The King's Fund
Bold thinking for better health

The future of patient voice

Learning from the Healthwatch model

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About this report

This project has been jointly funded by Healthwatch England and The King's Fund.

However, this output has been independently developed and written by The King's Fund.

Key messages

Background

- Since 2013, Healthwatch has operated nationally and locally to gather the views of people using the health and care system in England. Its primary role has been to support improvements to services by reporting people's experiences, which it has done by working with communities across England, collecting feedback on health and care services, and sharing this information with government bodies and local systems to inform policy and service development.
- On 27 June 2025, the government announced plans to close Healthwatch England and the network of 153 local Healthwatch organisations. In line with recommendations from the Dash review of patient safety, the government plans to transfer the strategic functions of Healthwatch England to the Department of Health and Social Care (DHSC), and the statutory functions of local Healthwatch organisations to NHS integrated care boards (ICBs) on health care and local authorities for views on adult social care.
- In light of these planned changes, this research explores what can be learned from the Healthwatch model, including what has worked well, what the challenges have been and how this can inform the government's planned changes to how patient and service user experiences are collected and used. The King's Fund reviewed existing evidence, conducted interviews and carried out two workshops with local and national stakeholders.

What did we learn from our research?

- Healthwatch's independence has ensured it's been seen as credible by communities and allowed scrutiny of issues the health and care system may overlook. Independence from government and services has enabled local Healthwatch and Healthwatch England to provide objective, impartial and trusted advice and guidance to help people navigate the health and social care system and understand their rights.
- The 'hub and spoke' structure, which successfully combined local reach with national influence, allowing insight from communities to shape policy debates. Strong local relationships – especially with people less likely to engage with statutory bodies and those affected by health inequalities – were also key to the model's strength.
- Healthwatch has also collected significant volumes of qualitative and quantitative feedback since it was first set up, including unsolicited insight not always captured elsewhere. This has helped the health and care system capture emerging issues that mattered to patients, service users and local communities, and helped place issues such as NHS admin failures and access to GP and dentistry higher on the national policy agenda.

- However, because of its limited statutory powers and policy levers to directly drive change, Healthwatch has had a limited ability to move from insight to action: it could report on issues but could not hold the health and care system to account for addressing them. Some participants also noted that the large volume of Healthwatch reports and recommendations could at times leave the health and care providers and commissioners unsure where to focus or how to respond.
- Local Healthwatch did not, at times, feel like 'equal partners' in the face of better resourced parts of the system. This became more pronounced with the move from clinical commissioning groups to integrated care boards (ICBs).
- While these dynamics were exacerbated by the increasingly unequal footprint, there were also deeper, longstanding issues rooted in the unequal power balance between the NHS and local Healthwatch, and in the lack of importance that patient and public voice has generally been afforded in the NHS over time.
- The relationship between Healthwatch England and local Healthwatch could be strained at times and tensions arose over the extent to which Healthwatch England could direct what local Healthwatch worked on, how they collected the data and how it was reported.
- The overall Healthwatch budget, particularly at a local level has also fallen over time, placing limitations on its impact and effectiveness. Due to the local commissioning model, funding received by each local Healthwatch also varies significantly, contributing to variation in capacity and capability across the network of local Healthwatch.

Implications for the future

- Whatever replaces Healthwatch must build on the core conditions that enabled it to have a positive impact: a voice independent of government and services; the capacity to gather unsolicited, varied and rich community insight, including from seldom heard groups; and a geographical scale that supports both local insight and system or national-level influence.
- Healthwatch has operated alongside a range of other patient and service user feedback mechanisms. The abolition of Healthwatch creates a pivotal moment to review all the ways that people share their views and provide feedback to ensure patient and public voice is central to how services are both commissioned and provided.
- Any future model must enhance – not weaken – the system's capacity to hear, understand and respond to people's experiences. It needs to maintain a level of independence from the health and care system to ensure that whatever is put in place can speak truth to power and raise difficult messages where necessary.
- The merging of ICBs and workforce reductions raise concerns about their ability to engage communities meaningfully at scale. A hub and spoke architecture for any future model should remain, but there should be clarity on how this aligns more deliberately to local government, new ICB clusters and neighbourhood structures and footprints.

- The government should provide clarity on what comes next and must manage the transition carefully to retain expertise and avoid losing trusted relationships built over many years. This means engaging with local Healthwatch and system partners quickly and meaningfully to understand how and when the full range of its functions that extend beyond gathering feedback and include helping people navigate the complex health and care system and understand their rights will transfer to new bodies as part of the proposed reforms.
- The new Director of Patient Experience role in the DHSC has the potential to give patient experience the prominence it needs, but only if it carries sufficient authority and the ability to hold others to account across government and the health and care system.
- Any new model needs to reflect the importance of partners listening together and acting on what they learn. There should be a renewed focus on ensuring that patient and service user voice is central to how the health and care system operates – this will rely on leadership and organisational cultures that genuinely prioritise the experiences and perspectives of those who use services.

1 Introduction

Since 2013, Healthwatch has operated nationally and locally to gather the views of people using the health and care system in England. Created, in part, as an early response to the care scandals at Mid Staffordshire Foundation Trust (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013), its role has been to support improvements to services by reporting people's experiences, which it has done by working with communities across England, collecting feedback on health and care services and sharing this information with government bodies and local systems to inform policy and service development.

On 27 June 2025, the government announced plans to close Healthwatch England and the network of 153 local Healthwatch organisations. This decision was informed by the Dash review (Department of Health and Social Care 2025), which concluded that there has been considerable duplication between different patient and public voice organisations (*see* section on the Dash review below for more information). The intent to abolish Healthwatch was then made explicit in the 10 Year Health Plan (Department of Health and Social Care 2025a).

In line with the Dash review recommendations, the government revealed plans to transfer the strategic functions of Healthwatch England to the Department of Health and Social Care (DHSC) and the statutory functions of local Healthwatch organisations to NHS integrated care boards (ICBs) on health care and local authorities for views on adult social care. However, beyond this, there has been little clarity so far about when the abolition of Healthwatch will happen (apart from acknowledgement that it will require primary legislation), what gaps the abolition will create and what will be put in place to fill the gaps it leaves.

These decisions alone are significant, but even more so when taken together with the scale of changes on the horizon for the health and care system, including the abolition of NHS England (Department of Health and Social Care 2025b) and the merging of 42 integrated care systems (ICSs) into 26 clusters (Williamson and Tether 2025). As such, the abolition of Healthwatch raises big questions about where and how patient and public voice will sit in the new – as yet unclear – system architecture.

In light of these changes, we have conducted work to explore what can be learned from the Healthwatch model, including what has worked well, what the challenges have been and what could be done differently in the future. The work considers what this learning means for the future of patient and service user experience and how health and care systems will hear from those who use their services.

There are two substantial sections to this report. First, the research findings, in which we share stakeholders' views and insights from the evidence scan about what can be learnt from the Healthwatch model, the impact it has had and the future of listening to patients and communities. The second substantial section outlines The King's Fund's views on these findings, based on what we've learnt from this project and ongoing conversations with key stakeholders and drawing on our broader body of work, particularly on integration and patient experience.

A note on language

Where we use the term 'the network', we are referring to the network of local Healthwatch organisations, of which there are (at the time of writing) 153. When we refer to Healthwatch England we are referring only to the national body.

Where we refer to 'Healthwatch', we are speaking about both Healthwatch England as the national body and the network of local Healthwatch organisations.

Where we mention 'the new patient experience function', we are referring to the government's proposal to establish a National Director of Patient Experience within the DHSC.

About this project

This project has been jointly funded by Healthwatch England and The King's Fund. However, this output has been independently developed and written by The King's Fund.

The work has involved an evidence scan (led by Healthwatch England), two workshops and six interviews with national and local stakeholders (led by The King's Fund). Please see the appendix for more information about our methods.

Through these activities, we have engaged 33 national and local stakeholders, and with them we have explored:

- what can be learnt from the Healthwatch model, including challenges and successes
- the impact Healthwatch England and the network of local Healthwatch organisations have had in the 14 years since they were created
- how, in the absence of Healthwatch, the health and care system can most effectively hear from patients and communities in the future.

