Staffordshire and Stoke-on-Trent Integrated Care System

Healthy Ageing and Frailty Strategy, 2025-2030

Staffordshire and Stoke-on-Trent Integrated Care System

Foreword

We are proud to introduce the Healthy Ageing and Frailty Strategy 2025–2030 for Staffordshire and Stoke-on-Trent Integrated Care System (ICS). This strategy represents a significant milestone in our collective commitment to supporting people to age well, live independently, and enjoy the best possible quality of life.

Healthy ageing and frailty are among the most pressing priorities for our local communities. As our population grows older, it is essential that we anticipate and adapt to changing needs, offering support that is proactive, inclusive, and sustainable. This strategy outlines our shared vision for enabling healthier ageing and delivering compassionate, high-quality care for those living with frailty. It reflects our determination to address these challenges in ways that deliver meaningful and lasting improvements in people's lives.

Building on the foundation laid by the 2021 strategy, this updated document captures the evolving health and care landscape, including new approaches and innovations, as well as the implications of national policy and local developments. It recognises the unprecedented challenges posed by the COVID-19 pandemic, which has both highlighted and intensified the need to support vulnerable individuals and communities. Looking ahead, it also considers the ongoing pressures within the NHS and our shared responsibility to maximise resources while ensuring equity and excellence in care.

In developing this strategy, we have engaged extensively with partners across the health and care system, as well as with individuals and communities who bring invaluable lived experience. Their insights and perspectives have shaped the strategy's priorities and provided assurance

that it reflects the needs and aspirations of Staffordshire and Stoke-on-Trent's diverse population. We extend our thanks to all who contributed to this effort; your voices have been essential in helping us design a strategy that is ambitious, inclusive, and grounded in real-world experience.

Delivering this strategy will require genuine and sustained collaboration. The ICS is committed to fostering stronger partnerships between health, care, local government, voluntary, and community organisations - as well as with the people we serve. Together, we will focus on prevention, early intervention, and personalised support that empowers individuals to maintain their independence and thrive.

The ambitions set out in this strategy are bold, but we are confident they are achievable with the shared dedication of our system partners. By working together, we can create a future where healthy ageing is not only a possibility but a reality for all, and where those experiencing frailty are supported with dignity, compassion, and the highest standards of care.

Thank you for your commitment and collaboration as we move forward together.

David Pearson MBE

Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) Non-Executive Chair.

Neil Carr OBE

Chair, Staffordshire & Stoke-on-Trent Integrated Care System (ICS) End of Life, Long Term Conditions and Frailty (ELF) Portfolio Board, Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) Partner Member – Physical Health, and Chief Executive, Midlands Partnership University NHS Foundation Trust.

Introduction

Over the next decade, we can expect to see approximately 23,000 more people aged 65 years or older living in the Staffordshire and Stoke-on-Trent (SSoT) Integrated Care System (ICS) area. Over 40% of the NHS budget is spent on people aged over 65, and frailty has a significant impact on primary, acute and community care services. However, we note that although medical complexity is starting earlier, many people are living into their 80s without the need for extra support with activities of daily living. Not all old people are frail, and not all frail people are old.

Since our last Healthy Ageing and Frailty Strategy was published in 2021, the world has continued to change. We are feeling the impacts of life after COVID-19 and our systems are taking steps towards recovery. Over the last four years we have been working on projects aimed at creating the right environments for healthy ageing; preventing deterioration of mild, moderate and severe frailty; and targeting the prevention of, and reaction to falls. We are increasing awareness of frailty in acute care settings and have been working towards more holistic assessments of those with frailty or at risk of falls. We have been innovative and have made use of population health data to direct our decision-making. We have learnt a lot from these endeavours. But there is still much to do.

A refreshed strategy is needed as there have been several changes at a national level to the approach which should be taken to healthy ageing. The Chief Medical Officer's Report (2023) laid down the challenge that we should aim for quality of life over quantity of life. And there is an increased push towards proactive identification and prevention of frailty. More recently, Professor Lord Darzi has outlined in the Independent Investigation of the National Health Service In England, in no uncertain terms that the status quo is not acceptable.

More locally there have also been changes. The ICS financial recovery programme requires a re-examination of the strategic objectives and in particular the pace and delivery of the existing strategy. We continue to be aware that there are inequities in both the health need and in the health provision to our communities.

