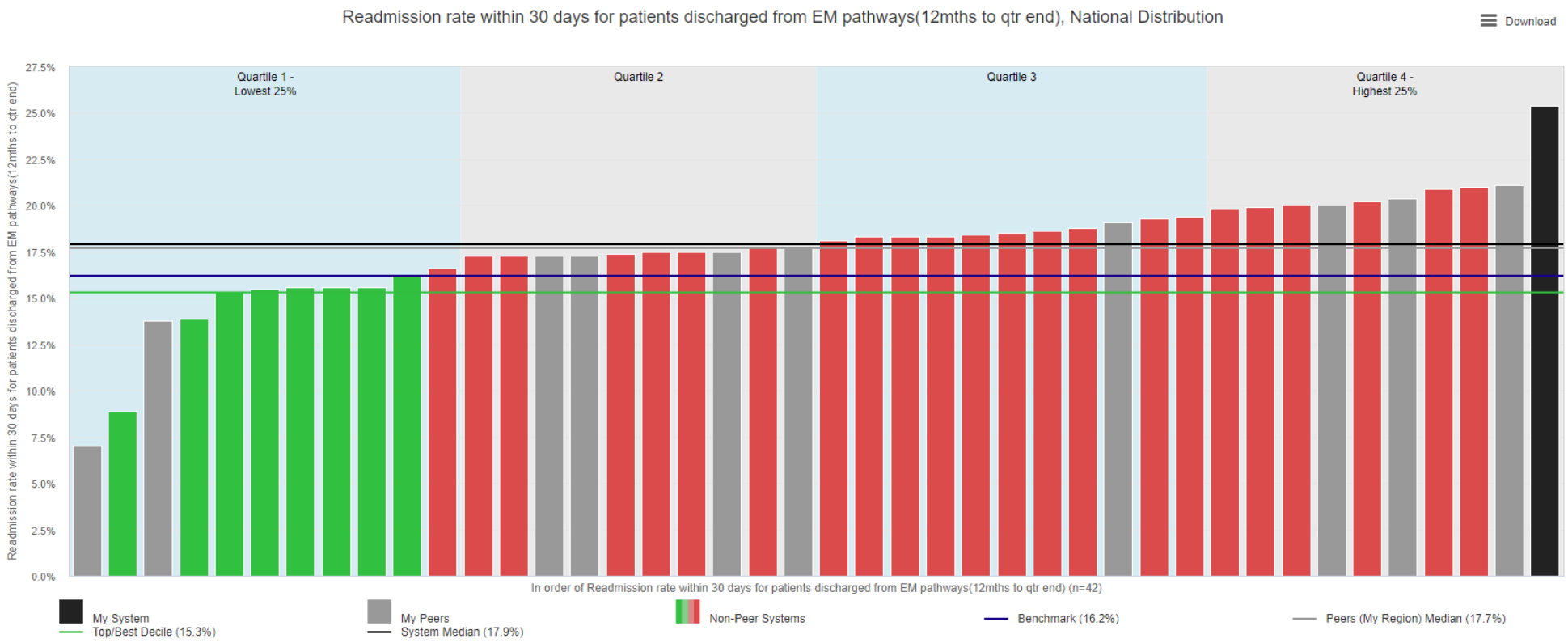


Figure 31 Showing emergency readmission rates, by ICB. Quarter 4 22/23 www.model.nhs.uk

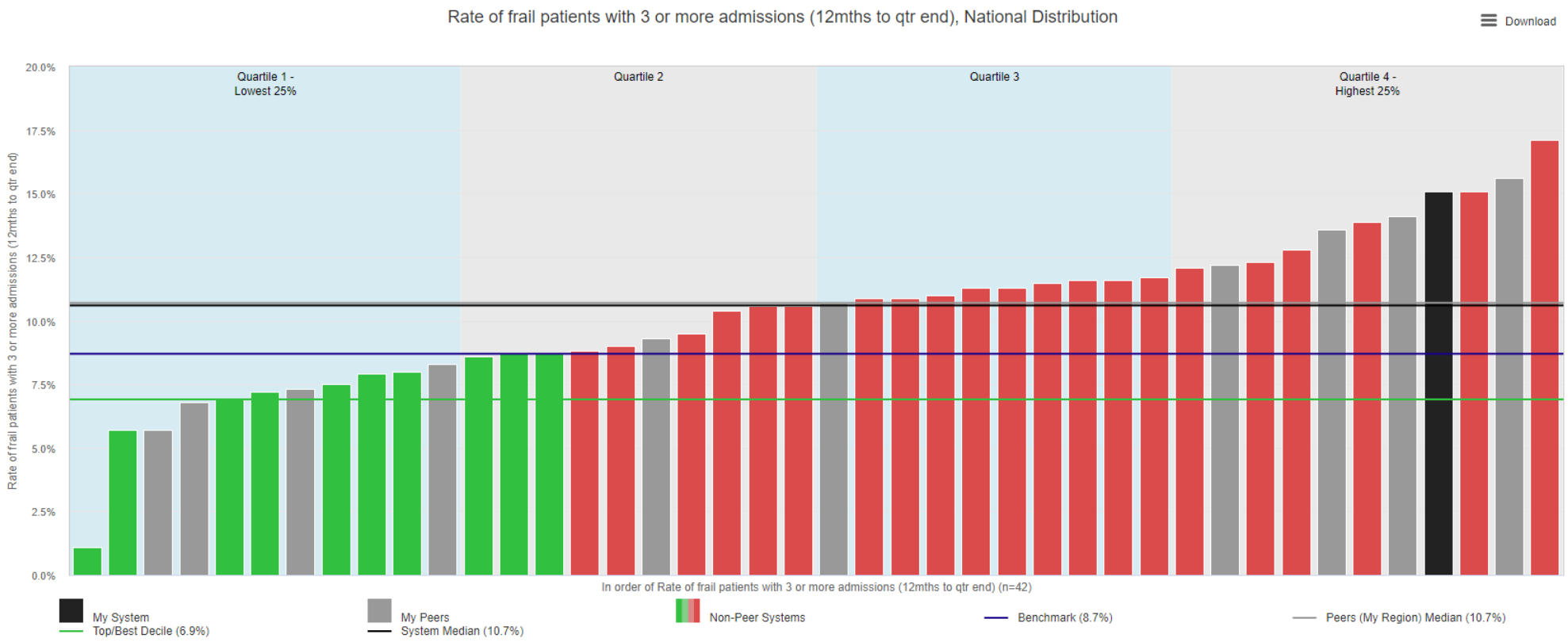


Figure 32 Showing rate of frail patients with three or more admissions, by ICB. Quarter 4 22/23 www.model.nhs.uk

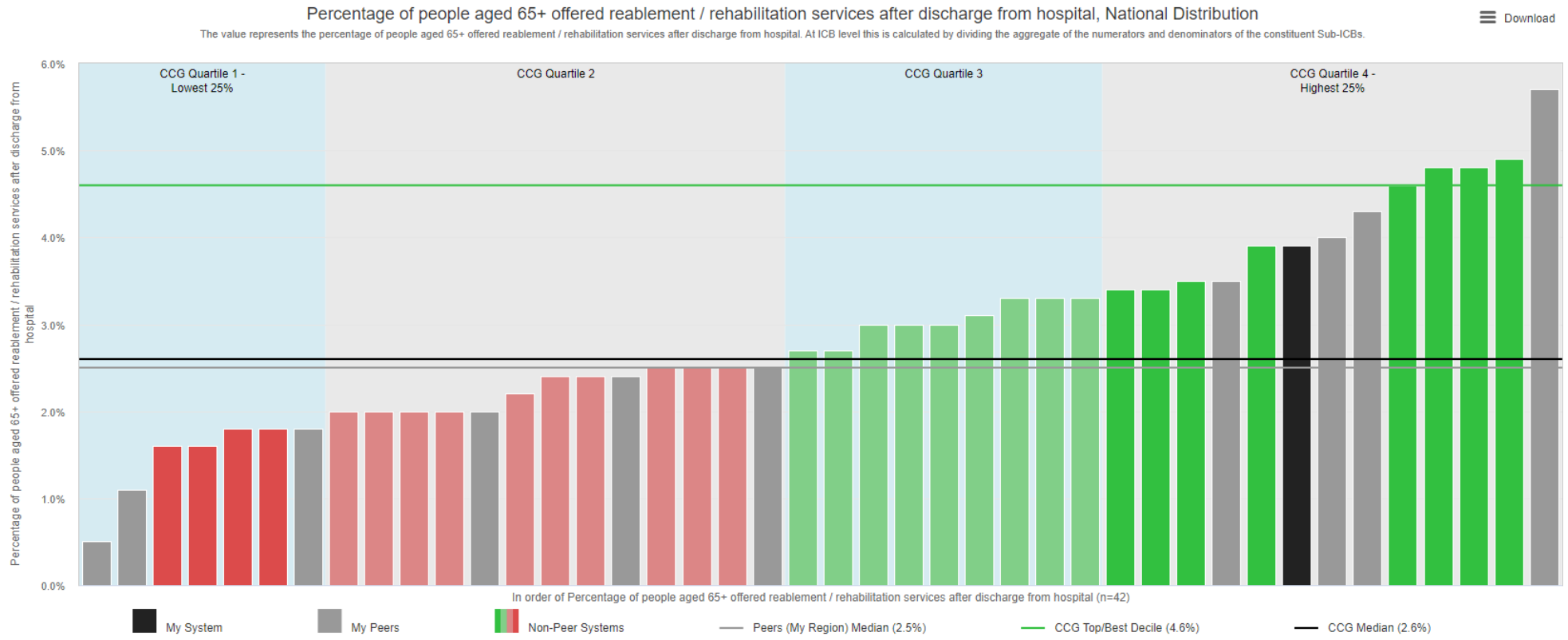


Figure 33 Percentage of people aged 65 years or older who have been offered reablement or rehabilitation service on discharge from hospital, by ICB. 2021/22. www.model.nhs.uk

