Primary Care Trusts
Establishing Better Services
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The new NHS set out a vision for the future of the National Health Service. Primary Care Groups and Trusts are a key part of the drive to improve health, address inequalities and make the NHS modern and dependable. The introduction of Primary Care Groups and the development of Primary Care Trusts will mean that primary and community services will be at the very heart of the National Health Service.

We believe that Primary Care Trusts offer an unparalleled opportunity for local stakeholders - family doctors, nurses, midwives, health visitors, the professions allied to medicine, social services, and the wider communities they serve - to shape services to provide better health and better care. They will bring significant benefits to patients, clinicians and the NHS as a whole and will have unique freedoms and flexibilities to enable them to do this.

This document seeks to address some of the questions that GPs, and others, have been asking on how Primary Care Trusts will be established, how they will work, and the benefits they will bring. It should therefore enable all who have expressed interest in establishing a Primary Care Trust, or are considering doing so, to give more informed consideration to the opportunities and benefits. It is not intended to cover every issue to do with the establishment, formation or operation of Primary Care Trusts but aims to answer many of the initial questions individuals may have about Primary Care Trusts and their implications.

The development of Primary Care Trusts will be a process which allows these new bodies to evolve in response to changing local healthcare and social care needs, with a locally agreed pace of change. We will work in conjunction with those leading the process of establishing Primary Care Trusts, to identify and resolve the further issues that will inevitably arise as Primary Care Trusts develop.

John Denham
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Primary Care Trusts

What are Primary Care Trusts?

Primary Care Trusts will be new, free standing, statutory bodies with new flexibilities and freedoms, responsible for delivering better health and better care to their local population.*

They will have their own budget for local healthcare, be able to employ staff and develop new integrated services for patients. They will undertake many of the functions presently exercised by Health Authorities, for example commissioning health services, investing in primary and community care, and improving the health of the local population.

They will also, if they wish and are capable of doing so, be able to directly provide a range of community health services, creating new opportunities to integrate primary and community health services as well as health and social care provision.

Primary Care Trusts will have the same overall functions as Primary Care Groups, thus allowing continuity with the strategic plans developed by them for their community i.e.:

- improve the health of the community;
- develop primary and community health services;
- commission secondary care services.

Types of Primary Care Trust

There will be two kinds of Primary Care Trust, those which commission services only, and those which both commission and provide services.

"Level 3" Primary Care Trusts will undertake the full range of functions set out above, but will only be able to commission services, not directly provide them. They will, however, be able to do this as a separate, freestanding body, giving greater freedoms and flexibilities than a level 2 Primary Care Group. They will be able to employ a limited range of staff, much as Health Authorities do now.

"Level 4" Primary Care Trusts will bring together commissioning and primary care development with the provision of community health services. They will be able to commission and provide services, run community hospitals and community health services, employ the necessary staff, and own property. The precise range of community services provided will depend on local circumstances and views expressed during consultation.

* Establishments of Primary Care Trusts is subject to the successful passage of the Government’s proposals (the Health Bill) through Parliament.
What benefits will they bring?

Primary Care Trusts will be able to bring a range of benefits to patients, the community and professionals:

**Better support to practices**

Primary Care Trusts will be able to offer greater support to their constituent practices and primary health care teams who form the basic building blocks for delivering improved services to patients. General practice is the cornerstone of patient healthcare and at the heart of the Government's drive to modernise and improve care for patients. Primary Care Trusts will therefore be able to:

- invest to develop premises;
- support investment in appropriate practice based information systems;
- develop multi-disciplinary education and training programmes which support the continuing professional development of practice staff;
- develop qualified staff to support practices in delivering the necessary healthcare to their population.

**Better support to individual clinicians**

Primary Care Trusts will provide a vehicle for promoting continuing professional development, teaching and research opportunities, clinical governance, and sharing of resources and skills among primary care and community professionals.

They will enhance career opportunities for all clinical staff with greater diversification of training and work opportunities.

Whilst protecting independent contractor status, Primary Care Trusts will also provide opportunities for alternative employment models for those GPs who wish to take them up.

**Better integrated services**

Primary Care Trusts will be better placed to address integrated care pathways and long term service agreements. They will be able to build on the experience of Community Trusts in providing community-based services and services provided in conjunction with Social Services and also establish more integrated working between general practice and community health services. For example, they may develop better rehabilitation and recovery services, or provide greater support and co-operation between community and practice nursing teams.

Primary Care Trusts will also help those who need health and social care. Primary Care Trusts will be able to work more closely with Local Authorities on the planning and delivery of services with a focus on greater co-ordination of services at a practice and community level.

Primary Care Trusts will also facilitate the development of ‘intermediate care’ - i.e. those services that do not require the resources of a general hospital but are beyond the scope of the traditional primary health care team. Those needing intermediate care can have complex health and social care needs - level 4 Primary Care Trusts in particular will be able to better address such needs.
Better access
Primary Care Trusts will be better able to shape services in response to the needs of their local populations, identifying where it would be appropriate and remain cost-effective to offer more local facilities - reducing the need for patients to travel to a more distant hospital serving a larger population. This will provide greater opportunities for out-reach services and delivery of other community health services via practice-based teams. This will be particularly important in rural areas.

Better action to improve public health
Primary Care Trusts will also be better placed to play a major role in working with local authorities, voluntary organisations and others to improve the public’s health. Subject to Parliamentary approval, the powers set out in the Health Bill will allow Primary Care Trusts to develop closer partnerships with Local Authorities through, for example, pooled budgets and lead provider arrangements. They will be able to tackle health inequalities by entering into agreements or directly funding initiatives that improve the health of their population, and improve the health of the worst off in society at a faster rate. Primary Care Trusts offer the opportunity to focus on better meeting the health needs of deprived communities. Health Action Zones, in particular, are charged with achieving this.

