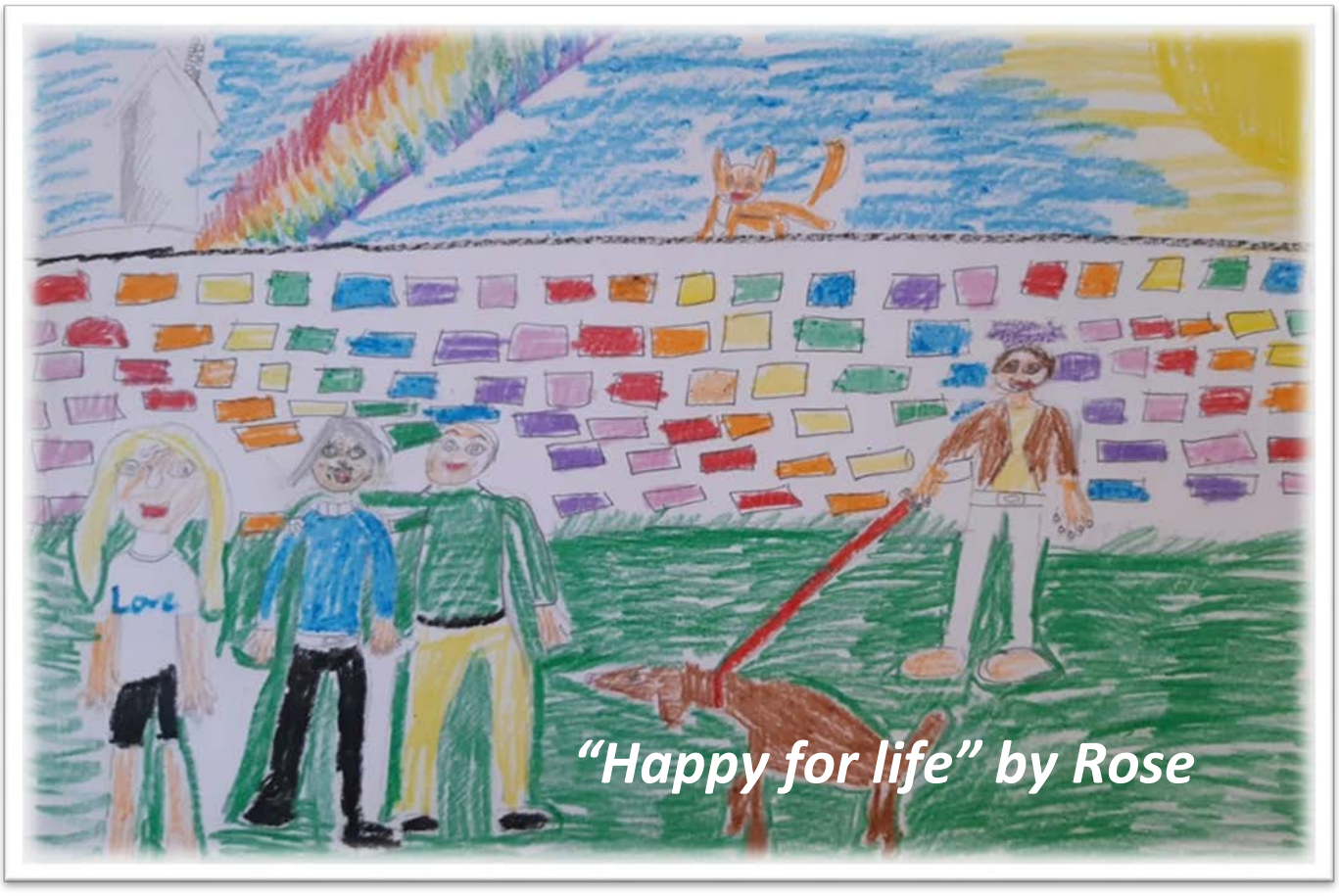
TOGETHER WE'RE BETTER
Transforming health and care for Staffordshire & Stoke-on-Trent

Healthy Ageing & Managing Frailty In Older Age Strategy



"Happy for life" by Rose

September 2021

OUR COMMITMENT

Prem Singh
Together We're Better
ICB Chair Designate
Staffordshire & Stoke on Trent

The Covid-19 pandemic and the ongoing Covid-19 vaccination programme has placed the health inequalities of the local population that we serve firmly under the spotlight. Partners across the health and care system of Staffordshire and Stoke-on-Trent have also shown a tremendous ability to innovate, adapt quickly to changing demands and work together. This combination creates an environment that we should absolutely maximise in terms of how we innovate and develop our approaches to looking after those most vulnerable in our communities and neighbourhoods.

This document sets out a new strategic approach to how we support local people to stay well for as long as possible. I am excited with the vision that is set out and will want to support its translation into local delivery, across the partnership, so that together we can have a positive impact on people's lives.

Jon Rouse CBE |City Director
City of Stoke-on-Trent

Our population is undergoing significant demographic change and this gives us a great opportunity to rethink the care we provide for our older residents and care groups. We need fundamentally to refocus our activities on preventing poor health, increasing healthy life expectancy and enabling older people to stay independent, living life to the full. This will require all of our partners working together to make this strategy a reality. I am delighted to commend this healthier ageing and managing frailty strategy which gives the Staffordshire and Stoke-on-Trent health and care system a direction of travel and a platform for exciting innovation.

FOREWORD

“We are all ageing and times are changing”

“This last year and a half has been an unprecedented time for the world. Whilst we continue to contend with the challenges that COVID-19 presents us with day by day across Staffordshire and Stoke-on-Trent, we now must also look to the future.

There is predicted to be a considerable increase in the number of people aged 65 years and older compared to the number of younger people across Staffordshire and Stoke-on-Trent and England as a whole and now the COVID-19 pandemic has also presented us with new and exacerbated public health issues. However, it has also given us pause for reflection and new ways of working.

Having spoken with many clinicians, health and care organisation representatives, volunteer and community organisations, and members of the public it is clear to see that there is great passion across Stoke-on-Trent and Staffordshire for working together to make ageing as positive as possible for as many people as possible.”

“The opportunity is huge and the right time is now”

Dr Zafar Iqbal|
Associate Medical Director Public Health (MPFT)

Dr Amit Arora |
Consultant Physician /Geriatrician (UHNM)
Associate Medical Director (MPFT)
Special Adviser to ICS for Older People