Dementia and delirium

Dementia is a key condition which underpins risk of developing frailty and its complications. NHS England has a long-term national target that two-thirds of those estimated to have dementia are identified and diagnosed. (https://www.england.nhs.uk/mental-health/dementia/) SSOT has exceeded this rate, suggesting that there is good screening and diagnostic activity around dementia. (Figure 34) By CCG area, there in an uneven distribution in attaining this target. Whilst Stoke-on-Trent has the highest achievement in the country. Stafford and surrounds CCG is in the lowest quartile. (Figure 35)

According to the Dementia Care Pathway (National Collaborating Centre for Mental Health, 2018), during the initial assessment in primary care a validated cognitive test should be carried out. Where appropriate, a referral should then be made to memory services. Across the ICB 11.8% of those who have had a dementia assessment have been referred to memory services. This is higher than the peer median of 10%, but lower than the CCG median of 14.5%. (Figure 36)

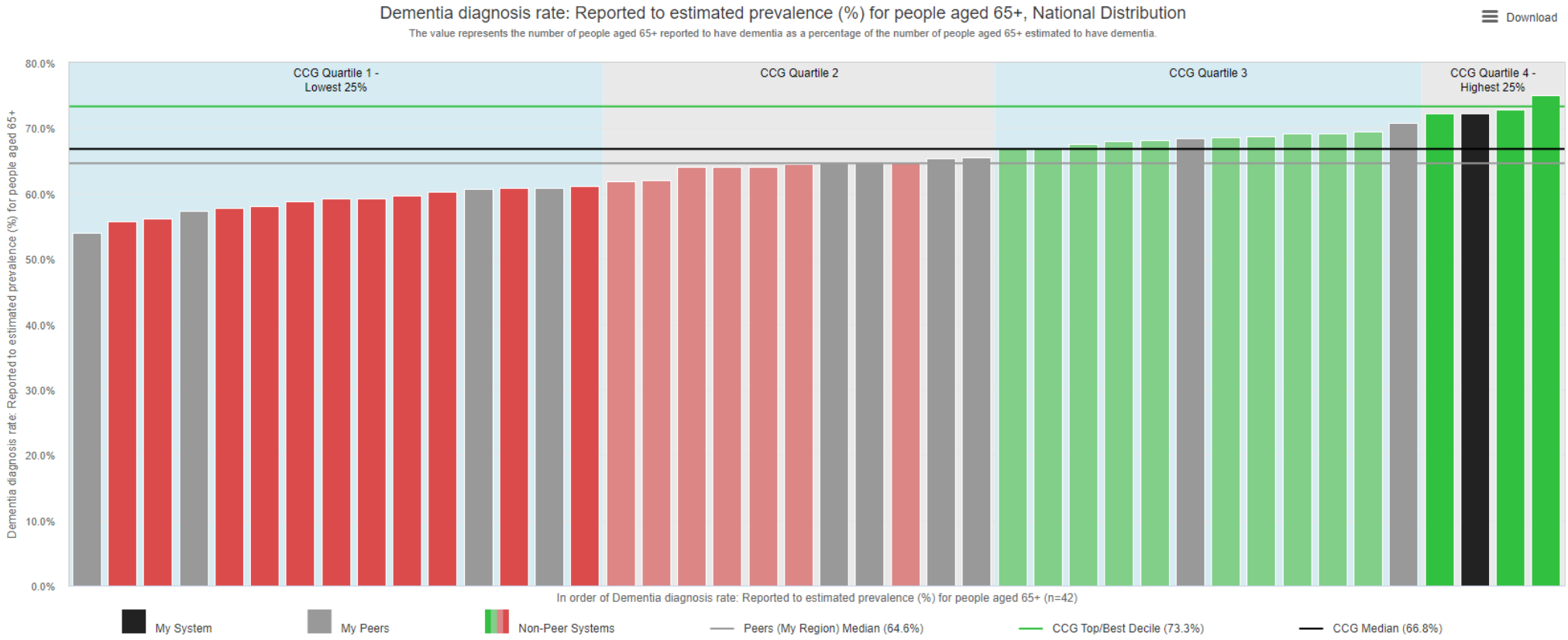


Figure 34 Showing percentage of people expected to have dementia who have received this diagnosis, by ICB area. 2022/23 www.model.nhs.uk

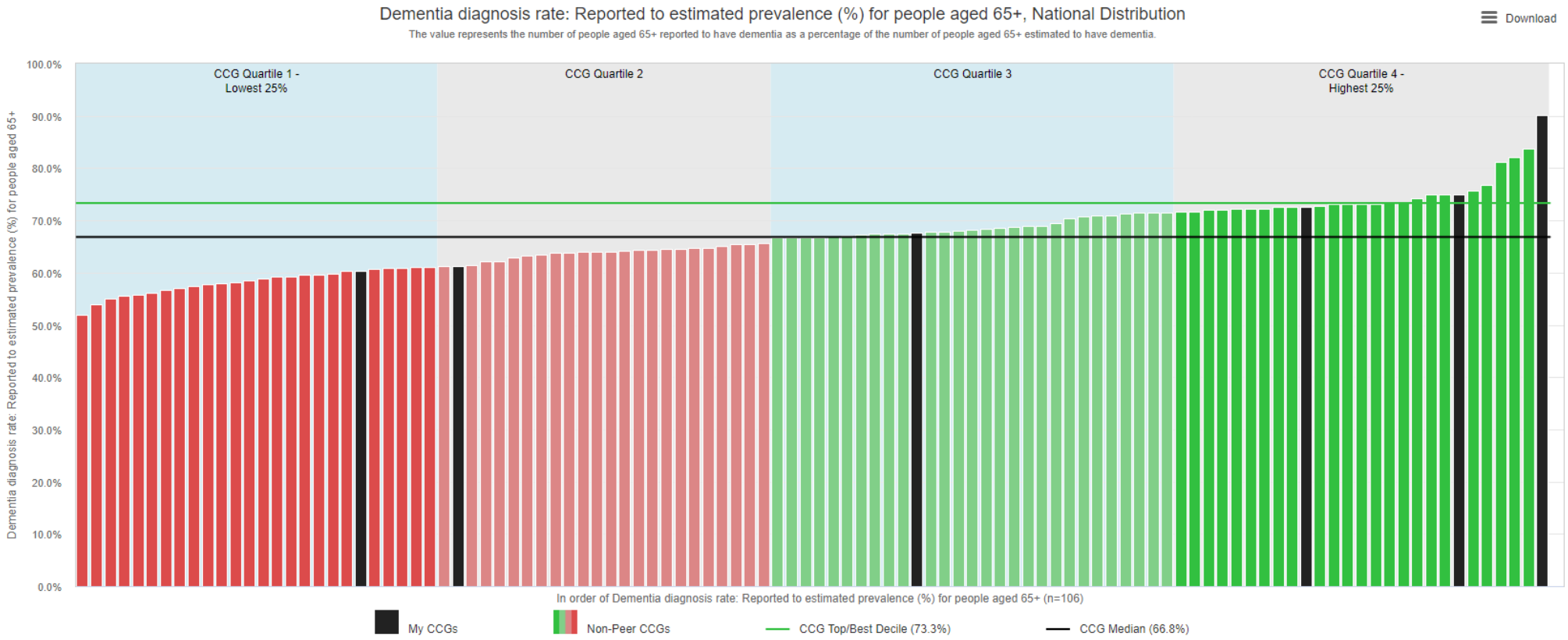


Figure 35 Showing percentage of people expected to have dementia who have received this diagnosis, by CCG area.2022/23 www.model.nhs.uk

From left to right the black bars indicate: Stafford and surrounds, East Staffordshire, Southeast Staffordshire and Seisdon, North Staffordshire, Cannock Chase and Stoke on Trent.

