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Working with Integrated Care Boards

How local Healthwatch engage, influence and adapt.

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How local Healthwatch engage, influence and adapt.

Survey findings, follow-up interviews and reflections on how different local Healthwatch engage with ICBs and the future of independent patient voice

PREPARED FOR

Healthwatch England

PRODUCED BY

The Advocacy People, on behalf of Healthwatch England

About this report

This report was commissioned by Healthwatch England and produced by The Advocacy People on its behalf in March 2026. It was produced during a period of significant national change – the Dash Review and the NHS 10 Year Plan proposed transfer of Healthwatch functions to the DHSC, ICBs and local authorities, with key details still to be confirmed. At the same time, ICBs are changing through mergers, clustering, governance redesign, and wider workforce pressures. This leaves organisations delivering local Healthwatch operating in a challenging and uncertain environment.

The report brings together survey findings from local Healthwatch on how they engage with Integrated Care Boards, alongside follow-up interviews that explore the practical realities behind those responses, to give a snapshot of how local Healthwatch are working and adapting in this challenging and uncertain environment.

Findings are grouped by theme rather than survey questions, to draw out practical learning for Healthwatch England, local Healthwatch and system partners.

ABOUT THE ADVOCACY PEOPLE

We are an independent charity that delivers advocacy services across southern England. We also deliver local Healthwatch services in Hampshire, Portsmouth, Reading, Southend, Somerset, West Berkshire and Wokingham

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Executive summary

This report was produced during a period of significant national change for both ICBs and patient voice arrangements. Following the Dash review and the publication of the NHS 10 Year Health Plan in July 2025, the government has signalled that the future architecture for patient and public voice is likely to change, including proposed transfer of Healthwatch functions to DHSC, ICBs and local authorities. The detail, timing and delivery model remain uncertain. At the same time, ICBs are changing through mergers, clustering, governance redesign, and wider workforce pressures. Against this backdrop, local Healthwatch continue to deliver their current statutory role, including gathering and sharing insight, while adapting to change and trying to protect independent patient voice.

Despite ongoing changes to integrated care systems, NHS guidance (NHS England » Working in partnership with people and communities: Statutory guidance) continues to recognise the statutory role of local Healthwatch. ICBs are expected to build on this role by working with local Healthwatch to coordinate and analyse user experience data, involve local people and communities, and contribute to Joint Strategic Needs Assessments (JSNAs) and Integrated Care Strategies. How these arrangements operate in practice is shaped by local system context, geography and resourcing.

This report draws on 21 survey responses and six follow-up interviews. Together, they show both current practice and a system responding to change.

Local Healthwatch engage with ICBs in different ways. The strongest arrangements usually combine formal roles, place-based working, trusted relationships and, in some areas, commissioned insight work.

Formal governance was the most common primary model reported in the survey, with 13 respondents saying they regularly sit on committees, forums or key boards such as Health and Wellbeing Boards. However, the interviews suggest that formal access alone is rarely enough. Influence often depends on credibility, persistence, good timing and trusted relationships.

Place-based working remains important. Many respondents said they gain the strongest traction at neighbourhood or place level, where relationships are closer and local knowledge is stronger. Several also warned that local insight can be lost when structures become larger and more remote.

Collaboration between local Healthwatch is now common. Eighteen respondents (86%) said they work with neighbouring Healthwatch. These partnerships can strengthen influence across larger footprints, but they need trust, clarity and enough capacity to work well.

Additional ICB funding can support useful engagement and insight work. Interviewees did not usually see funding itself as a threat to independence. The bigger concern was whether there was a clear route from evidence to action, and whether systems followed through on accepted recommendations.

The report also shows that Healthwatch can make a practical difference. Examples included work on the NHS 10 Year Plan, discharge and recovery, audiology and earwax services, patient transport and access to care. But direct impact is not always easy to prove. Often, Healthwatch influences and shapes thinking, strengthens a case for change, or helps decision-makers hear lived experience more clearly.

