HFMA introductory guide to NHS finance

Chapter 8: NHS finance – the role of local authorities, health and wellbeing boards and HealthWatch

Chapter 8. NHS finance – the role of local authorities, health and wellbeing boards and HealthWatch

Overview

This chapter looks at the role of local authorities with a focus on how they work with (and link to) the NHS. To see where they fit into the NHS structure, refer to the diagram on page 11.

8.1 What are local authorities?

Local authorities, also known as councils, provide public services to local communities and are run by democratically elected councillors who are accountable to their electorate. Local authorities work with local partners (including charities, businesses and other public service providers like the police and the NHS) and residents to determine and deliver local priorities. They provide a wide range of services, either directly themselves or by commissioning them from other organisations. They also have responsibility for the economic, social, and environmental wellbeing of their area.

Local authorities choose how to organise their operations based on their responsibilities. They are organised in different ways in different areas and can fall into one of the following categories:

- two-tier – a county council (responsible for county-wide services - for example, education, transport, planning, fire and public safety, social care, libraries, waste management and trading standards) or a district/ city/ borough council (responsible for rubbish collection, recycling, council tax collection, housing, and planning applications in their area)
- unitary – this type of authority can be a metropolitan council (responsible for an urban area), a London borough or a unitary authority (covering the whole or part of a county or a large town or city) and is responsible for all the services listed above
- town, parish, and community – these councils are the smallest and most local. They exist in certain parts of the country for historical reasons. They work to maintain local amenities such as allotments, bus shelters and play areas and may be consulted on in relation to planning applications and highway issues.

A two-tier or unitary authority can also be part of a combined authority whereby all the local authorities in an area come together in a voluntary arrangement - for example, Greater Manchester. This allows local authorities to work more closely together in relation to economic development, regeneration, and local transport.

All local authorities elect a leader who in turn appoints and chairs the cabinet/ executive. Each cabinet member has a specific area of responsibility - for example, housing or resources.

8.2 How local authorities are financed

Local authorities are required by law to provide certain services - for example, maintaining graveyards, ensuring asbestos is disposed of safely, giving grants to disabled people to adapt their homes and agreeing licenses for pubs and clubs. These are known as statutory services. The main categories include the provision of social care, schools, and roads.

There are three main sources of local government funding. These are government grants, council tax revenues and business rates. Local authority finance[133] is entirely separate from the NHS and so is not discussed further here. However, some NHS money does go to local authorities for two key purposes:

- health improvement – a ring fenced grant for local public health services is allocated to local authorities. In spending this money, local authorities must have regard to the public health outcomes framework[134] and publish a director of public health's annual report on the health of the local population. In 2023/24 the total grant to local authorities is £3.530bn[135].
- integration of health and care services – the better care fund (BCF) requires integrated care boards (ICBs) and local authorities to enter into pooled budget arrangements and agree an integrated spending plan.

If councils get into serious financial difficulty and cannot achieve a balanced budget, they may be issued with a section 114 notice under the Local Government Finance Act 1988[136]. This prohibits new spending while the sole focus is on maintaining statutory services - for example, safeguarding those who are vulnerable. Section 151 of the Local Government Act 1972[137] requires every local authority to make arrangements for the proper administration of their financial affairs and requires one officer to be nominated to take responsibility for the administration of those affairs. This essentially makes it a legal duty for a local government body to live within a balanced budget. In the English NHS although similar provisions are made for each NHS body, the equivalent of the section 151 obligation for the NHS sits with the Secretary of State for Health and Social Care.

8.3 How local authorities link to the NHS

NHS organisations have long been expected to engage with their local communities to improve health and wellbeing and reduce health inequalities. For many years, this has involved NHS organisations working in partnership with local authorities to manage and deliver services in which both parties have an interest.

Social care is the main interface between health organisations and local authorities because people often need social care services when recovering from ill health or when they suffer from a long-term condition. Although the Department of Health and Social Care (DHSC) is responsible for setting national policy for adult social care and securing its funding from HM Treasury within the spending review process (see chapter 12), local authorities deliver the services.