This strategy has been developed after undertaking an extensive examination of the data, speaking to colleagues and seeking the views of patients and carers. We will describe our enablers, our interactions with other portfolios of work and our disease specific aims.

The strategy aims to prepare the ICS for preventing frailty, reducing inequalities and responding to health and care needs of older adults. This is not something we can achieve in isolation. Our core enablers are integrating care, developing our workforce and harnessing digital tools. This requires strong leadership, a clear action plan and co-ordinated effort across the ICS.

What is 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 Geriatrics Society, 2023). Advancing frailty is associated with many negative consequences including hospitalisation, falls, admissions for long-term care, impaired quality of life and loneliness.

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.

What now and what next?

To provide a sound basis for developing our strategy, a needs assessment was carried out. This describes where we are now and how the needs of the population are likely to change over time.

1. The population of SSoT will continue to age over the next decade. And in those aged 85 years or older, the rate of change in SSoT will be greater than the growth seen in England or the West Midlands.

2023
249,685

17.85% increase in those aged 65+

2033
294,244

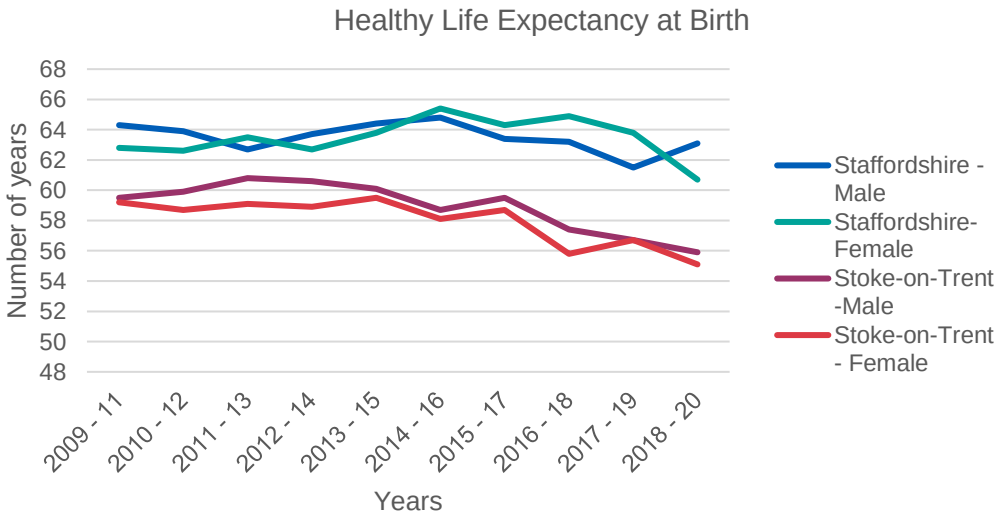
2023
31,019

47.6% increase in those aged 85+

2033
45,809

2. People aged 65 now risk spending at least half of the remainder of their lives in poor health.

	Sex	England	Staffordshire	Stoke-on-Trent
Life expectancy at 65	Male	18.4	18.4	17
Life expectancy at 65	Female	20.9	21	19.2
Time spent living in poor health	Male	7.9	6.8	9.9
Time spent living in poor health	Female	9.6	10	12