Bringing decision-making closer to patients and local communities
Primary Care Trusts will provide further scope for primary care professionals - who deliver most local services, and who understand patients’ needs - and local people to have a greater say in shaping services.
Making it happen

In the new NHS, Health Authorities will increasingly focus on their strategic role in the planning and development of health services for their population; in identifying and agreeing health priorities that need to be addressed in their area; and, in working with local partners to ensure good progress. Health Authorities will need to provide strategic leadership to local NHS partners. They will be supported in this role by the NHS Executive, who will ensure that local solutions are developed to solve local problems. The emphasis will be on a flexible approach which enables and encourages Health Authorities and Primary Care Trusts to develop shared strategies to meet local needs.

Primary Care Trusts will be key agents for securing services that better meet the needs of their population. They will be able to play a leading role in improving the health of their community by: for example:

- by assessing health needs;
- developing interventions to address them - either through direct provision or commissioning (for example, providing nicotine replacement therapy);
- and monitoring their outcomes.

They will have detailed first hand knowledge about primary and community health services, the investment it needs, the standards which should apply and the approach to clinical governance which should ensure development and implementation.

They will also have a clear view and direct experience of hospital and community care particularly the services patients need and how responsive existing services are. They will be well placed to work with NHS Trusts to draw upon the expertise of staff working in these settings, as well as the knowledge of professionals within the Primary Care Trust and the local community, to commission and improve the services provided.

Clearly, Primary Care Trusts cannot operate in isolation from others working to support and care for patients. They will come together with the rest of the local NHS community to agree a Health Improvement Programme, and will be held to account for delivering their part of it. However within this, Primary Care Trusts will have significant flexibilities and responsibilities, as a statutory NHS body in their own right, to develop and shape local services to better meet local needs.
Developing and shaping local services

To enable them to develop and shape services to meet local needs Primary Care Trusts will be able to:

- hold and decide how to deploy the local healthcare budget for the broad mass of hospital and community health services, as well as General Medical Services (GMS) infrastructure and prescribing;
- enter into service agreements with NHS Trusts in their own right;
- employ staff: as a level 4 Primary Care Trust this will create scope for more integrated working across primary and community health services;
- acquire, own, fund and make available premises (including entering into Private Finance Initiative deals for this purpose);
- enter into Personal Medical Services (PMS) and Personal Dental Services (PDS) contracts and establish their own GMS local development schemes (giving Primary Care Trusts an important flexibility in tackling particular local problems in primary care);
- develop their own incentive arrangements;
- utilise new operational flexibilities for health and social care, for example, pooled budgets and lead commissioner with local authorities;
- at level 4, provide a limited or wide range of community health services.

Devolving Health Authority responsibilities

As Health Authorities will in future focus on the strategic planning and development of health services for their populations, it is intended that Primary Care Trusts should take on the direct responsibility for securing the majority of services for their population. The Health Authority will formally delegate these responsibilities to the Primary Care Trust and the Primary Care Trust will be accountable to the Health Authority for their delivery.

Some services may be better organised by neighbouring Primary Care Groups and Trusts acting in concert, for example in providing district wide services or treatments where a critical mass of clinicians or numbers of patients is required. Where this is the case a Primary Care Trust will either pool funds or ask the Health Authority to organise the service and retain associated funding.

However, in addition to their strategic planning and regulatory functions, Health Authorities are expected to maintain responsibility for certain services, for example working together in the commissioning of highly specialised services. They will also retain the responsibility for dental, optical and pharmacy services provided under part II funding arrangements (i.e. other FHS contractor services).
General Medical Services

Primary Care Trusts will be responsible for decisions about investment in GMS infrastructure and local development schemes but will not be able to provide General Medical Services themselves.

In this way the independent contractor status of GPs will not be affected by these changes and the bulk of GMS functions - such as payment of fees and allowances - and disciplinary arrangements will remain with Health Authorities.

Commissioner and provider bodies

Level 4 Primary Care Trusts will have the flexibility to build on the successful experience of primary care professionals operating as both commissioners and providers of services. They will therefore be able to commission services or to provide such services themselves for their local populations. This flexibility will allow the Primary Care Trust to deploy resources in the light of local judgement about how best to maximise benefits to patients and achieve value for money.

If there is more than one Primary Care Trust in an area, it may make sense for one Primary Care Trust to provide a service to, or on behalf of, another Primary Care Trust, or indeed, a Health Authority or other NHS body. It would do so, as a service provider, under the terms of a service agreement with the other body concerned.

These services may be health services, for example, health visiting, and speech and language therapy. This flexibility may be helpful where a Primary Care Trust has particular expertise or a well-developed service that other parts of the NHS locally might sensibly want to use. Equally, however, the services provided by a Primary Care Trust could comprise management or support services. This flexibility therefore offers opportunities to arrange services in more efficient ways, for example, by allowing a Primary Care Trust to provide support services (such as payroll management, estate management or IT support) to other parts of the NHS.

Any arrangement for a Primary Care Trust to provide services to other parts of the NHS will be subject to agreement between all the interested parties and, in particular, the Health Authority will have to satisfy itself that any arrangement is consistent with the Local Health Improvement Programme.

There will be other imperatives on a Primary Care Trust to seek the most efficient mode of delivering a service. The unified budget will, of itself, lead to greater efficiency - it will allow and encourage Primary Care Trusts to deploy resources to best clinical effect. In addition, Primary Care Trusts will need to demonstrate their achievement of economy, effectiveness and efficiency especially in those services that they choose to provide themselves.
Funding of Primary Care Trusts

Funding arrangements for Primary Care Trusts will be similar to those for Health Authorities and Primary Care Groups. Health Authorities will fund Primary Care Trusts from their unified budget allocation, which covers:

- hospital and community health services;
- the costs of prescribing by GPs and some community nurses;
- the development of GP practice infrastructure (i.e. the costs of GP practice staff, premises improvement and IT formerly funded from Health Authorities’ GMS cash limited budgets).

