“To prevent ill-health and promote long-life and well-being”

SOUTH STAFFORDSHIRE PCT’s STRATEGIC PLAN

2008 – 2013
What a difference a plan makes...

“If we reduce by 10% the gap between how long people in different parts of South Staffordshire live, we will save 13,600 extra years of life”
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction from the Chairman, Chief Executive and Professional</td>
<td>5</td>
</tr>
<tr>
<td>Executive Committee (PEC) Chairman</td>
<td></td>
</tr>
<tr>
<td>2. Vision</td>
<td>6</td>
</tr>
<tr>
<td>2.1 Who we are</td>
<td>6</td>
</tr>
<tr>
<td>2.2 Our purpose</td>
<td>6</td>
</tr>
<tr>
<td>2.3 Our values</td>
<td>6</td>
</tr>
<tr>
<td>2.4 What you tell us</td>
<td>7</td>
</tr>
<tr>
<td>2.5 Our vision for the future</td>
<td>8</td>
</tr>
<tr>
<td>2.6 Our model of care</td>
<td>9</td>
</tr>
<tr>
<td>2.7 Our strategic priorities</td>
<td>11</td>
</tr>
<tr>
<td>2.8 Turning vision in to reality</td>
<td>11</td>
</tr>
<tr>
<td>3. Context</td>
<td>13</td>
</tr>
<tr>
<td>3.1 Our population</td>
<td>13</td>
</tr>
<tr>
<td>3.2 Health needs</td>
<td>14</td>
</tr>
<tr>
<td>3.3 Current performance</td>
<td>16</td>
</tr>
<tr>
<td>3.4 Provider landscape</td>
<td>16</td>
</tr>
<tr>
<td>3.5 Commissioning landscape</td>
<td>17</td>
</tr>
<tr>
<td>3.6 Financial situation</td>
<td>19</td>
</tr>
<tr>
<td>3.7 Activity commissioned</td>
<td>20</td>
</tr>
<tr>
<td>4. Strategy</td>
<td>22</td>
</tr>
<tr>
<td>4.1 Strategic Priorities</td>
<td>22</td>
</tr>
<tr>
<td>4.2 Strategy Development</td>
<td>22</td>
</tr>
<tr>
<td>4.3 World Class Commissioning Outcomes</td>
<td>23</td>
</tr>
<tr>
<td>5. Implementation</td>
<td>25</td>
</tr>
<tr>
<td>5.1 Improve children’s health</td>
<td>25</td>
</tr>
<tr>
<td>5.2 Increase life expectancy</td>
<td>28</td>
</tr>
<tr>
<td>5.3 Ensure quicker, high quality healthcare</td>
<td>31</td>
</tr>
<tr>
<td>5.4 Improve care for people with long-term conditions</td>
<td>34</td>
</tr>
<tr>
<td>5.5 Improve mental health and learning disability services</td>
<td>37</td>
</tr>
<tr>
<td>5.6 Improve end of life care</td>
<td>40</td>
</tr>
<tr>
<td>6. Delivery</td>
<td>43</td>
</tr>
<tr>
<td>6.1 Past delivery performance</td>
<td>43</td>
</tr>
<tr>
<td>6.2 Risk management</td>
<td>44</td>
</tr>
<tr>
<td>6.3 In-year monitoring</td>
<td>44</td>
</tr>
<tr>
<td>6.4 Organisational requirements and enablers</td>
<td>45</td>
</tr>
<tr>
<td>6.5 Provider requirements</td>
<td>45</td>
</tr>
<tr>
<td>7. Conclusion</td>
<td>47</td>
</tr>
<tr>
<td>8. Glossary</td>
<td>48</td>
</tr>
</tbody>
</table>
1. Introduction from the Chairman, Chief Executive and Professional Executive Committee (PEC) Chairman

South Staffordshire PCT is a PCT with ambition. We aim to make significant improvements in the health of our residents, by focusing on preventing ill-health and developing health services which are safe, effective, more responsive to people’s needs, promote independence and deliver care closer to people’s homes.

This Strategic Plan is the statement of our intent for the next 5 years and will guide the PCT and its partners in securing the improvements we want. It builds upon work undertaken since the creation of the PCT in October 2006 and sets out our strategic priorities, which are:

- Improving child health
- Increasing life expectancy
- Ensuring quicker, high quality healthcare
- Improving services for long term conditions
- Improving mental health and learning disability services
- Improving end of life care

Serving a population of approximately 609,000 people, South Staffordshire PCT is one of the largest PCTs in the country and has an unprecedented opportunity to create and lead change. It is an opportunity we will not fail to grasp. We recognise the importance of working with other organisations which impact on the health and well-being of our residents. Collaboration with local authorities, NHS Trusts, third sector organisations and others will be critical to our success.

We are also determined to see the NHS re-engage with local residents. The PCT is committed to improving patients’ experiences, maximising their choice and control over their care. The public have been involved in the shaping of this Strategic Plan to ensure we are addressing their issues.

This strategic plan marks a new exciting chapter for NHS reform and health improvement in South Staffordshire. Join us in making the next five years the period when health in South Staffordshire was transformed as never before.

Alex J H Fox, MBE, Chairman
Stuart Poynor, Chief Executive
Dr Phil Ballard, PEC Chairman
2. VISION

2.1 Who we are

South Staffordshire PCT was created in October 2006 following the merger of four smaller PCTs. We cover the southern 2/3rds of the county of Staffordshire, which includes the towns of Stafford, Cannock, Burntwood, Lichfield, Tamworth and Burton-upon-Trent and a large number of rural communities.

Our job is to be a world-class ‘commissioner’ of health services, that is, using our skills in assessing the health needs of our population, engaging with clinicians and the public to identify how best to meet those needs and then investing our resources to secure the greatest possible health gain for the 609,000 people living in South Staffordshire.

We also have a significant ‘provider’ function, employing 2,047 staff, who deliver community and home-based health services to our population.

Our style is proactive and we demonstrate through this strategic plan our commitment to address the major health challenges faced by our community and to make a difference.

2.2 Our purpose

Our purpose is simple.

Our Purpose:
To prevent ill-health and promote long-life and well-being

This strategic plan embodies how we will systematically live up to this purpose.

2.3 Our values

South Staffordshire PCT has signed up to the values of the NHS Constitution as guiding principles to shape the way we work and to reflect our culture and aspirations as we focus on the future and implement our vision. These core values underpin all of the work of our PCT and form a clear statement to our public, patients, staff, partners and other stakeholders.

We believe that our core values actively reflect our organisational culture and underpin the behaviours of our staff as we commission to meet the needs of our residents.

- **Respect and dignity**: We will commission services in a way which values each person as an individual, respects their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest about our point
of view and what we can and cannot do, running our business with transparency.

- **Commitment to quality of care**: We earn the trust placed in us by insisting on quality in all our commissioned services, ensuring they strive to get the basics right every time: safety, confidentiality, professional and managerial integrity, accountability, dependable service and good communication. We welcome feedback, learn from our mistakes and build on our successes.

- **Compassion**: We find the time to listen and talk when it is needed, make the effort to understand, and get on and do the small things that mean so much – not because we are asked to but because we care. We reflect this value in our commissioning activities and how we treat our staff.

- **Improving lives**: Our core purpose is to improve health and well-being and people’s experiences of the NHS. We value excellence and professionalism wherever we find it – in the everyday things that make people’s lives better as much as in clinical practice, service improvements and innovation.

- **Working together for our residents**: We put our residents first in everything we do, by reaching out to staff, patients, carers, families, communities, and professionals outside the NHS. We put the needs of individuals and communities before organisational boundaries.

- **Everyone counts**: We use our resources for the benefit of the whole community, and make sure nobody is excluded or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste others’ opportunities. We recognise that we all have a part to play in making ourselves and our communities healthier.

### 2.4 What you tell us

We have listened carefully to what people who depend on our health services tell us. By holding a series of listening events across South Staffordshire, we have identified the themes that matter and how people want services to change. We have also looked at the results of a MORI Telephone Poll, conducted in May 2008 on behalf of the West Midlands Strategic Health Authority, which highlights areas for concern for our population.

Our listening events identified the following views from local people:

- People want their services to be local
- People want their services to be safe and of the highest possible quality
- People want to see more done for people suffering from dementia
- People want the care they and their loved ones receive at the end of their lives to respect their dignity and preferences
- People want different services to talk to each other and treat people as individuals
- People want more help to avoid becoming ill and stay out of hospitals
The MORI Telephone Poll shows that people want to see the most improvement in:-

- The cleanliness of hospitals
- Access to NHS dentists
- Waiting times in A&E Departments

Those views, coupled with evidence about the health needs our population and best practice in health care delivery, have helped shape our vision and strategic priorities.

2.5 Our vision for the future

Our vision of how healthcare should change in South Staffordshire over the next five years reflects what people have told us is important to them. It can be summed up through the following key themes.

**Our Vision**

- **“Working Together”**
  
  We will achieve ever closer integration between healthcare and other services for children and adults in Staffordshire. We know many people who rely heavily on the NHS also use other public and voluntary services. By working more closely together we can cut duplication, spot problems before they occur and tailor care to their individual needs, increasing their independence and improving their health.

- **“Preventing Ill-Health”**
  
  We will shift the balance of investment and attention to keeping people well, not just treating them when they are sick. We know that preventing ill-health is often the most cost-effective solution to keeping people healthy and we can add most years to life and life to years by identifying risks and tackling them early.

