Local Healthwatch: Evidence from the ongoing Post-Implementation Review of the Health and Care Act 2022

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Summary

This report presents emerging findings from an ongoing research study: Post-Implementation Review of the Health and Care Act 2022 (PRP ST-01-49; 2023-2026). The report draws on evidence from a nationwide survey of local Healthwatch employees and 84 interviews with leaders and staff across two Integrated Care Systems (ICSs; 32 of which directly inform the presented findings). Regarding the operation of local Healthwatch, respondents and interviewees emphasised that:

- The operational autonomy of local Healthwatch organisations is highly valued by NHS, local government, and VCSE system partners. Operational independence and strong relationships between local Healthwatch and other system partners underpins their ability to offer appropriate scrutiny, feedback, and advice.
- Local Healthwatch organisations contribute to service development and commissioning decisions. They monitor patient and public experiences of services and disseminate their findings to ICBs (Integrated Care Boards) and system partners, as well as to central government and to the public. They also perform a range of functions beyond their statutory role.
- Local Healthwatch organisations can function in ways and spaces rarely available to other system partners; this is because they are viewed as independent and are widely trusted and well-connected with local communities.
- Local Healthwatch organisations know their local provider landscape and act as network facilitators for system partners, researchers, patients, and the wider public.
- NHS Trusts and ICBs currently find it difficult to collect and use patient 'voice' as a specific source and type of data. ICBs are unlikely to be able to replicate current local Healthwatch functions due to a lack of funding, lost independence, and the potential for real or perceived conflicts of interest.
- VCSE organisations and local authorities usually have good links to local communities, and carry out consultative, co-production, and engagement work, but they tend to complement and utilise the work of local Healthwatch rather than duplicate or replace their functions.
- The scope and quality of local Healthwatch activity varies across the country, as local arrangements for funding and management differ between local authority areas.

Interview and survey findings suggest that the closure of local Healthwatch will represent a significant loss of valued activities. The best way to mitigate this is to ensure:

(a) that functions are transferred to the right actors. Interviewees suggested that the VCSE sector is best placed to take over these functions but would need appropriate commissioning and funding to do so. ICBs are regarded as least equipped to take over Healthwatch roles;
(b) that the transfer entails adequate ringfenced funding, a commitment to ongoing operational independence, the maintenance of existing relationships with providers, and the retention of institutional memory wherever possible.

Introduction

Since 1974 and the introduction of Community Health Councils, there has been some form of publicly funded organisation with a statutory remit to capture, disseminate, and champion patient and public voice in the English NHS. Since 2008, this function has existed in relation to social care as well. These organisations have been constituted and hosted in a variety of ways, but operational independence has been a consistent feature of how they have functioned. In the case of local Healthwatch, operational independence means that they have the freedom to set their own priorities and work programmes, exercise their statutory functions, and publicly report findings without interference from their commissioning local authority or other organisations whose services they scrutinise.

Established following the 2012 Health and Social Care Act, Healthwatch represents the latest in a long line of statutory bodies responsible for supporting accountability of the NHS and social care system to the public that it serves. Unlike Community Health Councils which were largely citizen-led (Bates, 1982), Healthwatch can be understood as representing a 'contractualisation' of Patient and Public Involvement (PPI) in the NHS and adult social care, though its remit extends well beyond involvement.

Local authorities are legally mandated to establish a local Healthwatch to serve their local communities; this can take the form of an independent social enterprise, a Community Interest Company (CIC), a charity, or 'hosted service'. Healthwatch is funded via a DHSC grant (formerly part of the Local Reform and Community Voices grant); and the MHCLG Local Government Finance Settlement. These are non-ringfenced funds, so local authorities determine how they commission Healthwatch organisations and how much funding they allocate to Healthwatch functions. Local Healthwatch organisations are therefore accountable to the funding local authority. They must also report annually to Healthwatch England on how they have met their statutory responsibilities, and Healthwatch England in turn reports to the Care Quality Commission (CQC) and to Parliament. Local Healthwatch annual reports are also disseminated to local stakeholders and must be publicly accessible online.

Local Healthwatch organisations have multiple statutory duties and powers, including:

- Obtaining the views of people about their health and care services
- Communicating these views to: Healthwatch England; Clinical Commissioning Groups (CCGs; now ICBs); CQC; local authorities/scrutiny committees (via annual reporting); and the wider public
- Responding to enquiries and providing information to the public about accessing health and care services
- Monitoring the quality of health and care services using 'enter and view' powers
- Promoting patient and public involvement in health and care planning, service delivery and monitoring

Neither NHS Trusts nor ICBs have specific requirements to respond to Healthwatch reports and, as digital forms of feedback have proliferated, Trusts and ICBs now have more direct routes to receive public concerns and complaints. In addition to ongoing communication with ICBs and formal annual reporting, local Healthwatch organisations can escalate specific issues to Healthwatch England, which is a formal sub-committee of the CQC, or they may escalate directly to the CQC where appropriate. Since the creation of ICBs, local Healthwatch organisations need to collaborate over a larger footprint, potentially giving them a stronger voice at system level, but they are simultaneously competing against one another for project funding and contracts.

