Working with local government: a guide for GP commissioners

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Key points

- Councils and councillors work very differently to GPs and the NHS, but their work is integral to health and health services.
- Differences in the purpose, backgrounds, culture and structure of local government can present barriers or benefits to joint working, depending on how they are approached.
- Understanding and awareness are the most important first steps for GP commissioners wanting to foster strong, productive relationships with local government.

This short guide summarises some of the need-to-know structural and operational features of local government and presents advice from GPs, NHS managers and local councillors on the important cultural stumbling blocks that often occur when working across the NHS-local government divide.

Health and wellbeing boards (HWBs) bring together NHS, local government and Healthwatch representatives to improve the lives of their local populations. The model relies on strong productive partnerships and mature individual relationships. To succeed, board members will need a good understanding of how their partner organisations differ from their own. For GP commissioners, this includes learning how to work with council officers and councillors.

At a glance

- **Audience**: This document is aimed at NHS members of health and wellbeing boards, in particular GPs active in their local clinical commissioning group.
- **Purpose**: To help GP commissioners understand some of the structural and cultural differences between the NHS and local government and suggest ways of bridging these to build strong, productive local partnerships.
- **Background**: This document was developed by a health and wellbeing board learning set (see back cover) and supported by the Department of Health, the NHS Confederation, the Local Government Association and the NHS Institute for Innovation and Improvement.

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Top tips for health colleagues when working with local government

- Develop an understanding of how local government works and of your local context – speak with councillors and officers in your local authority to get their perspective.
- Focus on building relationships with elected members before trying to tackle specific (especially contentious) issues.
- Engage equally with all councillors with different functions – members of the HWB, the overview and scrutiny committees, neighbourhood forums and the cabinet, wherever possible, so that all are kept informed.
- Understand their personal constraints – councillors often have full-time jobs away from council and receive little in return for the time they put into being a councillor.
- Tap into the local knowledge of councillors – their primary role is to represent their local ward and they often know their communities very well through councillors' surgeries, neighbourhood forums and case work. They will have a depth of insight to contribute, particularly around engagement, communication and felt needs of the community.

What do councils do?

Local authorities have responsibility for the economic, social, environmental and overall health and wellbeing of their area, and provide or commission over 700 services to those ends. They work with residents and partners in the public, private and community sectors to determine and deliver on local priorities.

Council services include: children's services; highways, roads and transport; adult care; housing; culture; leisure and recreation; environmental services; fire and community safety services; and planning and development. They also have income raising responsibilities, such as council tax.

Councils also employ large groups of professionals who contribute to the health and wellbeing of the community – such as social workers, some teachers, housing support workers, youth workers, leisure staff, research and policy staff, environmental health officers and planners.

How councils work across different tiers

Local authorities can be structured in many different ways. In most of England there are two tiers – county and district. However, London, other metropolitan areas and parts of shire England operate under a single-tier structure. Health and wellbeing boards are statutory bodies within the upper tier of local authorities.

Councillors are elected to represent people in a defined geographical area for a fixed term of four years, unless elected at a by-election, in which case the time will be shorter. There are different types of councillors – the leader, cabinet member, overview and scrutiny and front-line councilors representing their wards.

Councillors can have a number of roles, including: representing their wards; being involved in decision-making as part of committee or board membership; policy, strategy review and development; overview and scrutiny; regulatory duties; and community leadership and engagement.

Cabinets, made up of councillors who hold a responsibility, or 'portfolio', for a particular area of work, are the main decision-making body for most local authorities and will reflect the political balance of the council as a whole. Not all councillors will sit in the cabinet. Cabinet members are not permitted to be part of overview and scrutiny committees, which are responsible for scrutinising decisions, plans and services provided by the council or by health bodies.

Most councils elect a councillor to be the ceremonial head, usually in a non-political style, rather like the Speaker of the House of Commons. This person may be called the 'chairman of the council' in a county or district council but may be called the 'mayor' in a borough council. In a city council, they may be a 'lord mayor'. Such mayors should be distinguished from directly elected mayors, for example Boris Johnson and others in some cities. Directly elected mayors have specific powers which they exercise instead of local councillors.

A common source of confusion is the difference between councillors and officers. Councillors are elected

Types and tiers of local authority

There are over 400 councils in England and Wales, but their size, structure and responsibilities vary significantly depending on their type.