- **“Local Services”**
  
  We will provide care closer to home if appropriate, to reduce reliance on hospital services and because often the best place to look after someone is in their own home.

- **“Safe and Effective”**
  
  We will make local health services among the safest and most effective in the country to restore public trust and confidence in the quality of the NHS and make sure our residents are offered only safe, effective services.

- **“Patient Experience”**
  
  We will make sure people have an excellent experience when they use their health service, putting them more in control to improve their independence and choices and to respect their status as the most important contributors to their own health and wellbeing.
2.6 Our Model of Care

This vision of health for the future is underpinned by our ‘model of care’ for South Staffordshire. The model ensures we only design and put in place health services compatible with our vision.

The model works to a principle of anticipating and addressing risks to people’s health early, then tailoring responses in effective, holistic ways.

The model is based on a ‘pyramid of care’, identifying different levels of need for particular groups. Those in need of an immediate intervention are at the top of the pyramid (level 3), probably through a statutory service response. Level 2 looks at the needs of those with chronic care needs (not necessarily health) where a shared care model between the individual, professional support and voluntary sector is most appropriate. Level 1 is a more universal model aimed at evidence-based services preventing ill-health in the longer term.

The aim of our interventions (the blue arrows) will be to reduce or sustain people’s level of dependence at the lower levels of the pyramid.

The components of our model bring UK and international best practice to South Staffordshire.

Level 1 – Universal and Preventive Services

The aim at Level 1 is to inform and empower people to manage their own health risks and lifestyle

- **Risk assessments** - Cardiovascular risk assessments, capturing people at risk of developing heart disease and systematic use of risk stratification
to proactively identify people not necessarily engaged with services but at risk of ill-health

- **Screening programmes** – Screening for early signs of cancer, sexual health, aortic aneurysm, hepatitis C
- **Immunisation** – ensuring high take up of established childhood immunisations and introducing new HPV immunisation programme for girls
- **Obesity** - Weight management and exercise schemes
- **Alcohol** - Support services run in conjunction with local authority partners
- **Antenatal Services** – Improving health in pregnancy, supporting early breastfeeding and support to stop smoking
- **Smoking cessation** – Relentless attention to increase support to stop smoking
- **Health trainers** – Community-based individuals there to support individuals with their lifestyle changes

**Level 2 – Targeted interventions**

The aim at Level 2 is to manage identified risk and ill-health effectively, to sustain independence, avoid escalation to a health ‘crisis’ and reduce unnecessary reliance on hospital-based care

- **Health Net** - A multi-agency Healthy Living Centre project which targets disaffected families and those who fail to access services.
- **Psychological Therapies** – Primary care-based interventions for people with mild to moderate mental health needs
- **A&E Primary Care Front-End** – a scheme which puts primary care expertise (GPs) at the start of the hospital A&E care pathway to avert unnecessary use of emergency hospital services and admission.
- **Intermediate care** – health and social care working together to deliver care outside of hospital and rehabilitation
- **Long-term conditions management** – personalised and expert advice to people living with a long-term condition.
- **Ambulatory care pathways** – i.e. systematically routing patients to the right care in the right venues where hospital-based care is unnecessary

**Level 3 – Case Management**

The aim at Level 3 is to provide personalised holistic support to those at highest risk of hospital admission

- **Unique Care** – integrated health and social care teams working with practice-based registers of individuals at highest health risk, providing each individual with a bespoke plan
- **End of life care** – Support to individuals at the end of their life to exercise choice about place of death
- **Integrated care pathways** – for those for whom hospital care is appropriate, integrated care pathways establish the routes in and out and ensure the right interventions are performed in timely way. For instance, the PCT has agreed across the local health economy the stroke care pathway covering all stages of diagnosis, treatment and rehabilitation
2.7 Our strategic priorities

Our strategic priorities link directly to what people in South Staffordshire have told us matter to them and to the evidence we have of their particular health needs. The achievement of these goals will be driven by our model of care which underpins our approach to improvement.

The strategic priorities are shown in the table below:

<table>
<thead>
<tr>
<th>Our Strategic Priorities</th>
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</thead>
<tbody>
<tr>
<td>1. “Improve children’s health” by working with the Staffordshire Children’s Trust to ensure that services for children across South Staffordshire will be equitable and easy to access.</td>
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<tr>
<td>2. “Increase life expectancy” by focussing on prevention and lifestyle services to tackle key conditions such as heart disease, stroke, cancer and respiratory disease, to improve the quality and length of people’s lives and address health inequalities.</td>
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<tr>
<td>3. “Ensure quicker, high quality health care” including reducing waiting times for hospital treatment, improving access to GPs and NHS dentists, redesigning planned and urgent care services, raising standards of cleanliness and safety in hospitals and building the PCT’s capacity drive up quality through clinical governance and commissioning.</td>
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<tr>
<td>4. “Improve care for people with long-term conditions” through provision of proactive community-based care for patients with long-term conditions, by developing individual care plans designed to improve quality of life. The aim is to replace avoidable hospital admissions by supporting patients and carers at home and improve, in particular, the quality of stroke care.</td>
</tr>
<tr>
<td>5. “Improve mental health and learning disability services” providing modern services for vulnerable adults which promote their dignity and independence.</td>
</tr>
<tr>
<td>6. “Improve end of life care” through a range of community services (both health and social care) in order to support patients in deciding on their preferred place of care and place of death.</td>
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2.8 Turning vision into reality

There are three key stages to making our vision a reality:-

Firstly, The PCT launched its inclusive Joint Strategic Needs Assessment process in September 2007 with the engagement of a wide number of local stakeholders. The baseline report was produced in December 2007 along with
specific JSNAs on alcohol, older people’s mental health, end of life care and adult mental health. These have all informed PCT and joint commissioning in 2008 – 09 and are available to all Staffordshire partners on the PCT website. Detail of needs assessment information is described in Section 3 below.

Secondly, we have followed a clinically-led process to engage our partners, clinicians and patients in designing the strategies and solutions to meeting those needs. This process, called ‘One Step Beyond’, has involved the creation of nine Service Improvement Boards, each mirroring the Care Pathway Groups established as part of Lord Darzi’s Next Stage Review of the NHS. These Boards are:

- Maternity and Newborn Care
- Child Health
- Staying Healthy
- Planned Care
- Urgent Care
- Long Term Conditions
- Mental Health, Learning Disability and Substance Misuse
- Dementia
- End of Life Care

The membership of these groups includes clinicians from across South Staffordshire and patient involvement has been a major part of their work. A team of Clinical Champions, senior leaders in their own fields, have also been appointed to provide dedicated clinical leadership and direction to the work of the Boards. The recommendations of these Boards have led the development of the PCT’s Strategic Plan.

Finally, We have aligned all our key plans and are committed to implementing them i.e.

- our strategic plan i.e. our statement of what we will achieve in the next five years
- our financial plan i.e. where we will invest our financial resources
- our organisational development plan i.e. how we will design the structure and processes of the PCT
- our operating plans i.e. our yearly set of objectives which will take us towards our strategic vision
3. CONTEXT

3.1 Our population

South Staffordshire PCT is responsible for the health of a population of 608,850 people. This section describes some of the key features of our population.

Index of Multiple Deprivation Scores 2004 for South Staffordshire PCT

- The map above shows the larger proportion of pockets of deprivation are found in the centres of East Staffordshire, Tamworth and Cannock Chase local authorities.
Tamworth, East Staffordshire and Cannock Chase have relatively high numbers of young people; South Staffordshire, Stafford and Lichfield have higher numbers of older people.

All areas will see a significant growth (higher than the national average) in those aged 65 and over and in particular those aged 75 and over.

24% of South Staffordshire PCT’s population is ‘rural’ compared to 19% nationally with high proportions in South Staffordshire, Stafford and Lichfield living in rural settings.

South Staffordshire PCT has a lower proportion of residents from an ethnic minority background than nationally (2.7% compared with 9.1%) with East Staffordshire having the largest proportion (6.1% or 6,630 people).

### 3.2 Health needs

There are particular health issues affecting our population.

**Health Inequalities**: Overall life expectancy is 79 years which is similar to the national average however it is lower in Cannock Chase for men and women and the gap is widening amongst women in East Staffordshire and Tamworth compared to England.

There are significant inequalities with 8% of the population living in the most deprived areas in England mainly in East Staffs, Tamworth and Cannock. There is 11 years difference in life expectancy between some wards in South Staffordshire.
Seven wards in South Staffordshire have significantly low life expectancy compared to the national average.

Whilst the overall population of people from BME communities is low 2.7% compared to the national average of 9.1% some health conditions such as type 2 diabetes and stroke are higher among some ethnic groups.

The number of migrant workers is low however there has been a 171% increase compared to the national average.

There is a large prison population of 2,900 in South Staffordshire who have poorer health outcomes.

- **Mortality**: Rates are decreasing however they are significantly higher for men and women compared to the national average. Circulatory disease, cancer and respiratory disease account for 75% of all deaths.

There is a strong correlation between premature mortality and deprivation with 22 of the 123 wards reporting significantly higher rates than the national average.

![Causes of Death Across Staffordshire 2003 -2005](image)

- **Lifestyle and health**:

  **Smoking**
  23% of the PCT adult population smoke and 9% of 11-15 years smoke. National surveys estimate that 70% want to quit.