Our findings suggest that local Healthwatch are adapting to ICB change through a series of practical adjustments, rather than one uniform approach. These include working more collectively across wider footprints, rebuilding relationships as leadership changes, trying to shape future patient voice arrangements, leaning more on informal feedback routes, and becoming more consciously focused on transition. However, many respondents also stress that these adjustments are being made in a context of uncertainty, which means that local Healthwatch are often adapting without yet knowing exactly how the longer-term picture will settle.

The strongest message across the survey and interviews is that independent patient voice needs to remain visible, credible and connected to decision-making. This echoes the findings in the recent Kings Fund Report (March 2026). Participants emphasised the importance of strength at neighbourhood level alongside a formal route to influence at strategic level, whether that means retaining dedicated seats for independent patient voice in key governance and scrutiny structures, or alternative means. As systems change, clear routes for independent voice into governance, quality oversight and service improvement will become even more important.

Introduction

As ICBs evolve through mergers, boundary changes and shifting responsibilities, local Healthwatch need practical ways to keep gathering insight, influencing decisions and working together across larger footprints. They are already doing this through a range of approaches, including formal representation, engagement activity, escalation of patient experience, partnership working and involvement in service change. However, the context is shifting. Restructures, clustering arrangements, workforce reductions and wider changes in responsibility mean local Healthwatch must consider not only how to influence systems now, but also what the future of independent patient voice might look like in the context of the Dash Review and the NHS 10 Year Plan.

This report focuses on four linked questions.

- How are local Healthwatch currently engaging with ICBs?
- What helps or limits influence?
- How are local Healthwatch adapting to larger footprints, collaboration and changing structures?
- What does this tell us about the future of independent patient voice?

Methodology

A structured survey was sent to all 153 local Healthwatch through established Healthwatch networks and communication channels, with reminders and follow-up activity to encourage responses. The survey covered engagement with ICBs and place structures, governance touchpoints, routes to influence, collaboration, resourcing, examples of impact, and views on future risks and opportunities.

We received twenty-one survey responses, representing twenty-three local Healthwatch, an encouraging response given the short timescales for this project. Responses were gathered during a period of uncertainty about the future of independent patient voice and evolving ICB structures, which may also have affected both response rates and the emphasis respondents placed on future risks and possible future models. Responses included structured data and detailed free-text comments. Several also shared links or files with additional evidence and case study material.

Follow-up interviews were carried out with six local Healthwatch, covering a range of local Healthwatch models including standalone and hosted Healthwatch, Healthwatch working within a single Local Authority, multi-Healthwatch collaborations and merged Healthwatch covering large ICB footprints. They reflected very different geographies including urban, rural, coastal and mixed system areas from across England, and included County, Metropolitan Borough and City Healthwatch.

The interviews explored what works in practice, what makes ICBs act, funding, and how it affects or does not affect independence, and what respondents think is needed to protect independent patient voice in a changing system.

Findings are grouped thematically rather than by survey question. Case studies are used to show different models, challenges and outcomes.

It was agreed that responses would be anonymised. While the need to remove identifying information limited our ability, in some cases, to present specific examples, this approach enabled us to collect more, and more honest, insights from respondents, particularly given the proposed changes to NHS structures, and uncertainty about their roles and how patient voice will be harnessed in future.

Response profile

The survey received 21 responses from local Healthwatch across a range of ICB footprints. ICBs represented in the responses when the survey was carried out are:

- NHS Bedfordshire, Luton and Milton Keynes ICB
- NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
- NHS Cambridgeshire and Peterborough ICB
- NHS Cornwall and the Isles of Scilly ICB
- NHS Devon ICB
- NHS Lancashire and South Cumbria ICB
- NHS Mid and South Essex ICB
- NHS North East and North Cumbria ICB
- NHS Northamptonshire ICB
- NHS Somerset ICB
- NHS South East London ICB
- NHS South West London ICB
- NHS South Yorkshire ICB
- NHS Surrey Heartlands ICB
- NHS Sussex ICB
- NHS West Yorkshire ICB

Mapping this on to the new/proposed ICB footprints, we received responses from:

- NHS Central East ICB
- NHS Cornwall and the Isles of Scilly ICB
- NHS Devon ICB
- NHS Essex ICB
- NHS Lancashire and South Cumbria ICB
- NHS Northamptonshire ICB
- NHS North East and North Cumbria ICB
- NHS Somerset ICB
- NHS South East London ICB
- NHS South West London ICB
- NHS South Yorkshire ICB
- NHS Surrey and Sussex ICB
- NHS Thames Valley ICB
- NHS West Yorkshire ICB

This mapping is based on the current ICBs selected in the survey and then aligned to the new and proposed merged/restructured ICB footprints. Where one survey response covered more than one current ICB within the same proposed footprint, it has been counted once against that proposed footprint.

Among the responses, the most common primary model for engaging with ICBs was embedded formal governance, selected by 13 respondents. Four described commissioned activity in addition to core funding, Four described place-based partnerships as their main route, one described an ad hoc or relationship-led approach, and one selected 'all of the above'.

The most commonly reported forums were Health and Wellbeing Board or ICP-related forums, place-based partnership boards, ICB committees, and patient or public involvement groups.

Collaboration was widespread. Eighteen respondents said they collaborate with other local Healthwatch.

Additional ICB funding was also common. Sixteen respondents, 76%, said they receive additional funding from the ICB. Reported funding ranged from under £5,000 to more than £50,000.

The interviews add important context. They show that the same overall model can feel very different depending on the strength of relationships, the stability of ICB structures, the capacity of engagement teams, and whether local Healthwatch have routes into both place and system-level conversations (ICB and ICS). They also show that responses were gathered in a period of significant transition. Several interviewees described mergers, clustering arrangements, staff reductions and uncertainty about future roles and structures. This means the findings capture both current models of engagement and the early effects of system change on how those models are working. This wider uncertainty also forms part of the national context in which respondents were reflecting on the future of independent patient voice.

What we found

1. Local Healthwatch are using a mix of engagement models with ICBs

The clearest message from the survey is that there is no single model for engaging with ICBs. Local Healthwatch are using a mix of routes, and many described hybrid arrangements rather than one neat category.

Formal governance is the most common primary approach, selected by 55% of respondents. Most respondents (90%) have regular seats on key system or place committees linked to reporting, escalation or assurance, for example ICB Boards; ICB committees (e.g., Quality, People, Finance, Inequalities); Patient/public involvement or engagement committees/groups. This can create visibility and regular access, and can help local Healthwatch feed insight into live discussions rather than relying on ad hoc contact. It is worth mentioning that some Healthwatch report that they have, or will shortly lose their place on the board, as ICBs are having to reduce the size of their governance. This raises the question of how to ensure the ICB continues to hear patient voice at that strategic level.

Place-based engagement also matters. 20% of respondents described their strongest traction through place teams, neighbourhood structures and local partnership forums. Others described commissioned or contracted work, especially where Healthwatch had been asked to carry out engagement or insight work on behalf of the ICB. This is consistent with NHS England's statutory guidance on working with people and communities, which says ICBs should work with partners

including Healthwatch and should have arrangements for gathering and using community insight in decision-making and quality governance. The guidance does not prescribe a single governance model, but it does reinforce the expectation that local intelligence should inform both planning and accountability. As this report is being prepared, NHS England is updating the guidelines to accompany this guidance.

Collaboration helps. In some areas, several local Healthwatch work together so that system leaders hear a coordinated message across the whole footprint. In others, collaboration is more informal, through shared calls, memoranda of understanding or a lead Healthwatch role.

The interviews sharpen this picture. For example, in the Sussex ICB area, collaboration across three local Healthwatch has developed over time and now includes a memorandum of understanding and regular insight-sharing with the ICB. Within the Bedfordshire, Luton and Milton Keynes ICB footprint, four local Healthwatch have built a collaborative arrangement that helps them work through differences, coordinate messages and use different relationships to gain traction. In South West London, clustering is prompting local Healthwatch to organise collectively so they can engage with a new shared executive team.