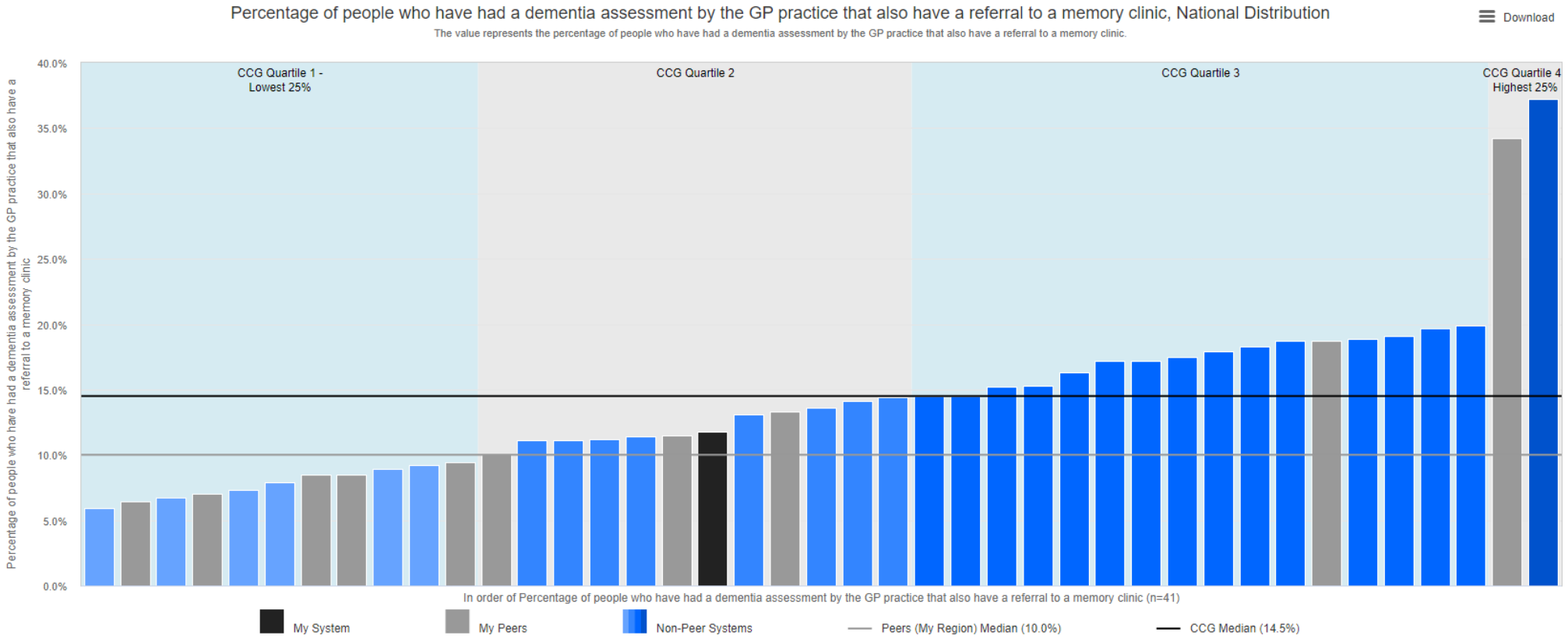


Figure 36 Showing the percentage of people who have had a dementia assessment by the GP practice that also have a referral to memory clinic, by ICB. 2022/23 www.model.nhs.uk

Approximately 9617 (4.06%) people in the ICB are affected by dementia (2020 data). ((UKHSA Fingertips Public Health Profiles., n.d.) The prevalence of dementia varies across the ICB by practice. (Figure 37) The Quality and Outcomes Framework includes incentivisation for all patients with dementia to have a face-to-face review of their annual care plans. This offers an important opportunity for identification of new needs, medication reviews and discussions about end-of-life care. Across the ICB, approximately 80% of eligible patients receive these reviews. However, rates vary across GP practices (Figure 38) and in some cases over 30% of eligible cases are reported as exceptions from this measure.

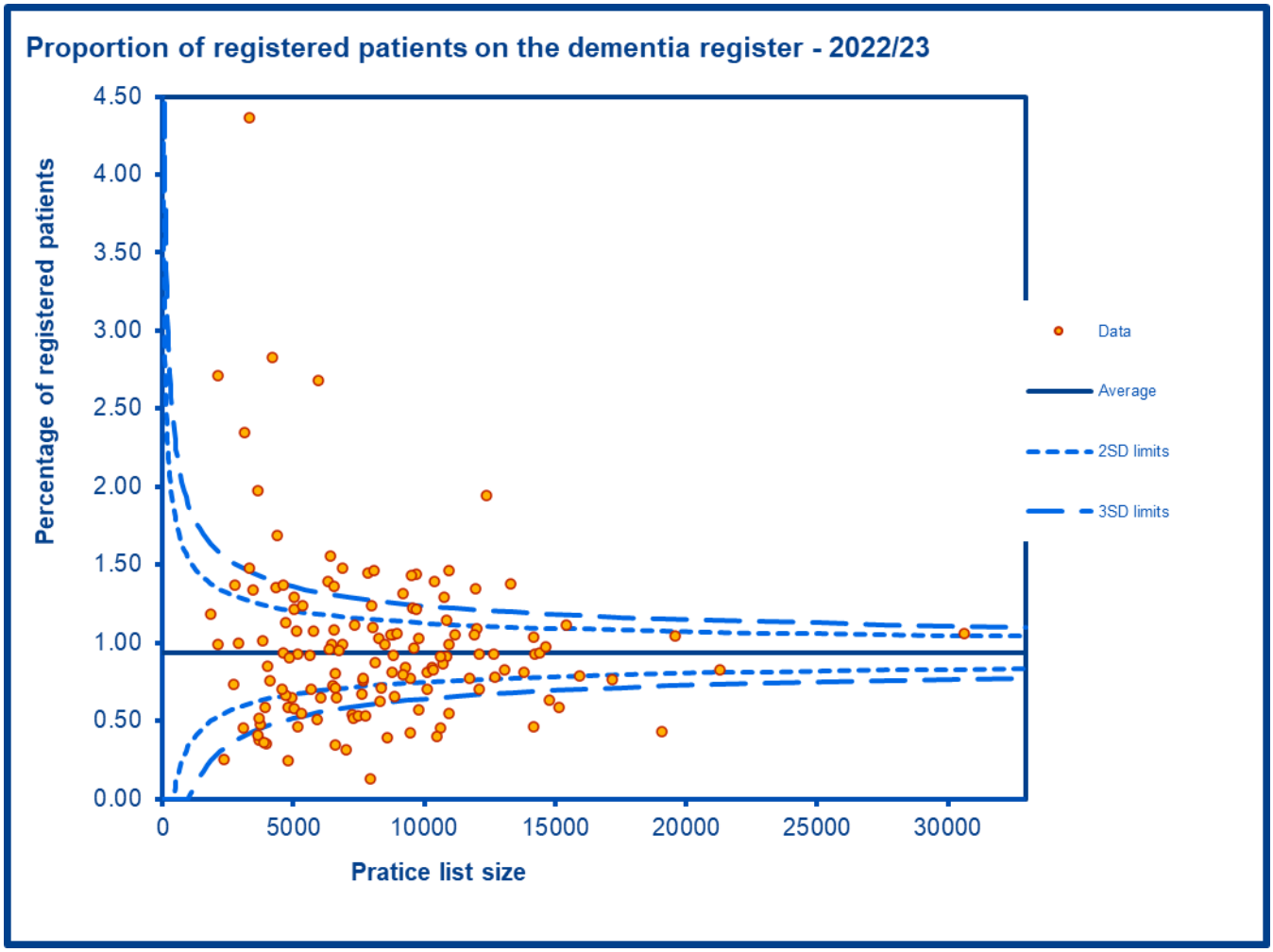


Figure 37 Funnel plot show the proportion of registered patients on the dementia register per practice. Data from [Quality and Outcomes Framework, 2022-23 - NHS England Digital](). Funnel plot generated using PHE's Funnel Plot tool.

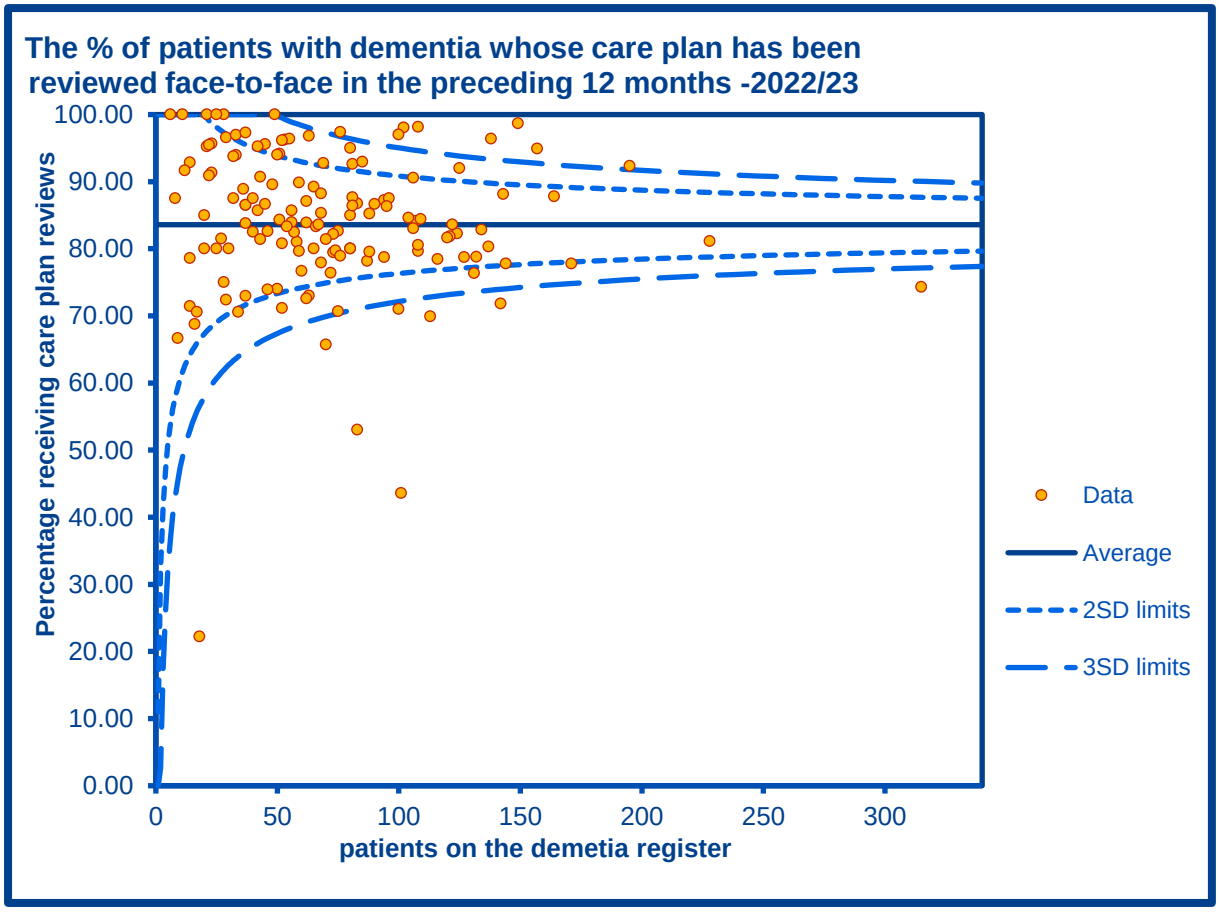


Figure 38 Showing the percentage of patients with dementia who have had a face-to-face review of their care plan. Data from [Quality and Outcomes Framework, 2022-23 - NHS England Digital](). Funnel plot generated using PHE's Funnel Plot tool