  **Alcohol**
  Mortality rates for alcohol specific conditions have increased over the past 15 years by 154% for men and 87% for women (40 per year 1990-1994–110 per year 2002-2006)

  There are estimated to be 95,000 hazardous drinker, 23,000 harmful drinkers, 16,000 dependent drinkers, and between 76,000-99,000 are categorised as binge drinking.
Amongst children and young people 30% of 11-15 year olds report drinking in the last week compared to 21% nationally.

**Obesity**
23% of the adult PCT population are estimated to be obese along with 18% of children aged 2-15 years (18,400)

**Physical Activity**
In South Staffordshire only 12% men and 11% women locally achieve the recommended levels of moderate physical activity (5 x 60 mins per week) with 47% of men and 54% of women who participate in no physical activity at all.

**Sexual Health**
Teenage conception rates are similar to the national average with higher rates in Cannock Chase. There are 13 wards where rates are significantly higher than England. Teenage pregnancy is associated with deprivation.

Sexually transmitted infections are steadily increasing especially Chlamydia with highest rates being in women 16-24 years.

### 3.3 Current Performance

The 2007/08 Annual Health Check performance rating for the PCT was ‘Fair’ for quality of services and ‘Good’ for use of resources.

Performance against targets and priorities directly linked to the PCT’s vision and strategic themes is generally good. There are concentrated efforts to integrate services across health and social care for both adults and children, with specific models of care being developed. Similarly, the South Staffordshire health economy has been successful in making ahead-of-target progress to reduce total waiting time from GP referral to definitive treatment to a maximum of 18 weeks.

There are currently a number of areas of risk based on current performance information. In the main these reflect service areas relating to Health Improvement and Health Inequalities. For example;

- Early access to maternity services
- Prevalence of breastfeeding at 6-8 weeks
- Smoking rates/quitters
- Number of drug misusers recorded as being in effective treatment
- % of practices with Cardiovascular Disease registers
- Chlamydia Screening
- Teenage Pregnancy

The PCT’s strategy will address performance against all these targets.

### 3.4 Provider landscape

The PCT has the following significant providers of care within its borders.

**Primary Care**
• **95 GP Practices**: The PCT has relatively good access to primary care with an average of 1,650 patients per GP.

• **83 Dental Practices**: In addition, the PCT provides its own dental services from 10 locations.

• **113 Pharmacies**: An increasing number of services are delivered from Pharmacies and set to increase as a result of the Pharmacy White Paper

• **66 Optometry Practices**: Including an extensive primary care-delivered diabetic retinopathy screening service.

• **6 Prisons**: The PCT commissions all health services for the 2,900 prisoners within its borders. This figure is increasing as more prison spaces are created and will nearly double by 2012 when a new prison, Featherstone 2, opens.

**Secondary Care**

• **Burton Hospitals NHS Trust**: A medium-size district general hospital serving the eastern catchment of the PCT, which accounts for 70% of its total activity. Our annual contract value with the Trust in 2008/09 is £65m.

• **Mid Staffordshire Hospitals NHS Foundation Trust**: A similar-sized hospital with sites in Stafford and Cannock. The vast majority of its services are provided to the PCT’s patients. Our annual contract value with the Trust in 2008/09 is £113m.

• **South Staffordshire and Shropshire Healthcare NHS Foundation Trust**: The predominant provider of specialist mental health, learning disability and community children’s services for the PCT’s population. Our annual contract value with the Trust in 2008/09 is £54m.

• **South Staffordshire PCT**: The main provider of community healthcare services, including two community hospitals in Lichfield and Tamworth. Our annual contract value with the Provider Arm in 2008/09 is £69m.

• **Midland Treatment Centre**: A Wave 1 Independent Sector Treatment Centre located on the Burton Hospitals campus. Our annual contract value with the Treatment Centre in 2008/09 is £12m.

**Ambulance Services**

• **West Midlands Ambulance Service NHS Trust**: Provider of ambulance services across all 17 PCTs in the Region. Our annual contract value with the Ambulance Service in 2008/09 is £13m.

As the result of the distribution of our population, transport links and travel times to nearest hospitals, it is notable that 40% of secondary care activity is commissioned from providers outside our boundaries.

The PCT currently has a modest level of provision sourced from the 3rd sector.

**3.5 Commissioning landscape**

• **Practice Based Commissioning**

  The PCT has supported the development and empowerment of Practice Based Commissioning (PBC), which are organised in to five consortia and four independent Practice Based Commissioners.
PBC The map below gives an illustration of the population catchments of the larger consortia.

PBC are responsible for commissioning all health services relating to their population with the exception of primary care services, prison health and specialised services.

- **Collaborative Commissioning**: The PCT benefits from collaborative commissioning arrangements which operate at national, regional and sub-regional level for specialised services. The PCT is part of the Shropshire and Staffordshire local collaborative commissioning arrangements.

- **Joint Commissioning Unit**: The PCT as joined with North Staffordshire PCT and Staffordshire County Council Directorate of Social Care and Health to create a Joint Commissioning Unit (JCU) for the strategic commissioning of mental health, learning disability, physical and sensory disability and older people’s services. The JCU has the remit of setting strategic direction and a framework for local NHS and social care commissioners to operate within and secure more integrated service solutions.
3.6 Financial situation

The PCT’s financial resource limit in 2008/09 is £830m. It is spent in the following ways:

<table>
<thead>
<tr>
<th>How the money is spent</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Headquarters &amp; Admin</td>
<td>2%</td>
</tr>
<tr>
<td>Commissioning health services</td>
<td>9%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1%</td>
</tr>
<tr>
<td>GP Practices</td>
<td>12%</td>
</tr>
<tr>
<td>Dental Services</td>
<td>11%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>1%</td>
</tr>
<tr>
<td>Provider Arm</td>
<td>63%</td>
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</table>

The financial strategy of the PCT at the time of reconfiguration on 1 October 2006 was to address the recurring deficit inherited from three of the former legacy PCTs. The next phase of the strategy was to generate a relatively small surplus of around 0.5% of budget on a recurring basis. Each year the PCT would reinvest this small surplus to improve the range and quality of services for our population.

The legacy PCTs reported a combined financial deficit of £9.5 m in 2006. KPMG, external auditors for the legacy PCTs and the newly emerged South Staffordshire PCT reported in December 2006 that the PCT was heading for a deficit of £16.1 m. Following delivery of a successful financial recovery plan the PCT delivered a surplus for year end 2007/2008 of £804,000. This achievement demonstrated a significant milestone for the PCT and a catalyst for further successes and improvement in financial regulation. The development of this significant improvement was down to the dedication of staff in the PCT and the successful partnership with our staff side representatives. The decision to take clear financial recovery actions at this very early stage was a clear factor in the turnaround of the PCT’s financial position.

The PCT delivered a surplus of £4.606 m for the financial year ending 31 March 2008. This was very close to the control target aim with the SHA of £4.600m. The figure for this financial year is £4.6m and the PCT is confident that it will manage its finances positively throughout the year to achieve actual outturn close to this financial aim.

This improvement in financial performance over the two years since the establishment of the PCT has been not only reflected in improved external audit local evaluation score, with an improved rating from 2 (fair) to 3 (good) but was also confirmed in the Annual Audit Letter. KPMG have advised that the PCT has become a much stronger organisation in a relatively short space of time.
The financial trend moving forward for the PCT, reflected in the Medium Term Financial Plan, is the continued delivery of a relative surplus each year of around 0.5% of turnover, reinvested in improved services.

Key assumptions that drive the future forecasted position are as follows:

- Robust financial management
- Clear identification of cost pressures, risks and opportunities
- Identification of contingency reserves at the start of the financial year of around 0.5% of budget.
- The contingency reserve is released in-year to mitigate newly identified risks and secure improved patient services.
- The finance systems are of a high standard and the finance teams throughout the PCT are dedicated highly skilled professional team
- Quality of financial reporting is of a high standard and financial reporting is timely.

3.7 Activity commissioned

The PCT commissions services from a large number of NHS Trusts. Due to the geography and population distribution within the PCT, 40% of healthcare activity is sourced from outside the PCT’s borders.

This means 40% of our hospital-based activity is outside the direct commissioning control of the PCT due to the NHS’s arrangements for ‘co-ordinating PCTs’ leading contractual negotiation and agreement with their host NHS providers. Nonetheless, the PCT is implementing a number of demand management and care pathway redesign schemes which assert our influence over usage of hospital-based care.

The top ten contracts by value, totalling £397m, are shown below.

![Commissioning Expenditure by Provider](image)
The PCT has used a capacity planning model (AETNA) to forecast how demographic change will impact on demand for hospital services. The demand model shows that, with no intervention on the part of the PCT, the cost of acute hospital-based services would grow year on year as follows:

### Effect of Demographic Change

<table>
<thead>
<tr>
<th>Care Category</th>
<th>Annual Expenditure (£ms)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
</tr>
<tr>
<td>Elective Day Case</td>
<td>39.8</td>
</tr>
<tr>
<td>Elective Inpatient</td>
<td>31.4</td>
</tr>
<tr>
<td>Non-Elective</td>
<td>158.8</td>
</tr>
<tr>
<td>Outpatient</td>
<td>48</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>278</td>
</tr>
<tr>
<td>Cumulative % increase (2008 baseline)</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

It is interesting to note that between 2008 and 2013 the total size of our population grows by only 2.8%, but due to the rapidly ageing profile, demand for non-elective care in volume terms will grow by 6.9% and total activity expenditure will grow (unadjusted for inflation) by 8.3%.
4. STRATEGY

4.1 Strategic Priorities

Our strategic priorities link to what people in South Staffordshire have told us matter to them and to the evidence we have of local health needs. The achievement of these priorities will be driven by our model of care which underpins our approach to improvement.