In terms of the impact of Healthwatch, research highlights (Stewart, Desai and Zoccatelli, 2023):

- **significant variability** between local areas, including variability in operating model, organisational form, and membership
- **potential for overlap** between the role of Healthwatch and that of other PPI mechanisms set up by ICBs and NHS Trusts
- **problems with funding** due to the significant pressure on local authority budgets

An ethnographic study of local Healthwatch organisations by the same team (Zoccatelli, Desai, Robert, Martin, & Brearley, 2022) found that this 'significant variability' led to a mixed picture across the country, making it difficult to generalise impact:

> Key points of divergence that were consequential for Healthwatch activities included the degree of autonomy from host organisations and local understandings of accountability to various constituencies. These points of divergence gave rise to very different modes of operation and different priorities for enacting the nationally prescribed responsibilities of Healthwatch organisations locally. Large variations in funding levels created Healthwatch organisations that diverged not just in scale but in focus.

Nonetheless, they are regularly characterised as 'a part of the health and care system that makes space to find out about the unknown unknowns' through the quality of their relationships within communities and systems (Tiratelli, 2026). In addition to this intelligence gathering, they are valued for their propensity to 'go against the grain and speak truth to power' within the system in fulfilment of their responsibility as consumer champions (ibid.).

Methods & evidence

This report presents emerging findings from the ongoing Post-Implementation Review of the Health and Care Act 2022 (PRP ST-01-49; 2023-2026).

Evidence to date includes:

- 84 interviews in two ICSs (2025-26; 32 of which directly inform this report). Interviewees came from a wide range of bodies and groups, including: ICBs; Integrated Care Partnerships (ICPs), Place-based Partnerships; NHS Trusts and collaboratives; VCSE organisations; local authorities; Health and Wellbeing Boards; and local Healthwatch organisations.
- 38 respondents to a national online survey of local Healthwatch employees (out of around 500 local Healthwatch employees nationally) (May 2024 - June 2024) exploring their experiences engaging with ICSs, post-2022 Act, as a means of understanding how ICSs are incorporating patient and public perspectives into their development and operation. Section 5.2 of the project Interim Report contains more detail regarding the survey and its results.

Our interview findings relate to two ICS case studies. We have selected our two case studies carefully to include and contrast several key aspects of ICBs, such as the size and nature of the population they cover, their urban-rural coverage, and the type and number of system partners. We have carefully compared our findings across the two cases, and considered them in the light of existing literature on Healthwatch and PPI more broadly.

The findings presented in this report relate to the operation of *local* Healthwatch and not Healthwatch England. Interview extracts are denoted in the report with a four-character pseudonym code in brackets; where appropriate we have also included genelised reference to an interviewee's employing organisation and/or role. Findings may be subject to further analysis and refinement

Local Healthwatch across the country

In our online survey of local Healthwatch organisations across the country, we found significant variability in organisational arrangements, both in terms of structure and scale. Our interviews in two case study ICSs also revealed significant variation in local Healthwatch priorities and approaches, even within a single ICS area and even where local Healthwatch leads were working jointly in their representations to the ICB. Differences in funding levels affect local capacity, though the short-term nature of commissioning cycles makes it difficult for local organisations to sustain longitudinal work more generally. Local Healthwatch organisations also rely on the support of volunteers, whose contributions enhance the work and go some way to ameliorating these pressures.

As one Healthwatch interviewee explained to us: "I'm not sure there is a typical, because we're all funded for different amounts with different specs. And some of that variation is because needs are different in different areas … But if I was starting something off, we'd want to at least be consistent [with] resources that are [in] proportion to needs" (FQDC).

Geography

The geographical organisation of local Healthwatch branches is different in different areas. In some areas, the local Healthwatch organisation is coterminous with an NHS 'Place' and/or local authority footprint. An NHS 'Place' within an ICS system typically serves a population size of 250,000–500,000 and is organised at borough/local authority/former CCG level as a local site of coordination between health and wider partners. Some work collaboratively across the borders of multiple ICSs where necessary.

System and place

Local Healthwatch activity tends to be focused at Place scale and below, reflecting their local authority-aligned commissioning footprint and the community-scale nature of much engagement work. Place is widely regarded as a key level for partnership working across health and care, given its position as the operational level where community health services, social care, Place-based VCSE infrastructure, and (for some types of trust) NHS provision typically interact. As one survey respondent noted: "Partnership working is easier at place and the public respond and are more interested in their city than across the region" [R012]. There is also a history of NHS commissioning being organised at this scale, through CCGs and before them Primary Care Trusts.