Information about admissions due to dementia are dated. In 2019/20, SSOT has the highest emergency admission rates for dementia in the Midlands region (though data were not available for all ICBs). (Figure 39) And the rates were increasing compared to England rates. (Figure 40)

Dementia: Direct standardised rate of emergency admissions (aged 65 years and over) - CCG responsibility 2019/20

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	374,432	3,517	3,506	3,529
Midlands NHS Region	–	-	-	-	-
NHS Staffordshire and Stoke-on-Trent Integrated Care Board - QNC	–	10,230	4,559	4,470	4,649
NHS Leicester, Leicestershire and Rutland Integrated Care Board - QK1	–	7,405	3,795	3,709	3,883
NHS Coventry and Warwickshire Integrated Care Board - QWU	–	6,460	3,566	3,480	3,655
NHS Shropshire, Telford and Wrekin Integrated Care Board - QOC	–	3,695	3,439	3,329	3,552
NHS Lincolnshire Integrated Care Board - QJM	–	5,340	2,963	2,884	3,044
NHS Herefordshire and Worcestershire Integrated Care Board - QGH	–	4,890	2,699	2,623	2,776
NHS Birmingham and Solihull Integrated Care Board - QHL	–	-	-	-	-
NHS Black Country Integrated Care Board - QUA	–	-	-	-	-
NHS Derby and Derbyshire Integrated Care Board - QJ2	–	-	-	-	-
NHS Northamptonshire Integrated Care Board - QPM	–	-	-	-	-
NHS Nottingham and Nottinghamshire Integrated Care Board - QT1	–	-	-	-	-

Figure 39 Showing rates of emergency admissions for dementia in the Midlands, by ICB.2019/20. www.fingertips.phe.org.uk

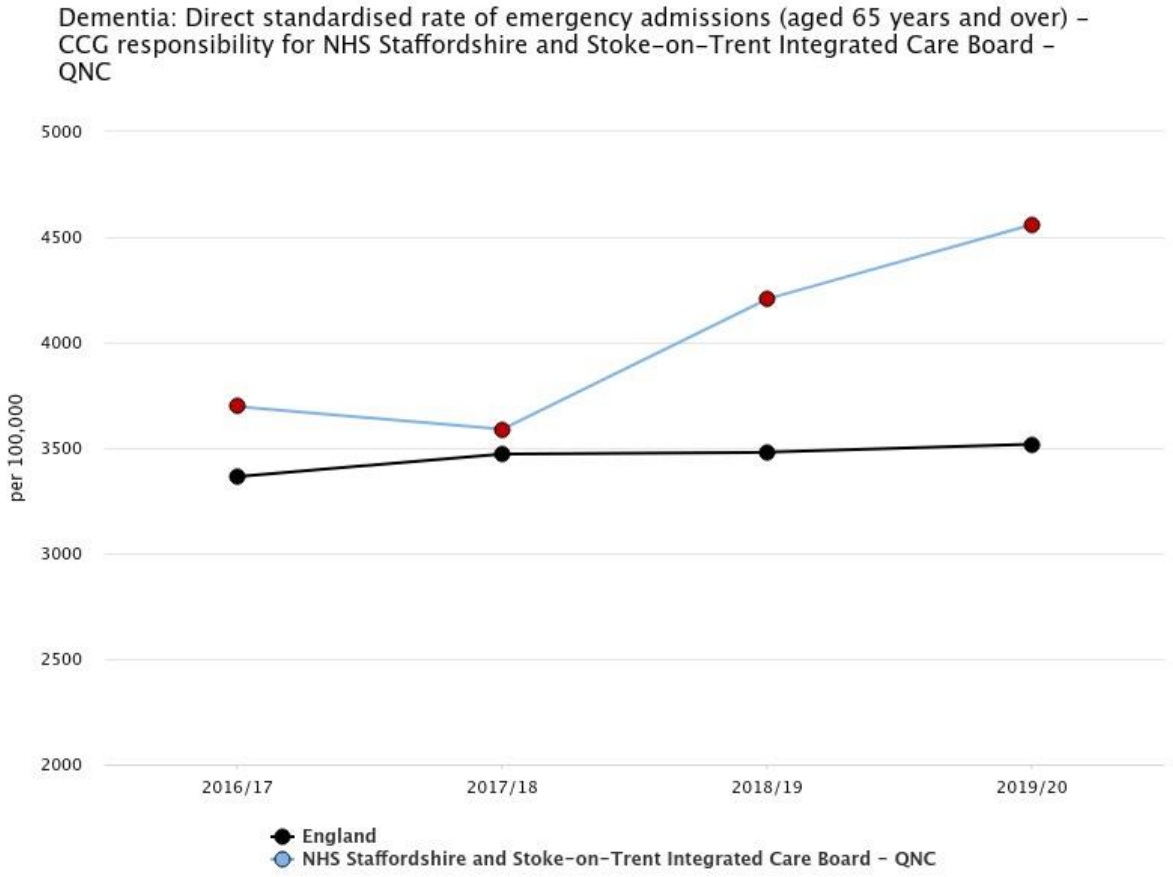


Figure 40 Showing trends in the rates of emergency admissions due to dementia. www.fingertips.phe.org.uk

Mortality data are again from 2019/20. They show that the ICB has the highest mortality rates in the region where dementia was mentioned as a contributing or underlying cause. As with national data, there is a downward trend in this statistic which likely reflects more recognition of dementia as the primary cause of death. (Figure 41)

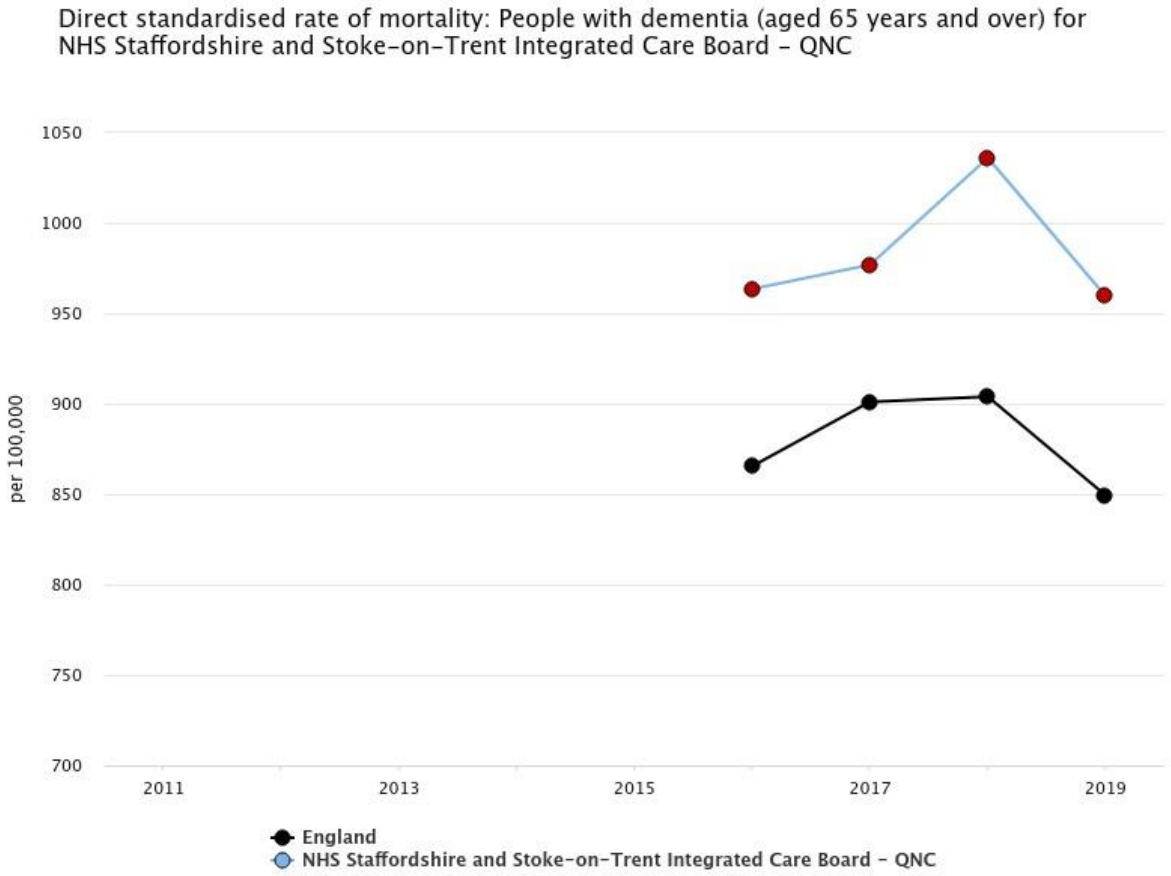


Figure 41 Showing trends in mortality where dementia was a contributing or underlying cause. www.fingertips.phe.org.uk

Disorientation caused by delirium or dementia also contributes to burden of admissions. SSOT spent £563,693 in quarter 2 of 2023/24 on inpatient activity for disorientation alone. SSOT spend on non-elective admissions due to disorientation has been higher than demographic peers since 2012 and the gap appears to be widening. (Figure 42)