Fair share allocations

To ensure continuity of arrangements with Primary Care Groups, Health Authorities will be required to set fair share target allocations for their Primary Care Trust based on health care need using a national formula but with some local flexibility. They will move Primary Care Trusts towards these targets as quickly as practicable.

The allocation will be based on the number of patients registered with the Primary Care Trust’s GPs plus an estimate of the number of unregistered patients within its geographical boundary. Work is in hand to ensure that fair allocation can be made on the basis of accurate lists of registered patients. Movement from current funding to fair share allocations will be achieved through levelling up - through differential allocation of growth monies. All money allocated for commissioning should be available to the Health Authority's Primary Care Trusts and Primary Care Groups, even if they subsequently agree with the Health Authority to use parts of it for the collective commissioning of some services which might, by mutual consent, be organised by the Health Authority.

Management costs

Primary Care Trusts will be given a realistic management cost target according to their functions and in accordance with their devolved responsibilities and requirement to have enhanced arrangements for corporate governance. We expect the management cost ceiling for Primary Care Trusts to be commensurate with their new responsibilities.

Additional sources of funding

Primary Care Trusts, particularly at level 4, may also receive additional funds through:

- providing services for other Primary Care Trusts or Primary Care Groups - for example providing a specialised community health service for a larger geographical area;
- their ability to develop income generation schemes, within national guidance.
Deploying resources

Within national guidance on priorities and service frameworks, Primary Care Trusts will be free to deploy their resources as they see fit, provided only that they are delivering on the targets and outputs agreed as part of the local Health Improvement Programme, which they will have helped to shape, and, deliver the GMS investment floor. As part of this they will be able to develop their own incentive schemes for their constituent practices and will need to maintain arrangements for monitoring activity and spend at practice level.

Capital charges

Primary Care Trusts will pay capital charges on their assets in a similar way to Health Authorities. The charges will have two elements:

- a depreciation charge on fixed assets other than land over a standard life for the type of asset;
- a 6% return will be charged on all assets.

This will ensure that Primary Care Trusts are treated in the same way as other NHS bodies and have an incentive for the efficient use of capital. Premises owned by GPs or rented from the private sector are not included in the capital charge regime.

Financial accountability

The Chief Executive will be the accountable officer for the Primary Care Trust in the same way as Chief Executives of Health Authorities and NHS Trusts are now. Just like Health Authorities, Primary Care Trusts will have a statutory duty not to exceed their cash limit. They will be able to draw upon the advice, experience and knowledge of their Health Authority to support them in carrying out this responsibility; for example in accessing brokerage arrangements where absolutely necessary.

In their plans for primary care investment, Primary Care Trust expenditure will be subject to the same Government commitment in maintaining the level of spending on GMS infrastructure that covers Primary Care Group expenditure.

In drawing up their accounts, Primary Care Trusts will need to distinguish between money spent on commissioning and money spent on their own services, so that the ‘value for money’ aspects of the Primary Care Trust’s own services can be reserved. The Audit Commission will be responsible for auditing Primary Care Trust accounts. They will also include Primary Care Trusts in their value for money studies.
Governance arrangements

No other NHS body has the same range of flexibilities and opportunities to improve services as Primary Care Trusts. But with freedoms must come responsibility and proper accountability: the way Primary Care Trusts are governed must reflect this balance.

Subject to the necessary legislation, the arrangements for governing Primary Care Trusts will establish a national approach that provides this balance. Governance arrangements must deliver four key principles.

1 - Primary care professionals in the driving seat
This will give professionals greater awareness of how their decisions fit within the wider service and financial framework of their local health economy.

2 - Public accountability
Primary Care Trusts will be firmly part of the NHS. They will be responsible for large sums of money and must command public confidence in the way they manage their affairs.

3 - Public involvement
Primary Care Trusts need to be firmly rooted in the local community and be responsive to local people's health needs and wishes. This calls for the direct involvement of lay people drawn from the local community (including local government): it also calls for continuing dialogue with various stakeholders in the local community over the planning and delivery of services.

4 - Probity
The public must have confidence that robust safeguards are in place to ensure the proper use of public funds. At the same time, these safeguards need to protect primary care professionals from suggestions that their greater control over NHS resources may give rise to conflicts of interest.

Striking a balance between these considerations is not easy. A number of possible approaches have been discussed with various NHS groups over the last few months. The proposed governance arrangements for Primary Care Trusts are based on these discussions and offer the best way forward.

While Primary Care Groups are committees of Health Authorities, Primary Care Trusts will be free standing, legally established bodies. This will reinforce professional influence and give more operational flexibility. But the need remains for Primary Care Trusts to have a similar balance between professional influence and public accountability as do Primary Care Groups.

This will be achieved by establishing Primary Care Trusts under the overall supervision of a lay majority board, but with a Trust Executive, where primary care and community care professionals will be in the majority and therefore the driving force.
Arrangements for level 3 and level 4 Trusts

In general the arrangements for both level 3 and level 4 Trusts are similar, however, the different proposals reflect the different responsibilities the Trusts will be able to exercise.

The functions of level 3 Trusts are similar to level 2 Primary Care Groups, although with more extensive powers and responsibilities. For this reason, the make up of the Trust Executive will be similar to that for the boards of level 2 Primary Care Groups. At level 4 it will again be possible for the Trust Executive to have a professional majority, but the balance of members will reflect the need to ensure that, in addition to nurses*, other community health professionals are properly involved in the running of such Primary Care Trusts.

The Primary Care Trust Board

The Chair and lay members of the Trust Board will be appointed by the Secretary of State: this mirrors the arrangements for other NHS bodies. The Chair and lay members of the Board, with significant input from professional members of the Executive or its preceding Primary Care Group Board will then determine the Chief Executive appointment. It is also expected that Finance Director appointments should follow a similar pattern but with the Chief Executive on the panel.