Because local Healthwatch is organised and embedded at Place scale, it may be weakened by recent changes in the ICB landscape, such as the expansion of areas covered by ICBs due to ICB mergers and the proposed transfer of Place-development functions away from ICBs (DHSC, 2025) – all of which potentially deprioritise NHS Places. The move toward neighbourhood health may offer important opportunities, but this is an emerging picture (DHSC, 2026).

Collaboration

Local Healthwatch organisations work together with their neighbours, but our survey indicates that the depth and extent of this collaboration varies. In some areas, collaboration is formalised – e.g. with memoranda of understanding or an ICB working group – but in others collaboration is informal, looser, and more occasional. A major barrier to collaboration is limited staff capacity: "Without any extra funding to attend this myriad of meetings, it is very difficult to find capacity to attend and prepare in advance by reading the papers." [R026, interim report]. This has prompted new ways of partnership working in some local Healthwatch organisations, with a rotation of Healthwatch representatives attending meetings and committees within a shared ICS footprint so they can jointly feed into system decision-making and feedback information to the group. Our survey data indicated some ICBs have funded a Healthwatch 'network coordinator' at system level.

Influence

While all local Healthwatch organisations carry out the activities outlined below, there is variability in the extent to which they influence decision-making in ICSs. Our survey indicated that:

- Only a third of Healthwatch leaders rate their influence as six or above out of ten
- Some complain of 'tick box exercises' and 'generic ICB responses'
- But where it works well, there is significant involvement

Our survey also indicated that limited core funding can restrict local Healthwatch's activities and involvement in ICBs, and the sporadic and short-term nature of project funding makes it difficult to plan strategically.

Local authorities are legally bound to consider information provided by Healthwatch, though they are not obliged to act on it. ICBs must 'have regard to' information, advice, and reports from local Healthwatch, as ICS partners whose role is to represent the public and patient voice (particularly via Integrated Care Strategies and Joint Forward Plans). Healthwatch interviewees reported that this is not always acted upon. Nonetheless, Local Healthwatch organisations must navigate competing demands – such as attending multiple committee meetings at both System and Place levels and responding to calls for evidence and intelligence – from ICSs and local authorities.

Activities and impact of local Healthwatch

While recognising that there is variation nationally, we heard from our case study interviewees that because local Healthwatch organisations and staff are perceived as both trustworthy and independent, they play a crucial and quite unique role in health and care systems in practice. Their roles and activities go well beyond their statutory obligations and functions, and they are uniquely positioned actors within the system.

Acting independently

Interviewees emphasised that the value of local Healthwatch lies in their operational autonomy and their trusted status both within communities and as system partners. Although local Healthwatch organisations are funded by DHSC and MHCLG grants and are commissioned by local authorities, they are perceived to be unbiased and independent in their core functions of collecting, collating, and reporting patient and public experiences of health and social care. They are also viewed as independent and unbiased in their relationships and interactions with communities, providers, and other system partners.

Our survey data showed that many local Healthwatch representatives do not have voting rights in ICS meetings, despite being formal committee members. Our interviewees explained that declining this lever is viewed as a strength, enabling them to 'speak truth to power', and is a strategic decision to reinforce the perception of their independent,

unbiased status: “We’re there as independents and we absolutely fight to keep our independence and therefore we can freely discuss and talk and speak both in public and in private … the voluntary sector have voting rights … Well, they're a provider … We are independent and therefore voting, we believe, would be inappropriate” (KBAC). Concerns around the loss of this ‘independent voice’ was expressed by several interviewees. One ICB leader said “that independence matters [and] that function moving into ICBs removes some independence. … That’s going, so that’s a risk, from my perspective” (FA2L). From the local government side, a councillor argued, even more starkly, that “it would be a grave mistake to get rid of Healthwatch in its current form and not bring in some other form of independent voice,” and that looking forward “some form of independent voice of the patient in the committee is going to be needed” (7FWM).

From the perspective of a local Healthwatch team member, the “greatest fear […] is just about the loss of an independent voice, an independent place or space that people can have conversations, [and] an independent organisation that can do good stuff with that insight. That is the greatest sense of loss and concern” (CHY0). This often-overlooked aspect of Healthwatch’s independence – creating a space to share experiences with an impartial listener – was highlighted by a local Healthwatch interviewee from another system: “…independence is not just about us sharing information, it’s about people contacting us and feeling that they’ve got a place to go” (KBAC).

Healthwatch’s reputation for neutrality has built up over many years and depends on embedded relationships and mutual trust with local service users and providers. Their statutory ‘Enter and View’ powers are a rarely-invoked backstop, which allows them access to monitor services and a degree of ‘clout’ with providers: "[W]e don’t often have to use the statutory powers … we know we’ve got them, so if they were to say, oh no, no, no [NAME], we don’t want you to come in there, I could say, well actually I’m invoking my statutory powers, and I’m coming in anyway” (FQDC). This again raises concerns about the loss of independence, because it is not clear how these powers could be reallocated within ICBs or Trusts, given the obvious contradiction of “a service [attempting to] Statutory Enter and View itself” (FQDC).