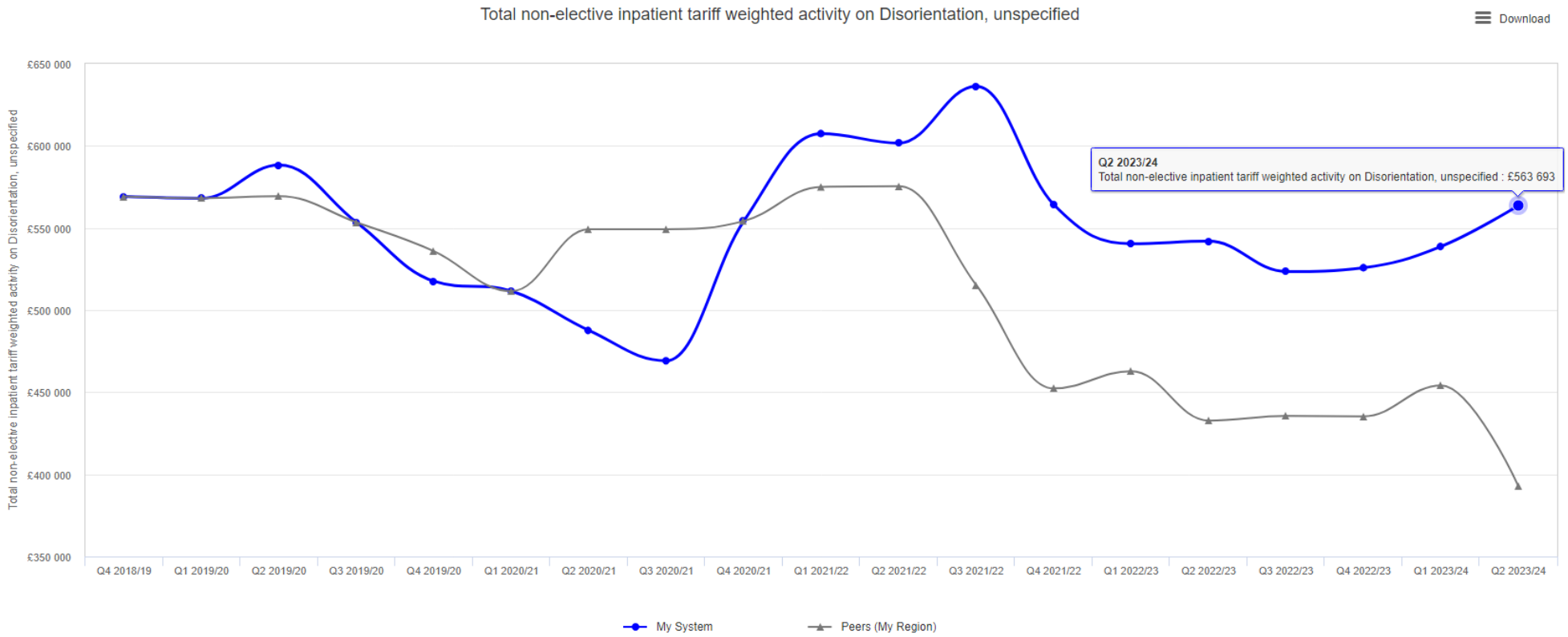


Figure 42 Showing trends in spend for non-elective admissions due to disorientation. www.model.nhs.uk

Dementia pathways involve assessment in primary care with onward referral to MPFT memory team. Here further assessments and diagnoses are carried out. Those with vascular dementia are discharged to primary care and those with Alzheimer's Disease remain under annual review with MPFT.

Take home messages

Dementia pathways should begin at prevention. There appears to be a good level of activity in identifying dementia across the ICB. Further investigation is needed to understand barriers in referring those who have had a dementia assessment in primary care. And work is needed to explore the high mortality and admissions due to dementia.

Falls

Falls are an important cause of mortality, morbidity and reduction in quality of life. According to report by NHS England:

- falls were the ninth highest cause of disability-adjusted life years (DALYs) in England in 2013 and the leading cause of injury
- unaddressed fall hazards in the home are estimated to cost the NHS in England £435 million
- the total annual cost of fragility fractures to the UK has been estimated at £4.4 billion which includes £1.1 billion for social care; hip fractures account for around £2 billion of this sum
- short and long-term outlooks for patients are generally poor following a hip fracture, with an increased one-year mortality of between 18% and 33% and negative effects on daily living activities such as shopping and walking
- a review of long-term disability found that around 20% of hip fracture patients entered long-term care in the first year after fracture
- falls in hospitals are the most commonly reported patient safety incident with more than 240,000 reported in acute hospitals and mental health trusts in England and Wales (OHID, 2022)

Falls and frailty overlap in many of their risk factors and can increase the severity of each other. Falls are included as a deficit in the eFI.

The directly standardised rate of emergency admissions for falls in people aged 65 years and older (2022/23) in Stoke-on-Trent was 1589 per 100,000 (700 falls). This was significantly lower than the rate in England (1933 per 100,000) and was the lowest rate compared to nearest statistical neighbours. The rate of falls has been decreasing in Stoke-on-Trent over time (Figure 43) In Staffordshire the rate was 2025 per 100,000 (4030 falls) and was significantly higher than England. Staffordshire ranks fifth highest compared to nearest statistical neighbours. There has been no statistical change in the rate of falls over time in Staffordshire. (Figure 44)

Emergency hospital admissions due to falls in people aged 65 and over 2022/23

Area	Recent Trend	Neighbour Rank	Count	Value
England	↓	-	209,989	1,933
Neighbours average	↓	-	-	-
Wolverhampton	↑	10	1,315	2,864
Derby	→	11	1,135	2,491
Walsall	↑	1	1,280	2,435
Sandwell	→	7	1,150	2,256
Rochdale	↓	6	780	2,197
Tameside	→	2	785	2,040
Dudley	→	8	1,390	2,039
Oldham	↓	3	745	1,996
Bolton	→	9	995	1,989
Blackburn with Darwen	→	14	430	1,980
Bury	↓	15	675	1,910
Middlesbrough	→	5	450	1,871
Rotherham	↓	12	920	1,780
Kingston upon Hull	↓	4	705	1,780
Telford and Wrekin	↓	13	525	1,641
Stoke-on-Trent	↓	-	700	1,589

Figure 43 Showing emergency hospital admissions in Stoke-on-Trent due to falls in people aged 65 years or older compared to nearest statistical neighbours. www.fingertips.phe.org.uk

Emergency hospital admissions due to falls in people aged 65 and over 2022/23

Area	Recent Trend	Neighbour Rank	Count	Value
England	↓	-	209,989	1,933
Neighbours average	↓	-	-	-
Cheshire East	→	12	2,145	2,248
West Sussex	↓	9	4,730	2,098
North Northamptonshire	↓	15	1,325	2,070
Derbyshire	↓	3	3,570	2,043
Staffordshire	→	-	4,030	2,025
Kent	→	10	6,575	1,955
Warwickshire	↓	6	2,485	1,913
Wiltshire	→	14	2,290	1,907
Leicestershire	→	11	2,845	1,867
Nottinghamshire	↓	1	3,370	1,865
Central Bedfordshire	↓	8	975	1,842
Essex	↓	5	5,825	1,766
Hampshire	↓	7	5,705	1,708*
Worcestershire	↓	2	2,355	1,624
Suffolk	↓	13	2,840	1,471
Gloucestershire	↓	4	2,070	1,395

Figure 44 Showing emergency hospital admissions in Staffordshire due to falls in people aged 65 years or older compared to nearest statistical neighbours. www.fingertips.phe.org.uk

The rate of falls increases with age. In Stoke-on-Trent, the rate of emergency admissions due to falls in those aged 65-79 years was 877 per 100,000 whereas in those aged 80 older the rate was 3653 per 100,000 (2022/23). In Staffordshire, the rate in those aged 65-79 years was 924 per 100,000 whereas in those aged 80 older the rate was 5219 per 100,000 over the same time period. (UKHSA Fingertips Public Health Profiles., n.d.)

Several points need to be considered in interpreting the data around falls. First these do not represent need, since many who fall and injure themselves are not seen in secondary care, let alone admitted. Rather they are a measure of service utilisation. Secondly, the many of the diagnostic codes underpinning the data refer to injuries without specification of the mechanism.

Hip fractures are an important consequence of falls. One third of those with hip fractures end up needing to move out of their homes. About one in ten people with a hip fracture die within 1 month and about one in three within 12 months of a fracture. (UKHSA Fingertips Public Health Profiles., n.d.)

The directly standardised rate for emergency hospital admission for hip fractures in Stoke-on-Trent in those aged 65 years or older was 612 per 100,00 in 2022/23. This rate has remained stable over time. It is interesting to note that despite having the lowest rate of admissions due to falls, Stoke-on-Trent does not have the lowest rate of hip fractures compared to nearest statistical neighbours. (Figure 45) This may suggest a higher fall to fracture conversion.

