The role of the Primary Care Trust board in world class commissioning

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Document purpose: Best Practice Guidance

Title: The role of the Primary Care Trust board in world class commissioning

Author: Department of Health World Class Commissioning Team

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Target audience: PCT Chairs and board members, PCT CEs, SHA CEs, Directors of Commissioning/Specialised Commissioning Groups

Description: This document forms part of the wider WCC board development programme. It provides an update on the role and purpose of the PCT board in the context of world class commissioning.

Cross-reference: Commissioning Assurance Handbook
Commissioning to Make a Bigger Difference

Superseded documents: N/A

Action required: N/A

Timing: N/A

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For recipient’s use
Purpose of the document

1. The purpose of this document is to provide Primary Care Trust (PCT) boards with guidance on their specific role and purpose in the context of the Department of Health’s aspirations for world class commissioning. The generic role of boards is well defined and amply illustrated in the Financial Reporting Council’s Combined Code on Corporate Governance and other documents, for example, Governing the NHS produced by the NHS Appointments Commission.

2. World class commissioning (WCC), officially launched by the Department of Health in December 2007, lays out an ambition for “Adding life to years and years to life”. World class commissioning aims to have a direct impact on the health and well-being of the population, driving unprecedented improvements in patients' outcomes, and ensuring that the NHS remains one of the most progressive high-performing health systems in the world. Ultimately, world class commissioning will deliver better health and well-being for all, better care for all and better value for all. The PCT board has a pivotal role in determining how this is achieved in an environment where needs will always have the potential to exceed the resources available.

3. This document aims to provide consolidated guidance on:
   • the role and functions of the PCT;
   • the role of the PCT board;
   • the composition of the PCT board;
   • the competencies and characteristics of a high-performing PCT board; and
   • key sources of further guidance.

4. This guidance forms part of a package of support designed to develop the capacity of PCT boards to direct the commissioning agenda and to ensure that all board members understand their roles, have the skills they need to undertake this and are empowered to act corporately and collectively. Further information on the support available to PCT boards can be found at: www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Supportanddevelopment/DH_0849999.

The role and functions of the Primary Care Trust

5. Primary Care Trusts (PCTs) were created in 1999. They are corporate bodies established by statute – most recently the National Health Service Act 2006. As a statutory body, a PCT’s functions, powers and duties are set out in legislation. A comprehensive list of PCTs’ statutory functions is included at Appendix 1.

6. The Department of Health most recently published its view on the roles and responsibilities of PCTs as part of the NHS reconfiguration programme in 2005. But the role of the PCT is changing: PCTs are the leaders of their local health economy and, as such, are faced with a range of new aspirations and challenges. A new emphasis on strengthened commissioning and the need to create internal separation arrangements for any provider service functions as outlined in the NHS Operating Framework 2008/09 mean that it is time to once again bring our understanding of the purpose and role of the PCT up to date.

1 The Combined Code on Corporate Governance, June 2008, can be found at www.frc.org.uk/CORPORATE/COMBINEDCODE.CFM
4 The National Health Service Act 2006 consolidated legislation relating to the NHS, including the provisions providing for the establishment of PCTs (the National Health Service Act 1977, as amended by the Health Act 1999), and can be found at www.opsi.gov.uk/acts/acts2006/ukpga_20060041_en_1
6 The Operating Framework for the NHS in England 2008/09 can be found at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094
In the current context, the role of the PCT can be expressed as:

- leading the achievement of better health and well-being for the local community and reducing health inequalities;
- commissioning high-quality services in partnership with professionals and patients, designed to meet the needs and preferences of people locally; and
- creating the right balance of co-operation and contestability to ensure that patients and taxpayers benefit.

The role of the PCT board

The PCT board is ultimately responsible for ensuring that the role and functions listed above are carried out. In doing so, the PCT board must determine its strategic priorities, be well governed, demonstrate full commissioning competencies in all that it does and be financially sound. An effective board will consider the assurance arrangements necessary to ensure that the responsibilities of the PCT are discharged effectively and that the board adds value where it is uniquely placed to do so.

There is significance in the re-naming of PCTs as ‘NHS Local’; it positions PCTs as the front-line commissioners of patient care and makes them identifiable as such to their local populations. A key role of the PCT board is to manage the reputation of the PCT and to develop it as the local leader of the NHS and a key organisation with which to do business in relation to health.

Lord Darzi’s recent review of the NHS and his report *High Quality Care For All* build on earlier reforms but set a new challenge around the quality of care and the publication of performance information on quality. PCT boards will have a significant role in reviewing information on patient safety, patient experiences and the effectiveness of care and will need to work with providers on priorities for improvement.

PCTs will be expected, on behalf of the populations they serve, to challenge providers to achieve high-quality care. The PCT board will ensure that there is strong clinical engagement in commissioning, going beyond practice-based commissioning and professional executive committees (PECs) to involve all clinician groups in all aspects of strategic planning and service development to drive improvements in health outcomes.

The board will also need to consider incentives and support to ensure that practice-based commissioners are empowered to provide innovative high-quality services to meet the needs of patients locally. In parallel, the board will need to ensure that there are appropriate and proportionate governance arrangements in place for managing practice-based commissioning arrangements.

Action on the inequalities which persist in every PCT irrespective of overall deprivation levels must be at the forefront of board consideration. *Tackling Health Inequalities: 2007 Status Report on the Programme for Action* reports that, nationally, the gap in infant mortality is narrowing and life expectancy in the most deprived areas has increased. However, the gap between the life expectancy of women in the most deprived areas and women in the rest of the country is still widening. The challenge for PCT boards is to address these underlying issues in partnership with others from within the public, private and third sector.