Local Healthwatch interviewees pointed out that local Healthwatch also provides independent information and advice to the public about accessing services and the options available to them, based on their longstanding and detailed knowledge of local provision. This in turn facilitates their role as an independent conduit for feedback and complaints. A Healthwatch team member explained that they “provide that independent information offer to our residents to signpost them and provide that support to people to make sure they get to the services they need” (KBAC).

Collecting patient and public perspectives

To bring patient and public voice to decision makers, local Healthwatch has two main ways of working. These were described to us by several local Healthwatch team members.

Healthwatch **proactively** obtain the views of people about their needs and experience of local health and social care services.

> "The proactive way that we'll do it is if we are starting to hear something, so I know somebody will put a shout out and say we're starting to hear such and such, we're hearing grumblings around X, Y or Z, and we'll all go right, okay, let's have a look, let's see what we're already hearing, or we'll go 'shopping'. So, we'll actually say to our team can you keep an eye out for, can you keep an ear out for. And that will be something that very much then is population led" (KBAC)

Case study example: Dentistry

In relation to problems with dentistry, local Healthwatch team members were "hearing those messages months and months before the system were beginning to understand the scale of the issue" (KBAC). They produced a report and update reports that now feed into the dental recovery plan. This has led to a greater focus on access to services for vulnerable groups.

Healthwatch also respond **reactively** to the activities and reports of commissioners and providers.

> "The [ICB] papers come out, we see what topics are pertinent to us. We know if there's something that doesn't make sense to us that we will then ask each other, again, it's a collective ask, who knows what about this … The insight and intelligence comes from all our different feedback mechanisms. So we have different feedback centres or we have different ways of gathering information, databases, but we will trawl those and pull those in … So that's the reactive way we do it" (KBAC)

Case study example: Statin use

Recently the ICB has reached out to local Healthwatch team members to try to understand why people are not taking statins. This was unexpected and a new issue for Healthwatch, but they were able to draw on existing networks and data banks to begin writing a response. The findings might not necessarily be turned into action, but they will form an important part of the evidence that the ICB will use to respond.

Through both the proactive and reactive routes, Healthwatch engages with people on their experience of health and care systems. Crucially, this means that they gather perspectives on people's overall care pathways, and the ways in which care is coordinated, rather than just on one particular service or interaction:

> “When people talk to us … they talk about their experience … around lots of different things. It might be around their GP practice [or] 111 or the ambulance service. They [might] have spent time in hospital, they are now relying on maybe social care to get home. When people talk, they share their feedback as a story. It concerns me that … won't exist in the same way. So, the system potentially will have a more partial picture” (CHY0).

Communicating public and patient views to decision-makers

Our interviewees described how local Healthwatch make the views of patients and the public known to those involved in the commissioning and scrutiny of health and care services, supporting commissioners in identifying local priorities and alerting them to emerging issues with service provision. This allows them to act as a critical friend throughout the system.

As explained by an ICB Director, “I will say to Healthwatch, I’m picking up some concerns about A&E here, can you go in and do a bit of a [interim] review? And they will. And they bring back the voice of the patients thematically, or individually. So, I think they’re really good” (LSNN). According to a Director in another ICB, Healthwatch “are very constructive and get lots of useful feedback that is helpful for service delivery” (FA2L).

One local Healthwatch interviewee raised concerns that turning insight into knowledge and into action is the bit that is more challenging: “… [given that] what might matter most to people isn't necessarily what services are particularly wanting to hear about” (CHY0). However, they went on to argue that this “is part of the value of an organisation like Healthwatch to be like … we need to have one conversation, you have got your agenda [and Healthwatch is] holding the system to account for doing that well” (CHY). Another interviewee, working in primary care, was ambivalent about the impact Healthwatch has had, particularly where their findings were not acted upon by the ICB or other system partners: “I never know exactly what Healthwatch is there for. I know that they're there to act, be the patient's sort of eyes and ears and to again be a critical friend and to reflect information that they gather from patients, back into the system to hopefully make the system work better. Yes they do that, but does anyone listen, well of course they listen. Does anyone do anything with it, well no because they can't. … So does that help anyone? Maybe it makes some people feel better.” (MV0U). For example, “There was a presentation that Healthwatch gave to [ICB 3] regarding access to dental care in an emergency. Well for as long as I've been around access to dental care in an emergency has been abysmal. … Every so often it will tell us about the examples of poor access there is, but it doesn't make any difference. So you have to ask yourself, is it achieving anything?” (MV0U).

Therefore, while the ICB and providers value the insights of local Healthwatch, local Healthwatch also needs to hold system partners to account for ensuring that patient and public insights are given sufficient weight in decision-making. There are others in the

system that support this role, as one local councillor explained: "we've always been very keen that Healthwatch have a voice and ensure that that voice is heard" (7FWM).

A further role described was the hub-and-spoke relationship between Healthwatch England and local Healthwatch, whereby local Healthwatch organisations make the views and experiences of people known to Healthwatch England via annual reporting and the escalation of specific concerns, both of which are intended to ensure that the hub can carry out its role as a national consumer champion.