The focus of this work has not been to seek views on the decision to abolish Healthwatch but rather to rapidly review what can be learnt from the Healthwatch model and how the system can hear from patients and communities in the future. The work has been done at pace because of the imminence of the planned abolition of Healthwatch and in order to capture the learning to help inform upcoming legislation and national guidance. This piece of work is not by any means intended to be a comprehensive evaluation of the Healthwatch model.

We have also chosen to predominantly gather views on the proposed new patient experience function within the DHSC and not explore all the potential options for continuing Healthwatch's work in the future, of which there are of course very many.

About Healthwatch

Healthwatch was first proposed in a 2010 government White Paper (Department of Health 2010) and was formally established through the Health and Social Care Act 2012 (Local Government Association 2012), becoming fully operational in 2013. It emerged from a long line of patient engagement bodies, succeeding Community Health Councils (1974–2003) (The National Archives, undated), Patient and Public Involvement Forums (The Health Committee's Report on Patient and Public Involvement in the NHS 2007) and the Commission for Patient and Public Involvement in Health (both 2003–8) (Wikipedia 2024), and later Local Involvement Networks (LINks) (The Health Foundation, undated), which operated from 2008 until 2013.

Its creation was significantly shaped by the findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry, which exposed serious failings at the Mid Staffordshire Foundation Trust (The King's Fund, undated). The inquiry's recommendations influenced both the rationale for establishing Healthwatch and the model it adopted (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013) – particularly the needs to strengthen the collective voice of patients, service users and the public, and ensure that local Healthwatch bodies operated independently from the NHS.

Today, Healthwatch's role is to understand the needs, experiences and concerns of people using health and social care services and represent those views to decision-makers. It operates nationally as Healthwatch England and locally through a network of 153 Healthwatch organisations across England. A full summary of the statutory duties for both Healthwatch England and local Healthwatch is available on the Healthwatch website (Healthwatch, undated).

Healthwatch England

Healthwatch England is legally constituted as a subcommittee of the Care Quality Commission (CQC), with its chair appointed by the Secretary of State for Health and Social Care. However, it is operationally independent from the CQC, with a direct relationship to the DHSC sponsor team and a requirement to publish an annual report to parliament. Its role is to ensure that the voices of patients and the public are heard by decision-makers (Healthwatch, undated), using feedback to influence improvements in care and providing advice to health and care system leaders. At the start of 2025/26, Healthwatch England had 35 full-time equivalent staff, and its budget for the year was £3,350,000.

Healthwatch England advises the Secretary of State for Health and Social Care and NHS England on the public's experiences and improvements needed and can escalate the most serious concerns formally to the CQC. It is also a statutory consultee on the government's annual NHS mandate to NHS England and reports annually to parliament.

Healthwatch England supports local Healthwatch with training on engagement, research, communications and influencing, and provides day-to-day support from a team of regional managers. Healthwatch England also supports patients to access information and advice about health and care – primarily through online articles, social media and call handlers based in the main enquiries team of its host body, the CQC. In 2023/24, 219,761 people came to Healthwatch England for information and advice.

Local Healthwatch

Local Healthwatch are commissioned by local councils (Healthwatch, undated, a). Local Healthwatch vary in size, geographical footprint and commissioning models. Local Healthwatch are not accountable to Healthwatch England. The commissioning models in place for different local Healthwatch can be broadly grouped into the following:

- standalone – a social enterprise that shares the same name as the single local Healthwatch service it delivers
- single host – a social enterprise that carries a different name to the Healthwatch it delivers, with a single Healthwatch contract
- multiple host – a social enterprise hosting multiple Healthwatch contracts, and sometimes other contracted services, such as NHS Complaints Advocacy
- jointly commissioned – a local Healthwatch (regardless of delivery model) is commissioned jointly by a number of local authorities within a geographical footprint.

Local Healthwatch gather people's views about their needs and experiences of local health and social care services and raise them with the organisations that commission, provide and review health and social care, as well as sharing this information with Healthwatch England.

They gather these views and experiences through a combination of community outreach, surveys, online forms, focus groups, interviews, workshops and using 'enter and view' legal powers to speak to service users in health and care settings (Healthwatch 2022).

Local Healthwatch also promote the involvement of people in their local health and care services and provide impartial information and advice to the public about how to find and use services, their rights and where to raise formal complaints about care.

Local Healthwatch also have a guaranteed seat on council-led, statutory health and wellbeing boards, which produce local health and wellbeing strategies and drive partnership working between NHS, social care, public health and communities.

Information collected by Healthwatch England shows that the median local Healthwatch covers a population of 360,000, receives £144,000 of contracted funding from their council, employs 3.5 full-time equivalent staff and is supported by 20 volunteers (although there is significant variation). Councils receive non-ring-fenced funding from both the DHSC and the Ministry of Housing, Communities and Local Government (MHCLG) to commission a local Healthwatch service. In total, there are over 500 local Healthwatch staff and over 3,500 volunteers.

About the Dash review

What was the Dash review?

The Dash review (Department of Health and Social Care 2025) was a major independent review of patient safety across the health and care landscape in England led by Dr Penny Dash and commissioned by the DHSC. It was published on 7 July 2025.

Its purpose was to examine how well the health and care system protects patients, identify duplication and gaps across multiple safety-related bodies and recommend reforms to create a more coherent, effective and accountable patient safety architecture.

The review looked at six key organisations involved in patient safety, including Healthwatch England and local Healthwatch. The other organisations were the CQC, the National Guardian's Office, the Health Services Safety Investigations Body, the Patient Safety Commissioner and NHS Resolution.

What did it conclude overall?

The review concluded that there has been too much duplication and fragmentation, with too many bodies investigating, regulating and collecting patient-safety information. This has led to numerous recommendations from multiple bodies, which can overwhelm staff rather than support improvement, leading to limited impact. The review found inconsistent structures for listening to patients and frontline staff.

What did it say about Healthwatch?

The review recognised Healthwatch's role in amplifying patient and community voices but found that its impact was constrained by fragmented national and local structures. It found that the existing arrangement does not give patient voices the strategic influence required across health and care.

The review concluded that the work of Healthwatch England should transfer to a new directorate for patient experience within the DHSC. It recommended that the work of local Healthwatch should be transferred to ICBs and local authorities.

The Dash review's rationale for this was to:

- ensure greater clarity and improved effectiveness in bringing patient, user and community inputs into care planning
- support greater accountability from all organisations within an ICS to their local populations
- support improved commissioning of social care.

The review argued that these changes will help allow the existing deep patient advocacy expertise of Healthwatch England and local Healthwatch to have a greater impact, thanks to closer alignment with the commissioning and provision of care and greater emphasis on patient voice by the DHSC, commissioners and providers.

The review recognised that for this change to be meaningful and impactful (and to have the confidence of users and patients), the DHSC, local authorities and all 42 ICBs would need to fully embrace the ethos, responsibility and imperative to listen to the voice of users.

2 Research findings

Learning from the Healthwatch model

This section presents participants' insights shared in the evidence scan, interviews and two workshops on the key lessons to be learnt from the Healthwatch model: what has worked well, what has worked less well, the impact it has had and how the system should hear from patients and communities in the future.

What's worked well about the Healthwatch model

During our research, we heard the following key messages from participants about what has worked well about the Healthwatch model.

- Healthwatch's independence has ensured it's been seen as credible by communities and allowed it to influence improvements effectively within the health and care system.
- The 'hub and spoke' design of the Healthwatch model has been effective in terms of giving Healthwatch both a local presence and a national voice. Insights have been able to flow between these two levels.
- Local Healthwatch organisations have been able, for the most part, to build highly effective relationships with local communities, including with those who may have been otherwise less likely or able to put their voices forward.
- Healthwatch has been able to collect a very substantial amount of both qualitative and quantitative data, reflecting both solicited and unsolicited feedback from patients and communities.

Independence

A clear message that emerged during our research was around the value of Healthwatch's independence. When Healthwatch was set up in the wake of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013), independence from the NHS and the central government was seen as a key attribute by the then Department of Health. It is important to note, however, that as local Healthwatch are commissioned by local authorities, they are not independent from the commissioners of social care but are independent from NHS commissioners and providers. Local Healthwatch reports relating to adult social care are however conducted and presented independently of council involvement.

