

Integrated Care Partnership Briefing

Staffordshire and Stoke-on-Trent Integrated Care
Partnership (ICP) Meeting

June 2025



This briefing aims to keep partners and members of the public informed of the discussions at the NHS Integrated Care Partnership (ICP) meeting.

Alcohol Strategy

This is public health strategy underpinned by data, evidence of good practice, engagement with stakeholders and produced through partnership from the Integrated Care System. Our vision for the Alcohol Strategy:

“Staffordshire and Stoke-on-Trent to be a place where alcohol-related harm is minimised, to improve the health and wellbeing of our local population, making Staffordshire and Stoke-on-Trent the healthiest places to live and work.”

The reason for an alcohol-specific focus:

- An estimated 10 million people in England regularly exceed the Chief Medical Officers' low-risk drinking guidelines, including 1.7 million who drink at higher risk and around 600,000 who are dependent on alcohol.
- Shifting patterns of alcohol consumption, with consumption increasing in those with alcohol user disorder during and after the COVID-19 pandemic.
- An estimated 79% of people living with alcohol dependency in Staffordshire and Stoke-on-Trent are not in contact with treatment.
- Evidence shows that on average, every £1 spent on treatment immediately delivers £3 of benefit and significantly more in the longer term.
- Alcohol harm costs society in England £27.44 billion each year with an estimated cost to Staffordshire and Stoke-on-Trent Integrated Care System (ICS) of £449million, of which an estimated £81million is on health and care services.
- Alcohol-related deaths have increased with risk factors including being male, living in rural areas, increased deprivation and occurring most frequently in the population aged 50-69 years.
- There hasn't been a national alcohol strategy since 2012, and strategic focus has been more on reducing drug harm.
- The opportunity to address harmful impacts of alcohol on our population is clear from different system strategy and assessments of need.

What is our response?

We have taken a joint public health approach to the strategy and its development.

Extensive engagement has taken place, and we have undertaken an evidence review ensuring we have a strategy that is rooted in the needs of the local population.

We have conducted an Alcohol Needs Assessment, which has been instrumental in providing data-driven insights and evidence to help us prioritise our areas of focus.

The Alcohol Needs Assessment provides valuable insight into how alcohol misuse and dependency is impacting the local population's health and wellbeing with evidence gathered from data provided by local and national partners, stakeholder views and research.

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Alcohol Needs Assessment outcome high-level summary:

- Our communities are affected by the significant availability of alcohol.
- Our social care system is burdened by alcohol-related disability and housing issues.
- Our health and care system is struggling with alcohol-related liver disease and health impacts from alcohol.
- Our criminal justice system has significant alcohol needs in prison and probation services.
- Our economy is paying more per capita for alcohol-related conditions than average in England.

Priorities of the Alcohol Strategy:

- Universal Prevention: Prevent the use of alcohol or to change behaviours so alcohol misuse and alcohol related crime is prevented from happening
- Targeted Prevention: Halt the progression of alcohol misuse by early identification and prompt support, reducing alcohol-related harm.
- Treatment and Recovery: Rehabilitate people with established alcohol misuse/dependence by providing tailored, effective support and recovery interventions.
- Enforcement and Criminal Justice: Manage the availability of alcohol and developing innovative criminal justice solutions/practices to reduce alcohol misuse or alcohol-related offending and recidivism.
- Attitudinal Change: Change attitudes and behaviours towards alcohol at a societal, community and personal level.

Neighbourhood Health and Care Programme

The Neighbourhood Health and Care Programme aims to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasing their agency in managing their own care. This will be achieved by better connecting and optimising health and care resource through three key shifts at the core of the government's health mission:

- From hospital to community: providing better care close to, or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care.
- From treatment to prevention: promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health.
- From analogue to digital: greater use of digital infrastructure and solutions to improve care.

Our vision

The population of Staffordshire and Stoke-on-Trent can access health and care services that can meet their needs proactively, shifting the focus from hospital to community and delivering care closer to home.