The strategic goals are to:

1. **Improve children’s health** by working with the Staffordshire Children’s Trust to ensure that services for children across South Staffordshire will be equitable and easy to access.

2. **Increase life expectancy** by focussing on key conditions such as heart disease, stroke, cancer and respiratory disease to improve the quality and length of people’s lives.

3. **Ensure quicker, high quality health care** including reducing waiting times for hospital treatment, improving access to GPs and NHS dentists, redesigning planned and urgent care services and raising standards of cleanliness and safety in hospitals.

4. **Improve care for people with long-term conditions** through provision of proactive community-based care for patients with long-term conditions, by developing individual care plans designed to improve quality of life. The aim is to replace avoidable hospital admissions by supporting patients and carers at home.

5. **Improve mental health and learning disability services**, providing modern services for vulnerable adults which promote their dignity and independence.

6. **Improve end of life care** through a range of community services (both health and social care) in order to support patients in deciding on their preferred place of care and place of death.

4.2 Strategy Development

The development of our strategy has been an inclusive effort which has involved our Board, clinical leaders and patients at every stage. It has built upon work undertaken last year when we developed the PCT’s Strategic Direction, which identified the six strategic themes we should concentrate on.

This year we have held seven community engagement events across South Staffordshire, inviting the public and key stakeholders to share our thoughts and provide their input to the priorities we should adopt.

The detail of the objectives and initiatives within each strategic theme has been created by through our ‘One Step Beyond’ clinical engagement process, described in section 2.8.
We have considered the recommendations of the regional Care Pathway Groups which reported on each of the clinical themes addressed in the NHS Next Stage Review ‘Our NHS, Our Future’ and the review’s final report published in July 2008, ‘High Quality Health Care for All’.

At our invitation, national clinical leaders from the Department of Health have visited South Staffordshire to work alongside our Service Delivery Board and help us refine service strategies, including Prof George Alberti who supported our Stroke Strategy and Urgent Care Strategy and Prof Louis Appleby in respect of Mental Health.

We have taken note of the ‘7 big challenges’ for healthcare identified in West Midlands Strategic Health Authority’s response to the NHS Next Stage Review, ‘Investing for Health – Delivering Our Vision for a World Class Service.’

The seven challenges are:

1. Despite some improvements in overall health status, there are still unacceptable differences across the region.

2. There remains variability in the quality and safety of services and individual care.

3. Patients expect services to be joined up and to have co-ordination across teams caring for them. Yet the fact is that at present patients and the public often struggle to understand how services work.

4. The public, our ‘customers’ have little confidence that their local NHS will get better.

5. We are not focusing on upstream investment around prevention.

6. We continue to spend substantial amounts of resources on clinical activities where the evidence suggests there is little or no return on the investment.

7. The rate of cost pressures arising from doing “more of the same” with an ageing population, a rising tide of long term conditions and an accelerating pace of technological development.

By implementing the changes set out in our strategic plan, we will make substantial progress towards tackling these challenges.

4.3 World Class Commissioning Outcomes

The PCT has selected 10 outcomes against which we will be measured as part of the World Class Commissioning Assurance Framework. We have selected outcomes which directly relate to our strategic goals to ensure complete alignment and focus of effort for the organisation.

The outcomes are:
1. Increase **life expectancy** year on year across South Staffordshire.
2. Reduce the **gap in life expectancy** between Tamworth and East Staffordshire (females) and in Cannock Chase (males and females) where it is widening, and the rest of the PCT.
3. Increase the proportion of **deaths at home** to 24% in 3 years
4. Reduce death rates from **cardiovascular disease** by 6% year on year
5. Increase the proportion of **stroke admissions** given a brain scan within 24 hours to 60%
6. Reduce growth in annual rate of **alcohol related admissions** to <1%
7. Reduce **teenage pregnancies** by 50% by 2010 (1998 baseline)
8. Reduce the **infant mortality** rate in East Staffordshire so it is not significantly different from the England average
9. Increase % of **adults participating in sport** and active recreation from 20.3% to 25.3%
10. Increase by 100% the number of patients on **dementia** registers who have a care plan.
5. IMPLEMENTATION

5.1 STRATEGIC PRIORITY 1: IMPROVE CHILDREN’S HEALTH

Why is it a priority?
Although infant mortality has fallen in South Staffordshire from 6.3 per 1,000 live births in 1999-2001 to 5.6 in 2004-2006, unacceptable differences still exist. Babies from certain population groups (routine and manual socio-economic groups, students, unemployed and lone mothers) are more likely to die before their first birthday. Also infant mortality in East Staffordshire appears to be on an upward trend since 2000-2002, and in 2004-2006 was significantly higher at 8.4 per 1,000 live births than the England average of 4.8 per 1,000 live births.

Under-18 conception rates have reduced but remain higher than the Government’s target to cut teenage pregnancy rates by 50% by 2010 (base year 1998). While rates in Staffordshire are on average lower the England average, they are significantly higher in Cannock Chase and Tamworth.

Alcohol consumption between 11 and 16 year olds is increasing. 33% of Staffordshire children in this age group reported having an alcoholic drink in the last 7 days, significantly higher than the England average of 21%. The highest reported rate was in Tamworth (38%)

16,380 South Staffordshire children are estimated to have an emotional or mental health problem at any time. Wait times for assessment at by the Child and Adolescent Mental Health Service are as long as 6 months and diagnosis of some conditions is currently taking up to 2 years.

A regional report into Paediatric Services in the West Midlands (Durrow Report, 2007) identified the need to review the future service model for acute paediatrics in South Staffordshire.

Strategic Objectives

1. Address inequalities in infant mortality rates by reducing current 3-year average rate in East Staffordshire (8.4 deaths / 1000 live births 2004-06) to England average (4.8 deaths / 1000 live births)
2. Reduce under-18 years pregnancy rates by 50% from 1998 baseline to 21.6 per 1000 in 2010
3. Provide equitable and easy access to Child and Adolescent Mental Health Services (CAMHS) by addressing current service gaps, reducing admissions to tier 4 services by 50% and reducing wait times for initial assessment to 6 weeks maximum.
4. Develop integrated children’s services with local authorities and other partners, establishing multi-agency care pathways in all public health services eg. obesity, sexual health, safeguarding.
5. Address needs of children with disabilities and/or life limiting conditions, by increasing access to short breaks and the number of terminally ill children dying at home
6. Reduce the consumption of alcohol by under 16 year olds and reduce the impact of alcohol on children and families.
### Initiatives

<table>
<thead>
<tr>
<th>Strategic objective</th>
<th>Year 1</th>
<th>Years 2-5</th>
</tr>
</thead>
</table>
| Infant Mortality                         | • Increased early access to maternity services (extra 7,600 maternity bookings per annum)  
  • Public awareness campaign of standard antenatal care pathway  
  • Increased antenatal and parenting skills for all pregnant women  
  • Implement breastfeeding action plan in Trusts  
  • Mandatory smoking cessation interventions for all pregnant women | • Comprehensive review of maternity services in line with Durrow report recommendations |
| Under-18 pregnancy                       | • Increase provision of Clinic in a Box service  
  • Increase Early Hormonal Contraception service provided through pharmacies  
  • Support additional Sex & Relationships Education post for schools | • Targeted actions for hotspot districts and wards |
| CAMHS                                    | • Commission new Autistic Spectrum Disorder service  
  • Mainstream screening of looked after children  
  • Expand access to specialist support to 24/7 availability  
  • Address transition to adult services for children with Attention Deficit Hyperactivity Disorder (ADHD) | • Development of intensive outreach service (Tier 3+)  
  • Increased support and training for primary care and Community Learning Partnerships for early identification and intervention |
| Integrated services                      | • Integration project launched, appointment of project manager  
  • Comprehensive review of paediatric services in line with Durrow report recommendations | • School nurses and health visitors part of multi-disciplinary integrated teams  
  • Each district with access to Public Health Nurse specialists for key childhood health risk factors |
| Children with disabilities and/or life limiting conditions | • Increase capacity of community paediatric nurse teams to improve equity of access  
  • Improve access to short breaks for children with disabilities | • Integrated care pathways in place for palliative care and ambulatory care  
  • Develop hospital at home services and reduce hospital admissions.  
  • Increase access to specialist palliative care in community |
<p>| Safeguarding                             | • Robust coordination systems in place to support practitioners in completing the Common Assessment | • Consolidate multi-agency working and risk assessment processes |</p>
<table>
<thead>
<tr>
<th>Framework (CAF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All Initial Health Assessments (IHAs) completed for looked after children</td>
</tr>
<tr>
<td>• Ensure access available for children to Sexual Assault Referral Centre</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Children and Alcohol</th>
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</thead>
<tbody>
<tr>
<td>• Implement an alcohol public health information campaign.</td>
</tr>
<tr>
<td>• Take forward the LPSA 2 alcohol programme for children through the LAA</td>
</tr>
<tr>
<td>Alcohol Delivery Plan.</td>
</tr>
<tr>
<td>• Develop a multi-agency evidence based education programme for young people</td>
</tr>
<tr>
<td>• Develop accredited alcohol training for health and other professionals who</td>
</tr>
<tr>
<td>work with families and young people</td>
</tr>
<tr>
<td>• All secondary schools prioritise alcohol education</td>
</tr>
<tr>
<td>• Alcohol brief intervention training provided to health and other professionals working with families and young people</td>
</tr>
<tr>
<td>• Commission alcohol services specifically designed for young people and families affected by alcohol</td>
</tr>
</tbody>
</table>

**Strategy in Action**

Amy is 30 years old and discovers she is pregnant with her fourth baby. Amy thinks that she is about 8 weeks pregnant and contacts her local midwife to arrange an initial appointment at the children centre. She has seen the number displayed in the GP surgery. The midwife undertakes a complete social/medical assessment. The midwife is the lead professional who sees Amy throughout her pregnancy at the children’s centre. She receives her scans and blood tests at the centre.