Statutory responsibilities

Local authorities have several health-related statutory responsibilities. Local authorities are required to:

- join up commissioning of NHS services, social care, public health, and health improvement

[133] Institute for Government, *Local government funding in England,* 2020
[134] Office for Health Improvement and Disparities, *Public health outcomes framework,* updated September 2023
[135] Department of Health and Social Care, *Public health ring-fenced grant 2023 to 2024: local authority circular*, November 2023
[136] UK Parliament, Local Government Finance Act 1988
[137] UK Parliament, Local Government Act 1972

- jointly appoint a director of public health with the Secretary of State for health and Social Care
- jointly commission some services with integrated care boards (ICBs)
- lead joint strategic needs assessments (JSNAs) and joint local health and wellbeing strategies (JLHWS) to ensure coherent and co-coordinated commissioning strategies (a role carried out jointly with ICBs via health and wellbeing boards – see below)
- support local voice and the exercise of patient choice
- lead on local health improvement and prevention activity (with their partners).

Therefore, local authorities have statutory responsibilities in relation to health improvement and receive a ring-fenced grant from the NHS allocation.

Emergency planning

The Civil Contingencies Act 2004 sets out the roles and responsibilities of emergency responders in England and Wales. All principal local authorities are category one responders under the Act, alongside the emergency services and the NHS[138]. The Act sets out a duty for these bodies to co-operate, usually through a local resilience forum and undertake joint planning to prevent, or to be able to respond to, emergencies.

System role

In an integrated care system (ICS), NHS organisations in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. 'Place' has become an important focus for health and care integration and in many cases, this aligns with local authority boundaries and existing health and wellbeing boards (HWBs).

The Health and Care Act 2022[139] established ICSs on a statutory footing with integrated care boards (ICBs) as the statutory NHS body. The other statutory element is the integrated care partnership (ICP). This is a joint committee of the ICB and includes those local authorities that fall wholly or in part in the area covered by the ICB. The ICP is made up of:

- one member appointed by the ICB
- one member appointed by each of the responsible local authorities
- members appointed by the ICP.

The ICP determines its own procedures including its quorum. Chapter 4 provides further details on the role of ICSs.

8.4 Local authorities' statutory roles and responsibilities in relation to the NHS

Health scrutiny

Since 2003, local authorities with social care responsibilities have been able to establish committees of councillors to provide overview and scrutiny of local NHS bodies. The Health and Social Care Act 2012[140] extended this scrutiny role to cover any provider of NHS funded services. It also gave local authorities the ability to discharge their health scrutiny functions in 'the way they deem most suitable'. The aim of this scrutiny role is to secure health improvement for local communities by encouraging

[138] Cabinet Office, *Preparation and planning for emergencies: responsibilities of responder agencies and others,* February 2013
[139] UK Government, Health and Care Act 2022
[140] UK Government, Health and Social Care Act 2012

authorities to look beyond their own service responsibilities to issues of wider concern to local people. This is achieved by giving democratically elected representatives the right to scrutinise how local health services are provided and developed for their constituents.

Local authorities' health scrutiny powers

Health scrutiny powers and duties of local authorities are summarised below[141]:

- review and scrutinise planning, provision and operation of the health service in the area
- require information from NHS bodies that is reasonably needed to carry out health scrutiny
- require attendance of employees, including non-executive directors to answer questions
- make reports and recommendations and expect a response within 28 days
- can set up joint health overview and scrutiny committees with other local authorities. Authority to for scrutiny of health services can be delegated to an overview and scrutiny committee of another local authority.

In relation to local authority overview and scrutiny of NHS services, the 2012 Act:

- requires officers of all NHS bodies to attend local authority scrutiny committees when requested
- requires NHS bodies to provide health scrutiny committees with information about the planning, commissioning, provision, and operation of health services
- requires NHS bodies to respond to reports and recommendations of health scrutiny committees
- empowers health scrutiny committees to refer proposals for substantial developments or variations in health services to the Secretary of State.

Health and wellbeing boards

The Health and Social Care Act 2012 required every upper tier local authority to establish a health and wellbeing board (HWB). This is a forum for public accountability and joins up commissioning across the NHS, social care, public health, and other services relating to health and wellbeing. HWBs assumed their powers and duties as statutory committees of (and therefore financed by) local authorities in April 2013.