Reaching underserved communities

System partners suggested local Healthwatch organisations help health and care services reach underserved communities and are able to identify and report back when these communities are excluded from certain services.

For example, one local authority interviewee talked about "working with Healthwatch to try and talk to kids about what's important to them [and trying] to think about that means around the priorities that we have to do as system" (ALT5). They explained that they've "been able to use Healthwatch, certainly twice ... quite substantially over the past three years, to help us engage with children" (ALT5).

On the NHS side, local Healthwatch team members report filling a gap at system level in terms of community outreach: "we were seen as an answer for our system because our system doesn't have that outreach into the communities. It doesn't have it. And the [REGION 10] Integrated Care Partnership had said that they saw us as an answer" (KBAC). Local Healthwatch organisations thus perform an important function of ensuring that underserved communities are represented and linked into the wider system.

Case study example: The NHS App
Local Healthwatch run the NHS App survey. They found that 25-49 year olds are least likely to use the app because they don't trust the IT and they don't trust the system. This group are thus missing things like appointment letters: "[Local committees] [are] trying to fix something but they don't actually understand what the problems are" (KBAC).

Local Healthwatch interviewees raised concerns that their abolition might leave certain groups without a voice: "Who's going to pick that up from an independent point of view and be the eyes and ears on behalf of some of our most vulnerable residents in nursing residential care" (KBAC).

Directly supporting service improvements

Local Healthwatch interviewees reported producing toolkits and recommendations to improve services. This activity included making recommendations to Healthwatch England

to advise the CQC to carry out special reviews or investigations into areas of concern. Interviewees further suggested that in some instances, local Healthwatch organisations provide small-scale interventions that directly lead to service improvements.

Case study example: Hospital Discharge

Healthwatch were commissioned to review hospital discharge. They identified a negative feedback loop of frailty and in-hospital inactivity. They produced a guide for keeping active in hospital. As explained by a Healthwatch team member: "doing stuff on a whole system level is way more complex to get that in place because of the way the NHS is set up" (CHY0).

Case study example: Corridor Care

Healthwatch raised concerns about patient treatment during corridor care. They helped redesign the processes and minimal standards for corridor care. This has been rolled out across multiple trusts. Healthwatch are now also evaluating progress and running wider coordinated research into corridor care.

In other instances, local Healthwatch organisations support the ICB to implement policies. One local Healthwatch team member noted that the ICB have "made a toolkit that [has] got a lot of sensible things in it, but the way it was going to land was very much lots of neurotypical people telling you how you should do things that you know you should be doing, but they're actually really hard to do" (FQDC). To help the ICB implement this toolkit, the local Healthwatch "gathered together a load of people with ADHD," observing that "the more things that [were] checked out with people … the closer we're going to get to something that they're actually going to be able to respond well to" (FQDC). This role therefore extends beyond informing decisions into facilitation and implementation.

Connecting up the system

Our interview findings suggest that local Healthwatch are relational organisations which act as a 'network connector' in local systems, sitting between local government, the NHS, and the VCSE sector. Our survey data found that across the country, local Healthwatch leaders contribute to a wide range of committees and forums at both Place and System level. Local Healthwatch interviewees in our case studies explained this means they form many important links between different parts of the wider health and care system. Some local Healthwatch interviewees in one system argued that "there [isn't] anything else that operates at the same rate of levels and scope that we do. […] There's people who are real experts in their little silo but they rely on us to make the connections between all the different strands of their work to join things up" (KBAC).

Local Healthwatch interviewees also explained that collaboration within an ICS between the local Healthwatch organisations creates an important link across places, especially where a Trust sits across multiple places. As one Healthwatch lead noted: "we are separate organisations, separate board, different work plan …different local authorities to

answer to [but] yes, we do collaborate, we have to in a way and we have done that historically over the years" (CHY0). In another system, neighbouring local Healthwatch team members report an even stronger mode of collaboration: "...we kind of had the deal that we weren't going to go for each other's contracts. And because of that we could share our weaknesses as well as our strengths and help each other with those weaknesses" (FQDC).

Holding NHS leaders to account

Interviewees in our case studies voiced concerns about the accountability of both ICBs and Trusts to the patients and public they serve. There was a view that accountability of these bodies tended to flow up to the centre rather than down to local people. Local Healthwatch was felt to provide an important function that can support the accountability of health and care providers to patients and the public, in a way that is distinct but complementary to the mechanisms of local democracy. One local Healthwatch team member summarised their organisational purpose as "holding the system to account ... and shining a light on those voices that aren't heard" (CHY0).