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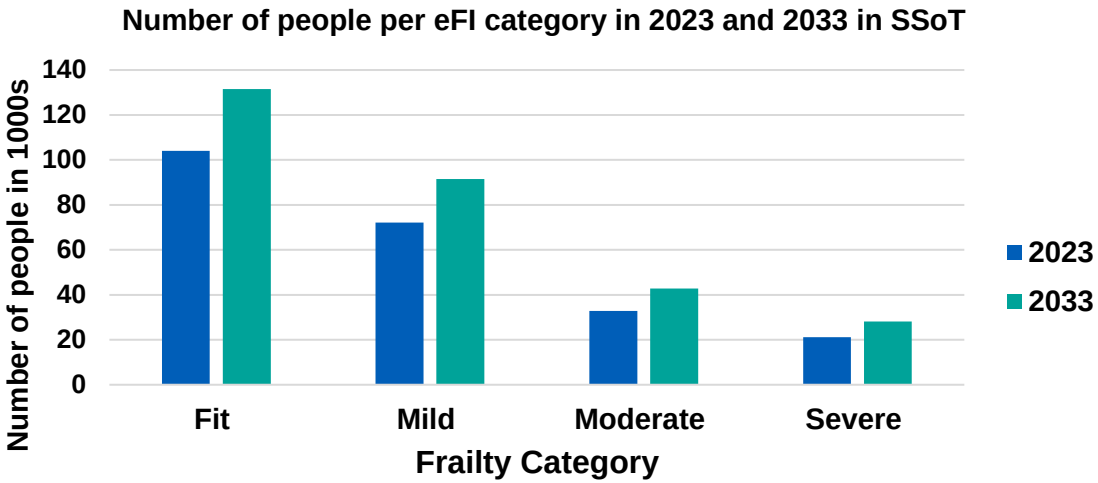
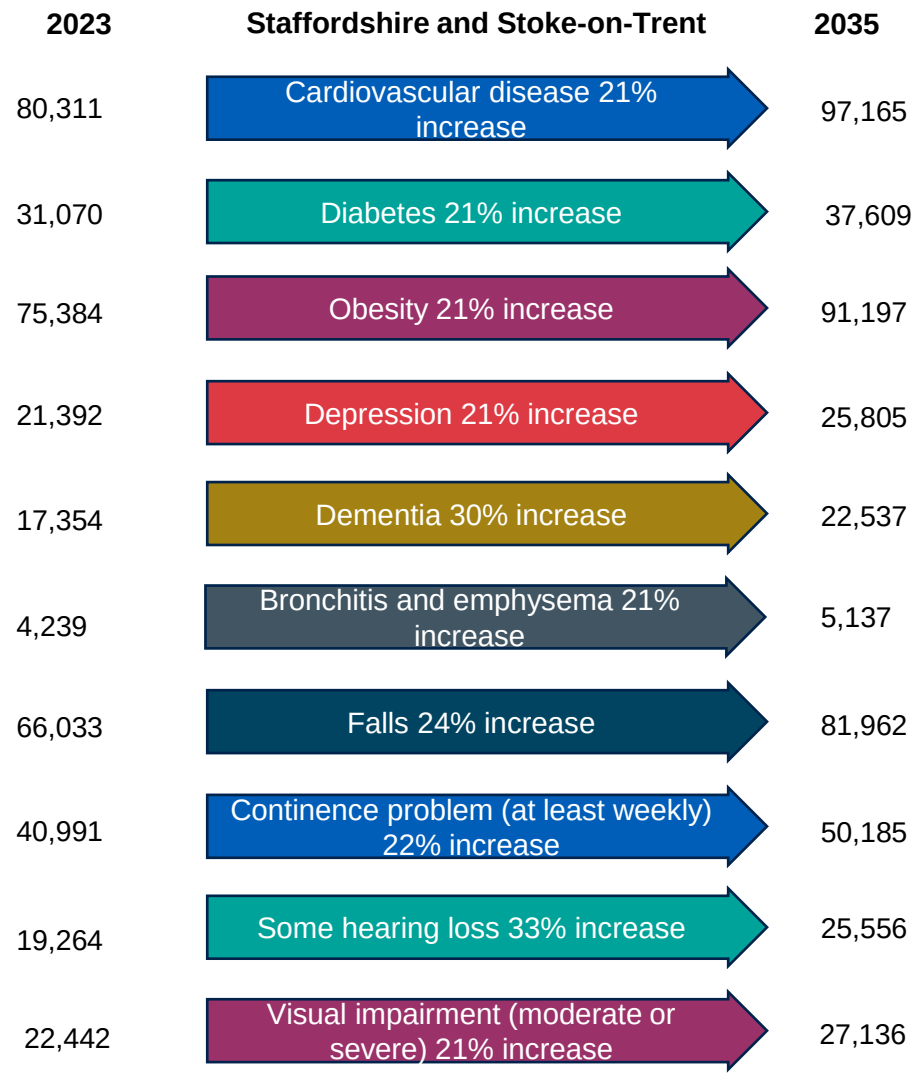
4. Frailty will increase, with the largest increases being in the fit to mild categories.



What is eFI?

eFI is the electronic Frailty Index. It was developed as a screening tool for frailty in those aged 65 years or older using routinely collected primary care data. It is not the same as having a clinical diagnosis of frailty.