Amy feels able to confide in her midwife the concerns she has. Her midwife is able to offer her support with quit smoking and puts her in touch with Citizens Advice Bureau for help with managing her finances. Amy attends the children’s centre regularly and this has helped her with feeling low. At term she delivers her baby in a midwife led unit and on discharge is breast feeding her baby. She attends for postnatal care at the children’s centre.
5.2 STRATEGIC PRIORITY 2: INCREASE LIFE EXPECTANCY

Why is it a priority?
Nationally life expectancy has improved year on year for the past ten years however there are still marked differences amongst those who are more disadvantaged. Health inequalities still exist resulting in poorer health for those who are more disadvantaged. In some areas the gap between those who have the best and worst health is continuing to widen.

There is national recognition reflected in the performance and quality assurance frameworks for PCT's that the government wants a stronger focus on improving the health of those living in areas with the worst life expectancy.

In South Staffordshire life expectancy is 79 years which is similar to the national average however there are variations across the county. Life expectancy for males is higher than the national average however it is lower for females. Tamworth is a spearhead area (so is included in the national targets) In Tamworth life expectancy has increased for males and is now higher than the national average but for females it has decreased. In Cannock Chase life expectancy is lower in males and females than the national average and the gap is widening. In East Staffs life expectancy in women is lower than the national average and the gap is widening.

In addition some specific wards have significantly lower life expectancy when compared to England. Improving the life expectancy of those living in these areas would reduce both premature death and disease and improve quality of life.

Some diseases impact more greatly on life expectancy and include circulatory disease, cancer and respiratory conditions. Interventions that would be beneficial in reducing the gap in life expectancy include smoking cessation, therapies and lifestyle changes for those with cardiovascular disease, early detection of cancer and the management and prevention of respiratory and alcohol related diseases.

The PCT has prioritised an ambitious programme for primary and secondary prevention which aims to increase life expectancy across the population and particular in areas of greatest need and to groups who have lifestyle risk factors.

Strategic Objectives

1. Achieve an overall increase in life expectancy from baseline of 2004 - 2006 average = 77.5 years for men and 81.2 for women
2. Achieve a 6% reduction in cardiovascular mortality year on year, ie 2009/10 = 67.19 per 100,000 population; 2010/11 63.2 per 100,000 population
3. Achieve year on year reduction in gap in life expectancy between England average and areas where it is widening (Tamworth and East Staffordshire females and Cannock males and females)
4. Reduction in prevalence of obesity from baseline of 26,500 adults
5. Reduction in prevalence of smoking from baseline of 114,000 adults
6. Reduction in rate of growth of alcohol related hospital admissions (increasing by 15.7% per annum)
7. Increase the number of adults participating in sport or active recreation from 20.3% to 25.3%
### Initiatives

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Year 1</th>
<th>Years 2-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>• Implement Health Trainers, starting with spearhead areas&lt;br&gt;• Social marketing campaign to promote a self-care culture&lt;br&gt;• Ensure people access immunisation, screening and dental care.</td>
<td>• Health trainers rolled out to all areas</td>
</tr>
<tr>
<td>Cardiovascular mortality</td>
<td>• Implement CVD risk register and intervention programme across South Staffordshire&lt;br&gt;• Implement thrombolysis action plan&lt;br&gt;• Implement primary angioplasty protocols</td>
<td>• Develop cardiac strategy</td>
</tr>
<tr>
<td>Obesity</td>
<td>• Targeted weight management programmes to double take-up from 10% of registered obese to 20%&lt;br&gt;• Assess usage and impact of prescribing for obesity&lt;br&gt;• Staff training programme to enforce positive weight loss messages and use of care pathways</td>
<td>• Structured support and access to bariatric surgery for most severely challenged.</td>
</tr>
<tr>
<td>Smoking</td>
<td>• Double capacity of smoking cessation services in spearhead areas</td>
<td>• Increase capacity of smoking cessation services in all areas</td>
</tr>
<tr>
<td>Alcohol</td>
<td>• Launch refreshed model of care for alcohol services&lt;br&gt;• Commission additional tier 1 capacity&lt;br&gt;• Consolidate capacity required for tier 2-4</td>
<td></td>
</tr>
<tr>
<td>Participation in sport</td>
<td>• Development of PCT physical activity strategy and action plan&lt;br&gt;• Promotion and implementation of existing PCT physical activity programmes including Exercise on Referral, Health Fit, Retain, Walking for Health&lt;br&gt;• Employment of physical activity programme manager to work with key partners &amp;</td>
<td>• Train staff in primary care &amp; community in brief interventions around physical activity&lt;br&gt;• Development of healthy workplaces across health economy and with key partners&lt;br&gt;• Commission Green Exercise programmes for adults with learning disabilities/older people/mental health service users/LTC&lt;br&gt;• Develop a travel plan for</td>
</tr>
<tr>
<td>research/monitoring officer</td>
<td></td>
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<tr>
<td>----------------------------</td>
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<tr>
<td>Stakeholder event/conference to promote the benefits of physical activity</td>
<td></td>
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<tr>
<td>Delivery of LAA action plans in targeted areas and targets in local district plans</td>
<td></td>
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<tr>
<td>Work with the local authority planning, transport, and environment. Leisure service dept to ensure that appropriate levels of accessible leisure facilities and open spaces are provided in community locations for the population levels in their area and that opportunities are used to develop and encourage physical activity</td>
<td></td>
<td></td>
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<tr>
<td>the PCT</td>
<td></td>
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<tr>
<td>Implementation of GPAQ questionnaire (General Practice Physical Activity Questionnaire) into primary care</td>
<td></td>
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</tr>
<tr>
<td>Identify sedentary people in specific populations through existing programmes (Health Trainers, CVD risk assessment)</td>
<td></td>
<td></td>
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<tr>
<td>Commission programmes to deliver effective physical activity programmes for families and adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commission programmes through PBC that specifically address the needs of older people / adults with learning disabilities / families / women</td>
<td></td>
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</tbody>
</table>

**Strategy in Action**

Bob is a 52 year-old, overweight, inactive smoker who drinks too much. He is just one of 350,000 adults in South Staffordshire with lifestyle and health risk factors. Bob was identified as a CVD and diabetes risk using the GP data system and risk stratification tool. His GP is concerned about his blood pressure and cholesterol so starts medication but he also talks to him about his weight, smoking and alcohol.

The GP refers Bob to a health trainer who spends time working with Bob to make some changes to his lifestyle. Two weeks in to the programme Bob has lost 4lbs and the next 3 months, with support from the health trainer, loses another stone, walks three times a week and has decided to give up smoking.

After 12 months, Bob is back for a review with his GP. He has lost 3 stone, exercises regularly, stopped smoking and drinks moderately. His blood pressure and cholesterol are well under control and his risk of diabetes has reduced.
5.3 STRATEGIC PRIORITY 3: ENSURE QUICKER, HIGH QUALITY HEALTHCARE

**Why is it a priority?**
In a 2008 telephone MORI poll of South Staffordshire residents, people cited cleanliness of hospitals, access to an NHS dentist and waiting times in A&E as their top three areas in need of improvement.

The final report of NHS Review ‘High Quality Care for All’ has put fresh emphasis upon quality being at the heart of everything the NHS does.

Up to 40% of people attending A&E with a minor injury or illness could be cared for by local primary care or neighbourhood teams.

Our urgent care system is fragile and susceptible to slight changes in demand which then generate e.g. delayed discharges from hospital, delayed turnaround times for ambulances bringing patients to A&E, long waits for patients in A&E or hospitals not being able to accept all their planned and unplanned admissions consistently.