The role of the Board

Much of the day-to-day decision making and strategic development will rest with the Executive. However, the Chairman and the Board will be accountable to the local Health Authority and ultimately the Secretary of State for the overall performance of the Trust. As such it will hold the Executive to account and, in the last resort, have the final say. But to be successful, Board and Executive will have to work corporately, meeting together to decide any of the major issues facing the Trust.

The Board will also need to reserve some decisions to itself to ensure probity. Decisions reserved for the Board will include, for example, all matters to do with the remuneration of Executive members, proposals for expenditure on GMS infrastructure in line with GMS cash-limited payments to GPs, establishing GMS local development schemes and entering into contracts for services under the Primary Care Act.

Board composition

The Board will typically consist of 11 members:

- Chair
- 5 lay members (which will be open to local authority elected members)
- Chief Executive
- Finance Director
- 3 professional members drawn from the Executive (typically Clinical Governance Director, one GP and one nurse).

* For brevity the term nurse is used throughout unless there is a need specify, for example, community midwife, practice nurse, health visitor or school nurse.
The Primary Care Trust Executive

The Trust Executive will be the “engine room” of the Primary Care Trust. This is where the detailed work of the Trust will be done or initiated. The Executive will lead the Board through detailed thinking on priorities, service policies, and investment plans. Decisions about how to take these forward will largely be delegated to the Executive.

The Executive will be able to co-opt officers of the Trust and others to help with its deliberations or implement policies and, for example, will be able to set up project teams to review service issues. This may include other health professionals, for example dentists, pharmacists, and professions allied to medicine. In this way the Executive will shape commissioning policy, primary care development and investment, and clinical governance arrangements.

The Primary Care Trust Board will need to approve all Executive appointments on the basis of the local approach. One of the Trust Executive members will be elected as Chair of that group.

Membership of the Executive

Membership of the Trust Executive will have a professional majority. It will also include the Chief Executive (the accountable officer) of the Trust and the Finance Director. As with Primary Care Groups there will also be a social services officer nominated by the relevant Local Authority.

Members of the Executive will be officers of the Trust only for the purpose of their executive functions (i.e. a GP could continue to be an independent contractor and officer of the Trust at the same time).

Level 3 and 4 Executive Membership

The balance of professional members will differ between level 3 Primary Care Trusts and level 4. This enables the full involvement of community health service staff (e.g. community consultants and professions supplementary to medicine) to be involved in level 4 Trusts.

For level 3 the professional members of the Executive will typically be:
- up to 7 GPs
- 2 nurses
- a professional with public health and health promotion expertise
- a Social Services officer.

For level 4, there is a strong case for allowing greater flexibility in the balance of professional members in the Executive to reflect local variations in the configuration and range of services provided by the Trust. It is envisaged that the Executive will have up to 10 clinicians, with significant representation from general practice balanced with local nurses and other community professionals, public health expertise and Social Services.

Primary Care Trusts will be expected to work in partnership with NHS Trusts and hospital doctors and with local authorities and others involved in the provision of care for patients - especially in the commissioning of services through NHS service agreements. Primary Care Trusts will also be expected to develop links with, and consult others in, the local community such as Community Health Councils, Local Medical Committees, dentists, pharmacists, optometrists and local voluntary groups.
Developing alternative approaches

The detail of Primary Care Trust governance arrangements will be flushed out in Regulations, subject to primary legislation. It is envisaged that the approach set out will apply in the majority of Primary Care Trusts. However, there is recognition that other governance models could meet the needs identified and that there may be virtue in allowing some local flexibility in the design of such arrangements.

Proposals from potential Primary Care Trusts for alternative governance arrangements will therefore also be considered, with the intention to allow a limited number to be established with such arrangements, providing they allow the Trust to fulfil its key functions and demonstrate compliance with the key principles of public accountability, public involvement, professional influence and probity.

The success of Primary Care Trusts’ governing arrangements will be monitored and reviewed, including any variations to the national model, to ensure they are working effectively and meeting the criteria in the way intended.
Accountability

Primary Care Trusts will be an integral and key part of the NHS. Like other NHS bodies they will need to be accountable at a number of levels:

- nationally to the Secretary of State and working within national policy frameworks, including guidance on national priorities;
- locally to the Health Authority, the Health Improvement Programme, the public and to the wider body of professionals in the area they serve.

Accountability to the Health Authority

A Primary Care Trust will be accountable to its Health Authority (and, as with all other NHS bodies, to the Secretary of State) by means of an annual accountability agreement which will spell out agreed aims and targets for improving health, health services and value for money.

However, one of the main purposes in establishing a free standing Primary Care Trust is to give it more freedom of manoeuvre than a Primary Care Group has as a committee of a Health Authority. Unless there are particular difficulties within the Primary Care Trust, the role of the Health Authority should be one of monitoring overall performance rather than direction or day-to-day involvement. It will be for the Primary Care Trust to decide how best to meet the needs of its population within this framework. The Secretary of State will retain similar reserve powers to those he holds for all NHS bodies to take action, if necessary.

Accountability to the Public

Primary Care Trusts will also have a wider accountability to the public and to the wider body of professionals in the area they serve. Accountability to the public locally will be exercised formally through:

- the lay members of the Board;
- public Board meetings and an annual published report;
- complaints procedures which mirror those of Health Authorities for commissioning activities, and NHS Trusts for direct service provision, including being within the remit of the Parliamentary Commissioner for Administration;
- relationships with the Community Health Council on a par with Health Authorities for "commissioning" activities, and with NHS Trusts for direct service provision.
Responsibility to local clinicians and professional bodies

As with Primary Care Groups, Primary Care Trusts will be expected to have developed local mechanisms to secure the views and involvement of primary care professionals and to command their confidence.