Taken together, the evidence suggests five broad models: governance-led, place-led, commissioned insight, collaborative footprint working, and blended models that combine more than one of these. In practice, the strongest arrangements usually combine formal access, local relationships, and evidence shared at the right moment to influence a live discussion, decision or piece of work. The survey and interviews suggest these models are also being used more flexibly as ICBs change. In some areas, collaboration across a wider footprint has become more important as services are commissioned at system level. In others, local Healthwatch are relying more heavily on place relationships, regular insight-sharing or less formal routes while governance and leadership structures are in flux.

The table below summarises the main models identified through the survey and follow-up interviews. In practice, many local Healthwatch combine elements of more than one model.

Model	What it looks like	Where it works best	Main strengths	Common risks
Governance-led	Regular seats on ICB, place or partnership forums, with insight raised through standing governance routes.	Systems with clear committee structures and named senior contacts.	Visibility; formal access; routine escalation; easier link to assurance and oversight.	Can become presence without influence; local issues may not get enough agenda space; weak follow-through.
Place-led	Influence is built mainly through place, neighbourhood or local partnership relationships, with issues then escalated upwards.	Areas where local relationships are strong and practical problem-solving happens at place level.	Strong local knowledge; practical traction; closer connection to communities and lived experience.	Local insight may not travel into system decisions; larger footprints can flatten local differences.

Commissioned insight / contracted	The ICB funds Healthwatch to deliver specific engagement, research or insight activity in addition to core arrangements.	Where the system needs focused engagement, deep dives or independent evidence on a live issue.	Flexible; can generate detailed independent insight; shows clear added value to the system.	Short-term or project-based; unfunded expectations; independence must stay visible; weak system ownership.
Collaborative footprint	Several local Healthwatch work together across a wider ICB footprint through a network, MoU, lead role or shared priorities.	Larger or merged footprints where one local Healthwatch alone cannot represent the whole system.	Stronger system voice; pooled intelligence; wider reach; shared priorities across a larger footprint.	Coordination burden; uneven capacity; competition or different local pressures; place-level issues can get lost.
Blended model	Combines formal governance, place relationships, collaborative work and commissioned activity rather than relying on one route.	More mature systems where Healthwatch works across several levels and needs flexibility.	More resilient; multiple routes to influence; adaptable when structures change.	Can stretch capacity; priorities can become unclear; over-reliance on a few key staff relationships.

2. Access helps, but relationships and follow-through determine influence

Respondents were broadly positive about the routes they had into ICBs, but more cautious about how consistently those routes led to action. Confidence that ICBs would act on issues raised was mostly in the middle range, clustering around 3 or 4 out of 5 rather than at the top end.

This suggests an important distinction between access and influence. The overall picture is not one of exclusion, as many local Healthwatch are already in the room. The issue is whether there are clear mechanisms for turning that access into visible, timely change. This echoes the Kings Fund Report findings.

The survey points to four things that help local Healthwatch influence ICBs.

- Trusted relationships. The most common contacts were engagement leads, place teams, quality and patient safety colleagues, communications teams and strategy leads. Respondents often described influence as something built over time through visibility, credibility and constructive challenge. Several respondents described this becoming harder in the current climate as key contacts leave, roles are merged and new leaders take up posts. In that context, influence can become more fragile, even where formal access remains in place.
- Timing. Several responses suggested that Healthwatch is most effective when involved early in live system work, rather than being asked to comment after plans are already largely set. One interviewee described this clearly in relation to engagement on the NHS

10 Year Health Plan, where early involvement helped reach more than 3,500 residents and feed local views into wider planning.

- Evidence. Respondents repeatedly suggested that ICBs are more likely to act when insight is specific, timely and clearly linked to a current system issue. This was especially strong in examples where local Healthwatch brought focused evidence about a particular service, pathway or group of patients.
- Follow-through. Some respondents described strong feedback loops and ongoing dialogue. Others described a less consistent picture, where insight was received but the route to action or response was unclear. Some interviewees also suggested that change within ICBs is weakening follow-through. Recommendations may be accepted in principle, but restructures, reduced capacity and unclear ownership can make it harder to track what happens next.