Independence was widely regarded by participants as a key factor in the impact achieved by local Healthwatch and Healthwatch England, enabling them to raise issues that providers, commissioners or government may have overlooked or found uncomfortable to raise.

> *[Healthwatch has] no skin in the game.*
>
> Interview participant

Many participants in our research felt that local Healthwatch's independence from the NHS and central government had enabled these organisations to develop trusting relationships with their local communities, including among those who may otherwise have been less likely to be engaged by NHS institutions or councils. Participants felt that independence from government has also enabled local Healthwatch and Healthwatch England to provide objective, impartial and trusted advice and guidance to help people navigate the health and social care system and understand their rights.

A workshop participant highlighted that being independent and not target driven has enabled local Healthwatch to respond to emerging issues and 'set our agendas... on the basis of what local people are telling us'.

Many participants expressed concern that removing the independence of the patient experience function by relocating it within ICBs, councils and central government could significantly limit its ability to provide effective scrutiny of the system.

Structure

Many participants in our workshops felt that the 'hub and spoke' design of the Healthwatch model had been successful at drawing up local experiences and issues and funnelling them into a national organisation that was able to set direction and have impact through relaying messages to the government and the wider system. For example, the work Healthwatch did to promote the issue of NHS dentistry (Healthwatch 2024).

We heard that the local Healthwatch 'spokes' have enabled close connections with local communities and allowed localised issues to be picked up. We also heard that many local Healthwatch have successfully managed a bridging role between patients and the public and different parts of the system since the creation of ICSs because they sit across multiple boards and structures.

> *[Local Healthwatch have a] consistent seat around the table... on both a local and a national level.*
>
> Workshop participant

Many participants suggested that because the remit of Healthwatch covers both health and social care, local Healthwatch hold a distinctive position, with an overview of the whole health and care system in their area. As such, they are able to warn against people 'falling through the gaps' between services and can co-ordinate feedback from multiple organisations across different sectors.

> *We are system wide, and there are not very many organisations that cross the system in the way that we do.*
>
> Workshop participant

Relationships with communities

The strength of the relationships local Healthwatch have with their local communities was emphasised by many participants. These relationships were enabled by the footprint they worked at, their independence, their ability to 'set their own agenda' and their consistency, having been in place for many years now. Healthwatch regulations ensured this by requiring local Healthwatch to involve members of the public in decision-making on their annual work programmes.

Local Healthwatch participants felt very strongly that this has enabled them to develop more trusting relationships with local communities than other organisations, noting that it 'takes time to build relationships and to be visible and to build trust' with communities who might be less likely to come forward and share their views.

We also heard of local Healthwatch organisations' strength in their ability to convene a range of people and communities locally, for example for research projects, due to their existing, trusted relationships.

Data collection

Healthwatch has collected a very significant amount of quantitative and qualitative data in the 13 years since its creation. Local Healthwatch and Healthwatch England receive both solicited and unsolicited data, which enables them to hear what patients and service users are experiencing and what is important to them and seek further information on particular issues that emerge.

The findings from the evidence review highlight that Healthwatch England hears from people in a number of ways: via the national online feedback form on the Healthwatch website, through commissioned national polling, at deliberative workshops and through commissioned projects run by selected local Healthwatch. Local Healthwatch hear from the public via phone, through online feedback forms and in person at public events and through targeted projects designed to reach specific groups of service users or seldom-heard people.

Healthwatch England and the network together now receive more than 16,000 pieces of (solicited and unsolicited) feedback from service users each month on average (Healthwatch 2022a). This figure drastically increased to 61,000 a month on average during the Covid-19 pandemic, when gathering patient views and experiences was especially critical.

Data collected by the network is shared with Healthwatch England, which then takes a qualitative thematic approach to analysis of this raw data. Three topics are chosen for 'deep-dive' analysis each month: a service area, a group of people and a cross-cutting topic. This has enabled Healthwatch England, through its analysis of all Healthwatch data, to explore and champion a wide range of issues.

Some participants spoke of the challenges local Healthwatch faced over many years in achieving consistent collection of demographic data and shared views that these have recently been addressed through the adoption of a shared taxonomy across the network, enabling Healthwatch England to collate and analyse data consistently across demographic groups. This progress took significant time to achieve – around a decade and multiple attempts – reflecting both limitations in earlier direction and governance and changing external requirements that rendered previous approaches less effective.

We heard from participants that in recent years, Healthwatch England developed an ability to pull together an 'intelligence system' to see whether an issue had been raised or work was being done on a particular topic anywhere across Healthwatch. This was useful to the wider health policy system.

Who Healthwatch hears from

During 2024/25, 79% of all Healthwatch England webform feedback came from women, and less than 1% came from people from Black and ethnic minority groups. In comparison, a more diverse mix of people gave feedback to local Healthwatch: 49% of feedback was from women, and 19% was from people from Black and ethnic minority groups in 2024/25.

Healthwatch England mitigates feedback gaps by commissioning national polling and surveys that capture a representative sample of the population. Local Healthwatch too undertake targeted research projects with specific communities, often highlighting a strong focus on health inequalities, including feedback from a wide range of demographic groups. Specific research has often been conducted to address the biases inherent in the unsolicited feedback – targeting particular groups affected by health inequalities.

This was reflected by many participants, who suggested that local Healthwatch have done a good job of building relationships with communities and hearing from a diversity of voices because of the trusted relationships built over time and their ability to collect data in a range of ways. For example, Healthwatch Herefordshire worked to understand and address barriers preventing people with learning disabilities from having annual health checks, which led to greater awareness among health care staff of the challenges experienced and better access to health checks for local people with learning disabilities (Healthwatch 2024a). Healthwatch Barking and Dagenham carried out research to explore why South Asian residents were not taking up social care support. This led to the council working with community groups to tackle misconceptions and make information more accessible to those whose first language is not English.

A range of stakeholders suggested that this activity varies greatly between different organisations in the network and that, overall, Healthwatch could do more to listen to those who are often excluded – crucial to any work to address health inequalities.

What's worked less well about the Healthwatch model

During our research, we heard the following key messages from participants about what has worked less well about the Healthwatch model.

- The Healthwatch model was conceived to correspond to a commissioning geography that no longer exists. Adapting to the advent of ICSs has not always been easy for local Healthwatch organisations that work at a much smaller geographic scale than ICBs.
- Healthwatch's commissioning model is widely seen as inefficient and ineffective. Participants argued that it leads to unhelpful competition between local Healthwatch organisations, and that having funding come from local authorities can be problematic for their level of independence when looking at social care issues.
- The fact that Healthwatch's budgets fell substantially over time led to resource issues in many local Healthwatch areas. The unequal way in which this occurred has accentuated variability between the effectiveness of different local Healthwatch organisations.
- Maintaining consistent and positive relationships over time between Healthwatch England and local Healthwatch organisations, and between Healthwatch England and other national organisations, has been challenging.

Geographical scale and footprint

The Healthwatch model was introduced in 2012 as part of a wider health system reorganisation that created 212 clinical commissioning groups (CCGs) (Department of Health and Social Care 2012), establishing a network of small local organisations that Healthwatch could easily align with.

While there was some geographical alignment between local Healthwatch and the commissioning system, this was not consistent across all areas. CCGs were more often – but not always – coterminous with local government boundaries and therefore with Healthwatch (Local Government Association 2012a), resulting in a closer overlap than is now the case with ICBs. In many areas, individual Healthwatch organisations engaged with multiple CCGs, and this picture shifted further as the number of CCGs reduced over time, declining from over 200 to around 170.

Several participants told us that things have become more challenging since the creation of ICSs. ICSs operate at a much larger geographical scale than CCGs did, and this, we were told, left local Healthwatch organisations feeling 'outgunned' at times by their system partners.

This dynamic has manifested in different ways. Some of our participants spoke about the power differences between highly paid and highly experienced ICB leaders and colleagues from local Healthwatch, who were perceived as less experienced and more junior. This was talked about as part of a broader issue of local Healthwatch struggling to feel like 'equal partners' in the face of better resourced parts of the system, whose primary concerns were often about issues that operated on much larger geographical scales. While these dynamics were exacerbated by the unequal footprint, some participants noted that they reflected deeper, longstanding issues rooted in the unequal power balance between the NHS and local Healthwatch, and in the lack of importance patient experience has generally been afforded in the NHS over time.