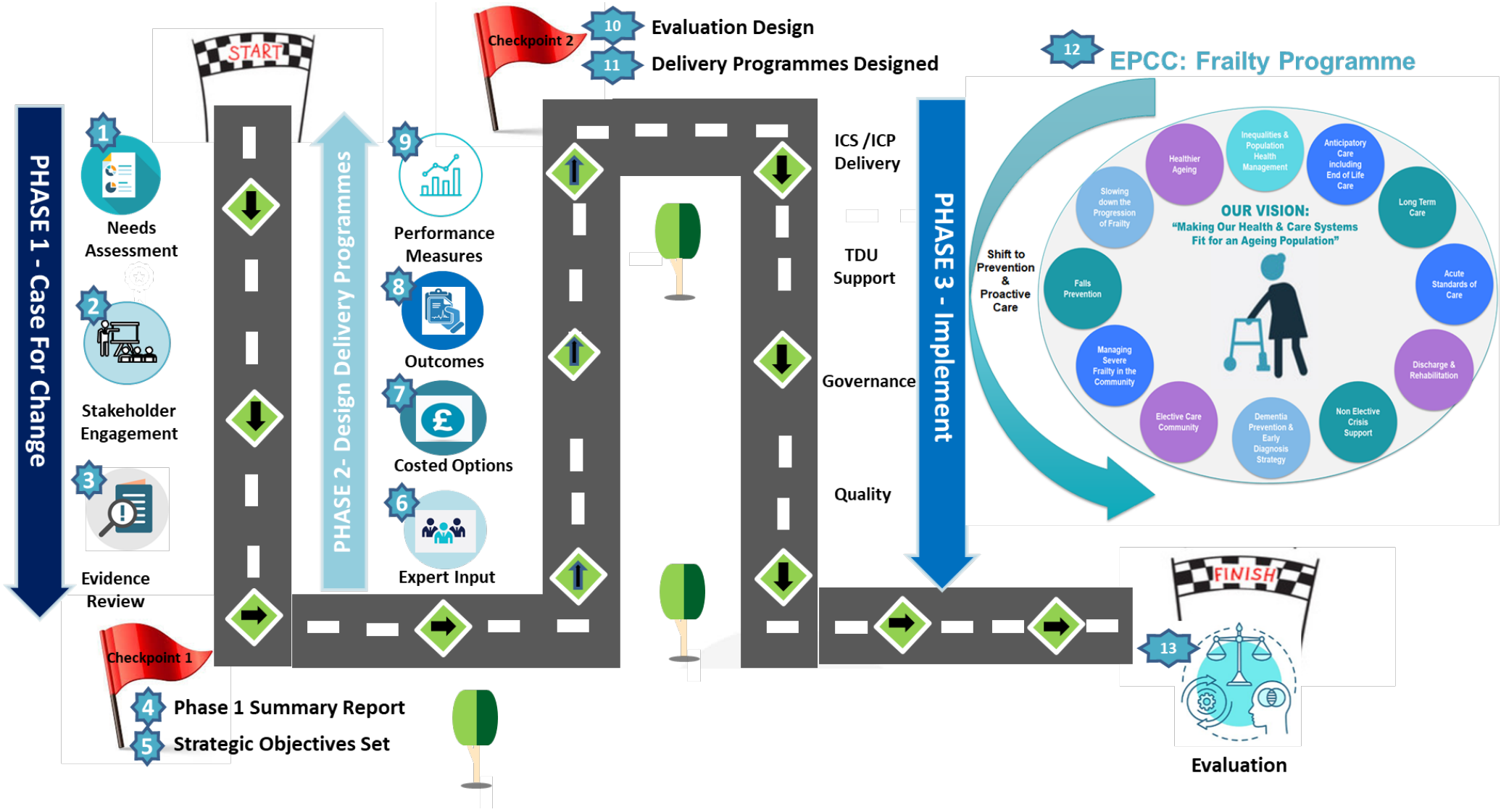
Dr Susan Roberts |
Public Health Specialty Registrar (MPFT)

Steve Grange |
Executive Director of Strategy & Strategic Transformation (MPFT)
TDU Director (Staffordshire ICS)
Programme Director EPCC (Staffordshire ICS)

OUR VISION:

"Making Our Health & Care Systems Fit for an Ageing Population"

Staffordshire & Stoke on Trent
Healthy Ageing & Managing Frailty in Older Age
Strategy on a Page



INTRODUCTION

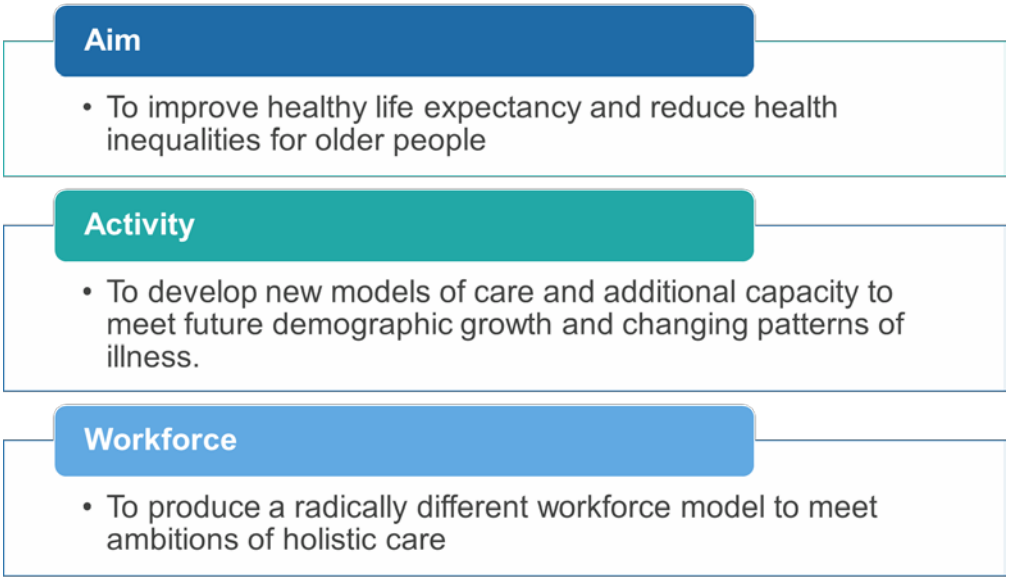
Background

Frailty and care of older people remain a key challenge across the NHS especially with rapidly changing demographics and patterns of illness. There is recognition that many parts the health and care system fail to sufficiently improve the quality of life of older people and there are unacceptable variations in health inequalities. Much more needs to be done to delay the onset of frailty and slow down its progression. Care of older people can be streamlined to make it more collaborative, integrated and patient-centered. It is hoped that such an approach will benefit the population; and improve the efficiencies and outcomes within the NHS. The newer developments in treatments, service reconfigurations and technology should enable such a strategic change.

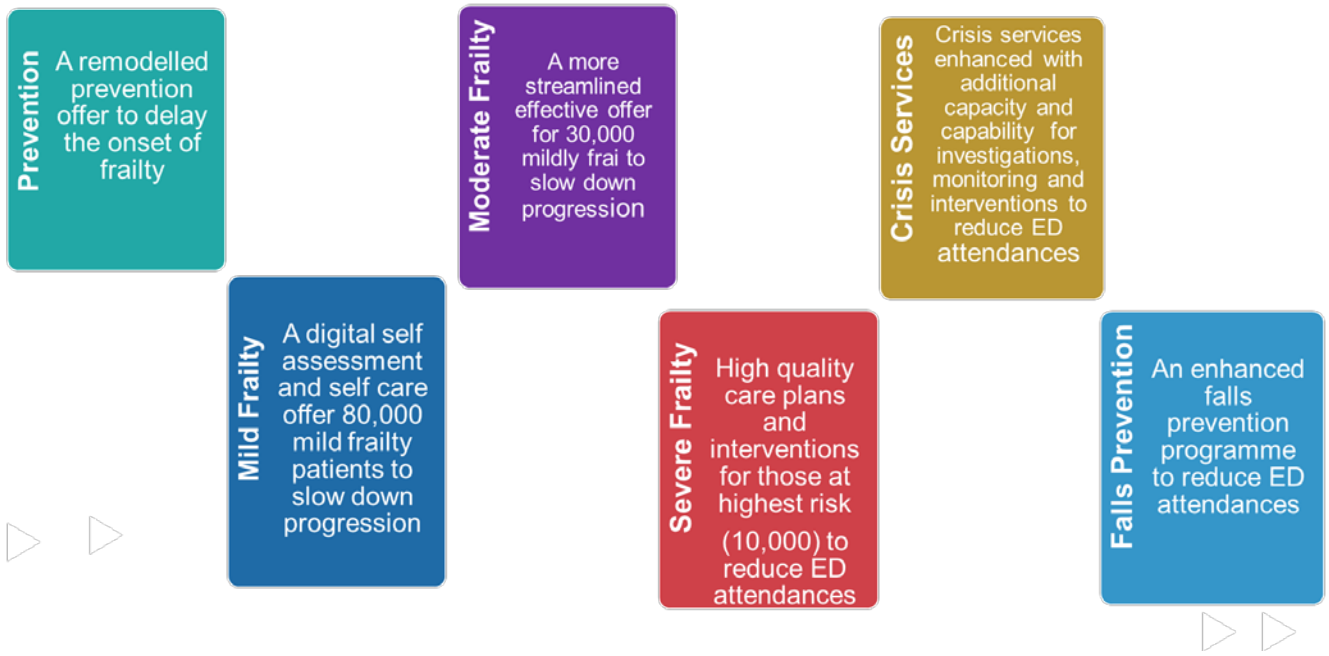
The strategy will enable the Integrated Care System to address some key questions:

- How do we promote healthier ageing?
- What prevention programmes do we need to stop/prevent healthy cohorts becoming frail?
- How do we reduce health inequalities for older populations?
- How do we slow down progression of frailty?
- How do we strengthen falls prevention programmes?
- What further developments are needed in our crisis services?
- How do we develop social care to meet the future demographic challenges?
- How do we promote self-care and remote supervision for patients and support in our community?
- How do we build in innovation?
- What are the workforce implications?

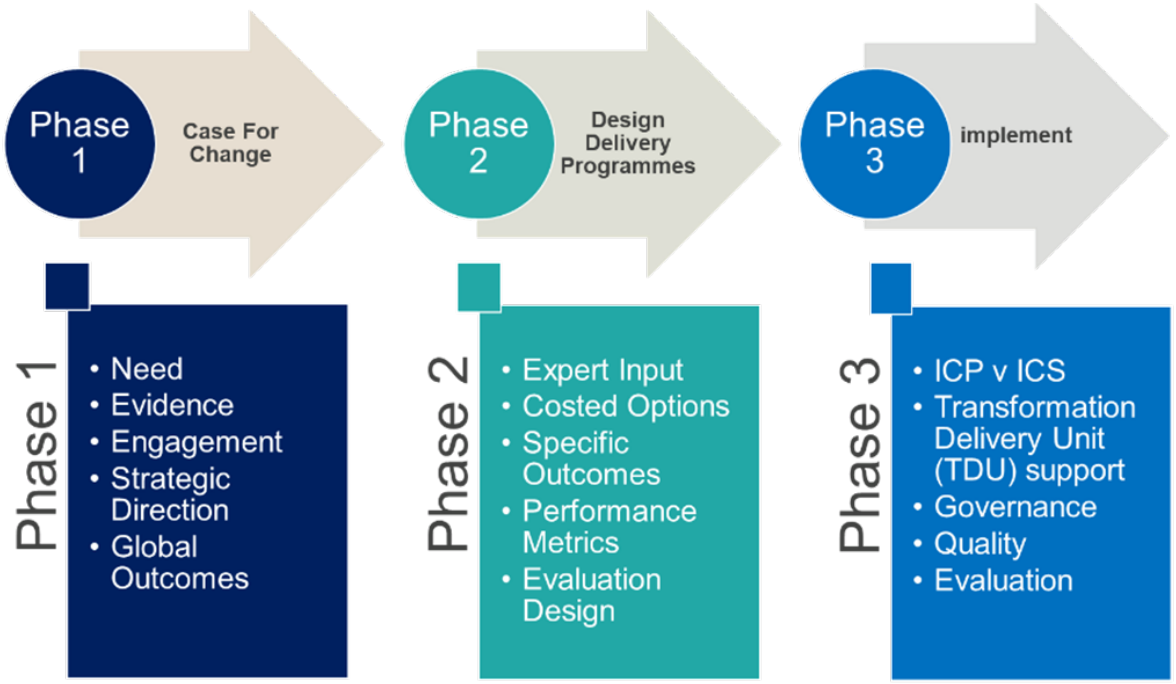
What will be different?...The bigger picture