Core membership of each HWB must include members of ICBs, the director of adult social services, the director of children's services, the director of public health, local HealthWatch (see later in this chapter) and at least one democratically elected councillor. HWBs can also require the attendance of NHS England when relevant. It must be noted that there is a wide variation in HWB memberships, voting structures and remit over and above the statutory requirements.

At a practical level, HWBs should:

- make themselves aware of how quality is being monitored locally, and of the priority issues and concerns in their locality
- where necessary, ensure action is taken and reported on those priority issues
- ensure a joined-up approach and good information-sharing, between agencies
- be aware of the work of the quality surveillance group for their area – that coordinates quality assurance activity for the NHS

[141] Department of Health and Social Care, *Local authority health scrutiny*, January 2024

- identify the priorities for fuller scrutiny - for example, by HealthWatch and/ or the overview and scrutiny committee.

HWBs lead the development of the joint strategic needs assessment (JSNA) and the high-level joint local health and wellbeing strategy (JLHWS) (see below). They also have a duty to involve service users and the public and work with ICBs to ensure that joint forward plans meet local needs. This approach is designed to provide strategic co-ordination to the commissioning of NHS services, social care, and health improvement.

Joint strategic needs assessments (JSNAs)

JSNAs are designed to 'identify the current and future health and wellbeing needs of a local population'[142] and have been in place since their introduction in section 116 of the Local Government and Public Involvement in Health Act 2007[143]. The Health and Social Care Act 2012 placed the responsibility for producing them jointly on local authorities and ICBs. The Act also required local authorities and ICBs to undertake the JSNA through the HWB so, in practice, it is the HWB that pulls the strategy together with local authorities and ICBs ultimately responsible for it and required to 'have regard to it' when exercising their functions.

The Health and Care Act 2022 states that the ICP must be given the local authorities' joint strategic needs assessment. The ICP prepares an integrated care strategy that sets out how the assessed needs of the area are to be met by the exercise of the functions of the ICB, NHS England and local authorities. This strategy must consider the extent to which those needs could be met more effectively by making pooled budget arrangements under section 75 of the NHS Act 2006[144]. Each new JSNA should result in the refresh of the ICP's integrated care strategy.

Joint local health and wellbeing strategies (JLHWSs)

The 2012 Act required local authorities and ICBs to produce (again via the HWB) a joint local health and wellbeing strategy. This sets out plans to address the needs of the local population and reduce inequalities identified in the JSNA. NHS and local authority commissioners must then 'have regard to' the JLHWS when exercising their functions.

Health improvement

The 2012 Act reintroduced a statutory duty on affected local authorities (upper tier (county councils) and unitary) to improve the health of the local population. The Act also gave the Secretary of State the power to require local authorities to carry out certain health protection functions and to prescribe how they carry out their health improvement activities.

There are also statutory arrangements for local authority leadership in this area, with local directors of public health being appointed jointly by local authorities and the DHSC. These local directors have a ring-fenced health improvement grant to deliver national and local priorities (the grant is allocated by the DHSC). There is direct accountability to both the local authority, and (through the Office for Health Improvement and Disparities at the DHSC) to the Secretary of State. As they are employed by the local authority, local directors of public health advise councillors and are part of the senior management team of the local authority.

At a practical level, local authorities are responsible for commissioning a range of health improvement services. A limited number of these services are mandated by government via regulations under section 6c of the NHS Act 2006. Other services can be commissioned on a discretionary basis guided by the public health outcomes framework, the JSNA and the JLHWS.

---

[142] Department of Health and Social Care, *JSNAs and JHWS statutory guidance,* Updated August 2022
[143] UK Government, Local Government and Public Involvement in Health Act 2007
[144] UK Government, National Health Service Act 2006

Mandatory services – examples

- to deliver the NHS health check
- to provide population based public health advice to NHS commissioners
- to provide comprehensive sexual health services (excluding abortion, contraceptive services and HIV treatment).

Discretionary services – examples

- lifestyle interventions – for example, to promote physical activity, improve diet and prevent obesity
- drug and alcohol misuse services
- stop smoking services
- local initiatives to reduce seasonal mortality.

As well as commissioning services themselves, local authorities can also work with ICBs and NHS England to ensure services are integrated.

As with other local services, local authorities are accountable primarily to their electorates for work on improving health.