Commissioning

Many participants frequently criticised the commissioning model for local Healthwatch. They reported that recurrent retendering consumes significant time and diverts effort from core activities. The competitive nature of the process was also viewed as deeply counterproductive, at times forcing providers to compete aggressively with each other.

In addition, reliance on funding from the same local authority whose services a local Healthwatch is mandated to visit and collect experiences about was seen as suboptimal due to perceived conflicts of interest. Some participants said that local Healthwatch had been less effective in influencing social care than the NHS because of this funding relationship.

Funding

Funding emerged as a recurrent theme across our research as one of the factors, along with the others listed in this section, that at time hindered the effectiveness of the model. The DHSC and MHCLG both fund local Healthwatch; the former through a grant to local authorities and the latter through funds rolled into the main local government settlement. Councils then use these to commission local Healthwatch services.

A National Audit Office (NAO) briefing to the Health and Social Care Committee in April 2020 highlighted the complexity of local Healthwatch funding (National Audit Office 2020). It reported that although £43.5 million was made available to local authorities in 2013/14 to fund local Healthwatch, only £33.5 million was ultimately received by local Healthwatch organisations, a discrepancy the NAO suggested may be due to the funding not being ring-fenced. Over the following decade, funding pressures continued to intensify. A report published in January 2026 showed that the overall local Healthwatch budget had fallen from £33.2 million in 2013 to around £25.9 million in 2024/25, representing a 43% real-terms reduction (Healthwatch 2026).

> *We should have sufficient funding to cover a 'base' number of staff, that gives us security then to apply for other funding. We just don't have the capacity to go for much other work. It's a chicken and egg situation – what comes first – the funding or resources to do the work?*
>
> Workshop participant

While some felt that local authority funding helps preserve local Healthwatch's independence from the NHS (*see* the 'The importance of independence' section), it also exposes services to wider pressures on council finances. The January 2026 report mentioned above also noted that many local authorities are under significant financial strain and often 'top-slice' Healthwatch budgets, which in some areas has resulted in no Healthwatch contract being awarded following a competitive tendering process. This was echoed by research participants.

> *The money that comes from the Department of Health… not transparent at all what happens to that money en route.*
>
> Workshop participant

The variability that exists between different local Healthwatch organisations was a theme that came up repeatedly in our research. Participants felt that there was a spectrum of ability among local organisations. This manifested in terms of how well they built relationships with their local communities (*see* 'About the Dash review' section). It also manifested in terms of how well they were able to then advocate for those communities within systems. This variability was in part about capabilities, but it was also impacted by funding. A February 2024 report on local Healthwatch funding made this relationship explicit (Healthwatch 2024b).

> *Some Healthwatch have experienced a disproportionate level of cuts. This has affected the original equitable distribution of Healthwatch funding and consistency in delivery across the network. Ten local authorities fund Healthwatch at levels falling significantly below half of the amount stated by the Department of Health and Social Care as the expected threshold. Twenty-three Healthwatch deliver their statutory functions on budgets of £100,000 or less with just two or less full-time equivalent staff.*

There was broad acknowledgement among participants that, while local Healthwatch should tailor their approach to local needs, the sector should aim to reduce unwarranted variation in capacity and capability – particularly where this stems from inequitable funding. Many participants underscored the link between impact and investment, noting that resources have often been insufficient and have declined over time.

Faced with shortfalls, many local Healthwatch have been resourceful and raised extra income, which in some cases has been worth 85% of the funding they receive from councils. There has been some support from NHS commissioners in bolstering local Healthwatch resourcing, with the network reporting £1.45 million in funding from some, but not all, ICSs in 2022/23. This might be for one-off commissioned engagement projects, or long-term funding of facilitation posts across multiple local Healthwatch in complex ICS footprints.

Relationships

Between Healthwatch England and the network

Local Healthwatch existed in various forms prior to the creation of Healthwatch England (*see* 'About Healthwatch' section), which was set up to help make sense of the data being collected by the network (a major challenge on which significant progress has been made: *see* 'What's worked well about the Healthwatch model' section) and support local organisations to do their work effectively and be a conduit for national escalation to government and regulators.

One participant suggested that in the early days of the national function being set up, local Healthwatch organisations – with their well-established relationships with other organisations and communities – helped the national team to navigate their new role. Over time, this dynamic shifted, as Healthwatch England took on more policy analysis and development work and focused on cohering efforts across the local organisations. It was suggested that this shift in power dynamics gradually intensified tensions between the national and local organisations.

Another key tension highlighted was around data collection and sharing between the network and Healthwatch England. Some participants suggested that the root cause of this was that local Healthwatch systems were not designed for effective data sharing and some in the network did not share the required data, in part because they saw

Healthwatch England as just another stakeholder rather than a central co-ordinating body. Others suggested that the reporting requirements for local Healthwatch organisations were too onerous, especially in combination with reporting requirements to other organisations, eg, the commissioning local authorities, and often have only very small teams.

Some suggested that this tension was compounded by the variation across the network, which made consistency and collaboration difficult to achieve.

Between Healthwatch England and national bodies

Participants suggested that Healthwatch England established strong relationships with NHS England directors and maintained good connections with the DHSC.

> *[NHS England] have consistently called us in to understand what evidence we've got about policy issues.*
>
> Interview participant

However, it was also suggested that these relationships were not always consistent. Levels of engagement varied over time, reflecting changing priorities among ministers, officials and Healthwatch England itself.

We heard from one participant that early in its development, Healthwatch England experienced uncertainty about the scope of its public role, including what it could or could not comment on, which at times created tension with the DHSC. Although expectations became clearer over time, these informal understandings were not always dependable, and occasionally broke down.

More broadly, it was suggested that this instability highlights the fragility of relationships and the difficulty of maintaining consistent influence within a shifting political and organisational environment. Some participants suggested that these challenges may intensify if the patient experience function is positioned within the DHSC as expected.

Impact of the Healthwatch model

During our research, we heard the following key messages from participants about the impact of the Healthwatch model.

- The Healthwatch model was felt to have more impact than previous iterations of patient voice functions. Some suggested it had worked out ways to have more impact over time.
- Healthwatch drew attention to key policy issues (for example dentistry, GP access and NHS admin) at times when those issues were being overlooked by the wider system.
- However, some felt that Healthwatch only had limited levers available to make impact. At times, some felt that it was overly reliant on simply writing reports about chosen topics.
- There has been variation in terms of the impact different local Healthwatch organisations have been able to achieve.

Many participants were largely positive about the impact Healthwatch has had over the years. It was acknowledged that Healthwatch had become more effective over time and had more impact than the previous iterations of patient voice organisations that came before it (as outlined in the 'About Healthwatch' section).

> *This is the most effective version that's been developed so far.*
>
> Workshop participant

Some participants were keen to emphasise that Healthwatch took opportunities beyond its statutory duties to improve patient care and experience. For example, Healthwatch England has been closely involved in health and care policy development by working with organisations such as NHS England and by putting forward its own policy recommendations, thereby increasing its impact. Some highlighted that because of this, it is crucial to consider the impact of Healthwatch in the round – acknowledging all the many contributions it has made – and not just against its statutory duties (Healthwatch, undated).

There was a strong view that Healthwatch has effectively drawn attention to important issues at critical moments, helping generate political focus and drive policy changes in areas that had been overlooked by the system but were causing negative experiences for patients and service users.

Participants highlighted some notable successes Healthwatch had in the following areas where it successfully brought issues to the attention of health policy-makers leading to tangible policy change: dentistry (Healthwatch 2024), the Accessible Information Standard (Healthwatch 2025), maternal mental health (Healthwatch 2023), waits for elective care (Healthwatch 2023a), GP access (Healthwatch 2022b), NHS admin (Healthwatch 2025a) and hospital discharge (Healthwatch 2025b). Healthwatch revisited some of these issues on numerous occasions, which one participant noted increased Healthwatch's impact.

The Dash review noted a number of areas where Healthwatch England has had impact, including the *Suffering in silence* report, when Healthwatch collaborated on a consumer-led complaints system, which is now part of the CQC's inspection framework (Healthwatch 2014). The Dash review also cited its work around Covid-19, the national data opt-out and patient transport support, which led to improved non-emergency transport criteria, addressing challenges faced by those in need of reliable transport to health care facilities.

