



factsheet

June 2010

Primary care trusts: an introduction

What are primary care trusts?

- Primary care trusts (PCTs) are the statutory bodies in England responsible for ensuring NHS services are available in a defined geographical area and for improving the health of people living in that area. This role is referred to as 'commissioning'.
- Most PCTs are known by the name of their area, for example Sheffield PCT is known as NHS Sheffield.
- PCTs set their own local priorities and strategies for improving health and health services. However, they must work within a national and regional policy framework that sets certain standards and targets, and they cannot spend more than the allocated budget they receive from the Government.
- PCTs have responsibility for providing some community health services, although many of these services are now being transferred to other healthcare providers such as hospitals and mental health trusts.
- There are currently 151 PCTs in England, the majority of which share broadly the same boundaries as local government authorities. All PCTs are overseen regionally by one of ten strategic health authorities.
- Collectively, PCTs are responsible for managing around 80 per cent of the NHS budget. The average PCT allocation is about £555 million, but budgets can range from £172 million to almost £1.8 billion.
- PCTs cover an average population of 342,000 people, but population sizes range from just over 100,000 to almost 1.3 million.

This factsheet is a guide to the roles and responsibilities of primary care trusts (PCTs) in England as they currently stand (June 2010).

In May 2010, the Coalition's Programme for Government outlined a number of commitments relating to the NHS. Many of these will impact on PCTs and the structures and relationships described in this document will therefore change over time.

The purpose of this factsheet is to provide readers with a concise description of the current system to help place these forthcoming changes, and the process of transition they will involve, in context.

PCTs are responsible for 'commissioning' local health services. What does this involve?

The Department of Health (DH) allocates funding to PCTs based on a formula which takes into account the healthcare needs of the people who live in the PCT area. As commissioners, PCTs then make decisions on how that funding

should be used locally to ensure the best possible range and quality of health and health improvement services are available. To do this, PCTs regularly assess the health status of the local population by analysing information about life expectancy, levels of disease and disability, and use of health services for people living in the area.

PCTs also assess the availability and quality of local health services on an ongoing basis. Based on this information, commissioners make judgements about whether the current range of NHS services in the area is meeting the needs of local people in the most effective way and, if not, which changes are required. They then work with local healthcare providers (such as GP practices, hospitals and ambulance trusts) to agree what range of services they will offer, what aspects of their services they need to change or improve, and how much funding they should receive. Commissioners then agree contracts with these organisations, monitor them to ensure the right standards of care are being delivered, and pay them according to the quality and nature of the services they provide.

Which services receive the bulk of PCT funding?

PCT spending on services, in order of greatest expenditure first, is broadly as follows:

- **acute and specialist healthcare** – mainly hospital-based services, including elective care requiring referral from a GP, such as an outpatient appointment with a consultant or planned surgery, and urgent or emergency care, such as A&E

- **primary healthcare** – general practice, including prescribing by GPs, and NHS-funded dentistry, optometry and community pharmacy services
- **community health services** – such as district nursing, health visitors, sexual health services and rehabilitation services
- **mental health and learning disability services** – including community-based and residential services
- **ambulance services.**

Why do PCTs make different decisions on which services to fund and what changes to make?

As local commissioners of NHS services, PCTs aim to ensure that everyone has fair access to health services of a consistently high quality. When making commissioning decisions, PCTs will consider:

- the healthcare needs of the population – for example, whether there are relatively more older people or young families in the area, or groups at higher risk of particular diseases
- factors such as the geographical context and density of population – services in rural areas will differ from those in urban areas
- the types of organisations – such as hospitals or GP practices – currently providing NHS services in the area and the quality and type of services they offer.

No two PCT areas are exactly alike and, as a result, services will be provided differently across the country. However, where differences

in the services offered stem from poor quality or inefficiency, it is the job of the commissioner to work with the organisation providing the service to eliminate this variation over time, so that everyone has access to the highest quality of care possible.

Why do decisions about funding new or expensive treatments vary from region to region?

On a day-to-day basis the vast majority of decisions about the treatment of patients are made by clinicians. However, the NHS needs to have systems for deciding whether to fund treatments that are not routinely offered by clinicians because they are new, or because they are of relatively high cost and/or of generally limited value.

These decisions are made at a national level by the National Institute for Health and Clinical Excellence (NICE). At a local level, PCTs have to make their own decisions if a request to fund a new drug or treatment is made before there has been a national assessment of effectiveness and value by NICE. They also have to make some decisions about funding uncommon or non-approved treatments in exceptional cases.

All PCTs have policies for making such decisions and ensure there is appropriate input from clinicians into this process. They must be transparent, providing sufficient information to the local population to explain why they have reached their decision.

Although PCTs do increasingly work together on making decisions about funding such requests, in the

absence of a single national approach there are inevitably regional differences in their decisions.

How do PCTs involve the public in their decision-making processes?

PCTs aim to involve representatives of all those affected by their decisions – staff, patients and the public – in local decision-making, and to consult at an early stage on any planned changes in funding and provision of services.