**Strategic Objectives**

1. Make ‘*quality*’ the organising principle for the NHS in South Staffordshire
2. Ensure that all residents who want *access to a local NHS dentist* can find one conveniently
3. Achieve a reduction in *non-elective hospital admissions* of 10% by 2013.
4. Ensure all national targets for *access to health services* are met (e.g. maximum 18 week wait from referral to treatment, extending GP Practice opening hours)
5. Reduce *healthcare acquired infections*
6. Implement the national *Cancer* Reform Strategy

**Initiatives**

<table>
<thead>
<tr>
<th>Strategic Initiative</th>
<th>Year 1</th>
<th>Years 2-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>• Develop quality metrics for all contracts</td>
<td></td>
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<tr>
<td></td>
<td>• Incorporate National Institute for Clinical Excellence (NICE) guidance in to all commissioning decisions</td>
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<tr>
<td></td>
<td>• Use benchmarking information to monitor providers’ performance</td>
<td></td>
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<tr>
<td></td>
<td>• Refine incentives and incorporate patient experience measures in contracts</td>
<td></td>
</tr>
<tr>
<td>NHS Dentistry</td>
<td>• Commission new dental services in Burton-upon-Trent, rural East Staffordshire, Tamworth and Cannock</td>
<td></td>
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<tr>
<td></td>
<td>• Implement redesigned care pathways for orthodontics</td>
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<tr>
<td></td>
<td>• Improve the efficiency and impact of prison dental services through reviews of the screening and triage pilots</td>
<td></td>
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<tr>
<td></td>
<td>• Regularly publicise the availability and scope of NHS dental services in local press</td>
<td></td>
</tr>
</tbody>
</table>
| Non-elective admissions | • Mainstream pilot scheme for GPs working in A&E at Mid Staffs Hospital  
• Roll-out of HealthNet scheme  
• Enhance levels of urgent care services commissioned from Minor Injuries, Community Pharmacies and primary care  
• Integrate health and social care services for intermediate care and rehabilitation  
• Roll-out Unique Care model of case management for individuals with complex needs  
• Implement Care Outside of Hospital project in East locality (3 strands: 1. beds 2. care pathways 3. workforce) | • Deepen integration of health and social care teams  
• Development of Ambulance Service Emergency Care Practitioners  
• Develop Health and Well-Being Centres offering multi-agency services under one roof |
| --- | --- | --- |
| Access to health services | • Increase number of GP Practices offering extended opening hours above current level of 65%  
• Commission preventive services to reduce demand for planned services e.g. smoking cessation (respiratory disease), falls prevention (hip surgery)  
• Adopt evidence-based care pathways for planned care (e.g. Map of Medicine)  
• Focus on non-Consultant delivered services to identify ‘hidden’ long waits  
• Use capacity planning model to inform commissioning of services with poor access  
• Develop functionality and flexibility of Choose and Book system | • Develop more GP direct access services and self-referral services for patients  
• Systematic use of benchmarking data to inform market management of planned care providers |
| Healthcare Acquired Infections (HCAI) | • Root cause analysis undertaken for every community-acquired HCAI  
• Audit of compliance with and effectiveness of infection control policies  
• Provision of advice to primary care and prevention of inappropriate antibiotic prescribing | • Infection control successfully embedded in the culture of the PCT and all providers at all staff levels  
• Infection control input to design of new health facilities and procurement of hotel services with infection control implications |
Cancer

- Local implementation plan agreed for Cancer Reform Strategy
- Implement key milestones of Cancer Reform Strategy

Strategy in Action

Mr & Mrs A are an elderly couple who were living in a two bed terraced house with their son who has learning disabilities. They had no central heating and the only means of heating was a coal fire. Mr & Mrs A were worried about their deteriorating health due to their accommodation and the accompanying problems this incurred.

Mr A is the main carer for his wife who has heart trouble and arthritis. Mr A has arthritis, mobility problems and giddy turns. Their son has Down’s syndrome and suffers poor mental health.

Mrs A was unable to climb the stairs due to her health and had to sleep on a chair in the lounge. Mr A was only able to climb the stairs by crawling up on his hands and knees, and had great difficulty getting the coal in from outside to make up the fire.

The family’s local councillor contacted ‘Health Net’ who approached the housing provider on behalf of the family explaining the full circumstances of their health issues. Additional points were subsequently awarded and the family were offered a bungalow within 6 days. ‘Health Net’ then referred their case to the Department of Work and Pensions for a full benefit check, resulting in an additional £2,400 per annum.

Imminent health crises and unscheduled admission to hospital were averted for all three members of the family.
5.4 STRATEGIC PRIORITY 4: IMPROVE CARE FOR PEOPLE WITH LONG-TERM CONDITIONS

Why is it a priority?
5% of patients are estimated to take up 49% of hospital bed days. By better management and identifying people at risk of hospital admission earlier we could make a huge difference to people’s health and avoid the costs of unnecessary hospital admissions.

8% of the population suffer from a long-term condition (approximately 50,000 people in South Staffordshire). The ageing profile of our population will lead to more demand on hospital services if not addressed.

The National Sentinel Stroke Audit revealed that the quality of stroke care in South Staffordshire had room for improvement and that too few patients were experiencing the recommended care pathway.

There is good evidence of effective interventions which can limit the harm caused by long-term conditions.

Strategic objectives

1. To **identify people who are in need of help** to prevent them becoming ill and also those who suffer the effects of deprivation
2. To put **individuals in control** of their lives
3. To **improve the Quality of life** for people with long term conditions
4. Provide services that are **proactive rather than reactive**
5. **Reduce length of stay** when hospital admission is required
6. To work in **partnership** with other agencies

Initiatives

<table>
<thead>
<tr>
<th>Strategic Initiative</th>
<th>Year 1</th>
<th>Years 2-5</th>
</tr>
</thead>
</table>
| Identify people who are in need of help | • Implement predictive modelling across the PCT  
• Develop new integrated roles in response to population needs such as ‘Integrated support worker’ | • Continuously improve predictive modelling mechanism to reflect the needs of the population  
• Employ integrated workforce to work with those in need of help |
| Individuals in control | • Place electronic Health and Social care information points “Elephant Kiosks” in publicly accessible places around the PCT  
• Expand the menu of Patient Self Management and Carers Programmes.  
• Implement the MET office Anticipatory care Service for patients with COPD across GP practices | • Expand the menu of Patient Self Management Programmes which will meet the needs of those sections of our population, who do not want to attend the more formal courses.  
• To pilot a system for patients to have their own personalised health budgets  
• Jointly develop a series of Telecare and Assistive Technologies with Social Care and Health |
| Quality of life | Develop specific and Generic rehabilitation programmes in line with national clinical guidelines | Develop formal opportunities for Long term conditions “buddy system” | Demonstrate through patient opinion that their quality of life is improved |
| Proactive rather than reactive | Patients with a long term condition who are known to a Case Manager/Community matron will have a patient held individualised care plan. | To offer all patients with a long term condition an individualised care plan | Further develop disease specific care management services |
| Reduce length of stay | Ensure that discharge planning commences on admission to hospital | Increase the capability of primary care and community teams to manage complex needs in the community |
| Partnership | Work in partnership with patients and carers by involving them in service developments | Create partnership arrangements with universities and industry to work together on new models of care for people with long term conditions |
| | Work with social care and health to deliver integrated services | | |
| | Develop new roles across social care and health and third sector organisations | | |
| | Work with third sector agencies to deliver community based services such as stroke care in the community | | |
Mrs F is a 67 year old lady who has been Diabetic since childhood. She has smoked for over 40 years and 10 years ago was diagnosed with Chronic Obstructive Airways Disease. In recent months she has been admitted to hospital on two separate occasions with shortness of breath and a chest infection.

Mrs F lives alone and due to her illness finds it difficult to go out and cannot walk long distances. Her only means of communication with her family is through her home computer and telephone. A neighbour shops and cleans for her once a week. She feels isolated and lonely.

Following her last admissions, Mrs F was assigned a Case Manager who works closely with her GP. The Case Manager has worked with Mrs F over the last few weeks and agreed a management and support plan with her. The Case Manager has also helped Mrs F to understand how to live with her conditions and limit the effects of disease on her life. Mrs F now has access to a Tele Care Manager who contacts her by phone to provide regular health advice. She receives health alerts telling her to take action to prevent worsening of her respiratory problems when the weather changes. In addition she has been put in touch with a lady who lives nearby with similar problems and they speak regularly on the phone and are planning to visit one another.

Mrs F has requested that as she begins to feel better she wishes to learn more about her illness through taking a course. Her care manager has suggested the ‘Expert patient program’
5.5 STRATEGIC PRIORITY 5: IMPROVE MENTAL HEALTH AND LEARNING DISABILITY SERVICES

Why is it a priority?
Mild to moderate mental health issues are extremely prevalent (23% of the population at any one time), causing negative effects on an individual’s mental and physical health. Treating underlying stress and improving coping skills in this group of mild-moderate mental health problems would lead to significant savings in otherwise unhelpful expenditure.

There is often confusion between different organisations leading to a multitude of potential services and referral pathways but with lack of clarity how each organisation works or what clinical governance is in place within each set-up.

Older people in South Staffordshire with dementia will increase in number from 7,000 currently to 10,000 by 2017, the second highest rate of growth in the West Midlands.

People with learning disabilities often have a poor experience of primary care services which acts as the gateway to screening and treatment, leading to unequal access and treatment, exacerbated by the difficulties that some people have in advocating for themselves. Some of the health inequality experienced is due to poor recognition of the particular health needs of people with learning disabilities by the NHS.

Most people with learning disabilities live with their families. Many live with aging parents who are increasingly at risk of experiencing health problems. Often people living with older carers only become known to services when a crisis occurs. Large numbers of people are still cared for in institutional settings.