Hip fractures in people aged 65 and over 2022/23

Area	Recent Trend	Neighbour Rank	Count	Value
England	↓	-	60,796	558
Neighbours average	↓	-	-	-
Bury	→	15	250	699
Middlesbrough	→	5	170	694
Kingston upon Hull	→	4	265	672
Rochdale	→	6	235	670
Bolton	→	9	335	669
Sandwell	→	7	340	669
Tameside	→	2	255	661
Telford and Wrekin	→	13	210	652
Dudley	→	8	445	647
Blackburn with Darwen	→	14	135	628
Stoke-on-Trent	→	-	270	612
Oldham	→	3	230	611
Derby	→	11	275	598
Wolverhampton	→	10	275	592
Walsall	→	1	310	588
Rotherham	→	12	280	536

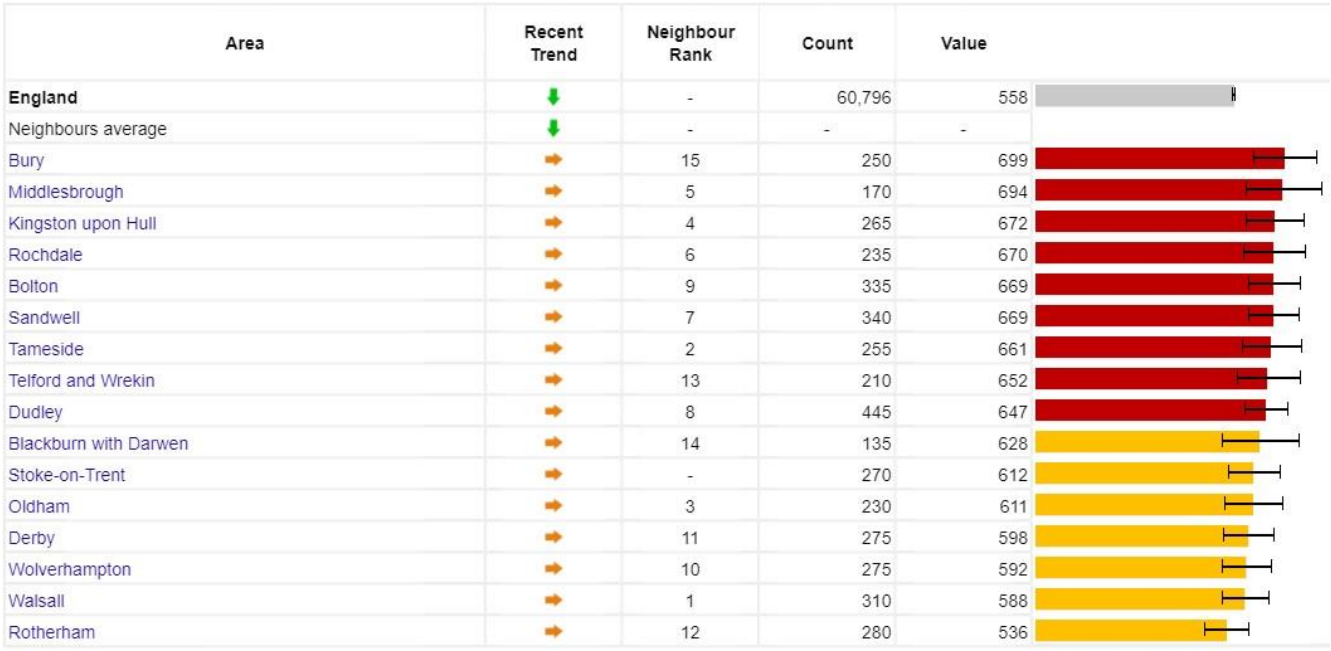


Figure 45 Showing emergency hospital admissions for hip fractures in Stoke-on-Trent in people aged 65 years or older compared to nearest statistical neighbours. www.fingertips.phe.org.uk

The directly standardised rate for emergency hospital admission for hip fractures in Staffordshire in those aged 65 years or older was 578 per 100,00 in 2022/23. This rate has remained stable over time. Unlike the rate of falls, the rate of fractures is not statistically higher than the England rates.

Hip fractures in people aged 65 and over 2022/23

Area	Recent Trend	Neighbour Rank	Count	Value
England	↓	-	60,796	558
Neighbours average	↓	-	-	-
Worcestershire	→	2	905	622
North Northamptonshire	→	15	390	606
Nottinghamshire	→	1	1,090	602
Central Bedfordshire	→	8	315	589
Kent	→	10	1,965	582
Cheshire East	→	12	555	580
Staffordshire	→	-	1,150	578
Warwickshire	→	6	755	574
Essex	→	5	1,890	572
Leicestershire	↓	11	860	566
Derbyshire	→	3	985	564
Gloucestershire	→	4	785	526
West Sussex	→	9	1,170	515
Wiltshire	→	14	580	478
Hampshire	↓	7	1,570	468*
Suffolk	↓	13	875	451

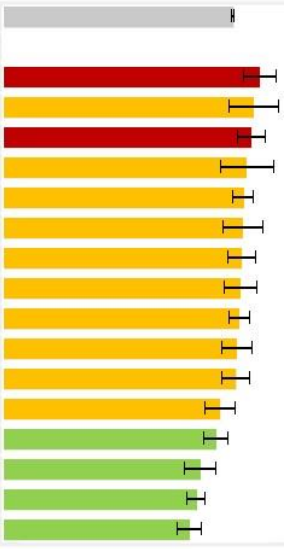


Figure 46 Showing emergency hospital admissions for hip fractures in Staffordshire in people aged 65 years or older compared to nearest statistical neighbours. www.fingertips.phe.org.uk

As with falls, the rate of hip fractures increases with age. In Stoke-on-Trent, the rate of emergency admissions due to hip fractures in those aged 65-79 years was 286 per 100,000 whereas in those aged 80 older the rate was 1577 per 100,000 (2022/23). In Staffordshire, the rate in those aged 65-79 years was 258.2 per 100,000 whereas in those aged 80 older the rate was 1506 per 100,000 over the same time period. (UKHSA Fingertips Public Health Profiles., n.d.) Despite having a much lower rate of falls, Stoke-on-Trent has a similar rate of hip fractures compared to Staffordshire.

Hip fractures and falls are patterned on deprivation (Figure 47) and affect females (Figure 48) more than males.

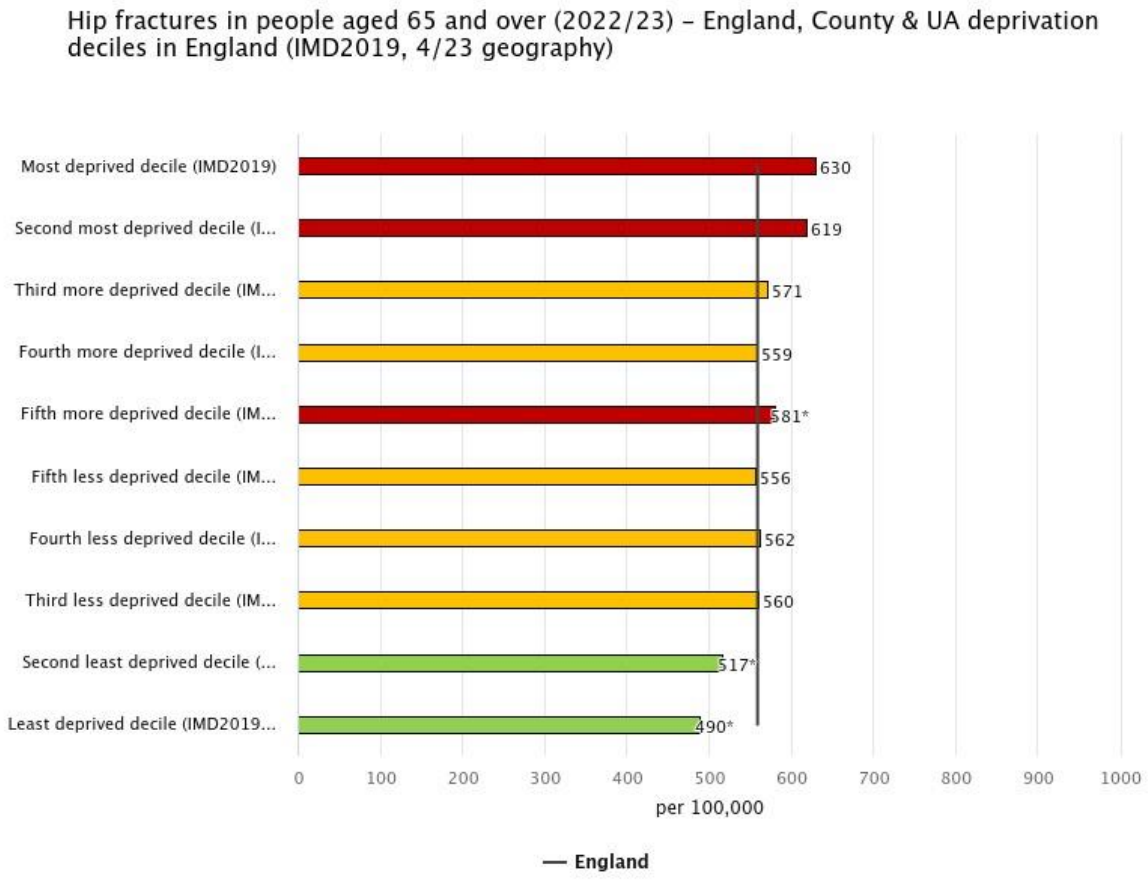


Figure 47 Showing emergency admissions for hip fractures by deprivation in England - 2022/23 www.fingertips.phe.org.uk