5. If we do nothing, health needs will increase substantially



Considers changes in demographics but not changes in disease epidemiology
Data from www.poppi.org.uk Derived from ONS data. Crown copyright 2020

6. Factors impacting on the need for increased social support will also increase.

2023	Staffordshire and Stoke-on-Trent	2035
45,406	Unable to manage at least one mobility activity unaided 27% increase	57,611
66,881	Day-to-day activities are limited a lot by illness 23% increase	82,349
37,575	Providing unpaid care 19% increase	44,811
72,046	Need help with at least one domestic task 23% increase	88,435
71,261	Need help with at least one self-care activity 23% increase	87,546
692	Moderate or severe learning difficulty 20% increase	833
2,364	Autistic spectrum disorders 22% increase	2,876
81,421	Living alone 21% increase	98,181
8,330	Living in a care home with or without nursing 35% increase	11,265

Considers changes in demographics but not changes in disease epidemiology
Data from www.poppi.org.uk Derived from ONS data. Crown copyright 2020

Vision

To enable our population to live a healthy older age, with independence and dignity.

Increase healthy life expectancy by 5% by 2030.

Interactions and interfaces

The ICS Long Term Conditions Strategy describes a series of priority portfolio areas for service and quality improvement. Many of these interface with aspects of the work we describe in this strategy. Portfolios include:

- Urgent and Emergency Care (UEC)
- Planned Care, Cancer and Diagnostics
- Mental health, Learning Disabilities and Autism
- Children and Young People (CYP)
- Primary Care
- End of Life, Long Term Conditions and Frailty (ELF)

This strategy falls under the ELF portfolio. Clinical Improvement Groups (CIGs) within the ELF portfolio are tasked to deliver an improvement plan for their disease area. Within the ELF portfolio, we are working closely together to ensure shared aims across cardiovascular disease, respiratory disease, diabetes, healthy ageing and frailty, and palliative and end of life care. A new dementia board has been established and we will integrate aims where possible. We also continue to work closely with local authority colleagues and to keep action plans aligned.

Our Local Authorities

Stoke-on-Trent

One of our ambitions in the city of Stoke-on-Trent as set out within Our City Our Wellbeing and our Health and Wellbeing Strategy for 2025 is to enable older people to live as independently as possible, and we aim to achieve this by focusing on our communities, reducing health inequalities, and by improving healthy life expectancy. Healthy life expectancy in the city is significantly lower in Stoke-on-Trent in comparison to the England average, and too many people from our city end up in institutional care when they could be supported to live in our communities. We will work with our partners to change this by ensuring that support is tailored to the specific needs and preferences of individuals wherever possible.

Staffordshire

Staffordshire County Council's vision is that Staffordshire is an ambitious, innovative and sustainable county, where everyone can prosper, be healthy and happy – including people with adult social care needs. Healthy ageing is a strategic priority.

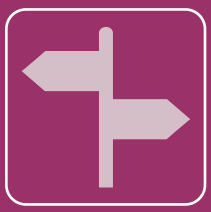
The Council's strategy has been co-produced with ICS partners, health and social care professionals, and older people and their carers. The Council would like to thank everyone who has supported its development. It will promote well-being, resilience and independence for older people in Staffordshire and help them live at home for as long as possible. It will also help ensure that they know how to access support and that if they need adult social care, there are good quality services available when they need them and at a cost we can all afford. The strategy is available here: Older-Peoples-Strategy-24-proof-v4.pdf

The views of patients and carers

A survey captured the views of 161 people. There were 50 people present at an event where focus group discussions were held. One to one interviews were held with a service user and a patient representative. The main themes were:

Understanding frailty:

- the term frailty is not liked, but it is understood
- however, there is little understanding that it may be reversible
- most, but not all, feel confident looking after themselves and detecting when they are unwell. But many value input from healthcare in making assessments
- the future can be frightening and uncertain



Feeling involved in decisions:

- approximately 2/3 felt involved in decisions about their care
- this is enhanced by good relationships with GPs, having choices explained and proactive research
- continuity of care and better listening are key to this
- the main barriers are difficulty accessing care from the right person and appointments being too short

Digital tools:

- communication at the interfaces is not good
- shared records are acceptable to most people, but confidence is needed that confidentiality will be respected and that extent of access is determined by the role of the person
- the use of digital tools to aid integration and multi-disciplinary work are acceptable
- Acceptability of digital communication needs is varied