The evidence scan revealed that Healthwatch's reach has also increased over the years, with more than 9,000 media mentions in 2024/25 and almost 100,000 visitors to the Healthwatch England website each month during the last quarter of 2024/25. According to stakeholder perception polling commissioned by Healthwatch England, between 2018/19 and 2023/24, awareness of Healthwatch also grew from 51% to 60% among MPs, remained around 60% among councillors and increased from 76% to 88% among local stakeholders (including commissioners).

Several participants highlighted an over-reliance on producing reports within Healthwatch. Some participants noted that the large volume of Healthwatch reports could at times leave the NHS unsure where to focus or how to respond. They felt Healthwatch had since adapted its approach, concentrating more on areas where change was feasible and working more closely with NHS organisations to support service improvement.

> *I think there was an over-reliance on publishing reports… you do a bit of insight work and then you publish a report, and I think that is not a great way of working… where it's worked best of late has been where Healthwatch England has been able to*

> *inform the policy cycle and to take advantage of the policy cycle to make sure that what they are investigating are things which are reasonably likely to change.*
>
> Interview participant

Linked to this was a criticism that Healthwatch has been good at identifying where things were not working, but not good at showing where they were so they could be learnt from.

> *I think I agree with some of the critique, especially that it's not really tenable to have an ecology where you've got so many recommendations being put forward to the same organisations to try and make sense of and I think had too much of a focus on the surfacing and what's going on and not enough on the change and improvement.*
>
> Interview participant

Some participants reflected that Healthwatch (particularly the national function) has not been very effective at communicating the implications of research findings and policy messages beyond the delivery of written reports and associated communications around them, which were likely to only serve specific audiences. However, it is important to note that Healthwatch only had limited levers at their disposal in this regard considering their statutory duties.

We heard that many local Healthwatch, despite their small size and sometimes extremely limited resources, have had impact locally, including through their reports and insight, additional complaints advocacy work and supporting patients to navigate a complex system. The Dash review also cited a number of examples of local Healthwatch's impact, including work in Derbyshire on improving discharge and reducing readmissions and work in Milton Keynes that led to improvements in care and safety for women on mental health inpatient units.

> *On the ground, they've [local Healthwatch organisations] produced a lot of really good work for what are quite often small organisations... the product has often been very good, the insight has often been very good.*
>
> Interview participant

There have also been examples of national impact from the work undertaken by the network:

- Healthwatch Lincolnshire gave evidence to a 2022 Health and Social Care Committee inquiry about the impact of residents living in a 'dental desert' along with written submissions from nearly 30 other local Healthwatch. In its subsequent report, the cross-party committee of MPs declared a 'crisis of access' in dentistry (Healthwatch Lincolnshire 2023).
- During the Covid-19 pandemic, intelligence from local Healthwatch about Do Not Attempt CPR (DNACPR) being applied to patients without sufficient discussion was escalated via Healthwatch England to the CQC (Care Quality Commission 2020), which ultimately issued guidance on DNACPR decisions (Care Quality Commission 2021).
- Healthwatch Blackpool produced work on vaping among young people that was referenced in the House of Commons debates on the Tobacco and Vapes Bill (Healthwatch 2025c).

Local Healthwatch also hold a legal 'enter and view' power, enabling them to visit health and social care services and gather first-hand feedback. One participant highlighted how evidence from an enter and view visit had directly informed a subsequent CQC investigation and even a public inquiry, suggesting that this demonstrates the importance of enter and view as a mechanism for generating insight into individual services.

While the independence of Healthwatch was seen as a key strength, some participants questioned its ability to drive change. Healthwatch has been able to draw attention to issues both at a national and local level, however, its rather limited statutory powers (Healthwatch, undated) mean it has had little leverage to ensure that findings are acted upon. A recurrent theme was that local Healthwatch are often not heard by system leaders, clinicians, practices and providers – partly because there is no statutory obligation on those bodies to act on local Healthwatch feedback or recommendations, although there is a statutory duty for those bodies to respond in some way within 20 days.

Despite this, several participants also suggested that local Healthwatch were impacted by having 'too many masters' (eg, Healthwatch England, local authorities, the wider system and communities themselves) and that they therefore had to spend an unhelpful amount of time meeting onerous reporting requirements.

Some participants commented on the lack of effective data collection mechanisms across the network, which resulted in methodological issues and constraints (eg, lack of sufficient evidence) on what Healthwatch England could comment on. Others, particularly participants from local Healthwatch, suggested that more support from Healthwatch England (eg, engagement and methodology toolkits) would have helped to ensure consistency of data collection across the network and therefore the impact of their outputs.

> *The design part of projects is extremely time consuming. All local Healthwatch delivering slightly different projects on the same theme makes combining data difficult and therefore difficult to have national impact.*
>
> Workshop participant

Healthwatch England runs multiple workshops each year for local Healthwatch to give advice on engagement and research methods. However, the nature of the model prevents Healthwatch England mandating all local Healthwatch follow the same approach. Healthwatch's challenges in achieving consistency in collecting demographic data and improvements over time are discussed in the 'What's worked well about the Healthwatch model' section.

Another challenge has been the health and care system's preference for quantitative metrics. Qualitative evidence – often central in exploratory work – was not always well understood or valued by system leaders, making it harder to translate insights into action.

One participant expressed the view that the existence of Healthwatch may inadvertently allow provider organisations and commissioners to abdicate responsibility for understanding and improving patient experience, relying on external reports rather than taking proactive internal action. Furthermore, relying on external organisations for patient experience feedback can lead to delayed action and missed opportunities. This view held that while Healthwatch and similar organisations can produce high-quality reports that prompt reflection, lasting change within provider organisations requires leadership and cultural change at the board level.

Some also raised questions about how Healthwatch's impact is assessed. Measures were sometimes viewed as crude – focusing on outputs (eg, numbers engaged) – rather than outcomes linked to changes in services or patient experience. Given Healthwatch's limited control over how its insights are used, demonstrating impact is inherently difficult. The cost-effectiveness of Healthwatch has rarely been assessed at the local level. Small, not-for-profit providers operating with shrinking budgets often lacked the capacity to fund formal evaluations of their impact.

More broadly, many participants felt that Healthwatch operates within a policy space that is not consistently valued across the NHS. As a result, listening to and learning from communities often remains peripheral rather than central to organisational decision-making, limiting the extent of Healthwatch's influence.

Listening to patients and communities in the future

During our research, we heard the following key messages from participants about how to most effectively hear from patients and communities in the future.

- Many were in favour of replicating the 'hub and spoke' design of the Healthwatch model going forward. However, views differed on what the optimal geographical scale of any new organisations should be, particularly in terms of how that scale relates to ICSs.
- There is scope to go beyond simply being a function that gathers and shares feedback. Some of our participants wanted to see a new model become something that is able to engage in co-production to collectively find solutions and improve services.
- We encountered strong sentiment that any new model must be independent from government and the wider health and care system if it is to gain public trust.
- A new model that focuses on ensuring minimum standards among local bodies will have a chance to address variation in capability and impact across geographies.
- We heard a range of views about whether a new function would be best led by a subject matter expert or by someone with significant existing profile and relationships who would serve more as a catalyst for action.

Some participants held a pragmatic view that creating a new model could help to address some of what had been working less well in recent years (as discussed in the previous section) and create a more streamlined and focused system that is easier for the public to navigate. Above all else, there was a general consensus that whatever is put in place to replace Healthwatch must build on its strengths and address the areas for improvement.

> *What comes next has to be better than Healthwatch.*
>
> Interview participant

Here we summarise participants' views on how the system should hear from patients and communities in the future.

Local bodies and geographical scale

In terms of structure, there was consensus among participants that retaining a 'hub and spoke' model would be desirable. This would involve retaining a national or regional organisation as the 'hub' and a network of local organisations spread across the country as the 'spokes'. The benefit of local Healthwatch or other organisations at this scale, it was argued, is that they are able to build genuine relationships with communities.

> *The bigger it [the organisations that make up the system] gets, the less connected to people it becomes.*
>
> Workshop participant

However, many participants raised questions about what the scale of the 'local' bodies should be going forward. The previous model was established to correspond to CCGs, but in a world of ICSs, some felt that the scale may need to be larger so that local organisations don't feel 'outgunned' by system partners (as described earlier).