This scrutiny role of local Healthwatch was explained by one ICB Director in terms of bringing patient and public voice to the fore: "in the [Place] Board [...] we are challenged by the Healthwatch groups, the Patient and Public Involvement groups, particularly the non-NHS aspect about, have you really truly taken on the voice of the people with lived experiences?" (M1YE). A similar role is played within trusts, with one trust chair sharing concern that "...we'll abolish governors and Healthwatch without a solid plan as to how we're accountable to our communities" (FFNB). While some argue that accountability can come through councillors, this trust board member explained that it "cannot be [...] because they don't have the level of expertise that experts by experience have" (FFNB).

Can others perform the functions of local Healthwatch?

The proposed abolition of local Healthwatch raises questions about whether current functions can be performed by other actors in the health and care system. In this section, we look at other system actors to consider their existing role in patient and public voice and their suitability to take on local Healthwatch functions.

NHS Trusts

Participants from across the health and care system suggested that statutory NHS organisations rarely engage directly or effectively with public and patient voices. They see uncertainty around the commitment from such organisations to the ongoing funding of PPIE activities and follow-up action, not least because of financial and performance related pressures from above.

Statutory NHS organisations often rely on local Healthwatch and VSCE organisations to deliver their public engagement responsibilities. An NHS trust board member was asked

whether there are any areas where the patient voice isn't listened to as well as it should be. They responded: "Loads, loads and loads, we're working on it really hard but there isn't resources to do this, it's quite hard at a time where, for example, there is a restriction on non-clinical roles" (FFNB). Therefore, they "work closely with Healthwatch" and "really value the work that they do" (FFNB).

One VCSE interviewee argued that the rhetoric on public engagement within the NHS has not kept pace with the reality: "…it's never been very good at that, the NHS but I think over the last three years, that misnaming of co-production as just purely co-design has embedded something where it talks a better game than it ever did but in reality, it's not got the flexibility" (DTW6).

Place-based partnerships

Whilst Place-based partnerships know their communities well and are seen as providing some public engagement, Place managers noted engagement activities are limited by lack of dedicated managerial capacity. Current reductions in ICB management funding have reduced the scope for this activity further. One interviewee put this very clearly: "…we don't have any engagement resource at Place and we don't have any communications resource at Place, that's a centralised […] function and that function isn't big enough to facilitate some of these things. So we are reliant on our partners, … that's how we do it, we have to work through our partnership to coordinate all that" (0KPN). Another interviewee summarised this partnership approach in relation to meetings of the Place-based partnership: "…our VCSE sector organisation is the voice of the community … Healthwatch comes to the meeting as well so there's a voice there. The PCN will be representing their patients in that space" (5NP6).

An interviewee in another Place explained how they "…get close to [public engagement], and then we're pulled back to the money and A&E and all the things that are on fire regularly in the NHS, and we never do that long-term, bottom-up, reconnecting with people at about what matters to them" (LSNN). They went on to highlight a "disconnect … with people." and that if this is not fixed, then "the NHS has lost the body of the room" (LSNN).

Local authorities

In our case studies, interviewees noted that local authorities represent the voice of residents and have some good connections to their communities, especially via public health teams. Interviewees also gave examples of local authorities carrying out consultative, co-production, and engagement work. In the absence of local Healthwatch, one interviewee suggested that local authorities are in a better position to connect with the public than the NHS: "I think [it would] be really led and driven by the local authorities, and bringing back the voice of the residents far more powerfully, than we as the NHS have done in terms of engaging with the population" (LSNN). Local Healthwatch team members themselves agree: "I have a little bit more confidence [in the local authority picking up

Healthwatch duties] than I would the ICBs … public health certainly could kind of use that network of other support that they've got" (FQDC).

However, it was also suggested that some communities have minimal trust in local authority officers, which may limit their scope to conduct effective public engagement around health and care services. The same local Healthwatch interviewee noted a "…degree of cynicism about the council in communities, so if you're having a hard time, and you think your Neighbourhood's not getting money and things spent on it, when the council turn up, you just want to kind of ignore them, or you want to sound off about … You're not necessarily going to get into the deeper conversations … The council might be the person that's chasing you, 'cause you've not paid your council tax" (FQDC).

A Health and Wellbeing Board member explained that Health and Wellbeing Boards primarily connect with citizens through data about people, rather than their voice: "I don't see a big voice there, but that doesn't mean that people don't have them in mind and aren't trying to serve the communities [and] people. … There's lots of stats on health inequalities, health trends, there's a lot of good work happening" (E0IM). Another Health and Wellbeing member expressed concern about the system's ability to hold itself to account or deal effectively with patient concerns and complaints: "If it becomes internal, then you can almost forget hearing the voices of patients just because of…as somebody who has dealt many, many times with people complaining about the system, once … a complaint goes into the system, it's never heard of again or takes years or the system becomes defensive. I'm not saying Healthwatch is perfect, but there is a real role for them and their voice and what they can do" (7FWM). These are some of the reasons Health and Wellbeing board members value local Healthwatch: "I think Healthwatch leaving is a real shame. I think they did some really valuable work. And the fact that Healthwatch aren't going to be around any longer is really quite disappointing" (LM1W).