The transition to an environment increasingly underpinned by legally binding contracts means that boards need in-depth skills in finance, strategic planning, performance, risk management, public health, clinical governance, provider services, market and commercial issues as well as an understanding of public needs and patient experience.

The emerging NHS Constitution has significant potential to establish a set of pledges to patients while also setting out those legal rights that already exist. The board will once again be expected to ensure that these are delivered alongside local priorities, specifically promoting choice.

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16. The board of a world class commissioning organisation will drive stretching strategic priorities from the joint strategic needs assessment and local opinion. It will ensure the PCT is listening to people, seeking opinions, working with clinicians, using knowledge and working through priorities and choices in all that it does. The board will add value in synthesising all the information and making any necessary hard choices. The board will have a key role in ensuring that effective markets drive improvements in outcomes for patients. Ultimately, world class commissioning will deliver better health and well-being for all, better care for all and better value for all.

17. With an ambition similar to that of the Monitor process for Foundation Trusts, world class commissioning creates a set of expectations for PCT boards which are higher than ever before. Like Monitor, the assessment process is designed to support a step change in board performance. PCTs will, at best, reach the second of four levels on the competency aspect of the Assurance Framework, immediately challenging all boards to demonstrate greater ambition and drive in quality, engagement and leadership.

Governance vs performance

18. PCT boards will need to understand and adjust to the new commissioning environment, which is both complex and challenging. They will need to strike the right balance between providing effective organisational governance and driving forward organisational performance. The right balance will be determined by such factors as organisational maturity, stability or recovery; in more stable times boards will devote more time to being entrepreneurial, and in more turbulent times the board will need to focus on governance and assurance.

19. In terms of governance, the PCT board has a responsibility to ensure that the key public service values of accountability, probity and openness – as set out in the Code of Conduct and Code of Accountability in the NHS – are maintained across all aspects of PCT business. The PCT board will put in place Standing Orders, Delegated Powers and Standing Financial Instructions to help discharge this responsibility. A model framework for PCT Standing Orders is available to help PCTs with this requirement.

20. The PCT board will drive the overall performance of the PCT. High-performing PCT boards will strike the right balance between controls, assurance and strategy, risk-taking and delivery. The Institute of Directors’ factsheet, ‘The role of the board’, has identified a number of key challenges for boards, including the need for boards to be simultaneously entrepreneurial and driving the business forward while keeping it under prudent control.

World class commissioning

21. Within world class commissioning it is expected that the whole board will take strategic responsibility for the commissioning agenda. In considering its role in relation to commissioning, the board may choose to refer to the overall commissioning cycle of the PCT and determine where best it can add value. The commissioning cycle for health services in figure 1 can be summarised into three phases of activity:

- needs assessment and strategic planning;
- shaping and managing the market; and
- performance monitoring and evaluation.

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10 World class commissioning assurance system documents can be found at www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Assurance/index.htm
12 Primary Care Trust: Model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, August 2006, can be found at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139133
13 ‘The role of the board’ factsheet produced by the Institute of Directors can be found at www.iod.com/intershoproot/eCS/Store/en/pdfs/theroleoftheboard.pdf
Phase 1: Needs assessment and strategic planning

22. The board’s role is to develop a meaningful strategic plan for commissioning. The board will need to develop a clear vision based on rigorous needs assessment involving local health stakeholders. The plan will need to set out priorities and be underpinned by a robust and consistent long-term financial plan that demonstrates how the PCT is investing to improve health outcomes and that complies with all statutory and SHA requirements. The associated risks of the strategy should be identified and assigned management. The strategy should be refreshed annually and rewritten every three years.

The Financial Reporting Council’s Combined Code on Corporate Governance recommends that the board should set the organisation’s strategic aims, ensure that the necessary financial and human resources are in place to meet its objectives and review management performance. It goes on to suggest that non-executive directors should constructively challenge and help develop proposals on strategy.

Phase 2: Shaping and managing the market

23. The board’s role is to ensure that a range of responsive providers are in place to meet the health and care needs of the local population. The board will need a detailed understanding of the aspirations of local people and will consider investment options to increase choice, innovation and improvements.

The Framework for Managing Choice, Cooperation and Competition sets out the responsibilities for PCTs as:

- designing local incentives and drivers;
- driving quality in provision;
- contracting and procurement;
- market development;
- delivering the choice offer;
- patient, public and market information; and
- alignment with local partnerships.

16 The Combined Code on Corporate Governance, June 2008, can be found at www.frc.org.uk/CORPORATE/COMBINEDCODE.CFM
Phase 3: Performance monitoring and evaluation

24. The board's role is to ensure that progress is made against planned objectives. In taking this collective responsibility, the different board members play different roles. It is the task of the executive team to manage the organisation for best operational outcomes and its members should report to the board regularly on progress. It is then the role of the whole board, executive and non-executive alike, to probe, discuss and advise so that the board can confirm, revise or update plans as required.

The Intelligent Commissioning Board suggests four key areas of PCT activity against which boards might look at a number of key indicators.

- Strategy
- Commissioning
- Contract management
- Operational performance.

Managing the PCT's provider functions

25. PCTs need to introduce an appropriate governance mechanism to ensure that there is no potential conflict of interest with their commissioning role, while maintaining their responsibility as a healthcare provider. All PCTs should create an internal separation of their operational provider services, and agree service-level agreements for these. When the PCT board executes its responsibilities as a healthcare provider, it should be mindful that these responsibilities are at arm's length from its commissioning functions and will have varying agendas and timelines.