The views of providers and professionals

Two provider and professional workshops were held. Attendees (67 in total) included primary care, community care, local authority, medicines management, secondary care and voluntary sector representatives. Several important themes emerged:

Prevention is important across the frailty spectrum:

- there is lots of activity happening
- but work is needed to build relationships with patients, local voluntary groups and system partners
- prevention does not stop in hospitals
- one size does not fit all
- there are gaps such as weight management services

We need to actively increase our use of digital tools:

- for communication across system partners
- for communication with patients
- to help with risk stratification
- for service delivery
- A functioning shared care record is essential

Holistic, integrated care should be prioritised:

- this requires a shared vision and leadership
- there should be shared ownership of assessment outcomes and a care co-ordinator is needed
- upskilling of wider workforce is needed
- this should not become a tick box exercise
- patient views, including refusal, must be respected

Supporting carers

Many older adults are in receipt of informal care from friends and family. A large number are themselves carers. Carers make an enormous contribution to communities and societies. Caring is vital and rewarding but for some people it will come at enormous personal cost. National data suggests that carers have poorer health outcomes than the general population. Their needs should be taken into consideration when planning services and interventions

Stoke-on-Trent
Our ambition within the city of Stoke-on-Trent also includes caring for our carers as well as the people that they care for through the development of community level support, for example our Community Lounges and North Staffs Carers. We aim to achieve our ambition through the delivery of key priorities co-produced via our Carers Strategy, led by our Carers Partnership Board. Our priorities include: identification and recognition, realising and releasing potential, life outside of caring, supporting carers to stay healthy, and young carers.

Staffordshire
At some point in our lives, most of us will be a carer. Staffordshire County Council and the NHS cannot solve all the difficulties that carers experience, but we can try and make life a little easier by addressing some of the top priorities.

The strategy recognises the extraordinary contributions made by carers and aims to ensure they can lead happier, healthier and more independent lives, in a society that values and supports them to maintain their caring role.

Find out more in Staffordshire's All Age Carers Strategy.

Enablers

At an ICS level there are several factors which enable better delivery of the objectives outlined in this strategy.

Integrated care:

- this means people receive the care they need at the time that they need it, delivered by those who are qualified to deliver it
- It reduces variation, improves outcomes and is preferred by patients

Workforce development:

- all staff should have access to opportunities to increase their knowledge, confidence and skills
- this will allow expansion of skills to meet different needs without changing job roles
- this should include those working in the voluntary and care sectors

Greater use of digital and data tools:

- shared electronic records to enable smoother communication and integrated care
- better coding practices make data more reliable
- using data to risk stratify
- using digital tools to deliver interventions
- remaining alert to those being left behind

Overview of healthy ageing and frailty

This model shows how healthy ageing and increasing frailty can be conceptualised across the ICS. It indicates activities which may be taken by system partners to meet the needs of the older population and to prevent deterioration. Activities are intended as incremental rather than mutually exclusive. It reflects how different portfolios need to work together to deliver comprehensive care. The emphasis is on proactive action and regular reassessment of needs since ageing and frailty are dynamic states.

Prevention

Objective: We will make prevention a core activity in all services and care settings regardless of severity of frailty

Rationale:

- health care costs increase, and quality of life decreases with increasing frailty severity. Therefore, prevention is important at all stages
- age and multimorbidity are the strongest but not the only risk factors for frailty
- local data show that there are high levels of smoking, inactivity and alcohol-related admissions in some areas. There are also poor levels of fruit and vegetable intake. These risk factors overlap with deprivation and loneliness in some areas meaning that there are pockets of the population at high risk of developing frailty and multimorbidity and developing them at a younger age
- healthy lifestyle choices even if started late in life can prevent frailty
- early detection of cancer, respiratory and cardiometabolic disorders can prevent underlying multimorbidity and therefore avoid significant negative impacts on health and wellbeing
- Pneumonia, flu and COVID-19 infections may be particularly deleterious in older adults. These can be prevented by vaccines, warm homes and good nutrition. There is good uptake of pneumococcal polysaccharide vaccine but poorer uptake of flu vaccine in those most at risk in the ICS. Within the ICS there are areas with the worst fuel poverty in the country
- there is evidence that general exercise interventions from age 40 can prevent falls
- there is evidence that decreasing alcohol intake, addressing social isolation, eating a balanced diet and exercise can prevent dementia
- evidence from behavioural science suggest that multipronged approaches and regular reminders improve the success of lifestyle change interventions