According to some participants, there is a risk that as ICSs merge and grow, this dynamic will become more problematic. However, others felt that the new model could include smaller sized organisations in order to work at a scale conducive to the government's proposed new focus on neighbourhood health (NHS England 2025).

Ensuring all voices are heard

Many participants we spoke to felt that a limitation of Healthwatch is that it has often been limited to simply gathering information and relaying it to others. They hoped that a new model might have powers to go further – perhaps being able to coproduce solutions to the problems they uncover with the communities they work with.

One of the issues raised by participants was how confusing it can be at present for members of the public to work out where to take their views and experiences.

> *[Currently] there are too many people trying to represent patient and public voice, so it's confusing to the public.*
>
> Interview participant

Participants suggested that a new model should therefore aspire to being radically simplified and have sufficient status and trust so that people can come to it proactively, believing the information they share will be acted on.

Some participants felt strongly that any new model should retain the ability to collect and analyse unsolicited feedback – not just feedback on issues the system specifically asks for – so as to ensure a mechanism for learning about issues experienced by people and communities but not necessarily known by the system.

Throughout the research, several participants expressed concern that the new model could place too much reliance on the NHS App as the primary channel for collecting feedback. They warned that this could exacerbate digital exclusion and limit progress in listening to a broader range of people over time.

> *I am optimistic if they seize the opportunity in the right way, but it could go horribly wrong. This could turn into an app analysed by ChatGPT. And that would really do a massive disservice to health inequalities and actually just patient experience generally.*
>
> Interview participant

Several participants also highlighted that an over-reliance on the NHS App risks producing shallow or fragmented insights rather than the depth of understanding needed to drive meaningful improvement. Others, however, noted that if used appropriately, digital technology could help bring together data collected across different organisations, enabling richer analysis and greater overall impact.

Addressing variation and ensuring standards

The majority of participants felt strongly that local bodies should form the basis of the new patient experience function, given their proximity to communities and history of having built trusted relationships with them over time. However, one issue inherent to this model that was repeatedly mentioned in our research was the variation between the capacity and capability of different local organisations to do this.

Throughout the research, we heard that some organisations within the network have been better than others at, for example, building relationships with the wider system, reaching all the communities within their footprints and building effective and skilled teams within their own organisation.

> *[When you look at] Healthwatch around the country, you can see that variation, and that was always something that was of concern to the leadership of Healthwatch England. Particularly in a climate where budgets were reducing year on year.*
>
> Interview participant

We heard from some that the approach of local Healthwatch have been varied to ensure organisations' meet local needs, and that this is both to be expected and appropriate. However, some participants felt strongly that variation in capacity and capability caused in part by inequity in funding should be reduced in a new model. It was suggested that in order to remedy this, more joined-up approaches are required to help ensure minimum standards are met across all the local bodies involved in whatever model comes next.

Ensuring independence going forward

Perhaps the strongest message we heard during our research about what needs to be ensured in the design of a new patient experience function was that it should be independent, or at least there should be robust processes in place to avoid conflicts of interest. This was felt to be important for numerous reasons. First, several participants suggested that patients will not offer their feedback if they do not believe they are speaking to an independent organisation – one that is seen to be separate from central government and the NHS – for fear of upsetting their clinical team, which may impact on relations and future treatment.

> *The reality is that people won't raise a concern if the only place they've got to raise it is with the organisation [itself].*
>
> Workshop participant

Second, many participants felt that independence is key to ensuring that difficult messages are communicated and emerging issues are not ignored. They therefore raised concerns about the legitimacy of a new model which operates from within central government and/or relies on data collected directly by providers.

> *If what comes next is essentially providers marking their own homework, then we will have very little scrutiny and ability to shift practice.*
>
> Workshop participant

If the new model will not safeguard independence, it was suggested that it must at the very least be fully transparent (eg, about what data is collected and how it will be acted upon) and clear about how it will be held to account.

Leadership of the new model

A key question raised by several participants was what the leadership of the new system should look like. Some were concerned that a new National Director of Patient Experience role sat inside the DHSC may struggle to be sufficiently critical of – and independent from – the wider system. For some, there was an inherent issue with this kind of work being done by civil servants, as it may be difficult for those duty bound to deliver the government's agenda to also scrutinise it.

Some suggested that there might be an opportunity to create more practical and powerful levers for the patient experience function if it could be brought into closer orbit with quality improvement work within the DHSC, as well as connect with the work of other departments across government. They also felt strongly that for patient experience to drive meaningful and sustained improvements in quality, it needs to sit within a more central part of the department rather than be located within nursing or medical directorates as a subsidiary function, where its reach and impact may be constrained.

Several participants also raised questions about what kind of person might best fulfil the new director role. Some felt that it would be most beneficial to have a subject matter expert, while others made the case for someone with some existing profile and wide-ranging relationships within government and the system who could bring people together and catalyse action.

3 The King’s Fund’s reflections

This work does not constitute a formal evaluation. However, it offers a good understanding of Healthwatch’s evolution – its achievements, areas for improvement and, most importantly, lessons for how the health and care system should engage with people and communities in the future.

The research identifies some important unresolved questions that need to be answered to deliver transformative improvements to how the health and care system listens to and learns from patients and the public. However, if these questions are addressed with due care, the approach to listening to and learning from patients and service users could be transformative.

Whatever follows the abolition of Healthwatch must build on what has worked before

There is a wider challenge in how the health and care system listens to and learns from the people it serves at both local and national levels. While Healthwatch has operated alongside a range of other feedback mechanisms – such as patient surveys, the Friends and Family Test, complaints processes and engagement functions within providers and commissioners – the decision to abolish Healthwatch was taken without a comprehensive review of the overall patient feedback landscape. Although the Dash review examined aspects of Healthwatch’s national role and governance, it did not assess the full breadth of local and national feedback systems or how these different mechanisms work together. As a result, the implications for the wider ecosystem of patient voice and experience were not fully explored.

This moment therefore presents an opportunity to take a holistic look at how people share their views, provide feedback and influence services, and to better align these approaches with the ambitions set out in the 10 Year Health Plan. This project has begun to outline what that future might entail.

Patient power features prominently in the 10 Year Health Plan. If the government is serious about ensuring patients’ voices are central to the future of the health and care system, it must take seriously what might be lost with the abolition of Healthwatch (Woolnough 2026). Crucially, it must ensure that whatever model is put in place to replace it preserves and strengthens some of the core conditions that enabled Healthwatch to succeed: genuine independence, rich and varied data collection and an appropriate geographical scale for engagement and influence.

Decommissioning effectively

The DHSC needs to draw on lessons from previous attempts to abolish public services (Dalton *et al* 2023), recognising the importance of considering wider system impacts and ensuring leaders and staff have the clarity, capability and incentives needed to deliver genuine improvement through the abolition process. This means engaging with Healthwatch quickly and meaningfully to understand the full range of its functions and identifying which functions will be retained and how and when they will transfer to new bodies as part of the current reforms. Work also needs to be done with ICBs, local authorities and other health and care partners to explore what is needed from their perspective. Decommissioning Healthwatch effectively, and clearly outlining how the new arrangements will work, will help to minimise all that might be lost in the transition. This includes the risk of losing experienced staff and volunteers with deep understanding of their local communities. A prolonged period of uncertainty risks deepening doubts about the decision and will likely make securing people's support for the new model more difficult.

The importance of independence

Independence emerged as the single most important theme throughout this work. Stakeholders consistently emphasised the need for an independent body – both locally and nationally – that is able to speak truth to power. Healthwatch's perceived position of having 'no skin in the game' has historically supported this independence: because Healthwatch has not been responsible for delivering services, it has been seen as a neutral and trusted voice, able to reflect people's experiences without organisational interests shaping its stance. However, this same position has also limited Healthwatch's power to create meaningful impact, as it has lacked the formal levers and authority required to ensure that its findings translate into real system change.

The proposed abolition of Healthwatch has therefore raised questions about how genuine scrutiny can be exercised if the function responsible for capturing and reporting people's experiences is embedded within the very system it is meant to hold to account. In particular, there is concern about whether a function situated within central government, NHS organisations or councils would be able to reflect and report people's experiences honestly, especially when those experiences are critical or expose systemic failings.