The composition of the PCT board

26. Members of each PCT board include a chair, certain senior employees of the PCT (including the chief executive) and a number of people who are not employees (non-officer or non-executive members). All these members are responsible for the exercise of the PCT's statutory functions and are referred to collectively as the PCT board.

27. The membership arrangements for PCT boards are set out in Regulations. The composition of the board should be as follows:

- The chair of the PCT.
- A number of non-officer members (non-executives).
- Up to seven officer members (but not exceeding the number of non-officer members) including:
  - the chief executive (CE)
  - the director of finance (DoF)
  - the chair of the professional executive committee (PEC)
  - the director of public health (DPH)
  - at least one but not more than three, appointed by the chair of the PCT following nomination by the PEC, to include one doctor and one nurse
  - officers of the PCT, other than the CE, DoF and DPH, appointed by the chair and non-executives of the PCT.
- The PCT shall have not more than 14 members (excluding the chair).

28. The Regulations provide that the chair and non-officer members are appointed by the Secretary of State, but in practice appointments are made by the NHS Appointments Commission.
Monitor (the independent regulator of NHS Foundation Trusts) recommends that the board should be collectively responsible for the success of the company and that it should include a balance of executive and non-executive directors such that no individual or small group can dominate the board’s decision making. Furthermore, the board should not be so large as to be unwieldy.22

The competencies and characteristics of a high-performing PCT board

29. World class commissioning is a statement of intent, designed to raise ambitions for a new form of commissioning that has not yet been developed or implemented in a comprehensive way across any of the developed healthcare economies.

Competencies for a high-performing PCT board

20. World class commissioning requires PCTs to develop the knowledge, skills, behaviours and characteristics that underpin effective commissioning. PCT boards have a key role in prioritising and driving the development of the competencies needed to reach world-class status. The board will have a key role in strategic organisational development, including the need to consider succession and talent planning, investing in internal capacity and ensuring that the capability required for world class commissioning is being sought. Furthermore, the PCT board should consider how it measures up against the 11 world class commissioning organisational competencies.

Competencies for a high-performing PCT board

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<thead>
<tr>
<th>Competency</th>
<th>Unique role of the PCT board</th>
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<tbody>
<tr>
<td>1. Are recognised as the local leader of the NHS</td>
<td>• set priorities</td>
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<td>• manage reputation</td>
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<td></td>
<td>• ensure an ethical approach and that all necessary parties are engaged</td>
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<td></td>
<td>• oversee the market development interface with partners</td>
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<td>• ensure that the strategy and implications are appropriately communicated to the wider public</td>
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<td>2. Work collaboratively with community partners to commission services</td>
<td>• ensure that the range of stakeholders is known and understood (stakeholder analysis)</td>
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<td>that optimise health gains and reduce health inequalities</td>
<td>• ensure that the PCT and local authority are delivering on their duty of partnership</td>
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<td>3. Proactively build continuous and meaningful engagement with the</td>
<td>• ensure that the board and PCT’s work is informed by appropriate ongoing patient and public engagement</td>
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<td>public and patients to shape services and improve health</td>
<td>• ensure that patient opinion is balanced by clinical evidence</td>
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22 The NHS Foundation Trust Code of Governance, September 2006, can be found at www.monitor-nhsft.gov.uk/publications.php?id=930
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<th>Competency</th>
<th>Unique role of the PCT board</th>
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<tr>
<td>4. Lead continuous and meaningful engagement of all clinicians to inform strategy and drive quality, service design and resource utilisation</td>
<td>• ensure that the board and PCT’s work is informed by appropriate clinical engagement</td>
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<td>• ensure that the evidence of financial/clinical effectiveness is balanced with public opinion and that reputation risks are assessed</td>
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<td>5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs</td>
<td>• understand key messages from needs assessment and determine how this drives the priorities of the PCT</td>
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<td>• ensure that the PCT uses information and knowledge to inform decisions</td>
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<td>6. Prioritise investment according to local needs, service requirements and the values of the NHS</td>
<td>• ensure that the PCT bases its decisions on resources, taking into account appropriate future needs and trends</td>
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<td>• ensure that resource use reflects needs and priorities</td>
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<td>7. Effectively stimulate the market to meet demand and secure required clinical and health and well-being outcomes</td>
<td>• ensure that the PCT’s commissioning approach is effective in stimulating the market</td>
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<td></td>
<td>• deliver quality, choice, optimum care pathways, effectiveness and value</td>
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<td>8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration</td>
<td>• ensure that outcomes and quality drive commissioning decisions and that contracted standards are monitored and delivered</td>
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<td>• ensure that innovation is stimulating continuous improvement</td>
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<td>9. Secure procurement skills that ensure robust and viable contracts</td>
<td>• ensure that best practice in procurement is enhancing the commissioning process</td>
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<tr>
<td>10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvement in quality and outcomes and value for money</td>
<td>• ensure that systems are rigorously managed and that performance is monitored in-year</td>
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<td>• in a situation that has reached an impasse, be the point of escalation and added value in resolution of issues</td>
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<tr>
<td>11. Make sound financial investments to provide sustainable development and value for money</td>
<td>• ensure that financial plans are in line with strategy and fulfil statutory duties and any DH/SHA requirements</td>
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Characteristics of a high-performing board

31. A number of experienced specialists in board effectiveness were asked to consider the key characteristics of a successful board. The following is a summary of those key characteristics with some useful tips for running an effective board.