Two-tier areas

In two tier areas **county councils** cover the whole county and provide approximately 80 per cent of services within the area, including children's and adult social care services. **District councils** cover a smaller area within the county and provide more local services, such as housing, planning, waste and leisure, but not children's or adult social care services. They can be called district, borough or city councils.

One-tier areas

In one-tier areas **unitary authorities** are responsible for all local services and can be called a council (for example, Medway Council), a city council (for example, Leeds City Council) or a borough council (for example, Reading Borough Council).

The London boroughs are unitary authorities and the Greater London Authority provides London-wide government, including special responsibility for police, fire, strategic planning and transport.

Parish or **town councils** work at a sub-district level in some parts of England and are responsible for certain local services, such as management of town and village centres, litter, verges, cemeteries, allotments and public spaces.

members, serving four-year terms. Their key roles are to set the overall policy of the council through the decisions they make and represent the needs and concerns of their communities. Most, but not all, councillors are members of political parties, meaning they will have defined commitments to a range of policy positions outlined in their party manifesto.

Officers, such as the director of children's services, by contrast are employees of the council. They give impartial advice to councillors on policy and are responsible for carrying out their decisions, as well as for the overall performance of services. Unlike civil servants in central government, however, officers are accountable to the whole council.

The health and wellbeing board will operate differently from existing local authority committees because, for the first time, officers (director of adult social services, director of children's services and director of public health), clinical commissioning groups and local Healthwatch will have the same statutory status as councillors.

Another important feature of local authority decision-making is overview and scrutiny committees. All councillors, except for leaders and cabinet members, are able to be members of overview and scrutiny committees. They review the policies made by the council and its partners. They can refer decisions back to the cabinet or decision-maker for reconsideration if they have concerns.

First-tier local authorities (those responsible for social care) have specific legal powers to scrutinise decisions around health. This includes the right to scrutinise and make reports to NHS bodies, require officers of NHS

Council representation on health and wellbeing boards

All health and wellbeing boards are required to have at least one councillor, as well as three officer roles – the directors of adult social services, children's services and public health.

Survey data from shadow health and wellbeing boards, collected by the King's Fund,[1] showed that most boards were sticking fairly close to those numbers, although shadow boards from shire counties tended to be larger (more than 12 members), reflecting the decision of some county councils to include representatives from district councils.

In most cases the shadow health and wellbeing board is chaired by a councillor – often the leader of the council.

bodies to attend scrutiny committee meetings when requested, ask for information about the planning and provision of services from NHS bodies and require them to respond to their recommendations. Where scrutiny committees have concerns about substantial changes being proposed by NHS bodies, they can refer decisions back to the NHS and, if these are not satisfactorily resolved, they can be referred to the Secretary of State.

For more information about how local government works, see *The LGA quick guide to local government*.[2]

What responsibilities do councils have for health?

Councils in England and Wales are responsible for net expenditure of around £125 billion in 2011/12. Local authorities are responsible for more than 15 different types of services, and a great many have a direct relationship with the NHS. The Health and Social Care Act 2012 gives upper-tier councils additional responsibilities for public health.

In addition to their duties in co-creating the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy through their health and wellbeing board, local authorities are responsible for commissioning the public health services highlighted below.[3]

Mandatory public health services

- appropriate access to sexual health services
- ensuring there are plans in place to protect the health of the population
- ensuring NHS commissioners receive the public health advice they need
- the National Child Measurement Programme
- NHS Health Check assessment.

Other public health services local authorities are responsible for

- tobacco control and smoking cessation services
- alcohol and drug misuse services
- children and young people public health services (ages 5–19 and 0–19 from 2015)
- obesity, community lifestyle and weight management services
- locally-led nutrition initiatives
- physical activity in the local population
- public mental health services
- dental public health services
- accidental injury prevention
- population-level interventions to reduce and prevent birth defects
- preventive campaigns on cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health and NHS services, such as immunisation programmes
- local initiatives to reduce excess seasonal deaths
- promotion of community safety, violence prevention and response
- tackling social exclusion
- reducing the impact of environmental risks.