Members of the Primary Care Trust Executive will therefore need to be selected in a manner that commands the confidence of their colleagues.

Primary Care Trusts will also have a duty, like Health Authorities, to make arrangements to secure sound professional advice in carrying out their responsibilities from a wide range of health professionals which extend beyond the ‘members’ of the Primary Care Trust. For example, in developing local commissioning strategies and service agreements they might need to involve relevant acute sector clinicians, those engaged in NHS education and research, professions allied to medicine and local family health service contractors such as dentists, pharmacists and optometrists.
Primary Care Trusts and Clinical Governance

The new NHS states that every NHS Trust will be required to ‘embrace’ the concept of clinical governance so that quality is at the core, both of their responsibilities as organisations and of each of their staff as individual professionals. The Health Bill places a new statutory duty of quality on NHS Trusts and Primary Care Trusts: clinical governance will therefore be an important issue for Primary Care Trusts to address.

The main components of clinical governance are:

• clear lines of responsibility and accountability for the overall quality of clinical care;
• a comprehensive programme of quality improvement systems (including full participation in national clinical audit, supporting and applying evidence-based practice, implementing clinical standards and guidelines, workforce planning and development);
• education and training plans;
• clear policies aimed at managing risk;
• integrated procedures for all professional groups to identify and remedy poor performance.

Clinical governance can be defined as:

"A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."

It should act as a mechanism for bringing together all local activity for improving and assessing clinical quality into a single coherent programme which everyone in the organisation can be part of and work towards.

Implementing clinical governance locally

Both level 3 and level 4 Primary Care Trusts will need to demonstrate that they have a systematic approach to monitoring and developing clinical standards in practices. In addition, at level 4, this will also apply to the community health services provided by the Trust.

For the individual Primary Care Trust clinical governance will mean moving to a culture of quality in a systematic and demonstrable way, moving away from a culture of ‘blame’ to one of learning. This will include changes, over time, in ways of working together and aspiring to an open and participative culture in which education, research and sharing good practice are valued. It should ensure that these activities are brought together in a way that will deliver continuous improvement in patient care.

In order to achieve this there will need to be regular Board level discussions of the big quality issues and strong leadership. Each Trust will need to have a Clinical Governance Director who will be a member of both the Trust Executive and the Trust Board.
Primary Care Trusts will have responsibility for:

- Undertaking the four key implementation steps (establishing leadership and accountability arrangements, baseline assessment, development plan, reporting arrangements) for clinical governance

- Further developing the programme of clinical governance in accordance with the principles outlined in guidance

- Making sure that clinical governance principles are developed and applied which cover the full range of services they provide and those that are delivered by other providers on their behalf

- Assuming joint accountability for clinical governance of services which are delivered on a multi-sector, multi-agency basis

- Establishing an open, learning relationship with bodies which may make judgements about the quality of their services or their programme of clinical governance (particularly the Commission for Health Improvement)

- Making sure that clinical governance principles are applied to services delivered by other providers on their behalf through Long Term Service Agreements and through contracts with non-NHS providers

- Supporting their member practitioners in applying clinical governance to the delivery of the general medical service and personal medical services in the Primary Care Act pilots.

The national picture

Primary Care Trusts will be helped in the development of clinical governance though the introduction of National Service Frameworks, guidelines and audit methodologies published by the National Institute of Clinical Excellence (NICE), support and advice from NHS Executive Regional Offices and the Commission for Health Improvement (CHI).

The Commission will have a key role in providing the public and the Secretary of State with the assurance that clinical governance is being implemented appropriately at every level within the NHS. It will conduct a rolling programme of reviews, visiting every NHS and Primary Care Trust over a period of around 3-4 years. It will look for evidence that clinical governance arrangements are working, that these are consistent with established standards, and can deliver and sustain quality services.

The Commission's core functions are to:

- Provide national leadership to develop and disseminate clinical governance principles

- Independently scrutinise local clinical governance arrangements to support, promote and deliver high quality services, through a rolling programme of local reviews of service providers

- Undertake a programme of service reviews to monitor national implementation of National Service Frameworks, and to review progress locally on implementation of these programmes and NICE guidance

- Help the NHS identify and tackle serious or persistent clinical problems. The Commission will have the capacity for rapid investigation and intervention to help put these right

- Over time, increasingly take on responsibility for overseeing and assisting with external incident inquiries.
Staff and Primary Care Trusts

Unlike Primary Care Groups, Primary Care Trusts will be able to employ their own staff. Level 3 Trusts will be able to employ a range of staff consistent with their functions which do not involve direct service provision (i.e. commissioning only). For Level 4 Primary Care Trusts the range will be much wider, in accordance with the services the individual Trust will be delivering.

Moving to a Primary Care Trust

Because Primary Care Trusts will be established as new bodies, they will have to ‘create’ a staff structure. Health Authorities (either within the Primary Care Group, or within the Health Authority itself) or other NHS Trusts providing community services will already employ many of the required staff. The majority of peoples’ roles may not change within the new organisation - they will just be under a different employer - in this case the Primary Care Trust.

The Secretary of State will be able to make an order to provide for the transfer of staff from a Health Authority or NHS Trust providing community services to a Primary Care Trust (or indeed from one Primary Care Trust to another). It is intended that staff transferred under such an order should have the same safeguards as staff transferring under the Transfer of Undertakings (Protection of Employment) Regulations 1981 (“TUPE”). This will mean that staff will be able to retain their existing terms and conditions of service and that there will be no break in service. Staff will be consulted before any transfer order is made. These arrangements are the same as those applied in establishing NHS Trusts and new Health Authorities.

Terms and conditions

As for NHS Trusts, subject to direction by the Secretary of State, Primary Care Trusts will be able to employ staff on the terms and conditions they see fit. They will be expected to demonstrate preparedness and commitment to follow the values and priorities for action set out in the national Human Resource framework, Working Together, to be equal opportunities employers and to follow normal NHS employment practice as set out in central guidance.