**Focus on strategy**
- A successful board is clear about its vision and shares a common understanding of its purpose as members jointly defined this direction. The board is thus unanimous in driving the achievement of the agreed strategy and has set and adheres to clear values for the organisation.
- The focus is on strategic priorities and maintaining effective control over operational activities through a system of risk management, information flow, regular reporting and assurance.
- Performance of the PCT against key performance indicators is reported clearly using a good balance of core metrics, and board discussion is based around a highlighted sub-set.

**Manage reputation and partnerships**
- High-performing boards are clear about their relationship with stakeholders and invest time in managing and regularly enhancing these relationships.
- The board has a core role in reputation management – internal and external. Effective boards are outward facing – to stakeholders, partners, the community and patients; they pay attention to signals and actively elicit feedback on performance both of their organisation and of themselves as a board.

**Act transparently**
- Decisions are made in a transparent way against a backdrop of risk management and reliable evidence. Decisions, together with the underlying rationale, are clearly recorded and communicated.
- A high-performing board understands its role in relation to assurance and internal controls, which are activities separate from the day-to-day management of the organisation.

**Continually seek improvement**
- A high-performing board takes time to review its own performance with a view to continual improvement in its overall effectiveness. The board will invest time in reviewing its effectiveness and addressing gaps in current performance to raise effectiveness to best in class.
- An effective board undertakes regular external assessment of its commissioning strategy through stakeholder and patient/public feedback.

**Run effective board meetings**
- The chair and chief executive are clear about their respective roles and are seen to guide and direct the meeting, but they do not dominate the discussion.
- All board members have an important role to play – both executives and non-executive members should make a strong contribution, have robust and effective working relationships and challenge each other constructively.
- Members bring to the meeting varied experience and specialist expertise but share a common core of technical knowledge.
- Meeting agendas and associated papers are well organised and provided to board members in a timely fashion. Papers are focused and it is clear what the board has agreed to do in relation to each item such as assurance, approval and decisions. Non-executive time is limited so agendas must be focused and time-efficient.
- The board agenda reflects agreed priorities and board members have a forward plan that enables the board to divide its time between strategic and operational issues, and commissioning and provision, and includes key risks and critical current issues as well as regular updates on performance.

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23 The DH PCT Board Development Framework includes seven organisations which have been rigorously assessed to provide board development services to PCTs. Further information can be found at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085246
Key sources of further guidance

32. Appendix 2 sets out sources of further guidance which may be useful to PCT boards when considering their role.

Conclusion

33. World class commissioning brings about expectations for a step change in the role of the PCT as a commissioning organisation. The boards of PCTs are being called upon to respond and raise their game. This is an opportunity for boards to re-examine their role, strengthen their grip on the strategy of the organisation and manage the risks of the organisation through clear performance management. PCT boards will need to set ambitious priorities to improve the health of their population and have the grip to ensure that these priorities are delivered, “Adding life to years and years to life”. 
Primary Care Trusts – Statutory Functions

Introduction
1. For the purpose of this Appendix, the statutory functions (i.e. powers and duties) of Primary Care Trusts (PCTs) are divided into various subject areas. The Appendix provides an extensive list of the statutory functions exercised by PCTs, but is not necessarily exhaustive.

Commissioning and provision of health services
Secondary care and functions conferred by directions given by the Secretary of State
2. Under section 7 of the National Health Service Act 2006 (“the NHS Act 2006”), the Secretary of State has the power to direct PCTs to exercise any of his functions relating to the health service. The main directions are contained in the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 20021 (“the Functions Regulations”). A complete list of the delegated functions is set out in Annex A.

3. The key functions are duties and powers to provide health services – see, in particular, sections 2, 3 and 4 of, and Schedule 1 to, the NHS Act 2006. It is in the exercise of these functions that PCTs are responsible for ensuring hospital, community health and certain public health services for their local population.

4. The functions under sections 2 to 4 and Schedule 1 are stated as duties or powers to provide; but the duty is to provide services “to such extent as [the PCT] considers necessary to meet all reasonable requirements”. PCTs must determine local health needs and determine what services are to be provided to meet those needs, having regard to the resources available to them. In addition, the Secretary of State has delegated to PCTs his power under section 12 of the Act to arrange for other persons or bodies to provide services. This enables PCTs to enter into commissioning arrangements for secondary care and community services with NHS Trusts, Foundation Trusts and independent providers.

5. In exercising the Secretary of State’s functions, PCTs must comply with directions about the exercise of those functions – in particular those set out in the Functions Regulations. Key requirements are:
   a) PCTs exercise the functions for the benefit of persons registered with the PCT’s GPs, or who are not registered but are resident in the area; this is subject to exceptions – for example, PCTs must provide or secure certain services (including A&E and ambulance services, walk-in centres and GUM services) for all persons present in their area.2
   b) In exercising the functions in so far as they consist of providing or securing the provision of specialised services, and preparing/implementing population screening programmes, the PCT requires the approval of the appropriate Strategic Health Authority (SHA).3

6. Power to provide goods or services which it provides to its local population (e.g. in-house community health services) to other NHS bodies (section 21(2) of the NHS Act 2006).