Many other council responsibilities also have an impact on the wider determinants of health, such as air quality, green spaces, employment and transport. For more information on this, see *From transition to transformation in public health*.[4]

How to foster strong, productive partnerships with councils

For positive working relationships to develop, it is important that all members of a health and wellbeing board are clear about their own roles and responsibilities, and how these compare to others on the board. Professional and personal differences can be a challenge if misunderstood, or can create added value if acknowledged and harnessed. Both GP commissioners and elected members are keen to make a difference to the health of their population – and quickly. They will be a powerful combination if working together.

Councillors and GP commissioners may not have previously worked together. There are some areas that need to be considered when developing a partnership, outlined on page 5.

Professional backgrounds, values and legitimacy

- A GP is used to acting autonomously insofar as they make independent judgments within their work and there is a strongly held value of 'professional

freedom'. As commissioners, some will have extensive experience through practice-based commissioning groups, although many will be new to planning services across a population.

- Councillors come from a very wide variety of backgrounds and live within the community they serve. All receive support and development from a members' services team within their councils or take part in other development initiatives organised regionally and nationally.
- Councillors do not receive a salary as such, though they do receive an allowance, and often perform their duties alongside a full-time job. Many GPs are self-employed.
- Legitimacy for councillors is derived from their mandate from the local population, whereas for GPs it will be both local (representing the nearby GP practices) and national (as part of the NHS). GPs and councillors use evidence to guide their decision making, although the evidence they use may be of different forms.
- Councillors and GPs have a degree of visibility and status within the local community and both roles are dedicated to serving others.

Structural

- Councillors and GPs are both accountable to others. A councillor is accountable to their council, their constituents and to their political party, whereas a GP commissioning lead is accountable to the members of their clinical commissioning group, local patients and other parts of the NHS structure (particularly the NHS Commissioning Board).
- Councillors and GPs will both come from organisations which may have developed well-

Insight: Working with GP commissioners – Councillor Roger Gough, Kent County Council

Roger Gough is a cabinet member for business strategy, performance and health reforms, and is a member of the collective leadership learning set for health and wellbeing boards.

He says: "We'd previously had very little contact with the local GPs, so there's been a lot of catching up to do.

"The main priority for us now is getting awareness and understanding on both sides. From the GPs' perspective there are lots of health-related things that councils do which they may not be familiar with – children's centres, for example. Getting their heads around those, as well as grappling with local authority decision-making processes, is a really important first stage.

"The NHS has historically had a much more top-down culture than councils, so it's great to be working with a group who are more locally rooted. It's a very different role for them, though, and I think they recognise the need to adopt a more population-level view, focusing more on upstream approaches and prevention."

Top tips for strong and cohesive working on health and wellbeing boards

- Make collaborative leadership for local community wellbeing a priority. Board members should think of themselves as health and wellbeing board advocates as well as representatives for their own organisation.
- Establish a shared vision.
- Promote a culture of honesty and openness, especially on issues where there is disagreement.
- Agree that 'this isn't like before'. All partners need to be open and willing to change – there are no 'sacred cows'.
- Recognise the diversity of knowledge and experience on the board and use it effectively.
- Ensure roles and responsibilities are clearly defined for all board members.
- Nurture relationships between organisations and key individuals as equally critical.
- Regularly meet to share problems and solutions.

established ways of working over time but which are now required to develop new partnerships and collaborative approaches.

Procedural and financial

- There are differences in the planning, budget cycles, funding mechanisms and resource flows within councils and the NHS, which will need to be managed in the context of the health and wellbeing board.
- Every four years a council may see a change in the political party in power and, therefore, the priorities which they promote may change. However, more often than not, the incoming party will look at existing policies and strategies and build on them rather than start from scratch. If councillors do change, GP commissioners will need to be aware of renewing their relationship building efforts.

References

1. The King's Fund (2012), *Health and wellbeing boards: system leaders or talking shops?*
2. http://www.local.gov.uk/c/document_library/get_file?uuid=474fc988-02fc-4373-aa87-6aa4b562e335&groupId=10161
3. For further information, see http://healthandcare.dh.gov.uk/public-health-system
4. www.local.gov.uk/c/document_library/get_file?uuid=efcd26e6-7201-4990-922e-def6630ee5e1&groupId=10171

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- Liam Hughes, Oldham Shadow Health and Wellbeing Board
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- Ian Parker, Middlesbrough Borough Council
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