At a local level, independence is especially important for people experiencing serious problems with their care. When providers are defensive or unwilling to engage, individuals need somewhere trusted and separate to turn for support. The government admits (Streeting 2024) that the NHS has historically struggled to open itself up to scrutiny driven by patient concerns, often with tragic consequences (Wellings 2023). This places a premium on having credible, independent routes through which people can raise issues safely and confidently. For this to work, local arrangements must actively support people to come forward and must foster organisational cultures that are willing to listen, learn and act on what patients say rather than dismissing or managing concerns.

There are also significant risks around conflicts of interest. Some local Healthwatch organisations have already faced challenges when reporting on people's experiences of social care because they are funded by local authorities. If Healthwatch functions are brought into NHS organisations, similar tensions could arise, particularly where organisations are perceived to be the only bodies scrutinising their own performance. Mechanisms for local accountability, scrutiny and challenge that allow future patient and public voice functions to retain a degree of independence from those directly commissioning and delivering services and avoid conflicts of interest should be explored. There will need to be genuine commitment to transparency and improvement.

Power and transparency are also key

However, this work has also raised a critical and related question: what does independence achieve if it is not accompanied by the power – or at least the means – to drive change? Healthwatch both locally and nationally could raise issues but lacked the ability to drive change. Reporting people's views and experiences carries little value if it does not lead to action. Local and national Healthwatch bodies have historically lacked statutory powers to compel change, limiting the impact of their insights. Any new structures should address this gap by strengthening the links between insight, accountability and improvement.

Independence has made building trust with communities and enabling meaningful relationships easier, especially among those who are typically less likely to trust statutory bodies. Stakeholders expressed concern that losing this independence would also mean losing the ability to hold the system to account effectively. Where full structural independence cannot be guaranteed, this must be offset by a robust package of transparency and accountability measures. For example, producing annual reports or giving annual public hearings, such as through the Health and Social Care Select Committee. The NHS Quality Committee could also play an important role here. Any new function should routinely set out what it has learnt from data collection and engagement and clearly explain what actions will follow. Closing the loop from insight to improvement will be essential for making accountability tangible and maintaining public confidence.

Geographical scale: finding a balance between local engagement and system-level impact

Local Healthwatch organisations have been well suited to engaging communities directly, building trust and reaching groups that the health and care system often struggles to engage with, including those experiencing health inequalities. This is critical work: gathering insights from and working with communities who are among the highest users of health and care services, yet often experience the poorest outcomes, is essential to understanding where change is most needed. The Healthwatch Impact Awards provide good examples of this (Healthwatch 2024a).

However, Healthwatch has not been the only part of the system carrying out this work. Many voluntary and community sector organisations also play a significant role in engaging seldom-heard communities, often drawing on deep, longstanding relationships that allow them to surface perspectives that statutory services may otherwise miss.

Despite this broader ecosystem, the impact of local Healthwatch has been uneven, with variability in capacity, capability and focus across areas, driven in part by differing funding levels.[1] While this has resulted in inconsistent influence, it has also enabled a valuable diversity of local insight, surfacing issues that are specific, unexpected and highly relevant to individual communities. A future model should seek to reduce inequity in provision while

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[1] The amount of funding received by local Healthwatch from councils varies widely – from £45,000 to £500,000 a year. According to 2024/25 figures, this works out as between 19p and over £1 per capita. Ten per cent of Healthwatch organisations received less than 30p per head, and the average across the country was 46p.

retaining the strengths that come from local responsiveness and variation, supported by systematic sharing of good practice.

Changes to system architecture have further complicated this picture. Local Healthwatch were originally aligned with local authority boundaries, but the introduction of sustainability and transformation plans (Local Government Association, undated) and then ICSs disrupted this coterminous relationship, making it harder for community insight to influence system-level decision-making. With ICBs now reducing in number from 42 to 26, their footprints are becoming significantly larger, raising legitimate concerns about whether they can meaningfully engage with local communities at scale. These challenges are compounded by ICB workforce reductions (NHS England 2026) and cuts to engagement with local partners (Arnold *et al* 2025), at a time when patient and public engagement has been identified as a strategic growth area – further increasing the risk that community voice is marginalised.

There are tensions in the proposals to transfer Healthwatch functions into ICBs and to local authorities

Beyond concerns about independence, this approach risks weakening connections with communities if the skills, relationships and local knowledge developed by Healthwatch are not actively retained.

Moreover, the proposals to split Healthwatch's functions across multiple organisations (eg, between ICBs and local authority engagement teams) could also undermine its distinctive value: being well positioned to collect data across a range of services and settings rather than engagement focused on organisational silos (as provider-gathered feedback is). There has been a move in recent years to better understand how people experience the co-ordination of services (Thorstensen-Woll *et al* 2021), including between the NHS and social care, where people can often face challenges. This moves potentially replicates the silos that prevent this co-ordination.

At the same time, Healthwatch's role has evolved beyond insight gathering to include providing advice, co-production, advocacy and developing more asset-based approaches to working with communities. Decisions will need to be made about where all these functions should sit, balancing the benefits of integration against the risks of duplication or fragmentation, if split across multiple organisations. The strategic commissioning framework shows intent that patient engagement will form a key part of ICBs' strategic commissioning process and suggests that ICBs may be able to commission third-party organisations to do this work. However, it is not clear what funding will be available for these functions, with decisions on any changes to the funding regarding the transfer of local Healthwatch functions to ICBs not due to be made until after the legislation (Berry and Dalton 2025). At a time when ICBs are being asked to make significant cuts to running costs, the lack of clarity on what money will be available makes understanding what comes next even more difficult.

The absence of clarity at a national level is leading to confusion and speculation about what comes next. At the local level, some ICBs and local authorities are already involving local Healthwatch in discussions about retaining some kind of independent patient voice in the future. The risk here is that in the absence of a clear national direction, there will be very different arrangements in place across the country, with significant variation in terms of what is in place.

What could a new model look like at both national and local levels?

A new model could feasibly involve three tiers – national, regional and local – each of which could serve a distinct function. For example, the national tier could set standards and champion patient experience across government, a regional tier could convene partners and share learning, and local units could retain the core community-facing role, engaging directly with people and communities. This model needs to reflect joined-up listening between health and social care and avoid siloed working.

Aligning these tiers with the new structures emerging across the NHS, such as neighbourhoods, could help create a more coherent and streamlined approach. In particular, alignment could make it easier to share insight across the system, reduce duplication and ensure that intelligence gathered at the local level can flow upwards in a consistent way. However, challenges around footprints and boundaries remain, especially when trying to integrate insights across NHS and social care services, which often operate on different geographical footprints and therefore make joined-up analysis more difficult.

Care will be needed if engagement functions are outsourced to local organisations, including former Healthwatch providers, to preserve the networked approach that has been a major strength of Healthwatch and to avoid a fragmented landscape that weakens collaboration and shared learning. In some areas, local Healthwatch organisations have also found themselves competing against one another for contracts, influence or visibility; this has sometimes been counterproductive, creating duplication and diluting the collective impact of the network. At the same time, a degree of competition can be healthy – providing a mechanism for challenging poor-performing incumbents and encouraging innovation among providers. Balancing these dynamics will be essential, especially given the complexity and constraints involved in retrofitting a new function into existing system structures.

Leadership within the DHSC must drive system improvement while providing internal challenge

The proposal to establish a National Director of Patient Experience within the DHSC brings welcome visibility and focus to the patient experience agenda at the centre of government. However, its impact will depend heavily on how the directorate is designed, the authority and budget it is given and how it works with delivery organisations, local systems and existing networks towards shared objectives. Given that Directors of Patient Experience have previously existed within the DHSC and continue to do so within NHS England, it is important that lessons from these roles are systematically reviewed and used to inform both the design of the new post and how it is positioned within, and works across, the department and wider system.

A key strength of Healthwatch has been its ability to surface emergent issues through the collection of unsolicited feedback – highlighting areas such as dentistry and NHS administrative failures that were not being actively monitored by the system but were having a significant impact on patients. Any new patient experience function must preserve this capability by ensuring open, transparent routes for people to share their experiences and by establishing clear lines of accountability for how those insights are acted upon. Recent high-profile failures where people's voices were ignored or marginalised, including maternity care scandals (Department of Health and Social Care 2025c), underline that the conditions that led to the creation of Healthwatch have not disappeared.