Our mission

- To develop a Neighbourhood Health and Care Programme which promotes integrated working between the NHS, local government, social care and partners to create healthier communities.
- To implement a consistent model of care that is fit for the future and enables person-centred and proactive health and care to be delivered close to home (own home or community setting).

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- Ensure equity of access, experience and outcomes for residents across Staffordshire and Stoke-on-Trent and support a move to a more sustainable financial position, investing in prevention and care in home, or community settings.

Our places

- Place – Accountability and Planning
 - Staffordshire
 - Stoke-on-Trent
- Localities – Delivery
 - Four localities in Stoke-on-Trent
 - Eight districts and boroughs in Staffordshire
- Neighbourhoods – Change
 - People and Communities
 - Wards, Primary Care Networks (PCNs), villages, parishes

Key principles

We will build upon the work of the Integrated Care System (ICS) portfolios to enhance and strengthen key areas to:

- Utilise population health level data to use segmentation and risk-stratification methodologies to identify those most at risk.
- Prioritise proactive preventative care services.
- Ensure our population know how to access the right care they need and support themselves to self-care.

We will work effectively with general practice and community and hospital specialist care (on both acute and community hospital sites) to reduce unplanned and inappropriate use of hospital resources and increase the ability of people to live independently for as long as safely possible. We will do this by:

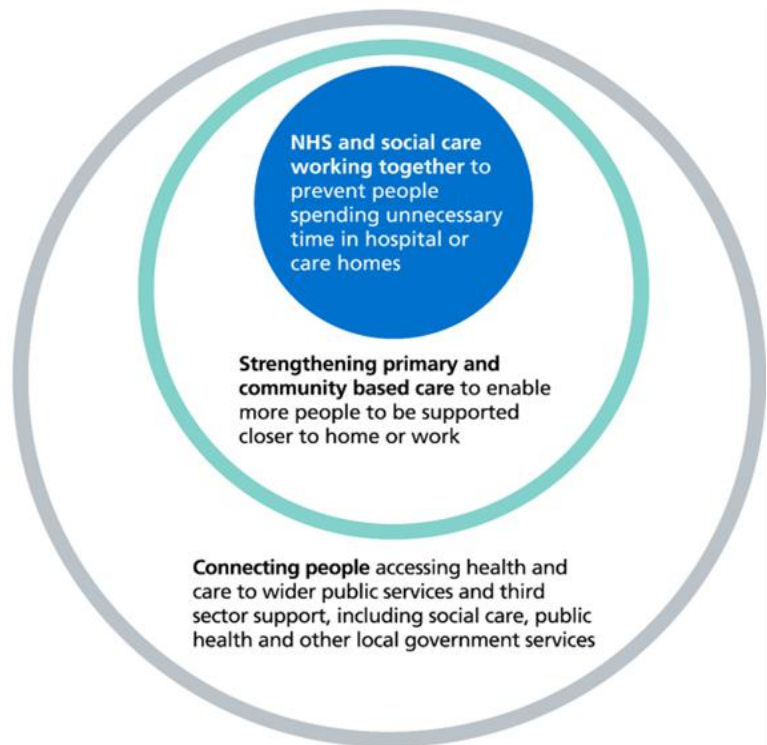
- Enhancing our proactive care model for those with long-term conditions and frailty through the development of integrated community neighbourhood teams (building upon Fuller Stocktake report).
- Strengthening our out of hospital services for those people who are at risk of admission and need support in a crisis.
- Increase the numbers of people utilising digital/tech-enabled care to manage their own conditions.
- Supporting a community-based workforce that has the capacity, the capability and the morale to make a difference in people's lives.
- Living within the financial means available to the healthcare system of Staffordshire and Stoke-on-Trent.
- Making best use of local estate and capital budgets, and minimising risk to patients' health from inadequate facilities.