Where NHS funding has been provided, there are additional accountability mechanisms – specifically:

- the Office for Health Improvement and Disparities (OHID) publishes data about national and local performance against the public health outcomes framework so local people will be able to see how their local authority is doing
- each local authority chief finance officer must provide a 'statement of grant' showing how the allocation has been spent
- each director of public health must produce (and each local authority publish) an annual report.

Although the DHSC can incentivise progress in health improvement, it does not performance manage local authorities or set targets for them.

8.5 HealthWatch England and local HealthWatch

HealthWatch England is the national body that champions people who use health and social care services and has a key focus on the design of integrated care. HealthWatch England is established as a committee of the Care Quality Commission (CQC). The chair of HealthWatch England is appointed by the Secretary of State and has a seat on the CQC's board.

In addition to HealthWatch England, each local authority area has a local HealthWatch; these organisations are separately commissioned by local authorities but 'feed into' the national network. Local HealthWatch powers are designed to be 'more like a citizen's advice bureau' for health and social care. HealthWatch England provides leadership and support to enable local HealthWatch to deliver its statutory activities and be a powerful advocate for services that work for people.

Each local HealthWatch is concerned with local engagement – collecting and channelling the views of patients, users and the public to decision-makers. They have powers to scrutinise local services (including local authority, NHS, and independent sector services), and this includes visiting and

observing their operations. Each local HealthWatch also has responsibilities for supporting people in communities by giving them information or signposting them to the support they need. Local HealthWatch is required by law to be represented on HWBs.

Local authorities, health services and regulators have a duty in law to respond to issues raised by HealthWatch. Local HealthWatch should:

- keep in touch with local people's experience of services
- channel information from networks, voluntary and community groups, identifying any key themes or trends
- alert commissioners and planning and scrutiny bodies (including the HWB and overview and scrutiny committee) to any significant concerns
- carry out bespoke research into people's experience in priority areas, having consulted about what these priorities are
- report to local providers, commissioners, and planning and scrutiny bodies on their findings.

Local HealthWatch organisations are financed via contracts with the relevant local authorities and are accountable to them for their ability to operate effectively and provide value for money.

The Health and Care Act 2022 gave the CQC a new duty to review local authority adult social care functions.

8.6 Local strategic partnerships

Section 82 of the NHS Act 2006 requires NHS bodies and local authorities to co-operate with each other 'to secure and advance the health and welfare of the people of England and Wales'. In England local strategic partnerships (LSPs) have been used to help achieve this aim. Where they are in place, LSPs operate at a strategic level and are led by local authorities. LSPs are non-statutory, non-executive, multi-agency bodies that are designed to bring together different parts of the public sector (including the NHS) as well as the private and voluntary sectors at a local level, so that initiatives and services can support each other and work together.

Section 75 flexibilities

There are several arrangements for joint working between NHS organisations and local authorities included within section 75 of the NHS Act 2006. These so-called 'section 75 flexibilities' include:

- pooled budgets
- aligned budgets
- lead commissioning
- integrated provision.

The 2012 Act placed a duty on ICBs and local authorities (through the HWB) to consider how to make best use of the flexibilities when drawing up the JSNA and JLHWS. To reinforce this duty, NHS England has a duty to promote the use of these flexibilities by ICBs.

The white paper *Joining up care for people, places and populations*[145] set the expectation that the use of pooled and aligned budgets will increase, to support integrated approaches to health and care.

[145] Department of Health and Social Care, *Joining up care for people, places and populations*, February 2022

Pooled budgets

The pooling of budgets involves partner organisations contributing funds to a single pot, to be spent on agreed projects for designated services. They exist where a local authority and an NHS body combine resources and jointly commission or manage an integrated service. The idea is that, once a pooled budget is introduced the public will experience a seamless service with a single point of access for their health and social care needs. There are some areas that are particularly well suited to pooled budgets - for example, services for people with a learning disability.

Where a pooled budget exists, regulations for England and Wales require that the partners have written agreements setting out:

- the functions covered
- the aims agreed
- the funds that each partner will contribute
- which partner will act as the 'host' (i.e., which organisation will manage the budget and take responsibility for the accounts of the pooled funds and auditing).