VCSE Sector

VCSE organisations were identified as having good reach into communities and perform many similar functions to local Healthwatch, but they tend to be underutilised and lacking sufficient dedicated funding for engagement activities beyond their primary remit. Taking over local Healthwatch functions would require additional funding and expertise, and in many places would mean shoring up VCSE infrastructure organisations. A VCSE leader explained that "the role of infrastructure and certainly my organisation … is to listen to all the noise … that cacophony of sound [and] then take it and shape it and land it" (08NM). Interviewees highlighted that the VCSE sector needs well-funded structures to be able to perform this role.

NHS interviewees valued the role the VCSE sector currently plays in this space. A trust board member noted "…really good links with the third sector through a range of different measures [and the VCSE sector is] a really good route into us to get direct community links" (FFNB). And from the ICB side, they report "working with the voluntary sector to

understand from our population and hear from our population, so that voice role" (JNEY). VCSE leaders describe their contribution as "soft intelligence" but are concerned that this is not being fully utilised: "...we think that there's much greater potential to engage the voluntary sector, both in terms of service user feedback, but also wider community feedback" (L1FI).

Local Healthwatch and VCSE were seen by interviewees to perform complementary roles. From the local Healthwatch side, team members see their role as "bridge-building between the different communities" (FQDC). Meanwhile, VCSE interviewees distinguished between local Healthwatch's role "as more around patient inclusion and involvement", while the VCSE sector is "very much about how do we work better with communities" (DTW6). However, there were disagreements between VCSE interviewees about the impact of local Healthwatch. One VCSE lead said "I think that's very damaging, the end of Healthwatch" (DTW6), while another commented "I think some Healthwatches nationally probably have done a really good job but some it's a bit like, not quite sure what they've achieved really. But yeah, I do see the [VCSE] sector being able to step in there" (TXYE). Another went further to argue that local Healthwatch "sits in a space where the voluntary sector should be sat" (08NM).

Integrated Care Boards

Interviewees raised a number of concerns about the suitability and feasibility of tasking ICBs to take on local Healthwatch functions, with three core issues arising.

First, ICBs lack the capacity and expertise to engage the public and currently lean on local Healthwatch. When asked how the ICB represents public and patient voice, an ICB board member said "I would say we are poor at that, the ICB; I think ICBs are poor" (HHER). They went on to say that they "do have organisations that tap into the community" but that local Healthwatch is one of those organisations and that the ICB is "just not necessarily clever at that" (HHER). A Local Healthwatch interviewee highlights the ICB's financial pressures, both in terms of stretched budgets and high staff costs: "they are losing so many staff ... If they got a section of money and were told, you can only spend this on engagement, they might. ... But they would probably get one engagement person. [Healthwatch] have a whole fleet of them" (FQDC).

Second, interviewees noted that ICB engagement with community voices has been inconsistent and does not drive decision-making. A VCSE leader complained that the VCSE are "asked to be part of some sort of collaboration" only to find out that the ICB or provider "has already thought of what the programme might be and how it will work" (TXYE). They argue that ICBs "need to speak to some of the service users first and see what they would like" (TXYE). An ICB interviewee was more positive, reporting workshops, engagement exercises, a community board that "were bringing everyone together" and the ICB were "listening" and "cocreating" (FR2Q). However, just as they were "starting to make traction," they were "thrown off track" by the announcement of ICB cuts (FR2Q).

Third, interviewees suggested that the public does not understand or connect with ICB structures. An ICB Director observed that "over the years, when you try and, say, communicate what a CCG is and what a PCT is and what an ICB is, it generally means nothing to most people" (2SO1). Another ICB interviewee acknowledged this, and emphasised the importance of bodies like Healthwatch in linking commissioning organisations with the public: "I don't think many people understand what we do and, I suppose, there's a bit of me thinks does that really matter? Because we're so far removed from some people, but it's about how you use the agencies and the advocates [to] bring it together, the intelligence and the feedback" (TTBZ).

Several interviewees from different parts of both our case study ICSs expressed confusion about the decision to abolish Healthwatch, and concern about how their core functions could be maintained or redistributed by other actors. As one local Healthwatch team member told us: "none of them we've spoken to at ICB or any of the local councils have said that they wanted this change to happen, they all wanted it to stay exactly as it was, they didn't have a problem" (FQDC).

How might others respond to the abolition of Healthwatch?

As outlined above, various organisations currently perform public engagement functions. NHS Trusts and ICBs often have 'community engagement officers', and/or 'quality assurance officers', but neither of these roles amounts to the multiple functions that Healthwatch bring to the system. These roles, and existing patient forums in some Trusts, are likely to continue post-Healthwatch, though they may lose some coherence and statutory clout.