Targets:

- meet national targets for existing large-scale screening and prevention programmes for those who are eligible (for example NHS Health Checks and cancer screening)
- meet national targets for flu, pneumococcal polysaccharide, COVID-19, RSV and zoster vaccines in those at risk.
- increase training for and delivery of Making Every Contact Count (MECC), Five Ways to Wellbeing and Patients Know Best (PKB) for all public facing staff in clinical and non-clinical roles
  - make increased use of digital tools to deliver these messages
  - ensure that primary falls prevention advice reaches target audiences
- embed smoking cessation services into all clinical settings by 2030
- meet the national target of an adult smoking prevalence of 5% or less by 2030
- increase the proportion of adults engaging in physical activity especially for those who are already frail or at risk of falling
- ensure that dietary guidelines for increased protein intake and obesity prevention in older adults are embedded into primary prevention messaging and nutritional guidelines for care settings
- continue to develop and evaluate interventions aimed at social isolation
- publish ICS prevention strategy by 2027 which includes aims to
  - decrease the proportion of adults consuming more than the recommended amounts of alcohol
  - work with system partners to reduce fuel poverty and improve housing quality
  - increase in fruit and vegetable intake

Early detection

Objective: We will proactively identify frailty in at risk populations

Rationale:

- early detection increases the opportunity to prevent and reverse frailty.
- it allows time to plan for future health and social care needs at individual and system levels
- frailty can be identified in primary care, community care, acute settings, by reception staff, carers and others in public facing roles
- screening for frailty has been embedded in the General Medical Services (GMS) primary care contract, but local uptake is variable
- there is increasing screening for frailty in acute settings and through ambulance services. But frailty status is poorly communicated or poorly coded
- assessing risk for falls does not fully overlap with frailty risks and should be considered independently

Targets:

- to agree a system-wide approach to screening for frailty and falls, at least annually in all those aged 65 or older by 2027
- to agree a stratified training programme for clinical and non-clinical staff so that all staff are frailty, falls and dementia literate by 2027
- to extend the offer of this training to the broader service provision sector for example, voluntary sector, fire services, police and social services
- to improve sharing of coded frailty status across services using One Health and Care record by 2027
- to use the most robust screening tools available to identify frailty through risk stratification of population data
- to explore the possibility of identifying frailty in younger age groups, especially in areas of high deprivation by 2028

Well or stable

Objective: All those who are in a stable state are empowered to improve their health and wellbeing and to age well.

Rationale:

- those who are well or stable represent the largest cohort of the ageing population. This category is not restricted to those with mild frailty scores. Even those with moderate or, rarely, with severe frailty scores may be living in a state of stability
- there is potential to reverse or limit the progression of frailty and reduce the risk of falls
- embedding lifestyle changes increases resilience against future episodes of ill health
- there is good evidence for physical activity, reduction in social isolation, nutritional interventions and addressing osteoporosis risk in this group
- education and improving health literacy continue to be cornerstones to influence behaviour change

Targets:

- scale-up prevention offers (see examples below) so that all of those in a stable state have access to information to support physical health, mental health and social care needs by 2027
- to roll out the digital prevention offers across the ICS by 2026
- explore non-digital, multilingual and sign language-based options for delivery of resources addressing the same material
- make resources available to younger adults with frailty or those without frailty who are motivated to make changes
- ensure that movement-based prevention services targeted at falls and frailty are accessible to all residents regardless of language communication or transport needs
- increase awareness of osteoporosis risk management

My Health, My Way is an online collection of information around 14 modifiable risk factors for preventing frailty progression, chosen by NHS professionals, all brought together in one place for invited patients to access. A pilot sample of around 5,000 have been invited to sign up, from a much larger cohort of around 75,000 adults aged over 65 with mild frailty registered with a GP in SSoT. My Health, My Way has videos, leaflets and links - including how to find local groups and services in the community. The aim is to proactively offer an at-risk cohort health and wellbeing resources that empower them to self-manage the risk of frailty progression.

We are extremely proud of our Community Lounges as assets embedded within our communities across the city of Stoke-on-Trent, which aim to help to achieve our ambition for older people by providing a place for people to gain local advice and available support, including carers support, independent living, community activities to prevent loneliness and isolation, and information to prevent fuel poverty etc.