Pensions

The staff of Primary Care Trusts will be eligible for membership of the NHS pension scheme.

Industrial relations

There is a commitment to an approach in industrial relations in the National Health Service based on social partnership. Recognition of locally representative unions is a key part of this approach. It is envisaged that staff representation within Primary Care Trusts would follow similar lines to current practice in NHS Trusts.

Staff training and research

Provision for staff training and research will also be similar to other NHS employers, which will enable Primary Care Trust staff to have continuous professional development.
Establishing a Primary Care Trust

Primary Care Trusts are a natural evolution from Primary Care Groups. It is hoped that as they develop over time, Primary Care Groups can exploit the advantages offered to take on more responsibilities through progression to Trust status.

It is expected that typically a Primary Care Group wishing to move to Trust status will have moved on from acting in an advisory capacity to their Health Authority (level 1) and have taken on managing commissioning through devolved budgetary responsibility (level 2). Such a Primary Care Group will be able to move directly to either a level 3 or level 4 Primary Care Trust.

Generating proposals and consultation

Primary Care Trusts will be established by The Secretary of State. Because Primary Care Trusts are there to meet local healthcare needs, progression to Primary Care Trust status will be locally driven and based on local views: they will therefore only be established after a process of local consultation, conducted by the Health Authority.

It will be possible for any individuals locally within a Primary Care Group, NHS Trust providing community services or Health Authority to generate proposals to establish a Primary Care Trust. The Health Authority will, however, only be required to consult if a proposal has been made or endorsed by either a Primary Care Group or an NHS Trust providing community health services. This will ensure that at least one of the relevant local NHS bodies is signed up to a proposal before entering formal consultation. It also gives Primary Care Groups and Trusts providing community services a central role in developing proposals.

The Secretary of State, acting through the relevant Regional Office, will consider the results of the consultation. The views of Primary Care Groups, local GPs and other professions as well as those of the Health Authority, Local Authority, NHS Trusts and wider community will clearly be key considerations for the Secretary of State in deciding whether to establish a Primary Care Trust. The assumption will generally be that a Primary Care Trust would not be established without the support of the relevant Primary Care Group.
Criteria for establishment

The basic criteria for establishing a Primary Care Trust will be:

- broad local support for its establishment including amongst those GPs affected;
- a clear vision of the service and health benefits which establishing a Primary Care Trust will bring, backed by agreed standards and targets to make progress towards them;
- making an effective contribution to the local Health Improvement Programme and working well with partner organisations;
- effective arrangements for developing clinical standards, including at practice level;
- proper arrangements for monitoring activity, sound financial management and accountability;
- a clear assessment of the local impact of change and reconfiguration;
- access to good, high quality human resources support;
- for level 4 Primary Care Trusts that the proposals take proper account of the wide range of community health services including those more specialised ones.

The Primary Care Trust itself will be legally brought about through an Establishment Order, similar to those for NHS Trusts. The Order will set out the boundaries of the Trust and its functions (including whether it is a level 3 or a level 4 Trust) and provide for any necessary transfer of NHS staff and property to the new body.

Geography and size

The function of a Primary Care Trust is to meet local health care needs and contribute to health improvement. Like Primary Care Groups, the aim is to make decision making more receptive to the local situation by bringing it closer to the community served, to improve health and to develop primary and community health services.

Clearly, where Primary Care Trusts seek to take on responsibilities for providing a greater range of services, or to provide services to a wider population, then they will need to be of a size that supports the delivery of high quality services. However this should be determined locally and will be a consequence of ensuring the delivery of improvements to the local population. Likewise, the starting point for determining a Primary Care Trust boundary should be on the basis of ensuring a coherent and cogent focus on meeting the needs of all people living within that community.

In achieving this, plans for Primary Care Trusts should seek the best possible coterminosity with other bodies. Primary Care Trusts will need to be situated within a single Health Authority geographical area unless there is a very good reason why they would better perform the functions listed above by crossing a Health Authority boundary.

Local Authority boundaries are also important. While coterminosity is not a requirement to attain Primary Care Trust status, there is a general Government policy to move towards coterminosity between Local Authority and all other administrative boundaries. To perform a Primary Care Trusts health improvement functions, links with County and District / Borough councils are relevant. Coterminosity with Social Services Authorities may prove to be particularly helpful in enabling pooling of budgets, with the service delivery benefits which that will bring.
Preparatory period

As for NHS Trusts, there will be a preparatory period between the establishment of the Primary Care Trust and its operational date. During this period the Trust will be able to:

- appoint members;
- advertise, recruit and employ staff where necessary;
- enter into NHS agreements and other contracts;
- plan the internal arrangements for the day to day operation of the Primary Care Trust.

Moving from level 3 to level 4

If a level 3 commissioning only Primary Care Trust wishes to move to level 4, there will need to be a further round of consultations as outlined above and a new establishment order as if the Primary Care Trust was starting afresh.
Timetable

Subject to the necessary legislation the first Primary Care Trusts will be established by April 2000. 1999-2000 will be used as a development year both to refine proposals locally and to work up the necessary detailed plans. Formal consultations on proposals for Primary Care Trust status cannot start until the legislation has been passed.

Next steps

Primary Care Groups and Trusts providing community health services were invited to submit expressions of interest in moving to Primary Care Trust status from 31 January 1999 onwards. As of 1 March 1999 more than 170 expressions of interest have been received.

Those identified will be offered a range of support mechanisms designed to:

- track policy development as the legislation progresses;
- help potential Primary Care Trust applicants to network together;
- provide support on organisational development;
- allow potential Primary Care Trusts to contribute to and shape policy on their establishment.

This initiative will be supported and backed up by resources made available by the NHS Executive and Health Authorities.