Prioritisation in the NHS will always be contentious because of high expectations from the public about what the NHS should offer, variation in clinical opinion and differing priorities, and interests of different groups and individuals.

PCTs cannot satisfy all of these interests and expectations all of the time, but must provide opportunities for them to be heard and considered, and be open and transparent with the public about how decisions have been made and why.

How do PCTs involve GPs and other clinicians in their decision-making processes?

At least one local GP sits on the board of every PCT. All detailed planning, service design and commissioning processes carried out by PCTs will involve clinicians, some of whom will be employed by the PCT, others members of consultative committees, and some brought in as independent clinical advisers when necessary.

Practice-based commissioning also provides a formal way of involving GPs in the commissioning of

local services. This system allows GPs to work closely with their local PCT and hospitals to make decisions on and to be involved in monitoring the performance of local health services. The coalition government has announced its commitment to further strengthen the commissioning powers of GPs.

How do PCTs work with healthcare providers and what actions can commissioners take if they are not providing high-quality standards of care?

A range of healthcare providers deliver NHS services under contracts held with PCTs.

For most services PCTs use standard contracts, with common terms and conditions that have been agreed nationally and that neither the commissioner nor provider can change. Some of these standard contracts also include agreed national prices and quality requirements for particular services, while in others these are subject to local negotiation.

For some types of service a PCT will agree a contract with a single provider or set of providers for a specified range of services, or to provide services to a defined population such as people with mental health problems. Other services – such as planned surgery – are commissioned on an ‘any willing provider’ basis, where patients can choose to receive care from any organisation accredited to provide NHS services. PCTs reimburse each provider according to the amount of work carried out.

When commissioning a new service, or when a contract with an

existing provider expires, PCTs may undertake a procurement process to identify a suitable provider. Once a contract with a provider is in place, the PCT is responsible for managing it, by monitoring service quality and activity levels, ensuring standards are being met, and intervening if things go wrong or if patient satisfaction is low.

If a PCT is not satisfied that a provider is meeting the agreed standard of care, it has powers to intervene where necessary. Such intervention is likely to start with a discussion during regular quality review meetings, but in extreme cases, where a commissioner considers there to be a serious threat to the health and safety of patients, it can use the standard NHS contract to partially or totally suspend the service.

PCT management costs have been rising year on year. What is the reason for this? Will they reduce in the coming years?

Over the last few years PCTs have been required to take on significant extra responsibilities as expectations of their performance as commissioners have risen and Government-led strategies to shift more health services from hospitals to community settings have been pursued. Most PCTs have increased their investment in management to meet these new requirements.

While there was an increase in the number of senior PCT managers in the NHS between 2005 and 2009, it was significantly lower than the growth in the number of doctors during the same period. PCT management costs account

for 1.46 per cent of the total NHS annual budget.¹

Management costs are due to reduce in the coming years with plans for all PCTs to make a 30 per cent reduction in management costs by 2013/14.

How are PCTs governed and held to account for their decisions and performance?

PCTs are governed by boards made up of non-executive and executive board directors, including a chair and chief executive. At least three of the executive members of a PCT board are healthcare professionals, including at least one GP. The chair and non-executive directors are lay-people appointed by the Appointments Commission.

The main role of the PCT executive board is to set the overall strategic direction of the PCT and to hold the organisation to account.

PCTs' direct accountability is to the regional strategic health authority, which in turn is accountable to the Department of Health, ministers and ultimately to Parliament.

PCTs' decisions are also subject to scrutiny by local authority overview

and scrutiny committees which have the power to refer plans for substantive service change to an independent review panel.

PCTs are subject to a number of public assessments of their performance.

The Coalition's Programme for Government made a commitment to have locally elected representatives on the board of every PCT, with other board members appointed by the relevant local authority or authorities. The coalition agreement also announced plans for every PCT chief executive appointment to be approved by the Secretary of State on the advice of an independent NHS board.

This independent board will set out the priorities for the NHS and oversee the commissioning of care.

The government has also announced that strategic health authorities will no longer exist after 2012. Instead, there will be a number of regional offices which will report directly to the NHS chief executive to help the board exercise its functions.

The role of PCTs is likely to significantly change in the coming

years as the new government implements its policy on commissioning.

The PCT Network will be working closely with its members and policy makers to help support this transition.

The Primary Care Trust Network

The PCT Network was established as part of the NHS Confederation to provide a distinct voice for PCTs. The Network aims to improve the system for the public, patients and staff by raising the profile of the issues affecting PCTs and strengthening the influence of PCT members.

The NHS Confederation is the only independent membership body for the full range of organisations that make up today's NHS.

For more information, contact pctn@nhsconfed.org or visit www.nhsconfed.org/pctn

¹House of Commons Health Committee: *Public expenditure on health and personal social services 2009*.

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NHS CONFEDERATION



The NHS Confederation
29 Bressenden Place London SW1E 5DD
Tel 020 7074 3200 Fax 0844 774 4319
Email enquiries@nhsconfed.org
www.nhsconfed.org