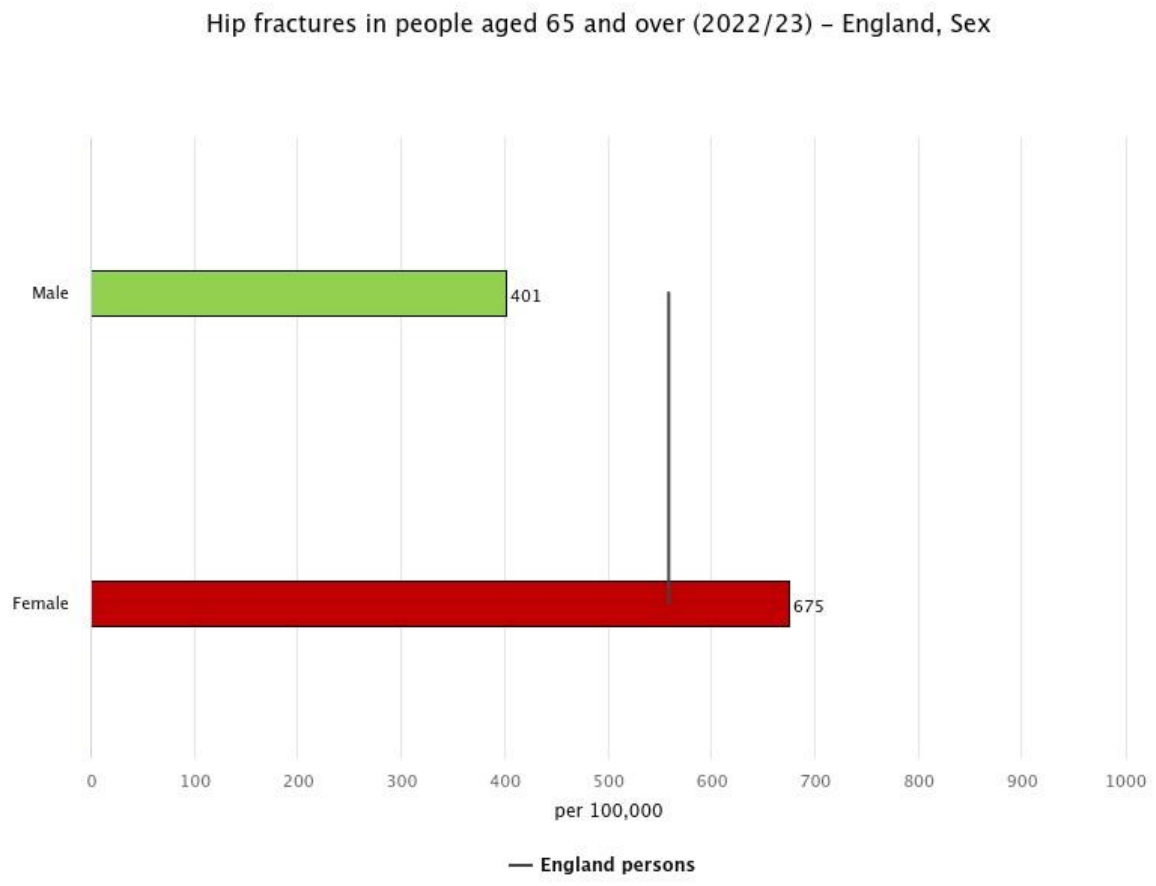


Figure 48 Showing emergency admissions for hip fractures by sex in England - 2022/23 www.fingertips.phe.org.uk

Take home messages

Falls contribute to morbidity and mortality in older adults. There are interventions which can prevent falls and improve recovery. Although absolute numbers are lower in Stoke-on-Trent, there appears to be a higher conversion rate from falls to hip fractures in the area. This would benefit from further investigation.

Care homes

The number and proportion of older adults living in care homes in England will increase over the next decade. This increase is steepest in those aged 85 years and older. There are significantly more older adults living in private care homes compared to Local Authority care homes. (Table 19)

	2023	2030	%change	2035	% change
People aged 65-74 living in a LA care home with or without nursing	1,391	1,610	16%	1,741	25%
People aged 75-84 living in a LA care home with or without nursing	4,851	5,437	12%	5,631	16%
People aged 85 and over living in a LA care home with or without nursing	8,758	10,490	20%	13,018	49%
People aged 65-74 living in a non-LA care home with or without nursing	34,280	39,683	16%	42,904	25%

People aged 75-84 living in a non-LA care home with or without nursing	107,576	120,566	12%	124,869	16%
People aged 85 and over living in a non-LA care home with or without nursing	198,088	237,270	20%	294,451	49%
Total population aged 65 and over living in a care home with or without nursing	354,943	415,056	17%	482,615	36%

Table 19 Showing the number of people living in care homes in England, but age at type of home. Data from Poppi.org.uk. Crown Copyright 2020

Data for admissions into care homes are available as crude rates only, so should be interpreted with caution. In Stoke-on-Trent there are 878 permanent admissions to residential and nursing care homes per 100,000 people aged 65 years or older, 2021/22. This trend is increasing. In Staffordshire, the rate is 569 per 100,000. The trend is stable. (UKHSA Fingertips Public Health Profiles., n.d.)

Staffordshire and Stoke-on-Trent both have over 97% of their residential care and nursing home beds assessed by the Care Quality Commission (CQC). The percentage of residential care home and nursing home beds, suitable for a person with dementia (65+), in Stoke-on-Trent which are rated as 'good' or 'outstanding' by the CQC was 61.9% in 2020. In Staffordshire, this percentage was 63.4%. In both areas, quality rating was statistically worse than the England average and most of the statistical peers. (Figure 49 and Figure 50)

Dementia: Quality rating of residential care and nursing home beds (aged 65 years and over) 2020

Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	236,094	74.1	74.0	74.3
Neighbours average	–	-	18,718	72.6*	72.1	73.1
Gateshead	–	5	1,412	95.9	94.7	96.8
Derby	–	13	1,244	88.8	87.0	90.3
Middlesbrough	–	3	1,149	84.4	82.3	86.2
Tameside	–	4	1,058	81.7	79.5	83.7
St. Helens	–	14	694	80.0	77.2	82.5
Wigan	–	11	1,390	79.0	77.0	80.8
Doncaster	–	6	1,347	78.3	76.3	80.2
Sheffield	–	12	2,248	75.4	73.8	76.9
Kingston upon Hull	–	2	1,393	74.9	72.8	76.8
Rotherham	–	8	1,091	69.0	66.7	71.2
Rochdale	–	7	685	66.8	63.9	69.6
Dudley	–	10	1,218	64.4	62.2	66.5
Bolton	–	1	714	63.8	60.9	66.5
Stoke-on-Trent	–	-	1,219	61.9	59.7	64.0
Wakefield	–	15	1,302	60.7	58.6	62.8
Walsall	–	9	554	41.7	39.1	44.4

Figure 49 Showing percentage of residential care home and nursing home beds, suitable for a person with dementia (65+), which are rated as 'good' or 'outstanding' by the CQC, Stoke-on-Trent and its statistical neighbours, 2020. [Public health profiles - OHID (phe.org.uk)]

Dementia: Quality rating of residential care and nursing home beds (aged 65 years and over) 2020

Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	236,094	74.1	74.0	74.3
Neighbours average	–	-	64,075	73.8*	73.6	74.1
Gloucestershire	–	2	3,362	90.9	90.0	91.8
Suffolk	–	3	4,893	84.1	83.2	85.1
Somerset Cty	–	5	3,377	83.3	82.1	84.4
Devon	–	14	4,016	80.6	79.4	81.6
Lancashire	–	8	6,418	76.7	75.8	77.6
Worcestershire	–	1	3,546	76.4	75.1	77.6
Lincolnshire	–	9	4,463	75.2	74.1	76.3
Essex	–	15	6,816	74.9	74.0	75.8
East Sussex	–	13	2,721	72.9	71.5	74.3
Leicestershire	–	6	2,528	71.3	69.8	72.8
West Sussex	–	12	3,727	71.2	70.0	72.4
Derbyshire	–	11	3,636	70.3	69.0	71.5
Nottinghamshire	–	4	4,190	69.5	68.3	70.7
Staffordshire	–	-	3,798	63.4	62.2	64.7
Warwickshire	–	7	2,695	62.9	61.5	64.4
Norfolk	–	10	3,889	62.8	61.6	64.0

Figure 50 Showing percentage of residential care home and nursing home beds, suitable for a person with dementia (65+), which are rated as 'good' or 'outstanding' by the CQC, Staffordshire and its statistical neighbours, 2020. Public health profiles - OHID (phe.org.uk)

These data refer to facilities for patients with dementia only, and not for CQC rating for other types of residents.

For care home residents aged 65 years and over living registered with SSoT ICB GPs, rates of admission increased in April 2023 (likely due to a change in data coding or collection) and have been stable since then. The most common causes of admissions overall are lower respiratory conditions and falls (most frequently coded consequence is fractured neck of femur). The number of ambulance conveyances has been increasing annually since 2021/22.

The number of deaths in care homes in both Stoke-on-Trent and Staffordshire tend to be lower than the England average both in total and across age groups, though not significantly so. The exception for this is in the under 65 age group where there were more deaths in Stoke-on-Trent than the England average, though again this difference is not significant. The trends have remained stable (Table 20).

Indicator	Stoke	Staffordshire	England
Temporary Resident Care Home Deaths, All Ages (%), 2022	36.9%	36.1%	41.2% (range 25.5% to 75%)
Percentage of deaths that occur in care homes (All ages) , 2022	17.1%	19.0%	20.5% (range 5.9% to 32.6%)
Percentage of deaths that occur in care homes (<65 years) , 2022	3.1%	2.3%	2.6% (range 0.4% to 10.1%)
Percentage of deaths that occur in care homes (65 – 74 years) , 2022	6.9%	7.4%	8.1% (range 3.3% to 19.7%)
Percentage of deaths that occur in care homes (75 – 84 years) , 2022	15.4%	15.2%	17.4% (range 4.7% to 30.0%)

Percentage of deaths that occur in care homes (85+ years) , 2022	31.3%	32.4%	34.6% (range 11.1% to 45.8%)

Table 20 - Deaths in care homes and temporary residences - Source OHID: Public health profiles - OHID (phe.org.uk)

Take home messages

There is a care home working group who are offering support to an initial group of care homes. Overall, further work is needed to meet CQC standards, prevent falls and enable early identification, assessment and treatment of lower respiratory conditions in the care home setting.

There are interdependencies between actions needed to prevent falls, reduce the risk of pneumonia and reduce the risk of delirium. These factors impact on admissions in older adults in general and more so in those who are care home residents.

End of life

There is a statutory requirement for ICBs to provide high quality safe services that are tailored to the needs of the individual who is need of palliative or end of life care. (NHSE , Sept 2022) Pubic facing data are not available for death in preferred place in adults experiencing frailty. However, SSOT has higher rates of admission in the last three months of life compared to demographic peers. (Figure 51) It is likely that some of these admissions are preventable.