Primary care services
7. The NHS Act 2006 confers specific functions on PCTs in relation to primary care services. In particular:
   a) Duty to provide or secure the provision of primary medical services in its area (section 83 of the Act).
   b) Duty to provide or secure the provision of primary dental services in its area (section 99 of the Act).
   c) Duty to provide or secure the provision of certain ophthalmic services, including sight-testing, in its area (section 115 of the Act).
   d) Duty to make arrangements for the provision

1 S.I. 2002/2375
2 See regulation 3 of the Functions Regulations
3 See regulation 8(4) of the Functions Regulations
of pharmaceutical services in its area – i.e. the provision of drugs, medicines and certain appliances prescribed by GPs or dentists, and such additional pharmaceutical services as directed by the Secretary of State (sections 126 and 127 of the Act).

e) Power to run pilot schemes for the provision of local pharmaceutical services (section 134 of the Act).

f) Duty to administer the arrangements for primary care services (i.e. the services referred to above), and perform such other management and other functions as may be prescribed (section 22 of the Act).

g) Power to provide premises for the use of persons providing primary care services (section 21(3) of the Act).

8. Further detailed functions and provisions governing the performance of the main functions are set out in Parts 4 to 7 of the NHS Act 2006 (sections 83 to 168) and in regulations and directions made by the Secretary of State under the Act.

9. PCTs have a power to provide services under primary medical services and primary dental services agreements (section 21(1) of the NHS Act 2006).

Quality and standards

10. Duty to put and keep in place arrangements for the purpose of monitoring and improving the quality of healthcare provided by or for the PCT, in accordance with standards published by the Secretary of State (“the duty of quality”) (sections 45 and 46 of the Health and Social Care (Community Health and Standards) Act 2003).

Planning, partnership and co-operation

11. Duty to make arrangements with a view to securing that it receives appropriate advice from persons with professional expertise relating to health (section 23 of the NHS Act 2006).

12. Duty to prepare health improvement plans (section 24).

13. Duty to co-operate with other NHS bodies (section 72).

14. Duty to co-operate with local authorities (section 82).

15. Power to enter partnership arrangements (pooled budgets, etc) with local authorities (regulations under section 75).

16. Power to make payments to local authorities and voluntary organisations towards expenditure on community services (sections 256 and 257).

17. Duties under the Local Government and Public Involvement in Health Act 2007 (local area agreements and joint strategic needs assessments):

a) Duty to co-operate with local authorities in determining local improvement targets, additional targets or changes to or removal of existing targets in local area agreements (sections 106(3) and 111(5)).

b) Duty to have regard to local improvement targets in their local area agreement (section 108).

c) Duty to prepare joint strategic needs assessments for health and social care with local authorities and other PCTs (section 116).

18. Duties in relation to childcare and child welfare:

a) Duty to co-operate with local authorities and others to improve the well-being of children (section 10 of the Children Act 2004).

b) Duty to make arrangements to ensure that PCT functions are discharged having regard to the need to safeguard and promote the welfare of children (section 11 of the Children Act 2004).

c) Duty to work with local authorities in connection with the authorities’ arrangements for improving the well-being, for example, of young children (section 4 of the Childcare Act 2006).

19. Duty to consider requests from local authorities for assistance in the planning of services for carers etc (section 3 of the Carers (Equal Opportunities) Act 2004).

20. Power to give grants to voluntary organisations (section 64 of the Health Services and Public Health Act 1968 – Secretary of State functions delegated to PCTs by direction – see Annex A).

4 To be replaced by section 23A of the National Health Service Act 2006, when section 139 of the Health and Social Care Act 2008 is brought into force.
21. Various Secretary of State functions relating to local authorities are delegated to PCTs by direction – see Annex A.

22. Duty to assess, plan and advise in relation to emergencies and the risk of emergencies (Civil Contingencies Act 2000).

23. Co-operation in relation to criminal justice:
   a) Duty to co-operate with the prison service with a view to improving the way in which functions are exercised in relation to the health of prisoners (section 249 of the NHS Act 2006).
   b) Duty to formulate and implement, with local authorities and others, strategies for the reduction of crime and disorder, and for combating the misuse of drugs, alcohol and other substances (section 6 of the Crime and Disorder Act 1998).
   c) Duty to co-operate with local authorities in relation to youth justice services, youth offending teams, etc (sections 38 and 39 of the Crime and Disorder Act 1998).
   d) Duty to co-operate with the police, probation and prison services in relation to arrangements for assessing the risks posed by violent or sexual offenders (section 325 of the Criminal Justice Act 2003).

**Public engagement, involvement and consultation**

24. Duty to make arrangements with a view to securing that health service users are involved in the planning of the provision of services for which the PCT is responsible, the development and consideration of proposals for changes in the way those services are provided, and decisions to be made by that body affecting the operation of those services (section 242 of the NHS Act 2006).

25. Duty to consult local authority overview and scrutiny committee(s) on proposals for substantial developments in or variations to the local health service (regulations made under section 244).

**Finance, administration, etc**

26. A PCT has various financial duties under the NHS Act 2006, including:
   a) to secure that its expenditure in any financial year does not exceed its allotment from the Secretary of State for that year (section 229);
   b) to secure that its use of resources in any financial year does not exceed the amount specified by the Secretary of State (section 230);
   c) to keep proper accounts and related records (Schedule 15, paragraph 2); and
   d) to prepare annual accounts and send a copy of those accounts to the SHA and Secretary of State (Schedule 15, paragraphs 3 and 4).

27. Duties to prepare an annual report, send it to the SHA and Secretary of State and publicise the report and annual accounts (Schedule 3, paragraphs 20 and 21).