Registering an expression of interest to date does not commit the organisation to proceeding at the point when the legislation is completed. Each potential Primary Care Trust applicant will be able to decide at that time whether it wishes to proceed with consultation on moving forward to Trust status. Similarly where potential applicants have not yet registered an expression of interest, but subsequently wish to do so and enter consultation, this can be done at that later stage.
Questions and Answers

What do Primary Care Trusts mean for GPs and their practice staff?

Primary Care Trusts offer GPs and their staff an opportunity to shape health care locally, develop their skills and improve the range and quality of services practices currently offer to their patients.

They can also provide better support and a more responsive service to individual practices - for example a Primary Care Trust could provide regular locum cover for practice staff; or perhaps give better managerial and administrative support to a group of small practices if required. But it will be for practices themselves to take the opportunities that Primary Care Trusts offer through their freestanding nature and the range of freedoms and flexibilities they possess. Primary Care Trusts will support, not take over, practices.

Does becoming a Primary Care Trust affect GP’s independent contractor status?

No. The independent contractor status of GPs will not be affected by either Primary Care Group, or Primary Care Trust status. GPs will be free to remain independent contractors under the national contract if they wish.

For those who do not wish to be independent contractors there will also be opportunities to become salaried GPs or to provide services under a PMS contract. The aim is to offer professionals the flexibilities they sometimes need: all options are possible under Primary Care Trusts - but the choice is personal and voluntary.

Will being part of a Primary Care Trust affect GMS payments?

The provision of non-cash limited General Medical Services will not be affected by Primary Care Trust status: the bulk of GMS functions - for example payment of various fees and allowances, maintenance of patient lists and disciplinary functions, will remain with Health Authorities.

The Government do, however, see the development of General Medical Services as an important part of a Primary Care Trust's role. It is therefore intended that a limited range of GMS functions be delegated to Primary Care Trusts, including the ability to determine cash-limited payments to GPs and GMS local development schemes. This will provide opportunities for the Primary Care Trust, and practices within it, to develop services to better meet local health care needs.

Can Primary Care Trusts provide General Medical services independent of local GPs?

No. Primary Care Trusts can only undertake responsibilities that have been provided to them by the Secretary of State and delegated from their Health Authority. Primary Care Trusts will have no function to provide General Medical Services only to support the delivery of such services.
What about PMS pilot schemes?

Existing PMS pilots will be able to continue to operate under Primary Care Trusts, much as they will have done under Primary Care Groups. Primary Care Trusts, where it is agreed with existing PMS pilots, will take over the commissioning function from their Health Authority. This will mean the PMS pilot will be in contract with their Primary Care Trust for the remainder of the piloting period.

What about new PMS pilot schemes?

Once a Primary Care Trust has been set up it may have two different roles in any new PMS pilot scheme. Firstly and in their own right, Primary Care Trusts will be able to provide Personal Medical (or Dental) Services under contract with Health Authorities, by directly employing a GP (as some Community Trusts do now) or by jointly entering into local partnership arrangements with local GPs who remain independent contractors.

Secondly, where the PMS provider is a body other than the Primary Care Trust (e.g. a GP practice, Community Trust or nurse), the contract will be between the Primary Care Trust and the PMS provider. In this way, the function of negotiating and implementing local PMS contracts with GPs and other primary care providers will rest with Primary Care Trusts, once the pilot application has formally been approved by the Secretary of State. Primary Care Trusts will not be able to become the contract holder with Personal Dental Service pilots, such pilots will continue to maintain contracts with their Health Authority.

In either case, the following underpinning principles will continue to apply:

• that the PMS pilot will continue to be voluntary
• that the proposals must be prepared by the Health Authority on behalf of the potential pilot applicants; and, most importantly
• that the proposal will still be subject to final approval by the Secretary of State following local consultation

If a Primary Care Trust becomes a PMS pilot how will a fair distribution of resources be guaranteed between the Primary Care Trust and practices within it who continue to provide GMS?

Fair play will be ensured by the Health Authority, which will have overall responsibility for the Health Improvement Programme and for ensuring that Primary Care Trusts and other local NHS bodies contribute effectively to it. Primary Care Trusts are freestanding bodies but are part of an integrated local health community, accountable to the Health Authority, but with responsibilities to local GPs, nurses and other health and social care providers as well as their local community.

Where a Primary Care Trusts becomes a PMS pilot the contract will be held by the Health Authority and funding for that contract will be retained by the Health Authority. All funding decisions will be transparent both as part of the PMS contractual agreements reached but also as part of the process of agreeing Primary Care Investment Plans. Health Authorities also have to demonstrate that the Primary Care Investment Plans will deliver the GMS expenditure floors. Local Medical Committees will be consulted before Primary Care Investment plans are agreed.

How will being a part of a Primary Care Trust impact upon practice premises?

It is expected that Primary Care Trusts will take a leading role in the provision of primary care from modern and appropriate premises. They will be able to support developments from their unified budgets through:

• improvement grants;
• cost rent;
• GMS local development schemes.

Such developments will form part of the Primary Care Investment Plan proposed by the Trust Executive and agreed with the Trust Board and Health Authority.

Primary Care Trusts will also be able to provide premises for the provision of GP and hospital and community health services. Such developments would be subject to existing regulations and could only be realised with the willing participation of the professionals concerned.
Will GP premises be threatened by compulsory purchase?

No. The power of compulsory purchase of land for NHS purposes is not new. The Secretary of State, Health Authorities and NHS Trusts have this power. But it is a power to be used only very exceptionally and only after rigorous hurdles have been overcome. Indeed use of compulsory purchase is rare (only a handful of times since 1948) and has been used solely for hospital land, rather than the primary care sector.