Some respondents also suggested that action depends on whether the ICB actually holds the relevant levers. In one large system working on a principle of subsidiarity, influence was felt to sit increasingly at place, provider partnership and neighbourhood level, with Healthwatch able to shape agendas and create a people's voice route within committee structures, but finding that cross-system action was harder where strategic priorities did not fully match the issues communities most wanted addressed.

The interviews also highlight a softer form of influence. Several interviewees described how local Healthwatch makes it easier for NHS staff to hear lived experience by turning large amounts of feedback into accessible reports, briefings and themed summaries, even where this does not lead to a simple, attributable line of impact. One interviewee explained how their organisation helped NHS staff hear patient voice by doing the work of gathering, analysing and presenting people's experiences in a format that leaders could use. Another described an ongoing arrangement for regularly sharing local insight with ICB staff so that public concerns could feed into live conversations and planning. A third described large-scale engagement that gathered thousands of views and translated them into outputs used by system leaders in wider planning discussions. In these examples, the impact was not always a single attributable decision, but a clearer understanding of patient experience that shaped priorities, strengthened the case for action and improved the quality of discussion.

3. Place often provides the strongest route to practical traction

A strong theme in the survey is that place and neighbourhood structures often provide a practical route to influence, even when strategic decisions sit at ICB level. Although only 19% of respondents described place-based partnerships as their primary model, 85% said they engage through place-based partnership boards and 75% identified place directors or place teams as regular contacts.

An example from a West Yorkshire Healthwatch captured this clearly, describing how place-based work is effective because of strong relationships with the place team and population health colleagues. Their work on access to services led to the creation of a steering group to develop a

referral pathway, bringing together partners across the ICB, acute trusts, mental health providers and children's social care.

Other respondents made similar points in different ways. Some described neighbourhood or integrated community team relationships as becoming more important. Others stressed that future arrangements still need to stay local. One described working across neighbourhood, place and strategic structures, with a clear view about what should sit at place level and what belongs in strategic commissioning.

For some respondents, this appears to be becoming more important as wider system structures grow, become more remote, or are reconfigured through clustering and merger arrangements. Place-level work can create more immediate traction, especially around access, communication, pathway gaps and neighbourhood inequalities.

The interviews reinforce this. One local Healthwatch described a large, partly rural area where face-to-face engagement remains essential because some communities are remote and digital access is uneven. Others described local population groups whose voices are already at risk of being missed, including people with significant communication barriers, people with severe mental ill health and people with low health literacy. Their concern was that if local routes weaken, these voices may disappear from the system altogether.

The challenge is what happens next. Several respondents suggested that local insight does not always travel cleanly upwards into system-level decisions. Where system structures are large, remote or changing quickly, there is a risk that local differences become flatter and less visible.

The implication is not that system-level engagement matters less. It is that place and system need to connect better. It was felt by respondents that the strongest models are those where local Healthwatch can use place relationships to identify and evidence issues, and also have a clear route to raise those issues into wider decision-making.

4. Collaboration is becoming more important as footprints grow and structures change

The survey strongly suggests that collaboration between local Healthwatch is no longer optional in many systems. Eighteen of the twenty-one respondents said they collaborate with other local Healthwatch.

The interviews suggest that greater collaboration is increasingly a response to change. As footprints widen, leadership is shared and long-standing relationships shift, local Healthwatch are using collaboration to maintain visibility, protect local voice and engage new leadership more effectively.

For some, this is formal. Six respondents described a formal consortium or memorandum of understanding model. Others described informal coordination, an agreed lead Healthwatch or a shared work programme. The models vary, but the direction is clear: wider footprints require local Healthwatch to work together if they want to influence at system level.

South West London is a strong example: a collaborative covering six local Healthwatch, supported by a South West London Healthwatch Executive Officer funded by the ICB and hosted

by one local Healthwatch. Respondents also described how clustering with South East London is prompting an even wider collective approach, with local Healthwatch planning to meet the new shared executive team together rather than individually.