Strategic Objectives

1. Develop a detailed knowledge and evidence base of services in Staffordshire.
2. Ensure everyone with mild to moderate mental health problems has access to preventative and primary care based services.
3. Ensure that people with severe and enduring mental health problems have access to safe, supported services and that physical health needs are supported.
4. Address the mental health needs of all individuals in culturally appropriate ways, tailored to the individual circumstances.
5. Develop services for people with dementia which minimise their reliance on hospital-based services or other institutional care, and ensure 100% of those on a dementia register have a care plan.
6. Give people with a learning disability more independence, choice and control in their lives.
7. Deliver more appropriate less socially-excluding services, particularly in respect of accommodation and care.
## Initiatives

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<tr>
<th>Strategic Initiative</th>
<th>Year 1</th>
<th>Years 2-5</th>
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| Knowledge and evidence base                  | • Develop a comprehensive map of services outlining service type, cost, number of places/beds, geographical location, caseload size  
  • Complete a detailed mental health needs assessment  
  • Develop more robust service user involvement processes to ensure that services users participate in planning and service development                                                                 | • Establish process for progressing the personalisation agenda in mental health commissioning                                                                                                           |
| Preventative and primary care                | • Secure support through ‘Improved Access to Psychological Therapies’ programme  
  • Address public perception and stigma associated with mental health  
  • Develop an employment strategy for people with mental health needs                                                                                                                                 | • Continue development of primary care mental health capacity using stepped-care approach                                                                                                           |
| Severe and enduring mental health            | • Support integration of health and social care mental health teams  
  • Enhance capacity of crisis resolution / home treatment services                                                                                                                                 | • Develop rehabilitation service to improve care closer to home and reduce reliance on long-term placements                                                                                       |
| Culturally appropriate services              | • Recruitment of Community Development Workers                                                                                                                                                         | • Commission services targeted for those suffering cultural barriers to service access                                                                                                                  |
| Dementia                                     | • Run public and professionals dementia awareness campaign  
  • Establish ‘dementia pathway co-ordinator’ role  
  • Establish early diagnosis memory assessment service  
  • Pilot clinician-led dementia pathway in an acute hospital  
  • Enhance dementia training for home-care and community health staff  
  • Review prescribing and medication monitoring protocols for dementia                                                                                                                                   | • Support specialist dementia care homes  
  • Extend function of intermediate care and rehabilitation services to include dementia  
  • Enhance end of life care for dementia                                                                                                                                                            |
| Learning Disability                          | • Unify person centred planning across Staffordshire                                                                                                                                                   | • Complete review of specialist learning disability services                                                                                                                                           |
| Accommodation and Care | Recommission services for 35 people living in NHS campus accommodation | Support further schemes to maximise social inclusion and independence for people with learning disabilities. |

**Strategy in Action**

Mrs P, a recently widowed 78 year old lady, was worried that she was forgetting things. She was referred to the Community Mental Health Team (CMHT) by CRUSE the bereavement counselling agency; she was assessed initially by a Community Mental Health Worker (CMHW) who found she had memory impairment as indicated by Mini Mental State Examination (MMSE).

The CMHW suggested a more thorough assessment in a memory clinic run in the GP practice. She attended the clinic with her daughter and was assessed using Addenbrooke’s Cognitive Examination (ACE). This confirmed memory problems, but with re-calling of memories rather than a failure to make new memories. This and other difficulties suggested that the problem was not Alzheimer’s disease.

Mrs P had been treated for high blood pressure in middle age but was no longer on treatment. Her memory problems tended to fluctuate with good and bad spells. This all suggested vascular dementia (brain damage cause by poor blood supply). She had tests including blood tests, which showed raised cholesterol, a heart tracing, which showed evidence of a previous heart attack, and an MRI scan which showed changes confirming small vessel vascular dementia.

Mrs P and her daughter were seen again in the memory clinic. She was given the diagnosis and the illness and its management was explained. She was prescribed a cholesterol-lowering tablet and low dose aspirin to help her circulation. She was given lifestyle advice about diet, exercise and the importance of maintaining vascular health. She was seen at home by the memory clinic nurse a few days later for further counselling, information and advice. The nurse was able to answer her questions and address her concerns.

She was seen again by the nurse a week later. She was given information about planning for the future including the option of advance statements and Lasting Power of Attorney. She was told about the local Alzheimer Society, Alzheimer Café and other sources of support. She was later seen by a psychologist for who advised how to make the most of her memory using specific techniques.

By this time Mrs P and her daughter had been given a lot of information and explanation about dementia, its management and prognosis and had been provided with emotional and practical support. The vascular risks had been identified and treated; her GP had arranged routine check up to monitor blood pressure and cholesterol.
5.6 STRATEGIC PRIORITY 6: IMPROVE END OF LIFE CARE

Why is it a priority?
6,000 residents die each year in South Staffordshire and for the vast majority of them these are not sudden deaths and so they would benefit from a planned end of life care pathway that maximises their choice.

Our home death rates are 17% and this is below the national average. If we assume that this is a proxy indicator for people expressing choice, then it is a priority for us to increase this figure.

In addition, we are served by 4 adult and 2 children’s hospices which provide excellence in end of life care. However, these services predominantly provide to patients with cancer. Only 25% of the 6,000 deaths are from cancer and there is therefore a need to improve access to specialist palliative care for those with COPD, end stage diabetes, heart failure, dementia, etc.

By 2012 the number of over 65’s will increase by 17% (nationally it will be by 11%) and therefore the number of anticipated deaths will increase and our services need to grow and change accordingly.

Investment in this area is very important but so is redesign. It is worth noting that over 50% of patients who die in hospital do so in the first week. This may indicate people are admitted to die. If we reduce by half the numbers of patients dying in hospital, it would release £4.8m. We need to strengthen the culture and ethos that end of life care is everyone’s business.

Strategic Objectives

1. **Identify appropriate patients** as their needs arise and assess them for supportive, palliative and end of life care.
2. All those with life limiting progressive disease will receive high quality end of life care, reflecting their preferences, maintaining dignity, and promoting self determination.
3. Ensure timely access to a range of specialist and non specialist palliative care services appropriate to their needs.
4. Increase the percentage of deaths at home from 17% to 25% of all deaths

**Initiatives**

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</tr>
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<tbody>
<tr>
<td>Identify appropriate patients</td>
<td>• Monitor implementation of Gold Standards Framework across all GP Practices, exceeding 90% of compliant practices</td>
<td>• Provision of regular training sessions for identified staff groups including communication skills, advanced care planning and symptom management</td>
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<tr>
<td></td>
<td>• Fund 3 End of Life Facilitator posts</td>
<td>• Audit completion of baseline assessments related to end of life care</td>
</tr>
<tr>
<td></td>
<td>• Completion of baseline assessments</td>
<td>• Conduct a public</td>
</tr>
</tbody>
</table>
| High quality end of life care | • Provide dedicated care service 24/7 for those placed on the end of life pathway  
• Scoping exercise of bereavement services across the PCT | • Conduct carer survey to monitor improved carer satisfaction and feeling of support  
• Enhance joint working with partners to enhance range and responsiveness of associated services |
|-------------------------------|--------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| Range of specialist and non-specialist palliative care services | • Develop short-notice care options e.g. nurse admission to community hospital or nursing home beds  
• Establish links to rapid response teams and discharge liaison & planning services  
• Carers’ telephone support service for advice and access to help | • Increase palliative care medical sessions to improve availability and equity  
• Develop a recognised hub / centre as a single port of call for booking services like home care or sitting services |
| Percentage of deaths at home | • Root cause analysis for patients who do not die in their expressed place of choice  
• Development of locally sensitive models of care in line with Darzi End of Life Group recommendations  
• Build specialist palliative care capacity to support increasing numbers of people at home  
• Ensure access to palliative care medication in the home for 50% of GP Practices / community teams | • Work with identified nursing homes to deliver structured service improvement  
• Roll-out of Do Not Resuscitate policies in nursing homes  
• Ensure access to palliative care medication in the home for 90% of GP Practices / community teams |
Strategy in Action

Mary is a 75 year old widow who lives on her own. She has a good social circle of women friends but her family live away. She has just been diagnosed with cancer and been told she has not got long to live. She very much wants to die at home but is worried because one of her friends died last year in hospital having first been taken in to a care home. She remembers her friend saying how powerless she had felt towards the end.

She shares her worries with her Macmillan Nurse who is visiting her for the first time since her diagnosis. The Nurse listens and supports her, talks through her emotions and worries and tells her about the care plan they will draw up together which will make explicit her wishes at each stage. They talk about how she might use her friends to help her with day to day tasks; and how, through her nursing key worker, her health needs will be supported and managed responsively by both specialist and general nursing care teams.

As the weeks pass, Mary has grown weaker. Carers are coming in every other day but while on her own one day she stumbles and falls and finds she hasn’t the strength to get up. She has had assistive technology installed in her house which summons help. Instead of sending an ambulance to take her to hospital, the Rapid Response Team attend. They conduct an immediate care assessment and put in place a more intensive package of homecare support. Mary’s case is discussed at the GP Practice the next day and she receives a medication and physical review which puts further adjustments in place.

As her final days approach, her friends are with her providing basic care and emotional support, while the Macmillan specialist teams are on-hand to support the carers and ensure Mary’s palliative care medication is available and well-managed.

She dies, peacefully and pain free, on her terms with her friends and family around her at home.
6. DELIVERY

6.1 Past Delivery Performance

In its first full year of operation (2007/08) the PCT performed well, not least in turning round an inherited net financial deficit of £16m from its predecessor PCTs in to a £4.8m surplus for the year 2007/08.