What could be different? ...Examples of service pathways

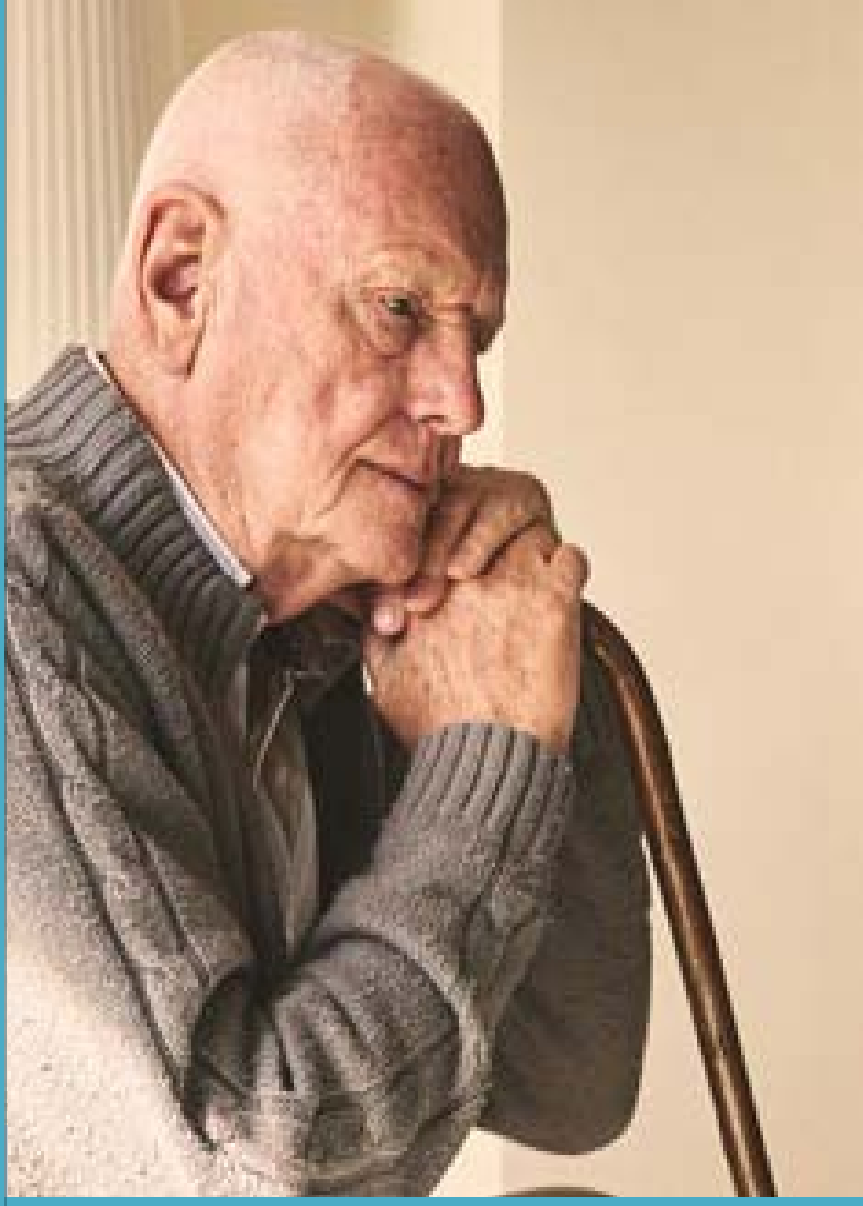


Strategy Approach

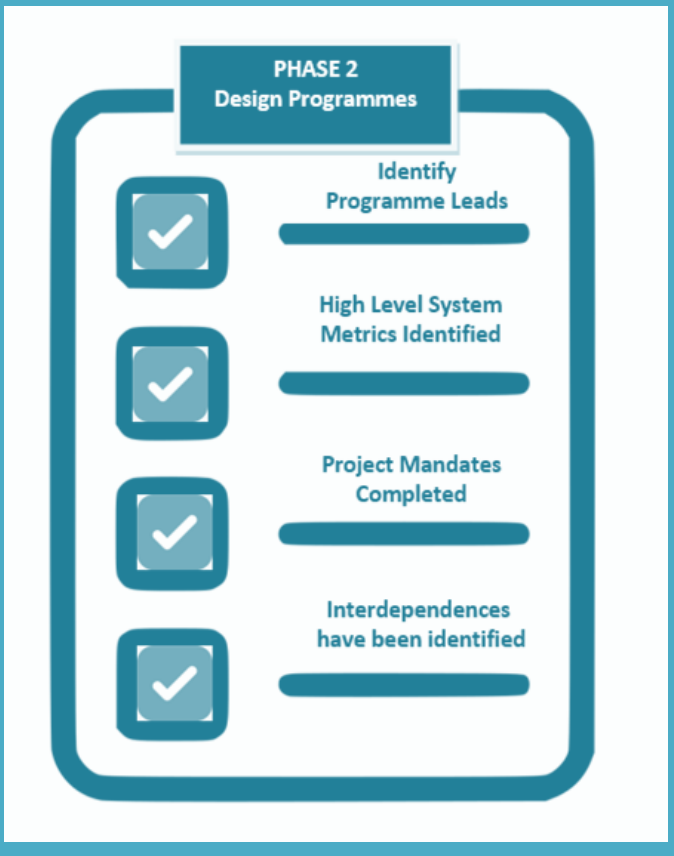


PROGRESS TO DATE

Building a Case for Change...



Design Delivery Programmes...



SUMMARY OF NEEDS ASSESSMENT

A strategic needs assessment has been undertaken to understand current and future health and wellbeing need and demand in older people and to shape the Staffordshire Integrated Care System approach to promoting healthy ageing and managing frailty.

Information provided in this summary has been collated through an iterative and collaborative process. It draws upon information provided through routinely available public health tools, and resources obtained through literature searches, collation of past work from local and regional partners, and from wider professional networks.

The system-wide strategy for Healthy Ageing & Managing Frailty in Older Age is based on a comprehensive needs and evidence-informed approach.

Whilst an overview of need has been produced, a series of in-depth needs assessment focused on specific healthy ageing and managing frailty programmes will be required. These should incorporate additional data sources and new local data that capture health and wellbeing since the COVID-19 pandemic. Further focused evidence reviews would also be beneficial.

Summary of Needs Assessment

Projected population estimates in Staffordshire & SOT[1]

Based on 2018 estimates, between 2020 & 2030 projections:

- Increase of **3.7%** across **the total population.**
- Number of people aged **65 years + (17% increase) 239,338 to 280,853**
- Number of people aged **85 years + (38% increase) 28,573 to 39,425**

Inequalities

Before the COVID-19 pandemic:

Across Staffordshire and Stoke-on-Trent

- Deprivation is unequally distributed across **Staffordshire/Stoke-on-Trent Integrated Care System area.**[3]
- The highest proportions of registered patients within deprived areas **were seen within the North ICP footprint.**[4]
- Life expectancy and disability-free life expectancy were **significantly lower than England average in Stoke-on-Trent.**

Since the COVID-19 pandemic:

- Health inequalities have been exacerbated across England

Wider Determinants & Lifestyles

Wider Determinants and Lifestyles

Before the COVID-19 pandemic

- Based on estimates from before the pandemic, there is projected to be nearly **15,000 more people aged 65 years and older living alone across Staffordshire and Stoke-on-Trent in 2030 compared to 2020**.[6]
- Across England, the **proportion of people that are physically active reduces with age.**[7]
- Staffordshire and Stoke-on-Trent were both significantly worse than **England in terms of eating five portions of fruit and vegetables a day and admissions for alcohol-related conditions.**[4]
- Stoke-on-Trent was significantly worse than England **for physical inactivity and smoking prevalence, whilst Staffordshire is significantly worse for adult obesity prevalence.**[3]
- Staffordshire and Stoke-on-Trent were below targets **for flu and shingles vaccinations**.[4]
- Staffordshire was significantly worse than England **for people aged 40-74 years receiving an NHS health check.**[4]
- Stoke-on-Trent was significantly worse than England **for abdominal aortic aneurysm, cervical cancer and bowel cancer. screening coverage.**[4]

Since the COVID-19 pandemic: (across England)

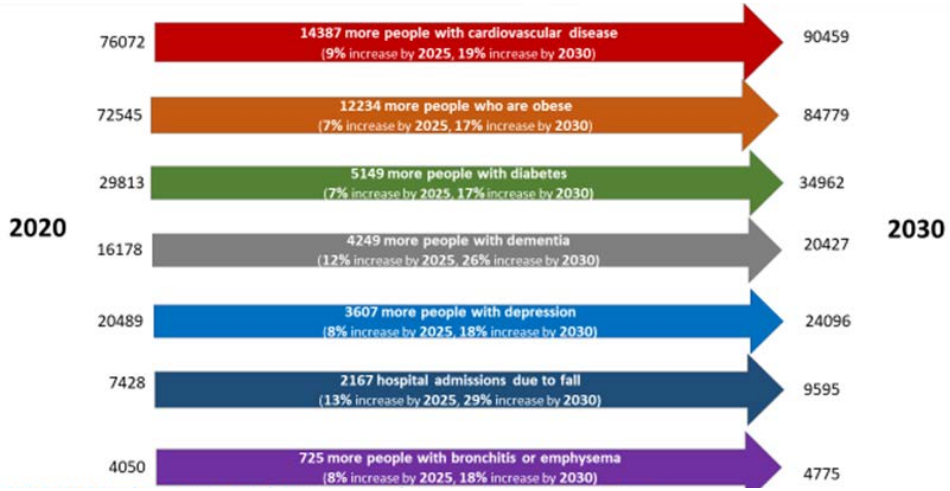
- Comparing November 2019/20 and November 2018/19, there was a **1.3 % drop in the proportion of people aged 55-74 years that were physically active and a 2.9% drop in people aged 75 years and over being physically active**.[8] Whilst data for the most recent months suggests that rates of physical activity have improved back to pre-pandemic levels in those aged 55-74 years, there has been a **sustained reduction in the rate of physical activity in people aged 75 years & over.**[8]
- Work presented by AgeUK (undertaken during August and September 2020) suggested that of people aged 60 and older, since the start of the pandemic:[9]
  - **One in five people felt less steady on their feet**
  - **One in four people were able to walk less far**
  - **36% felt less motivated to do things they used to enjoy**
  - **40% of people felt less confident going to a GP surgery**
  - **34% of people agreed their anxiety was worse** than before the pandemic started
  - **One in five people stated it was harder to remember things**
- The Centre for Ageing Better highlighted that since the pandemic:[10]
  - **Double the number (600,000) of people aged 50+ were claiming unemployment benefits** in September 2020 compared to March 2020.
  - **2.7 million People aged 50+ were furloughed.**
  - **Return to work is a major challenge in this age group.**
  - **Those most in need of social connections may have lost access to them.**
- **Widening inequities** in power, money and resources between individuals, communities and regions have generated **inequalities in the conditions of life** COVID-19 Marmot Review.[5]