Stakeholder discussions would suggest that there are challenges identifying when palliative and end-of-life care should be started in adults with frailty. Guidelines are available from the British Geriatric Society and may be helpful in this context. (End of Life Care in Frailty: Identification and prognostication | British Geriatrics Society (bgs.org.uk))

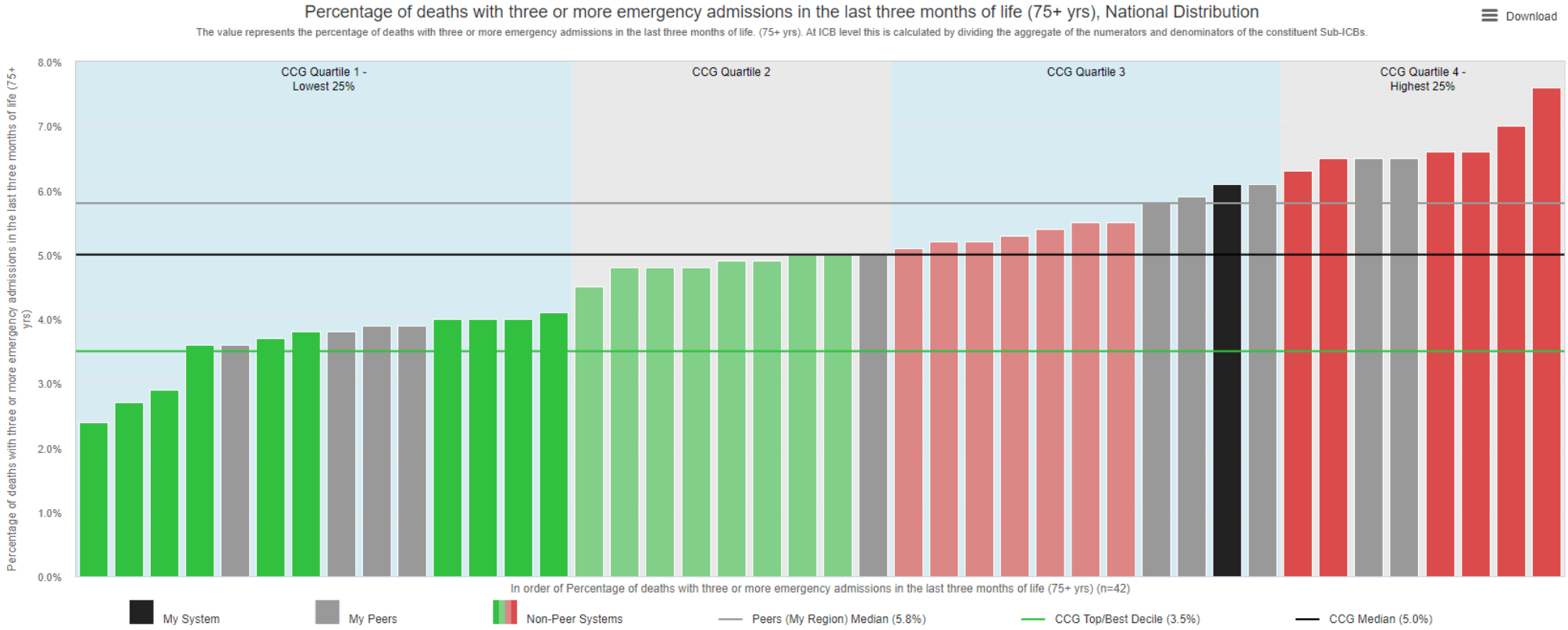


Figure 51 Showing percentage of deaths with three or more emergency admissions in the last three months of life (age 75 years and older) 2022. www.model.nhs.uk

Benchmarking activities

Several benchmarking activities were taken as part of identifying gaps in the previous strategy.

Benchmarking against reports

Recommendations from 6 reports were extracted and themed. The themes were then compared to objectives from the previous ICB strategy. (Table 21) The previous ICB strategy included most of the recommendations made by reports published since 2021. Continuity of care was implied, and mood disorders were considered as aspect of the discussion around loneliness.

Recommendations	**Chief Medical Officer's annual report 2023: health in an ageing society - GOV.UK (www.gov.uk)**	**NHS England » Proactive care: providing care and support for people living at home with moderate or severe frailty**	NHS England » FRAIL strategy	**Joining the dots: A blueprint for preventing and managing frailty in older people | British Geriatrics Society (bgs.org.uk)**	Reablement, Rehabilitation, Recovery: Everyone's business | British Geriatrics Society (bgs.org.uk)	GIRFT	**Prev ICB Strategy**
Year of publication	Nov 2023	Dec 2023	Feb 2024	March 2023	May 2024	Feb 2021	June 2021
Health promoting, age friendly environments							
Primary prevention							
Secondary prevention							
Loneliness							
Identifying and stratifying the needs of those with frailty in all health settings							
Holistic assessments to enable personalised care plans							
medication reviews to avoid inappropriate polypharmacy							
avoid admissions - increasing							

ambulatory care options							
make admissions short							
avoid readmissions							
prevent deconditioning							
discharge to preferred place of care with good post-discharge support							
reablement and reconditioning							
MDTs							
Support for care homes and those needing long-term care							
End of life care and anticipatory care							
Falls - prevention and reaction							
Dementia and delirium							
Mood disorders in older adults							
Integrated care							
Continuity of care							
Workforce skills and knowledge development (incl coding)							
IT and governance structures to allow data sharing							

Table 21 Showing benchmarking of previous frailty strategy against published guidelines and recommendations

Benchmarking against previous objectives.

There has been considerable work on the frailty workstreams within the ICB. VSCE partners have also been developing their offers.

Programme Area	Progress
Healthy Ageing/Prevention	BAU - A Volunteer Buddy scheme Pilot has been commissioned, running until mid 2024 (in the Staffordshire Moorlands, Cannock Chase, Lichfield & South Staffs Districts) with the aim of helping individuals to access their local communities. SCC's community development programme called Supportive communities underwent a review in 2023 which has resulted in the development of a new plan for 2024. Plans are also being developed to identify how this programme can be delivered on a more local basis across the 8 Staffordshire districts.
Mild Frailty	Pilot of the 'My Health, My Way' Platform launched on 24 May 2024. 9 pilot practices engaged, targeting cohort of 5,000 patients, over 65 with mild frailty EFI score. Evaluation report by end of 2024, with business case for scale up in early 2025. We're in week 5 - over 2000 invites have gone out.
Moderate Frailty	Staying Well Service and Evaluation scope against 4 outcome measures is being agreed including timelines. Want to ensure that we have collected enough data in the north and south services in order to be able to detect a change against 4 standardised outcome measures being used in both services. Proposal to go to August Frailty Programme Board.
Severe Frailty	Options appraisal complete and proposal to come to the portfolio board in July as to next steps.
Proactive management of Falls - Improving Access to Falls Services from A&E	Project completed. Challenges include workforce capacity and financial resourcing. A business case will be needed to sustain the service into 24/25 as demand continues to grow. During a review meeting on 4th June, it was decided that the full evaluation and options appraisal for everything would be submitted in Jan 2025 to the ICB with the proactive work. Patients would be transferred from the North to the South due to capacity issues for now and a full capacity/demand review would be completed late in the summer.
Falls (Transformation)	Falls is Everyone's Business Comms Campaign continues; raising the profile of the project and delivering key messages to staff and partners. Risk stratification pilot has commenced in the East. 12-week KOKU pilot now concluded within both pilot sites: Newcastle-under-Lyme and Seisdon. Options Appraisal being drafted. Falls Assistant online self-assessment tool: pilot concluded. Evaluation underway.

	Low engagement with healthy lifestyle advice via local employer's Repeat faller and clinic pilots underway and staff are well engaged CIG undertook deep dive in June and agreed to establish T&F group in relation to Strength and Balance, working with partners to integrate services where possible. Also agreed to establish link with the care homes group as to what more can be done to focus on falls.

Additional workstreams include:

- Development of place-based healthy ageing plans in Stoke-on-Trent and Staffordshire
- Care homes workstream – currently involving care homes in Phase 1 of the intervention plan
- Dementia board has been formed – benchmarking exercise has been carried out and planning is in progress to fill the gaps.
- Development of a frailty at the front door programme at UHNM to embed comprehensive geriatric assessments in ED settings
- Discussions about deconditioning including "'Sit up, get dressed, keep moving" campaign and 'EndPJparalysis'
- Move towards reconditioning "Recondition the Nation"
- Development of inpatient food and drink policy at MPFT highlighting importance of hydration and macronutrients (especially protein).
- Development of SSOT inequalities strategy (complete)
- Development of SSOT prevention strategy (ongoing)
- Formation of People at the end of life CIG – strategy under development.
- Fuel poverty pilots are running.

Most services are in pilot phases. Those which are not, are delivered in different ways across the ICB.

A small survey was carried out to capture qualitative experiences with developing and piloting new services. Feedback from participants shows:

- There is enthusiasm for change
- The number struggling silently at home is increasing as those self-funding access to community services face financial challenges.
- There is huge value in allowing patients and carers to speak and make decisions in periods of calm
- The needs of carers are not considered sufficiently
- Referrals to and uptake of prevention offers needs to be improved
- Data collection, choice of variables and sharing agreements should be refined
- There is excellent work happening in pockets around the ICB. These need to be better linked together.
- Behavioural science is underutilised.
- Capacity and cost are barriers
- There are opportunities when commissioning services to embed prevention aspects. This is not being done enough.

Take home messages

There has been a large amount of work taking place across the ICB in different sectors. There remains variation in services. There are some areas which have received little attention:

- response times of urgent care services,
- developing admission avoidance pathways,
- utilising virtual clinics to avoid admissions,
- reviewing rehabilitation services,
- To build on opportunities for early rehabilitation,
- To explore schemes which provide alternatives to care home placements.

Conclusion

This needs assessment offers a snapshot of current service use and possible future trajectories. It is clear that without proactive and preventative action, the level of care needed will be difficult to manage.

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