Primary Care Trusts will only be able to purchase land compulsorily for the purposes of their functions. They will have no functions to provide General Medical Services. They will not therefore be able to use this power to purchase premises in order to provide GMS. Nor will they be able to do so to provide PMS - as this will continue to be a voluntary option for GPs.

How will Primary Care Trusts relate to Local Medical Committees?

Primary Care Trusts will have the same relationship with LMCs as Health Authorities do now in any decisions they take over GMS matters.

Will being part of a Primary Care Trust increase practice workload?

Unless the practice or GPs within it wish to play a more prominent role in the Primary Care Trust (e.g. a member of the Trust Executive) there should be no difference between Primary Care Group and Primary Care Trust status in terms of practice workload.

Will being on the Trust Executive and therefore an officer of the Trust affect status as a GP and independent contractor?

No. Trust Executive members will only be officers of the Trust for Trust business.

What are the workload implications of being a member of the Trust Executive?

It is expected that membership of a Trust Executive would be similar to that of Primary Care Group Board membership.

How will practice be affected?

Practice staff can continue to be employed by the practice, or can move their employment to the Primary Care Trust, wishing to take advantage of the opportunities that Primary Care Trusts offer for developing skills, providing greater support and having a direct say in how local health care should be developed. They will not be required to transfer to Primary Care Trust employment unless they are already employed by an NHS Trust under a PMS pilot.
What do Primary Care Trusts mean for NHS Trusts with community services and their staff?

Primary Care Trusts, like Primary Care Groups, offer community health services staff a real opportunity to have a direct say in how health needs can be tackled and services developed. They offer new opportunities for staff from different disciplines to work together and develop their skills.

At level 3, the relationship between an NHS Trust, its staff and the Primary Care Trust will be much as they are with Primary Care Groups. The real benefits however will be secured at level 4, when community health services will become part of an integrated unit.

The proposals in the Health Bill to allow further integration with social services through for example pooling of budgets and development of “lead commissioners” and “integrated providers” will bring further opportunities.

What will the employment arrangements be?

Community nurses and other professional staff will continue to be employed through an NHS statutory body in the same way as they are now.

Establishment of a level 4 Primary Care Trust will not mean that community health service staff are employed by individual GPs or practices. Staff transferring will keep their existing terms and conditions of service. All will have access to the NHS Pension scheme.

Key criteria in considering an application for level 4 Primary Care Trust status will be whether proper account has been taken of the range of services currently being provided and service delivery safeguarded. In practice, a Primary Care Trust for example, may take on only a limited range of services, leaving specialised ones to be provided by an NHS Trust or another Primary Care Trust.

Will staff be consulted about the establishment of a Primary Care Trust and any transfer of employment to it?

Yes.

How will the HR infrastructure in the Primary Care Trust work?

The existing consultation process with Union representatives, the Alliance for Health Professionals and a forum of Community Trust HR Directors will be important. This process has been and continues to be helpful in informing the HR aspects of the development of Primary Care Trusts. It is envisaged that guidance will be issued either in conjunction with other guidance, or under separate cover as happened with Primary Care Groups. Primary Care Trusts will also be expected to demonstrate preparedness and commitment to sign up to the HR Strategic Framework in ‘Working Together’ and to meet the same standards expected of the NHS as a whole.

How will staff be transferred to a Primary Care Trust?

The Secretary of State will be able to make an “establishment order” to provide for the transfer of staff from either a Health Authority, Primary Care Group or NHS Trust. The NHS Bill (Schedule 1 para 9) provides for consultation with the staff concerned before an order can be made.

Will the principles of TUPE always apply in relation to staff transfers?

It is intended that any staff transferring into a Primary Care Trust under an “establishment order” from the Secretary of State will have the same safeguards as if transferring under TUPE. They will retain their existing terms and conditions, or receive better terms and conditions, and there will be no break in service. This is similar to any other transfer in the NHS such as the establishment of a new NHS trust through a merger or a new Health Authority.
**How will the role of Health Authorities develop in the future?**

Health Authorities in future will focus on the strategic planning of health services for their populations. They will be expected to work in partnership with local stakeholders to improve the health of local people. This will require Health Authorities to develop effective monitoring arrangements to ensure the local Health Improvement Programme is delivered.

The Health Bill will give them stronger powers to improve the health of their residents and oversee the effectiveness of the NHS locally. For example, the Health Improvement Programme will have a statutory underpinning ensuring everyone participates in the process, and abides by the agreed plan.

The successful Health Authority of the future will have enabled the development of mature Primary Care Groups and/or Primary Care Trusts, on which it can rely with confidence for the actions which are their responsibility.

There will be no targets for further net reductions over the next three years in the national envelope for Health Authority and Primary Care Group / Primary Care Trust management costs. The future emphasis will be on Health Authorities redeploying resources to support the development agenda.

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**Will staff be eligible to join the NHS pension scheme?**

Yes, all staff in Primary Care Trusts will be able to join the NHS Pension Scheme. Staff who transfer from a practice to a Primary Care Trust will be able to remain in the scheme.

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**Will there be a provision for training in a Primary Care Trust?**

Yes. All NHS organisations are expected to do so. The Health Bill will give Primary Care Trusts power to provide training through adequate staffing, materials and premises.

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**Will membership of the Trust Executive of Level 4 be restricted to GPs and nurses?**

No. The Trust Executive will comprise up to 10 people with a majority of professionals. There will be considerable flexibility to suit the circumstances of the Trust. Although there will be significant representation from general practice, this will be balanced by a range of professionals from the community health service according to the services the Primary Care Trust provides. It will be for a potential Primary Care Trust to decide on Trust Executive membership and set out its proposals in its application.

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**There is a wide range of community health services, some quite specialised, which establishment of a Primary Care Trust might destabilise?**

Preserving the quality, and where it is relevant to this, the critical mass of community services will be an important consideration when the Secretary of State looks at proposals for establishing level 4 Primary Care Trusts.
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