Priority activities for Staffordshire include:

1. Develop tools for promoting independent living for example the Happy at Home interactive house providing information about daily living equipment which promotes independence.
2. Grow and enhance community capacity for communities to help themselves and others. Examples include volunteer buddies and grants for the voluntary sector to meet needs within communities.
3. Effective communication and engagement with both communities and the workforce. Examples include campaigns to reduce loneliness.

Complex

Objective: People living with more complex needs are supported with holistic assessments and personalised health and wellbeing plans

Rationale:

- complexity arises from physical health, mental health or social care needs. As complexity increases, so does the risk of being hospitalised, admitted to a care home, developing a mood disorder or falling
- risk factors mentioned previously continue to have a negative impact. They include excessive alcohol use, social isolation, smoking, under or over nutrition and cold homes
- polypharmacy is both a cause and a consequence of complexity. SSoT is third highest compared to peers for prescription of ten or more unique items to those aged 75 years or older, and highest compared to peers for those aged 85 years or older. Although many patients in this group are likely to have medication reviews due to comorbidities, it unclear whether frailty or falls are considered
- in December 2023, NHS England made recommendations for the proactive care of those living at home with moderate or severe frailty. Key recommendations were
    - carry out a holistic assessment
    - develop a personalised care plan
    - use a multi-disciplinary team
    - ensure continuity of care

- currently, the Facilitation of Admission Avoidance Scheme (FAAS) is delivered by GP practices in the north and the Staying Well Service (SWS) is delivered by Midlands Partnership University NHS Foundation Trust (MPFT)in the south. Both offer holistic assessments to patients with moderate frailty and both involve multi-disciplinary workforces. An evaluation is planned for winter 2024/25. Learning from this will be used to improve the offer
- continuity of care is valued by both patients and practitioners. There is evidence that continuity of care improves outcomes in those with long-term conditions

Targets:

- all those currently eligible for a review by FAAS or SWS are seen and assessed by 2030
- where medication reviews are not being carried out by FAAS or SWS, to increase uptake of timely and meaningful medication reviews in primary care and community pharmacies with the aim of assessing polypharmacy affecting both falls and frailty
- to work with colleagues in primary and community care to develop a blueprint to improve continuity of care by 2028
- to facilitate advance care planning for those who wish to have those discussions
- to align with the care home working group to ensure that the same services are available to those resident in care homes
- to align with falls and dementia pathways to ensure consistent messaging

Identifying at risk cohorts

Risk stratification aims to combine a series of observations, events and diagnoses to predict the risk of an outcome in the population. In this case we are interested in predicting those who would benefit the most from the interventions on offer. We are using a combination of eFI and Rockwood Frailty Scale, as well as clinical judgement for FAAS and SWS.

To identify more severe cases, we are developing a machine learning approach which will use local data to generate a predictive algorithm. The algorithm will then be used to identify those who may be eligible for more detailed holistic care offers.

At risk of deterioration

Objective: People living with frailty who are at risk of deterioration will be proactively identified and have their needs evaluated using a comprehensive geriatric assessment.

Rationale:

- people living with severe frailty and some living with moderate frailty have complex health and social care needs. They often have multimorbidity and may have input from multiple specialist teams. Local data suggests that this cohort are high users of community, primary care and secondary care services. They are at high risk of admission and deterioration. There are estimated to be 7,000 people in this category in SSoT
- however, pilot work with this group shows that some of those living with severe frailty fund their own care and try to manage at home until they reach crisis point
- the Comprehensive Geriatric Assessment (CGA) has been shown to identify actions which may reverse frailty, reduce GP appointments, reduce emergency department attendances and decrease admissions. It can be delivered in community and hospital settings.
- a pilot intervention carried out in SSoT found that patients valued the intervention, but that it was resource intensive
- there will be some people in this cohort who are nearing the end of their lives and would benefit from support in engaging with advance care planning

Targets

- to develop a risk stratification tool to identify those who would benefit most from CGAs by 2025
- to deliver a multi-disciplinary CGA to 50% of currently eligible patients by 2030
- to align with end of life pathways to ensure smooth transitions when needed
- to align with the care home working group to ensure that holistic care offers are made available to their residents

What is a Comprehensive Geriatric Assessment (CGA)?