Long Term Conditions

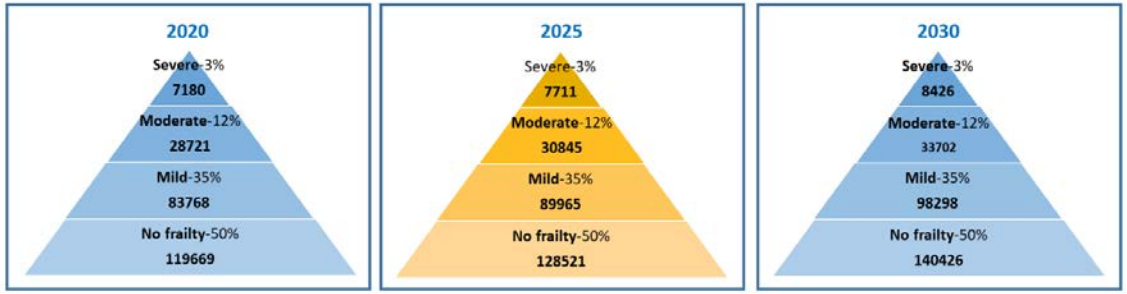
Long Term Conditions

Before the COVID-19 pandemic:

According to POPPI database projections for Staffordshire & SOT between 2020 and 2030 there could be:



Assuming a static prevalence over time and using ONS population projections, the following numbers of people aged 65 years and older might experience frailty over time:



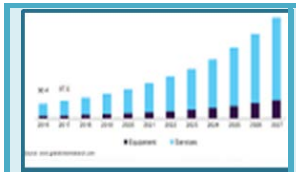
However, there is some evidence from 2017/18 of varied prevalence of frailty by Clinical Commissioning Group and of the extent to which the older population has been assessed for frailty. This analysis would benefit from being updated.

National projections suggest that by 2035; there will be higher proportions of people aged 65 years and over with multiple chronic conditions. The proportion of people aged 65 and over with 2+ conditions is projected to go from 54% in 2015 to 68% in 2035, and those with 4+ conditions from 10% in 2015 to 17% in 2035.[13] So it is possible that this increase could translate into even higher numbers of older people with frailty across Staffordshire and Stoke-on-Trent.

Since the COVID-19 pandemic (across England)

Work presented by Age UK (undertaken August and September 2020) suggested that of people aged 60 and older, since the start of the pandemic[9]:

- **43% of people** with a long term condition stated they were **unable to walk as far.**[9]
- **28% of people** with a long term condition stated they were **finding it harder to remember things.**[9]
- In Staffordshire and Stoke-on-Trent, **7.7% (c24,000) of people aged 60 and older were advised to shield** during the COVID-19 pandemic, according to NHS Digital figures.



Health & Care Demand Projections

Health and Care Demand Projections (before the pandemic) including Care at the End of Life

Before the COVID-19 pandemic:

Nationally, general practice demand has been projected to grow by 6% between 2020 and 2030 based on demographics alone.[14] With regards to social care projections, between 2015 and 2035, the prevalence of and **numbers of people with dependency are projected to fall for young-old adults aged 65–74 years in England**. For **people aged 85 years and older the number with low dependency (less than daily care) could increase by 148% and the number with high (24 hour care) dependency could increase by 92%, whilst prevalence will change minimally**. Older people with medium or high dependency and dementia could be more likely to have at least two other conditions.[15] There are also national projections that the demand for wound care will increase, with the annual prevalence of acute, chronic and unspecified **wounds found to be growing at the rate of 9%, 12% and 13%, respectively.**[18]

Across Staffordshire and Stoke-on-Trent:

- **Combined acute urgent and emergency care attendance and non-elective and planned inpatient and day case activity is expected to increase.**[16]
- There could be **an increase in the number of hospital admissions due to falls** by over 2000 by 2030, equating to a 29% increase.[6]
- Based on current MPFT referral numbers, **district nursing, intermediate care services and the adult community physiotherapy service could see a considerable increase in the number of people aged 65 and over referred to their service.**[17]
- There **could be approximately 2300 more people aged 65 years and older living in care homes.**[6]

Towards the end of life, across Staffordshire and Stoke-on-Trent[19]:

- **45% of people who die do so during an (often short) emergency admission.**
- **In the last two years of life around £154 million is spent on hospital services for decedents**. Urgent service events account for around two-thirds of this.
- The **number of deaths has begun to rise** and is set to continue with the greatest number among those aged 85 and above.
- If patterns of care do not change, the current growth in deaths per annum suggests that **over 270 additional beds** will be needed in the STP by 2040.

Please see Appendix 1 for Full Needs Assessment –
Current and projected health need in older people across Staffordshire and Stoke on Trent.

CONSULTATION FINDINGS

Healthy Ageing Workshop - Session Outputs

Frailty and care of older people remains a key challenge in today's society. Our Integrated Care System (ICS) is working to develop a system-wide strategy to promote healthy ageing and to make care of older people more collaborative, integrated and patient-centered.

58 Attendees - All types of organisations, service providers and interest groups came together to collaborate at a high energy and fast paced digital session.

Room to Improve

Attendees spent time reflecting on and sharing on the areas that could be better regarding the services and experiences for our population**.**

Here is what they came up with;

Areas that could be better….

Sky's the Limit

Attendees focused on all the areas that they felt were good with regard to healthy ageing.

Here are the outputs;

Areas felt were good….

To Promote Continuous Learning

How can we collectively grow and enhance our levels of collaboration?

Pathways that encourage togetherness

Bringing together offers more transparently to create seamless transitions of care and support

Commissioning & funding

Increased collaboration and transparency on the commissioning of services and greater two way feedback on the pinch points within various services

By continually growing networks actively

As a default position foster the essence of 'offices without walls' with a forward thinking digital programme of collaboration already determined and agreed for the next 12 months and rolling agendas

Person centred care

Developing offers that have users at the very heart of all decision making

Grow knowledge of roles that support pathways to aid in flexible offers for the whole person e.g social prescribers

Ask others

Develop interesting and innovative ways to draw from experiences and ideas, grow these within already existing services

Break down historical barriers by checking in with stakeholders and surveying on a regular basis on what people want

On Treatment & Prevention

How can we achieve greater levels of integration and be more progressive?

Be fully inclusive

Ensure that inclusivity threads throughout any strategy or approaches

Consideration of a stronger MDT approach
Create a transparent directory that all are part of

Create a collaborative on our transport approach

Establish a potential proof of concept through a strong focus on transport issues and what can be done as a collaborative to address this right across our footprint.

build a highly connected prevention strategy without limits

Share REAL examples and best practice when it comes to presentation. Ensure that as an element of the overall strategy this is upfront and centre with really transparent evidence of incremental learning

Provide multi-purpose formats

The ability to be able to reach many more people that may not know about what is on offer, consider and develop an approach to emerging technology but also the use of existing thus ensuring complete accessibility. In addition the need for a consistent recording of information

Progressive marketing approach that also includes intergenerational support

A sustained programme of raising awareness and sharing resources and expertise across systems and boundaries for the greater good. Utilisation of social media channels for ongoing sharing and collaboration

Whilst looking towards being future-proof (taking into consideration digital enhancements)

How can we be more person-centred?