In our first year (2025/26) we will prioritise:

- Six core components for consistency
 1. Population Health Management
 2. Modern General Practice
 3. Standardising Community Health Services
 4. Neighbourhood Multidisciplinary Teams (MDTs)
 5. Integrated Intermediate Care ('Home First' Approach)
 6. Urgent Neighbourhood Services

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- Integrating services to improve coordination, starting with those with the most complex needs (7% of the population, responsible for approximately 46% of hospital costs).
 - Scaling successful approaches to benefit more people.
 - Evaluating impact to ensure better outcomes and effective use of resources.
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- For 2025/26 through the standardisation and scaling of the initial six components, we are asking systems to focus on the innermost circle (on the diagram to the right) to prevent people spending unnecessary time in hospital and care homes. As core relationships between the local partners grow stronger, we expect systems to focus increasingly on the outer circles (on the diagram to the right).



Integrated Neighbourhood Teams – where we want to be in Staffordshire and Stoke-on-Trent

- Person health outcomes: Improvement in clinical health metrics and reduction in hospital admissions and readmissions.
- Service efficiency: Timeliness of care delivery and increased number of people supported within a neighbourhood.
- User satisfaction: High satisfaction scores and positive feedback from community engagement.
- Service performance: Effective coordination and communication, adherence to care protocols and guidelines.
- Cost effectiveness: Reduction in overall health and care costs and savings from decreased hospital admissions and improved preventative care.
- Community engagement: Active participation of the community in health programmes and success of outreach and education initiatives.

Implementing Integrated Neighbourhood Teams in Staffordshire and Stoke-on-Trent

- Quarter 1 (25/26): Initial assessment and strategic planning
- Quarter 2 (25/26): Operating model
- Quarter 3 (25/26): Pilot implementation
- Quarter 4 (25/26): Further rollout
- Quarter 1 (26/27): Monitoring and evaluation

Community engagement will take place throughout all quarters.

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Improving Population Health – Population Health Management (PHM)

PHM is an approach that underpins all our community transformation work including:

- Locality Improvement Framework (LIF)
- Core20 PLUS5 (adults)
- Core20 PLUS5 (children and young people)
- Neighbourhood development
- Inclusion groups
- Presentation programmes/projects

Feedback

The partnership split into groups to discuss and capture feedback on the following topics of discussion:

- What should / can partners bring to the neighbourhood programme?
- How do we build upon the work currently underway?
- How to we support people to look after their own health?

The following points were fed back to the group:

- Anchor institutions were discussed and leveraging their assets within communities.
- Identify clinical needs or vulnerabilities and enable follow-up support.
- Recognising that not one size fits all, tailored approaches are needed.
- Acknowledgement that different partners contribute uniquely.
- Stronger collaboration with Fire and Rescue and Police services was highlighted.
- Engagement with community team is essential to understanding local assets.
- Importance of:
 - Consistent language and common purpose
 - Simplifying messages to support clarity
 - Balancing immediate action with longer-term commissioning changes
 - Creating space for joint service development.
- Universal commitment to collaboration.
- Build on existing work rather than reinventing the wheel.
- Opportunity for a mapping exercise to identify and build upon existing programmes and assets.
- Emphasis on the importance of data:
 - Data sharing is essential for informed decision making
 - Supports deeper understanding of patient and population needs.
- Need to shift the focus to prevention to achieve real impact.
- Tackling health inequalities by rejection of one-size fits all solutions
- Services must be delivered in ways that reflect community preference and realities.
- We need to help people to understand how to access services.
- Focus on improving health literacy not just for patients, but also for families, carers and the wider community.
- It is important that we understand and map current resources and investments.
- Cross-boundary issues were noted as a challenge to service consistency.
- There is a need for flexibility, especially as PCNs often span multiple geographical boundaries.

Date and time of next meeting: Monday 1st September 2025, 3pm – 5pm, via MS Teams.