Sussex provides another example, where long-standing collaboration between the three local Healthwatch across the Sussex footprint, which has become more important as more services are commissioned at system level. Other local Healthwatch gave a similar message from a more fragile position: collaboration across small local Healthwatch has allowed them to speak with one voice where it counts, but it relies on trust, compromise and informal effort.

Collaboration is not effortless. Respondents and interviewees described barriers including different organisational cultures, capacity pressures, staff turnover, personality clashes, funding differences and uncertainty about future structures. One respondent also explained how, due to the reduction in ICB budgets, the funded roles that support the collaborative within that ICB footprint are ending from June 2026.

The lesson is that collaboration can strengthen influence, but it works best where there is clarity about roles, trust between organisations, realistic expectations and enough capacity to coordinate.

5. Additional funding can unlock useful work, but independence must remain visible

Sixteen survey respondents said they receive some additional ICB funding. This ranged from small amounts to more than £50,000. The most common purposes were engagement programmes, research or insight work, and inequalities work, although one respondent also framed funding as supporting the core Healthwatch role of bringing independent challenge and insight into decision-making spaces. In most cases, funding appears to have come through direct approach from the ICB or a relationship-led process, rather than a formal competitive model.

This suggests that in many areas, additional funding is being shaped pragmatically around trust, need and opportunity rather than a standard national template. It also suggests that as ICBs change, funded work may become more uneven, with some systems reducing capacity while others continue to use commissioned engagement and insight to fill gaps in their own reach.

There are clear benefits. Commissioned work can allow local Healthwatch to carry out deeper, more focused engagement. It can give the system access to independent insight it might not otherwise gather. It can also create a route for Healthwatch to shape live priorities rather than only commenting from the outside.

A South East London Healthwatch talked about the value of being commissioned to carry out independent deep dives into services or pathways. They described how this kind of work gives the system a more detailed and trusted understanding of where services work well and where improvement is needed.

The interviews show how this works in practice. For example, local Healthwatch in the South were commissioned to carry out engagement and delivered one of the strongest examples in the dataset, reaching around 3,500 people through workshops, events and other activity. Another Healthwatch described a smaller but more formalised model, where ICB funding supports

capacity for representation and insight-sharing under a memorandum of understanding. Another interviewee described project funding, including £50,000 for each of the local Healthwatch within their ICB footprint for a year-long programme, but was clear that the money did not fully solve the infrastructure challenge.

As regards maintaining independence, interviewees did not usually present funding itself as a threat. For example, memoranda of understanding make clear that funding supports capacity and will not influence findings or outcomes. A bigger issue was lack of ownership and follow-through after recommendations had been accepted.

Respondents were still clear about the risks. If independent patient voice is funded directly by the system, governance and culture need to protect independence. Several respondents warned against models where patient voice becomes internalised within the system it is supposed to scrutinise. Others argued that provider-led or commissioner-led engagement should complement, not replace, independent voice. One interviewee expressed this starkly as a risk of 'marking your own homework'.

A related tension was also raised during the interviews - systems may value Healthwatch outputs, but not always recognise the resource and infrastructure needed to produce them. Respondents also highlighted sustainability. Some areas described high levels of influence but very limited capacity. Others said they were already doing substantial unpaid or under-resourced work. This raises a practical question for the future: if systems want organisations like local Healthwatch to contribute meaningfully at system level, what level of infrastructure are they willing to fund to enable this to happen?

Overall, the evidence suggests that additional ICB funding can be valuable, provided independence remains visible, expectations are realistic and there is a credible route from evidence to action.

6. Impact is often real, but direct attribution is not always clear

The survey included a strong set of practical impact examples, moving the discussion beyond whether local Healthwatch are involved, to what difference that involvement can make.

Respondents described influence on service redesign, quality and safety, inequalities work, patient experience and funding for specific pieces of work. For example:

- One respondent described how their local Healthwatch brought women's health concerns to the ICB, used comparisons with neighbouring areas to show variation in provision, and kept the issue live through follow-up over 2025/26. This contributed to changes in commissioned services and a commitment to a formal women's health strategy in the new commissioning model.
- Another told us how their work with children and families led to a new multi-agency pathway being developed where no pathway had previously existed, bringing together commissioners, acute, mental health and children's services.
- One local Healthwatch escalated problems with an audiology pathway. The ICB responded with an improvement plan and commissioned additional provision.