Equality of costings

There is a potential 'digital divide' based on all sorts of factors 'but' as example cost of connections and tools

Offers need to take into consideration, for example what is and what isn't universally available such as hearing aids

Parallel better ageing focus with consideration of other conditions

Increase awareness through various ways about what this means in regard to other conditions and diagnosis so that support is more profoundly linked and person centred, this achieved through education, sharing and experiential learning

Link, grow and promote support groups

Connect health and wellbeing groups and ensure a well promoted and robust offer, use this as one mechanism, 'but' not the only one to address any levels of isolation supplemented with telephone support lines. Aim to personalise support to provide the correct technology and the incremental change required to support others more effectively

Rapid Stocktake

Rapid review of options that exist and some level of benchmarking so that best practice becomes part of any reviews or enhancements of future services or options

Understanding and working on what the art of the possible is. There needs to be a blend to be truly person centred

Engage (digi-engagement)

Understand the issues and engage with users and providers/supporters to ensure understanding end to end. Thus recognising and addressing any fears that may exist e.g. use of digital and security worries

A sustained and obvious programme of support that cares for the carers

Early Consultation Findings from Ethnically Diverse Communities across Staffordshire and Stoke-on-Trent.

Method

Consultation with medical & former medical staff from ethnically diverse communities as well as involving community voices, Healthwatch and non-medical groups to:

- Highlight early themes
- Develop the consultation process further

Early themes

- Issues with awareness of services available
- Issues around security of their homes
- Digital engagement/education/enablement
- Language barriers
- Cultural needs
- Dietary needs/preferences
- Social isolation
- Need for meeting places
- Need for informal care
- Financial needs

What we need to do next……

- Reach out to more groups.
- Have small group discussions.
- Have conversations with religious groups.
- Need for face-to-face meetings.
- A new revised questionnaire is also planned.
- Face to face visits with community leaders and places of worship to get direct feedback.

SUMMARY OF EVIDENCE REVIEW

The ageing population brings with it enormous opportunities and challenges to our health and care systems. The WHO has referred to 2020-2030 as the healthy ageing decade, where we will focus on creating a more sustainable healthcare system, providing proactive, preventative and predictive medicine. In order to do this, we must consider primary, secondary and tertiary prevention, as well as looking at population and individual based approaches.

Primary Prevention

Healthy ageing - population and individual approaches

Population approach: Looking at the social determinants of health, we need **healthy ageing cities/environments** which include good transport, civic participation and employment, outdoor spaces and buildings, respect and social inclusion, housing and social participation. The strategy for tacking loneliness is focused on **empowering social connections** through community infrastructure, utilising the full potential of digital technology to connect people, maximising the use of community spaces (that are underutilised), embedding a sense of community in the planning of housing developments and considering social connections as well as community connections when creating transport links. **Community development via group activities** can be used to improve mental wellbeing.

Individualised approaches: **Making Every Contact Count**: physical activity, smoking, diet, alcohol. The **NHS long term plan** which promotes prevention through doubling prevention programmes set out for diabetes, increasing its alcohol care teams into more areas, offering smoking cessation to all admitted to hospital who require it and increasing social prescribing to benefit almost one million individuals by 2023-2024.

Secondary Prevention

Preventing progression Individuals with pre-frailty have an increased risk of progression of frailty, hospitalisation, falls, morbidity and mortality compared to robust individuals. **Physical activity produced the largest reduction in frailty,** even more effective when conducted in groups. Other interventions are health education, counselling, nutrition, home visits and hormone supplements. **Lifestyle factors and nutritional interventions** have been shown to be effective in delaying and reducing the progression of frailty. Improving energy intake, prevention of fractures, physical function and fitness and quality of life.

Reducing care home admissions

Are we going to need more or less care homes in the future, what models of care have been trialled to reduce avoidable care home admission, and how do we make people more independent? These are some of the questions which need answers. **Ageing in a desirable location** of care may contribute to the overall health and wellbeing in the late-life period. Models such as **falls prevention programmes** using physical activity, home share, live in care hub, ageing in place technology have been trialed but have been inconclusive.

Tertiary prevention

Optimisation of Multidisciplinary teams (MDT)

There are over 100,000 older people with frailty in the ICS area. **MDTs have been proven to be a powerful and effective intervention** which bridge the gap between primary, secondary and community care. They reduce frailty severity, offer timely referrals to secondary care or community services, addressing an unmet need. They also help in early identification of frailty and dementia, rationalisation of medications and medical cost savings.

Dementia services

There are several government guidelines on dementia services to improve awareness, prevention, research, diagnosis and increasing range of services. How best to deal with the big expected rise in people with dementia? This section describes various interventions and innovative approaches to future dementia services, having a **one stop diagnostic service, support from staff and relative**, use of **telehealth technology** and **wrap around service**. The main goal of dementia care is for early diagnosis and delay of onset to ensure good quality of life. It is possible to reduce an individual's risk of dementia; **what is good for your heart is good for your brain**.

Workforce

Do we need more of super specialists or just generalists with a special interest? **Leadership roles for holistic care** involve geriatricians, GPwSIs, AHPs, nurses, psychologists and pharmacists to make a smooth shift towards the community.

Interface between community and secondary care

There are some admission avoidance schemes which show promising evidence in managing acute admission and reducing hospital readmission. The **Hospital at Home** service has evidence that shows there could be a reduction in mortality and a reduction in living in institutions. The Scottish Government has produced guidance on **Rapid Elderly Assessment Care Team** (REACT) service which is a MDT within a home setting. **Telemedicine** is another innovation that looks promising, providing virtual and faster access to care and advice from specialist clinical teams.

STRATEGIC OBJECTIVES

The following section outlines our vision and strategic objectives for the Staffordshire and Stoke-on-Trent Healthy Ageing & Managing Frailty in Older Age Strategy. The objectives have been grouped into broad themes that predominantly follow the approach in the King's Fund document: "Making our health and care systems fit for an ageing population" [1] with the objectives under each theme developed through local needs assessment, further evidence review and consultation.