The CGA is an evidence-based multidimensional, interdisciplinary approach designed to holistically assess the needs of an older person. It takes into consideration functional ability, physical health, cognitive and mental health as well as wider social and environmental circumstances. It aids in the establishment of joint management plans. It requires a multidisciplinary team (MDT) comprising doctors, nurses, physiotherapists, occupational therapists, and other experts. The British Geriatric Society has developed a CGA Toolkit for GPs. CGA will not only identify but also quantify frailty, looking at function as well as risks. This allows clinicians to identify reversible areas of frailty and use interventions to prevent further deterioration.

Interventions which include CGAs have been shown to improve quality of life, decrease hospital admissions, reduce emergency department attendance and may reduce GP appointments.

Reactive care in frailty crises

Setting targets for urgent and acute care is outside the scope of this strategy. However, we have been working and will continue to work with the Urgent and Emergency Care (UEC) portfolio at Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) and acute trusts to support with frailty considerations in all settings. National guidelines support frailty awareness training, screening and CGAs in acute settings.

Whilst improvements in diet, lifestyle, sleep and mood can improve health status, deconditioning due to intercurrent illness at home, in a care home or in a hospital can rapidly lead to increased frailty. A co-ordinated plan is needed.

Palliative and end of life care

Objective: Our older populations will have access to compassionate care at the end of their lives, or when symptom control is needed

Rationale:

- death is inevitable. There are tools to help identify those most at risk of death
- local data shows that there are high rates of admissions in the last three months before death. These may be preventable with proper anticipatory care discussions
- Palliative care may be needed for symptom control in cancer and non-cancer patients. Access to palliative care should not be restricted to the end of life only

Targets

- To support the development of the ICB's All Age Palliative and End of Life Care Strategy
- to provide education and support to clinical staff in identification of those nearing the end of life
- to collect data about death in preferred place

Falls

Objective: To prevent first and subsequent falls, reduce the risk of adverse consequences when a fall occurs and to optimise pathways of managing the person who has fallen.

Rationale:

- risks for falls and frailty overlap, and each phenomenon can potentiate the other
- falls are a major public health concern in older adults, which lead to morbidity, mortality and decreased quality of life
- local data show that falls are a common reason for admissions and readmissions in older adults and especially so for care home residents
- local data also flags that falls lead to disproportionality high rates of fractures in Stoke-on-Trent
- a series of pilots targeting different aspects of falls have been carried out and are being evaluated
- work so far has led to development of a comprehensive falls risk assessment model

Falls Risk Stratification Model			
Pre-Low	**Low**	**Intermediate**	**High**
Adults with no history of falling	Adults with no history of falling but had a recent non-severe fall	Adults who have had a single non-severe fall (have gait and balance problems)	Adults who have fallen with injury/had multiple falls/known frailty/long lie/lose consciousness
Education and advice for healthy lifestyles and increased exercise	Additionally offer falls prevention education if motivated	Additionally offer targeted exercise or physiotherapy referral to improve strength and balance	Multi-factorial risk assessment to inform individualised tailored interventions
Offer falls risk self-assessment • offer healthy lifestyle advice • refer to talking therapies if there is a mood disorder	Additionally: • advise patient to consult GP if needs change or they have another fall • ask patient how they might safely optimise their activity / exercise levels • provide written information	Additionally: • complete multi-factorial checklist • Referral to SWS for falls prevention group	Additionally: refer to local specialist falls service unless needs better met elsewhere

Targets:

- to agree a system-wide suite of written resources for consistent messaging
- to develop a system-wide falls collaborative to support with aligned messaging
- to develop and integrate a digital falls prevention offer to compliment face to face offers
- to integrate mechanisms of delivery of primary falls prevention advice with other primary prevention advice (as per earlier targets)
- to identify opportunities to implement falls-specific risk stratification to ensure those at risk receive the right offer at the right time
- to establish a task and finish group to make community-based strength and balance exercises equitably accessible in all localities by 2027, by making use of existing resources as well as developing new offers
- to hold community falls prevention workshops to raise awareness and upskill staff
- to ensure that falls prevention offers including strength and balance exercises are available to care home residents and those making use of day care facilities
- to develop an integrated falls pathway from prevention, to reaction, to dealing with consequences by 2028

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