It seems highly unlikely that this would expand or fill the gap left by Healthwatch. Our broader analysis shows a system in which all organisations are under heavy pressure in terms of demand and finances. It is not realistic to assume that any part of this system will 'step up' to fill a new duty unless it is made a statutory requirement. If the duty was made a statutory requirement (e.g. of ICBs), there remains a financial challenge. Our interviewees report that if the ICB were given the same funds currently allocated to Healthwatch, there would be less activity – the ICB have higher staffing costs, they lack the volunteer programme, and don't have the same active networks. If those resources were not ringfenced, the ICB would likely divert some of the resources to address budgetary shortfalls elsewhere.

VCSE organisations might take on more committee roles or PPIE commissions post-Healthwatch, but interviewees in this sector complain about a lack of remuneration and recognition for their existing work. And, for the VCSE to channel public voice, much depends on the existence of infrastructure organisations, which are likely to serve effectively but only in some parts of the country. Local authorities report even greater

financial pressure, with the cutting of HDRCs and an over-stretched public health budget, which makes it difficult for them to move into the space vacated by Healthwatch.

Conclusion

This briefing has outlined findings from our ongoing research as part of the 'Post-Implementation Review of the Health and Care Act 2022', which relate to the functioning of local Healthwatch in the NHS and social care landscape since the Health and Care Act came into force in 2022. Of the 80+ interviews undertaken at the time of writing, the vast majority of those who spoke about Healthwatch viewed them positively; just two interviewees expressed ambivalent views about the influence of Healthwatch where ICBs did not act upon their findings.

The most significant finding from our research relates to the high value placed by local service commissioners and providers on the independence of the local Healthwatch voice. Local Healthwatch organisations are uniquely positioned actors across the health and social care system because of their operational independence from local NHS and social care organisations. They often operate at a similar scale to many service providers, allowing them to build good relationships with local communities, including service commissioners and providers. Local Healthwatch organisations are seen as an independent and neutral voice, which can represent and advocate for patients and the public as a trusted local partner.

Our findings suggest that, despite local differences in the delivery of local Healthwatch functions shaped by funding, differing organisational structures and local partnership working arrangements, there are aspects of local Healthwatch working which are common across many local Healthwatch organisations. We identified a wide range of local Healthwatch activities, from contributing to service development and commissioning decisions, to monitoring and sharing patient and public experiences of services. However, the influence of Healthwatch on the planning and provision of services can vary. This reflects both limits to commissioner and provider engagement, and the impact of limited Healthwatch funding.

The proposed abolition of local Healthwatch represents the loss of several important functions, as well as the loss of relationships and institutional memory. The majority of our interviewees expressed misgivings about the decision to close Healthwatch and reported little appetite for other parts of the system taking on its functions and responsibilities. No other system partner is a perfect replacement for Healthwatch, though some are more suitable than others. The VCSE sector would be best placed to take on local Healthwatch functions, though this depends on the provision of adequate funding and the local presence of VCSE infrastructure organisations. It would also require a public body to act as a commissioner. Our findings suggest ICBs are the least suitable system actor to take

on Healthwatch functions given ongoing budget cuts, their lack of independence, and a relatively poor track record of PPI.

Whoever takes on Healthwatch functions, there are issues inherent in any such transfer; primarily, a lack of funding, competing priorities and the potential for real or perceived conflicts of interest. If local Healthwatch functions are transferred to organisations that directly commission or provide services, it would be essential to consider how to maintain an independent PPI voice. Our research has highlighted the importance of this independence, together with the provision of adequate funding and strong relationships between Healthwatch and service providers. These issues are fundamental to ensuring that public and patient voices continue to be heard by health and care decision-makers.

References

Bates, E. (1982) Can the Public's Voice Influence Bureaucracy? The Case of Community Health Councils. *Public Administration*, Vol. 6. http://doi.org/10.1111/j.1467-9299.1982.tb00467.x

DHSC (2025) *Model Integrated Care Board – Blueprint v1.0*. https://www.digitalhealth.net/wp-content/uploads/2025/05/Model-Integrated-Care-Board-%E2%80%93-Blueprint-v1.0.pdf

DHSC (2026) *Neighbourhood health framework*. https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework

National Audit Office (2020) Healthwatch Funding. Briefing for the Health and Social Care Committee, April 2020. Briefing for the Health and Social Care committee on funding for Healthwatch

Tiratelli, L. (2026) Healthwatch, unknown unknowns, and the value of a friend who tells you the truth. 31 March 2026. https://www.kingsfund.org.uk/insight-and-analysis/blogs/healthwatch-unknown-unknowns-value-of-a-friend-who-tells-you-the-truth#comments

Stewart, E., Desai, A., & Zoccatelli, G. (2023). Our NHS? The changing involvement of patients and the public in England's health and care system. In M. Exworthy, R. Mannion, & M. Powell (Eds.), *The NHS at 75: The State of UK Health Policy,* Bristol: Policy Press.

Zoccatelli, G., Desai, A., Robert, G., Martin, G., & Brearley, S. (2022). *Exploring the work and organisation of local Healthwatch in England: a mixed-methods ethnographic study*. National Institute for Health and Care Research. https://doi.org/10.3310/YUTI9128