- A report on access to a primary care treatment pathway led to clearer messages to practices and patients, reminders about referral routes, better public information, and action to reduce inequality barriers such as translation support.
- In one area, insight on support for people waiting for care led to a co-designed framework for a more consistent and equitable offer. Separate transport work in the same system resulted in a bus route being moved closer to healthcare facilities and travel support being provided for people who could not afford appointments.
- Another respondent described a deep dive into discharge and recovery at home. Feedback from patients, families and staff was used to improve coordination between hospital and community teams, strengthen discharge guidance, and link people more effectively to community support.
- One respondent said that using videos and soundbites in committee meetings helped bring lived experience directly into senior decision-making, while focused work with seldom heard groups informed future service planning and an inclusion health strategy.
- Respondents also described impact through additional funding, including support for lived-experience participation groups and targeted engagement work to inform commissioning and strategy.

The interviews do not undermine this picture, but they complicate it in a useful way. People described how Healthwatch influence is often real, but hard to pin down. Reports may shape thinking, support a business case, reinforce concerns already known within the system, or make it easier for decision-makers to hear lived experience. That can lead to change, but it does not always produce a clear statement saying the change happened because of Healthwatch evidence.

They also described the long game of influence. For example, one interviewee described how their work on patient transport led to positive action because Healthwatch kept returning to the issue over several years, through engagement, commissioning, procurement, contract KPIs and later assessment of the new provider. This is a useful reminder that impact is not always quick.

The interviews suggest that impact should be understood in more than one way: direct service change, clearer commissioning choices, stronger accountability, improved understanding of lived experience, and the quieter day-to-day influence that comes from being a trusted critical friend. This may become more pronounced during periods of change, when decisions move quickly, responsibilities shift and local Healthwatch can help shape thinking without always being visibly linked to the final outcome.

7. The central strategic issue for local Healthwatch who responded is the future of independent patient voice

While not the primary focus of the project, the strongest cross-cutting theme in both the survey and interviews is concern about the future of independent patient voice.

As well as describing current engagement models, respondents also reflected on what might be lost if independent patient voice becomes weaker, more fragmented or more internal to the system. The interviews suggest this concern is not only about the future. In several areas,

respondents already feel that restructures, staff loss and changing governance are weakening established routes for independent voice.

Several specific risks recur. One is the loss of formal routes into decision-making. One Healthwatch in the South described the loss of a seat at the Board as a real reduction in the ability of community voice to reach senior leaders and decision makers within the ICB, while the ending of Healthwatch representation at South West London ICB Board meetings was highlighted as a missed opportunity. Several emphasised the importance of retaining dedicated seats for independent patient voice in key governance and scrutiny structures. One interviewee explained – 'At in person ICB meetings you can have independent patient representatives who say, this is my lived experience. That is powerful, it will make the ICB engaged because it's much harder to ignore someone who's sitting in front of you, who's telling you things.'

A second risk is reducing patient voice to a general insight or engagement function. It was felt strongly that patient voice needs to connect to contract monitoring and provider accountability, not just to strategy and population health conversations. Several interviewees expressed concern that systems can become comfortable collecting and summarising insight, but less comfortable acting on what it reveals or using it to hold providers to account.

A third risk is over-reliance on provider-led or system-led engagement. An explicit parallel was drawn with self-monitoring, arguing that internal models risk letting organisations mark their own homework. System-led engagement can be useful, but it should not be treated as a substitute for independent voice. One interviewee described concerns that the voices of local population groups whose voices are already at risk of being missed, including people with significant communication barriers, people with severe mental ill health and people with low health literacy, and those already disengaged with the NHS and other professionals, may disappear from the system altogether

The interviews also highlight how quickly established routes can weaken when structures change. Interviewees all described the loss of key relationships as staff leave, retire or take voluntary redundancy in response to recently announced changes, and, while it is too early to measure the full impact, feel that it is likely to affect levels of engagement with their ICBs, at least in the short term.