Other key performance targets which were achieved were:

- Treating 86.5% of admitted patients within 18 weeks (target 85%)
- Treating 94% of non-admitted patients within 18 weeks (target 90%)
- No patient waiting over 6 weeks for an audiology assessment (2,517 patients were waiting longer than 13 weeks in March 2007)
- Exceeded all cancer wait time targets
- 98% of patients seen within 4 hours of attending A&E (target 98%)

Significant progress has been made against our key strategic themes since their adoption in 2007. Examples include

1. Improving children’s health
   - Reviews of children’s services completed and commissioning of improved services underway from 2008.
   - Pilot of alternative exercise in schools including street dance, salsa, cheerleading, saw schools record an uptake in PE lessons – one by 75% - and a roll out of the programme more widely

2. Increasing life expectancy
   - Significant improvements in cervical screening technology reducing the proportion of inadequate smears from 11.8% to 1.3%
   - A Healthy Living Centre in a Young Offenders Institute was named winner of the World Health Organisation (WHO) Health in Prisons Project ‘Best Practice Award’.

3. Quicker, high quality healthcare
   - One of the first PCTs in the country to introduce the digital x-ray archiving system, PACS.
   - 29 dental practices – over a 1/3 of all practices - were awarded capital grants to improve services for patients.

4. Improving care for people with long-term conditions
   - A redesigned diabetes service is allowing patients to receive their service in a variety of locations including clinics, within local pharmacies and supermarkets, supported by specialist diabetes nurses.
   - Rolling out the Expert Patients Programme which enhances people’s own skills to self-manage their long-term condition.

5. Improving mental health and learning disability services
   - A primary care mental health worker services was brought in to the Seisdon area which had no other services for mild to moderate depression.
Consultation has taken place to reprovide the short breaks service for people with a learning disability, currently available in hospital accommodation, in more appropriate settings.

6. End of life care
   - Over 90% of GP Practices are now participating in the Gold Standards Framework which improves support and palliative care to people nearing the end of their lives
   - 19 nursing homes have been engaged in a service improvement programme run by a clinical nurse specialist.

The year resulted in an overall Healthcare Commission Annual Health Check result of ‘Fair’ for quality of services and ‘Good’ for use of resources.

6.2 Risk management

We have identified the risks associated with progressing our strategic priorities. These are incorporated within an Assurance Framework which receives regular Trust Board scrutiny.

The risks of delivery for each strategic priority will be managed throughout the life of the strategic plan and form a key part of the Board’s assurance that the PCT is performing and delivering against its stated objectives.

6.3 In-year monitoring

The ‘Implementation’ section above gives details of the milestones and measures by which the PCT will monitor the delivery of its strategy.

To assist with this task, the PCT has established an integrated performance management system called ‘Corvu’, which allow real-time monitoring of performance and automated reporting, for instance, for Trust Board monitoring of progress.

The following scorecards have been developed and are updated by the Performance Team on either a monthly, quarterly or annual basis as data sources become available.

- Corporate Objectives
- Vital Signs
- The Department of Health Existing Commitments
- Local Area Agreements
- Targets from 2007/08
- Standards for Better Health (S4BH) Core Standards (further development required)

These Scorecards reflect a hierarchical structure, which presents the ability to drill down to find the data behind the overall results, allowing the user to see how their area is performing and pin-point where there is any under-performance.
6.4 Organisational requirements and enablers

Two years into the new organisation, the PCT is gaining organisational maturity. We are clear about our function and role and the vision for the future. We want to embed a culture of trust and openness, which is non-hierarchical, welcoming, and engenders a “can do” feel. Staff will feel proud to work for the PCT, hold a shared set of values and be clear of the impact they are having on patient care, reducing inequalities and improving health outcomes for our residents.

The Strategic Plan offers an exciting vision for healthcare in South Staffordshire and our Organisational Development Plan details how the PCT will change and grow to deliver that vision as a world class commissioner.

The organisational development plan is a key document that will lead to the enhancement of our commissioning processes. It describes our journey from formation to establishment and the structural and cultural steps we took along the way. As we describe our vision, values and current structures we review our position and analyse our organisational development challenges and strengths. Finally, we detail the actions required to implement this plan and identify a process for measuring success over the next 3 years.

The plan describes how we will develop our commissioning competencies and how as an organisation we will achieve the organisational change needed to deliver our plans. The plan will build on our current strengths and ensure that we can move forward in a systematic way.

We have grouped 15 key actions into 5 key areas which will form the cornerstone of our development agenda over the next three years.

- Working in Partnership
- Leadership Development
- Quality and Innovation
- Clinical Engagement
- Commissioning Competencies

The organisation development plan has been endorsed by the Trust Board and we will enhance our structure to ensure that the Organisational Development agenda has dedicated leadership within the Executive Team. Performance against our plan will be formally monitored within the Strategic Commissioning sub committee of the board. Progress will be reported both within the organisation and externally.

6.5 Provider requirements

Our strategic plan will shape the way local providers of healthcare plan and deliver their services. As such, the PCT has engaged proactively with its providers to support the creation of a market and improve their capacity to deliver our priorities.

Examples include:

- A conference in October 2008 for all the Non-Executive Directors of the PCT the four NHS Trusts and Foundation Trusts in South Staffordshire to explain our strategy and the implications of World Class Commissioning.
- A 'Meet the Buyer' conference for the 3rd Sector, organised in conjunction with Social Care and Health, designed to improve relationships and awareness of opportunities between the PCT and voluntary organisations
- Investment in a business support unit for the 3rd Sector to improve their access to skills needed by potential suppliers in preparing business cases and responding to tender procurement exercises
- Involvement of our providers in the ‘One Step Beyond’ clinical strategy development programme, meaning that our priorities are shaped and co-created across the local health economy
- Many examples of collaborative projects which are designing new integrated care pathways across secondary and primary care
- Excellent engagement with clinical networks which guide strategic planning and engagement across wider geographical areas than South Staffordshire

The emphasis of our strategy is to reduce historical reliance on hospital-based services in favour of preventive, proactive community-based services. While this poses challenges to providers of, for instance, secondary acute care, innovations such as the implementation across the West Midlands of Payment By Results tariffs for lifestyle services, open up new market opportunities both to existing and potential new providers.

Where strategic reviews of current service configurations are required, these will be undertaken in a collaboration with providers and the users of services to ensure all perspectives are taken in to account and protect patients’ best interests.

We have adopted a transparent approach to procurement, in line with national Principles of Co-operation and Competition, which further level the playing field and encouragement of plurality and choice for South Staffordshire residents
7. CONCLUSION

This strategic plan has been created through a collaborative process with clinicians, partners and the public and has been actively shaped by the Board of the PCT.

It marks a significant shift in direction by emphasising the primacy of preventing ill-health and proactively keeping people well.

We have set out a challenging agenda to:

- improve children’s health
- increase life expectancy
- ensure quicker, high quality healthcare
- improve care for people with long-term conditions
- improve mental health and learning disability services, and
- improve end of life care

We will share its key messages widely and engage all those necessary to bring its aims to fruition.

The conversation does not stop here, however. We are committed to continuing to engage and adopt the insights and energies of our partners, patients and staff to ensure we remain at the cutting edge of service improvement in the NHS.

On behalf of the Board of South Staffordshire PCT, I have pleasure commending our strategic plan to the community of South Staffordshire whom we serve.

Alex J H Fox
Chairman
South Staffordshire PCT
8. GLOSSARY

**A&E: Accident and Emergency.** A hospital Department providing immediate health assessment and treatment for injuries or sudden onset illness

**BME: Black and Minority Ethnic.** A description of ethnicity in population groups

**CVD: Cardiovascular Disease.** Circulatory disease of the heart and blood vessels associated with e.g. angina, heart attack and stroke

**Elective Care.** An admission to hospital which is planned for and arranged by prior appointment.

**Health Net.** A Healthy Living Centre project which targets disaffected families and those who fail to access services, encouraging them to identify their needs and empowering them to seek help from appropriate agencies who can facilitate and support them in lifestyle changes.

**JSNA: Joint Strategic Needs Assessment.** The means by which PCTs and local authorities describe the future health, care and well-being needs of their population

**Long-term conditions.** Diseases which can not be ‘cured’ and need to be effectively managed to minimise complications and unplanned admission to hospital e.g. diabetes, respiratory disease, neurological diseases etc.

**MIU: Minor Injuries Unit.** A unit which assesses and treats non-life-threatening injuries or sudden onset illness

**Non-Elective Care.** An admission to hospital which is unplanned or an emergency

**PBC: Practice Based Commissioning.** A policy which gives GPs and other front-line clinicians more decision-making power about how services are designed and delivered for their patients

**PCT: Primary Care Trust.** The NHS organisation charged with leading the commissioning of healthcare and improvement of health for a given population

**PEC: Professional Executive Committee.** A sub-committee of the PCT Board, made up of appointed clinicians, charged with supporting the PCT’s development of strategy, commissioning policy and clinical engagement with partners

**Primary Care.** Health services delivered in community settings by GP Practices, Optometrists, Dentists or Community Pharmacists.

**Secondary Care.** More specialised health services, delivering ‘second line’ interventions after initial primary care solutions, e.g. in hospital.

**Third Sector.** Another name by which the non-profit or voluntary sector is known (government and the private sector being the first two sectors)
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