28. Power to provide hospital services for private patients or provide other services, or carry out other activities, for the purpose of making additional income available (“income generation”) (section 21(5)).

29. Power to raise money (by appeals, competitions, etc) (section 222).

30. Power to form, or participate in the formation of, companies for the purposes of improving primary care facilities or services (in LIFT areas) (section 223 – Secretary of State power delegated to PCTs by directions – see Annex A).

31. Power to delegate functions to another PCT (by agreement) and to exercise functions jointly with other PCTs, SHAs, SpHAs and NHS Trust bodies (regulations under section 19).

32. Schedule 3 to the NHS Act 2006 confers various miscellaneous powers, including:
   a) to employ staff (paragraph 7);
   b) to pay remuneration and allowances to the chair and other board members of the PCT (paragraph 11);

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5 See regulation 4 of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (S.I. 2002/3048)
6 See regulation 10 of the Functions Regulations
c) to do anything that appears to the PCT to be necessary or expedient for the purposes of or in connection with its functions, including acquiring and disposing of property, entering contracts and accepting gifts of property (paragraph 15);
d) to enter externally financed development agreements (PFI, etc) (paragraph 17);
e) to conduct, commission or assist the conduct of research (paragraph 18);
f) to make staff available for training purposes (paragraph 19); and
g) to purchase land compulsorily where approved by the Secretary of State (paragraph 22).

Equality, human rights and information law


34. Duties not to discriminate in the provision of services or otherwise in the exercise of the PCT’s functions:
   a) sections 19B and 20 of the Race Relations Act 1976 (race);
   b) sections 46 and 52 of the Equality Act 2006 (religion);
   c) sections 21A and 29 of the Sex Discrimination Act 1975 (sex);
   d) sections 19 and 21B of the Disability Discrimination Act 1995 (disability); and
   e) regulations 4 and 8 of the Equality Act (Sexual Orientation) Regulations 2003 (sexual orientation).

35. Duties to have due regard to the need to eliminate unlawful discrimination and promote equality of opportunity:
   a) section 71 of the Race Relations Act 1976 (race);
   b) section 76A of the Sex Discrimination Act 1975 (sex); and

36. Duties to publish race, sex and disability equality schemes (Race Relations Act (Statutory Duties) Order 2001; Sex Discrimination Act 1975 (Public Authorities) (Statutory Duties) Order 2006; and Disability Discrimination (Public Authorities) (Statutory Duties) Regulations 2005).

37. Duty not to discriminate in relation to staff and recruitment:
   a) section 4 of the Race Relations Act 1976 (race);
   b) section 6 of the Sex Discrimination Act 1975 (sex);
   c) section 4 of the Disability Discrimination Act 1995 (disability);
   d) regulation 6 of the Equality Act (Sexual Orientation) Regulations 2003 (sexual orientation); and
   e) regulation 7 of the Employment Equality (Age) Regulations 2006 (age).

38. Data Protection Act 1998:
   a) Duty to process personal data in accordance with the Act.
   b) Duty to grant individuals access to personal data relating to them (sections 7 to 15 of the Act).
   c) Duties to register with the Information Commissioner (sections 17 to 21).

39. Freedom of Information Act 2000:
   a) Duty to comply with requests for information in accordance with the Act (sections 1 to 16).
   b) Duty to adopt and maintain a publication scheme and publish information in accordance with that scheme (section 19).

Miscellaneous

40. Health and safety:
   a) Duty to ensure, so far as is reasonably practicable, the health, safety and welfare of employees at work (section 2 of the Health and Safety at Work etc. Act 1974).
   b) Duty to ensure, so far as is reasonably practicable, that persons who may be affected by the PCT’s undertaking are not exposed to risks to their health and safety (section 3 of the 1974 Act).
c) Duty to ensure that PCT premises are safe for visitors, etc (section 4 of the 1974 Act).

d) Function of making arrangements for a medical practitioner to provide medical records of persons under 18 to employment medical advisers (section 60 of the 1974 Act).

41. Health Act 2006:

a) Duties to prevent smoking and to display “no smoking” signs in PCT premises (sections 6 and 8).

b) Duties in relation to the supervision and management of controlled drugs (regulations under sections 17 and 18).

42. Duty to provide periodical reports on matters relating to HIV and AIDS (section 1 of the Aids (Control) Act 1987).

43. Power to enter into agreements for the provision of overseas development, etc (section 9 of the International Development Act 2002).
The Secretary of State’s functions in relation to the National Health Service exercisable by Primary Care Trusts