Vision: "Making Our Health & Care Systems Fit for an Ageing Population"

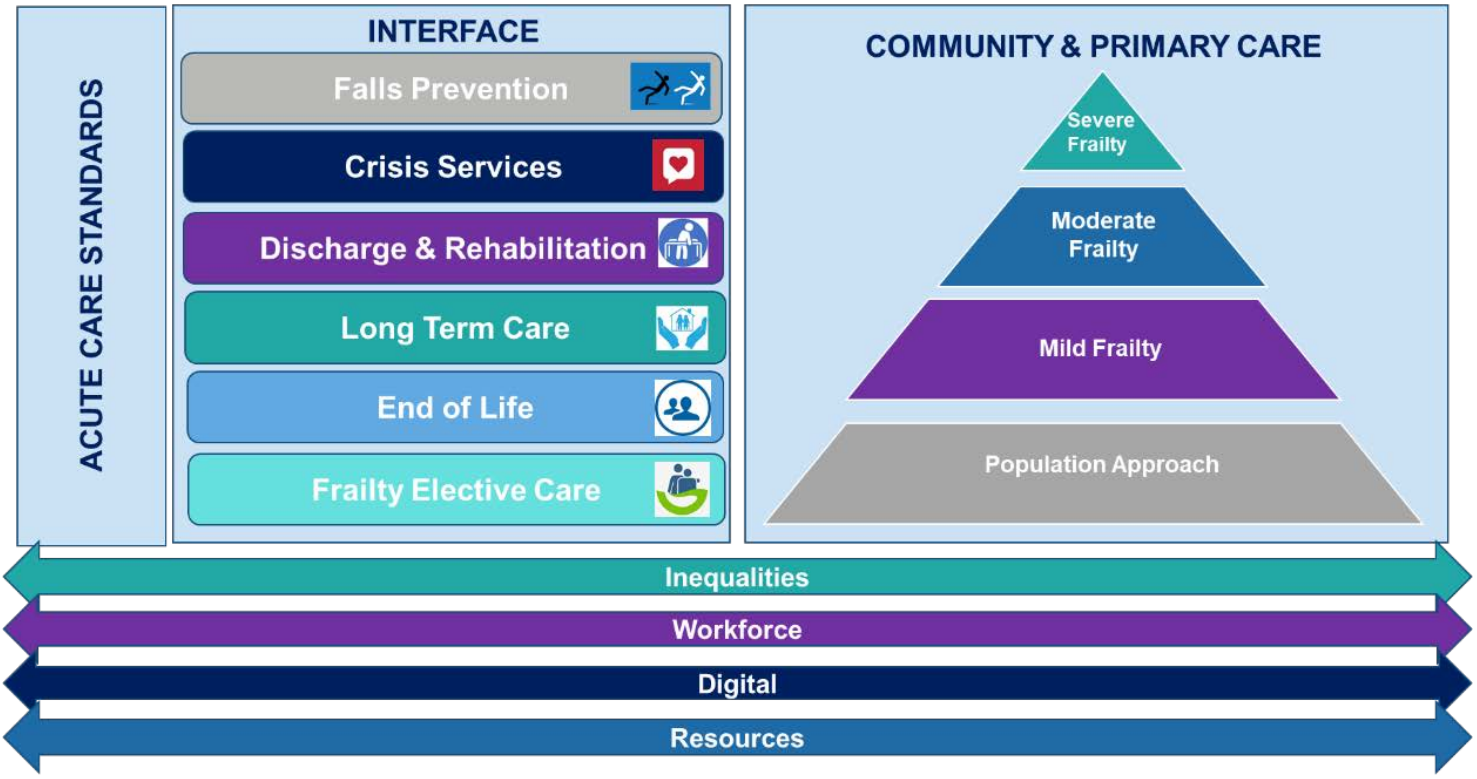
Aim: To Improve Health Life Expectancy & Reduce Health Inequalities for Older People

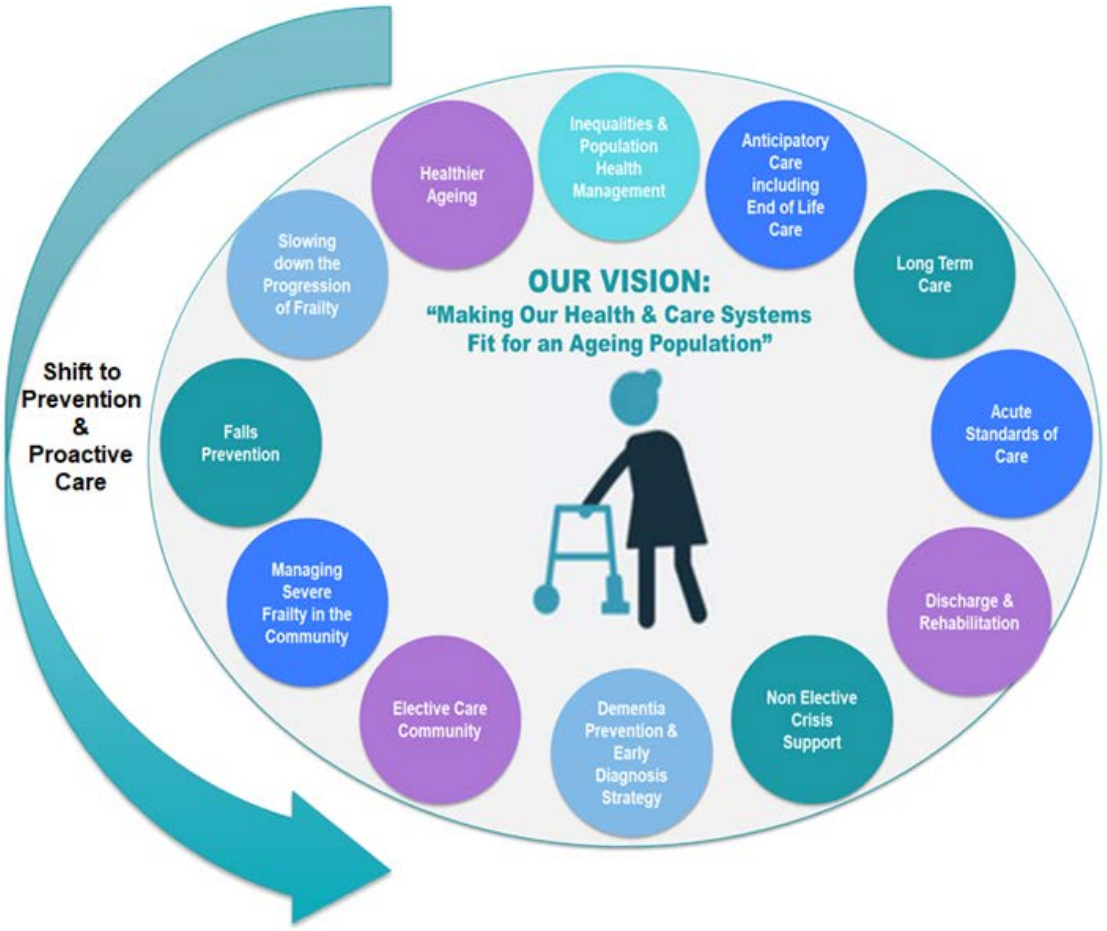
Strategic Objectives by Theme
Addressing Inequalities
To undertake a place based needs and assets analysis to understand the inequalities in the older population and the contribution of different social determinants, such as social networks.
Ageing Well
To explore how a positive shift can be achieved in societal attitudes towards ageing and frailty amongst the general population and professionals.
To develop a coherent multisector strategy to tackle social isolation and loneliness.
To modify the 'Make Every Contact Count' programme, to suit the needs of frontline staff and of the frail population.
To implement focused community development programmes for older people, investing in proactive prevention and fully utilising local community assets.
To develop a large scale prevention programme offered to those who are pre-frail or may become frail over the next decade.
Slowing the Progression of Frailty
To broaden the 'Staying Well' and equivalent services to cover the whole of the Integrated Care System area for those with moderate frailty.
To complement the 'Staying Well' service with a large scale offer to promote education, awareness and independence for mild to moderate frailty, including holistic self-assessment tools and digital-based interventions.
Supporting Complex Co-Morbidities and Frailty
To enhance the falls prevention programme, with an aim to reduce the rate of falls in the area.
To develop a dementia strategy with partners, focusing on prevention and early diagnosis.
To develop a consistent Multidisciplinary Team (MDT) offer for severe frailty and those with long term conditions in the community, based on need.
To standardise and optimise case management by MDTs. Ensure effective identification and tracking of patients who will benefit most from this approach.