The pooling of funds does not override an individual organisation's statutory responsibilities or lines of accountability. It is each body's responsibility to determine the appropriate governance and accounting treatment for their pooled budget, based on their individual circumstances.

The accounting transactions of the 'pool' will therefore need to be reflected in the accounts of the partner bodies as appropriate. How this is reported is dependent on the levels of control that can be exercised by the partners (as laid out in the agreement documentation). For instance, at a very simple level, if there were three equal partners, each would reflect their one-third share of the 'pool'.

Better care fund (BCF)

Launched through the spending round in June 2013 and highlighted as a key element of public service reform, the BCF[146] seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible. BCF plans are jointly developed with local government partners and approved by HWBs. The BCF is intended to:

- deliver better services to older and disabled people who have multiple and complex needs
- keep people out of hospital
- avoid people staying in hospital for long periods.

Aligned budgets

Aligned budgets can be either an informal or formal (using section 75 flexibilities) arrangement whereby partners align resources to meet agreed aims but have separate accountability for the respective funding streams. The management arrangements can be separate, joint, or led by one partner but with joint performance monitoring arrangements against the objectives. An aligned budget can also be used as an interim stage towards implementing a pooled budget.

[146] NHS England, *Better Care Fund*, n.d.

Lead commissioning

Under a lead commissioning arrangement, partners agree to delegate commissioning of a service to one lead organisation. As with pooled budgets, lead commissioning was made possible by section 31 of the 1999 Act (now section 75 of the NHS Act 2006).

Integrated provision

Integrated provision involves partners joining together their staff, resources, and management structures so that the service is fully combined (or integrated) from managerial level to the front line. One partner acts as the host for the service to be provided. Again, this way of working was made possible by section 31 of the 1999 Act (now section 75 of the NHS Act 2006).

8.7 Grants

Government grants are available to the NHS for community-based projects run in conjunction with local authorities. Typically, these grants are linked to regeneration and renewal programmes in deprived communities where a partnership board with representation from many elements of the local community (including NHS bodies) has successfully bid for and then managed the distribution of the grant. In terms of the financial framework for these projects, the structure is straightforward – the grant is paid directly to the participating NHS body to cover the costs incurred.

8.8 Grants from the NHS to local authorities

NHS bodies have for many years been able to make grants to local authorities for the provision of health services (under sections 256/ 257 of the NHS Act 2006 as amended). This is broadly permissive and allows the transfer of revenue or capital resources for most health-related functions (excluding emergency ambulance services, surgery, and other similar invasive treatments) and for most social services and housing functions. ICBs and/ or NHS England can make payments to local authorities (or other bodies) towards expenditure on community services - for example, a local authority operating a unit for people with learning difficulties may receive a grant from the NHS body to cover the provision of healthcare to the clients in the unit. Such grants must pay only for medical care and must not contribute towards the provision of social care. They must not involve the transfer of health functions to a local authority.

8.9 Grants from local authorities to the NHS

Section 76 of the NHS Act 2006 (as amended) is a parallel provision to section 256 and allows the local authority to make payments to NHS bodies for the performance of prescribed functions. Local authorities can make payments to NHS England or ICBs. Again, this includes most hospital and community health services but not surgery, emergency ambulance services, or similar.

Key learning points

- Local authorities, also known as councils, provide public services to local communities and are run by democratically elected councillors who are accountable to their electorate.
- Local authorities are required by law to provide certain services. These are known as statutory services. The main categories are the provision of social care, schools, and roads.
- There are three main sources of local government funding. These are government grants, council tax revenues and business rates. Local authority finance is entirely separate from the NHS.
- Social care is the main interface between health organisations and local authorities because people often need social care services when recovering from ill health or when they suffer from a long-term condition.
- HealthWatch England is the national body that champions people who use health and social care and has a key focus on the design of integrated care.
- Section 82 of the NHS Act 2006 requires NHS bodies and local authorities to co-operate with each other 'to secure and advance the health and welfare of the people of England and Wales'.

Additional HFMA resources

The HFMA maintains a directory of resources which provides links to other HFMA outputs such as briefings and webinars across a range of subjects, including a dedicated section on local government. It also highlights online learning courses that are available. The directory of resources can be found here.