At the same time, respondents and interviewees pointed to a way forward. They argued for independent patient voice to be involved earlier and more consistently in decision-making, for clearer governance routes, more realistic funding, stronger place-to-system feedback loops and a clearer shared understanding that independent insight is part of system intelligence and accountability, not a peripheral engagement exercise.

Conclusions

The survey and interviews show that local Healthwatch are already engaging with ICBs in a wide range of credible and often effective ways.

There is no single best model. The strongest arrangements are usually blended, combining formal access, local relationships, timely evidence, and routes into both place and system decision-making.

Many local Healthwatch appear to gain their strongest traction through place and neighbourhood relationships, even where strategic decisions sit at system level.

Collaboration is also important. As footprints grow and structures shift, local Healthwatch increasingly need shared approaches at system level. But collaboration needs time, trust and enough infrastructure.

Additional ICB funding can be valuable. It can unlock focused engagement and insight work that systems find useful. But the bigger question is whether systems create clear routes from evidence to action while keeping independence visible.

A key strategic finding is about the importance of independent patient voice. The issue is not whether systems will continue to gather feedback, but whether they will keep credible, independent and well-connected routes for community insight to influence decisions, shape accountability and challenge the system where needed.

Change itself is now part of the operating context. Local Healthwatch are responding pragmatically, but the current level of restructuring and uncertainty is already affecting relationships, continuity and routes into decision-making.

Reflections

For the DHSC

1. Preserve independent patient voice as part of governance, accountability and improvement.

The DHSC should ensure that any future patient voice model preserves the conditions that make independent voice effective: independence, strong local reach, rich unsolicited insight, and clear routes into strategy, governance and accountability. It should make the case nationally that independent patient voice is not just an engagement function and help shape clearer expectations about how independent patient voice connects to governance, quality oversight, contract monitoring and decision-making.

For Healthwatch England

2. Share practical learning on engagement and collaboration models.

Local Healthwatch are working with ICBs in different ways, including governance-led, place-led, commissioned and collaborative footprint models. Healthwatch England should continue to share what helps these models work well, and how local insight can remain visible in larger or changing systems.

For ICBs and system partners

3. Build independent patient voice into decision-making early, and link it to accountability and follow-through.
ICBs should involve local Healthwatch and independent patient voice, early enough to help shape live discussions, service reviews and commissioning decisions, rather than asking for views once plans are already well advanced. They should also have clear and visible arrangements for receiving insight, identifying who is responsible for responding, recording what action will be taken and closing the loop through feedback. If ICBs remove local Healthwatch seats on the board, they must consider how they will continue to receive that insight and ensure independent patient voice doesn't just sit within engagement or communications functions, but feeds into governance, quality oversight, contract monitoring and service improvement.

4. Protect strong place-level as well as system-level routes.
ICBs should make sure local insight can be raised and acted on at place level as well as through wider system structures. Many respondents said place-based routes often provide the strongest practical traction, particularly where local relationships and community knowledge are strongest.

5. Commission independent engagement and insight work transparently, with clear safeguards and realistic resourcing.
Additional ICB funding can support valuable work and does not automatically weaken independence. However, commissioned work should be transparent, realistically resourced, and supported by clear expectations about independence, ownership and action.

For local Healthwatch

6. Link insight to live decisions and continue evidencing both impact and influence.
Influence is strongest when evidence is specific, well-timed and connected to a live issue, service review or commissioning decision. Local Healthwatch should continue to demonstrate value through clear examples of change, and also through the quieter work of shaping thinking, strengthening the case for action and acting as a constructive critical friend.

For Local Authority Commissioners

7. Support Collaboration where footprints require it, while retaining strong local intelligence.
As footprints grow and structures shift, collaboration is increasingly important. However, local differences can be lost in larger systems. Collaborative working should strengthen system-level influence without weakening place-level understanding. Local Authority commissioners should ensure contracts, funding levels and work programmes give local Healthwatch enough capacity to collaborate across wider footprints where needed, while retaining strong place-level intelligence and community relationships.

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