<table>
<thead>
<tr>
<th>National Health Service Act 2006</th>
<th>Power to provide services considered appropriate for discharging duties imposed on the Secretary of State and doing other things calculated to facilitate the discharge of such duties¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>section 2</td>
<td>+--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>section 3(1)</td>
<td>Duty to provide, to such extent as PCT considers necessary to meet all reasonable requirements, the following – hospital and other accommodation</td>
</tr>
<tr>
<td>– section 3(1)(a) and (b)</td>
<td>medical, dental, nursing and ambulance services</td>
</tr>
<tr>
<td>– section 3(1)(c)</td>
<td>facilities for the care of expectant and nursing mothers and young children</td>
</tr>
<tr>
<td>– section 3(1)(d)</td>
<td>facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered illness</td>
</tr>
<tr>
<td>– section 3(1)(e)</td>
<td>other services required for the diagnosis or treatment of illness</td>
</tr>
<tr>
<td>section 4</td>
<td>Duty to provide high-security psychiatric services²</td>
</tr>
<tr>
<td>Schedule 1, paragraphs 1 and 2</td>
<td>Duties and powers to provide for the medical inspection and treatment of pupils, their dental inspection and treatment and their education in dental health</td>
</tr>
<tr>
<td>Schedule 1, paragraph 8</td>
<td>Duty to arrange for the giving of advice on contraception, for the medical examination of persons seeking such advice, for the treatment of such persons and for the supply of contraceptive substances and appliances</td>
</tr>
<tr>
<td>Schedule 1, paragraphs 9 and 10</td>
<td>Power to provide vehicles for people with physical disabilities</td>
</tr>
<tr>
<td>Schedule 1, paragraph 12</td>
<td>Power to provide a microbiological service</td>
</tr>
<tr>
<td>Schedule 1, paragraph 13</td>
<td>Power to conduct or assist, by grants or otherwise, persons to conduct research into matters relating to illness or other matters connected with a service under the Act³</td>
</tr>
<tr>
<td>section 12(1) and (2)</td>
<td>Power to arrange with any person or body (including a voluntary organisation) for that person or body to provide or assist in providing any service under the Act</td>
</tr>
<tr>
<td>section 12(3) and (4)</td>
<td>Power to make available to persons or bodies acting under s.12(1) arrangements, or to health/social care voluntary organisations, facilities and services of persons employed in connection with such facilities</td>
</tr>
</tbody>
</table>

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¹ The power is exercisable only to such extent as is necessary for the proper exercise of one or more other functions exercisable by the PCT – regulation 6(3) of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements)(England) Regulations 2002 (SI 2002/2375) (“the Functions Regulations”)

² PCTs may only contract for the provisions of such services with an NHS Trust approved by Secretary of State/Welsh Ministers – regulation 8(1) of the Functions Regulations

³ PCTs cannot establish or recognise research ethics committees – regulation 8(2) of the Functions Regulations
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12(5)</td>
<td>Power to agree terms and payments in connection with arrangements made under section 12 of the Act</td>
</tr>
<tr>
<td>80(1) to (4)</td>
<td>Power to supply goods, services and other facilities to local authorities and other public bodies and carrying out maintenance work in connection with any land or building, the maintenance of which is a local authority responsibility</td>
</tr>
<tr>
<td>80(5)</td>
<td>Power to supply prescribed goods, materials or other facilities to persons providing pharmaceutical services, or providing services under a general medical services contract, a general dental services contract or a general ophthalmic services contract, or providing services in accordance with arrangements under section 92 or 107 of the Act, or providing services under a pilot scheme or a local pharmaceutical services scheme</td>
</tr>
<tr>
<td>80(6)</td>
<td>Duty to make available to local authorities any services or other facilities and the services of employed persons to enable local authorities to discharge their functions relating to social services, education and public health</td>
</tr>
<tr>
<td>80(7)</td>
<td>Power to make available to local authorities the services of persons providing primary care services and others to enable such authorities to discharge their functions relating to social services, education and public health</td>
</tr>
<tr>
<td>81(1) and (2)</td>
<td>Duty to consult before the services of any officer of certain health bodies are made available to a local authority</td>
</tr>
<tr>
<td>81(4) and (5)</td>
<td>Power to agree terms and charging for services and facilities provided under section 81 of the Act</td>
</tr>
<tr>
<td>168</td>
<td>Power to make accommodation available to persons providing pharmaceutical services</td>
</tr>
<tr>
<td>175</td>
<td>Power to determine charges for prescribed services provided to overseas visitors</td>
</tr>
<tr>
<td>189(1)</td>
<td>Power to authorise use of single rooms or small wards in hospitals, determining the extent to which it is to be made available and determining and recovering charges in respect of the use of such accommodation</td>
</tr>
<tr>
<td>223</td>
<td>Power to form or participate in the formation of companies to provide services to NHS bodies, etc; and to invest in and to make financial provision in respect of such companies</td>
</tr>
<tr>
<td>258(1)</td>
<td>Duty to exercise functions under the Act so as to secure the availability of facilities for research connected with clinical medicine or dentistry</td>
</tr>
<tr>
<td>267(1), (3) and (4)</td>
<td>Power to make available health service accommodation or facilities for the purpose of providing medical, dental, pharmaceutical, ophthalmic or chiropody services to non-resident private patients</td>
</tr>
</tbody>
</table>

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4 The power is exercisable only in relation to LIFT companies – regulation 8(3) of the Functions Regulations
5 The power cannot be exercised in so far as it is concerned with securing availability of facilities for clinical teaching – regulation 6(4) of the Functions Regulations
<table>
<thead>
<tr>
<th>Schedule 3, paragraph 11(3)</th>
<th>Power to determine travelling and other allowances payable to members of a committee of a Primary Care Trust&lt;sup&gt;6&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Services and Public Health Act 1968</strong> section 63(1), (5) and (6)</td>
<td>Power to provide for instruction of officers of health bodies and other persons employed or contemplating employment in activities connected with health or welfare</td>
</tr>
<tr>
<td>section 64(1)</td>
<td>Power to give financial assistance to voluntary organisations</td>
</tr>
</tbody>
</table>

<sup>6</sup> The power is exercisable only in relation to PCT executive committees – regulation 6(6) of the Functions Regulations
The European Convention on Human Rights
Rights and Freedoms

Article 2
Right to life
1. Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:
   a. in defence of any person from unlawful violence;
   b. in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
   c. in action lawfully taken for the purpose of quelling a riot or insurrection.