(1) Reference: Oliver D, Foot C, Humphries R (2014) Making our health and care systems fit for an ageing population. The King's Fund. 6 March 2014. Available from: https://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population

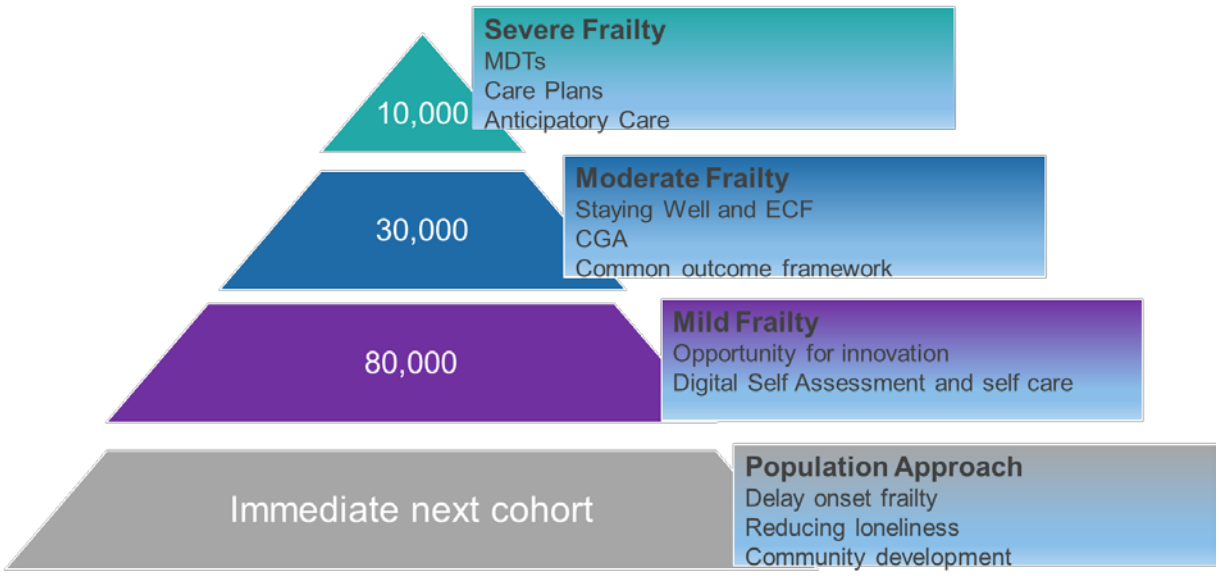
Effective Crisis Support
To develop a comprehensive admission avoidance and crisis management offer with enhanced capacity and capability to meet the increase in our future demand.
To ensure response times of urgent care services in the community and ambulances are within targets, maximising opportunities to treat patients outside of acute hospital settings.
High Quality Person-Centered Acute Care
To explore how length of stay could be reduced to avoid prolonged hospital admissions.
To reduce acute bed occupancy of those aged more than 70 years.
To prevent deconditioning in hospitals and care homes and community dwelling adults.
To improve patient outcomes as measured by patient and staff experience measures and patient reported outcome measures.
Good Discharge Planning and Post-Discharge Support
To increase the number of patients being discharged directly to their usual place of residence.
To prevent avoidable readmissions of patients.
To utilise virtual clinics for post-discharge follow up.
Effective Rehabilitation & Reablement
To build upon opportunities for early rehabilitation intervention e.g. presentation to minor injuries units.
To review rehabilitation services to facilitate timely discharge from hospitals.
To ensure appropriate and timely provision of community services after discharge from hospital.
Person-Centered Dignified Long Term Care
To explore schemes which provide alternatives to care home placements, commissioning these services if required.
To optimise care home MDTs and other community MDTs.
Support, Control & Choice at End of Life
To improve the early use of advance planning in order to support patients' wishes towards the end of their life.
To critically appraise our model of palliative and EOL care.
Workforce Development
To produce a workforce model which can meet the needs arising from future demographic changes and the associated increase in health and social care activity.

FRAILTY TRANSFORMATION PROGRAMME





Healthy Ageing & Managing Frailty in the Community & Primary Care



"Our reluctance to honestly examine the experience of ageing and dying has increased the harm we inflict on people and denied them the basic comforts they most need. Lacking a coherent view of how people might live successfully all the way to their very end we have allowed our fates to be controlled by the imperatives of medicine technology and strangers."

"Three plagues of nursing home existence: boredom, loneliness and helplessness."

Atul Gawande, Being Mortal: Medicine and what happens in the end.

APPENDICES

APPENDIX 1

Full Needs Assessment

Current and projected health need in older people across Staffordshire & Stoke on Trent

Please click on the paperclip icon to see **Appendix 1** attached.

APPENDIX 2

Summary of Needs Assessment

References

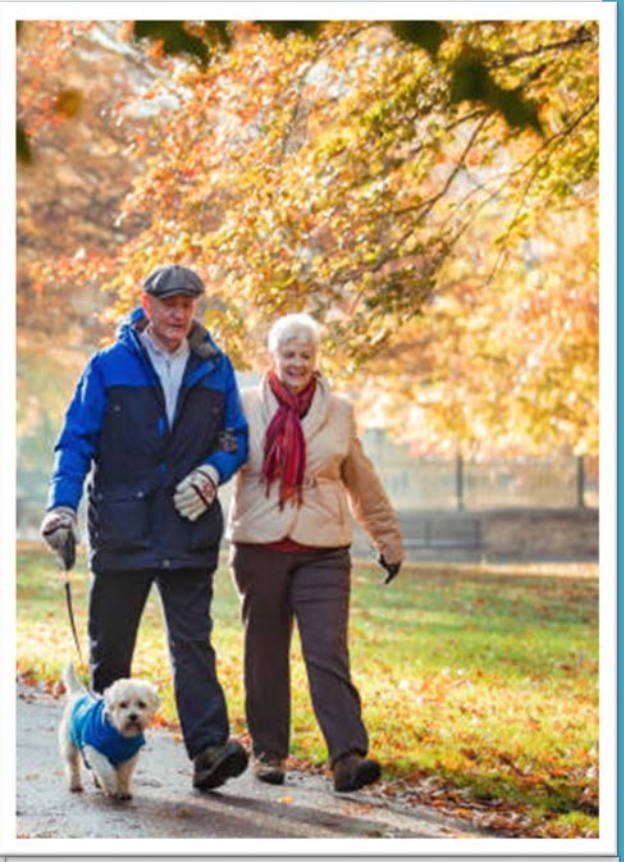
Please click on the paperclip icon to see **Appendix 2** attached.

APPENDIX 3

Supporting Evidence Reviews

References

Please click on the paperclip icon to see **Appendix 3** attached.



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Alex Hemming

Claire Charnley

Lisa Basini

Joanne Adams

Dr Karnjit Johal

Dr Ijeoma Ugwa

Dr Eleanor Hendicott

Dr Makpa Tanze

Dr Augustine Isirima

Dr Saleha Azhar

Rose Craker

Eliza Iqbal

TOGETHER WE'RE BETTER
Transforming health and care for Staffordshire & Stoke-on-Trent

Healthy Ageing & Managing Frailty In Older Age Strategy

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