The National Director of Patient Experience and their new directorate must play a powerful role in setting expectations, ensuring comprehensive and meaningful data collection and deploying levers and incentives that drive improvement across the system.

But responsibility for patient experience must be shared across all parts of the department, with policy areas such as urgent and emergency care, primary care, system transformation, and strategy each held accountable for their contribution to improvement. The same principle applies locally: national leadership should support the formation of networks that bring together heads of patient experience in providers, ICB engagement teams, councils that provide adult social care and place- and neighbourhood-level partners, addressing fragmentation and strengthening collective learning and action.

Ultimately, the credibility of the new function will rest on its willingness to challenge the system from within. This includes the ability to commission work that critiques departmental policies and to draw attention to inconvenient or uncomfortable truths about services for which the department is responsible. The DHSC's goal is to help people live independent, healthier lives for longer (Department of Health and Social Care, undated). So, this function should serve to challenge the system from within, to help the system achieve its own goals. Leadership will therefore be pivotal.

A national role 'inside the tent' has the potential to give patient experience the prominence it currently lacks, but only if it carries sufficient authority, visible cross-government reach and an explicit mandate to challenge and co-ordinate efforts across departments. The post holder must have the credibility to command attention and open doors – akin to the status afforded to roles such as the Chief Medical Officer – and must embed listening and learning as a core discipline across the system rather than confining it to a single directorate or policy area.

Patient experience must become core to the system

There is a significant opportunity to transform how the health and care system listens to people and communities. Historically, patient feedback has too often been treated as peripheral rather than central to the NHS's core mission. Actively listening to people about what works, what could improve their health and how services should be designed around their needs must become a fundamental priority.

Patient experience should not sit as a separate or marginal function. From the early 2000s until the middle of the past decade, there was a huge amount of work both at national and local levels to ensure patient voice and how people experience services were far more central to how the NHS runs (Wellings 2023). National initiatives were put in place on treating people with dignity and respect and involving people in decisions about their care and treatment. There is a clear opportunity to reconnect with that focus now. This moment enables the system to move beyond collecting views on existing services and towards a more mature model that listens, collaborates and works with people to shape meaningful change in how care is experienced.

Healthwatch has been one part of a much broader feedback landscape, and there is now an opportunity to bring greater coherence to how insight is gathered and used across the system. As new collection and analysis routes develop – including the NHS App and the use of digital and AI-enabled approaches – this is the right time to reassess the overall feedback architecture. While the NHS has long been effective at collecting data, it has been less consistent at acting on what it learns. Any future system must place action and improvement at its core, not collection alone.

We are at a moment when there is also an opportunity to rethink how the system hears from people affected by health inequalities. Existing mechanisms, including those used by Healthwatch, have faced challenges in reaching under-represented groups, yet many local organisations have built trusted relationships with those communities. Preserving and strengthening these connections will be critical if future approaches are to be fair, inclusive and genuinely representative.

Some of the most effective work involves designing services with people rather than just seeking feedback on individual services. National leadership, supported by a 'hub and spoke' model, can help embed this shift from consultation to co-design across the system, recognising the importance of both collective and individual voice.

To sustain system learning, the fate of existing Healthwatch datasets and analyses needs to be addressed: a national repository should be established, with a taxonomy that enables consistent demographics and topic coding across local bodies, building on the conventions Healthwatch England refined over time. At present, feedback lacks standardisation due to variable staff and non-uniform IT systems, as well as the lack of a national mandate for local collection methods. The new model should set out a small number of minimum data standards and a light touch common framework to ensure consistency, quality and comparability of insight across the system, enabling learning and action at regional and national levels. At the same time, it should avoid being overly prescriptive, allowing local teams the flexibility to prioritise issues relevant to their communities, respond to emerging concerns and use engagement approaches suited to local contexts.

The bigger picture

The emphasis on patient feedback in the 10 Year Health Plan is welcome, but listening alone is not enough. Any future models must focus not only on how people's voices are gathered but on how they are acted upon. Acting on what you hear is essential, and this relies on leadership and organisational cultures that genuinely prioritise the experiences and perspectives of those who use services.

While many organisations across the health and care system take this responsibility seriously, too many remain reluctant to listen, are unwilling to accept criticism and are often defensive. This gap is part of the reason Healthwatch was created in the first place. If these functions are to be brought inhouse, it will be vital to ensure the right conditions are in place to treat patient and public voice as a core tool for improvement – not an optional extra.

Bringing together the different parts of the system responsible for listening to people and communities with those that need to act on what they hear will be essential. With strong leadership, the right culture, clear governance and a commitment to transparency and multi-method data collection, there is a genuine opportunity to preserve the strengths of the Healthwatch model while adapting to new realities. Done well, this could ensure that patient and community voice is central to improving health and care services now and in the future.

Appendix: Our methods

Evidence scan

The King's Fund developed a set of guiding questions to inform the evidence scan conducted by Healthwatch England. The evidence scan provided information on the following:

- the history of Healthwatch – how and why it was set up
- how Healthwatch England and the network of local Healthwatch organisations work together
- the budgets allocated to Healthwatch England and local Healthwatch organisations
- how data is collected
- who Healthwatch hears from
- examples of impact.

Interviews

The King's Fund completed semi-structured, qualitative interviews with national and local stakeholders, all of whom had past or present experience of working in patient experience organisations or particular expertise in this area.

Interviewees were selected specifically for their national or local experience in patient experience roles (in the public and charity sectors) and/or their specialist knowledge of how patient and community voices are gathered and used. This ensured all participants could offer informed reflections on the Healthwatch model and alternative patient experience models.

In total, we completed six interviews: four of these were completed before the workshops (*see* below) and two were completed afterwards, with a more specific focus on testing our learnings from the workshops.

In each interview, we explored what can be learnt from the Healthwatch model and how the system should hear from patients and communities in the future.

Workshops

Workshop 1

This was a 90-minute online workshop with eight representatives from a range of local Healthwatch organisations.

We requested Healthwatch England select a sample that represented a mix of:

- organisational delivery models (*see* 'About Healthwatch' section)
- organisational size (by budget)
- coverage of urban and rural areas.

Healthwatch England aimed to put forward organisations that had not recently been involved in other research activities.

We aimed to recruit individuals with lead officer roles, as we believed they would be best placed to share day-to-day experiences of their organisations. We also requested individuals to represent a mix of genders.

In this workshop, we explored what can be learnt from the Healthwatch model, how the system should hear from patients and communities in the future and views on the current state of patient experience.

Workshop 2

This was a 120-minute in-person workshop combining national and local stakeholders. These included individuals connected to or with previous experience of working in: NHS patient experience functions, patient experience charities, national policy charities, health care membership organisations, local government, NHS England, the CQC, the DHSC, local Healthwatch and Healthwatch England.

Individuals with past or present experience of working in patient experience organisations or roles, or those with particular expertise on the topic, were invited to the workshop. Key national bodies were represented, as were patients and local Healthwatch organisations (suggested by Healthwatch England using a similar sampling approach as for Workshop 1, as summarised above).

In this workshop, we explored what can be learnt from the Healthwatch model and how the system should hear from patients and communities in the future. It involved group discussions, various activities and plenary sessions.

Analysis

Our approach to the data analysis was iterative and inductive. Interviews were recorded and summarised in an Excel framework to aid thematic analysis. Notes from the two workshops were also summarised in the framework. The King's Fund project team held a series of analysis sessions to draw together findings from the different activities.

The final section of this report, 'The King's Fund's reflections' is based both on what we heard and our wider work on patient experience and hearing from people and communities.

Limitations

Given the time-sensitive nature of this work, linked to the development of government policy in this area, the project was not intended to be a full evaluation of Healthwatch, nor did it include a cost–benefit analysis.

This was a qualitative study based on a relatively small, purposive sample. While participants represented a diverse group of stakeholders and came from a range of different organisations, the sample cannot claim to be representative of all views held.

Moreover, we recognise that those we spoke to who work for Healthwatch will have a particular perspective. We managed this by ensuring the research materials were balanced, asking respondents to reflect both on strengths and weaknesses of the model.

We took an analytical approach that was rigorously independent and drew on The King's Fund's long history of critically appraising how patient experience is used in the health and care system to contextualise what research participants told us.

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