Article 3
Prohibition of torture
No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Article 4
Prohibition of slavery and forced labour
1. No one shall be held in slavery or servitude.
2. No one shall be required to perform forced or compulsory labour.
3. For the purpose of this Article the term “forced or compulsory labour” shall not include:
   a. any work required to be done in the ordinary course of detention imposed according to the provisions of Article 5 of this Convention or during conditional release from such detention;
   b. any service of a military character or, in case of conscientious objectors in countries where they are recognised, service exacted instead of compulsory military service;
   c. any service exacted in case of an emergency or calamity threatening the life or well-being of the community;
   d. any work or service which forms part of normal civic obligations.

Article 5
Right to liberty and security
1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
   a. the lawful detention of a person after conviction by a competent court;
   b. the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;
   c. the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;
   d. the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;
   e. the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;
   f. the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.
2. Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.
3. Everyone arrested or detained in accordance with the provisions of paragraph 1(c) of this Article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear for trial.

4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

5. Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation.

**Article 6**
**Right to a fair trial**

1. In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interest of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.

2. Everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.

3. Everyone charged with a criminal offence has the following minimum rights:
   a. to be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusation against him;
   b. to have adequate time and facilities for the preparation of his defence;
   c. to defend himself in person or through legal assistance of his own choosing or, if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require;
   d. to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;
   e. to have the free assistance of an interpreter if he cannot understand or speak the language used in court.

**Article 7**
**No punishment without law**

1. No one shall be held guilty of any criminal offence on account of any act or omission which did not constitute a criminal offence under national or international law at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the criminal offence was committed.

2. This Article shall not prejudice the trial and punishment of any person for any act or omission which, at the time when it was committed, was criminal according to the general principles of law recognised by civilised nations.

**Article 8**
**Right to respect for private and family life**

1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

**Article 9**
**Freedom of thought, conscience and religion**

1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.
2. Freedom to manifest one’s religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

Article 10
Freedom of expression
1. Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. This Article shall not prevent States from requiring the licensing of broadcasting, television or cinema enterprises.

2. The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary.

Article 11
Freedom of assembly and association
1. Everyone has the right to freedom of peaceful assembly and to freedom of association with others, including the right to form and to join trade unions for the protection of his interests.

2. No restrictions shall be placed on the exercise of these rights other than such as are prescribed by law and are necessary in a democratic society in the interests of national security or public safety, for the prevention of disorder or crime, for the protection of health or morals or for the protection of the rights and freedoms of others. This Article shall not prevent the imposition of lawful restrictions on the exercise of these rights by members of the armed forces, of the police or of the administration of the State.

Article 12
Right to marry
Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.

Article 14
Prohibition of discrimination
The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

Article 16
Restrictions on political activity of aliens
Nothing in Articles 10, 11 and 14 shall be regarded as preventing the High Contracting Parties from imposing restrictions on the political activity of aliens.

Article 17
Prohibition of abuse of rights
Nothing in this Convention may be interpreted as implying for any State, group or person any right to engage in any activity or perform any act aimed at the destruction of any of the rights and freedoms set forth herein or at their limitation to a greater extent than is provided for in the Convention.

Article 18
Limitation on use of restrictions on rights
The restrictions permitted under this Convention to the said rights and freedoms shall not be applied for any purpose other than those for which they have been prescribed.
The First Protocol

Article 1
Protection of property

Every natural or legal person is entitled to the peaceful enjoyment of his possessions. No one shall be deprived of his possessions except in the public interest and subject to the conditions provided for by law and by the general principles of international law.

The preceding provisions shall not, however, in any way impair the right of a State to enforce such laws as it deems necessary to control the use of property in accordance with the general interest or to secure the payment of taxes or other contributions or penalties.

Article 2
Right to education

No person shall be denied the right to education. In the exercise of any functions which it assumes in relation to education and to teaching, the State shall respect the right of parents to ensure such education and teaching in conformity with their own religious and philosophical convictions.

Article 3
Right to free elections

The High Contracting Parties undertake to hold free elections at reasonable intervals by secret ballot, under conditions which will ensure the free expression of the opinion of the people in the choice of the legislature.
Key sources of further guidance

The following guidance may be useful to PCT boards when considering their role.

The world class commissioning programme website

www.frc.org.uk/CORPORATE/COMBINEDCODE.CFM

NHS Appointments Commission and Dr Foster (2006) The Intelligent Commissioning Board
www.appointments.org.uk/docs/intell Comm_board.pdf

www.monitor-nhsft.gov.uk/publications.php?id=930

Institute of Directors (2006) ‘The role of the board’ factsheet

The National Health Service Act 2006 consolidated legislation relating to the NHS, including the provisions providing for the establishment of PCTs (the National Health Service Act 1977, as amended by the Health Act 1999)
www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH_064103

Department of Health (August 2006) Primary Care Trust: Model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions


www.berr.gov.uk/whatwedo/businesslaw/corpgovernance/higgs-tyson/page23342.html

www.icaew.com/index.cfm/route/154604/icaew_ga/en/Library/Links/Corporate_governance/UK_Corporate_Governance_Codes_and_Reports

www.icaew.com/index.cfm/route/154604/icaew_ga/en/Library/Links/Corporate_governance/UK_Corporate_Governance_Codes_and_Reports

Stanton, P and Bevington, Dr J (March 2005) Trust in the NHS Boardroom

Bevington, Dr J et al. (September 2004) Getting on Board
